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| <p><b>21. APLA Health and Wellness: Data Acquisition with Innovacer</b></p> <p>Note Taker: Warria Esmond</p> <p>Conversation Highlights:</p> <ul style="list-style-type: none"> <li>• Journey to implement discussed - conversations with EMR vendor, etc.</li> <li>• Needed to create internal database to allow for data exchange with Innovacer</li> <li>• Evaluating ROI and sustainability factors across the organization - fiscal, operations, quality</li> <li>• Many measures to validate - time consuming</li> <li>• Data for RHs not included in data acquisition</li> <li>• "Would consider evaluation of other PCH programs - benefits and challenges"</li> <li>• Tools and Resources Shared:</li> <li>•</li> </ul> <p>Key Takeaways:</p> <ul style="list-style-type: none"> <li>• Challenges with duplicate charts/mismatched specs</li> <li>• Importance of EHR data quality to support reliable reporting</li> <li>• Health plan relationships key to success in PHM - MCO data access or breaks the value of the system</li> </ul> | <p><b>22. Northeast Valley Health Corporation: Spreading Improvements through Practice Improvement Teams (PITs)</b></p> <p>Note Taker: Chelsi Schriver</p> <p>Conversation Highlights:</p> <ul style="list-style-type: none"> <li>• Started PITs in 2009 to improve care for diabetic patients to bend or implement change at practice levels</li> <li>• Started PITs in 3 question assessment</li> <li>• "AD members from all different levels</li> <li>• Evaluating ROI and sustainability factors across the organization - fiscal, operations, quality</li> <li>• "Many measures to validate - time consuming</li> <li>• Data for RHs not included in data acquisition</li> <li>• "Would consider evaluation of other PCH programs - benefits and challenges"</li> <li>• Tools and Resources Shared:</li> <li>•</li> </ul> <p>Key Takeaways:</p> <ul style="list-style-type: none"> <li>• Challenges with duplicate charts/mismatched specs</li> <li>• Importance of EHR data quality to support reliable reporting</li> <li>• Health plan relationships key to success in PHM - MCO data access or breaks the value of the system</li> </ul> | <p><b>23. Onni Family Health: Creating a Reliable Chart Outgoing System to Better Prepare for the Visit</b></p> <p>Note Taker: Fiona Donato</p> <p>Conversation Highlights:</p> <ul style="list-style-type: none"> <li>• Onni has 38 clinics, service Bakerfield and surrounding areas</li> <li>• One clinic site, Birimball has been the focus of PHM work</li> <li>• Deania Piliadis is lead provider at Birimball and leadership, line staff, front of house, MA, LVNs, administrators, etc.) - allows change to come from ground up; to identify problems and address change at all levels</li> <li>• "Ideas may not always be implemented, but everyone is always heard and empowered to speak up"</li> <li>• Important to establish ongoing process and process between PIT team and everybody else</li> <li>• Important to establish communications process between PIT team and everybody else</li> <li>• "Coaches have a role to assess status, track feedback, facilitate, change process and connect resources"</li> <li>• Health plan relationships key to success in PHM - MCO data access or breaks the value of the system</li> </ul> <p>Tools and Resources Shared:</p> <ul style="list-style-type: none"> <li>• Presentation packet with highlights and historical context of PIT process (Debbie to email to Claire)</li> </ul> <p>Key Takeaways:</p> <ul style="list-style-type: none"> <li>• enablers confidence for team members to speak up - everyone has a voice to contribute and respect is established</li> <li>• Clinical administrators help with accountability with PIT and QA, sharing best practices</li> <li>• PHM practices team is different</li> <li>• "Many measures and data helped to identify QI ops</li> <li>• There is a Clinical Performance Improvement Program that has demonstrated goals being met and improved</li> <li>• A lot of this QI work, including the sharing of interventions has aligned with PHM</li> <li>• Goal: best practices to be institutionalized at every site</li> </ul> | <p><b>24. UMMA: Colgaurd Implementation at UMMA</b></p> <p>Note Taker: Maggie Jones</p> <p>Conversation Highlights:</p> <ul style="list-style-type: none"> <li>• Transitioned fully from IT to Colgaurd recently. Have decided to provide them full patient lists and surrounding area</li> <li>• "Mammogram bus, gft card"</li> <li>• "Mammogram bus (Alma) - low no show with planning, successful flow with pre-filled forms and packets for screening"</li> <li>• "Another health clinic shared that they had all the help services (WV, CPOF etc.) at their events and included them in the packages for the event which was helpful in implementing sharing w/ patients"</li> <li>• "Paps went from 44% to 52% screening rate"</li> <li>• "Left over gft cards given to staff who worked the events. Not planned but nice incentive for staff participation."