Leading the Way to a Primary Care Medical Home

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5/19/2014 IHS/CAL
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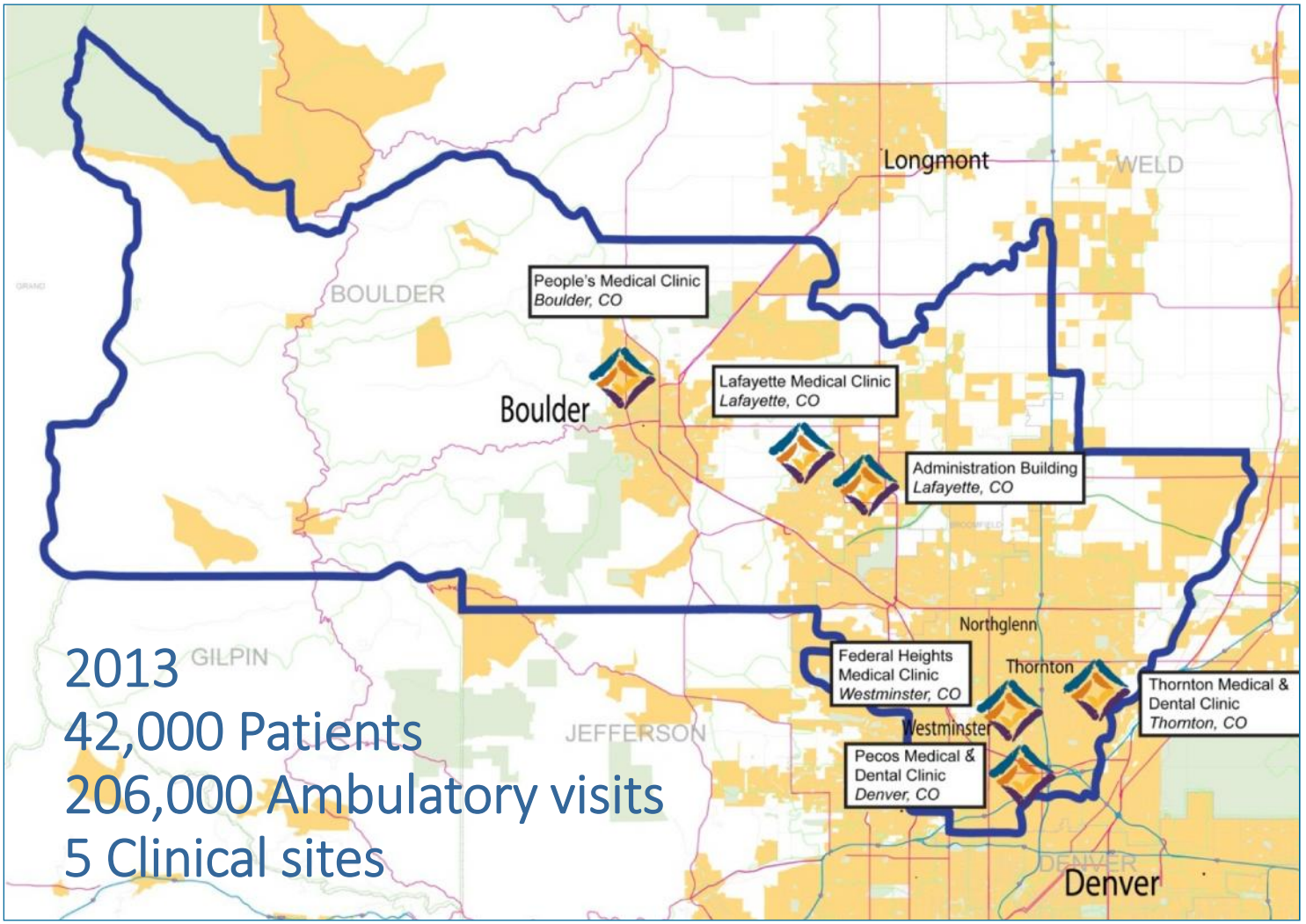
Objectives

- Describe the role of leadership in adoption of PCMH practices
- List strategies and methodologies for incorporating PCMH guidelines into clinic operations
- Describe potential financial benefits of the PCMH model (total cost of care, retention and recruitment)

Conversation for today

- Challenges in Healthcare and the Safety Next
- Is PCMH the answer?
- What is the leader's role
- How did Clinica get to PCMH recognition
- Tools for leading change
  - Change management strategies
  - Performance improvement
  - Population based management
  - Leadership time matrix
- Team based care models
- Role of IT
- Benefits to Clinica of PCMH transformation

Clinica Family Health Services



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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

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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

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Healthcare in Transition

Issues

- Changing payment
- Aging population, growth of the insured
- Variation in safety, reliability and care
- Chronic disease epidemic
- Health care costs are rising

Impact

- Caught between two business models
- Access problems
- Preventable harm and unjust disparities
- Unsustainable ineffective care models
- Lack resources to meet other social needs

Adapted from IHI

U.S. | REMAKING MEDICINE

In New Health Care Era, Blessings and Hurdles

By ABBY GOODNOUGH MARCH 30, 2014

LOUISVILLE, Ky. — In a plain brown health clinic on a busy boulevard here, the growing pains of the Affordable Care Act are already being felt — almost too sharply for the harried staff trying to keep up with the flow of patients.

Tamekia Toure, 40, is typical of the clinic's new patients, a single mother and recent arrival from Alabama with diabetes, high blood pressure, chronic pain and, for much of her adult life, no health insurance. For her, the new law is a godsend, providing Medicaid coverage that she would not have received before.

VIDEO | 5:06

Treating the Newly Insured

In Kentucky, 80 percent of the Affordable Care Act's newly insured have Medicaid. At Family Health Centers in Louisville, serving these patients is both a challenge and a potential financial boon.

Then there is Donna Morse, 61, a widowed dental hygienist and yoga buff who is long overdue for a mammogram and blood work. She lost her insurance last year because it did not meet the new law's standards. Now she has a new plan with much higher premiums, and which few doctors and hospitals will accept. So she too, warily, has landed at the clinic, one of seven here called Family Health Centers.

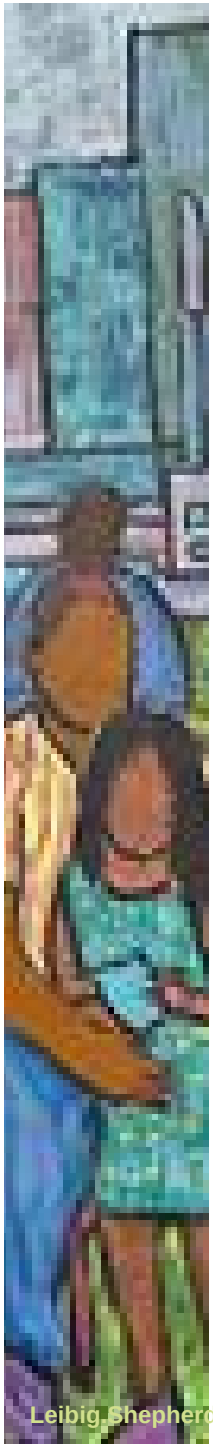
David Elson, 60, who has been coming to Family Health Centers for several years now, is a self-employed businessman with a multitude of health problems and medical bills. Despite chronic ailments, he went without insurance for years before enrolling in a subsidized private plan. He has not paid the first month's premium, and could well fall back into the ranks of the uninsured.

RELATED COVERAGE


Remaking Medicine: New Law's Demands on Doctors Have Many Seeking a Network MARCH 2, 2014


Remaking Medicine: For Uninsured, Clearing a Way to Enrollment NOV. 4, 2013


A Louisville Clinic Races to Adapt to the Health Care Overhaul JUNE 22, 2013



The Vision: Patient-Centered HEALTH Home!

