TRANSFORMING PRIMARY CARE PRACTICE

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5/20/2014
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

2013
42,000 Patients
206,000 Ambulatory visits
5 Clinical sites
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 Recognition 2011/2014
- NCQA Patient-Centered Medical Home Recognized Practice 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

Community
- Resources and Policies
- Self-Management Support

Health Systems
- Organization of Health Care
  - Delivery System Design
  - Decision Support
  - Clinical Information Systems

Improved Outcomes
- Informed, Activated Patient
- Prepared, Proactive Practice Team
- Productive Interactions
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.
Change Management-Start Small!

Big Three
- Continuity
- Access
- Groups
- Team

Big Six
- Continuity
- Access
- Groups
- Team
- Clinical IT
- Patient activation
**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

- Patient Activation
- Continuity
- Access
- Information Systems
- Delivery Models
- Team Care
Six Must Pass Elements 2014

1. PCMH 1, Element A: Patient-Centered Appointment Access.
2. PCMH 2, Element D: The Practice Team.
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
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

Pecos Red - Average HbA1C

Average A1C

Clinica
Pecos
Red Pod
Red Provider
Data for the Team
## Use the data: Panel Report

### Panel Size Report

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

TRIMESTER AT ENTRY FOR PRENATAL CARE

Outreach:
- Elementary schools
- High schools
- Churches
- Homeless shelters
- Coin-operated laundries
- Pawn shops
- Door to door
6100 patients with something due/30 days/13 pods = 15 patients a day/3 team members = 5 patients/day
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

<table>
<thead>
<tr>
<th>Person Nbr</th>
<th>Patient Name</th>
<th>PCP/ Status</th>
<th>Phone Number</th>
<th>Age/ DOB</th>
<th>Gender</th>
<th>Last Visit</th>
<th>ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td>9999</td>
<td>Steve</td>
<td>PCP: Chen, Carolyn Sze-yun</td>
<td></td>
<td>62 Year(s)</td>
<td>M</td>
<td>09/28/2012 Chen, C CarePlan Revw:</td>
<td>X</td>
</tr>
</tbody>
</table>

### 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 with 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

<table>
<thead>
<tr>
<th>Start Date</th>
<th>Stop Date</th>
<th>Brand Name</th>
<th>Generic Name</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/31/2012</td>
<td>11/29/2012</td>
<td>VICODIN</td>
<td>HYDROCODONE</td>
<td>take 1 Tablet by Oral route every 12 hours</td>
</tr>
<tr>
<td>07/11/2012</td>
<td>07/12/2013</td>
<td>Lisinopril</td>
<td>Lisinopril</td>
<td>1 tablet daily</td>
</tr>
<tr>
<td>07/11/2012</td>
<td>07/12/2013</td>
<td>Omeprazole</td>
<td>Omeprazole</td>
<td>take 1 capsule (40MG) by oral route every day before a meal</td>
</tr>
<tr>
<td>07/11/2012</td>
<td>07/12/2013</td>
<td>Simvastatin</td>
<td>Simvastatin</td>
<td>take 1 tablet (10MG) by oral route every day in the evening</td>
</tr>
<tr>
<td>07/11/2012</td>
<td>07/12/2013</td>
<td>Glipizide</td>
<td>Glipizide</td>
<td>take 1 tablet (5MG) by oral route every day with a meal</td>
</tr>
<tr>
<td>07/11/2012</td>
<td>07/10/2013</td>
<td>Metformin HCL</td>
<td>Metformin HCL</td>
<td>take 1 tablet (500MG) by ORAL route every evening for 365 days at bedtime</td>
</tr>
<tr>
<td>03/20/2013</td>
<td>03/19/2013</td>
<td>Accu-Chek Aviva</td>
<td>Blood Sugar Diagnostic</td>
<td>take by Misc (Non-Medic, Combo Route) route for 365 days as directed</td>
</tr>
<tr>
<td>03/19/2013</td>
<td>03/19/2013</td>
<td>Lancets</td>
<td>Lancets</td>
<td>apply by Misc (Non-Medic, Combo Route) route for 365 days as directed</td>
</tr>
<tr>
<td>03/19/2013</td>
<td>03/19/2013</td>
<td>Accu-Chek Aviva Plus</td>
<td>Blood-Glucose Meter</td>
<td>apply 1 Strip by Percutaneous route 2 times every day to test blood sugar for</td>
</tr>
</tbody>
</table>

### Chronic Pain
- Contract Date: 7/29/11
- Functional Assessment: 2/29/08
- Pain Intensity: 3/12
- Medication Misuse: unable to afford increase in Prozac, almost running out of Flexeril

**Open Referrals**
- 10/01/2012 - Refer to Dr. May ophthalmology
- 09/26/2012 - 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 dashboard program to get better
- You are never done