CCI
CENTER FOR CARE INNOVATIONS

Booster Webinar - Evaluation Update

Virtual Care Innovation Network

A community health collaboration founded by KAISER PERMANENTE

NOVEMBER 2, 2021, 12 – 1 PM PDT

Agenda

1. Housekeeping & Agenda Review
2. Reminder - Share & Learn #2
3. Evaluation Update
4. Q&A

Housekeeping

Mute

Minimize Interruptions

Please make sure to mute yourself when you aren't speaking.

Chat

Go Ahead, Speak Up!

Use the Zoom chat to ask questions and participate in activities.

Naming

Add Your Organization

Represent your organization and add your organization's name to your name.

Tech Issues

Here to Help

Chat Nhi privately if you are having issues and need tech assistance.

Share & Learn # 2

Share & Learn Presentation Schedule

Teams Presenting on
November 18, 2021, 12 – 2 PM PDT

1. Center for Pan Asian Community Services
2. CommuniCare Health Centers
3. Community Clinic of Maui
4. Country Doctor Community Health Centers
5. Eisner Health
6. Family Health Centers of Baltimore
7. Golden Valley Health Centers
8. Greater Baden Medical Services
9. Los Angeles Christian Health Centers
10. Mission City Community Network

Teams Presenting on
January 18, 2022, 12 – 2 PM PDT

1. Clinica Family Health
2. Clinica Msr. Oscar A. Romero
3. KCS Health Center
4. Neighborhood Healthcare
5. Outside In
6. Peach Tree Health
7. Petaluma Health Center
8. Public Health – Seattle & King County
9. San Francisco Community Clinic Consortium
10. So Others Might Eat
11. STRIDE Community Health Center
12. Total Health Care
13. Tri-State Community Healthcare
14. West County Health Centers

Presentation Overview

Each team presents for 15-minutes:

- Share your AIM statement and the population you're focusing on
- Briefly share highlights, or any aha! moments, from your interviews and journey map
- Share where you are taking your project from here by reviewing your driver diagram and/or your high-level rapid testing plan
- Feel free to also share any other information you have (e.g. data, initial learnings from your tests, etc.)

Share 2 Resources

Presenting organization are requested to:

- Submit at least 2 items your organization has developed as part of our Virtual Care Innovation Network project
- Examples include things like workflows, flowcharts, educational videos, flyers, scripts, etc.

Share your work early + often

We don't anticipate these examples being perfect as we are still in our testing phase!

It's okay if these workflows, scripts & approaches are still being prototyped.

Evaluation Update

Natasha Arora, MS

Evaluation & Learning Associate

Center for Community Health and Evaluation

VCIN Evaluation Booster Webinar

11/02/2021

Center for Community Health and Evaluation

Objectives and Agenda for today

Objectives

- Inform VCIN program teams on changes to data collection for the evaluation
- Respond to questions

Agenda

1. Outline changes to VCIN data submission
2. Sharepoint tour of documents/resources
3. Q & A

Goals of the Evaluation

- Assess **changes in organizations' capacity to serve target populations** via telehealth, including
  - Telehealth utilization
  - Promising practices
  - Facilitators and barriers to telehealth
- Understand **changes in telehealth policy** and their influence on health center needs and practices
- Understand the **contribution of the learning collaborative** to organizations' progress
- Provide **real time information to CCI** about program progress and participant experience.
- Synthesize and **communicate** results and learnings from the program to key stakeholders

Guiding Principles for the Evaluation

Minimize burden on organizations and other partners

Build **trust** to increase the likelihood of **candor**

Ensure sufficient **reach & rigor** for credible results

Provide value to stakeholders

VCIN Current Data Collection

Current Data Collection

- Monthly number of visits throughout organization by modality (primary care and behavioral health)
  - segmented by payer (required)
  - segmented by race/ethnicity, language, age
- Monthly number of visits at pilot project sites
- Monthly number of unique patients throughout organization by modality (primary care and behavioral health)
- Specialties offered at HC and amount provided by telehealth (ordinal scale)

Underlying Assumptions

- VCIN projects would drive overall telehealth utilization or choice of telehealth modalities
- VCIN projects would involve tests of change/innovation at particular clinic sites
- Segmented data would allow us to look at the extent to which expanded telehealth access was equitably distributed

VCIN Current Data Collection

Successes

- All health centers submitted data
- Most health centers were able to categorize visits by modality
- Data illustrate the use of virtual care across the safety net
- Utilization data are of interest to PCAs and for use with policy/advocacy efforts

