Booster Webinar - Evaluation Update

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.)
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

#### Unique Patients, Organization-wide reporting

3. **Unique patients**
   - Total number of unique patients who completed one or more primary care visits using the advanced modality (e-clinic, phone, video) during the calendar month throughout the whole organization.

<table>
<thead>
<tr>
<th></th>
<th>Mar 21</th>
<th>Apr 21</th>
<th>May 21</th>
<th>Jun 21</th>
<th>Jul 21</th>
<th>Aug 21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic</td>
<td>1290</td>
<td>1270</td>
<td>25</td>
<td>1460</td>
<td>1200</td>
<td>50</td>
</tr>
<tr>
<td>Phase</td>
<td>1001</td>
<td>1001</td>
<td>50</td>
<td>1001</td>
<td>1053</td>
<td>57</td>
</tr>
</tbody>
</table>

#### Visits, Organization-wide reporting

5. **Organization-wide Visits**
   - Total number of completed primary care visits during the calendar month throughout the whole organization.

<table>
<thead>
<tr>
<th></th>
<th>Mar 21</th>
<th>Apr 21</th>
<th>May 21</th>
<th>Jun 21</th>
<th>Jul 21</th>
<th>Aug 21</th>
</tr>
</thead>
<tbody>
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<td>Clinic</td>
<td>1290</td>
<td>1270</td>
<td>25</td>
<td>1460</td>
<td>1200</td>
<td>50</td>
</tr>
<tr>
<td>Phase</td>
<td>1001</td>
<td>1001</td>
<td>50</td>
<td>1001</td>
<td>1053</td>
<td>57</td>
</tr>
</tbody>
</table>

#### Visits segmented by payer

6. **Visits segmented by payer**
   - Segmentation includes the whole organization.

<table>
<thead>
<tr>
<th>Payer</th>
<th>Mar 21</th>
<th>Apr 21</th>
<th>May 21</th>
<th>Jun 21</th>
<th>Jul 21</th>
<th>Aug 21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid (or CHN)</td>
<td>1200</td>
<td>1000</td>
<td>66</td>
<td>1500</td>
<td>920</td>
<td>10</td>
</tr>
<tr>
<td>Dual Eligible</td>
<td>1200</td>
<td>1000</td>
<td>66</td>
<td>1500</td>
<td>920</td>
<td>10</td>
</tr>
<tr>
<td>Medicare</td>
<td>267</td>
<td>123</td>
<td>13</td>
<td>217</td>
<td>320</td>
<td>12</td>
</tr>
<tr>
<td>Other Public Insurers</td>
<td>8</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Private/Commercial</td>
<td>125</td>
<td>151</td>
<td>1</td>
<td>125</td>
<td>152</td>
<td>0</td>
</tr>
<tr>
<td>Total (all segments)</td>
<td>1776</td>
<td>1422</td>
<td>40</td>
<td>1660</td>
<td>1067</td>
<td>54</td>
</tr>
</tbody>
</table>

#### Visits segmented by age

7. **Visits segmented by age**
   - Segmentation includes the whole organization.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Mar 21</th>
<th>Apr 21</th>
<th>May 21</th>
<th>Jun 21</th>
<th>Jul 21</th>
<th>Aug 21</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2</td>
<td>110</td>
<td>120</td>
<td>30</td>
<td>130</td>
<td>150</td>
<td>20</td>
</tr>
<tr>
<td>18-44</td>
<td>120</td>
<td>130</td>
<td>40</td>
<td>150</td>
<td>170</td>
<td>25</td>
</tr>
<tr>
<td>45-64</td>
<td>120</td>
<td>130</td>
<td>40</td>
<td>150</td>
<td>170</td>
<td>25</td>
</tr>
<tr>
<td>65 and Over</td>
<td>120</td>
<td>130</td>
<td>40</td>
<td>150</td>
<td>170</td>
<td>25</td>
</tr>
</tbody>
</table>

#### Visits segmented by language

8. **Visits segmented by language**
   - Segmentation includes the whole organization.

