# Community Transformation Grant (CTG)

## High Impact Clinical Services Ad Hoc Committee Meeting

Friday, May 11, 2012
9:00 – 10:00 a.m.
Health Services Agency
830 Scenic Drive
Modesto, Ca 95350
Lobby Conference Room

I. Welcome & Introductions

II. CTG Process Overview

III. Review of CDC Indicators & Policy

IV. Community Health Assessment Roles & Responsibilities

V. Training Calendar

VI. Establish Next Meeting

   a. Reoccurrence:

   b. Date:

   c. Time:

   d. Location:

Community Transformation Grant (CTG)

High Impact Clinical Services Ad Hoc Committee Meeting

Friday, June 8, 2012
12:30 – 2:00 p.m.
**(Brown Bag Lunch)**
Health Services Agency
820 Scenic Drive
Modesto, Ca 95350
Public Health Conference Room

I. Welcome & Introductions

II. CTG Training: Best Practices

III. Discussion: CDC Indicators & Policy

IV. Community Health Assessment (CHA) Check-in

   a. What is the CHA?

   b. The Basics of Asset Mapping & Sample

V. Training Calendar Check-in

Next Meeting:

**NO JULY MEETING DUE TO HOLIDAY**

Friday, August 10, 2012
12:30 - 2:00 p.m.
Health Services Agency
820 Scenic Drive, Modesto
Public Health Conference Room

# Community Transformation Grant (CTG)

# High Impact Clinical Services Ad Hoc Committee Meeting

Friday, August 10, 2012
12:30 – 2:00 p.m.
**(Brown Bag Lunch)**
Health Services Agency
820 Scenic Drive
Modesto, Ca 95350
Public Health Conference Room

| | |
|---|---|
| I. Welcome & Introductions | 12:30 - 12:40 p.m. |
| II. *Community Health Needs Assessment* Data | 12:40 – 1:00 p.m. |
| III. Determination: CDC Indicator | 1:00 – 1:45 p.m. |
| a. Model Program Sharing and Reimbursement Options | |
| IV. Community Health Assessment (CHA) Check-in | 1:45 – 1:55 p.m. |
| a. Asset Mapping | |
| b. Community Readiness Model – Key Informant Interviews | |
| c. Policy Scan | |
| V. Training Calendar Check-in | 1:55 – 2:00 p.m. |

Next Meeting:

**Tentatively Set**

Friday, September 14, 2012
12:30pm - 2:00pm
Health Services Agency
820 Scenic Drive, Modesto
Public Health Conference Room

Community Transformation Grant (CTG)

High Impact Clinical Services Ad Hoc Committee Meeting

Friday, September 14, 2012
12:30 – 2:00 p.m.
**(Brown Bag Lunch)**
Health Services Agency
820 Scenic Drive
Modesto, Ca 95350
Public Health Conference Room

I. Welcome & Introductions — 12:30 - 12:45 p.m.
   a. National News: High Blood Pressure

II. CHA: Review Assessment/Interview — 12:45 – 1:30 p.m.

III. Determine Format — 1:30 – 2:00 p.m.
   a. Survey Monkey / In-Person
   b. Confidentiality
   c. Forward to 2 staff or colleagues

IV. Adjourn

Next Meeting:

**Tentatively Set**

Friday, October 12, 2012
12:30pm - 2:00pm
Health Services Agency
820 Scenic Drive, Modesto
Public Health Conference Room

**Community Transformation Grant**
**High Impact Clinical Preventative Services Ad Hoc Committee**
**Meeting Notes**
**May 11, 2012**

| **Present:** | | **Facilitator/Coordinator:** |
|---|---|---|
| Alan Roth – Respiratory Health<br>Colleen Woolsey – Health Services Agency<br>Esmeralda Gonzalez – Health Services Agency<br>Jennifer Downs-Colby – Memorial Medical Center | Robert Watson, MD – Stanislaus Medical Society<br>Rocio Huerta-Camara (via phone) – Sutter Gould Medical Foundation<br>Sharrie Sprouse – Health Services Agency<br>Vance Roget, MD – Medical Director Last Resort/Modesto Marathon | John Walker – Health Services Agency<br>Amelia Goodfellow – Health Services Agency |

| Topic | Discussion | Outcome/Action |
|---|---|---|
| 1. Welcome/Introductions | The meeting was called to order, self introductions were made. | |
| 2. CTG Process Overview | *Purpose & Outcomes*<br>• To provide an overview of the components and process of CTG.<br>• To establish CTG indicators/policy guidance.<br>• To establish roles and responsibilities.<br>• To establish trainings and schedule.<br>• To establish meeting schedule.<br>*Grant Priorities for Stanislaus County*<br>• Tobacco Free Living<br>• Increase Use of High Impact Quality Clinical Preventive Services (high blood pressure & high cholesterol)<br>• Active Living & Healthy Eating<br>*CDC Requirements:* CTG Core Principles (Mandated)<br>• Use & Expand Evidence Base<br>• Maximize Health Impact – jurisdiction-wide policy and environmental change strategies<br>• Advance Health Equity<br>*Definitions & Terms*<br>• **Indicators** – measurable change, indicator driven POLICY (CDC's 3 Levels: core, optional and innovative)<br>• **Health Equity** – equality in the quality of health and health care across different populations; assuring no differences in health, that are unnecessary, avoidable, unfair and/or unjust. | |

| Topic | Discussion | Outcome/Action |
|---|---|---|
| | • **Health Disparity** – inequalities that exist when members of certain population groups do not benefit from the same health status as other groups leading to a higher incidence of mortality rate. Health disparities can usually be identified along racial and ethnic lines, however can also extend beyond race to include areas such as access to healthcare, socio-economic status, gender, and biological or behavioral factors.<br>*CTG Core Capacity Building Requirements (18 months):*<br>• Mobilize the Community – Leadership Team, Coalition and 3 Ad Hoc Committees<br>• Community Health Assessments – secondary data, policy scan, asset mapping, community readiness model (pre and post), focus groups, PRISM, community engagement<br>• Tell Your Story – Leadership Team, Coalition and community forums<br>• Implementation Plan - end product of the CTG Capacity Building (aka strategic planning) process. | Grant timeline:<br>Community Health Assessment completed by 09/30/2012<br><br>Capacity Building/Strategic Planning (Implementation Plan) completed by 04/30/2012 |
| 3. Review of CDC Indicators & Policy – Tobacco Free Living | *Core Indicators:*<br>• Use of pharmacists as health care extenders to promote control of hypertension and high BP<br>• Use of community health workers/patient navigators<br>• Use of health information technology for provider prompts/feedback, patient communication & data gathering<br>• Instituting and monitoring aggregated/standardize quality measures at the individual provider level and systems level (HEDIS, NCQA, physician quality reporting system<br>• Working with businesses community to improve access to and coverage of preventive clinical services for employees through health plans (purchaser's guide) and worksite policies<br>*Optional:*<br>• Diabetes prevention and tobacco cessation through the clinical setting<br>*Discussion*<br>Attendees discussed each of the indicators listed above:<br>• Health Care Extenders – already utilized in pharmacy settings (i.e. immunizations/vaccines), blood pressure machines in pharmacy setting, the Childhood Obesity and Diabetes Taskforce is using recent data collected to state the case for children's lipid levels and blood pressure be added as part of the standard 7th grade screening.<br>• Patient Navigators/Community Health Workers – role would be similar to a hospital/clinic case manager (i.e. reminders, follow up calls, prescription reminders, etc.); opportunity to expand the screenings conducted by school nurses; opportunity to explore the role of the Promatoras network/model; review models in place at County HQFC clinics/Golden Valley and the Comprehensive Perinatal Services Program; | • Indicators discussion will continue at next meeting.<br><br>• More clarification on the role of health care extenders.<br>• Health Care Extenders – invite Caranza Pharmacy and Kathy Rix, coordinator for pharmacology students (completed by Rocio Huerta-Camara) to join the CTG Clinical Ad Hoc Committee |