Primary Medical Services

Pharmacy Services

Patient and Family Centered

Pediatrics

Care Management & Coordination

Group Visits

Healthy Eating and Active Living

Immunizations

Chronic Disease Management

Obstetrics

Family Medicine

Laboratory Services

In-Patient Hospital Services

Oral Health Services

Nutritional Support

Well Visits through the Life Cycle

Behavioral Health Services

PCMH Vision and IHS/CAL

1. Patients are thrilled with the quality and ease of accessing care and they get what they want and need when they want and need it, creating stellar clinical outcomes.
2. Staff and providers are extremely happy with their work, recruitment and retention are not problems. Your work life balance is excellent.
3. There is great communication and collaboration across the continuum of care in your community where your partners embrace your patients when they need their care.
4. Your community is healthier than it was 10 years ago and there are no disparities in healthcare. The cost of health care is going down in your community because health is increasing.

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AHRQ Definition for PCMH

- **Patient-centered:** A partnership among practitioners, patients, and their families ensures that decisions respect patients' wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own care.
- **Comprehensive:** A team of care providers is wholly accountable for a patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care.
- **Coordinated:** Care is organized across all elements of the broader health care system, including specialty care, hospitals, home health care, community services and supports.
- **Accessible:** Patients are able to access services with shorter waiting times, "after hours" care, 24/7 electronic or telephone access, and strong communication through health IT innovations.
- **Committed to quality and safety:** Clinicians and staff enhance quality improvement to ensure that patients and families make informed decisions about their health.

What we know about PCMH

- Reduces hospitalizations
- Reduces ER visits
- Costs reduction per patient
- Decreased staff burnout
- Improved patient experience
- Improved HEDIS scores

(Reid RJ, et al. The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, And Less Burnout for Providers Health Affairs 29:5 (2010): 835-843)

Create a Plan: All models are wrong, some models are useful. Deming

- NCQA
- Joint Commission
- AHRQ
- Safety Net Medical Home Initiative
- AAFP
- AAAHC
- State Based Programs
- HealthTeamWorks

PCMH 2011 Content and Scoring

PCMH1: Enhance Access and Continuity	Pts
A. Access During Office Hours**	**4**
B. After-Hours Access	4
C. Electronic Access	2
D. Continuity	2
E. Medical Home Responsibilities	2
F. Culturally and Linguistically Appropriate Services	2
G. Practice Team	4
	20

PCMH2: Identify and Manage Patient Populations	Pts
A. Patient Information	3
B. Clinical Data	4
C. Comprehensive Health Assessment	4
D. Use Data for Population Management**	**5**
	16

PCMH3: Plan and Manage Care	Pts
A. Implement Evidence-Based Guidelines	4
B. Identify High-Risk Patients	3
C. Care Management**	**4**
D. Manage Medications	3
E. Use Electronic Prescribing	3
	17

PCMH4: Provide Self-Care Support and Community Resources	Pts
A. Support Self-Care Process**	6
B. Provide Referrals to Community Resources	3
	9

PCMH5: Track and Coordinate Care	Pts
A. Test Tracking and Follow-Up	6
B. Referral Tracking and Follow-Up**	**6**
C. Coordinate with Facilities/Care Transitions	6
	18

PCMH6: Measure and Improve Performance	Pts
A. Measure Performance	4
B. Measure Patient/Family Experience	4
C. Implement Continuously Quality Improvement**	**4**
D. Demonstrate Continuous Quality Improvement	3
E. Report Performance	3
F. Report Data Externally	2
	20

** Must Pass Elements

Plan-its all about behavior change

1. Help people understand the gathering storm
2. Create a “critical mass” leadership team
3. Create a vision for PCMH
4. Communication of the vision and the plan
5. Remove barriers to new behaviors

Cont.

Plan-its all about behavior change

6. Recognizing and celebrating successes

7. Create a “critical mass” implementation team

8. Ensure that behavior changes become the culture
   - Spread and sustainability
   - Structure and process in place for this
   - Be a learning organization

9. Get patients involved

Your Part

"There is lots of evidence that a good relationship with a freely chosen primary-care doctor, preferably over several years, is associated with better care, more appropriate care, better health, and much lower health costs."

Your part: Seek and address barriers

- Organizational chart or in supporting structures (such as meetings)
- Space-physical or virtual
- Protocols or procedures
- Skills and orientation
- Aim and measurements
- Communication plan
- Identify champions, include pts
- Rewards, celebrations, acknowledgement

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PCMH Transformation vs Recognition:

Understand where you are now

- 2 paths
  - To get you started
  - To demonstrate all that you have done
- Set your timelines appropriately
  - Using PCMH recognition as a framework to start your change management
  - Using PCMH recognition to document your location in the transformation journey

PCMH Recognition: Measuring

- Both framework and measuring tools
  - NCQA
  - Joint Commission
  - AAAHC
  - State Based Programs

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PCMH Recognition:
Planning Steps

Agree on why your are doing this

- Collect wheelbarrows full of bucks
- The storm is so big out there
- Keep up the Joneses
- Get people off your back
- Demonstrate your patient centeredness
- Map a leg of your transformation journey

PCMH Recognition :
Form a Team

- Formed a small team (4)
  - VP of Clinical Services
  - VP of Operations
  - Clinical Quality Manager
  - Clerical Support staff person
- Chose a team lead
  - Organized the documentation
  - Ensured all documentation present
  - Communicated with NCQA
  - Completed and submit NCQA application

DSM OCD Dx:

Diagnosis Search

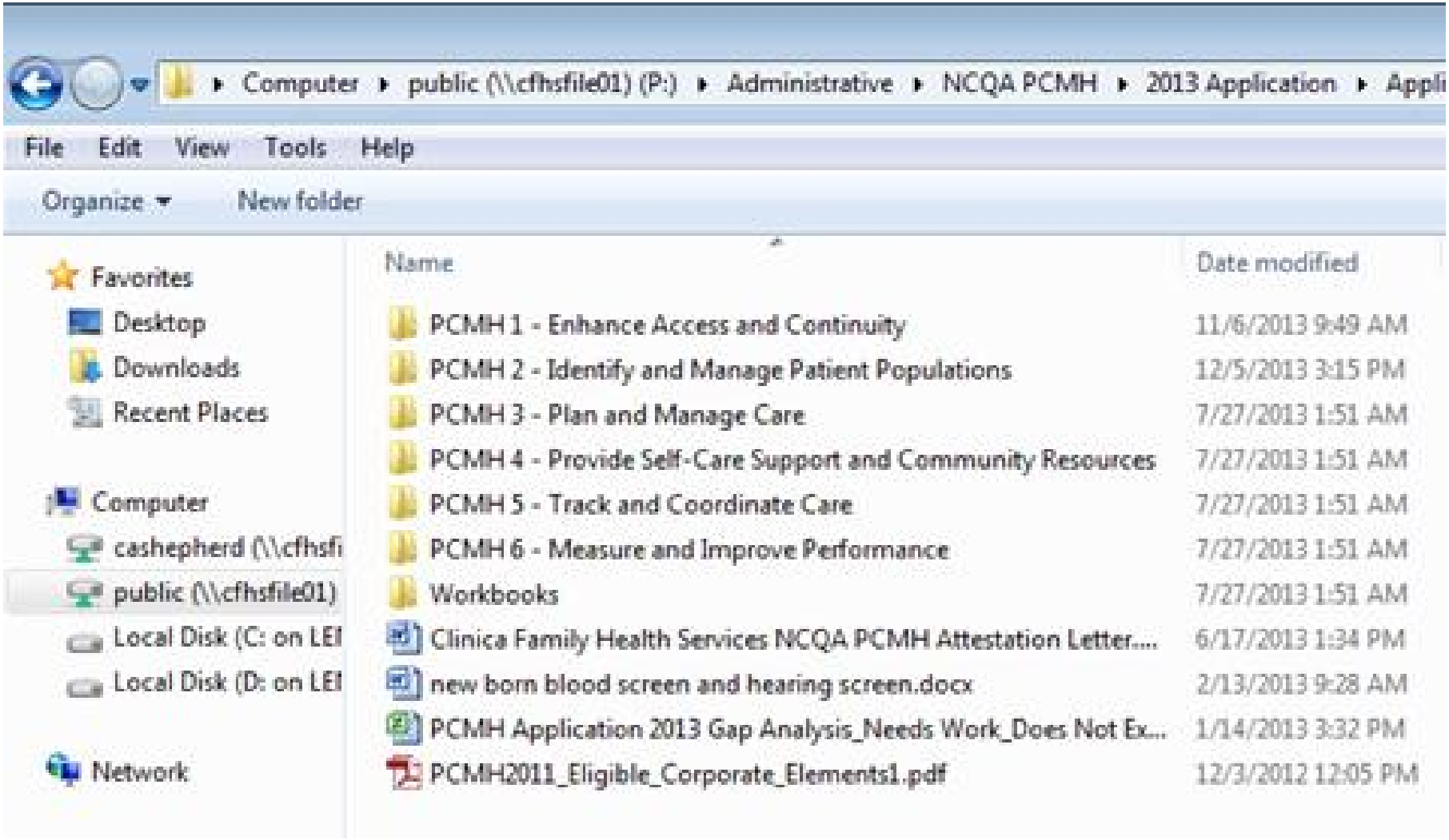
Preferred ICD9 Code:	○ **300.3** Obsessive-compulsive disorders
Secondary ICD9 Code:	
Other ICD9 Code(s):	
Preferred SNOMED-CT:	Obsessive-compulsive disorder - 191736004 (exact match)
Other SNOMED CT Code(s):	
Lexical Definitions:	An anxiety disorder characterized by recurrent, persistent obsessions or compulsions. Obsessions are the intrusive ideas, thoughts, or images that are experienced as senseless or repugnant. Compulsions are repetitive and seemingly purposeful behavior which the individual generally recognizes as senseless and from which the individual does not derive pleasure although it may provide a release from tension.
MeSH Maps:	Compulsive Behavior Obsessive-Compulsive Disorder