Challenges

- Disconnect between data submission and applied projects
- Extracting segmented data is time-consuming
- In some cases, challenging to categorize visits by modality (phone/video)

Next Steps

- Reduce clinical utilization data requirements for Dec 15 & June 15 data submissions
- Integrate data gathered during current projects/PDSA cycles

Revisions to Clinical Utilization Data Submission

Revised data submission

- Monthly number of visits throughout organization by modality (primary care and behavioral health)
  - Optional: segmented by race/ethnicity, language, age, **payer**
- ~~**Monthly number of visits at pilot project sites**~~
- Monthly number of unique patients throughout organization by modality (primary care and behavioral health)
- ~~**Specialties offered at HC and amount provided by telehealth (ordinal scale)**~~

Changes to the data submission form

- Previous data submission forms in sharepoint
- Your previously-submitted data will still appear in your form; however, the changes below have been made to format
- Rows for "visits at pilot project sites" have been hidden
- Rows for payer data have been marked "optional"
- Extra tabs have been deleted
- Sheets are protected so that you can only make changes to relevant cells

Virtual Care Innovation Network Data Collection Tool

Primary Care

		Complete by June 15, 2021									Complete by							
		Mar-21			Apr-21			May-21			Jun-21			Jul-21			Aug-21	
		A. Clinic	B. Phone	C. Video	A. Clinic	B. Phone	C. Video	A. Clinic	B. Phone	C. Video	A. Clinic	B. Phone	C. Video	A. Clinic	B. Phone	C. Video	A. Clinic	B. Phone
Required data submission	**Unique Patients: Organization-wide reporting**																	
	3. Unique patients Total number of unique patients who completed one or more primary care visits using the indicated modality (in-clinic, phone, video) during the calendar month throughout the whole organization	1,319	1,279	75	1,460	1,283	59	1,331	1,053	57								
	Visits: Organization-wide reporting																	
	5. Organization-wide Visits Total number of completed primary care visits during the calendar month throughout the whole organization	1,676	1,642	91	1,880	1,683	70	1,615	1,312	64								
	6. Visits segmented by payer Segmented visit data should be for the whole organization.																	
	6.1 None/Uninsured	227	355	11	282	400	8	228	274	5								
	6.2 Medicaid or CHIP	1,126	903	66	1,253	829	50	1,078	709	48								
	6.3 Dual Eligible	0	0	0	0	0	0	0	0	0								
	6.4 Medicare	207	233	13	217	322	12	188	214	8								
	6.5 Other Public Insurance	0	0	0	0	0	0	0	0	0								
	6.6 Private/Commercial	116	151	1	128	132	0	121	115	3								
	Payer total (calculated field)	1,676	1,642	91	1,880	1,683	70	1,615	1,312	64	0	0	0	0	0	0	0	0
Optional data submission	**7. Visits segmented by age** Segmented visit data should be for the whole organization.																	
	7.1 <=17	360	140	38	385	150	28	340	108	25								
	7.2 18-44	813	870	30	899	921	25	843	763	22								
	7.3 45-64	366	465	17	429	420	11	289	267	10								
	7.4 65 and Over	137	167	6	167	192	6	143	174	7								
	Age total (calculated field)	1,676	1,642	91	1,880	1,683	70	1,615	1,312	64	0	0	0	0	0	0	0	0
	8. Visits segmented by language Segmented visit data should be for the whole organization.																	
	8.1 Best Served in English	688	725	48	735	765	33	633	622	29								
	8.2 Best Served in a Language Other than English	957	895	42	1,112	906	37	943	677	34								
	8.3 Unreported/Refused to Report	31	22	1	33	12	0	39	13	1								
	Language total (calculated field)	1,676	1,642	91	1,880	1,683	70	1,615	1,312	64	0	0	0	0	0	0	0	0

Virtual Care Innovation Network Data Collection Tool

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Telling the story of your project

Project-specific data

- Integrated into PDSA cycles and your team's storyboard; not a separate data collection effort or aligned across collaborative
- Collected on the timeline that makes sense to your project
  - May be frequent for some projects; baseline/endpoint for others
- Focused on the population that you are working with in your VCIN applied project
- Measures are chosen by your team to help you assess progress toward your aim statements
  - We provide a "menu" of measures and encourage you to select from the menu

What should we measure?

Process Measures

- Look at:
  - What were the inputs into the project?
  - What activities occurred? Who participated?
  - How could activities/processes be improved?
- Most teams will focus on process measures given the phase of the project
- We encourage teams to choose at least one process measure that moves beyond project reach
- What are the best indicators that you're moving toward your aim statement?

