



Spreading Solutions That Work

2018-19 Outcomes Celebration Webinar

Moderated by Melissa Schoen

Group Visits

Melissa Schoen, Schoen Consulting
Cohort Coach

Spreading Solutions That Work
2018-19 Outcomes Celebration Webinar



Spreading Solutions That Work

In partnership with Blue Shield of California Foundation, CCI supports the spread and implementation of five successful solutions:

❖ Patient Portal Optimization

❖ Medical Scribes

❖ Group Visits

❖ Telephone Visits

❖ Texting Solutions



Group Visits Grant Goals & Teams

Goal: Leverage the power of peer support to provide better education, support and care for specific patient populations

TEAMS:

- Northeast Valley Health Corporation
- St. Jude Neighborhood Health Centers
- Salud Para La Gente
- Santa Cruz Community Health Centers
- San Ysidro Health



Northeast Valley Health Corporation

Who We Are



Northeast Valley Health Corporation
a californiah⁺center



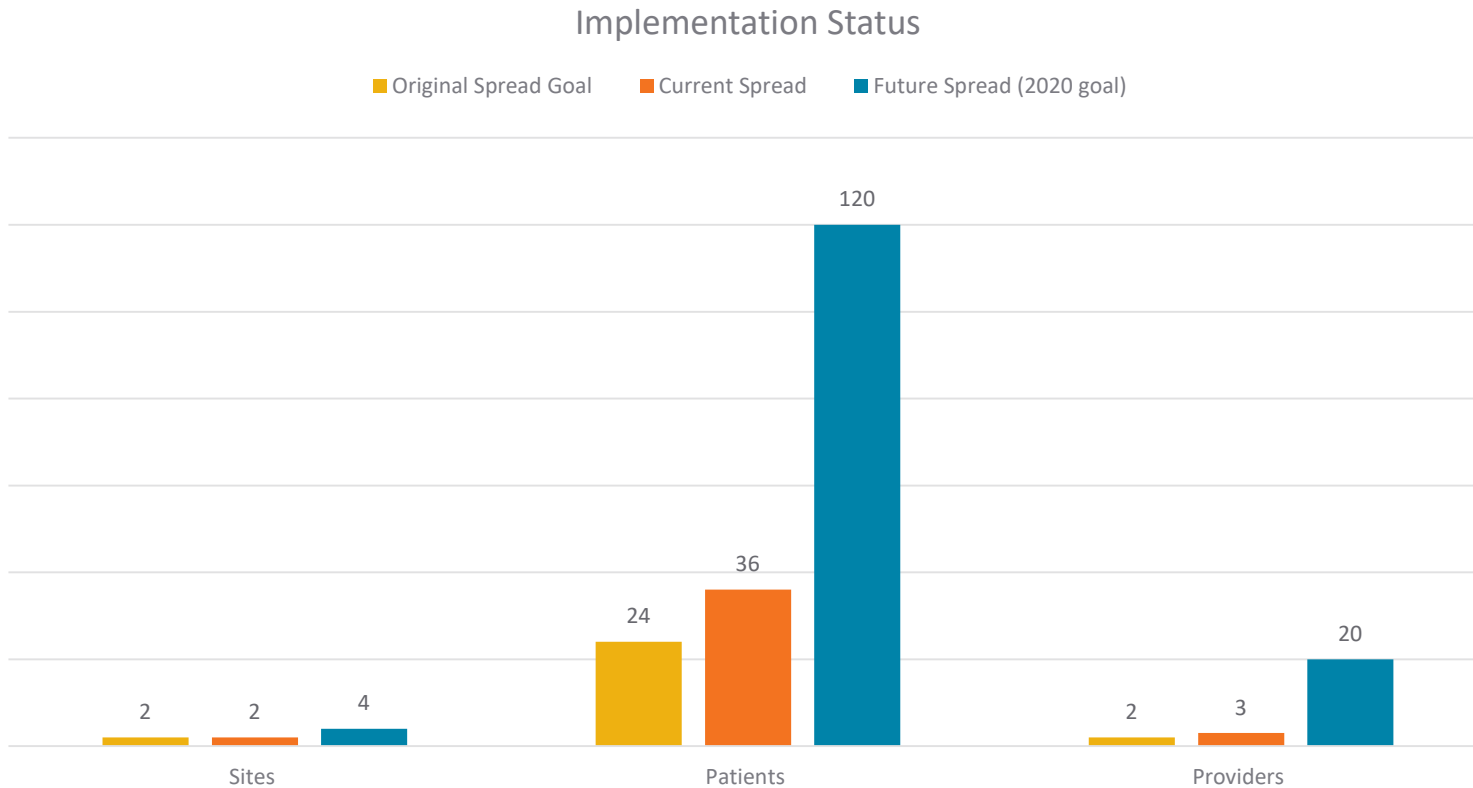
- Located: Northeast San Fernando and Santa Clarita Valleys
- Clinics in the Organization: 15 licensed health centers, 1 mobile, and 2 more are under construction
- FTE Providers: 75.3 FTE Medical Providers and 28 FTE BH Providers
- Solution Implemented: Shared Medical Visits (SMV)
- Live: August 2018
- Target Population:
 - Spanish speaking, adults with diabetes
 - Youth ages 9 – 13 with obesity/overweight



Implementation Status



- Current phase of this work: Spread



Our Value Proposition



"I understood everything that the doctor told me."



Our Value Proposition



"It's an opportunity for me to connect with my patients in a different way."