| Topic | Discussion | Outcome/Action |
|---|---|---|
| | weakness identified that community health works may require a fair amount of oversight by a nurse or complete an extensive certification program (similar to a program in Texas).<br>• Health Information Technology – Electronic Medical Records (EMR) instituted at Memorial, Sutter-Gould, Sutter Hospital, Kaiser, no EMR at DMC; Identified as a critical element of policy change.<br>• Standard Quality Measures at Provider and System Level - Utilized by Health Plan of San Joaquin, Kaiser, etc.; due to penetration of managed care in our county, this may not be a big challenge to achieve.<br>• Business Community – market the indicator as a business case/cost effective (can improve employee health and save employers the high cost of lost work hours, sick days, etc.) to offer prevention and early intervention for a silent killer, high blood pressure; consider whether health access is available for all employees; revisit after the Supreme Court hearing in June; health club memberships purchased as a group; work wellness plan at the worksite; employee fitness programs; promotion of Walking trails; provide basic screening and informational sessions to increase awareness of the issue; target "pre-contemplative" employees<br>• (optional) Clinical Setting Diabetes Prevention/Tobacco Cessation – Diabetes has already been identified as high priority /chronic disease for Stanislaus County and will be included in a core indicator; Tobacco related indicators are already being addressed by the Tobacco Ad Hoc Committee. | • Survey Ad Hoc Committee members regarding EMR indicator<br>• Invite UC Merced health economics professor to join ad hoc committee<br>• Opportunity/overlap with HEAL Ad Hoc Committee (worksite wellness and school settings) |
| 4. Community Health Assessment (CHA) Roles & Responsibilities | *Discussion*<br>The components of the CHA, as mentioned in the above section, *CTG Core Capacity Building Requirements* were discussed.<br>• Determined that the Clinical Ad Hoc Committee's role within the CHA will be slightly different than the other two committees.<br>• The Clinical Ad Hoc will serve as the interviewees for the Community Readiness Model (aka key informant interviews) as well as provide any contacts for the other priority areas. | |
| 5. Training Calendar | *Discussion*<br>• Attendees discussed trainings and methods. Determined to host webinar trainings at the Agency, as well as on the web and archiving (via website).<br>• Attendees also recommended a presentation of Best Practices of policy-level initiatives. | |
| 6. Next Meeting | Attendees determined to meet monthly while required, due to the amount of tasks and that an | |

| Topic | Discussion | Outcome/Action |
|---|---|---|
| | hour and a half was needed.<br>*Meeting Schedule*<br>Reoccurrence: 2nd Fridays of the month<br>Location: **Public Health** Conference Room<br>Time: 12:30am-2:00pm (Brown Bag Lunch)<br><br>**NOTE: NO JULY MEETING**<br>*Next Meeting Tasks*<br>• Update on member recruitment<br>• Update on the role of health care extenders in pharmacy setting<br>• Discuss EMR survey questions<br>• Continue discussion on possible policy indicators and trainings | |

**Community Transformation Grant**
**High Impact Clinical Preventative Services Ad Hoc Committee**
**Meeting Notes**
**June 8, 2012**

| | | |
|---|---|---|
| **Present:**<br>Bryan Fusco – University of the Pacific<br>Colleen Woolsey – Health Services Agency<br>Esmeralda Gonzalez – Health Services Agency<br>Jennifer Downs-Colby – Memorial Medical Center<br>Karryn Unruh-Salomen - Health Services Agency, McHenry Medical Office | Katherine Rix – Sutter Gould Medical Foundation<br>Robert Martin – Mended Hearts<br>Robert Watson, MD – Stanislaus Medical Society<br>Vance Roget, MD – Medical Director Last Resort/Modesto Marathon | **Facilitator/Coordinator:**<br>John Walker – Health Services Agency<br>Amelia Goodfellow – Health Services Agency |

| Topic | Discussion | Outcome/Action |
|---|---|---|
| 1. Welcome/Introductions | The meeting was called to order, self introductions were made. Welcome to Katherine Rix, Sutter Gould Medical Foundation and Bryan Fusco, University of the Pacific. | |
| 2. CTG Training: Best Practices | Amelia conducted a training which highlighted best practices for high impact clinical preventative services, conducting clinical preventive services policy scan-examples in practice, and community impact projects-examples in practice.<br>**Best Practices:** Recommendations from Dr. Thomas Frieden Director, CDC<br>1. Clinical approaches should focus on the ABCS<br>• Aspirin for high risk patients<br>• Blood pressure control<br>• Cholesterol control<br>• Smoking reduction (*addressed by the Tobacco-free Living Ad Hoc Committee)<br>2. To improve delivery of preventive services, clinical approaches should:<br>• Focus on measurement<br>• Generate regular feedback to providers<br>• Utilize health information technology<br>• Employ team-based approaches to treatment<br>3. Connect clinics with community through:<br>• Panel management, including community members on decision-making boards<br>• Partnership with groups that provide opportunities for physical activity<br>• PHN presence in clinics<br>• Using outreach workers to extend services beyond clinic walls | |

| Topic | Discussion | Outcome/Action |
|---|---|---|
| | 4. Key documents<br>• Summary of Recommendations for Clinical Preventive Services, American Academy of Family Physicians<br>• National Prevention Strategy<br>• Guide to Clinical Preventive Services, U.S. Preventive Services Task Force<br>• Guide to Community Preventive Services, Task Force on Community Preventive Services<br>• Multiple Chronic Conditions: A Strategic Framework<br>**Conducting A Policy Scan:** Examples in Practice<br>1. Identifies gaps, opportunities, and barriers for delivery of chronic disease prevention services<br>2. Mix of methods including, but not limited to:<br>• Key informant interviews<br>• Document reviews<br>• Secondary data review<br>Example: Centre for Rural and Northern Health Research , Lakehead University<br>1. *Chronic Disease Prevention and Management for the North West LHIN*<br>• Representatives of significant organizations<br>• Key informant interviews<br>- Novel chronic disease management models<br>- Implementation of best practices<br>- Health education resources<br>- Self-management programs<br>- Community initiatives<br>- e-Health supports<br>- Barriers to integrated chronic disease management<br>- Ideas for improving integrated services<br>**Community Impact Projects:** Examples in Practice<br>1. The Asheville Project: Core indicator 1: Use of pharmacists as health care extenders<br>***The intervention*:** Employees of the City of Asheville with chronic conditions received intensive education at a local hospital, and were matched with community pharmacists who coached them on medication adherence.<br>***The outcome*:** Improved A1C levels, fewer sick days, lower total health costs, and improved patient-pharmacist relationships.<br>2. Beacon Community Cooperative Agreement Program: Core indicator 3: Use of health information technology<br>***The intervention*:** HHS Office of the National Coordinator for Health IT has identified 17 communities nationwide that have begun to adopt secure, private, accurate electronic health records (EHR) systems, providing $250 million over three years to strengthen EHR infrastructure, lower healthcare costs, and implement performance measurements.<br>***The outcome*:** Better patient follow-up and coordination of care, greater analytic capacity, and mobile patient communication. | |

| Topic | Discussion | Outcome/Action |
|---|---|---|
| | 3. businessgrouphealth.org: Core indicator 5: Working with the business community<br>***The intervention:*** Provides resources, evidence and support for employers addressing preventive healthcare in the workforce<br>**Validated interventions:** Eliminate co-pays for preventive health screenings, institute on-site biometric screenings, disseminate health education materials, develop employee – physician communication guides<br>**Resources:**<br>1. American Academy of Family Physicians: Summary of Recommendations for Clinical Preventive Services http://www.aafp.org/online/etc/medialib/aafp_org/documents/clinical/CPS/rcps08-2005.Par.0001.File.tmp/May2012.pdf<br>2. National Prevention Strategy http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf<br>3. Guide to Clinical Preventive Services, U.S. Preventive Services Task Force http://www.uspreventiveservicestaskforce.org/adultrec.htm<br>4. Multiple Chronic Conditions: A Strategic Framework http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf | |
| 3. Discussion:<br>CDC Indicators & Policy | Leadership Team updates were shared with the members and the indicators discussion was re-opened.<br><br>Indicator 1: Use of pharmacists as health care extenders<br>• Although the American Medical Association has been traditionally cautious about changing any providers' scope, we may be best positioned as a county to work on this indicator.<br>• The members supported the "medical home" model, using a collaboration of providers with the physician as the lead, to ensure no one provider is extending beyond their scope of practice.<br>• Immunizations (IZ) are a great example of how this indicator can work in our county. Pharmacists' reimbursement of IZ services is structured differently than physicians', making it easier for them to facilitate services.<br>• Pharmacists may be soon reimbursed for cognitive services such as counseling (Rx adherence, self management).<br>• There may be a possibility of using TCM (targeted case management) dollars down the line with use of RN/PHN in medical teams.<br>• However, currently there is a lack of programmatic use of pharmacists as healthcare extenders in the county.<br><br>Indicator 2: Use of CHWs and patient navigators:<br>• Concern over necessary oversight and rate of success of these practices without sufficient oversight. | Invite Carranza Pharmacy and San Joaquin Valley Pharmacist Association of Independent Pharmacists, to provide insight on indicator number one. |

