Prevention First Project
Environmental Scan Report:
Providers’ use of Electronic Health Records, Team Based Care, Community Health Workers, and the National Diabetes Prevention Program for the prevention and management of diabetes and hypertension in Monterey County

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1 Please see attached documents: 1) “MC Prevention First Report-Appendices A-C” and 2) “MC QIPMC Survey Data-Appendix D"
Introduction

Background

The 2010 Patient Protection and Affordable Care Act (ACA) changed the way healthcare is delivered, monitored, coordinated, and paid for. These changes include “value based incentives,” provisions for healthcare reimbursement based on quality outcomes as opposed to the standard “fee for service” model. This is a dramatic shift in how healthcare has been reimbursed through insurance since the evolution of government sponsored healthcare plans. With value based incentives, healthcare providers now have to prove they are improving the overall health of a population rather than just billing the insurers each time an individual visits their office or facility.

The ACA also created the Prevention and Public Health Fund (PPHF) which has provided the Centers for Disease Control & Prevention (CDC) with resources for prevention and for programs to improve population health outcomes, enhance health care quality and reduce private and public health care costs. One of the key goals of the ACA is to transform the nation’s health care system from one that focuses on curing illness to one that promotes health and wellness.

The Institute of Medicine (IOM) Roundtable on Population Health Improvement met in 2013 to explore the implications of provisions of the ACA for population health improvement efforts, i.e., to expand health care providers’ focus beyond episodic medical treatment to include a broader array of factors that impact health outcomes. This wider focus involves understanding the distribution of health outcomes across a population within a particular geographic boundary (e.g., Monterey County or Tri-County region) and “requiring nonprofit hospitals to transform their understanding of community benefit.”

The new reimbursement model is one direct intervention into healthcare management, and the Prevention First 1305 program is one way the CDC is attempting to improve how certain chronic diseases are managed - specifically diabetes and hypertension.

Prevention First 1305 Project Description and Purpose

The Monterey County Health Department (MCHD) has partnered with the Institute for Community Collaborative Studies (ICCS) at California State University, Monterey Bay to implement the Prevention First 1305 Project. This four year project is funded by the CDC through the California Department of Public Health (CDPH) and is aligned with the California Wellness Plan (CWP-2014), the state chronic disease plan, and with the Governor’s Let’s Get Healthy CA Task Force Report Priorities (2012). With this funding from the CDC, the CDPH selected Monterey County (MC) as one of four county health departments to address diabetes and hypertension through the coordination of chronic disease prevention and health promotion efforts.

The Prevention First Project year 1 activities culminated in a report of initial findings on providers’ use of electronic health records and community health workers from data collected as part of the 2012 Monterey County Safety Net Provider Study and initial planning and development for an assessment of providers’
activities. In year 2, the Prevention First Team identified and engaged a broad range of community partners to participate in the Quality Improvement Processes in Monterey County Health Care System (QIPMC) survey to assess Monterey County healthcare providers’ use of Electronic Health Records/Electronic Medical Records (EHR/EMR), Team Based Care (TBC), the National Diabetes Prevention Program (NDPP), and Community Health Workers (CHWs). The focus of the survey was on prevention of diabetes and hypertension, in preparation for efforts to share data and engage providers in years 3 and 4.

In years 3 and 4, the Prevention Team will utilize survey findings to collaboratively develop and implement Learning Action Networks (LANs), and other educational opportunities. With input and participation from key partners and champions, the goals will be to:

- guide local EHR implementation and use of EHRs for reporting on performance measures
- develop or expand the use of Team Based Care approaches
- develop opportunities to expand the use of the National Diabetes Prevention Program
- promote the engagement of Community Health Workers in the provision of high blood pressure and diabetes self-management programs.

Learning Action Networks (LANs) will bring together key players in the health and human service sector (hospitals, safety net providers, private practices, community based organizations, etc.) to collaboratively address diabetes and hypertension, to improve delivery of clinical and other preventative services, and to improve community-clinical linkages through health systems interventions. These LANs will involve in-person and online trainings, educational workshops, and the development and distribution of resources for use by providers, community-based organizations and other partners. LANs will allow key stakeholders to share resources and best practices, improving the quality of and access to care for those at risk of or living with diabetes or hypertension, and reducing the obstacles that prevent people from receiving the necessary care.

In year 1 the Prevention First Project focused on identifying partners, building relationships and creating preliminary information as a basis for the year 2 assessments which included:

1) Review/discuss 2012 Safety Net Provider study findings related to establishing priorities, identifying existing provider resources and promoting data sharing and communication.
2) Identify partners, roles and expectations for collaborating on standardizing performance measures for diabetes and hypertension.
3) Review, complete and implement QIPMC survey, and report on findings.
4) Collect Key Informant Interviews data re: utilization and effectiveness of CHWs for provision of patient/participant education and support (especially for self-management).

The long term outcomes of this project include improved prevention and control of hypertension and diabetes, with specific strategies focusing on the promotion of better management, communication, tracking and sharing of health data, especially for reporting performance measures, and involving patients in self-management of diabetes and hypertension. As illustrated in Figure 1, over the next two years the Prevention First project’s objectives include utilizing information gathered from the QIPMC survey and Key Informant Interviews (for CHWs) to collaboratively develop and implement information sharing activities including presentations, articles in local health related publications and trainings or local learning area networks, to promote and encourage: local EMR/EHR implementation and use for reporting on selected performance measures, use of Team Based Care approaches, engagement of Community Health Workers in the provision
of high blood pressure and diabetes self-management programs, and opportunities to expand the use of the National Diabetes Prevention Program.

Figure 1. Monterey County Prevention First 1305 Project Objectives

This report presents a profile of the utilization of Electronic Health Records/Electronic Medical Records, Team Based Care, Community Health Workers and the National Diabetes Prevention Program by Monterey County safety net6 clinics, hospitals, and private physician/medical group practices. The focus is on the prevention of high blood pressure and diabetes. This assessment will provide Monterey County Health Department with baseline information about providers’ activities in these four areas as a first step in a process to establish, expand and improve services for individuals at risk of or living with diabetes and/or hypertension.

This report evaluates what is already being done in the local healthcare system to address these issues. It can also serve as a starting point for a discussion of what might be done to improve services to prevent and better manage these conditions for the benefit of Monterey County residents.

Monterey County Population Profile

Monterey County is a geographically diverse area located on the central coast of California, which contains a diversity of natural resources and opportunities, from Salinas Valley, known as the “salad bowl of the world”

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6 Institute of Medicine (2000) “Those providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable patients.” In addition, IOM states that in most communities a subset of the safety net exists and is described as the “core safety net providers” that generally have “two distinguishing characteristics: (1) either by legal mandate or explicitly adopted mission they maintain an ‘open door,’ offering access to services for patients regardless of their ability to pay; and (2) a substantial share of their patient mix is uninsured, Medicaid, and other vulnerable patients.”
for its expansive agricultural capacity, to Monterey Bay, home to popular coastal destinations and the vast open lands of the Los Padres National Forest. Monterey County has 433,898 residents in 12 incorporated cities (Carmel-by-the-Sea, Del Rey Oaks, Gonzales, Greenfield, King City, Marina, Monterey, Pacific Grove, Salinas, Sand City, Seaside, Soledad) and rural communities across 3,322 square miles. Monterey County residents are Hispanic or Latino (57.4%), non-Hispanic White (31.2%), Asian (6.9%), African American (3.5%), American Indian and Alaska Native (2.7%) and Native Hawaiian/other Pacific Islander (0.6%). Linguistically diverse, over half (52.8%) of county residents speak a language other than English in the home, and of languages other than English spoken, Spanish predominates in 45.8% of households.

According to the US Census Bureau, the median household income in Monterey County is $58,582, with 17% of residents falling below the federal poverty level, compared with 14.8% nationally and 16.4% in California. The California Health Interview Survey (CHIS) reports the largest segment of the population (18.7%), earns $20,001-$30,000 per year and the second largest (12.4%) earns more than $135,000 per year. Nearly 40% of Monterey County residents’ incomes fell below 200% of the federal poverty level in 2012 compared with 34% in the US and 36% in California. The biggest employment sectors in Monterey County are agriculture and hospitality combined at 48%, compared with 14% in California as a whole. These sectors are highly seasonal and low-paying, but during the period 2003-13 the agriculture sector grew relative to the rest of California. While these sectors provide important employment opportunities for many, the structural disadvantages created by the sector’s low wages and lack of benefits exacerbate the economic instability of families and individuals which reduces residents’ ability to tend to their health needs.

This situation is compounded by the significantly higher rates of un-insurance in the county. In 2015, Monterey County had the third highest (24.4%) uninsured rate among counties in California, more than twice the national average of 12% and significantly higher than California’s average of 14%.

The sizable percentage of low income residents and those who are uninsured raises concerns about the impact health disparities have on not only individuals, but on entire communities. Specifically, chronic conditions such as diabetes and hypertension disproportionately affect low income and minority populations leading to a decreased quality of life and an increased cost of treating disease.

