HEALTH MANAGEMENT ASSOCIATES

Grantee Feedback Survey – Initial Results And Grantee Strategies for Patient Engagement

Million Hearts Learning Collaborative

May 17, 2023

DC | HEALTH

CME

- The AAFP has reviewed the Million Hearts Learning Collaborative Webinar Series and deemed it acceptable for AAFP credit. Term of approval is from 6/15/22 to 6/24/23. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
- This session is approved for 1.0 Online Only, Live AAFP Prescribed credits.
- **<u>If you would like to receive CME credit, the online evaluation will need to be completed</u>.** You will receive a link to the evaluation shortly after this webinar**.**
- Certificates of completion will be emailed within 10-12 business days of course completion.

Faculty	**Elizabeth Wolff, MD, MPA** **CME Reviewer**	**Mary Kate Brousseau, MPH** **Facilitator**	**Aiswarya Bulusu, MPH** **Metro Health** **Presenter**	**Ikechukwu Nwosu, FNP** **Family and Medical Counseling Services** **Presenter**	**Latrice Hughes, MPH** **Facilitator**
Company	No Financial Disclosures	No Financial Disclosures	No Financial Disclosures	No Financial Disclosures	No Financial Disclosures
Nature of relationship	N/A	N/A	N/A	N/A	N/A

PRESENTERS AND FACILITATORS

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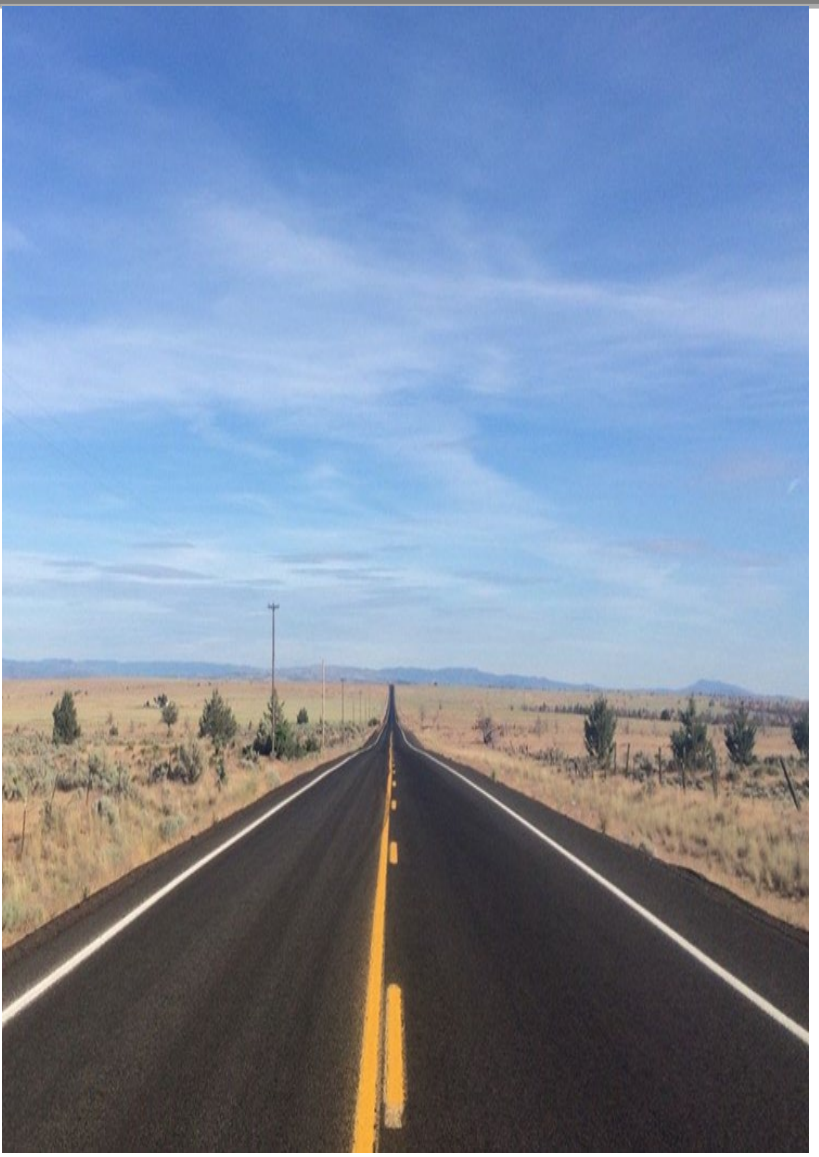
AGENDA



- Welcome and Introductions
- Update and Initial Results from Grantee Feedback Survey
- Patient Engagement Strategies from Grantees
  - Metro Health
  - Family and Medical Counseling Service
- Program Updates, Q&A, Discussion

LEARNING OBJECTIVES

- Define initial findings from the Million Hearts Grantee Feedback Survey and plans for next steps by DC Health.
- Identify opportunities to improve programming and data tracking activities by learning from other grantees.
- Apply lessons learned from other grantees in ongoing Million Hearts activities.

