WELCOME

PHASE Grantee Convening

Engaging Patients as Active Partners

June 11, 2019

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PHASE

PREVENTING HEART ATTACKS & STROKES EVERY DAY

Jean Nudelman

Director, Northern California Community Benefit

Welcome!

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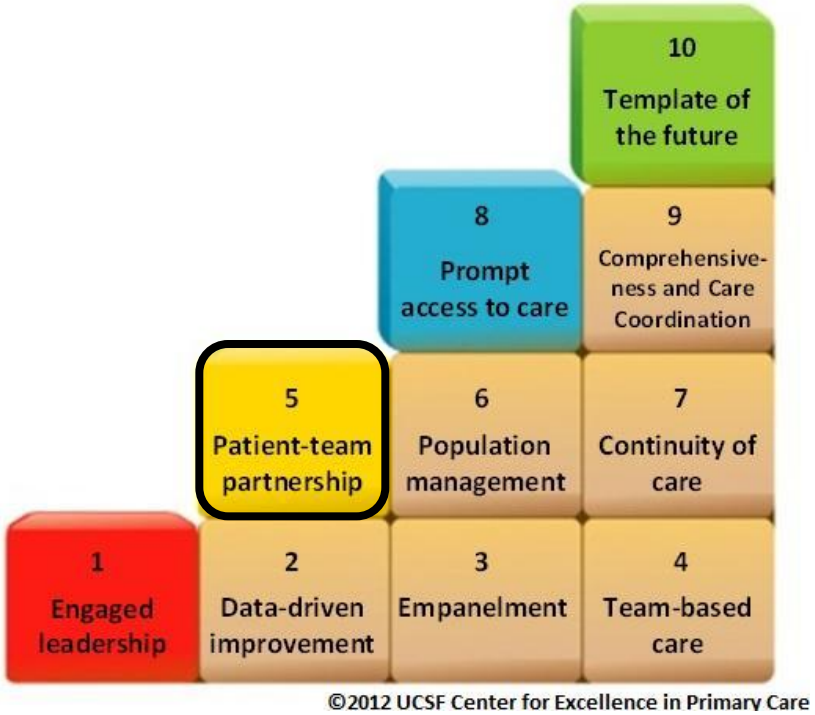
Frameworks

Levels of Patient Engagement

10 Building Blocks of Primary Care



Kristin L. Carman, Pam Dardess, Maureen Maurer, Shoshanna Sofaer, Karen Adams, Christine Bechtel and Jennifer Sweeney Patient And Family Engagement: A Framework For Understanding The Elements And Developing Interventions And Policies doi: 10.1377/hlthaff.2012.1133 *Health Affairs* 32, no.2 (2013):223-231

Agenda

8:30 – 9:00	Breakfast & Registration
9:00 – 9:15	Welcome and Overview of the Day Alexis Wielunski, MPH, Center for Care Innovations Kaiser Permanente Northern California Community Health
9:15 – 10:45	Patient Partnership in Direct Care Moderator: Michael Rothman, DrPH, Center for Care Innovations Care Neighborhood CHW Case Management Program, Community Health Center Network Health Coaching Program for MAs, Livingston Community Health Center Using the Patient Activation Measure, Judith Hibbard, PhD, University of Oregon
10:45 – 11:00	Refresh & Stretch
11:00 – 12:30	Patient Partnership at the Clinic and Systems Levels Moderator: Anjana Sharma, MD, MAS, UCSF Department of Family & Community Medicine Black/African American Hypertension Equity Workgroup, San Francisco Health Network Patient Voice Collaborative, LifeLong Medical Care
12:30 – 1:30	Lunch & Networking
1:30 – 3:00	Workshops Engaging Patients in Self-Management Kate Lorig, DrPH, Self-Management Research Center Virginia Gonzalez, MPH, Self-Management Research Center Using Human Centered Design to Bring Patient Voice to Improvement Projects Diana Nguyen, Center for Care Innovations Jennifer Covin, Health Quality Partners Change Ideas for Patient Engagement Denise Armstorff, Performance Improvement Expert, Master Coach, & Trainer
3:00 – 3:15	Refresh and Stretch
3:15 – 3:45	Team Activity: Reflection and Action Planning Session Denise Armstorff, Performance Improvement Expert, Master Coach, & Trainer
3:45 – 4:00	News from Your Support Partners, Closing & Evaluations Alexis Wielunski, MPH, Center for Care Innovations

Organization:

Patient Partnership in Direct Care	Current State	Session 1 Ideas We Could Try	PDSA Plan
Patient Partnership at Clinic and Systems Level	Current State	Session 2 Ideas We Could Try	PDSA Plan

Your Guide to the Day

PHASE
Champion
Center for Care Innovations

Table: #
WS: ABC

Turn to p. 3 for how to decode your nametag

Slides and materials will be posted at
https://www.careinnovations.org/resources/phase-engaging-patients-as-active-partners/

Look out for a post- convening email with this link!

Michael Rothman, DrPH

Center for Care Innovations

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Angela O'Brien, LCSW

Laura Miller, MD

Community Health Center Network

Care Neighborhood Addressing Patient Needs through Partnership and Trust

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COMMUNITY HEALTH CENTER NETWORK

Care Neighborhood
Addressing Patient Needs through Partnership and Trust

Angela O'Brien, LCSW

Laura Miller, MD

Community Health Center Network

- Founded in 1994, Community Health Center Network (CHCN) is a managed service organization working to improve access to healthcare and the quality of that healthcare to its members in medically-underserved communities throughout Alameda County, CA and surrounding counties.
- In 2017, CHCN member health centers served 263,084 patients with 1,225,508 visits.
- CHCN contracts on behalf of eight health center organizations for professional risk, giving all members access to primary care at our health centers and specialty care services
- Services provided include:
  - Utilization Management
  - Provider Relations
  - Eligibility
  - Claims
  - Inpatient / Concurrent Review
  - Special Projects

Health Center Organizations

Context

Healthcare spend is concentrated in a small percentage of members with frequent hospital use

These “high utilizer” members have complex medical, behavioral and social needs

Complex case management programs exist at health plans but have had challenges outreaching and engaging members

Federal and state funding incentivizing new care models for high risk members and social determinants – Health Homes, Accountable Health Communities, Whole Person Care Pilots

Care Neighborhood Key Program Elements

Case Management System

CHCN developed a case management system for CHWs. The system integrates claims, EHR and community data to drive workflow and help CHWs manage their high risk panel.

Inpatient Support

CHWs are notified in real time of an inpatient admission and work with CHCN inpatient RNs on discharge planning.

Data Analytics

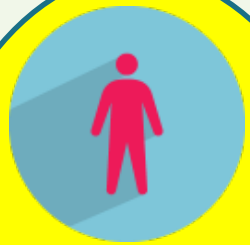
CHCN developed a predictive risk model to identify high risk patients. CHCN also provides monthly dashboards and is conducting an impact evaluation.

Embedded Care Team

Care is given by an embedded care team that includes a community health worker, who is the primary care coordinator.

Technical Training and Support

Experienced SWs train and provide consultative support for CHWs.



Person Centered Care

CHWs employ a person centered approach and use techniques such as motivational interviewing, harm reduction, and trauma informed care to build meaningful relationships.

COMMUNITY HEALTH CENTER NETWORK

Person-centered care and empowerment

Care Neighborhood Model --2019

Case Identification

- CHCN receives list of eligible patients from AAH
- These members are identified in Welkin, CHCN's complex case management system which is used by the embedded care team
- Providers can also refer into the program. Referrals will be sent to AAH for review.

Outreach

A clinic-based community health worker, with support from an RN and SW:

- Completes a pre-outreach review of utilization and the EHR medical record
- Outreaches to member at a clinic appointment, phone call, or hospital visit. On average, it takes 3-4 interactions with a member to engage

Assessment

All engaged high risk members receive a general health and social determinant assessment (BA) with triage and referral to an appropriate high risk program

Care Neighborhood Intervention

Case management program includes:

- Comprehensive Biopsychosocial Assessment and Care Plan (Supervisit)
- Navigation, Home visits, Care Coordination
- Education around chronic conditions
- Enhanced CHCN support services around inpatient concurrent review , prior authorizations and transitional care
- Linkage to community and social supports
- Accompaniment to medical or other community appointments as needed

Other Programs for High Risk members

- Integrated Behavior Health
- Addiction or substance abuse treatment
- Sutter's Advanced Illness Management (AIM)
- CBAS
- SMI coordination

Pre-Outreach Review

- Before outreach, CHW dives into EHR and Welkin
- EHR clues: Inpatient admissions, ER visits, chronic conditions, behavioral health notes, medications, referrals, missed appointments, references to SDOH needs. Generates ideas on how to support patient.
- Welkin clues: Count of IP and ER, specialty claims, ACG risk score.

Pre-outreach review

Example:

High outreach priority, 7 ER, 3 IP, risk score 12, HTN, DM2 (A1c 9.2), COPD, schizophrenia, sees community BH, 50% no-shows, homeless, needs to see endocrinologist.

Possible impact: housing, transportation, POH, med. education and adherence, navigation to endocrine appt, perhaps more!

Basic Assessment (BA)

- CHWs outreach to patient with a fixed set of questions, information from pre-outreach review woven in
- Each BA is both standardized and personalized, with questions around food, housing, income, transportation, and caregiving needs
- Goals are created based on need and patients requests.
- Trust is formed prior to enrollment

Care Neighborhood CHW Basic Assessment and Outreach

Pt. Name: Provider: Date of Outreach Attempt:

Pre-outreach review findings to weave into questions (key medical needs, clinic access)

_____

_____

_____

Identify needs:

Food	**In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?**	Yes / No
	Are you receiving CalFresh/EBT/Market Match? (will not qualify if on SSI) (consider referral)	
	Have you ever tried a food pantry/food bank? Interested in one near your home?	
	Do you have problems shopping for or preparing your own food? (consider IHSS, MOW)	
	Ask about chronic conditions in relation to food here (diabetes, high blood pressure. Consider referral to POH)	
	Assess if patient is eligible for any clinic resources	
	Notes	
Transportation	**In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?**	Yes / No
	Do you need: disabled placard, disabled/senior bus pass, Paratransit, insurance benefit?	
	Assess if patient is eligible for any clinic resources	
	Notes	
Financial	**Do you have an income right now?**	Yes / No
	What is the source of your income?	
	Are you pursuing any type of disability? (SSI, SSDI, etc. consider referral to Bay Area Legal Aid)	
	Do you have debt, need connection to CalWorks or employment resources?	
	In the past 12 months, has your utility company shut off your service for not paying your bills?	Yes / No
	Discuss PG&E Care program, Lifeline telephones, EBMUD discount, HEAP	

	Notes	
Housing	**Do you have a safe, stable place to sleep and store your possessions?**	Yes / No
	Are you worried that in the next 2 months, you may not have this situation?	Yes / No
	Are you in need of finding alternative housing? (consider Home Stretch referral if literally or chronically homeless)	
	Do you need advice about renter's rights (eviction, bad conditions like mold, rodents, insects, etc.)	
	Notes	
IHSS	**Do you have or need a caregiver?**	Yes / No
	Does this person get paid through IHSS? (consider application for IHSS and/or Alameda County Care Alliance)	
	Do you need to find a new IHSS worker? (consider application for IHSS registry)	
	Notes	

Supervisit and enrollment

- Each step feeds the next
- Supervisit = patient agreement signed, a biopsychosocial assessment, medication list, ADL/IADL and DME screen, PHQ-9
- Short and long term goals are created and the patient drives the goal priority for. No goals are added to the care plan if the patient does not want to work on them

Patient: Date of Visit: Meeting Location:

Provider: CHW:

Check items that patient has, circle what is needed

	Details
Name/Pronoun	Preferred Name: Preferred Pronoun:
UPDATES	Address: ***Please add any new addresses directly to NextGen Phone: Emergency Contact #1 Name: Emergency Contact #1 Phone: Emergency Contact #2 Name: Emergency Contact #2 Phone: Do we have a ROI for patient's selected contacts? ☐Yes ☐No
Support System	**Family** Name: Relation to patient: Additional family members as needed: Name: Relation to patient:
	Community Name: Relation to patient: Additional community members as needed: Name: Relation to patient:
	Pet:
	☐IHSS Hours/month: ____ ☐Other: _____ ☐ Issues Caregiver: Caregiver:
Transportation	☐Car ☐Public ☐Family/Friend ☐ParaTransit ☐ City Paratransit ☐ Health Plan
Housing	☐Subsidized ☐Section 8 ☐Rent ☐ Own ☐ Needs repairs/mold/vectors ☐ Homeless

COMMUNITY HEALTH CENTER NETWORK

Safety / Medical Equipment	Are you concerned about your personal safety? ____ *Also see ADL/IADL and DME Screening
Food Access	☐Meals on Wheels ☐Food Bank/Pantry ☐ Cal Fresh ☐ Market Match ☐ POH ☐None
Daily Activities	☐ Support Groups ☐ Day Program ☐ Volunteering ☐ School ☐ Church/religious ☐Caregiver Support ☐None
Finances	☐ Employed ☐GA ☐ SDI ☐ SSDI ☐SSI ☐ CalWorks ☐ none ☐CAPI
Health Insurance	☐ Dental ☐ Vision ☐Specialist ☐Podiatry ☐None
Legal	☐ Public Benefit assistance ☐ Safety at home (intimate partner violence?) ☐ Immigration/Nationalization ☐ Post incarceration ☐ Debt ☐None
Medications	**Reconciliation:** ☐ done recently ☐ needs to be done ☐ nurse visit ☐None **Services:** ☐ BubblePack ☐ Delivery **Current Pharmacy** Name of Pharmacy: Address and contact information: Name of Pharmacy: Address and contact information:
Behavioral Health	Current BH support: Psychiatry: Counseling: History (from chart/ team) ☐ Trauma ☐ 5150 ☐ SI ☐HI Mental Health: ☐ PHQ-9 ____ ☐ Needs:
Substance Use Hx Healthy Drinking Limits Per Day Women: ≤ 4; Men: ≤ 5 65 and older: ≤ 3	☐ Tobacco Use If tobacco is currently used, how often? _____ Alcohol: How many times in the past month have you had 4/5 or more drinks in a day? Substance Use: How many times in the past month have you used an illegal drug or used a prescription medication for non-medical reasons?
End Of life Issues ***DPA:***	☐ Advanced Directives Location: ☐ POLST Location:

Early Success
2016 pulse check

	Control	Care Neighborhood	Change from expected utilization without treatment
Inpatient Admission	+2%	-41%	43% less utilization
ER visits	-20%	-41%	21% fewer ER visits
Specialty Visits	-17%	+11%	28% more specialty visits
PCP appts.	-34%	-2%	32% more PCP visits

"My experience with Care Neighborhood has been very impressive. My case manager empowered me to take on a more active role in my rehabilitation. She allowed me to realize the importance of taking charge of my own health, while at the same time, offering guidance in avenues where I may need some extra support."

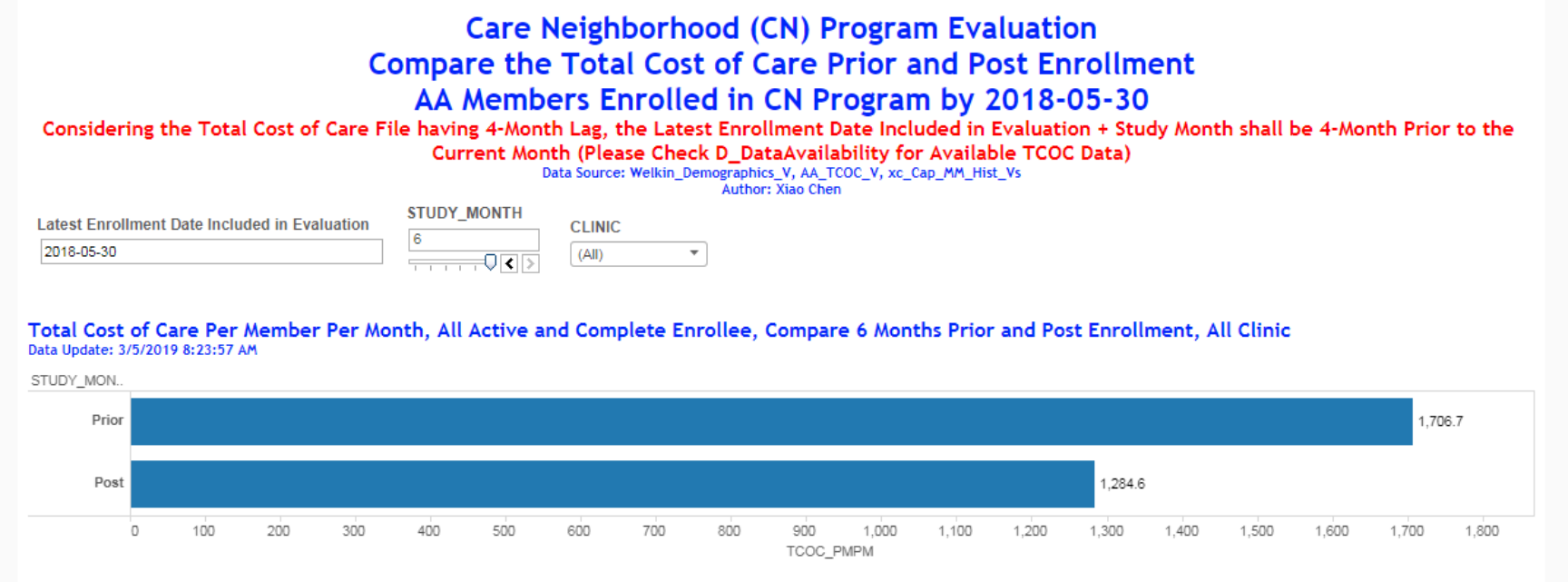
- Care Neighborhood Member

"Having more staff besides medical providers serving our members has been helpful. We appreciate support from others. Members appreciate the attention they receive."

- Provider, LifeLong Medical Care

Control = 80 propensity score matched members
N = 41 members enrolled in Care Neighborhood at least 7 months
Pre = 1-180 days before enrollment; Post = 31-210 days after enrollment

CN showed cost reduction -- 2018



- Total cost of care data for ALL health centers involved in CN
- Data for AAH members only
- 6 months pre and 6 months post
- Members enrolled by May 30, 2018
- Total number of members represented in this analysis = 1047 members
- Savings of $458.10 per member per month

Care Neighborhood right now

- Successful pivot to AC3 (Whole Person Care) population
- In contract process for HHP (Health Homes Program) with AAH and ABC for July 1, 2019
- 24 CHWs, all 8 health centers have at least one CHW
- 2,263 people served to date, with almost 400 currently in care.

