# TRANSFORMING PRIMARY CARE PRACTICE

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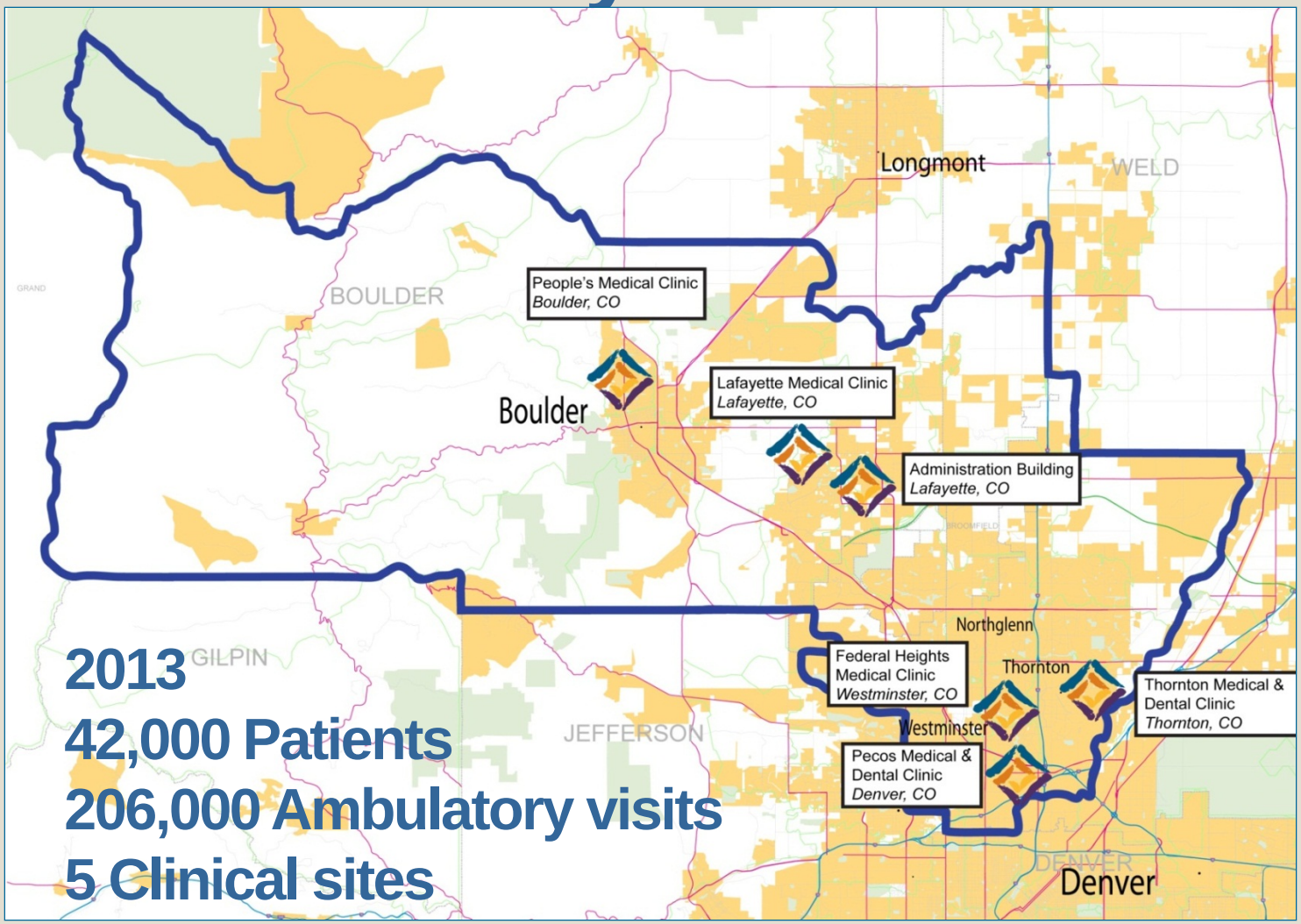
# Objectives for this Session

- List examples of applying PCMH standards to improve patient outcomes
- Define the three types of outcomes data and their uses in a PCMH
- Describe examples of EHR data which improve team based care and clinical outcomes

# Clinica Family Health Services



# Clinica Family Health Services

- 50% uninsured
- 40% Medicaid until 1/1/14
- 56% < Poverty
- 98% < 200% of Poverty
- 44% 18 and under
- 26% women ages 20-44
- 1700 deliveries in 2012
- 60% prefer to speak in a language other than English

# Clinica Family Health Services

- 46 Physical Health Providers
- 14 Behavioral Health Providers
- 8 Dental Providers
- Clinic in the Homeless Shelter
  Mental Health Center
- 2 Full Pharmacies, 2 Pharmacy Outlets, 2 Schools of Pharmacy
- Total Staff over 400
- Admit to 2 community hospitals
- Community-wide EHR in the iPN

# Clinical Family Health Services Model

- Co-located team based care
  - Primary medical care
  - Primary dental care
  - Integrated behavioral health care
  - Integrated clinical pharmacy services
  - Integrated nutrition services

