CCI
CENTER FOR CARE INNOVATIONS

Final Convening

Virtual Care Innovation Network

A community health collaboration founded by KAISER PERMANENTE®

MAY 31, 2022, 12 – 2 PM PDT

Agenda

1. Housekeeping & Agenda Review
2. Project Life Cycle
3. Coaches Share Out
4. Break
5. Cohort Conversations
6. Guest Speakers
7. Wrap & Next Steps

Welcome!

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 we will answer them during Q&A

Naming

Add Your Organization

Represent your team and add your organization's name to your name. You can also add your pronouns

Tech Issues

Here to Help

Chat Nhi Tran privately if you are having issues and need tech assistance.

This webinar is being recorded & will be posted on the program's academy page

Connecting Your Phone to Zoom Audio

Step 1

Find “Mute”

At the bottom of your Zoom screen, click the upside-down carrot (^) next to “Mute.”

Step 2

“Switch to Phone Audio”

Choose the option “Switch to Phone Audio” in the list.

Step 3

“Phone Call”

In the pop-up, make sure the “Phone Call” tab is selected. Follow the instructions.

Step 4

Enter Your IDs

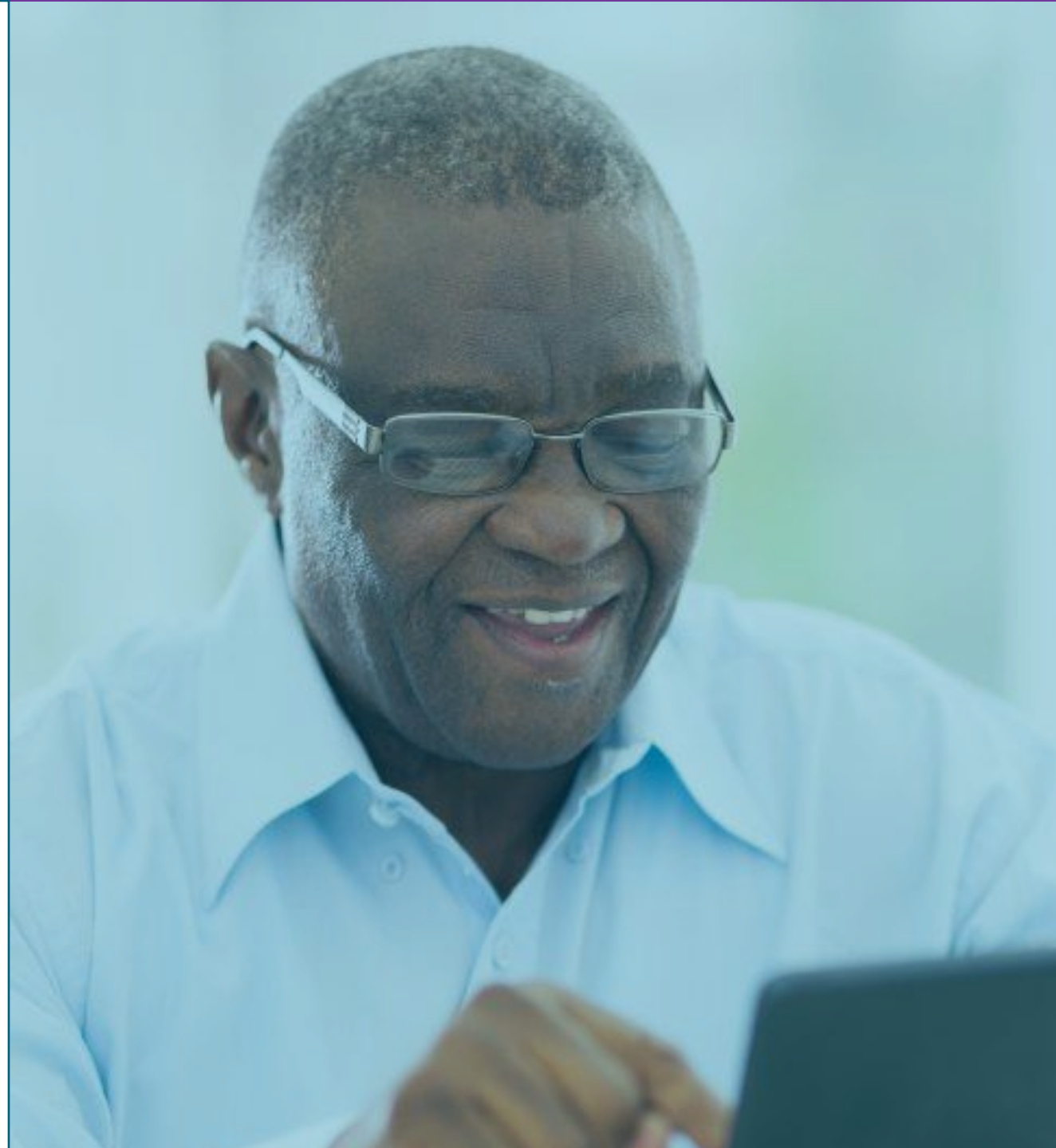
Enter your Meeting ID and Participant ID. *Do not skip this step!*