Questions?

Rosa Pavey, LVN

Hope Perez, LVN

Livingston Community Health

The Journey to Health Coaching

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The Journey to Health Coaching

Presented by :
Rosa Pavey, LVN
Hope Perez, LVN

Livingston Community Health is a non-profit Federally Qualified Health Center (FQHC) established in 1970.

We currently have seven sites throughout Merced and Stanislaus County

Mission:
To provide comprehensive primary & preventive health care services to all patients regardless of their ability to pay.

Livingston Community Health Campus

Opened 5/6/2019

Why Start the Journey?

Health Coaching…….

- Creates Team-Based Care
- Allows Medical Assistants to function at the Top of their Scope
- Creates a Career Ladder
- Improved Patient Outcomes

The Impact of a Health Coach

A Health Coach…….

- Creates partnerships with patients to help identify their skills, strengths and abilities
- Builds a relationship to assist in identifying barriers
- Unlocks a patient's potential by teaching and utilizing behavior change techniques.
- Empowers patients to take charge of their lifestyle choices and actively participate in their healthcare to reach self-identified goals.

Health Coach Training

Approximately 30 hours of combined Theory and Practice Sessions which included;

- Observation
- Discussions
- Role Play
- Motivation Interviewing
- Written Exam
- Skills Observation

Health Coach Interventions

- Diabetes/Foot Exams
- Hypertension
- Obesity
- Hyperlipidemia
- Asthma

Health Coach Foot Exam Training May 2019 With Dr. John Abordo

Health Coach Process

Patient Visit Summary (Health Maintenance Form)

									Last Vitals	This Visit
Patient ID:	92911	MR:	92911	Age:	32 Yrs	DOB:	2/22/1987	Sex: F	Date:	5/23/2019	
Name:	Test, Lauren Portal			Race:	White				Height (inches):	65	
Address 1:	1234 Raleigh Street			Language:	English				Weight (lbs):	100	
Address 2:				Phone:	111-111-1111				Blood Pressure:		
City:	Raleigh			PCP:	Qadeer MD, Afnan A				BMI:	16.64	
State:	NC	ZIP:	27603	Insurance:	Managed Care				LMP:	7/3/2018	

ALLERGIES: NO KNOWN ALLERGIES - Allergen; Penicillin

PROBLEMS: Childhood obesity - 444862003; Diabetes mellitus - 73211009; Hypertensive disorder - 38341003; Tobacco User, Current

MEDICATIONS: ACE Inhibitor; ADVIL 200 mg (IBUPROFEN); AMOXICILLIN 250 mg (AMOXICILLIN); Antibiotic; Antibiotic *; Antihypertensive ; Antihypertensive Pharmacologic Therapy *; ATENOLOL 25 mg (ATENOLOL); Beta Blocker; BICILLIN L-A 600,000 unit/mL (PENICILLIN G BENZATHINE) - SYRINGE; Lipid Lowering Medications; LIPITOR 10 mg (ATORVASTATIN CALCIUM); LISINOPRIL 20 mg (LISINOPRIL) - TABLET; MULTIVITAMINS - (MULTIVITAMIN); PRAVASTATIN SODIUM 10 mg (PRAVASTATIN SODIUM); PRENAVITE 28 mg-800 mcg (PRENATAL VIT/IRON FUMARATE/FA); PRENAVITE 28 mg-800 mcg (PRENATAL VIT/IRON FUMARATE/FA); Statins; TYLENOL 325 mg (ACETAMINOPHEN)

Alerts:

Immunizations	C	Date	N
Vaccine: Influenza	Received	8/20/2018	

Labs	C	Date	N
HbA1c			
Cr			
eGFR			
LDL			
HDL			
TG			
Microalb/Creat Ratio			
Microalb Serum mg/L			
Microalb Urine mg/dL			
ALT			
K			
Hgb			
FIT			
QFT-TB			
TSH			

Problems	C	Date	N
Pre-Diabetes (Abnormal Gluco			

Procedures / Referrals	C	Date	N
Pap Test, Management	Received	4/10/2018	
Diagnostic Mammogram			
TB Risk Assessment			

Other Values	C	Date	N
SOGI - Gender Identity	Received	10/30/2018	
SOGI - Sexual Orientation	Received	5/7/2019	

Medications

Blood Pressure	
Date	Val
5/17/19	135/78
12/11/17	100/70
12/11/17	118/78

Weight (lbs)	
Date	Val
5/23/19	100
5/17/19	145
4/25/19	150
4/23/19	130
8/20/18	152
12/11/17	100

BMI Percentile	
Date	Val

BMI	
Date	Val
5/23/19	16.64
5/17/19	24.13
4/25/19	26.57
4/23/19	23.03
8/20/18	46.38
12/11/17	30.51

HbA1c	
Date	Val

LDL	
Date	Val

Microalb Urine mg/dL	
Date	Val

Appt Time	Room
8:15 AM	Exam 01
8:45 AM	
9:00 AM	Exam 02
9:15 AM	
9:30 AM	HC
9:45 AM	
10:00 AM	HC
10:45 AM	HC
11:00 AM	
11:15 AM	
1:15 PM	
1:45 PM	HC
2:00 PM	HC
2:30 PM	HC
2:45 PM	HC
3:15 PM	

HTN Health Coach Matrix

MA/HEALTH COACH SERVICES FOR PRE HTN & HTN

MA HEALTH COACH	LEVEL 0	WHAT'S THE GOAL?	MA HEALTH COACH FOLLOW-UP GUIDELINES
Normal HTN DX	<120 <80	Establish An Action Plan: *Healthy Eating *Increase exercise 30 to 60 minutes most days of the week *Decrease fast foods, trgn/sat fat & processed foods. *Decrease sugar & salt intake *Spend less than two hours day watching TV, using computer or playing video games *Decrease or avoid tobacco, alcohol and drugs *Decrease Alcohol Intake	MA/HC will follow-upon Action Plan one month and encourage training for self-monitoring form MA/Health Coach will follow-up 3 - 6 month Reinforce Action Plan, Labs, apt. *Recheck B/P & Log *Obtain labs(Lipids, Potassium) as directed by provider 1)If unable to contact patient after two telephone calls (1 week/calls) 2)Send an inability to contact letter –allow 10 days to respond 3)Remove from health coach follow-up list-if no response from letter

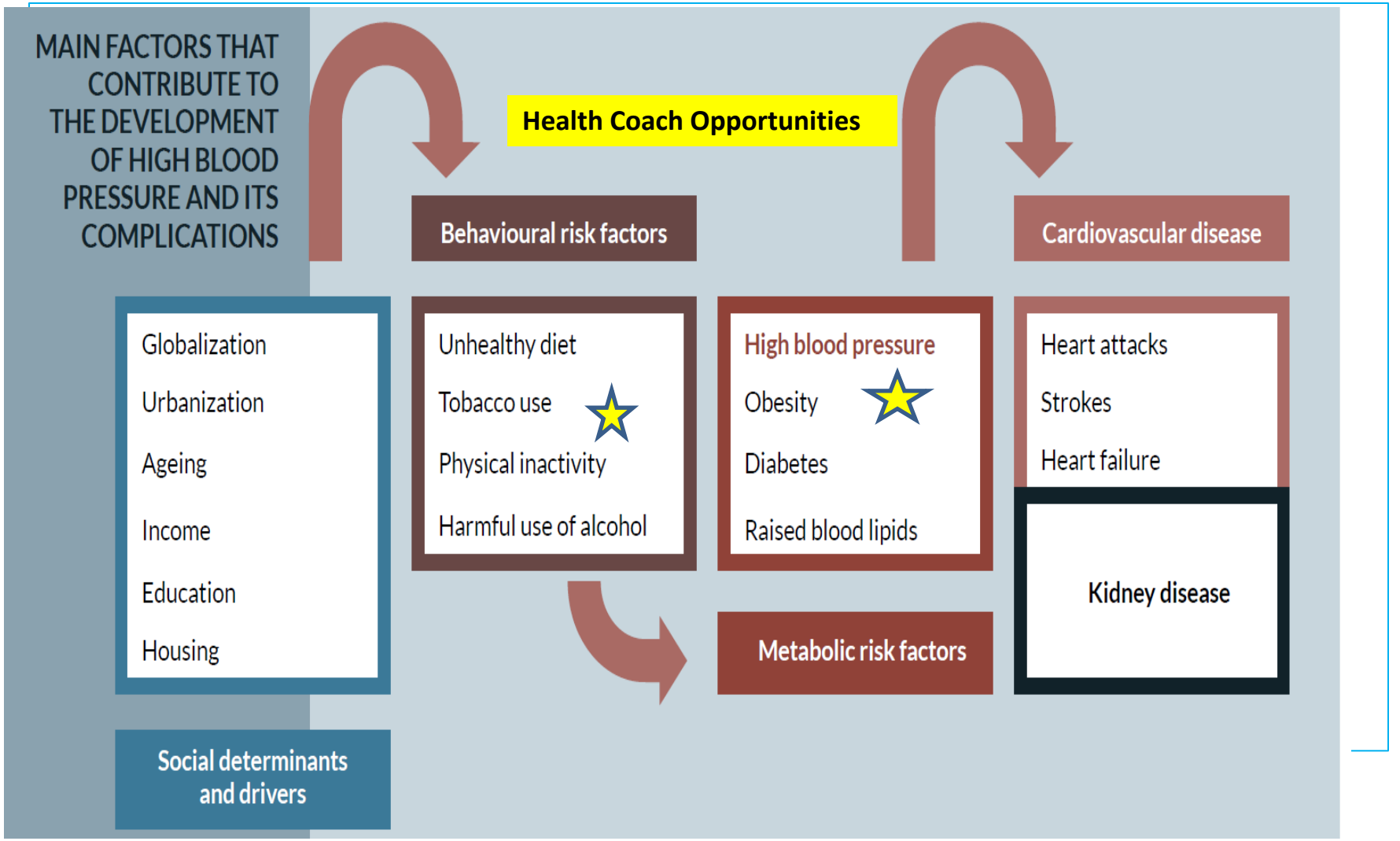
MA HEALTH COACH	LEVEL I	WHATS THE GOAL?	MA HEALTH COACH FOLLOW-UP GUIDELINES
Elevated	Between 120-129 or <80	Establish An Action Plan: *Healthy Eating *"Eat this instead of that" *Increase exercise 30 to 60 minutes most days of the week per Dr's order *Decrease fast foods, trgn/sat fat & processed foods. *Decrease sugar & salt intake *Spend less than two hours day watching TV, using computer or playing video games *Decrease or avoid tobacco/smoking, alcohol and drugs **Review medication adherence as prescribed if applicable *DASH Meal Plan *Decrease Stress * Obtain labs as directed by provider Decrease Alcohol Intake	MA/HC will follow-up on Action Plan two weeks, MA/HC will follow-up one month. and encourage training for self-monitoring form MA/Health Coach will follow-up in 3-6 months Reinforce Action Plans, Labs apt. *Recheck B/P & Log **Obtain labs (Lipids, Potassium)* 1)If unable to contact patient after two telephone calls (1 week/calls) 2)Send an inability to contact letter –allow 10 days to respond 3)Remove from health coach follow-up list-if no response from letter

HTN Health Coach Matrix

MA HEALTH COACH	LEVEL II	WHAT'S THE GOAL?	
Stage 1	D 130-139 or between S 80-89	Establish An Action Plan: Establish An Action Plan *Healthy Eating *"Eat this instead of that" *Increase exercise 30 to 60 minutes most days of the week per Dr's order *Decrease fast foods, tran/sat fat & processed foods. *Decrease sugar & salt intake *Spend less than two hours day watching TV, using computer or playing video games *Decrease or avoid tobacco/smoking, alcohol and drugs * *Review medication adherence as prescribed *DASH Meal Plan *Decrease Stress *Decrease alcohol intake * Obtain labs as directed by provider	MA/HC will follow-up on Action Plan in two weeks, MA/Health Coach will follow-up on Action Plan in one month and encourage training for self-monitoring form MA/Health Coach will follow-up in 3-6 months Reinforce Action Plans, Labs apt. *Recheck B/P & Log *Obtain labs (Lipids, Potassium) *Review risk factors *BMI, Salt Free Diet *Rx med- assessment of provider 1)If unable to contact patient after two telephone calls (1 week/calls) 2)Send an inability to contact letter –allow 10 days to respond 3)Remove from health coach follow-up list-if no response from letter

MA HEALTH COACH	LEVEL III	WHAT'S THE GOAL?	MA HEALTH COACH FOLLOW-UP GUIDELINES
Stage 2	D 140 or > S 90 or >	Establish An Action Plan: Establish An Action Plan *Healthy Eating *"Eat this instead of that" *Increase exercise 30 to 60 minutes most days of the week per Dr's order *Decrease fast foods, tran/sat fat & processed foods. *Decrease sugar & salt intake *Spend less than two hours day watching TV, using computer or playing video games *Decrease or avoid tobacco/smoking, alcohol and drugs *Review medication adherence as prescribed *Decrease Alcohol Intake *DASH Meal Plan *Decrease Stress * Obtain labs as directed by provider	MA/HC will follow-up on Action Plan in 2 weeks MA/HC will follow-upon Action Plan one month and encourage training for self-monitoring form MA/Health Coach will follow-up 3 - 6 month Reinforce Action Plan, Labs, apt. *Recheck B/P & Log *Obtain labs(Lipids, Potassium) 1)If unable to contact patient after two telephone calls (1 week/calls) 2)Send an inability to contact letter –allow 10 days to respond 3)Remove from health coach follow-up list-if no response from letter Resource: www.acc.org Revised: 7/27/2018

Hypertension Risks



Action Plans

Date: _____

MY ACTION PLAN

I, _____ and _____

have a plan to improve my health.

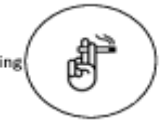
1. I want to work on ONE activity:

___Work on something that is bothering me:

___Increase my physical activity

___Improve my food choices

___Cut down on smoking



___Take my medicine

___Reduce my stress

_____

___Test blood sugar

2. What I will do:

What: _____

How much: _____

When: _____

How often: _____

Where: _____

With whom: _____

Start Date:_____

Follow up Date:_____

How to follow up: _____

_____

For Office Use Only:

☐ DM ☐ Pre-DM ☐ HTN

☐ Hyperlipidemia ☐ Obesity

3. What is my confidence level? How sure am I that I can do this action plan?

1---2---3---4---5---6---7---8---9---10

Not sure Somewhat sure Sure Very sure

UCDAVIS BETTY IRENE MOORE SCHOOL OF NURSING

LIVINGSTON COMMUNITY HEALTH

CAMARENA HEALTH

CVHN

How do we know its working?

Monthly Health Coach Data Meetings to Review:

- ✓ Dashboards for Chronic Conditions
- ✓ Refine workflows
- ✓ Develop programs-***(SMBP)***
- ✓ Review and monitor HgbA1c, B/P's, Lipid, Medications, and Weight Loss goals
- ✓ Action Plan goals or revisions
- ✓ Follow-up rates
- ✓ Quarterly Team Based Care review to identify next steps

Challenges

- Coordinating coverage for staff to attend trainings
- Incorporating Health Coaching into the visit
- Establishing time for follow-ups

Success

Currently 37 Health Coaches

Additional Co-hort completed on May 20, 2109

Q&A

Moderator: Michael Rothman, DrPH, CCI

Community Health Center Network
Care Neighborhood

Angela O'Brien, LCSW
Laura Miller, MD

Livingston Community Health
The Journey to Health Coaching

Rosa Pavey, LVN
Hope Perez, LVN

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Team Time

What is the current state of patient partnership in direct care for our patients with hypertension and diabetes?

Step 1: Write or draw on a stickie your response to this question

Step 2: Share your stickie with your team and post it on your poster under “Current State” for “Patient Partnership in Direct Care”

Judith H. Hibbard, DrPH

Health Policy Research Group, University of Oregon

The Case for Patient Activation

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The Case for Patient Activation: Research Findings and Real World Examples

Judith H. Hibbard, DrPH
Health Policy Research Group
University of Oregon

Agenda

1. What is patient activation and why measure it?
2. Evidence that PAM (Patient Activation Measure) is linked with behaviors, health, utilization, costs
3. How are health care delivery systems using PAM measurement to improve care?

What is Patient Activation?

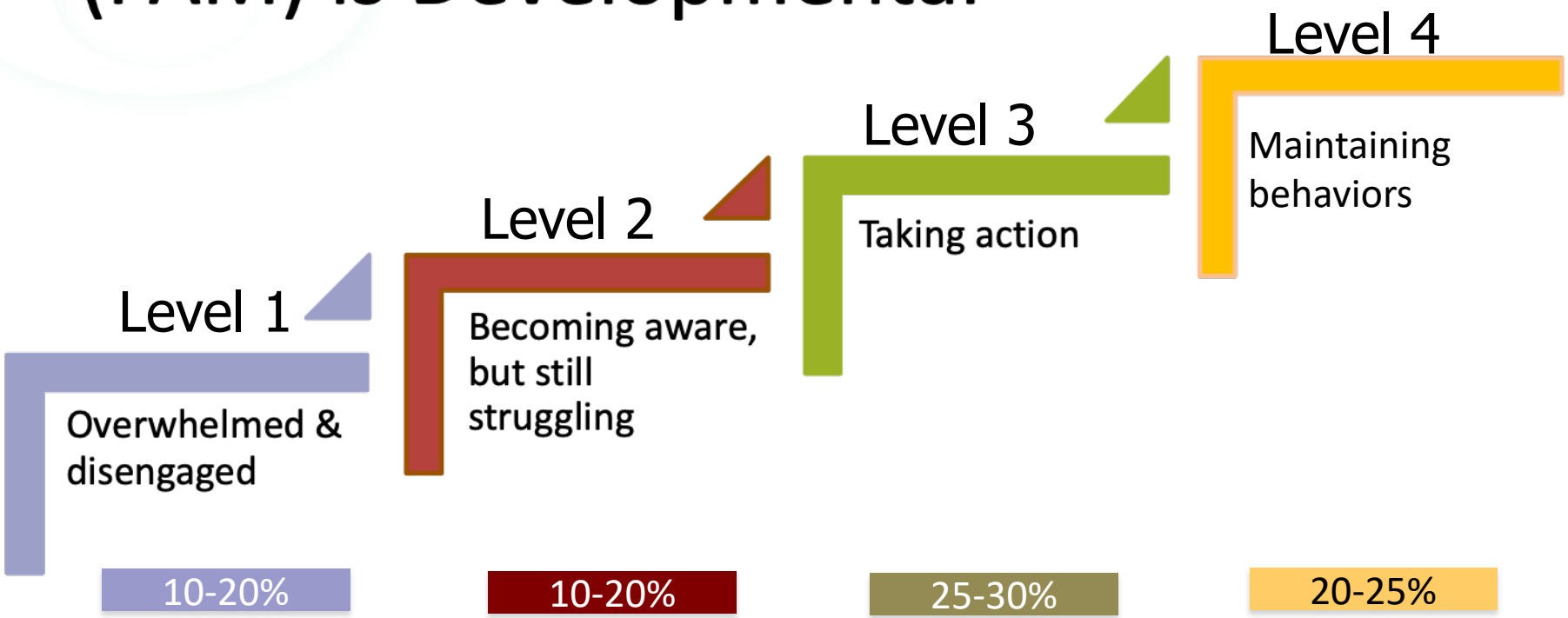
An activated individual:

- Has the knowledge, skill and confidence to take on the role of managing their health and health care

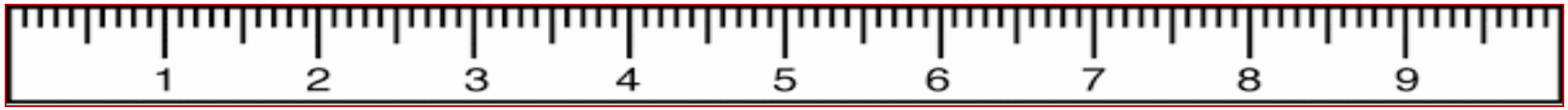
First insights…..

