Care Teams & Population Health

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Objectives

Overview of our patient population

Leadership & care team structure

Population health strategies

La Clinica in 2018

- **Six community health centers**—Birch Grove, Central Point, Family and Women's, Phoenix, West Medford, and Wellness centers
- **One dental clinic**—East Medford Dental Clinic (plus dental care at Central Point Health Center)
- **11 school-based health centers**—Central Point, Jackson, Jewett, Mae Richardson, Oak Grove, Phoenix, and Washington elementary schools; Scenic and Hanby middle schools; Crater High School; Kids Unlimited Charter School
- **La Clinica Mobile Health Center**

Staff

- **374 employees** *(many bilingual)*
- **37 medical providers**

(Family physicians, OB/GYNs, nurse practitioners, physician assistants, certified nurse midwives)

- **13 mental health providers**
- **11 dentists**

2017 by the numbers

Patients served
29,736

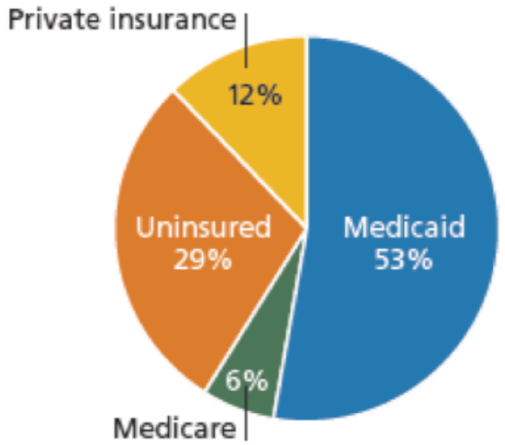
Total patient visits
147,365

Race

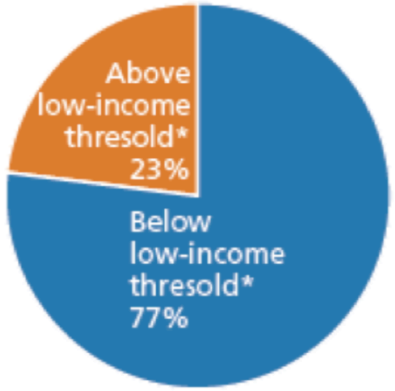
Ethnicity

Special populations

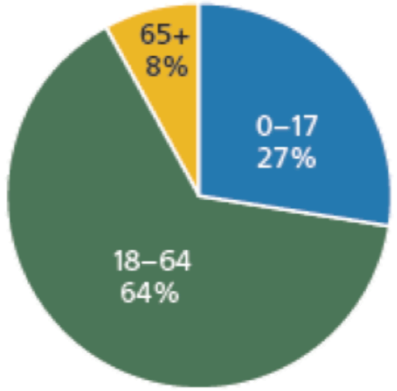
Homeless: 4,778
Veterans: 898
Agricultural workers: 3,104
Public housing residents: 934