What goals did we have when we started?

Expand access to high-quality virtual care, including supporting homeless health care providers to address the complex needs of individuals experiencing homelessness

Support the safety net to rapidly design, test, learn and share virtual care strategies

Support the sustainability of the health care safety net to serve communities impacted by COVID-19 by supporting continued reimbursement for telehealth



Program Participants

Washington - 8 health centers

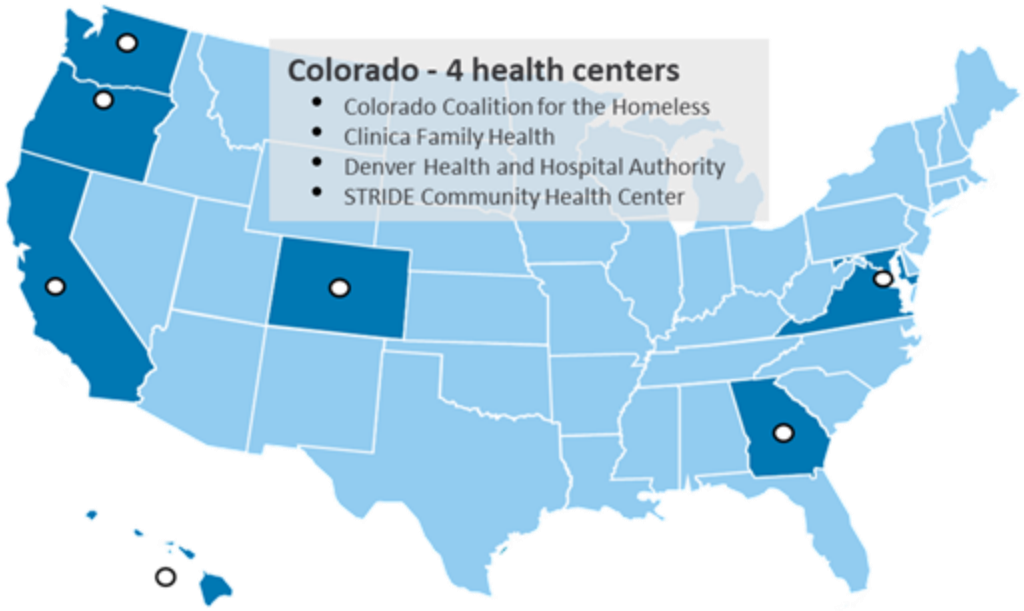
- Country Doctor Community Health Centers
- Public Health Seattle and King County
- Yakima Neighborhood Health Services
- CHAS Health
- Unity Care NW
- Neighborcare Health
- Cowlitz Family Health Center
- Valley View Health Center