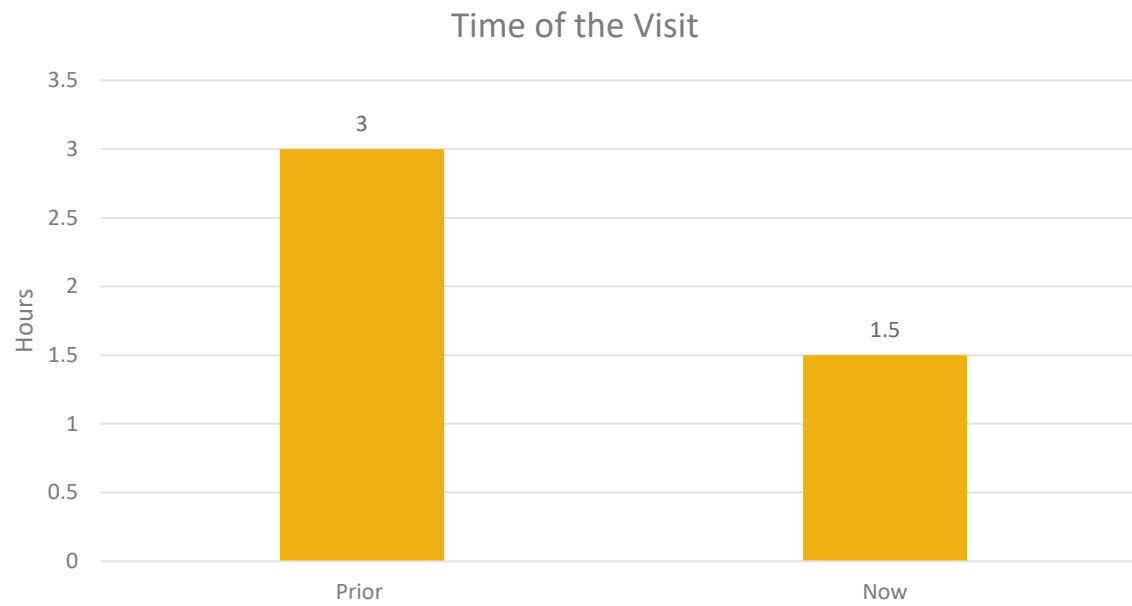
Our Value Proposition



"I enjoy the shared medical visits. It's a nice break from the ordinary routine."



Data!



What did you Accomplish?



Our biggest win in this last year:

- Collaboration between patients, providers, and ancillary staff.
- Leadership and staff buy-in.
- Providers are signing up to be on the shared medical visit "wait list" (~20 +)





Challenges and Solutions

Our biggest challenge (and solution) in this last year:

- Defining roles – who drives the visits?
- Training
- Logistics – room/space, scheduling adjustments, staffing



Tips for Making an Impact



The biggest impact we've seen from this solution:



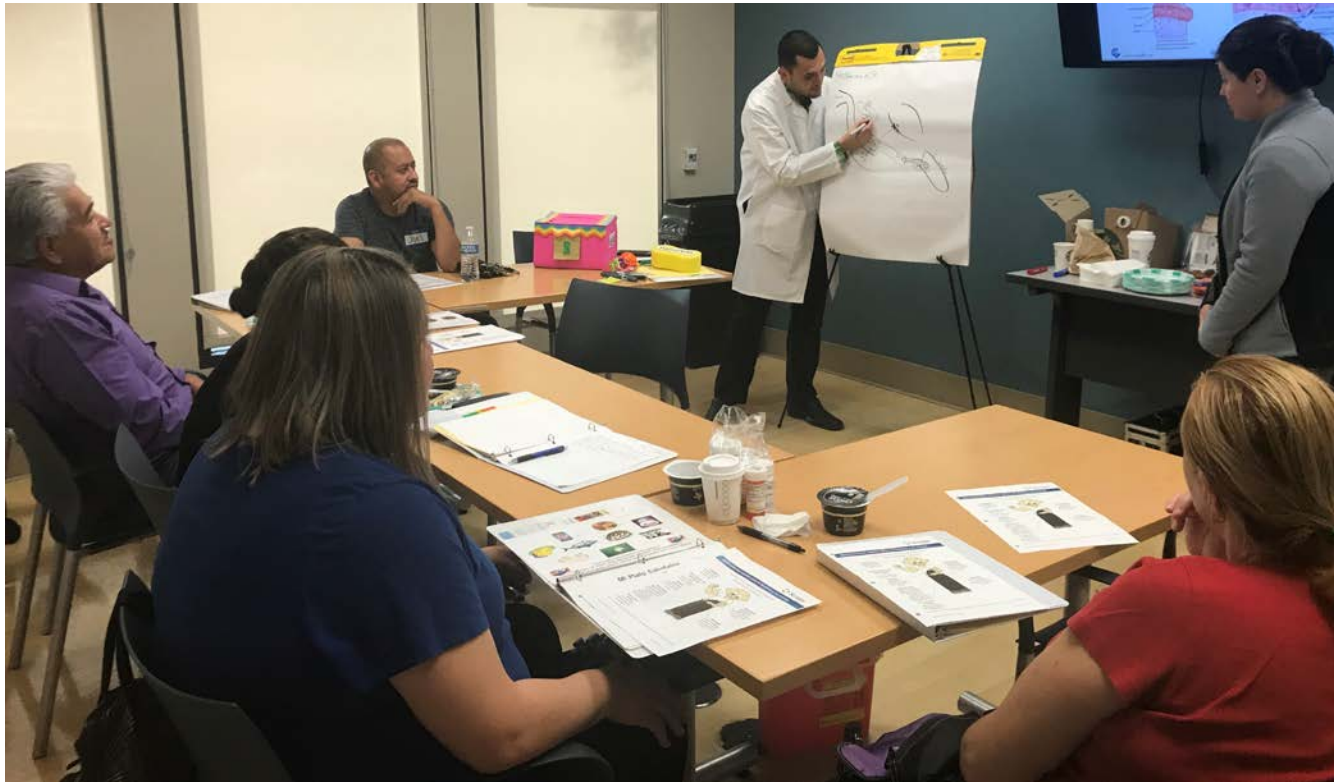
"A special thank you to my supervisor who has encouraged and supported our efforts to try new ways of caring for our patients." ~ Dr. Arunrut (pediatrician)



