Welcome!

DECEMBER 13, 2017

Serve the People, Inc.

OUR BEGINNINGS

2008 – Stood-up volunteer led and operated Food Pantry

2009 – Obtained non-profit status

– Served as host satellite site for local free clinic

2011 – Secured DHS licensed community clinic status

Serve the People Community Health Center

EVOLUTION AND JOURNEY

2012 – Start of Serve the People Health Center operations

– Services Offered – Medical

– Providers – 1.20 FTE

– Staff – 5.20 FTE

– Patients Served – 3,898

2013 – Awarded 330 New Access Point Grant

– Added Dental & Vision Services

2014 – Obtained NCQA – PCMH Level 3 Recognition

Serve the People Community Health Center

EVOLUTION AND JOURNEY

2015 – Build-out 5 chair Dental Clinic and 3 lane Vision Suite

– Launched comprehensive Mobile School-Based Preventative Oral Health Services Program

2016 – Added Behavioral Health and Alternative Services to scope

Serve the People Community Health Center

EVOLUTION AND JOURNEY

2017 – Launched Mobile Medical Homeless Health Program

– Added School-Based Vision Services

– Services Offered – Medical, Dental, Vision, Behavioral Health including the Medication Assistance Treatment Program, and Alternative Health Services

– Providers – 11.6 FTE

– Staff – 26 FTE

– Patients Served – 14,615

Family and Medical Counseling Service, Inc.

- Overview
- Services Offered
- Future goals

- Overview
- Services Offered
- Future goals

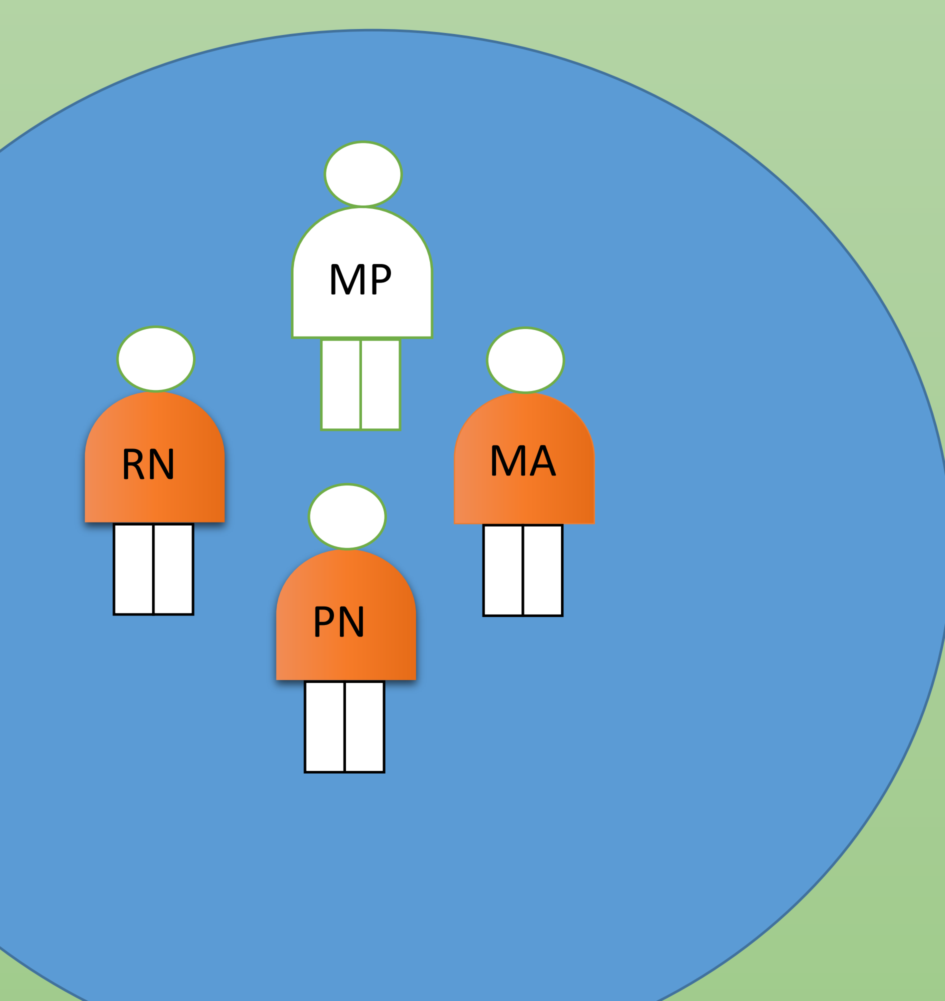
Care Team Model:

BUILDING A PATIENT-CENTERED HEALTH HOME

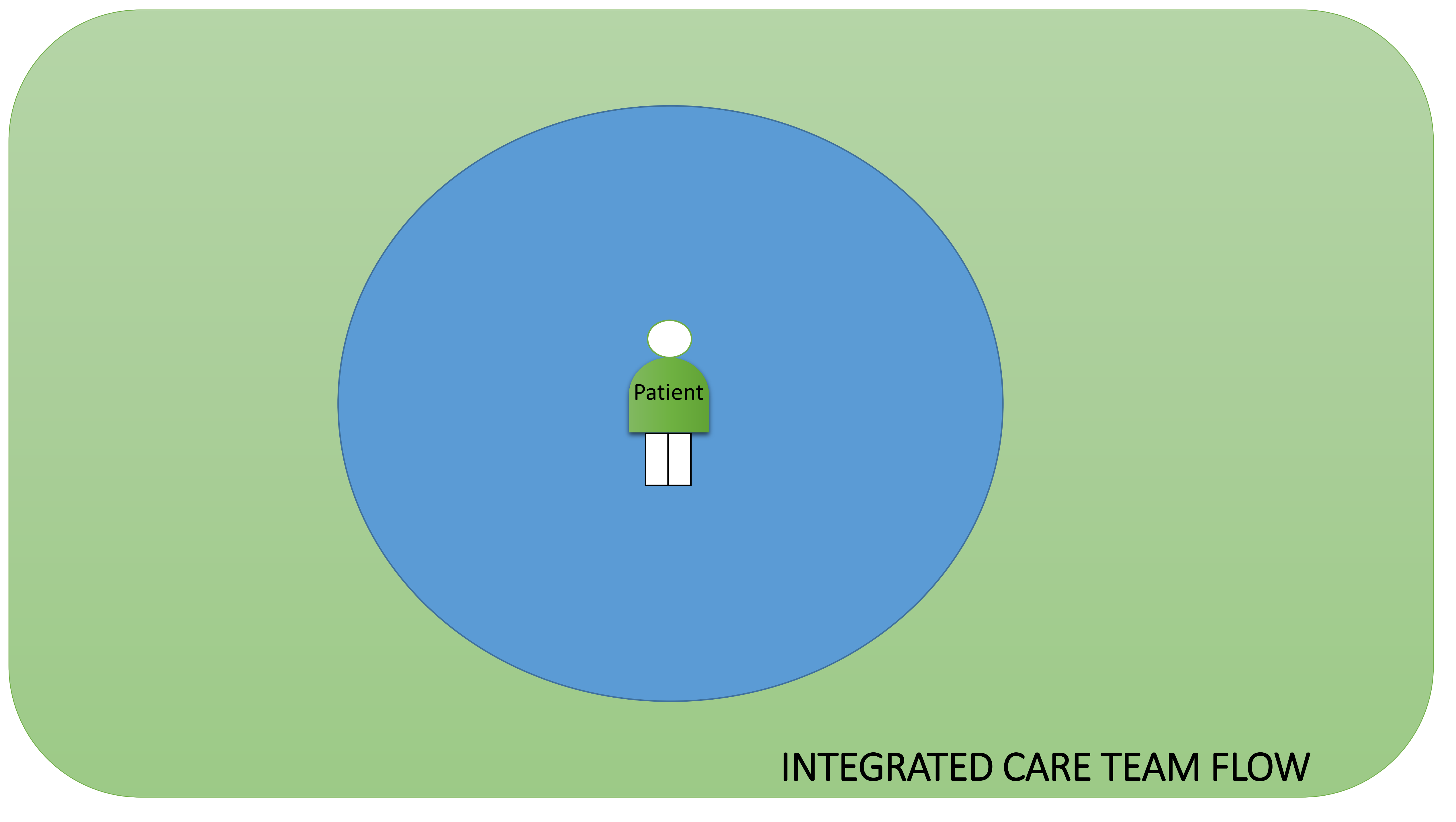
Patient Experience

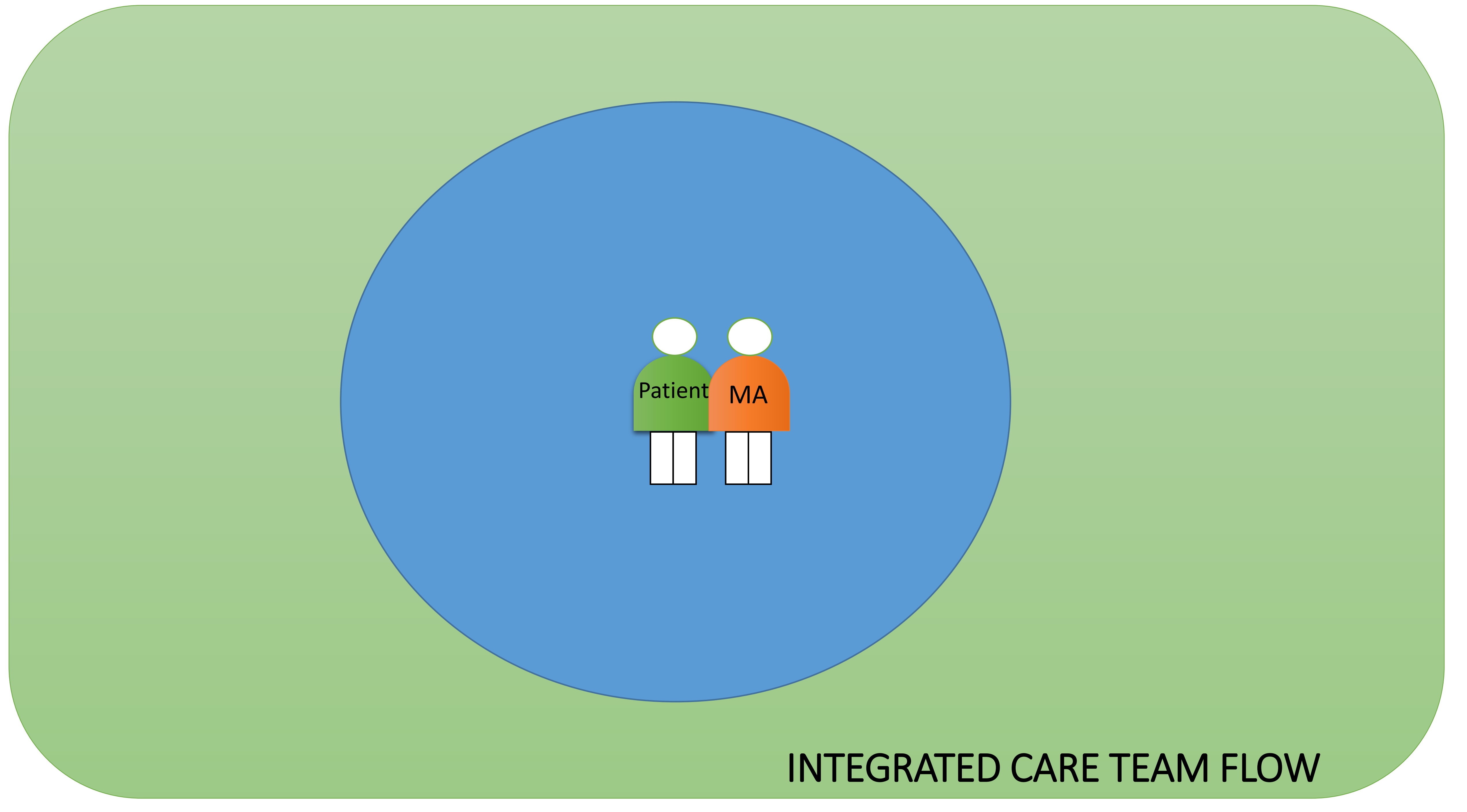
Serve the People Community Health Center