# Clinica Family Health Services Recognition

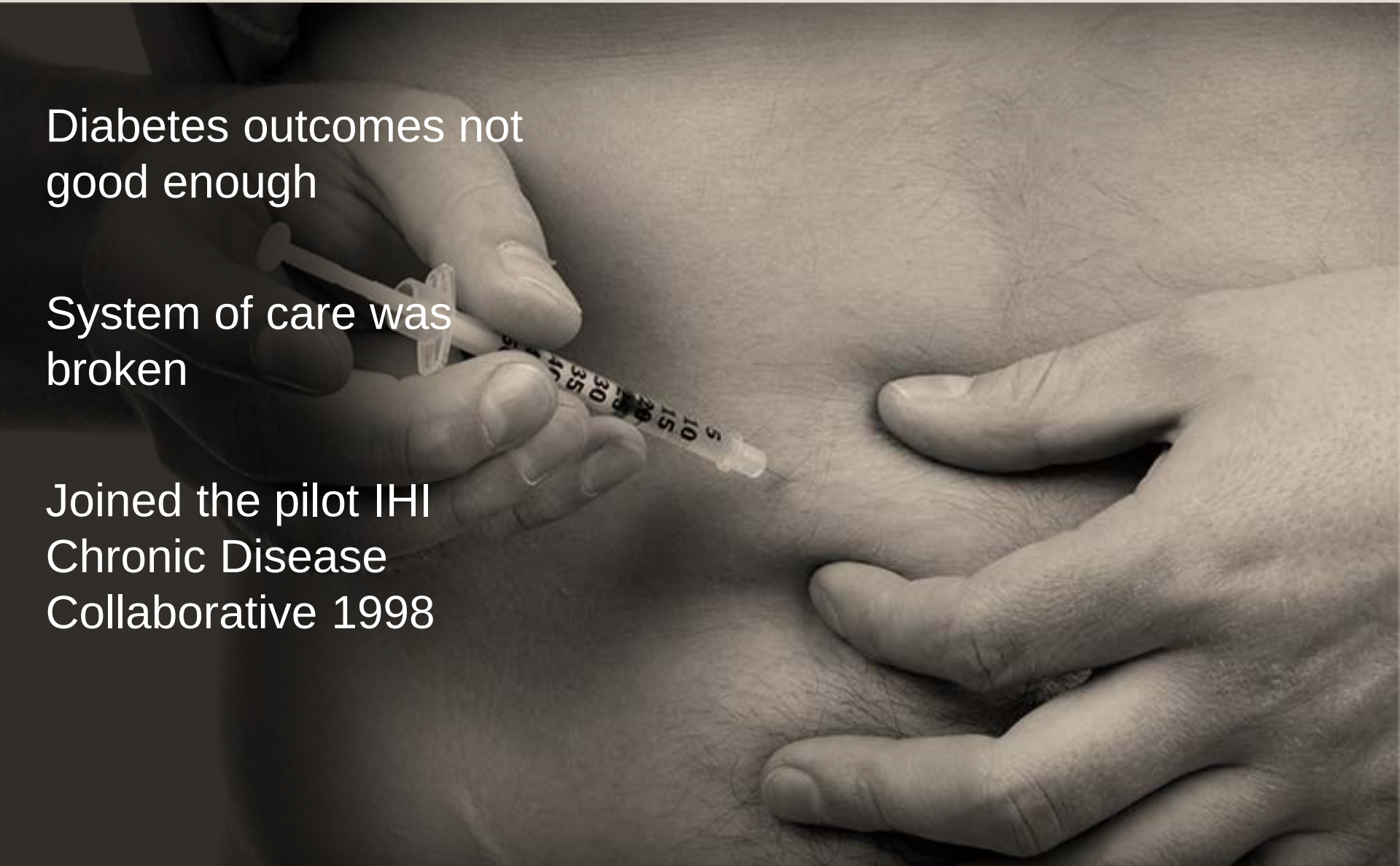

NCQA
Diabetes
2011/2014


NCQA
PCMH
Level 3
2010/2013


Joint
Commission
Accredited
since 2002


Nominated
by staff,
awarded
2012/2013

# Drivers for Change in 1998

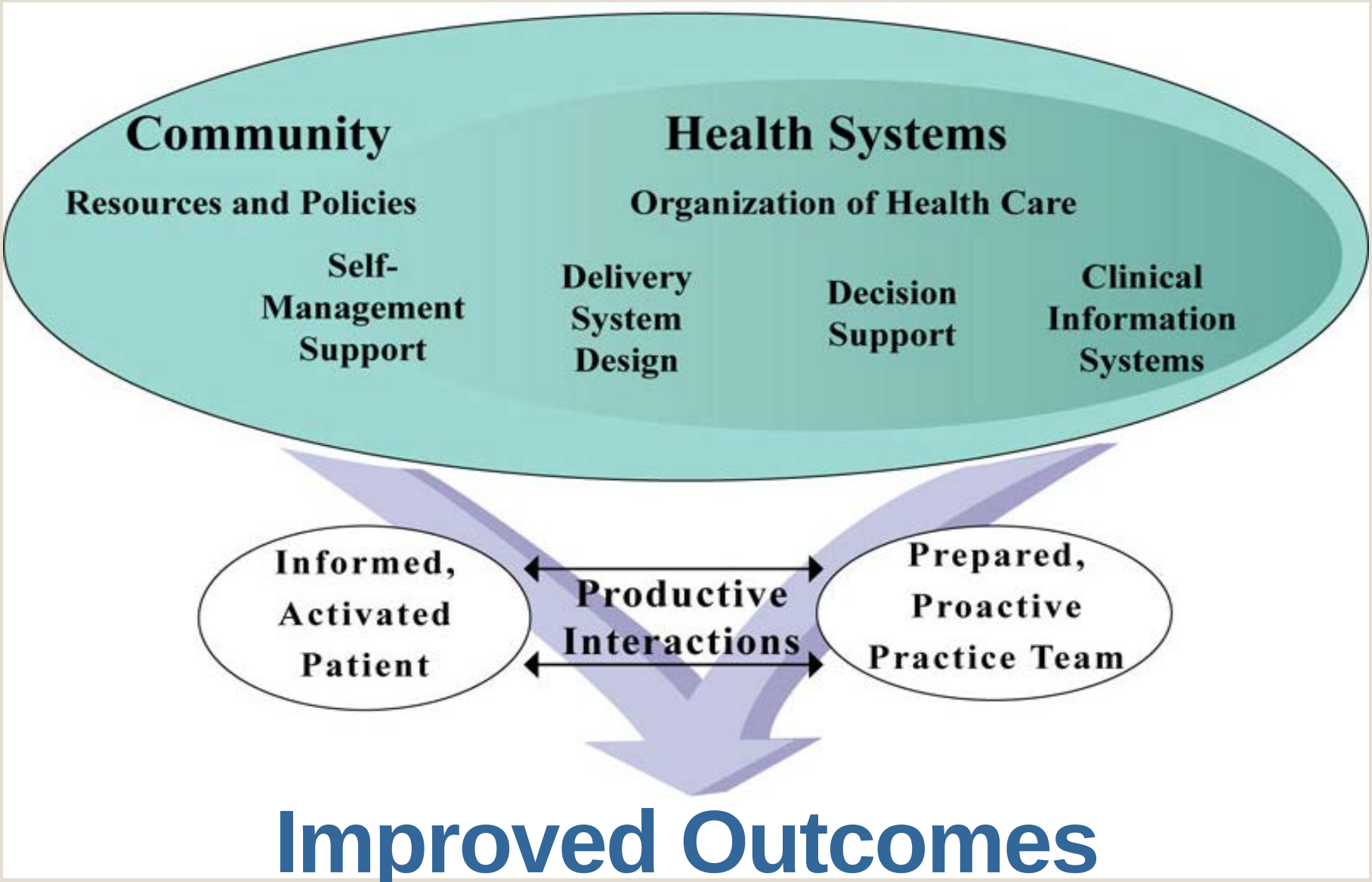


Diabetes outcomes not good enough

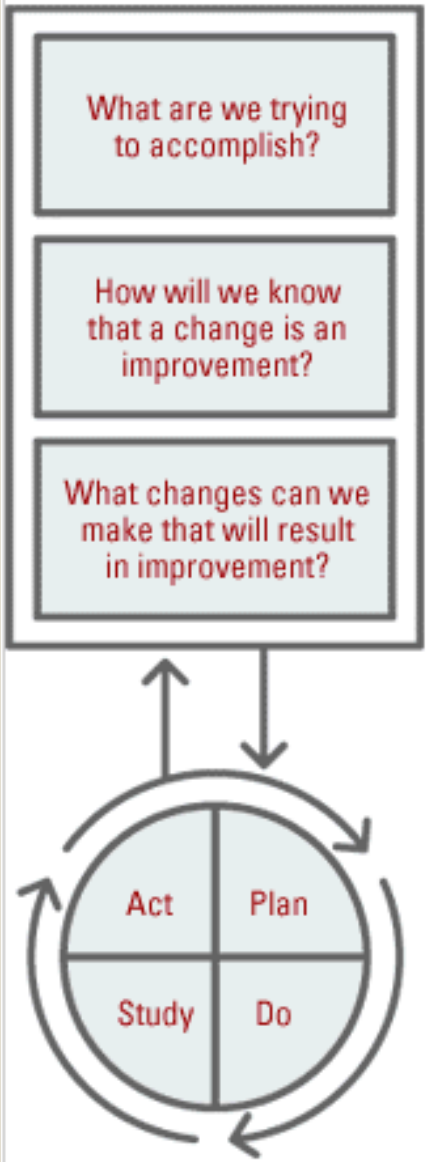