Tips for Making an Impact



The biggest impact we've seen from this solution:



"I look forward to helping out with as many future shared visits as possible." ~Nader Tossoun, PharmD, APh, BCPS (Clinical Pharmacist)



Looking Forward



Shared Medical Visit Task Force scheduled in March 2019

- Create standardized policy and procedures
- Marketing and Promotion to patients and providers (recruitment and retention)



Thank you



For more information, please contact:
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Resources:

[Passport to Wellness](#)

[Flier](#)

[Loteria Game](#)



St. Jude Neighborhood Health Centers

Who We Are

St. Jude Neighborhood
Health Centers 



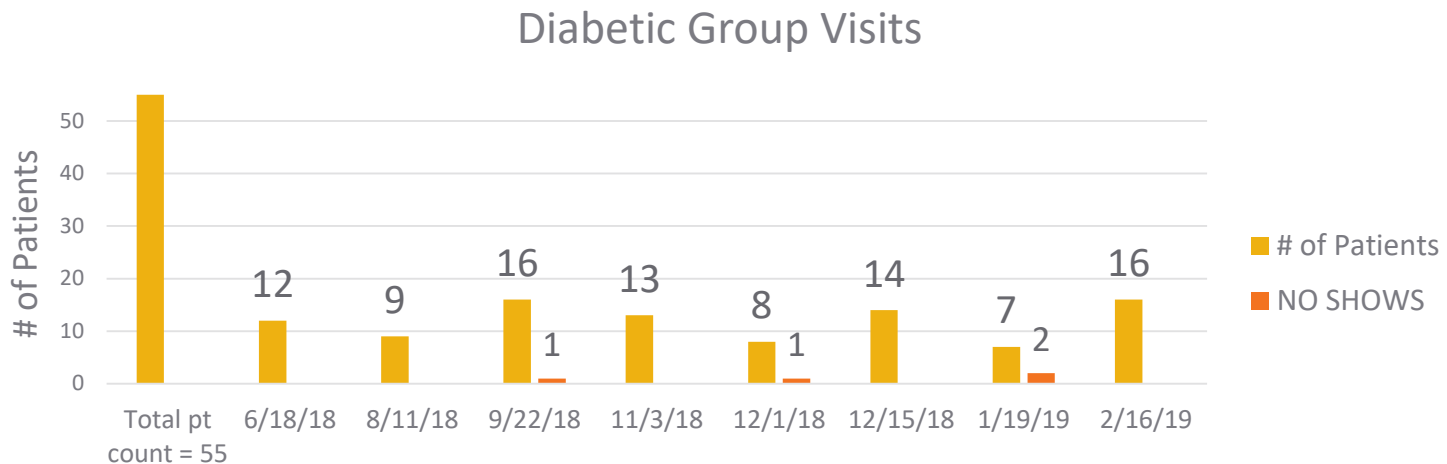
- Where We Are Located: [Orange, CA](#)
- Number of Clinics in the Organization: [1 medical site used for group visits](#)
- Total Number of FTE Providers: [0.5](#)
- Solution Implemented: [Group Visits](#)
- Date GV First Went Live: [June 2018](#)
- Target Population: [Diabetic Adults](#)



Implementation Status



- Current phase of this work:
 - Original spread goal: 1 site, 1 provider (with assisting staff and NP student), 1 facilitator (LVN), and 10-12 patients per group.
 - Current spread: above goal met:
 - Total # of patients attending group visits: 55
 - Average # of patients per group visit: 11
 - Total # of group visits facilitated: 8
 - No Show Rate: 4.2%



