Advancing Behavioral Health Equity in Primary Care

Building a Data-Informed Culture

August 31, 2022 | 12-1:30pm

CCI CENTER FOR CARE INNOVATIONS + California Health Care Foundation + ADVANCING BEHAVIORAL HEALTH EQUITY

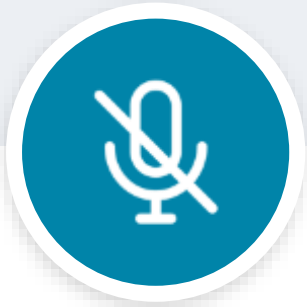
While you are waiting…

****

Please rename yourself by adding your organization's name.

How: Right-click on your name in the Participant list, and click, "Rename"

Housekeeping



Mute

Minimize Interruptions

Please make sure to mute yourself when you aren't speaking.

Chat

Go Ahead, Speak Up!

Use the Zoom chat to ask questions and participate in activities.

Naming

Where Are You From?

Please rename yourself and add your organization's name.

Tech Issues

Here to Help

Chat Brianna Harris privately if are having issues and need tech assistance.

Update Your Zoom Name

Click on "Participants" Icon	Click "Rename"	Type Name and Click "Ok"

Welcome!

Welcome ABHE Teams!

華埠服務中心
Chinatown Service Center

CHC
Community Health Centers
Healthcare For Life

EISNER HEALTH

"Healing with Heart"
Elica
Health Centers

KCS

LAC+USC
HEALTHCARE NETWORK

MARIN CITY
Health & Wellness Center

Petaluma
Health Center

Samahan
HEALTH CENTERS

Santa Barbara
Neighborhood Clinics
Quality Affordable Healthcare

achievable

UCDAVIS
HEALTH

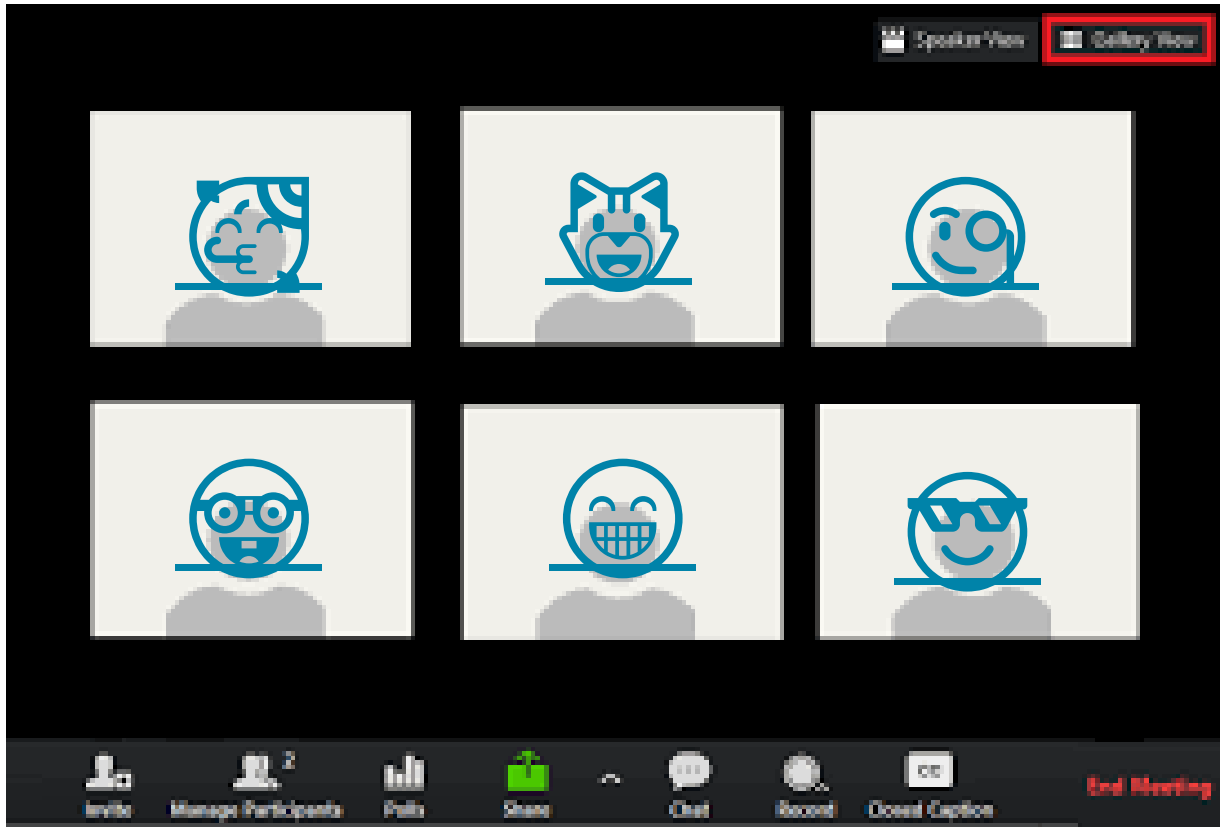
VALLEY SPRINGS
HEALTH & WELLNESS CENTER

ViaCare
community health center

Cohort Photo!

Instructions

1. Unmute yourselves, turn your cameras on and wave!
2. We will be taking three group photos.
3. We will take screen shots of everyone in gallery view.



Setting the Stage

Agenda

1. Leveraging Your Data Sources
2. Best Practices: Using Data to Improve Outcomes
3. Breakouts: Reflecting on Today’s Lessons
4. Storyboards: Sharing Your ABHE Journey
5. Closing and Next Steps

Invitation:

As you listen to our speakers, we encourage you to identify best practices that you can adopt at your clinic. You'll have an opportunity to share these during breakouts.

Today's Objectives

By the end of our session today, you will ...

1. Strengthened their practice of aligning all ABHE data to drive learning and improvement

2. Identifying gaps in the relationships and processes that contribute to a data-driven culture

3. Established action steps to improve daily data practices to drive improvement

4. Gained clarity on the purpose and process for completing the final storyboard, and how it will be informed by current activities

Introductions

CCI Team

Juliane Tomlin, (she/her)
Program Director

Juan Carlos (he/him)
Program Manager

Briana Harris-Mills (she/her)
Program Manager

Lydia Zemmali (she/her)
Program Coordinator

Joining us today…

Jerry Lassa
Metrics & Analytics Consultant
Data Matt3rs

Danielle King, PsyD
Director of Clinic and
Community Collaborations
Cherokee Health Systems

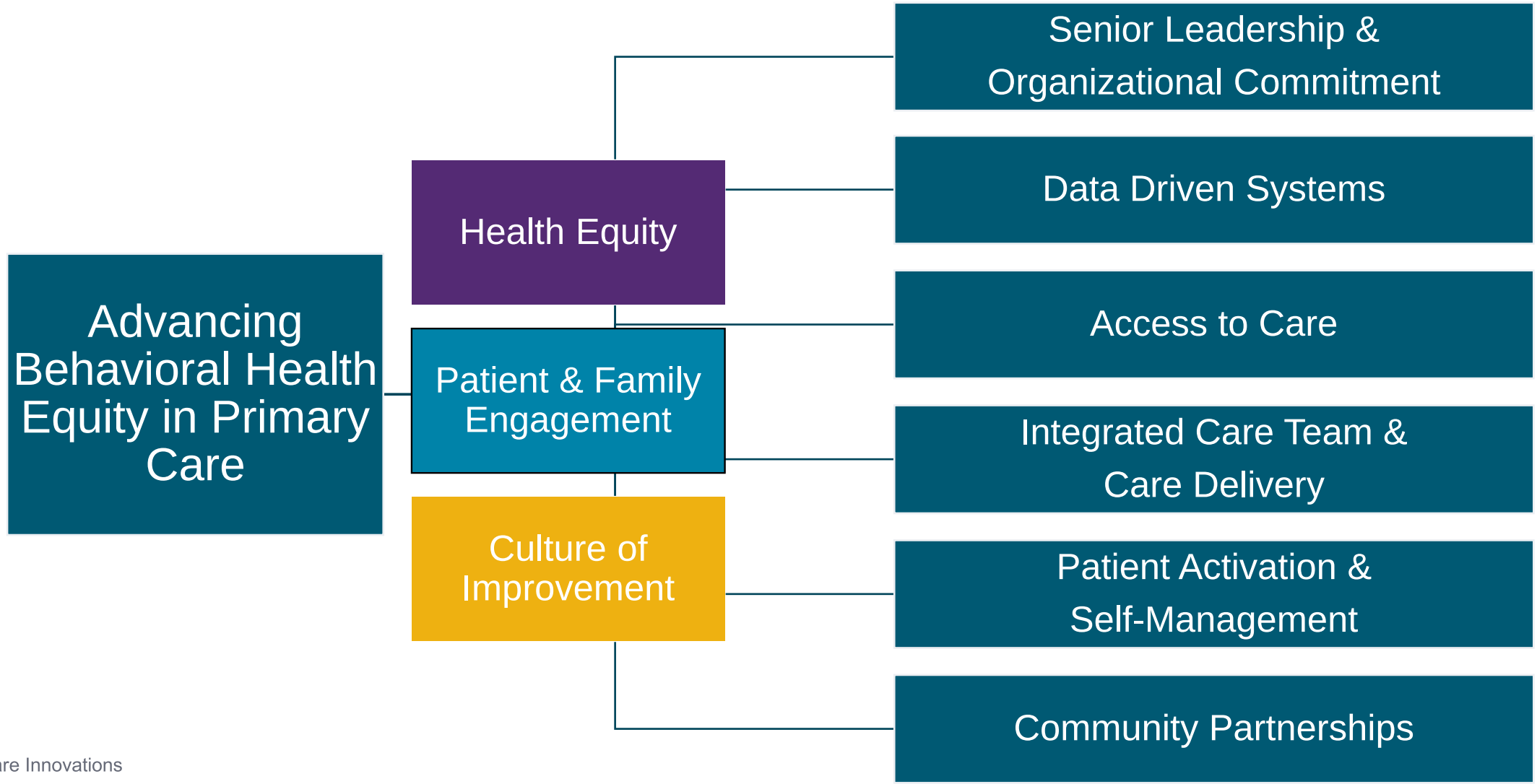
Andy Rhea
Chief Information Officer
Cherokee Health Systems

Reviewing Team’s Progress

ABHE Program Timeline

	2021			2022				2023		
	OCT-NOV	DEC-JAN	FEB-MAR	APR-MAY	JUN-JUL	AUG-SEPT	OCT-NOV	DEC-JAN	FEB-MAR	APR-MAY
Phase	COMMIT, COLLECT, CHOOSE			COLLABORATE & LEARN		HARVEST, INTEGRATE, IMPLEMENT			RE-COMMIT, SPREAD, SUSTAIN	
Events	Kick-off (11/3)	Learning Session 1 (12/2)	Topical Webinar 1 (3/3)	Learning Session 2 (5/18)		TW 2 (8/31)	LS 3 (10/26)	TW 3 (12/14)	TW 4 (TBD)	LS 4 (TBD)
Deliverable (Data)	CAT Baseline	Data Abstraction	Patient Interviews Patient Surveys Project Roadmaps	UMS Data Submission Revise Roadmaps	Q1&2: Reflection Q1&2: Dashboard	CAT Midpoint	Q3: Reflection Q3: Dashboard			CAT Endpoint Story boards
Activities				• Test / Refine / Implement • Collect Improvement Data • Quarterly Progress Reports • Collect Stories / Communications Activities				• Develop Draft Storyboard		

Where We Are Focusing



Strengthening Team's Use of Project Tools, Data and Measures

Team Data & Measures Journey

Project AIM statement & Roadmap

Q4 2021

(1)
Patient Interviews & CAT

What areas do we have the most opportunity to impact for our patients?

What aligns with our organization strategy? (e.g., pops of focus, site focus, clin/ops/fin goals)

Q1 2022

(2)
Universal Measure Set

Further refine focus: What measures do we have the most opportunity to impact?

How do these align with the CAT and our areas of focus?