System of care was broken

Joined the pilot IHI Chronic Disease Collaborative 1998

# Population Based Health-Chronic Care Model



# Science of Improvement



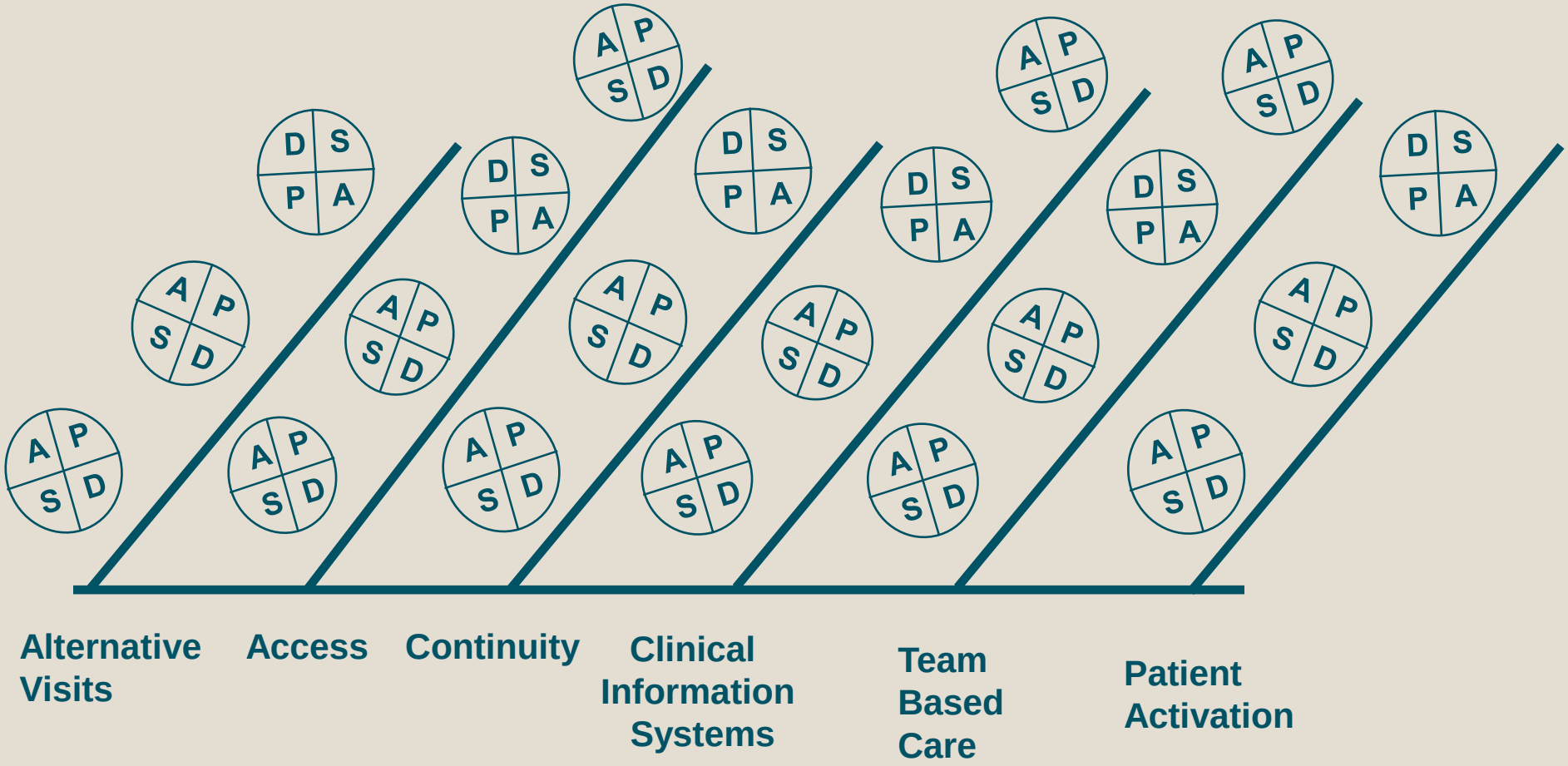

**Setting Aims**
Improvement requires setting aims. The aim should be time-specific and measurable; it should also define the specific population of patients that will be affected.