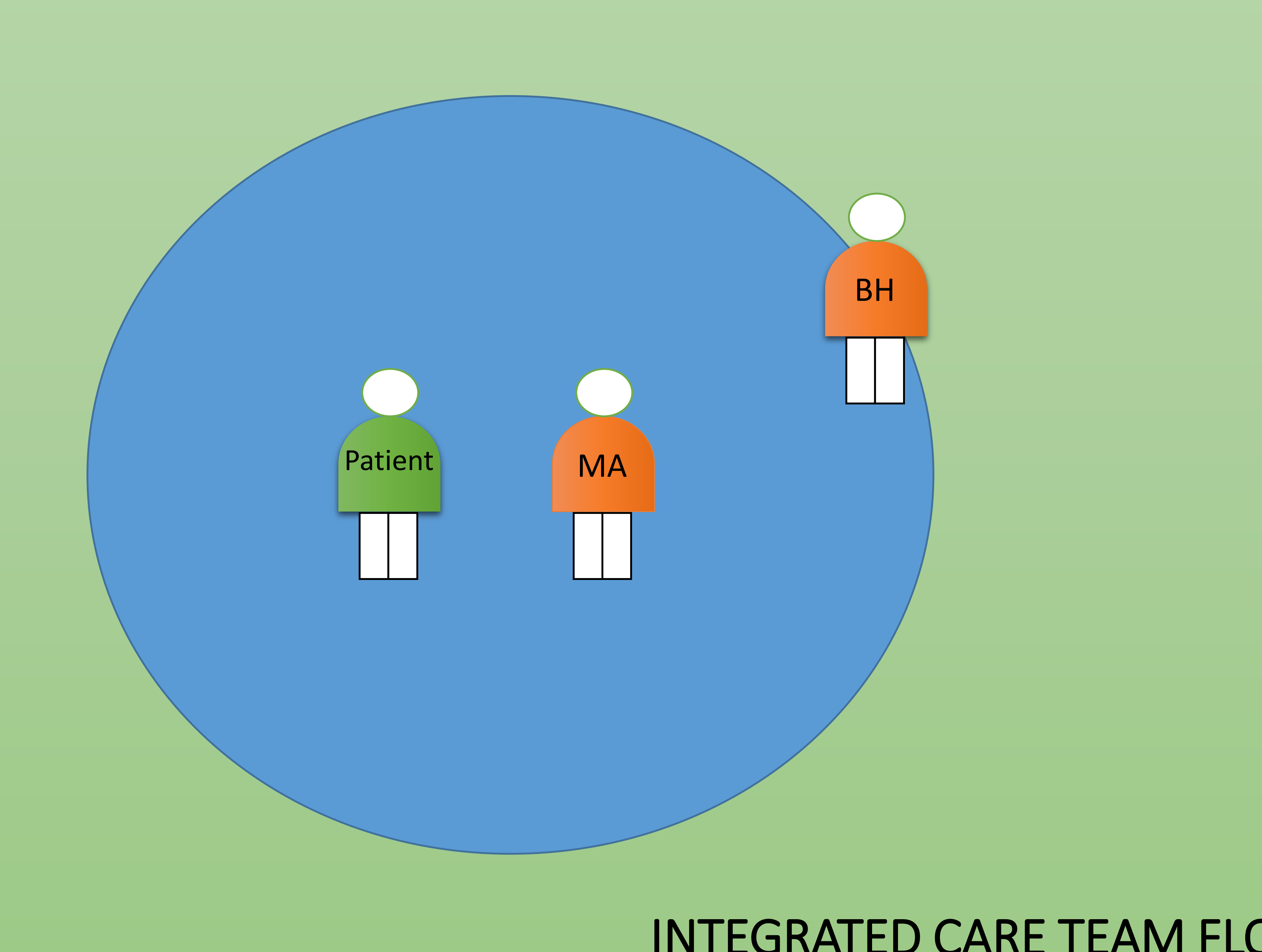
Morning Huddle



- Medical Provider
- Medical Assistant
- Patient Navigator
- Registered Nurse


Patient
INTEGRATED CARE TEAM FLOW


Patient
MA
INTEGRATED CARE TEAM FLOW



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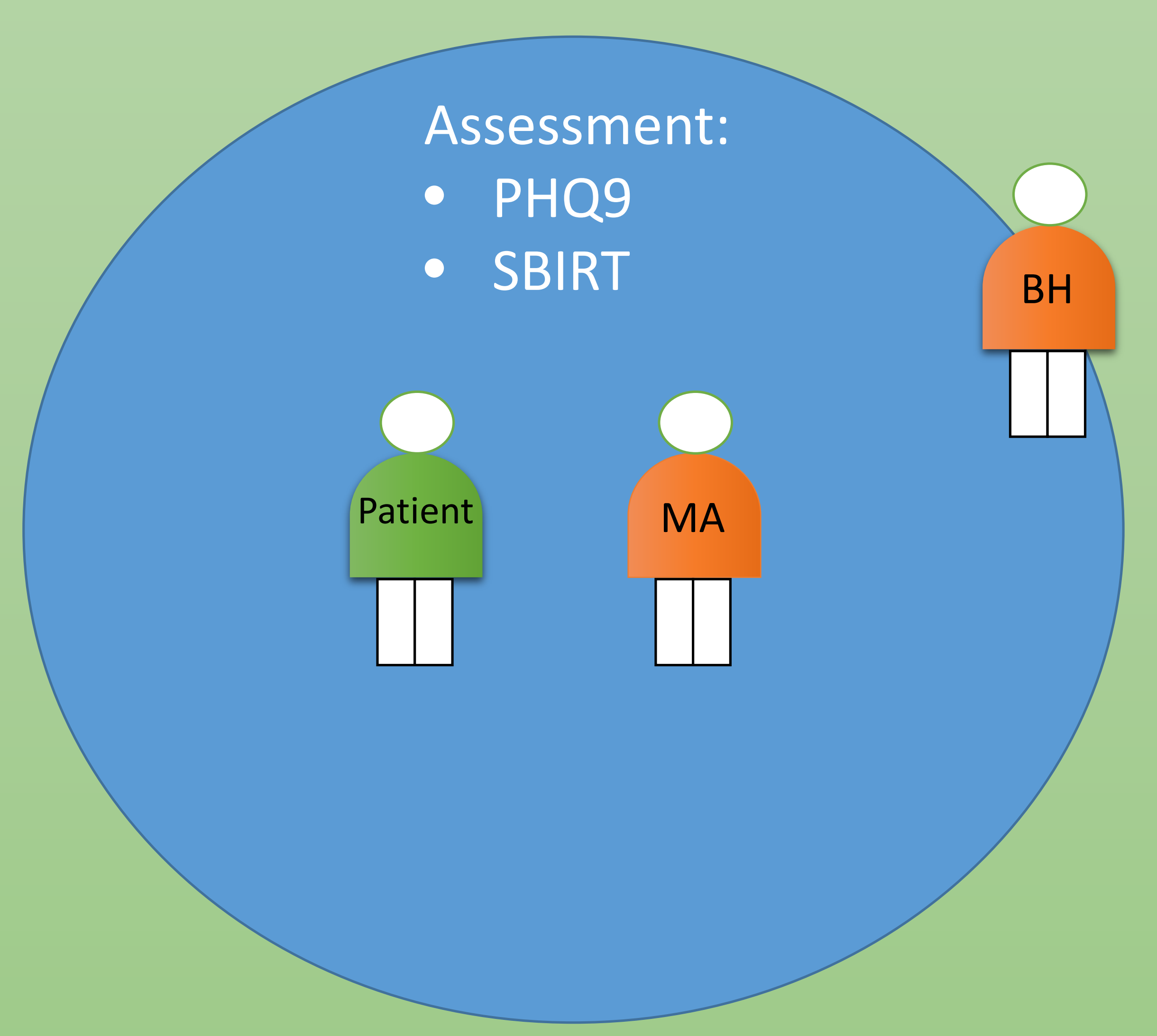

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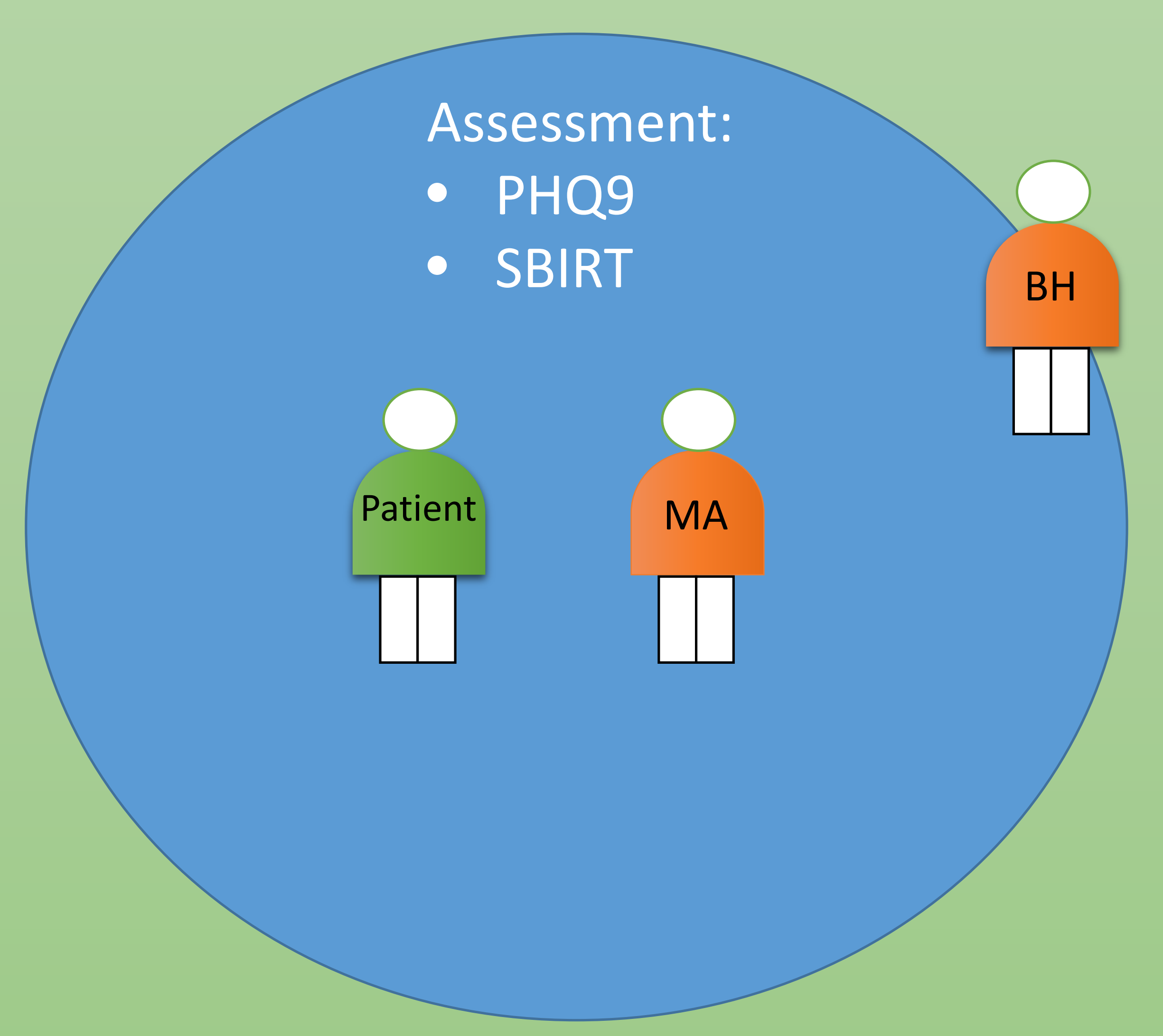