Monterey County residents experience high rates of pre-diabetes and obesity. 2016 data from CHIS shows that 12% of the MC population has been diagnosed with diabetes compared with 10.3% in California as a whole. An additional 45% have pre-diabetes. 37.1% of MC residents are overweight (OW) for their age and 25.1% are obese (OB), compared with national (OB-37.9% OW&OB-70.7%) and California (OB-24.7% Adult) levels. In a study conducted by ICCS in 2014-15, over half (57%) of Monterey County residents reported overweight/obesity as one of the most significant community health problems; about half of respondents (51%) indicated that a lack of exercise was a significant community health problem, and

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1 US Census Bureau (2015)  
2 Monterey County Health Department (2013)  
3 US Census Bureau (2015)  
5 US Census Bureau (2015)  
6 Monterey County Health Department (2014)  
7 UCLA Center for Health Policy Research (2014)  
8 Judson, Navarro, Arevalo & Kelly (2015)  
12 Babey, Wolstein, Diamant & Goldstein (2016)  
13 Monterey County Community Health Assessment (2013)  
14 CDC (2014)
about a third indicated that significant community health problems included: a lack of needed medical, dental and mental health care; diabetes; and a lack of nutritious food.

Monterey County\textsuperscript{21} has slightly higher rates of hypertension than the state (28.7\%)\textsuperscript{22} and the US as a whole, with 33\% of adults being told at some point that their blood pressure was high.\textsuperscript{23} Luckily, obesity, diabetes and hypertension can be prevented for many individuals, and effectively managed for those that experience these conditions, through lifestyle intervention, self-management programs, and improvements to healthcare delivery processes. The Environmental Scans\textsuperscript{24} (QIPMC survey) serve as a starting place to evaluate what is already being done in the local healthcare system to address these issues and ultimately improve services provided to prevent and better manage these conditions for the betterment of Monterey County residents and the entire community.

**Methods**

**Questionnaire design, selection of participants, and data collection**

Year 2 Prevention First project activities consisted of implementing the Quality Improvement Processes in Monterey County Health Care System Survey and analyzing the data collected. Institute researchers initially compiled questions from four Environmental Scans (surveys) created by UC Davis for the Prevention First Project – one for each of the four focus areas – into one survey instrument. Additional questions were included as a follow-up to the 2012 Monterey County Safety Net Provider survey. The Safety Net Integration Council (SNIC), which is comprised of representatives from the county’s safety net clinics and hospitals,\textsuperscript{25} provided oversight and leadership in the development, design and implementation of the QIPMC survey. SNIC also reviewed the selection of organizations to participate in the survey, which involved identifying healthcare providers who serve as part of the safety net serving residents of Monterey County.

The survey distribution list included the SNIC member clinics and hospitals, individual physicians and group medical practices listed in the Central California Alliance for Health (Alliance)\textsuperscript{26} provider directory, and other clinics that participated in the MCHD 2012 Safety Net Provider Study.\textsuperscript{27} Research to identify additional relevant organizations included: using Google maps to search for medical providers; using SAM’s Guide (a Monterey County listing of public and non-profit resources) to identify practices that specifically address hypertension and diabetes; and a visual environmental search throughout the main population areas of the County. When necessary, direct calls to provider’s offices were made to obtain email addresses for distribution of the online survey instrument. Fax or hand delivery of a paper copy of the survey was offered to the few organizations that did not wish to complete the survey electronically. Each organization that provided an email address received a follow-up email prior to the survey launch date, with more information about the Prevention First Project and the QIPMC survey, highlighting the importance of their participation.

The final QIPMC survey consisted of ninety-two questions\textsuperscript{28}, 44 of which were adapted from the UC Davis Environmental Scans. The survey included closed-ended questions that provided respondents with answer

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\textsuperscript{21} Study included the following cities in Monterey County: Monterey, Carmel, Big Sur, Seaside, Marina, Pacific Grove, Pebble Beach, Salinas & Carmel Valley

\textsuperscript{22} Trust for America's Health and the Robert Wood Johnson Foundation (2014)

\textsuperscript{23} Professional Research Consultants, Inc. (2013)

\textsuperscript{24} See Appendices for Environmental Scan Questions

\textsuperscript{25} Definition of safety net providers: The “safety net” is described as providers that deliver health care and other related services to uninsured, Medicaid, and other vulnerable patients.

\textsuperscript{26} The CCAH is a regional non-profit health plan that serves 328,486 members, predominantly low income, in Santa Cruz, Monterey and Merced counties. (Central California Alliance for Health, 2015)

\textsuperscript{27} See appendices for survey questions
options for a specific question and open-ended questions that included a comment box in which respondents could write responses in their own words. In the analysis, closed-ended item (quantitative) responses are expressed in frequency tables with percentages and response counts calculated through Survey Monkey analytics. Cross tabulations were created using Excel pivot tables. The limited open-ended questions were manually compiled and analyzed for themes. A complete list of the survey questions can be found in Appendix A.

The QIMPC survey was administered from January 11 through April 12, 2016 to organizational managers of safety net clinics, hospitals, independent physician practices and group medical practices that provide services for MediCal beneficiaries and other residents of Monterey County. It was distributed through an online survey application (SurveyMonkey) to 75 participants across Monterey County including eleven safety-net clinics, four safety-net hospitals, and sixty private practices/medical groups. In an effort to increase the response rate, email reminders and direct calls were made to participants throughout the data collection period.

Results

Survey Responses
A total of 24 questionnaires were completed. The response rate for the 1028 safety-net clinics and 4 safety-net hospitals was 100%, whereas the response rate for private practices/medical groups was 16.7% (or 10 total) for an overall response rate of 32%. Additionally, four organizations, whose responses were included in the analysis, did not complete the survey in its entirety. The majority of responses (79%) were submitted online, with five (21%) submitted in hard copy and then entered by ICCS staff.

General information collected at the beginning of the survey included the organization’s name, address, phone number, fax number, website address, hours of operation, and name of the person responsible for completing the survey, their title and email address; the number of current individual sites operated by their organization, as well as additional new clinics or medical practice sites planned within the next three years.

Table 1 provides details on the sites identified through the QIPMC survey including four safety net hospitals, ten safety-net clinics and ten private practice/medical groups delivering care through (67) sites throughout the county.

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28 This rate excludes two surveys, from one safety-net clinic, that were deleted at the request of the organization.
29 Contact list available upon request.
Table 1. Providers identified in Monterey County, and (south) Santa Cruz County that serve MC residents

<table>
<thead>
<tr>
<th>Organizations</th>
<th>Sites</th>
<th>2012 – # sites</th>
<th>2016 – # sites</th>
<th>New planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 SAFETY NET HOSPITALS</td>
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<tr>
<td>1</td>
<td>Community Hospital of the Monterey Peninsula (CHOMP)</td>
<td>1</td>
<td>1</td>
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<tr>
<td>1</td>
<td>George L. Mee Memorial (Mee Memorial)</td>
<td>1</td>
<td>1</td>
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<tr>
<td>1</td>
<td>Natividad Medical Center (NMC)</td>
<td>1</td>
<td>1</td>
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<tr>
<td>1</td>
<td>Salinas Valley Memorial Hospital (SVMH)</td>
<td>1</td>
<td>1</td>
<td></td>
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<tr>
<td>10 SAFETY NET CLINIC ORGANIZATIONS</td>
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<tr>
<td>Clinica de Salud del Valle de Salinas (CSVS)</td>
<td>Castroville, Chualar, Greenfield, King City, Mobile Clinic, Salinas (Alvin), Salinas (Circle), Salinas (North Main), Salinas (Sanborn), Soledad, Pajaro</td>
<td>8</td>
<td>11</td>
<td>2 (Seaside &amp; East Salinas)</td>
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<tr>
<td>Monterey County Health Dept., Clinic Services Bureau</td>
<td>Alisal, BienEstar, Marina (2), Salinas (4-Laurel), Seaside</td>
<td>7</td>
<td>9</td>
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<tr>
<td>Planned Parenthood</td>
<td>Salinas, Seaside</td>
<td>3</td>
<td>2</td>
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<tr>
<td>Other independent safety net clinics</td>
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<tr>
<td>1. Big Sur Health Center (BSHC)</td>
<td>1</td>
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<td>2. Blind &amp; Visually Impaired Center of Monterey (BVICM)</td>
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<td>3. Casa de Cultura</td>
<td>-</td>
<td>1</td>
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<td>4. Mee Memorial Clinics *</td>
<td>2</td>
<td>5</td>
<td></td>
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<tr>
<td>5. Natividad (Specialty Clinic &amp; Natividad Medical Group)*</td>
<td>-</td>
<td>2</td>
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<td>6. Peninsula Primary Care (PPC)</td>
<td>1</td>
<td>-</td>
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<td>7. Salud Para la Gente (SPLG – Oral Medical Unit 1 &amp; 3)</td>
<td>2</td>
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<td>8. Soledad Medical Clinic (SMC)</td>
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<td>9. Taylor Farms (formerly Gonzales Medical Group)</td>
<td>1</td>
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<td>10. Rota Care</td>
<td>-</td>
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<td>11. Salinas Valley Medical Clinic PrimeCare</td>
<td>-</td>
<td>2</td>
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<td>12. SVMH*</td>
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<tr>
<td>1) Cancer Care</td>
<td>-</td>
<td>8** (5)</td>
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<tr>
<td>2) Healthcare for Women</td>
<td>-</td>
<td>1</td>
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<tr>
<td>3) Central Coast Surgery</td>
<td>-</td>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td>4) Central Coast Cardiology</td>
<td>-</td>
<td>1</td>
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<tr>
<td>5) PrimeCare (2)</td>
<td>-</td>
<td>2</td>
<td></td>
<td></td>
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<tr>
<td>6) SV Medical Clinic-Multispecialty</td>
<td>-</td>
<td>1</td>
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<tr>
<td>7) Taylor Farms Family Health &amp; Wellness Center</td>
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<tr>
<td>PRIVATE PHYSICIANS AND GROUP MEDICAL PRACTICES</td>
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<tr>
<td>1. Cypress Coast Cardiac Surgeons, Inc.</td>
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<tr>
<td>2. Doctors on Duty Medical Clinics</td>
<td>-</td>
<td>6</td>
<td></td>
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<tr>
<td>3. Edmonds and Lee Healthcare Practice</td>
<td>-</td>
<td>1</td>
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<td>4. Gregory S. Tapson, M.D.</td>
<td>-</td>
<td>1</td>
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<td>5. Monterey Bay Center for Integrated Health</td>
<td>-</td>
<td>3</td>
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<td>7. Pacific Family Medical Group</td>
<td>-</td>
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<td>8. Pediatric &amp; Adolescent Medical Associates of the Pacific Coast, Inc.</td>
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<td>9. Pinnacle HealthCare</td>
<td>-</td>
<td>3</td>
<td>1 (Soledad)</td>
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<td>10. Susan M. Kubica, M.D.</td>
<td>-</td>
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<td>Total reported</td>
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<tr>
<td>31</td>
<td>67</td>
<td>3</td>
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</tbody>
</table>