Patient insurance
29,736

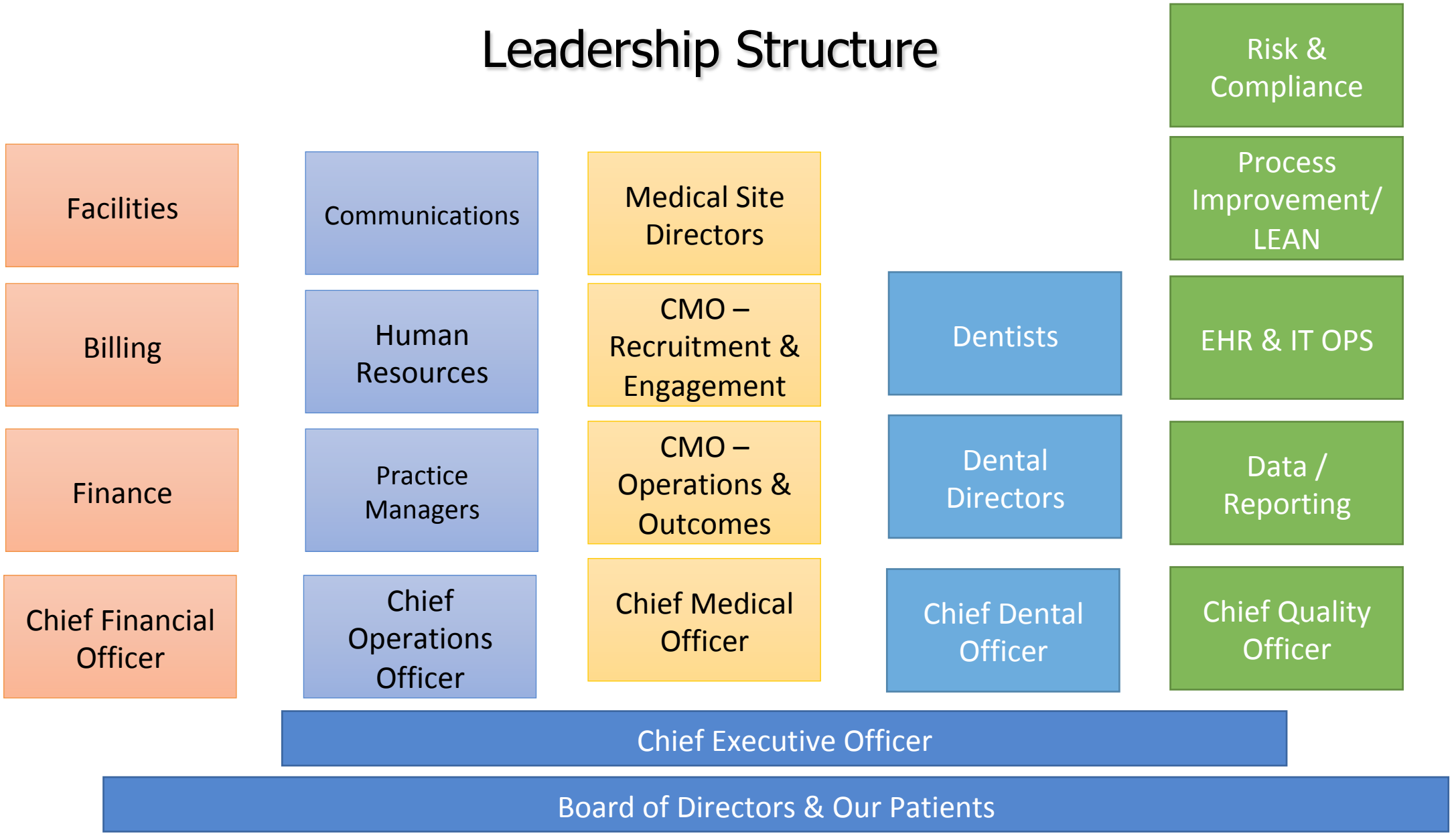


Patient income
*200% of poverty level



Patient age

Leadership Structure



Care Team Structure

Clinical Services Assistant

Wellness Coach

Lab Tech

Nurse

Medical Assistant

Prevention & Engagement Specialist

Benefit Eligibility Specialist

Medical Records

Patient Service Representative

Integrated Behavioral Health Clinician

Call Center

Referrals

Centralized Support Services

Back Office Team Lead

Front Office Team Lead

Medical Providers

Practice Manager

Medical Site Director

Care Team Formulas

1.5 FTE RN

0.75 FTE RN case manager

1.5 FTE Wellness Coach

1.0 FTE Behavioral Health Clinician

4.0 FTE MA

1.0 FTE Lab Tech

1.0 FTE Clinical Services Assistant

3.0 Provider FTE

1.0 FTE Benefit Specialist

1.0 FTE Call Center (allocation)

1.0 FTE Referrals (allocation)

2.0 FTE Reception

1.0 FTE Medical Records

1.0 FTE Engagement & Prevention Specialist


Health

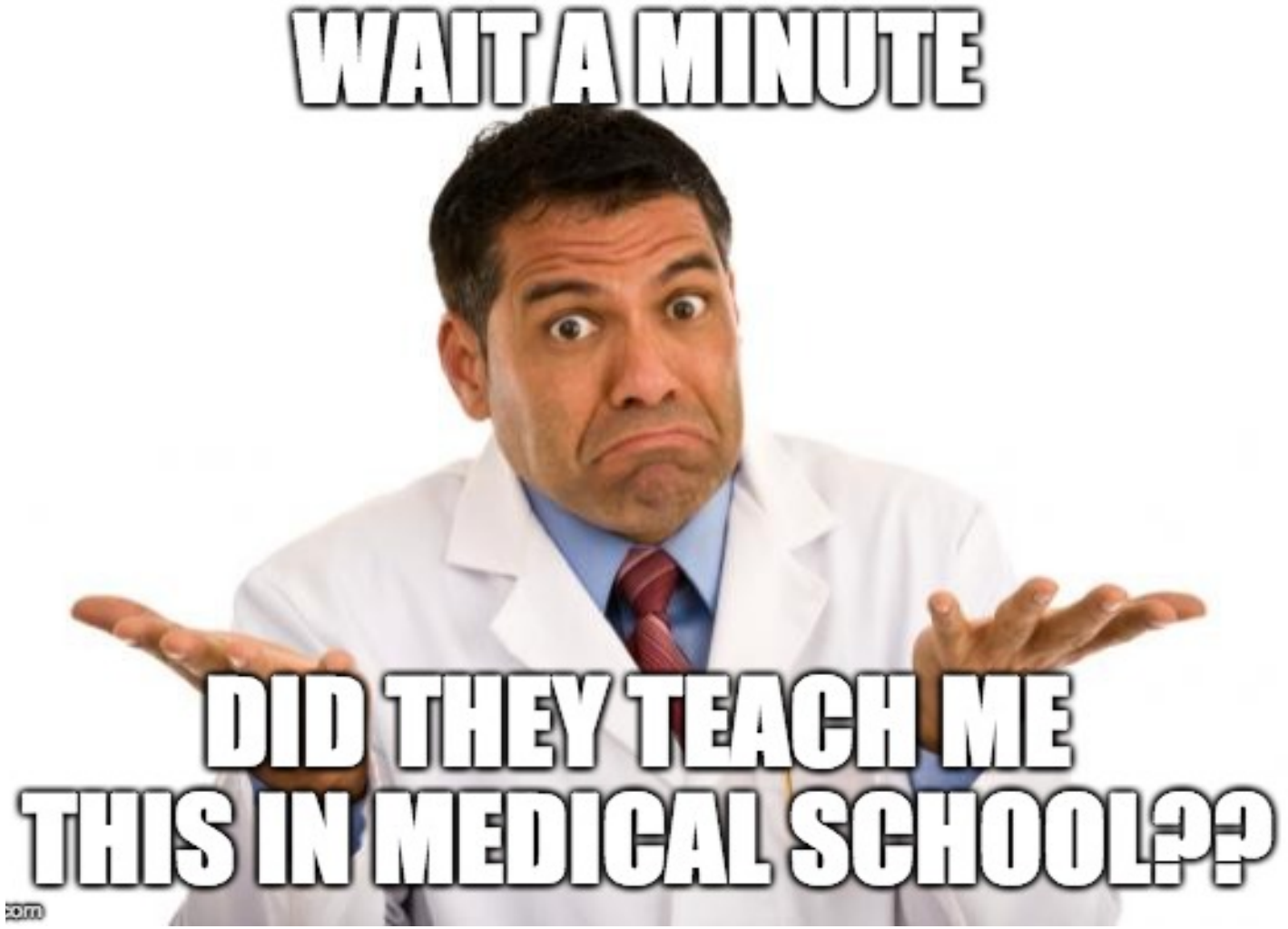
Current Core Metrics

Measure	Definition
Adolescent Well Visits Benchmark 66%	Adolescents ages 12-21 years old that had at least one comprehensive well- care visit during the measurement year.
Use of Appropriate medications for Asthma Benchmark 88%	Percentage of patients 5-64 years of age with a diagnosis of persistent asthma and were appropriately ordered medication during the measurement period
Cervical Cancer Screening Benchmark 55%	Percentage of women 23-64 years of age, who were screened for cervical cancer using either of the following criteria: * Women age 23-64 who had cervical cytology performed every 3 years * Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years
Childhood Immunization Status Benchmark 81%	Percentage of children 2 years of age who were fully immunized by their second birthday.
Colorectal Cancer Screening Benchmark 54%	Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer
Coronary Artery Disease (CAD): Lipid Therapy Benchmark 80%	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) who were prescribed a lipid-lowering therapy
Screening form Clinical Depression and Follow Up Plan Benchmark 63%	Percentage of patients aged 12 years and older screened for depression on the date of the visit using an age appropriate standardized depression screening tool AND if screening is positive, a follow-up plan is documented on the date of the positive screen