WHY ARE WE ASKING FOR GRANTEE INPUT?

Our Goals:

- ❑ Better serve District residents and the providers who care for them through continuous performance improvement
- ❑ Elicit feedback to complement the metrics, work plan reports, and impact statements for grant and program evaluation
- ❑ Learn from Grantees about the MHLC experience
- ❑ Strategize for innovative approaches to addressing disparities in cardiovascular health

SUMMARY OF INITIAL RESULTS

- Six of the eight grantees responded.
- Positive input overall:
  - Appreciative of opportunity to provide feedback.
  - Appreciate flexibility allowed through partnership, reporting and communication.
  - Great experience with Million Hearts and appreciate DC Health support and alignment with other service areas.
- Opportunities for improvement:
  - Data collection – challenges, capacity issues, varied ability to use data in daily practice.
  - TA – Request for more streamlined approach and less administrative burden.
  - Ongoing barriers to implementation and sustainability.

RESULTS

Rating the partnership	Needs development	Somewhat Needs Development	Neutral	Somewhat Well Developed	Well Developed
1. Relationship between my site and DC Health				✓✓	✓✓✓✓
Comments or Areas for improvement	Respondents appreciated the collaboration with DC Health to support the goal of improving health outcomes for their patients and help them live healthier lives.				
2. Maximizing the Partnership's Value				✓✓✓	✓✓✓
Comments or Areas for improvement	Respondents appreciate the TA from DC Health and HMA, especially with feedback on CIPs and flexibility to help teams achieve goals. Request for structured training in QI process. Partnering with HMA is helpful for providing more TA.				
3. Partnership Communication				✓	✓✓✓✓✓
Comments or Areas for improvement	Communication is consistent, respectful, and responsive. Requests: Session with just PMs and Medical Directors to come up with ideas to perfect the program; clearer goals.				

RESULTS

Rating our Project	Needs development	Somewhat Needs Development	Neutral	Somewhat Developed	Well Developed
4. Internal Buy-In				✓✓✓✓ ✓	✓
Comments/areas for improvement	Request: After each meeting with grantees, a follow up message with notes and action items. Organizational buy-in is varied – some are supportive in name but not as supportive in resources; some have up to date and involved boards; others have delegated authority to the project lead so leadership isn't as involved.				
5. Securing Revenue		✓	✓	✓✓✓	✓
Comments/areas for improvement	Teams have varied accounts of funding sustainability. Some have organizational funding committed, some rely only on this specific grant's funds and have been unable to secure other grant funding to support it.				
6. Service Alignment				✓	✓✓✓✓✓
Comments/areas for improvement	Respondents report alignment with patient care goals and have found learning collaborative meetings and training to have been helpful for meeting goals. Respondents also report infrastructure barriers to implementing and sustaining all aspects of program.				

RESULTS

Question	Needs development	Somewhat Needs Development	Neutral	Somewhat Developed	Well Developed
7. Service Delivery Capacity	✓	✓	✓	✓ ✓ ✓	
Comments/areas for improvement	Respondents asked for more community health workers, more support for teams that are stretched thin. Staff turnover and recruitment remain challenges that impact program implementation, but sites are still looking for ways to grow the program, recognizing there are many more potential participants than they are currently able to serve.				
8. Workflow Processes			✓	✓ ✓ ✓	✓ ✓
Comments/areas for improvement	Respondents report challenges adapting workflows for COVID and telemedicine/remote monitoring, but continue to work to adapt and develop P&P to support workflows.				
9.Patient and Community Engagement			✓ ✓	✓ ✓	✓ ✓
Comments/areas for improvement	Respondents report varied pathways for patient engagement. Some are proponents of using personal connection to promote monitoring, others are invested in client involvement in policy/advocacy; still others are working to extend health education and promotion/prevention activities through methods like health literacy sessions on-site and virtually				

RESULTS

Rating our Project	Needs development	Somewhat Needs Development	Neutral	Somewhat Developed	Well Developed
10. Data Collection			✓	✓✓	✓✓✓
Comments/areas for improvement	Respondents report various challenges with data collection, citing varying abilities withy tools like Azara, EMR's Relevant, as well as varying capacity for data management.				
11. Data Usage				✓✓	✓✓✓✓
Comments/areas for improvement	Respondents report the data usage concerns as a good opportunity to promote partnership with DC Health; and report varying levels of ability/opportunity to use data in daily practice.				

