PHASE Grantee Convening
Engaging Patients as Active Partners
June 11, 2019
Welcome!

Jean Nudelman
Director, Northern California Community Benefit
Frameworks

Levels of Patient Engagement

10 Building Blocks of Primary Care


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

PHASE Champion
Center for Care Innovations

Turn to p. 3 for how to decode your nametag

Engaging Patients as Active Partners

PHASE Grantee Convening
June 11, 2019
Oakland, CA

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!
Community Health Center Network

Care Neighborhood Addressing Patient Needs through Partnership and Trust
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.

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

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

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.

**Data Analytics**

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

**Technical Training and Support**

Experienced SWs train and provide consultative support for CHWs.

**Inpatient Support**

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

**Embedded Care Team**

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

**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.
Person-centered care and empowerment

Person-Centered Approach

- Motivational Interviewing
- Trauma Informed Care
- Cultural Humility
- Comprehensive Biopsychosocial assessment
- Harm Reduction
- Care Plan and Shared Action Plan
- Root Cause and Social Justice Framing

Comprehensive Biopsychosocial assessment

Harm Reduction

Cultural Humility

Trauma Informed Care

Motivational Interviewing

Root Cause and Social Justice Framing

Care Plan and Shared Action Plan

Person-Centered Approach
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

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

<table>
<thead>
<tr>
<th>Identify needs:</th>
<th>In the last 12 months, did you ever eat less than you felt you should because there wasn’t enough money for food?</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Food</strong></td>
<td>Are you receiving CalFresh/EBT/Market Match? (will not qualify if on SSI) (consider referral)</td>
<td></td>
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<tr>
<td></td>
<td>Have you ever tried a food pantry/food bank? Interested in one near your home?</td>
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<td></td>
<td>Do you have problems shopping for or preparing your own food? (consider IHSS, MOW)</td>
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<tr>
<td></td>
<td>Ask about chronic conditions in relation to food here (diabetes, high blood pressure. Consider referral to POH)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assess if patient is eligible for any clinic resources</td>
<td></td>
</tr>
<tr>
<td><strong>Notes</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Transportation</strong></th>
<th>In the last 12 months, have you ever had to go without health care because you didn’t have a way to get there?</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Do you need: disabled placard, disabled/senior bus pass, Paratransit, insurance benefit?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assess if patient is eligible for any clinic resources</td>
<td></td>
</tr>
<tr>
<td><strong>Notes</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Financial</strong></th>
<th>Do you have an income right now?</th>
<th>Yes / No</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>What is the source of your income?</td>
<td></td>
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<tr>
<td></td>
<td>Are you pursuing any type of disability? (SSI, SSDI, etc. consider referral to Bay Area Legal Aid)</td>
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</tr>
<tr>
<td></td>
<td>Do you have debt; need connection to CalWorks or employment resources?</td>
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<tr>
<td></td>
<td>In the past 12 months, has your utility company shut off your service for not paying your bills?</td>
<td>Yes / No</td>
</tr>
<tr>
<td></td>
<td>Discuss PG&amp;E Care program, Lifeline telephones, EBMUD discount, HEAP</td>
<td></td>
</tr>
<tr>
<td><strong>Housing</strong></td>
<td><strong>Notes</strong></td>
<td><strong>Do you have a safe, stable place to sleep and store your possessions?</strong></td>
</tr>
<tr>
<td>-------------</td>
<td>-----------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td><strong>Are you worried that in the next 2 months, you may not have this situation?</strong></td>
<td>Yes / No</td>
</tr>
<tr>
<td></td>
<td>Are you in need of finding alternative housing? (consider Home Stretch referral if literally or chronically homeless)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do you need advice about renter’s rights (eviction, bad conditions like mold, rodents, insects, etc.)</td>
<td></td>
</tr>
<tr>
<td><strong>IHSS</strong></td>
<td><strong>Notes</strong></td>
<td><strong>Do you have or need a caregiver?</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Does this person get paid through IHSS? (consider application for IHSS and/or Alameda County Care Alliance)</strong></td>
<td></td>
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<tr>
<td></td>
<td><strong>Do you need to find a new IHSS worker? (consider application for IHSS registry)</strong></td>
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</table>
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
## Details