**Establishing Measures**
Teams use quantitative measures to determine if a specific change actually leads to an improvement.

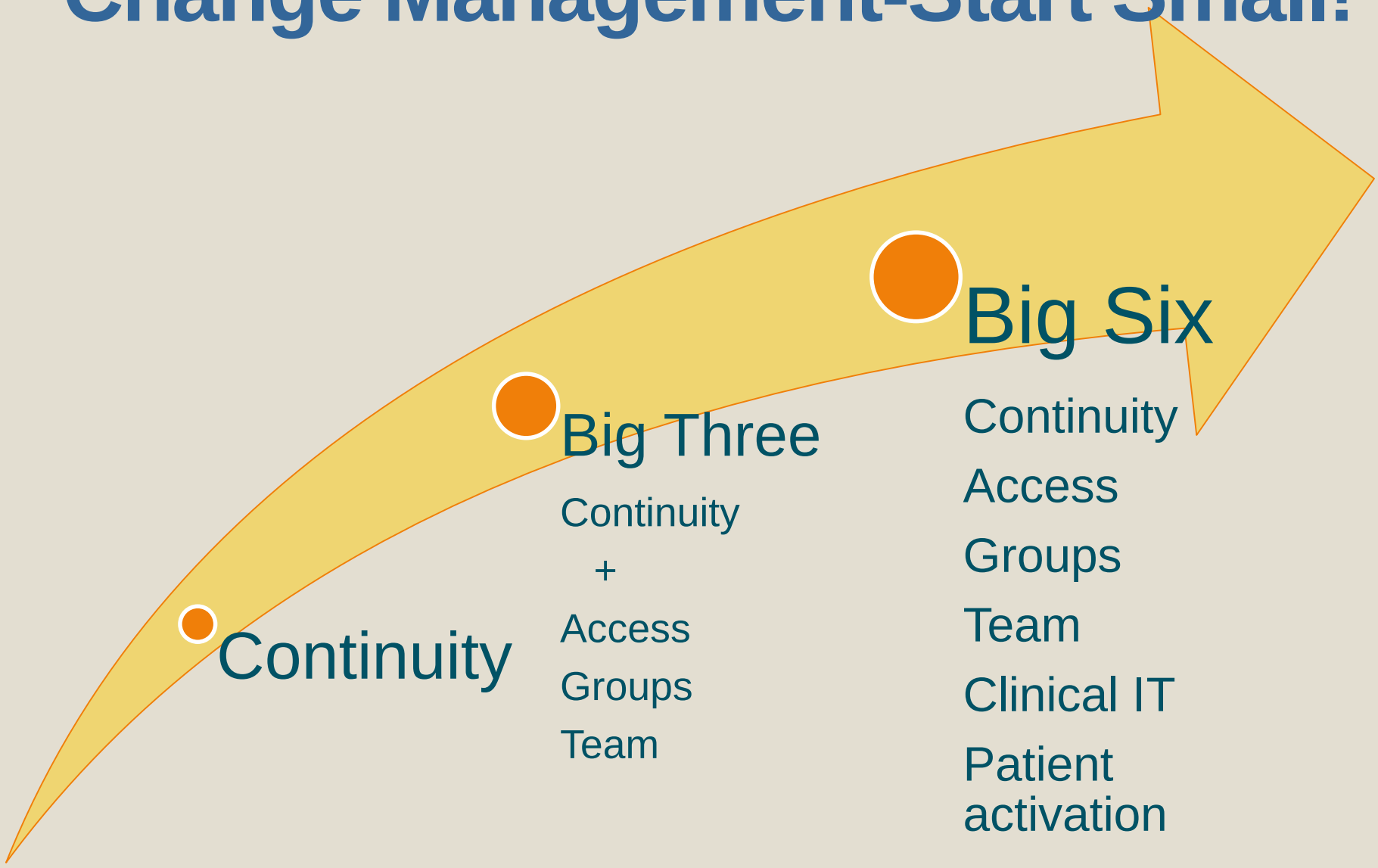
**Selecting Changes**
All improvement requires making changes, but not all changes result in improvement. Organizations therefore must identify the changes that are most likely to result in improvement.

**Testing Changes**
The Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change in the real work setting — by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method used for action-oriented learning.

# Sequential and Shared Learning



# Change Management-Start Small!



# NCQA PCMH 2014 Standards

1. Enhance Access and Continuity
2. Identify and Manage Patient Populations
3. Plan and Manage Care
4. Provide Self-Care Support and Community Resources
5. Track and Coordinate Care
6. Measure and Improve Performance

1. Patient-Centered Access
2. Team-Based Care
3. Population Health Management
4. Care Management and Support
5. Care Coordination and Care Transitions
6. Performance Measurement and Quality Improvement

