CP3 Population Health Management

Comprehensive Track, In-Person Learning Session #3
Tuesday, December 3, 2016 from 8:00am-5:00pm
Hotel Shattuck, Berkeley, CA
Why care about care delivery transformation in the face of the election?
Reflection

What big questions or fears do you have related to the APM or care delivery transformation work in general in the face of the election and what comes next?
CP3 Pop. Health: Looking Back
Program Aim

By April 2017, all nine federally qualified health centers will test and measure care delivery changes in at least one of the following modules:

(1) team-based care,
(2) population health management, and/or
(3) planned care,

to support the delivery of high value care in a capitated payment environment.
Core Activities

• Pre-work virtual meeting - identify opportunities for improvement, set aims (May)

• In-person learning sessions focused on preparing orgs. for change, team-based care, planned care, population health management (July, Sept, Dec, March)

• Coaching Calls (monthly, 2hr min, max 6hrs/org)

• Swap meets virtual peer sharing/learning (when assigned presenter/reactor)

Optional

• Faculty Office Hours
• Site visits
• Technical webinars focused on timely content, spread and sustainability
# Program Timeline

<table>
<thead>
<tr>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
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<tbody>
<tr>
<td>Pre-work virtual meeting 5/26</td>
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<tr>
<td>Onsite #1: 7/21</td>
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<td>Onsite #3: 12/6</td>
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<td>Onsite #4: 3/2</td>
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- Monthly Coaching Calls (up to 6 hrs/mo per organization, across participating sites)
- “Swap Meets”
- Curbside Consults with faculty (expert office hours)
- Site visits
- Technical Webinars
Comprehensive Track Areas of Focus

- Team Based Care
  - Teamwork & Task work

- Planned Care
  - Prepared Team Activated Patient

- Population Management
  - Identify & Segment Populations
  - Patient Outreach

CCI CENTER FOR CARE INNOVATIONS
Our Three Step Approach

1. Understand & Set Aims
   1) Identify opportunity areas to develop or strengthen: what do your current data tell you?
   2) Test assumptions: Do others (i.e. frontline staff) agree these are the right areas?
   3) Set 1-3 Aim statements for your selected module.

2. Identify Changes & Test
   4) Brainstorm multiple solutions for the opportunity area you would like to improve.
   5) Use PDSA to learn which of your solutions work better and which do not. Prototype your solutions in a live or semi-live environment. Monitor early indicators for learning purposes.

3. Sustain & Spread Planning
   6) Identify changes to sustain, spread and scale with support from coaches and the learning community.

Training Modules
Site Visits
Coaching
Office Hours

Coaching
Webinars
Office Hours

Prework + Change Mgmt. Session
Wins!

Standardize scrubbing of charts & daily huddles
MONTERREY

Care management program is now centralized
VENICE

Implemented training on Azara reporting tool to improve utilization & help improve HEDIS measures
TIBURCIO VASQUEZ

Implemented new MA training program
LIFELONG

Started to establish teams, review job description, and review ways to strengthen the teams
RAVENSWOOD

Began implementing RN" pre-visit" calls to new patients
COMMUNICARE

Reconciling “patient lists” with health plan to identify patients that are not “active” with HC
OLE HEALTH

Spreading care team model from main site to two additional sites
SAN MATEO

Re-working Aims
VISTA

TIBURCIO VASQUEZ
Today’s Agenda

• 8:00am – 8:30: Breakfast & Registration
• 8:30 – 8:55: Welcome, Ice-breaker & Overview of the Day
• 8:55 – 9:55: Key Components of a Successful Pop. Health Management Strategy for VBC
• 9:55 – 10:10: Break and Storyboard Assembly & Decoration
• 10:10 – 11:15: Storyboard Gallery
• 11:15 – 11:45: Panel Presentations: Non-traditional Visits and IT Enabled Care
• 11:45 – 12:30: Lunch
• 12:30 – 2:30: Non-traditional Visits Learning Labs
• 2:30 – 2:45: Break
• 2:45 – 3:25: Team Time: What are you Learning and What are the Next Steps?
• 3:25 – 3:50: Uses for Data Measurement, Accountability, and Improvement
• 3:50 – 4:00: Wrap-Up & Closing
• 4:00 – 5:00pm: Networking Reception & Celebration
Organization Capability for Providing High-Value Care

Tammy Fisher, Senior Director
Center for Care Innovations
Wins!

Standardize scrubbing of charts & daily huddles

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Re-working Aims

VISTA

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SAN MATEO
First, Some Context...