- Every patient population has full diversity of activation from low to high
- Demographics (age, ed, income, gender) tend to account for 5% to 6% of PAM score variation

The Patient Activation Measure (PAM) is Developmental



0-100 point scale



Why Measure?

- To tailor your efforts to patients' individual needs
- To know if you are making progress on supporting patients
- To more effectively and efficiently use your resources to support populations of patients

PAM Evidence Base

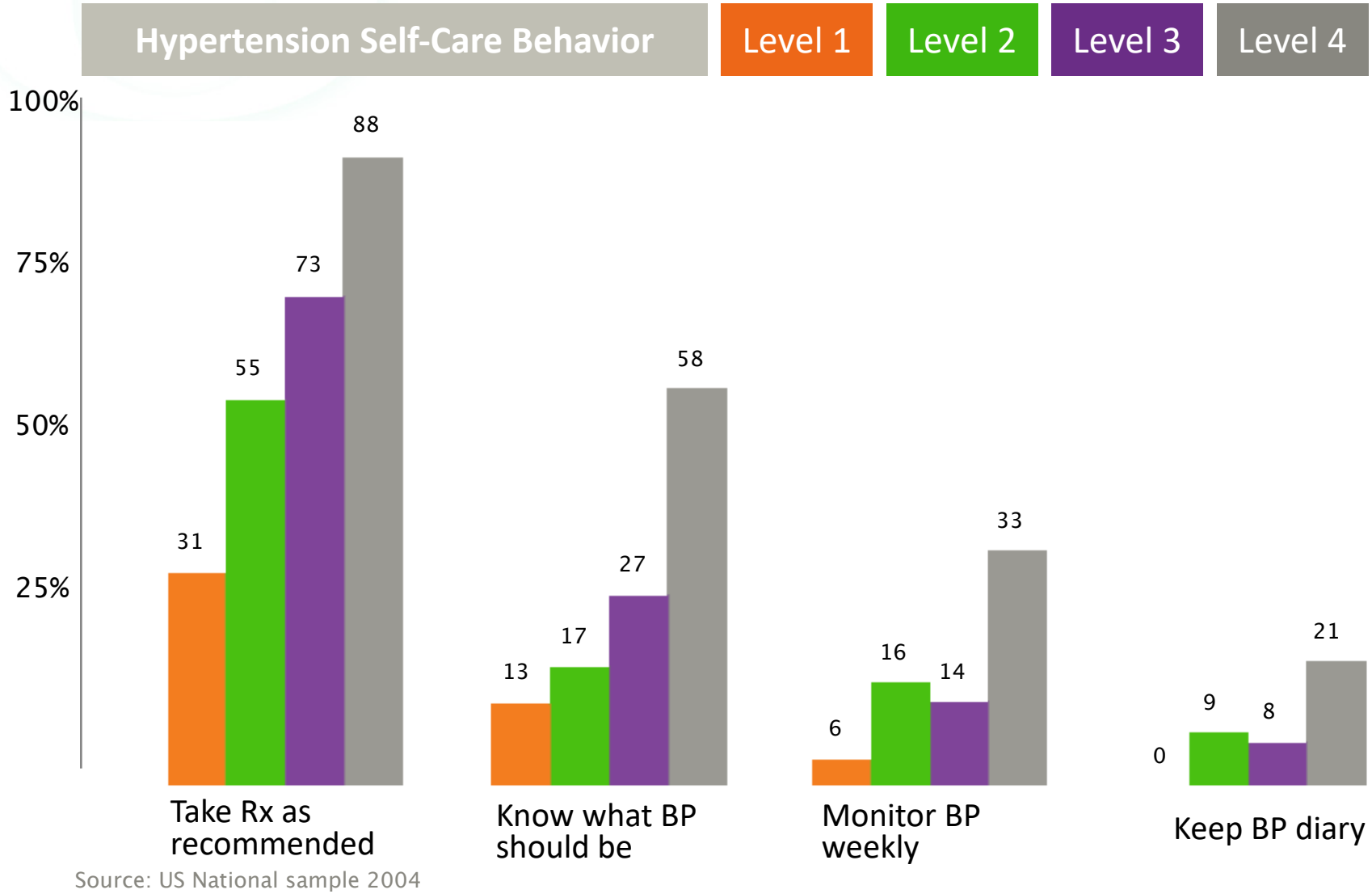
Over a Decade of Research Shows that the PAM Is a Good Predictor of:

- Most health behaviors
- Many clinical outcomes
- Health trajectories
- Overall costs
- These findings hold true after controlling for demographics and health status
- Results are found across populations and within condition specific groups

Does PAM work with disadvantaged populations?

- Used in Medicaid programs in 20 states
- Studies with low income & low literacy populations show PAM is predictive of behaviors
- A large study in the UK shows that PAM is ***more*** predictive of clinical outcomes among disadvantaged populations than it is with more advantaged groups.

Activation and Behavior



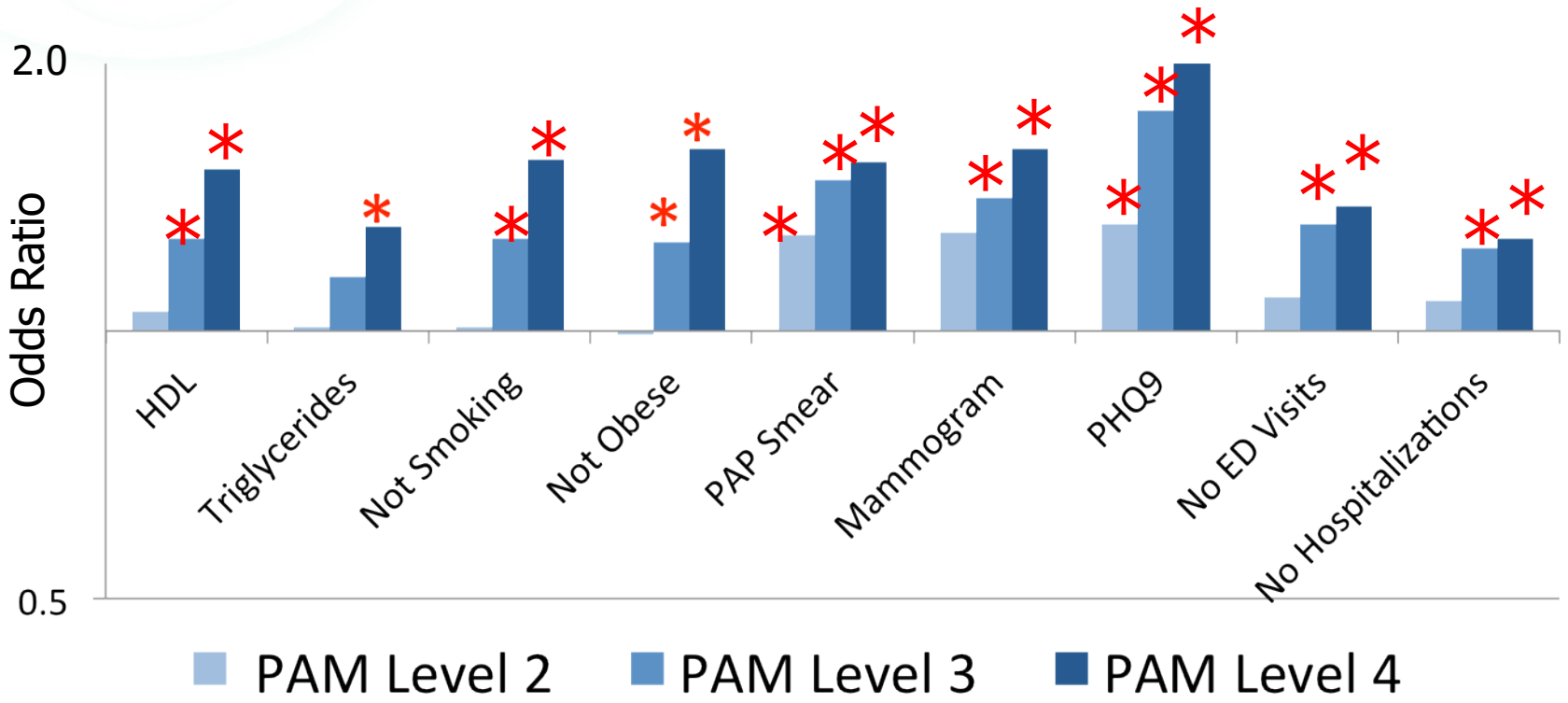
Source: US National sample 2004

Insights: PAM and Health Behavior

1. Only the most activated patients do many key self-management behaviors
2. Focusing on more complex and difficult behaviors might discourage least activated
3. Start with behaviors more feasible for patients: increases a person's experience of success

Impacts of Being Engaged are Enduring:

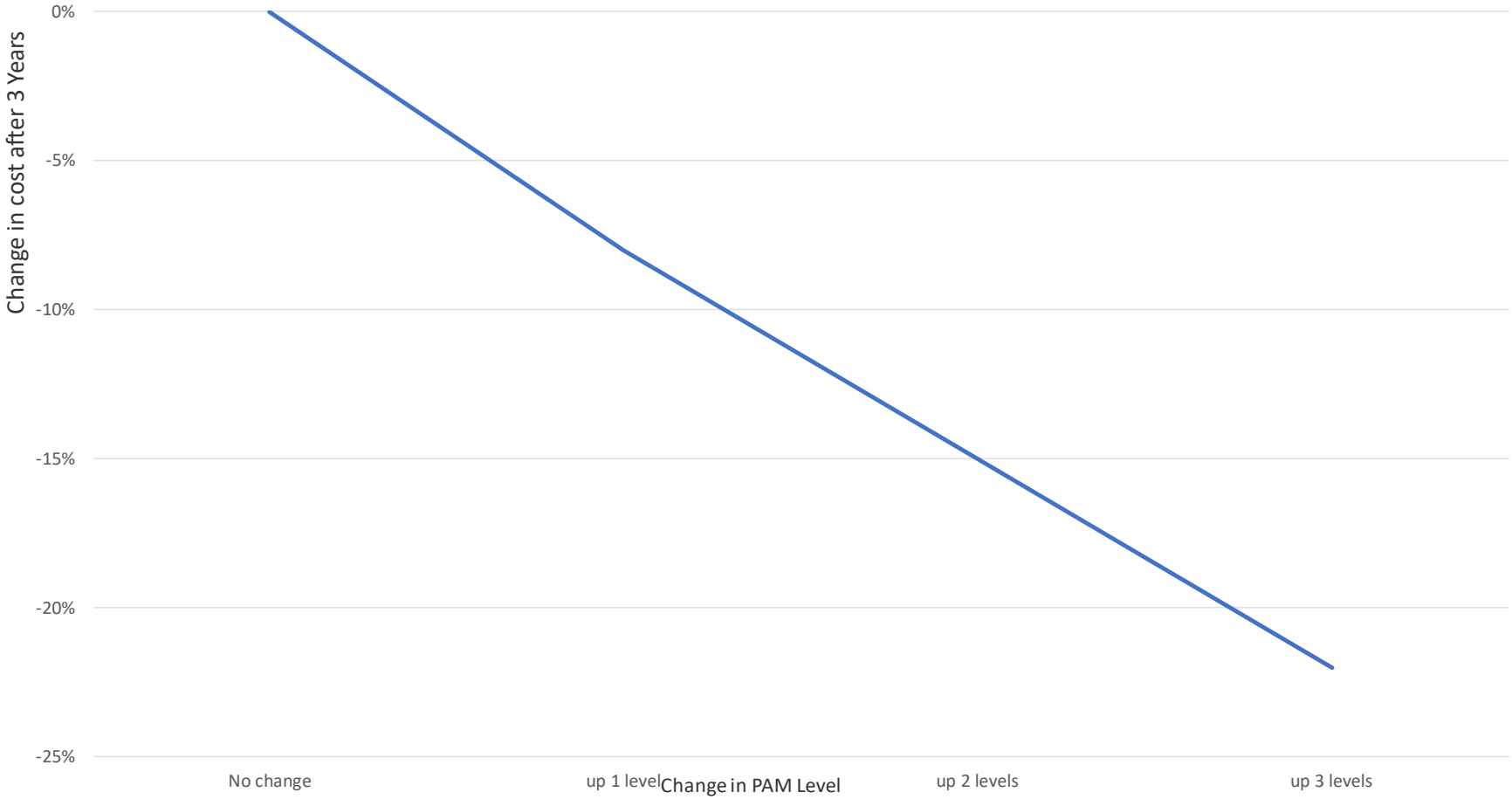
PAM in 2010 Predicts Outcomes 2 Years Later



Models included controls for age, sex, number of chronic conditions, income, and percent of care that was received in-network. * Significantly different from PAM Level 1 at $p<0.05$ Health Affairs Mar 2015

As PAM goes up Costs go down

(n=2155 high risk patients across multiple medical groups)



Source: J Gen Int Med, Dec. 2018, pp. 2106-2112.

Insights from Research

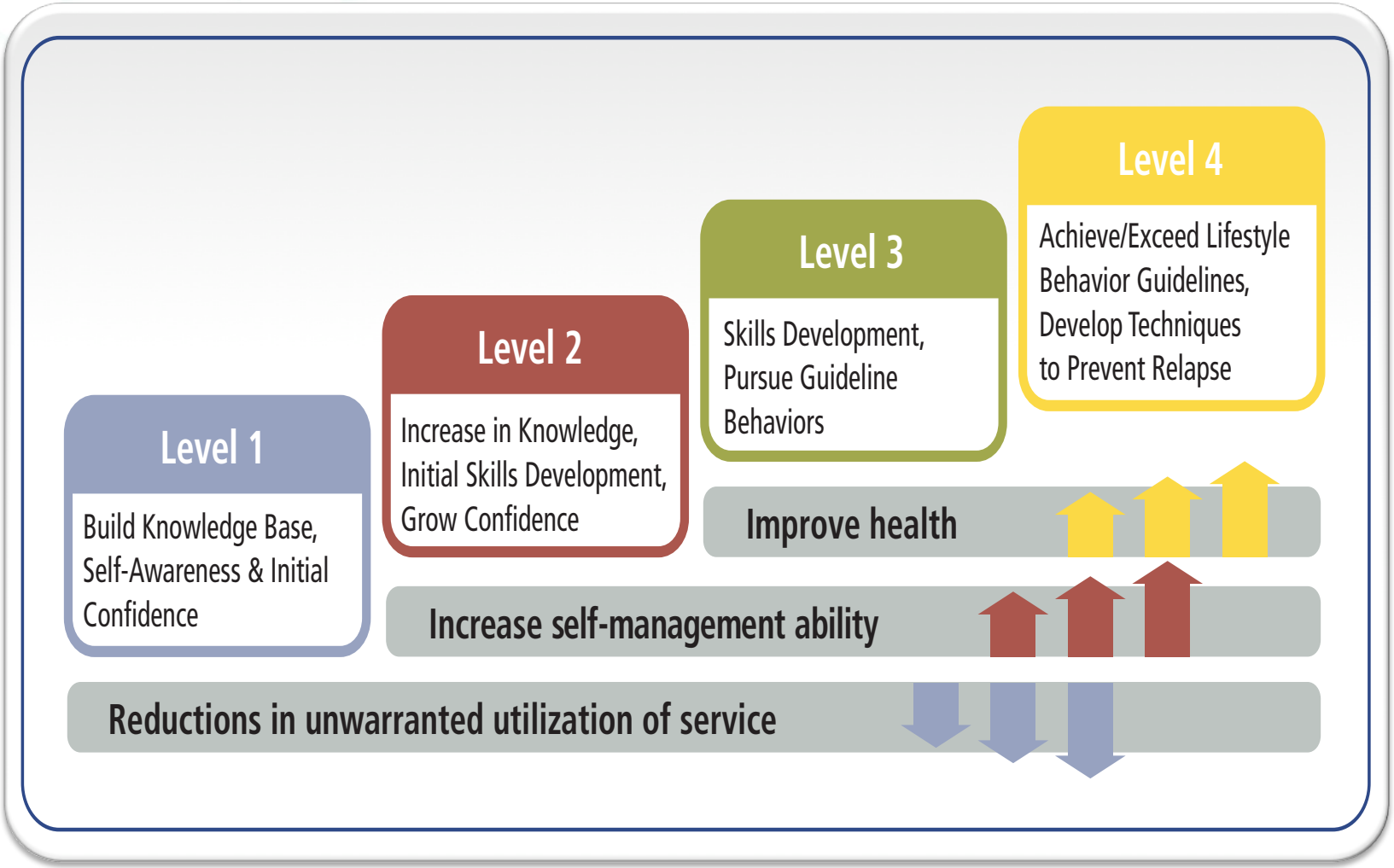
- When activation increases, many behaviors improve
- Least activated gain the most when supported
- Higher activated patients show up when offered self-management resources
- Lower activation patients are more likely to develop chronic disease and experience disease progression

Using PAM for Population Health Management

Key Opportunity

Redefine risk assessment to include the risk that the patient will **not** engage

Tailoring Support to the Patient's Activation Level is a way to Increase Scores



Innovative Delivery Systems

- PAM score is a Vital Sign
- Tailored coaching / support
- Using PAM as a measure of risk, along with clinical risk measures to manage patient populations
- More efficient use of resources: target those who need more help
- Used as a way to assess accountability or quality