Developmental Screening Benchmark 74%	Percentage of children who were screened for risk of developmental, behavioral or social delays in the 12 months prior to eligible birthday. Developmental screening (ASQ) for kids < 3 years
Diabetic A1c Benchmark 16%	Percentage of patients age 18 to 75 with a diagnosis of Type I or Type II diabetes, whose hemoglobin A1c (HbA1c) was less than or equal to 9% at the time of the last reading in the measurement year.

Current Core Metrics (Cont.)

Measure	Definition
Effective Contraceptive Use Benchmark 50%	Percentage of women ages 15-50 years old who use effective contraceptive methods during the measurement year. Evidence of use may include surveillance of a contraceptive method as well as NDC prescription codes in addition to diagnosis and procedure codes.
HIV Linkage to Care Benchmark 100%	Percentage of newly diagnosed HIV patients who were seen for follow-up treatment within 90 days of the first-ever HIV diagnosis
HTN Control Benchmark 71%	% of patients 18-85 diagnosed with HTN with most recent blood pressure less than 140/90
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic Benchmark 79%	Patients age 18 and older with a diagnosis of Ischemic Vascular Disease (IVD) or Acute Myocardial Infarction (AMI), or who have had a Coronary Artery Bypass Graft (CABG) or Percutaneous Transluminal Coronary Angioplasty (PTCA) procedure, and received aspirin or another antithrombotic therapy.
Tobacco Screening Benchmark 86%	This section reports patients age 18 and older who were screened for tobacco use once or more during the measurement year or prior year and, for those who used tobacco, received a cessation counseling intervention or medication.
Urine drug screen for CS patients	% of patients on CS contract with UDS in last 6 months
Weight Screening for Adults Benchmark 63%	Percentage of patients 18-65 with their Body Mass Index (BMI) charted and, for patients who are overweight or underweight, a follow-up plan documented (<18.5 or >25). Adults who receive weight assessment and follow-up are more likely to achieve and maintain a healthy weight.
Weight Screening for Children Benchmark 63%	Percentage of patients patient age 3 to 17 (on or prior to December 31 of the measurement year) with a Body Mass Index (BMI) percentile documented, along with counseling on nutrition and physical activity during the measurement year.