<table>
<thead>
<tr>
<th>Name/Pronoun</th>
<th>Preferred Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Preferred Pronoun:</td>
</tr>
</tbody>
</table>

### 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

---

**Patient:**

**Date of Visit:**

**Provider:**

**CHW:**

**Check items that patient has, circle what is needed**
<table>
<thead>
<tr>
<th>Safety / Medical Equipment</th>
<th>Are you concerned about your personal safety? ____________</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Also see ADL/IADL and DME Screening</em></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Food Access</th>
<th>Meals on Wheels</th>
<th>Food Bank/Pantry</th>
<th>Cal Fresh</th>
<th>Market Match</th>
<th>POH</th>
<th>None</th>
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</table>

<table>
<thead>
<tr>
<th>Daily Activities</th>
<th>Support Groups</th>
<th>Day Program</th>
<th>Volunteering</th>
<th>School</th>
</tr>
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<tbody>
<tr>
<td>Church/religious</td>
<td>Caregiver Support</td>
<td>None</td>
<td></td>
<td></td>
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<tr>
<th>Finances</th>
<th>Employed</th>
<th>GA</th>
<th>SDI</th>
<th>SSDI</th>
<th>SSI</th>
<th>CalWorks</th>
<th>None</th>
<th>CAPI</th>
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<thead>
<tr>
<th>Health Insurance</th>
<th>Dental</th>
<th>Vision</th>
<th>Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Podiatry</td>
<td>None</td>
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<tr>
<th>Legal</th>
<th>Public Benefit assistance</th>
<th>Safety at home (intimate partner violence?)</th>
<th>Immigration/Nationalization</th>
<th>Post</th>
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<tr>
<th>Legal Services</th>
<th>None</th>
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<thead>
<tr>
<th>Medications</th>
<th>Reconciliation: done recently</th>
<th>needs to be done</th>
<th>nurse visit</th>
<th>None</th>
</tr>
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<table>
<thead>
<tr>
<th>Current Pharmacy</th>
<th>Name of Pharmacy:</th>
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<tbody>
<tr>
<td>Address and contact information:</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Name of Pharmacy:</th>
<th>Address and contact information:</th>
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<tr>
<th>Behavioral Health</th>
<th>Current BH support:</th>
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<tr>
<th>Psychiatry</th>
<th>Counseling</th>
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<tr>
<th>History (from chart/team):</th>
<th>Trauma</th>
<th>S150</th>
<th>SI</th>
<th>H1</th>
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</table>

<table>
<thead>
<tr>
<th>Mental Health:</th>
<th>PHQ-9</th>
<th>Needs</th>
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<tr>
<th>Substance Use Hx</th>
<th>Tobacco Use</th>
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<table>
<thead>
<tr>
<th>Healthy Drinking Limits</th>
<th>Per Day</th>
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<tbody>
<tr>
<td>Women: ≤ 4; Men: ≤ 5</td>
<td></td>
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<tr>
<td>65 and older: ≤ 3</td>
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<tr>
<th>Alcohol: How many times in the past month have you had 4/5 or more drinks in a day?</th>
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<table>
<thead>
<tr>
<th>Substance Use: How many times in the past month have you used an illegal drug or used a prescription medication for non-medical reasons?</th>
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<thead>
<tr>
<th>End Of Life Issues</th>
<th>DPA:</th>
<th>Location:</th>
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</thead>
<tbody>
<tr>
<td>Advanced Directives</td>
<td>Location:</td>
<td></td>
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</table>

| POLST | Location: |
Early Success
2016 pulse check

<table>
<thead>
<tr>
<th></th>
<th>Control</th>
<th>Care Neighborhood</th>
<th>Change from expected utilization without treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Admission</strong></td>
<td>+2%</td>
<td>-41%</td>
<td>43% less utilization</td>
</tr>
<tr>
<td><strong>ER visits</strong></td>
<td>-20%</td>
<td>-41%</td>
<td>21% fewer ER visits</td>
</tr>
<tr>
<td><strong>Specialty Visits</strong></td>
<td>-17%</td>
<td>+11%</td>
<td>28% more specialty visits</td>
</tr>
<tr>
<td><strong>PCP appts.</strong></td>
<td>-34%</td>
<td>-2%</td>
<td>32% more PCP visits</td>
</tr>
</tbody>
</table>

