REGION IX CLINICAL EXCELLENCE- JUNE 2019 NEWPORT BEACH CA

Conference Materials

To access the materials for the Region IX Clinical Excellence Conference scan the QR code. Or you can visit www.clinicalexcellenceconference.com to download all session materials.

http://www.clinicalexcellenceconference.com/session-materials.html

SUN JUN 23:

BPHC Med Director Listening session- Judy Steinberg, CMO HRSA
We asked for:

- crosswalk between HEDIS and UDS measures- seemed like a novel idea to her 😣
- AZ and CA clinics getting pushed into taking risk- no answer about how HRSA could help
- Productivity requirements: no HRSA requirements any more
- many of the CMOs saying the new crop of MDs can't/won't have the same productivity we do, they want a life
- More NAPs? unknown, this is up to congress, not HRSA
- Payment for tele-health: this is a state-level decision

Keynote: Leadership skills

- Survey of clinic MDs re what we want: money 10th; #1/2- opportunity to learn and grow; breaks/time for lunch and bathroom; collaboration with colleagues; communication with and respect by admin
- 5 level os 'why' in coaching- ask why they want to do X 5 times, gets to the core motivation and probably a common goal; have this over a cup of coffee; rather than why x 5, drill down on the key words- 'what do you mean by…'
- we and our orgs need to be ready for anything- key skill is an open mind and curiosity

MON JUN 24

NACHC-
summer grassroots mobilization to advocate for 5 year base grant approval; a couple of bills pending but $20B cost and large deficit
340b - many states taking it back; NACHC looking at legislation and lawsuits
competition- big players entering our market;
Developing support for CHC PA training sites- contact Ron Yee at NACHC

Judy Steinberg, MD CMO BPHC

- BPHC trying to move from being compliance-oriented to being primary care leaders, more interconnected, continuous community-oriented comprehensive care, pop health and SDoH,; BPHC is trying to become less siloed and use data more for decision-making
- Work force a top priority:
- see special edition of BPHC Primary Care Digest- newsletter re workforce
- encouraging education of clinicians- rotations to having your own program
- BH Integration- dep and SUD screening increasing
- DM- tracking a1c>9; not moving the needle much; now BPHC aligning efforts to focus on DM; need systems change and (all the stuff we're doing already
- HIV: focus on reduction in new cases- collaboration across multiple agencies; targeting geographic hot spots; our role will be in prevention, testing in house and in community; PrEP for high risk
- Value based care: will include DM measures

Open Notes Panel: Panel: Sandy Flynn (EMR admin Open Door), Liz- Open Notes Beth Israel; Chethan Sarabu MD Stanford (peds)
http://www.clinicalexcellenceconference.com/uploads/8/1/4/9/81491828/g2_-_opennotes_deck_v2_-_3slide.pdf

website: opennotes.org

Open Notes- med records open to pts- many already doing Open Door, Clinics Romero, LA County Health Dept
Why Open Notes?:

Liz talked about there experience with KP going through recurrent astrocytoma rx; blogged, used portal for communicating with MD, tracking labs etc.; had to transfer records to new HC system; had never seen her MD notes before; it was illuminating in a good way and valuable to her. Open Notes put pt and MD on same page, increases pt understanding (evidence-based 90 publications).

- studies: lower level edu pts benefit most; improves adherence; very few confused by notes; vast majority like it and want to keep access, 50% do access after initial curiosity period; 90% pts feel the same or better about their MD after reading just one note;
- Most of early adopters are academic centers
- 70,000 heath related searches every minute
- her whole HC journey happened on her phone and computer
- Transparency is logical and ethical; pts need info in order to engage
- Pts can't remember what we talk about with them sometimes, esp with bad dx like CA
- older pts like them
- no data on homeless
- no increase indeed malpractice cases, no known cases related to open notes; some studies how a decrease in med mal cases due to improved communication and ability to ask questions about certain things

Open Door: 7 sites, 285 miles between sites, 365k pt visits

- OCHIN Epic 2008; Pt portal 2010;
- BH is not sharing notes with pts at this time
- All pt records defaulted to open, except BH; no issues. Can hide individual notes pen
- 2% of daily notes are read
- 85% of OCHIN client have open notes
- No financial impact on Open Door