Outcome measures

- Look at:
  - Were our goals achieved?
  - How was patient health improved?
- In general, your outcome measure **can come directly from your aim statement**

		Example Measures
Process	What activities occurred?	• # of patients who accessed telehealth appointments • # of patients who received a blood pressure monitor
	Who participated?	• # MAs in primary care clinic trained in supporting patients with telehealth platform • # of patients with hypertension who participated in virtual health education group
	How could activities/processes be improved?	• Percentage of video appointments that had to be converted to telephone • # of same-day telehealth appointments available each week
Outcome	Were our goals achieved?	• Percentage of patients with LEP who completed depression screening
	How was patient health improved?	• % of patients with controlled A1c

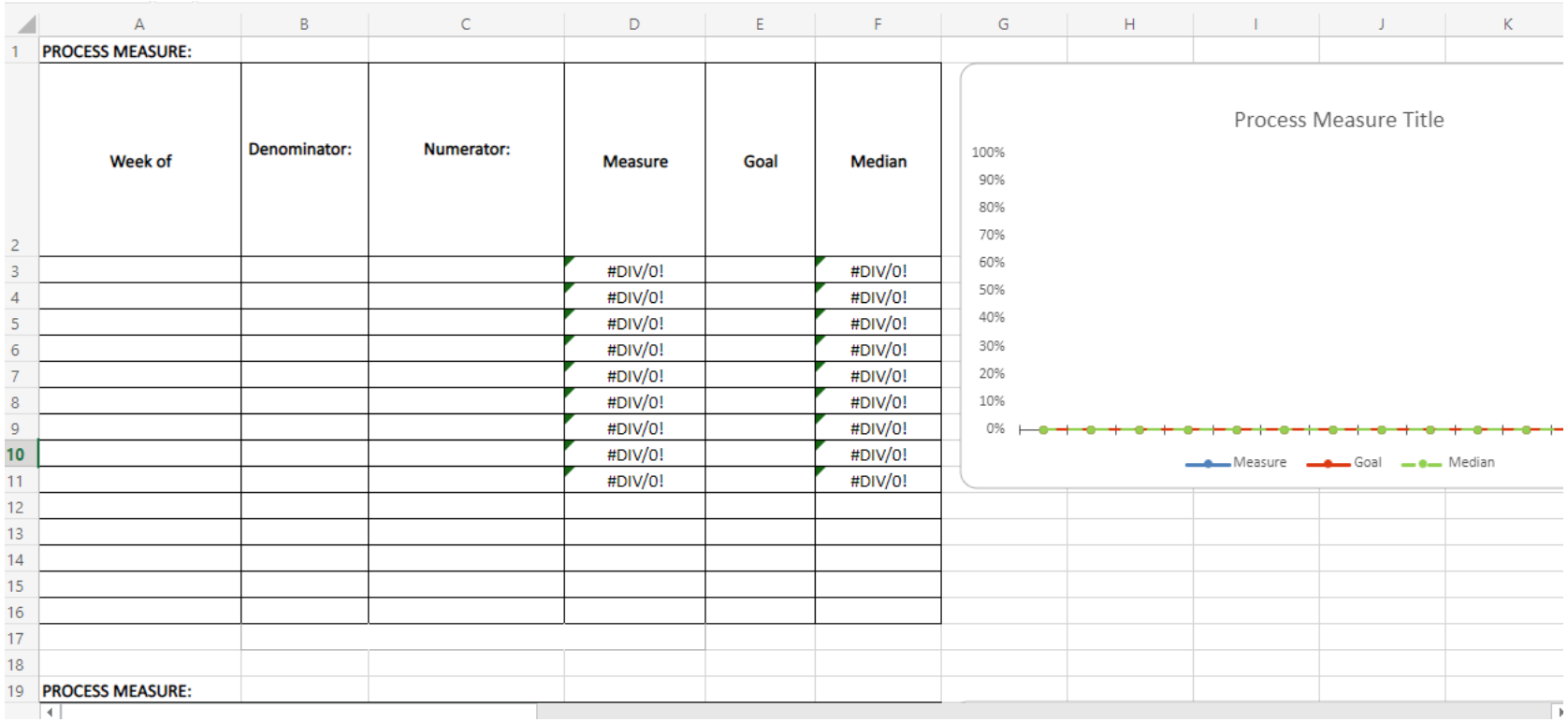
How should we document our measures?