| Topic | Discussion | Outcome/Action |
|---|---|---|
| | Indicator 3: Use of health information technology<br>• Moving forward with EHR is vital for clinical service provision quality, but many clinics are in transition and may take years to adopt EHR. Although it's an important indicator, we may not be ready to move forward in this area.<br><br>Indicator 4: Instituting and monitoring standard quality measures<br>• There may be a way to combine some elements of this indicator with those of indicator number one.<br>• Strong support for using this indicator, specifically with the optional indicator of diabetes cessation. We'd be able to address both of our key areas (CV health and diabetes).<br>•<br>Indicator 5: Working with the business community<br>• Lack of support; not discussed exhaustively. | Eliminate the 2, 3, and 5 indicators and decided to focus on indicators 1 and 4. |
| 4. Community Health Assessment (CHA): Check-In<br><br>a. What is the CHA? | CHA Check-In was proposed to be a standing agenda item. Members agreed this would be a productive item to have.<br><br>A handout was provided that outlined the components of the CHA.<br>1. Review secondary data, including population subgroup disparities analyses where applicable, on:<br>• Chronic disease risk factors<br>• Chronic disease prevalence<br>• Hospitalization and ER visits<br>• Quality of care<br>• Mortality<br>2. Engage population subgroups experiencing health disparities in identifying community needs (Focus Groups) – sub-contact with Samuels & Associates<br>3. Review assets, tools and resources in your community (key informant interviews using the Community Readiness Model, Asset Map)<br>4. Identify how your community adopts policy and environmental changes<br>5. Conduct a scan of existing policies to identify gaps and opportunities to address these gaps (policy scans, key informant interviews) sub-contract with Public Health Law and Policy | |
| b. The Basics of Asset Mapping & Sample | Background information on asset mapping and an example were provided to the members. The members discussed the progress on the asset mapping and key informant interviews. Discussion was limited due to time constraints. | CHA components and committee member's roles to be discussed in detail at the next meeting. |

| Topic | Discussion | Outcome/Action |
|---|---|---|
| 5. Training Calendar | Training Calendar Check-In was proposed to be a standing agenda item. Members agreed, as this would allow for an opportunity to discuss training needs. A web-based access option and calendar are still being developed. | |
| 6. Next Meeting | **NOTE: NO JULY MEETING**<br>Date: Friday, August 10, 2012<br>Location: **Public Health** Conference Room<br>Time: 12:30am-2:00pm (Brown Bag Lunch) | |

**Community Transformation Grant**
**High Impact Clinical Preventative Services Ad Hoc Committee**
**Meeting Notes**
**August 10, 2012**

| | | |
|---|---|---|
| **Present:**<br>Alex Lanzas - Health Net<br>Bryan Fusco – University of the Pacific<br>Karryn Unruh-Salomen - Health Services Agency, McHenry Medical Office<br>Lisa Poley - Health Services Agency | Marissa Mendoza - Health Services Agency<br>Robert Watson, MD – Stanislaus Medical Society<br>Rocio Huerta-Camara (via conference call), Sutter Gould Medical Foundation<br>Sharrie Sprouse - Health Services Agency<br>Vance Roget, MD – Medical Director Last Resort/Modesto Marathon<br>Vanessa Anderson - Health Services Agency | **Facilitator/Coordinator:**<br>John Walker – Health Services Agency<br>Amelia Goodfellow – Health Services Agency |

| Topic | Discussion | Outcome/Action |
|---|---|---|
| 1. Welcome/Introductions | The meeting was called to order, self introductions were made. Welcome to Lisa Poley, Health Services Agency - CPSP, Vanessa Anderson, Health Services Agency - Finances and Alex Lanzas, Health Net | |
| 2. Community Health Needs Assessment Data | Amelia initiated the meeting by presenting the agenda items. Lisa Poley and Vanessa Anderson were in attendance to provided clarification regarding program and reimbursement questions that maybe needed in order to determine an indicator.<br><br>Dr. Walker presented data from the Community Health Needs Assessment completed in partnership with Memorial Medical Center. The data provided some context to the evidence based data that will include CTG's and the Ad Hoc's role in future work to address health disparities<br><br>• Lisa's expertise was called upon subsequently to the teams' concerns that needed clarification. Lisa presented information in regards to the Comprehensive Perinatal Services Program (CPSP). The CPSP is a program that includes Comprehensive Perinatal Health Worker (CPHW). The CPHW's role falls perfectly in with indicator #2 (**Use of Community Health Workers/Patient Navigators**) with minimum requirements as follows:<br>o Must be at least 18 years old<br>o High School Graduate or equivalent<br>o Minimum one year, full-time paid experience providing perinatal care<br>o Must work under the direct supervision of a physician<br>*Note: Typically, a CPHW are medical assistants prior to becoming a CPHW..* | *****Dr. Walker will provide the team with the actual decreased number of deaths as a result of diabetes vs. the increased number of hospitalization.<br><br>*****Lisa Poley will be a key informant interviewee.<br><br>*****Sharrie Sprouse will e-mail the link to the Community Health Needs Assessment To the members. |

| Topic | Discussion | Outcome/Action |
|---|---|---|
| 3. Determination: CDC Indicator<br><br>a. Model Program Sharing and Reimbursement Options | Indicator #2 has been appointed by consensus. That is, with the expansion of "patient navigators" to include health program groups such as pharmacy and nursing students and existing CHWs.<br>• Bryan Fusco may be able to commit 2 pharmacy students to an eventual pilot<br>• Independent pharmacies in the area could be looked into for additional buy-in<br>• When constructing any eventual pilots the following must be taken into account: oversight, training, and experience.<br><br>Vanessa also provided useful information; clarification ensued:<br>o No TCM monies may be applied to outreach and health education as it is a very structured system that would be difficult to utilize for this purpose.<br>o MAA is similar in that all monies used for outreach are specific to Medi-Cal recruitment. Therefore, this method cannot be used for this project either. | |
| 5. Community Health Assessment (CHA): Check-In<br><br>a. Asset Mapping<br><br>b. Community Readiness Model - Key Informant Interviews<br><br>c.. Policy Scan | <br><br>The HEAL and Tobacco-Free Living asset mapping has begun. The clinical component of the asset mapping still needs to be determined.<br><br>Completed one major component (selected an indicator). The next step will be to develop key informant interviews questions around the selected indicator.<br><br>To be determined | |
| 6. Training Calendar Check-in | The training calendar, archived webinars, resources and other tools will all be located within the CTG website. The website is currently in the internal PIO review process. | |
| 7. Next Meeting | **NOTE: Tentatively**<br>Date: Friday, September 14, 2012<br>Location: **Public Health** Conference Room<br>Time: 12:30pm-2:00pm (Brown Bag Lunch) | **Please note the next CTG Coalition meeting will be on Friday, September 21st from 11:30am-1:00pm in the Martin Conference Room. A policy training will be conducted. |

