10-1-2019

Clinical Evaluators Take Your Mark

Jodi Polaha  
*East Tennessee State University*, polaha@etsu.edu

McKenzie Highsmith  
*East Tennessee State University*, highsmithm@etsu.edu

William Lusenhop  
*University of New Hampshire*

Deepu George  
*The University of Texas Rio Grande Valley*

Adrian Sandoval  
*The University of Texas Rio Grande Valley*

Follow this and additional works at: [https://dc.etsu.edu/etsu-works](https://dc.etsu.edu/etsu-works)

Part of the [Family Medicine Commons](https://dc.etsu.edu/etsu-works), and the [Pharmacy and Pharmaceutical Sciences Commons](https://dc.etsu.edu/etsu-works)

Citation Information


This Presentation is brought to you for free and open access by the Faculty Works at Digital Commons @ East Tennessee State University. It has been accepted for inclusion in ETSU Faculty Works by an authorized administrator of Digital Commons @ East Tennessee State University. For more information, please contact digilib@etsu.edu.
Clinical Evaluators Take Your Mark

Copyright Statement
Authors are permitted to submit their presentation materials to repositories. The document was originally provided by Collaborative Family Healthcare Association Annual Conference.
CLINICIAN EVALUATORS: TAKE YOUR MARK!

Jodi Polaha & McKenzie Highsmith
East Tennessee State University

Will Lusenhop
University of New Hampshire

Deepu George & Adrian Sandoval
University of Texas Rio Grande Valley

Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.

Conference Resources

Slides and handouts shared by our conference presenters are available on the CFHA website at https://www.cfha.net/page/Resources_2019 and on the conference mobile app.

OBJECTIVES

Discuss two implementation outcomes and why they are important for clinicians to measure and report.

Name sources of data that are accessible to clinicians in healthcare settings.

Describe a range of dissemination activities that can have impact.

BRIDGE EXERCISE

EXAMPLE 1
EXAMPLE 1
ADOPTION OF PHYSICIAN REFERRAL PROCESS

Problem: Complex patients represent patient population often with the most problems, least resources and highest cost of care.

Action: Complex patient clinic developed to move towards a patient-centered approach to caring for complex patients. During implementation, various methods of enrollment in complex patient clinic utilized. Physicians have been trained on criteria that qualify a good candidate for complex patient clinic.

Question: Do risk assessment screening tools vs. a physician referral process result in better treatment reach?

Adopt: Do physicians adopt the referral method?

Reach: % of patients who receive low (just the assessment), medium (assessment plus some services), and high “dose” (comprehensive/graduation) of team care intervention

THE BRIDGE

Data:
- Electronic Health Record
- Physician feedback
- Appointment data
- Payer-provided information

EXAMPLE 2

HOW FAR TO REACH: IDENTIFYING UNDERSERVED STUDENTS FOR A PCBH MASTER'S TRAINING PROGRAM

Goal
Recruit students of Color and lower income students for PCBH Master’s Level Training Program (2nd Yr. MSW/MSOT)

Questions
- How far to REACH?
- Do students receive information about the training program?
- What factors affect the choice of training options?
- Of those REACHED, what percentage enroll in the program?

DATA --------------------------- BRIDGE

Data Sources / Issues
- Business Office: Incomplete Data
- Self-Report
  Issue: Response Rate

HOW FAR TO REACH: IDENTIFYING UNDERSERVED STUDENTS FOR A PCBH MASTER'S TRAINING PROGRAM

- All First Year SW and OT Students
- All Jun/Sev Undergraduate SW and OT
- All Current Undergraduate Students
- All Potential Students in NH
- All Potential Students in New England
- All Students in the U.S.