12. Technical Assistance Methods and Resources	Not at all	Somewhat Not	Neutral	Somewhat	Very
a. Grantee meetings				✓✓✓✓	✓✓
Comments/areas for improvement					
b. Monthly MHLC				✓✓	✓✓✓✓
Comments/areas for improvement					
c. Living Well DC			✓✓✓	✓	✓✓
Comments/areas for improvement					
d. Alignment of TA with other DC Health grant activities				✓✓✓	✓✓✓
Comments/areas for improvement	Request for streamlined TA for fewer team meetings to avoid blocking clinical hours for HCPs; monthly CIP posed administrative burden.				

RESULTS

13. Administrative Processes/Reporting/ Payment	Not at all	Somewhat Not	Neutral	Somewhat	Very
a) How useful are the monthly grantee meetings and other individual TA			✓ ✓	✓ ✓	✓ ✓
b) How helpful was DC Health's reporting process as an opportunity to reflect/learn?	✓			✓ ✓	✓ ✓ ✓
c) How useful was the Million Hearts data reported back to your site?	✓			✓	✓ ✓ ✓ ✓
d) How useful/informative was the comparative data from other sites				✓ ✓	✓ ✓ ✓ ✓
e) How well does the invoicing and payment structure work?			✓	✓ ✓ ✓ ✓	✓
f) How well did the grant off-set costs associated with the work?		✓	✓	✓ ✓ ✓	✓
Comments/areas for improvement	One respondent noted administrative burden vs the size of the grant and requested a reduction of burden. They found the reports to be grant management tools rather than learning tools. Another grantee reported that their finance team found the invoice requirements a struggle.				

14. Additional Funding Opportunities	Not at all	Somewhat Not	Neutral	Somewhat	Very
a) How interested is your health center in additional opportunities for grant funding to address cardiovascular health and health disparities?				✓ ✓	✓ ✓ ✓ ✓
b) How capable would your health center be to take on additional grant funded activities to address cardiovascular health and health disparities		✓		✓ ✓ ✓ ✓	✓
c) How important is addressing cardiovascular health and health disparities in your health center's population/patient panel?				✓	✓ ✓ ✓ ✓ ✓
Comments/areas for improvement	Most grantees reported interest in new opportunities and appreciation for working with DC Health. One grantee expressed concern about additional workload but would consider it if able to pivot to particular new or refocused grant objectives.				

15. Additional Feedback

Grantees thanked DC Health for the opportunity to provide feedback.
Grantees expressed Million Hearts has been a great experience and they appreciate DC Health's support and commitment to improve health.