**Community Transformation Grant**
**High Impact Clinical Preventative Services Ad Hoc Committee**
**Meeting Notes**
**September 14, 2012**

| **Present:** | **Facilitator/Coordinator:** |
|---|---|
| Kennoris Bates - Golden Valley Health Centers<br>Marissa Mendoza - Health Services Agency<br>Robert Watson, MD - Stanislaus Medical Society<br>Vance Roget, MD - Medical Director Last Resort/Modesto Marathon | Amelia Goodfellow – Health Services Agency<br>Esmeralda Gonzalez - Health Services Agency<br>John Walker – Health Services Agency |

| Topic | Discussion | Outcome/Action |
|---|---|---|
| I. Welcome/Introductions<br>a. National News: High Blood Pressure | The meeting was called to order, self introductions were made. Welcome to Kinnoris Bates, Golden Valley Health Centers .<br><br>• Dr. Walker commenced the meeting by presenting a recent CDC press release, which identified high blood pressure as the 2nd key contributor for heart disease and stroke; the first and fourth leading causes of death in the United States. Hence, proving that our efforts are in tune with national data. | **Dr. Walker suggested that this media clip be provided to the upcoming Heart Coalition Committee.* |
| II. CHA: Review Assessment / Interview | Amelia developed 3 of the 4 components of the Clinical Ad Hoc assessment tool/survey (Policy Scan, Focus Groups and Asset Mapping). The tool will provide first-hand feedback on health care providers' practices, as well as, the importance of the indicator chosen; the use of community health workers/health care students as patient navigators.<br><br>Amelia presented the drafted Clinical Ad Hoc assessment tool/survey as follows:<br>• The assessment tool consists of 4 sections that include: 1. Demographics (11 questions), 2. Worksite Policies (9 questions), 3. Clinical Preventive Services Best Practices (17 questions) and 4. Community Health Workers and Patient Navigators (25 questions). | **There will be additions to Question #1, Section 1, to read: "What is your profession or title?*<br><br>**Question #6, Section 2, is being developed and will have the same structure as its previous question (#5) and potentially target a 'healthy eating' topic (i.e. vending machine policies).* |

| Topic | Discussion | Outcome/Action |
|---|---|---|
| III. Determine Format<br>a. Survey Monkey / In-Person<br>b. Confidentiality<br>c. Forward to 2 staff or colleagues | Sections 1-3 will be in a survey format on survey monkey.<br>• All answers will be kept in confidentiality. However, there will be a bar at the end of the survey in which to insert your name if you wish to do so.<br>• All Ad Hoc Committee members will receive a link to complete survey. Committee members are encouraged to then forward the link to, up to 2, staff members or colleagues who work within their site.<br>• After completing sections 1-3, there will be a place to submit a best time that fits your schedule to do the face-to-face interview.<br><br>Section 4 will be conducted as a face-to-face interview or small (2-3 person) focus group.<br>• Normally, an hour is set for the completion of this section. However, the average time, according to interviews already conducted, is approximately 30 - 35 minutes.<br>• Due to time constraints and staff availability, the face-to-face interviews can be conducted in groups within an Ad Hoc Committee's work site. | **A team member suggested that the survey be timed, as leaving it open could prolong the time of completion.*<br><br>**The face-to-face interview will be audio taped to better capture each response.* |
| IV. Adjourn | All team members have until Wednesday, September 19th to provide feedback, suggestions, comments etc… before the final draft is sent out to the committee. Team members will then have approximately one week to complete the survey. | |
| V. Next Meeting | **NOTE: Tentatively**<br>Date: Friday, October 12, 2012<br>Location: **Public Health** Conference Room<br>Time: 12:30pm-2:00pm (Brown Bag Lunch) | |

# Community Transformation Grant
# Process Overview

## CTG High Impact

## Clinical Preventative Services

## Ad Hoc Committee

## Friday, May 11th

## 9:00am-10:00am

Stanislaus County HEALTH SERVICES AGENCY

# Purpose & Outcomes

- To provide an overview of the components and process of CTG.
- To establish CTG indicators/policy guidance.
- To establish roles and responsibilities.
- To establish trainings and schedule.
- To establish meeting schedule.

Stanislaus County HEALTH SERVICES AGENCY

# Grant Priorities for Stanislaus County

- Tobacco Free Living
- Increase Use of High Impact Quality Clinical Preventive Services (high blood pressure & high cholesterol)
- Active Living & Healthy Eating

Stanislaus County HEALTH SERVICES AGENCY

# CDC Requirements:
# CTG Core Principles (Mandated)

- Use & Expand Evidence Base
- Maximize Health Impact – jurisdiction-wide policy and environmental change strategies
- Advance Health Equity

Stanislaus County HEALTH SERVICES AGENCY

# Definitions & Terms

- **Indicators** – measurable change, indicator driven POLICY
  - (CDC's 3 Levels: core, optional and innovative)
- **Health Equity** – equality in the quality of health and health care across different populations; assuring no differences in health, that are unnecessary, avoidable, unfair and/or unjust.
- **Health Disparity** – inequalities that exist when members of certain population groups do not benefit from the same health status as other groups leading to a higher incidence of mortality rate. Health disparities can usually be identified along racial and ethnic lines, however can also extend beyond race to include areas such as access to healthcare, socio-economic status, gender, and biological or behavioral factors.

Stanislaus County HEALTH SERVICES AGENCY

# CTG Core Capacity Building Requirements: (18 months)

- Mobilize the Community
- Community Health Assessments
- Tell Your Story
- Implementation Plan

Stanislaus County HEALTH SERVICES AGENCY

# Mobilize Community

**Leadership Team**

- 24 Leadership Team Members
- Guide the capacity building process
- Spokespersons for the initiative
- Trainings & skills assessments

**Coalition**

- 47 Coalition Members
- Multi-disciplinary that supports strategic direction
- Engage in planning activities
- Trainings & skills assessments

**Ad Hoc Committees**

- 3 Ad Hoc Committees: Tobacco Free Living -14, Clinical -16 and HEAL 21 members
- Engage in planning activities
- Trainings & skills assessments

# Clinical Preventive Services

## Core Indicators:

- Use of pharmacists as health care extenders to promote control of hypertension and high BP
- Use of community health workers/patient navigators
- Use of health information technology for provider prompts/feedback, patient communication & data gathering
- Instituting and monitoring aggregated/standardize quality measures at the individual provider level and systems level (HEDIS, NCQA, physician quality reporting system
- Working with businesses community to improve access to and coverage of preventive clinical services for employees through health plans (purchaser's guide) and worksite policies

**Optional:** Diabetes prevention and tobacco cessation through the clinical setting

Stanislaus County HEALTH SERVICES AGENCY

# Community Health Assessments

**Secondary Data**

- Tobacco Free Living, HEAL, and Clinical Preventive Measures
- Includes: Census, CHIS, CHK, FitnessGram, broad determinants of health, OSHPD, HEDIS, Federal Office of Healthcare Quality, Death Statistical Mater File, County Health Status profiles

**Policy Scan**

- Tobacco Free Living - Local City Ordinances, ALA Local Grades, local funded programs
- HEAL – Subcontracted with Public Health Law & Policy it will include schools, employers, communities, general plans, etc.
- Clinical Preventive Measure (?)

**Asset Mapping**

- Tobacco Free Living, HEAL and Clinical Preventive Measures
- Local efforts
- Local resources

**Community Readiness**

- Key Informant Interviews - Tobacco Free Living and HEAL
- 6 Subgroups (Health care, community member, local leaders, faith-based, schools, & social services (FRC)
- Identifying KII per city/area

# Community Health Assessment – Con't

**Focus Groups**

- HEAL & Tobacco Free Living – Samuels & Associates Train the Trainer
- Coordinate and conduct throughout the county

**PRISM**

- CDC PRISM Training
- Populate with data and identify potential implementation strategies