Oregon - 5 health centers

- Outside In
- Multnomah County Community Health Center
- Wallace Medical Concern
- Clackamas County Health Centers
- Neighborhood Health Center

California - 27 health centers

- Alliance Medical Center
- Asian Health Services
- Bay Area Community Health
- Clinica Msr Oscar A Romero
- CommuniCare Health Centers
- Eisner Health
- Elica Health Centers
- Family Health Centers of San Diego Inc
- Golden Valley Health Centers
- KCS Health Center
- LifeLong Medical Care
- Los Angeles Christian Health Centers
- Marin Community Clinics
- Mission City Community Network
- Neighborhood Healthcare
- Northeast Valley Health Corporation
- Peach Tree Healthcare
- Petaluma Health Center
- Roots Community Health Center
- San Francisco Community Clinic Consortium
- San Francisco Department of Public Health Fourteen Primare Care Health Centers
- San Mateo County Healthcare for Homeless and Farmworker Health Program
- South Bay Family Health Care
- TriState Community Healthcare Center
- TrueCare
- Vista Community Clinic
- West County Health Centers



Colorado - 4 health centers

- Colorado Coalition for the Homeless
- Clinica Family Health
- Denver Health and Hospital Authority
- STRIDE Community Health Center

Maryland, Virginia, & D.C. - 10 health centers

- Community of Hope
- Family Health Centers of Baltimore, Inc.
- GPW Health Center
- Greater Baden Medical Services
- HealthWorks for Northern Virginia
- La Clinica del Pueblo
- Mary's Center for Maternal and Child Care Inc.
- So Others Might Eat
- Total Health Care
- Unity Health Care

Georgia - 1 health center

- Center for Pan Asian Community Services Inc Community Health Center

Hawaii - 4 health centers

- Community Clinic of Maui Inc.
- Hawaii Health and Harm Reduction Center
- Kokua Kalihi Valley Comprehensive Family Services
- West Hawaii Community Health Center

KAISER PERMANENTE®

Project Lifecycle

We are here!

March & April ‘21

1. Define

Define the problem you will solve over the next 15 months and set a target.

May & June ‘21

2. Discover

Uncover the current state. Learn from those that experience your processes.

July & August ‘21

3. Prioritize & Design

Select and create tests of change that may improve your processes.

September – February ‘22

4. Test & Refine

Test your improvement ideas and measure their impact.

March – May ‘22

5. Implement & Spread

Hardwire and spread successful tests.

Patient Portal Enrollment & Engagement

GOAL

Increase patient portal enrollment and engagement within specific population(s)

Workflow / Process

- **Staff ensure a clear browser** prior to launching the MyChart application or open a new browser window
- **Assist in person** when patient is on site to set up and access portal
- **Develop processes for family sign-up** using proxy features rather than individual sign-ups, often families usually help older family members (patient / caregiver engagement)
- **Schedule video visits** as a follow-up from in person visit
- **Complete each check** prior to patient leaving the clinic
- **Set up video visits in blocks**, providers work from home to reduce burn out
- **Consider adding care navigators**
- **Trade off ideas** — staff to know that they aren't being asked to do more work

Staff Provider Engagement

- **Create staff buy-in** which can include internal adoption (staff take the tool and initiate the electronic tool and engage the activity)

Language Accessibility

- **Develop central team of bilingual / bicultural care navigators** to guide patients through technical barriers
- **Improve care coordination instructions** for non-English speakers' patients in after visit summary (e.g., maps for referrals in their language, video instructions for Google map links)
- **Educate providers** how to effectively work with interpreters
- **Have interpreters available** for video visits through a video connection, not only audio
- **Develop a process to collect a patient's correct dialect** to find the right interpreter for the video visit
- **Improve MyChart in Spanish**, currently not all in target languages

Community Engagement

- **Explore partnerships** with health centers, housing, and social services organizations
- **Continued relationship building** and shared understanding between privacy officers and other leaders
- **Participate in community events** attended by non-English-speaking patients to educate the community about the benefits of video telehealth
- **Use patient education videos** to encourage patients download all necessary software in the clinic

