Leading the Way to a Primary Care Medical Home

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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

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

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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
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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.

Tameka 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.

Then there is Donna Morse, 65, 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.
The Vision: Patient-Centered HEALTH Home!
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

<table>
<thead>
<tr>
<th>PCMH1: Enhance Access and Continuity</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Access During Office Hours**</td>
<td>4</td>
</tr>
<tr>
<td>B. After-Hours Access</td>
<td>4</td>
</tr>
<tr>
<td>C. Electronic Access</td>
<td>2</td>
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<tr>
<td>D. Continuity</td>
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<td>E. Medical Home Responsibilities</td>
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<tr>
<td>F. Culturally and Linguistically Appropriate Services</td>
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<tr>
<td>G. Practice Team</td>
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<table>
<thead>
<tr>
<th>PCMH2: Identify and Manage Patient Populations</th>
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<tbody>
<tr>
<td>A. Patient Information</td>
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<td>B. Clinical Data</td>
<td>4</td>
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<td>C. Comprehensive Health Assessment</td>
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<tr>
<td>D. Use Data for Population Management**</td>
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<th>PCMH3: Plan and Manage Care</th>
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<td>A. Implement Evidence-Based Guidelines</td>
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<td>B. Identify High-Risk Patients</td>
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<td>C. Care Management**</td>
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<td>D. Manage Medications</td>
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<td>E. Use Electronic Prescribing</td>
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<tr>
<td>A. Support Self-Care Process**</td>
<td>6</td>
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<tr>
<td>B. Provide Referrals to Community Resources</td>
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<th>PCMH5: Track and Coordinate Care</th>
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<tr>
<td>A. Test Tracking and Follow-Up</td>
<td>6</td>
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<tr>
<td>B. Referral Tracking and Follow-Up**</td>
<td>6</td>
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<td>C. Coordinate with Facilities/Care Transitions</td>
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<th>PCMH6: Measure and Improve Performance</th>
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<td>A. Measure Performance</td>
<td>4</td>
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<tr>
<td>B. Measure Patient/Family Experience</td>
<td>4</td>
</tr>
<tr>
<td>C. Implement Continuously Quality Improvement**</td>
<td>4</td>
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<td>D. Demonstrate Continuous Quality Improvement</td>
<td>3</td>
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<td>E. Report Performance</td>
<td>3</td>
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<td>F. Report Data Externally</td>
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<td><strong>Total</strong></td>
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</tbody>
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**Must Pass Elements**

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Plan—it's 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.

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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
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
Agree on why you 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

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<th>Preferred ICD9 Code:</th>
<th>300.3 Obsessive-compulsive disorders</th>
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<td>Secondary ICD9 Code:</td>
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<td>Other ICD9 Code(s):</td>
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<table>
<thead>
<tr>
<th>Preferred SNOMED-CT:</th>
<th>Obsessive-compulsive disorder - 191736004 (exact match)</th>
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<tbody>
<tr>
<td>Other SNOMED CT Code(s):</td>
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### 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
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

- PCMH 1 - Enhance Access and Continuity
- PCMH 2 - Identify and Manage Patient Populations
- PCMH 3 - Plan and Manage Care
- PCMH 4 - Provide Self-Care Support and Community Resources
- PCMH 5 - Track and Coordinate Care
- PCMH 6 - Measure and Improve Performance
- Workbooks
- Clinica Family Health Services NCQA PCMH Attestation Letter
- Newborn blood screen and hearing screen.docx
- PCMH Application 2013 Gap Analysis_Needs Work_Does Not Exist
- PCMH2011_Eligible_Corporate_Elements1.pdf
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 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.