“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
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 Process

## Patient Visit Summary (Health Maintenance Form)

<table>
<thead>
<tr>
<th>Patient ID</th>
<th>Name</th>
<th>Age</th>
<th>DOB</th>
<th>Sex</th>
<th>Date</th>
<th>Lead Visit</th>
<th>This Visit</th>
</tr>
</thead>
</table>

**ALLERGIES:** No known allergies - Allergen: Folic Acid

**PROBLEMS:** Childhood obesity - ADHD - Diabetes mellitus - Hypertension disorder - Tobacco user - Current

**MEDICATIONS:**
- AVPIL 25 mg (IBuprofen): Aroxolin 25 mg (Ibuprofen)
- Atenolol extended release: Atenolol 25 mg (Ibuprofen)
- Bisoprolol: Bisoprolol LA 25 mg (Ibuprofen)
- Propranolol: Propranolol 2 mg (Ibuprofen)
- Lisinopril: Lisinopril 25 mg (Ibuprofen)
- Atorvastatin: Atorvastatin 10 mg (Lisinopril)
- Simvastatin: Simvastatin 20 mg (Atorvastatin)
- Pseudoephedrine: Pseudoephedrine 8 mg (Atorvastatin)
- Furosemide: Furosemide 40 mg (Atorvastatin)

** Diabetic Foot Care: No abnormal signs/symptoms

**Blood Pressure:**"
# HTN Health Coach Matrix

## MA/HEALTH COACH SERVICES FOR
PRE HTN & HTN

<table>
<thead>
<tr>
<th>MA HEALTH COACH</th>
<th>LEVEL 0</th>
<th>WHAT'S THE GOAL?</th>
<th>MA HEALTH COACH FOLLOW-UP GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>&lt;120</td>
<td>Establish An Action Plan:</td>
<td></td>
</tr>
<tr>
<td>HTN DX</td>
<td>&lt;80</td>
<td>&quot;Healthy Eating&quot;</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>&quot;Increase exercise 30 to 60 minutes most days of the week&quot;</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>&quot;Decrease fast foods, tran/sat fat &amp; processed foods.&quot;</td>
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- MA/HC will follow-up on 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

<table>
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<tr>
<th>MA HEALTH COACH</th>
<th>LEVEL 1</th>
<th>WHAT'S THE GOAL?</th>
<th>MA HEALTH COACH FOLLOW-UP GUIDELINES</th>
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<tr>
<td>Elevated</td>
<td>Between 120-129 or &lt;80</td>
<td>Establish An Action Plan:</td>
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<td>&quot;Healthy Eating&quot;</td>
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<td>&quot;Eat this instead of that&quot;</td>
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<td>&quot;Decrease fast foods, tran/sat fat &amp; processed foods.&quot;</td>
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<td>&quot;Review medication adherence as prescribed if applicable&quot;</td>
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<td>Decrease Alcohol Intake</td>
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</table>

- 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
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<tr>
<th>MA HEALTH COACH</th>
<th>LEVEL 11</th>
<th>WHAT'S THE GOAL?</th>
</tr>
</thead>
</table>
| **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, trim/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 |

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<tr>
<th>MA HEALTH COACH</th>
<th>LEVEL III</th>
<th>WHAT'S THE GOAL?</th>
<th>MA HEALTH COACH FOLLOW-UP GUIDELINES</th>
</tr>
</thead>
</table>
| **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, trim/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-up Action Plan one month and encourage training for self-monitoring form  
 MA/Health Coach will follow up 3 - 6 months.  
 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)  
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Resource: [www.aca.org](http://www.aca.org)  
Revised: 7/27/2018
Hypertension Risks

MAIN FACTORS THAT CONTRIBUTE TO THE DEVELOPMENT OF HIGH BLOOD PRESSURE AND ITS COMPLICATIONS

Social determinants and drivers
- Globalization
- Urbanization
- Ageing
- Income
- Education
- Housing

Health Coach Opportunities

Behavioural risk factors
- Unhealthy diet
- Tobacco use
- Physical inactivity
- Harmful use of alcohol

Health Coach Opportunities

Cardiovascular disease
- Heart attacks
- Strokes
- Heart failure
- Kidney disease

High blood pressure
- Obesity
- Diabetes
- Raised blood lipids

Metabolic risk factors
Action Plans

MY ACTION PLAN

I, ___________________________ and ___________________________

have a plan to improve my health.

