# AHEC Scholars Community Projects: Learning by Doing

DATE: October 4,2019

# Disclosures

There are no financial conflicts to disclose.

# Speakers

- Eric Wiser MD OHSU Department of Family Medicine
- Emma Felzien MD 2020
- Sherry Liang MD 2020
- Sarah Hayes MD 2021
- William Hockett MD 2020
- Ashley Stading MD 2020
- Daniel Stone MD 2020



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# Oregon AHEC System


*For more information on Oregon AHEC visit:* **www.ohsu.edu/xd/outreach/ahec**



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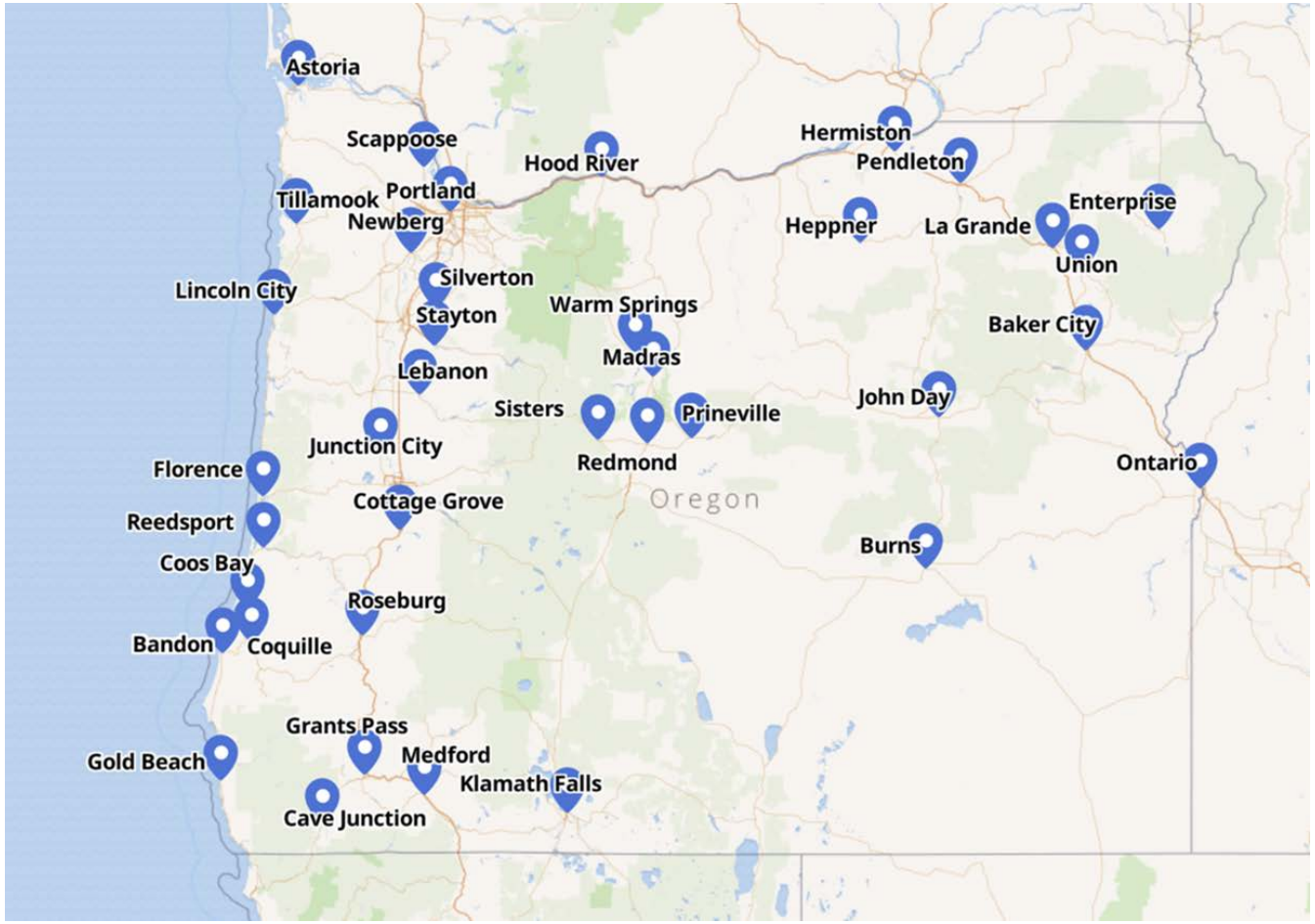
# Locations of Past Community Projects



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# Oregon AHEC Scholars Requirements

- Enrolled for 2 years
- Minimum 40 hours of team based clinical training per year
  - Rural or underserved setting
- 40 hours/year of didactics in 6 core topic area (supplemental to existing curriculum)
  - Inter-Professional education
  - Behavioral health integration
  - Social determinants of health
  - Cultural competency
  - Practice transformation
  - Current and emerging health issues



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# Current and emerging health issues

- Opioid abuse
- Team based ready provider training
- Infant mortality
- Tobacco use
- Suicide
- Alcohol abuse
- HTN
- Diabetes
- CVD
- Cancer
- Asthma
- Physical in-activity
- Low HS grad rates
- Lack of preceptors in rural areas
- Diversity
- Poverty



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# AHEC Scholars in Oregon

- Academic partners:
  - COMP-Northwest
  - OHSU
  - OSU
  - Pacific University
- 150-250 students state-wide each year


Oregon
Area Health Education Center

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# AHEC Scholars

- Five different professions from nine different programs:
  - Physician (DO, MD)
  - Physician Assistant (PA)
  - Pharmacist (PharmD)
  - Family Nurse Practitioner (FNP)
  - Dentist (DMD)
  - Nursing (BSN)


Oregon
Area Health Education Center

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# OHSU Family Medicine AHEC Scholars

- 12 week rotation
  - First 4 weeks FM Core
  - Next 8 weeks FM rural elective
- Weekly web based meetings
  - Case based student presentations
  - Behavioral health integration
  - Practice transformation
- Concludes with a community project

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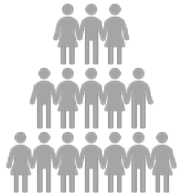
# One Key Question in Rural Oregon

"Would you like to become pregnant in the next year?"

# The Why

Teenage pregnancy – anecdotally high

Limited education and understanding of contraception



Goal: increase adolescent birth control use in Madras

“Would you like to become pregnant in the next year?”

# If they answer "Yes" or "Unsure"

"What **medications** or supplements are you currently taking?"

- Screen for teratogenic medications such as:
- ACE inhib, Isotretinoin, some Antibiotics, Warfarin, Seizure meds, Lithium, Methotrexate

"Are you taking **folic acid** or **prenatal** vitamins?"

- Educate regarding prevention of Neural Tube Defects

Educate importance of **birth spacing**

- Recommendation is to wait at least 18mos between pregnancies for hormone regulation.

Encourage **cessation of alcohol and drug** use

- Discuss risks of fetal and maternal harm

Review **immunizations**

- Give necessary live vaccines, avoid pregnancy for 1 month after vax

# If they answer "No"

"What are your **chances** of becoming pregnant right now?"

- Allow patient to offer their thoughts

"Are you **currently** using **birth control**?"

- If not using birth control, offer conversation about options

"Are you **satisfied** with that method?"

- Offer other options, especially LARCs (Implant, IUD)

"Do you have **emergency contraception**?"

- Discuss 3 options: Paraguard, Ella, Plan B

# Follow-up Conversations

- “I would recommend you chose a contraceptive method to protect against pregnancy until you are sure.”
- “I want you to know in a year’s time- 85 out of 100 women who have unprotected sex will become pregnant.”