* These clinic organizations are associated with their respective hospital system and not counted separately.
** SVMH reported 15 clinic/practice sites, but only named 8, 3 of which (PrimeCare-2 & Taylor Farms-1) were separately surveyed. For purposes of this table/report sites are only counted once and only for sites/locations indicated in the QIPMC survey.
Figure 2 maps the respondents’ current sites’ (purple stars) locations which range from King City in the south, through the Salinas Valley to Pajaro at the county’s northern border, and along the coast from Big Sur in the south to the Monterey Peninsula. Survey respondents also indicated plans for three new practice sites (yellow stars) within the next three years in Soledad, Seaside, and East Salinas. Sites located in south Santa Cruz County that serve Monterey County (Pajaro) residents are indicated with (green diamonds).

Figure 2 Map of Respondents Sites

Respondents also identified their organization’s status or type. Many organizations had multiple responses. The most common healthcare organization types indicated by the survey respondents were Patient Centered Medical Home (21%) (PCMH), Private (Independent) Physician Practice and Private Physician Medical Group (19% respectively), followed by Rural Health Center/Clinic (15%) (RHC) and Community (Nonprofit) Health Center (13%) (CHC). A complete list of respondent types can be found in Appendix B.

Electronic Health/Medical Records
Health Information Technology (HIT) was developed in the 1960s and 1970s to manage and store patient information, and enhance medical providers’ ability to care for their patients. Electronic Health Records/Electronic Medical Records systems may track and record patient demographics, medical history (allergies, lab test histories, current and past health conditions, etc.), and encounter summaries. Additional functionality offered by EHR/EMR systems may include, but is not limited to: appointment scheduling; provision of after visit summaries/medical history to patients; some billing functions; and reporting and
information sharing with other points of care such as pharmacies, labs and other healthcare providers.\(^{30}\) It was the intention of the original EHR/EMR system developers to include social determinants of health (SDH) information such as patient-reported stressors related to financial and housing status: “[Dr. Weed] believed that all data, including SDH, could be acquired, stored in the EHR as structured data, and used to support clinical decision-making”\(^{31}\). Incorporating social, economic, and environmental factors that contribute to patients’ overall health into these systems can open the doors for comprehensive patient care that addresses health at the (individual) point of prevention, as well as at the population level. The added benefits of utilizing EHR/EMR systems include improving the quality of care and lowering health care costs, all while informing patients and engaging them in their care.\(^{32}\)

In Monterey County, 95.2% (20) responding organizations are currently using a certified EHR/EMR system, with one organization stating they did not know if it is certified. Only one organization stated they did not use an EHR/EMR system and did not know whether their organization had a plan to acquire or implement one.

Of the 20 organizations reporting currently using a certified EHR/EMR system, the majority (70%) implemented their EHR/EMR system after 2009, 20% before 2009 and the remaining 10% indicated no year. Organizations report the most commonly used EHR system is eMD (30%), followed by AthenaHealth (20%), Meditech (10%), Allscripts (10%), NextGen (10%), HealthFusion/MediTouch (5%), eClinicalWorks (5%), Amazing Charts (5%), and epic/OCHIN (5%).\(^{33}\) As indicated in Figure 3, most report some level of satisfaction with their current EHR/EMR system, with 21.1% very satisfied, 47.4% somewhat satisfied, 5.3% neutral about their satisfaction, 21.1% somewhat unsatisfied and 5.3% very unsatisfied. Figure 3 Satisfaction with Current EHR/EMR System

The majority (90%) of practices report that their EHR/EMR systems are certified by the Office of the National Coordinator for Health Information Technology (ONC) for the EHR/EMR Meaningful Use incentive program, and 10% report not being certified. When asked what level of “Meaningful Use” their

\(^{30}\) Ludwick & Doucette (2009)  
\(^{31}\) Bazemore et al. (2015)  
\(^{32}\) Xierali et al. (2013)  
\(^{33}\) Note: One organization reporting eMDs as their first EHR/EMR system, also noted using eClinicalWorks and OncoEMR
organization has achieved, a third (35%) of respondents report they are working towards Stage 2 in 2016, followed by 20% reporting they have achieved Stage 2 of Meaningful Use (MU) (displayed in Table 2).

Table 2. Participation in EHR/EMR Meaningful Use Incentive Program by Level of MU Achieved

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Frequency</th>
<th>Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, we are in the Adopt, Implement, Upgrade (AIU) phase for our first year in 2015</td>
<td>15.0%</td>
<td>3</td>
</tr>
<tr>
<td>Yes, we are working toward Stage 1 in 2016</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>Yes, we have achieved Stage 1 of Meaningful Use including: Data capture and sharing: E-prescribing, lab results into EHRs, send clinical summary to providers/patients, public health reporting, quality reporting</td>
<td>5.0%</td>
<td>1</td>
</tr>
<tr>
<td>Yes, we are working toward Stage 2 in 2016</td>
<td>35.0%</td>
<td>7</td>
</tr>
<tr>
<td>Yes, we have achieved Stage 2 of Meaningful Use including: Advanced clinical processes: Patient PHR access, e-prescribing refills, electronic summary record, receive health alerts, immunization information</td>
<td>20.0%</td>
<td>4</td>
</tr>
<tr>
<td>Yes, we have achieved Stage 3 of Meaningful Use including: Improved outcomes: Access comprehensive patient data, automated real-time surveillance</td>
<td>10.0%</td>
<td>2</td>
</tr>
<tr>
<td>No, we are not participating in the Meaningful Use program at this time (Please indicate why below)</td>
<td>10.0%</td>
<td>2</td>
</tr>
<tr>
<td>Don't know</td>
<td>5.0%</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: n=20

One barrier to realizing the maximum health benefits and savings associated with EHR/EMR system adoption is failure to address and develop interoperability and information exchange networks.34 In Monterey County, half of respondents with an EHR/EMR system report that they participate or collaborate with a Health Information Exchange (HIE), 20% do not participate, and an additional 20% report that they don’t know. Of the remaining two organizations, one reports being in the process of implementing and the other reports probably end of 2016 or 2017. Additionally, 74% (14) report that their EHR/EMR system has the ability to send/receive information between providers and about a third have the ability (allows providers) to search and/or request accessible clinical information on a patient from other providers (shown in Table 3). Slightly more than half (55%) report their system allows patients to access and manage their personal health information online.

Table 3: EHR/EMR System Support for Types of Health Information Exchange Functionality

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Yes</th>
<th>No</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directed Exchange – EHR/EMR system has the ability to send and receive secure (clinical and/or administrative) information electronically between health care providers to support coordinated care</td>
<td>14</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Query-based Exchange – EHR/EMR system has the ability (allows providers) to search and/or request accessible clinical information on a patient from other providers</td>
<td>7</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Consumer Mediated Exchange – EHR/EMR system has the ability (allows patients) to access and manage their health information online (e.g., similar to managing personal finances through online banking).</td>
<td>11</td>
<td>2</td>
<td>7</td>
</tr>
</tbody>
</table>

Note: n=20

34 Hillestad et al. (2005)
Additionally, fifteen respondents (75%) report that their health care providers exchange patient health information electronically with other providers within their organization and slightly less than half (47.4%) report exchanging patient health information outside their organization.