Discussion

METRO HEALTH – GRANTEE PRESENTATION AND DISCUSSION

AISWARYA BULUSU, MPH
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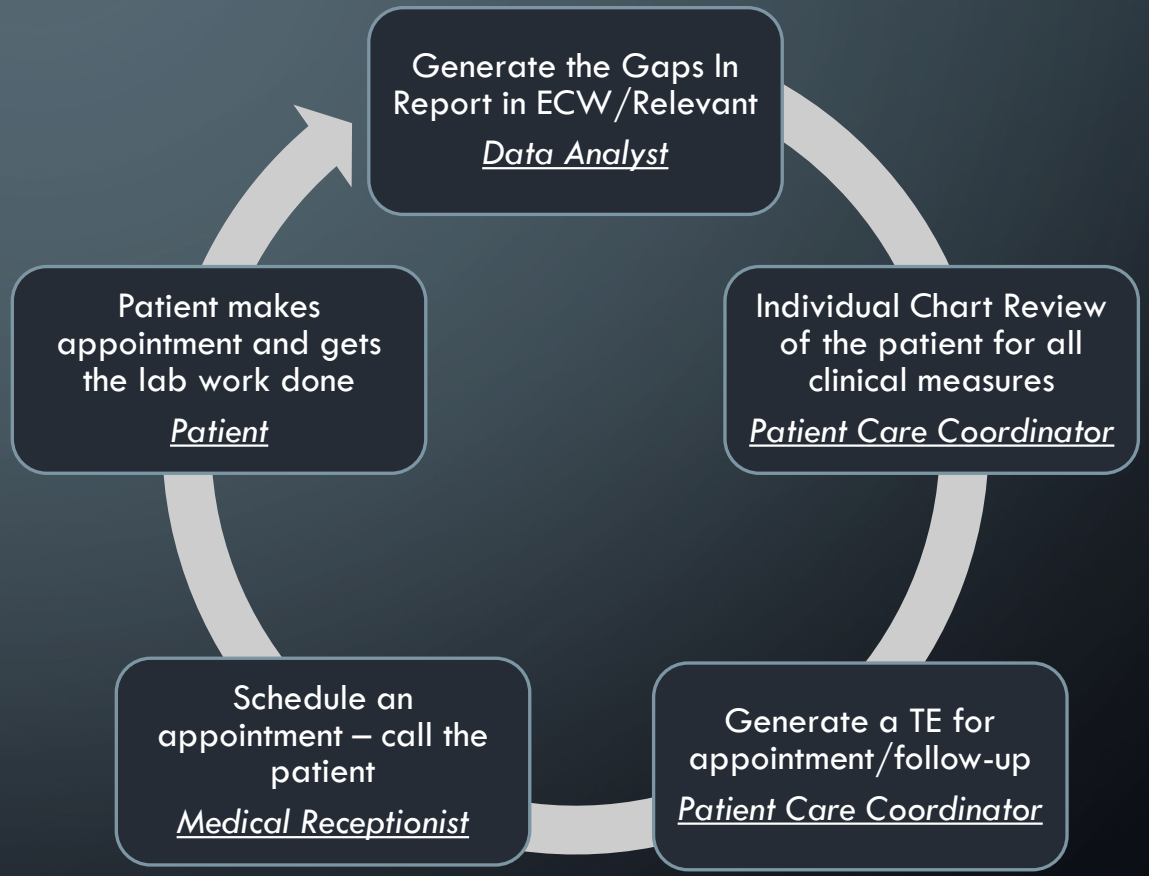
METRO HEALTH - MCO DAYS

- Partnerships with AmeriHealth Caritas, MedStar and Amerigroup
- Hosts MCO day 1-2 times per month, where MCO patients are prioritized for office visit scheduling.