# What can we do?

ASK One Key Question to **EVERY** patient (***male and female***) **15 – 50yo**, only excluding currently pregnant women

**Track** current use of birth control methods, counseling provided, and interventions made

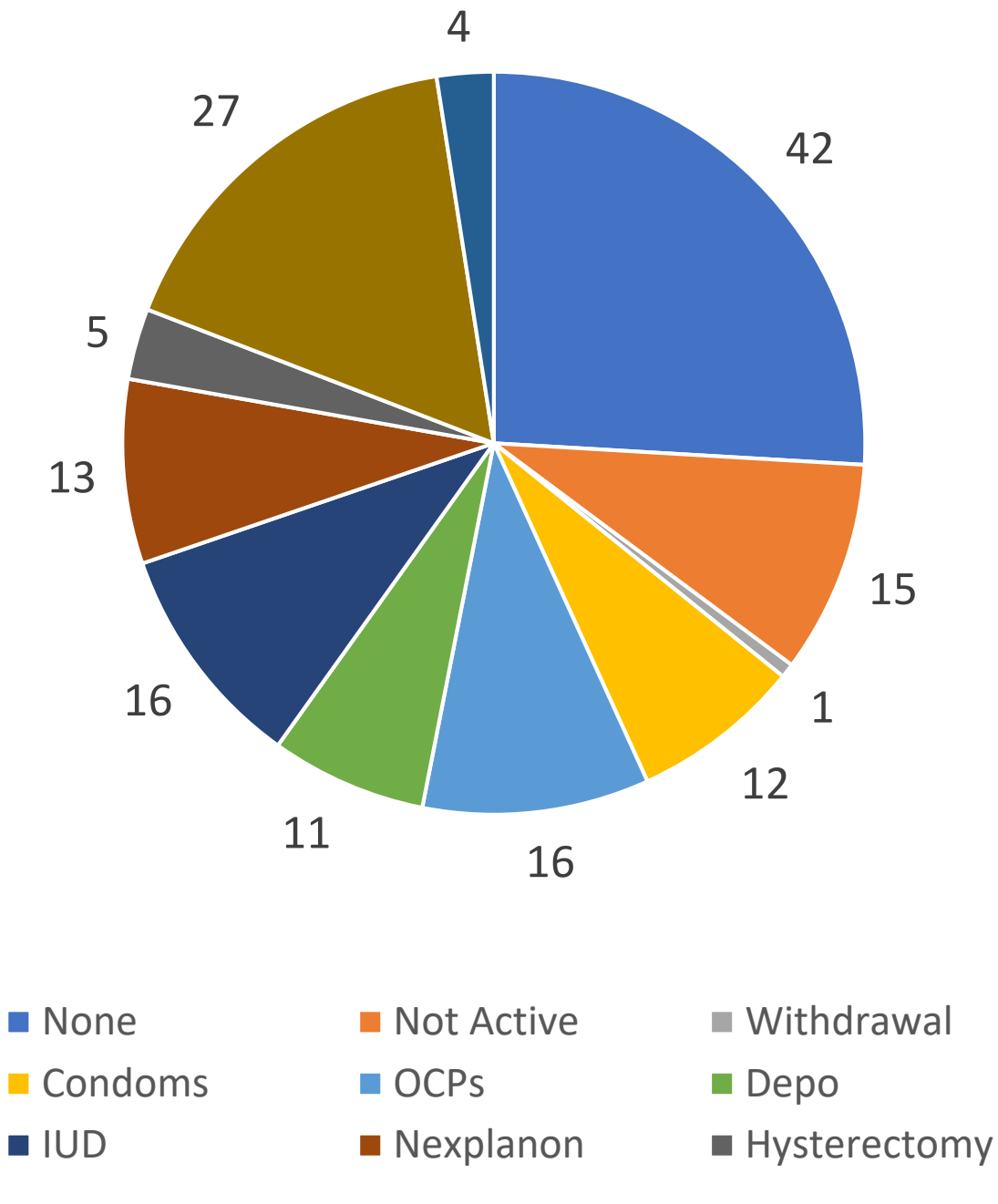
# Data Collection

## 162 Patients Screened

- Female: 121
- Male: 40
- Female-to-Male: 1

## Want to become pregnant?

- Yes: 13
- Maybe: 3
- No: 146 (HECK NO: 1)


4
27
42
5
13
15
16
1
12
11
16
None
Not Active
Withdrawal
Condoms
OCPs
Depo
IUD
Nexplanon
Hysterectomy

