Spreading Solutions That Work

Informational Webinar

11/17/17

Welcome

CCI Program Team

Jaclyn Lau
Program Coordinator

Jennifer Wright
Program Manager

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Housekeeping

❖ **Webinar is being recorded and will be emailed with slides**
❖ **Line is muted**
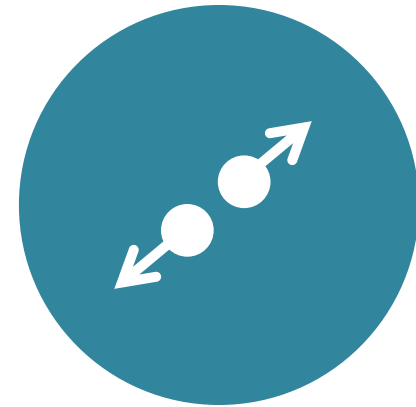❖ **Use chat box for questions**

Setting the Context

SPARK   SEED   SPREAD

Spreading Solutions That Work

CCI
CENTER FOR CARE INNOVATIONS

In partnership with Blue Shield of California Foundation, CCI will support the spread and implementation of five successful solutions:

- ❖ Patient Portal Optimization
- ❖ Medical Scribes
- ❖ Group Visits
- ❖ Telephone Visits
- ❖ Texting Solutions

Patient Portal Optimization

> ➤ Dedicate a year to focusing intensely on improving use of patient portal functionalities by a broader group of patients

Benefits:

- Increased patient interaction with their health information, such as appointments, labs, medication lists, etc.
- Ability for patients and providers to communicate with each other outside the office visit
- Increase patient and staff satisfaction
- More timely response to address the needs of patient populations

Commitments:

- Focus at least 6 months of the project on a targeted provider and patient use
- Commit to increasing enrollment, use and functionality of the portal
- Report metrics on portal enrollment, use, and satisfaction
- Participate in 3.5 hour on-site strategic planning workshop

Medical Scribes

> ➤ **Working in partnership with providers, the scribes record exam findings and care plans in the EHR system.**
>
> ➤ **Use scribes to reduce the burden of the EHR on providers and provide additional benefits to the provider and patient.**

Benefits:

- Increase provider satisfaction and retention
- Reduce documentation burden on providers via EHR
- Improve quality of clinical documentation in health records
- Reduce interference with face-to-face patient care

Commitments:

- Determine staffing model for the scribes
- Have scribe(s) and scribe trainer(s) available for 3-day in-person training
- Develop new workflows and role responsibilities
- Leadership and staff buy-in to develop new role and adapt workflow

Group Visits

> **Leverage the power of peer support to provide better education, support and care for specific patient populations**
> **Target patients with chronic conditions, such as diabetes or chronic pain**

Benefits:
- Increase access for patients
- Maximize provider or nurse's time
- Increase time for in-depth teaching
- Provide social support
- Increase patient and provider satisfaction

Commitments:
- Learn and practice new facilitation skills to deliver care in a group setting
- Develop new scheduling models and workflows
- Communicate availability and benefits of groups to patients and staff
- Create education materials for group visits
- Have provider(s) available for 2-day in-person training in CO

Telephone Visits

> **Provide an alternative to face-to-face visits for patients via clinical exchanges over telephone**
>
> **Discuss laboratory/diagnostic test results, medication management, management of chronic conditions, health education, preventive care, etc.**

Benefits:

- Improve patient access
- See more patients in a timely manner
- Increase provider and patient satisfaction
- Prepare your organization for value-based care

Commitments:

- Create new workflows and scheduling
- Engage pilot providers
- Buy-in from staff and leadership to sustain new visit model

Texting Solutions

> **Use for specific needs such as appointment reminders, chronic disease self-management, closing the loop on specialty referrals**

Benefits:
- Increase patient satisfaction
- Open up face-to-face appointment times for other patients
- Improve clinical outcomes
- Reduce no show rates
- Increase patient accountability toward achieving their goals and adhering to the care plan
- Increase patient awareness about their health condition

Commitments:
- Partner with a texting vendor (or leverage existing EHR solution)
- Develop new workflows and consent policies
- Engaging patients to leverage technology
- Staff and leadership buy-in to test and sustain technology-enabled care

Program Support

Grants of $15,000

Coaching (1:1 and group)

Host Site Visit

Support for measurement

Peer-learning community

Toolkits, resources and webinars

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Host Sites

Learn from these host sites how to operationalize the solution, gain buy-in from key stakeholders, train staff, redesign workflows and build a business case to sustain the solution.

- ❖ **Patient Portal Optimization:** Shasta Community Health Center
- ❖ **Medical Scribes:** Shasta Community Health Center
- ❖ **Group Visits:** Clinica Family Health (CO)
- ❖ **Telephone Visits:** Riverside University Health System
- ❖ **Texting Solutions:** Monterey County Health System

What We're Looking For

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- Engaged Leadership
- Commit to Sustainability and Strategic Priority Alignment
- Dedicated Project Team
- Strong Quality Improvement Capability
- Clear Measurement and Work Plan

Eligibility Criteria

California-based nonprofit health center or governmental, tribal, or public entity that provides comprehensive primary care services to primarily underserved populations.

- Free-standing community clinics and health centers
- Ambulatory care clinics which are part of public hospital systems either located in the public hospital or out in the community
- Primary care health centers (including those sponsored by Public Health departments)
- American Indian Health Centers

How to Apply

Spreading Solutions That Work
Application Details

- **Applications Due:** Dec 15th 5pm PT
- **Awards Announced:** Feb 2, 2018
- **Program Start/End:** March 1, 2018 – February 28, 2019
- **Site Visits:** March – April 2018
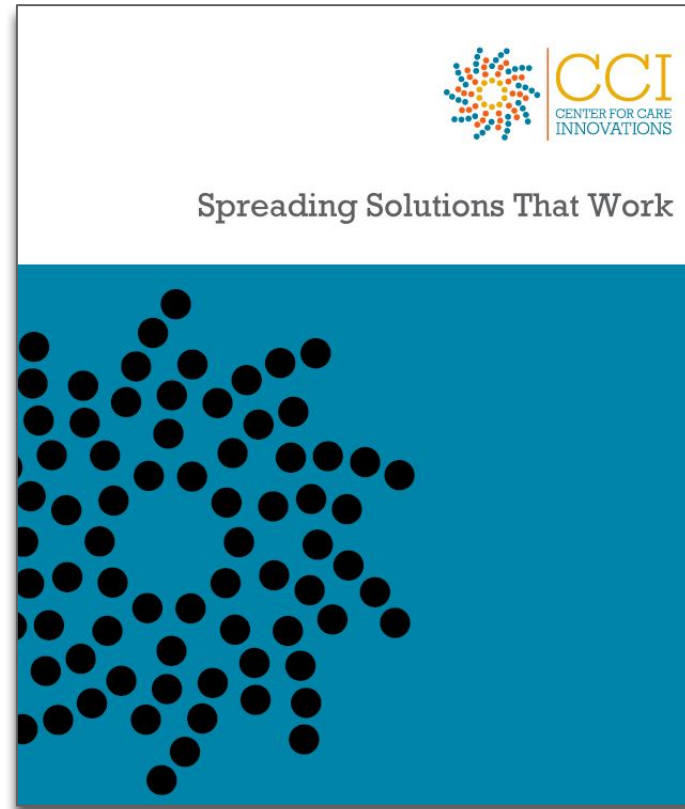
Contact Us

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