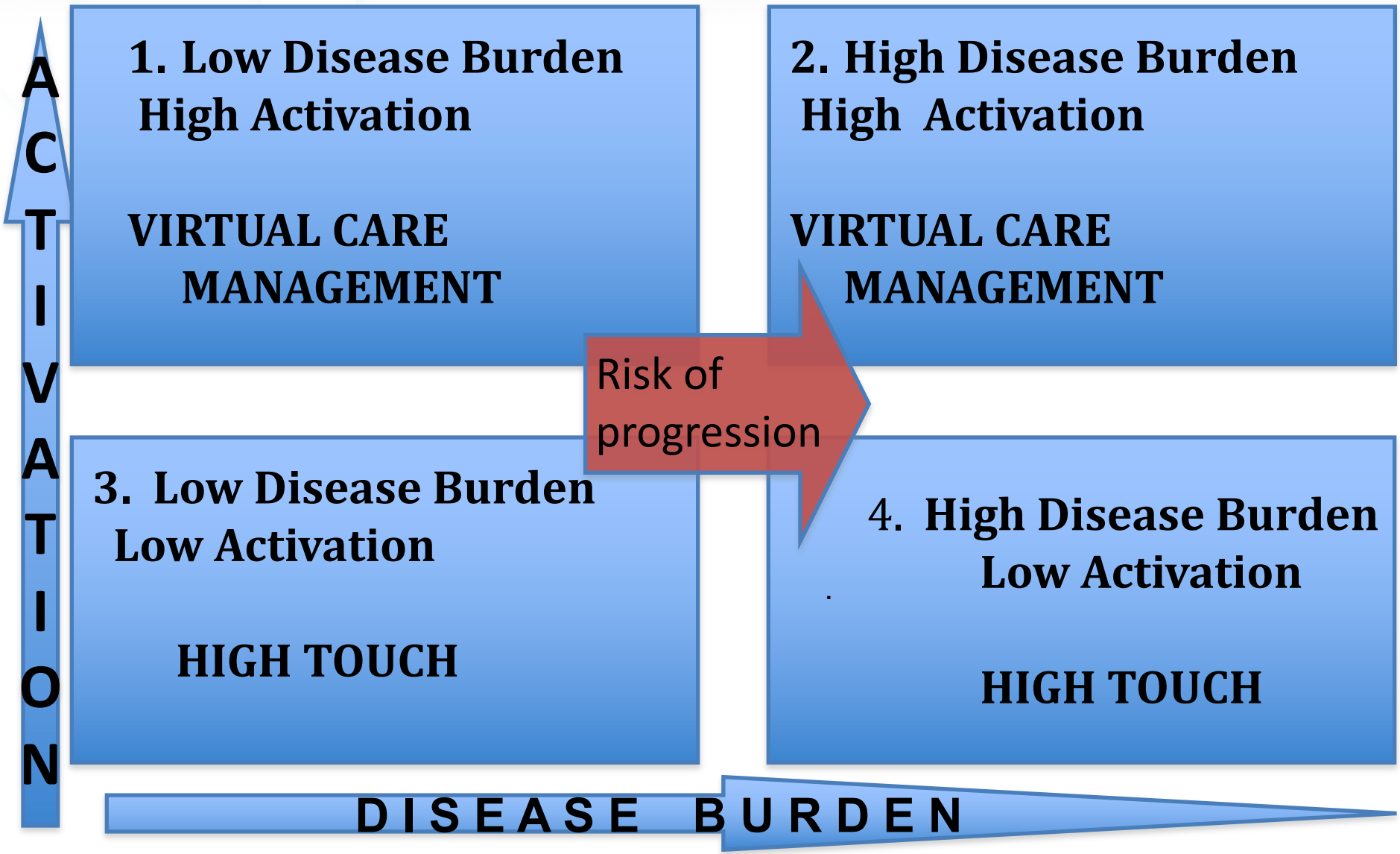
Examples of how delivery systems are applying Activation Strategies

- PAM Tailored care pathways (mammograms)*
- Extra help for less activated patients (patient portal; trained MA)*
- Segmenting populations (cancer care): person-mediated support vs. electronic supports#

*Fairview Health System

#Anthem

Primary Care Population Health Management



Summary

Using measurement so you can meet patients where they are

- By understanding patient activation, providers can:
  - Provide the right type and intensity of support
  - Target resources more efficiently
- Ultimately improving outcomes, patient experience, and reducing costs

Q&A

Moderator: Michael Rothman, DrPH, CCI

Health Policy Research Group,
University of Oregon
The Case for Patient Activation

Judith H. Hibbard, DrPH

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Team Time

Step 1: Share your team stickies of ideas you captured during this first session

Step 2: Post your stickies on your poster under "Session 1: Ideas We Could Try" and cluster similar ideas together

Step 3: Using dot stickers – vote on which ideas you would want to try first (each person gets 3 dots)

BREAK

We will resume at 11:00am

Anjana Sharma, MD, MAS
Ana Vilma Aquino, Patient Advisor

UCSF Department of Family and Community Medicine

Patient Partnership at the Clinic and Systems Levels

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PATIENT PARTNERSHIP AT THE CLINIC AND SYSTEMS LEVELS

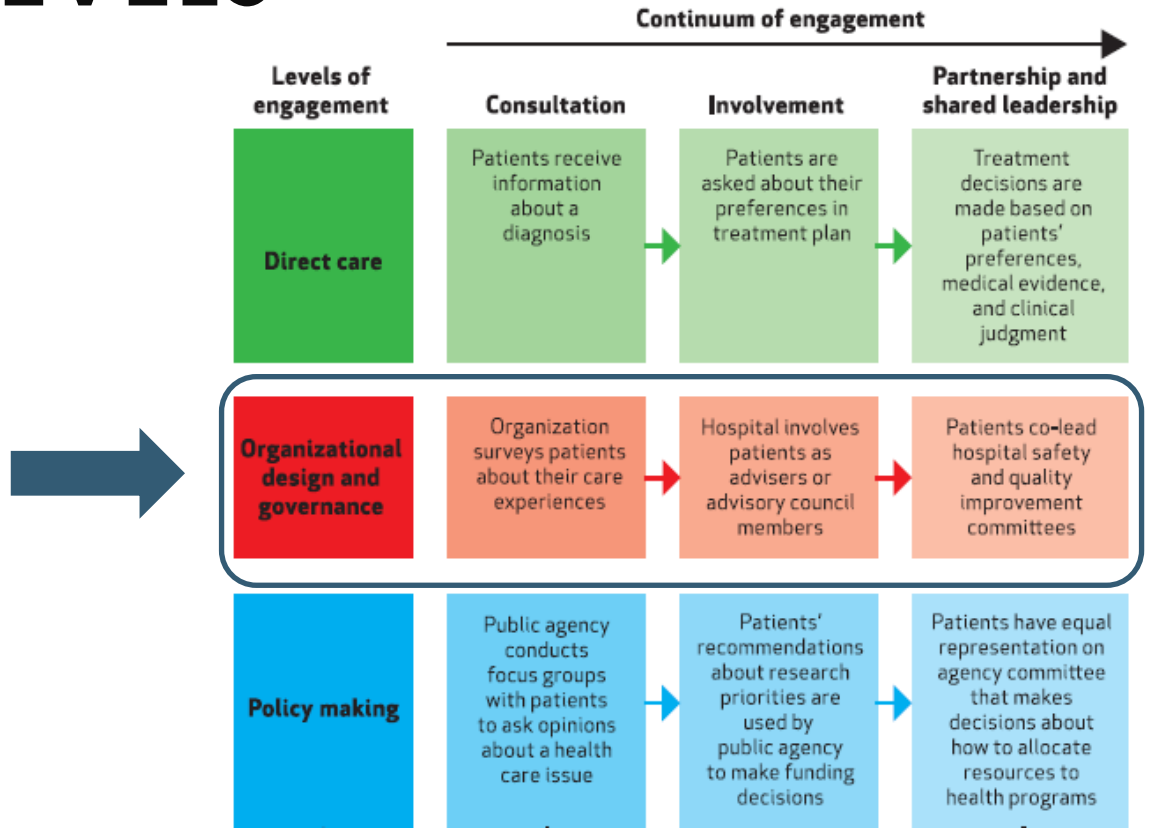
PHASE Convening
June 11 2019
Oakland, CA

PATIENT AND FAMILY ENGAGEMENT

"Patients, families, their representatives, and health professionals working in active partnership at various levels across the healthcare system – direct care, organization design and governance, and policy making – to improve health and health care."

Carman KL & colleagues. Health Affairs. 2013;32(2): 223-231.

PATIENT ENGAGEMENT ON THREE LEVELS



Source: Carman KL & colleagues. Health Affairs. 2013;32(2): 223-231.

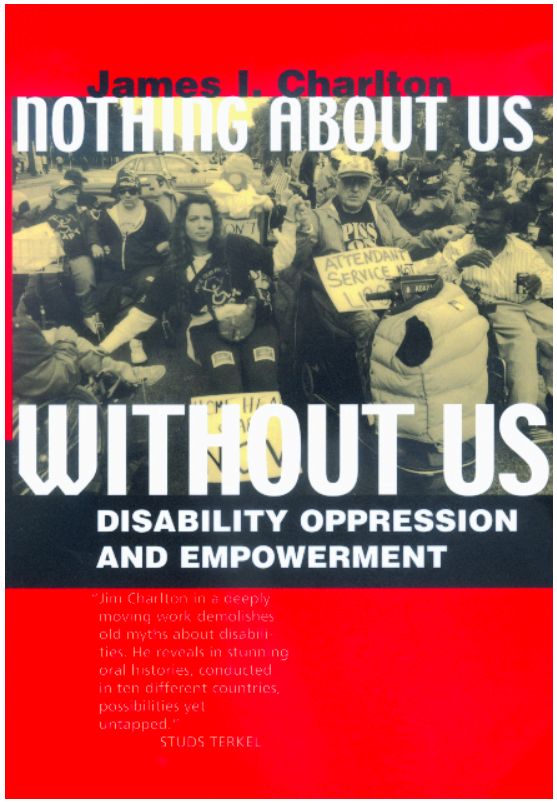
WHY SHOULD WE ENGAGE PATIENTS?

Justice issue: shift control back to historically oppressed populations

Ethical issue: It's the right thing to do

Utilitarian issue:

- Helps for PCMH certification
- Required for FQHCs
- Attracts consumers
- It makes healthcare interventions more effective



CLINICAL OUTCOMES

Colorado based quality improvement initiatives of "boot camp translation" – community advisors helped translate health messages

- Blood pressure
- Asthma
- PCMH messaging
- Colorectal cancer

Boot Camp Translation: A Method For Building a Community of Solution

Ned Norman[1], Chris Bennett[1], Shirley Cowart[1], Maret Felzien[1], Martha Flores[1], Rafael Flores[1], Connie Haynes[1], Mike Hernandez[1], Mary Petra Rodriquez[1], Norah Sanchez[1], Sergio Sanchez[1], Kathy Winkelman[1], Steve Winkelman[1], Linda Zittleman, MSPH[2], and John M. Westfall, MD, MPH[2]

[1]Community Advisory Council of the High Plains Research Network, Department of Family Medicine, University of Colorado Denver School of Medicine, Mail Stop F496, AO1, Aurora, CO 80045

[2]High Plains Research Network, Department of Family Medicine, University of Colorado Denver School of Medicine, Mail Stop F496, AO1, Aurora, CO 80045

Abstract

Objective—The National Institutes of Health (NIH) spend billions of dollars annually on biomedical research. A crucial, yet currently insufficient step is the translation of scientific evidence-based guidelines and recommendations into constructs and language accessible to every-day patients and community members. By building a community of solution that integrates primary care with public health and community-based organizations, evidence-based medical care can be translated into language and constructs accessible to community members and readily implemented to improve health.

BENEFITS TO PATIENT ADVISORS

Ana Vilma Aquino

Patient advisor, Spanish-Language Council, Family Health Center, San Francisco General Hospital

- Serving 50,000 patients per year
- Serve multilingual patients and refugee clinic
- Educational material translation, advice to residents on their quality improvement projects

Benefits of participation in the Patient Advisory Council

GOALS FOR TODAY

- Consider your PHASE quality goal for your site
- What are your current needs for…
  - *…Developing educational materials?*
  - *…Communicating a new service your site offers?*
  - *…Meeting your goal for a specific patient population/demographic?*
  - *…Understanding what social determinants are current barriers?*
- *How can you work in partnership with patients to meet these goals?*

Lucinda Bazile

Mr. Johnnie Clark

LifeLong Medical Care

Patient Voice Collaborative

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LifeLong Medical Care's
Patient Voice Collaborative

Putting the community back in Community Health!

LifeLong Medical Care
Health Services For All Ages
a california health+ center

Our purpose:

- The PVC seeks to engage patients, providers and staff in partnership so that their collective voices can enhance LifeLong's mission. The PVC accomplishes its purpose by supporting the creation of a patient-centric culture.

- Specifically, the PVC develops tools and methods for systematically collecting and evaluating data, conducts projects to gain knowledge about patients, and works toward a LifeLong where our multitude of voices are heard and responses are built into LMC's programs and infrastructure.

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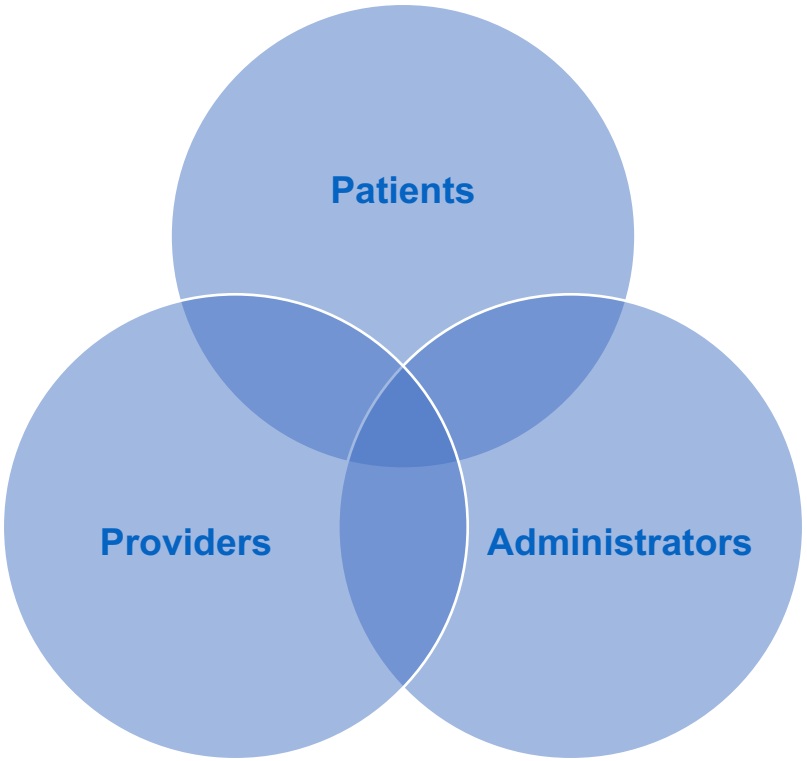
What is our model?



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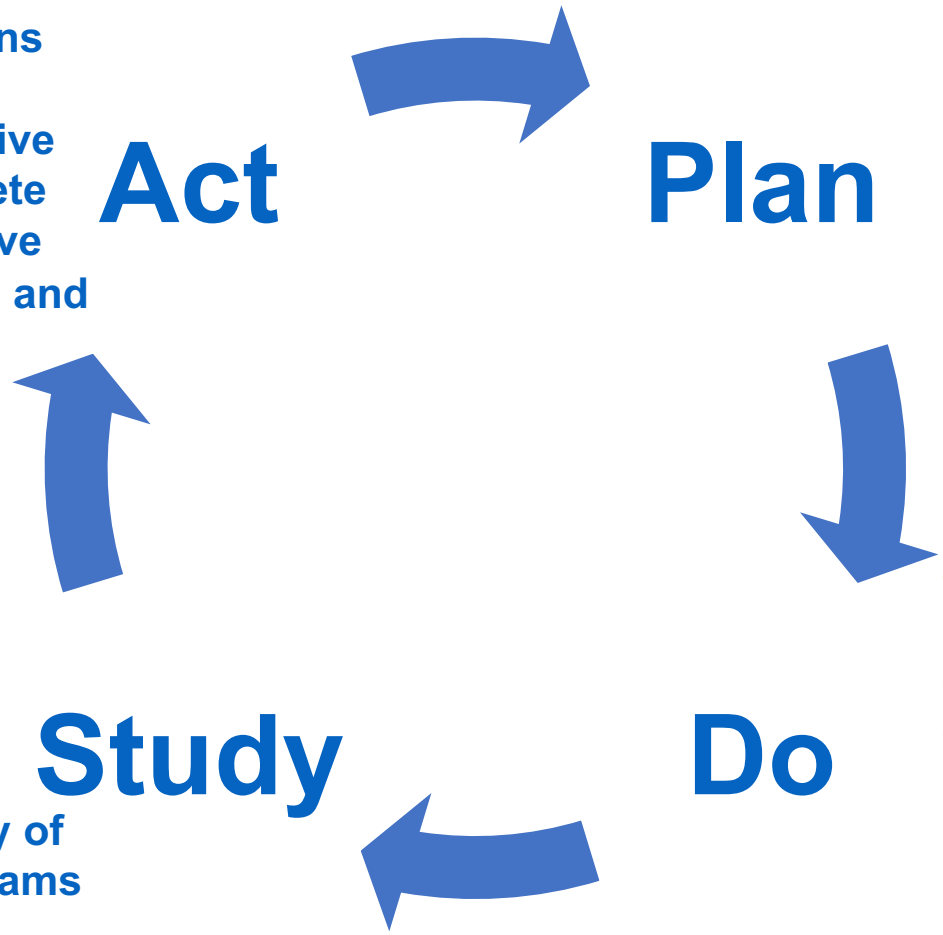
Methodology



Plan — PVC selects a manageable change priority or project for review.

Do — Quality improvement (QI) staff at LifeLong will conduct a study to gather the data required to answer the Collaborative's key question(s).

Study — PVC analyzes data collected and evaluates the efficacy and quality of the reviewed programs and services.

Act — Recommendations from the Patient Voice Collaborative will guide concrete actions to improve our performance and quality.

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We're part of a growing trend…

- The Dana-Farber Cancer Institute, Cambridge Health Alliance of Massachusetts and Health Choice Network of southern Florida have shown that involving patients in decision-making and planning processes leads to improvements in care, design and services offered.