Select and Add to Saved Diags | Select | Cancel

PCMH Recognition Clinica:

- Started with must pass elements
- Reviewed all the standards
- Assigned a team member to all elements of each standard based on expertise
- Created folders on our intranet for each standard and element
- Gathered current evidence of performance
- Set completion dates
- Reviewed for gaps, opportunities to improve

Clinica Planning-Organize Process



Clinica PCMH Recognition Plan

- Must pass elements
  - Access, Continuity and Behavioral Health
- Use tools already developed for application process
- Solve problems once to create bandwidth for work
  - Apply tools that work for quality improvement
  - Covey's leadership matrix
- Vigilant about ceremoniously taking things off the plate
  - Enlist the staff and patients to help with this
- Contingency plans
  - New patients

The Must-Pass Elements 2011

- PCMH 1
  - Element A: Access During Office Hours
- PCMH 2
  - Element D: Use Data for Population Management
- PCMH 3
  - Element C: Care Management
- PCMH 4
  - Element A: Support Self-Care Process
- PCMH 5
  - Element B: Referral Tracking and Follow-Up
- PCMH 6
  - Element C: Implement Continuous Quality Improvement

The Must Pass Elements 2014

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

PCMH 1: ENHANCE ACCESS AND CONTINUITY									
		Documentation Requirements			Document Status				
NCQA Element	Factors	Data Source	Specific	Comments	Green = ok Yellow = Needs Work Red=Does not exist	Comments (Include details on assignments for completion)	Documen-tation	Location	Status
1C Electronic Access The practice provides the following information and services to patients and families through a secure electronic system.	1. More that 50 percent of patients who request an electronic copy of their health information (e.g., problem list, diagnoses, diagnostic test results, medication lists, allergies) receive it within three business days*	Report of percent of patients who received electronic copy within 3 days of request. Denominator = # of patients who requested electronic copy of record. Numerator = # who received copy within 3 business	Percentage based on 12 months of data. If 12 months of data are not available, may use a recent 3 month period	Includes others who have legal authorization to the information but is only assessing the capabilities of the practice's electronic system. This is not used to assess the legal issues surrounding access to records.		Changed from Red to Green. P:\Committees\Meaningful Use\Attestation Measures Criteria\EP Core Measures with FAQs	Ben will get report		
	2. At least 10 percent of patients have electronic access to their current health information (including lab results, problem list, medication lists, and allergies) within four business days of when the information is available to the practice** (Menu Meaningful	Report of percent of patients who were given electronic access within 4 business days of request Denominator = # of patients seen Numerator = # who have timely access to their electronic health information	Policy on Web site or portal that includes turn-around time between registering for use and capability to access information. Report of patients registered on the Web site or portal Percentage based on 12 months of data. If 12 months of data are not	Can use frequency of portal uploads/updates to demostrate accessabilty within 4 days		Judy to talk to Sean about adding to pt registration. Ben will look into the MU report.	Ben and Judy	12/19 Ops	
	3. Clinical summaries are	Report of percent of patients who	Policy on providing clinical summaries;	Clinical summary is a visit summary		Action: PDSAs occuring at each	Ben - MU report	Shortcut to MU Data	Done

NCQA-PCMH Application

- Watch the webinar
- Put supporting materials for each element in one document
- Supporting materials may be used more than once
- Consider more than one example

NCQA-PCMH Application

Clearly identified supporting materials

PPC1: ACCESS AND COMMUNICATION
Element A: Access and Communication Processes

Item 1: Scheduling each patient with PCP for continuity of care

From Provider Manual:

for conditions which may result in legal action such as child abuse and domestic violence and they specifically require the patient's signature or the signature of a guardian. Medical records should check with the primary care provider before sending any of these "special release" documents.

2. In accordance with state law, consents for HIV testing are required prior to performing any testing and are scanned into the patient's chart.
3. Before records are printed, the primary care provider is asked to sign the release to assure the appropriateness of printing the record.

E. Chaperones

All providers will have access to a chaperone when caring for patients of any gender. Male providers performing gynecological exams and breast exams are encouraged to have a chaperone in the room during the exam.

F. Continuity

Continuity of care is recognized as one of the most important dimensions of quality care. When a new patient is seen for an appointment other than an acute visit, the patient is assigned that provider as a Primary Care Provider (PCP).

Because the PCP is not always available, the providers in the clinic have been arranged into teams. Every attempt will be made to schedule the patient with the PCP or their team member to improve continuity of clinical staff (medical assistant, case manager, social worker, provider, etc.). In order to help clients identify their PCP, we are using color-coded appointment and business cards. There are also pictures of the providers in the patient care areas at each clinic.