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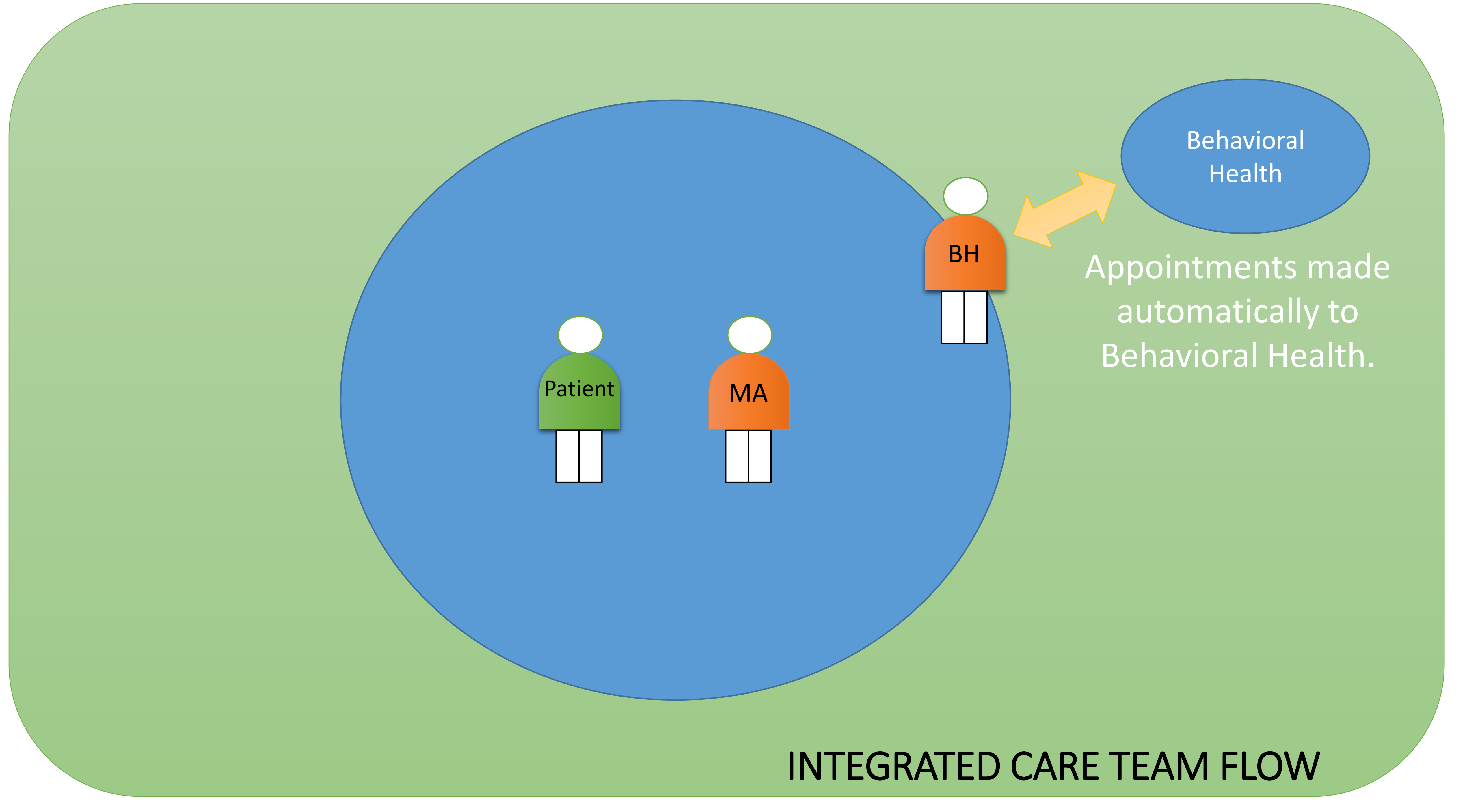
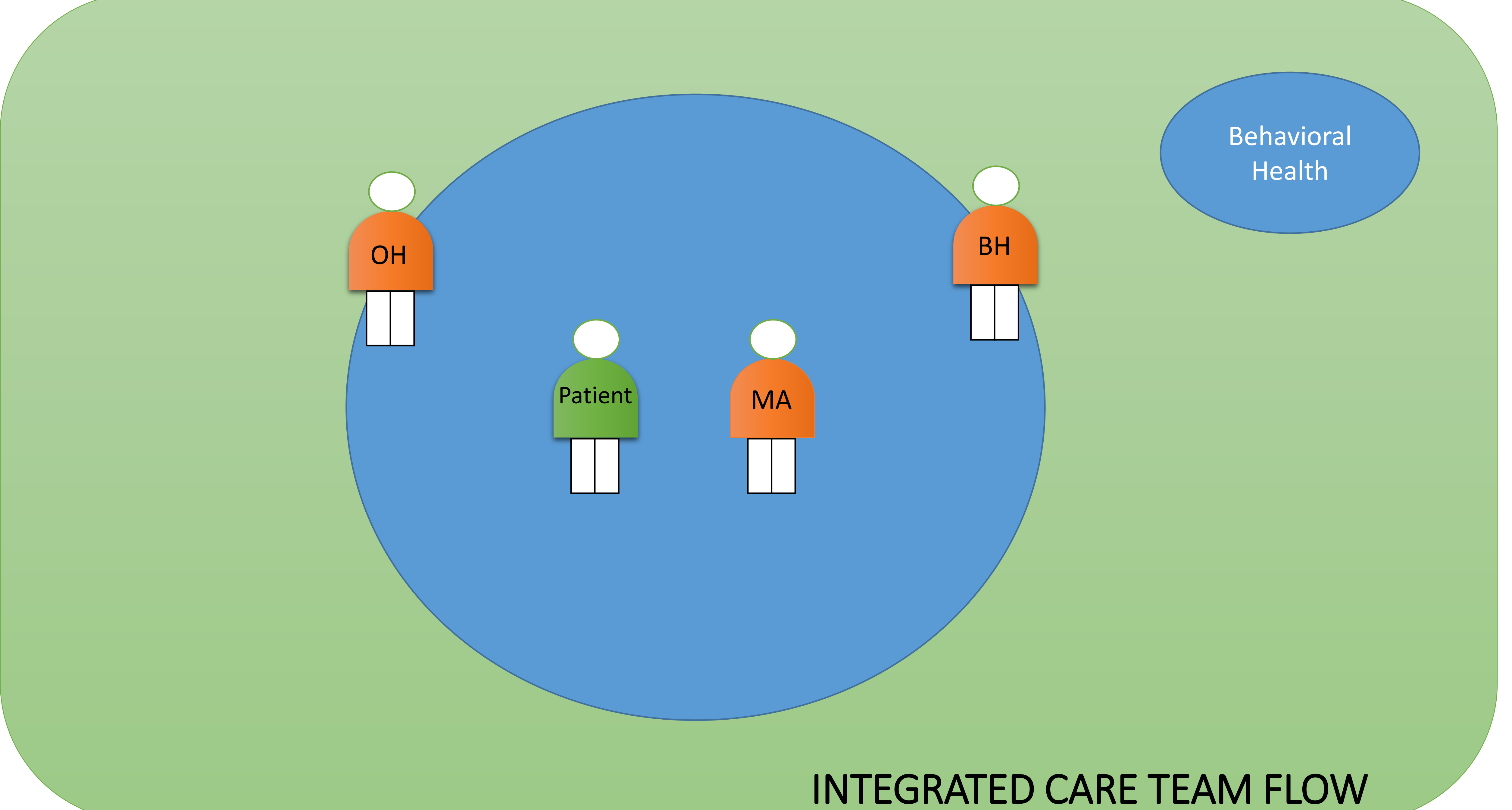

Behavioral Health
BH
Appointments made automatically to Behavioral Health.
Patient
MA
INTEGRATED CARE TEAM FLOW


Behavioral Health
OH
BH
Patient
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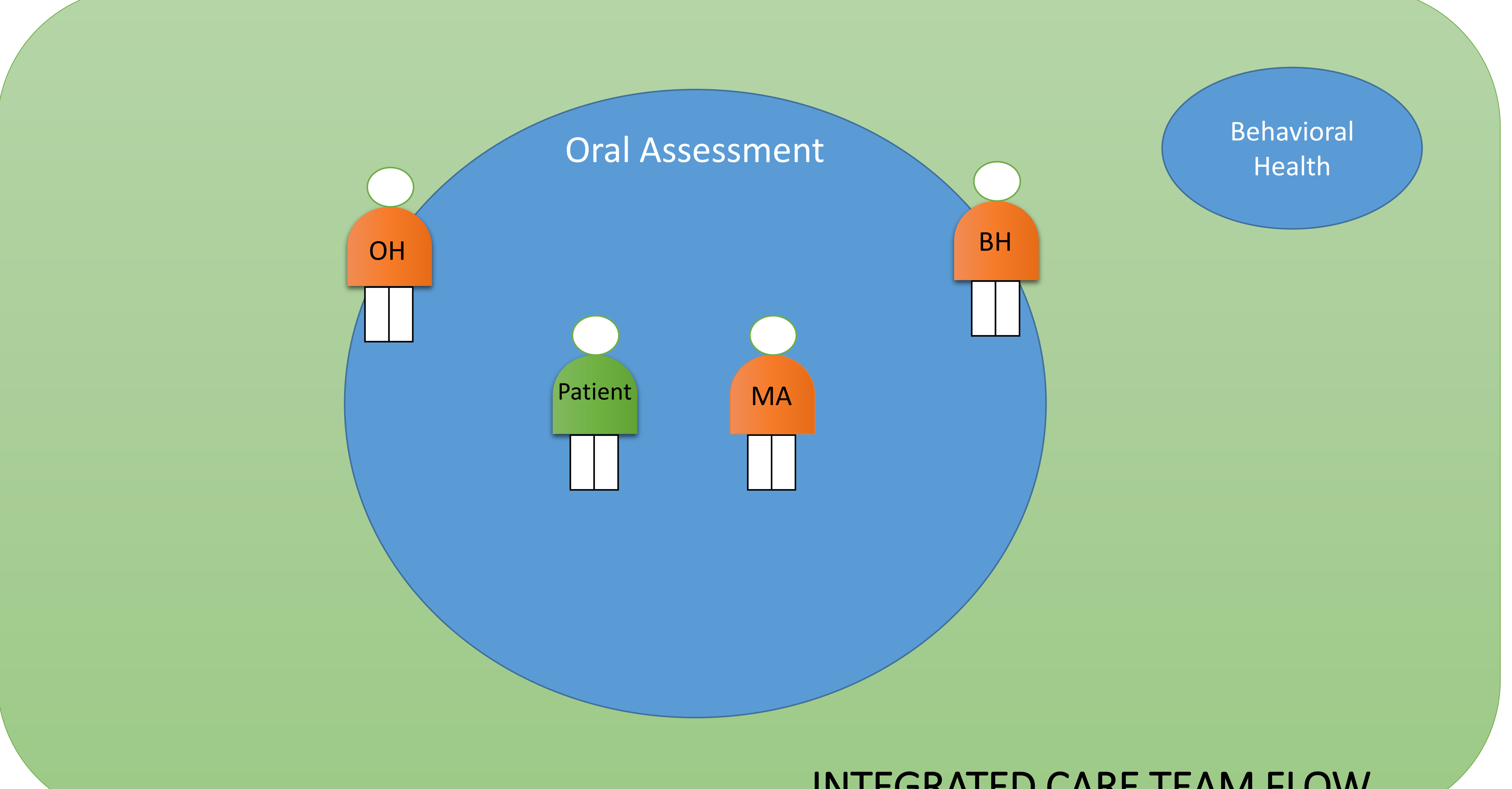
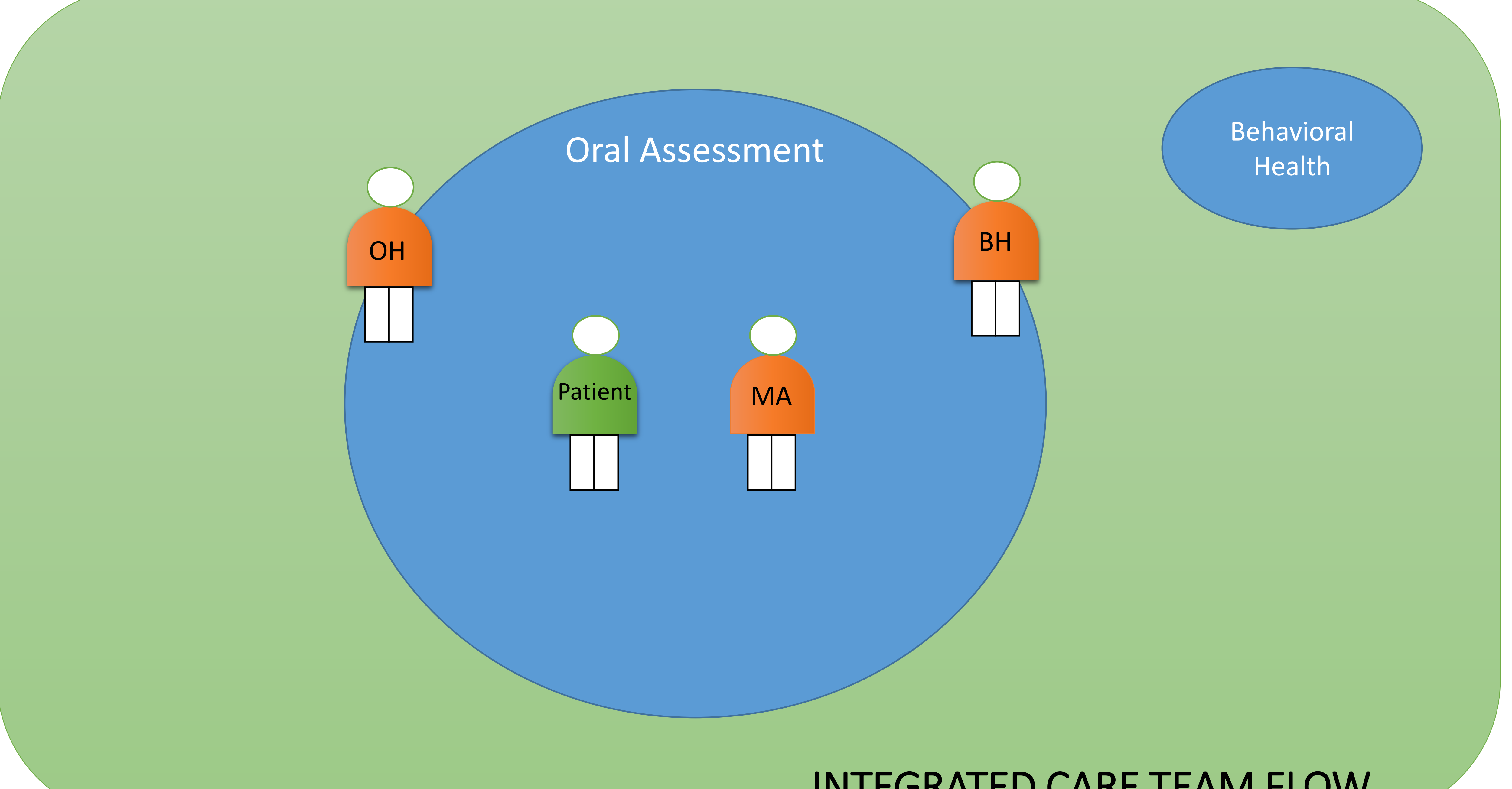
INTEGRATED CARE TEAM FLOW