# Non-quantifiable Information

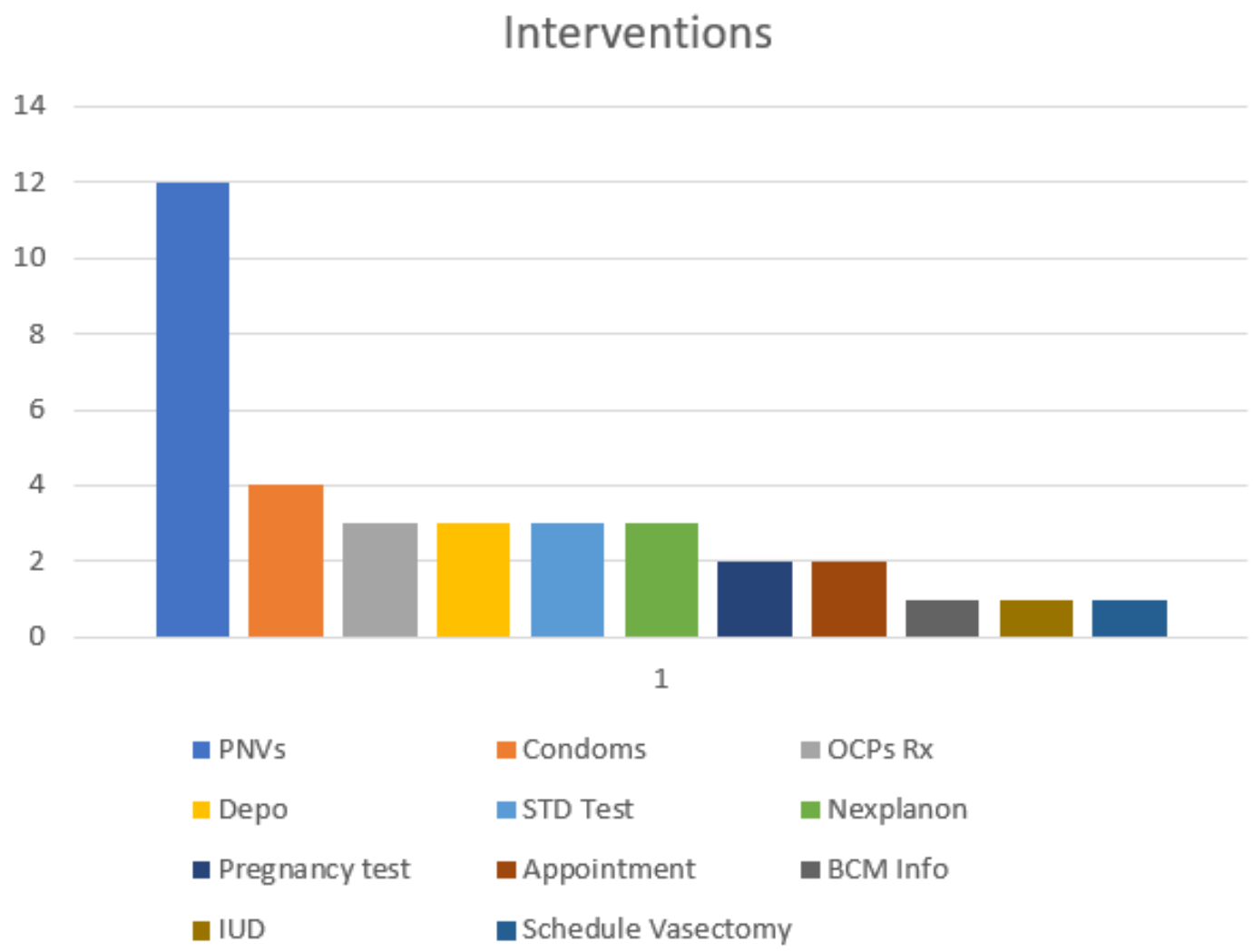
RAPPORT BUILDING

TIME SPENT DISCUSSING OKQ

PROVIDER COMFORT + PATIENT COMFORT

CLARIFYING MISUNDERSTANDINGS

Actionable Steps

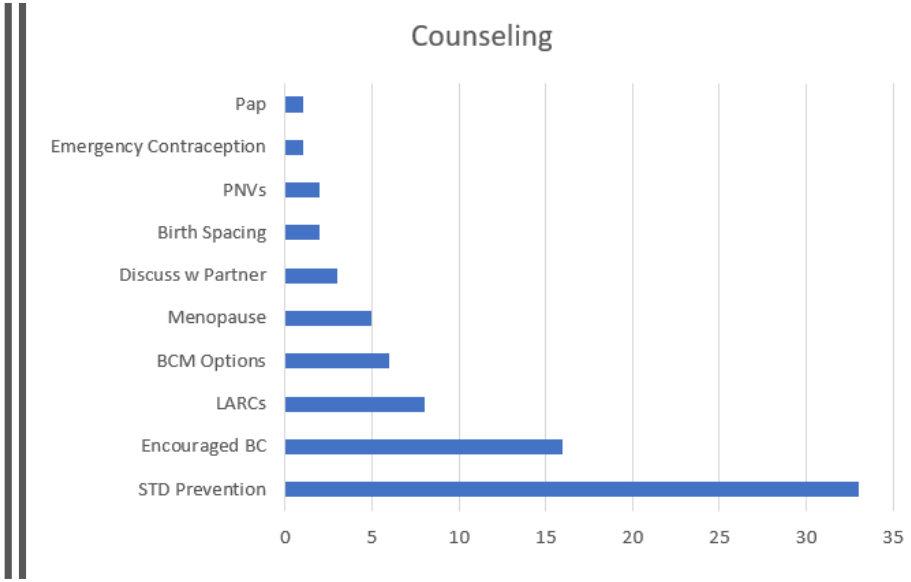


# How did we do?

- Of the **162** patients screened, **146** of them stated they **did not want to become pregnant** in the next year. Of those that did not want to become pregnant, 58 did not have any method to prevent pregnancy.
  - 88 already using birth control
- We **started 16 "birth control naïve"** patients on some form of contraception
- Encouraged birth control use in nearly ALL encounters

# Counseling and Discussion

| | |
|---|---|
| STD Prevention | 33 |



# Take-Aways

The One Key Question doesn't take much time – and can quickly improve rapport with patients!

In only 4 weeks, we implemented quite a few interventions and counseled many topics!

A birth control method handout would do WONDERS – sorry it didn't come in time

Most patients don't know their options

It's great to get the males involved in birth control.

# Collaborative Care in Primary Care Clinics: A Comparative Analysis

Sara Hays and Sherry Liang
AHEC Scholars
Lebanon, Oregon

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# Basics of Behavioral Health

- Studies estimate that mental health needs affect 10-15% of Western populations at any given time.
- There are a number of models through which it can be provided, including:
  - Integrated systems
  - Collaborative care
  - Colocation
  - Unaffiliated
- Fortunately, many types of providers work in mental health! (Psychiatrists, PCPs, NPs, clinical psychologists, social workers, etc)
  - Unfortunately, we don't have enough

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# The Collaborative Care Model —(CoCM)

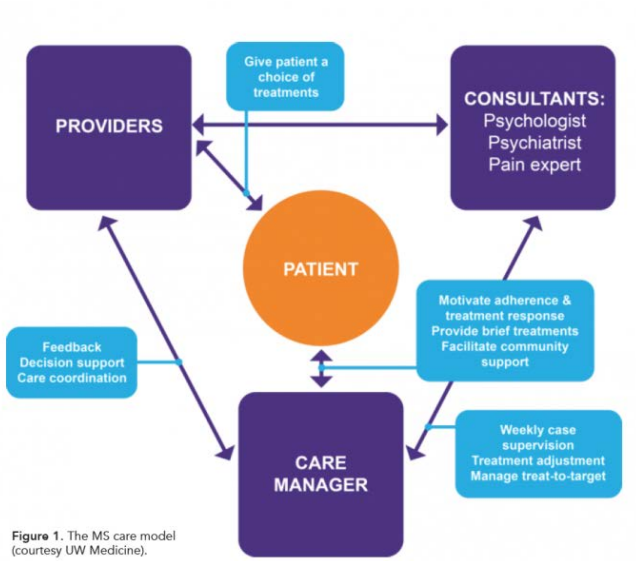


**Figure 1.** The MS care model (courtesy UW Medicine).

In a nutshell: a model involving a three-way interaction between the patient, the primary care provider (PCP), and a care manager, who inventories the patient's needs and shares the information with a consulting psychiatrist.

Why: improved clinical outcomes, lower costs of care, and greater satisfaction for patients and providers

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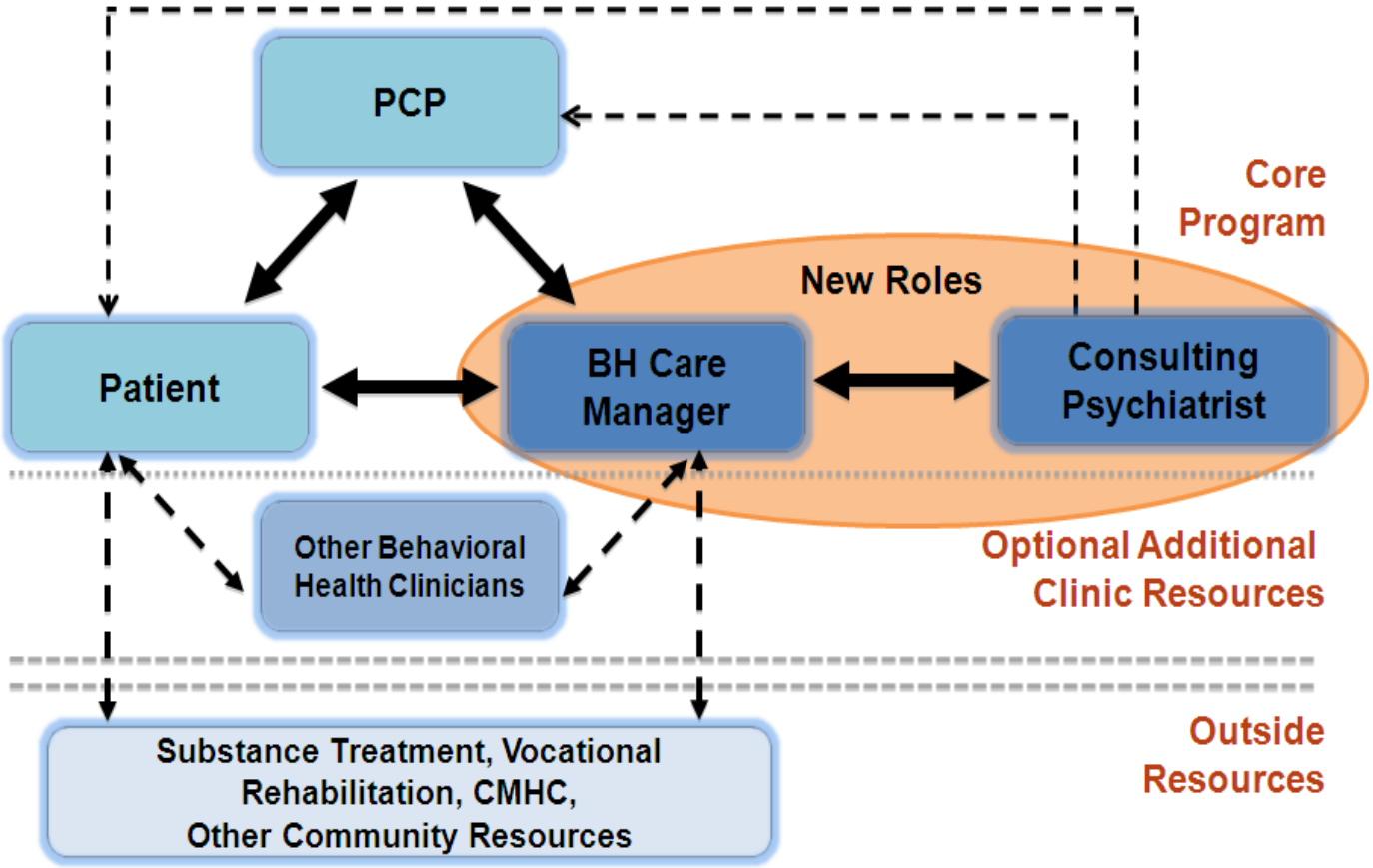
# Another view of this:

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# Origins and Expansion

The model was initially developed by University of Washington's Advancing Integrated Mental Health Solutions Center

- Officially established in 2004 based on the results of the IMPACT study
- Now widely expanded across many states

AIMS CENTER
UNIVERSITY of WASHINGTON

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# But why this? Why behavioral health?