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<table>
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<tr>
<th>NCOA Element</th>
<th>Factors</th>
<th>Data Source</th>
<th>Specific</th>
<th>Comments</th>
<th>Document Status</th>
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<tbody>
<tr>
<td>1C Electronic Access</td>
<td>More than 50% 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.</td>
<td>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 days.</td>
<td>Percentage based on 12 months of data. If 12 months of data are not available, may use a recent 3 month period.</td>
<td>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.</td>
<td>Changed from Red to Green. P:\Committees\Meaningful Use\Attestation Measures\Criteria EP Core Measures with FAQs</td>
</tr>
<tr>
<td>2. At least 10% 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.</td>
<td>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.</td>
<td>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 available, may use.</td>
<td>Can use frequency of portal uploads/updates to demonstrate accessibility within 4 days.</td>
<td>Judy to talk to Sean about adding to pt registration. Ben will look into the MU report.</td>
<td></td>
</tr>
<tr>
<td>3. Clinical summaries are</td>
<td>Report of percent of patients who have clinical summaries; Clinical summary is a visit summary</td>
<td>Policy on providing clinical summaries;</td>
<td></td>
<td></td>
<td>Ben - MU report</td>
</tr>
</tbody>
</table>

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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.
- In accordance with state law, consents for HIV testing are required prior to performing any testing and are scanned into the patient’s chart.
- 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 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
### 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⁽²⁾
  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**
### CarePlan

**PCP:** Farrell, Edward  
**Status:** Active  
**Payer:** Medicare Clinica FQHC  
**Group Visits:** DM EF  
**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**

**Appointments**
- 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 Laura 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 &lt;70 - 272.4  
- 03/15/2012 - Obesity - 278.00  
- 03/15/2012 - Unspecified essential hypertension - 401.9  
- 06/01/2010 - DM renal manifest, type II - 250.40  
- 10/02/2009 - Emphysema - 492.8  
- Anticoagulant therapy - V58.61  
- Chronic ischemic heart disease - 414.9  
- DM renal manifest, type II - 250.40

**Active Medications**

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

**Diabetes - High Risk**

<table>
<thead>
<tr>
<th>Systolic</th>
<th>Diastolic</th>
<th>Eye Exam</th>
<th>Foot Exam</th>
<th>A1c (Last 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>120</td>
<td>66</td>
<td>06/23/11</td>
<td>8/23/13</td>
<td>02/07/2014 - 8.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>01/17/2014 - 8.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>11/15/2013 - 8.4</td>
</tr>
</tbody>
</table>

**Anticoagulation**

**Indication(s):**
- 7111-OTH PULMONARY EMBOLISM&INFARCTION

<table>
<thead>
<tr>
<th>Therapy Start</th>
<th>Therapy Duration</th>
<th>INR</th>
<th>Goal Range</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/1997</td>
<td>lifelong</td>
<td></td>
<td>3.00 - 4.00</td>
<td>Low</td>
</tr>
</tbody>
</table>

**Open Referrals**


**Future Labs**

- 06/20/2013 - scheduled - MRI, cervical spine, w/o contrast -
Meaningful Use and PCMH Clinical Visit Summary

PATIENT PLAN

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

Assessment:
DM uncontrolled (HbA1c 25.62)
Ran and IP medicine: Allopurinol 1/2 tablet twice daily.
Follow up IP check for quality cost. 
Corticosteroid modified.
Be sure to take ASA.

Medications:

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Brand</th>
<th>Dose</th>
<th>SH</th>
<th>1/2 Tablet by mouth every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allopurinol</td>
<td></td>
<td>25 mg</td>
<td></td>
<td>1 Tablet once daily</td>
</tr>
<tr>
<td>Ranitidine</td>
<td></td>
<td>50 mg</td>
<td></td>
<td>1 Tablet (300mg) by mouth every day</td>
</tr>
<tr>
<td>Levothyroxine</td>
<td></td>
<td>50 mcg</td>
<td></td>
<td>1 Tablet (30mcg) by mouth every day</td>
</tr>
<tr>
<td>Labetalol</td>
<td></td>
<td>50 mg</td>
<td></td>
<td>1 Tablet (100mg) by mouth every day</td>
</tr>
</tbody>
</table>

Vital Signs:

<table>
<thead>
<tr>
<th>Time</th>
<th>Temp</th>
<th>Pulse</th>
<th>Respi</th>
<th>BP-Sys</th>
<th>BP-Dia</th>
<th>Ht</th>
<th>Wt</th>
<th>BMI</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:20 PM</td>
<td>97.50</td>
<td>70</td>
<td>16</td>
<td>140/90</td>
<td>80/68</td>
<td>140.00</td>
<td>26.26</td>
<td>sitting</td>
<td></td>
</tr>
</tbody>
</table>

Allergies:

<table>
<thead>
<tr>
<th>Allergy Ingredient</th>
<th>Brand/Comments</th>
<th>Reaction</th>
<th>Date of Onset</th>
</tr>
</thead>
<tbody>
<tr>
<td>Levofloxacin</td>
<td>Levulan in D5W</td>
<td>Anxiety</td>
<td>11/19/2009</td>
</tr>
</tbody>
</table>

Self Management Goals:

Continue to attend the 2 meetings a week through the church here in Lafayette. This gives her the most peace of mind and support.