- These health care providers report that patient involvement has led to ***changes in the attitudes of participating staff and patients and the culture of their organizations.*** This has proven critical to the success of their patient engagement efforts and their larger goals of becoming patient-centered medical homes.

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How is our Collaborative innovative?

- Working toward structural change and building genuine support for the institutionalization of patient participation in decision-making.

- Taking these steps for transformational power of small integrated workgroups, where patients and staff act as equal partners.

- An integrated council changes the way providers perceive t patients *and* the way patients perceive their role in their personal health care. Both become more actively engaged and begin to act as partners and equals, not only in the workgroup, but also in their one-on-one medical visits. ***This transformation is at the heart of patient-centered primary care.***

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Financial Impact

- LifeLong is always looking to maximize precious financial resources that at times can be uncertain.
- Creates a need to maximize our efficiency in service provision.
- Can best be done with patient input!

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Evidence supports the advantages of patient engagement.

- Patient involvement in planning, quality improvement and operations is key to enhancing the efficiency, effectiveness, quality and relevance of health center services to the community.

- To make these enhancements, groups such as the Patient Centered Primary Care Collaborative and the Committee on Quality of Healthcare in America of the Institute of Medicine call for the formation of partnerships among practitioners, patients, and their families to ensure that the care delivered is respectful of and responsive to patients' preferences, needs and values.

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Results?

- We have a vibrant and committed group of participants that meets regularly.

- PVC has discussed issue of power and hierarchy and has been trained in facilitation, communication, and group participation techniques by SFSU's Health Equity Institute.

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Moving forward with our Change Priorities

- Assistance and feedback with development of our Patient Satisfaction Survey Tool;
- Customer Service Training;
- Prescription Refill Process;
- Increase in Colorectal Screenings Project;
- Feedback on Organizational Brochures and Community Outreach;
- Call Center Response Time;
- Communications between PCP and Urgent Care;

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How do patients benefit from the PVC?

- By engaging the perspectives of LifeLong patients with staff, we are able to develop strategies to make our care more patient-centered,culturally appropriate and better aligned with patients' real-life experiences and expectations.

- As PVC Members learn about the wider health context and practice leadership and communication skills, they gain experience necessary to become effective advisors and advocates for their health and of their friends and families.

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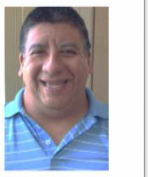




We want you on *our* team.

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Jacqueline McCright, MPH
Robin George, MPH

Mr. Patrick McKenna
Ms. Rosalyn Frazier

San Francisco Department of Public Health

Hypertension Equity Work Group

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Hypertension Equity Work Group

PHASE Conference June 11, 2019

Jacqueline McCright, MPH
Robin George, MPH
Mr. Patrick McKenna
Ms. Rosalyn Frazier

POPULATION HEALTH DIVISION
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Engaging Patient Advisory Council Members in the Hypertension Equity Work Group

- The Hypertension Equity Work Group has been convening for 3 ½ years to increase the blood pressure control for B/AA patients with hypertension from 62% to 66%.
- We recruited PAC members from SFHN Primary Care clinics to attend the hypertension meetings.
- We engage patients once a month at every meeting in dialogue and breakout sessions with clinical and community team members to obtain/integrate their input into interventions/strategies and media collateral to improve the disparity gap between B/AA and the total population within the SF Health Network.

POPULATION HEALTH DIVISION
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

B/AA Heart Health Brochure

KNOW YOUR RISK!

Take this self-test to find out if you are at risk for heart disease.

The following things can put you at risk for heart disease.
Check all your risk factors that apply and follow up with your doctor:

- ☐ High blood pressure — ☐ Not sure
- ☐ High cholesterol — ☐ Not sure
- ☐ Diabetes — ☐ Not sure
- ☐ Chronic kidney disease — ☐ Not sure
- ☐ Family history *(father or brother with heart disease before age 55 or mother or sister with heart disease before age 65)* — ☐ Not sure
- ☐ Cigarette smoking
- ☐ Age *(older than 45 for men, over 55 for women)*
- ☐ Being overweight
- ☐ Lack of physical activity — ☐ Not sure
- ☐ Unhealthy diet — ☐ Not sure
- ☐ Depression, stress, mental health conditions — ☐ Not sure

HEALTHY LIFESTYLE AND PHYSICAL ACTIVITY RESOURCES

Community Wellness Center at Zuckerberg
San Francisco General Hospital (ZSFG)
(415) 206-4995

American Heart Association
http://heart.org/healthyliving

For FREE physical activities, go to
http://sfrecpark.org/recreation-community-services/rec-programs/

Write the name and phone of your healthcare provider here:

POPULATION HEALTH DIVISION
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
COMMUNITY HEALTH EQUITY & PROMOTION

San Francisco Health Network

Produced by 510media

Sources: 1) National Heart, Lung, and Blood Institute; National Institutes of Health; U.S. Department of Health and Human Services. 2) Mozaffarian D, Benjamin EJ, Go AS, et al. Heart Disease and Stroke Statistics—2015 update: A report from the American Heart Association. Circulation. 2015; 131(4):e29-322. | August 2016

STEPS TO
Prevent Heart Disease At All Ages

Heart disease is a serious health problem. Family history and habits can make you more likely to develop heart disease.

Most people do not know that they might be at risk for heart disease, even though it is the number one killer of Americans. Nearly 44% of African American men and 48% of African American women have some form of heart disease, which includes heart attack and stroke.

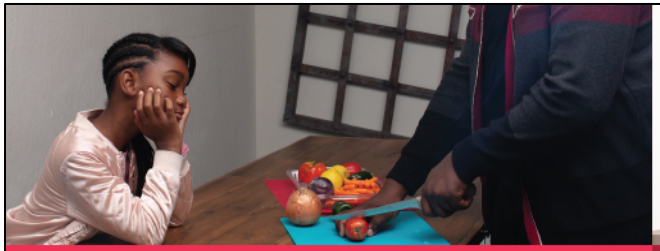
The good news is that you can take steps now to lower your risk of heart disease. Lowering your blood pressure, blood sugar, and cholesterol can decrease your chances of a heart attack and stroke. Heart healthy changes are good for your whole body. ***Turn the page for ideas!***

KNOW YOUR RISK!

Take the **self-test** on the back of this booklet to find out if you are at risk for heart disease.

POPULATION HEALTH DIVISION
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

B/AA Heart Health Brochure



THINGS YOU CAN DO TO IMPROVE YOUR BLOOD PRESSURE

If you already have high blood pressure, take your medications as agreed upon with your doctor. ***Check all your goals that apply:***

☐ **1. How can I reach and maintain a healthy weight?**
- Set a healthy weight goal for yourself.
- Drink water. Try to avoid soda and juice with added sugars.
- Eat smaller portions. Eat healthy foods and snacks.

☐ **2. How can I get a least 30 minutes of physical activity each day?**
- Walk with family, friends, or neighbors.
- Take the stairs instead of elevator.
- Make time to exercise in addition to your usual activity.

☐ **3. How can I eat less salt and saturated fat?**
- Minimize pre-prepared and processed food.
- Cook and prepare your own food as often as you can.
- Use herbs and spices while cooking and less salt.
- Try to avoid frying food.

☐ **4. How can I eat heart healthy foods every day?**
- Eat more fresh fruits, vegetables, and whole grains.
- Buy fresh, frozen, or no-salt-added canned vegetables and sauces.

☐ **5. How can I reduce stress in my life?**
- Try deep breathing. It can help you relax and lower your stress level.
- Think about the positive aspects of your life.
- Talk to friends and family.

☐ **6. How can I limit alcohol and enjoy living smoke-free?**
- Talk to your doctor about cutting back or quitting.
- Try to avoid places or situations that may trigger you to drink or smoke.

☐ **7. How do these goals affect my blood pressure numbers?**
- Check your blood pressure at home, as agreed upon with your doctor.
- Pay attention to the influence that physical activity, diet, and stress have on your blood pressure.

CHECKING YOUR BLOOD PRESSURE AT HOME

My blood pressure goal (If you don't know, ask your doctor):

My heart healthy goal for this month is:

KNOW YOUR RISK!

High blood pressure is called the "silent killer". It can have no warning signs or symptoms and leads to heart attack and stroke.

HEART ATTACK SYMPTOMS
- Crushing or squeezing chest pain
- Back, neck, or left arm pain
- Weakness
- Shortness of breath
- Sick to the stomach or stomach pain

STROKE SYMPTOMS
- Face drooping or numbness
- Arm or leg weakness or numbness
- Trouble talking
- Confusion
- Balance problems
- Severe headache

IF YOU FEEL ANY OF THESE SYMPTOMS, CALL 911 IMMEDIATELY

POPULATION HEALTH DIVISION
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Public Service Announcement

Heart Health - 30 second Public Service Announcement - Designed to reach females to encourage them to take care of their heart health and control their blood pressure, so they can be good role models for their children by engaging in physical activity and taking the time to take care of themselves.

https://www.dropbox.com/s/9jriwzefjvhhb60/HHSF%20V3.mp4?dl=0

Acknowledgements

- Jacque McCright, Robin George, Sarah Cox, Ellen Chen, Erin Franey, Rita Nguyen, and Kim Tucker

- Hypertension Equity Workgroup

THANK YOU!

Jacqueline McCright, MPH
Deputy Director of Community Health Equity & Promotion
Population Health Division
SF Dept. of Public Health
25 Van Ness Ave., Suite # 325
San Francisco, CA 94102
(628) 206-7637

POPULATION HEALTH DIVISION
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Q&A

Moderators: Anjana Sharma, MD, MAS
Ana Vilma Aquino, Patient Advisor

UCSF Department of Family and Community Medicine

LifeLong Medical Care
Patient Voice Collaborative

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Team Time

Step 1: Share your team stickies of ideas you captured during this second session

Step 2: Post your stickies on your poster under “Session 2: Ideas We Could Try” and cluster similar ideas together

Step 3: Using dot stickers – vote on which ideas you would want to try first (each person gets 3 dots)

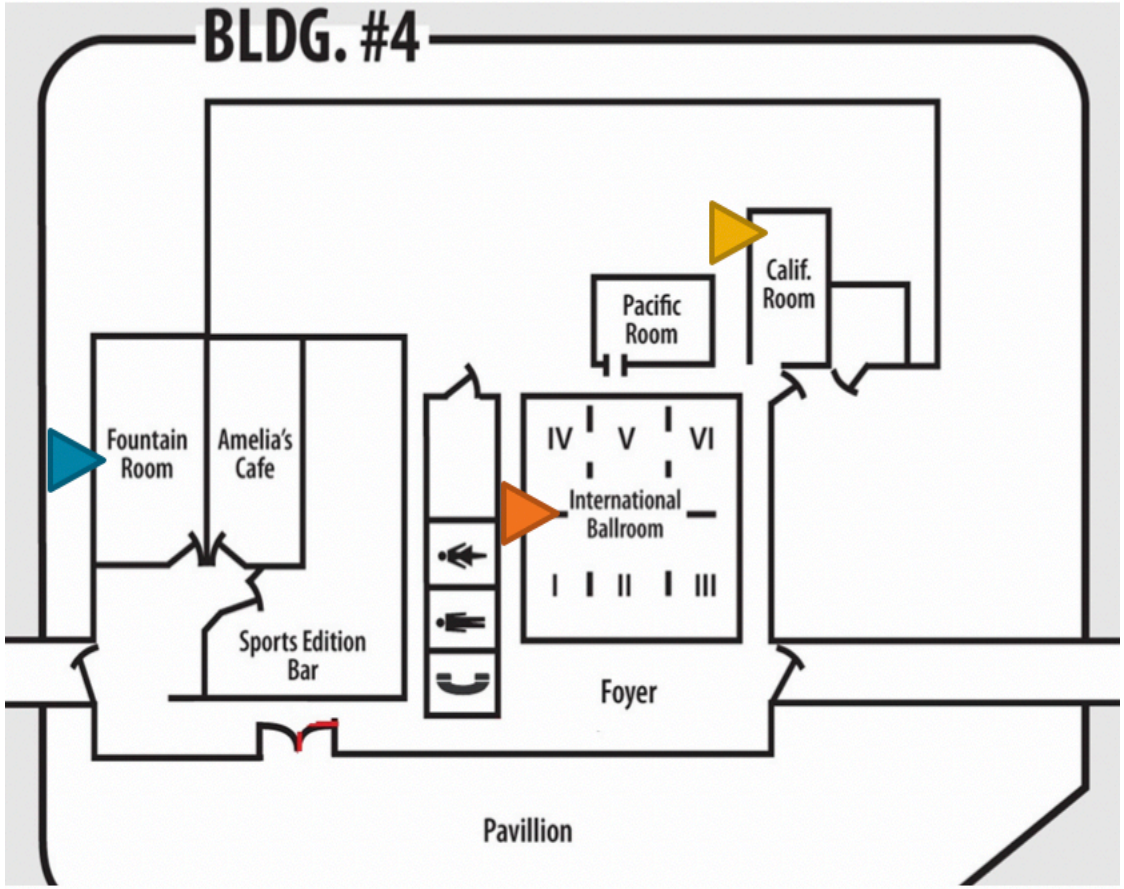
LUNCH

Workshops will start at 1:30pm

Fountain Room
Engaging Patients in Self-Management

California Room
Using Human Centered Design to Bring Patient Voice to Improvement Projects

International Ballroom
Change Ideas for Patient Engagement



Denise Armstroff

Performance Improvement Expert, Master Coach & Trainer

Change Ideas for Patient Engagement

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Developing Change Ideas:

It starts with a *SMALL* "PLAN"

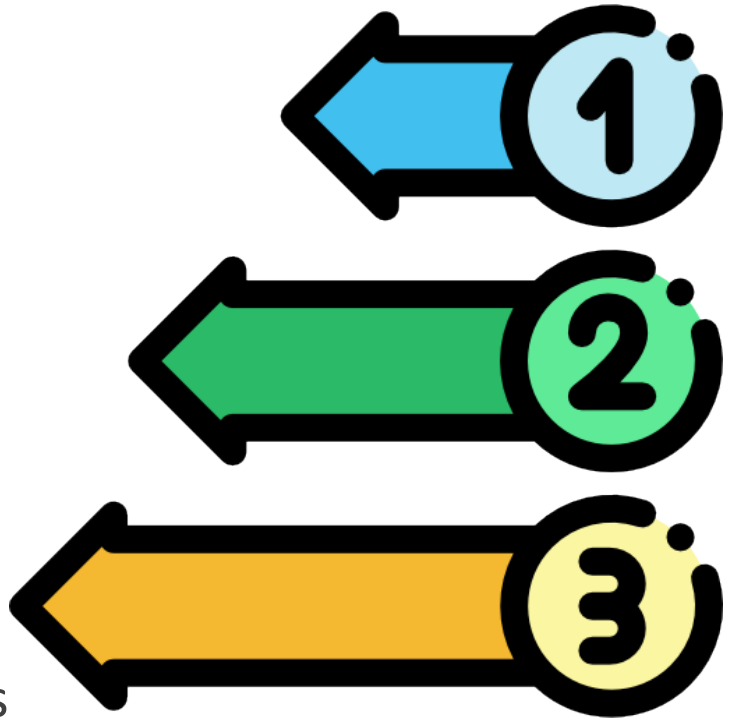
DENISE ARMSTORFF

JUNE 11, 2019

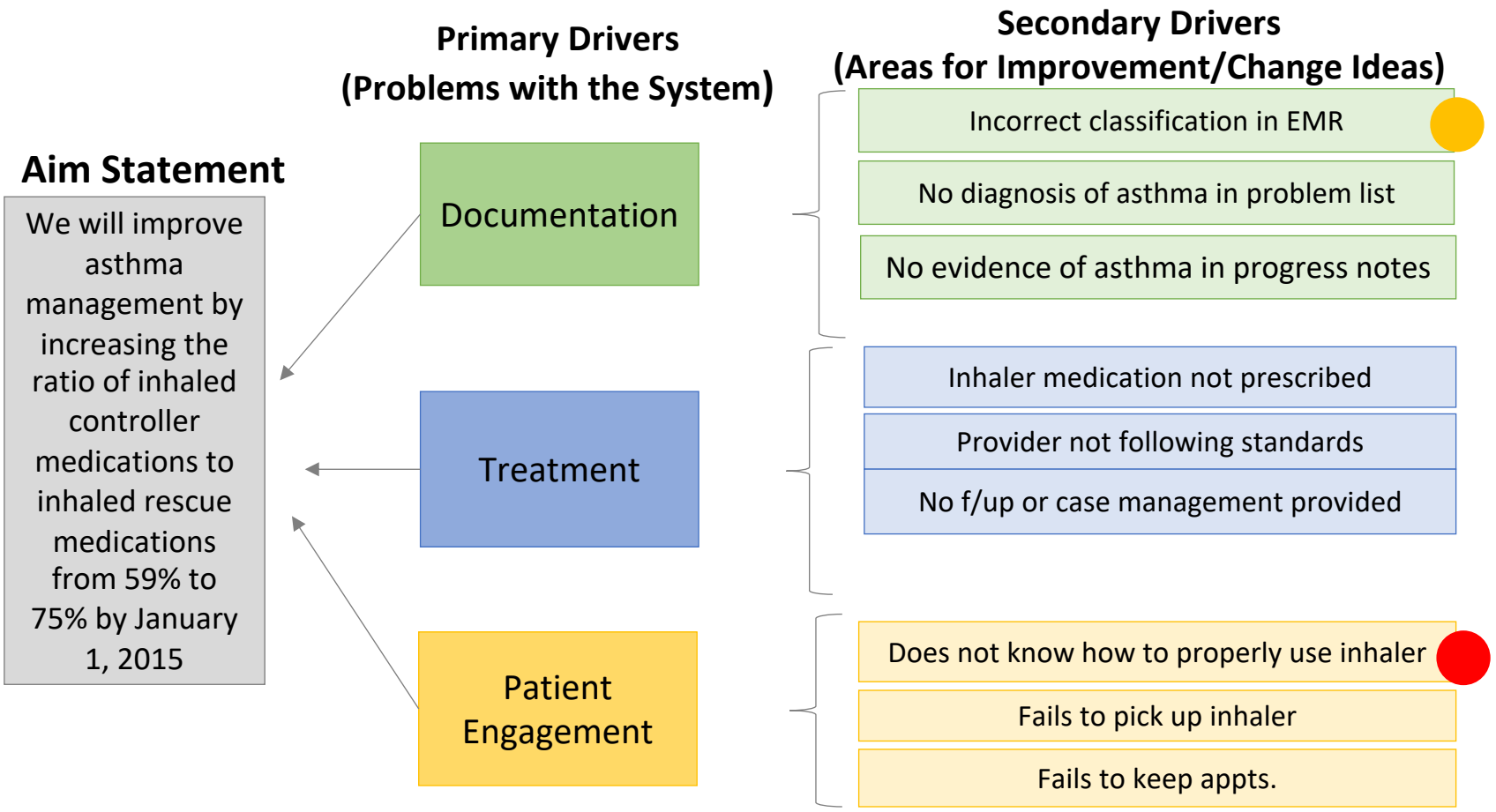
Think about a Change . . .

