

October 17, 2019
*Data Driven Population
Health Management*

Population Health Learning Network

blue of california
foundation

 Dignity Health.



CHCF

PHLN Webinar Faculty



Megan O'Brien,
Senior Program
Manager,
CCI



Dr. Carolyn Shepherd,
Clinical Director



Jerry Lassa,
Data Metrics
Consultant

Webinar Reminders

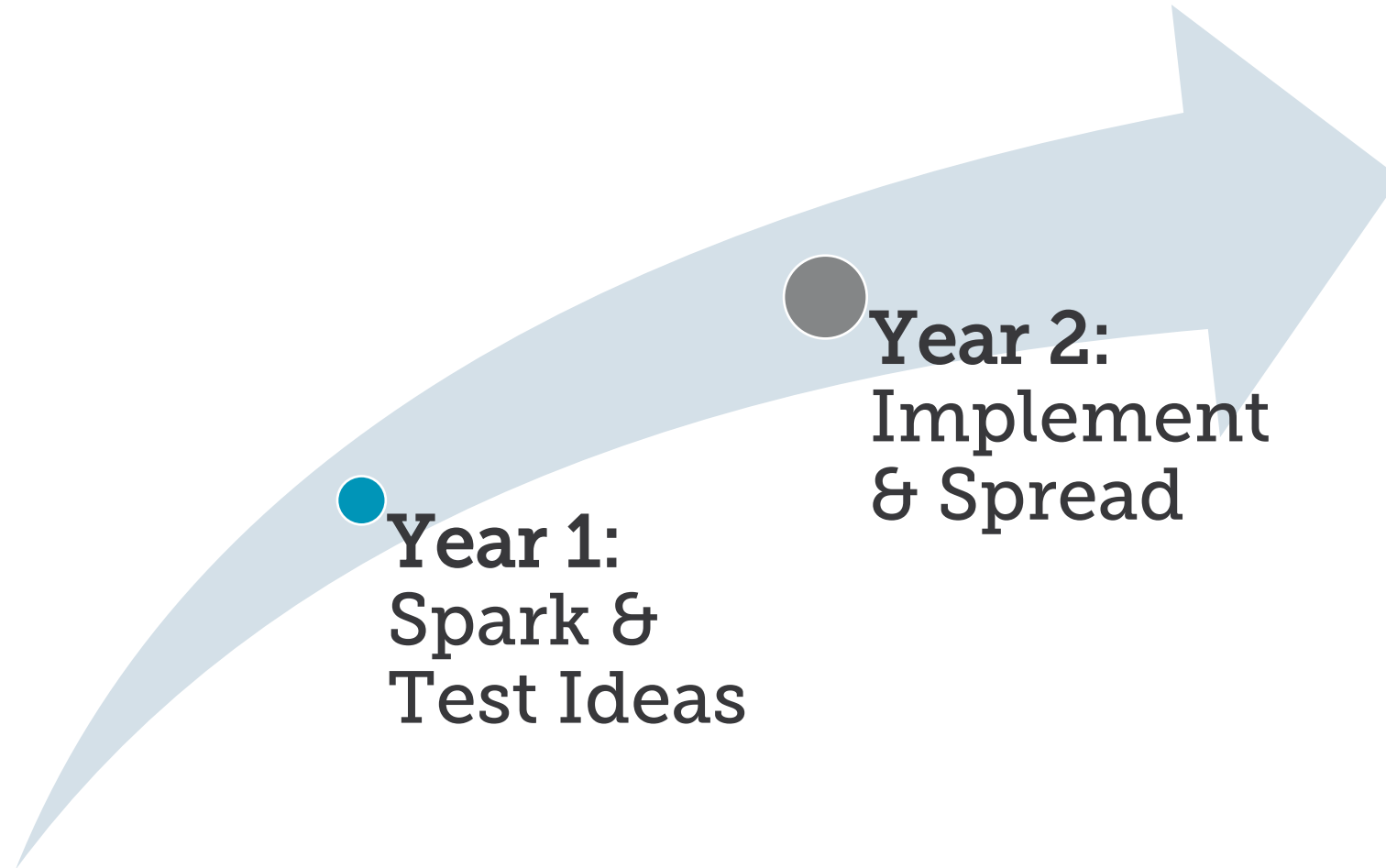
1. Everyone is muted.
 - **Press *6 to mute and unmute yourself.**
2. Remember to chat in questions along the way!
3. Webinar is being recorded and will be posted on CCI's website and sent out via email.