NCQA-PCMH Application

- For chart review elements
  - Chart audits
  - Divided the work
  - First few charts together
    - Consensus on where looking for the data
- Several meetings to finalize and agree on documentation
- Business Support Specialist
  - Formatted all documents to be similar
  - Created system to guide reviewers to the documentation
  - Put headers and footers on all documents

NCQA-PCMH Application Stats

- Over 200 woman hours for each application
- Began process in December 2009
- Submitted application May 2010
- Received NCQA Multi-site Level 3 Recognition July 2010

- Continued to work on must pass elements
- Began application process in December 2012
- Submitted in May 2013 (150 person hours)
- Received NCQA Multi-site Level 3 Recognition December 2013
- Now working on 2014 standards

NCQA-PCMH Lessons Learned

- Single person for communication, keep log
- Multi-site application
  - Steps not very clear in the Policies and Procedures Handbook
    - How to apply?
    - When to apply?
    - How to document?
  - Ended up with a lot of rework, especially around the audits
- Study the Standards/Elements/Factors
- Unable to attend a Survey Tool learning session
  - Would have been very valuable in saving time
- Get started now

After the Recognition

- No wheelbarrows $$
- Helping the Joneses
- Storm still out there
  - Recognition from healthcare leaders
  - Soon to be a floor, not a stretch goal
- Pushed us forward
  - Patient portal
  - Addressing the continuum of care
  - Better collaboration with the patient around the plan of care
  - Looking more at health
  - Dialing up competency in Motivational Interviewing, SFBT, CBT,

PCMH and MU Overlap

Access Standards
Survey Patient Experience
Team Based Care

Care mgnt
Track referrals
Language Barriers
Care mgmt support
Order/retrieve tests
Demographic Pt info
Report std measures
Identify important Dxs
Coord between services
Performance improvement
Pt communication standards
ERx with safety & cost checks
Track tests & abnl results
Searchable clinical data
Pt-interactive website
Organize clinical info
>3 EBM guidelines
Lists of Pts & alerts
External Reporting
Pt Identity mgmt
Prev reminders
Pt self-mgmt
Use the data

CPOE
Vital Signs
Problem List
Demographics
Clinical Results
Feed Imm registry
Med reconciliation
Lists Pts by condition
Exchange key data set
Syndromic surveillance
Clinical decision support
Care Transition summary
Pt access to health info
Pt copy of health info
Drug-Drug Drug-Allergy cks
Insurance eligibility
Privacy & Security
Pt visit summaries
Quality reporting
Electronic claims
Smoking status
Medication lists
Pt reminders
Allergy
eRX

PCMH and MU Strategy

PCMH

- Organizational Commitment
- Empanelment
  - Continuity
  - Access
- Design care teams
  - Integrate BH

Meaningful Use

- EPM
  - Submit claims
  - Check insurance
- Privacy and Security
  - EHR

PCMH and MU Strategy

PCMH

- Identify teams
- Explicit roles
- Begin reporting outcomes

Meaningful Use

- Develop interfaces
  - Usually this is labs and imaging
- CPOE
  - Medication module "mini-bang"

PCMH and MU Strategy

PCMH

- Team continuity
- Team delegation
  - Standing orders for algorithm based care

Meaningful Use

- Structured data fields for QI
  - VS, Meds, Allergies, problem list, prevention interventions
  - Patient, family, caregiver parameters
  - Team parameters

PCMH and MU Strategy

PCMH

- Referral and lab tracking
- In-reach tools
- Out-reach tools
- Patient care summary at each visit (2011)

Meaningful Use

- Decision support tools
- Outcomes reporting for quality improvement
- Patient care summary

PCMH and MU Strategy

PCMH

- E-visits, telephone visits (not triage)
- Self-management support
- Shared decision making
- Patient care plan

Meaningful Use

- Patient Portal
- State immunization, cancer, newborn screening interfaces
- Reporting for judgment

PCMH and MU Strategy

PCMH

- Care transitions
  - Community partners
- Medication reconciliation
- Track care
  - Labs
  - Imaging
  - Referrals

Meaningful Use

- Health Information Exchange (HIE)
- CCD, PHR

PCMH and MU Strategy

PCMH

- Measure & Report Performance
- Measure Patient Experience
  - Access
  - Communication
  - Coordination
  - Whole person care/self-management support

Meaningful Use

- Report Outcomes
  - CMS
  - Other
    - Immunizations
    - Syndromic surveillance
    - Cancer registries

Meaningful Use and PCMH Pesky Elements-Patient Handouts-2011

3C: Care Management *MUST PASS*	The care team performs the following for at least 75 percent of the patients for the patients identified in Elements A and B: 1. Conducts pre-visit preparations 2. Collaborates with the patient/family to develop an individualized care plan, including treatment goals that are reviewed and updated at each relevant visit 3. Gives the patient/family a written plan of care 4. Assesses and addresses barriers when patient has not met treatment goals 5. Provides patient/family a clinical summary at each relevant visit 6. Identifies patients/families who might benefit from additional care management support 7. Follows up with patients/families who have not kept important appointments
4A: Support Self-Care Process *MUST PASS*	The practice conducts activities to support patients/families in self-management: 1. Provides educational resources or refers at least 50 percent of patients/families to educational resources to assist in self-management 2. Uses an EHR to identify patient-specific education resources and provide to more than 10 percent of patients, if appropriate++ 3. Develops and documents self-management plans and goals in collaboration with at least 50 percent of patients/families 4. Documents self-management abilities for at least 50 percent of patients/families 5. Provides self-management tools to record self-care results for at least 50 percent of patients/families

CarePlanner

		PCP: Farrell, Edward **Status**: Active **Payer:** Medicare Clinica FQHC **Group Visits:** DM EF		57 Year(s)	M	04/04/2014 Farrell, E **CarePlan Rvw:** 4/12/13

Alerts

Past Due - Diabetes Eye Exam
Past Due - Yearly Substance Risk Screening (SBIRT)
Past Due - Self Management Goal (Diabetes, Hypertension, Anticoagulation,)
Past Due - CRC Screen (colonoscopy, sig or FOBT)
Due Now - INR - Last INR 2.30 on 4/4/14 Target 3.00 - 4.00
2 Wks - Last A1c 7 - 9 on 02/07/2014
Abnormal Body Mass Index - was 48.81 on 02/07/2014

Appts

Appt on 04/25/2014 at 08:20AM for BRF-Follow Up And INR with Farrell, Edward

Appt on 04/25/2014 at 08:20AM for BRF-Follow Up And INR with Thornton Charlotte Ricchetti PharmD

Active Problem List

08/23/2013 - S/P CABG x 1, in 1999 and 2001-V45.81
08/20/2013 - Hx of PE x 2 and DVT x 3 - 415.19
01/09/2013 - Hyperlipidemia LDL goal <70 - 272.4
03/15/2012 - Obesity - 278.00
03/15/2012 - Unspecified essential hypertension - 401.9
06/01/2010 - DM w/renal manifest, type II - 250.40
10/02/2009 - Emphysema - 492.8
Anticoagulant therapy - V58.61
Chronic ischemic heart disease - 414.9
DM w/renal manifest, type II - 250.40

Active Medications

Start Date	Stop Date	Brand Name	Generic Name	Dose	Instructions
01/08/2014	01/08/2015	HUMULIN R	INSULIN REGULAR, HUMAN	100 unit/mL	30 units SQ TID before meals and sliding scale
01/08/2014	01/08/2015	METOPROLOL TARTRATE	METOPROLOL TARTRATE	100 mg	take 1 tablet by oral route 2 times every day with meals
10/22/2013	10/21/2014	WARFARIN SODIUM	WARFARIN SODIUM	5 mg	take 2 Tablet by oral route every day
08/30/2013	08/29/2014	HUMULIN N	NPH, HUMAN INSULIN ISOPHANE	100 unit/mL	inject 120 units by Subcutaneous route every morning and 100 units every evening
08/23/2013	08/23/2014	ALBUTEROL SULFATE HFA	ALBUTEROL SULFATE	90 mcg	inhale 1 - 2 Puff(s) by INHALATION route every 4 - 6 hours as needed
08/16/2013	08/17/2014	GLUCOPHAGE	METFORMIN HCL	1,000 mg	1 tablet twice daily
08/16/2013	08/16/2014	AMLODIPINE BESYLATE	AMLODIPINE BESYLATE	10 mg	take 1 tablet (10MG) by ORAL route every day
07/02/2013	07/02/2014	CRESTOR	ROSUVASTATIN CALCIUM	40 mg	take 1 tablet by oral route every day (stop lipitor)
05/13/2013	05/12/2014	FUROSEMIDE	FUROSEMIDE	80 mg	take 1 tablet by oral route 2 times every day
05/07/2013	05/08/2014	METOLAZONE	METOLAZONE	5 mg	take 1 tablet (5MG) by oral route every day