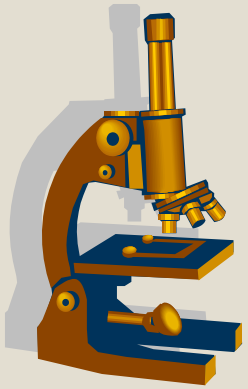
# Patient Centered Medical Home

# Six Must Pass Elements 2014

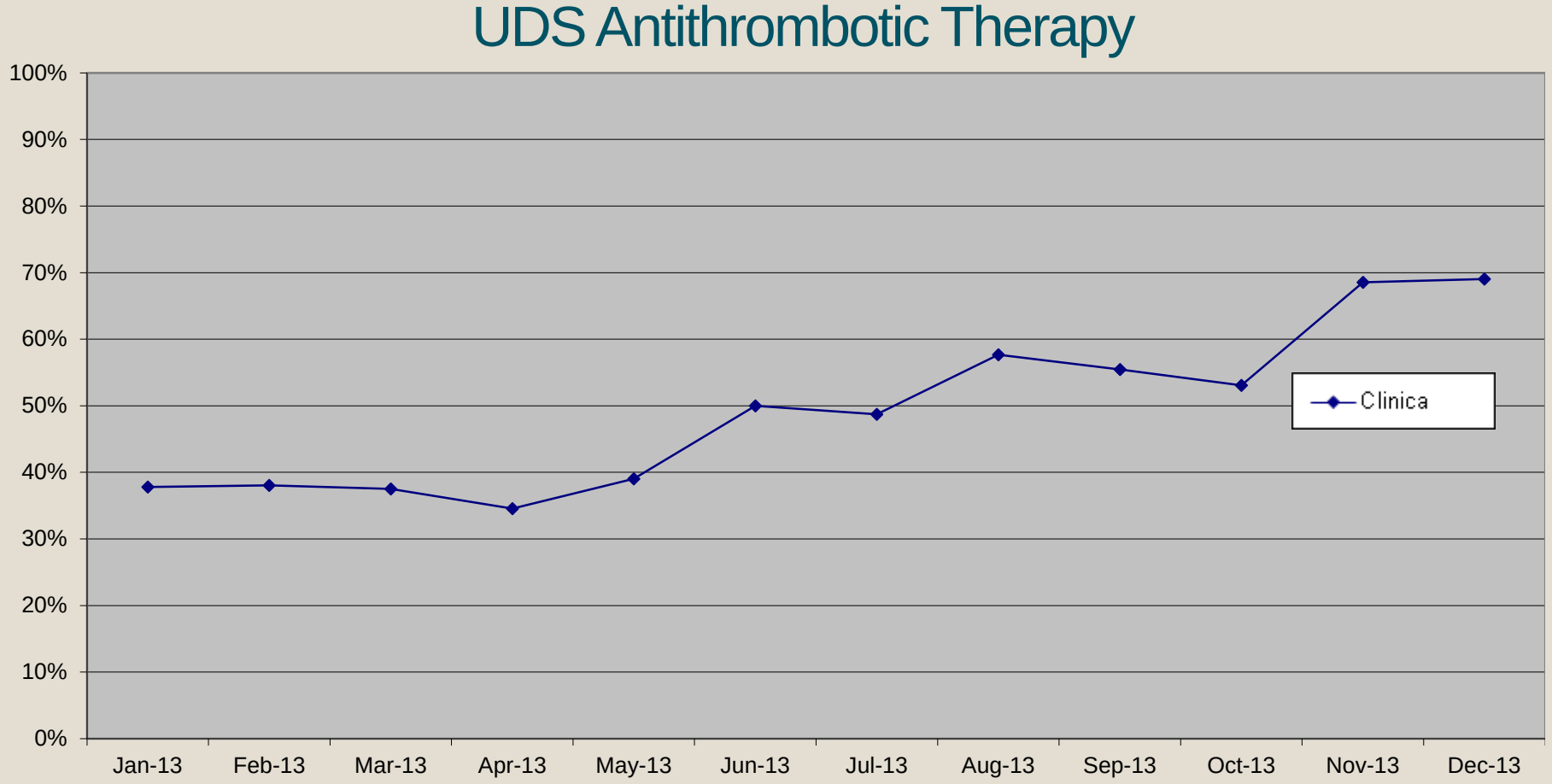
1. PCMH 1, Element A: Patient-Centered Appointment Access.
2. PCMH 2, Element D: The Practice Team.
3. PCMH 3, Element D: Use Data for Population Management.
4. PCMH 4, Element B: Care Planning and Self-Care Support.
5. PCMH 5, Element B: Referral Tracking and Follow-Up.
6. PCMH 6, Element D: Implement Continuous Quality Improvement.

# Outcomes

- Research outcomes
  - Statistical structure for studies
  - IRB, research institutions
- Accountability outcomes
  - Benchmark comparisons
  - Defined numerators and denominators
- Performance improvement outcomes
  - Decision support
  - Population based registry functions
  - Appropriate fine focus adjustment
  - Adding continuum data