Chethan Sarabu- Stanford: Peds data on open notes

- studies show: pts understand well enough, does not lead to more electronic messages or more phone calls, increases trust
- helps pts interpret other pt portal info like lab results- puts these into context
- high pt sat
- helps bring back pt-md relationship

http://www.clinicalexcellenceconference.com/uploads/8/1/4/9/81491828/1a_-_3slide.pdf - peds chronic care DM in AZ

Digitizing Peer Review:
http://www.clinicalexcellenceconference.com/uploads/8/1/4/9/81491828/1b_-_3slide.pdf- digitizing peer review

CIO Shasta:
40K pts, with FP residency; NextGen
SQL Server Reporting Services, STATA analysis tool
See the slides- have automated chart selection, assignment to reviewers, set up predefined questions to answer with rubrics
use Survey Monkey, customized using open API without transfer of PHI;
gave providers 2 monitors so they could complete the peer review form while note open on other monitor
takes 6 minutes per chart to complete, every medical provider does 1 per week
results: detected workflow and performance issues in MA med rec;

Bob Moore, CMO Partners Health Plan, former Ole CMO
Diagnostic error really the more important aspect of quality?
Book rec: Thinking, fast and slow, Daniel Kahneman
Ordering too many tests can also be a form of poor quality (Choosing Wisely campaign)
Common errors seen now in EMR: not noticing abnl VS, premature anchoring (making dx not supported by obj data based on hx only)
Heuristics: 'rules of thumb'- affect (if it feels good it is right); anchoring (recently acquired info is right); availability (what we are aware of is more common, can be criven by media); representative; commitment (too much investment to change despite evidence);
Biases: belief (how believably the conclusion is); confirmation (evidence seen selective to confirm your bias); optimism (overestimates good outcome); hindsight; framing (how info is presented creates bias); loss aversion (loss twice as powerful as gain); narrative fallacy (good story makes it true); regressing fallacy; planning fallacy (predicts outcomes to support conclusion); expert halo; law of small numbers; what you see is all there is

(my thoughts on this: underlying assumption is that we have to do chart review and that there is some inherent value in doing this; i don't necessarily agree especially with scribes- seems like lots of time and effort, one more task to do, without a clear benefit; our current system of CTL reviewing annually should detect major charting problems??? Bob Moore points out that the chart review process does not detect diagnostic error accurately)

*** should we have some targeted one time peer review looking for diagnostic error/mismatch with HPI? small survey of 70 charts to see if there is an issue

The Role of CHCs in Addressing Human Trafficking- Kimberly Chang, MD FP , Healthcare Policy Fellow Asian Health Services
http://www.clinicalexcellenceconference.com/uploads/8/1/4/9/81491828/g3_-_the_role_of_chcs_in_addressing_human_trafficking_wcn_2019_-_3slide.pdf- human trafficking (HT)