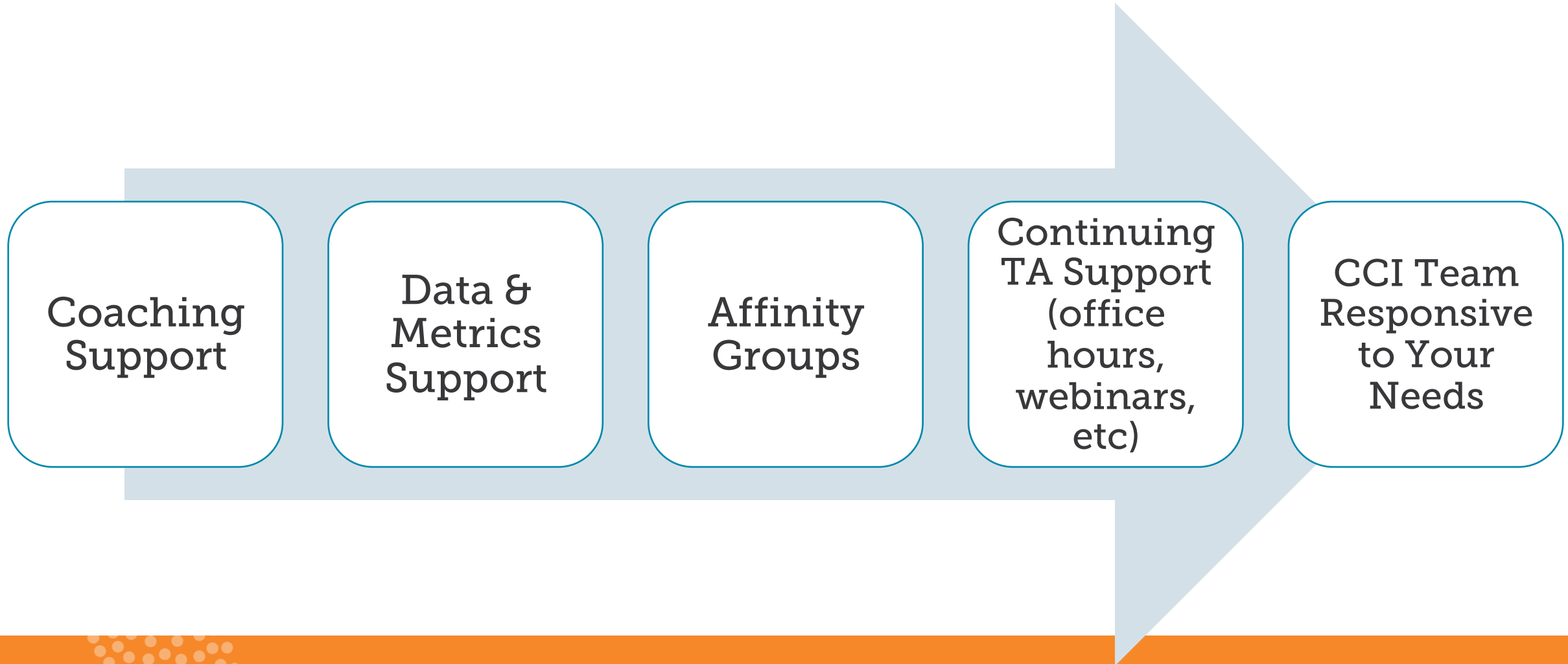
Today's Agenda

1. Welcome – Megan O'Brien
2. Overview of PHLN Measures & Metrics Examples – Jerry Lassa
3. PHLN Team Share – Community Medical Centers, Inc.
4. PHLN Team Share – Open Door Community Health Centers
5. PHLN Team Share – Salud Para La Gente
6. Q&A
7. What's Next?

