

CCHN 2021 Value Based Care Podcast Series

Transcript for Episode 2: Value-Based Care and HIT Staff Roles and Responsibilities

Shannon Connell [00:00:00] Hello and welcome to the Colorado Community Health Network value-based care podcast. This short podcast series is hosted by the Colorado Community Health Network, or CCHN. CCHN is the collective voice for Colorado's 20 Community Health Centers or CHCs and the patients they serve. Colorado's CHCs provide a health care home to more than 847,000 of their community members, one in seven people in Colorado, from 63 of the state's 64 counties. This is a three-part podcast series meant to provide short, digestible introductions on how work at Colorado's CHCs is changing in response to new models of care and payment in Medicaid. Each episode could be accessed at any time through CCHN's website. This series is not a comprehensive guide of what it means to operate under a value-based care framework. Instead, it provides an introduction to the topic of value-based care and investigates how the workforce at Community Health Centers will be impacted by this model. I'm Shannon Connell, and in this episode, we're going to be exploring more about the value-based care framework with those who know it best. In this episode, Kim Moyer, Health Center Data and Operations Manager at CCHN spoke with Ben Schmudlach, Vice President of Information Systems at Clínica Family Health. Kim and Ben talked about the current and upcoming changes that health information technology staff will experience under value-based care.

Ben Schmudlach [00:01:34] My name is Ben Schmudlach, at Clínica family health, and I am currently our Vice President of Information Systems. So, I currently oversee our I.T. department and our EHR systems department, so that's our entire health record, that is NextGen and our business intelligence department. I've been here for about 13 years now. I don't know that I necessarily sought out community health care, but once I arrived there, it was a very great working environment and it felt good to be doing good work for people who required it. I did appreciate the tenacity and the dedication of the people around me and that they provided to do their work. It made my work feel like it had more purpose.

Kim Moyer [00:02:17] Awesome, thank you. So, could you describe the typical work done by HIT staff at Clínica?

Ben Schmudlach [00:02:23] Yeah, so the typical work for our HIT staff, we do a lot of interfacing with our third-party folks, whether it be folks from our RAEs, CCHA, or COA, some work with some community partners, whether it be the county or mental health partners or just other various activities. A lot of the work that we do is trying to gather information and match information. So, we do a lot of work with the I.T. department to set up FTP type processes, and then working internally with getting those FTP processes tightly wound into our business intelligence processes to bring third party information into various tables. We can make what we believe is a very rich reporting system, a little bit more rich, in the fact that we can have more complete information of what our full patient perspective and experience is. And we do sometimes even take some of this information and publish it in various status indicators into the health record. So like specifically, like attribution, attribution status, and attribution type, that's something that we recently implemented that we are keeping to the banner of each of our patient's health records. So, our frontline staff are aware of whose attributed and what type of attribution they are. Those are just some of the core things that our HIT staff currently work on.

Kim Moyer [00:03:38] So if you were talking to a new staff member or a peer from one of the other Community Health Centers, how would you describe the value-based care and payment reform work that's currently being done by Clínica?

Ben Schmudlach [00:03:48] We're working hard to make a big master plan, something that's been talked about for a long, long time, and I think we've been waiting to realize how we can actually pivot an entire care team to work a little differently or posture to be successful. For a long time, we've focused, I'll say exclusively on quality and outcomes, and knowing that as we've been able to do that, we've identified different levers within care teams to really make those dreams of high-quality outcomes a reality. You know, a great unknown with all this work is how we can further our electronic engagement with patients. I think as we have a little bit more time and space that in APM would allow, that we can really lean into different electronic offerings. Not just to make them technically sound internally and like good technical workflows internally to work, but to get some patient input on it and some patient input as far as: does this work for you? Is it something that you would adopt? Because as much work as we've done internally to date for various offerings like that, it seems like that is a very critical kind of missing piece as to where we can be highly, even more highly successful, than APM.

Kim Moyer [00:04:56] Great, so as Clínica has engaged in payment reform activities, have there been new staff roles or duties identified specifically for the HIT department? And if so, what's changed? What are these roles? Are you using existing staff, or did you have to hire new staff?

Ben Schmudlach [00:05:12] Specific to APM, we've not had to hire new staff, but I will recognize that we have some unique talents within our existing BI and our EHR systems departments that I think have made some of these things a little easier for us to adopt. Had we not had a couple specific skill sets I don't want to say that we couldn't have done it without hiring new, but it just would have been a little bit more difficult. So, to the core of the question, no, we have not had to hire any new unique staff specific to HIT activities.

Kim Moyer [00:05:40] And do you have any thoughts on how payment reform work and value-based care might impact clinic staff in general?

Ben Schmudlach [00:05:47] I think the notion is that it should allow us to make some time and some space for us to do more intentional, thoughtful work and not like max pack visits. On the heels of what was a max pack last 14 months [due to the COVID pandemic]. It'll be interesting to see how care teams lean and kind of land into those spaces. I know that we've already kind of opened up some additional time that we would probably not have done historically to make sure we're making more thoughtful, intentional approaches to our care and to each one of our provider panels. It will be good but, it's hard to say too much until that dream kind of becomes a reality, like how we will actually respond to it. Because I think we've had some hypotheses as to how we're going to create care teams and what all these people will do, but I also realized, specifically in the last 14 months, you can plan something and you can find out quickly how it's actually going to behave. And I'm not sure how it's impossible for it to be as disruptive as a global pandemic, obviously, but it will be a little bit disruptive. So, I think there'll be some give and take, but I think overall it's going to be timely, pleasant change for our staff, especially considering big picture the overall morale, I think, of those who work and in health care these days.