</li> <li>• Mammograms did not meet partnership QPI 48% to 53%</li> <li>• Many women who got screening were 40-50 and was not at that time. Now it is.</li> <li>• Also discussed Coln CA screening methods</li> <li>• Colgaurd helped with mailing for patients, on site testing. Other centers verified staff returning to clinic and having clinic mail out helpful.</li> <li>• Using standing orders for mammom and colon ca screening</li> </ul> <p>Tools and Resources Shared:</p> <ul style="list-style-type: none"> <li>• Colgaurd CA screening was a good partner to work through the implementation process</li> </ul> <p>Key Takeaways:</p> <ul style="list-style-type: none"> <li>• Colgaurd benefits: they handle outreach and follow up with helps with staff capacity; test is only every three years; they are directly connected with Medi-Cal and will take referrals for gpts who are uninsured</li> <li>• Appreciation remains very useful</li> <li>• They will be able to navigate the needs of different segments of the population &amp; provide the extra support patients will need</li> <li>• Implementation overall has been very smooth</li> </ul> | <p><b>25. Long Valley Health Center: Women's Reliable Chart Outgoing System - Successful Practice, Lessons Learned and Benefits</b></p> <p>Note Taker: Lyn Yatsura</p> <p>Conversation Highlights:</p> <ul style="list-style-type: none"> <li>• "Discussed incentives for paps, sneak a paps"</li> <li>• "Discussed women's health clinics including children, transport, measures, gft card"</li> <li>• "Mammogram bus (Alma) - low no show with planning, successful flow with pre-filled forms and packets for screening"</li> <li>• "Another health clinic shared that they had all the help services (WV, CPOF etc.) at their events and included them in the packages for the event which was helpful in implementing sharing w/ patients"</li> <li>• "Paps went from 44% to 52% screening rate"</li> <li>• "Left over gft cards given to staff who worked the events. 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Eisner Health Center: Using Data to Plan and Evaluate a Change: Colorectal Cancer Screening and Ethnic Disparities</b></p> <p>Note Taker: Rosa Do</p> <p>Conversation Highlights:</p> <ul style="list-style-type: none"> <li>• Identified from data that non-Hispanic groups were struggling compared to other groups (in particular AF, Asian, Asian Am.)</li> <li>• Used data to target groups and instead using "broader". Simple words for "cancer" and also simple steps to complete the screening.</li> <li>• Case manager makes calls to the patients to explain things more.</li> <li>• Have multiple contact points, from multiple staff people (patients then feel cared about, you can get on good days, have pictures, videos, and words to explain the screening. A lot of patients have also done this in the life. The visit is also simpler these days. Some patients do some day of their visit at the clinic.</li> <li>• Follow-up through text, video link, call, in-person</li> <li>• Many touchpoints in the lab when patients have appointments</li> <li>• The change itself was really simple, so multiple team members took on specific and clear roles to make this work</li> <li>• Their screening numbers went from 40% to 60% with a peak of 80%</li> <li>• 10K patients answered 7 providers, were 150 visits through this multi-disciplinary engagement. 5-person team: case manager, MA, provider, lab technician (and 5th person might be a QI person)</li> <li>• It's a data driven</li> <li>• Loop starts and ends with the provider to create closed loops; it doesn't end with a random and open; provider opens the note in EHR, and the only person who can close the note is the provider</li> <li>• Brainstorming with a peer from Sonoma to apply this process to behavioral health: PFI of how I had a patient w/ a positive phob score, and the provider and case manager get them into behavioral health by same day signing them in, then case manager follows up, then case manager follow up, then case manager follow up, then outreach</li> <li>• Identify other social needs (PRAPEs) to