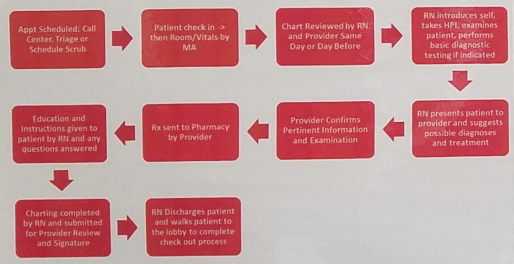
Alternative Visits

Serve the People Community Health Center

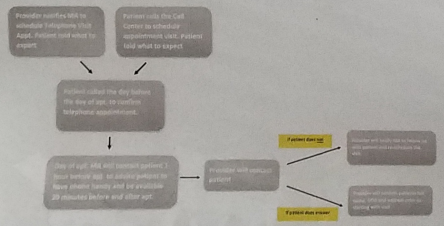
Flip Visits

- Facilitated by registered Nurse. Warm hand off is given to a provider who briefly checks and adjusts the nurses diagnosis and care plan
- Each provider has a total of 4 co-visits per day
- Co-visits Types:
  - Acute symptoms (cold, cough, earaches, fever, rashes)
  - Follow-ups (wound care, blood pressure checks)
  - TB (PPD) tests, pregnancy tests
  - Vaccinations
- Successes:
  - Increase productivity
  - Decrease cycle time an average of 15 minutes



Telephone Visits

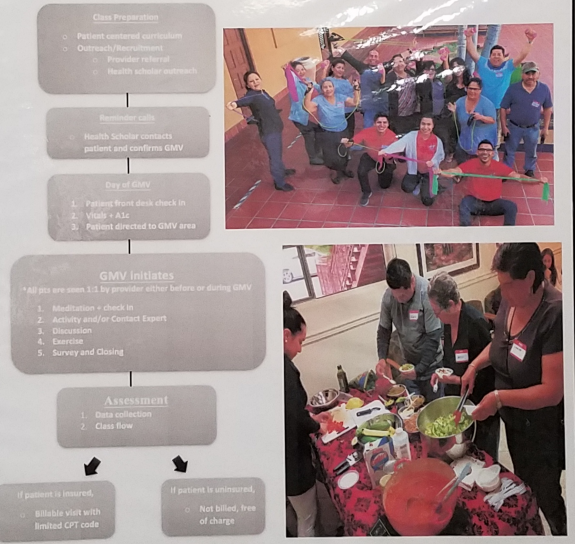
- Provider - patient interaction over the phone
  - Abnormal Lab/Imaging Results
  - Rx changes/ Questions or concerns
  - UTI, Cold/Flu Symptoms
  - Referrals, Post ER Follow-ups
- 4 telephone visits/day per provider
- No fee -> not billable visits
- Successes: Increased access and has reduced barriers



Group Medical Visits

Start: December 2017 with 1 GMV to now 3 GMVs a month

- Offered in Spanish, 3 times a month, 1.5 hour visits
- Examples of certain session types, ex. Herbal remedies, healthy cooking, mindfulness stress reduction, creative ways to be active
- Visits include Provider, MA, Contact Expert, and Health Scholars (Champion facilitators!)
  - Health Scholars Program: Facilitate GMV
    - Recruitment/outreach, class curriculum, and structure, standards of operation, data collection
    - Training required (Motivational interviewing, HIPAA, EMR (Axeium), Facilitation)



Challenges, Lessons learned, Strategies

- High No Show Rate -> Changed Scheduling Method (Treat appts as Walk-ins)
  - Decreased provider prep time from 2hrs to none
- Limited buy-in -> Outreach and Recruitment revamped
  - Providers using Rx Pads, staff pins
  - Surveys developed for direct patient feedback
  - No charge for self-pay patients (free visit and A1C testing)
  - From Staff: In-service trainings and attending GMVs
- Lecture style Curriculum -> patient centered interactive structure
- Assessing Success -> Surveys for patient feedback and Biometrics measured every visit
- Billed as face-to-face encounters (99213)

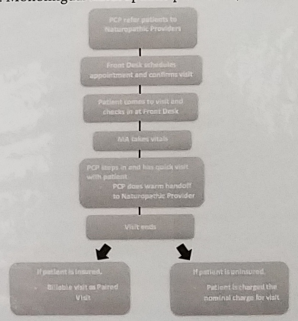
Data

- A1c: Average decrease from initial to current gmv for patients who attended 2+ visits (n=18)
- Majority of patients are concerned with and would like to improve their nutritional health.
- Self efficacy surveys distributed every 4 months. Data collection pending.