Q2 2022

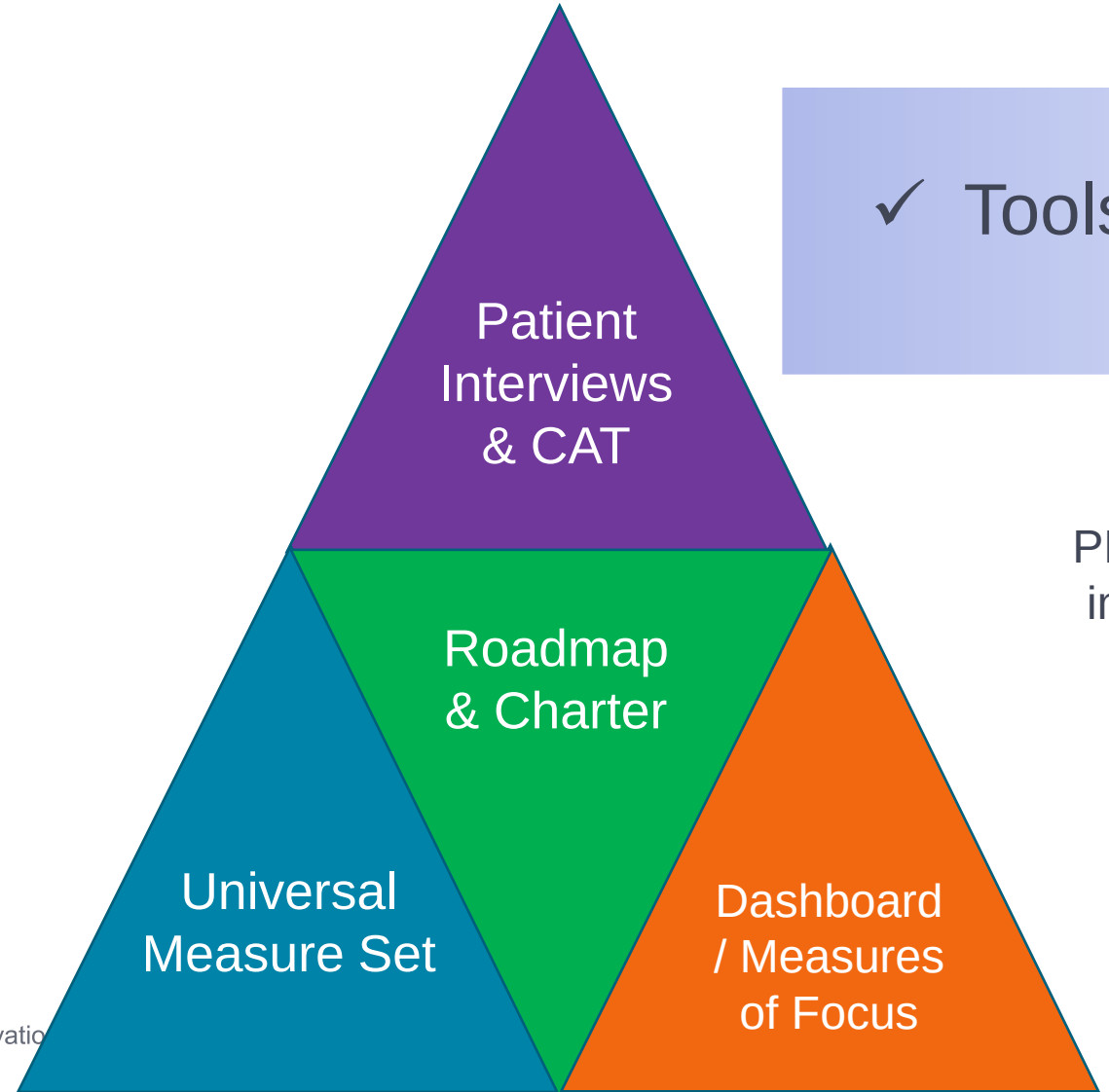
(3)
Dashboard / Measures

What process measures will help balance the universal measures?

What measures should we monitor routinely in a dashboard?

Identify opportunity, make change, monitor and improve.

Assessing Program Impact



✓ Tools to guide team focus

PDSA cycles to test change and improve measure performance

Putting the pieces together

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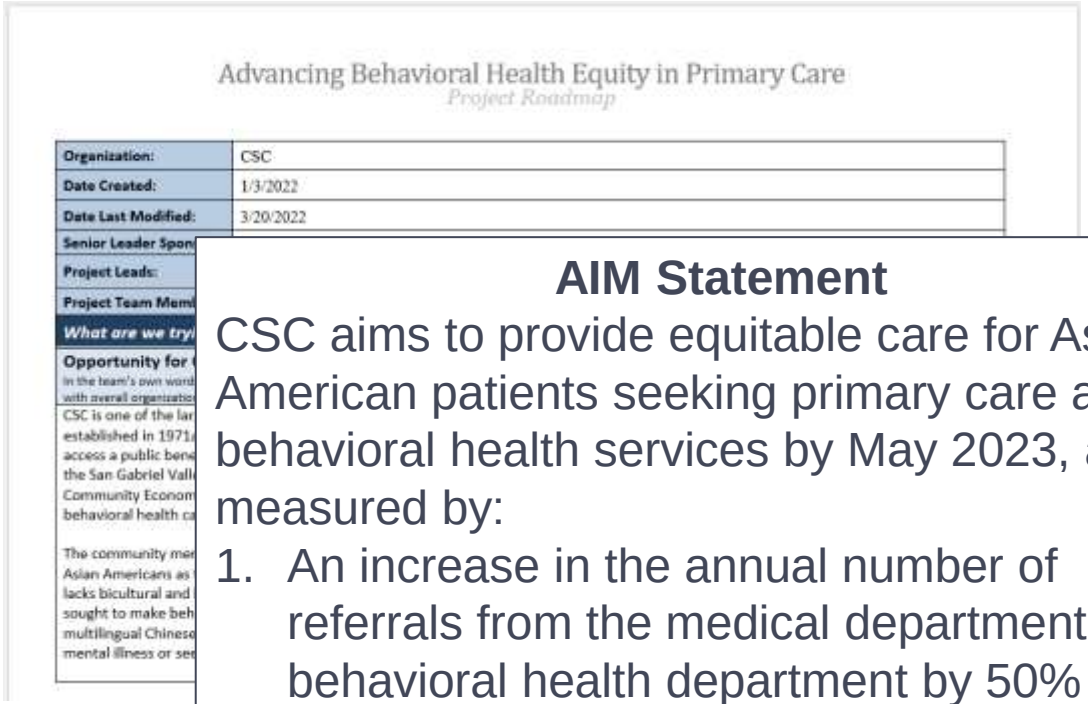
Chinatown Service Center

What are we trying to achieve?

Roadmap & Charter



Advancing Behavioral Health Equity in Primary Care

Project Roadmap

Organization:	CSC
Date Created:	1/3/2022
Date Last Modified:	3/20/2022
Senior Leader Spon	
Project Leads:	
Project Team Mem	
What are we try	
Opportunity for	

AIM Statement

CSC aims to provide equitable care for Asian American patients seeking primary care and behavioral health services by May 2023, as measured by:

1. An increase in the annual number of referrals from the medical department to the behavioral health department by 50% (from 210 referrals in 2021 to 315 referrals)
2. An increase in patients in screened for depression from 74% to 90%

Putting the pieces together

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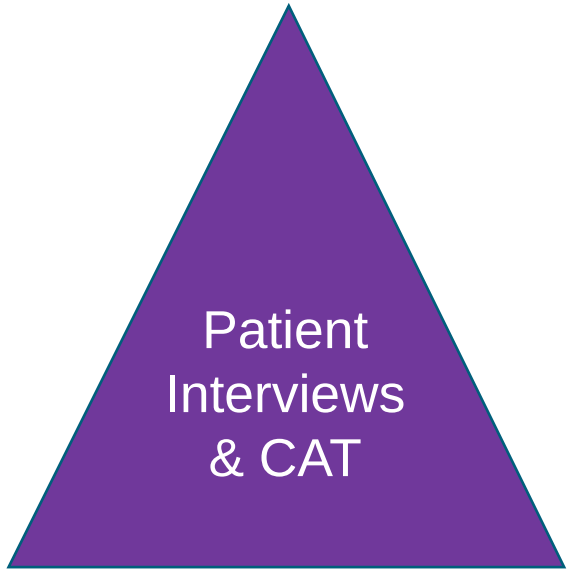
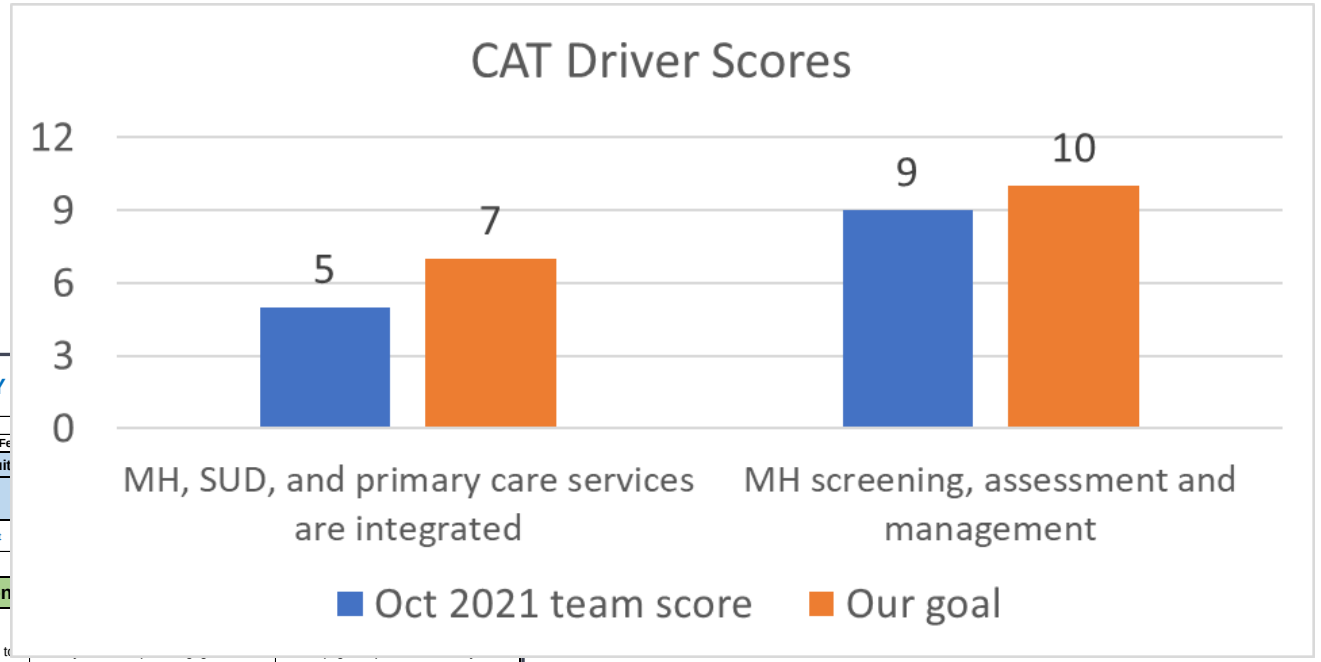
Chinatown Service Center

Patient Interviews



Where can we improve capabilities to better serve our patients?



ADVANCING BEHAVIORAL HEALTH EQUITY IN PRIMARY

	Organization Name:	Chinatown Service Center					
	Team members/roles	Chun Mei Lam, Nina Loc, Matthew Wong, Janet Yu, Jack Cheng, Angela Ching, Fe					
		Behavioral Health Equit					
	Drivers (Primary, Secondary)	Preliminary			Intermediate I		
	How many of the approaches described are deployed?	Some	Many	Most	Some	Many	Most
Driver #	Score:	0	1	2	3	4	5
	Senior Leadership & Organization						
SL&OC-2	**Listening to the voice of all patients.**	The health center staff wants to improve BHE, but patient and client input to improve BHE care, address unmet social needs, and reduce barriers to care is obtained indirectly (e.g., through patient comments and surveys). A more focused and structured approach is being considered.			Patients and clients are authentically engaged in understanding of their life experiences, how to improve access to care and information, and how to improve communication and collaboration with the care team. Staff members meet regularly with patients and clients to better understand community strengths, challenges, and historical disinvestment so they can effectively provide BHE care.	regular meetings using mixed modes (in-person, mail, email, smartphone, etc.) to inform equitable care practices. Staff actively build relationships with the community and community partners to understand BHE needs and provide equitable care.	advisory councils or boards, focus groups, peer navigators) and drive strategic efforts to improve BHE in meeting their whole care needs.