better understand and address root causes</li> </ul> <p>Tools and Resources Shared:</p> <ul style="list-style-type: none"> <li>• "Women's health passport"</li> <li>• Other clinics also discussed OB passport. For event had passports</li> </ul> <p>Key Takeaways:</p> <ul style="list-style-type: none"> <li>• Planned events with children and transport and presence of wrap services were very useful</li> <li>• Outreach before events helpful</li> <li>• Incentives from QPI budgets helpful</li> </ul> | <p><b>27. San Fernando Community Health Center: Focusing on Understanding Patient Education Materials</b></p> <p>Note Taker: Kristine Cristobal</p> <p>Conversation Highlights:</p> <ul style="list-style-type: none"> <li>• "Make the information for patients very very simple. Don't use "color" and instead using "broader". Simple words for "cancer" and also simple steps to complete the screening."</li> <li>• Case manager makes calls to the patients to explain things more.</li> <li>• Have multiple contact points, from multiple staff people (patients then feel cared about, you can get on good days, have pictures, videos, and words to explain the screening. A lot of patients have also done this in the life. The visit is also simpler these days. Some patients do some day of their visit at the clinic.</li> <li>• Follow-up through text, video link, call, in-person</li> <li>• Many touchpoints in the lab when patients have appointments</li> <li>• The change itself was really simple, so multiple team members took on specific and clear roles to make this work</li> <li>• Their screening numbers went from 40% to 60% with a peak of 80%</li> <li>• 10K patients answered 7 providers, were 150 visits through this multi-disciplinary engagement. 5-person team: case manager, MA, provider, lab technician (and 5th person might be a QI person)</li> <li>• It's a data driven</li> <li>• Loop starts and ends with the provider to create closed loops; it doesn't end with a random and open; provider opens the note in EHR, and the only person who can close the note is the provider</li> <li>• Brainstorming with a peer from Sonoma to apply this process to behavioral health: PFI of how I had a patient w/ a positive phob score, and the provider and case manager get them into behavioral health by same day signing them in, then case manager follows up, then case manager follow up, then case manager follow up, then outreach</li> <li>• Identify other social needs (PRAPEs) to better understand and address root causes</li> </ul> <p>Tools and Resources Shared:</p> <ul style="list-style-type: none"> <li>• "Women's health passport"</li> <li>• Other clinics also discussed OB passport. 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Colgaurd has a very brief return window, so patients may not get the test back in time, and the system requires a careful and accurate Care Gap report</li> </ul> <p>Resource at Exact Science: Any Larsen. If questions, contact Alfred McGough at Sonoma Health.</p> | <p><b>29. Redwoods Rural Health Center: Sustaining Improvement Levels Across EHR and Provider Transitions</b></p> <p>Note Taker: Scott Bergqvist</p> <p>Conversation Highlights:</p> <ul style="list-style-type: none"> <li>• "Developed a process with monthly reports to identify patients that have not been seen for a long time (inactive patients), and used this report to inform pre-active outreach to patients and ensure assignment to providers. They managed major care transitions without any impact on the number of empanelled patients, but now there has been a change from NextGen to Epic. It has made major challenges. Patients get empanelled with a different clinic"</li> <li>• "PHM impact is very high 77%. They must do extensive scrubbing. The monthly report of inactive patients they get from OCHIN is 49 pages long. OCHIN Epic also assigned patients to a different clinic, not part of Redwood rural. A clinic they linked to the local hospital and already was on OCHIN Epic. MCOs are also assigning on their own so providers get discharge summary for patients that a PCH has never seen."</li> <li>• "PHM is also struggling with assignments. They brought in an implementation manager as a result of PHM and this person is the ops department. They used to have many that were only own's health clinic people. Data sure they were in their own books so there was not an inflated paper. They are paying attention to how some of the children that grow older and have fewer visits. Exc</li></ul> |
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