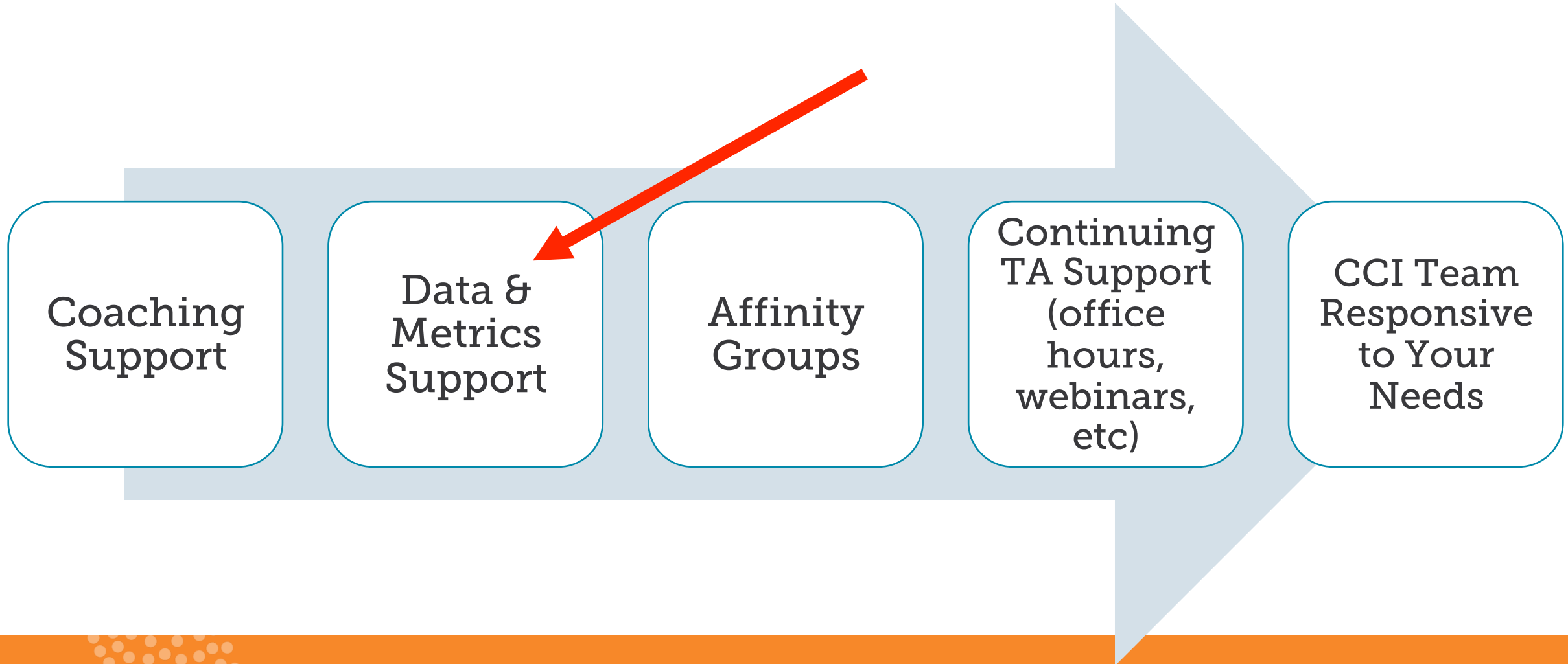
Our PHLN Destination



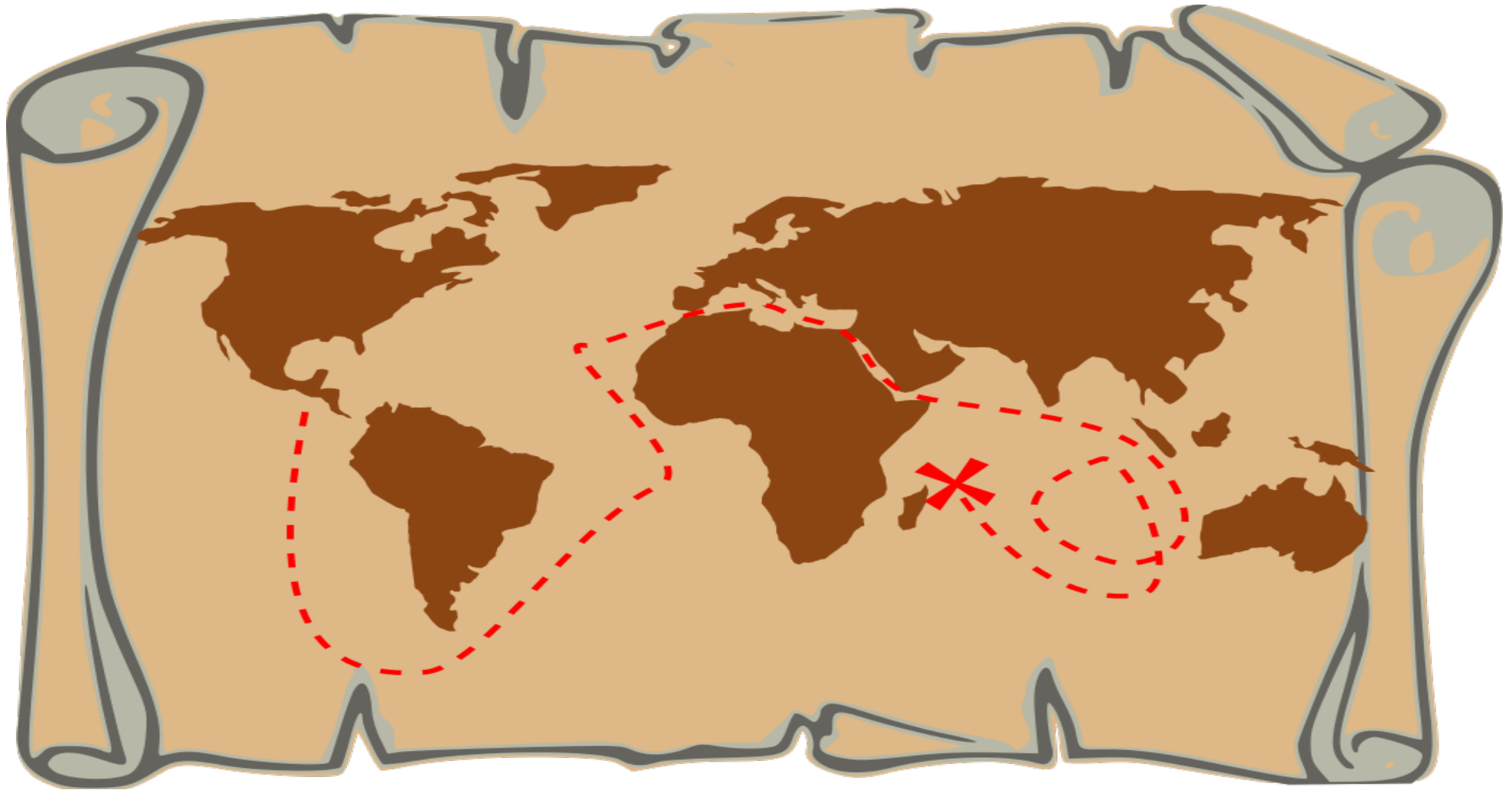
Setting You Up for Success in Year Two



Setting You Up for Success in Year Two



Your PHLN Metrics and Measurement Journey?



Poll 1: Your team's use of data and metrics to monitor interventions and impact improvement

- ☐ We hit it out of the ballpark
- ☐ We were fairly effective
- ☐ We struggled



Poll 2: We had challenges with...