Putting the pieces together

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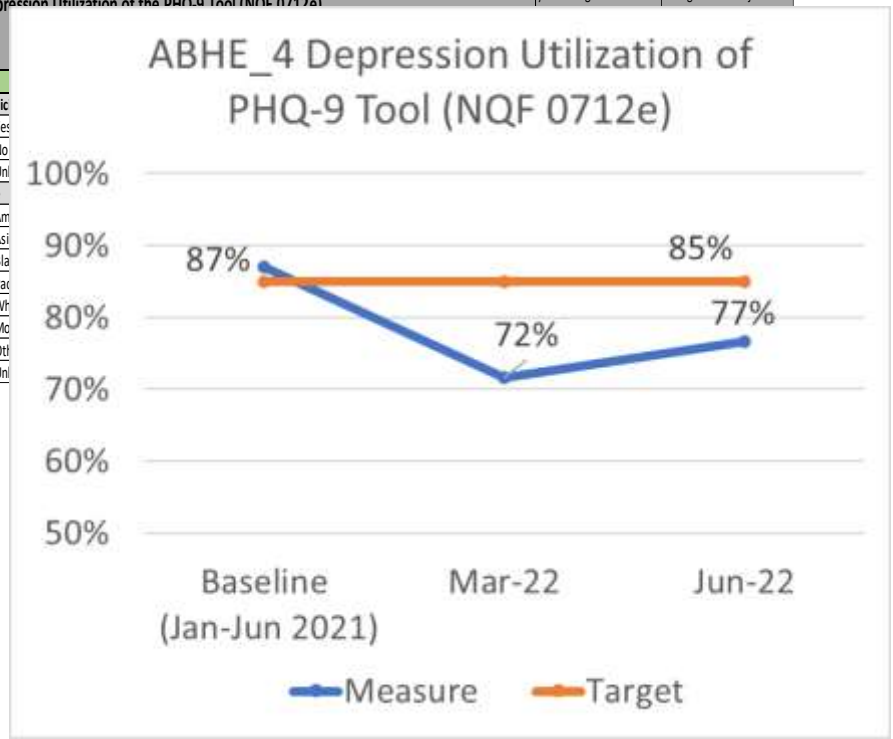
Chinatown Service Center

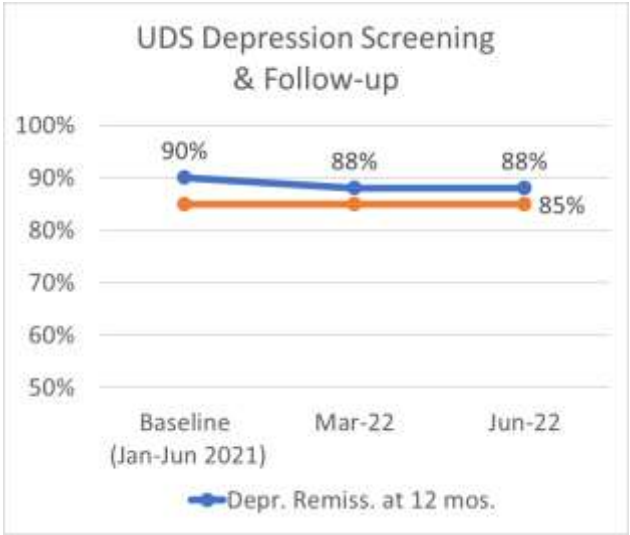
Which UMS measure(s) will help us assess improvement?

Data Element ID	Description and Response Options	Denominator	Numerator
ABHE_4_	Depression Utilization of the PHQ-9 Tool (NQF 0712e)	Number of patients 18 years of age and older	Number of patients 18 years of age or older with a diagnosis of major
ABHE_4_1	All		
	Ethnic		
ABHE_4_2	Yes		
ABHE_4_3	No		
ABHE_4_4	Unk		
	Race		
ABHE_4_5	Am		
ABHE_4_6	Asi		
ABHE_4_7	Bla		
ABHE_4_8	Pac		
ABHE_4_9	Wh		
ABHE_4_10	Mo		
ABHE_4_11	Oth		
ABHE_4_12	Unk		



Universal Measure Set

May also monitor related UDS measures



Putting the pieces together

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Chinatown Service Center

How can we track periodic progress of our efforts?

BH Services & Screening Tool Use

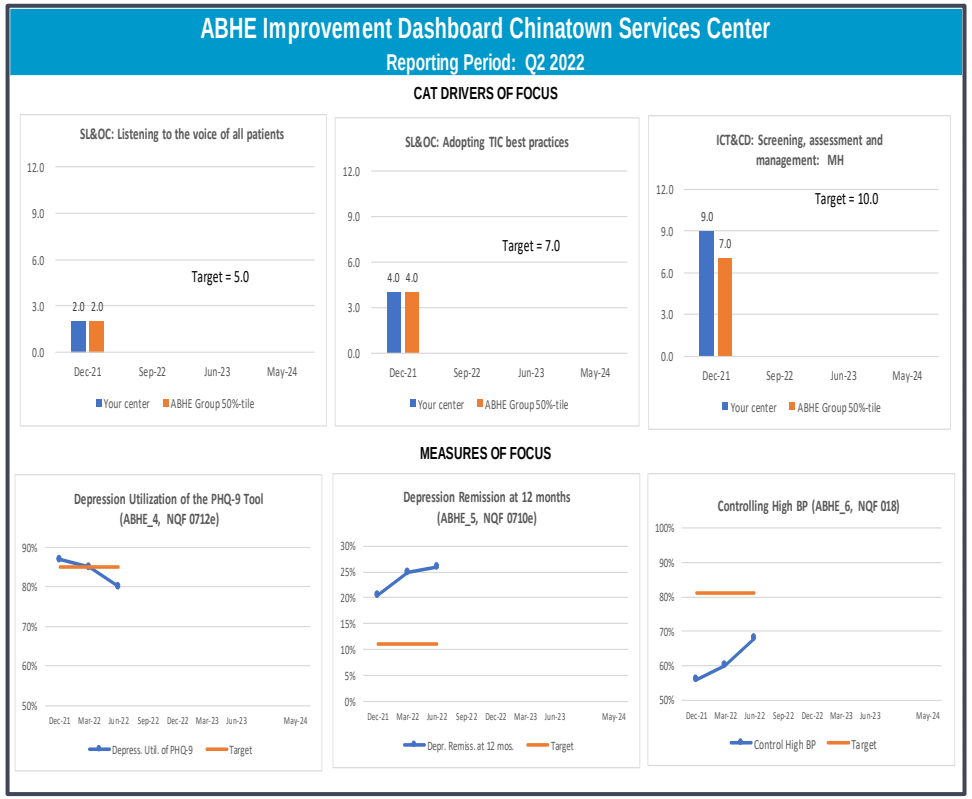
BH Services & Screening Tool Use		
	Baseline (Jan-Jun 2021)	
BH SERVICES OFFERED	Yes/No	Comments / clarification
Substance Use Disorder Treatment	Yes	
Behavioral medicine techniques (e.g., relaxation training, sleep promo	Yes	
Motivational interviewing	Yes	
Stages of change model	Yes	
Health behavior change interventions related to smoking, alcohol abuse, and obesity	Yes	Yes to alcohol abuse; not many clients comes with questions regarding smoking and/or obesity
Group interventions	Yes	
Chronic disease management	Yes	

Dashboard / Measures of Focus

Measures of Focus

CAT Drivers

UMS, SDOH, Internal measures



Putting the pieces together

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Chinatown Service Center

CSC Change Ideas

Area of Focus: Clear roles and develop integration workflow

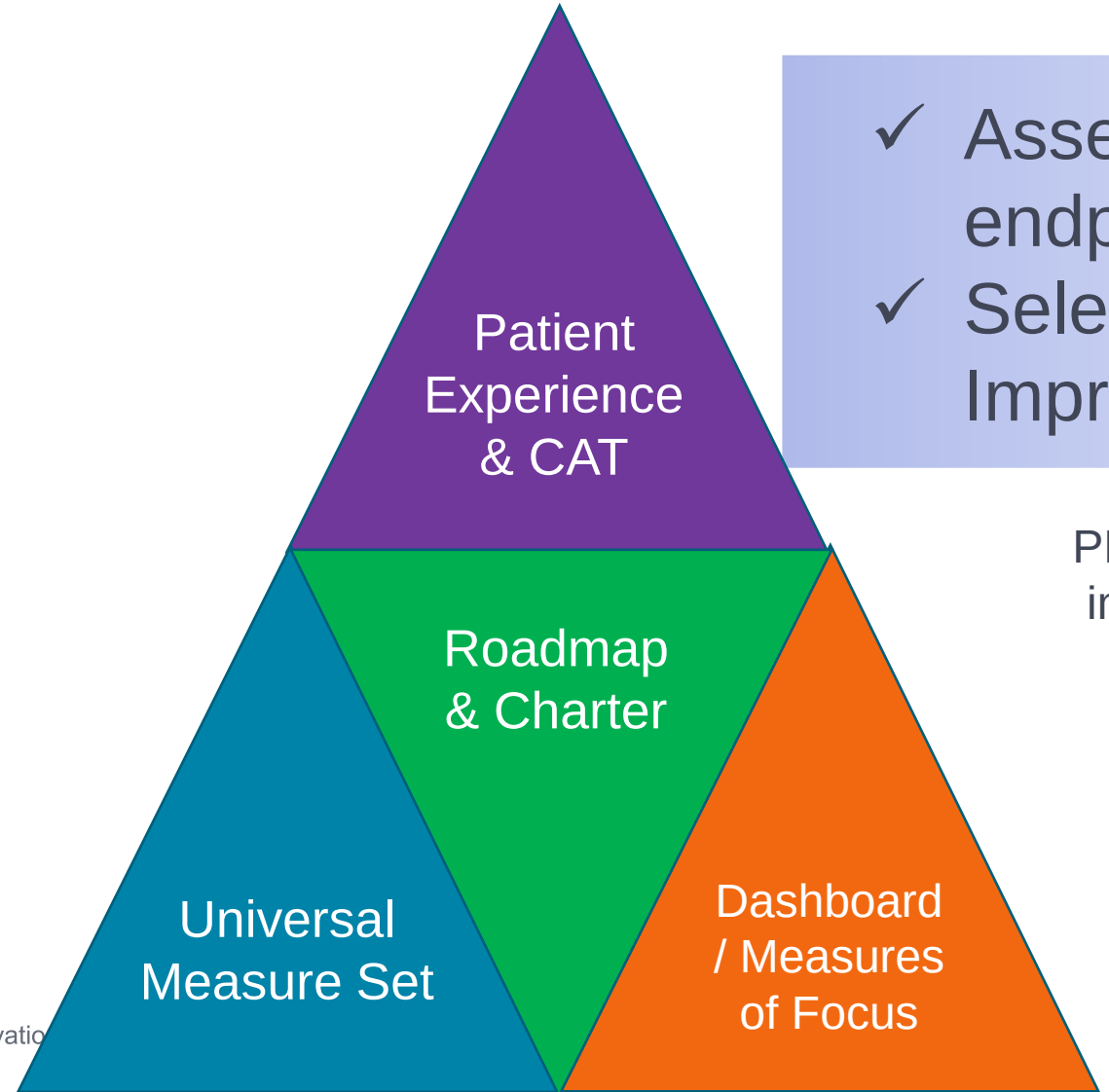
Prioritize Changes:

1. **Utilize interdepartmental meetings**/mutual patient consultations to clearly introduce and **identify roles and capacity** of each department/provider
2. **Develop clear and concise workflows** on how to conduct internal referrals and train all staff to understand the workflow (including triggers on when it is appropriate to make the referrals, i.e. mild to moderate emotional distress)
3. Discuss and **develop means to track referrals** and how to follow up with both provider and patient

What change ideas can we test to improve our capabilities and impact measures of focus?