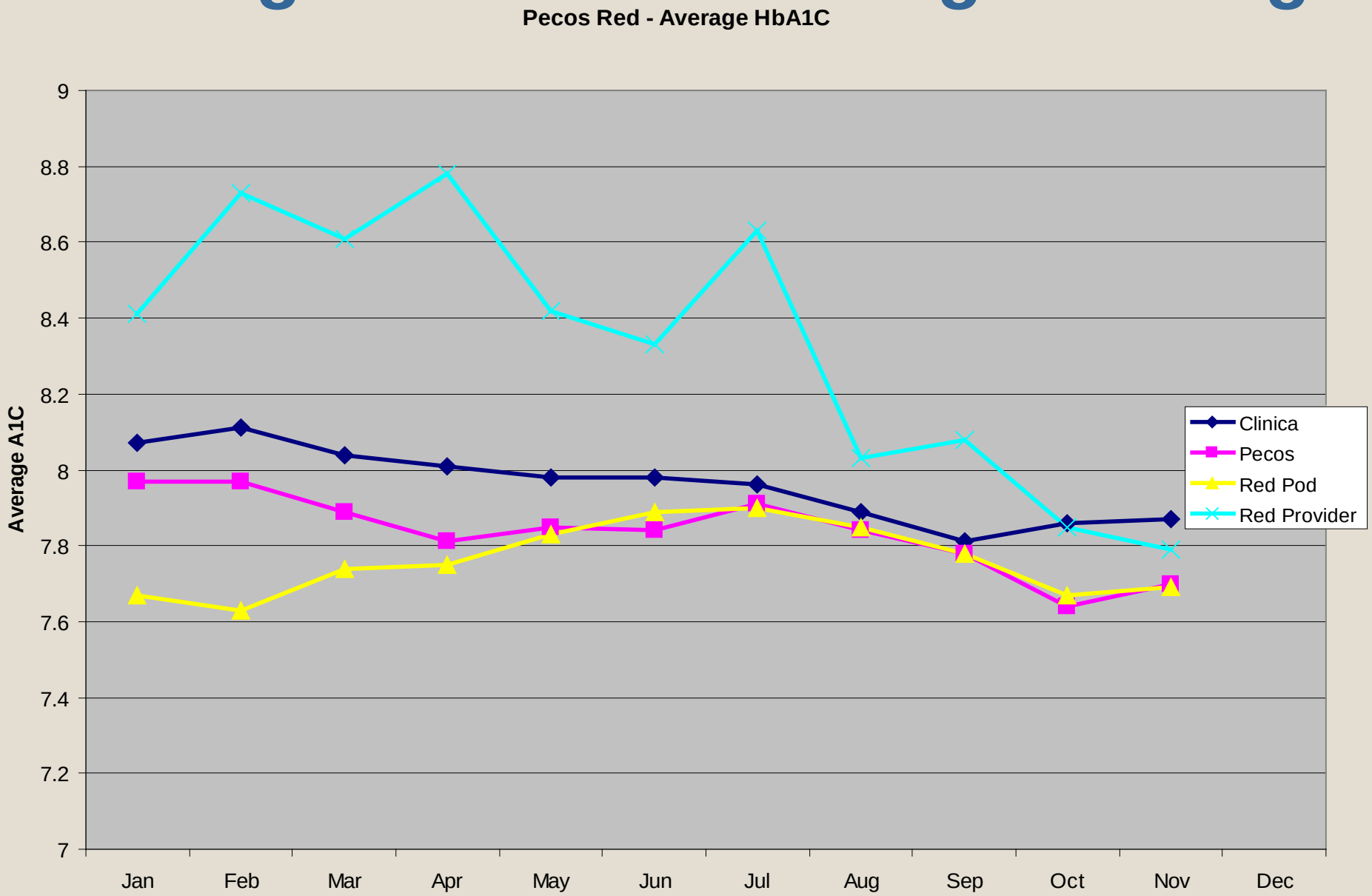


# Data for Performance Improvement




Patients aged 18 and older with a visit in the reporting year with a diagnosis of IVD or AMI,CABG, or PTCA procedure with aspirin or another antithrombotic therapy