Orders:

<table>
<thead>
<tr>
<th>Status</th>
<th>Order</th>
<th>Completed Date</th>
<th>Interpretation</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed</td>
<td>Glucose, Finger Stick</td>
<td>05/30/2013 see details</td>
<td>167 mg/dL</td>
<td></td>
</tr>
<tr>
<td>Completed</td>
<td>Hemoglobin A1C</td>
<td>05/30/2013 see details</td>
<td>6.8%</td>
<td></td>
</tr>
</tbody>
</table>

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 8 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.

<table>
<thead>
<tr>
<th>Check off when done</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td></td>
</tr>
<tr>
<td>Tuesday</td>
<td></td>
</tr>
<tr>
<td>Wednesday</td>
<td></td>
</tr>
<tr>
<td>Thursday</td>
<td></td>
</tr>
<tr>
<td>Friday</td>
<td></td>
</tr>
<tr>
<td>Saturday</td>
<td></td>
</tr>
<tr>
<td>Sunday</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Check off when done</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td></td>
</tr>
<tr>
<td>Tuesday</td>
<td></td>
</tr>
<tr>
<td>Wednesday</td>
<td></td>
</tr>
<tr>
<td>Thursday</td>
<td></td>
</tr>
<tr>
<td>Friday</td>
<td></td>
</tr>
<tr>
<td>Saturday</td>
<td></td>
</tr>
<tr>
<td>Sunday</td>
<td></td>
</tr>
</tbody>
</table>
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 Problem

• Paint a Picture (vision) of how it could be

• Have a well thought out Plan

• Describe what Part each person plays
Managing Transitions

**PROBLEM**

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

**PICTURE**

The Vision: Patient-Centered HEALTH Home!

**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

**PART**

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.”
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

Leibig.Shepherd@gmail.com
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

<table>
<thead>
<tr>
<th>Important</th>
<th>Urgent I ACTIVITIES:</th>
<th>Not Urgent II ACTIVITIES:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Important</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Crises</td>
<td>Prevention, PC activities</td>
</tr>
<tr>
<td></td>
<td>Pressing problems</td>
<td>Relationship building</td>
</tr>
<tr>
<td></td>
<td>Deadline-driven projects</td>
<td>Recognizing new opportunities</td>
</tr>
<tr>
<td>Not Important</td>
<td>III ACTIVITIES:</td>
<td>IV ACTIVITIES:</td>
</tr>
<tr>
<td></td>
<td>Interruptions, some calls</td>
<td>Trivia, busy work</td>
</tr>
<tr>
<td></td>
<td>Some mail, some reports</td>
<td>Some mail</td>
</tr>
<tr>
<td></td>
<td>Some meetings</td>
<td>Some phone calls</td>
</tr>
<tr>
<td></td>
<td>Pressing matters</td>
<td>Time wasters</td>
</tr>
<tr>
<td></td>
<td>Popular activities</td>
<td>Pleasant activities</td>
</tr>
</tbody>
</table>
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