Oral Assessment
Behavioral
Health
OH
BH
Patient
MA
INTEGRATED CARE TEAM FLOW


Oral Assessment
Behavioral Health
OH
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Patient
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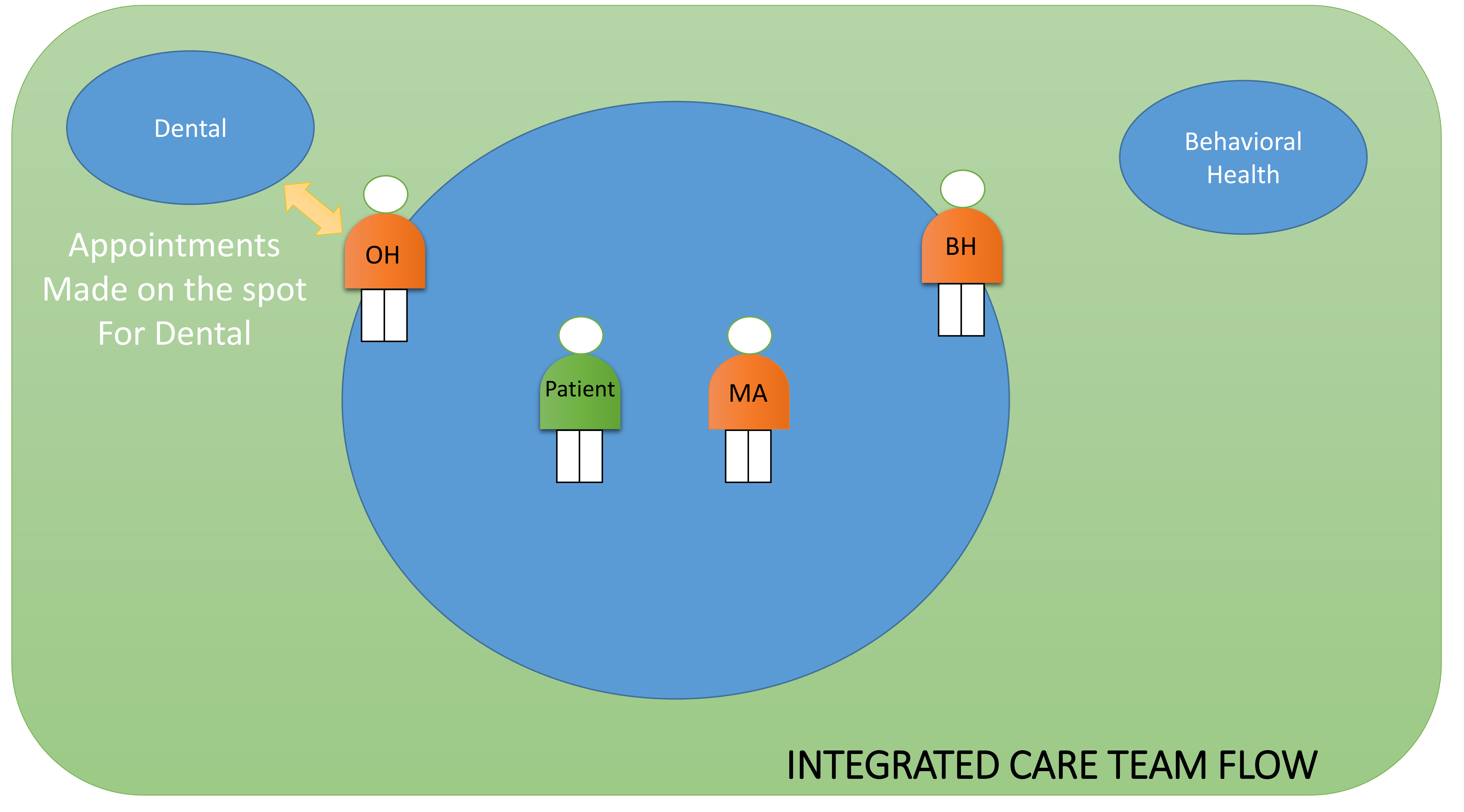
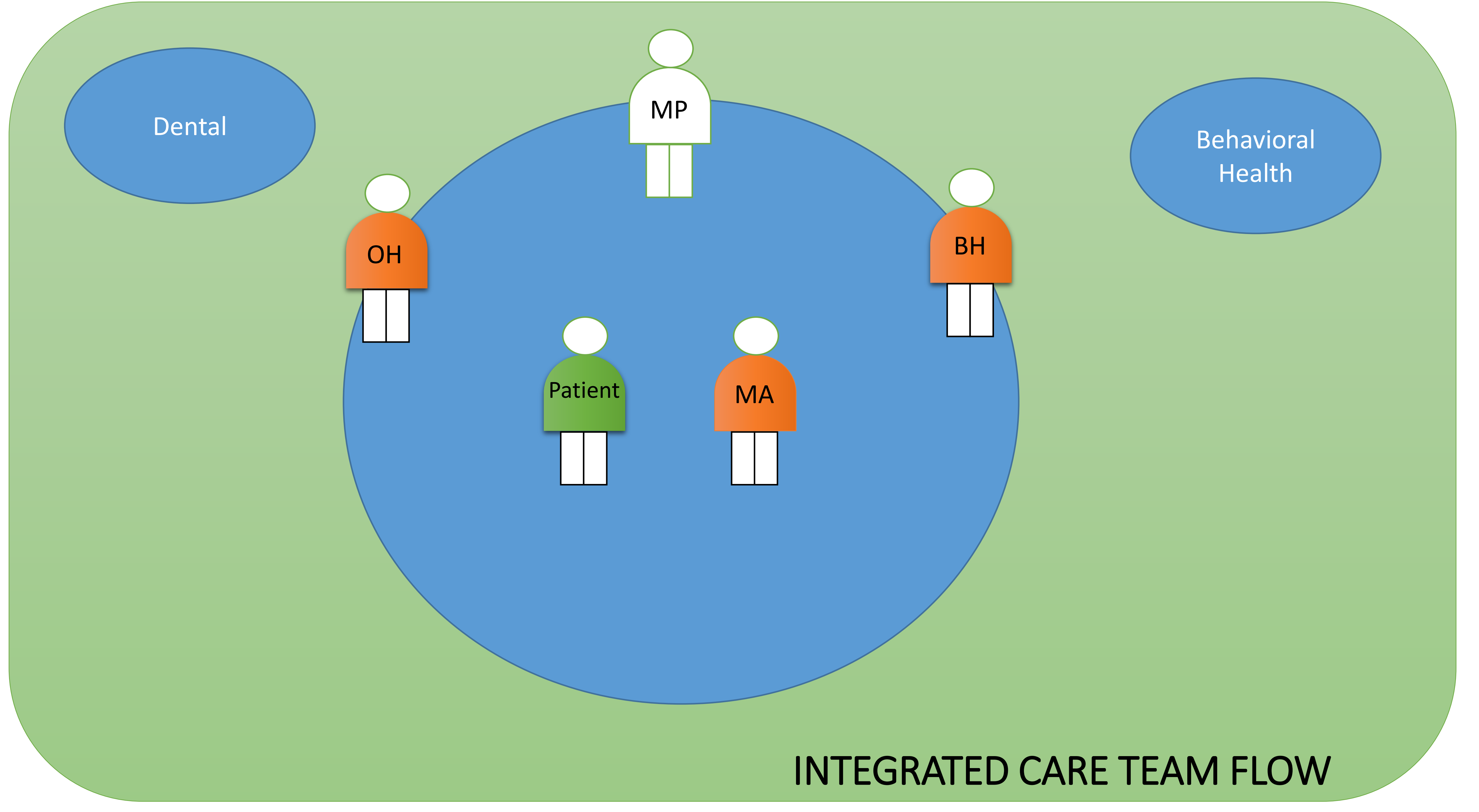
INTEGRATED CARE TEAM FLOW


Dental
Behavioral Health
Appointments Made on the spot For Dental
OH
BH
Patient
MA
INTEGRATED CARE TEAM FLOW