Our Value Proposition



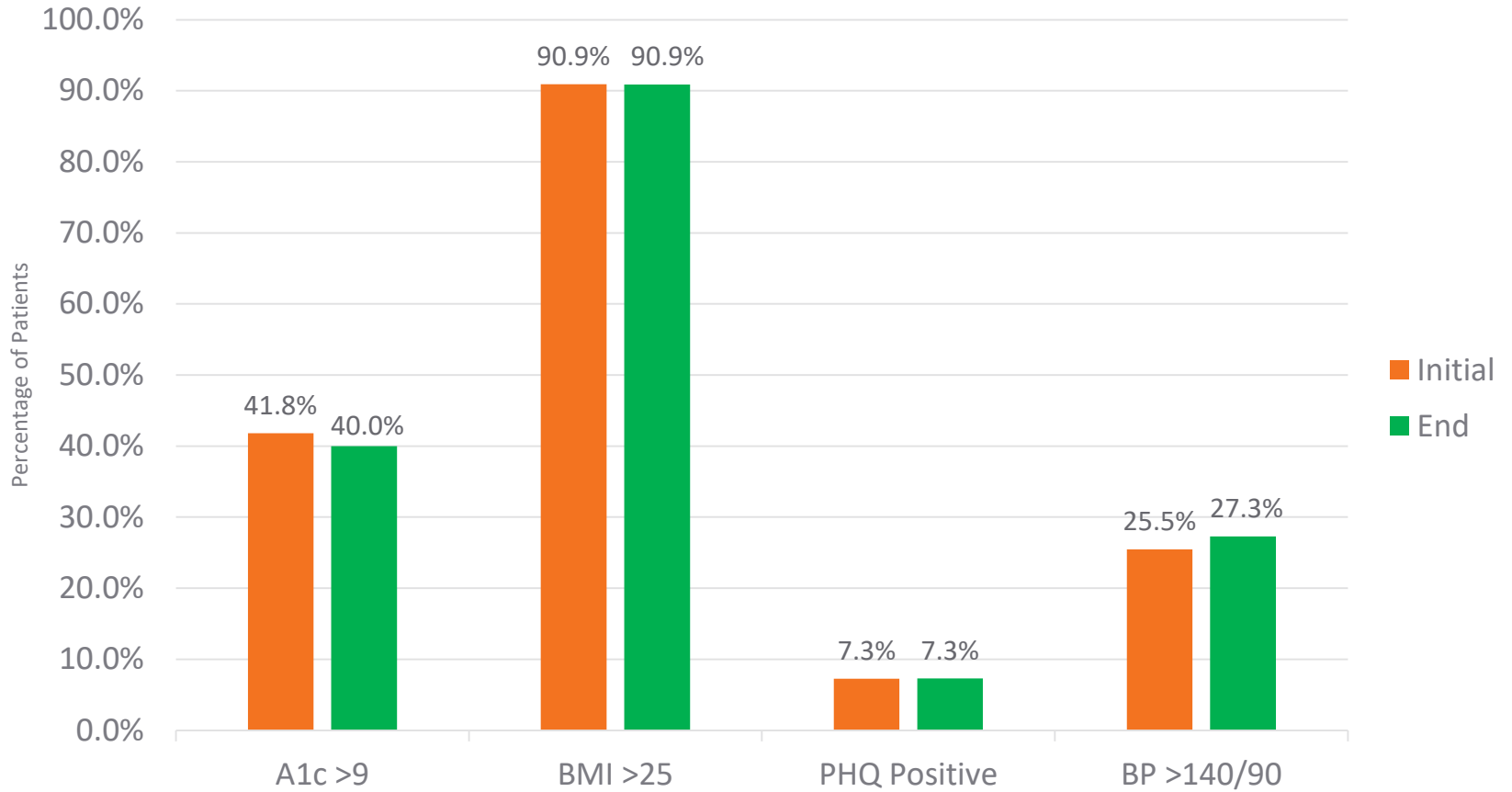
- *We have decided to implement group visits to not only improve access to our patients, but also to improve overall health outcomes through promotion of self-care, education, and patient engagement for our diabetic population.*
- *We do intend to spread the facilitation of group visits this year by giving other providers the opportunity to conduct them, and to expand our curriculums to include weight management, blood pressure control and heart health.*



Data!



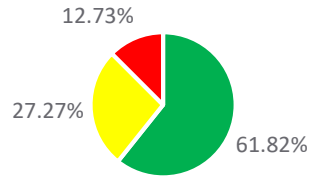
Diabetic Group Visits: Initial Stats



Outcomes

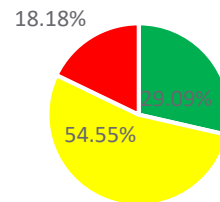


A1c Outcomes



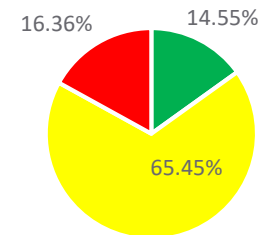
- A1c Decreased
- A1c No Change
- A1c Increased

BMI Outcomes



- BMI Decreased
- BMI No Change
- BMI Increased

Blood Pressure Outcomes



- BP Decreased
- BP No Change
- BP Increased



What did you Accomplish?



Our biggest win in this last year:

- 1) *Positive diabetic outcomes which display a significant decrease in A1c results for group visit patients over the last 6 months.*
- 2) *Creation of new policy and workflows around group visits.*
- 3) *A 4% no show rate.*



Challenges and Solutions



Our biggest challenge (and solution) in this last year:

1) Staff turnover.

- a. Required documented workflows for new staff training, utilization of students for extra help, and stronger communication when short staffed.

2) Documentation workflows

- a. We were able to get EHR trainers involved to help identify and mitigate the problem. We developed Standard Work around documentation to prevent the problems from reoccurring.

3) Clinic location change

- a. Utilized the lobby until the new space was available.



Tips for Making an Impact



The biggest impact we've seen from this solution:

- 1) Health Outcomes
- 2) Patient Access
- 3) Patient Satisfaction

Other key tips for an organization starting to implement group visits?

- 1) Select a frontline "lead" to coordinate patient cohorts.
- 2) Have a team huddle before and after group visit.
- 3) Utilize students.



Looking Forward



What are your 1-2 major next steps for this body of work?

- 1) Spread to other providers
- 2) Have new health educator facilitate groups
- 3) Add group visit facilitation to new hire orientation
- 4) Expand data analytics and reporting for other groups other than diabetics.