Lebanon has a complicated economic and cultural past:

- Once a logging town but the industry shut down, skyrocketing unemployment
- Physically dangerous jobs led to work injuries, subsequently treated with opioids
- Already a drug trafficking hub due to its central location
- Culture of physical and sexual violence

The result: substance use, psychiatric concerns, and incredibly high ACE scores

Similar situation for all counties served by Samaritan (Linn, Benton, and Lincoln)

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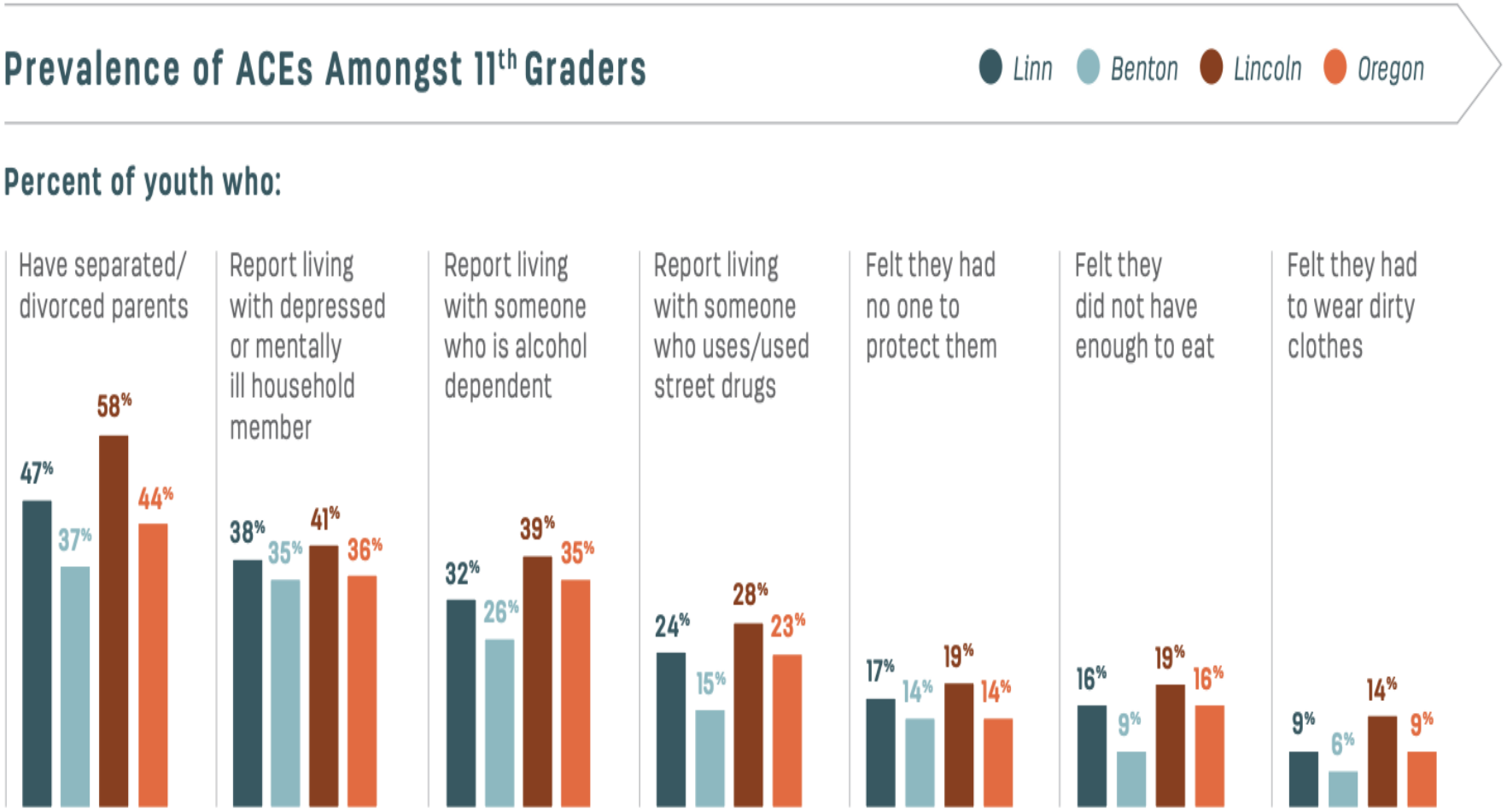
# Among Samaritan's counties:



# Recent Implementation

Samaritan Family Medicine Resident Clinic - Lebanon

Collaborative care started ~3 years ago in Lebanon, with expansions to 13 other sites since

- Family Medicine, Internal Medicine, and Pediatrics clinics
- Only a fraction of the clinics within Samaritan

So this started years ago, shouldn't there be data on this?

Theoretically yes, but in practice no

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# Objectives and Methods

**Aims of the study:**

1. To evaluate the primary care provider experience with CoCM at Samaritan sites.
2. Assess provider satisfaction with the model.
3. Solicit areas of improvement, from the provider perspective.

**How: Anonymous survey**

- 2 pages, designed to take <2 minutes to complete
- Based on previous studies assessing primary care-based collaborative care programs
- Personalized with input from Samaritan staff

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# Survey

**Primary Care Provider Perceptions of Collaborative Care (PATCH)**

The purpose of this survey is to understand the perceptions of primary care providers (PCP) on the collaborative care model in their respective clinics. The survey data will be utilized to understand what works well and what could be done better so that future quality improvement efforts can be targeted for better care, lower cost, healthier populations, and happier clinicians. *This survey is anonymous.*

**Collaborative care** is an evidence-based integrated care model in which PCPs partner with the mental health specialist embedded in the clinic to care for patients with mental health conditions. The mental health specialist works closely with a psychiatrist, who provides treatment recommendations for the PCPs via the electronic health record.