*Value equation is centered around the patient*

\[ \text{Value} = \text{Patient outcomes} + \text{Experience} + \text{Cost} \]
Past and Present

- Started in hospitals, now spreading
- Largely Medicare VBP
- FFS Medicare VBP – carrots and sticks
- Health plan P4P $$$ on top of “base rate”
- ACOs – shared savings and Pioneer program
- Medicaid/Medicare- MU incentives

Integration

P4P programs
One off programs

Standard measures across payors
Incentives linked to performance in measures

Advanced APM
This Transformation is an evolution to a new model for healthcare.

Old Healthcare

- Fee for Service
- Volume
- Delivery
- Employer-centric
- Prices unknown
- One way dialogue
- Transactional
- Data poor & disconnected
- Reactive
- Standards

New Healthcare

- Pay for performance
- Value
- Quality Outcome
- Consumer-centric
- Cost transparency
- Engaged & mobile
- Brand loyal
- Integrated rich “big” data
- Predictive & prescriptive
- Personalized & optimized

Source: Judy Murphy, RN, Chief Nursing Officer at IBM Global Healthcare
Managing “Assigned” Populations

Source: Judy Murphy, RN, Chief Nursing Officer at IBM Global Healthcare
Partner Sharing

CommuniCare and Clinica Family Health

- How are you working with your managed care plan to identify your assigned patients?

- Are there other data you are receiving from your managed care plan(s) to proactively manage the care of your assigned patients?

- Are others working with their managed care plans?
High Value Care—What’s Needed?

Practice level changes

Org-wide infrastructure changes

- Engaged leadership at all levels
  - Clear vision, and goals
  - Adaptive leadership style

- Robust data systems, measurement and reporting
  - Financial/operational analytics
  - Clinical informatics
  - Performance monitoring

- Training and knowledge management
  - Institutes, programs

- Continuous improvement
  - Improvement methodology
  - Clear plan for spread and scale
Adaptive Leadership

A common leadership framework – adaptive leadership (Heifitz)

**Get on the Balcony**
- A place from which to observe the patterns in the wider environment as well as what is over the horizon (prerequisite for the following six principles)

**Identify the Adaptive Challenge**
- A challenge for which there is no ready made technical answer
- A challenge requiring the gap between values, beliefs, attitudes and behaviours to be addressed

**Create the Holding Environment**
- May be a physical space in which adaptive work can be done
- The relationship or wider social space in which adaptive work can be accomplished

<table>
<thead>
<tr>
<th>Cook the Conflict</th>
<th>Maintain Disciplined Attention</th>
<th>Give back the work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create the heat</td>
<td>Work avoidance</td>
<td>Resume responsibility</td>
</tr>
<tr>
<td>Sequence &amp; pace the work</td>
<td>Use conflict positively</td>
<td>Use their knowledge</td>
</tr>
<tr>
<td>Regulate the distress</td>
<td>Keep people focussed</td>
<td>Support their efforts</td>
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Protect the voices of Leadership from below
- Ensuring everyone’s voice is heard is essential for willingness to experiment and learn
- Leaders have to provide cover to staff who point to the internal contradictions of the organisation
A Story from Clinica...

- Patient and staff’s #1 complaint.
- Complex problem, no clear solution
- Patient voices were very important
- Front office staff on team
- Curiosity essential
- Values and beliefs and behaviors needed changing
- Experiments and smart risks
- Clinician buy-in rule
Data Systems and Reporting
Org-Level Changes

Training and knowledge management
• What programs/support does your organization offer?
• How have you embedded this into your organization – or, how will you make it stick?

Continuous improvement
• What methodology do you use in your organization?
• How have you embedded this methodology into your organization – or how will you make it stick?
Identify Your High Leverage Changes

• As a team, identify the **top three** changes you are doing in your organization that move you towards high value care for your primary care patients?

• Team rotations
  – *Share with one other team*

• Group report out – share one pearl you got from the other team
Break/Storyboard Decoration
15 minutes
15 minutes to decorate your storyboard!
Storyboard Gallery
Storyboard Presentations

• Two groups – each team presents their storyboard (40 minutes)
• Storyboard gallery (20 minutes)
Storyboard Stealing & Sticky Note Consultation

• Post a spokesperson at your storyboard
• Circulate to learn from and help other health centers
• Use green and pink sticky notes for consultation
• Jot down ideas to steal and next steps on your worksheet
Panel Presentations: Non-traditional Visits and IT Enabled Care
Panel Presenters

Melissa Rombaoa, MPH CHFP
Operations Strategist
San Mateo Medical Center

Dr. Carolyn Shepherd,
CP3 Clinical Director,
former CMO of Clinica
Family Health

Charles Kitzman, MMI
Chief Information Officer
Shasta Community
Health Center
Technology Enhanced or Enabled Care

Adapted from: UCSF Center for Excellence and CareOregon Practice Coach Training, 2016
Non-Traditional Visit Models

- Group Visits/shared medical appointments
- Home Visits
- Flip visits (co-visits)