Kim Moyer [00:06:58] Thinking about the work in the future, sort of like you were talking about, do you think there's any skills or roles that you all might need to bring into the HIT department to continue the work?

Ben Schmudlach [00:07:10] There's been a lot of stuff that we've done. I mean, not necessarily specific to APM, but certainly complimentary to APM. Where EHR's support their core functions, but those core functions don't always blend exactly within the full care model. So, we will likely be adding to our EHR system's team a person that's going to be kind of an applications developer, like a full node stack developer that allows us to be more flexible in how we program within our NextGen API and other APIs. And I think that's something that we've had a skill set to do to date, but the plan on creating redundancy, which indicates that the long-term plan of that program is going to be here to stay at Clínica. It's going to be a part of a department, I think that has a tremendous opportunity because with all the various things that IT, EHR folks and BI folks do, those are primarily care team facing and opening up those other things to have patient facing electronic solutions is a real opportunity, but it certainly does require us to hire a little bit. I think that it'll be unique in the sense that I think this is a highly competitive tech market and it's been difficult internally to recruit in health care. But that is certainly a role that we intend on bringing in-house in the coming months.

Kim Moyer [00:08:38] As you reflect on the work that you've already done, what are some HIT related capabilities, equipment, software, staff knowledge that you would recommend that other health centers prioritize as they're starting these sorts of payment reform efforts?

Ben Schmudlach [00:08:53] We've offered some electronic screenings that we developed internally for patients to complete. We identify internally who's eligible for these screenings, and it's easily facilitated by the one who checks in these patients, but the completion process from a patient's perspective is very simple. It's very straightforward and, every step of it relates directly to our chart and alerts various members of the care team along the way. That skill set is a unique one that we have, but that's something that I think as people look at vendors and decide what it is they think they want, and they need, ensuring that that integration actually happens. Because it was one thing that we've done in the last year that I think we'll continue to lean in and we're going to expand it to different screenings beyond a PHQ 2 PHQ 9. That is like a true office efficiency and something that I see value for the patient. Is it's cool! Like it's going to a Community Health Center and completing stuff like that in that modality seems like a really cool, cutting-edge way to do a screening and also very private way to do screenings. That's certainly one thing. But other hardware and software, I think another software offering that I would recommend is a service that's facilitated through Twilio called Quick Connect where, I don't know that all health centers have a problem with a Central Communication Center to take all their phone calls. [Clínica's] has been struggling a bit in the past year, but what it offers is if I reach out to you, Kim, and I'm a nurse on the care team and I can't get a hold of you. I can subsequently send a text to you, or it provides you with what appears to be a phone number to call back. It'll call back exactly to the spot that I wanted to call, that I wanted you to be called back to. So, you skip an entire potential call center process, and you go right to the person, or the care team needed. That is something that I think is a very wise approach. I think it's very patient centered approach. I think on the patient facing part of it there is still the overhanging like patient's adoption rate of what is this and why we do it this way? Just kind of realizing that I think our patients and perhaps other CHCs will find a very common and comfortable way to interact with this. With the number one [means to interact] primarily being face to face in person and, secondarily, on the phone when they're initiating the contact. So that's a piece of it. Quick Connect, I think, is a fantastic offering

that is very patient centered, especially if they if they utilize it and they're able to quickly connect back to that exact care team member who is just in their chart or trying to deliver a specific message.

Kim Moyer [00:11:29] Great, I just have one more question. What are some of the outcomes that you hope to see for Clínica staff and patients through payment reform?

Ben Schmudlach [00:11:36] I think patient and staff satisfaction are two core ones that are very, very important and that we hope to realize some improvement there. As far as clinical measures, time and space and various other ways, modalities of engaging and care will kind of inform that work. I guess knowing that if you focus on what you can do electronically. I think we went through the various care gaps that we could cover in a virtual setting, and it makes up about 65-70% of what we can do. [Value-based care] should open that up. But it will be interesting, just the past several months going to all virtual and then in-person care again, and again realizing that for a lot of our patients and our care teams, the preferred method of care is in person face to face experience. So, I'm not sure I would definitely stick with the patient and staff satisfaction. But as far as core clinical measures, I'm not sure where we see the potential large levers for improvement. But certainly, the opportunity to iterate on our care model a little bit does feel good, and to have a little bit of time and space to be more thoughtful about that. Especially as the dust settles from the last 14 or 15 months.

Shannon Connell [00:12:54] Thank you all for listening and thank you to our speaker for sharing. Don't forget to listen to all the CCHN Value-Based Care podcast episodes. Take a moment to check out further resources on this topic found on CCHN's website and leave us a review by filling out the evaluation form on this series in our email communications. Questions about this podcast can be sent to Shannon Connell at sconnell@cchn.org. Have a great day and thank you for your time.