1. I want to work on ONE activity:
   - Increase my physical activity
   - Improve my food choices
   - Cut down on smoking
   - Take my medicine
   - Test blood sugar
   - Reduce my stress

2. What I will do:
   What: ___________________________
   Start Date: ___________________________
   How much: ___________________________
   Follow up Date: ___________________________
   When: ___________________________
   How to follow up: ___________________________
   How often: ___________________________
   Where: ___________________________
   With whom: ___________________________

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 — Not sure
2 — Somewhat sure
3 — Sure
4 — Very sure

UCD/LCH/CH Medical Assistant Health Coach Training 2016
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

Health Coach Graduation April 2019

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

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

Level 1
Overwhelmed & disengaged
10-20%

Level 2
Becoming aware, but still struggling
10-20%

Level 3
Taking action
25-30%

Level 4
Maintaining behaviors
20-25%

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

Hypertension Self-Care Behavior

- Take Rx as recommended
  - Level 1: 31%
  - Level 2: 55%
  - Level 3: 73%
  - Level 4: 88%

- Know what BP should be
  - Level 1: 13%
  - Level 2: 17%
  - Level 3: 27%
  - Level 4: 58%

- Monitor BP weekly
  - Level 1: 6%
  - Level 2: 16%
  - Level 3: 14%
  - Level 4: 33%

- Keep BP diary
  - Level 1: 0%
  - Level 2: 9%
  - Level 3: 8%
  - Level 4: 21%

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)

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

- **Level 1**: Build Knowledge Base, Self-Awareness & Initial Confidence
- **Level 2**: Increase in Knowledge, Initial Skills Development, Grow Confidence
- **Level 3**: Skills Development, Pursue Guideline Behaviors
- **Level 4**: Achieve/Exceed Lifestyle Behavior Guidelines, Develop Techniques to Prevent Relapse

- Improve health
- Increase self-management ability
- Reductions in unwarranted utilization of service
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
1. Low Disease Burden  
   High Activation  
   VIRTUAL CARE MANAGEMENT

2. High Disease Burden  
   High Activation  
   VIRTUAL CARE MANAGEMENT

3. Low Disease Burden  
   Low Activation  
   HIGH TOUCH

4. High Disease Burden  
   Low Activation  
   HIGH TOUCH

Risk of progression
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
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)
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
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.”

PATIENT ENGAGEMENT ON THREE LEVELS

Levels of engagement

Consultation
Patients receive information about a diagnosis

Involvement
Patients are asked about their preferences in treatment plan

Partnership and shared leadership
Treatment decisions are made based on patients’ preferences, medical evidence, and clinical judgment

Organizational design and governance
Organization surveys patients about their care experiences
Hospital involves patients as advisers or advisory council members
Patients co-lead hospital safety and quality improvement committees

Policy making
Public agency conducts focus groups with patients to ask opinions about a health care issue
Patients’ recommendations about research priorities are used by public agency to make funding decisions
Patients have equal representation on agency committee that makes decisions about how to allocate resources to health programs

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
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
LifeLong Medical Care’s
Patient Voice Collaborative
Putting the community back in
Community Health!
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.
What is our model?

Patients, providers and administrators come to the table as equals to share their experiences and perspectives.

