



## **FEBRUARY 21, 2005 - CCLC E-NEWSLETTER**

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Please share materials, questions, requests and/or advice with all Collaborative members by hitting "reply all" on your e-mail. Also, materials and information can be posted to the next CCLC E-Newsletter by e-mailing [cclc@caph.org](mailto:cclc@caph.org).

### **TOPICS DISCUSSED THIS WEEK:**

- 1) Action Period Call on Group Visits with James Nuovo, M.D. of the University of California, Davis Medical Center on 2.25.2005.
- 2) Additional Technical Assistance Offered on Group Visits
- 3) Richmond Health Center's Experience with Laotian Patient Group Visits
- 4) Silver Avenue Family Health Center: Strategies for Success
- 5) Question on Pilot Populations & LDL Control
- 6) Multilingual Health Education Resources
- 7) California Diabetes Prevention & Control Program Resources
- 8) Reminders for 2005
- 9) Resources on the SNI Website

### **1) ACTION PERIOD CALL ON GROUP VISITS WITH JAMES NUOVO, M.D. OF THE UNIVERSITY OF CALIFORNIA, DAVIS MEDICAL CENTER**

The next Action Period conference call will take place on Friday, February 25, 2005 beginning at 12:00 p.m. Guest speaker James Nuovo, M.D., a family practice physician at the University of California, Davis Medical Center will be discussing his experience with group visits and will focus particularly on the disease specific model. Please download the attached documents prior to this call.

### **2) ADDITIONAL TECHNICAL ASSISTANCE OFFERED ON GROUP VISITS**

Lisa Golden, M.D. ([lisa.golden@sfdph.org](mailto:lisa.golden@sfdph.org)) of Ocean Park Health Center and James Nuovo, M.D. ([james.nuovo@ucdmc.ucdavis.edu](mailto:james.nuovo@ucdmc.ucdavis.edu)) of the University of California, Davis Medical Center have both generously offered to provide additional consulting assistance around group visits, especially around specifics, curriculum and implementing an actual group visit program. As you might recall, Dr. Golden presented on her experience implementing group visits at Ocean Park Health Center of the San Francisco Community Health Network and Dr. Nuovo will be conducting our February 25, 2005 Action Period conference call.

### **3) RICHMOND HEALTH CENTER'S EXPERIENCE WITH LAOTIAN PATIENT GROUP VISITS**

In early February, 2005 I asked Troy Kaji, M.D. of the Richmond Health Center to reflect on 1) how they have recruited Laotian patients to attend group visits; and, 2) the process and growing pains of running these Drop In Group Medical Appointment (DIGMA) type group visits. Thank you to Dr. Kaji and the Richmond Health Center for sharing this helpful information with the Collaborative.

Background: The group visits idea has had a long, at least two year, gestation driven by the Khmhu community's desire to improve their language access. Although CCHS has Mien interpreters who are also fluent in Lao, it turns out that Khmhu is distinct enough from Lao that the Khmhu feel handicapped in communicating in Lao. CCHS has one business office staff person who speaks Khmhu and she provides a second interpreting channel, distinct from the interpreting staff, to help Khmhu patients make appointments and handle phone inquiries. However, since she has other duties besides interpreting, CCHS usually depends on Mien interpreters to work with the Khmhu.

Recruitment: The Khmhu recruited their friends and family members through word of mouth as they are all Roman Catholic and see each other at local parishes in Richmond. RHC also asked Mien interpreters and providers who staff the four Laotian half-day clinics to mention the group visits to both Khmhu and Mien patients.

Attendance: The Khmhu groups are always oversubscribed--at least a dozen people at each meeting with other unscheduled individuals who walk-in. The Khmhu patients are evenly derived from the four doctors who staff the Laotian clinics. The Mien groups have been tougher to sell to patients, perhaps because they perceive less of an access problem or perhaps their subgroup is more segmented/divided as it is larger and socially split into traditional and several Christian congregations/denominations. The Mien are predominantly Dr. Kaji's patients, rather than from his other three colleagues' Lao clinics. RHC did not use food as an incentive for attendance, although they later started bringing snacks to meetings. Dr. Kaji and RHC has generously allowed us to share the attached document which demonstrates that the issues patients raise really care about are around chronic care skills and health literacy issues.