Selecting and Prioritizing Change Ideas

- Which idea would most address . . .
  - Clinical quality?
  - Waste reduction?
  - Finances?
  - Patient/family care experience?
- Which idea is . . .
  - Easy to try?
  - Important to staff?
  - Important to leadership?
  - Most likely to get attention if it's successful?



Multi-voting (a.k.a. “Dot” Voting)



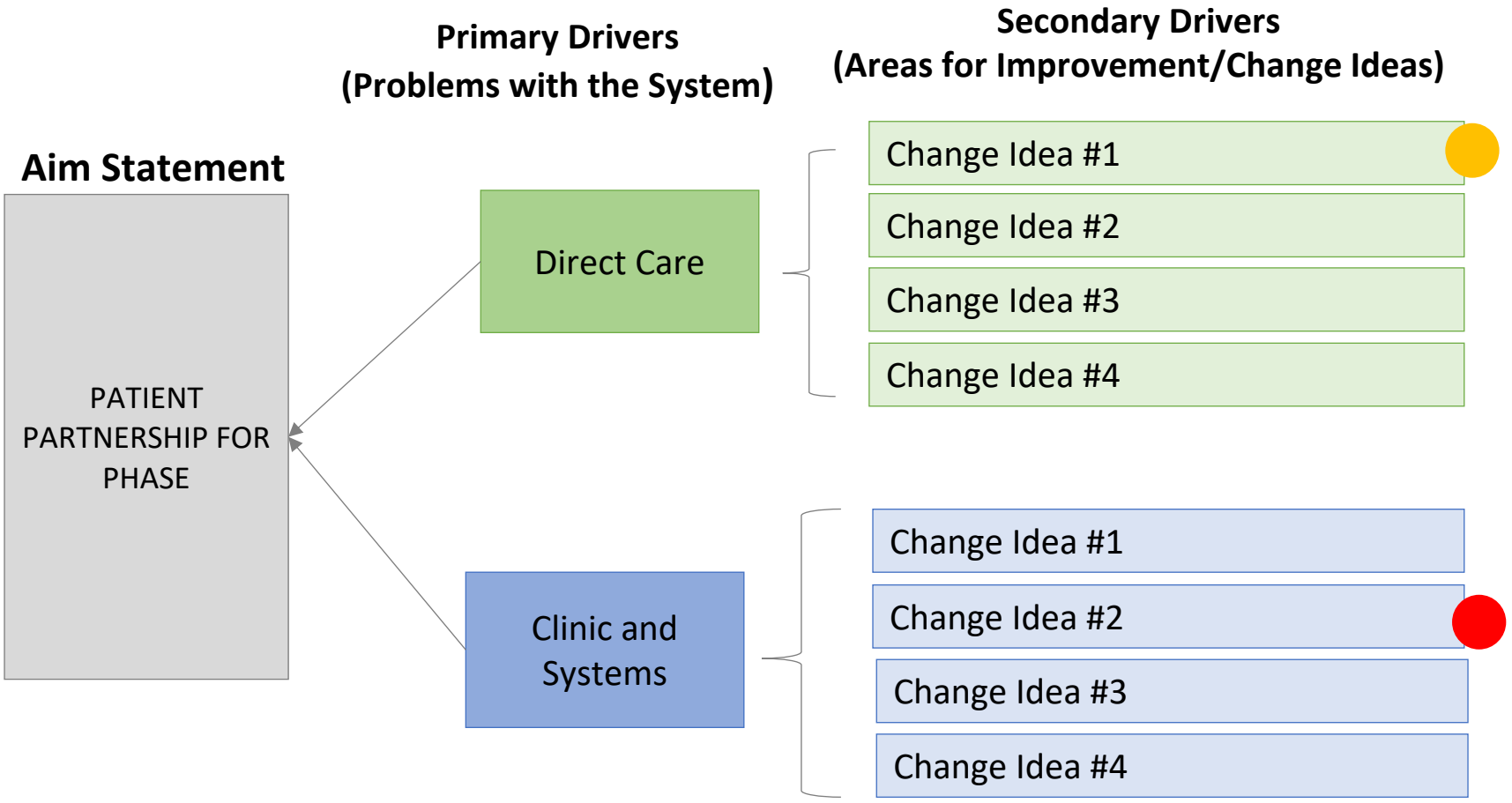
Asthma Example

Issue	Clinical Quality Improved? - is impact on quality of care positive?	Waste reduced with improved financial impact? - improved financial performance?	Patient Care Experience Improved? - Pt satisfaction improved?	Ease of Implementa-tion?	Leadership Support	Frontline Engage-ment	Overall SCORE TOTAL
Pt. keeps scheduled appt.	3	2	3	1	3	1	13
Correct classification in EMR	3	1	1	3	3	2	13
Pt. F/up with case manager	3	1	3	1	2	2	12

Instructions:

1. Score each item 1-3 (1 is lowest, 3 is highest)
2. Total scores across all categories
3. What is your #1 highest ranked small bone to test?

Multi-voting (a.k.a. “Dot” Voting)

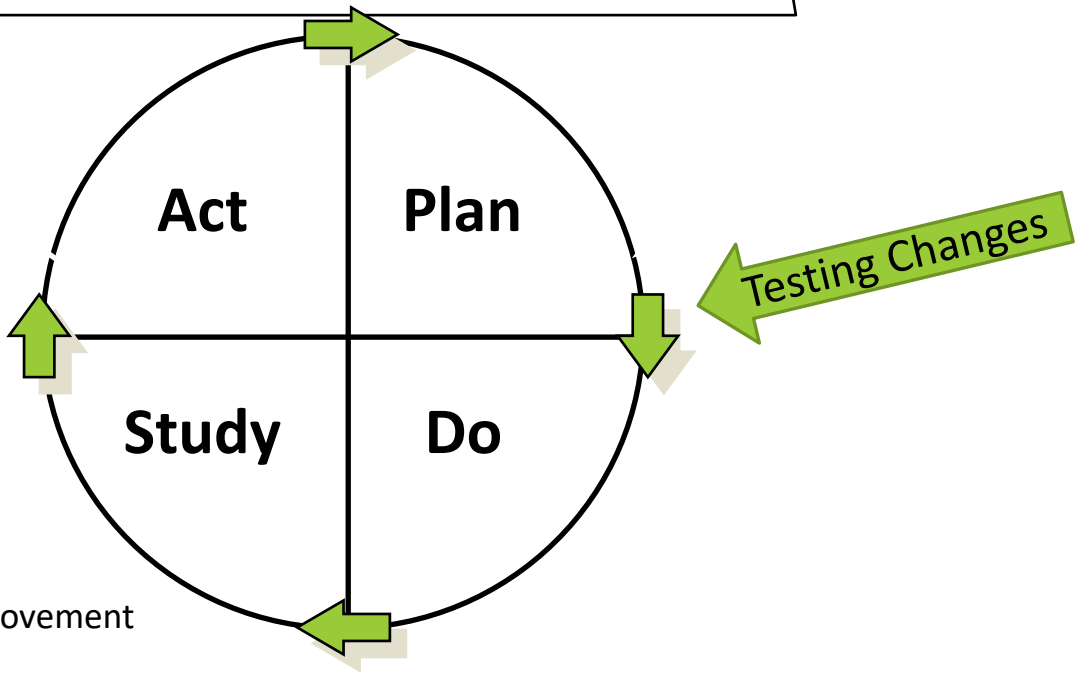


Model for Improvement

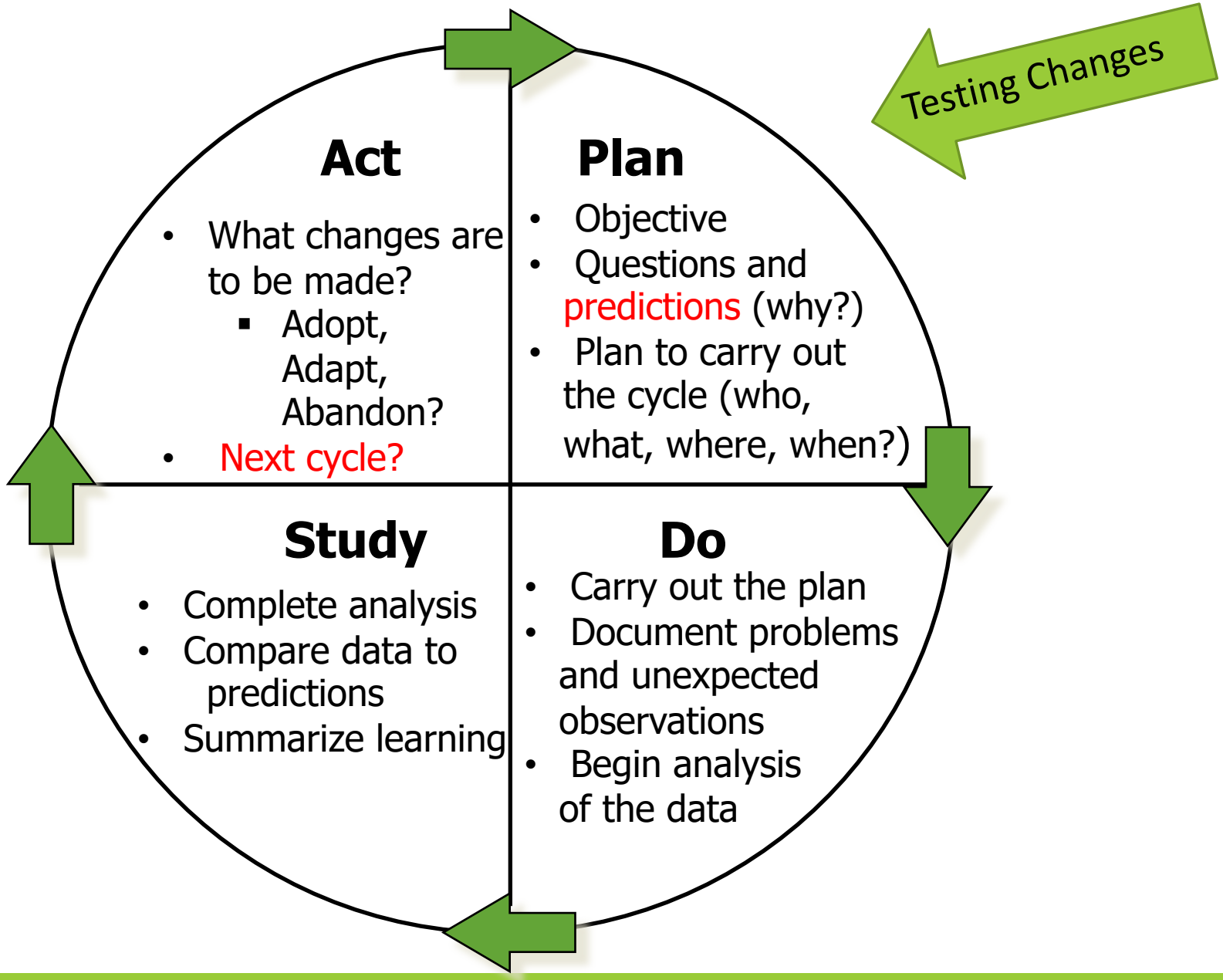
What are we trying to accomplish?

How will we know that a change is an improvement?

What changes can we make that will result in improvement?



From Associates in Process Improvement

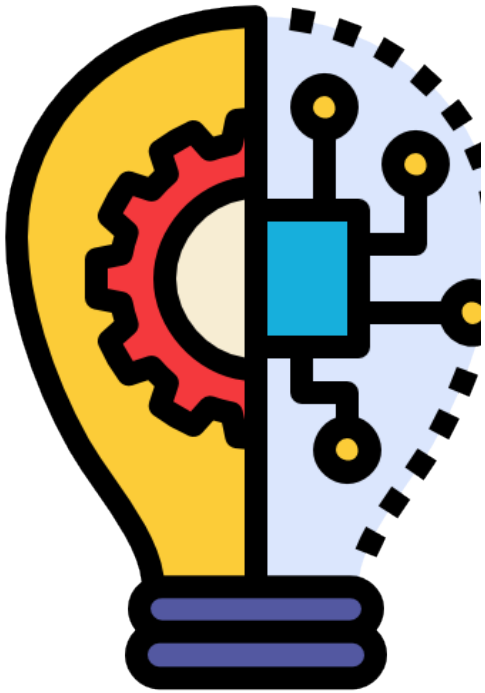

Testing Changes
Act
What changes are to be made?
Adopt, Adapt, Abandon?
Next cycle?
Plan
Objective
Questions and predictions (why?)
Plan to carry out the cycle (who, what, where, when?)
Study
Complete analysis
Compare data to predictions
Summarize learning
Do
Carry out the plan
Document problems and unexpected observations
Begin analysis of the data

Why Do Small Tests of Change?

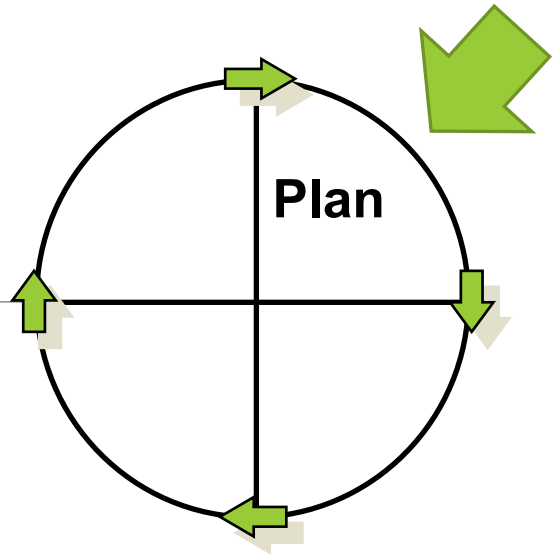
- Provides an opportunity to learn from a temporary situation
- Increases degree of belief that a change will result in improvement
- Provides information regarding the limitations of a change
- Addresses unexpected consequences EARLY
- Facilitates gaining buy-in
- Prevents implementation of the WRONG process

Testing Changes

- Small scale tests = BIG changes
- Experimentation is required
- Small, rapid tests of change → PDSA cycle



PDSA - Plan



- Record details of the test
  - Use a PDSA Template
  - Record the details
    - Who, what, where, when
- Formulate predictions
- Determine data collection needs for test evaluation

TEST = Diabetic Foot Exam Objective and Questions to Answer

- **Objective for PDSA cycle:**
  - To improve Diabetes Management and appointment efficiency by having MA conduct foot exam using filament

- **What questions do we want this test to answer with this PDSA cycle?**
  - How will this test:
    - Impact the % of exams being be completed?
    - Impact the cycle time of appointment?
    - Impact job satisfaction for both MA and provider?

TEST = Diabetic Foot Exam
Steps to Execute “PLAN”

- During the week of 6/11/2019, MA Sally, of Care Team B, will:
  - Receive training on filament foot exam
  - Identify 4 diabetic patients scheduled with Dr. Zee for next week
  - Conduct foot exam using filament for identified patients
  - Meet with Dr. Zee at the end of this test cycle to review, analyze and add comments to data collection form

TEST = Diabetic Foot Exam Data Collection Plan

- Was foot exam completed? (Y/N)
  - If not, why not?
- Did foot exam impact efficiency of appointment:
  - Time?
  - Treatment provided?
- Did MA and Provider feel satisfied with process?

Translating Data Collection to a Form

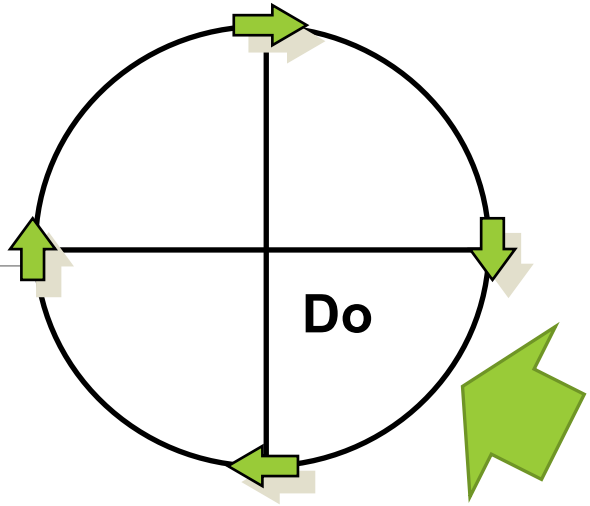
Identified Diabetic Patient Needing Foot Exam	Was Foot Exam Completed by MA? [If no, provide comments regarding why]	Did Foot Exam Impact Length of Scheduled Appt.? (Y/N)	If Yes, what was the difference in time	Satisfaction Rating (☺/☹)		Comments
				Dr. Zee	MA Sally	

TEST = Diabetic Foot Exam
Making Predictions

- Appointments may run longer until Sally gets comfortable with filament test process and adding it into her work day
- Four out of 4 patients identified will receive the foot exam
- Dr. Zee and Sally may not be satisfied with the process initially
- Dr. Zee may feel tentative to allow the MA to conduct the test in the beginning
- Sally will be both nervous and excited to take on this responsibility
- Both will be concerned about the cycle time

PDSA - Do

- Carry out the plan
- Document problems and observations
- Collect data and begin analysis



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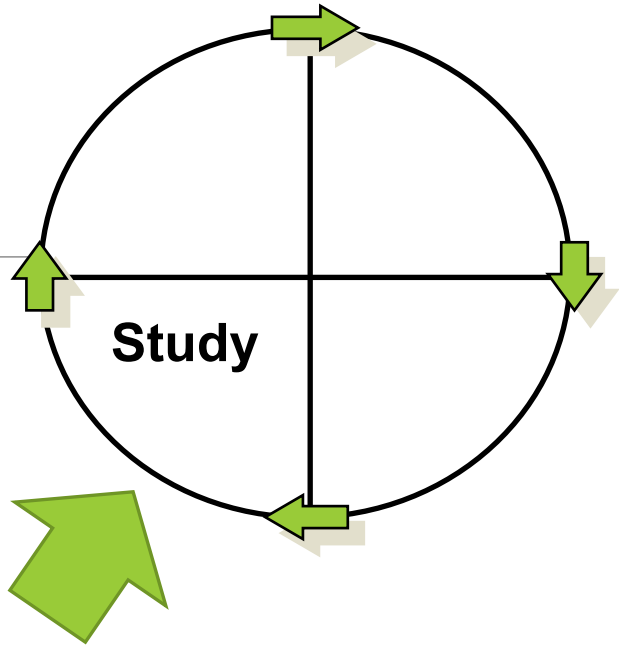
PDSA - Study