Technology Infrastructure

- **Inform patients about hot spots** available for use (e.g., parking lots)
- **Tablets provided should have account access**
- **Leverage existing tools** in electronic health record system
- **Identify resources** for further training (patients and providers)
- **Assess patient access to videos** — it is not always through portal

Increased Access & Capacity to Virtual Care

GOAL

Increase access and capacity to provide virtual care to specific populations that experience barriers

Patient Education & Engagement

- **Develop preparation materials / instructions for virtual care** with technical guidance and materials explaining benefits / opportunities of virtual care
- **Identify patients with upcoming telehealth visits** and connect patients and help navigate telehealth platform before visit
- **Establish and promote services** to troubleshoot connectivity challenges
- **Identify a peer mentor** to help patients with technology

Workflow

- **Ensure same-day virtual visit availability** work with provider for schedules
- **Roll out self-request / self-schedule** functionality via MyChart
- **Emphasize simultaneous video visit capability** through MyChart virtual visits
- **Standardized guidance / workflow** to incorporate language resources
- **Provide follow up support** to ensure implementation of video visits
- **Select a sample of patients** to "pilot" or "test" tablets provided on loan for virtual visits.
- **Provide staff devices** with portal access and assign new client to provider

Technology Infrastructure

- **Identify space** for technology and confidential visits
- **Install tech hubs** at community partner locations
- **Provide hot spot** or Wi-Fi to patients
- **"Lending" patient's tablets,** with limited internet access, to use for virtual appointments
- **Provide free or low-cost phones** or resources for free internet / Wi-Fi
- **Charging stations at health center** and community partner locations, solar chargers in the field
- **Organizational IT support** and continued IT support, keep IT involved to explore various digital platforms

Community Partnerships

- **Identify barriers such as transportation** and work with local groups to address them
- **Hire from within the community**
- **Patient navigator to regularly visit partnered sites** and ensure their telehealth equipment works
- **Complete memorandum of understanding** with community partners
- **School partnerships** that use student volunteers to help patients navigate the virtual world
- **Utilize therapists** to help patients with coping skills

Staff Engagement & Education

- **Staff scripts and training** to emphasize the various functions MyChart can offer patients
- **Promote remote virtual visits** as an option for patients with access to broadband and mobile devices to address transportation difficulties
- **Identify a telehealth provider champion** — shares success of telehealth and helps increase buy-in with other providers
- **Mobile case managers and medical assistants trained to help with initial MyChart setup** after a visit, while patient is face-to-face with support staff; staff receive "super user" training
- **Staff materials explaining benefits** / opportunities of virtual care
- **Establish staff recruitment** to aid with retention

Remote Patient Monitoring (RPM)

GOAL

Improve management of chronic conditions by increasing access to remote patient monitoring

Patient Education & Engagement

- **Identify barriers**, such as transportation; provide aid (e.g., taxi voucher)
- **Encourage family members** to learn device and usage
- **Provide device teaching** — tablets, phones, etc.
- **Make instructions** easier to understand
- **Improve program commitment** and adherence to appointments
- **Create videos** to support patients to self-troubleshoot
- **Educate on proper use** and carry over of cuffs and tablets
- **Patient assessment** to determine whether they would be successful using remote patient monitoring
- **Improve management** of chronic conditions by increasing access to remote patient monitoring

Workflow / Process

- **Plan for troubleshooting visits** during recruitment
- **Conduct digital health survey** to systematically assess barriers
- **Work around patient's schedule**
- **Conduct frequent check-ins** with patient
- **Send text notifications** and reminders
- **Providers create a congruent care plan** (e.g., hypertension management)
- **Create a referral system**
- **Create schedules and reminders** that are easier for both staff and patients to see
- **Develop real time information upload** for accuracy and quicker response time
- **Develop staffing model** to support deployment and sustainability of program