- Receives a list of patients from the MCOs due for annual physical exams, with uncontrolled gaps in care, or are chronic no-shows, etc.
- Helps to track and close the gaps in care of patients with underlying chronic conditions.
- Leverage data platforms to track these gaps on a monthly basis – Navinet, CRISP DC.

CLINICAL MEASURES AND GAPS IN CARE

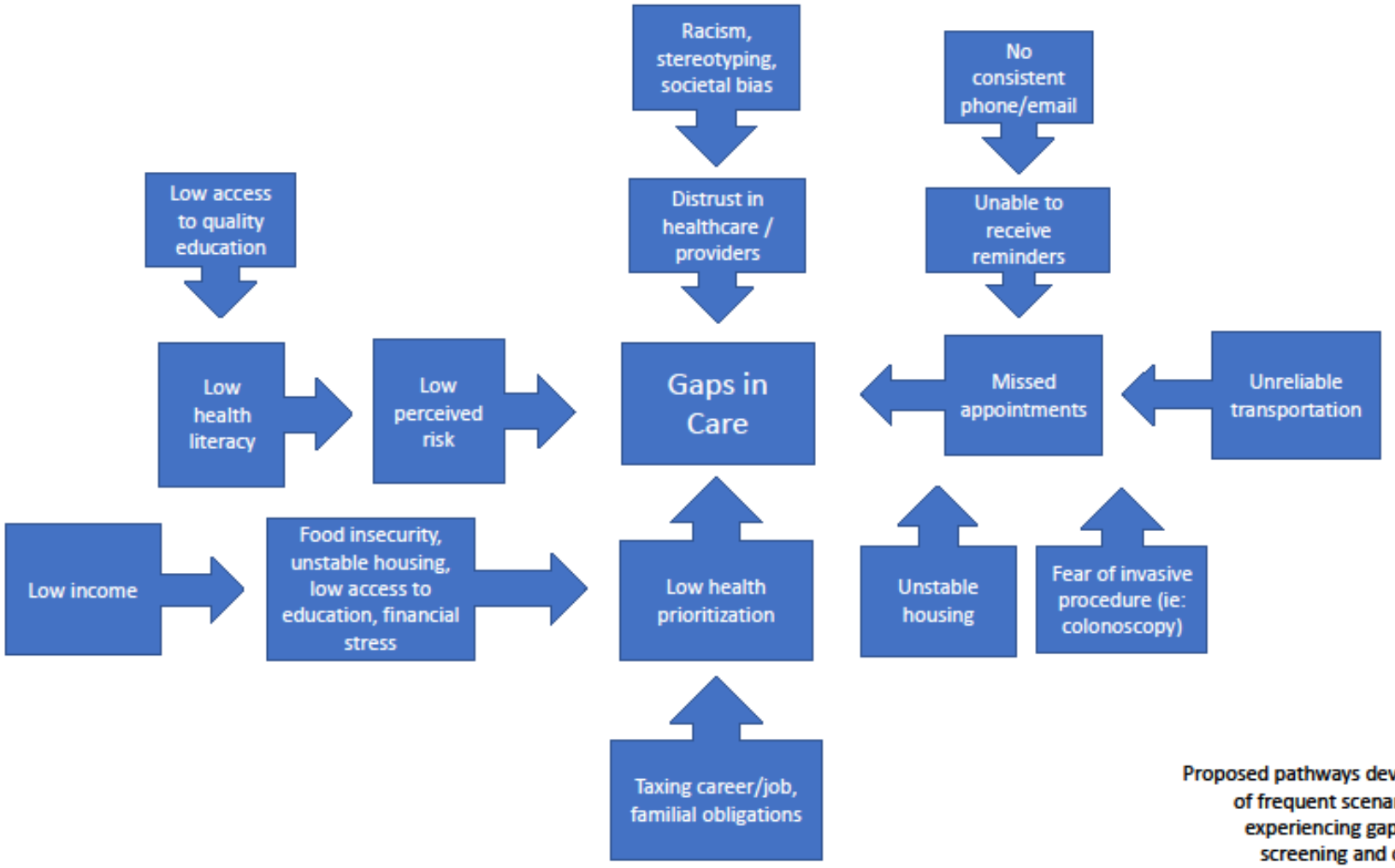
Data team tracks and report the clinical quality measures monthly