It is encouraging to note that while 27% of clinic sites reported in 2012 that they were entirely paperless and did not maintain paper charts, 50% of healthcare organizations report in 2016 that they are entirely paperless. While 40% of healthcare organizations report that they primarily rely on their EHRs/EMRs, but maintained paper charts for some patient/clinical information, the 2012 study showed that slightly more than a quarter did. Finally, in 2012, 36% of clinic sites reported using both paper and EHR/EMR systems and were in the process of transitioning to an entirely paperless system, just one health care organization responding is doing so now.

More than half of respondents report challenges in EHR/EMR adoption or use. Figure 4 shows the top two challenges reported as either somewhat of a significant barrier or a very significant barrier are difficulty in changing workflow patterns (63%) and cost to acquire (58%). Additionally, almost half of respondents indicated the following challenges as either somewhat of a significant barrier or a very significant barrier: disagreements about the usefulness of the system (45%); technology is not user friendly (45%); lack of staff education and training (45%); lack of internal knowledge/technical resources (47%); and justifying the expense (45%).

Figure 4. EHR/EMR System Challenges

Table 4 shows nearly half (45%), or nine organizations, use their EHR/EMR system to collect and submit Clinical Quality Measures (CQMs) reports to an outside agency/organization, whereas seven organizations
(35%) use a reporting tool that receives data from their EHR/EMR system to collect and report CQMs; in total 80% report CQMs through some mechanism. Those that report CQMs submit to the following agencies: CMS, OSHPD, CDPH and HEDIS.\(^{35}\) Three organizations (15%) indicate they do not use their EHR/EMR to collect or report CQMs.

Table 4. Organizations Utilization of EHR/EMR to Collect and Submit CQMs

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, we use our EHR/EMR system to collect and report CQMs</td>
<td>45%</td>
</tr>
<tr>
<td>Yes, we use a reporting tool that receives data from our EHR/EMR system to collect and report CQMs</td>
<td>35%</td>
</tr>
<tr>
<td>No, we do not use our EHR/EMR system to collect or report CQMs</td>
<td>15%</td>
</tr>
<tr>
<td>Don't know</td>
<td>5%</td>
</tr>
<tr>
<td>If yes, which organizations do you report CQMs to?</td>
<td>3</td>
</tr>
</tbody>
</table>

Note: n=20

Additionally, nine organizations (45%) report on a Hypertension CQM (i.e., National Quality Forum or NQF #18) and ten organizations (50%) report on the Diabetes CQM (NQF #59). Five organizations (25%) do not report NQF #18 and NQF #59; however, two of these organizations indicated some level of tracking with these measures, with one organization indicating they track this measure internally in our EHR/EMR system, and the other indicating their EHR/EMR system has the capability to track this measure internally. The remaining organizations, for both NQF #18 (30%) and NQF #59 (25%) did not know if their organization reports these measures.

Nearly all respondents (95%) report their organization is able to generate at least one report from your EHR/EMR system that lists patients by a specific condition (i.e., reporting to a disease registry). Of those, 79% currently generate reports for diabetes and 53% for high blood pressure (one reports that they also track for obesity). Finally, half of respondents report that their organization is able to provide data to local public health departments that conforms to HL7 standards and 30% do not know. This is an important function as the healthcare system moves towards tracking population health overall.

About two thirds (66.7%) of practices report having received technical assistance to support the adoption or use of an EHR/EMR system from another organization, agency or consultant besides their EHR/EMR vendor, four (19%) report they have not received assistance, and three (14.3%) don’t know (see Table 5). Organizations providing technical assistance included: Health Services Advisory Group (HSAG), a local hospital, Oregon Community Health Information Network (OCHIN), Healthcare Management Company, Allscripts, CHOMP, Computer Technical Services, Vigilance Health, Inc., and Meaningful Use support program. Additionally, 19% of respondents are interested in receiving technical assistance to support the adoption or use of an EHR/EMR system, and an additional 19% may be interested. One organization is currently seeking consulting assistance specific to consolidation of multiple EMR systems and possible migration to an alternative solution, and training.

\(^{35}\) CMS – 2 organizations, OSHPD – 2 organizations, CDPH -1 organization, HEDIS -1 organization
Team Based Care

Addressing patient needs collaboratively with multi-disciplinary clinical and non-clinical patient supports can allow for effective and comprehensive care. Team-Based Care requires adding new staff or changing the roles of existing staff to collaborate with a primary care physician (PCP) on an interdisciplinary team. Each team consists of the patient, the PCP, and other non-physician professionals such as nurses, pharmacists, dietitians, social workers, patient navigators, community health workers, and care coordinators or case managers: “Collaborative teams vary according to patients’ needs, patient load, organizational constraints, resources, clinical setting, geographic location, and professional skills”.

PCPs are facing heavy demands as a large sector of the population continues to age and healthcare reform continues to increase access for those previously uninsured. Healthcare reform is also responsible for many changes taking place in the healthcare environment as the system moves away from fee-for-service, patient-centered care to value-based payments and population health models: “Team care is a key component of health care reform initiatives that incorporate an integrated health care delivery system, especially those for chronic disease prevention and management”. There can be many benefits for both patient and provider when utilizing a TBC approach to address diabetes and hypertension: “Team care can minimize patients’ health risks by assessment, intervention, and surveillance to identify problems early and initiate timely treatment...benefits of diabetes team care include efficient patient education, improved glycemic control, increased patient follow-up, higher patient satisfaction, lower risk for the complications of diabetes, improved quality of life, reduced hospitalizations, and decreased health care costs”.

The Prevention First Project assessed the current utilization of TBC by providers across Monterey County. Healthcare organizations were asked if they currently used a team-based care approach for chronic disease management or general services delivery. Table 6 shows that less than half (42.9%) of respondents reported that their organization currently uses a team-based care approach for all medical services delivery and an equal number (42.9%) reported use of a team-based care approach for chronic disease management. More specifically, a third of respondents reported using a team-based care approach for patients with diabetes or

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36 Rodgers et al. (2014)
37 Warren-Boulton (2013)
39 Warren-Boulton (2013)
at-risk of diabetes and about a quarter use TBC for patients with blood pressure control issues. About a quarter reported that their organization does not use a team-based approach for any services and 9.5% did not know.

Table 6. Use of Team Based Care Utilization in Monterey County

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Frequency</th>
<th>Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, our organization currently uses a team-based care approach for all medical services delivery</td>
<td>42.9%</td>
<td>9</td>
</tr>
<tr>
<td>Yes, our organization currently uses a team-based care approach for chronic disease management</td>
<td>42.9%</td>
<td>9</td>
</tr>
<tr>
<td>Yes, our organization currently uses a team-based care approach for patients with blood pressure control issues</td>
<td>23.8%</td>
<td>5</td>
</tr>
<tr>
<td>Yes, our organization currently uses a team-based care approach for patients with diabetes or those at risk for diabetes</td>
<td>33.3%</td>
<td>7</td>
</tr>
<tr>
<td>No, our organization does not currently use a team-based care approach for any services</td>
<td>23.8%</td>
<td>5</td>
</tr>
<tr>
<td>Don't know</td>
<td>9.5%</td>
<td>2</td>
</tr>
</tbody>
</table>

Note: n=21

From a pre-populated list, organizations were asked to identify which members were represented on their team-based care models. As indicated in Table 7, the top five members reported in a team-based model for both diabetes and hypertension care were physician, nurse practitioner (NP)/physician's assistant (PA), Registered Nurse (RN), administrator and Care Case Manager (e.g., MSW or other patient navigator). For diabetes care, about a quarter of respondents also indicated inclusion of a dietitian/nutritionist. Only one reported the use of community health workers (4.8%) and one a pharmacist (4.8%); additionally, four organizations indicated other members included in their TBC teams as medical assistants and LVNs.

Table 7. Members Represented in Organizations' Team Based Care Models

<table>
<thead>
<tr>
<th>Top Five</th>
<th>Answer Options</th>
<th>For diabetes</th>
<th>For high blood pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Physician</td>
<td>17</td>
<td>14</td>
</tr>
<tr>
<td>2</td>
<td>Nurse Practitioner (APN) or Physician’s Assistant</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>3</td>
<td>Registered Nurse (RN)</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>4</td>
<td>Administrator</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>Care Case Manager (e.g., MSW or other patient navigator)</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Dietician/Nutritionist</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Pharmacist (or Pharmacy Tech)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Community Health Worker/Promotores</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Don't Know</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Other (please specify)</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>

Note: n=21

Fewer than half (43%) of respondents reported having a policy or system in place to encourage a TBC approach to diabetes care and a third to high blood pressure care. An equal number (23.8%) of organizations reported not currently having a policy or system in place to encourage a TBC approach for high blood pressure or diabetes care, but were in the process of establishing a policy or system to encourage a team-based care approach. Of those organizations that responded, all indicated implementation by 2015. Finally, 10% of organizations reported not having a policy or system in place to encourage a TBC approach to diabetes care, while less than 15% reported not having one in place for high blood pressure care.
Several barriers were identified by respondents when asked about the implementation of a policy or system to encourage a TBC approach for chronic disease management. A great majority of those that responded indicated a lack of the following: team support to encourage a TBC approach, the coordination to implement this approach, support staff to be a part of this approach, and space and financial resources. When asked if there was an interest in receiving technical assistance to implement or expand a policy or system to encourage a team-based approach to chronic disease management, 38.1% indicated that they might be open to the idea followed by 33.3% who were not interested and 19% who were not sure. Only 9.5% showed definite interest in receiving technical assistance. Of those that indicated Yes or Maybe, organizations reported an interest in the areas of allocating resources, developing policies and protocols, and financial sustainability.

