blue of california foundation

California Health Care Foundation

Population Health Learning Network

December 11, 2018

Bright Spots Webinar

Our Core Program Team

Megan O'Brien,
Program Manager, CCI

Tammy Fisher,
Senior Director, CCI

Diana Nguyen,
Program Coordinator, CCI

Dr. Carolyn Shepherd,
Clinical Director

Meaghan Copeland,
Program Consultant

Webinar Reminders

Please fill out the post webinar survey!

1. Everyone is muted.
   - Press *6 to mute and unmute yourself.
2. Remember to chat in questions!
3. Webinar is being recorded and will be posted on the PHLN Portal.
4. Continue the discussion on the PHLN Forum: www.forum.careinnovations.org

Agenda

- Welcome & Housekeeping
- 2 Presentations
  - Chapa-De Indian Health
    - Q&A
  - Axis Community Health
    - Q&A
- What's Next & Evaluations

PHLN: Moving Forward

Year 1: **Spark & Test Ideas**

- **Align ideas with organizational priorities**: how do ideas fit into your population health goals?
- **Strengthen work**: where are you stuck, what do you want to make better?
- **Get support from your leadership**: identify priority areas, get excitement and resources for new ideas
- **Find a place to try ideas out**: assign a team to work on ideas
- **Start working differently**: disrupt your system, create prototypes and pilots
- **Measure and learn:** capture just enough data to know if these new ideas are working

Year 2: **Seed & Spread Grants**

- **Implement or spread ideas in core PHLN focus areas:** identify something you want to spread, deepen, or something new to help remove a previous roadblock
- **Draft goals, measures, and changes** to help you reach your goals
- **Make the case:** why should we fund your project? How are you advancing population health management capabilities in an impactful way?

Emerging Bright Spots

1. Diabetes Group Visits

2. Behavioral Health Registries

Think:

What is one challenge and one pearl you would like to share about these topics?