Currently: In March, RHC is planning a food portion size measuring workshop modeled on Dr. Golden's ideas presented at LSII. RHC spent time at a Mien group visit asking which foods attendees eat and want to measure. Of course rice turned out to be a central item and at the next visit Dr. Kaji will be bringing both the regular sticky rice and a pot of short grain brown rice.

#### 4) SILVER AVENUE FAMILY HEALTH CENTER: STRATEGIES FOR SUCCESS

Thank you to Dr. Palazuelos and Silver Avenue Family Health Center for sharing the information below on their clinic's strategies for participating in the CCLC Collaborative.

Team Meetings: At the outset of the CCLC, Silver Ave FHC agreed to 1) meet at a regular time for ~1-2 hours a week, and 2) devote 1-2 additional hours a week to carry out assigned tasks. The meetings were put on the master schedule for all center staff. The agenda for the meeting consists of reviewing the previous week's changes and they limit debate so the meeting ends at 5 p.m. As each member reports on their task, the team brainstorms, discards and reassign tasks.

Team Roles: As dictated by the CCLC, Silver Ave FHC loosely divided tasks during the design of the first storyboard. These roles were initially stated and over time have been defined by the assignment with revisits to roles every now and then.

-Administrative Person: Computer entry, IT liaison, CDEMS download and note taker.

-Champion: Ideas, meet with our resources, plan big, develop leadership in the project implementation and stay excited.

-Data Entry Person: Audit charts, enter data, compile information for submission to the CCLC and work the clinical changes.

-Day to Day Leader: Alert general staff to changes and what's coming, present policies, contribute to problem solving, communication focused and manage timelines.

Computer Use: In addition to assigned meetings, a big assist was having a computer at meetings so notes could be entered in real time and reviewed as a reminder. The notes were placed on a shared drive and a folder was created with CCLC and CDEMS information. The notes are also available to the center staff.

In terms of "cleaning-up" the computer, excess trial and error documents are put into an "old" folder for reference.

Brainstorming: The team uses a software called Mindmapping to regularly facilitate brainstorming. As the "administrator," Dr. Palazuelos can outline details of the projects; and roughly map out the resources, facilities, staff and assignments necessary to accomplish tasks. She can also go back and revise these after input from the team and staff. When the time came to present new policy to staff, Dr. Palazuelos is able to print a Mind Map that allows non-team staff to see their roles in the larger process. Unfortunately, this software cannot be displayed on the center's shared computer server.

Commitment: Team members were almost self-selected by virtue of a strong interest in diabetes care and because they were positively motivated by the concept of change. When the CCLC Collaborative became available, the team had a means to focus their interest. The team has a commitment to the process of development. Once they discover that something does not work, problem solving begins again, followed by testing. They keep telling themselves that this is a test for deciding when and what to implement. Though there are many forces in the clinic that want to adopt the new "thing" before initial testing is done, the team is realistic about this new "thing". They have had our bumps too. New does not always mean better and they get feedback before implementing a new procedure. They are now working on a mind-map to get buy-in from other staff. This is the next step as this clinic is at the implementation stage on many levels. Additionally, a timeline of "start dates" and meetings help to push the team along.

## 5) QUESTIONS ON PILOT POPULATIONS & LDL CONTROL

QUESTION 1: In a patient database of XX patients, a number have been lost to follow-up for over four months. Apart from attempting to have these patients return to clinic or making sure they are being followed elsewhere, we are noticing that as a result, their labs generally reflect higher HGBA1c and cholesterol levels that skews the data. Do you have any suggestions? Should we omit them from our group and only include current and active patients?

REPLY 1 FROM IMPROVEMENT ADVISOR: If the patients you are referring to as being "lost to follow-up for over four months" were seen by your pilot team with two coded visits in the 12 months prior to October, 2004, then by definition they are part of your pilot population and there should be an attempt to find out what has happened to them. If they have moved, died, or changed providers, then you would omit them from your pilot population. Otherwise, you would keep them and their data for your pilot population. You have touched on an important challenge for helping people with chronic conditions: keeping track of them and reaching out to those who are overdue for a visit. Remember, you are not alone in the issue of how difficult it can be to keep tabs on patients in a public health system. The good news is that there can be improvement over time. Trying out ideas for keeping patients in the loop is an important effort in this Collaborative. We look forward to learning from your team's efforts.

TEAM'S FOLLOW-UP: They are working to contact all of the clients and link them back to the clinic and have had success with contacting their first client to set up a return appointment!