(select all that apply)

- ☐ Resources to pull data (e.g., staff and/or expertise)
- ☐ Access to data (e.g., availability of system reports, change in system)
- ☐ Data quality
- ☐ Timeliness/frequency of data
- ☐ Metric definitions (e.g., had to clarify and/or revise)
- ☐ Goal setting (e.g., had to adjust)
- ☐ Use of data to drive improvement (e.g., PDSA cycles)



Your Metrics/Measures

- Process

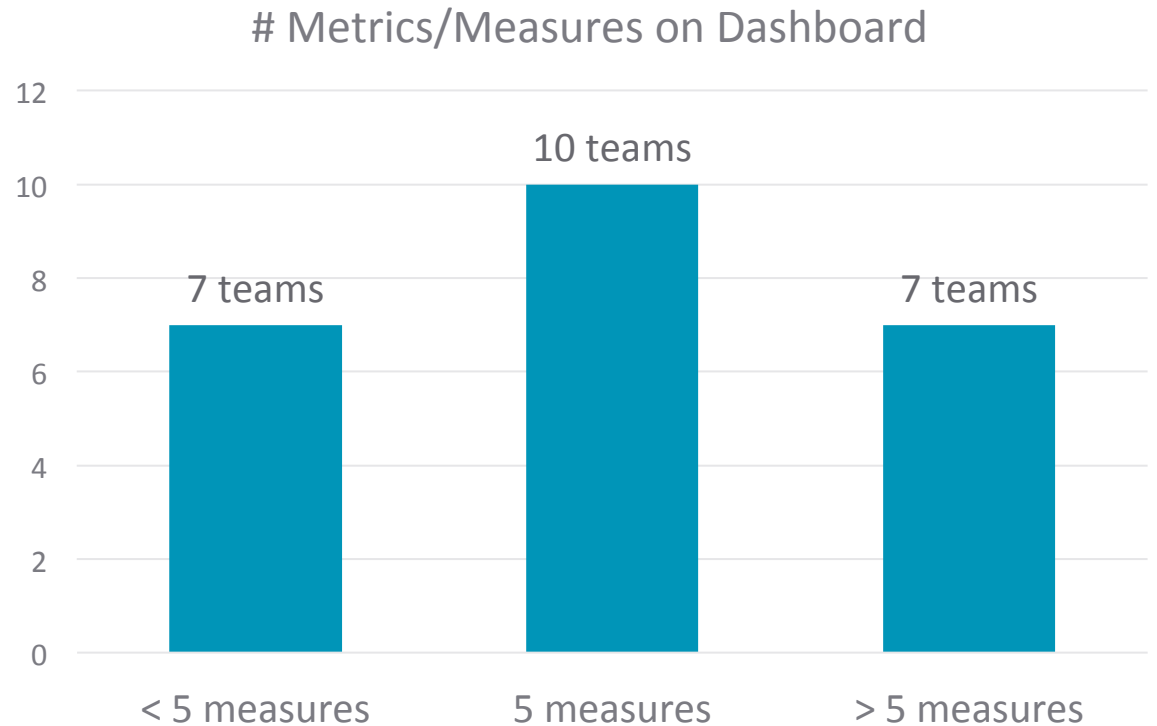
- #/% patients screened, assigned to risk tiers, in-outreached, Referred to BH
- #/% patients linked, with services offered/administered, scheduled for appointment, Followed-up
- Other - No show rate, TNAA