Thank you

- Kelly Carter, RN Quality Director Kelly.carter2@stjoe.org
- Janet Hildebrand, NP janett.Hildebrand@stjoe.org





Salud Para La Gente

Salud Para La Gente

Working Together for a Healthy Community



- Where We Are Located: Watsonville, Ca
- Number of Clinics in the Organization: 8 medical (11 with dental)
- Total Number of FTE Providers: 29 medical
- Solution/Technology Implemented: **Shared Medical Appointments**
- Date Group Visits First Went Live:
 - November 2017- official (March 2018 w/ program)
- Target Population: Diabetic Patients



Salud Para La Gente

Working Together for a Healthy Community



Implementation Status

- Original spread goal:
 - 1 SMA at Clinca del Valle del Pajaro
 - Team: 1 provider, 1 RN, 2 MAs
 - Not a cohort – different patients at each SMA
 - Schedule 9 patients/group to get 6 patients to attend
- Current spread:
 - Expanding to 2nd site
 - Team: Same team + coordinator
 - Will identify 1 cohort group of patients to attend

Salud Para La Gente

Working Together for a Healthy Community



Our Value Proposition

- *Patient Focus: To enhance Diabetes Self-Management education through a group visit focused on education, patient involvement, peer support, and goals setting.*
- *Provider Focus: To improve provider job satisfaction and efficacy through concentrating diabetic patients into a larger visit blocks (as opposed to several rushed visits), and utilizing a diabetic educator and the self-management education techniques above.*
- *Clinic Focus: To maintain or enhance patient satisfaction and clinic revenue, and continue to provide standard of care medical interventions, such as medication management and clinical examinations.*

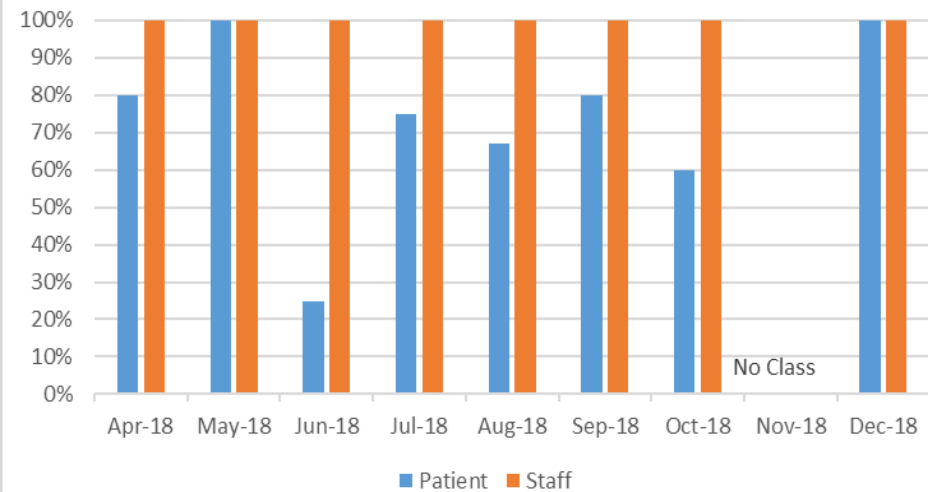


Salud Para La Gente

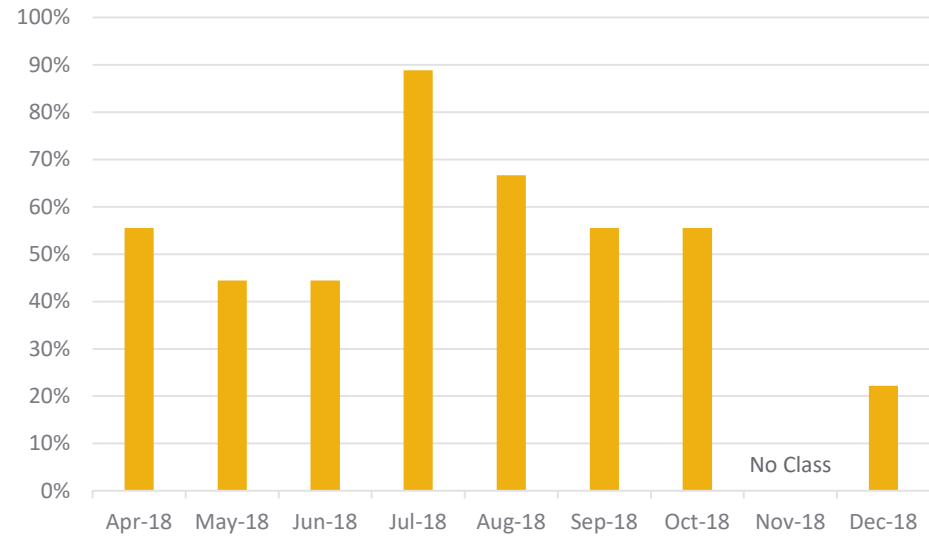
Working Together for a Healthy Community



Satisfaction



Patient Attendance Rate



Attendance Rate = $\frac{\text{Show Patients}}{\text{Scheduled Patients}}$



Salud Para La Gente

Working Together for a Healthy Community



What did you Accomplish?