We identify problems and solutions that are responsive to patients' needs and realistic in the community health center context.
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.
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.
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 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.*
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!
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.
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.
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;
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.
We want you on our team.
Hypertension Equity Work Group

PHASE Conference  June 11, 2019
Jacqueline McCright, MPH
Robin George, MPH
Mr. Patrick McKenna
Ms. Rosalyn Frazier
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.
**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
- High cholesterol
- Diabetes
- Chronic kidney disease
- Family history (father or brother with heart disease before age 55 or mother or sister with heart disease before age 65)
- Cigarette smoking
- Age (older than 45 for men, over 55 for women)
- Being overweight
- Lack of physical activity
- Unhealthy diet
- Depression, stress, mental health conditions

---

**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/

---

**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.
THINGS YOU CAN DO TO IMPROVE YOUR BLOOD PRESSURE

1. How can I reach and maintain a healthy weight?
   - Eat 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 at 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 fried 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 SYMPTONS
- 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
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
Q&A

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

UCSF Department of Family and Community Medicine

LifeLong Medical Care
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Lucinda Bazile
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San Francisco Department of Public Health
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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
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)

Aim Statement
We will improve asthma management by increasing the ratio of inhaled controller medications to inhaled rescue medications from 59% to 75% by January 1, 2015

Primary Drivers (Problems with the System)
- Documentation
- Treatment
- Patient Engagement

Secondary Drivers (Areas for Improvement/Change Ideas)
- Incorrect classification in EMR
- No diagnosis of asthma in problem list
- No evidence of asthma in progress notes
- Inhaler medication not prescribed
- Provider not following standards
- No f/up or case management provided
- Does not know how to properly use inhaler
- Fails to pick up inhaler
- Fails to keep appts.
## Asthma Example

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</thead>
<tbody>
<tr>
<td>Pt. keeps scheduled appt.</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>Correct classification in EMR</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Pt. F/up with case manager</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>12</td>
</tr>
</tbody>
</table>

**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)

Aim Statement

Primary Drivers
(Problems with the System)

Direct Care

Clinic and Systems

Secondary Drivers
(Areas for Improvement/Change Ideas)

- Change Idea #1
- Change Idea #2
- Change Idea #3
- Change Idea #4

- Change Idea #1
- Change Idea #2
- Change Idea #3
- Change Idea #4
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?

Model for Improvement

Act

Plan

Study

Do

Testing Changes

From Associates in Process Improvement
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 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

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

Changes That Result in Improvement

Implementation of Change

Wide-Scale Tests of Change

Follow-up Tests

Very Small Scale Test

Hunches Theories Ideas

Repeated Use of PDSA Cycle

DATA

Very Small Scale Test
Test Iterations

- Very Small-scale Tests
- Follow-up Tests
- Wide-scale Tests
- Implementation
**Small Scale** Test Iterations

MA Complete Foot Exam

---

**Hunches, theories, predictions, ideas**

- #1 – MA identify 4 diabetic patients and conduct foot exam
- #2 – Stock all exam rooms with filaments and repeat test #1
- #3 - Repeat Test #2 but complete foot exam BEFORE the exam
- #4 – Repeat #3 and add laminated, foot exam pt. ed. tool that will provide step-by-step
- #5 – Repeat #4 and provide mirror for patient to observe exam
- #6 – Repeat #5 and ramp up to 10 patients
- #7 – Repeat #6 and ramp up to two MAs

**High-Degree of Belief**

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

---

**DATA**
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
“Drop 2 Levels”

PDSA Tip #1 – Don Berwick Scale Down

- 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

- Hunches
- Theories Ideas
- Very Small Scale Test
- Follow-up Tests
- Wide-Scale Tests of Change
- Implementation of Change
- Changes That Result in Improvement

DATA

- A
- P
- S
- D
Small Scale Test Iterations
Patient Outreach

Hunches, theories, predictions, ideas

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

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

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

#4 - Repeat Test 3 for 10 patients

High-Degree of Belief
1. F/up Tests
2. Wide-scale tests

DATA

133
Small Scale Test Iterations: Shared Decision Making Tool

High-Degree of Belief
1. F/up Tests
2. Wide-scale tests

#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

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

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

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

#5 – Repeat both test #2 and #3 with an additional 10 patients to determine best tool to use (patient/provider/MA feedback)
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?
We will resume at 3:15pm
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
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 grantees)

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
PHASE Support Team at CCI

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, Novato, CA
  - Population Health Management Sessions: Protected Time for Care Teams

- Petaluma Health Center, Petaluma, CA
  - Morning huddles, onboarding new providers to POAP, nurse-led HTN visits

- Sonoma County Indian Health Project, Santa Rosa, CA
  - A unique multidisciplinary care team model for PHASE patients

- West County Health Centers, Sebastopol, CA
  - “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!