**Family Medicine Resident Clinic – Lebanon**

**Please indicate the total number of years you have been in practice as a PCP.**
- ❑ 0-5
- ❑ 5-10
- ❑ 10-20
- ❑ 20+

**I am confident in my ability to know when to refer a patient to the collaborative care model.**
- ❑ Definitely
- ❑ Possibly
- ❑ Unsure
- ❑ Possibly No
- ❑ Definitely No

**I know how to refer a patient to the collaborative care model in Epic.**
- ❑ Yes
- ❑ No

**Because of collaborative care, I feel more confident in my capacity to diagnose and treat mental health conditions.**
- ❑ Definitely
- ❑ Possibly
- ❑ Unsure
- ❑ Possibly No
- ❑ Definitely No

**The psychiatric consultation notes are communicated to me in a timely manner.**
- ❑ Always
- ❑ Most of the time
- ❑ Sometime
- ❑ Rarely
- ❑ Never

**From the psychiatric consultation notes, I learn something new that I can incorporate into my practice.**
- ❑ Always
- ❑ Most of the time
- ❑ Sometime
- ❑ Rarely
- ❑ Never

**The mental health specialist's visibility in clinic is:**
- ❑ Not enough
- ❑ Just right
- ❑ Too much

**The mental health specialist's availability in clinic (for warm handoffs, scheduling intakes, etc) is:**
- ❑ Not enough
- ❑ Just right
- ❑ Too much

**Please check the areas where you feel collaborative care is most helpful in providing care for your patients:**
- ❑ curbside consultations
- ❑ patient education
- ❑ diagnosis
- ❑ treatment recommendations
- ❑ proactive follow-up and monitoring of progress
- ❑ feedback from the mental health specialist on patient's progress
- ❑ other:

**Do you feel that the collaborative care model has improved the clinical outcomes of your patients who are enrolled in the model?**
- ❑ Definitely
- ❑ Possibly improved
- ❑ Unsure
- ❑ Possibly no improvement
- ❑ Definitely no improvement

**If you could change one thing in the clinic to improve care for patients with mental health conditions, what would you change?**

**Would you attend lunchtime didactics led by a psychiatrist (attending or resident) on psychiatry topics relevant to primary care?**
- ❑ Yes
- ❑ Maybe
- ❑ No

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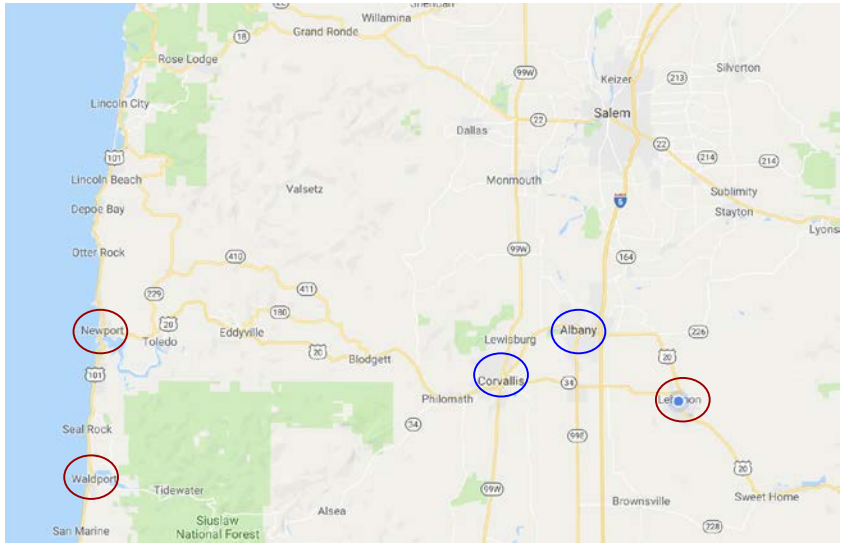
# Results

Preliminary findings from a sample of the 14 clinics:

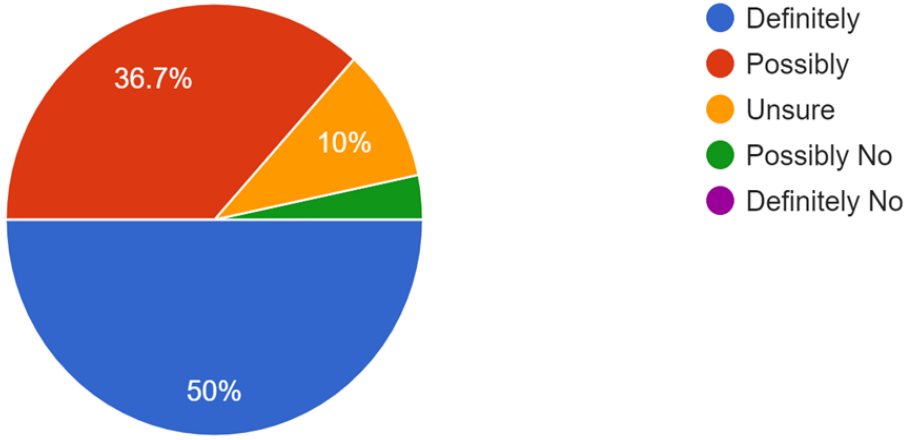
- 5 clinics from 3 counties: 3 rural, 2 urban
- 30 providers; 15 rural, 15 urban
- Even distribution of duration of practice
- Majority indicated confidence knowing when and how to use the model
- 56.7% responded that the mental health specialists were not available enough



# Confidence with mental health care: Aggregate

Because of collaborative care, I feel more confident in my capacity to diagnose and treat mental health conditions.

30 responses

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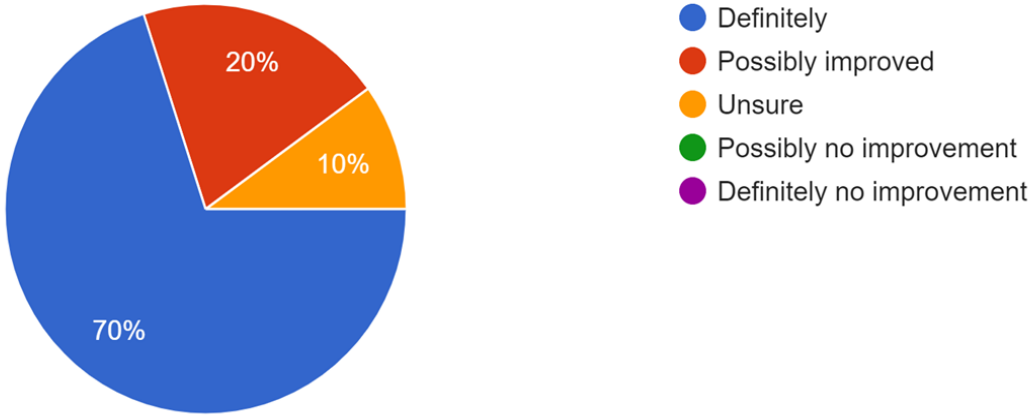
# Effect on patient outcomes: Aggregate

Do you feel that the collaborative care model has improved the clinical outcomes of your patients who are enrolled in the model?

30 responses

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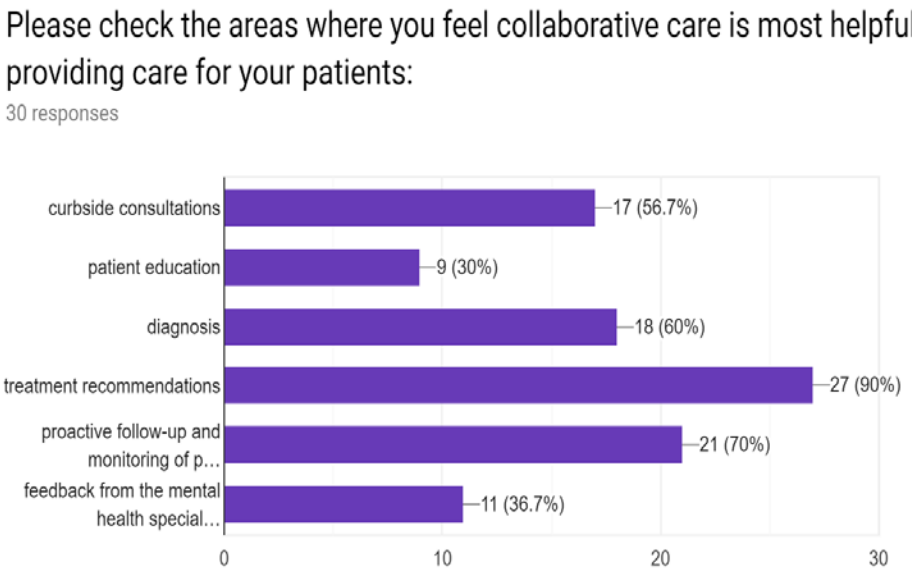
# How is the model helpful? Improvements?