Add to your storyboard

- New slides to indicate what you'll be measuring and add your data in the form of a run chart
- Select 1 outcome measure and 1-2 process measures
- Use the linked menu of measures for ideas/inspiration, or consult with your coach to determine measures
- Timeline is flexible based on the timing of your PDSA cycles
- Use the provided Excel sheet to create a run chart

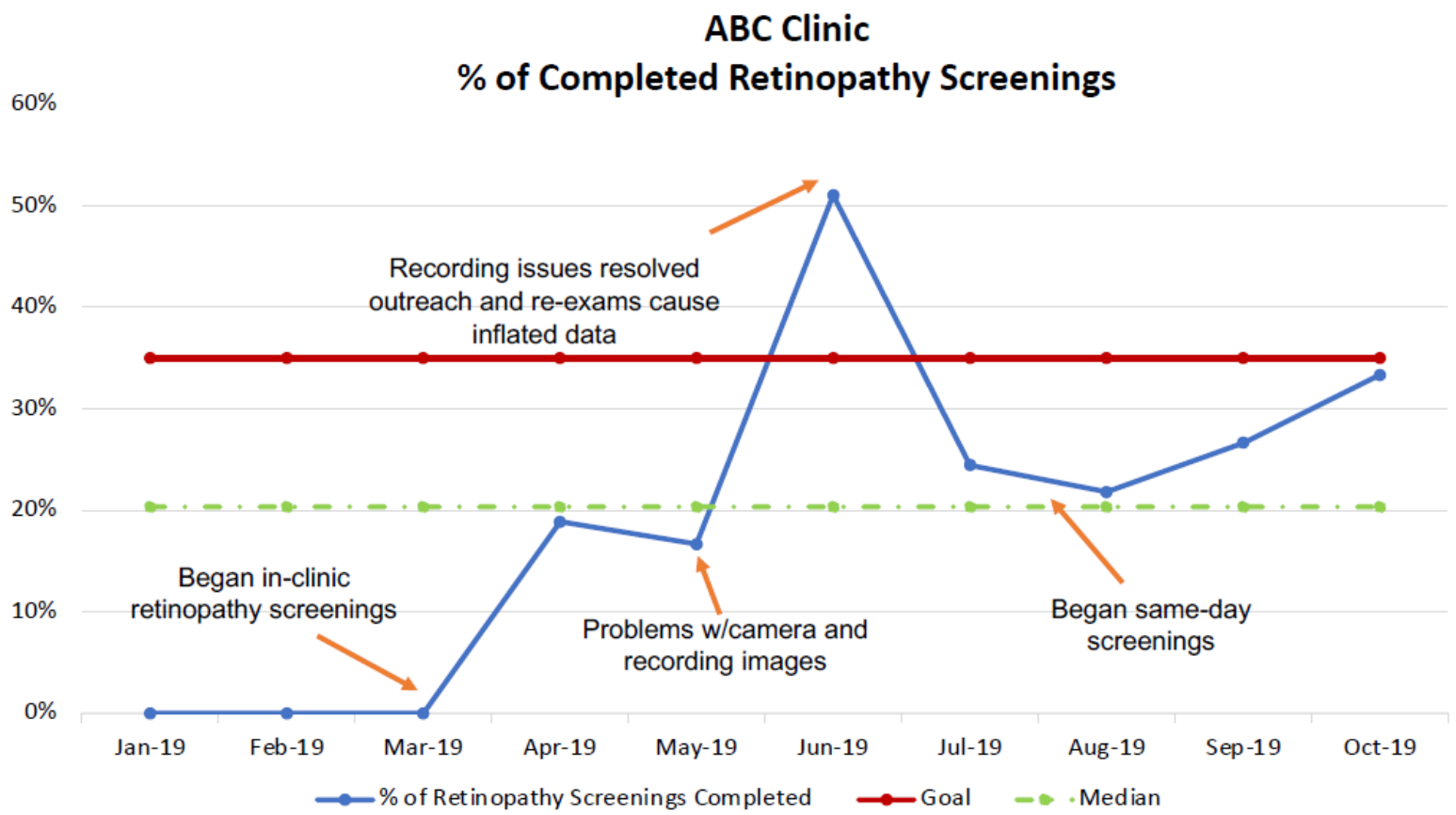
Using a run chart

- Makes performance of the process visible over time
  - Facilitates comparisons of the process before/after changes are made
  - Allows for monitoring of sustainability