Dental
MP
Behavioral Health
OH
BH
Patient
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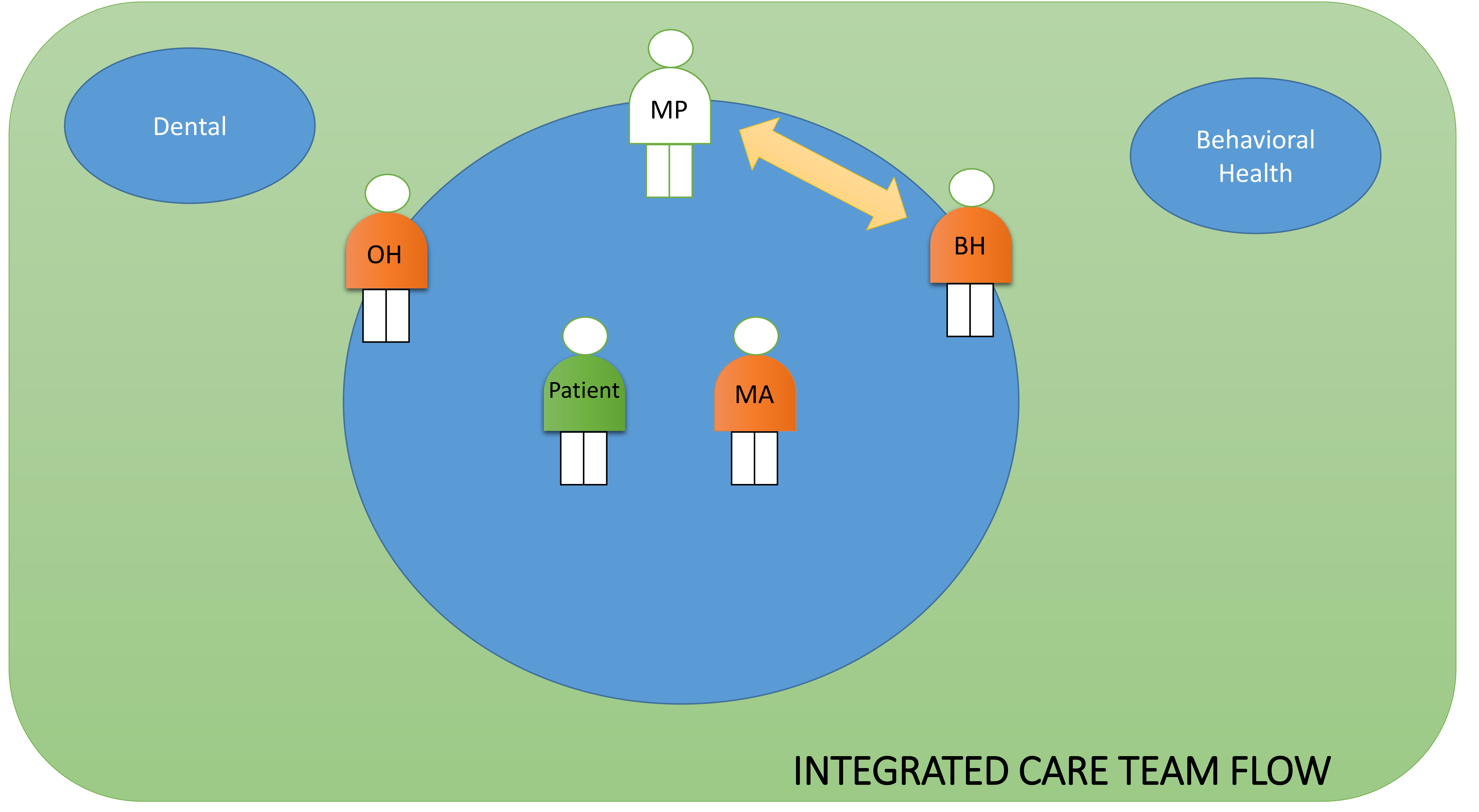
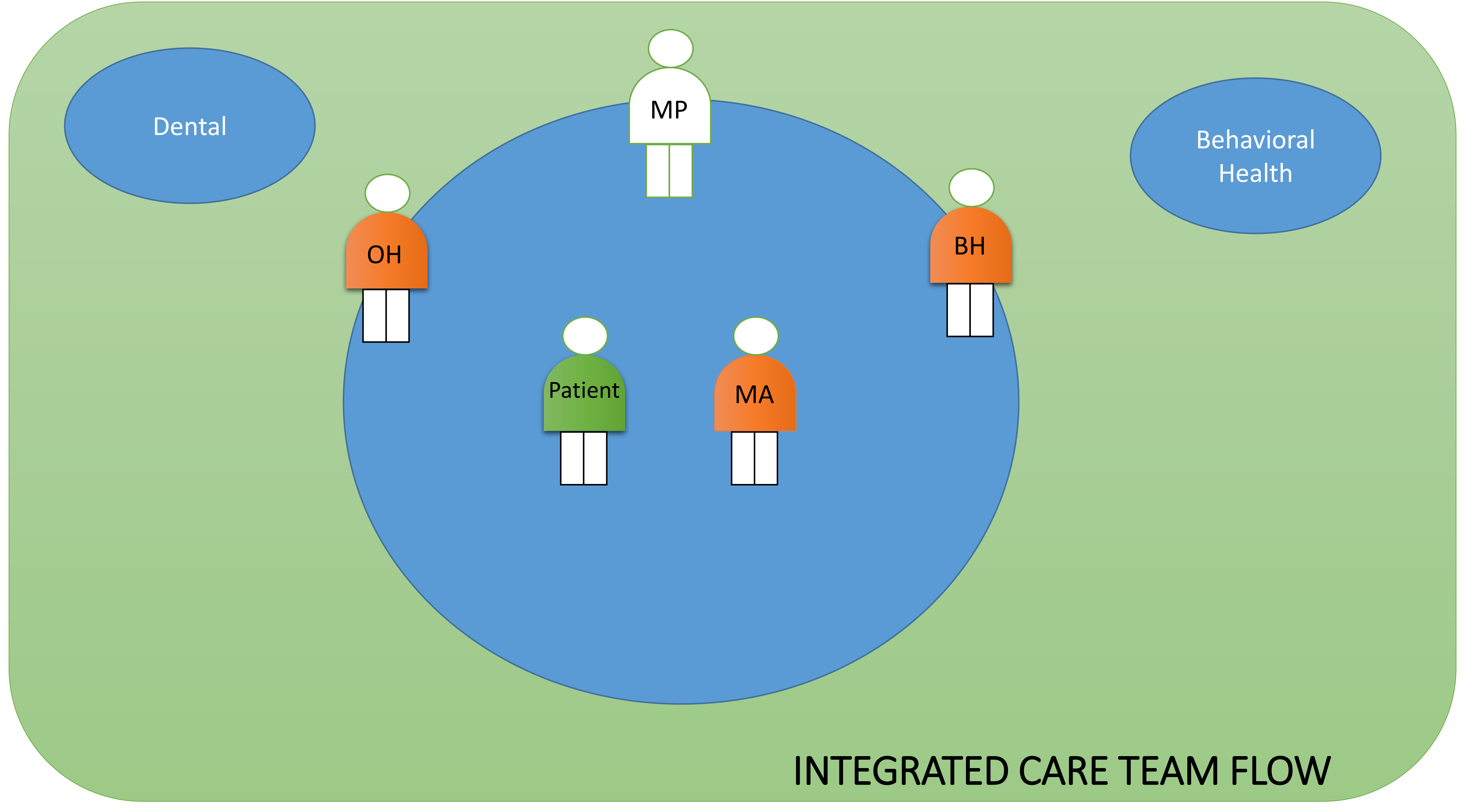
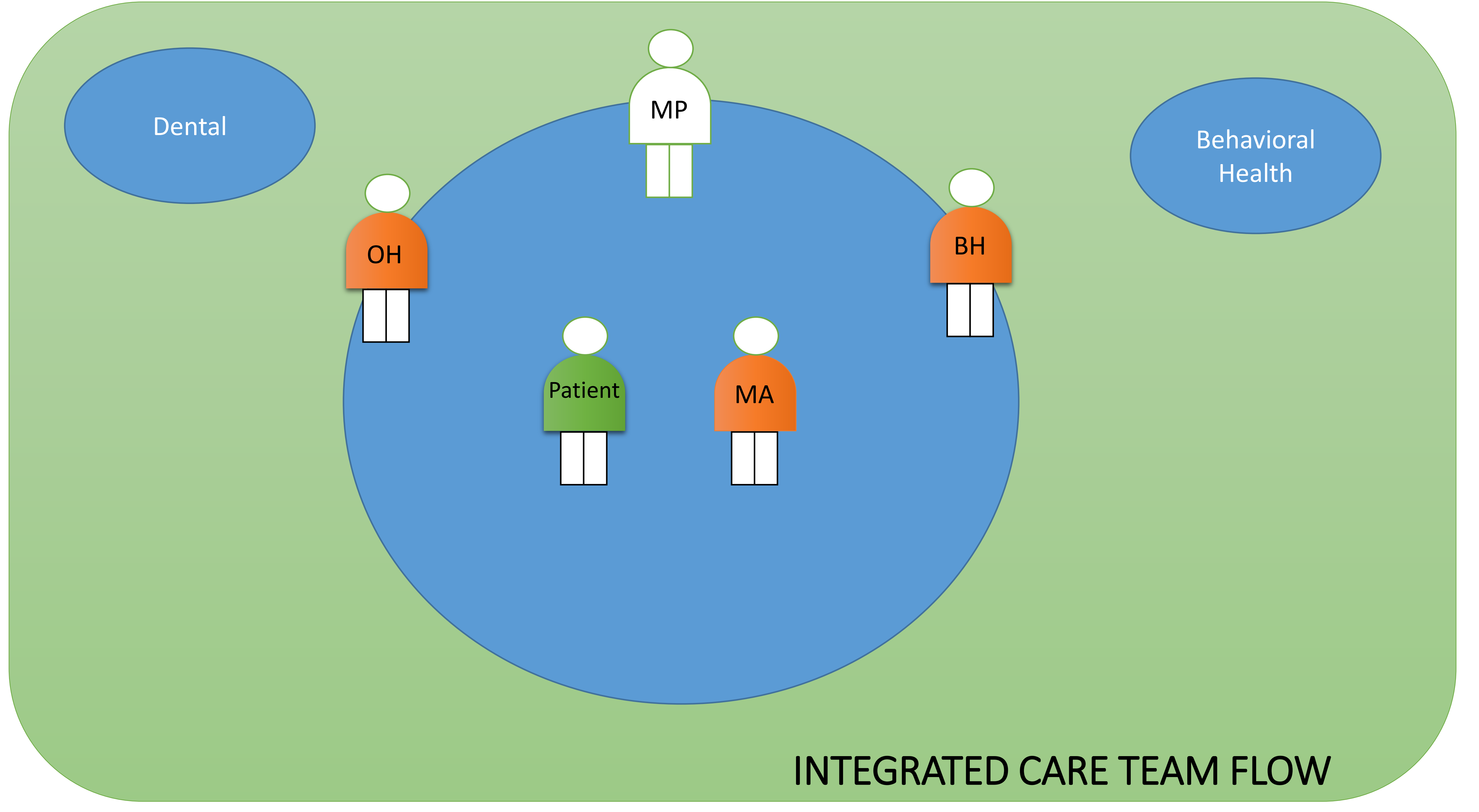
INTEGRATED CARE TEAM FLOW