Diabetes - High Risk

Systolic	Diastolic	Eye Exam	Foot Exam	A1c (Last 3)
120	66	06/23/11	8/23/13	02/07/2014 - 8.0 01/17/2014 - 8.0 11/15/2013 - 8.4

Group Visit: DM EF

Anticoagulation

Indication(s)	Therapy Start	Therapy Durtion	INR	Goal Range	Risk
7111-OTH PULMONARY EMBOLISM&INFARCTION	01/01/1997	lifelong	4/4/2014 - 2.30 3/21/2014 - 3.90 3/7/2014 - 2.20	3.00 - 4.00	Low

Open Referrals	Future Labs	Diagnostics
11/15/2013 - Referral: Orthopedics. Evaluate and treat.		06/20/2013 - scheduled - MRI, cervical spine, w/o contrast -

Meaningful Use and PCMH Clinical Visit Summary

Clinica
Family Health Services

PATIENT PLAN

Patient Name: Minnie Mouse
Date: 05/30/2013
Visit Type: Office Visit
Current Provider: Carolyn Shepherd MD

Assessment
DM w/neuro manifest, type II, uncontrolled (250.62)
Plan
Take new BP medicine Amlodipine 1/2 table each day.
Follow up BP check early in July.
Continue other medicines.
Be sure to take ASA.

Medications:

Generic Name	Brand	Dose	Sig
Amlodipine Besylate	Amlodipine Besylate	2.5 Mg	take 1/2 Tablet by oral route every day
Levothyroxine Sodium	Levoxyl	50 Mcg	1 tablet every other day
Enalapril Maleate	Enalapril Maleate	20 Mg	take 2 tablet (40MG) by ORAL route every day
Bumetanide	Bumetanide	0.5 Mg	take 1 Tablet (0.5MG) by oral route every day
Levothyroxine Sodium	Levoxyl	75 Mcg	1 tablet every other day.
Lovastatin	Lovastatin	20 Mg	take 1 tablet (20MG) by ORAL route every day with evening meal
Metformin Hcl	Metformin Hcl	500 Mg	take 1 Tablet (500MG) by Oral route every day for 365 days with morning meal

Vital Signs

Time	Temp F	Pulse	Resp	BP-Sys	BP-Dias	Ht	Wt	BMI	Position
2:38 PM	97.50	76	18	140	80	58.00	140.00	29.26	sitting

Allergies:

Allergen/Ingredient	Brand/Comments	Reaction:	Date of Onset
Levofloxacin	Levaquin In D5w	Anxiety	11/19/2009

Self Management Goal(s):
Continue to attend the 3 meetings a week through her church here in Lafayette. This gives her the most peace of mind and support.

Orders:

Status	Ordered	Order	Completed	Interpretation	Value
completed	05/30/2013	Glucose, Finger Stick	05/30/2013	see detail	167 mg/d
completed	05/30/2013	Hemoglobin A1C	05/30/2013	see detail	6.8%

Carolyn Shepherd

Authenticated By:
Carolyn Shepherd MD

Meaningful Use and PCMH Self Management Tool

Patient Self-Management Action Plan Form

Minnie Mouse
5/30/13

New Action Plan Goal:

What do you want:
Continue to attend the 3 meetings a week through her church here in Lafayette. This gives her the most peace of mind and support.

How you are going to achieve your goal?:
Patient will arrange to come with a friend each night she has a meeting.

	Check off when done	Comments
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Change Management

- Managing in the 21st Century Drucker
- Fifth Discipline Senge
- HBR 10 Must Reads On Leadership
- The Power of Habit Duhigg
- Switch Heath
- Drive Pink
- Leading Change Kotter
- Managing Transitions Bridges
  - Systems change
  - People transition from what they know to what is new

Change Management:

- Agreement that there is a **P**roblem
- Paint a **P**icture (vision) of how it could be
- Have a well thought out **P**lan
- Describe what **P**art each person plays

Bridges

Managing Transitions

PROBLEM

Healthcare in Transition

Issues	Impact
• Changing payment	• Caught between two business models
• Aging population, growth of the insured	• Access problems
• Variation in safety, reliability and care	• Preventable harm and unjust disparities
• Chronic disease epidemic	• Unsustainable ineffective care models
• Health care costs are rising	• Lack resources to meet other social needs

Adapted from IHI

PICTURE

PLAN

Plan-its all about behavior change

1. Help people understand the gathering storm
2. Create a "critical mass" leadership team
3. Create a vision PCMH vs Recognition
4. Communication of the vision and the plan
5. Removing barriers to new behaviors

Cont.

PART

"There is lots of evidence that a good relationship with a freely chosen primary-care doctor, preferably over several years, is associated with better care, more appropriate care, better health, and much lower health costs."

Try Out the 4 P Model-15 min

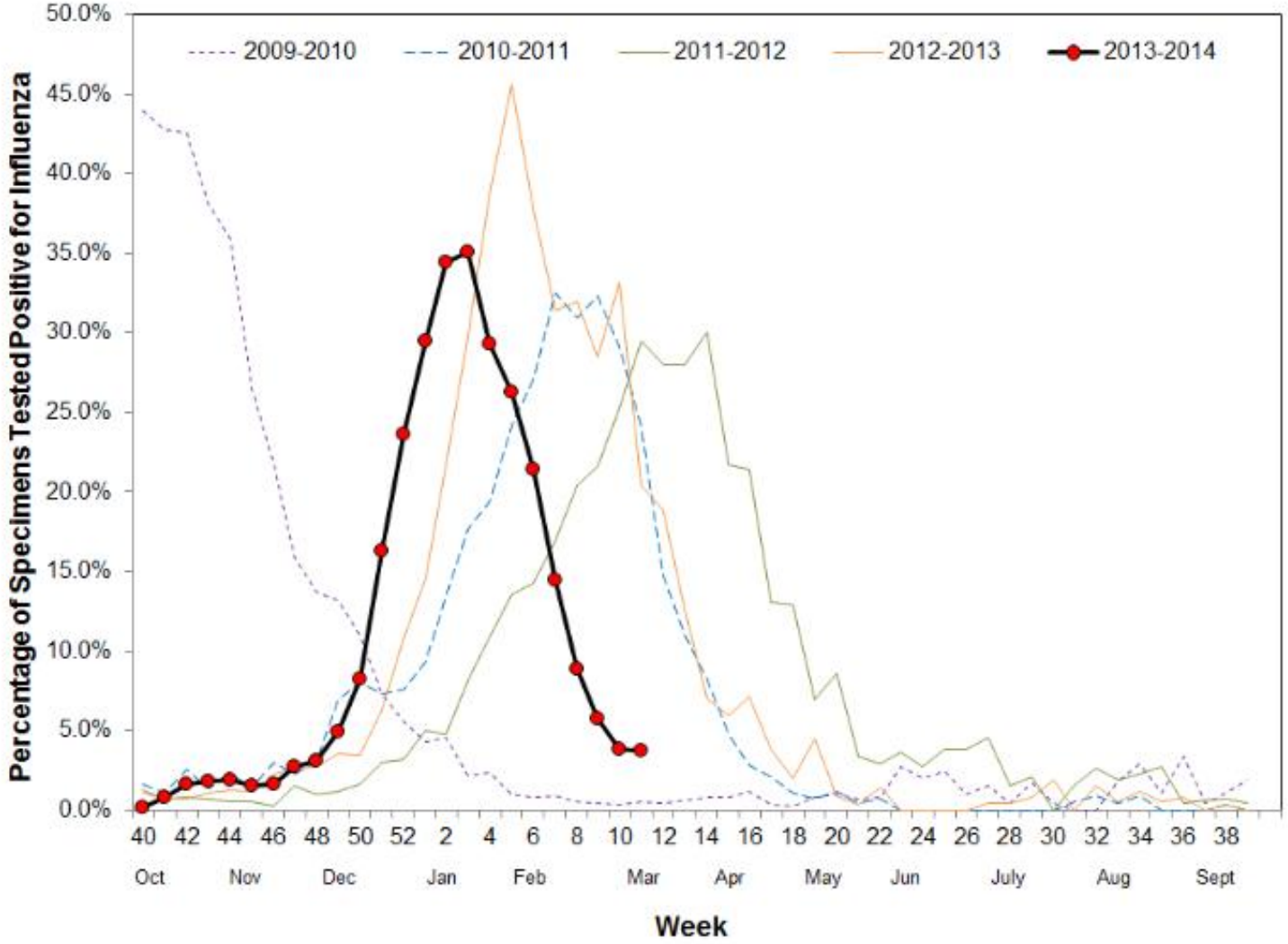
- Share a small process you are trying to impact.
- Choose one problem per table to present.
- Record a 4 Ps plan on form on table
  - Problem definition and agreement
  - Picture of what would happen if the problem didn't exist
  - Plan to address problem, including removing barriers
  - Part each person needs to play

