Stephanie Tubbs Jones Health Center: A Story of Transformation

Better Health Partnership
Spring 2017 Learning Collaborative Summit

April 7, 2017
Presenters

- Nana Kobaivanova, MD, FACP
  Medical Director, Stephanie Tubbs Jones Health Center

- Susan Cotey, RN, CDE
  Program Coordinator, Lennon Diabetes Center, Stephanie Tubbs Jones Health Center

- Marna Borieux, MBA
  Senior Director, Stephanie Tubbs Jones Health Center & East Region FHCs
“No financial or non-financial conflicts of interests relevant to this presentation.”
OBJECTIVES

1. Describe the historical context and genesis of the Stephanie Tubbs Jones Health Center.

2. Explain the culture of improvement as it relates to diabetes and other care gaps.

3. Describe the practice’s community engagement efforts and the health center’s role in Cleveland’s East Side.
IMPROVING THE HEALTH STATUS OF YOUR COMMUNITY

Nana Kobaivanova, MD, FACP

IMPROVING THE HEALTH STATUS OF YOUR COMMUNITY
Stephanie Tubbs Jones Health Center
Social Determinants

- Income
- Education
- Race and Ethnicity
- Transportation

- Housing
- Insurance
- Food access
- Complex health needs
## Demographics

<table>
<thead>
<tr>
<th>Demographics</th>
<th>2012</th>
<th>2016</th>
<th>Cuyahoga</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population*</td>
<td>17,593</td>
<td>17,344</td>
<td>1,249,352</td>
</tr>
<tr>
<td>Black</td>
<td>93.2%</td>
<td>89%</td>
<td>29%</td>
</tr>
<tr>
<td>65+ yrs</td>
<td>18.8%</td>
<td>17%</td>
<td>17%</td>
</tr>
<tr>
<td>HS Diploma/ GED</td>
<td>78%</td>
<td>79.7%</td>
<td>88%</td>
</tr>
<tr>
<td>Bachelor’s degree or higher</td>
<td>10.3%</td>
<td>11%</td>
<td>30.5%</td>
</tr>
<tr>
<td>Median Household Income</td>
<td>$19,848</td>
<td>$19,592</td>
<td>$44,190</td>
</tr>
</tbody>
</table>

## Payer Mix

<table>
<thead>
<tr>
<th>Payer</th>
<th>2012</th>
<th>2016</th>
<th>Cuyahoga</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>34%</td>
<td>17%</td>
<td>15%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>30%</td>
<td>58%</td>
<td>29%</td>
</tr>
<tr>
<td>Private</td>
<td>15.4%</td>
<td>15%</td>
<td>49%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>17.3%</td>
<td>7%</td>
<td>4%</td>
</tr>
</tbody>
</table>

*5Y Projected population change -3%

Source: Truven; US Census Bureau
Behavior & Risk Factor Prevalence

Source: Thomson
Diabetes & Obesity

Diabetes
- 9% of adults diagnosed with diabetes
- 7th leading cause of death in community

Obesity
- 24% of adults in community are obese
- Access and cost greatest barrier to fresh food

(Source: The Center For Health Affairs www.chanet.org)
Cardiovascular Health

- Heart Disease
  - Leading Cause of Death 6% in community survived heart attack (5% Ohio, 4% US)
- High Blood Pressure
  - 38% in community diagnosed (33% Ohio, 31% US)
- Greatest Risk Factors
  - Age 65 or older
  - Household income under federal poverty level
  - Classified as obese by BMI

(Source: The Center For Health Affairs www.chanet.org)
Mental Health

• Mental illness is frequently stigmatized and misunderstood in the community we serve
• This community is more likely to experience social circumstances that increase chances of developing mental illness
  - Utilizing social welfare services
  - Children in foster care
  - Exposure to violence
• Leads to a higher suicide rate

(Source: The National Alliance on Mental Illness (NAMI) www.nami.org)
Access

- 5% of community report using ER as their usual place of health care
  - Nearly 1/3 community uninsured
  - Perceived lack of entry point into system
  - No PCP; unsure how/where to follow up
- No easy access to healthy food options
  - Food Deserts
  - Fast food perceived as cheaper and is more easily accessed

(Source: The Center For Health Affairs www.chanet.org)
A HEALTH CENTER BUILT TO
MEET THE COMMUNITY’S
NEEDS
### What does the data tell us about community need & what are we doing?