PDSA cycles to test change and improve measure performance

Monitor progress and refine as needed



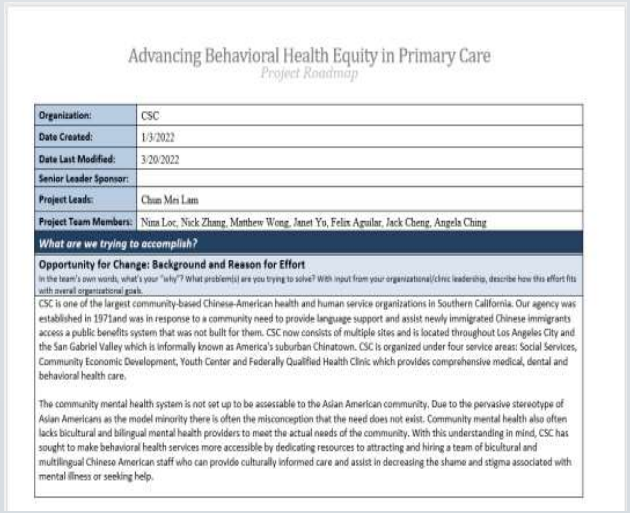
- ✓ Assessments at baseline, midpoint, endpoint, post program
- ✓ Selected measures quarterly in Improvement Dashboard

PDSA cycles to test change and improve measure performance

These pieces also tell your story

Improving Behavioral Health Equitable Care In Our Organization

The opportunity and why it's important to the patients we serve



Advancing Behavioral Health Equity in Primary Care

Project Roadmap

Organization:	CSC
Date Created:	1/3/2022
Date Last Modified:	3/20/2022
Senior Leader Sponsor:	
Project Leads:	Chun Mei Lam
Project Team Members:	Nima Loc, Nick Zhang, Matthew Wong, Janet Yu, Felix Aguilar, Jack Cheng, Angela Ching

What are we trying to accomplish?

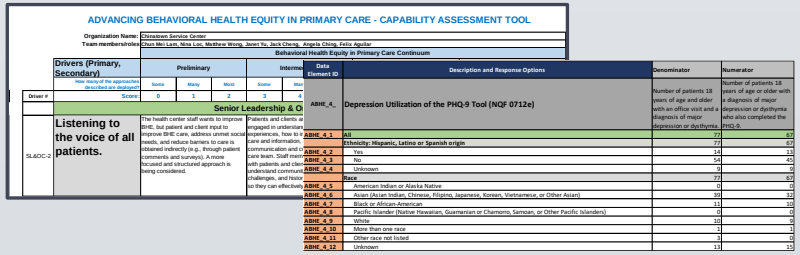
Opportunity for Change: Background and Reason for Effort

In the team's own words, what's your "why"? What problem(s) are you trying to solve? With input from your organizational/clinic leadership, describe how this effort fits with overall organizational goals.

CSC is one of the largest community-based Chinese-American health and human service organizations in Southern California. Our agency was established in 1971and was in response to a community need to provide language support and assist newly immigrated Chinese immigrants access a public benefits system that was not built for them. CSC now consists of multiple sites and is located throughout Los Angeles City and the San Gabriel Valley which is informally known as America's suburban Chinatown. CSC is organized under four service areas: Social Services, Community Economic Development, Youth Center and Federally Qualified Health Clinic which provides comprehensive medical, dental and behavioral health care.

The community mental health system is not set up to be assessable to the Asian American community. Due to the pervasive stereotype of Asian Americans as the model minority there is often the misconception that the need does not exist. Community mental health also often lacks bicultural and bilingual mental health providers to meet the actual needs of the community. With this understanding in mind, CSC has sought to make behavioral health services more accessible by dedicating resources to attracting and hiring a team of bicultural and multilingual Chinese American staff who can provide culturally informed care and assist in decreasing the shame and stigma associated with mental illness or seeking help.

How we assessed where to improve



ADVANCING BEHAVIORAL HEALTH EQUITY IN PRIMARY CARE - CAPABILITY ASSESSMENT TOOL

Organization Name: Chinatown Service Center

Team members/roles: Chun Mei Lam, Nima Loc, Matthew Wong, Janet Yu, Jack Cheng, Angela Ching, Felix Aguilar

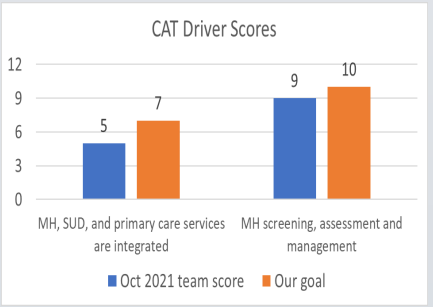
Behavioral Health Equity in Primary Care Continuum

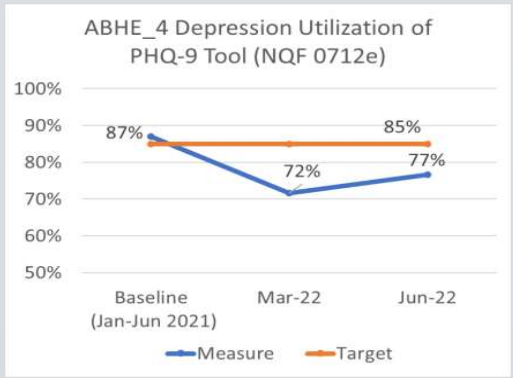
Drivers (Primary, Secondary)		Preliminary			Intermed		
How many of the approaches described are deployed?		Some	Many	Most	Some	Mos	
Driver #	Score	0	1	2	3	4	
	Senior Leadership & O						
SLADC-2	Listening to the voice of all patients.	The health center staff wants to improve BHE, but patient and client input to improve BHE care, address unmet social needs, and reduce barriers to care is obtained indirectly (e.g., through patient comments and surveys). A more focused and structured approach is being considered.			Patients and clients a engaged in understan experiences, how to i care and information. communication and c care team. Staff maxi with patients and clien understand communi challenges, and histor so they can effectively		

Data Element ID	Description and Response Options	Denominator	Numerator
ABHE_4_	Depression Utilization of the PHQ-9 Tool (NQF 0712e)	Number of patients 18 years of age and older with an office visit and a diagnosis of major depression or dysthymia	Number of patients 18 years of age or older with a diagnosis of major depression or dysthymia who also completed the PHQ-9
ABHE_4_1	All	77	67
	Ethnicity: Hispanic, Latino or Spanish origin	77	67
ABHE_4_2	Yes	14	13
ABHE_4_3	No	54	45
ABHE_4_4	Unknown	0	0
	Race	77	67
ABHE_4_5	American Indian or Alaska Native	0	0
ABHE_4_6	Asian (Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or Other Asian)	39	32
ABHE_4_7	Black or African-American	11	10
ABHE_4_8	Pacific Islander (Native Hawaiian, Guamanian or Chamorro, Samoan, or Other Pacific Islanders)	0	0
ABHE_4_9	White	10	9
ABHE_4_10	More than one race	1	1
ABHE_4_11	Other race not listed	0	0
ABHE_4_12	Unknown	13	11

The ways we tested changes

The measurable impact we made





Poll Question

How well is your team leveraging data and information to inform your improvement journey?

****

Instructions

- Take a moment to reflect on the poll question.
- Respond to the question.

Tips on data and measures hygiene

- Periodically revisit your AIM statement, drivers and sub-goals that contribute to AIM achievement, and measures of focus, to ensure they are all aligned.
- Give your team permission to de-prioritize activities or measures if there are too many.
- Identify measure "two-fers" where team efforts improve both.

  For example:

  ✓ CAT driver "MH screening workflows and R&R" & "UMS depression screening"

  ✓ CAT driver "MH/PC team integration" & "UMS HTN BP control improvement"

  If these correlations are not occurring, assess why.
- Ensure PDSA cycles are in support of AIM statement and other measures of focus.
- Change and improvement takes time. Consider staggering expectations.

  For example:

  ✓ Measure 1 improvement in Q1-Q2. Measure 2 improvement in Q3-Q4.

Using Data to Improve Outcomes: A Team-Based Approach

Using Data to Improve Outcomes

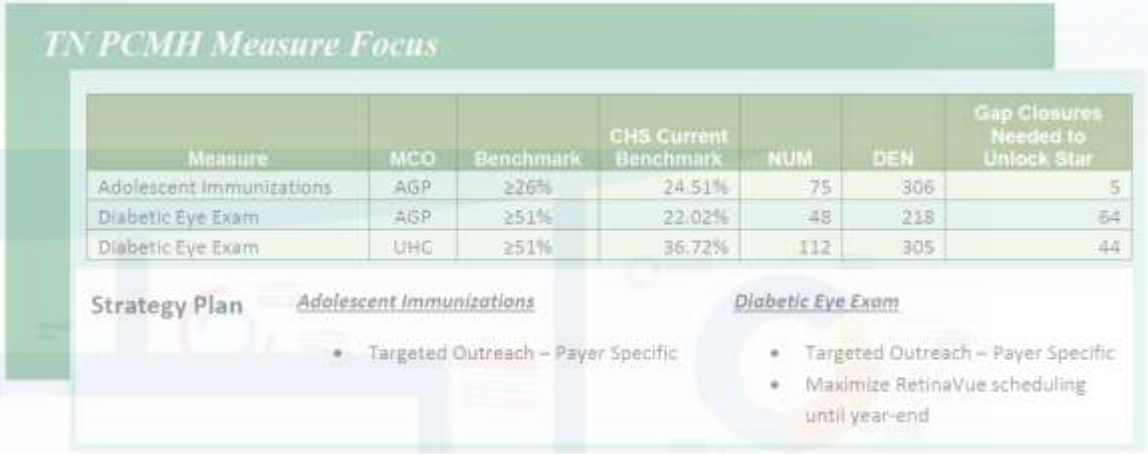
- Building the Team
- Using Data to Improve Outcomes
- Using Health Equity Data to Improve Outcomes for All
- The Next Chapter…

Cherokee HEALTH SYSTEMS

Primary Behavioral Health
INTEGRATED CARE
Training Academy

Building the Team

- IT and Clinical Teams Integration
  - Living in Two Different Worlds
  - Speaking Two Different Languages
  - IT and Clinical Collaboration
  - HIT Toolkit Development



Using Data To Improve Outcomes

Cherokee HEALTH SYSTEMS

Primary Behavioral Health
INTEGRATED CARE
Training Academy

The Importance of Data Collection

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INTEGRATED CARE
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CHS Data Warehouse

Data Sources

- Biometric Patient Data
- EHR Data
- Claims Data
- Pharmacy Data
- HIE Data
- Payor Data
  - Risk Scores
  - Rosters
  - Cost

Data Warehouse

Business Intelligence

- Data Mining
- Reporting
- Analytics

Cherokee HEALTH SYSTEMS

Primary Behavioral Health
INTEGRATED CARE
Training Academy

CHS Data Warehouse

- Provides interactive on-demand reporting
  - Quality metrics (UDS, PCMH, THL)
  - Outreach reports for non-compliant patients
  - Patient Dashboard
  - Predictive modeling
  - Executive summary dashboard reports
  - Population Management and Care Coordination