**Community Readiness**

- Conduct again at the end of the initiative
- Same sample

**Community Engagement**

- Leadership Team, HEART Coalition and all three Ad Hoc Committees

# Discussion & Determine

**Discussion:**

- Community Health Assessment Components

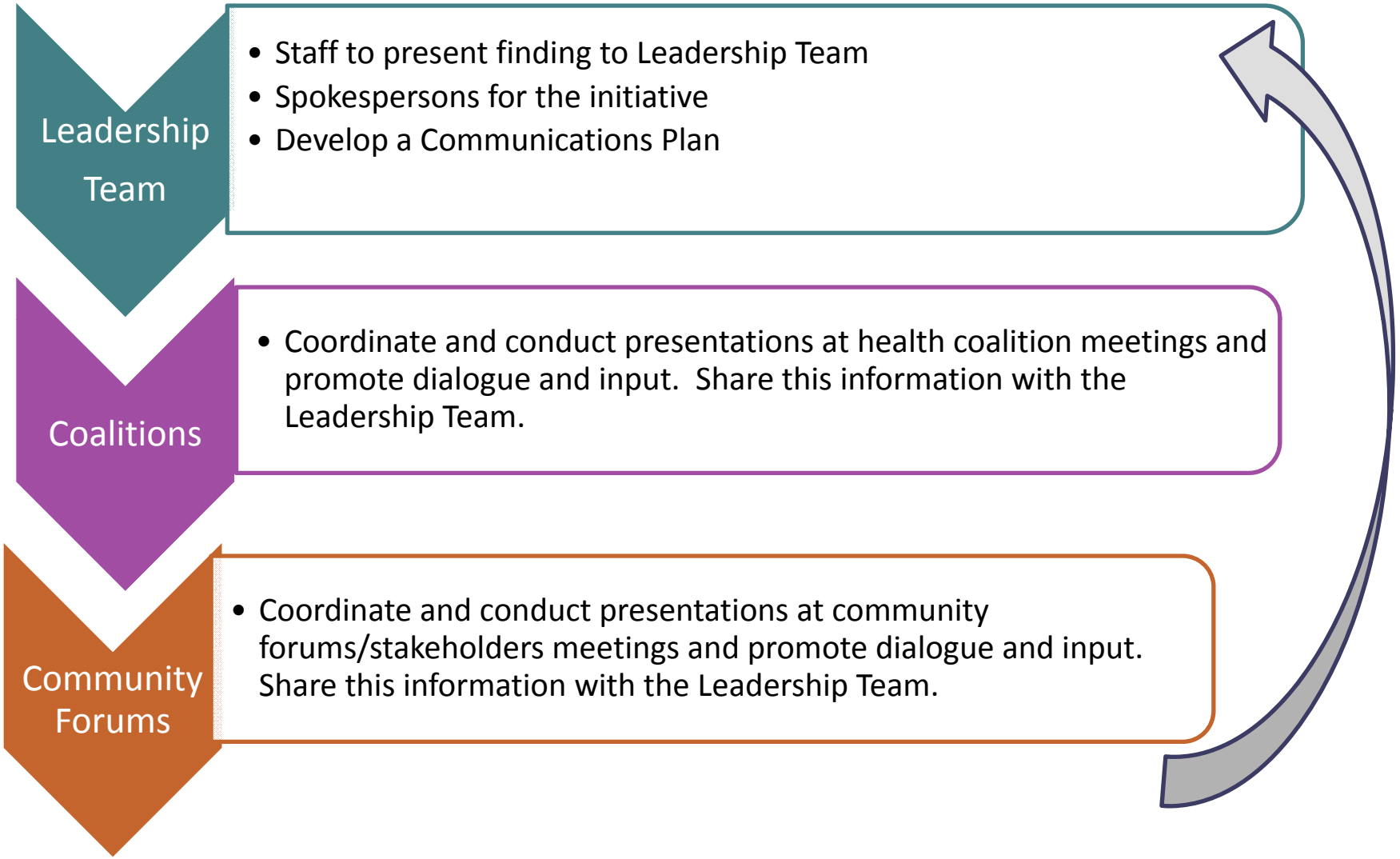
**Determine:**

- Clinical Ad Hoc Role
- Clinical Ad Hoc Responsibilities

(Utilize White Board)

# Compile All Assessments and Potential Strategies

# Tell Your Story



# Discussion & Determine

**Discussion:**

- Tell Your Story Components

**Determine:**

- Clinical Ad Hoc Role
- Clinical Ad Hoc Responsibilities

(Utilize White Board)

# CTG Overview – 18 months

# Implementation Plan

# Implementation

# Identify Trainings

# &

# Establish Training Calendar

**Community Transformation Grant**

***CDC Priority Area Indicators***

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**Grant Priority Area:** High Impact Clinical Preventative Services (high cholesterol, high blood pressure and diabetes)

**Core Indicators:**

- Use of pharmacists as health care extenders to promote control of hypertension and high blood pressure
- Use of community health workers/patient navigators
- Use of health information technology for provider prompts/feedback, patient communication and data gathering
- Instituting and monitoring aggregated/standardize quality measures at the individual provider level and systems level (HEDIS, NCQA, physician quality reporting system)
- Work with businesses community to improve access to and coverage of preventive clinical services for employees through health plans (purchaser's guide) and worksite policies

**Optional:**

- Diabetes prevention and tobacco cessation through the clinical setting
- Other innovative strategies as identified by community

**NOTES:**

Community Transformation Grant

High Impact Clinical Services Ad Hoc Committee

# Best Practices

June 8, 2012

# Overview

- Review of the core indicators
- Best practices for high impact clinical preventive services
- Conducting a clinical preventive services policy scan
- Community impact projects: examples in practice

# The Core Indicators

1. Use of pharmacists as healthcare extenders
2. Use of community health workers and patient navigators
3. Use of health information technology
4. Instituting and monitoring standard quality measures at the provider and systems levels
5. Working with the business community

*Optional:* Diabetes prevention and tobacco cessation through the clinical setting; other innovative strategies identified by the community

# Ad Hoc Focus Areas

- Cardiovascular health (core indicator)
  - Hypertension
  - High cholesterol
- Diabetes (optional indicator)

# Best Practices

Recommendations from

Dr. Thomas Frieden

Director, CDC

# Best Practices

- Clinical approaches should focus on the ABCS
  - Aspirin for high risk patients
  - Blood pressure control
  - Cholesterol control
  - Smoking reduction *

*Addressed in the Tobacco Free Living ad hoc group

# Best Practices

- To improve delivery of preventive services, clinical approaches should:
  - Focus on measurement
  - Generate regular feedback to providers
  - Utilize health information technology
  - Employ team-based approaches to treatment

# Best Practices

- Connect clinics with community through:
  - Panel management, including community members on decision-making boards
  - Partnership with groups that provide opportunities for physical activity
  - PHN presence in clinics
  - Using outreach workers to extend services beyond clinic walls

# Best Practices

- Key documents
  - Summary of Recommendations for Clinical Preventive Services, American Academy of Family Physicians
  - National Prevention Strategy
  - Guide to Clinical Preventive Services, U.S. Preventive Services Task Force
  - Guide to Community Preventive Services, Task Force on Community Preventive Services
  - Multiple Chronic Conditions: A Strategic Framework

# Conducting a Policy Scan

## Examples in Practice

# Conducting a Policy Scan

- CTG will conduct policy scan
- Identifies gaps, opportunities, and barriers for delivery of chronic disease prevention services
- Mix of methods including, but not limited to:
  - Key informant interviews
  - Document reviews
  - Secondary data review

# Centre for Rural and Northern Health Research , Lakehead University

- *Chronic Disease Prevention and Management for the North West LHIN*
  - Representatives of significant organizations
  - Key informant interviews
    - Novel chronic disease management models
    - Implementation of best practices
    - Health education resources
    - Self-management programs
    - Community initiatives
    - e-Health supports
    - Barriers to integrated chronic disease management
    - Ideas for improving integrated services

# Community Impact Projects

## Examples in Practice

# The Asheville Project

- Core indicator 1: Use of pharmacists as health care extenders

  *The intervention*: Employees of the City of Asheville with chronic conditions received intensive education at a local hospital, and were matched with community pharmacists who coached them on medication adherence.

  *The outcome*: Improved A1C levels, fewer sick days, lower total health costs, and improved patient-pharmacist relationships.

# Beacon Community Cooperative Agreement Program

- Core indicator 3: Use of health information technology

  *The intervention*: HHS Office of the National Coordinator for Health IT has identified 17 communities nationwide that have begun to adopt secure, private, accurate electronic health records (EHR) systems, providing $250 million over three years to strengthen EHR infrastructure, lower healthcare costs, and implement performance measurements.

  *The outcome*: Better patient follow-up and coordination of care, greater analytic capacity, and mobile patient communication.