Language Accessibility

- **Change phone language** to patient's primary language
- **Replace the English words** on device's buttons with stickers in patient's language
- **Have instructors** that speak Spanish / multiple languages
- **Create instructions** in Spanish / multiple languages

New Roles & Responsibilities + Staff Engagement

- **Digital health advocate**
- **Train all staff** so they are able to help patients with technology
- **Involve family members** in remote care process and trainings
- **Develop staffing model** to support deployment and sustainability of program
- **Third party providers to help** with outreach, data dashboard, and alerts

Technology Infrastructure

- **Troubleshoot technology** for home visits
- **Increase access to smartphones**
- **Increase access to blood pressure monitors**
- **Improve patient accessibility to Wi-Fi** and remote patient monitoring devices
- **Improve organization of referrals** in the electronic health record (increasing referrals)

Street Medicine & Mobile Units

GOAL

Improve access to care for unhoused individuals by leveraging virtual care to enhance street medicine and mobile unit programs

Staff Role, Responsibilities, and Engagement

- **Standardize training for all,** including new hires, and orient team to virtual visits model
- **Train frontline staff** on how to ask sensitive questions on the registration forms
- **Staff look for opportunities to celebrate milestones** with residents
- **Identify team** to complete dry-run of virtual visits
- **Providers adequately refer patients** across the agency for ancillary support services

Technology Infrastructure

- **Test equipment** (mobile hot spots, headsets) and set up Doxy.me on iPad
- **Explore virtual waiting rooms**
- **Identify resources for further trainings** (patients and providers) — provide and obtain phones

Workflow and Programs

- **Coordinate with clinic managers** and develop standby workflow
- **Establish workflow** of who, where, and how appointments are made
- **Establish secure message** to send pictures to doctors then conduct telephone visits
- **Ensure the provider has blocked time** for "walk in" telehealth appointments
- **Update registration form** and transfer information on the registration forms to patient's health record
- **As part of the appointment reminder call**, assess whether the patient would be able to access telehealth (e.g., mobile device, service, tech knowledge, etc.)
- **Hold weekly staff meetings** — discuss questions, thoughts, concerns
- **Clinic staff readily available** in-person and over the phone for residents

Patient Education

- **Educational material** on how the process works, roll-out "how to" posters
- **Inform patients of staff role** while session is underway
- **Have a script** explaining the whys of the virtual visit, process, and privacy
- **Orient patients** on how to use the device, orientation videos for sessions
- **Assist patients** with telephone set up and foster follow ups
- **Incentives for patient engagement,** follow-ups, and friend referrals
- **Boost internal marketing** of kiosks

Virtual Care Learning Hub

- CCI is sharing the best of the best for achieving health equity through virtual care. We've synthesized 20+ years of experience to create this learning hub filled with great ideas you can start testing right away.
- https://www.careinnovations.org/virtualcare/

Coaches Share Out

Teams Coached by Tineciaa Harris & Courtney Pladsen	State
CommuniCare Health Centers	California
Public Health - Seattle and King County	Washington
Northeast Valley Health Corporation	California
San Francisco Community Clinic Consortium	California
Elica Health Centers	California

Teams Coached by Denise Armstorff	State
Greater Baden Medical Services	Maryland
Asian Health Services	California
Outside In	Oregon
Family Health Centers of Baltimore	Maryland
Total Health Care	Maryland
Lifelong Medical Care	California

Teams Coached by John Gilvar	State
So Others Might Eat	Washington DC
Mission City Community Network	California
Eisner Health	California
Hawaii Health & Harm Reduction Center	Hawaii
Family Health Centers of San Diego	California

Teams Coached by Honor Childress	State
Alliance Medical Center	California
Clinica Family Health	Colorado
Clinica Msr. Oscar A. Romero	California
KCS Health Center	California
Yakima Neighborhood Health Services	Washington

