PHASING THROUGH COVID

Community Health Partnership

Devayani Kunjir, Elena Guzman and Kayla Williams

March 23, 2021

COMMUNITY HEALTH PARTNERSHIP

Supporting our health centers

Our Desired Future for PHASE/TC3

VISION: To advance equity in healthcare by expanding our capacity to collect and use more granular health disparity data to improve the health outcomes for patients with chronic conditions and scale it to preventive screening metrics.

COMMUNITY HEALTH PARTNERSHIP

Our Desired Future for PHASE/TC3

NEW AIM: By March 31, 2022 CHP will identify, track, and stratify data by race/ethnicity, language, or socioeconomic status to understand potential health disparities, the impact of telehealth visits for PHASE patients, and use of this data to advance health equity and leverage key community partnerships that address social determinants of health.

By March 31, 2022 CHP will create a system that would allow timely collection of high-quality data

1) To better understand the disparities among PHASE patients with respect to demographic characteristics such as age, race, ethnicity, socioeconomic background, housing, and access to health coverage.
2) To evaluate telehealth access, utilization patterns and impact among PHASE patients

Why It's Not Possible Now

- Focus on COVID makes it difficult to engage community health center members
- Decrease in patient visits due to sheltering in place/fear to come into the clinic for an in-person visit
- Shared vision by CHP's Board of Directors to expand CHPs role to collect and use patient level and demographic data to address health inequities

Learnings that Will Inform Our Desired Future

Bright Spots/Accomplishments

- Initiated health disparity data reporting
- Overall consortium performance showed an improvement in Diabetes poor control (>9% or no test)
- Data committee approved integration of PHASE metrics into consortium dashboard for CY 2021

COMMUNITY HEALTH PARTNERSHIP

Learnings that Will Inform Our Desired Future

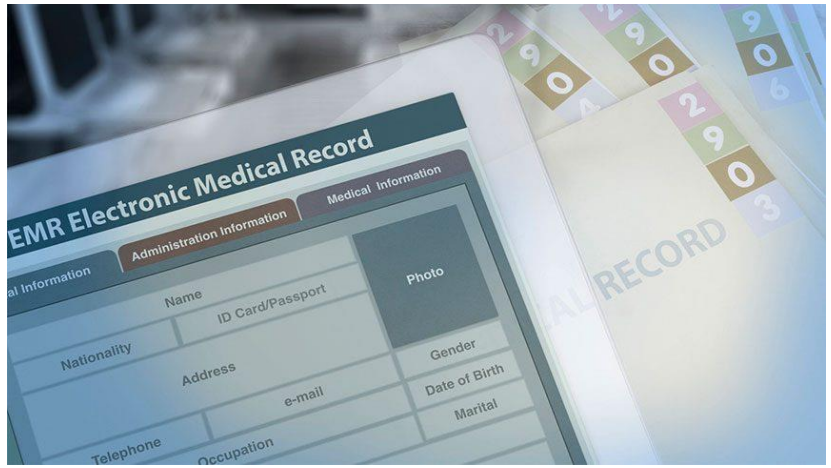
Activities We will Keep Doing Based on Learnings

- Established data governance & QI infrastructure
- Telehealth project focused on monitoring telehealth patterns and experience for PHASE patient population
- Mechanism to share data and communicate clinical performance and QI accomplishments that have results in positive impacts to CHCs patient populations

COMMUNITY HEALTH
PARTNERSHIP
Supporting our health centers

What Else is Possible?

- Pilot integration of one clinic's EMR data to collect more granular disparity data
- Collaborate with the health plan on a specific diabetic or hypertension health disparity metric for a specific MediCal patient population that will result in improved patient outcome and financial incentive for the CHCs



COMMUNITY HEALTH PARTNERSHIP
Supporting our health centers

Benefits of Achieving Desired Future

Thank you so much for taking on this pilot to test the HbA1C drive through. My hope based on the feedback thus far is that we will hone a procedure that will be pleasing to our patients and feasible for our staff and provide our clinical team with data to support our patients with diabetes to achieve control over their chronic condition. ***~ Quote from PPMM's Associate Medical Director***

The CMO had a patient come who had a visit to the ER because of a cardiovascular event. She said it was good to have the PHASE protocol to put the patient on, and nice to know that she might have helped prevent an acute cardiac event and avoided a future emergency. She said the benefit is that we have studies to show that the protocol works and helps save lives.
~ Quote from AACI's QI Manager

- Identification of innovative strategies and patient centered interventions that are effective in improving the health outcomes of patients with chronic conditions by using data to improve health disparities
- Benefits patients, staff, and the community

