SNMHI Summit 2011

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Improving Patient Experience

High Plains Community Health Center

Emily Minor, Prevention and Chronic Care Team, Health Educator Jay Brooke, Executive Director

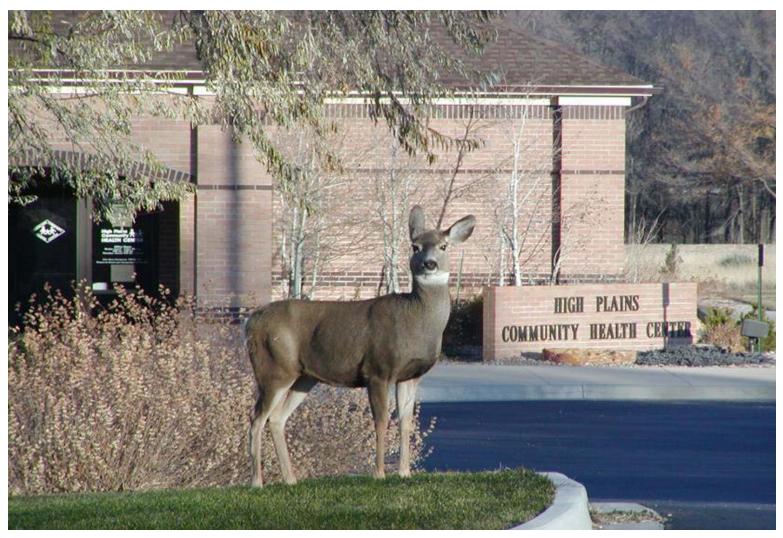
> Session 2C March 7, 3:45PM-5:00PM





MacColl Institute at Group Health Cooperative

HIGH PLAINS CHC...



About High Plains

- FQHC in Lamar, Colorado
- Rural site on Eastern Plains of Colorado
- 28,415 patient visits in 2010
- High percentage of patients with diabetes (12%), hypertension (19%) and asthma (8%).
- 33 % of patients are uninsured
- 33 % of patients carry private insurance
- 20 % of patients have Medicaid
- Contract with VA to provide primary care for veterans in the area
- NCQA Level 3 Recognized February 2011

Improving Patient Experience

Patient-Centered Access

CAHPS Survey

Preventive Care Team

Patient-Centered Access

- Appointments were booked ahead of time
 - Patients with acute care needs did not have timely access
- The plan for making the change
 - Implementing same day appointments
 - Assigning patients to provider team panels
- Same day appointments were achieved by blocking at least 60% of all appointments until day of
- Panels assignment was done by utilizing the four cut method of assignment
- Health Coaches assigned to provider teams
- Added evening and Saturday clinics

Patient Access, Results

- Provider team panels have been assigned
 - Provider teams are taking varying levels of responsibility
 - Provider teams are able to be much more proactive with their patients
 - Provider teams are more familiar with their patients
- Most patients are able to get same day access
 - No show rates have decreased greatly
 - Health outcomes have steadily improved