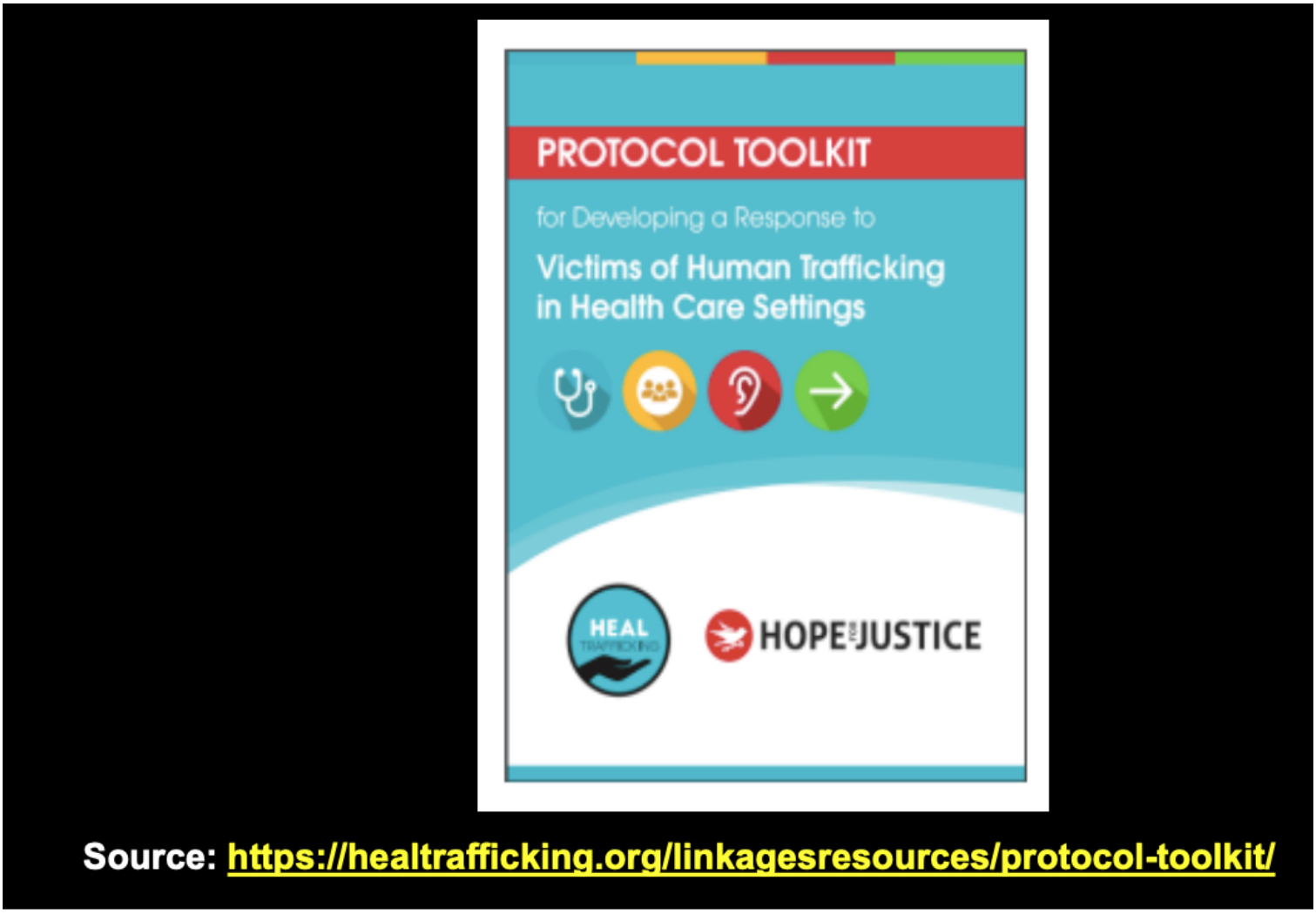
Human Trafficking (HT) is (legal definition)
A. Sex trafficking:
1. A commercial sex act induced by force, fraud, or coercion,
2. Or in which the person induced to perform such act has not attained 18 years of age
B. Labor Trafficking: The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

While being trafficked:
87.8% of trafficked victims encountered a health care provider and 57.1% visited a clinic
28-50% of victims in the US encounter health care professionals while being trafficked
None were identified as being trafficked
Some trafficked minors may disclose if screened in a clinic
CAN be identified in a health care setting
There are models of care for victims of HT, and those who are vulnerable
Once identified, there are ways for health care to respond; AND we can universally educate / provide prevention

No mandated reporting of trafficking

Most pts meet MD in ER of primary care; also dental 26.5%, OB/gyn 26.5%

Toolkit:



ipvhealthpartners.org : toolkit developed by and for CHCs

DV / SA / HT National Hotlines

National Domestic Violence
http://www.thehotline.org/
1-800-799-SAFE (7233)
TTY: 1-800-787-3224
- Live chat 24/7/365
- En Español:12pm-6pm Hora Central

The Trevor Project
www.thetrevorproject.org
866-488-7386 LGBTQ Youth

National Sexual Assault
https://www.rainn.org/
1-800-656-HOPE (4673)

StrongHearts Native Helpline
www.strongheartshelpline.org
1-844-7NATIVE (762-8483)
- safe, anonymous and confidential service for Native Americans affected by DV
- Monday-Friday 9am-5:30pm CST

Trans Lifeline 1-877-565-8860
www.translifeline.org/

National Human Trafficking
www.humantraffickinghotline.org
1-888-373-7888
Text Help to 233733 (BeFree)
3:00pm-11:00pm EST

BPHC has resources too:

http://www.clinicalexcellenceconference.com/uploads/8/1/4/9/81491828/2b_-_2slide.pdf- making great providers into great leaders
Paige went- get her notes

http://www.clinicalexcellenceconference.com/uploads/8/1/4/9/81491828/2b_-_3slide.pdf- incorporating pt risk factors into determining panel size