CHAPA-DE
INDIAN HEALTH

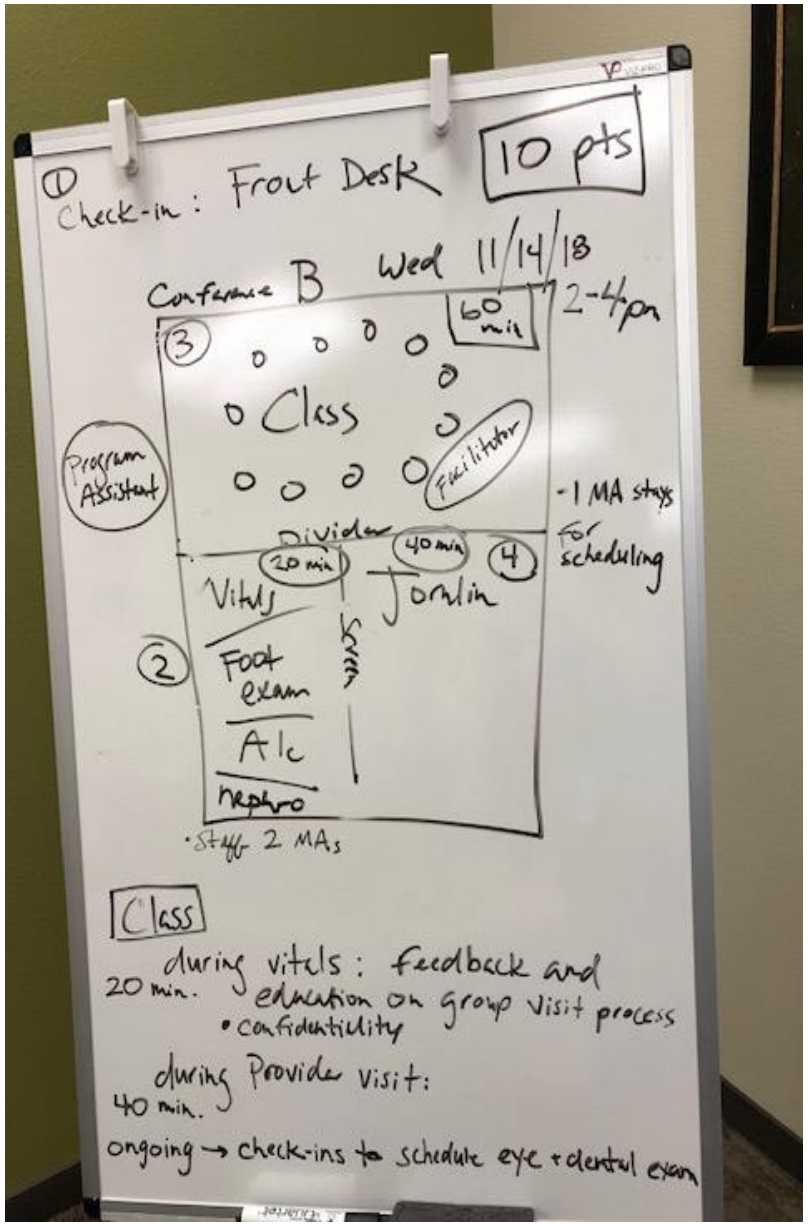
Who We Are

- Located north-east of Sacramento
- We serve AI/AN and low income clients. Our total population served in Medical was 11,000 last year.
- 2 clinic sites- Auburn and Grass Valley
- We have been using eCW for about 16 months for EHR

The Way We Were

- Provider Access was an issue
  - Our population has grown over the past couple of years. Providers often booked out 6-10 weeks.
- Group visits have been talked about for at least 2 years
- No movement forward due to:
  - No one in charge
  - What would group visits look like?
  - Do we have the space to do it?

- Dr. Carolyn Shepherd, our PHLN coach as a mentor.
- We jumped in planning a group visit
  - Getting buy in from the organization was not an issue
  - Dr. Mulligan was the driving factor. Deb DeCarlo, Diabetes Program Manager and Brandon Bettencourt, Director of Quality Improvement put together the plan of how we would organize the first group visit
- Visit set up in Conference Room in the clinic – space divided in half
  - Facilitator(Lifestyle Coach) to lead education/information session
  - 3 MA's to do VS, foot checks, blood work, vaccinations etc
  - Diabetes program assistant to bring pts to room & schedule appts with Diabetes team and retinal screens
  - Dental assistant to schedule dental appts
  - PCP to see each patient in screened off area



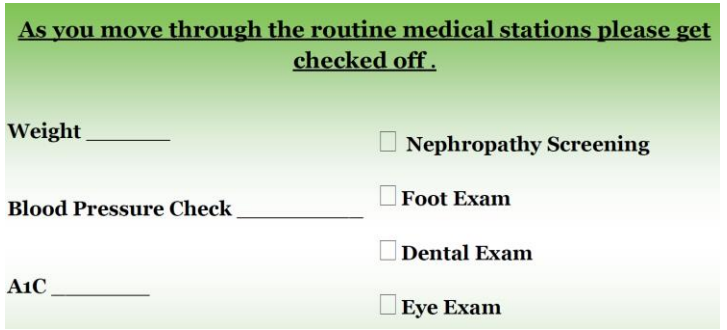
- eCW may not be giving the exact info we need all in one place
- MA's need to do chart prep
- Having patients scheduled before the group visit may delay starting
- Schedule many more patients- 38% attended

Just Do It: decide what you think will work best for your facility and give it a try.

Group meeting side

Medical side

Original "passport"



As you move through the routine medical stations please get checked off .

Weight _____

Blood Pressure Check _____

A1C _____

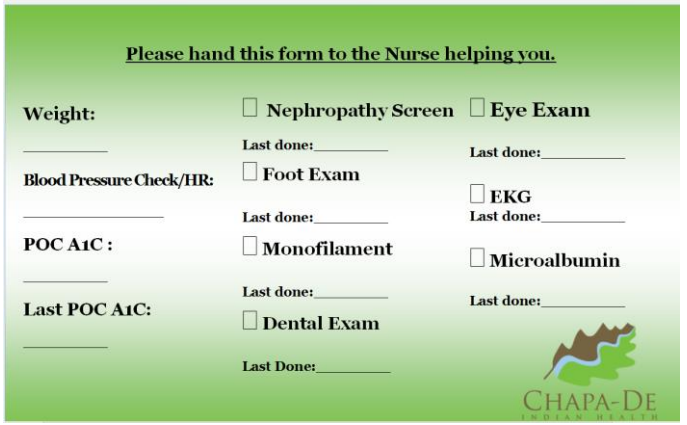
☐ Nephropathy Screening

☐ Foot Exam

☐ Dental Exam

☐ Eye Exam

Updated "passport"
Patient name & DOB on opposite side



Please hand this form to the Nurse helping you.