Community Health Workers

According to the American Public Health Association (APHA) Community Health Workers are trusted frontline public health employees who share key elements of life experience with the people they serve. They build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, coaching for self-management of chronic diseases, and advocacy. Serving in a non-physician role, CHWs provide a bridge between communities and the healthcare system, by facilitating access to services and improving the quality and cultural competence of service delivery. In 1975, CHWs were declared the “key to [health care’s] success” by the World Health Organization (WHO). They were first recognized by the U.S. Bureau of Labor Statistics in 2009 with projected employment growth of 25% by 2022. CHWs go by a variety of titles depending on location, specific duties, and the employer, but “regardless of title, CHWs are typically community members who assist in addressing social and health issues that affect the areas in which they live. Because of their ability to relate to patients, CHWs often can gain a high level of trust from patients and help improve health outcomes for vulnerable populations. They are particularly effective because of their ability to connect with the community and their experience-based expertise”.

These include patient navigators, community health representatives, outreach workers, and promotores de salud (‘health promoters’). From a prepopulated list, survey respondents were asked to choose all the terms that their organization uses to refer to CHWs. Case Manager was the most commonly chosen term by 40% of respondents, followed by Community Health Educator at 25%. Community Health Worker, Patient Advocate, Patient Navigator and Home Visitor/Support Worker are each used by 15% of respondents, and Community Outreach Worker, Health Advocate, and Helper/Supporter are each used by 10%. The remaining terms – Community Care Coordinator, Promotor(a) de Salud, Community Health Advisor, Community Health Aide, Community Health Advocate, Outreach Worker, Lay Health Advisor, Outreach Specialist, and Health Coach – were only used by 5% of respondents.

An equal number (45%) of respondents indicated that their organization currently utilizes CHWs/Promotores or does not currently utilize CHWs, while 5% said they don’t know. One respondent noted that they use their Medical Assistants for this purpose. Eight organizations report either directly managing/employing CHWs or utilizing CHWs through a subcontractor or external agency such as the Central Coast Alliance for Health (CCAH) and AstraZeneca. One respondent indicated that they only do referrals to community agencies.

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40 American Public Health Association (APHA, 2016)
41 Kangovi, Grande, & Trin-Shervin (2015)
42 Evans (2015)
43 CDC (2014)
44 CDC (2014)
Respondents were asked how many Full Time Equivalent (FTE) CHWs they utilized. One reported 4 FTE CHWs, one reported 2 FTE CHWs, three reported 1 FTE CHW, and two did not know how many FTE CHWs were utilized in their respective organizations; for a total of nine FTE CHWs. Slightly more than half of respondents (54.5%), reported not knowing if their CHWs are paid or volunteer and equal numbers (18.2%) reported that their CHWs are paid a salary for their services, paid stipends for their services, or their CHWs are volunteers. Although asked, none of the respondents specified the salary or stipend pay range.

Forty six percent, or 5 out of 11 respondents, report never receiving reimbursement for CHW services. Nine percent, or 1 respondent, reported usually (75-100% of the time) receiving reimbursement, while another respondent reported rarely (1-24% of the time) receiving reimbursement for CHW services. Thirty six percent reported they did not know if they received reimbursement for CHW services. Those surveyed indicated using grants, moving to capitation, and donations as strategies to create sustainable funding for CHWs.

When asked if their organizations would add or expand the use of CHWs if additional funding was available, 36.8% said that they would, and 42.1% said that they might. Figure 5 shows that of those organizations which indicated they do use CHWs, 7 stated that they would add or expand utilization if additional funding was available, while 8 organizations that do not currently utilize CHWs stated that they would. None of those surveyed said that they would not add or expand CHW delivered services if additional funding was available.

Figure 5. CHWs: Current Utilization & Possible Expansion

Notes: n = 20

Question 69: Does your organization currently utilize CHWs/Promotores?

Question 81: If additional funding was available to reimburse your organization for CHW delivered services, would you add or expand the use of CHWs?
There appears to be great variation throughout the county in the skills and utilization of CHWs. Four out of 11 (36%) respondents reported that their CHWs were only formally trained and no one reported having only informally trained CHWs. Eighteen percent, or 2 out of 11, report that their CHWs are both formally and informally trained, and 45.5 %, or 5 out of 11, reported that they don’t know how their CHWs are trained. Two respondents, or 18.2%, report that their CHWs receive on the job training through their organization, while 7, or 63.6%, report that they don’t know what type of training is available for their organization’s current CHWs.

Sixty four percent of the organizations that indicate they use CHWs reported using them for education/services as a part of the Diabetes Self-Management (DSME) program. Five of the 11 respondents, or 45%, report utilizing CHWs for other evidence-based chronic disease self-management.

Table 8 shows about half of respondents indicate that their organization’s CHWs currently coordinate needed services for complex and costly patients, and provide assistance with appointments, follow up calls and health education. About a third of CHWs provide case management, chronic disease management, language interpretation to address communication barriers during medical visits, links to medical services, and referral services. Finally, a quarter of CHWs provide general clinic support services, liaison for referral from health systems/health care providers, patient advocacy, and support for patients/program participants (linking to needed community/social resources). Fewer than 20% of organizations (or two) report their CHWs provide DSME education/services and two provide outreach to bring participants into DSME programs. Interestingly, only one organization reported their CHWs visit crop fields to educate migrant farmers on health promotion and disease prevention.

Table 8. Types of Activities/Services provided by Organizations’ CHWs

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Frequency</th>
<th>Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinate needed services for complex and costly patients</td>
<td>54.5%</td>
<td>6</td>
</tr>
<tr>
<td>Assistance with appointments</td>
<td>45.5%</td>
<td>5</td>
</tr>
<tr>
<td>Follow up calls</td>
<td>45.5%</td>
<td>5</td>
</tr>
<tr>
<td>Health education</td>
<td>45.5%</td>
<td>5</td>
</tr>
<tr>
<td>Case management</td>
<td>36.4%</td>
<td>4</td>
</tr>
<tr>
<td>Chronic disease management</td>
<td>36.4%</td>
<td>4</td>
</tr>
<tr>
<td>Language interpretation to address communication barriers during medical visits</td>
<td>36.4%</td>
<td>4</td>
</tr>
<tr>
<td>Link to medical services</td>
<td>36.4%</td>
<td>4</td>
</tr>
<tr>
<td>Provide referral services</td>
<td>36.4%</td>
<td>4</td>
</tr>
<tr>
<td>General clinic support services</td>
<td>27.3%</td>
<td>3</td>
</tr>
<tr>
<td>Liaison for referral from health systems/health care providers</td>
<td>27.3%</td>
<td>3</td>
</tr>
<tr>
<td>Patient advocacy</td>
<td>27.3%</td>
<td>3</td>
</tr>
<tr>
<td>Support for patients/program participants (linking to needed community/social resources)</td>
<td>27.3%</td>
<td>3</td>
</tr>
<tr>
<td>Delivery of DSME education/services</td>
<td>18.2%</td>
<td>2</td>
</tr>
</tbody>
</table>
Survey respondents indicate the following barriers to implementing the use of CHWs in any capacity, but especially for DSME programs in the delivery of education/services: cost, funding to hire enough staff, need for reimbursement of these services, availability & training, language barriers, lack of information on how to get started, what the national standards are, and what the models are. One quarter of respondents (5 of 20) report that they do have a strategic plan to increase the capacity of CHWs as a part of their DSME program, 40% were unsure, and 35% did not have a plan. One respondent indicated that they were collaborating with the YMCA program.

As indicated in Figure 6, four out of twenty respondents report they are interested in receiving technical assistance to increase the capacity of CHWs as a part of the DSME program, and another 4 report that they might be interested. Four out of 17 respondents report that they are interested in receiving technical assistance to increase the capacity of CHWs to deliver other evidence-based chronic disease self-management education programs other than diabetes, and another 5 report that they might be interested. The types of technical assistance that respondents indicated would be useful to them were educator & guidelines, policies & protocols, and all kinds.
Notes: n = 20

Question 87: Are you interested in receiving technical assistance to increase the capacity of CHWs: as a part of the DSME program; to deliver other evidence-based chronic disease self-management education programs other than diabetes?