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Social Environment</th>
<th>Access</th>
</tr>
</thead>
</table>
| • Healthy lifestyle education and campaign  
  • Nutrition / Diabetes Ed  
  • Mobile Food Pantry  
  • Cooking Demos  
  • Exercise Programs  
  • Smoking Cessation  
• Well visits / preventive  
  • Care Coordination  
  • Screenings  
  • Immunizations  
• Behavioral Health  
  • Social Work Navigator  
  • CC Neurology  
  • Centers in Building | • Strengthen social and physical environment  
  • Navigation Center  
• Establish a medical home  
  • Care Coordinators  
  • INTM Team Approach  
• Individual and community development  
  • Team with community on programming needs | • Access to Care  
  • Community Navigators  
  • Medicaid Expansion  
  • ACA Navigators  
• Non-emergent care options  
  • Express Care  
  • Same Day Appts  
  • CDU Referral Program  
• Service Lines  
  • Primary care  
  • Specialty care  
  • Behavioral Health  
  • Chronic disease mgmt  
  • Community access  
  • CC Transportation |

**Prevention**

**Access to Care**
**Pneumococcal Vaccine Rate**

Target: 85%

Actual: 83.9%

[Graph showing the trend of Pneumococcal Vaccination from 2012 to 2016, with the target set at 85% and the actual rate at 83.9%]
Colorectal Cancer Screening

Target: 78.1%
Actual: 73.3%
What does the data tell us about community need & what are we doing?

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Social Environment</th>
<th>Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy lifestyle education and campaign&lt;br&gt;  - Nutrition / Diabetes Ed&lt;br&gt;  - Mobile Food Pantry&lt;br&gt;  - Cooking Demos&lt;br&gt;  - Exercise Programs&lt;br&gt;  - Smoking Cessation&lt;br&gt; Well visits / preventive&lt;br&gt;  - Care Coordination&lt;br&gt;  - Screenings&lt;br&gt;  - Immunizations&lt;br&gt; Behavioral Health&lt;br&gt;  - Social Work Navigator&lt;br&gt;  - CC Neurology&lt;br&gt;  - Centers in Building</td>
<td>Strengthen social and physical environment&lt;br&gt;  - Navigation Center&lt;br&gt; Establish a medical home&lt;br&gt;  - Care Coordinators&lt;br&gt;  - INTM Team Approach&lt;br&gt; Individual and community development&lt;br&gt;  - Team with community on programming needs</td>
<td>Access to Care&lt;br&gt;  - Community Navigators&lt;br&gt;  - Medicaid Expansion&lt;br&gt;  - ACA Navigators&lt;br&gt; Non-emergent care options&lt;br&gt;  - Express Care&lt;br&gt;  - Same Day Appts&lt;br&gt;  - CDU Referral Program&lt;br&gt; Service Lines&lt;br&gt;  - Specialty Care&lt;br&gt;  - Behavioral Health&lt;br&gt;  - Primary care&lt;br&gt;  - Chronic disease mgmt&lt;br&gt; Community access&lt;br&gt;  - CC Transportation</td>
</tr>
</tbody>
</table>
Patient Navigation Model

- Financial
- Clinical
- Service
- Community
STJC Navigation Center Purpose

To access, engage, and coordinate the health and social needs for the community through outreach and partnership

COMPONENTS OF NAVIGATION MODEL

<table>
<thead>
<tr>
<th>Community outreach</th>
<th>Financial</th>
<th>Service</th>
<th>Clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Outreach and Education</td>
<td>- Patient Qualifications for insurance</td>
<td>- Refer to any needed services</td>
<td>- Chronic disease</td>
</tr>
<tr>
<td>- Health Screenings</td>
<td>- Assist with medical applications</td>
<td>- Assist with housing, food stamps, clothing</td>
<td>- Behavioral health</td>
</tr>
<tr>
<td>- Linkage to outside - Social service agencies</td>
<td></td>
<td>- Coordinate the needs of the patient across</td>
<td>- Women and children / Pediatrics</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Internal medicine</td>
</tr>
</tbody>
</table>
The Patient Navigation Model at STJHC aims to increase coordination across the continuum of care, from outreach to rehabilitation, using both clinical and lay navigators.

**Patient Navigation Services**
- Barrier identification / assessment
- Helps patient in navigating non-clinical elements of care
- First point of contact
- Maintains relationships with community groups
- Provides health and wellness programming to patients and community

**Community Outreach**
- Identifies patients needing HC services
- Promotes CCHS brand in community through events

**Financial Counselor(s)**
- Insurance Assistance
- Payment Plans

**Social Worker(s)**
- Psychosocial assessment and intervention

**External Resources**
- Community resources
- Social Resources

**Clinical Coordinators**
- Chronic disease management clinics (diabetes, CKD)

**Clinicians**
- Physicians
- Physical Therapy
- Pharmacy

**Types of Barriers**
- Cultural
- Logistical
- Financial
- Clinical
What does the data tell us about community need & what are we doing?