- Biggest Win: Gained experience conducting SMAs each month and seeing high patient and provider satisfaction scores.
- The implementation of surveys for staff and patients participating in the DM SMV.
- Received feedback from the Patients Advisory Committee in regards the DM SMV.
- Hired a SMA Coordinator
- Spreading Diabetes SMA to other site with other provider(s)



Salud Para La Gente

Working Together for a Healthy Community



Challenges and Solutions

- No one person responsible – Identified key staff
- Drop-in vs. Cohort
- Recruitment of patients – multiple strategies
 - Provider and MA encouraged participation when scheduling follow-ups.
 - Health coaches and MA's used registry to call patients and encourage participation.
 - Handouts utilized to promote new service.
- Patient confirmation – identified key staff
- Patient materials/handouts - keep in clinic vs have patients take home

Salud Para La Gente

Working Together for a Healthy Community



Tips for Making an Impact

- Create a cohort of patients to attend
- Train all Salud staff on SMA's
- Use of technology to inform patients about this new and exciting method for treatment
- SMAs contribute to provider engagement and satisfaction
- All SMAs recruit patients and promote services similarly



Salud Para La Gente

Working Together for a Healthy Community



Looking Forward

- Expanding to multiple sites and providers; Tying together different types of group visits to improve the overall diabetes program.
- Trying a cohort of 7-9 patients with one provider, and comparing this to drop-in visits with another provider.
- Accurately capture data
- Increase the amount of SMA's that both Main and Clinica offer to patients
- Improve consistency of SMA coordination



Salud Para La Gente

Working Together for a Healthy Community

Thank you

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Santa Cruz Community Health Centers

Santa Cruz Community Health Centers



- Santa Cruz, California
- 2 Clinics: Santa Cruz Women's Health Center (Downtown) and East Cliff Family Health Center (Live Oak)
- Serve approximately 11, 000 patients/ year
- 22 Medical Providers, 8 Behavioral Health Providers, 3 Case Managers
- Chronic Pain SMAs: Monthly reunion groups starting in May 2018, new groups in November 2018 and January 28, 2019
- Target Population: Adult patients (men and women) who live with Chronic Pain (using and not using opiates).



Implementation Status



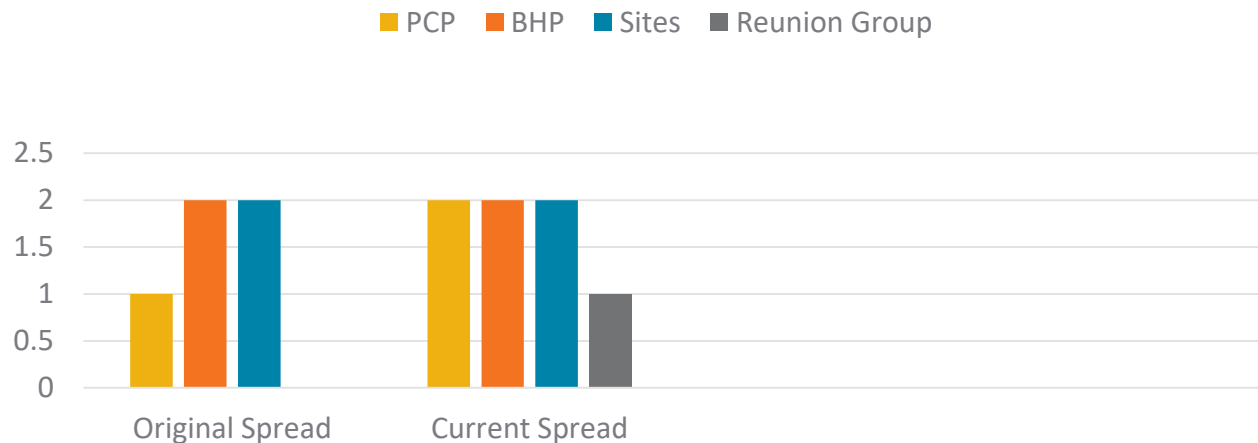
Original spread goal:

- Spread to 2 total clinic sites (add the East Cliff Family Health Center) and spread to 2 behavioral health providers.

Current spread:

- 2 sites, 2 medical providers, and 2 behavioral health providers, and a spin-off reunion group that meets once a month.

Spread of Chronic Pain SMA



Our Value Proposition



- *The Chronic Pain group offers alternatives and a supplement to opiates for the management of chronic pain through lifestyle management, behavioral health and peer support.*
- *The Chronic Pain group supports patients to increase their engagement and ability to communicate about their health needs, which promotes a more effective the patient-provider relationship.*



Data!



Attendance Data:

Reunion Group: Started February 2018 and has met monthly since at SC Women's Health Center

- 13 Unique patients all from previous groups- welcome new patients after each session
- Average 5.4 patients attend each group
- Patients requested this group to maintain the support, accountability, and information

Start Chronic Pain SMA at the East Cliff Family Health Center : Started January 28, 2019

- 11 patients attended (18 scheduled!) Men and Women. New Behavioral Health Provider, Original Medical Provider.
- After week 3 we have 9pts... (still 3 more than our goal of 6pts/ group).



What did you Accomplish?



Our biggest wins in this last year:

- Overcoming staffing and operational challenges to conclude with a very successful Chronic Pain SMA at the East Cliff Family Health Center (11 pts!)
- Clearly identifying key strategies for recruitment
- Identifying strategies necessary to promote program sustainability



Challenges and Solutions



Our biggest challenges (and solutions) in this last year:

- **Challenge: Significant staffing and operational obstacles.**

Solution: Hired new SMA Medical Assistant and created clear training/ work- flow binder for fill-in MAs. Future: train more MAs on SMA tasks.

- **Challenge: Sustaining consistent referrals from medical and behavioral health providers.**

Solution: Identifying importance of active SMA liaison in medical department, consistent promotion and advertisement of group, increased training on direct booking or referring to an SMA, easy-to-use referral tools for providers.