Self-Management of Chronic Disease/National Diabetes Prevention Program

In order to address diabetes and hypertension nationally and at the local level, it is crucial for effective prevention and self-management efforts to be considered. The CDC National Diabetes Prevention Program is an evidence-based lifestyle change intervention program for people with pre-diabetes or who are at risk for type 2 diabetes. It is a voluntary year-long program that is focused on helping individuals make the necessary choices to improve their health such as eating healthier, physical activity, and improving problem-solving and coping skills. Lifestyle changes address the factors within an individual’s control that contribute to their health and are key for successful prevention.

Once patients are diagnosed with diabetes or hypertension, self-management skills are needed to enable them to manage their illness and avoid complications. Patient self-management is the systematic provision of education and supportive interventions by staff to increase patients’ skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting (e.g., regular measurement of blood pressure by the patient outside the clinical setting, either at home or elsewhere) and problem-solving support. For those diagnosed with diabetes, evidence-based Diabetes Self-Management Education is a critical element of care. DSME trainings provide the knowledge, skill, and ability necessary for life-long diabetes self-care. This process incorporates the needs, goals, and life experiences of the person with diabetes and is guided by evidence-based standards. The overall objectives of DSME are to support informed decision-making, self-care behaviors, problem-solving and active collaboration with the health care team. Ample patient support for those at risk for diabetes and hypertension is crucial to delaying or avoiding the development of these two chronic diseases as well as allowing those with these diseases to avoid additional health complications.45

Providers in Monterey County were asked if there was a current policy or system in place to encourage patient self-management of diabetes or high blood pressure. Of the organizations that responded, many reported not knowing if there was such a policy or system for diabetes (42.9%) or hypertension (38.1%). Nineteen percent reported that there was a policy or system in place for diabetes and hypertension and 23.8% of organizations reported not currently having this in place, but that they are in the process of developing such a policy or system for diabetes. Only 14.3% of organizations reported developing a policy or system for the self-management of hypertension specifically.

Organizations were also asked what barriers they encountered while implementing a policy or system to encourage patient self-management of chronic disease, i.e., hypertension or diabetes. The majority of organizations reported that there was a lack of resources, staff, and training. Organizations reported a need for essential personnel such as dieticians, clinicians, and interpreters while also needing resources such as office space and access to healthier foods. They also indicated a need for training patients to be in compliance with treatment and to help them acquire technology skills.

**Diabetes**

Six organizations (31.6%) reported that they currently have a Diabetes Self-Management Education (DSME) program, while slightly more than a third reported that they do not, and about a third did not know. Organizations that reported having a DSME program were asked to identify how many adult participants (18+ years) were served in 2015. All programs served 500 or fewer patients/clients.

Organizations were asked if they had a policy or practice in place to refer persons to any other prevention or intervention program and/or refer persons with pre-diabetes or at high risk for type 2 diabetes to a lifestyle intervention program. Of those organizations that responded to the question, 50% reported they had such a policy or practice, 15% reported not having such a policy or practice and 30% did not know. Sixty percent reported having a policy or practice to refer persons with pre-diabetes or at high risk for type 2 diabetes to a lifestyle intervention program, while 10% reported not having such a policy or practice, and 25% reported they did not know. When asked to identify the names of the programs, organizations indicated that they refer patients to CHOMP diabetes services, eye and foot exams, the YMCA pre-diabetes program, and other dietary services.

Two organizations (CHOMP and YMCA) currently offer NDPP certified services in Monterey County. Table 9 shows that two additional organizations (NMC and SVMH) indicated an interest in becoming certified NDPP program sites, but the majority were interested in utilizing lifestyle change coaches available from existing diabetes education programs or developing a referral process - within the local health care system (for patients in need of NDPP services). A third were interested in developing reimbursement/insurance coverage options (e.g., MediCal, private insurance) for NDPP services or developing marketing/communication for NDPP information sharing.
**Table 9. Monterey County Organizations Interested in Partnering in County-wide NDPP Collaboration**

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Frequency</th>
<th>Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Becoming a certified NDPP program site</td>
<td>16.7%</td>
<td>2</td>
</tr>
<tr>
<td>Utilizing lifestyle change coaches available from existing diabetes education programs</td>
<td>75.0%</td>
<td>9</td>
</tr>
<tr>
<td>Developing a referral process - within the local health care system (for patients in need of NDPP services)</td>
<td>75.0%</td>
<td>9</td>
</tr>
<tr>
<td>Developing a reimbursement/insurance coverage options (e.g., MediCal, private insurance) for NDPP services</td>
<td>33.3%</td>
<td>4</td>
</tr>
<tr>
<td>Developing marketing/communication for NDPP information sharing</td>
<td>33.3%</td>
<td>4</td>
</tr>
<tr>
<td>Comment</td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>

*Note: n=12*

**Hypertension**

For the (8) organizations with or (3) in the process of establishing a policy or system to encourage patient-self management of hypertension, 47.6% reported that their patients with high blood pressure did not have a documented self-management plan in place to manage their high blood pressure, while 28.6% reported their patients did have a plan, and 23.8% indicated that they did not know. For patients with a documented self-management plan, 42.9% of respondents reported that their primary care providers (PCP) do follow-up, and 14.3% reported that their non-provider teams (NPT) do follow-up. The remaining 52.5% of organizations indicated don’t know (14.3%), N/A (28.6%) no (4.8%) or other (4.8%). No comments were provided to clarify these responses.

From a prepopulated list, organizations were asked to select resources/strategies they use to support self-management and monitoring of blood pressure among their patients. A small percentage reported use of the Million Hearts Initiative (4.8%) and the American Heart Association’s Check. Change. Control. Blood Pressure Program (4.8%), while no organization reported use of the American Medical Group Foundation’s Measure Up/Pressure Down Program. The majority of the respondents stated that they did not use any of the three identified resources/strategies (42.9%), did not know if they were being used (42.9%), or indicated using other (9.5%) resources/strategies.

Nearly a quarter (23.8%) of respondents indicated having some interest in receiving technical assistance to move towards implementing a policy or system to encourage patient self-management of high blood pressure, while 19% might be interested. Another 23.8% were not sure if they would want technical assistance for this purpose while 33.3% indicated not having an interest at all.
Conclusions/Recommendations

The 2012 Monterey County Safety Net Provider Report demonstrated the need for additional providers to serve an increased number of patients who would become eligible for health insurance through the Affordable Care Act. Since 2012, this study finds two additional organizations (Casa de Cultura and RotaCare of Monterey) are providing medical services, and six additional clinic sites (MCHD – 2, CSVS – 3, and Primecare – 1) have been added to the safety net clinic system. In addition, three new clinics have been reported under development for the future in separate locations – Soledad, Seaside, and East Salinas. This is a significant increase, as expansion of MediCal coverage for low-income individuals through the ACA has provided more Monterey County residents with access to health care services. These new clinical sites not only provide more access to direct medical care for increasing numbers of insured patients, but also may offer important opportunities for expansion of education, prevention and outreach services related to this project’s focus areas of diabetes and hypertension.

Electronic Health Records/Electronic Medical Records

Findings from this 2016 study indicate that all but one of the health care organizations reporting use an EHR/EMR system, with most (85%) certified by the Office of the National Coordinator for Health Information Technology (ONC) for the EHR/EMR Meaningful Use incentive program. These findings are similar to those from the 2012 Safety Net Provider study. One interesting issue is the number of different vendors. Whereas seven vendors were reported in use in 2012, eleven are reported to be in use in 2016; two were discontinued (Vitera and Voxent) from 2012 and four new (Allscripts, Amazing Charts, Athena and Health Fusion/MediTouch) vendors were reported. Although additional providers (from 2012) responded to this survey, it is instructive to note an increasing diversity of EHR/EMR systems that may or may not be compatible.

About half of respondents report that they participate or collaborate with a Health Information Exchange (HIE), e.g., Central Coast Health Connect; while 75% exchange patient health information electronically with other providers within their organization and slightly less than half (47.4%) report exchanging patient health information outside their organization. This information points to the need for improvements in connectivity among the various safety net providers across the system. These improvements could include focusing an EHR/EMR LAN on exploring the extent to which current vendors are compatible across platforms and with the HIE system; barriers to communicating across systems to exchange patient health information both within and outside organizations; and mechanisms for increasing or improving information exchange.

Submitting Clinical Quality Measures (CQMs) reports to an outside agency/organization is an important part of efforts to improve the overall population’s health outcomes, yet less than half (45%) of providers report using their EHR/EMR system to collect and submit CQMs. In addition, although nearly half of (or 9) organizations report more specifically on Hypertension CQM (i.e., National Quality Forum or NQF #18) and half of (or 10) organizations report on the Diabetes CQM (NQF #59), a quarter do not report on either NQF #18 or 59 and the remaining do not know if their organization reports. Finally, a small number of organizations (2) that do not report on either NQF 18 or NQF 59 indicate some level of tracking with these measures, with one indicating they have the capability to track these measures internally via their EHR/EMR system, and the other indicating they do track these measures internally via their EHR/EMR system.