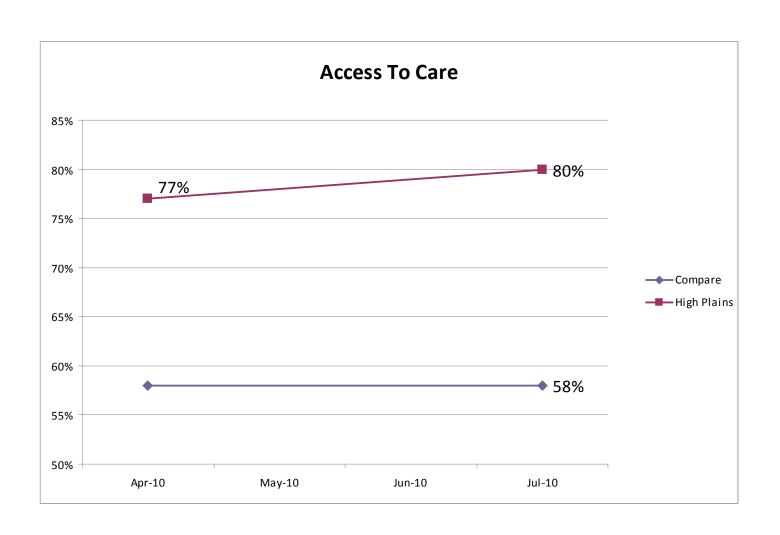
CAHPS Surveys

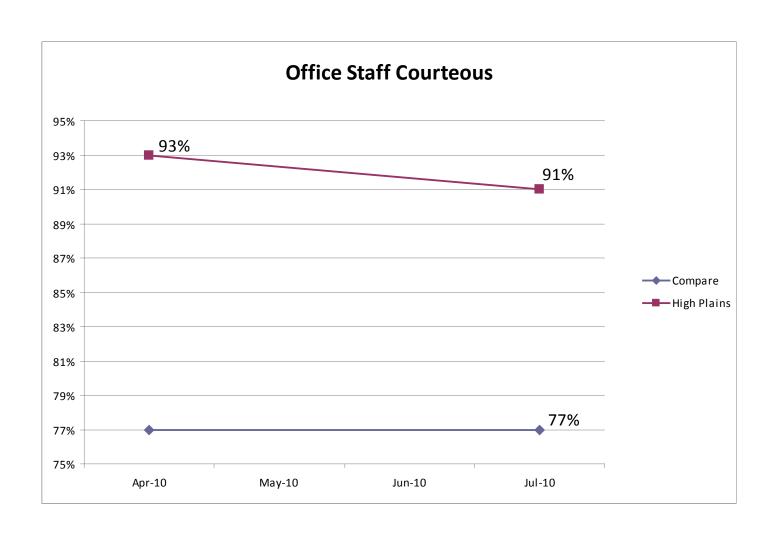
- History of doing patient satisfaction surveys
- 2010 used CAHPS surveys to collect better information and respond to what our patients were saying
- Medical home committee
 - Reviewed the instrument we had been using & considered alternatives
 - Ran PDSA's to test
 - Collected the data from patients, analyzed the data and implemented changes based on the analysis
 - Customized the CAHPS survey instrument

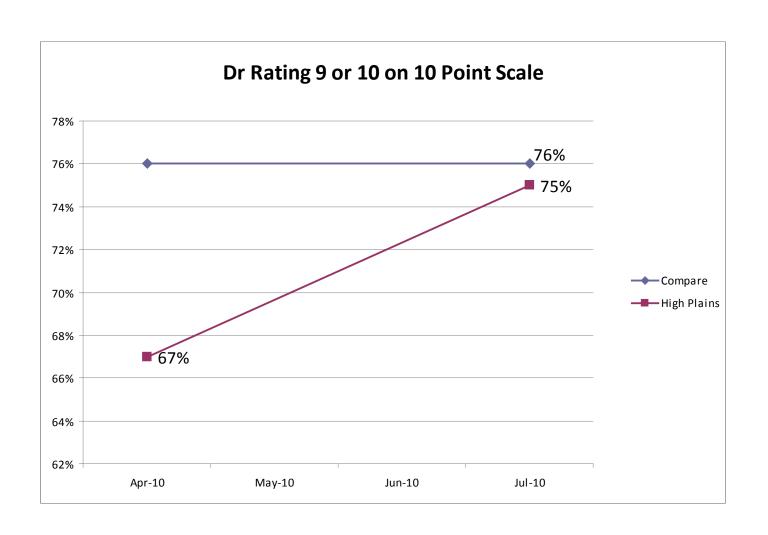
CAHPS Results

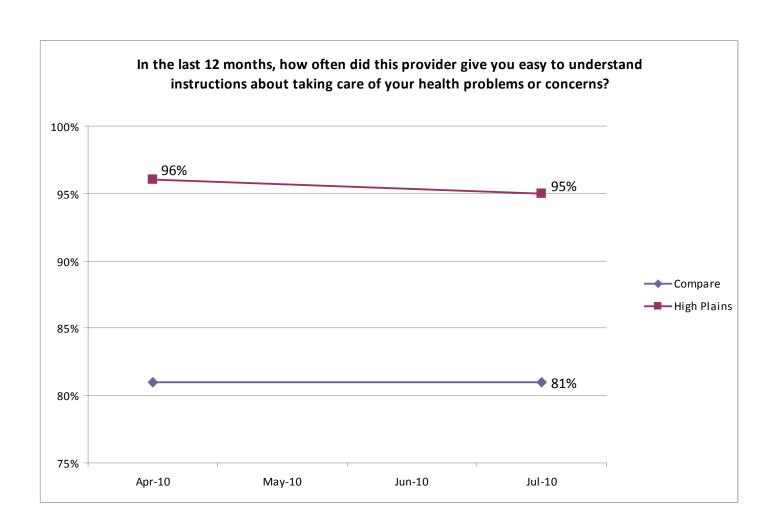
 Processing the CAHPS surveys and implementing changes is a work in progress