Gaps are reported to the Internal Clinical team, tracked and monitored.



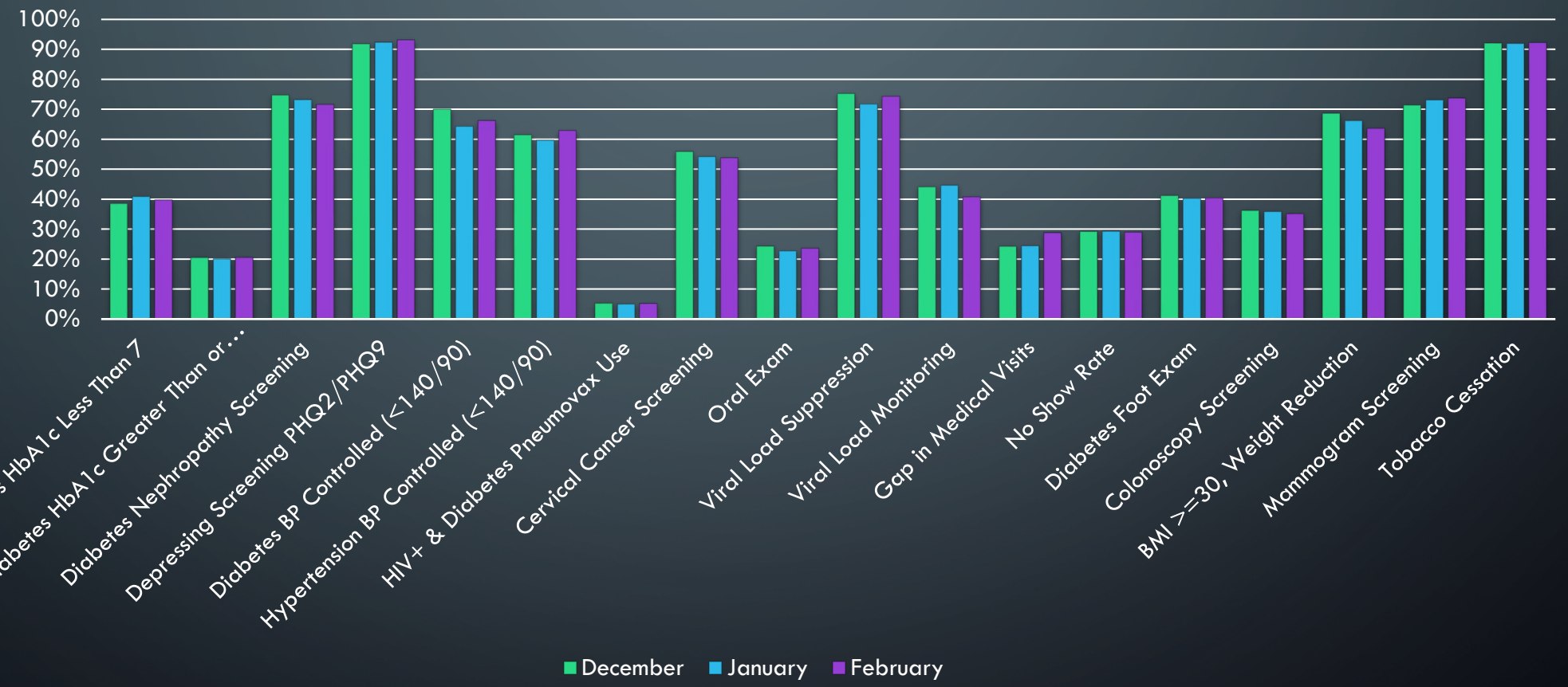
WHAT CAUSES GAPS IN CARE

Systems Thinking Model – Potential Paths to Gaps in Care for Metro Health Patients Needing Cancer Screening or Chronic Condition Follow-up Appointments



Proposed pathways developed from my observations of frequent scenarios for Metro Health patients experiencing gaps in preventative care (cancer screening and chronic disease management)

QUALITY OF CLINICAL MEASURES



CLINICAL QUALITY DASHBOARD

Report #	Measure Name	Patient Base	Compliant	Non-Compliant	Current Percentage	Percentage Change	Target
1	Diabetes HbA1c Less Than 7	151	60	91	39.7%	-1.16%	45.00%
2	Diabetes HbA1c Greater Than or Equal to 9	151	31	120	20.5%	0.43%	15.00%
3	Diabetes Nephropathy Screening	151	108	43	71.5%	-1.68%	85.00%
4**	**Depressing Screening PHQ2/PHQ9**	866	806	60	93.1%	0.77%	70.00%
5**	**Diabetes BP Controlled (<140/90)**	151	100	51	66.2%	1.93%	65.00%
6	Hypertension BP Controlled (<140/90)	399	251	148	62.9%	3.31%	70.00%
7	HIV+ & Diabetes Pneumovax Use	248	13	235	5.2%	0.14%	N/A
8	Cervical Cancer Screening	510	274	236	53.7%	-0.47%	60.00%
9	Oral Exam	131	31	100	23.7%	0.86%	N/A
10	Viral Load Suppression	132	98	34	74.2%	2.54%	90.00%
11	Viral Load Monitoring	81	33	48	40.7%	-3.96%	90.00%
12	Gap in Medical Visits	104	30	74	28.8%	4.35%	25.00%
13	No Show Rate	5,479	1,590	3,889	29.0%	-0.28%	20.00%
14	HIV+ & Diabetes Influenza Vaccine	248	22	226	8.9%	0.67%	N/A
15	Colonoscopy Screening	333	117	216	35.1%	-0.76%	50.00%
16	PCP Prophylaxis	35	7	28	20.0%	-2.90%	95.00%
17**	**Abnormal Cervical Cancer Screen Follow-up**	8	5	3	62.5%	0.00%	60.00%
18	BMI >=30, Weight Reduction	1,167	742	425	63.6%	-2.62%	70.00%
19**	**Mammogram Screening**	232	171	61	73.7%	0.61%	60.00%
20**	**Tobacco Cessation**	1,004	925	79	92.1%	0.23%	88.00%
21	Annual Visits	847	176	671	20.8%	1.28%	N/A
22	Urgent Visits	27	14	13	51.9%	1.85%	N/A
23	High Risk Patients	177	30	147	16.9%	0.05%	N/A
24	Diabetes Foot Exam	151	61	90	40.4%	0.10%	85.00%

HOW DOES METRO HEALTH PROMOTE HEALTH LITERACY TO THEIR PATIENTS

1. Monthly Newsletters
   - Include a section that covers COVID-19 updates.
   - Health awareness week every month to promote health literacy of the condition – for example (January is Cervical Cancer Screening Month – we talk about cervical cancer on our January newsletter and offer PAP screening for eligible women).
2. Outreach Team
   - Provides health education pamphlets on importance of regular HIV/STI testing for high-risk HIV negative population.
   - Offers on-site and online psychosocial support groups to our Ryan White clientele and provides specific health education on HIV/AIDS linkage to care, retention, and comorbidities.
3. E-Clinical Works
   - Use of E-Clinical Works health education modules to increase health literacy of our patient population.
4. Onsite Health Education
   - Provides information on health concerns to patients who have questions and concerns about themselves and their loved ones.