Dental
MP
Behavioral Health
OH
BH
Patient
MA
INTEGRATED CARE TEAM FLOW


Dental
MP
Behavioral Health
OH
BH
Patient
MA
INTEGRATED CARE TEAM FLOW


Dental
MP
Behavioral Health
OH
BH
Patient
MA
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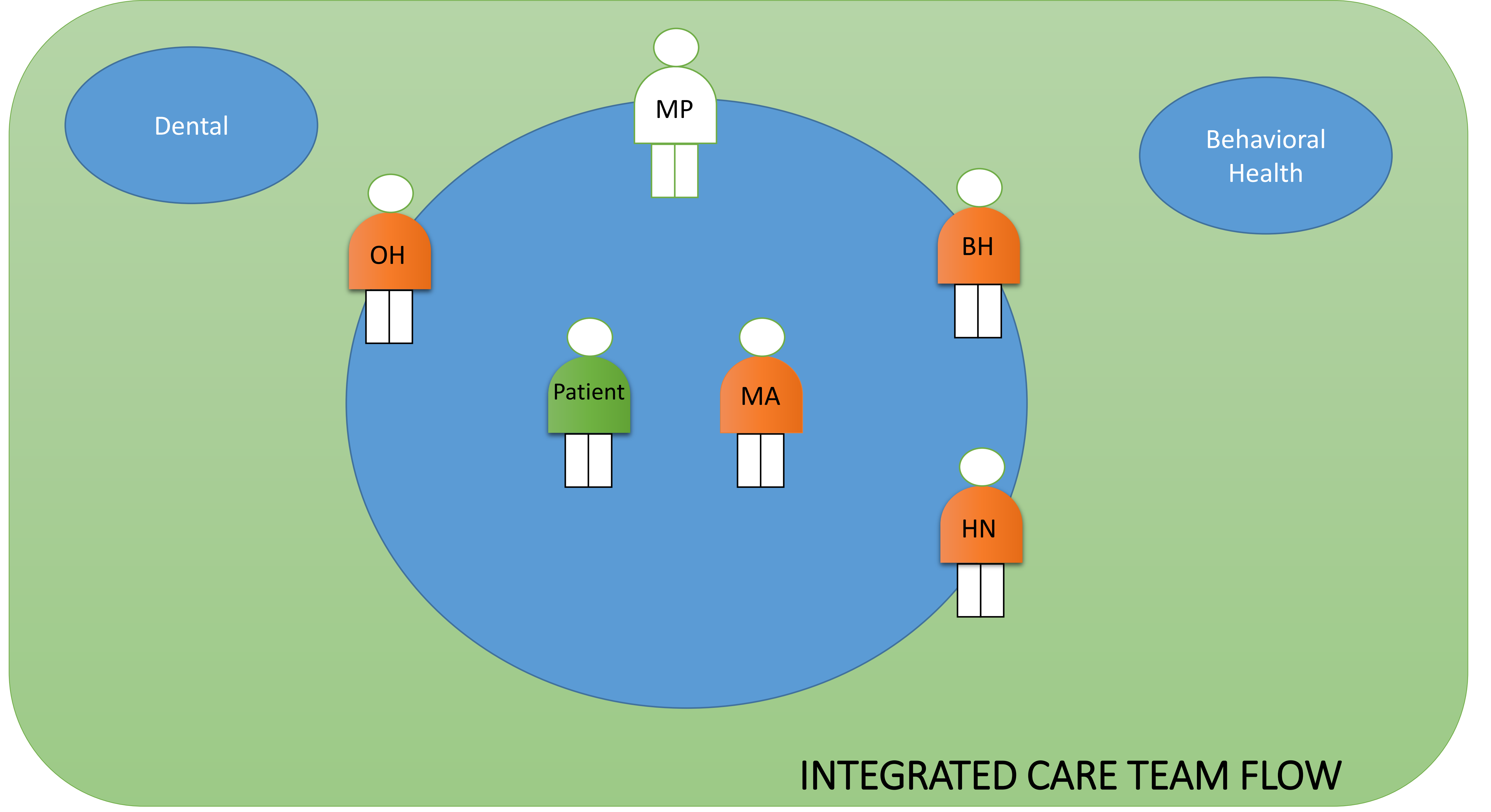
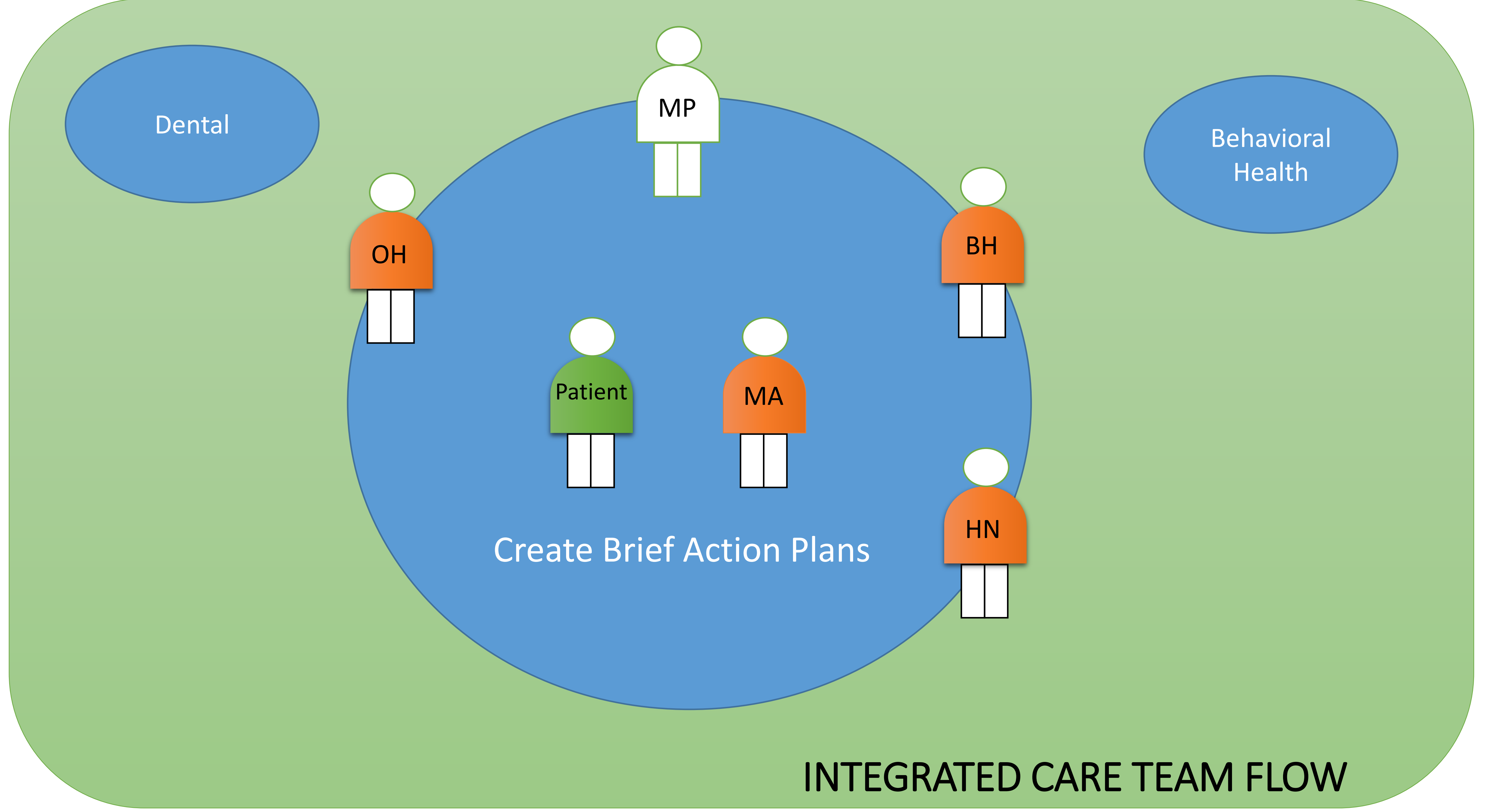
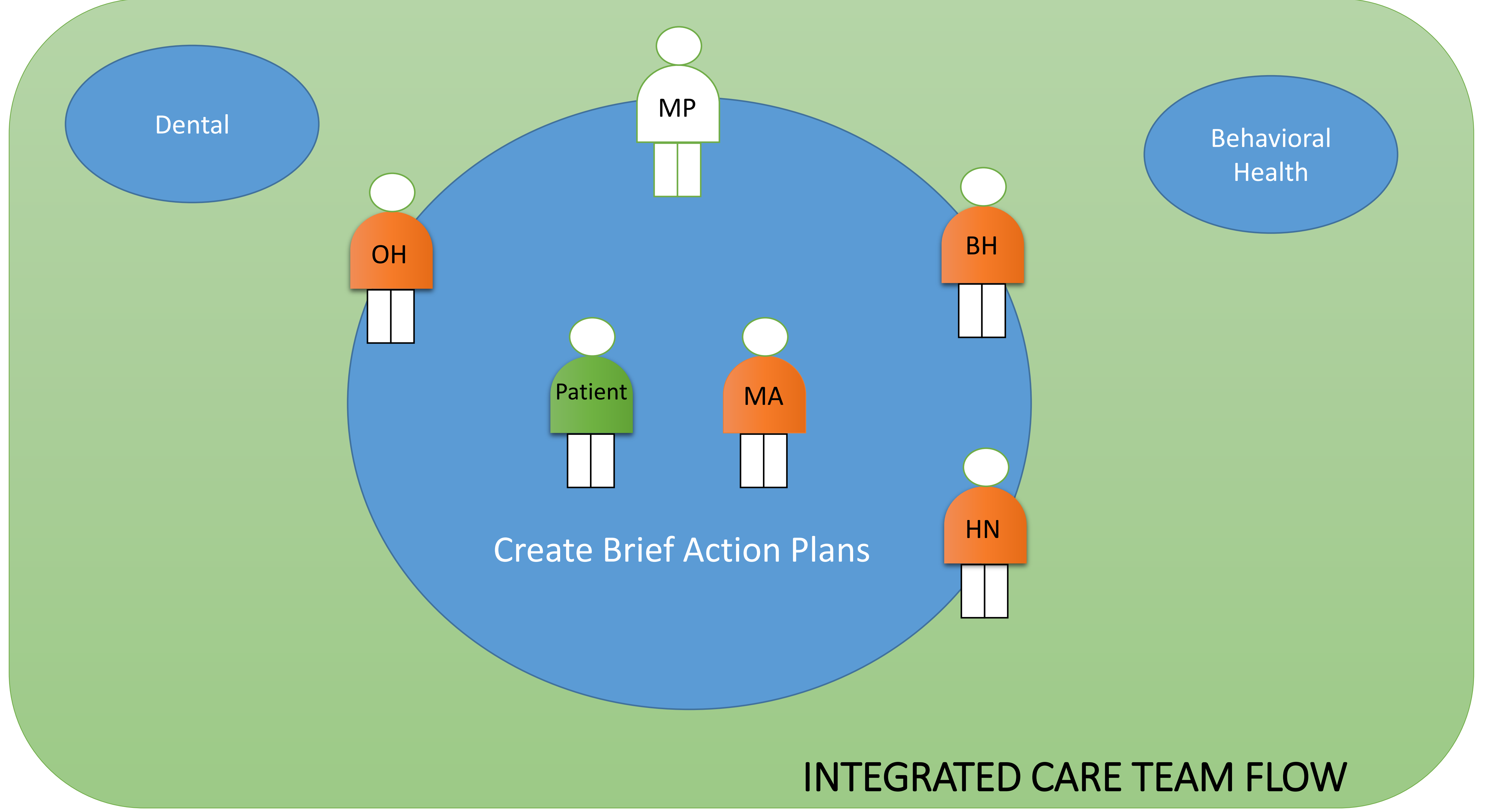
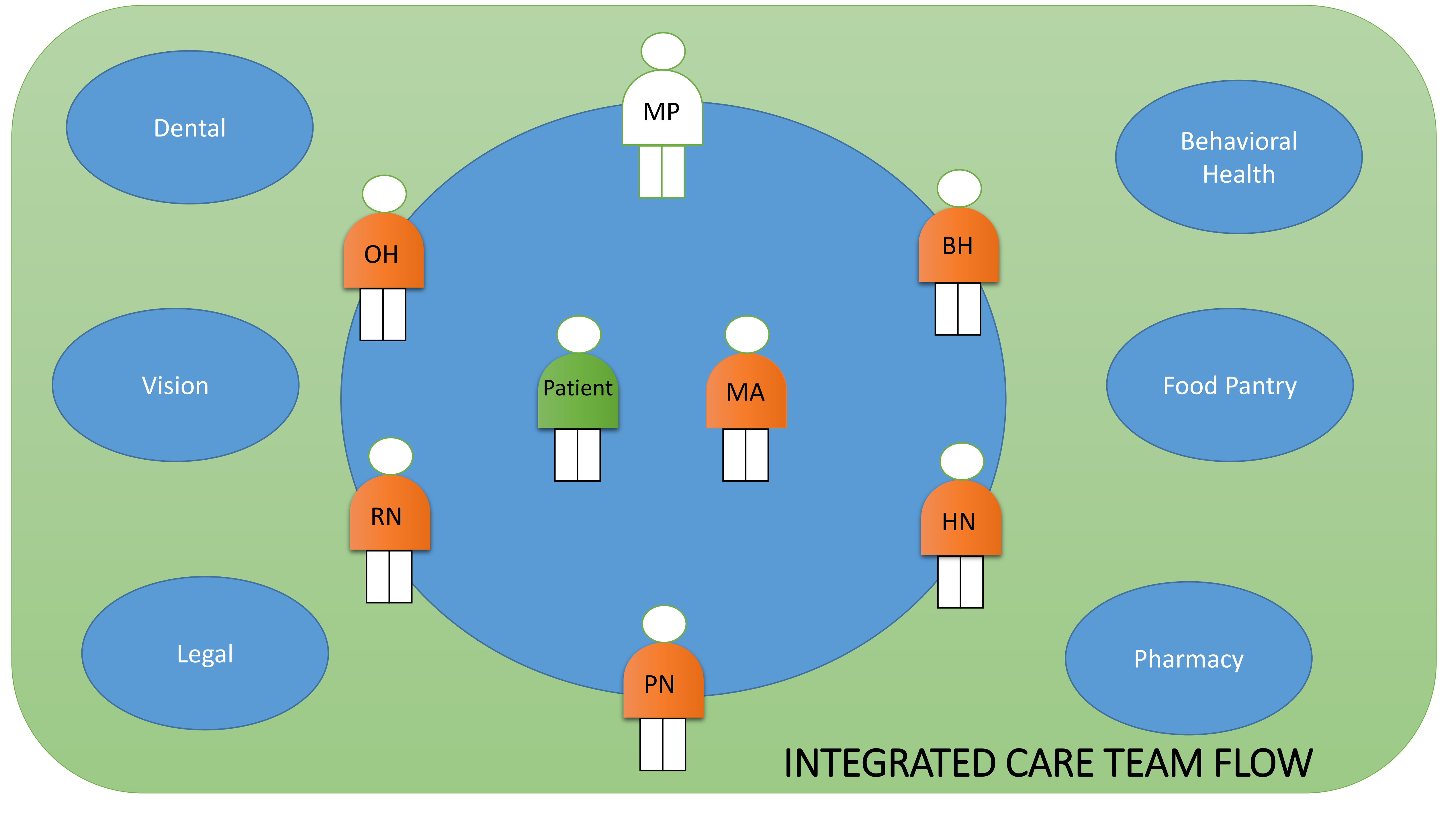