Naturopathic Visits

Pilot year, January 2018

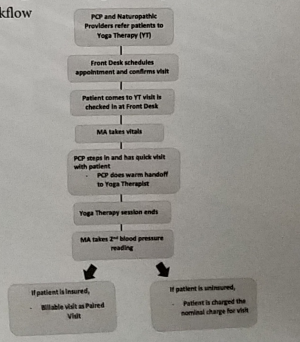
- Two Saturdays a month from 8:30-4:30PM
- 6 visits are scheduled per naturopathic provider, visits are 1 hour
- Referrals come from PCP
- Paired visit (Visits with our PCP and Naturopathic provider), codes are dependent on the level of evaluation of management
  - Bill PPS rate and our uninsured patients charged nominal fee
- A collaborative grant with the Susan Samueli Integrative Health Institute is covering the cost of pilot year
- Challenges: Monolingual naturopathic providers (translators needed)



Yoga Therapy

Beginning phase, March 2018

- Every other Tuesday and Saturday of the month from 8:30AM-12:30PM
- 4 visits per therapist, visits are 1 hour long
- Paired Visits, PCP initiates visit
- Challenges: Monolingual therapists, Recruitment, Establishing a workflow



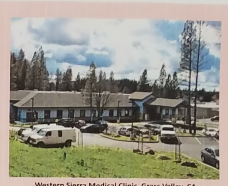
Dr. Marco Angulo, Chief Medical Officer, and George Heredia, Patient Navigator, presenting from Serve the People

WSMC- Better Health Together

Western Sierra Medical Clinic
Better Health Together

CCI Population Health Learning Network

Alternative Visits



Western Sierra Medical Clinic, Grass Valley, CA

***One-Stop* Health Center**

Current MAT Program Status

- MAT program initiated April 1, 2016
- # 75+ Current number of patients served with MAT
- On-site access Monday through Friday from 7 AM to 5 PM. 5 providers, 6 support staff
- Key services of current on-site program include:
  - Providers
  - Nurses
  - Medical Assistant
  - Substance Use Disorder Counselors
  - Youth Outreach Coordinator
  - Pharmacy
  - Primary Care
  - OB/GYN
  - Urgent Care
  - Dental

Our current MAT Care Team

- **Providers:**
  - Christina Lasich, MD
  - Heather Lucas-Ross, MD
  - Susan Shapiro, MD
  - Natalia Orozco, FNP
  - Seson Khan, FNP
- **RN Case Manager**
  - Laura Zieman
- **SUD Counselors:**
  - Doris Royer
  - Trisha Hartman
- **Behavioral Health:**
  - Kelly Cirner, LCSW
- **Health Educator**
  - Cassie Rodriguez
- **Pharmacist**
  - Ira Heidrichs

Traditional Visit

- **Patient** - Separate Appointments

RN Case Manager | Provider | SUD Counselor

- **Provider**- Conventional Schedule

Challenges

- **Patient**
  - Multiple appointments
    - Transportation
    - Finances
    - Access
  - More time with coordinating care
    - More phone calls
  - Less access
- **Provider**
  - Time spent on collaborating care versus providing care
  - Less team based care
  - Not enough access with schedules

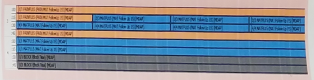
"Piggyback Visit"

"Piggyback" concept

- **Patient** – *One Appointment*

RN Case Manager | Provider | SUD Counselor

- **Provider**- Alternative Visit Schedule



Process

1. RN Case Manager/ Medical Assistant Room Patient

- Obtain:
  - Vitals
  - UDS
  - Wrapper Count
- Discuss:
  - Cravings
  - Triggers
  - Barriers to treatment
  - Anxiety
  - Insomnia
  - Coping/ Recovery Mechanisms Utilized
  - Therapy
  - Exercise

Process

2. Meeting with SUD Counselor/ Health Coach

- Conduct initial SUD assessment
- Set up and review goal sheets
- Coordinate community resources (Residential and outpatient services, Celebrate Recovery, NA, AA)
- Aid in coordination of care (Funding, Housing)
- Provide coping Education (Mindfulness, Journaling, Nutrition, Exercise)
- Follow up Calls
- Provide Crisis Intervention

Process

3. Encounter with provider

- Review all information
- Coordinate Care
- Manage Medication
- Schedule F/U appointment

Successes

- **Patients:**
  - One appointment with multidisciplinary team
  - Improved communication
  - Decreased no show rate
  - Increased access
  - Increased satisfaction
- **Providers**
  - Improved patient access to care
  - Improved team-based care
  - Increased productivity
  - Improved satisfaction