Axis health- CHC in E Alameda Co
They risk stratify their pts:

Category	Variable	Points
Diagnoses	Moderate chronic condition	1 each
	Severe chronic condition	2 each
Prescriptions	Actively prescribed to 1+ controlled substance	Yes = 1
Utilization	Inpatient visits	0.50 each
	Outpatient visits	0.25 each
Social Determinants	County specific supplemental health coverage	Yes = 0.25
	Interpreter not available	Yes = 0.25
	Smoker	Yes = 0.25
	Homeless	Yes = 1
Age & Gender	65+ Female	2
	65+ Male	1.5
	40 – 64 Female	1
	50 – 64 Male	0.50
	13 – 39 Female	0.25
	0 – 49 Male	0
	0 – 12 Female	0

Points	Variable	Subtotal

1	x	# of moderate chronic conditions	=
2	x	# of severe chronic conditions	=
1	IF	Actively prescribed to 1 or more controlled substances	=
0.50	x	# of inpatient visits	=
0.25	x	# of outpatient visits	=
0.25	IF	County specific supplemental health coverage	=
0.25	IF	Interpreter is not available	=
0.25	IF	Smoker	=
1	IF	Homeless	=
2	IF	65+ y.o. and Female	=
1.5	IF	65+ y.o. and Male	=
1	IF	40 – 64 y.o. and Female	=
0.50	IF	50 – 64 y.o. and Male	=
0.25	IF	13 – 39 y.o. and Female	=
0	IF	0 – 49 y.o. and Male	=
0	IF	0 – 12 y.o. and Female	=
Patient Risk Score			**TOTAL**

attribution: 18 month look back

PROVIDER RISK SCORE - EXAMPLE

$$\frac{\text{Sum of each Patients' Risk Score (in the Provider's Panel)}}{\text{\# of Patients (in the Provider's Panel)}}$$

- Patient A has a Risk Score of 13.25
- Patient B has a Risk Score of 1.5
- Patient C has a Risk Score of 2
- Patient D has a Risk Score of 0.5

- Provider Risk Score:

  (13.25 + 1.5 + 2 + 0.5) / (4 patients) =

  17.25 / 4 = **4.3**

Provider	Risk Score
A	2.8
B	3.2
C	3.3
D	3.3
E	3.5
F	3.5
G	3.5
H	3.9
I	4.0
J	4.1
K	4.1
L	4.3

Statistical Point	Value
Minimum	2.8
25th Percentile	3.3
Median	3.7
75th Percentile	4.5
Maximum	5.2
Average	3.8

Statistical Point	Value
Minimum	2.8
25th Percentile	3.3
Median	3.7
75th Percentile	4.5
Maximum	5.2

Statistical Range	True Range	Complexity
Minimum to 25th Percentile	2.8 – 3.3	Low
26th Percentile to 75th Percentile	3.4 – 4.5	Moderate
76th Percentile to Maximum	4.6 – 5.2	High

COMPILE ALL PROVIDER RISK SCORES

Provider	Risk Score	Complexity
A	2.8	Low
B	3.2	Low
C	3.3	Low
D	3.3	Low
E	3.5	Moderate
F	3.5	Moderate
G	3.5	Moderate
H	3.9	Moderate
I	4.0	Moderate

J	4.1	Moderate
K	4.1	Moderate
L	4.3	Moderate
M	4.7	High
N	5.2	High

Their 'sweet spot' : lowest complexity panel (median score 2.8)= 1100 pts

Risk Score Increment (Patients/0.1 Increase in Risk Score)	-10
FTE Increment (Patients/0.1 Increase in FTE)	+100
Where the FTE = 1 and the Risk Score = 2.8	1,100