- Complete data analysis
  - Leave time for reflection about the test
    - What is your “gut” reaction?
- Compare data to predictions
  - What happened?
    - Did you get expected results?
    - Did anything unexpected happen?
- Summarize what was learned



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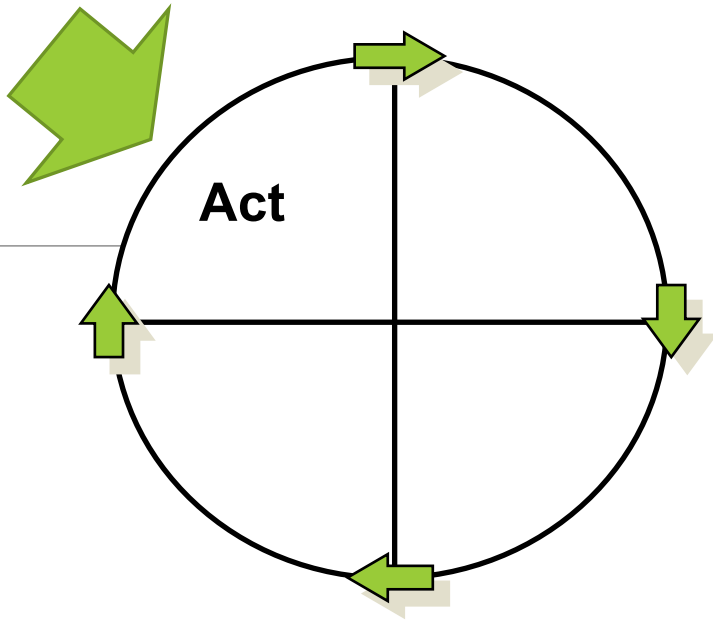
Identified Diabetic Patient Needing Foot Exam	Was Foot Exam Completed by MA? [If no, provide comments regarding why]	Did Foot Exam Impact Length of Scheduled Appt.? (Y/N)	If Yes, what was the difference in time	Satisfaction Rating (☺/☹)		Comments
				Dr. Zee	MA Sally	
1	No	Yes	15	☹	☹	Filaments had not been stocked in exam room; Dr. Zee prepared while Sally found filaments and Dr. Zee performed exam to save time
2	No	No	0	☺	☺	Pt. was experiencing chest pain, which was the focus of the appt.
3	Yes	Yes	5	☺	☺	Pt. needed some additional instruction/ education
4	Yes	Yes	0	☺	☺	MA felt well-prepared and Dr. Zee appreciated additional time that he could spend with patient

PDSA - Act



- What will do next?
  - Adopt
  - Adapt
  - Abandon
- Plan the next cycle or test iteration
  - Refine changes
  - Try it on a larger scale

A quote from IDEO

"Fail often to succeed sooner."

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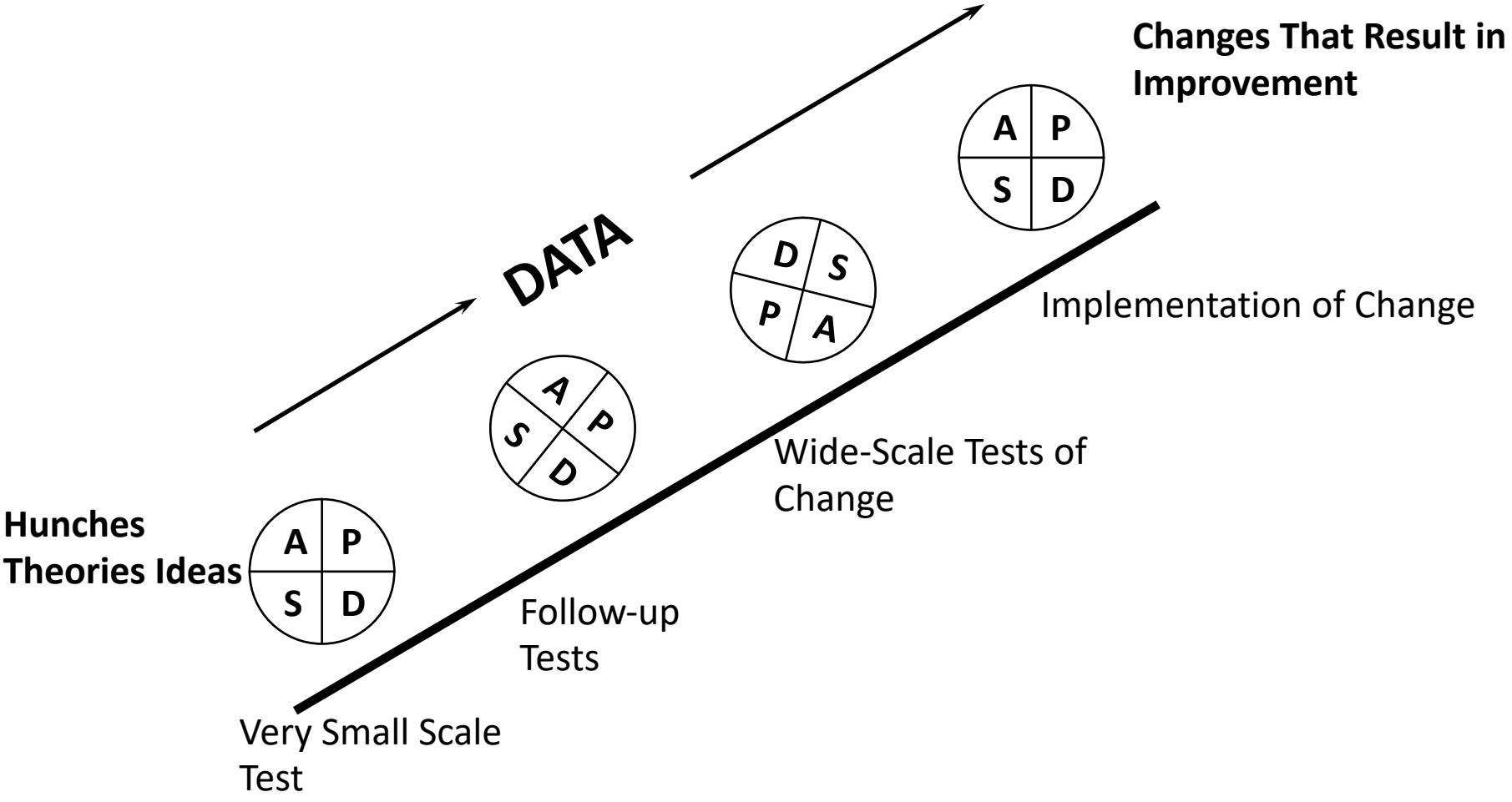
Repeated Use of PDSA Cycle



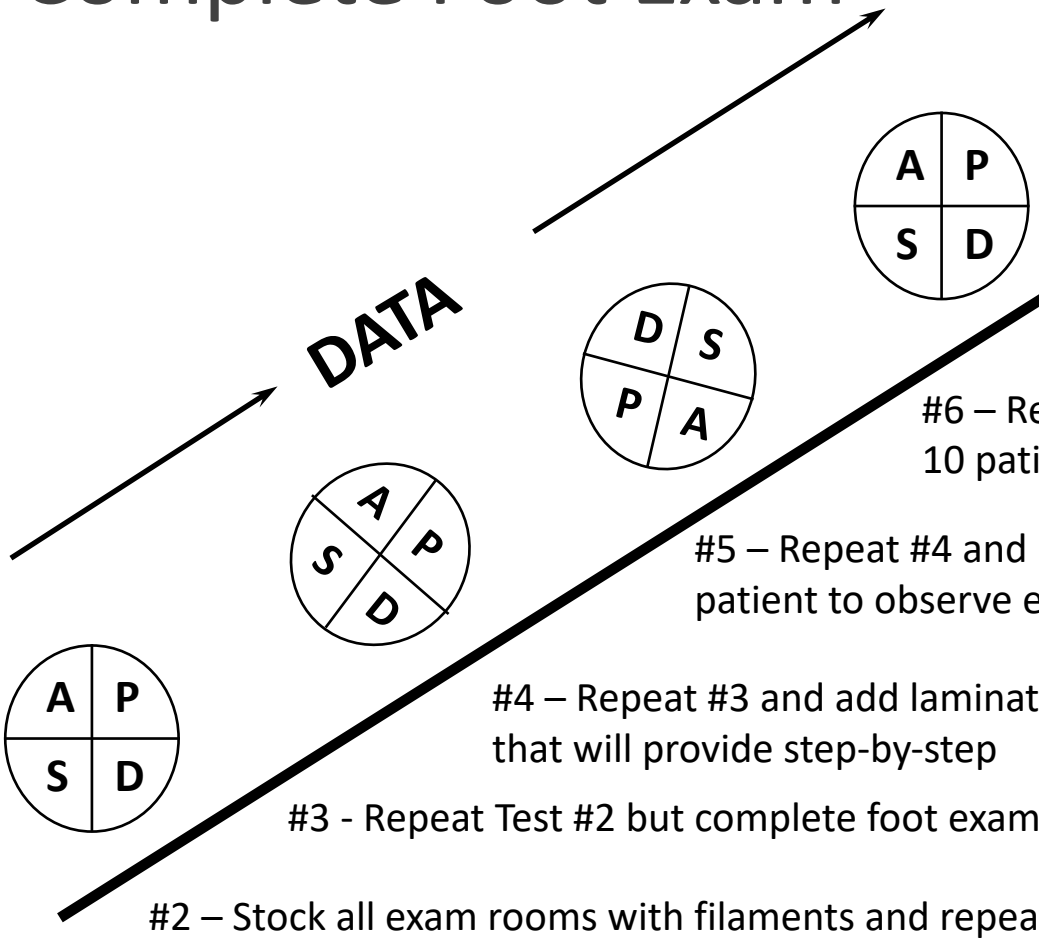
Test Iterations

- Very Small-scale Tests
- Follow-up Tests
- Wide-scale Tests
- Implementation

Small Scale Test Iterations
MA Complete Foot Exam

High-Degree of Belief

1. **F/up Tests**
2. **Wide-scale tests**



#7 – Repeat #6 and ramp up to two MAs

#6 – Repeat #5 and ramp up to 10 patients

#5 – Repeat #4 and provide mirror for patient to observe exam

#4 – Repeat #3 and add laminated, foot exam pt. ed. tool that will provide step-by-step

#3 - Repeat Test #2 but complete foot exam BEFORE the exam

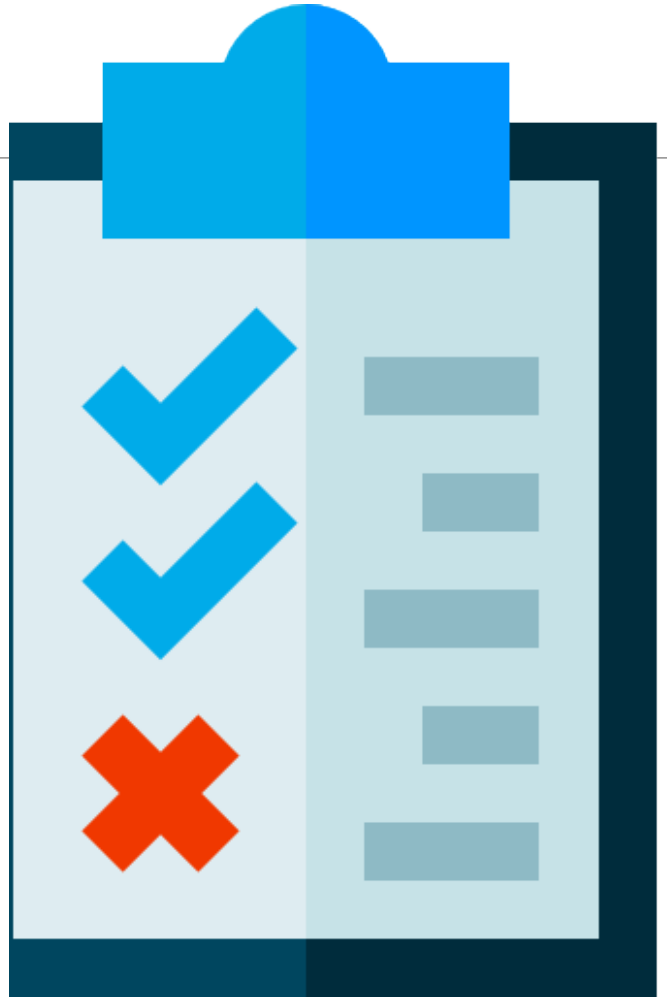
#2 – Stock all exam rooms with filaments and repeat test #1

#1 – MA identify 4 diabetic patients and conduct foot exam

Hunches, theories, predictions, ideas

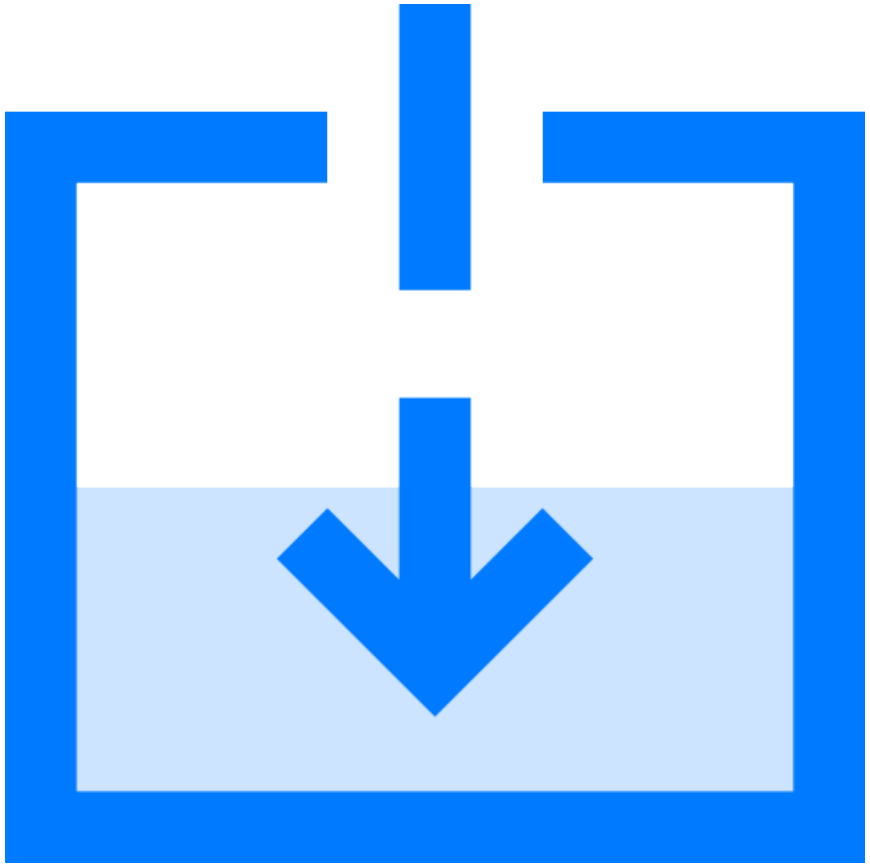
PDSA Cycle Considerations

- Conducting simultaneous tests can be
  - Keep testing population separate
- Bundling tests can be done
  - If your prediction is that BOTH elements are necessary for improvement

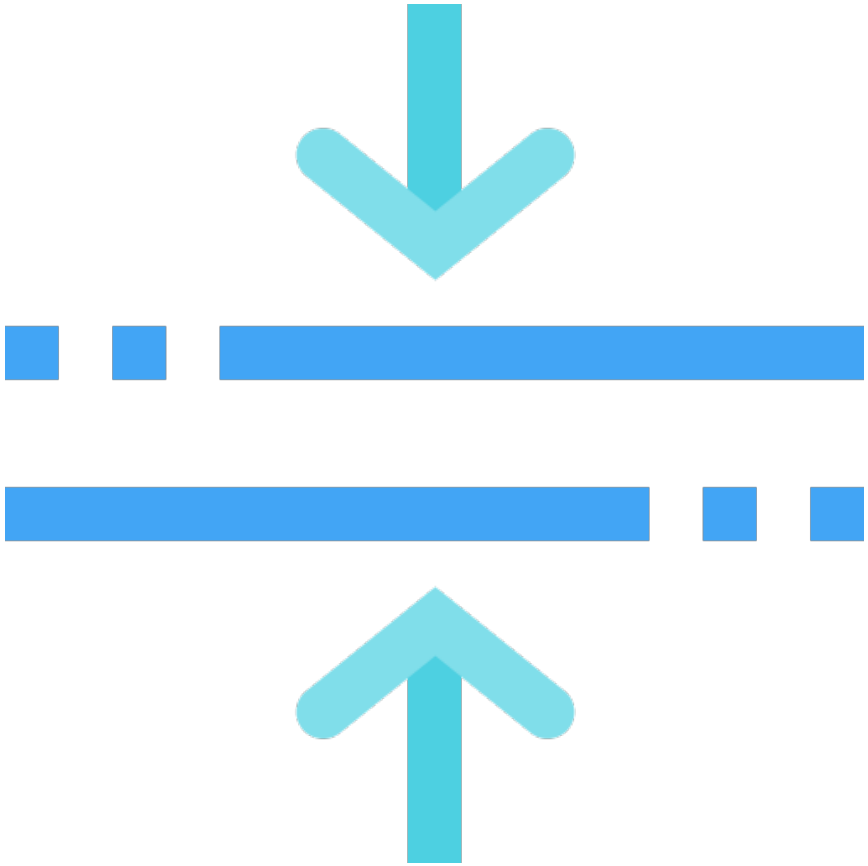


PDSA Tip #1 – Don Berwick Scale Down

“Drop 2 Levels”