**Suggested Improvements:**

- More mental health providers
- Better variety of mental health providers (i.e. women, people of color)
- Faster turnaround for consult notes
- More availability of additional behavioral health professionals (i.e. Certified Alcohol and Drug Counselor, etc)

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# Moving Forward

## Our next steps:

- Investigate the **patient perspective** through interviews
- Measure changes in **patient outcomes**
- Determine which patients are being referred to the model at each site
  - Identify common diagnoses, differentiate based on site, and determine if they are receiving adequate care

## Samaritan's next steps:

- Continue expansion, particularly in rural sites
- Focus on increasing staff, primarily behavioral health specialists
  - Increased variety as well
- Train PCPs on utility of this model and Epic!
- Provide online-based options for care!

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# Limitations

- Staff and provider turnover
- Clinic state at time of survey administration
- Inability to determine efficacy with no patient data
- Every community is different and can't be directly compared
  - Population-level differences
- Evidence for the model is limited to a specific subset of psychiatric conditions
  - We need to determine if clinics are using this model in an evidence-based manner

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# Take-Away Points

- Collaborative Care is gaining popularity given its improved outcomes and reduced cost
- Samaritan's implementation resulted in:
  - Reasonable PCP confidence navigating model and PCP-reported improved outcomes
  - Increased satisfaction for providers in rural areas
  - Enhanced treatment recommendations and proactive follow up
  - Possible improvements include increased number and variety of providers
- **Consider how this would impact your community:**
  - Is mental health an unaddressed need?
  - Do patients need more outreach and follow up?
  - Would providers appreciate an extra member of the care team?

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# Confidentiality During Adolescent Reproductive Health Visits

Will Hockett (MS-4)

October 2019

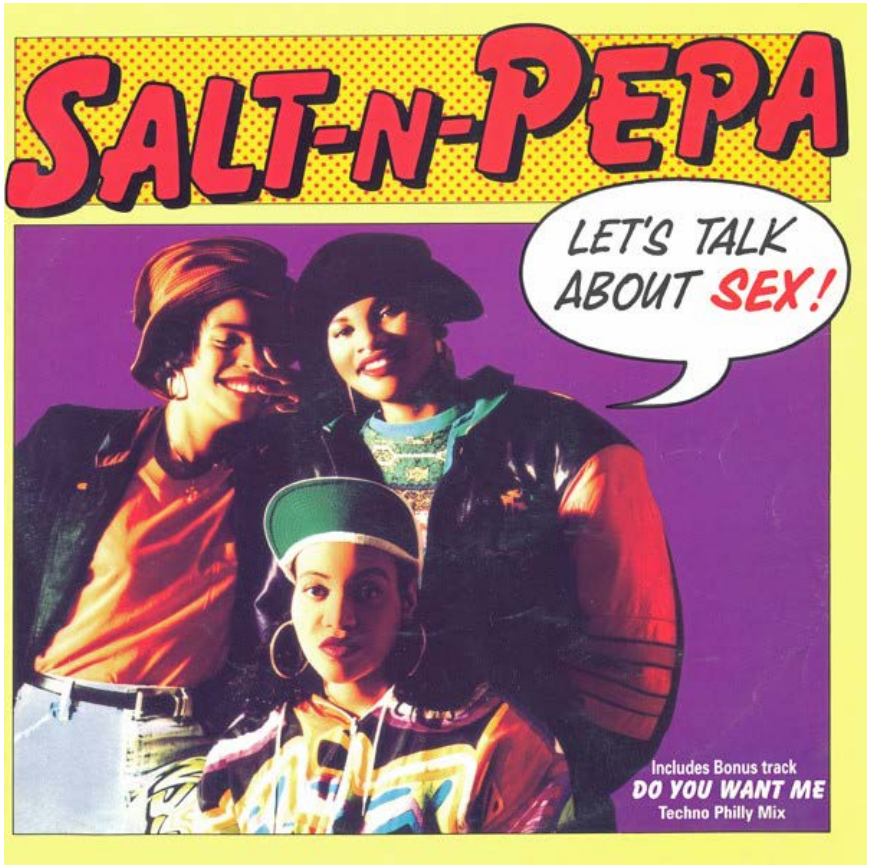
OHSU

# Case Presentation

14 y.o F presents to the clinic in need of **confidential** pregnancy testing and contraception. Her question to the front desk “Are you the new health department?”

What are some areas in the clinic workflow to be aware of to maintain confidentiality?

- **Billing (explanation of benefits)**
- **Appointment Notifications**
- **Access to online patient portals by parents**
- **Labs**

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# How did Wallowa County get here?

In April 2018, county commissioners voted to discontinue the county health department. One of the services that had been provided was reproductive health.

# A Statewide Issue

Oregon Health Authority Survey (2016)

- 32% redirected Care to another location. Either the Local Health Department or Planned Parenthood
  - Drive Time to Planned Parenthoods: Boise 4 hrs, Portland  5.5 hrs, Bend  6 hr drive.
- 41% of respondents report a financial impact. Because many locations don't bill insurance when the patient asks the visit to remain confidential

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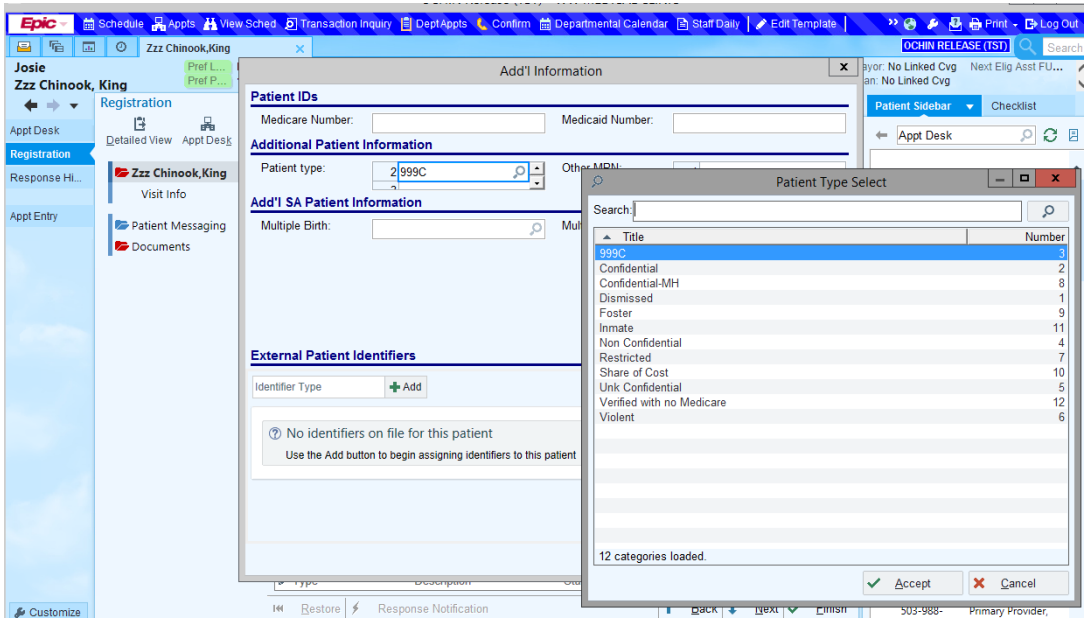
# Confidential Visits: 999C Method