---

**Possible Missed Immunization Opportunities**

<table>
<thead>
<tr>
<th>Person Nbr</th>
<th>First Name</th>
<th>Last Name</th>
<th>DOB (In Months)</th>
<th>Age (In Months)</th>
<th>MA or Nurse</th>
<th>Rendering Provider</th>
<th>PCP</th>
<th>DOS</th>
<th>Visit Type</th>
<th>Missing Vaccines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Garcia, Denicia CC</td>
<td>Garcia, Denicia CC</td>
<td>0</td>
<td>48</td>
<td>Hutcheson DO, Jonathan</td>
<td>Hutcheson DO, Jonathan</td>
<td>4/9/2014</td>
<td>Well Child Check</td>
<td>Flu,</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Garcia, Denicia CC</td>
<td>Garcia, Denicia CC</td>
<td>2</td>
<td>57</td>
<td>Hutcheson DO, Jonathan</td>
<td>Hutcheson DO, Jonathan</td>
<td>4/9/2014</td>
<td>Well Child Check</td>
<td>Flu,</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Guerrero, Paola CC</td>
<td>Guerrero, Paola CC</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td>21</td>
<td>27.27%</td>
<td>Flu,</td>
<td></td>
</tr>
</tbody>
</table>

---
Making Data Useful

Conference Rooms

Design
Design
Design

Real World

Reject!
Reject!
Reject!

Leibig.Shepherd@gmail.com
Performance Improvement Methodology

1. **Design**
   - Conference Rooms

2. **Test and Modify**
3. **Test and Modify**
4. **Test and Modify**

5. **Implement Design**
   - Real World

6. **Approve (if necessary)**

---

Leibig.Shepherd@gmail.com
Data Warehouse Logical Architecture

**Source Systems**
EHR, EDR, Pharm, HIE

**Legend**
- Source Systems
- Clinica Report Server
- Clinica Intranet

**Development**

**Information Delivery**

Leibig.Shepherd@gmail.com
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

Prevention Task Force
Broomfield Family Practice - Pneumococcal Vaccination
n = 801

Baseline
Mar-09 Jun-09 Jul-09 Aug-09 Sep-09 Oct-09 Nov-09 Dec-09 Jan-10 Feb-10 Mar-10 Apr-10 May-10 Jun-10 Jul-10 Aug-10 Sep-10 Oct-10 Nov-10 Dec-10 Jan-11

Pneumovax Achievable Goal
Clinica Financial Indicators
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
- **Sort by category**
  - Finance
  - Financial Screening
  - Front Desk
  - Group Visits
  - HR
  - Immunizations
  - IT
  - Master Planning/Scheduling
  - Medications/Pharmacy
  - Obesity
  - Other
  - Panel Management
  - PCMH/MU
- **PDSA w/incomplete act section**
- **Incomplete PDSA**
- **PDSA w/incomplete study section**
- **Completed PDSA**

Clinica Family Health Services

Leibig.Shepherd@gmail.com
Use IT to Support Organizational Learning

<table>
<thead>
<tr>
<th>Category</th>
<th>Title</th>
<th>First Name</th>
<th>Last Name</th>
<th>Site</th>
<th>Date entered</th>
<th>completed?</th>
<th>Date completed</th>
<th>Disseminated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open PDSA</td>
<td>Cold/Flu Cluster Visit II</td>
<td>Judy</td>
<td>Detweiler</td>
<td>Pecos</td>
<td>1/7/2008</td>
<td>✓</td>
<td>2/4/2008</td>
<td></td>
</tr>
<tr>
<td>Open PDSA</td>
<td>Financial incentives to increase attendance at CDSM group</td>
<td>Mary</td>
<td>Faltsinski</td>
<td>Lafayette</td>
<td>3/27/2008</td>
<td>✓</td>
<td>5/12/2008</td>
<td></td>
</tr>
<tr>
<td>Open PDSA</td>
<td>Cold &amp; Flu cluster spread &amp; having CCA schedule</td>
<td>Rebecca</td>
<td>Ballantine</td>
<td>People's</td>
<td>10/1/2009</td>
<td>✓</td>
<td>3/25/2010</td>
<td></td>
</tr>
<tr>
<td>Open PDSA</td>
<td>Share our Strength – Operation Frontline</td>
<td>Anne</td>
<td>Hansen</td>
<td>Thornton</td>
<td>10/26/2008</td>
<td>✓</td>
<td>12/1/2008</td>
<td></td>
</tr>
</tbody>
</table>
Benefits to Clinica of PCMH

- NCQA Diabetes Recognition
  2011/2014
- NCQA PCMH Recognized Practice
  Level 3
  2010/2013
- Joint Commission Accredited
  since 2002
- Nominated by staff,
  awarded 2012/2013

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