Adapted from: UCSF Center for Excellence and CareOregon Practice Coach Training, 2016
Defining the Problem (Opportunity)

- What are we trying to make **better**?
- What are our **problems** and the **root cause** of the problem?
  – 5 Why’s

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- Describe the **opportunity**.
  – Aim statement
- Identify solution to test
- PDSAs – adapt, abandon, implement
- Spread, scale and sustain what works!
Panelists, 5 minutes each

- Introduce yourself and your organization
- What is your **solution**?
- What **problem(s)** does your solution address? What is the **business case** for doing it?
- What **impact** has the solution had on your patients, clinicians and care team?
- What has **surprised** you most about your solution?
Lunch
45 minutes
Learning Labs
12:30-2:30pm
Break
10 minutes
Team Time!
Team Time!

• **Activity:** Get into teams, and reflect on the question:

  – What are you thinking about changing and trying back in your organization?
Purposes for Measurement
### The Three Faces of Performance Measurement

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Improvement</th>
<th>Accountability</th>
<th>Research</th>
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<tbody>
<tr>
<td><strong>Aim</strong></td>
<td>Improvement of care (efficiency &amp; effectiveness)</td>
<td>Comparison, choice, reassurance, motivation for change</td>
<td>New knowledge (efficacy)</td>
</tr>
<tr>
<td><strong>Methods:</strong></td>
<td></td>
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<tr>
<td>• Test Observability</td>
<td>Test observable</td>
<td>No test, evaluate current performance</td>
<td>Test blinded or controlled</td>
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<tr>
<td>• Bias</td>
<td>Accept consistent bias</td>
<td>Measure and adjust to reduce bias</td>
<td>Design to eliminate bias</td>
</tr>
<tr>
<td>• Sample Size</td>
<td>“Just enough” data, small sequential samples</td>
<td>Obtain 100% of available, relevant data</td>
<td>“Just in case” data</td>
</tr>
<tr>
<td>• Flexibility of Hypothesis</td>
<td>Flexible hypotheses, changes as learning takes place</td>
<td>No hypothesis</td>
<td>Fixed hypothesis (null hypothesis)</td>
</tr>
<tr>
<td>• Testing Strategy</td>
<td>Sequential tests</td>
<td>No tests</td>
<td>One large test</td>
</tr>
<tr>
<td>• Determining if a change is an improvement</td>
<td>Run charts or Shewhart control charts (statistical process control)</td>
<td>No change focus (maybe compute a percent change or rank order the results)</td>
<td>Hypothesis, statistical tests (t-test, F-test, chi square), p-values</td>
</tr>
<tr>
<td>• Confidentiality of the data</td>
<td>Data used only by those involved with improvement</td>
<td>Data available for public consumption and review</td>
<td>Research subjects’ identities protected</td>
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Find your Purpose for Measuring!

Quote from IHI...

“We are increasingly realizing not only how critical measurement is to the quality improvement we seek but also how counterproductive it can be to mix measurement for accountability or research with measurement for improvement.”

What does this mean to you?

• What challenges have you experienced when mixing measurement intended for different purposes?
## Data for Accountability

Click on medical group for group's star ratings and information:

<table>
<thead>
<tr>
<th>Medical Group</th>
<th>Uses Treatments Proven to be Effective</th>
<th>Patients Rate Their Medical Group</th>
<th>Average Annual Payment for Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affinity Medical Group</td>
<td>GOOD</td>
<td>GOOD</td>
<td>LOWER PAYMENT</td>
</tr>
<tr>
<td>Alta Bates Medical Group, a division of Brown &amp; Toland Physicians</td>
<td>FAIR</td>
<td>GOOD</td>
<td>LOWER PAYMENT</td>
</tr>
<tr>
<td>Hill Physicians Medical Group - Bay Region</td>
<td>GOOD</td>
<td>GOOD</td>
<td>LOWER PAYMENT</td>
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<tr>
<td>John Muir Health</td>
<td>GOOD</td>
<td>GOOD</td>
<td>LOWER PAYMENT</td>
</tr>
<tr>
<td>Kaiser Permanente - The Permanente Medical Group - Diablo/Antioch Medical Centers</td>
<td>GOOD</td>
<td>GOOD</td>
<td>LOWER PAYMENT</td>
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<tr>
<td>Kaiser Permanente - The Permanente Medical Group - Oakland/Richmond Medical Centers</td>
<td>GOOD</td>
<td>FAIR</td>
<td>LOWER PAYMENT</td>
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<tr>
<td>Sutter East Bay Medical Foundation</td>
<td>GOOD</td>
<td>GOOD</td>
<td>HIGHER PAYMENT</td>
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Data for Improvement