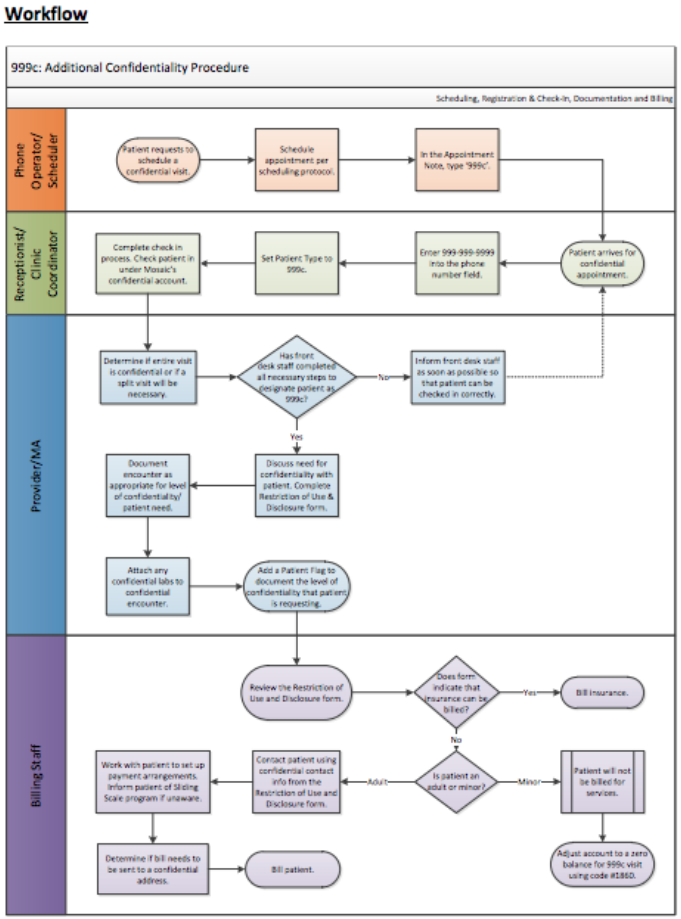
- Changes the patient note type
- Flags it as confidential
- Additional review by billing
- Suppresses automated phone system



# Clinic Workflow

## Multiple Stops for 999C Confidentiality:

- From the front desk on a full clinic workflow was adopted
- Created Specific Lab workflow
- Billing is handled individually

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# Campus Description

- Interprofessional education and training
  - Dental, Dietetic, Medical, Nursing, Pharmacy, and Physician Assistant students
- Shared living accommodations
- Shared participation in rural community-engaged projects
  - Student projects bridge interprofessional education, research and community needs

Credit: Amy Dunkak BS, Operations Director

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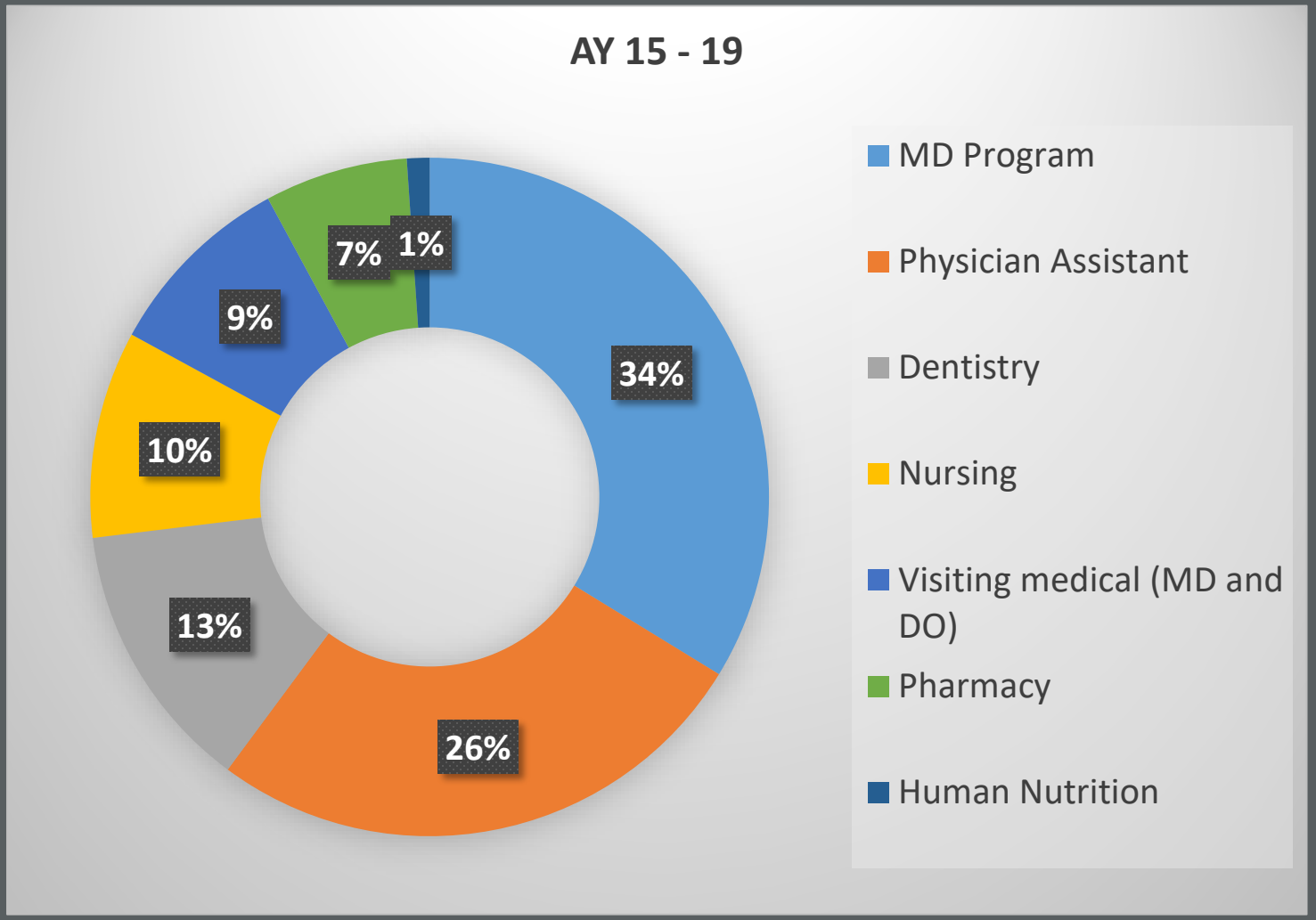
# Students/Programs




AY 15-16 through AY 18-19: 557 students served

Credit: Amy Dunkak BS, Operations Director

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# Campus for Rural Health staff

## Klamath

Joyce Hollander-Rodriguez, MD, Regional Associate Dean

Melissa Lemieux, Site Coordinator

## South Coast

Megan Holland, MD, Regional Associate Dean

Linda Martin, M.Ed., Education Coordinator

Roberta Meyer, Site Coordinator

## Northeast Oregon

Carla Hagen, PhD, MPH, RN, Regional Associate Dean

Meredith Lair, BS
Executive Director Northeast Oregon Area Health Education Center, Site Coordinator

Jill Boyd, MPH, CCRP
Primary Care Transformation Specialist
Eastern Oregon Coordinated Care Organization

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Elena Andresen, PhD, Executive Vice President, Provost

Jackie Shannon, PhD, Director, Integrated Program in Community Research

Amy Dunkak, BS, Operations Director

# How to Reach a Community to Make Change

Klamath fall Oregon Community Health Needs Assessment and peer education course creation