# businessgrouphealth.org

- Core indicator 5: Working with the business community
  - Provides resources, evidence and support for employers addressing preventive healthcare in the workforce

  *Validated interventions*

  - Eliminate co-pays for preventive health screenings
  - Institute on-site biometric screenings
  - Disseminate health education materials
  - Develop employee – physician communication guides

# Discussion and Questions

**Community Transformation Grant**

***What does the Community Health Assessment (CHA) entail?***

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Grant Components

1) Mobilize the community
2) Assess community health status and needs through a Community Health Assessment (CHA)
3) Tell your story
4) Develop an implementation plan

Grant Component 2: CHA

1) Review secondary data, including population subgroup disparities analyses where applicable, on
    a. Chronic disease risk factors
    b. Chronic disease prevalence
    c. Hospitalization and ER visits
    d. Quality of care
    e. Mortality
2) Engage population subgroups experiencing health disparities in identifying community needs (Focus Groups) – sub-contact with Samuels & Associates
3) Review assets, tools and resources in your community (key informant interviews using the Community Readiness Model, Asset Map)
4) Identify how your community adopts policy and environmental changes
5) Conduct a scan of existing policies to identify gaps and opportunities to address these gaps (policy scans, key informant interviews) sub-contract with Public Health Law and Policy

# Clinical Preventive Services

## Ad Hoc Committee

MEETING #3

**August 10, 2012**

**12:30 – 2:00 PM**

Public Health Conference Room

# Agenda

- Welcome and introductions (10)
- Needs assessment data (20)
- Determination: CDC Indicator (45)
  - Model program sharing and reimbursement options
- Community Health Assessment (CHA) Check-In (10)
- Training Calendar Check-In (5)

# Needs Assessment Data Sharing

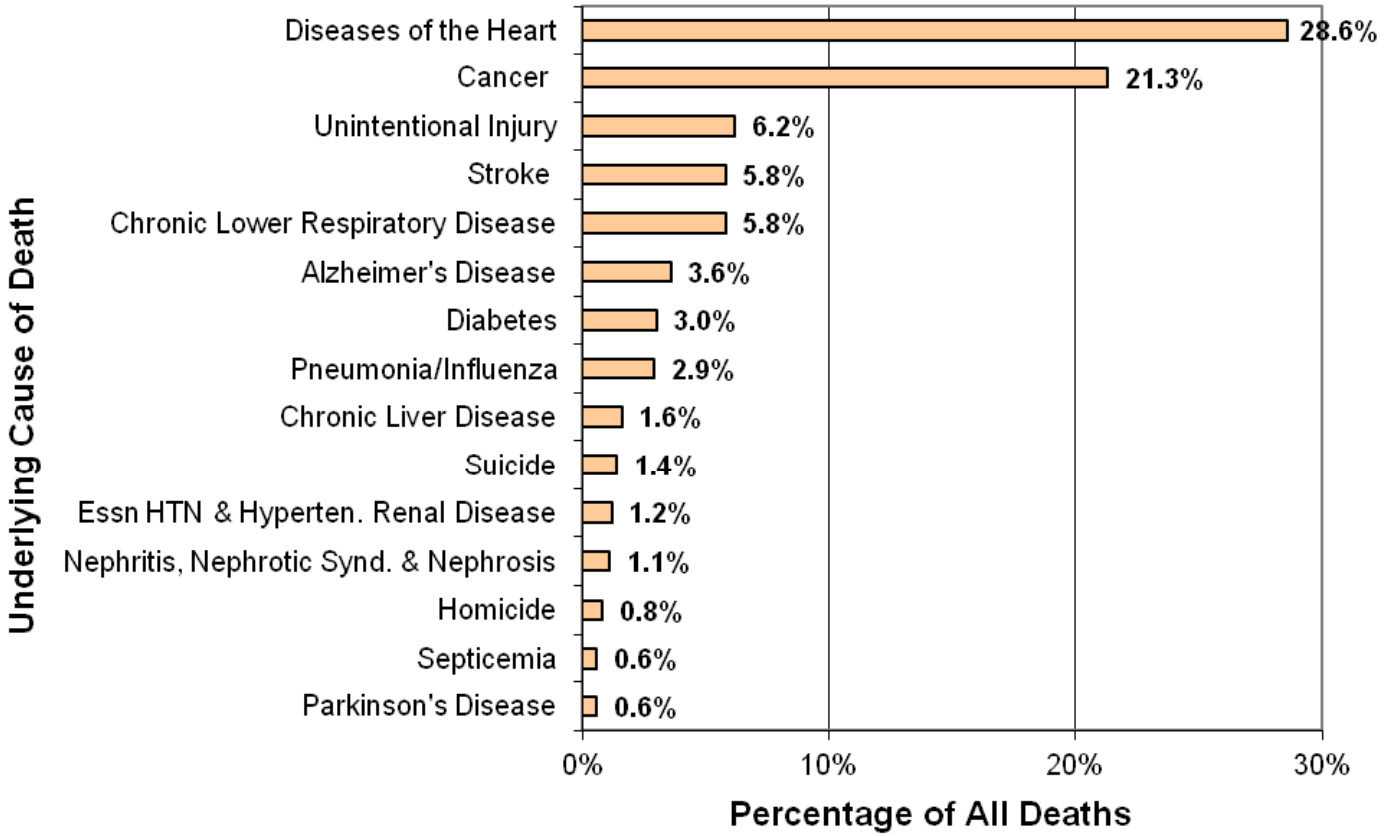
**COMMUNITY HEALTH NEEDS ASSESSMENT OF STANISLAUS COUNTY, 2011**

MEMORIAL MEDICAL CENTER

Available at hsahealth.org/PublicHealth/mainpages/data/index.html

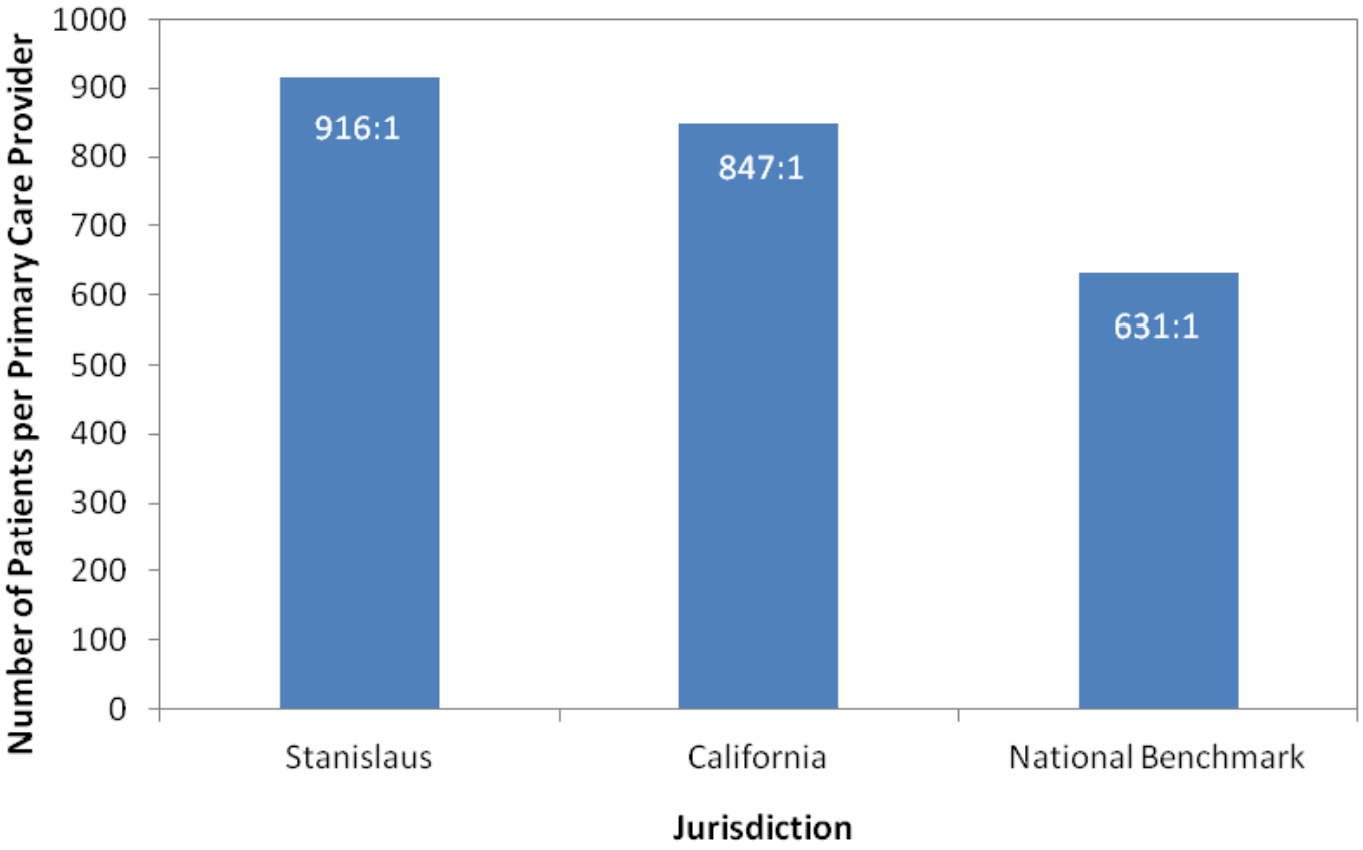
# Top 15 Causes of Death

## Stanislaus County 2005 – 2009




***Data Source***: California Department of Public Health, Health Information and Research Section, *Death Statistical Master Files* for Stanislaus County residents, 2005-2009