**Behavior**
- Healthy lifestyle education and campaign
  - Nutrition / Diabetes Ed
  - Mobile Food Pantry
  - Cooking Demos
  - Exercise Programs
  - Smoking Cessation
- Well visits / preventive
  - Care Coordination
  - Screenings
  - Immunizations
- Behavioral Health
  - Social Work Navigator
  - CC Neurology
  - Centers in Building

**Social Environment**
- Strengthen social and physical environment
  - Navigation Center
- Establish a medical home
  - Care Coordinators
  - INTM Team Approach
- Individual and community development
  - Team with community on programming needs

**Access**
- Access to Care
  - Community Navigators
  - Medicaid Expansion
  - ACA Navigators
- Non-emergent care options
  - Express Care
  - Same Day Appts
  - CDU Referral Program
- Service Lines
  - Specialty Care
  - Behavioral Health
  - Primary care
  - Chronic disease mgmt
- Community access
  - CC Transportation

**Prevention**

**Access to Care**
Primary & Specialty Services

- **Primary Care**
  - Internal Medicine
  - Women’s Health
  - Pediatrics

- **Specialty Care**
  - Urology
  - Rheumatology
  - Cardiology
  - Podiatry
  - Physical Therapy

- **Specialty Care Cont…**
  - Wellness
  - Adult Behavioral Health
  - Endocrinology
  - Ophthalmology
  - Pediatric Sickle Cell
  - Pulmonary
Additional Services

- **Chronic Disease Services**
  - Anticoagulation Clinic
  - Chronic Kidney Disease Care
  - Congestive Heart Failure
  - Diabetes Education
  - Outpatient Dialysis (Ohio Renal Care Group)

- **Other Services**
  - Imaging
  - Lab
  - Navigation Services
  - Social Work
  - The Center for Family & Children
    - Medication Management
    - Outpatient Mental Health Services
  - Pharmacy
  - Teaching Kitchen
Transportation Service

- Monday - Friday
- 6:00am - 6:30pm
- Patients/ Visitors (Ambulatory Only)
- Van Service
  - 5 Mile radius
  - Direct service from home to
    - STJHC
    - Euclid
    - Hillcrest
    - South Pointe
    - Fairview Moll Cancer Center
    - Lutheran
    - Marymount

- Average 150 Patients a day
TEAMBUILDING ACTIVITY
CREATING A CULTURE OF IMPROVEMENT

Sue Cotey, RN, CDE
About The Lennon Diabetes Center

• Diabetes Self-Management Education Classes consists of:
  - Individual Visit with Nurse Educator and Dietitian
  - Series of 4 group classes
    • Once a week, then 3 month follow up

• Medical Nutrition Therapy
  - Dietitian visit for pre-diabetes and / or weight management
Diabetes Care Improvement

Diabetes Care Composite (Met All 4 Care Processes)

Source: Better Health Partnership
Creating A Culture of Improvement in Diabetes Care

Establish trust with patients
Identify patient care needs
Activate patient’s voice
Standardize patient education content
Utilize technology
Streamline processes to improve patient experience
Identify gaps and close them
Culture of Improvement at Initial Assessment

• **Establish trust with patients**
  - Priority continues to be establishment of a relationship based on trust and respect. A mutually agreed upon individualized plan of care is initiated

• **Quickly Identify Patient Care Needs**
  - Health Maintenance record which includes diabetes modifiers can be reviewed quickly (even before the visit) and included in the plan of care
Culture of Improvement: Patient Centered Education

• **Patient Centered Standard Content**
  - System wide initiative to create one comprehensive book
  - Patient focus groups reviewed the new book prior to implementation

• **Using Technology to Improve Patient Education**
  - Power point slides were developed that contained important concepts and reminders for routine tests and preventative measures. Repetition is key
Diabetes ABCs: Let’s Review!