- Outcome

- Health outcomes/QIP measures
- Patient experience
- Staff satisfaction

134
Metrics/Measures
All teams

 ~23%
Improving
as of 7/31



Data and Measurement - PHLN Teams

Examples shared on the Forum

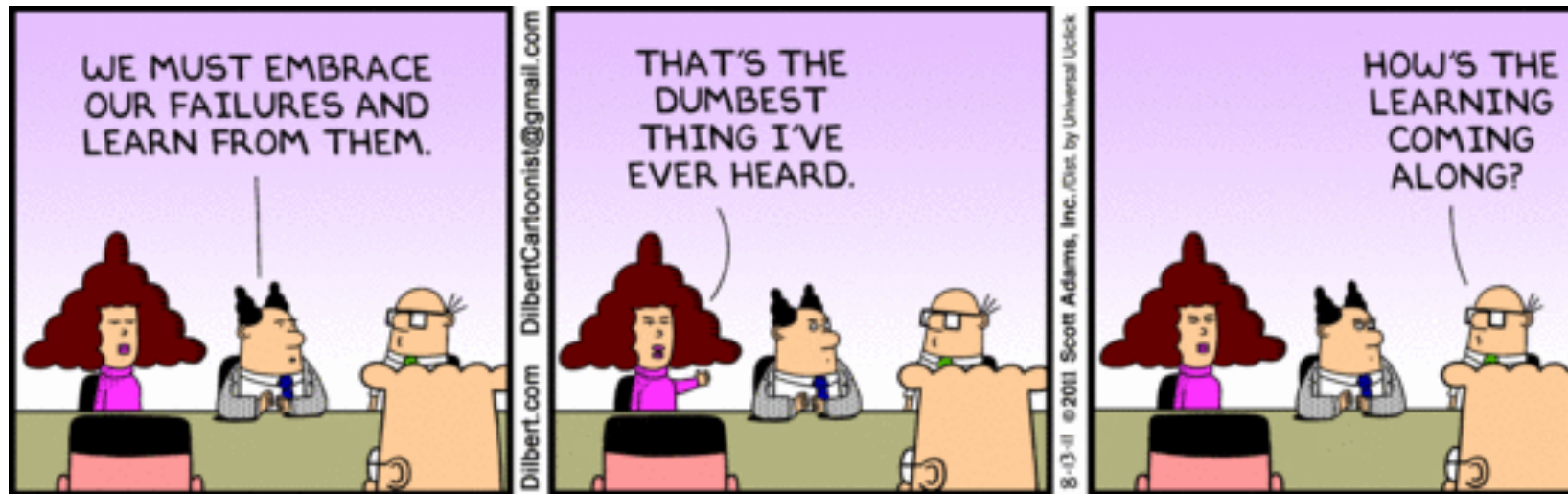
Topic	Team Approach
Data Collection	<ul style="list-style-type: none">- CommuniCare, Santa Rosa implemented PRAPARE Smart Form in eCW. Since form has structured data, can easily report on SDOH screenings.- Neighborhood created structured notes in eCW (easy to do). Aggregate data streams daily up to an org-wide dashboard.
Data Quality	<ul style="list-style-type: none">- Tri-City issue with child IZ outreach based on HEDIS Gap in Care report (Tableau via consortium). To meet HPL, need 3 pts to complete IZ, yet only 6 qualified for measure.- Axis had similar issue (e.g., had a pt that relocated or is seeing a PCP outside of their clinic). Were advised to reach out to the patient(s) and request they notify their payer of the update. This seems to be the only way for the patient to drop off from Gap In Care report but not many patients notify payer and end up in measure denom. and are labeled as “not actionable.”

Data and Measurement - PHLN Teams

Examples shared on the Forum

Topic	Team Approach
Measurement	<ul style="list-style-type: none">- Open Door shared that HRSA is adding a BH metric in 2020 called Managing Depression to Remission. The general description is: The percentage of adol. pts. 12-17 yo and adult pts. 18+ yo with PHQ9 > 9 who reached remission (PHQ9 <5) within 12 mos (+/- 60 days) of initial PHQ9. There are various exclusions, as well.
Using Data for Targeted In-Reach	<ul style="list-style-type: none">- Santa Rosa ran report for patients with A1c > 9 and no insurance. Report went to enrollers, who got in touch with patients to enroll in PRUCOL Medi-Cal. Patients can now afford diabetic medications and adhere to care plans.
PDSA Cycles	<ul style="list-style-type: none">- LA LGBT, Tri City shared approach for Patient FIT Kit Pilot to improve CCS.- SPLG testing improvement for obesity counseling.

Keep up the momentum!



- Revisit metrics/measures for final stretch as needed
- Continue to PDSA data management approach
- Leverage data resources for priority measurement needs
- Align PHLN metrics/measures with operations reports

Spotlight on...