Change Management-its all about behavior

1. Establishing a sense of urgency by identifying potential crises/opportunities
2. Putting together a powerful team to lead change
3. Creating a vision
4. Communicating the new vision, strategies, and expected behavior
5. Removing obstacles to the change
6. Recognizing and rewarding short-term successes
7. Identifying people who can implement change
8. Ensuring that the changes become part of the institutional culture

Kotter

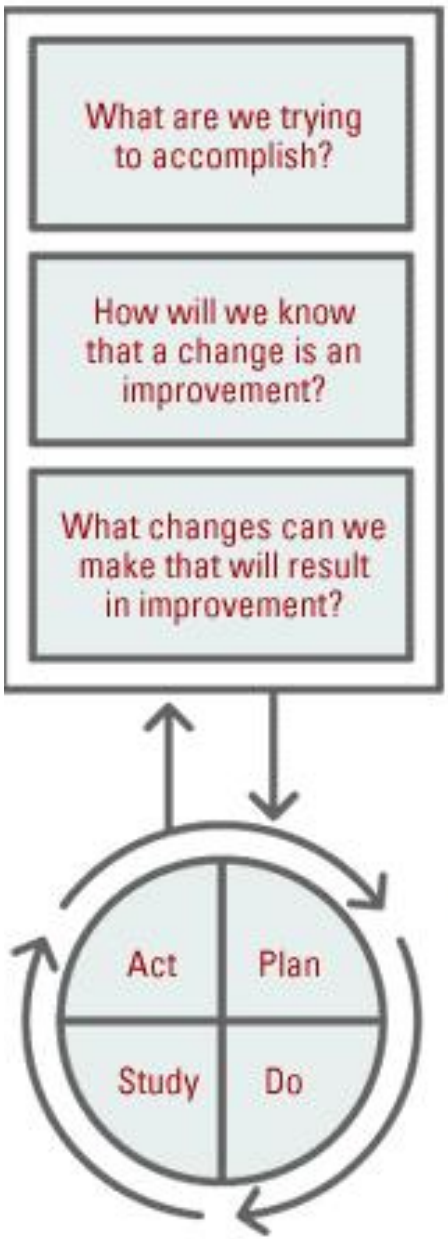
California Flu Season 2014 % detections of Influenza



Leadership Time Matrix

	Urgent	Not Urgent
Important	I ACTIVITIES: Crises Pressing problems Deadline-driven projects	II ACTIVITIES: Prevention, PC activities Relationship building Recognizing new opportunities Planning, recreation
Not Important	III ACTIVITIES: Interruptions, some calls Some mail, some reports Some meetings Pressing matters Popular activities	IV ACTIVITIES: Trivia, busy work Some mail Some phone calls Time wasters Pleasant activities

IHI Model for 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.

Success is the ability to go from failure to failure with no loss of enthusiasm… Churchill

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

Useful Data

Parameters:

- Time intervals
- Team
- Vaccines

SQL Server Reporting Services
Home > Reports > Clinical > Immunization >
Possible Missed Immunization Opportunities SSRS

View | Properties | History | Subscriptions

Start Date: 4/1/2014 End Date: 4/18/2014
Group Data By: Medical Assistant Encounter Location: Pecos
Patient's Pod: Pecos - Green Rendering: Aas Larson, Christine, Allen, Matth
Vaccine: Hep B, DTaP, Hib, PCV, Polio, MMR,

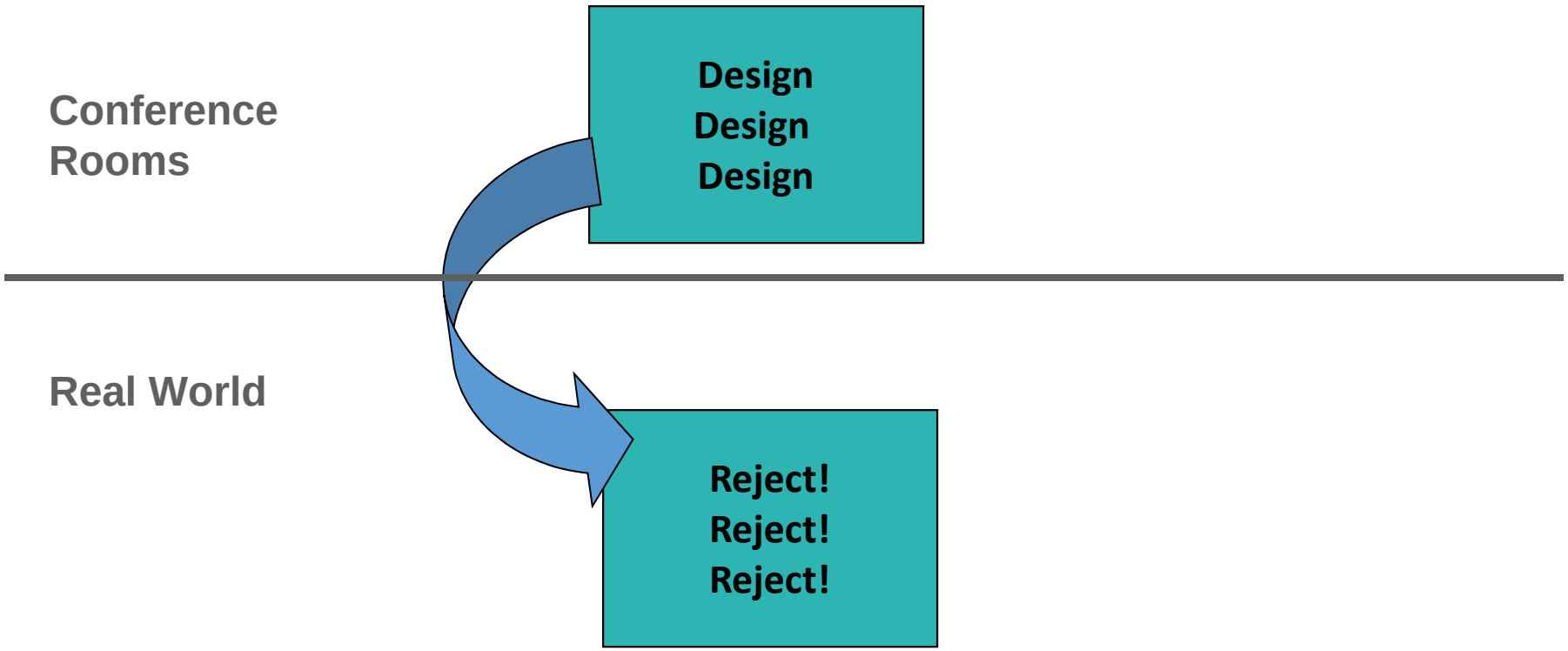
1 of 1 100% Find | Next Select a format Export