Internal Department Lists
Self-Report Surveys

Not Feasible
Reach AND Ongoing Evaluation

Value to This Approach
- Baseline enrollment data
- Can test marketing strategies by year and across programs, i.e. F2F, OL, Hybrid

R = \frac{\text{Enrolled}}{\text{Received Marketing}}

EXAMPLE 3: ADOPTION AND REACH – MEDICATION REFILL PROTOCOL
ADRIAN SANDOVAL, PHARM.D., BCPS, BCACP
ASSISTANT PROFESSOR
DIVISION CHIEF OF RESEARCH, DEPARTMENT OF FAMILY MEDICINE
UNIVERSITY OF TEXAS RIO GRANDE VALLEY SCHOOL OF MEDICINE

TIMELINE
A shared burden: A recognized need to improve efficiency for medication refills
- Patients
- Medical Assistants
- Residents and Faculty
Current problem:
- Not patient centered
- Extra burden on patient
- Extra burden on providers
Phase I of solution:
- Pharm.D. requested to create a protocol
- Established a stakeholder committee
- Physicians
- Medical Assistants
- Residents
- Administrators
Protocol development:
- A week to prepare the protocol
- 6-8 weeks for approval
- Implement into Cerner (EHR) after that

Data sources:
- ADOPTION
  Number is % of pts for whom MAs used protocol / Denominator is % pts for whom the protocol was relevant
- REACH
  Numerator is % of refill requests (via Cerner) / Denominator is % of total calls
  (P&I)
- Patient satisfaction with new refill
- Medical Assistant satisfaction, workload
- Implementation and scaling
  Second site added and a third site on board
  Would like to assess ease of adaptability of new protocol, based on clinic location and history (of patients calling in to use the new protocol)

EXAMPLE 4
INCREASING BEHAVIORAL HEALTH INTEGRATION:
CHANGING USE OF BEHAVIORAL HEALTH CONSULTANTS

Behavioral health integration systematically improves a healthcare team’s capacity to address whole person care.

Use of Behavioral Health Consultants: Conceptual buy-in; low frequency of referrals.

Low frequency and diversity in referrals: BHCS are called mostly for mental health referrals.

Low frequency and diversity in referrals systematically reduce opportunities for whole-person care.

MEASURE OF REACH: USING DATA AS FEEDBACK TO IMPROVE AWARENESS

Behavioral health integration systematically improves a healthcare team’s capacity to address whole person care.

Use of Behavioral Health Consultants: Conceptual buy-in; low frequency of referrals.

Low frequency and diversity in referrals: BHCS are called mostly for mental health referrals.

Low frequency and diversity in referrals systematically reduce opportunities for whole-person care.

September 20, 2019:
• AM Clinic
• 3 Residents in Clinic
• 21 scheduled patients (excluding walk-ins)
• 14 possible BHC consults

Medicare opportunities as a feedback and training opportunity:
• Collect data for 4 weeks
• Daily missed opportunities

Scrubbing the schedule:
Training residents to scrub the schedule
Systematize the process: inclusion / exclusion criteria, new patients and walk-ins.

Calculating reach:
Total number of completed BHC visits / Total number of possible BHC visits x 100 = reach
Total number of BHC visits / Total number of patients seen = population health penetration

AUDIENCE DISCUSSION

Name one study you could so evaluating adoption and/or reach in your setting
Describe sources of data you might use to evaluate this

DISSEMINATION OF SCIENTIFIC FINDINGS:
A TALE OF TWO WORLDS

Researchers
1. Journal articles
2. Face to face meetings
3. Media interviews
4. Press releases

Practitioners
1. Professional associations
2. Seminars/Workshops
3. Email alerts
4. Journal articles

Source: R. Brownson/TIDIRH
**DISSEMINATION**

Goals of dissemination

**Your Clinic:** how are we doing? what changes do we need to make?

**Clinical/Policy Community:** what innovations might help us with this problem?

**Scientific Community:** how can we study this better?

---

**Bibliography / Reference**


---

**Learning Assessment**

- A learning assessment is required for CE credit.
- A question and answer period will be conducted at the end of this presentation.

---

**Session Survey**

Use the CFHA mobile app to complete the survey/evaluation for this session.

---

Join us next year in Philadelphia, Pennsylvania! Thank you!