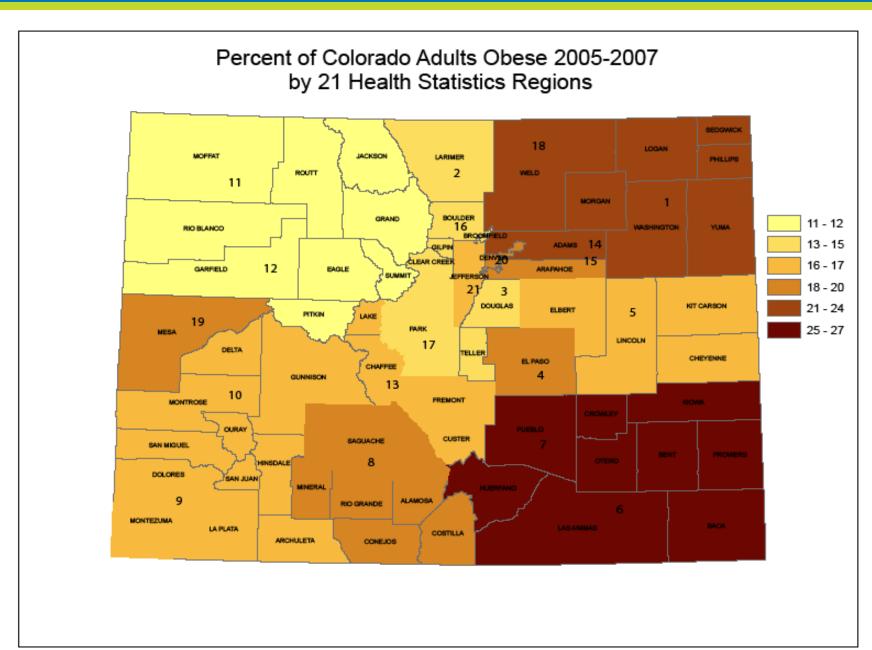
- Feedback given by provider team
- Significantly better patient satisfaction than national average data