Teams Coached by Jim Meyers	State
Peach Tree Healthcare	California
West County Health Centers	California
Tri-State Community Healthcare Center	California
Colorado Coalition for the Homeless	Colorado
Community Clinic of Maui Inc	Hawaii
Denver Health and Hospital Authority	Colorado
STRIDE Community Health Center	Colorado
Country Doctor Community Health Centers	Washington
Multnomah County Community Health Center	Oregon

Teams Coached by Melissa Schoen	State
Petaluma Health Center	California
Center for Pan Asian Community Services Inc. Community Health Center	Georgia
Los Angeles Christian Health Centers	California
La Clinica del Pueblo	Washington DC
Neighborhood Healthcare	California

Break

Cohort Conversations

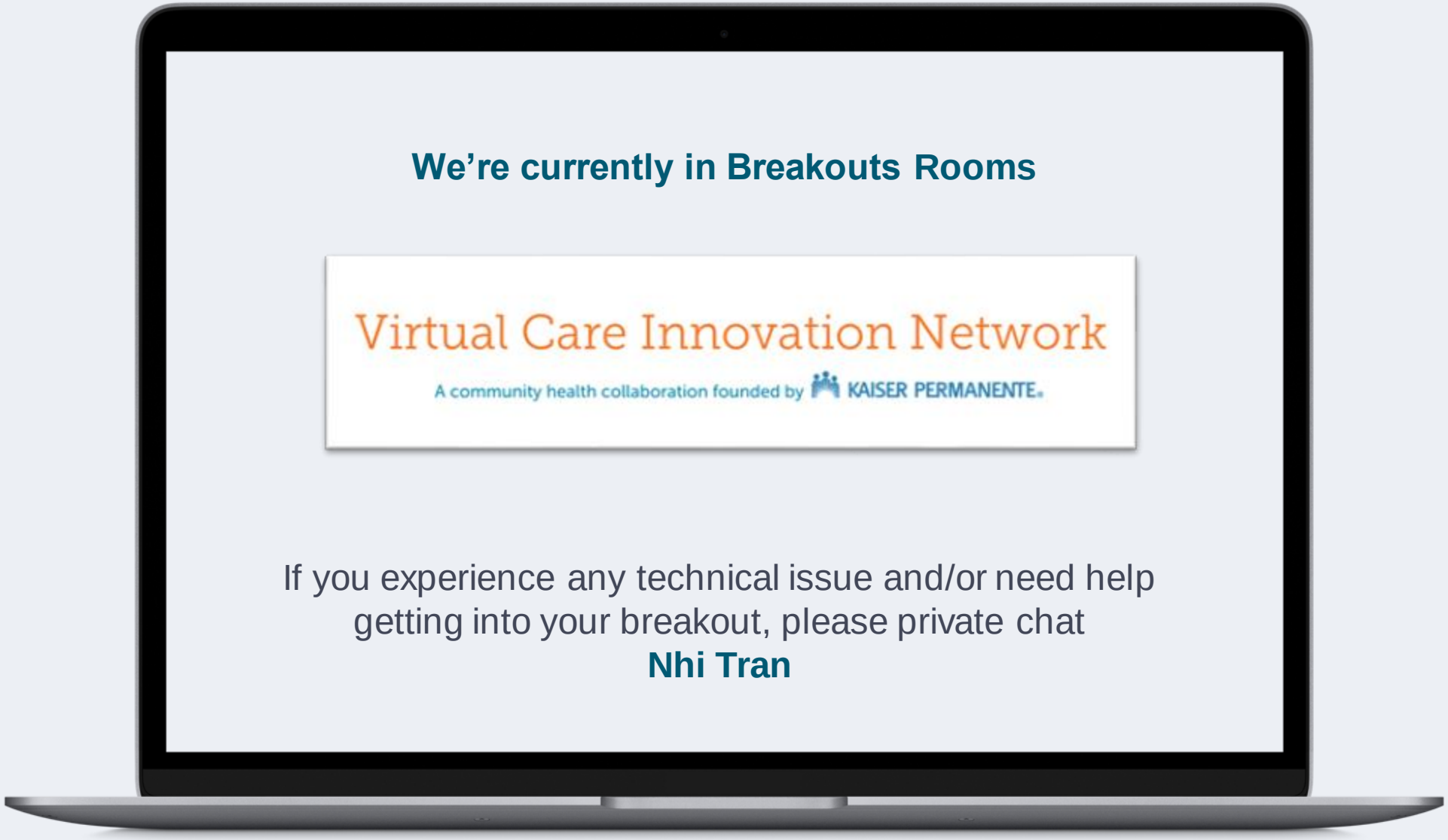
~30 minutes for discussion

1. What were the most exciting or promising tools that you learned from other organizations in VCIN?
2. What are the greatest opportunities and barriers in continuing this work?
3. Is there a particular topic you wish you had an opportunity to hear more about?

Conversation Guidance

1. Please identify which **breakout group number** you are – at the top of the screen.
2. Please assign **a notetaker** to take notes in the shared document on the main themes that the group discussed.
3. Please assign one **person to share out** when we come back for open discussion.
4. Please assign **a timekeeper** – you'll have 30 minutes in your breakout room.

We're currently in Breakouts Rooms



If you experience any technical issue and/or need help getting into your breakout, please private chat
Nhi Tran

Open Discussion

20 minutes for discussion

1. Please share what you heard about the most exciting or promising tools that you learned from other organizations in VCIN.

2. Please share your greatest opportunities and barriers in continuing this work.

3. Please share any particular topics you wish you had an opportunity to hear more about.

Cohort Spotlight

Natasha Jain

Quality Improvement Analyst

Anita Chang

Site Director/Telemedicine Lead

Vivian Quach

Telehealth Coordinator

Final Remarks

Next Steps


Virtual Care Innovation Network
A community health collaboration founded by KAISER PERMANENTE.
How Did We Do?
Take the next 2 minutes to answer our virtual event poll.

Applied Project Final Deliverables

Final Narrative

Due TODAY, May 31