A  A1C
B  Blood Pressure
C  Cholesterol
D  Diet
E  Eye Exams, Exercise
F  Foot Care
G  Glucose
### Diabetes Passport

<table>
<thead>
<tr>
<th>Checkpoints</th>
<th>ADA Standards</th>
<th>Patient Goals</th>
<th>Date: Visit Values</th>
<th>Date: Visit Values</th>
<th>Date: Visit Values</th>
<th>Date: Visit Values</th>
<th>Date: Visit Values</th>
<th>Date: Visit Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure (mm Hg)</td>
<td>&lt;140/90</td>
<td>Every Visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Foot Exam</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight (lbs. or kg)</td>
<td></td>
<td>Every Visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HbA1c</td>
<td>&lt;7%</td>
<td>Quarterly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Exam (Dilated)</td>
<td></td>
<td>Yearly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LDL (mg/dL)</td>
<td>&lt;100</td>
<td>Yearly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HDL (mg/dL)</td>
<td>&gt;40 Males &gt;50 Females</td>
<td>Yearly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Cholesterol (mg/dL)</td>
<td>&lt;200</td>
<td>Yearly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Triglycerides (mg/dL)</td>
<td>&lt;150</td>
<td>Yearly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urine Test (Protein)</td>
<td>Negative</td>
<td>Yearly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes Education</td>
<td></td>
<td>As Needed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td></td>
<td>As Needed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self Monitoring of Blood Glucose</td>
<td></td>
<td>As Needed</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

The Diabetes Passport is a tool that will help you keep track of your own personal health information.
Culture of Improvement: Streamlining Our Workflows

- Referral Process Improvements
  - Diabetes staff trained in scheduling patients
  - Simplified choices for providers in EPIC to include referrals for Diabetes Education and newly developed insulin clinic by searching “STJHC” in order entry
  - Pool created in EPIC for Diabetes Educators. Referrals are automatically routed to the pool, allowing them to assess need to be scheduled
Culture of Improvement: Identifying Gaps

- Proposal for Insulin Clinic
  - **January 2012**: Medical liaison assisted us with a literature search, multiple citations found supporting this type of clinic
  - **July 2012**: Launched insulin clinic which continues today
Results

Interventions to reduce A1c

STJHC applied the below interventions to the original population from Q1 2012 with the following results

<table>
<thead>
<tr>
<th></th>
<th>Q1 AVG</th>
<th>LD AVG</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>12.00</td>
<td>10.53</td>
<td>1.48</td>
</tr>
<tr>
<td>Provider</td>
<td>11.79</td>
<td>10.67</td>
<td>1.11</td>
</tr>
<tr>
<td>Education</td>
<td>12.30</td>
<td>10.31</td>
<td>1.99</td>
</tr>
<tr>
<td>Endo Ref</td>
<td>11.07</td>
<td>10.80</td>
<td>0.27</td>
</tr>
<tr>
<td>Insulin</td>
<td>12.60</td>
<td>10.04</td>
<td>2.56</td>
</tr>
</tbody>
</table>
Culture of Improvement: Identifying Gaps

- **Clinical Pharmacist Role in the Ambulatory Care Setting**
  - Pilot project at STJHC
  - Clinical pharmacist joined our staff in October 2013
  - Her role included patient education and medication titration in collaboration with providers and diabetes educators
  - This addition proved to be beneficial to patient care and served as a model for the enterprise
Culture of Improvement: Identifying Gaps

- Placement of Point of Care A1c Analyzers
  - 2015 First device was installed in Specialty Clinic
  - Additional device added January 2017 in Internal Medicine
  - Criteria for use determined and reviewed by providers
ACTIVATING THE PATIENTS VOICE: PATIENT OWNERSHIP OF CARE PLAN
Patient Centeredness

“The experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one’s person, circumstances, and relationships in health care.”

As Defined by Donald Berwick, Past President, Institute for Healthcare Improvement
How does the Lennon Diabetes Center optimize the patient’s strengths?

1. Motivational interviewing
2. Focus on positive change, no matter how small!
3. Ask the patient’s opinion, ie; focus groups, patient panels, patient advisory council
Diabetes Support Group

'How Did They Do That??'
Diabetes Support Group
"How Did They Do That??"
Patient Panel Themes

• “Sense of hope”
• It takes self-discipline to be successful
• “They told me what to expect, what was going to happen next, and who would be helping me along the way”
• Mutual respect, developing trust
• Being treated with dignity
ENGAGING THE COMMUNITY

Marna Borieux, MBA
## Commitment to Community

<table>
<thead>
<tr>
<th>STJ Community Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Benefit Hours</td>
</tr>
<tr>
<td>Community Benefit Dollars</td>
</tr>
<tr>
<td>Community Benefit # of People Impacted</td>
</tr>
</tbody>
</table>

*Represents 60% of Regional Operations Community Benefit*
Why Do We Partner?
### Socio-economic Barriers to Care