<table>
<thead>
<tr>
<th>Language Segment</th>
<th>Mar 21</th>
<th>Apr 21</th>
<th>May 21</th>
<th>Jun 21</th>
<th>Jul 21</th>
<th>Aug 21</th>
</tr>
</thead>
<tbody>
<tr>
<td>English Only</td>
<td>120</td>
<td>130</td>
<td>40</td>
<td>150</td>
<td>170</td>
<td>25</td>
</tr>
<tr>
<td>Other Language</td>
<td>120</td>
<td>130</td>
<td>40</td>
<td>150</td>
<td>170</td>
<td>25</td>
</tr>
<tr>
<td>Not Reported</td>
<td>120</td>
<td>130</td>
<td>40</td>
<td>150</td>
<td>170</td>
<td>25</td>
</tr>
</tbody>
</table>
### Virtual Care Innovation Network Data Collection Tool

**Primary Care**

#### 3. Unique Patients: Organization-wide reporting

<table>
<thead>
<tr>
<th>Mar-21</th>
<th>Apr-21</th>
<th>May-21</th>
<th>Jun-21</th>
<th>Jul-21</th>
<th>Aug-21</th>
</tr>
</thead>
<tbody>
<tr>
<td>A: Clinic</td>
<td>B: Phone</td>
<td>C: Video</td>
<td>A: Clinic</td>
<td>B: Phone</td>
<td>C: Video</td>
</tr>
<tr>
<td>1,212</td>
<td>1,213</td>
<td>13</td>
<td>1,440</td>
<td>1,282</td>
<td>59</td>
</tr>
</tbody>
</table>

#### 5. Organization-wide Visits

<table>
<thead>
<tr>
<th>Jan-21</th>
<th>Feb-21</th>
<th>Mar-21</th>
<th>Apr-21</th>
<th>May-21</th>
<th>Jun-21</th>
<th>Jul-21</th>
<th>Aug-21</th>
</tr>
</thead>
<tbody>
<tr>
<td>A: Clinic</td>
<td>B: Phone</td>
<td>C: Video</td>
<td>A: Clinic</td>
<td>B: Phone</td>
<td>C: Video</td>
<td>A: Clinic</td>
<td>B: Phone</td>
</tr>
<tr>
<td>1,670</td>
<td>1,648</td>
<td>21</td>
<td>1,560</td>
<td>1,540</td>
<td>70</td>
<td>1,515</td>
<td>1,512</td>
</tr>
</tbody>
</table>

#### 6. Visits segmented by payer

<table>
<thead>
<tr>
<th>Payer</th>
<th>Mar-21</th>
<th>Apr-21</th>
<th>May-21</th>
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</table>

#### 7. Visits segmented by age

<table>
<thead>
<tr>
<th>Age Group</th>
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<th>May-21</th>
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<td>1,560</td>
<td>1,540</td>
<td>70</td>
<td>1,515</td>
</tr>
</tbody>
</table>

#### 8. Visits segmented by language

<table>
<thead>
<tr>
<th>Language</th>
<th>Mar-21</th>
<th>Apr-21</th>
<th>May-21</th>
<th>Jun-21</th>
<th>Jul-21</th>
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<td>A: Clinic</td>
<td>B: Phone</td>
<td>C: Video</td>
<td>A: Clinic</td>
</tr>
<tr>
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<td>1,648</td>
<td>21</td>
<td>1,560</td>
<td>1,540</td>
<td>70</td>
<td>1,515</td>
</tr>
</tbody>
</table>

**Complete by June 15, 2021**

- **A:** Clinic
- **B:** Phone
- **C:** Video
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

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

ABC Clinic
% of Completed Retinopathy Screenings

- Recording issues resolved
- Outreach and re-exams cause inflated data
- Began in-clinic retinopathy screenings
- Problems w/camera and recording images
- Began same-day screenings

% of Retinopathy Screenings Completed
Goal
Median
**Project Measures & Data Metrics**

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

<table>
<thead>
<tr>
<th>Outcome Measure:</th>
<th>&lt;Add your selected outcome measure here.&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select at least 1 outcome measure. <em>(This measure should be directly related to your AIM Statement.)</em></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Process Measure:</th>
<th>&lt;Add your selected process measures here.&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select 1 – 2 process measures. <em>(These should reflect actions taken to move your outcome in the right direction.)</em></td>
<td></td>
</tr>
</tbody>
</table>

**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/LVNsts 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
Natasha Arora, Natasha.B.Arora@kp.org
Maggie Jones, Maggie.E.Jones@kp.org
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