	A	B	C	D	E	F
1	PROCESS MEASURE:					
2	Week of	Denominator:	Numerator:	Measure	Goal	Median
3				#DIV/0!		#DIV/0!
4				#DIV/0!		#DIV/0!
5				#DIV/0!		#DIV/0!
6				#DIV/0!		#DIV/0!
7				#DIV/0!		#DIV/0!
8				#DIV/0!		#DIV/0!
9				#DIV/0!		#DIV/0!
10				#DIV/0!		#DIV/0!
11				#DIV/0!		#DIV/0!
12						
13						
14						
15						
16						
17						
18						
19	PROCESS MEASURE:					

Example run chart



Project Measures & Data Metrics

How will you know your test has resulted in an improvement?

Outcome Measure: Select at least 1 outcome measure. *(This measure should be directly related to your AIM Statement.)*	<Add your selected outcome measure here.>
Process Measure: Select 1 – 2 process measures. *(These should reflect actions taken to move your outcome in the right direction.)*	<Add your selected process measures here.>

Need inspiration? Check out our menu of measures for various project types. This is not an exhaustive list, so please feel free to select measures that are not on this list.

Outcome Measure Run Chart

Paste a picture of your outcome measure run chart here.

Use the Run Chart Excel file to create this graph.

Menu of measures

- Measures are categorized by project type
- You can use measures from any category, depending on what makes sense for your project
- Categories include:
  - Remote patient monitoring
  - Increasing access/capacity for virtual care
  - Patient portal use
  - Device distribution (e.g., phones, data plans)
  - Telehealth kiosks
  - Mobile/street outreach
  - Text-based communication
- Menu focuses on process measures, since outcome measures are likely to come directly from your aim statement
- Work with your coach to figure out what makes sense for your project
- Some projects may use measures that aren't from this menu, depending on their focus

Patient Portal Use

Reach Measures

- Number/percentage of patients enrolled
- Number of secure messages sent to patients

Process Measures

- Number/percentage of active portal users
- Average number of business days responding to messages
- Number of lab results viewed
- Number of record downloads
- Number of prescription refill requests
- Number/percentage of unique patients sending secure message to provider

Outcome Measures

- Call center volume
- Average wait time on call

Remote patient monitoring

Reach Measures

- Number of patients referred to RPM
- Number/percentage of patients enrolled in RPM
- Number of monitors distributed
- Number of providers/RNs/LVNs trained in RPM

Process Measures

- Number/percentage patients who had a remote visit for BP reading + med titration
- Number/percentage of patients whose glucose readings were reviewed by provider

Outcome Measures

- Percentage of enrolled patients with BP at goal
- Percentage of enrolled patients with A1c at goal

Questions?

Center for Community Health and Evaluation
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Extra slides for reference: Menu of measures

Device distribution (e.g., phones, data plans)

Reach Measures

- Number of patients screened for device access
- Number of devices distributed/number of patients receiving device and/or data access

Process Measures

- Number/percentage of patients who used device to access an appointment
- Number/percentage of patients who used a device to access patient portal
- Number/percentage of patients who used device to communicate with care team

Increasing access/capacity for virtual care

Reach Measures

- Number of patients who received virtual visit training, education, outreach
- Number of unique patients who completed a virtual visit (within focus population)
- Number of virtual visits completed (within focus population)
- Number of phone visits completed (within focus population)
- Number of video visits completed (within focus population)

Mobile/street outreach

Reach Measures

- Number of unique patients who received outreach from mobile team including virtual visit offer
- Number of attempts by mobile team to connect patient to visit
- Number of patients trained on using device for telehealth appointment
- Number of providers/staff trained on facilitating telehealth visits for patients reached by mobile team

Process Measures

- Number of unique patients who received a visit via mobile team connection
- Number of completed visits via mobile team connection
- Number of same-day or real-time appointments accessed by patients reached by mobile team
- Number of same-day or real-time appointments available for patients reached by mobile team

Telehealth kiosks

Reach Measures

- Number/percentage of patients/residents who received outreach on kiosks
- Number of patients trained on use of kiosk
- Number of staff trained on use of kiosk
- Number of appointments completed via kiosk
- Number of unique patients seen via kiosk

Process Measures

- No-show rate for kiosk appointments
- No-show rate for patients who received appt reminders

Text-based communication

Reach Measures

- Number of appointment reminders sent
- Number of unique patients who received appt reminders

Process Measures

- Percentage of inbound patient texts that received a response
- Number of appt cancellations or reschedule requests received via text
- Number of inbound patient texts