IHS Medical Providers' Best Practices & GPRA Measures Conference

Roundtable Exercise Notes – 5/24/17 12:45pm-2:00pm session**: "Good Health and Wellness in Indian Country: Establishing Clinic/Provider Links to Community Health and Wellness Projects"**

Roundtable Exercise questions:

<u>Discuss the following at your table, recording comments on the provided sheet</u>:

1. **Which ideas from the presentation caught your attention and why?**
2. **Share your organization's/community's *challenges* and *successes* in:**
    a. **developing community-clinical linkages; and**
    b. **integrating patient health data of referrals to/participation in community-based health programs for outcome tracking (e.g., use of EHR or other coordinated system to assess referrals, follow up, disease management measures)**
3. **What are you *most doubtful* and *most hopeful* about in applying ideas from the presentation and roundtable discussion?**
4. **From this experience:**
    a. **what do you intend to apply to your work and community?; and**
    b. **what would it take to help to follow through with your intentions?**

Sheet 1 Notes:

1. Amount of $ available
   Impressed by garden idea
   Good video –kids make difference
   Start young to stop Diabetes!
2. Challenges: Access to resources/Geography
   Obtaining ↑ funding/$
    a. other facilities "cornering market"
       hard to share services
       lack of availability – rural
    b. Different programs not effective in tracking info
       ↓ communication between clinics
3. <u>Hopeful</u>: Increased awareness – positive outcome from Education.
   <u>Doubtful</u>: Timeframe of getting program started. Members not acting on education
   Improving communication tactics/empathy by clinic staff.
4. a. Educate Educate Educate!
      Get Involved
   b. Support
      Community Engagement
      ↑ Funding Accessibility to $

Sheet 2 Notes:

1. A. Behavioral health component is missing.
   B. We would like to see more examples of GHWIC programs.
   C. We liked seeing kids being involved in the LCTHC video → prevention ☺
2. A. Rewards programs to incentivize participation, raffles
   B. Sign-in sheets + waivers
   C. Challenges = space, rural locations of clinics, patient transportation.
   D. Successes = providing pt transportation, having extra staff available.
3. A. Sustainability and staff turnover make us most doubtful.
   B. We are hopeful about learning from other programs' experiences.
4. A. Mass email tips on walking/exercising – doesn't require extra staff.
   Community garden.
   B. Need staff to be onboard and to be willing to donate their time.

Sheet 3 Notes:

1. • $ – the grant funds
   • Lake County Project
   • Creative to start community garden – incl patients
   • The walk
   • Community buy in
2. • Success w/ community introduced to new foods
   • Getting healthy/fresh foods with little access – create awareness.
   • Raffle off/give away vouchers for farmer's market. @ Luncheon w/ fresh food.
   • Challenging using EHR to track

3/4. More hands on activities –

- gardening, food demos
- Be helpful to have funding specifically for garden/healthy eating
- Medicinal values of herbs can be taught.

Sheet 4 Notes:

1. Community Garden
   - Can take skills back home and start their own.
2. a. HPDP organize community walks throughout the service area. “Just Move it”
   b. Running reports for GPRA
3. Multiple barriers preventing implementation
   - system – restricted from sending people out into community
   - No space ie land
   ☺ + Potential change with Tribal FQHC
4. a. Growing a garden
   b. Support
      - someone to start garden & manage
      - funding

Sheet 5 Notes:

1. Like brochure – good reminder for provider
   helpful to give to patient
   Garden is positive, good teaching to change food focus and is spiritually healthy reconnecting to growing, earth
2. Challenges: not having access to community resources – too full
   Big challenge: new software, using referrals uniformly – computer vs paper
3. Taking information back to clinic and integrate into care
4. Apply listening, empathy skills
   Practice skills now, with each other

Sheet 6 Notes:

1. • Family centered activities
   • Map showed extent (need to see it) of Reach
   • Strategies, Chronic Care Model
2. Challenges: Geographic distances, other family priorities

   outreach, new staff, lack of coordination btwn programs: clinic, schools, TANF, Ed Centers, Substance Abuse

   environmental challenges: mold, vermin, funding, staffing, cell phones

   all the ACES, too few providers & too few behavioral Hlth providers

   Successes: Garden, 8 yms, DM program, bike share, clinic, CHR's, parenting + prenatal classes car seat, lactation counselor, Groups, GONA, safetalk, post acute Case Mgmt, Navigators, transportation.

   Onc Case Mgmt, telehealth, collaborations w/ Public Hlth Dept of Co.

   DV program, incentives + food, Acupuncture.

   Monthly Community/Clinic meetings with providers + Board present focused on substance abuse
3. Doubts: Tribal Council vs clinic, staffing turnover, so many programs not enough time or staff. Program management to help staff accomplish the goals, Recruitment & retention, funds, program ends

   Hopes: Gaining access into schools, Priorities shift with Grants → create sustainability, 1st 5, more IHS help + communication. Collaboration, Education in health delivery + models

   Increase knowledge of population health.
4. A. & B. Blessing of Garden, join more activities, learn about the programs and refer families, participate in funded study + apply for Grant monies, include community stakeholders + ceremonial leaders, coaches etc. Time & support more structure & guidance in development, execution + evaluation of programs

   collaboration with County Hlth, IHS, CRIHB, Youth leaders

   Mentoring. Internships. Cellphone Apps for Indigenous Health, wearables, more access/use of telehealth. More access to traditional & plant medicines, alternative & complimentary modalities, ↑ recruitment retention

   Community wellness assessments including GPRA + ACES + some Medicare screening tools

   Implementation of self management plans for CHR → providers to give Pts + care partners

   Implement Pt centered Medical Home

   Train CHR's to CHW's