Next Steps/ Future Goals

- Increase number of providers able to deliver MAT services
- Continue to collaborate with Community Partners to provide services
- Continue to build on planned visit template to be used by whole care team
- Explore providing Telemedicine services rural areas
- Expand and replicate services to our satellite sites
- Strengthen QI data collection tools

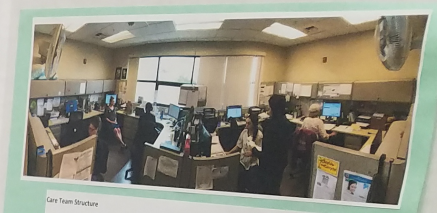
Big Questions

1. How to expand services with possibly different resources at satellite clinics?
2. Is it possible to coordinate group therapy?
3. Alternative billing structure?

Laura Zieman, Nurse Manager, and Jenny Rivard-Vobril, RN Case Manager, from Western Sierra Medical Clinic

opendoor
Community Health Centers

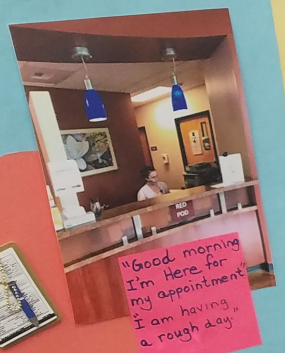
SHIFT AND SHARE TOPIC:
Alternative Visits



Care Team Structure

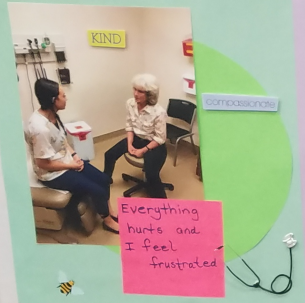
Core Care Team
1 Medical Providers
1 BH provider
1 Registered Nurse
3 Medical Assistant's
1 Coordinator
1 Clerical

Care Team Extenders
Call Center
Case Manager
Dental hygienist
Front Desk
Intensive Case Management
Laboratory
Medication room
Population health manager
Referrals
Telemedicine
Triage



"Good morning I'm Here for my appointment"
"I am having a rough day"

Reception
Alerts
Care
Team



Next Steps

In an ideal world **one year** from now, our integrated behavioral health services would...
increase from additional staffing and oversight by a behavioral health director.

In an ideal world **three – five years** from now, our integrated behavioral health services would...
be part of fully integrated social health services.

Lessons Learned

Our biggest surprise working on Alternative Visits is...
we do a lot of them.

If we could go back and do one thing different, it would be...
to be more pro-active with behavioral health provider recruitment

Discussion Questions

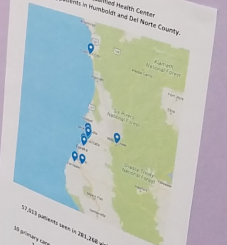
Challenges we would love your feedback on:

How are others developing their social health services?

How do you measure outcomes for your social health services?

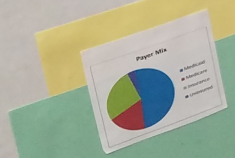
INSPIRE
hope

Federally Qualified Health Center
serving patients in Humboldt and Del Norte County.



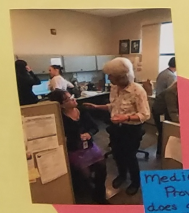
37,923 patients seen in 201,248 visits during 2017

10 primary care medical sites and 1 mobile medical van
2 dental sites and 1 mobile dental van
1 perinatal services site

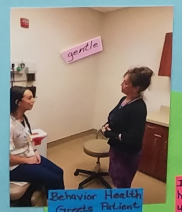


Electronic Health Record is OCHIN EPIC

Services Offered
Primary Care
Prenatal
Obstetrics
Gynecology
Nephrology
Orthodontics
Podiatry
Medication Assisted Treatment

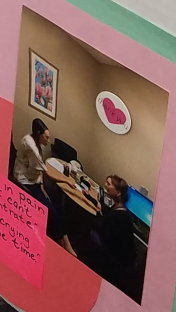


Medical Provider does a Warm Handoff to Behavior Health



Behavior Health Greets Patient in the Exam Room

I am a behavior health provider. Your provider told me you are having a hard time.



"I am in pain and I can't concentrate. I am crying the time."