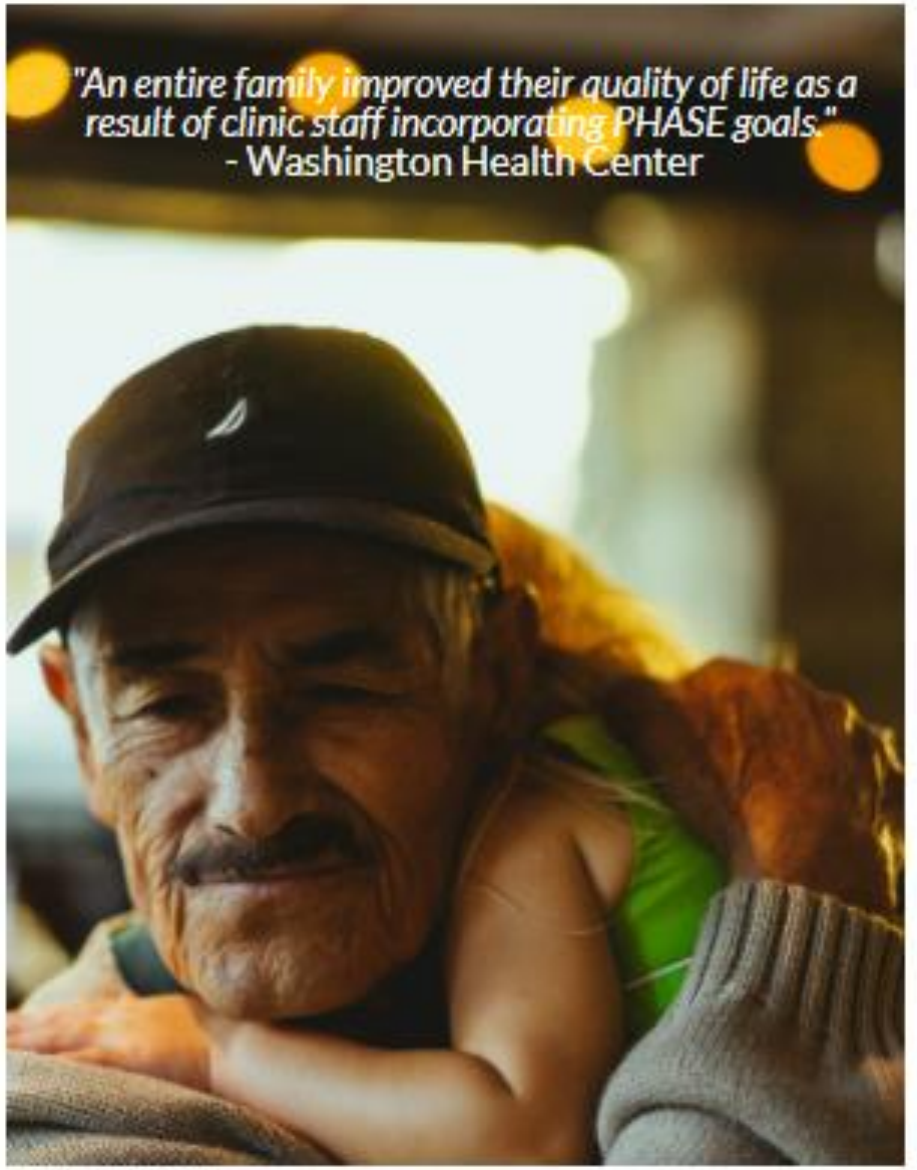
Challenges if We Don’t Move Forward with Solution

- Needs of marginalized patients will continue to get lost in the data resulting in inability to understand the scope of disparities or build strategies to solve the problem
- Piecemeal approach to collecting disparity data and spreading best practices across consortium
- Difficult to advocate for the CHCs, the patients they serve, and their surrounding communities without

What We Need from Our Leaders to Make it Happen

- Data Governance Committee's approval to share more than clinic level data with CHP
- Data Governance Committee's continued support while planning and implementing data collection system.
- Funding resources to support staffing and dedicated time to develop internal data infrastructure and organizations health equity priority focus
- Provides unrestricted funding to support initial activities.
- Motivate local payers provide direct funding to CHP to support the activities in the plan, particularly those that support the metrics and requirements that high priority for the health plans.

Thank you for your time!



Community Health Partnership
Devayani Kunjir, Elena Guzman and Kayla Williams
Primary Contact:
Elena Guzman, Deputy Director, Population Health
elena@chpscc.org