Population Management & Care Coordination

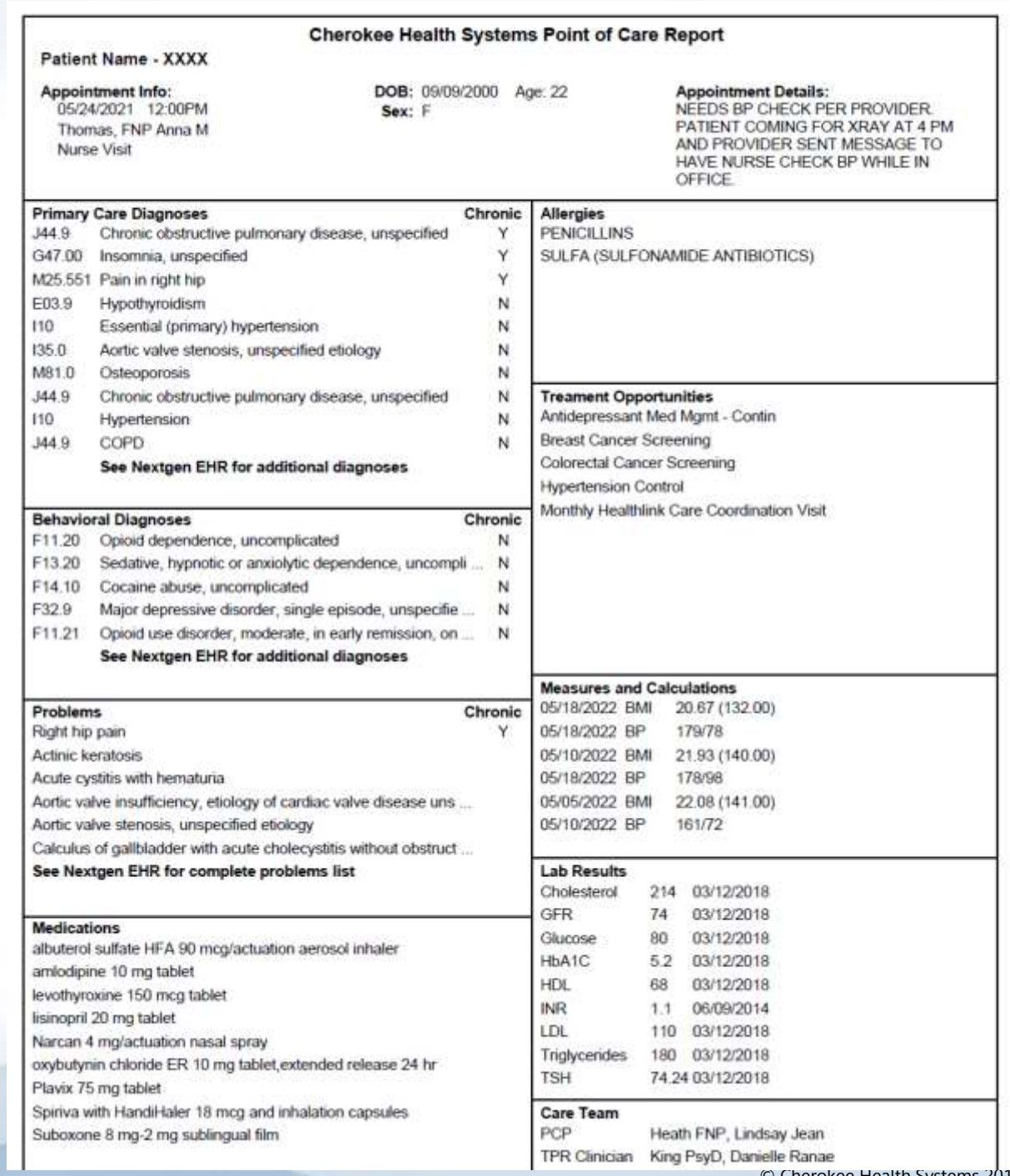
Daily automated integrated treatment opportunities reports

Integrated Opportunities Reporting | Current and Next Day Appointments | Filters | Export | Snapshot | Refresh | Database | Query | Guide | QView | Data Blox | Editor | Dashboard | Admin | Logout

No description set for report. | Location: CHS Center City

MRN	Patient Name	Treatment Opportunities	Next Appt	Next Appt Type	Next Appt Location	Next Appt Provider
0123451	Test, Alex	BMI Assessment Colorectal Cancer Screening Diabetes Care: A1c Poor Control(9 or higher) (Last: 07/12/2018 - 11.5) Diabetes Care: Retinal Eye Exam (Last: 02/19/2018 - CG)	6/18/2019 8:15:00 AM	PC Planned Est 15m	CHS Center City	Davis Jr MD, Tony Wayne
0123452	Test, Joe	Diabetes Care: BP Control Diabetes Care: Retinal Eye Exam (Last: 01/01/2016 - CG) Hypertension Control	6/18/2019 8:45:00 AM	BH 30 Therapy	CHS Center City	Breedlove PhD, Marci Michelle
0123453	Test, Karen	ER / Inpatient Alerts - 2 or more in the last 30 days (3)	6/18/2019 8:45:00 AM	Case Management	CHS Center City	Armbruster MPH, Sam Lyn Alcott
0123454	Test, Avery	Childhood Immunizations	6/18/2019 8:45:00 AM	PC Well Child Check	CHS Center City	Feehan MD, Tammy R
0123455	Test, Bill	Adherence to Antipsychotic Medications Diabetes Care: A1c Poor Control(9 or higher) (Last: 05/20/2019 - 11.7) Diabetes Care: BP Control Hypertension Control	6/18/2019 9:00:00 AM	Nurse Visit	CHS Center City	Major RN, Phyllis
0123456	Test, Jim	Well Child Check (Last: 07/26/2018)	6/18/2019 9:00:00 AM	PC Well Child Check	CHS Center City	Feehan MD, Tammy R
0123457	Test, Bob	Cervical Cancer Screening Diabetes Care: A1c Poor Control(9 or higher) (Last: 06/10/2019 - 11.9) Diabetes Care: Retinal Eye Exam (Last: 12/12/2018 - CG)	6/18/2019 9:00:00 AM	PC Pharmacy Consult	CHS Center City	Stout PharmD, Jacob Wade

Point of Care Report



Cherokee Health Systems Point of Care Report

Patient Name - XXXX

Appointment Info:
05/24/2021 12:00PM
Thomas, FNP Anna M
Nurse Visit

DOB: 09/09/2000 Age: 22
Sex: F

Appointment Details:
NEEDS BP CHECK PER PROVIDER. PATIENT COMING FOR XRAY AT 4 PM AND PROVIDER SENT MESSAGE TO HAVE NURSE CHECK BP WHILE IN OFFICE.

Primary Care Diagnoses

		Chronic
J44.9	Chronic obstructive pulmonary disease, unspecified	Y
G47.00	Insomnia, unspecified	Y
M25.551	Pain in right hip	Y
E03.9	Hypothyroidism	N
I10	Essential (primary) hypertension	N
I35.0	Aortic valve stenosis, unspecified etiology	N
M81.0	Osteoporosis	N
J44.9	Chronic obstructive pulmonary disease, unspecified	N
I10	Hypertension	N
J44.9	COPD	N

See Nextgen EHR for additional diagnoses

Behavioral Diagnoses

		Chronic
F11.20	Opioid dependence, uncomplicated	N
F13.20	Sedative, hypnotic or anxiolytic dependence, uncompli ...	N
F14.10	Cocaine abuse, uncomplicated	N
F32.9	Major depressive disorder, single episode, unspecifie ...	N
F11.21	Opioid use disorder, moderate, in early remission, on ...	N

See Nextgen EHR for additional diagnoses

Problems

	Chronic
Right hip pain	Y
Actinic keratosis	
Acute cystitis with hematuria	
Aortic valve insufficiency, etiology of cardiac valve disease uns ...	
Aortic valve stenosis, unspecified etiology	
Calculus of gallbladder with acute cholecystitis without obstruct ...	

See Nextgen EHR for complete problems list

Medications

albuterol sulfate HFA 90 mcg/actuation aerosol inhaler
amlodipine 10 mg tablet
levothyroxine 150 mcg tablet
lisinopril 20 mg tablet
Narcan 4 mg/actuation nasal spray
oxybutynin chloride ER 10 mg tablet,extended release 24 hr
Plavix 75 mg tablet
Spiriva with HandiHaler 18 mcg and inhalation capsules
Suboxone 8 mg-2 mg sublingual film

Allergies

PENICILLINS
SULFA (SULFONAMIDE ANTIBIOTICS)

Treament Opportunities

Antidepressant Med Mgmt - Contin
Breast Cancer Screening
Colorectal Cancer Screening
Hypertension Control
Monthly Healthlink Care Coordination Visit

Measures and Calculations

05/18/2022	BMI	20.67 (132.00)
05/18/2022	BP	179/78
05/10/2022	BMI	21.93 (140.00)
05/18/2022	BP	178/98
05/05/2022	BMI	22.08 (141.00)
05/10/2022	BP	161/72

Lab Results

Cholesterol	214	03/12/2018
GFR	74	03/12/2018
Glucose	80	03/12/2018
HbA1C	5.2	03/12/2018
HDL	68	03/12/2018
INR	1.1	06/09/2014
LDL	110	03/12/2018
Triglycerides	180	03/12/2018
TSH	74.24	03/12/2018

Care Team

PCP	Heath FNP, Lindsay Jean
TPR Clinician	King PsyD, Danielle Ranae

Cherokee HEALTH SYSTEMS

Cherokee Health Systems — Patient Dashboard

CHS Master Home (Old) | BH Home (New) | BH Consult | PC Home Page
Clinical Change Request | THL Enrollment Form | Add Care Plan Note | CHS Admin Page

Version 1.2.4 | Patient Portal Enrollment Status:

Tennessee Health Link Enrollment

MCO Assigned: No | Consent Form Signed: No | Attestation Submitted: No | Enrollment Date: --/--/----

Million Hearts Enrollment

Eligible: No | Enrollment Date: --/--/---- | Letter Given: No | ASCVD Score: --

Care Team

Type	Provider
PCP	Wallace MD, Febe
TX	Freeman PhD, Dennis
Psy	Perry MD, Gregory
DEN	Green DMD, Lawana J

Future Appointments

Provider	Event	Time	Date
Freeman PhD, Dennis	BH 45 Therapy	01:30 PM	06/16/2016
Green DMD, Lawana J	DT Extraction/Procedure	02:30 PM	06/16/2016
Wallace MD, Febe	PC Planned Est 30m	03:30 PM	06/16/2016
Perry MD, Gregory	BH Est Psy 15	11:30 AM	06/16/2016

Past Appointments

Provider	Event	Status	Date
Buchanan FNP, Crystal Kay	PC Physical	Cancelled	05/10/2019
Green DMD, Lawana J	DT Extraction/Procedure	Kept	05/01/2016

Self Management

Goal	Status	Start Date
Become more human.	In Progress	06/17/2019

Diagnoses

Chronic Conditions

Code	Description
250.00	DM, uncomplicated, type II
272.4	Hyperlipidemia NEC/NOS
401.1	Hypertension, benign essential

Behavioral

Code	Description	Axis	Date
F41.1	GAD (generalized anxiety disorder)	Ia	06/11/2019
F06.30	Mood disorder due to a general medical condition	Ib	06/11/2019

Hospital ER/Admissions *(Last 90 Days)*

Description	Date
Please be advised, your patient has been transferred from an outpatient to an inpatient at the Morristown Medical Center on 10/27/2014 : CHS PCP Aman Siddiqi, MD	10/24/2014

BPSA Score - Last Functional Needs Screening: 04/29/2019

BPSA	Low	Medium	High
Medical	9		
Behavioral	4		
Social	1		
Total	14		

Care Coordination

Care Intervention
Educate patient on what to do for high glucose.