Possible Missed Immunization Opportunities

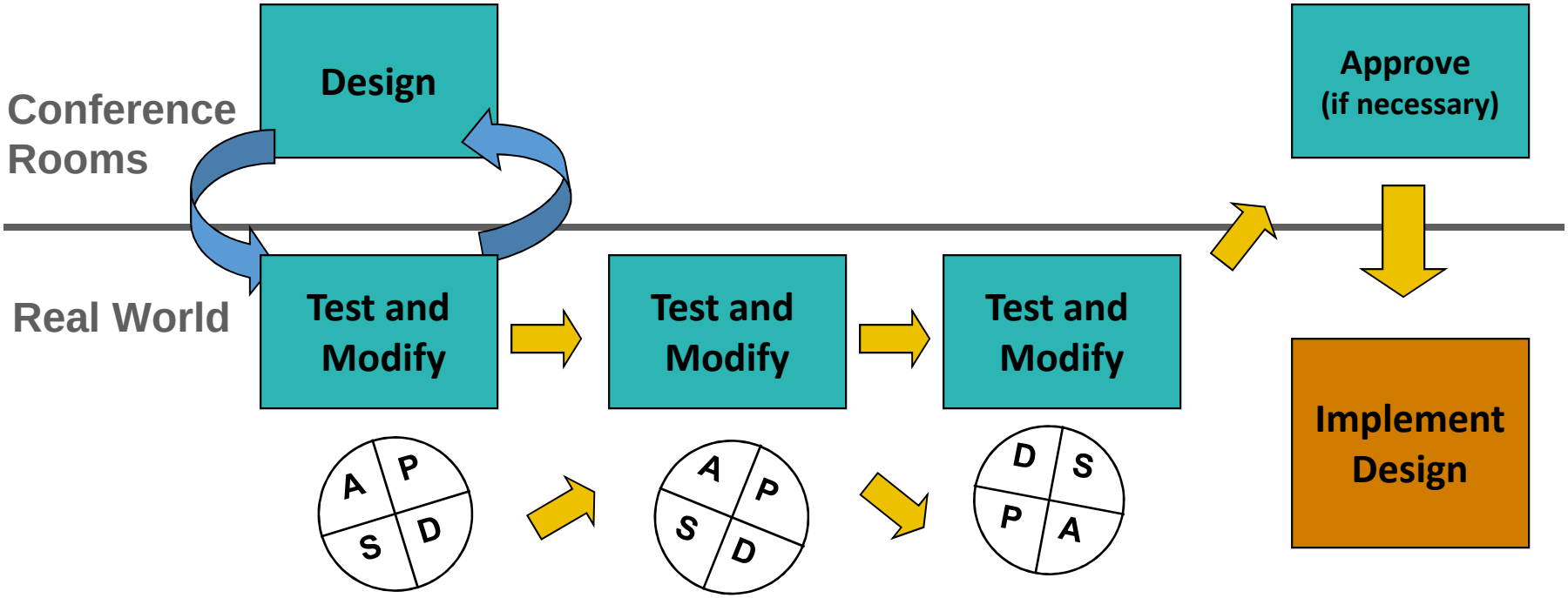
Visits	Patients	Missed Opportunities	% Missed Opportunities
1	1	0	0.00%
Garcia, Denicia CC			
4	4	2	50.00%
Guerrero, Paola CC			
22	21	6	27.27%

Person Nbr	First Name	Last Name	DOB	Age (In Months)	MA or Nurse	Rendering Provider	PCP	DOS	Visit Type	Missing Vaccines
				48	Garcia, Denicia CC	Hutcheson DO, Jonathan	Hutcheson DO, Jonathan	4/9/2014	Well Child Check	Flu,
				57	Garcia, Denicia CC	Hutcheson DO, Jonathan	Hutcheson DO, Jonathan	4/9/2014	Well Child Check	Flu,