• Identify measures/areas to focus on – where is variation greatest? Where is performance below expected?
  – Clinic-wide data
  – Care team specific data
  – Clinician specific data

• Data for population management
  – Data for use at point of care
  – Data for outreaching to patients with gaps or lost to care

• Data for “real time” learnings
  – PDSA data – are changes working?
## Operations & Access

### Clinical Care

- **Blood pressure control**
- **Annual smoking assessment**
- **Colorectal cancer screening**
- **Diabetes HgA1c screening**
- **Diabetes HgA1c control**
- **Diabetes LDL control**
- **Adult tetanus immunization**

### Patient Experience
- **Appointment show rate**
- **Patient-provider continuity**

### Staff Experience
- **Panel size per fte**
- **3rd next available appt**

### Blood pressure entry into LCR

## Reminder: What is on the DataWall?
Tobacco Counseling

Patients age 18 years and older who are tobacco users and who had a visit during the reporting year with documentation of advice to quit within 24 months of their last visit.

Strategic Plan Goal: 60.0%
Healthy People 2020 Goal: 21.1%
2012 UDS Value: 63.0% (2nd quartile)
2013 UDS Value: 67.9%

Lafayette – 77.5%
Pecos – 79.4%
People’s – 51.6%
Thornton – 70.6%
Federal Heights – 70.1%
<table>
<thead>
<tr>
<th>Coughlan, Claire</th>
<th>Total Patients</th>
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<tbody>
<tr>
<td></td>
<td>Patients</td>
</tr>
<tr>
<td></td>
<td>56</td>
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<thead>
<tr>
<th>HgA1c Control</th>
<th>One HgA1c (In the last 365 days)</th>
<th>Two (or more) HgA1c (In the last 365 days and &gt; 90 days apart)</th>
<th>Average HgA1c (last test)</th>
<th>HgA1c &gt; 9.0% (poor control)</th>
<th>HgA1c &lt; 7.0%</th>
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<tr>
<td></td>
<td>56</td>
<td>47</td>
<td>7.69</td>
<td>11</td>
<td>21</td>
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<table>
<thead>
<tr>
<th>Blood Pressure Control</th>
<th>Patients (with blood pressure reading)</th>
<th>Blood Pressure Control &lt; 140/90 mm HG</th>
<th>Blood Pressure Control &lt; 130/80 mm HG</th>
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<tbody>
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<td></td>
<td>56</td>
<td>40</td>
<td>21</td>
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<tr>
<th>Cholesterol Control</th>
<th>One LDL (in the last 365 days)</th>
<th>LDL &gt;= 130 mg/dl (poor control)</th>
<th>LDL &lt; 100 mg/dl</th>
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<td>48</td>
<td>9</td>
<td>30</td>
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<tr>
<th>Retinal and Foot Exams</th>
<th>Retinal Exam (Last 365 Days)</th>
<th>Foot Exam (Last 365 Days)</th>
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<tr>
<td></td>
<td>34</td>
<td>53</td>
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<tr>
<th>Nephropathy Screening Assessment</th>
<th>Eligible for Screening</th>
<th>Nephropathy Screening Assessment</th>
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<td></td>
<td>49</td>
<td>40</td>
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<table>
<thead>
<tr>
<th>Tobacco Status and Cessation Advice</th>
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<tbody>
<tr>
<td>Current Tobacco User</td>
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<tr>
<td>---------------------</td>
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<tr>
<td>10</td>
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</tbody>
</table>

<p>|                        | 17.86% | 90.00% |</p>
<table>
<thead>
<tr>
<th>Visits</th>
<th>Patients</th>
<th>Missed Opportunities</th>
<th>% Missed Opportunities</th>
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<tbody>
<tr>
<td>Alvarez, Joanna CC</td>
<td>8</td>
<td>0</td>
<td>0.00%</td>
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<tr>
<td>Andrade, Jeannette CC</td>
<td>7</td>
<td>0</td>
<td>0.00%</td>
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<tr>
<td>Correa, Manolo CC</td>
<td>4</td>
<td>0</td>
<td>0.00%</td>
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<tr>
<td>Garcia, Denicia CC</td>
<td>8</td>
<td>1</td>
<td>12.50%</td>
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<tr>
<td>Garza, Alma CC</td>
<td>7</td>
<td>2</td>
<td>28.57%</td>
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<tr>
<td>Guerrero, Paola CC</td>
<td>8</td>
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<td>0.00%</td>
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Need granular data for Performance Improvement
Wrap Up & Closing
Storyboard Winner!

Cowgirl Creamery Deluxe Collection
What’s Next?

Onsite session #4:  
March 2, 2017  
(Preservation Park  
Oakland, CA)

Swap Meet  
No Swap Meet in December

Resource website:  
cp3portal.com

Faculty Office Hours