PATIENT ENGAGEMENT AND COMMUNICATION

1. E-Clinical Works – text messaging and emails on important updates and clinical information (PHI not revealed)
2. E-Clinical Works – post visit patient satisfaction survey (originally anonymous) with option to leave name and contact to address patient grievances related to access, visit, staff, and clinical care.
3. On-site and online support groups – to address patient concerns and providing necessary support.

QUESTIONS AND COMMENTS

1. How do other Grantees work best with MCOs?
2. How do other Grantees track data to identify gaps?
3. Are there other tools that Grantees leverage and/or access through eCW?

THANK YOU!

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Million Hearts Learning Collaborative Presentation

Ikechukwu Nwosu, FNP

Family and Medical Counseling Service, Inc.

Goal

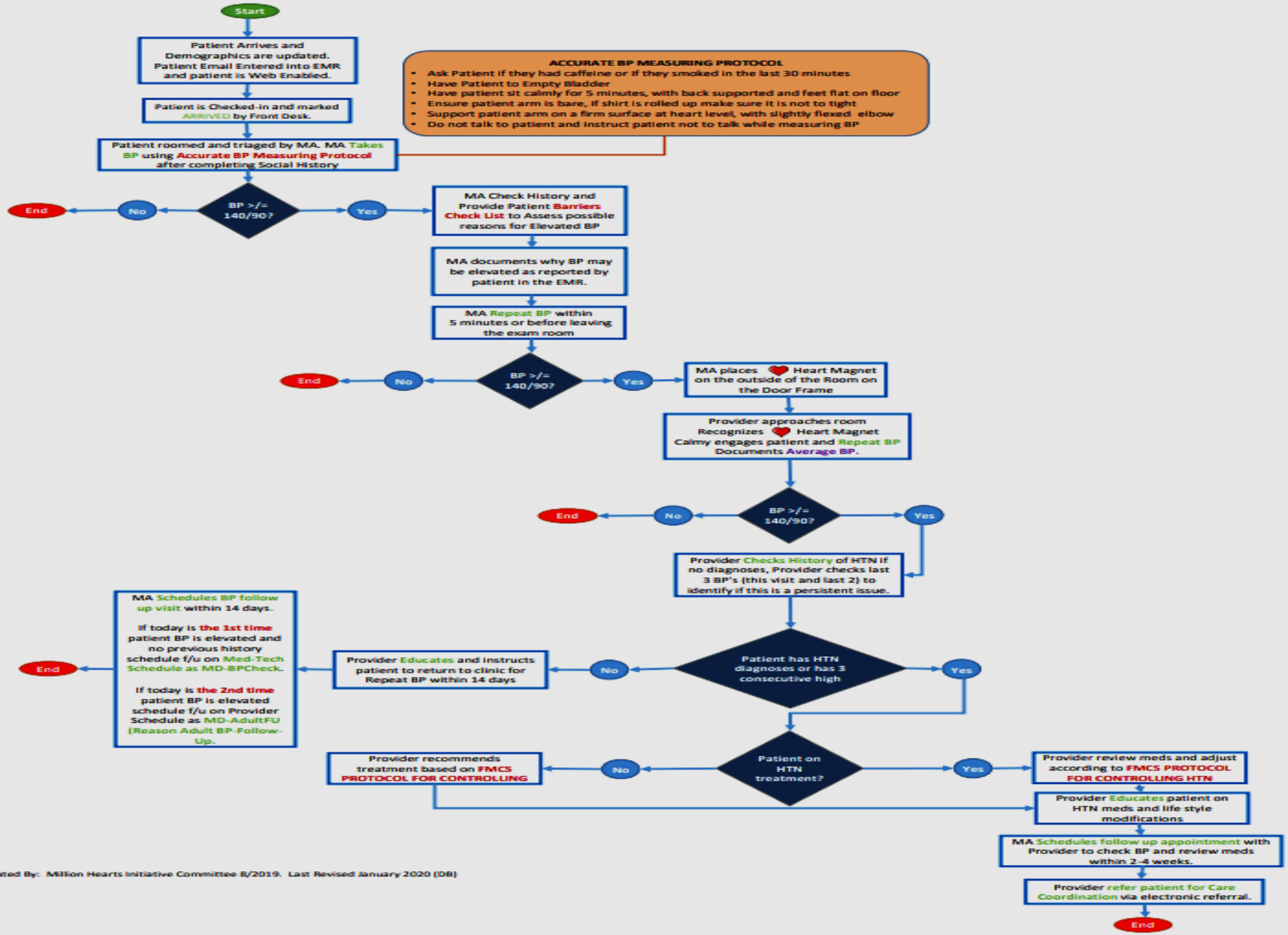
- Discuss interventions, success, and challenges to support patient engagement in management of diabetes and hypertension.