Ashley Stading MD 2020

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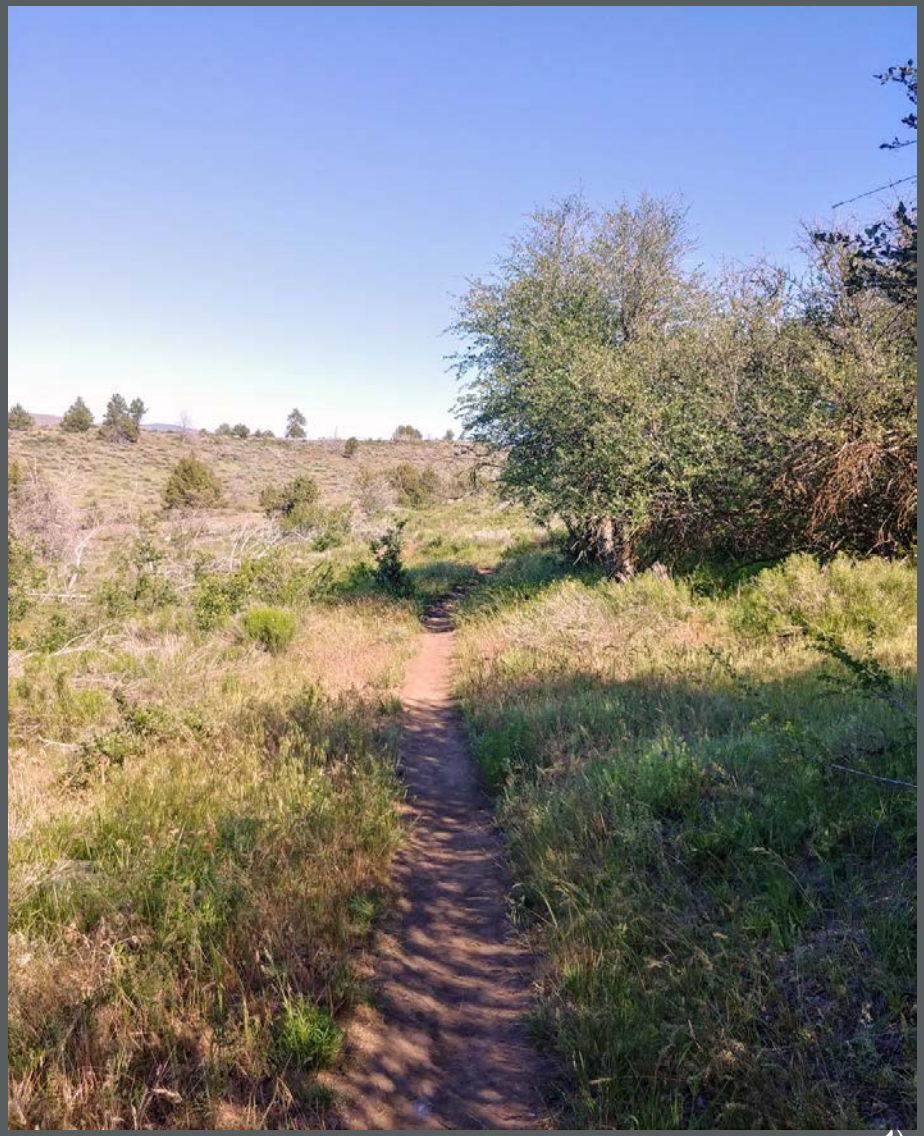
# Why a Peer Education Course?

- Klamath County has some of the highest rates of chronic disease
- Blue Zones  - Dan Buttener and the National Geographic identified the 5 regions of the world with the highest number of people in their 80s, 90s and 100s.
- 9 criterion associated with longevity
- Moais in Okinowa, Japan
  - Peer support groups
  - Longest living and heathiest of the aging community
- Health Klamath Coalition Created



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# Attempt One

- Peer education course directed at chronic health conditions and healthy living
- Those who attended and finished the course reported that the found it helpful
- Only 9 were able to finish the course

# Klamath Falls Health Needs Assessment

- Collected 400 surveys over several months
  - Health
  - Control over heath conditions
  - Desire for a peer group/course
  - LOGISTICS and BARRIERS
- Based on results creation of a diabetes peer education course
  - Location
  - Time of day and Day of week
  - Offering food

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# Course Creation

- Created a 1 day 1-2 hour Peer Education course on diabetes
  - Diabetes Empowerment and Education
    - My Body and Type 2 Diabetes
    - Visiting My Doctor
    - My A1c and Blood Glucose
    - Hyper and Hypoglycemia
    - My Medications: SQ vs Oral
    - Questions for My Doctor
  - Rounded out with Jeopardy
- Plan for several other topics if successful!

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# Tobacco Cessation

Daniel Stone MS IV
Oregon Health & Sciences University

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# Background

- During the Fall of my third year I spent three years doing rural continuity in La Grande OR at Grande Ronde Hospital.
  - September to December 2018
- This is a relatively new rural continuity for OHSU students and was created by a now surgery intern Michael Burt, MD
  - The normal continuity of community projects had not yet been established
  - Because of this, the
- The volume during the rotation was mostly endoscopy, skin lesion resections and elective hernia repairs.
  - There was an issue scheduling the elective procedures (requiring general anesthesia) with patients who had OHP and smoked
  - Thus the need for a smoking cessation project was born

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# Reason

- There is an abundance of reasons to start a smoking cessation program, this was created in a way to benefit the patients within the community.
- The project could not be proposed until there was appreciable interest and motivation to move forward with it from the hospital and the surgeons.
- The program was meant to be used to assist patients who are seeking help to quit smoking.
  - The program would need to be:
    - Financially sustainable
    - Carried out by social worker or community health worker
    - Easily accessible by patients
  - There is some evidence that patients need to be have invested in order to have success with cessation based behavioral therapy.[1]

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# Research

- There is an improvement in subjective / reported cessation rates among smokers who attempt to quit without help (3-5%), those who use pharmacologic assistance (7-16%), and as high as 24% in patients who use behavioral assistance programs.[2]
  - There is no evidence that individual or group based therapies are statistically different from each other.[3]
  - Despite this, one study in 2010 demonstrated that when asked retroactively, 72% of 3,583 smokers reported that they quitted without assistance.[4]
- Motivational interviewing has a direct effect on the patients number of quit attempts but does not directly impact abstinence rates.
  - Subjective reports of patients motivation to quit have a similar effect.  It has an impact on patients number of quit attempts [5]
  - USPSTF grades their recommendations on tobacco screening and cessation therapy as a “B’

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# Methods

- A curricula was created that would address the patients / participants smoking habits in four steps / modalities:
  - Motivational interviewing to determine barriers to quitting
  - Discussion regarding methods to quitting
  - Services to help cessation and abstinence
  - Relapse prevention
- This methodology was adapted from an behavioral program that addressed a similar barriers to care in Arizona.
- The methods would be carried out by community health workers (CHWs)
  - The CHWs would require certain certification by the State and the Easter Oregon Care Coordination Organization (EOCCO) in order to bill for their services. Medicaid is able to reimburse for these charges to make the program sustainable at the hospital level.
  - The CHWs are able to help with other social barriers that might prevent a patient  from quitting.

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# Outcome / Barriers

- The program has not yet been launched.
- The barriers that have existed are at a system level and are bureaucratic rather than any lack of motivation from those working on implementing it.
  - CHWs are unsure that they would have enough bandwidth to implement such a program between the 3 of them. There was a suggestion at making a new hire for the position.
  - The hospital is tentative to adopt a new payroll for such a program as the program would be the first of its nature and the agreement to charge OHP would depend on a meeting a patient quota and the charge per patient in the workshops.
  - There was no system to bill private insurance entities
  - Grants were targeted for the implementation of the project but there are logistics about the hospital transitioning the workshops into a (potentially) profitable.
  - Engagement was the biggest worry and with other resources in the area, CHWs and primary care offices chose to refer there in the meantime.

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# Future Work

- There are still plans to write a grant for a CHW to go to a tobacco cessation therapy training program to further stimulate the interest in the program.
- Assistance from local entity (NEON) has proven helpful to try to strike a deal between Grande Ronde and NEON to implement such a program.
- The local community surgeons and family medicine physicians were pulled into the conversations about next steps.
- More evidence based guidelines are continuing to grow and there should be center / urban / underserved / rural data to guide what type of program might benefit a healthcare system and its constituents.[6,7]

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# Things I would change (if I were to do this again)

- Occam's Razor
  - Most programs in Enterprise and Baker City involved local social workers or nurses to work one on one with patients in order to come to a plan to move forward with abstinence
    - La Grande was missing this person
  - This allowed for billable, evidence based visits to refer patients to programs within the county / city.
    - This method also did not require a volume reliant billing system like the group therapy sessions.
    - The group therapy sessions are more popular in areas that are more densely populated.
- Assessing a community's interest in a project is not always enough.
  - The assessment of interest needs to be done in tandem with an assessment of barriers that might exist and prevent the project from being completed.
  - Interest in implementing a community project is not always an accurate depiction of the motivation that staff might have to carry out an admittingly difficult project.

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# Thank You