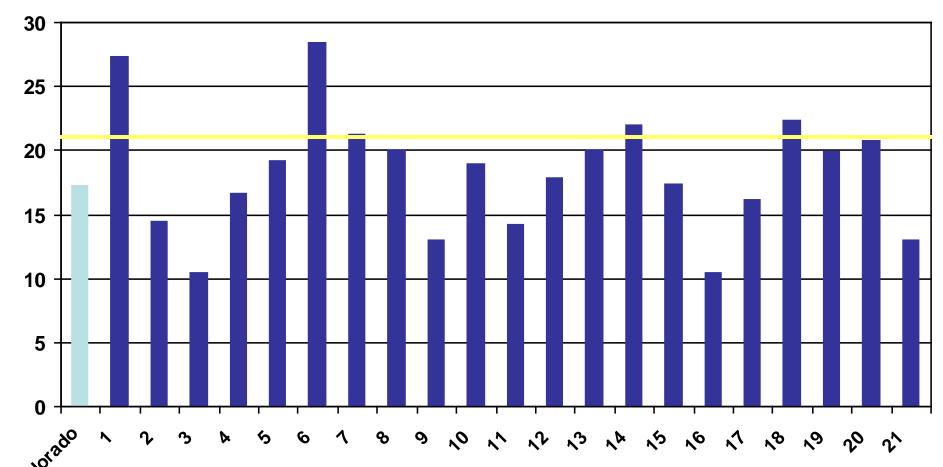






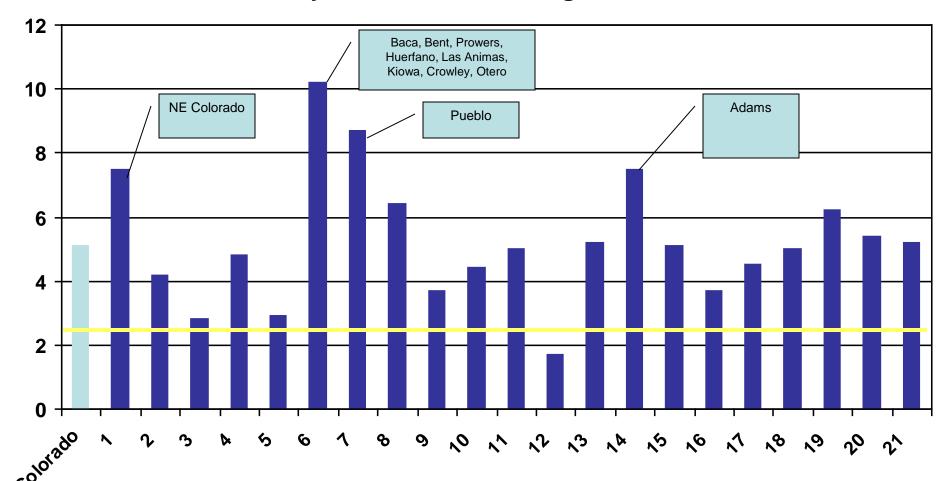


Percent of Colorado adults who are physically inactive, 2005-2007 by Health Statistics Regions



Source: Colorado Behavioral Risk Factor Surveillance System, Health Statistics Section, CDPHE

Percent of Colorado adults with diagnosed diabetes, 2005-2007 by Health Statistics Regions



Source: Colorado Behavioral Risk Factor Surveillance System, Health Statistics Section, CDPHE

HIGH PLAINS COMMUNITY HEALTH CENTER PREVENTIVE CARE TEAM

COMMUNITY HEALTH WORKFR

EXTERNAL HEART WELLNESS SCREENS. HEALTHIER LIVING COLORADO

HISPANIC HEALTH COACH INTERNAL **SELF MGMT. HEALTHIER. MORE ACTIVE LIVING &** TOMANDO CONTROL

HEALTH COACH INTERNAL/EXTERNAL **SELF MGMT. ACTIVE** LIVING, SILVER SNEAKERS **HEALTHIER LIVING COLORADO CLASS**

HEALTH EDUCATOR

INTERNAL/EXTERNAL TEAM LEAD **SELF-MANAGEMENT, DIABETES** CLASSES, NUTRITION CLASSES, **BMI'S, COMMUNITY EVENTS**

WOMENS WELLNESS CASE MGR INTERNAL/EXTERNAL

FREE PAPS & MAMMOS

IMMUNIZATION COORDINATOR INTERNAL/EXTERNAL

COLORECTAL PT NAVIGATOR INTERNAL **CHILDHOOD IZ MGMT** FREE COLONOSCOPY

HEALTH COACH INTERNAL/EXTERNAL **SELF MGMT. HEALTHIER ACTIVE LIVING, BEST BUYS** LISTS, SOCIAL MEDIA

DIABETES EDUCATOR

INTERNAL/EXTERNAL FREE CERTIFIED DIABETES **EDUCATION, INSULIN PUMP EDUCATION**

PATIENT NAVIGATOR

INTERNAL PLANNED CARE FOR BLOOD PRESSURE, LDL GOALS, FLU, IZ, CASE MANAGEMENT, HBA1C'S

> **HEALTH DISPARITIES** COORDINATOR INTERNAL/EXTERNAL **COMMUNITY FACILITATOR** FOR HEALTH DISPARITIES. & HISPANIC HEALTH COACH

SBIRT SCREENER

INTERNAL TOBACCCO, DRUGS, **ALCOHOL SCREEN, BRIEF INTERVENTION AND** REFERRAL

Preventive Care Team

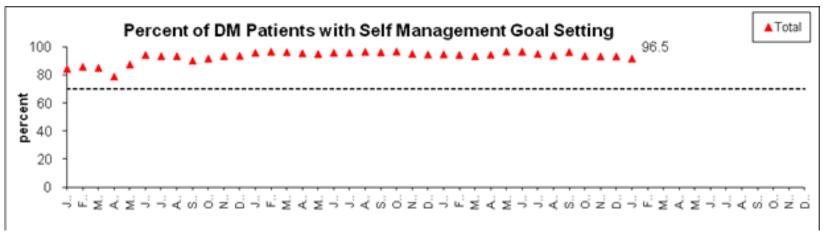
- Why a preventive care team?
 - Fits with Medical Home Model
 - Enhancing the Patient Experience
 - Improving Health
 - Time