FTE BY RISK SCORE TABLE: FILL IN

Risk Score (-10 Patients / 0.1 Risk Score)	FTE (+100 Patients / 0.1 FTE)									
	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8	0.9	1
5.2	-40	60	160	260	360	460	560	660	760	860
5.1	-30	70	170	270	370	470	570	670	770	870
5.0	-20	80	180	280	380	480	580	680	780	880
4.9	-10	90	190	290	390	490	590	690	790	890
4.8	0	100	200	300	400	500	600	700	800	900
4.7	10	110	210	310	410	510	610	710	810	910
4.6	20	120	220	320	420	520	620	720	820	920
4.5	30	130	230	330	430	530	630	730	830	930
4.4	40	140	240	340	440	540	640	740	840	940
4.3	50	150	250	350	450	550	650	750	850	950
4.2	60	160	260	360	460	560	660	760	860	960
4.1	70	170	270	370	470	570	670	770	870	970
4.0	80	180	280	380	480	580	680	780	880	980
3.9	90	190	290	390	490	590	690	790	890	990
3.8	100	200	300	400	500	600	700	800	900	1000
3.7	110	210	310	410	510	610	710	810	910	1010
3.6	120	220	320	420	520	620	720	820	920	1020
3.5	130	230	330	430	530	630	730	830	930	1030
3.4	140	240	340	440	540	640	740	840	940	1040
3.3	150	250	350	450	550	650	750	850	950	1050
3.2	160	260	360	460	560	660	760	860	960	1060
3.1	170	270	370	470	570	670	770	870	970	1070
3.0	180	280	380	480	580	680	780	880	980	1080
2.9	190	290	390	490	590	690	790	890	990	1090
2.8	200	300	400	500	600	700	800	900	1000	1100
	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8	0.9	1
	FTE (+100 Patients / 0.1 FTE)									

IDENTIFY OPTIMAL PANELS

Provider	Risk Score	FTE
A	2.8	1.0
B	3.2	0.4
C	3.3	1.0
D	3.3	1.0
E	3.5	0.8
F	3.5	0.5
G	3.5	1.0
H	3.9	0.1
I	4.0	0.8
J	4.1	0.9
K	4.1	1.0
L	4.3	0.8
M	4.7	0.6
N	5.2	0.9

Risk Score (-10 Patients / 0.1 Risk Score)	FTE (+100 Patients / 0.1 FTE)									
	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8	0.9	1
5.2	-40	60	160	260	360	460	560	660	760	860
5.1	-30	70	170	270	370	470	570	670	770	870
5.0	-20	80	180	280	380	480	580	680	780	880
4.9	-10	90	190	290	390	490	590	690	790	890
4.8	0	100	200	300	400	500	600	700	800	900
4.7	10	110	210	310	410	510	610	710	810	910
4.6	20	120	220	320	420	520	620	720	820	920
4.5	30	130	230	330	430	530	630	730	830	930
4.4	40	140	240	340	440	540	640	740	840	940
4.3	50	150	250	350	450	550	650	750	850	950
4.2	60	160	260	360	460	560	660	760	860	960
4.1	70	170	270	370	470	570	670	770	870	970
4.0	80	180	280	380	480	580	680	780	880	980
3.9	90	190	290	390	490	590	690	790	890	990
3.8	100	200	300	400	500	600	700	800	900	1000
3.7	110	210	310	410	510	610	710	810	910	1010
3.6	120	220	320	420	520	620	720	820	920	1020
3.5	130	230	330	430	530	630	730	830	930	1030
3.4	140	240	340	440	540	640	740	840	940	1040
3.3	150	250	350	450	550	650	750	850	950	1050
3.2	160	260	360	460	560	660	760	860	960	1060
3.1	170	270	370	470	570	670	770	870	970	1070
3.0	180	280	380	480	580	680	780	880	980	1080
2.9	190	290	390	490	590	690	790	890	990	1090
2.8	200	300	400	500	600	700	800	900	1000	1100
	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8	0.9	1
	FTE (+100 Patients / 0.1 FTE)									

TRUE VS OPTIMAL PANELS

Provider	Risk Score	FTE	True Panel	Optimal Panel	True to Optimal
A	2.8	1.0	1029	1100	<
B	3.2	0.4	337	460	<
C	3.3	1.0	723	950	<
D	3.3	1.0	950	950	=
E	3.5	0.8	821	830	<
F	3.5	0.5	567	530	>

- At Goal Panel Size = Optimal Panel Size Provider will continue to take on X patients per month to make up for their attrition rate.
- Above Goal Panel Size > Optimal Panel Size Provider will stop taking on new patients until their panel size falls to "At Goal" status.
- Under Goal Panel Size < Optimal Panel Size Provider will take on new patients until their panel size meets "At Goal" status, in addition to adding X patients per month to make up for their attrition rate.