CMC **Open Door** **SPLG**



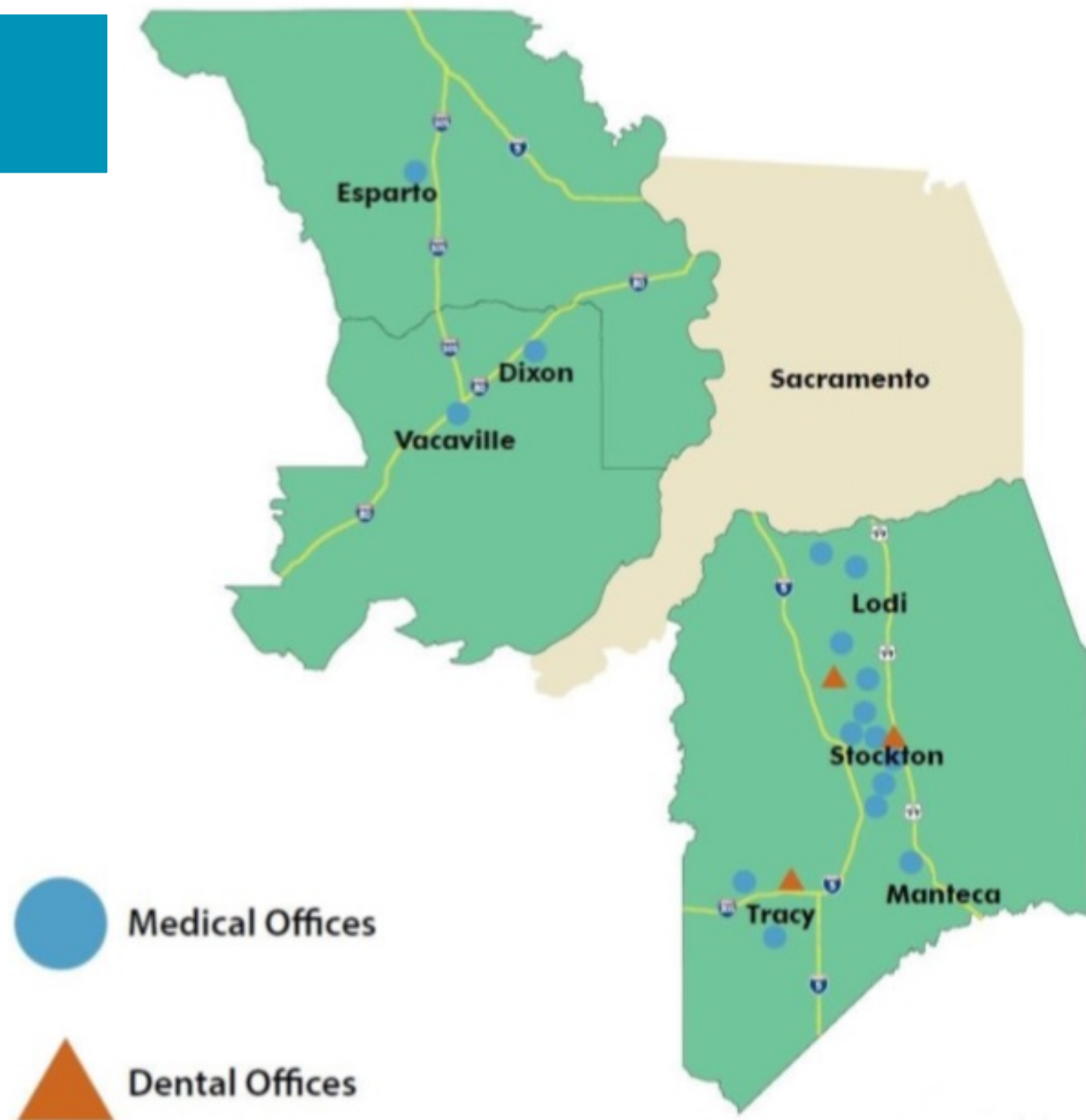


Community Medical Centers



Who We Are

- San Joaquin, Solano, & Yolo Counties
- Medical, Dental, & Behavioral Health
- 21 Locations in 7 Cities
- Patient Members
 - Medi-Cal: 81%
 - Uninsured: 15%
 - Medicare: 5%
- Hispanic 67%, Asian 13%, White 13%, African American 7%
- Next Gen & i2i Patient Registry