46 The SNP reported on 2010 data.
There are also significant barriers to utilization of EHR/EMRs, with nearly half of respondents reporting challenges to the adoption/use of the system including disagreements about the usefulness of the system (45%); technology is not user friendly (45%); lack of staff education and training (45%); lack of internal knowledge/technical resources (47%); and justifying the expense (45%). Additional comments indicate the difficulty of moving from use of multiple “silo’ed” systems to a single system, insufficient system functionality and reporting capabilities, no organized tracking system, short on analytics, and difficulty getting data from their EMR. Organizations also report the need for more personnel to conduct data analysis and management of quality improvement functions. Some report still relying on paper charts and continued resistance within their organization. As one respondent noted: “The physicians are not using the system as it was intended to be used. They decline the integration of lab orders and results. They decline to use the order tracking within the EHR. This makes it challenging for our organization to work on quality improvement.

While these new systems are expected to improve patient care and health outcomes in the long run, the transition from separate clinics/practices providing episodic care for individual patients, to an integrated arrangement of providers that collect, monitor and report on health outcomes of a patient population whose overall health outcomes need to be tracked and improved in the general population will require considerable coordination.

While some respondents needed training on accessing data and train staff and providers to continue to use EHR and use it to its highest potential and stop relying on paper, others needed a different system altogether or a single consolidated platform across all sites. Given the difficulties (and frustrations) expressed in working at a suboptimal level with EHR/EMR systems, it is likely that the existing EHR systems are simply barriers in and of themselves and providers’ frustration with their EMR systems is simply a rational response to a unworkable situation. Although the ACA created powerful incentives for individual healthcare organizations to adopt EHR systems, it did not provide sufficient EHR options that were user friendly, easily integrated across platforms, which had easy to access and reportable data. Unlike the smartphone revolution which was made possible by technology that is useable by a mass audience and compatible across platforms, the EHR/EMR experience has not been as uncomplicated for the healthcare provider community. If smart phones required the average user to hire technical consultants to decipher, train and upgrade on the same scale, the e-world would be a much smaller environment. While there are many costly options for making the current patchwork of EHR systems useable for the average practice, a turnkey operating system might be the best road forward – if one exists.

Despite these barriers, organizations report some strategies for using their systems to develop the capacity to track health improvement in their patient population utilizing their EHR/EMR system; these include learning how to extract data from the EHR/EMR and what reports can be pulled to monitor health improvement, tracking ED visits, readmissions, LOS over specified time frames; registry reporting and follow up; flow sheet development and tracking (Diabetes Mgmt.); PDSA; HgbA1C tracking for DM and annual health assessments performed by the patient in a patient portal, as well as annual wellness exams.

Despite these challenges, interest in receiving technical assistance (TA) varies. Twenty percent of organizations that have already received TA report that they are definitely interested in receiving additional assistance, and 14% report that they may be interested. This represents five organizations who may be interested in participating in further TA opportunities and who may already have experiences or best practices to share. Those who have not yet received TA showed slightly more interest, with 25% definitely interested and 50% maybe interested. None who reported not knowing if their organization has received technical assistance already, reported an interest in receiving technical assistance in the future (most simply did not know).
Team Based Care

Healthcare organizations were asked if they currently used a team-based care approach for chronic disease management or general services delivery. Less than half (42.9%) of respondents report that their organization currently uses a team-based care approach for all medical services delivery or for chronic disease management. More specifically, a third of respondents report using a team-based care approach for patients with diabetes or at-risk of diabetes and about a quarter use a team-based care approach for patients with blood pressure control issues. About a quarter reported that their organization does not use a team-based approach for any services and 10% didn’t know.

While the majority of organizations reporting use of a team-based care approach indicate that they include physicians and nurse practitioners or physicians assistants as part of their provider teams for diabetes and hypertension; the number of organizations that include RNs on these teams drops to less than half of those that use physicians and the use of care case managers or other patient navigators drops to a third. While dieticians/nutritionists are used by about 20% of organizations using TBC for diabetes management, only 1 uses them for high blood pressure management and only 1 each uses a pharmacist/pharmacy tech or Community Health Worker/Promotores as part of either team; four organizations indicated other members included in their TBC teams as medical assistants and LVNs.

Although fewer than half (43%) of respondents reporting having a policy or system in place to encourage a TBC approach to diabetes care and a third for high blood pressure care, equal numbers (23.8%) report not currently having a policy or system in place to encourage a TBC approach for high blood pressure or diabetes care, but were in the process of establishing a policy or system to encourage a team-based care approach. This provides the Prevention First project with an opportunity to encourage those in the process of implementing to do so which could potentially increase use of TBC to 67% for diabetes and 57% for hypertension.

Specific barriers to implementing a policy or system to encourage a TBC approach for chronic disease management were reported as a lack of team support to encourage a TBC approach, the coordination to implement this approach, support staff to be a part of this approach, and space and financial resources. Additional barriers reported include the lack of personnel resources including support staff, interpreters, and outpatient case manager/care coordinator. One organization reported lack of support to build a TBC approach and another reports a lack of knowledge on benefits of creating one. Still others report lack of coordination, organization structure and reimbursement issues and development of systems and protocols that will span across different organizations/settings of care. Some are currently developing this model and are still experimenting with what will work and not work and still in the infancy stages to have encountered barriers.

There was some definite interest in receiving technical assistance to implement or expand a policy or system to encourage a team-based approach to chronic disease management by 10% (or 2) organizations; with another 38.1% (or 8) indicating that they might be open to the idea. A third were not interested and 19% were not sure. Of those (10) indicating Yes or Maybe interested in receiving technical assistance, organizations reported more specific interests in allocating resources, developing policies and protocols, and financial sustainability. A few organizations responded with comments to the question: interested in receiving technical assistance to implement or expand a policy or system to encourage a team-based care approach to chronic disease management that management and staff may be interested, however physicians may not and they may need a guide to local resources & establishing a relationship w/ resources and if there
were a means of implementing team-based care that could be sustainable financially, we would definitely be interested...finally, one organization indicated that they need policies and protocols (for TBC).

Community Health Workers

About half (45%) of respondents report using and not using CHWs; and of those that do a total of about 9.0 FTE CHWs appear to be in use for all respondents, with eight organizations either directly managing/employing CHWs or utilizing CHWs through a subcontractor or external agency and one organization indicating they do both. Of those that utilize CHWS, an equal number of respondents reported that their CHWs are paid a salary for their services (20%), paid stipends for their services (20%), or are volunteers (20%). And fewer than half (46% or 5 out of 11) respondents report never receiving reimbursement for CHW services. One respondent (9%), reported usually (75-100% of the time) receiving reimbursement, while another respondent reported rarely (1-24% of the time) receiving reimbursement for CHW services. Thirty six percent reported they did not know if they received reimbursement for CHW services. Those surveyed indicated using grants, moving to capitation, and donations as strategies to create sustainable funding for CHWs.

When asked if their organizations would add or expand the use of CHWs if additional funding was available, 36.8% said that they would, and 42.1% said that they might. Of those organizations which indicated they do use CHWs, 7 stated that they would add or expand utilization if additional funding was available, while 8 organizations that do not currently utilize CHWs stated that they would.

Four out of 11 (36%) respondents reported that their CHWs were only formally trained and no one reported having only informally trained CHWs. Eighteen percent, or 2 out of 11, report that their CHWs are both formally and informally trained, and 45.5%, or 5 out of 11, reported that they don’t know how their CHWs are trained. Two respondents, or 18.2%, report that their CHWs receive on the job training through their organization, while 7, or 63.6%, report that they don’t know what type of training is available for their organization’s current CHWs.

Sixty four percent of the organizations that indicate they use CHWs reported using them for education/services as a part of the Diabetes Self-Management (DSME) program. Five of the 11 respondents, or 45%, report utilizing CHWs for other evidence-based chronic disease self-management.

About half of respondents indicate that their organization’s CHWs currently coordinate needed services for complex and costly patients, and provide assistance with appointments, follow-up calls and health education. About a third of CHWs provide case management, chronic disease management, language interpretation to address communication barriers during medical visits, links to medical services, and referral services. Finally, a quarter of CHWs provide general clinic support services, liaison for referral from health systems/health care providers, patient advocacy, and support for patients/program participants (linking to needed community/social resources). Fewer than 20% of organizations report their CHWs provide DSME education/services.

Survey respondents indicate the following barriers to implementing the use of CHWs in any capacity, but especially for DSME programs in the delivery of education/services: cost, funding to hire enough staff, need for reimbursement of these services, availability & training, language barriers, lack of information on how to get started, what the national standards are, and what the models are. One quarter of respondents (5 of 20) report that they have a strategic plan to increase the capacity of CHWs as a part of their DSME program, 40% were unsure, and 35% did not have a plan. One respondent indicated that they were collaborating with the YMCA program. Strategies offered to create sustainable funding for CHWs included
grants, moving to capitation and donations. It is apparent from organization’s responses that sustainable funding for CHWs is key to organization’s ability to add or expand their use. Using LAN opportunities to bring together providers and potential funders (CCAH) to discuss best practices, value/benefits of CHWs, and the level of funding needed could increase their capacity across the system.