They assign pt to panel based on who saw the pt for the 'establish care' visit type
Pt individual risk score calculated using IF/THEN function in excel; individual cells in Excel populated automatically pulling from several other reports (not a manual process)

They developed this while on NextGen but have since converted to Epic

How to Close the Transgender Health Disparity Gap in Healthcare
http://www.clinicalexcellenceconference.com/uploads/8/1/4/9/81491828/3a_-_3slide.pdf- how to close the transgender gap

Anitha, St John's, Corey Bohman, NP Lifelong (transgender male)

words to avoid: sex change (use gender affirming surgery), transgenders, transgendering, transvestite (transgender ok)
Transgender rates for poverty, homelessness, murder and sexual abuse much higher than gen pop

Waiting room: use 'patient' rather than gender-specific language; use name without pronoun Mr/Mrs/ma'am/sir etc;

Waiting room: use 'patient' rather than gender specific language, use name without pronoun Mr/Mrs/ms am/sir etc,
Ask the pt how they would like to be addresses and what pronouns they prefer?
Ask 'what sex were you assigned at birth' and ask about any surgeries including gender affirming surgery
EHR challenges- set us up to fail in this area; do need the legal name for billing/ins coverage; Epic is better in this area; use your nickname field, notes/alerts etc pro

Lifelong: created transgender working group incl all staff and BH, call center, multiple sites; after hours, staff compensated (gift cards) for time, good leadership support; created email list; had dinner cme type meetings lead by staff from Lyon-Martin Health Services (clinic in SFO); Transgender 101 training, created point person at each site- call center referred TG callers to this person to get pronouns/names set up correctly in EMR; continuity/ongoing training hard to keep up; trans pt voice collaborative to get feedback; starting to track TG pts separately for clinical outcomes; training other local CHCs; they have 600 transgender pts; sometimes it is better to have a 'transgender clinic' or set time to group the transgender pts

Dx ICD 10 is 'gender identity disorder'; no alternative at this point, need to explain it to the pts esp if open notes

St John's: have several TG staff; 85k pts in 10 clinics in South Central LA; started TG program 2014, main clinic Traynham Clinic near 10/jharbor fwy interchange; about 9000 visits (med, bh,dental) 2018; they help with insurance enrollment, do primary care, do hormonal rx, BH, sure referrals, all the usual CHC services; assist with legal marker change; have a job readiness training program; they do parties/promotions to attract TG pts to their clinic

medical guidelines: http://transhealth.ucsf.edu/

http://www.clinicalexcellenceconference.com/uploads/8/1/4/9/81491828/3b_-_3slide.pdf- hacking into the tele dentistry trend

http://www.clinicalexcellenceconference.com/uploads/8/1/4/9/81491828/4a_-_3slide.pdf- navigating conflict to improve communication

A New Epidemic: The Rise of Meth Use in Patients with Opioid Use Disorder
http://www.clinicalexcellenceconference.com/uploads/8/1/4/9/81491828/4b_-_3slide.pdf- new epidemic meth abuse in opiate abusers

increase meth esp white female, west coast; death rate rapidly increasing; deaths from opioids and stimulants and combined skyrocketing last 4-5 years; 64% of abusers have mental illness; serious withdrawal syndrome, powerful pavlovian trigger-response with stimulants esp meth; craving a big problem with stimulants;

methadone and buprenorphine don't really reduce stimulant use

Possible Rx:
Contingency management/motivational interviewing: positive behavior reinforced- eg reward for clean UDS; works a little, better than CBT alone
Exercise: helpful but helps more with comorbid anxiety and depression
Mindfulness training can help

Meth

resource: NIDA- lots of good resources for MDs
may be synergistic with heroin, downside of one helps the other
Reward circuit with meth:
meth blocks dopamine reuoptake in presynapse and increases dopamine in post synapse in limbic system—> pleasure response, sends out signals to much of the brain; met also increase NE and 5HT, and interacts with endorphin system and glutamate
Meth cheap: $40/3g; smoke/snort .01-.05 g; oral .06-.15g; inject .03-.1g; heavy users 1g/g
main source Mexico superlabs—> west US
prominent in US, SE asia, E asia, E europe
binge and crah phenomenon- several days in a row q1-4 h; agitation, psychotic, erratic, then crash (stops working); dysphoria then etch then heron then benzos-
depletes monoamines
peripheral effects also
neurotoxic- oxidative stress on neurons—> cognitive decline, dec, anxiety, paranoia, aggressiveness, parkinsonism (anti PD drugs don't help); some genetic variation
naloxone may help some? opiate system produces cravings so craving aspect of meth may be helped by naloxone
withdrawal- 14 days (maybe)- manage with BZs, antipsychotics, antidepressants; symptomatic mgmt only
some people use meth sporadically and casually, others quite addicted; some can stop it overnight, some can't
overpowers prescription amphetamines by a lot; if pt using meth do not continue rx for ADHD