# Meaningful Data for Meaningful Change



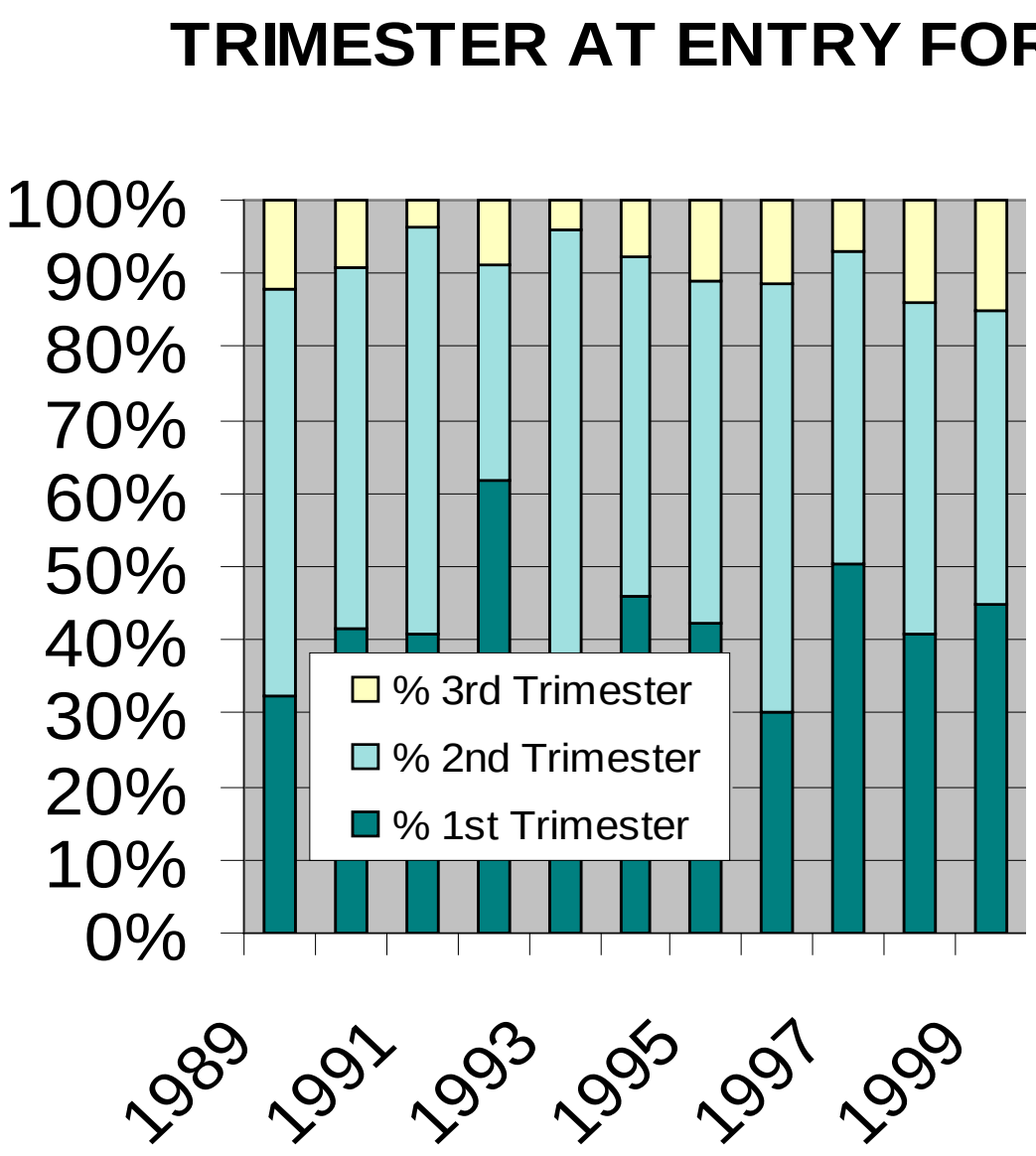
# Data for the Team

# Use the data: Panel Report

Panel Size Report

| Provider | Pod | FTE | Current Number of Patients | Goal (w/factor) | 2013-3 Panel (adjusted ) | 2013-4 Panel (adjusted) | Over (Under) |
|---|---|---|---|---|---|---|---|
| **Federal Heights** | | | | | | | |
| Andreen, Kristin | Green | 0.70 | 829 | 840 | 871 | 861 | 21 |
| Battaglia, Matthew | Green | 0.13 | 33 | 156 | | 37 | (119) |
| Federal Heights, Unsgn Green Pod | Green | 0 | 986 | 0 | 1,079 | 1,004 | 1004 |
| Romero, Lisa | Green | 0.93 | 40 | 1116 | | 45 | (1071) |
| Somerset, Maria | Green | 0.45 | 585 | 540 | 618 | 607 | 67 |
| Van Eimeren, William | Green | 0.90 | 924 | 1080 | 856 | 903 | (177) |
| Holgorsen, Kelle | Green-Gone | 0 | 3 | 0 | 3 | 3 | 3 |
| Poppish, Meredith | Green-Gone | 0 | 1 | 0 | 1 | 1 | 1 |
| Unassigned | No PCP | | | | | | N/A |
| **Total - Federal Heights** | | 3.11 | 3401 | 3732 | 3,428 | 3,461 | (271) |

# Using Panels to Improve Access and Outcomes




Outreach:
-Elementary schools
-High schools
-Churches
-Homeless shelters
-Coin-operated laundries
-Pawn shops
-Door to door

# Population Care Linked to the Patient

**Total Patients: 6090**

| Person Nbr | Patient Details | Visits and Appointments | | Outreach Details | Patient Care Alerts |
|---|---|---|---|---|---|
| | | **PCP**: Poppish, Meredith<br><br>**Last Visit:** 02/19/2013 Poppish, M-DIA<br>**Payer:** Clinica CICP H Sliding Scale<br>**Next appt:** | Edit | **Date Reviewed:**<br>**Comments:**<br>**Call Attempt:**<br>**Call Status:** | Past Due - Colorectal Screening (colonoscopy, sigmoidoscopy with a barium enema or FOBT)<br>Past Due - Diabetes Eye Exam<br>Past Due - FLU<br>Past Due - Microalbumin |
| | | **Last Visit:** 04/17/2013 Van Eimeren, W-RE<br>**Payer:** Medicaid FQHC<br>**Next appt:** | | **Comments:**<br>**Call Attempt:**<br>**Call Status:** | (colonoscopy, sigmoidoscopy with a barium enema or FOBT)<br>Past Due - Diabetes Eye Exam<br>Past Due - FLU<br>Past Due - Microalbumin |
| | | **PCP**: Van Eimeren, William<br><br>**Last Visit:** 04/19/2013 Van Eimeren, W-RE<br>**Payer:** Clinica CICP C Sliding Scale<br>**Next appt:** | Edit | **Date Reviewed:**4/10/2013<br>**Comments:** Appt schld for 4-19 for BP, mammo<br>**Call Attempt:**1st Call<br>**Call Status:**Made contact | Past Due - Mammography Screening<br>2 Wks - Last Blood Pressure >= 140/90 on 04/19/2013 |

6100 patients with something due/30 days/13 pods=
15 patients a day/3 team members=5 patients/day

Clinica
Family Health Services

# Missed Opportunities
# Population Based Outreach by Patient

- Mature outreach tools
- Great top of the license process
- Decision support
- Team based process

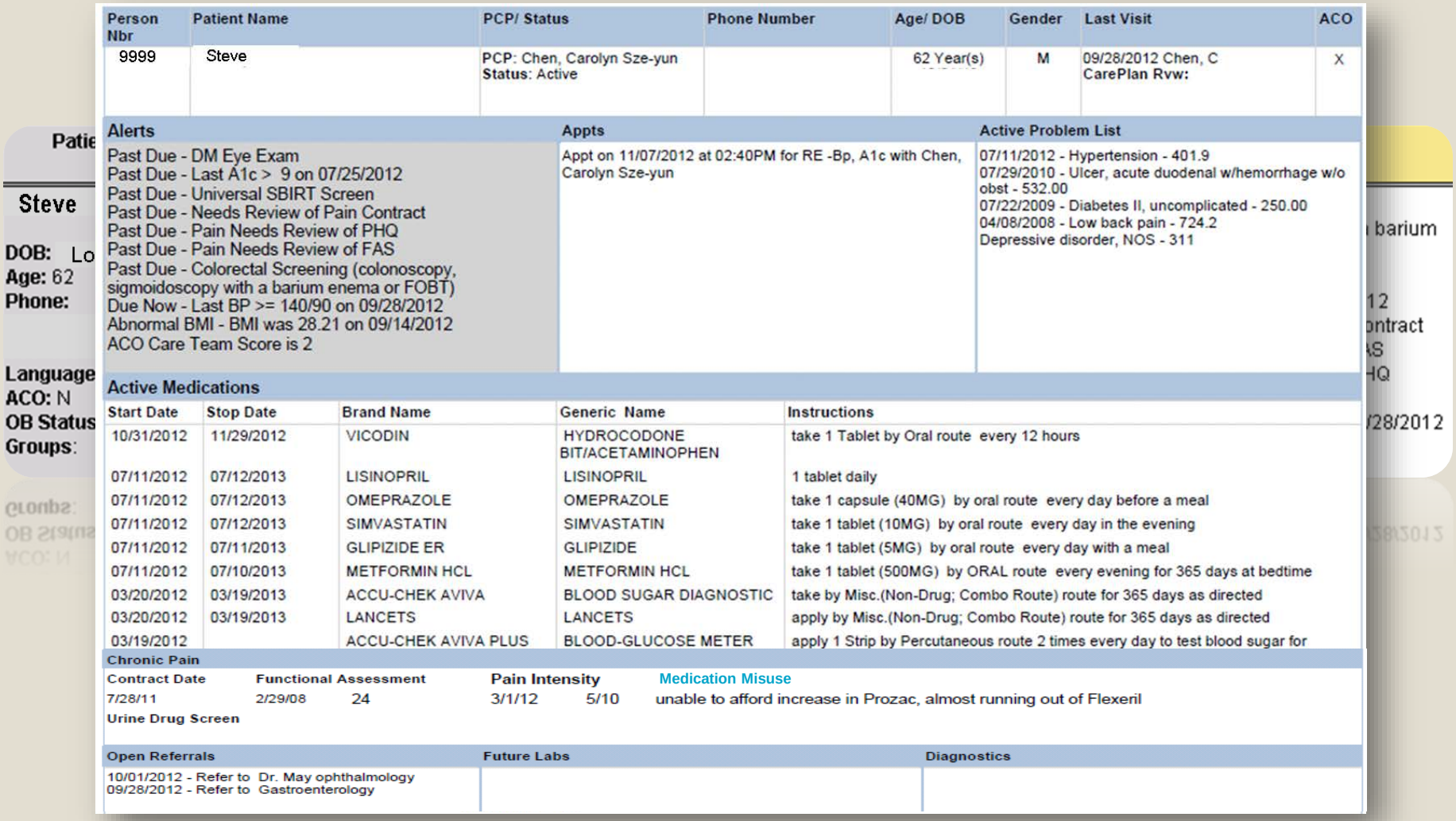
# Match the Population Outreach Work with Patient Level Decision Support Tools