- Share these with other health care organizations to improve health outcome of patients with diabetes and/or hypertension.

Interventions for Hypertension

- Setting agency-wide BP goal of less than 140/90 mmHg.
- Developing an accurate BP measuring protocol and management procedures (See diagram on page 4)
- Placement of special chairs in each exam rooms for accurate blood pressure measurement.
- Developing a barrier check list to understand possible reasons for elevated blood pressure.
- Placement of heart magnet in front of the door of the patient's room to alert provider of elevated blood pressure.
- Provider taking accurate history to identify if patient has h/o HTN, newly diagnosed HTN, or Elevated blood pressure without HTN.
- Scheduling follow up appointment for patients with BP equal to or greater than 140/90 mmHg within 2-4 weeks.
- Providing blood pressure machines for at home self monitoring.
- Referral to care coordination or cardiologist.

Hypertension Care Team Workflow



Created By: Million Hearts Initiative Committee 8/2019. Last Revised January 2020 (DB)

Successes of HTN Management

- Often times, the repeat of blood pressure by provider yields better blood pressure reading. This is can be attributed to patient having enough time to relax. Or provider performing some relaxation techniques on patient such as deep breathing exercise.
- Availability of rewards with gift cards at the care coordination level motivates patients to achieve blood pressure goals.
- Patient's reluctance of wanting to see cardiologist becomes a motivating factor.

Challenges of HTN management

- Some patients get frustrated when you are taking their blood pressure for the third time, especially if they came in for another reason other than blood pressure.
- Some patients not wanting to wait for BP recheck after treatment in the clinic.
- Some patient not wanting to be bombarded with another appointment of seeing another person for care coordination.
- Time constraint for some patient having to come back within 2-4 weeks.
- Unavailability of appointment slots for patients within 2-4 weeks.
- Some patients not adherent to at home self monitoring of blood sugar
- Lifestyle modifications and medication non-compliance.

Interventions for Diabetes

- Huddling with Medical Assistants to identify patients with diabetes who are without HA1C in the last 3 months.
- Checking blood sugar of every patient with diabetes at each visit even when the appointment is not for diabetes follow up.
- Conducting rapid HA1C when patient is not able to go the lab.
- Providing diabetes monitoring supplies for at home self-monitoring.
- Referrals to nutritionist (Counseling and Fresh Foods Pharmacy Program) and to care coordination/endocrinologist for patient with HA1C greater than 9%
- Utilizations of Sorogi Health for indebt diabetes education for patient who did not achieve HA1C goal at Care Coordination level.

Success of Diabetes Management

- Utilization of rapid HA1C enables providers to make appropriate and timely therapeutic change at the time of each visit without having to wait for a long period of time.
- Utilization of rapid HA1C testing saves time for patients and prevents hassles of blood draw.
- Availability of rewards with gift cards at the care coordination level motivates patients to achieve HA1C goals.

Challenges of Diabetes Management

- Some patients get frustrated when you are checking their blood sugar for the second time after in-office treatment, especially if they came in for another reason other than diabetes management.
- Some patients not wanting to wait for blood sugar recheck after treatment in the clinic.
- Some patient not wanting to be bombarded with another appointment of seeing another person for care coordination.
- Some patients not adherent to at home self monitoring of blood sugar
- Lifestyle modifications and medication non-compliance.

Summary

- Successful achievement of hypertension and diabetes management goals requires interventions of every medical personnel and shared decision making with patients.
- Expect challenges along the way, and know that the goal may not be achieve with just one or two visits by patients.

The End

THANK YOU FOR LISTENING

QUESTIONS/DISCUSSION

QUICK EVALUATION POLL

1. **To what extent did the session meet the stated objectives?**
   (1 - not at all to 5 - met all objectives)

   - Define initial findings from the Million Hearts Grantee Feedback Survey and plans for next steps by DC Health.
   - Identify opportunities to improve programming and data tracking activities by learning from other grantees.
   - Apply lessons learned from other grantees in ongoing Million Hearts activities.

2. **How would you rate the session overall?**
   (1 - poor to 5 - excellent)

TECHNICAL ASSISTANCE AVAILABLE

DC | HEALTH HMA

We are here to help you !

- ✓ For 1:1 site specific coaching, contact an HMA team member.
- ✓To access previously recorded sessions and tools, visit https://livingwell.dc.gov/page/million-hearts-providers or see the technical assistance inventory document sent via email.

HEALTH MANAGEMENT ASSOCIATES