Meds:
modafinil? not much success
bupropion? maybe helps some
naltrexone? attenuate cravings?
mirtazepine, topamax- studies pending
substitution rx- dextroamphetamine- no data

no good data on use of buprenorphine in meth abuse despite recent small articles; also DEA doesn't allow this use of suboxone
common to treat people abusing opiates and meth with buprenorphine and generally the opiate abuse improves but the meth abuse persists
due in part to the neurotoxicity these pts don't engage very well, can be erratic in follow up and have little sense of agency- makesit hard to take care of them

Contingency Management:
Jasmine Marozick, RN- runs MAT program Santa Cruz County Homeless Persons Health Project Clinic
CM: provides tangible reinforcers for objective evidence of behavior change
studies: it works some, better outcomes, higher retention rates, inc pt self esteem and staff morale
Basic principles: monitor behavior frequently, immediate tangible positive reinforcers
eg when UDS neg, get to draw from a fishbowl full of prizes; can do vouchers, prize cabinets. Their fishbowl is small tootsie rolls etc., and they have periodic drawings for gift cards to movies, burger king, coffee shops etc. Gift cards paid for by grants; mostly $5, usually for the 12 weeks program only; need to track how much per pt and a person responsible for tracking these
Pts seen in group setting, provider does refills in group, some pts who need more time pulled out for individual visits after group; (shared medical appt is their term)

false positive UDS for meth very rare
they use POC UDS

ADHD Rx vs meth abuse- ADHD meds much lower dose than meth; not much crossover from ADHD Rx to meth abuse but not much literature on this (remember the opiates story and how that ended up)

Thoughts about preventing opiate and meth abuse: complex answer; basic medical care, good BH, exercise/yoga etc. esp for people at risk for opiate abuse like low back pain- try to start for a more long term rehabilitative approach right from the start (but the system doesn't necessarily support or fund this well); try to keep them out of the 'disability' mind set but again system is actually set up to reward disability;

Pts going to program as a condition of parole: generally hard to engage more than 1-2 weeks;

The Social Change Model: Integrating Healthcare, Social Services, and education to Improve Outcomes- Seiji Hayashi, MD CTO Mary's Center, former CMO BPHC (FP)
http://www.clinicalexcellenceconference.com/uploads/8/1/4/9/81491828/g4_-_shayashi_-_3slide.pdf- social change model- how to use SDoH to improve health outcomes

What do we want to accomplish for our community?
How do we get there (where everyone has a home, access to good nutrition, open spaces, good healthcare, good education)? What can we do?
Mary's Center: FQHC in DC; mostly Central American migrants;
Social change model- typical CHC stuff plus education program- dual generation
provide edu to parents and children; parents: Eng language, parenting, digital lit; kids: day care, pre-K ($ from DC public schools), HS diploma, MA training, child dev training, associate degree program
pre-K is a public charter school; pre K plus adult edu; funded by DC dept of edu; this program had to separate from the CHC because their Charter Schools rule required a separate 501c3 but boards overlap
many of the women were already doing child day care in their home so now they get a certificate and have a more reliable source of income from their day care activities
many of the MAs then become nurses etc.
have their clinics colocated in 3 charter schools

how do you know it works? They really don't; hypothesis providing hc, edu leads to jobs and people will do better; now NIH looking at their EHR data; prelim results: decreased hen, obesity, dm, cholesterol; participants have high satisfaction; staff has high engagement, commit to mission;

they have dozens of community partners- schools, social service agencies

Opportunities and challenges:

- Integration of all these services
- Financial sustainability- pts can't pay
- Managing growth
- Evaluation

*** one of his key transformation tools at his CHC: getting people to text each other using microsoft teams- front to back, md-to-md etc.