How do population Metrics relate to clinical care?



Why is this important?

The Quadruple Aim

- Improving Patient Experience
- Improving Population Health
- Reducing Costs
- Improving Work Life of Health Care Providers.

Where do we stand now?

Measures by Location - Table View

Report Date: August 2018

Brief Measure Name	Display Goal	Improvement Target	Grand Total		
			Measure	Numerat..	Denomin..
Adult Weight Screening and Counseling	63% (UDS 2018)	Null	39.64%	4,621	11,657
Asthma Therapy	88% (UDS 2018)	Null	82.73%	412	498
CAD Lipid Therapy	80% (UDS 2018)	Null	71.10%	155	218
Cervical Cancer Screening	55% (UDS 2018)	Null	53.90%	3,010	5,584
Childhood Immunizations (UDS)	85% (Internal)	Null	59.75%	95	159
Childhood Weight Screening and Couns..	63% (UDS 2018)	Null	52.77%	2,019	3,826
Colorectal Cancer Screening (UDS)	47% (OHA 2015)	Null	36.95%	1,626	4,400
Dental Sealants (UDS)	Not Set	Null	34.25%	438	1,279
Depression Screening (UDS)	42% (UDS Goal)	Null	51.49%	6,275	12,187
DM A1C Good Control	81% (Internal)	Null	68.52%	1,049	1,531
HIV Linkages to Care	78% (UDS Goal)	Null	0.00%	0	1
HTN BP Control (UDS)	75% (Internal)	Null	71.56%	2,390	3,340
IVD Aspirin Therapy	79% (UDS 2018)	Null	77.07%	363	471
Low Birthweight Deliveries	8% (UDS 2018)	Null	6.08%	16	263
Tobacco Screening and Intervention	86% (UDS 2018)	Null	82.36%	6,988	8,485

Individual Provider Scorecards

Justin Adams, MD Quality Scorecard Measure	Benchmark	% achieved-June	% achieved-July	% achieved- Aug
Adolescent Well Visits	66%	57%	49%	45%
Asthma Therapy	88%	100%	100%	90%
Weight Screening for Adults	63%	66%	66%	67%
CAD	80%	85%	84%	83%
Cervical Cancer Screening	55%	57%	53%	52%
Fully Immunized by age 2	81%	50%	50%	0%
Childhood weight screening	63%		53%	62%
Colorectal Cancer Screening	54%	61%	61%	61%
Depression Screening	63%	54%	56%	57%
Developmental Screening age 3	74%	43%	43%	88%
Diabetic A1c	16%	25%	23%	18%
Effective Contraception Use				27%
Empanelment	90%	100%	100%	100%
HTN Control	75%	85%	83%	82%
IVD Aspirin Therapy	79%		89%	89%
SBIRT Screen	71%	89%	90%	91%
Tobacco Cessation	86%	87%	88%	87%

How do we move our metrics?

Understanding the Data and How to Move It

Metric Cheat Sheet			
Measure	**Benchmark**	**Definition**	**Teamlet**
Adolescent Well Visits	66%	Adolescents ages 12-21 years old that had at least one comprehensive well-care visit during the measurment year.	1. How to complete: Complete visit standards and documentation for WCC Visit using .xwell*** 2. How to improve: Flip sick visits into well care visits (modifier 25); Encourage Well Care Exams instead of Sports Physicals 3. Codes to use: CPT 99383-99385, 99393-99395; ICD-10 Z00.00, Z00.01, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9 "
Use of Appropriate medications for Asthma	88%	Percentage of patients 5-64 years of age with a diagnosis of persistent asthma and were appropriately ordered medication during the measurement period	"1. How to complete: Pt to have a Dx of persistent asthma in problem list, and appropriate medication for persistent asthma (long acting inhaler + rescue inhaler) 2. How to improve: Ensure pt does have correct dx in problem list (ex. no mildly persistent, etc) and ensure pt has long acting inhaler prescribed 3. Codes/Dx/Dotphrase to use: Persistent Asthma "

Questions? Comments? Ideas?

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