Weight: _____

Blood Pressure Check/HR: _____

POC A1C : _____

Last POC A1C: _____

☐ Nephropathy Screen Last done:_____

☐ Foot Exam Last done:_____

☐ Monofilament Last done:_____

☐ Dental Exam Last Done:_____

☐ Eye Exam Last done:_____

☐ EKG Last done:_____

☐ Microalbumin Last done:_____

CHAPA-DE INDIAN HEALTH

THE NEXT STEP

- What does your situation look like now?
  - We are moving forward…with some changes
    - Room set up-will have table for patients to sit around on education side
    - Only need 1 table on Medical side
    - Original appt time was 2pm; changing to 1pm so PCP doesn't have pt prior to group appointment
  - We have scheduled group meetings every 3 months for this particular provider
- What are your next steps from here on out?
  - We are currently deciding which provider will be the next to start group visits
  - Tentative plan is to schedule one group visit per provider until all providers are on board

Open Q & A (10 min)

- Contact information:
  - Chapa-De Indian Health
  - Deb DeCarlo Diabetes Program Manager ddecarlo@chapa-de.org
  - Brandon Bettencourt Director of Quality Improvement bbettencourt@chapa-de.org

Axis Community Health

axis community health

Who We Are

- Community Health Center Serving Eastern Alameda County and Southern Contra Costa County
- 70% Managed Care Medicaid / 15% HealthPac / 10% Medicare / 5% Private Pay
- 6 Sites
- NextGen ➔ OCHIN EPIC