Your final storyboard slides are due in your team's OneDrive folder by EOD today. Please be sure to complete your Project Measures & Data Metrics slides as well.

Final Budget

Due June 15
The final budget template has been emailed to each team in the VCIN monthly newsletter. Please submit your final budget directly by email to Nhi.

Final Data Submission

Due June 15
The most updated excel sheet with your data is in each team's OneDrive folder. Please download a copy to your computer, edit it, and re-upload to your OneDrive folder. If you have not submitted data for any of the previous months, you will need to submit that data as well.

Clinic Connection Final Deliverables – due June 15

Final Narrative

The final narrative template has been emailed to your project lead and grant manager. Please reach out to Nhi if you have not received it or if you have any issues accessing the form.

Final Budget

The final budget template has been emailed to each team in the VCIN monthly newsletter. Please submit your final budget directly by email to Nhi.

Final Data Submission

The most updated excel sheet with your data is in each team's OneDrive folder. Please download a copy to your computer, edit it, and re-upload to your OneDrive folder. If you have not submitted data for any of the previous months, you will need to submit that data as well.

Announcements

CCHE Final Survey

CCHE will be sending out a final endpoint survey to teams by email after our final convening. We value all your feedback, so please complete the survey once you receive it.

Gift Boxes

In appreciation and celebration of all your hard work this past year, CCI will be sending gift boxes to each VCIN team. Each gift box will be addressed to the project lead and sent directly to the address of your organization.

Final Grant Installments

Your final grant installments will be released after we have received all of your final deliverables. Your grant payments will be sent to the same address and with the same payment method as your past payments for VCIN. Please reach out to Nhi at nhi@careinnovations.org if you have any questions or concerns.

Thank You!

Angela Sherwin
She/her/hers

Program Manager
angela.sherwin@careinnovations.org

Nhi Tran
She/her/hers, they/them/theirs

Senior Program Coordinator
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