- Patient in clinic
  - Huddle, match care at the visit to the outreach
- Standing orders
- Providers can focus on the patient's agenda and building their relationship

# Inreach Decision Support (CarePlanner)

- Medication reconciliation
- Integration of health services
  - Behavioral Health
  - Dental
  - Clinical Pharmacy Services
- Partner with the patient around the health care plan
  - Patient engagement
  - Aligning patient and care team goals

# Outreach and CarePlanner



| Person Nbr | Patient Name | PCP/ Status | Phone Number | Age/ DOB | Gender | Last Visit | ACO |
|---|---|---|---|---|---|---|---|
| 9999 | Steve | PCP: Chen, Carolyn Sze-yun<br>Status: Active | | 62 Year(s) | M | 09/28/2012 Chen, C<br>CarePlan Rvw: | X |

**Alerts**

Past Due - DM Eye Exam
Past Due - Last A1c > 9 on 07/25/2012
Past Due - Universal SBIRT Screen
Past Due - Needs Review of Pain Contract
Past Due - Pain Needs Review of PHQ
Past Due - Pain Needs Review of FAS
Past Due - Colorectal Screening (colonoscopy, sigmoidoscopy with a barium enema or FOBT)
Due Now - Last BP >= 140/90 on 09/28/2012
Abnormal BMI - BMI was 28.21 on 09/14/2012
ACO Care Team Score is 2

**Appts**

Appt on 11/07/2012 at 02:40PM for RE -Bp, A1c with Chen, Carolyn Sze-yun

**Active Problem List**

07/11/2012 - Hypertension - 401.9
07/29/2010 - Ulcer, acute duodenal w/hemorrhage w/o obst - 532.00
07/22/2009 - Diabetes II, uncomplicated - 250.00
04/08/2008 - Low back pain - 724.2
Depressive disorder, NOS - 311

**Active Medications**

| Start Date | Stop Date | Brand Name | Generic Name | Instructions |
|---|---|---|---|---|
| 10/31/2012 | 11/29/2012 | VICODIN | HYDROCODONE BIT/ACETAMINOPHEN | take 1 Tablet by Oral route every 12 hours |
| 07/11/2012 | 07/12/2013 | LISINOPRIL | LISINOPRIL | 1 tablet daily |
| 07/11/2012 | 07/12/2013 | OMEPRAZOLE | OMEPRAZOLE | take 1 capsule (40MG) by oral route every day before a meal |
| 07/11/2012 | 07/12/2013 | SIMVASTATIN | SIMVASTATIN | take 1 tablet (10MG) by oral route every day in the evening |
| 07/11/2012 | 07/11/2013 | GLIPIZIDE ER | GLIPIZIDE | take 1 tablet (5MG) by oral route every day with a meal |
| 07/11/2012 | 07/10/2013 | METFORMIN HCL | METFORMIN HCL | take 1 tablet (500MG) by ORAL route every evening for 365 days at bedtime |
| 03/20/2012 | 03/19/2013 | ACCU-CHEK AVIVA | BLOOD SUGAR DIAGNOSTIC | take by Misc.(Non-Drug; Combo Route) route for 365 days as directed |
| 03/20/2012 | 03/19/2013 | LANCETS | LANCETS | apply by Misc.(Non-Drug; Combo Route) route for 365 days as directed |
| 03/19/2012 | | ACCU-CHEK AVIVA PLUS | BLOOD-GLUCOSE METER | apply 1 Strip by Percutaneous route 2 times every day to test blood sugar for |

**Chronic Pain**

| Contract Date | Functional Assessment | | Pain Intensity | | Medication Misuse |
|---|---|---|---|---|---|
| 7/28/11 | 2/29/08 | 24 | 3/1/12 | 5/10 | unable to afford increase in Prozac, almost running out of Flexeril |

**Urine Drug Screen**

**Open Referrals**

10/01/2012 - Refer to Dr. May ophthalmology
09/28/2012 - Refer to Gastroenterology

**Future Labs**

**Diagnostics**

# Clinica Lessons Learned

- Create the will…is what you are doing working?
- Put the patients first
- Find ways to add the patient's voice
  - On teams
  - Scan comment
  - Media
  - Have them lead on topics for groups

# Clinica Lessons Learned

- Start small but start!
- Optimize the team
- Hold on to the good, out with the bad
- Use the QI tools that work
  - Chronic Care Model,
  - The IHI Model for improvement
  - Sequential learning with PDSAs
  - Small, rapid test cycles followed by spread

# Clinica Lessons Learned

- Make improvement a system characteristic
- Make safety an explicit system characteristic
- Free up staff to innovate & “spin the fly wheel”
- Measure data over time
  - You don’t need a double blinded RCT or a dash board program to get better
- You are never done