Treatment Opportunities

Opportunity	Last Date	Last Result
Diabetes Care: A1c Poor Control(9 or higher)	03/22/2019	8.2
Diabetes Care: Retinal Eye Exam	09/18/2017	CG
ER / Inpatient Alerts - 2 or more in the last 30 days (3)	N/A	N/A
Monthly Healthlink Care Coordination Visit	N/A	N/A

Labs

Test	Result	Enc. Date
Cholesterol	241	03/13/2015
HbA1C	5.6	03/13/2015
HDL	41	03/13/2015
INR		
LDL	163	03/13/2015
Triglycerides	185	03/13/2015
TSH	2.683	03/13/2015

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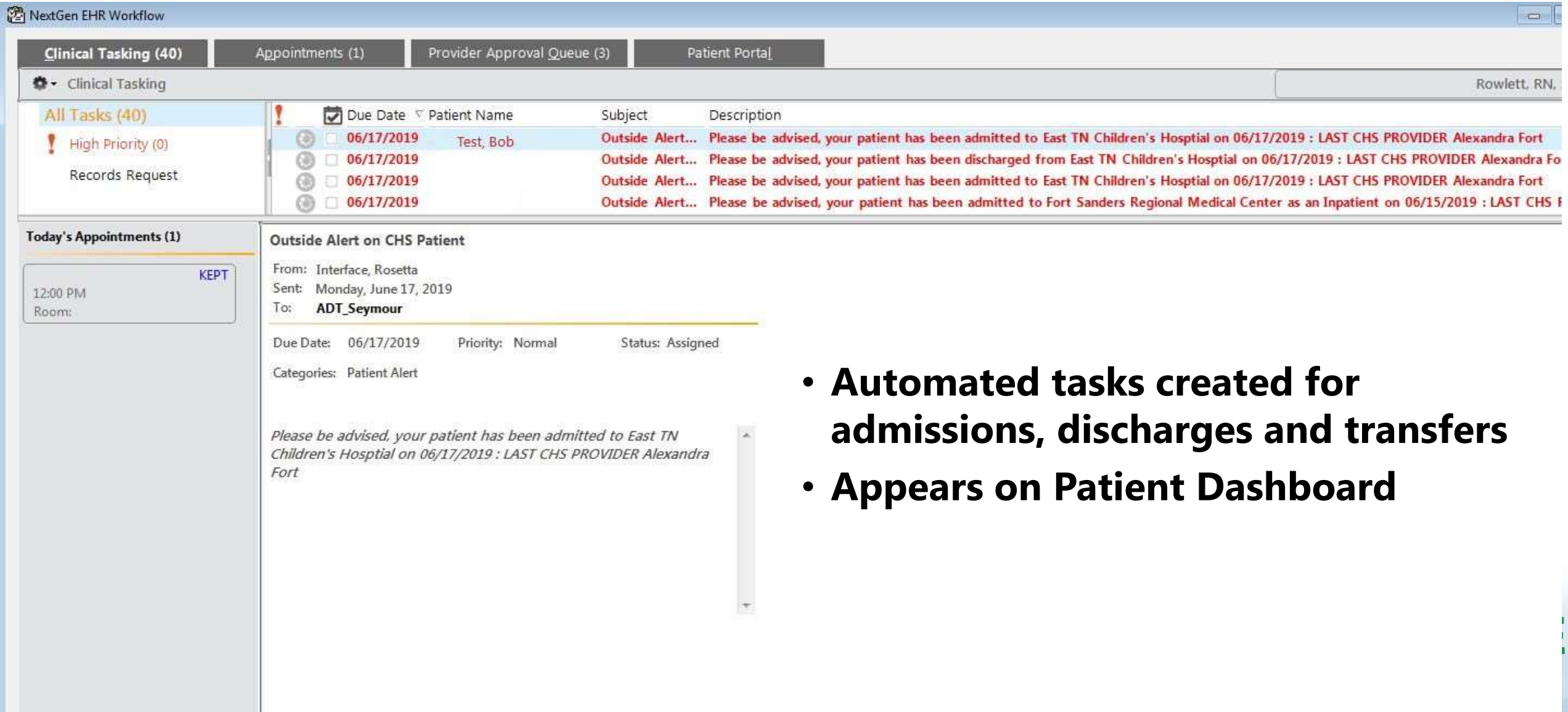
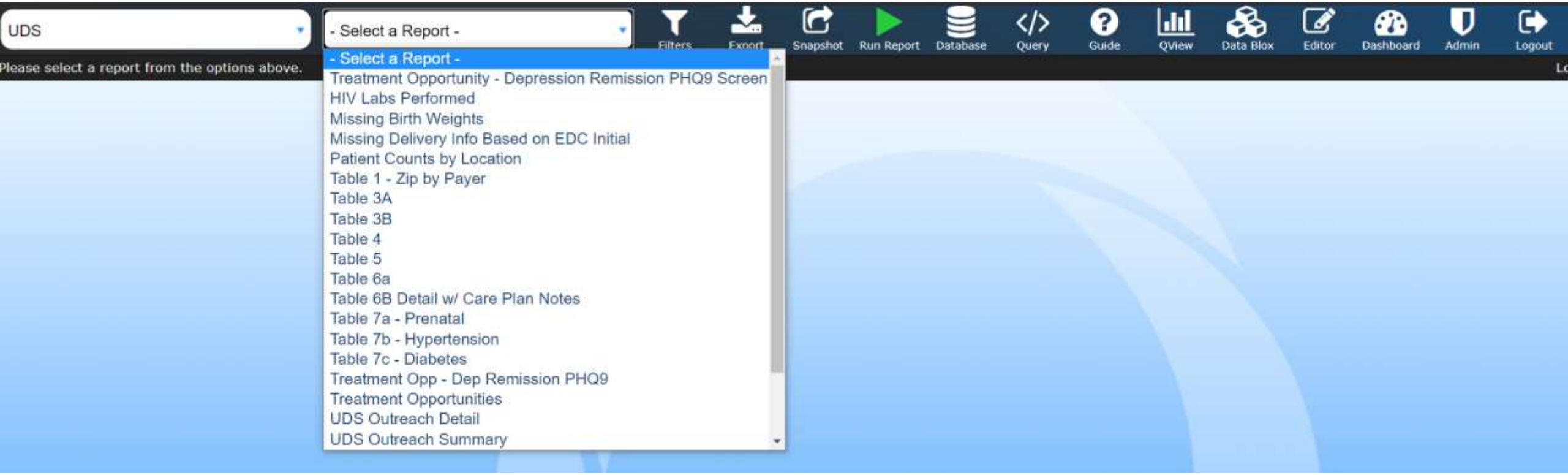
Communication

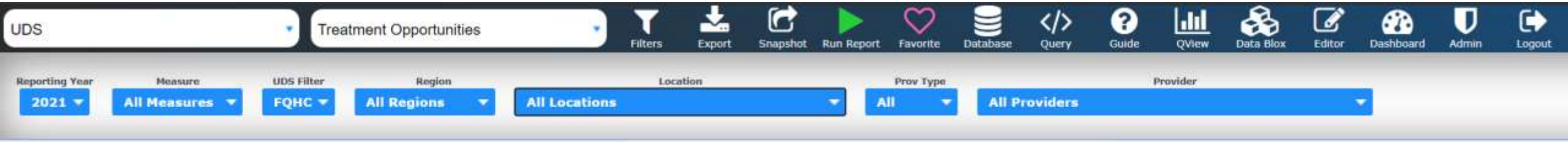
HIE & Payor Data Integration with EHR



- **Automated tasks created for admissions, discharges and transfers**
- **Appears on Patient Dashboard**

CHS Web Reporter





Cherokee HEALTH SYSTEMS

Primary Behavioral Health
INTEGRATED CARE
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Quality Measure Focus

TN PCMH Measure Focus

Measure	MCO	Benchmark	CHS Current Benchmark	NUM	DEN	Gap Closures Needed to Unlock Star
Adolescent Immunizations	AGP	≥26%	24.51%	75	306	5
Diabetic Eye Exam	AGP	≥51%	22.02%	48	218	64
Diabetic Eye Exam	UHC	≥51%	36.72%	112	305	44

Strategy Plan

Adolescent Immunizations

- Targeted Outreach – Payer Specific

Diabetic Eye Exam

- Targeted Outreach – Payer Specific
- Maximize RetinaVue scheduling until year-end

Goal - Promote targeted focus on performance measure progress and opportunities

UDS Measure Focus

Measure	Benchmark	CHS Current Benchmark	NUM	DEN	Gap Closures Needed
Ischemic Vascular Disease	≥90%	86.80%	1,577	1,820	61
Statin Rx for CVD	≥80%	75.10%	4,152	5,532	274

Strategy Plan

Ischemic Vascular Disease

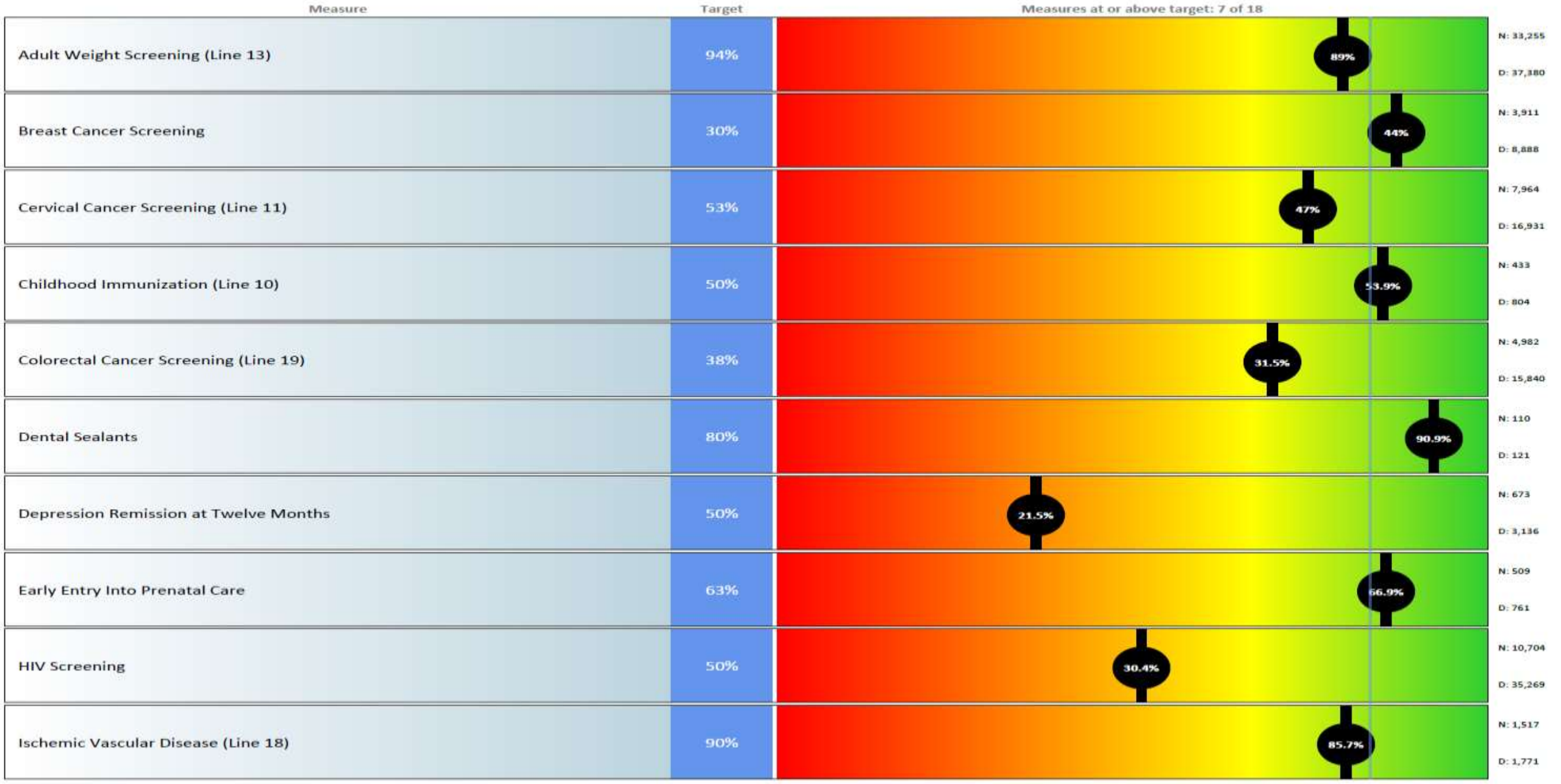
- Targeted Outreach
- Need Rx (e.g., aspirin) if clinically appropriate