Dental
MP
Behavioral Health
OH
BH
Patient
MA
HN
INTEGRATED CARE TEAM FLOW


Dental
MP
Behavioral Health
OH
BH
Patient
MA
HN
Create Brief Action Plans
INTEGRATED CARE TEAM FLOW



Dental
MP
Behavioral Health
OH
BH
Patient
MA
HN
Create Brief Action Plans
INTEGRATED CARE TEAM FLOW



Dental
MP
Behavioral Health
OH
BH
Vision
Patient
MA
Food Pantry
RN
HN
Legal
PN
Pharmacy
INTEGRATED CARE TEAM FLOW

Q/A and Discussion

Collaborating with Local Partners

Community Partners

- Established formal service agreements with **nine** local community partners
- **All** services added and/or expanded have been launched in collaboration with a Community Partner

Community Partners

2009 –

- **CHALLENGE:** Food Pantry clients experience little to no access to affordable medical care
- **COMMUNITY PARTNER:**
    - Lestonnac Free Clinic
- **IMPACT:**
    - Over 1, 900 uninsured patients served annually

Community Partners

2014 –

- **CHALLENGE:** No dental or vision referral providers for uninsured patients
- **COMMUNITY PARTNER:**
  - St. Joseph Hospital of Orange, *Puente a la Salud Mobile Community Clinics*
- **IMPACT:**
  - 1,203 Patients treated
  - 25% Higher PPS base rate than expected

Community Partners

2015 –

- **CHALLENGE:**
  - Low number of pediatric patients
  - Opening of pediatric dental clinic
  - 7,000 total short of HRSA target patients estimates
- **COMMUNITY PARTNER:**
  - Healthy Smiles for Kids of Orange County
- **IMPACT:**
  - 9,672 pediatric patients served
  - Pediatric Dental Clinic at 95% capacity within 2 months after opening
  - 200% increase in patients served
  - 400% increase in Medicaid encounters

Community Partners

2015 –

- **CHALLENGE:**
  - Increased demand of vision services for uninsured Diabetic patients
  - No safety-net vision clinic in service area
  - Limited experience of vision program operations
- **COMMUNITY PARTNER:**
  - Marshall B. Ketchum University
- **IMPACT:**
  - Fully operational vision clinic at launch
  - Over 1,400 patients served

Community Partners

2016 –

- **CHALLENGE:**
  - Increase of uninsured adult patients with chronic conditions
  - Little to no access for wellness care outside of STP
  - High no show rates
  - No knowledge of Group Medical Visits model operations
- **COMMUNITY PARTNER:**
  - Live Healthy OC
- **IMPACT:**
  - Alternative services available on site
  - Increase in Provider Productivity
  - Decrease in no show rate

Community Partners

2016 –

- **CHALLENGE:**
  - High demand of Behavioral Health (BH) services needs for uninsured patients
  - Referral safety net 15 miles distance with a cost of $150 per visit
  - Low show rate of Behavioral Health patients referred
  - No knowledge of Behavioral Health program operations
- **COMMUNITY PARTNERS:**
  - KCS Health Center
  - California State University, Long Beach
- **IMPACT:**
  - Fully operational Integrative Behavioral Health Services Program
  - Over 750 patients served

Community Partners

2017 –

- **CHALLENGE:**
  - Low numbers of pediatric patients seen for vision services
  - Low % of Medicaid billable encounters
  - No knowledge of school-based vision service program operations
- **COMMUNITY PARTNERS:**
  - Kids Vision for Life
- **IMPACT:**
  - Mobile school-based program operational within 30 days of launch
  - 308 pediatric patients served within two months
  - 65% increase in vision Medicaid billable encounters

Community Partners

2017 –

- **CHALLENGE:**
  - Low show rate in follow-ups and referrals by homeless patients
  - Local increase visibility of homeless population in service area
- **COMMUNITY PARTNERS:**
  - City Net, Inc.
- **IMPACT:**
  - 192 patients served in over 3 months
  - Decrease in no show to 5%

Q/A and Discussion

Service Delivery Model:

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Service Delivery Challenges

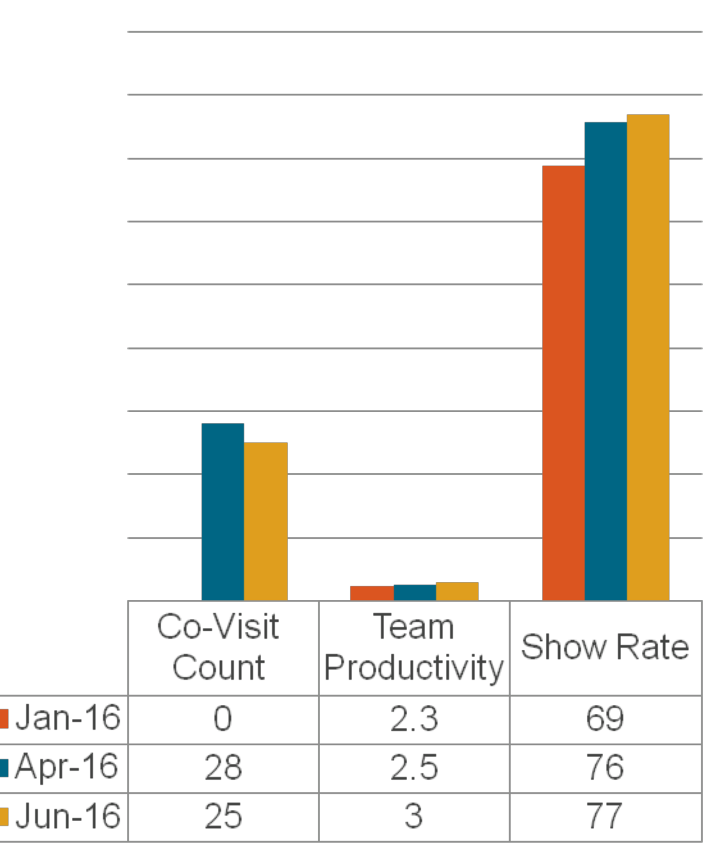
1. High no show rates
2. High number of uninsured patients
3. Transportation
4. Cycle Time
5. Provider Productivity

Co-visits

IMPROVING ACCESS

Our Co-Visit Goals

- Improves Patient Access to Care
- Improves Team Based Care
- Gives Patients Choice



	Co-Visit Count	Team Productivity	Show Rate
Jan-16	0	2.3	69
Apr-16	28	2.5	76
Jun-16	25	3	77

Daily Schedule

	Provider A	RN	Provider B	RN	Provider C	RN
8:00 AM	Huddle	Huddle	Huddle	Huddle	Huddle	Huddle
8:20 AM	1		1		1	
8:40 AM	2	**1**	2		2	
9:00 AM	**Co-Visit 1**		3		3	
9:20 AM	3		4		4	**2**
9:40 AM	4		5		**Co-Visit 2**	
10:00 AM	5		6	**3**	5	
10:20 AM	6		**Co-Visit 3**		6	
10:40 AM	7	**4**	7		7	
11:00 AM	**Co-Visit 4**		8		8	
11:20 AM	8		9		9	**5**
11:40 AM	9		10		**Co-Visit 5**	
12:00 PM	10		11		10	
12:20 PM	11		12		11	
12:40 PM	Charting	Charting	Charting	Charting	Charting	Charting
1:00 PM	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch
1:20 PM						
1:40 PM						
2:00 PM	Huddle	Huddle	Huddle	Huddle	Huddle	Huddle
2:20 PM	12		13	**6**	12	
2:40 PM	13		**Co-Visit 6**		13	
3:00 PM	14	**7**	14		14	
3:20 PM	**Co-Visit 7**		15		15	
3:40 PM	15		16		16	**8**
4:00 PM	16		17		**Co-Visit 8**	
4:20 PM	Charting	Charting	Charting	Charting	Charting	Charting
4:40 PM						
5:00 PM						

Nurse Responsibilities

- Responsible for obtaining and documenting Subjective / HPI
- Scribes for provider for the rest of the patient visit (physical exam, plan)
- Reviews Assessment and Plan with patient
- Appropriate patient education reviewed with patient
- Patient plan given to patient
- Maintain communication with provider about co-visit schedule, changes of schedule

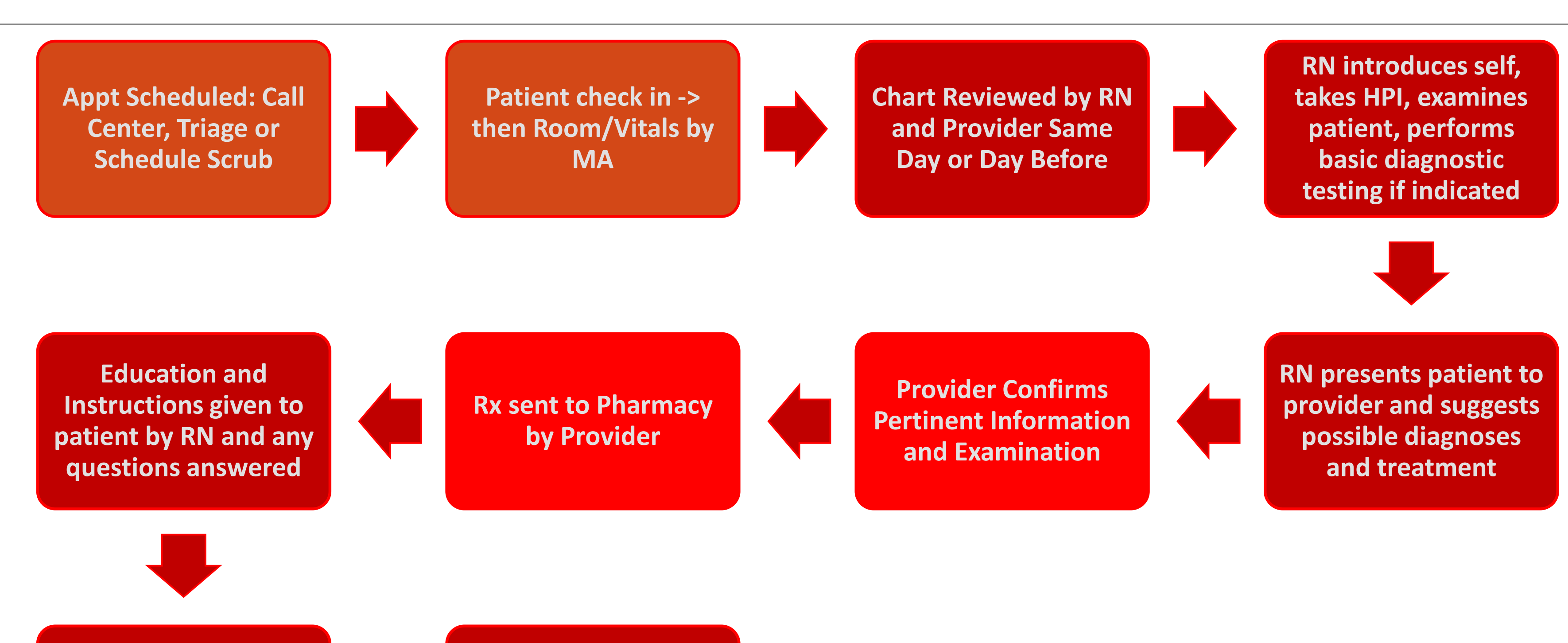
Provider Responsibilities

- Responsible for Assessment, and Plan. This includes medical decision making (MDM) and coding.
- Make necessary changes to the HPI if needed
- Perform physical exam on patient
- Assessment and plan of care thoroughly reviewed with nurse
- Verbal orders for labs, written orders meds, and diagnostics as needed for this acute visit