QUESTION 2: Our LDL control (clients with LDL <100 in the past 12 months) has dropped. One possible factor is that clients are not coming back for LDL tests exactly 12 months from the last test. Any suggestions?

REPLY 2 FROM IMPROVEMENT ADVISOR: Regarding the LDL test, since the population is people with diabetes, it is probably advantageous to monitor yearly so that LDL stays in control, doing so is a highly recommended preventive strategy. The Change Package for helping people with diabetes is very proactive - we want to keep them as healthy as possible and catch any potential problems as quickly as possible.

## 6) MULTILINGUAL HEALTH EDUCATION RESOURCES

A Family Physician's Practical Guide to Culturally Competent Care: This free electronic training module is a continuing medical education activity that can be used both in an online format and as a DVD. Participants can register for this online course or request the DVD. (<http://cccm.thinkculturalhealth.org/>)

Consumer Health Brochures in Multiple Languages: An electronic access resource to over 200 health education brochures in 24 different languages which is primarily focused on physical health with some resources that address behavioral health issues/concerns. (<http://medstat.med.utah.edu/24languages/>)

Multilingual Health Education Resources from the National Network of Libraries of Medicine: An electronic resource with General Health Resources, Racial/Ethnic Group Health Links and multilingual/cultural Consumer Health Trifolds. (<http://nnlm.gov/mcr/resources/community/minority.html>)

## 7) CALIFORNIA DIABETES PREVENTION AND CONTROL PROGRAM RESOURCES

The California Diabetes Program (CDP), within the California Department of Health Services, is dedicated to preventing diabetes and its complications in the diverse communities of California. Working to improve the quality of care for people living with diabetes they inform their partners about available diabetes tools and resources, develop programs designed to empower people with diabetes to teach others about good diabetes care and advocate for that care and participate in national, state and local diabetes-related initiatives. In addition, they help guide policy changes, review proposed legislation that could impact those with diabetes and track diabetes prevalence in California. Many of their resources fit within the Chronic Care Model components. They are your resource for:

- The Basic Guidelines for Diabetes Care
- Diabetes Health Record Cards
- Take Charge! Program
- National Diabetes Education Program Materials
- Diabetes Consumer Action Groups
- Diabetes Care Coordinator Program Training
- Information about the California Smokers Helpline
- County Fact Sheets on Diabetes Prevalence
- The Diabetes Information Resource Center (DIRC)

For more information about the California Diabetes Program please visit their website ([www.caldiabetes.org](http://www.caldiabetes.org)) or contact your local Program Health Promotion Specialist: Pamela Manning, MS.,RD. (415) 883-1408 or [pmanningrd@comcast.net](mailto:pmanningrd@comcast.net).

8) IMPORTANT DATES FOR THE CCLC IN 2005: Below is a list of updated dates and locations for the CCLC Collaborative for 2005.

- Action Period Conference Call on February 25, 2005, 12 p.m.
- Monthly Report Due, March 10, Please send to [hovisfilms@gbroline.com](mailto:hovisfilms@gbroline.com) and [cclc@caph.org](mailto:cclc@caph.org)
- Action Period Conference Call, Friday, March 25, 12 P.M. - 1 P.M.
- Monthly Report Due, April 10, Please send to [hovisfilms@gbroline.com](mailto:hovisfilms@gbroline.com) and [cclc@caph.org](mailto:cclc@caph.org)
- Action Period Conference Call, Friday, April 29, 12 P.M. - 1 P.M.
- Monthly Report Due, May 10, Please send to [hovisfilms@gbroline.com](mailto:hovisfilms@gbroline.com) and [cclc@caph.org](mailto:cclc@caph.org)
- Action Period Conference Call, Friday, May 27, 12 P.M. - 1 P.M.
- Learning Session III, June 8 at 1 Kaiser Plaza, 22nd Floor, Oakland
- Monthly Report Due, June 10, Please send to [hovisfilms@gbroline.com](mailto:hovisfilms@gbroline.com) and [cclc@caph.org](mailto:cclc@caph.org)
- Outcomes Congress, December 7, 8, or 9, 8:30 A.M. - 5:00 P.M.

9) Resources on the SNI Website

-Materials from LSII have been added to the website at <http://www.safetynetinstitute.org/UpdatedSite/CCLCMaterials.htm>

-Additional Self-Management and Group Visits materials have been added to the website at <http://www.safetynetinstitute.org/UpdatedSite/OtherChronicResources.htm>

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