- Years
- Quarters
- Months
- Weeks
- Days
- Hours
- Minutes
- 25 patients

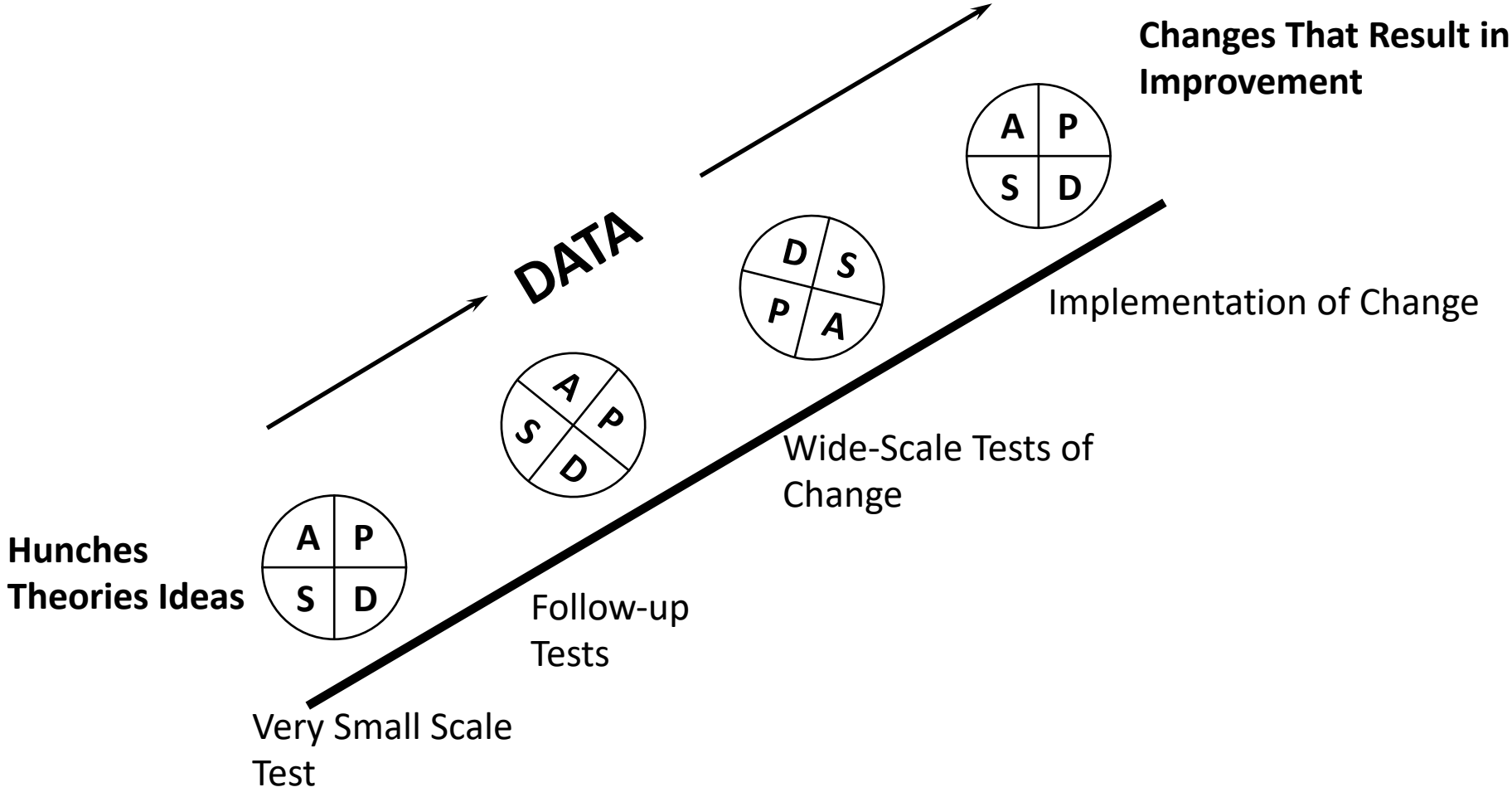


How Would You Size Down the Tests?

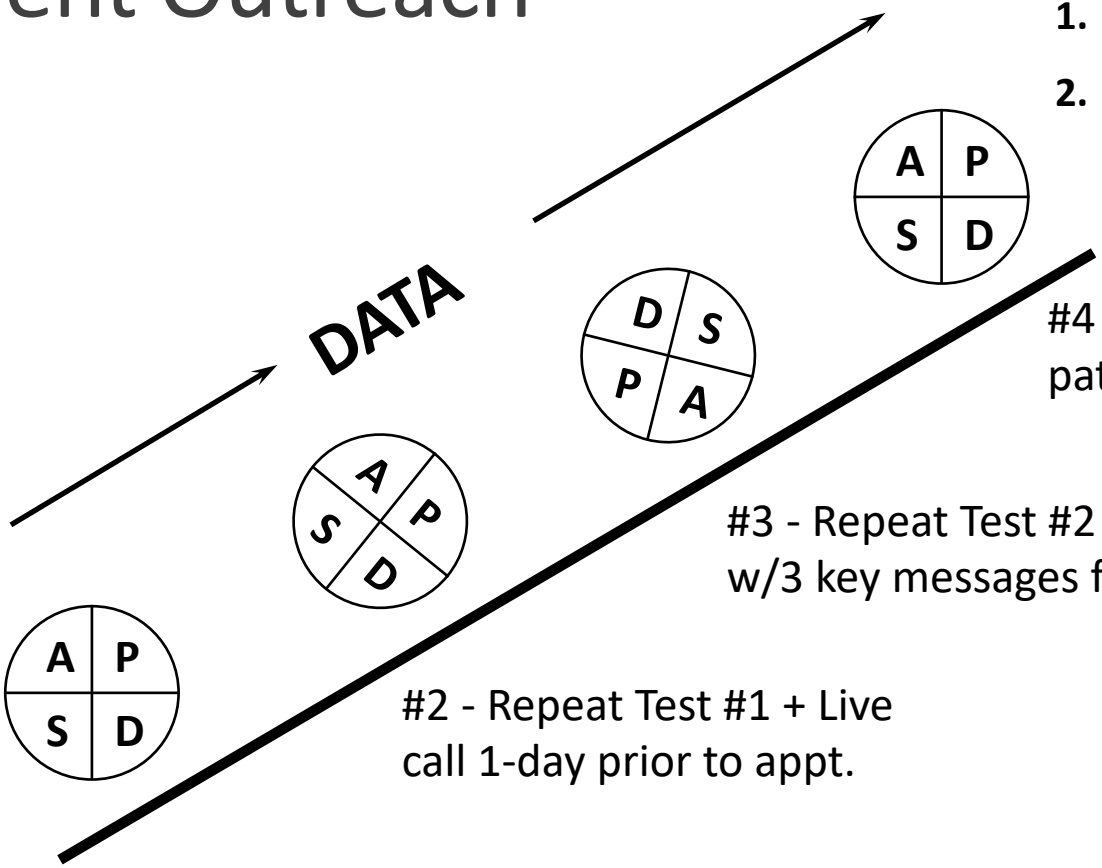
- Huddles for a week
- Pre-visit planning for all patients with chronic illness
- Standardizing exam rooms
- Creating distributed multi-professional work stations

PDSA Tip #2: “Oneness”

Repeated Use of PDSA Cycle



Small Scale Test Iterations Patient Outreach



High-Degree of Belief

1. **F/up Tests**
2. **Wide-scale tests**

#4 – Repeat Test 3 for 10 patients

#3 - Repeat Test #2 + use script w/3 key messages for patient

#2 - Repeat Test #1 + Live call 1-day prior to appt.

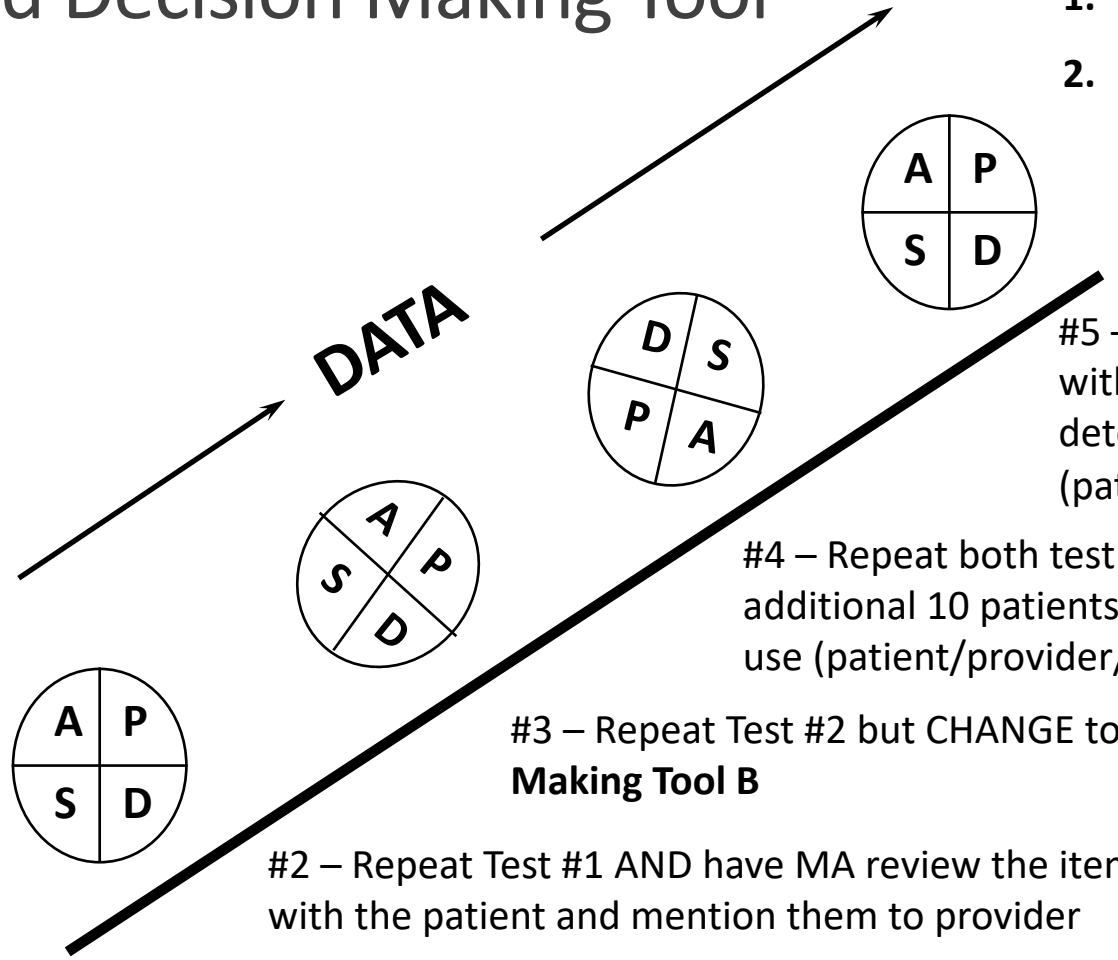
#1 - Test robo-call reminders 3 days before scheduled appt. for 5 patients next week

Hunches, theories, predictions, ideas

Small Scale Test Iterations: Shared Decision Making Tool

High-Degree of Belief

1. **F/up Tests**
2. **Wide-scale tests**



#5 – Repeat both test #2 and #3 with an additional 10 patients to determine best tool to use (patient/provider/MA feedback)

#4 – Repeat both test #1 and #3 with an additional 10 patients to determine best tool to use (patient/provider/MA feedback)

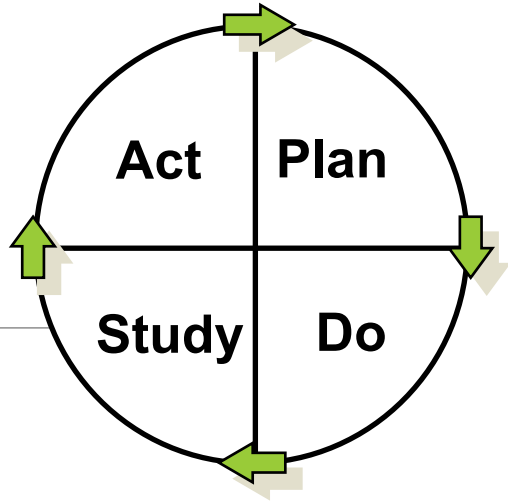
#3 – Repeat Test #2 but CHANGE to **Shared Decision Making Tool B**

Hunches, theories, predictions, ideas

#2 – Repeat Test #1 AND have MA review the items for discussion with the patient and mention them to provider

#1 – Provide 2 patients with **Shared Decision Making Tool A** during registration and invite them to fill in blanks for 2 things they want to discuss with the provider; conduct exit interview to ask the patient and provider about experience

PDSA Cycle must include



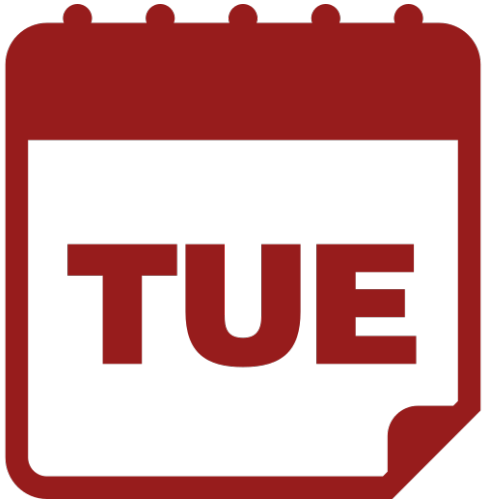
- A question
- A prediction
- The test or observation was planned - include a plan for collecting data
- The plan was attempted - do the plan
- Time was set aside to analyze the data and study the results compared to prediction
- Action was rationally based on what was learned

A Quote from Don Berwick

"What can we do next Tuesday, without harming a hair on the head of a patient?"

Develop A PDSA to Implement "Next Tuesday"

- Review the prioritized ideas on your Storyboard
  - Re-prioritize, if necessary
- Select one idea that you can try "next Tuesday"
- Develop the "PLAN" portion of the PDSA worksheet
- Identify possible "next" test iterations
  - What other questions do you have?



BREAK

We will resume at 3:15pm

Team Time

Step 1: Meet with your team to refine your PDSA plans

Step 2: Find another team. Share your PDSA plans with each other. Ask each other questions and give each other feedback (“I like…, I wish…, I wonder…”)

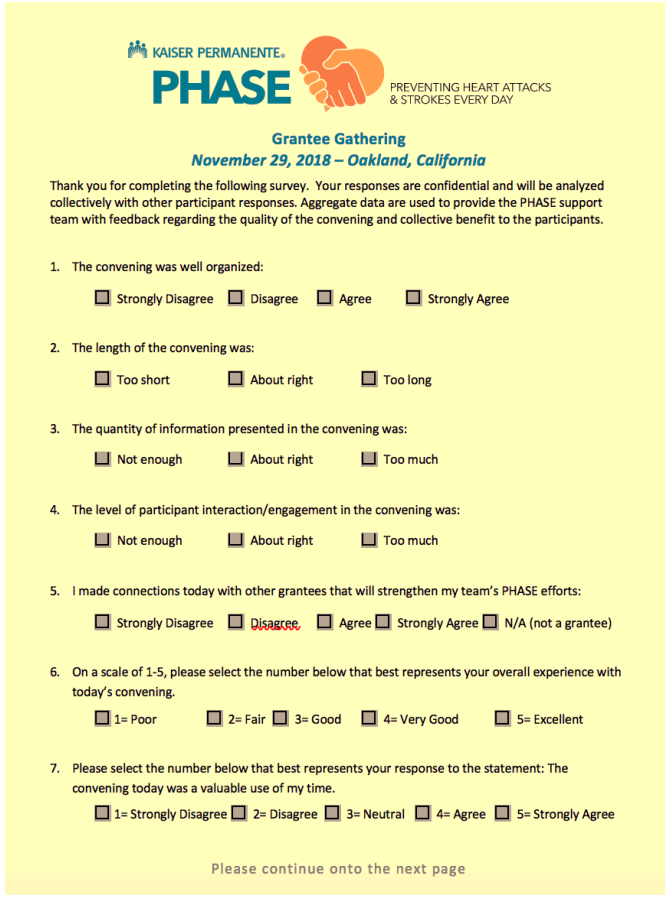
News from your support partners!

CCI

Closing and evaluations

KAISER PERMANENTE®
PHASE
PREVENTING HEART ATTACKS
& STROKES EVERY DAY

Convening Evaluation



KAISER PERMANENTE®
PHASE
PREVENTING HEART ATTACKS & STROKES EVERY DAY

Grantee Gathering
November 29, 2018 – Oakland, California

Thank you for completing the following survey. Your responses are confidential and will be analyzed collectively with other participant responses. Aggregate data are used to provide the PHASE support team with feedback regarding the quality of the convening and collective benefit to the participants.

1. The convening was well organized:
   ☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

2. The length of the convening was:
   ☐ Too short ☐ About right ☐ Too long

3. The quantity of information presented in the convening was:
   ☐ Not enough ☐ About right ☐ Too much

4. The level of participant interaction/engagement in the convening was:
   ☐ Not enough ☐ About right ☐ Too much

5. I made connections today with other grantees that will strengthen my team's PHASE efforts:
   ☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree ☐ N/A (not a grantee)

6. On a scale of 1-5, please select the number below that best represents your overall experience with today's convening.
   ☐ 1= Poor ☐ 2= Fair ☐ 3= Good ☐ 4= Very Good ☐ 5= Excellent

7. Please select the number below that best represents your response to the statement: The convening today was a valuable use of my time.
   ☐ 1= Strongly Disagree ☐ 2= Disagree ☐ 3= Neutral ☐ 4= Agree ☐ 5= Strongly Agree

Please continue onto the next page

PHASE Support Team at CCI

CCI
CENTER FOR CARE INNOVATIONS

PHASE Project Office
TA, Training, and Coaching
Learning Community

Welcome Nikki!

Nikki Navarrete, Program Coordinator nikki@careinnovations.org
Alexis Wielunski, Program Manager alexis@careinnovations.org
Michael Rothman, Executive Director michael@careinnovations.org

PHASE Performance Improvement Coaches:
Denise Armstorff
Jerry Osheroff

Communication Tools

Monthly Newsletter (First Thursday each month)

Calendar invites for program events

PHASE Support Portal Page
(www.careinnovations.org/phasesupport/)

Peer Learning Site Visit: July 10

Grantees in the PHASE and TC3 programs will have the opportunity to visit a health center that exemplifies innovative population health management practices. On July 10th, participants can visit one of these four sites:

marin community clinics
connecting for health

Petaluma Health Center

SONOMA COUNTY INDIAN HEALTH PROJECT

West County Health Centers
Caring for our Communities

Novato, CA	Petaluma, CA	Santa Rosa, CA	Sebastopol, CA
Population Health Management Sessions: Protected Time for Care Teams	Morning huddles, onboarding new providers to POAP, nurse-led HTN visits	A unique multidisciplinary care team model for PHASE patients	"Hike through the Measures" to connect with the meaning of data

Space is limited – please register your interest by Monday, June 17.

https://www.surveymonkey.com/r/PHASESiteVisits

Thank you for spending the day with us!

KAISER PERMANENTE®

PHASE

PREVENTING HEART ATTACKS
& STROKES EVERY DAY