Community Need Index (CNI)*, 2015

<table>
<thead>
<tr>
<th>Zip</th>
<th>City</th>
<th>Culture</th>
<th>Education</th>
<th>Income</th>
<th>Insurance</th>
<th>Housing</th>
<th>CNI</th>
</tr>
</thead>
<tbody>
<tr>
<td>44108</td>
<td>Bratenahl</td>
<td>5.0</td>
<td>4.0</td>
<td>5.0</td>
<td>4.0</td>
<td>5.0</td>
<td>4.6</td>
</tr>
<tr>
<td>44110</td>
<td>Collinwood</td>
<td>5.0</td>
<td>4.0</td>
<td>5.0</td>
<td>4.0</td>
<td>5.0</td>
<td>4.6</td>
</tr>
<tr>
<td>44112</td>
<td>East Cleveland</td>
<td>5.0</td>
<td>4.0</td>
<td>5.0</td>
<td>4.0</td>
<td>5.0</td>
<td>4.6</td>
</tr>
<tr>
<td></td>
<td>Cuyahoga</td>
<td>3.6</td>
<td>2.3</td>
<td>3.8</td>
<td>2.4</td>
<td>4.0</td>
<td>3.2</td>
</tr>
</tbody>
</table>

1 *lowest barriers to care, 5 *highest barriers to care

- The area around STJHC has the highest levels of community need
- Creates significant barriers to care for the population living there

* The Community Needs Index is a compilation of demographic and socio-economic variables used to identify population segments that experience access barriers to healthcare. The model was originally created by Catholic West in collaboration with Thomson Reuters. See [Appendix](#) for details.
Community Impact

- Annual Health Fair: ‘Take A Love One to the Doctor’ Day
- Free health screens & mini physicals in partnership with MedWorks
- Quarterly legal advice clinics in partnership with Legal Aid
- Monthly mobile food pantry in partnership with Cleveland Food Bank
- Mammogram programs in partnership with Taussig Cancer Institute
Community Stakeholder’s Forum

- **Why**: Partner in creating a healthy community

- **When**: Quarterly

- **Who**: Key Community Organization leaders

- **Where**: STJ & Community Organizations
How Do We Partner?

- East Cleveland Schools
  - Monthly meetings with Superintendent, Community Outreach, Pediatric Institute
  - Prevention Education: Hypertension 101, Diabetes 101 and Stroke 101
  - Recess walking program in schools
  - Bike Safety
  - Mobile Unit at Chambers Elementary
  - 2016 Community Partner of the Year
  - Heart Healthy Kickboxing Class
How Do We Partner?

- **Youth Programming**
  - MyCom City Youth Programming
  - Boys & Girls Club Involvement
  - CEOGC Fit U Programming for HeadStart
  - Northern Ohio Recovery Association Teen Summit Support
  - Safe Summer Panel
How Do We Partner?

- East Cleveland Library
  - Safe Summer Panel Discussion
  - Baby Shower
  - IDEAS Panel Discussion
  - Minority Health Education Center
  - Pilot for Wellness Portal
How Do We Partner?

- Women’s Health Programming
  - New Life Cathedral Women’s Health Day
  - The Word Church Victory in Pink Mammogram Clinics
  - Hitchcock Center for Women clinics
  - Healthy Beginnings & Centering for Pregnant Women
  - Community Baby Showers & Hospital Tours
How Do We Partner?

- Financial Health Programming
  - Medicare Education Programs
  - Partnership with Human Arc, Cuyahoga Health Access Partnerships (CHAP) and Carmella Rose to verify Medicaid/Marketplace insurance eligibility
How Do We Partner?

- Benjamin Rose Institute on Aging- Health education; Helen Brown Sr. Center
- Candlewood Park Healthcare Center- Referrals and health education
- Centers for Families and Children Behavioral Health Services
- McGregor House- Health Education
- East Cleveland Neighborhood Center: Turkey Takeover, Youth Diversion program
How Do We Partner?

- Carrington Academy
- Ohio University Students
- John Carroll Students
- Case Western Reserve University
- Coit Rd Market- produce prescription program and healthy food demonstrations
- East Cleveland Fire- Safety programming; mobile pantry volunteers
- East Cleveland Police- Safety programming
- East Cleveland Salvation Army
- Ohio Benefit Bank
- Job Corps
“The test of our progress is not whether we add more to the abundance of those who have much, it is whether we provide enough for those who have little”

Franklin Roosevelt
Cleveland Clinic

Every life deserves world class care.