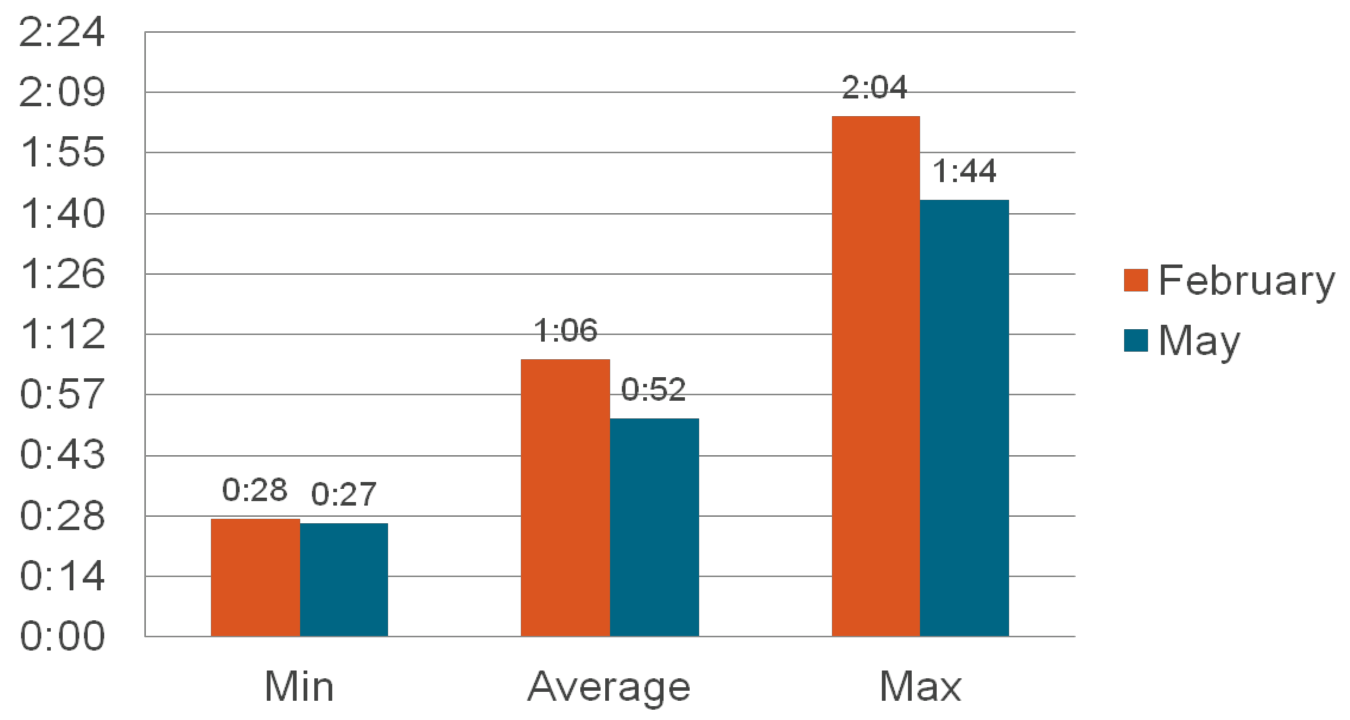
Types of Co-Visits

- Colds symptoms
- Cough
- Depro provera (contraception)
- Earaches
- Fever
- Rashes
- Wound care follow ups
- Blood pressure checks follow ups
- Urinary tract infections symptoms
- Vaccinations
- Pregnancy tests.
- Tb (PPD) tests

Co-Visit Workflow Diagram



Data – Cycle Time



Opportunities for Growth

- Better education and inclusion of staff members.
- Staff satisfaction
- Better communication amongst care team member when appointments where changed into a regular visits
- Sometimes a co-visit would become a more complicated appt. having to switch the apt to a regular appt. therefore, provider would get behind

Group Medical Visits

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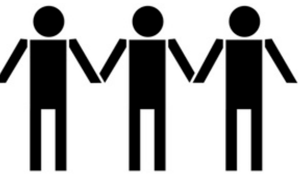
Group Medical Visits (GMV)

- A group medical visit is a unique, supportive, and interactive visit where multiple patients are seen as a group for follow-up care or management of chronic conditions (i.e. Diabetes, Hypertension, Asthma, Chronic pain, etc.) through health education, interactive activities, and incorporation of integrative modalities of care (i.e. MBSR, Yoga, Naturopathic medicine, Acupuncture)

Patients being exposed to Mindfulness Stress-Based Reduction

GMV Goals



1. Create a patient support system
2. Manage the development and treatment of chronic illnesses
3. Introduce patients to alternative modalities of treatment
4. Improve patient health outcomes
5. Improve Provider productivity and staff satisfaction

Vital Components for a successful GMV

- Community Health Center Champion!
  - Dr. Angulo, Chief Medical Officer
- Live Healthy OC

  - Support in providing more holistic services for patient care
  - Staff buy-in
- Health Scholars

  - Training Required
    - Motivational interviewing, HIPAA, EMR (Axeuim), Facilitator
    - *Facilitator's Guide to Participatory Decision Making* by Sam Kamer
  - Developing protocol, working with STP, facilitating classes
  - Live Healthy OC initiative collaboration

GMV Typical Schedule

- Vitals and 1:1 with Provider
- Housekeeping Rules
- Meditation
- Introduction
- Activity/Introduction to Integrative Providers
- Exercise
- Raffle
- Conclude

Logistics, Challenges, and Lessons Learned

- Logistics
  - Space
  - Recruitment
  - Registration/Intake
  - Provider Time
  - Curriculum
  - Metrics
  - Billing
- Other Challenges
  - High No Show Rates
  - Low Attendance
  - Space limitation

Rx Para la salud y el bienestar

Nombre de Paciente: ____

Fecha: ____

Como parte de su plan de cuidado, usted ha sido invitado a asistir a

____

Fecha: ____

Ubicación: ____

Hora: ____

Traiga esto al día del evento

____

Firma del profesional de la salud

livehealthyoc

Positive Outcomes and Future Directions

- ➢ Increase in Patient Self-efficacy
- ➢ Patient Support System
- ➢ Provider Satisfaction

Moving forward

- Wellness focus
- Integrative providers
- Alternative medicine
- Improving recruitment and staff involvement
- Wellness Center coming April 2018

Telephone Visits

IMPROVING ACCESS

Goals and Visit Types

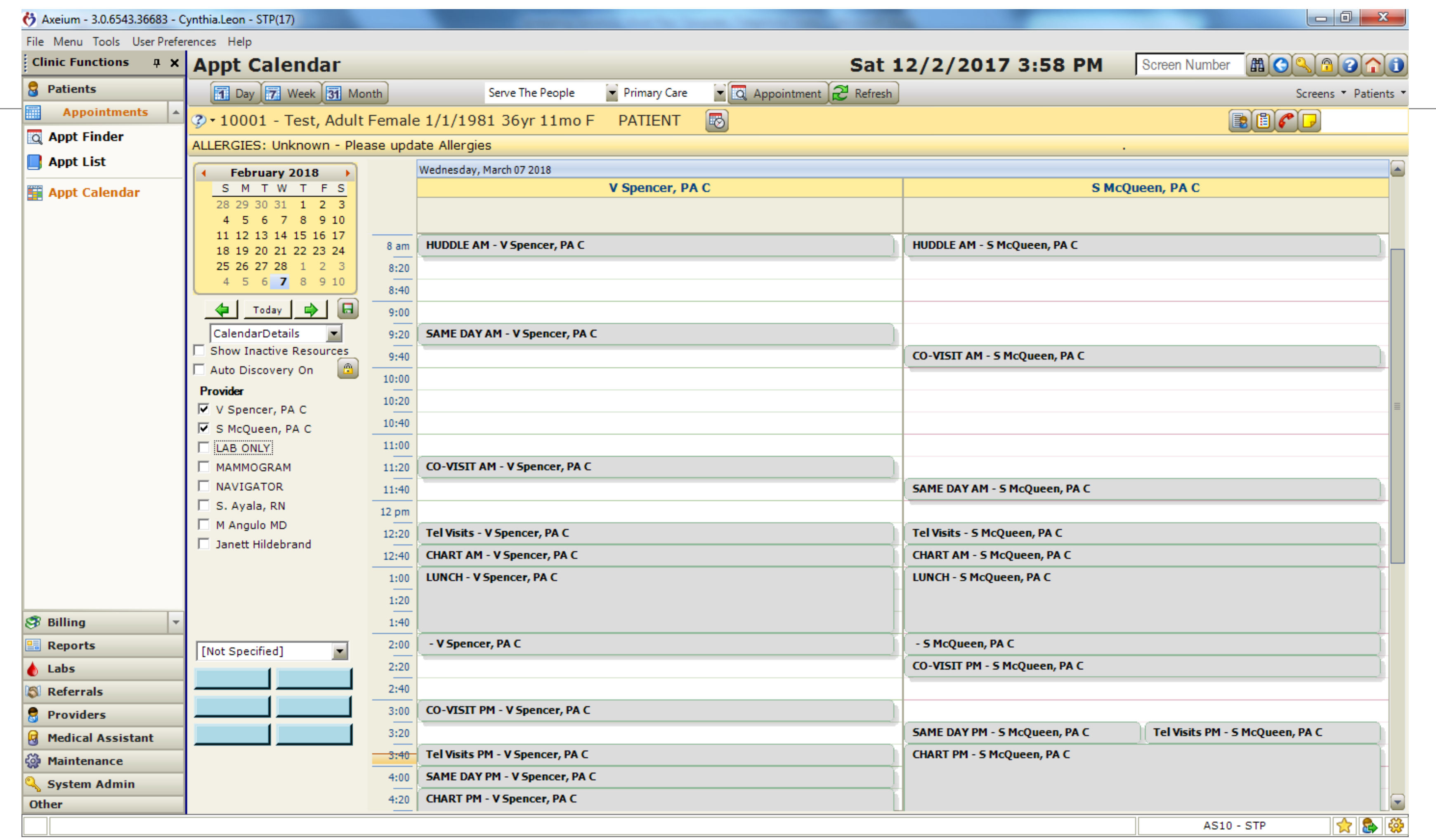
GOALS

- Improve patient satisfaction
- Improve provider satisfaction
- Decrease no show rates
- Productivity

VISIT TYPES

- Abnormal Lab/Imaging Results
- Rx Changes/Questions or Concerns
- UTI
- Cold/Flu Symptoms
- Referrals
- Post ER Follow-Ups
- Incoming Calls that Require Provider Input

Appointment Template



Telephone Visit Process

- Providers have a total of 4 calls per day
- Each telephone visit is given a 10 minute appointment slot
- Patient receives an appointment reminder call from the front desk
- MA prints labs/Imaging results, if necessary
- There is **no charge** for Telephone Visits
- Providers initiate the Telephone Visit and confirm patient's name and DOB
- **Required Documentation**
  - Date and time of the call
  - Reason for the call
  - Diagnosis/Assessment
  - Plan/Next Steps
  - Coding level of Service

Our Journey

CHALLENGES

- Provider Schedule
- Patient & Staff Awareness

STRATEGIES

- Ensure telephone visit slots are blocked for next year
- Created a video for our staff

Q/A and Discussion

Future Direction & Vision

Expansion Service Collaboration

- **Use of Telemedicine**
  - UC Riverside Psychiatry *(February 2018)*
    - Dermatology
    - Nephrology
    - Endocrinology
    - Cardiology
- **Implement Naturopathic Services**
  - UC Irvine, Susan Samueli Center for Integrative Medicine *(January 2018)*
    - Herbal Medicine, Herbal Remedies
    - Acupressure
    - Acupuncture
    - Massage Therapy
    - Yoga
    - Healing Touch

Expansion Service Collaboration

- **Establish On Site 340B Drug Pricing Program**
  - AllCare Pharmacy
- **Retinal Clinic**
  - Orange County Ophthalmologist

Improve Health Center Infrastructure

- **Build-out**
  - Wellness Center
  - Community Health Center site expansion
- **Expand mobile unit clinics**
  - Dental Unit *(December 12, 2017)*
  - Vision Unit *(February 2018)*
  - State-Of-the-Art Medical/Behavioral Unit *(June 2018)*
- **Build Electronic Information Capacities**
  - Texting
  - Video Conferencing
  - Telehealth
  - Patient Portal

Q/A, Discussion, and Closing Remarks

Thank you!

DECEMBER 13, 2017