Tips for Making an Impact



The biggest impact we've seen from this solution: Operational Improvements

- Have clearly written plans, protocols and timelines for group implementation. It helps guide the process and allows others to participate with confidence and success.
- Promote the group with ample time ahead of group launch... at least 2 months. Preferably 3-4 months for no/ low stress implementation.
- Standardize how groups fit into a provider schedule- protect groups from provider absence.
- Continuous promotion



Looking Forward



1. To maintain the Chronic Pain SMA as a regular SMA offering at the SCCHC
2. To standardize the implementation process for any SMA that starts at the SCCHC.



Patient Facing Flyer for EC Chronic Pain SMA

GROUP SUPPORT MINDFULNESS NUTRITION GENTLE YOGA

JOIN A COMMUNITY AT THE -NEW-
**WELLNESS FOR
CHRONIC PAIN
GROUP VISIT**

8 Week Series Meets on Mondays
Starting January 28, 2019
12:20pm- 1:40pm

JAN 28
FEB 4, 11, 25
MAR 4, 11, 18 25

*NO MEETING PRESIDENT'S DAY HOLIDAY

**EAST CLIFF FAMILY HEALTH CENTER
21507 E. CLIFF DR.
SANTA CRUZ, CA**

MUST be referred by PCP/BHP and must be pre-registered
Snacks and light refreshments provided.

No cost with Medi-Cal Ask about co-pay with private
insurance and Medi-Care. Sliding Scale Available



Thank you



- Primavera Hernandez, MPH, Programs Manager phernandez@schealthcenters.org
- Kristina Muten, MD kmuten@schealthcenters.org
- Paulina Uribe, Clinical Support Manager puribe@schealthcenters.org
- Website: www.schealthcenters.org
- SCCHC SMA Implementation Guide:



Microsoft Word
Document

- Provider Satisfaction Evaluation:



Microsoft Word
Document





San Ysidro Health



San Ysidro Health



Where We Are Located: San Diego, CA

- Number of Clinics in the Organization: 13 clinical sites
- Total Number of FTE Providers: 106
- Solution Implemented: Group Visits for Diabetes and Childhood Obesity
- Went Live: July 2018
- Target Population: Adults ages 18+ w/diabetes and obese children 2-5



Implementation Status



- Current phase of this work: Spread
 - Original spread goal:
Enroll at least 10 patients into group visits. One provider dedicated to each initiative (diabetes and childhood obesity)
 - Current spread:
Diabetes- 19 total patients completed the classes.

Obesity- 3 completed the 5 sessions.