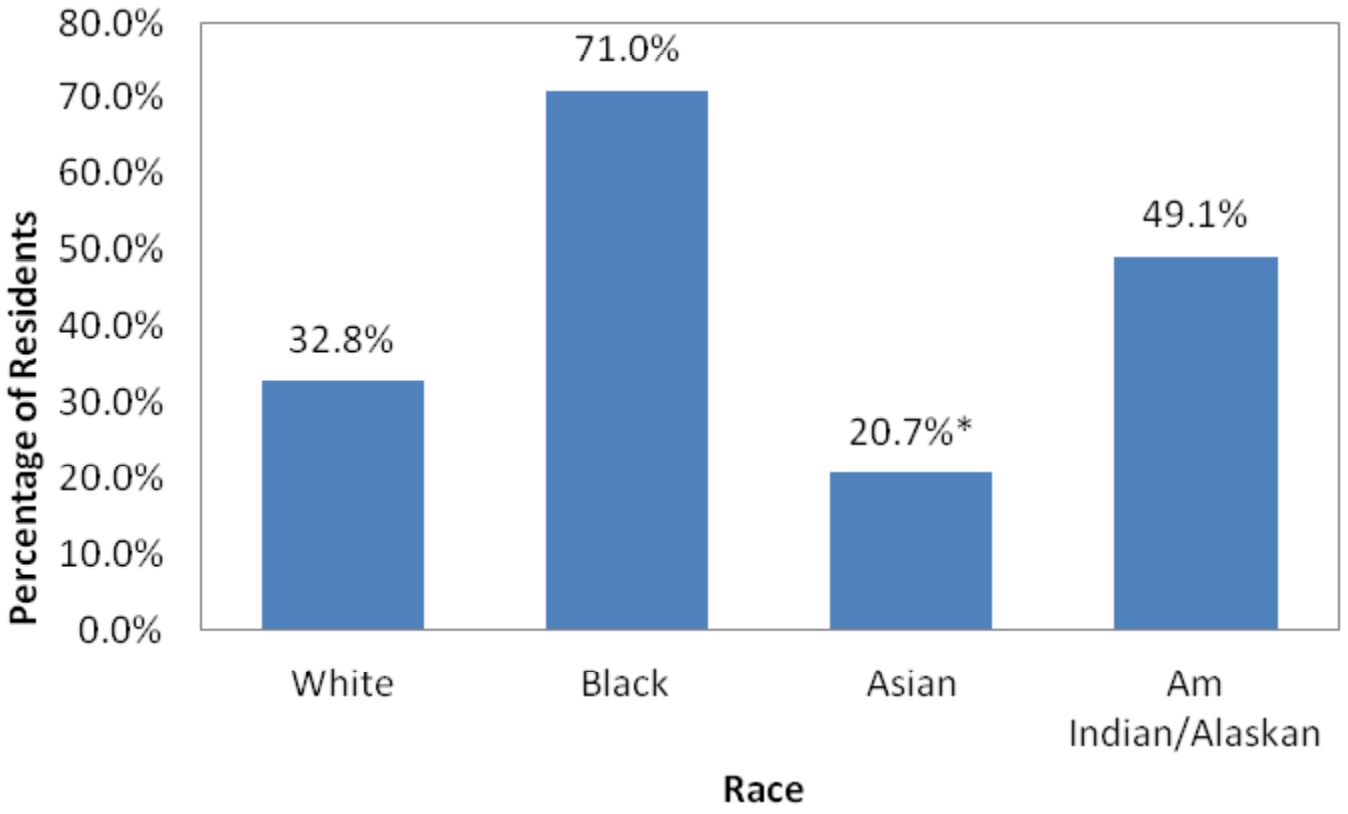
# Ratio of population to primary care providers




*Source: Robert Wood Johnson Foundation & University of Wisconsin's Population Health Institute, County Health Rankings.*

Available at hsahealth.org/PublicHealth/mainpages/data/index.html

# Stanislaus adults ever diagnosed with high blood pressure, by race, 2007 &2009

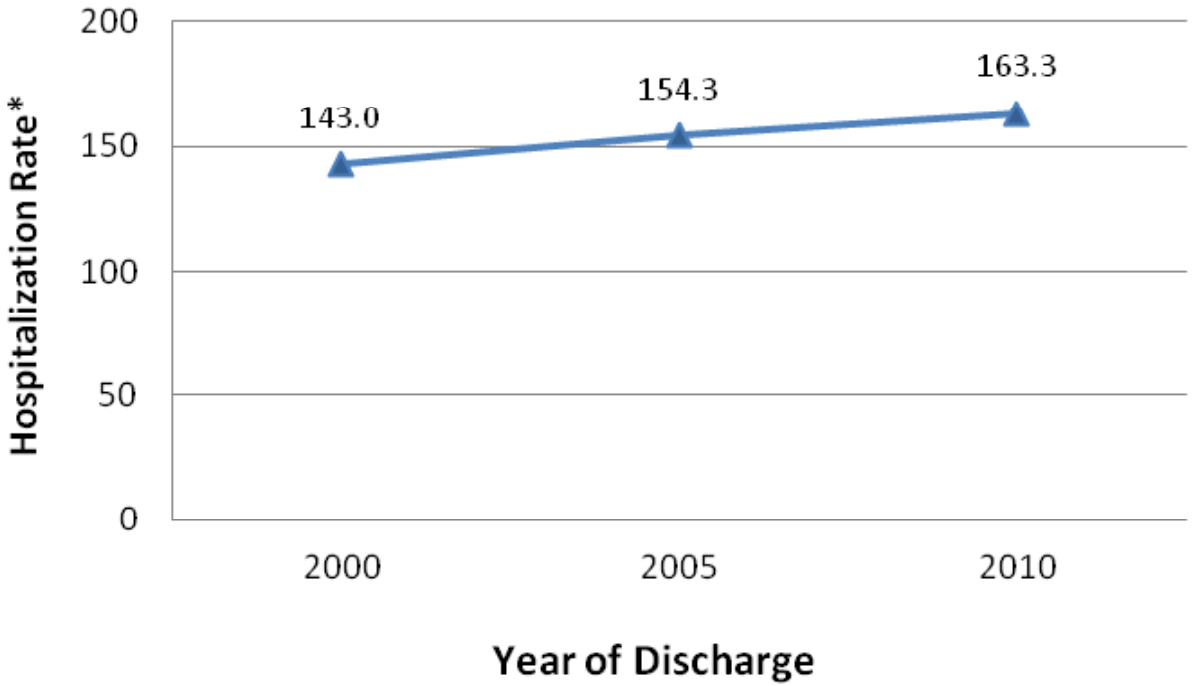



*Data Source: UCLA's California Health Interview Survey*

** = Statistically unstable*

Available at hsahealth.org/PublicHealth/mainpages/data/index.html

# Diabetes hospitalization rate over time in Stanislaus County




**Data Source:** Numbers of hospitalizations per year from the Office of Statewide Health Planning and Development's Patient Discharge Data Files for 2000, 2005 and 2010. Population figures from the 2000 US Census, the 2005 American Community Survey and the 2010 US Census.
*Rate of hospitalizations per 100,000 population