Statin Rx for CVD

- Targeted Outreach
- Need Rx for statin if clinically appropriate

Cherokee HEALTH SYSTEMS

Executive Summary UDS Dashboard



UDS Location Summary

	BMI Adult	BCS	PAP	IMM	Colorectal	Sealants	Dp Remission	Trimester	HIV Screen	IVD	New HIV F/U	Dep Screen	Statin Tx	Diabetes	Hypertension	Birthweight	Tobacco	BMI Peds
Target	94%	30%	53%	50%	38%	80%	50%	63%	50%	90%	70%	90%	80%	72%	65%	91%	92%	94%
Center City	80%	43%	50%	65%	27%		22%	57%	32%	91%		95%	81%	61%	56%	90%	88%	99%
Clinton	91%	30%	40%	24%	19%		14%		34%	83%		95%	81%	59%	66%		96%	97%
Dameron Ave	92%			57%			4%		26%			95%			100%		93%	98%
East Knox	95%	79%	54%	12%	36%		23%		50%	89%		93%	72%	68%	62%		97%	99%
Fifth Avenue	89%	45%	41%		22%		25%		38%	78%		94%	70%	56%	54%		93%	
Lonsdale	92%	52%	41%	36%	26%		17%		48%	71%		91%	65%	67%	63%		87%	98%
Mobile Clinic	100%	100%	0%		0%				0%						0%		100%	

Provider Interactive Dashboard

Provider Summary

Coffey FNP-BC, Carla Renee ▾

Coffey FNP-BC, Carla Renee

Overview | Opportunities | Today's Opportunities | Export Report

All Categories

Meaningful Use
0/0 Compliant

PCMH
1/8 Compliant

Provider Incentive
2/4 Compliant

TN Health Link
2/15 Compliant

UDS
9/11 Compliant

Group	Description	Target %	Coffey FNP-BC, Carla Renee Compliant%	CHS 5th Street Compliant%	CHS Average	Denominator	Numerator
UDS	Adult Weight Screening	93%	98.74%	90.80%	83.37%	717	708
UDS	Asthma Pharmacologic Therapy	80%	86.67%	86.49%	71.05%	15	13
UDS	Cervical Cancer Screening	53%	50.56%	53.69%	46.50%	269	136
UDS	Colorectal Cancer Screening	34%	35.14%	33.33%	30.28%	350	123
UDS	Early Entry Into Prenatal Care	60%	100.00%			1	1
UDS	Ischemic Vascular Disease	88%	95.65%	86.44%	85.32%	23	22
UDS	Patients Screened for Depression and Follow-Up	85%	96.39%	96.02%	79.23%	166	160
UDS	Prenatal - Complete Data	95%	100.00%		83.97%	1	1
UDS	Table 7 - Diabetes	75%	55.63%	55.31%	64.64%	151	84
UDS	Table 7 - Hypertension	63%	70.09%	66.67%	62.16%	438	307
UDS	Tobacco Use Screening and Cessation	90%	98.40%	98.13%	90.76%	687	676

Showing 1 to 11 of 11 entries (filtered from 38 total entries)

Cherokee HEALTH SYSTEMS

Primary Behavioral Health
INTEGRATED CARE
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What Has Worked For Us?

Relationship Building

- Clinician on EHR team
- Communicate often

Understanding Different Worlds

- Clinicians understand IT's parameters and goals
- IT understands clinical flow and goals

Cherokee HEALTH SYSTEMS

Primary Behavioral Health
INTEGRATED CARE
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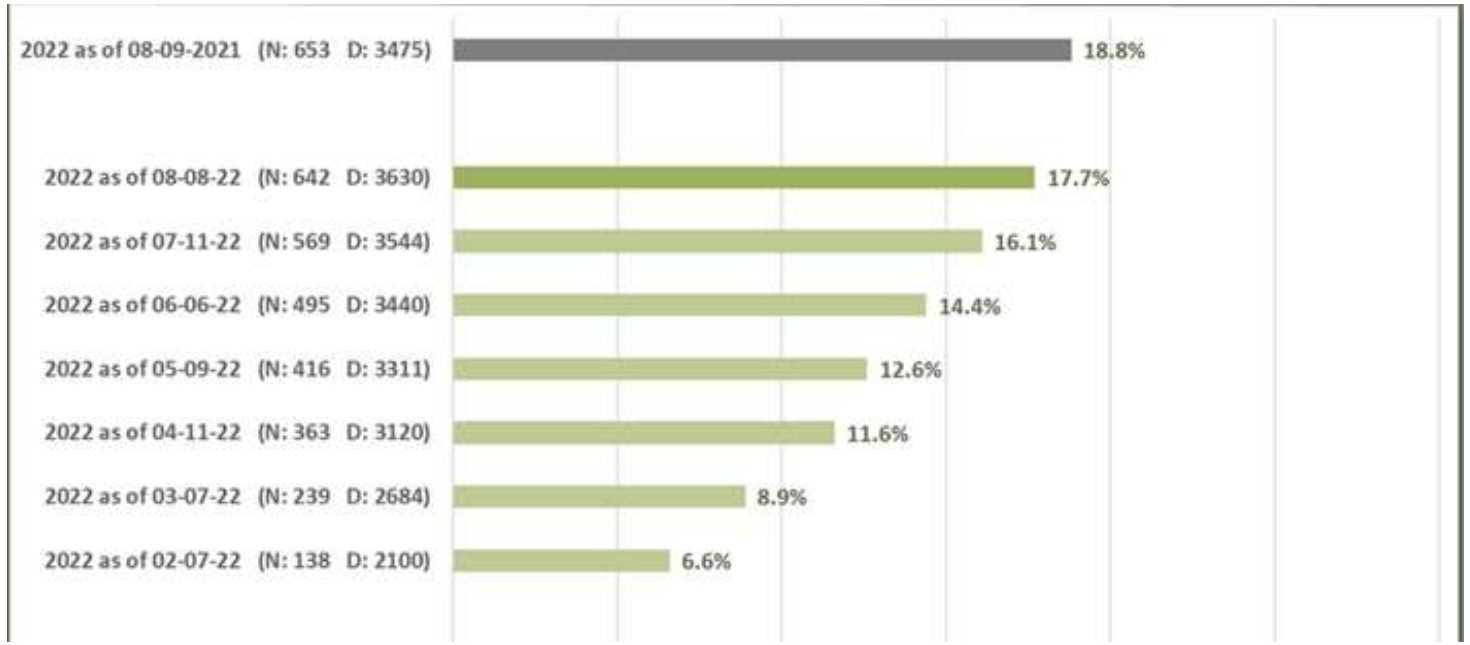
Improving Outcomes: Quality Measures

- Depression Remission
- CHS Baseline: 6.6%
- CHS Current: 18/8%
- National: 13.8%



Cherokee HEALTH SYSTEMS

Primary Behavioral Health
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Improving Outcomes: Quality Measures

- What we did:
  - Staff Trainings
    - → Check the numbers
  - Creating Alerts
    - → Check the numbers
  - Standard Screening Protocols
    - → Check the numbers
  - Staff Meeting Updates
    - → Check the numbers
  - Opportunity Report
    - → Check the numbers

Cherokee HEALTH SYSTEMS

Primary Behavioral Health
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The Next Step: Developing a Health Equity Lens

- The Turning Point
- Health Equity Committee
- Data Collection
  - Clinic Processes – SOGI
  - State of Health Equity Report
  - Weekly Health Equity Summary Report

UDS Health Equity Summary - Birth Sex

Summary for reporting period ending August, 08 2022 - Report Group: All CHS

	BMI Adult	BCS	PAP	IMM	Colorectal	Sealants	Dp Remission	Trimester	HIV Screen	IVD	Dep Screen	Statin Tx	Diabetes	Hypertension	Birthweight	Tobacco	BMI Peds
Target	94%	45%	50%	50%	38%	90%	25%	65%	50%	85%	94%	80%	72%	65%	91%	92%	96%
Female	91%	48%	42%	47%	28%	97%	17%	67%	52%	80%	95%	69%	60%	63%	96%	84%	95%
Male	94%			44%	26%	89%	19%		50%	86%	94%	75%	59%	58%		78%	95%
Other	100%				0%		0%		25%		75%			0%		83%	
All CHS	92%	48%	42%	45%	27%	93%	18%	67%	51%	84%	95%	71%	60%	61%	96%	82%	95%

Cherokee HEALTH SYSTEMS

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UDS Health Equity Summary - Ethnicity

Summary for reporting period ending August, 08 2022 - Report Group: All CHS

	BMI Adult	BCS	PAP	IMM	Colorectal	Sealants	Dp Remission	Trimester	HIV Screen	IVD	Dep Screen	Statin Tx	Diabetes	Hypertension	Birthweight	Tobacco	BMI Peds
Target	94%	45%	50%	50%	38%	90%	25%	65%	50%	85%	94%	80%	72%	65%	91%	92%	96%
Hispanic or Latino	88%	53%	61%	60%	19%	96%	15%	63%	56%	76%	96%	63%	53%	65%	97%	89%	97%
Not Hispanic or Latino	93%	48%	37%	32%	28%	81%	18%	79%	50%	84%	94%	72%	61%	60%	92%	80%	94%
Unknown / Not Reported	93%	51%	38%	47%	22%	100%	13%	0%	55%	84%	95%	77%	53%	56%	100%	83%	91%
All CHS	92%	48%	42%	45%	27%	93%	18%	67%	51%	84%	95%	71%	60%	61%	96%	82%	95%

Cherokee HEALTH SYSTEMS

Primary Behavioral Health
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UDS Health Equity Summary - Gender Identity

Summary for reporting period ending August, 08 2022 - Report Group: All CHS

	BMI Adult	BCS	PAP	IMM	Colorectal	Sealants	Dp Remission	Trimester	HIV Screen	IVD	Dep Screen	Statin Tx	Diabetes	Hypertension	Birthweight	Tobacco	BMI Peds
Target	94%	45%	50%	50%	38%	90%	25%	65%	50%	85%	94%	80%	72%	65%	91%	92%	96%
Choose not to Disclose	96%	45%	39%	67%	30%		13%	0%	51%	75%	92%	78%	74%	56%	100%	84%	92%
Female	92%	50%	42%	48%	29%	96%	18%	69%	52%	81%	95%	69%	61%	64%	96%	84%	94%
Female-to-Male/Transgender Male	94%	14%	22%		19%		11%		33%		81%	50%	61%	57%		83%	100%
Genderqueer	93%		24%		13%		22%		32%	100%	90%	33%	80%	60%		80%	100%
Male	94%	25%	21%	46%	27%	93%	20%		51%	87%	94%	75%	60%	59%		79%	94%
Male-to-Female/Transgender Female	97%	33%	23%		14%	100%	13%		41%		87%	86%	58%	65%		83%	100%
Other	95%	0%	39%		0%		0%		43%		77%	60%	57%	75%		79%	100%
Unknown / Not Reported	85%	37%	42%	42%	23%	86%	10%	46%	45%	78%	94%	75%	50%	50%	92%	77%	96%
All CHS	92%	48%	42%	45%	27%	93%	18%	67%	51%	84%	95%	71%	60%	61%	96%	82%	95%

UDS Health Equity Summary - Sexual Orientation

Summary for reporting period ending August, 08 2022 - Report Group: All CHS

	BMI Adult	BCS	PAP	IMM	Colorectal	Sealants	Dp Remission	Trimester	HIV Screen	IVD	Dep Screen	Statin Tx	Diabetes	Hypertension	Birthweight	Tobacco	BMI Peds
Target	94%	45%	50%	50%	38%	90%	25%	65%	50%	85%	94%	80%	72%	65%	91%	92%	96%
Bisexual	92%	54%	35%	100%	28%		11%	71%	50%	60%	92%	52%	61%	62%	100%	79%	96%
Choose not to disclose	91%	45%	44%	49%	27%	83%	18%	64%	54%	80%	95%	72%	61%	64%	96%	85%	94%
Do not Know	89%	43%	54%	48%	23%	88%	20%	54%	55%	86%	96%	70%	56%	60%	91%	86%	96%
Lesbian, gay or homosexual	93%	43%	29%		25%		16%		59%	75%	92%	55%	48%	59%		80%	83%
Other	94%	41%	34%	0%	22%		9%	33%	48%	100%	92%	58%	61%	63%	100%	85%	100%
Straight or Hetrosexual	93%	50%	42%	43%	28%	100%	19%	74%	51%	85%	95%	72%	61%	62%	97%	82%	95%
Unknown / Not Reported	84%	36%	42%	46%	23%	92%	9%	42%	46%	80%	94%	75%	50%	50%	92%	77%	95%
All CHS	92%	48%	42%	45%	27%	93%	18%	67%	51%	84%	95%	71%	60%	61%	96%	82%	95%

Improving Outcomes: Health Equity

- Weekly review of health equity report
- Disparity identified - Low birth weight in 79% of Black/African American OB patients
- Reached out to local leaders to collaborate and established informal birth coalition
- The story continues…

Cherokee HEALTH SYSTEMS

Primary Behavioral Health
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QUESTIONS

Cherokee HEALTH SYSTEMS

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Let’s Reflect!