Four (or 20% of) respondents report they are interested in receiving technical assistance to increase the capacity of CHWs as a part of the DSME program and another 4 report that they might be interested. Four respondents report that they are interested in receiving technical assistance to increase the capacity of CHWs to deliver other evidence-based chronic disease self-management education programs other than diabetes, and another 5 report that they might be interested. The types of technical assistance that respondents indicated would be useful to them were educator and guidelines, policies & protocols, and all kinds. Given the small number of respondents interested in either DSME or other self-management education programs, the related LANs might be configured to include information on DSME programs as part of a TA session that provides information for those interested in the utilization of CHWs in more general evidence-based chronic disease self-management education programs.

When organizations were asked what are the most important high value contributions that CHWs make for improving patient health outcomes, they generally responded that CHWs provide many benefits for patients including they know the community and will know what is [the] best way to educate and reach out to the specific population group and serve as a bridge to the community where they can spend more time with the patient, [where] services [are] not limited to patient[s] going to our facility but the CHWs can go out into the community where it will be most convenient for the individuals and [where they] are more comfortable, they also provide patient advocacy and culturally supportive engagement [that will help with] care plan adherence and understanding. They also reported that CHWs provide benefits for the organization including keeping patients engaged and navigating the health system, assisting with walk-ins to social services, ED discharges, MHU discharges and follow-up care at home [which improves] patient compliance. Ultimately, they report that the system benefits through improved health outcomes which can result in higher reimbursement and a healthier community.

In terms of training, if a standardized and locally relevant CHW training program was available, about half of (9) respondents appeared to be receptive to this training with five respondents who would encourage their CHWs to attend and become certified, three would consider requiring the CHWs to become certified and one would require their CHWs to attend and become certified.

There also appeared to be a reasonable level of interest in participating in the development of a standardized and locally relevant CHW training program for services needed by your communities (e.g., chronic disease self-management training) with five definitely (yes) interested, six maybe and four that did not know.

Respondents also commented on barriers their organization have encountered (currently or in the past) implementing the use of CHWs in any capacity, but especially for Diabetes Self-Management Education (DSME) programs in the delivery of education/services (for both intervention and prevention efforts. Funding was the most common theme with comments such as the need to hire enough staff, [with] appropriate language (Spanish) skills, as well as to be reimbursed for expenses for hiring staff to support DSME. Respondents also commented on the lack of training, a lack of national standards and unfamiliarity with the model and getting more information on how to get started would be helpful.

A number of respondents also indicated an interest in receiving technical assistance to increase the capacity of CHWs; about 20% each said yes or maybe as part of the DSME program, as well as to deliver evidence-
based chronic disease self-management education programs other than diabetes. The types of TA mentioned include educator and guidelines, policies and protocols, and all kinds.

National Diabetes Prevention Program/Self-Management of Chronic Diseases

A small number (less than 20%) of providers in Monterey County indicated that they had a current policy or system in place to encourage patient self-management of diabetes or high blood pressure. About a quarter of organizations reported not currently having this in place, but they are in the process of developing such a policy or system for diabetes and about 14% reported developing a policy or system for the self-management of hypertension. Many respondents did not know if there was such a policy or system in place for either diabetes (42.9%) or hypertension (38.1%).

Organizations were also asked what barriers they encountered while implementing a policy or system to encourage patient self-management of chronic disease, i.e., hypertension or diabetes. The majority of organizations reported that there was a lack of resources, staff, and training. Organizations reported a need for essential personnel such as dieticians, clinicians, and interpreters while also needing resources such as office space and access to healthier foods.

They also indicated barriers for patients including a need for patient education (literacy), patient compliance and resources (to effectively manage their care), disparities in technology literacy, patient social/economic disparities, limited incentives and access to healthier food choices. Patient compliance was a common theme as comments included patient not following orders, lack of commitment and many of our patients fail to "own" their conditions, especially diabetes and hypertension, because "if I don't feel bad or have a serious event, I don't really have it or need to worry about it."

Respondents indicated an interest in receiving technical assistance to move towards implementing a policy or system to encourage patient self-management of high blood pressure with comments including the need for resources and assistance with policies, protocols, providing staff education, workflow process and tools to implement patient self-management.

While few (2) organizations indicated an interest in becoming a certified NDPP program site, nearly half (9) were interested in utilizing lifestyle change coaches available from existing diabetes education programs and developing a referral process - within the local health care system (for patients in need of NDPP services), and 4 were interested in developing reimbursement/insurance coverage options (e.g., Medi-Cal, private insurance) for NDPP services or developing marketing/communication for NDPP information sharing.

Given the recent addition of the first non-medical CBO (YMCA) as a certified NDPP provider in the county, providing information about their services, partnerships and process in implementing these national standards could encourage other interested organizations to move forward towards one of these options.
Next Steps

For years 3 and 4, the Monterey County Prevention First 1305 project team will create an individual LAN planning document for each of the four focus areas that include the following information:

I. Identify the Domain/Strategy/Intervention

II. Identify the LAN Topic: EHR/EMR, TBC, CHWs, and/or NDPP

III. Outline related scope of work activities and deliverables for each of the upcoming two years (FY16-17 and FY17-18) for each of the four focus areas.

IV. Create two lists of organizations responding to the QIPMC Survey for the related focus area and include their responses for challenges or barriers to implementing each of the four areas; strategies used to expand use of the focus area, and level of interest in technical assistance and specific topics of interest identified for the related focus area.

1) LIST OF FOCUS AREA CHAMPIONS/SPEAKERS: Respondents reporting on QIPMC survey that they utilize important aspects of each topic area (EHR/EMR, TBC, CHWs, NDPP). For example, organizations that responded yes to questions regarding certified EMR/EHR by national ONC, under MU, part of HIE (CCHC); EHR/EMR system has capability to and they do report on CQMs in general and NQF measures 18 & 59 specifically.

2) LIST OF FOCUS AREA ATTENDEES: Respondents reporting on QIPMC survey that they do not utilize specific aspects of each topic area, e.g., they responded no or don’t know to questions regarding certified EMR by national ONC, under MU, part of HIE (CCHC); system has capability to but they do not report on CQMs in general or NQF measures 18 & 59 specifically, and are interested in receiving technical assistance.

V. Agenda of related items from SOW and topics of interest indicated from QIPMC survey responses

VI. Logistics of LAN preparation and implementation, e.g., date, time, location, etc.
References


Appendices

Appendix A QIPMC Survey

Appendix B Organizational Status/Type

Appendix C Environmental Scans

Appendix D Monterey County QIPMC Survey Data (Excel Workbook)

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1 MCHD has previously collaborated with faculty researchers at ICCS to complete the Safety Net Provider Study (SNP) in 2013. The report, Health Care Reform: An Analysis of Demand for Health Care Services & Safety Net Provider Capacity to Serve Monterey County Residents, included an analysis of the county’s safety net provider capacity to expand medical services to meet the anticipated added demand that would result from implementation of the Affordable Care Act (ACA), the California Health Benefit Exchange and expanded MediCal programs.

2 The California Wellness Plan (CWP) was developed through a statewide process facilitated by the California Department of Public Health (CDPH) to “develop a roadmap with partners to create communities in which people can be healthy, improve the quality of clinical and community care, increase access to usable health information, assure continued public health capacity to achieve health equity, and empower communities to create healthier environments” (CDPH, 2014).

3 Chronic disease state plan (TBD) references: (California Department of Public Health, 2013) (California Conference of Local Health Officers-County Health Executives Association of California, 2013)

4 Governor Jerry Brown established the Let’s Get Healthy CA Task Force to “develop a 10-year plan for improving the health of Californians, controlling health care costs, promoting personal responsibility for individual health, and advancing health equity” with two strategic directions. The first “Health Across the Lifespan” establishes three goals for health across the lifespan including “Goal 1. Healthy Beginnings: Laying the Foundation for a Healthy Life, Goal 2. Living Well: Preventing and Managing Chronic Disease, and Goal 3. End of Life: Maintaining Dignity and Independence.” The second “Pathways to Health,” covers the practice and policy changes needed to improve the quality and efficiency of the health care system and to make community environments more conducive to being healthy” which includes three additional goals: “Goal 4. Redesigning the Health System: Efficient, Safe, and Patient-Centered Care, Goal 5. Creating Healthy Communities: Enabling Healthy Living, and Goal 6. Lowering the Cost of Care: Making Coverage Affordable and Aligning Financing to Health Outcomes.” Additionally, the Task Force identified 30 priorities and created a Dashboard with 39 measurable indicators (at the population and system levels); nine additional indicators were identified without a data source. This Framework also makes clear that health equity should be fully integrated across the entire effort.” (CDPH, 2012).

5 The Safety Net Provider Study (SNP) was completed in 2013 by CSUMB/ICCS faculty researchers, under contract with the MCHD. The report, Health Care Reform: An Analysis of Demand for Health Care Services & Safety Net Provider Capacity to Serve Monterey County Residents, included an analysis of the county’s safety net provider capacity to expand medical services to meet the anticipated added demand that would result from implementation of the Affordable Care Act (ACA), the California Health Benefit Exchange and expanded MediCal programs. (Judson, Navarro, Kelly, Spellman, Snow, Ramirez, Calderon, 2013)