Preventive Care Team

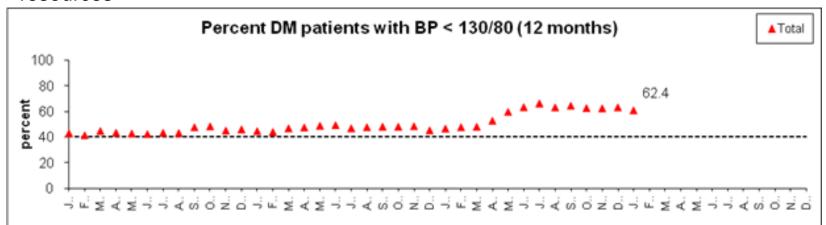
- Game Plan:
 - Motivational Interviewing
 - Patient-Centered
 - Experts on Resources
 - Incorporate into routine care
- The POWER of an Open-Ended Question!

Why Health Coaches??

We have always had great self management goal setting



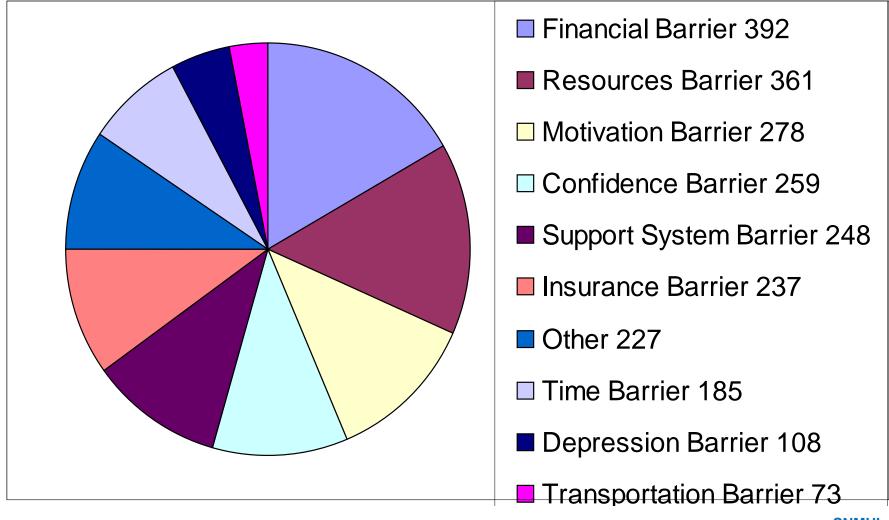
 But now we have better control because there are meaningful conversations and many more resources



Role of A Health Coach

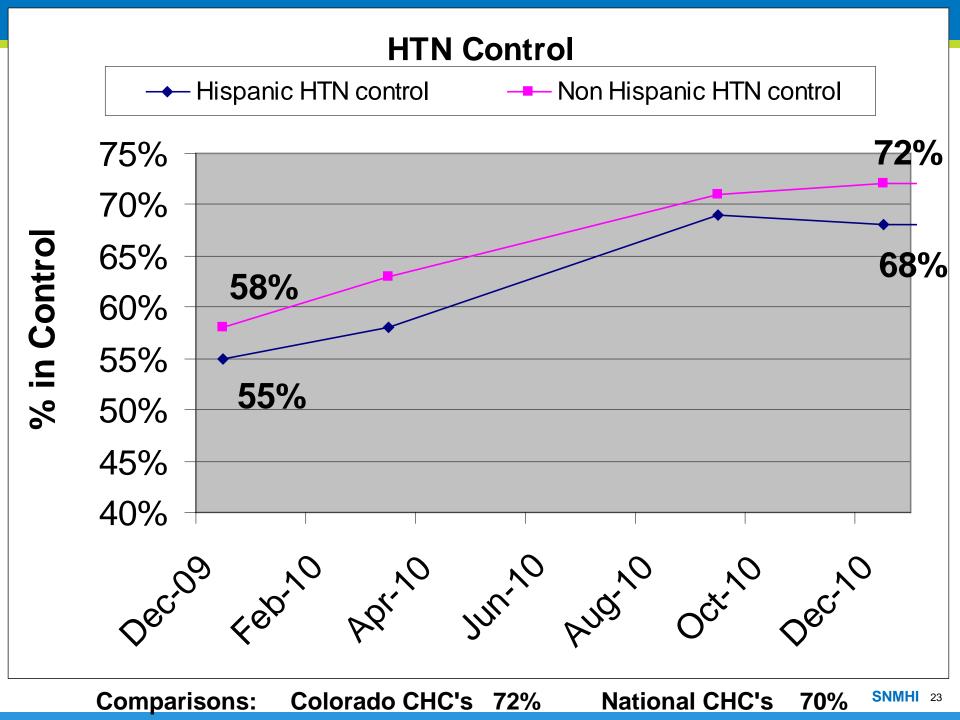
- Collaborate to set Self-Management Goal
- Create action plan
- Assess barriers
- Connect to clinic and community resources
- Support change: follow-up
- Provide patient education and skill building