Breakout Groups
15-minutes

Prompts

1. **Based on what you've heard, what are the** bright spots that you can build on?
2. What are some of the best practices that your team can adopt?

Instructions

- Prompt 1: (12-minutes)
  - Each person has 2-min to share their reflections.
  - Each person has 2-min to add to what's been shared.
- Prompt 2: (3-minutes)
  - Each person has 1-min to share a best practice.
- Reconvene Teams
  - Volunteers to share reflections with cohort.

Best Practices

- Align your aim statements & data sources
- Spread out your change ideas across the program
- Develop PDSAs that support your project goals
- Strengthen relationships between departments
- Develop your data warehouse processes
- Review data charts to identify opportunity areas
- Commit to debriefing data reports with your team

Reminder:
Small, incremental, progress leads to long-lasting change!

Waterfall Chat

What are some of the best practices that your team can adopt?

****

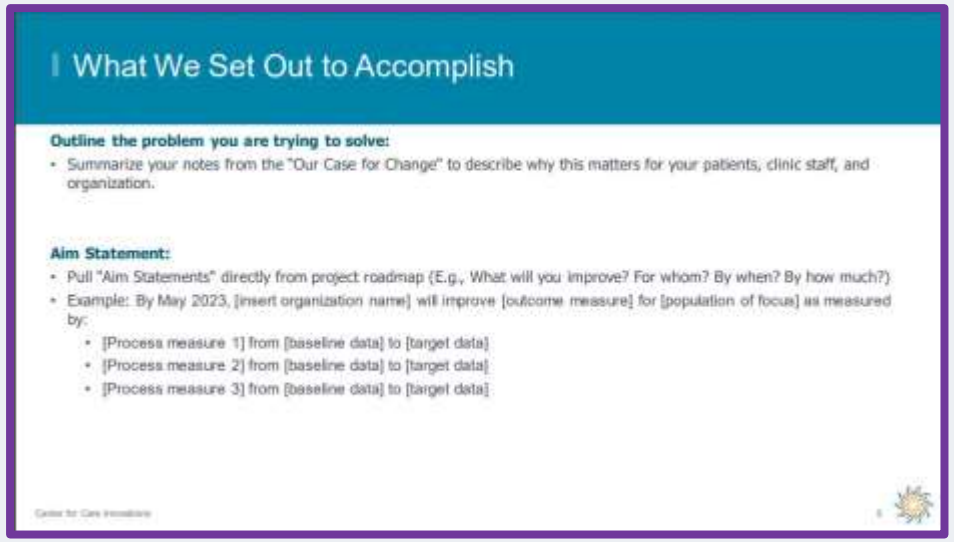
Instructions

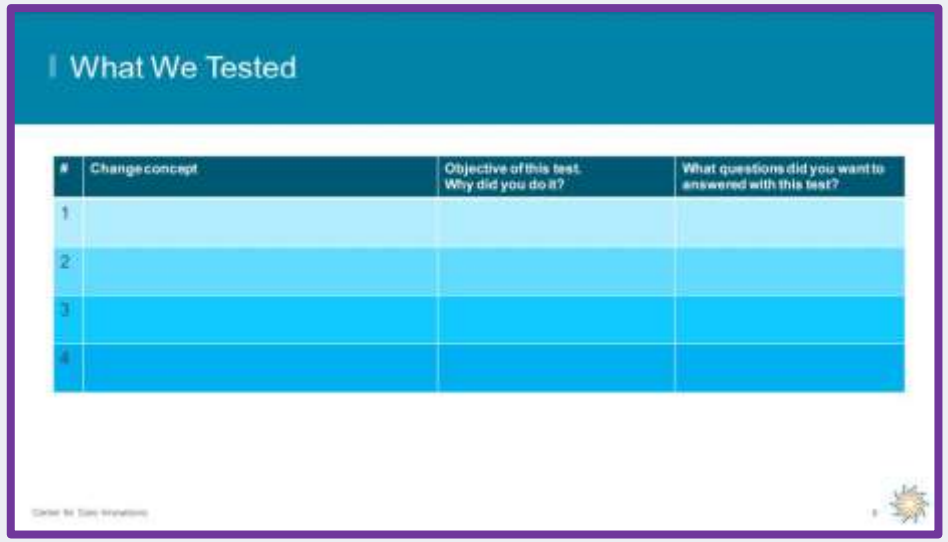
- Take 30-seconds to reflect on the prompt
- Type your response in the chat box.
- Don't click "send" yet!
- Wait for Juan Carlos to say "click send"

Sharing Your Journey through the Storyboard

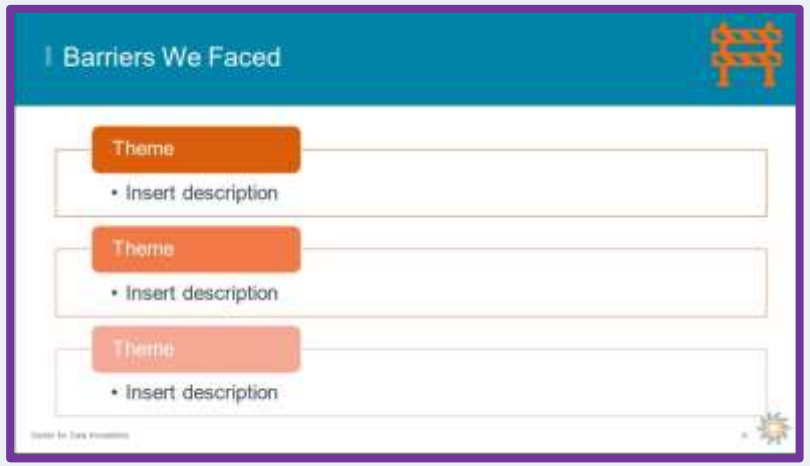
Part 1: Introducing Your Organization and Team

Part 2: Defining Your Project Goals and Measures

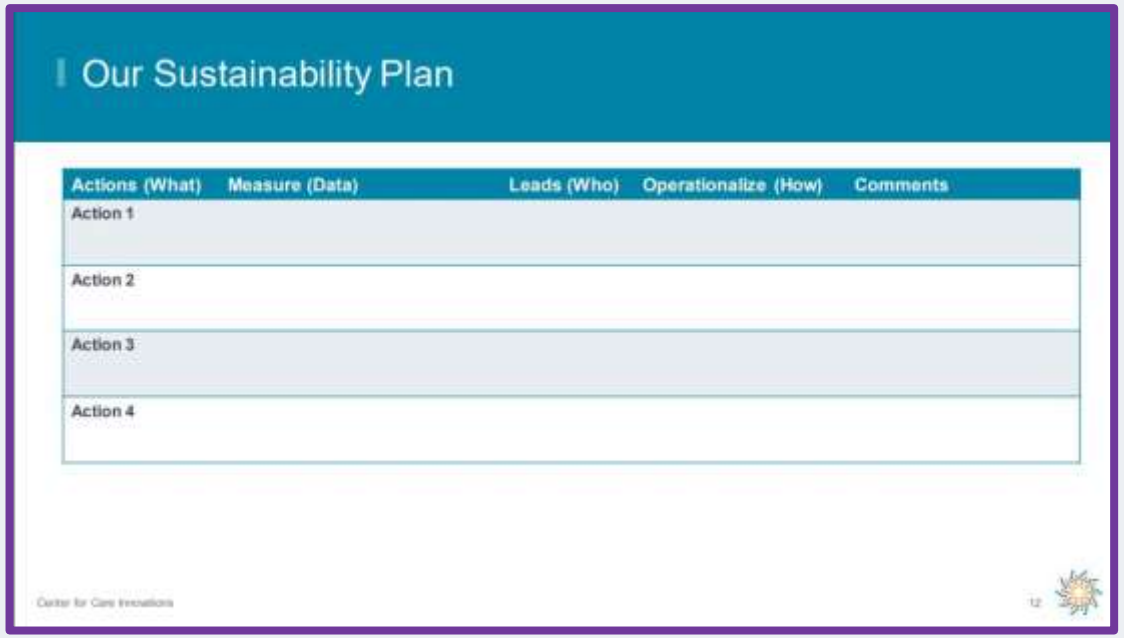




Part 3: Sharing Lessons from Your Data & Patient Stories



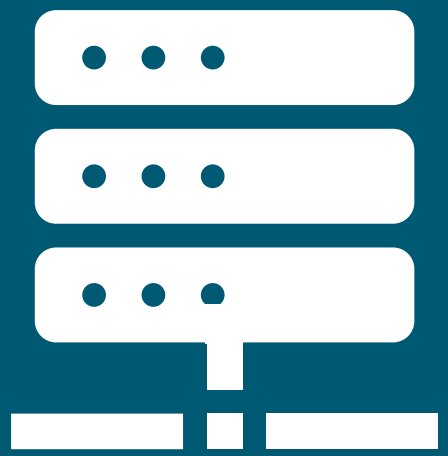
Part 4: Sharing Your Plan to Continue the Work



Question & Answers

Closing & Next Steps

Poll Questions



1. Please select the number that best represents your experience with today's session.

5 – Excellent
4 – Very Good
3 - Good
2 - Fair
1 – Poor

2. Please select the number that best represents your response to the statement: Today's session was a valuable use of my time.

5 – Strongly Agree
4 - Agree
3 - Neutral
2 - Disagree
1 – Strongly Disagree

3. Please select the number that best represents your response to the statement: "Today's session presented information in a way that was accessible to me"

5 – Strongly Agree
4 - Agree
3 - Neutral
2 - Disagree
1 – Strongly Disagree

4. Please select the number that best represents your response to the statement: "I know what is expected of my team over the next few months."

5 – Strongly Agree
4 - Agree
3 - Neutral
2 - Disagree
1 – Strongly Disagree

Upcoming Dates & Activities

1. **9/2**: Midpoint CAT due
2. **9/19-9/20**: Site Visit at Cherokee Health Systems
3. **10/26:** Register for learning session 3
4. **10/26:** Q3 Improvement dashboard due
5. **10/26:** Q3 Quarterly reflection due

We're Coming Together In-Person!

When & Where

Two-day site visit at CHS in Knoxville, TN from 9/19 - 9/20

Topics

- Leveraging Community Partnerships & Patient Voices as Data
- Integrated Care Planning and Implementation
- Using Data to Inform Improvement
- Integrated Care Clinical Model
- Clinical Roles Differentiation
- Equity in Health Care

Activities

- Tour of the Facility
- Panel Discussions
- Group Workshops
- Patient Testimonials
- Wine & Cheese Reception (Meet Your Peers)
- Dinner with the CCI Team (Meet the CCI Team)

Cherokee HEALTH SYSTEMS

Site Visit Sneak Peek

Stay Connected

Email

- Reach out to the CCI team if you have questions about upcoming events, activities, or program components.

Program Club

- Log in to access public forums and get updates about program announcements, assignments, and resources.

Newsletters & Bi-monthly Buzz

- Learn about upcoming events, activities, and resources.

Meetings with Coaches

- Meet with your coach to thought partner and troubleshoot program challenges.

Questions

Juan Carlos Piña

He/Him

Program Manager

juancarlos@careinnovations.org

Lydia Zemmali

She/Her

Program Coordinator

lydia@careinnovations.org


Thank you!
CCI
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INNOVATIONS