Available at hsahealth.org/PublicHealth/mainpages/data/index.html

# Hospitalization rates for Prevention Quality Indicators (PQI) in Stanislaus

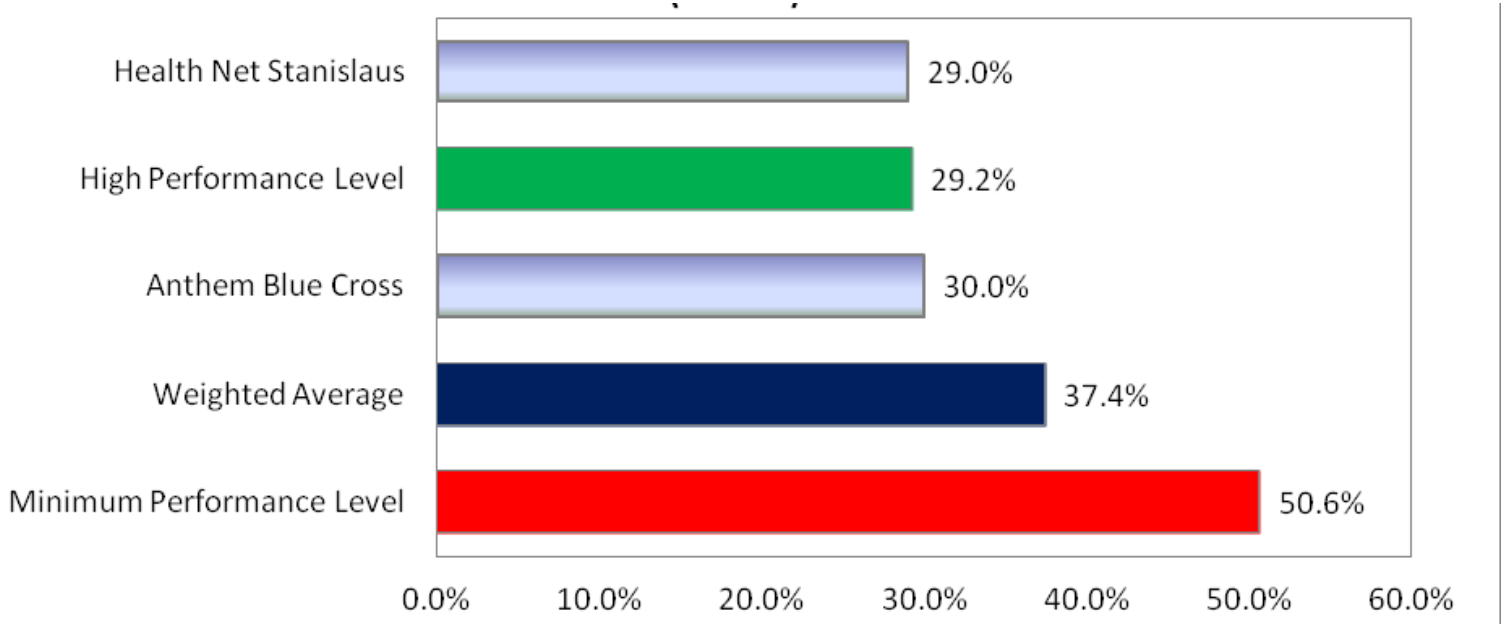
| Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators | Stanislaus Hospitalization Rate | California Hospitalization Rate |
|---|---|---|
| Bacterial pneumonia | 379.3 | 235.8 |
| Congestive heart failure | 368.9 | 272.4 |
| Chronic obstructive pulmonary disease (COPD) | 282.0 | 134.7 |
| Urinary tract infection | 185.9 | 155.9 |
| Diabetes long term complications* | 128.5 | 109.2 |
| Adult asthma | 103.8 | 87.3 |
| Dehydration | 65.1 | 57.7 |
| Diabetes short term complications** | 63.2 | 45.4 |
| Angina without procedure | 42.3 | 25.4 |
| Lower-extremity amputation among patients with diabetes | 38.7 | 28.3 |
| Hypertension | 36.8 | 36.0 |
| Perforated appendix | 29.6 | 27.0 |
| Uncontrolled diabetes | 12.3 | 11.9 |

**Diabetes long term complications include Diabetes with renal manifestation, Diabetes with ophthalmic manifestations, Diabetes with neurological manifestations and Diabetes with peripheral circulatory disorders.*
***Diabetes short term complications include ketoacidosis, hyperosmolarity and coma.*

Available at hsahealth.org/PublicHealth/mainpages/data/index.html

# 2010 HEDIS Measure for Medi-Cal Managed Care

## Poor HbA1c Control >9.0%

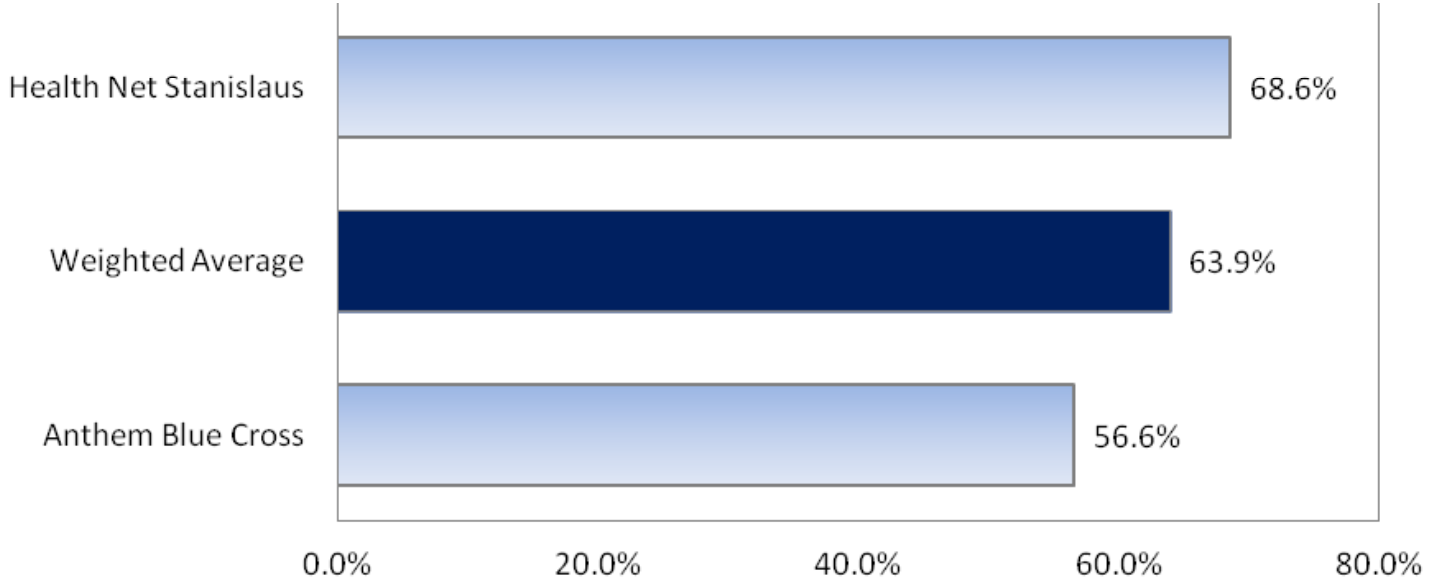



**Percentaeg of members 18-75 years of age with diabetes whose most recent HbA1c test showed a greater than 9% HbA1c level, indicating poor control**

Data Source: California Department of Health Care Services; 2010 HEDIS Aggregate Report for Medi-Cal Manaegd Care; see http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/HEDIS_Reports/HEDIS2010.pdf

# 2010 HEDIS measure for Medi-Cal Managed Care

## Blood Pressure Control (<140/90 mm Hg)




**Percentage of members 18-75 years of age with diabetes who had a blood pressure reading of <140/90 mg Hg**

Data Source: California Department of Health Care Services; 2010 HEDIS Aggregate Report for Medi-Cal Manaegd Care; see http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/HEDIS_Reports/HEDIS2010.pdf

# Determination: CDC Indicator

MODEL PROGRAM SHARING AND REIMBURSEMENT OPTIONS

# Core Indicator Choices

1. Use of pharmacists as health care extenders to promote control of hypertension and high cholesterol
2. Use of community health workers/patient navigators
3. Use of health information technology for provider prompts/feedback, patient communication and data gathering
4. Instituting and monitoring aggregated/standardized quality measures at the individual provider and systems levels (HEDIS, NCQA, physician quality reporting system)
5. Work with business community to improve access to and coverage of preventive clinical services for employees through health plans and worksite policies

*Optional: Diabetes prevention and tobacco cessation in the clinical setting; or other innovative strategies as identified by the community*

# Core Indicator Choices

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5. ~~Work with business community to improve access to and coverage of preventive clinical services for employees through health plans and worksite policies~~

*Optional: Diabetes prevention and tobacco cessation in the clinical setting; or other innovative strategies as identified by the community*

# Model programs and reimbursement

- Indicator 2: Use of community health workers as patient navigators
  - Promotora network
  - Perinatal services program CHWs

Should the info be on Indicator 1???

# Model Programs and Reimbursement

- Indicator 2: Use of community health workers as patient navigators
  - Promotora network
  - Comprehensive Perinatal Services Program (CPSP) which utilizes CHWs

# Administrative

COMMUNITY HEALTH ASSESSMENT (CHA) CHECK-IN

TRAINING CALENDAR CHECK-IN