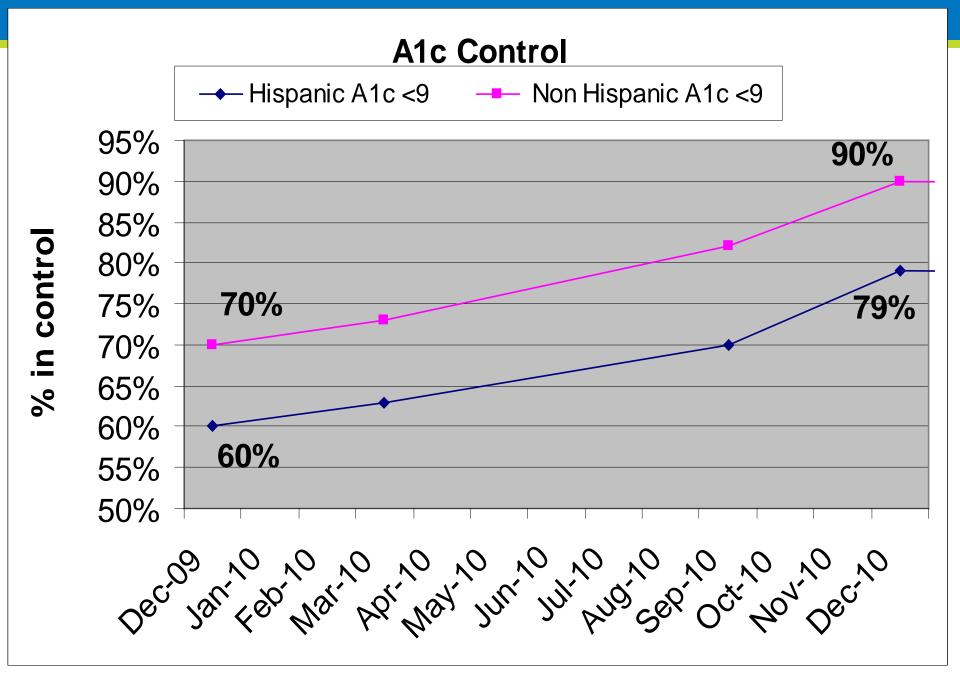
Barriers

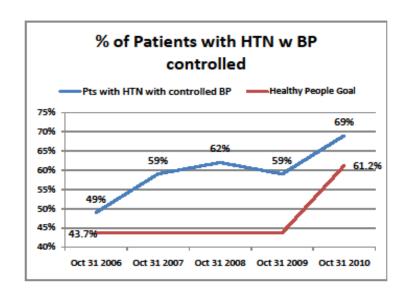


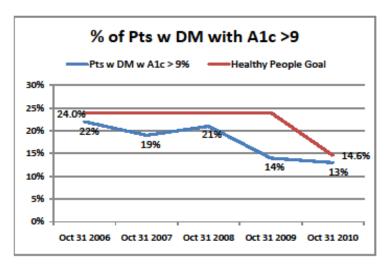
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SM GOAL BRIEF EDUCATION CLASSES/REF	ERRALS PLAN, F/U AND SIG PHQ9	<u>O</u> utline View				
Diabetes Class	Saturday Stroll		Go Lean Lamar Suppor		Provider Appointment	
Thurs Mar 3rd 10th 5:45-7:30 Part 1-What Is Diabetes and How to Care For It by Mary Shy,	LCC Fitness Center LCC Voucher		Health Coach Hispanic Health Coach		Other: FREE TEXT	
Certified Diabetes Educator. Part 2-How to Eat Right for Diabetes by Emily Montoya, Registered Dietitian.	Community Bldg Workouts		Culturally compentent assi	istance for Spanish speaking	Dentist / Dental Care	
Nutrition Class	Community Building Punch Card		patients- help with SM goal barriers to better health		A healthy mouth is import overall health. Some chri	
Hearty Eating, Feb 24th, 6-7:30 pm. SPANISH CLASS AT SAME TIME	HC Publications Fitness Video/DVD Library		Patient Navigator Kacee Lucero, Heart Sma	∑ art Patient Navagator, helps	diseases cause poor der health and poor dental h	ealth
Healthier Living Colorado Classes FREE 6 wk class. Get help withchallenge of living	Recreation Library		patients over come barrier with making appointments	rs to medical care, assists s, paying for medications, and	contributes to some chro diseases. See a dentist regularly	onic
with an ongoing conditions: heart disease, lung disease, diabetes, or arthritis. Helps patients cope	In Balance (Fall Prevention Class) FREE 8 week class Jan 10-Mar 2. To teach	Seniors	finding resources for patie Prowers Co Community			11
with fatigue, frustration, pain, and stress. Tomando Control Classes	about preventing falls and strengthing their o	core.	CERT: Amy Hobbs, Project	ct Coordinator, will help		- 1
FREE SPANISH 6 wk class Jan 11-Feb 15. 5:30-8	Cooking Matters- 6 wk class FREE healthy, budget-friendly cooking class	<u> </u>	families with info about ser referrals, advocacy, case problem-solving.		ADULT GENERAL	
pm. Get help with the challenges of living with an ongoing condition like heart disease, lung disease, diabetes, or arthritis. Helps patients cope with	Attendees recieve free groceries each week Tobacco Cessation	(M	Outreach Department	<u> </u>		
fatigue, frustration, pain, and stress.	Freshstart Cessation Workshop Jan11-Feb1		Becky, Maura Reyna enr assistance programs: CICF	oll eligible patients into		