Making Data Useful



Performance Improvement Methodology



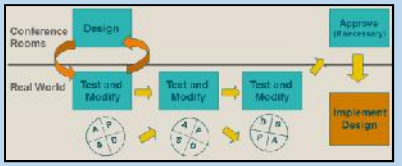
Data Warehouse Logical Architecture

Source Systems
EHR, EDR, Pharm, HIE

Stage Database

Data Mart Database

Development



Information Delivery

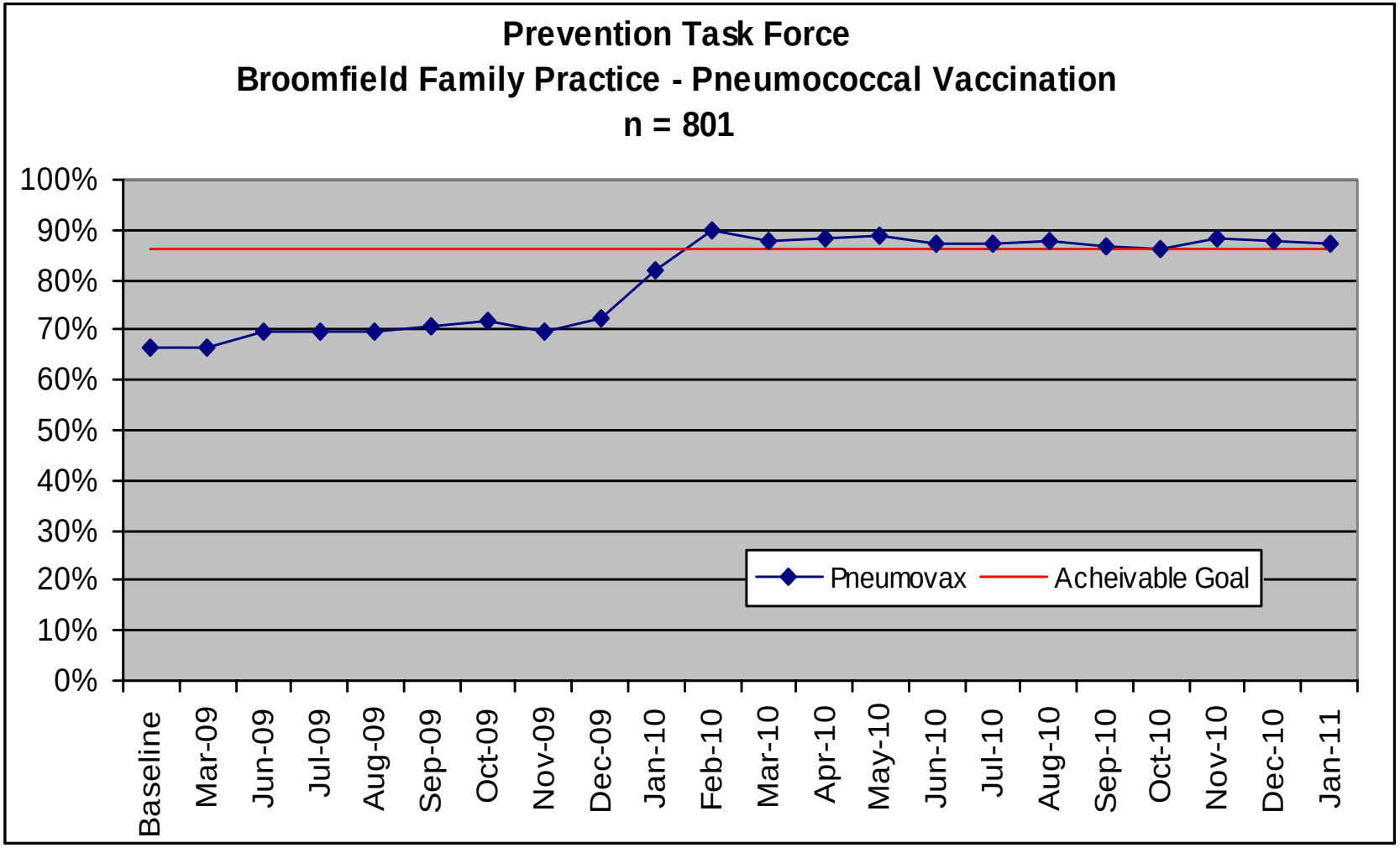
Legend

- Source Systems
- Clinica Report Server
- Clinica Intranet

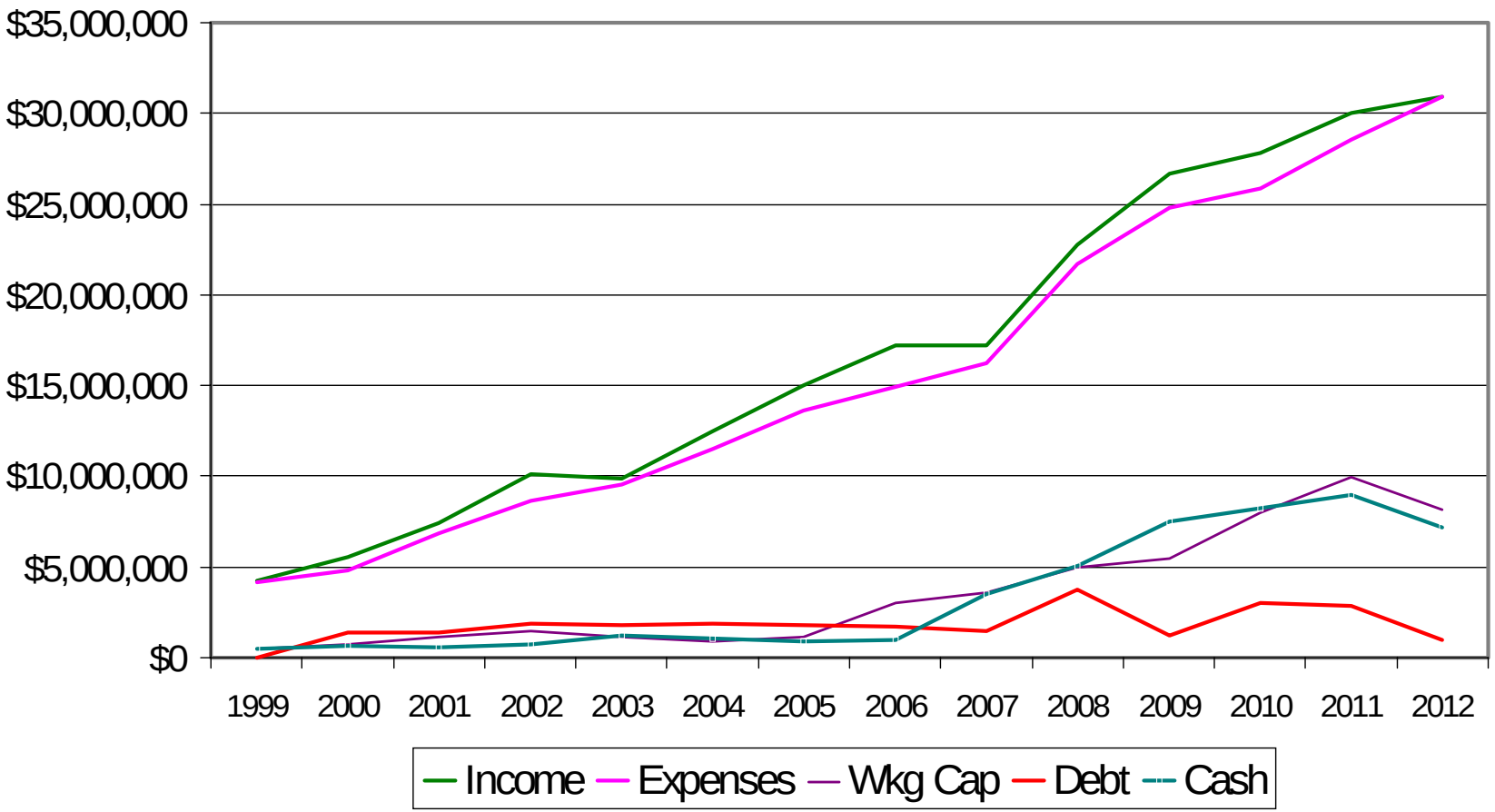
Leverage EHR data

- Align data entry strategies with organizational goals
- Include parameters that are critical
- Always record important data in a structured format
- Design and test the data in the “real world” setting

Data for Teams



Clinica Financial Indicators



Clinica
Family Health Services

PDSA Confusion!

Clinical Information Systems

Delivery System Design

Decision Support

Self-Management Support

Use IT to Support Organizational Learning

PDSA Database

Cycle for Learning and Improvement

Add New PDSA

View all PDSA entries

Search PDSA entries

Sort by site

Admin
All clinics
Federal Heights
Lafayette
Pecos
People's

Search

Sort by category

Finance
Financial Screening
Front Desk
Group Visits
HR
Immunizations
IT
Master Planning/Scheduling
Medications/Pharmacy
Obesity
Other
Panel Management
PCMH/MU

Search

PDSA w/incomplete act section

PDSA w/incomplete study section

Incomplete PDSA

Completed PDSA

Clinica Family Health Services

Leibig.Shepherd@gmail.com

Use IT to Support Organizational Learning

File | Home | Create | External Data | Database Tools

	Category	Title	First Name	Last Name	Site	Date entered	completed?	Date completed	Disseminati
Open PDSA	Group Visits	Centering Patient Recruitment	Judy	Troyer	Pecos	10/9/2008	☑	9/1/2009	☑
Open PDSA	Group Visits	Cold/Flu Cluster Visit III	Judy	Detweiler	Pecos	2/4/2008	☑	3/1/2008	☑
Open PDSA	Group Visits	Cold/Flu Cluster Visit II	Judy	Detweiler	Pecos	1/7/2008	☑	2/4/2008	☑
Open PDSA	Group Visits	Group Visits for Sports Physicals	Beth	Versaw	People's	7/10/2009	☑	7/30/2009	☐
Open PDSA	Group Visits	Geriatric New patient group	Amy	Russell	Pecos	10/8/2008	☑	1/15/2009	☐
Open PDSA	Group Visits	Patient Specific New Patient Group Visits	Judy	Detweiler	Pecos	7/25/2008	☑	10/20/2008	☐
Open PDSA	Group Visits	Financial incentives to increase attendance at CDSM group	Mary	Faltynski	Lafayette	3/27/2008	☑	5/1/2008	☐
Open PDSA	Group Visits	New Patient Group Visit for all Clinicians	Victor	Montour	Thornton	3/4/2008	☑	6/1/2008	☐
Open PDSA	Group Visits	Back Pain Group Visit	Martina	Paiz	Thornton	3/4/2008	☑	3/11/2008	☐
Open PDSA	Group Visits	New Patient Group Visit	Victor	Montour	Thornton	11/1/2007	☑	12/1/2008	☐
Open PDSA	Group Visits	Cold & Flu cluster spread & having CCA schedule	Rebecca	Ballantyne	People's	10/1/2009	☐	3/25/2010	☑
Open PDSA	Group Visits	Share our Strength – Operation Frontline	Anne	Hansen	Thornton	10/26/2008	☐	12/1/2008	☐

Benefits to Clinica of PCMH

NCQA Diabetes 2011/2014

NCQA PCMH Level 3 2010/2013

Joint Commission Accredited since 2002

Nominated by staff, awarded 2012/2013