Ramona Pantoja, Back Office Manager, and Holly Scaglione, Health Resources Manager, from Open Door Community Health Centers

Venice Family Clinic

ALTERNATIVE VISITS

DIABETES MANAGEMENT VISITS/ HEP C TELEPHONE VISITS

ORGANIZATION CONTEXT

- **Number of patients:** More than 26,000 annually
  - 76% live below the federal poverty level
  - 28% are children
  - 14% are homeless
  - 39% speak Spanish as their primary language
  - 73% have health insurance—the most in the Clinic's history
- **Patient visits:** ~114,000 annually
- **Payer Mix:** MediCal, Medicare, MHLA, CoveredCA, Sliding fee
- **EHR used:** NextGen
- **Care Team Structure:** Provider/MA dyad

ORGANIZATION CONTEXT

- **Organization model**: FQHC
- **Number of Sites**: 12
- **Types of services offered**: Medical care • Dental care • Vision care • Behavioral health • Substance use services • Laboratory services • Pharmacy services • Health and wellness education • Chronic disease management • Case management • Support groups • Parenting classes • HIV/AIDS care • Reproductive health • Prenatal care • Early childhood development • Early Head Start • Integrative medicine • Domestic violence intervention

DIABETES MANAGEMENT VISITS

- Started as a pilot on September 2015
- 12 weekly group visits with health educator and a provider
  - Health educator leads group activity and discussion
  - Provider has a one-on-one visit with each patient during the course of group visit
- Target population:
  - Diabetes diagnosis
  - Spanish speaking
    - Historically higher participation from Spanish speaking ppl.
  - Have a PCP at Simms Health Center
  - Have an A1C between 7-9
    - Open to any diabetic pt.

DIABETES MANAGEMENT VISITS

- Average attendance of 20 patients
- Group Visit Topics include:
  - Diabetes 101
  - High Blood Pressure
  - Depression
  - Physical Activity
  - Healthy Eating
  - Weight Management

LESSONS LEARNED

Our biggest surprise working on Diabetes Management visits is that…

- Saw improvement in weight loss, blood pressure and A1C for participants

If we could go back and do one thing different, it would be…

- Have a stronger recruitment effort
  - Started with just sending letters
  - Provider can see 12 patients to be sustainable

NEXT STEPS

In an ideal world one year from now, our Diabetes Management visit would…

- Expand to other locations
- Expand to patients of all A1C over 7
  - The more touch points, the better patient health outcome
- Identify pts with higher need and linking them to care resources

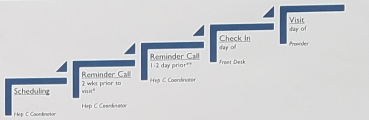
In an ideal world, three-five years from now, our Diabetes Management visits would…

- Be a standardized protocol for diabetic patients
- Provide English speaking group visits
- Have a separate "graduated" group visits
  - Extended learning support
- Have DM group visits on the forefront of providers and coordinator minds
  - For patients that need extra touch point/education
  - Patients that need a supportive community (i.e. elderly, retired patients)

HEP C TELEPHONE VISITS

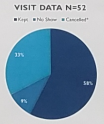
- Started on April 10th, 2017
- Eligible Patients
  - Patients on Hep C treatment
  - Needs 2nd or 3rd Hep C Visit at VFC
  - Can access a phone
  - Likely to answer phone at appt time
  - Likely to understand info over the phone
  - History of compliance and keeping appt.

HEP C TELEPHONE VISITS



*Hep C Coordinator reminds pt to do labs if need be.
** Hep C Coordinator cancels visit if patient's labs are not done.

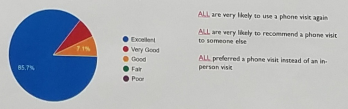
HEP C TELEPHONE VISITS



* Hep C Coordinator cancels visit if patient's labs were not done

HEP C TELEPHONE VISITS

Patients Overall Rating of Phone Visit (n=14)



ALL are very likely to use a phone visit again

ALL are very likely to recommend a phone visit to someone else

ALL preferred a phone visit instead of an in-person visit

LESSONS LEARNED

Our biggest surprise working on Hep C Telephone Visits is…

- How much it improved provider satisfaction!
  - Visit and charting are fast (~10 min)
    - Quick to address pt one issue
  - Given allocated time to do phone calls

If we could go back and do one thing different, it would be…

- Revisit patient satisfaction surveys and learn more from other organizations doing similar work.
- Reenforce the importance of having labs completed prior to visit

NEXT STEPS

- In an ideal world one year from now, our Hep C telephone visits would…
  - Expand to more Hep C population
- In an ideal world, three-five years from now, our Hep C telephone visits would…
  - be reimbursed for phone visits and not just face to face encounters

DISCUSSION QUESTIONS

- How do you improve recruitment?
- What strategies do you utilize to make alternative visits cost-effective with the absence of reimbursement?

Jonathan Vargas, Population Health Coordinator, from Venice Family Clinic