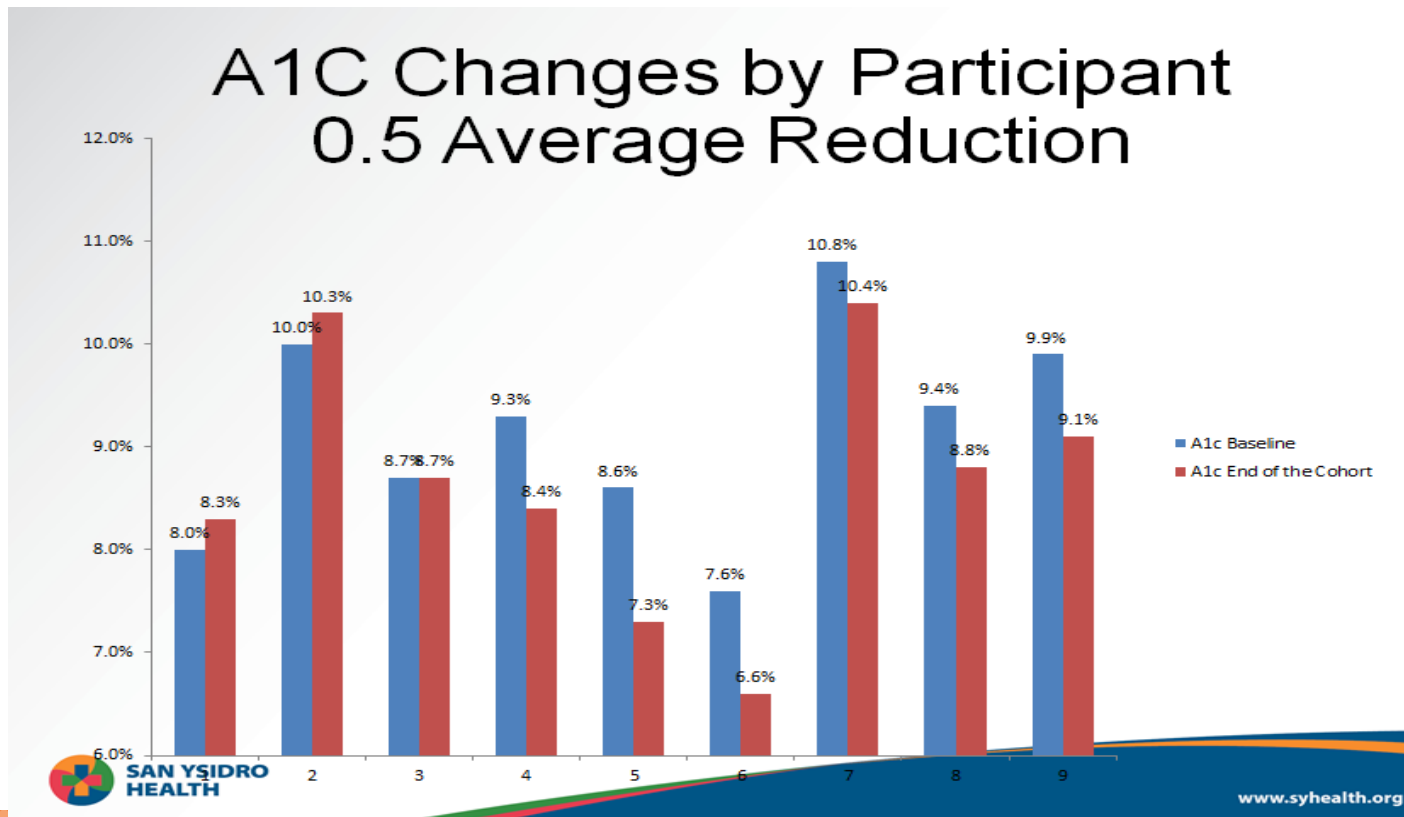


Our Value Proposition



- *Average Reduction in A1C levels for diabetes groups.*

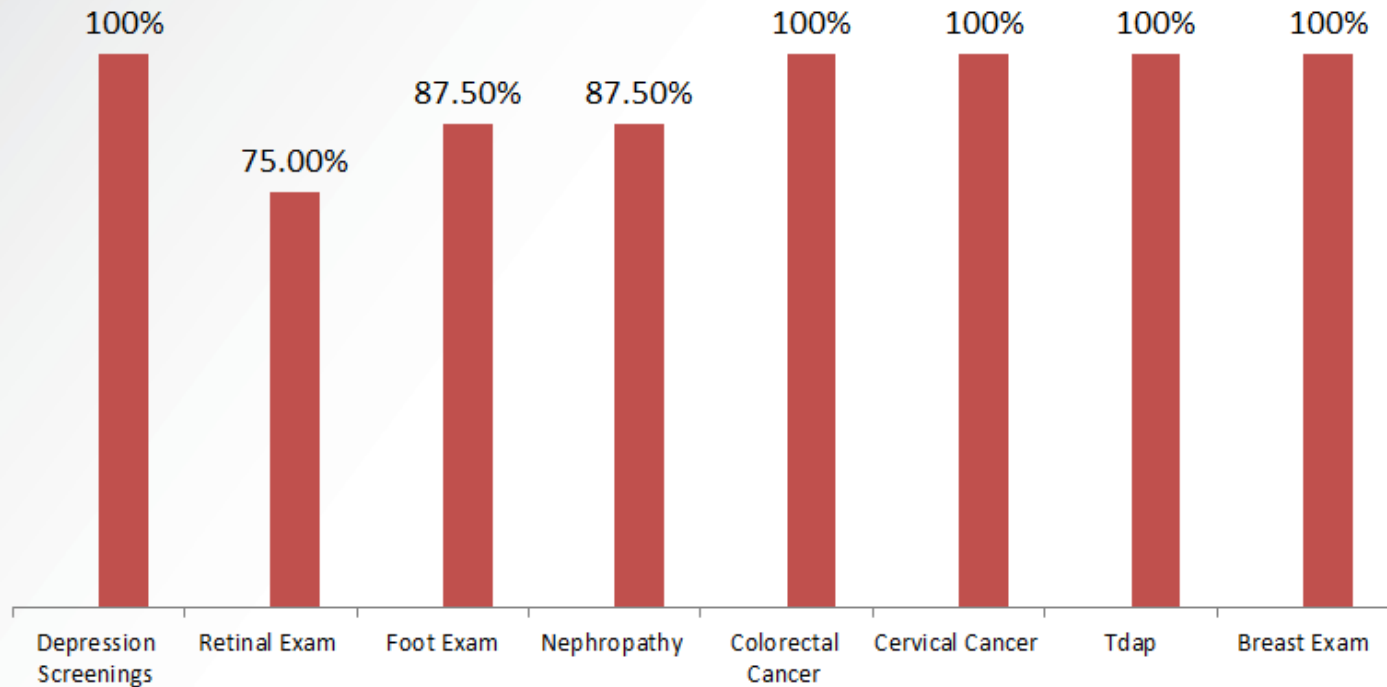
Cohort 1: .0. 5 reduction, Cohort 2: 0.7 Reduction .



Data- Diabetes Group Visits



Screening Rates for Participants that meet Criteria



What did you Accomplish?



- Our biggest win in this last year: Patients in diabetes classes wanting to stay in touch with the rest of the cohort to continue supporting each other.
- Group visit model fully developed for SYH.
- Provider satisfaction and engagement in leading group visits

"I am really happy to be doing this, it is such a great way to help patients." - SYH Provider

Additional Benefits from Patients:

- Patients engaged
- Patients learn more about their health
- Support
- Friendships
- Patients had fun
- Self Management



Challenges and Solutions



- Our biggest challenge (and solution) in this last year:

Challenge: Engaging pediatric patients to group visits.

Solution: Surveying patient population to better understand their needs. Found that these classes might not be the best approach for prevention. Future plans entail focusing on group well child visits, or other visits that typically patients will show up for. These can be an opportunity to provide additional obesity prevention interventions.



Tips for Making an Impact



- ✓ Get buy-in from key stakeholders early (providers, management, care team)
- ✓ Over communicate project and goals with all care team members
- ✓ Celebrate small successes!



Looking Forward



Next Steps

Plan: To spread diabetes group visits to one clinic site per quarter for 2019 and continue the same model.

Incorporate the diabetes group model into our care coordination program.



Thank you

Myrna Torresdey, MPH

Director of Patient Centered Care and Practice Transformation

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A few words from the CCI team...



Jaclyn Lau
Program Coordinator



Jennifer Wright
Program Manager