Silver Sneakers Tues and Thurs 9-10 am LCC Fitness Center.	SBIRT Health Educator Meet one on one with Lisa Thomas, SBIRT	Health	Women's Wellness Conne OB programs.	ection, Medicaid, CHP+, and		
Muscular strength, range of motion, activity for daily living skills, hand held weights, elastic tubing	Educator, to learn healthy levels of alcohol unduration about substance use risk to health	use,	Compassionate Drug F	Program 🛛 🗖		
with handles, resistance ball. A chair is used for seated and/or standing support. \$37.12 /4 mos. FREE w Mcare + AARP, Humana, Secure	necessary, referral to treatment.		Pharmacutical companies programs for patients who	cannot afford their		
Horizions Community Health Worker	Registered Dietitian Meet one on one with Emily Montoya, RD, to	o learn how	medications. See Rome in Mental Health	n our dispensary. 📉 🗖		v
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Encounter Health Educator Form



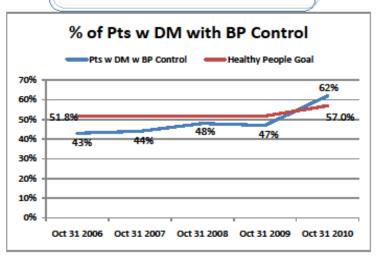








The RED line denotes the HP2010 goal thru 2009 and goes up in 2010 to the new goal for HP2020



Lessons Learned

- The patient has to come first; systems have to be in place to support this
 - When patients are given support from providers and care teams, they can make changes and improve their health
 - Care teams engaging patients will improve health outcomes
 - Medical care only does not move the metrics
- The transition to same day appointments and panels is a major change
- Leadership commitment, provider support and consistency in implementing the changes
- There will be resistance

Recommendations to Other Sites

Find a way to fund these important services

- Demonstrate the value to everyone
- Employ people-oriented, enthusiastic staff to do the job

Next Steps

- Patient portal which will create additional access to provider teams for scheduling, ordering scripts and asking questions
- Embedding health educators and health coaches further in the provider teams
 - Increase number of health educators and coaches so they have smaller patient panels to engage
- Figure out how to maintain prevention team in face of federal and state budget cuts until there is some sort of payment reform to support medical homes

Questions?







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