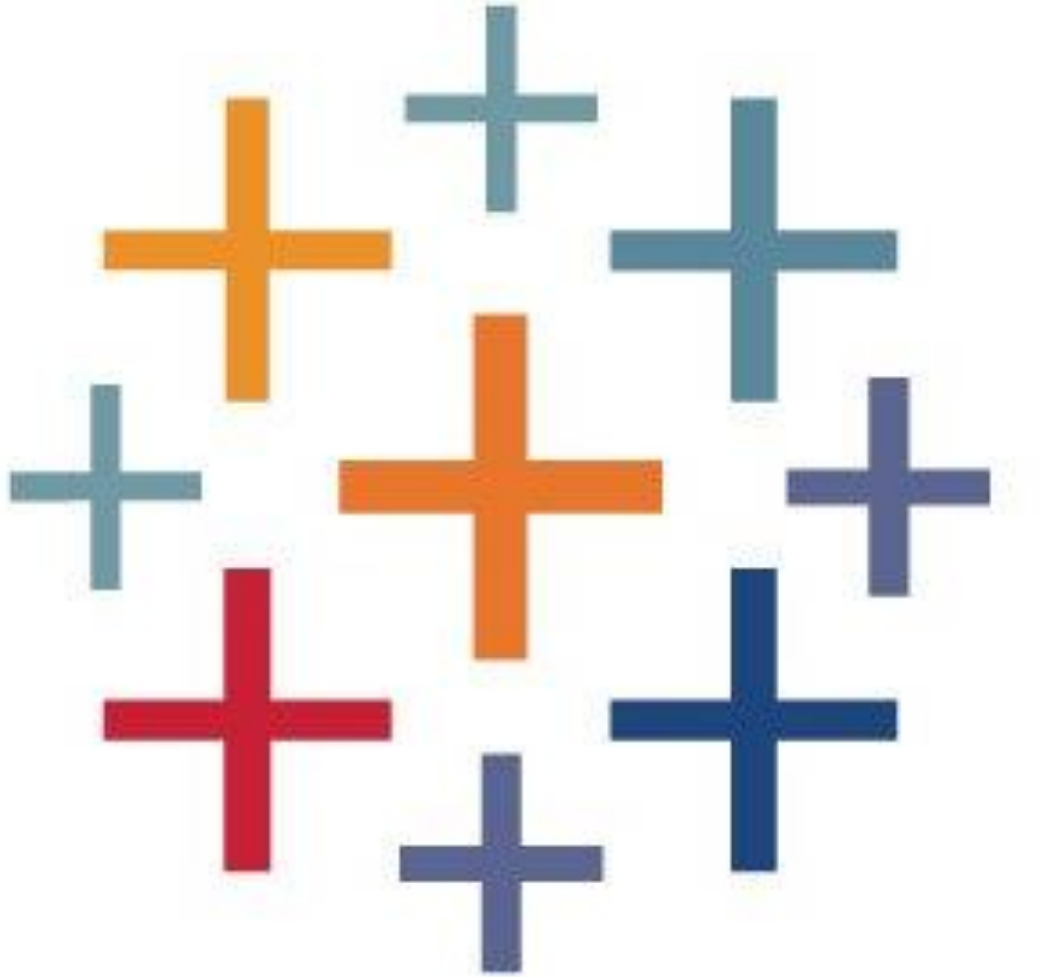
Previous Situation

- Most of the focus has always been on Clinical Care and Quality
- Lack of Behavioral Health Quality Indicators or Program
- Unable to assess BH program and effectiveness
- Unable to measure health outcomes relating to patients' Mental Health
- Defining what a BH population is. Not every patient is diagnosed with a BH condition
- Built the capacity to serve BH population without actually having real time data to act on
    - Moving away from passive referrals to proactive outreach and motivational interviewing

The Change

Strengthen the Behavioral Health program by developing:

- ✓ A set of BH specific reports
- ✓ BH Disease Registry



Lessons Learned So Far…

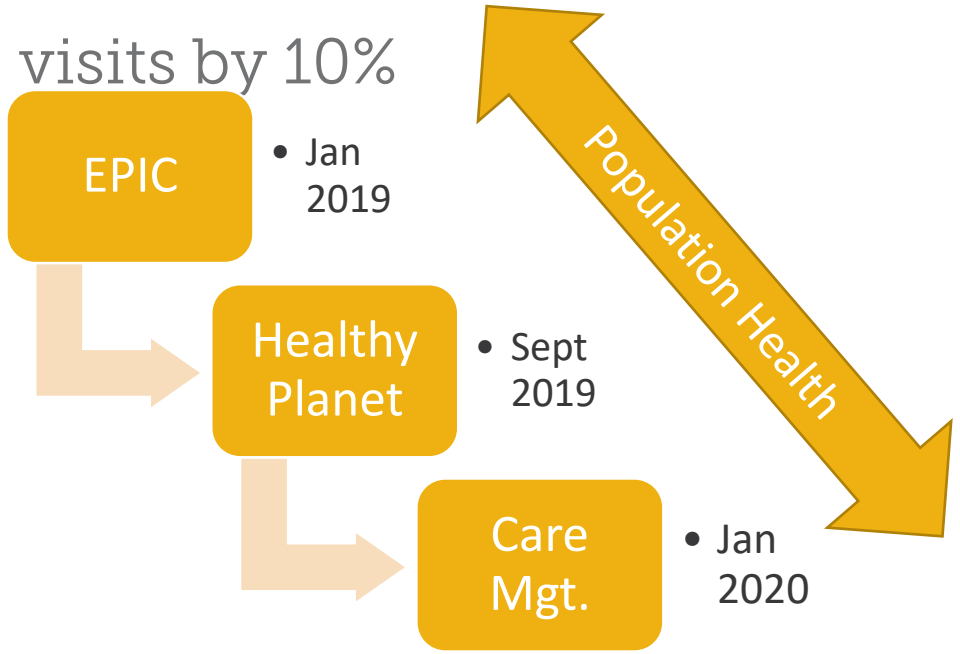
- Come to a consensus around what a BH population is: Diagnoses ➔ Medications ➔ Referrals ➔ SDOHs
  - Project Management: schedule reoccurring meeting with Key Stakeholders (BH, Primary Care, Quality, I.T.) and assign deliverables
- Outreach: Not effective unless you use a patient engagement model to motivate the patient to come in for an intervention
- Must develop a workflow to track the patient and document the alternative touches

Next Steps/Current Situation

Preliminary Results:

- Increased the % of patients with a BH Dx & accessing BH services from 35% to 49-50%
- Increased BH visits by 10%

Next Steps:



Open Q & A

- Contact information:
  - Axis Community Health
  - Amit Pabla, MHA
  - apabla@axishealth.org

Upcoming Activities & Reminders

Activities

- **January 16-17, 2019:** In-Person Convening #2 at the Westin Los Angeles Airport.
- **January 17, 2019:** Year 2 Grant Opportunity Announcement. Applications due February 8th.

Reminders & Asks

- Register for the Convening by December 14th!
- Sign up for Deeper Dive Learning Labs by January 4th
- Complete your Pre-Work slides by January 4th (check Meaghan's email).


CCI
CENTER FOR CARE
INNOVATIONS
Questions?

Thank you!

Please fill out the post webinar survey!

For questions contact:

Megan O'Brien
Senior Program Manager, VBC
Center for Care Innovations
mobrien@careinnovations.org

Diana Nguyen
Program Coordinator
Center for Care Innovations
diana@careinnovations.org