PHLN Team Spotlight

Case Studies in Effective Use of Data for Improvement

Health Center	Community Medical Centers, Inc.
Project	Service Delivery to a Higher Percentage of Our Assigned Membership Consistent With Organization's Mission
Affinity Group	Access Affinity Group
Project Goals	Increase the percentage of assigned members seen



Improving percentage of assigned members seen



- During 2018, CMC provided one or more health care services to 68.6% of assigned membership with our largest Medi-Cal Managed Care plan, the Health Plan of San Joaquin (HPSJ). Our goal is to increase that percentage to a 80% by December 31, 2019. In 2018, although we dedicated resources equivalent to 3.0 FTEs, divided among 10 different staff, to outreaching and tracking our results, we did not meet our expectation of what improvements we would like to have achieved due to a number of barriers that have been partially overcome.

Outcome:

- As of June 30, 2019, Health Plan of San Joaquin has told us we have seen 54.5% of assigned members
- We have established a new health based roster management system, **eMedApps Enrollment Manager**, with automated filtering and tracking capabilities, which shows we have seen 55.7% percent of assigned Health Plan of San Joaquin members within the last 12 months



Results



Enrollment Manager Member Processing

File Source: ⓘ

Panel Control: ⌵ Toggle ⬆️ ↺ Cycle ⬇️

Member Statistics ⓘ



Members by Current Status

Total: 66906

Status	Count
EM_Active Member	37299
EM_New Enrollment	2417
EM_No Contact From Member	30
EM_Not Engaged	26237
EM_Scheduled Member	922
EM_Termed Member	1

File Processing Status

Processed Date	Total	Added	Existing	Exceptions	Termed
09/16/19 9:47:23 AM	75128	586	58905	15637	0
08/07/19 11:17:18 PM	6707	111	5457	1139	0
08/01/19 8:07:12 PM	61090	1507	47224	12359	0
06/05/19 9:35:26 PM	61809	540	49602	11667	0

Takeaways



	What worked (successes)	What didn't work (lessons learned)
People-related	<p>Staff now have a software tool to document our Population Health Outreach efforts.</p> <p>Management can readily see results.</p> <p>We developed an interdisciplinary team to evaluate results and outcomes which meets biweekly and supports other CMC initiatives.</p> <p>Current focus has been on new membership; CMC can choose to expand this focus once resources are available.</p>	<p>We had two false starts on the implementation of the Enrollment Manager roster program.</p> <p>Staff were trained and had to be retrained.</p> <p>Still have fragmentation in dedicated resources.</p> <p>Need to implement good feedback loops for staff who work on the project.</p>

Takeaways Continued



	What worked (successes)	What didn't work (lessons learned)
Process-related	<p>Monthly download of member roster from the health plan(s), then our Applications Dept. uploads into the actual Enrollment Manager roster program.</p> <p>Effective staff documentation tools now in place.</p> <p>The generation of lists for Welcome Letters still requires some manual intervention separate from Enrollment Manager.</p> <p>Training materials on using the roster product have been developed by our Applications Dept.</p> <p>Our Outreach Team can filter the membership and no longer have to contact members who have already scheduled an appointment for services.</p>	<p>100% of membership data is not part of data denominator for these reasons: There has to be manual matching of roster data, over 10% (8,000+ members) are not currently included in our data due to not having similar elements to be auto matched by the program. This influences our results and outcomes.</p> <p>78% of our overall CMC enrollment is now integrated into this Roster program. Two other health plans will be mapped in the future to this new process, and once that has been accomplished, then 92% of CMC assigned membership will be able to be monitored and worked.</p> <p>Related to our Welcome Letter, our positive response rate (new member scheduling and keeping an appointment) has been less than 3% on a monthly basis – this has been manually tracked.</p> <p>With this new Enrollment Manager roster we will be able to do follow up contacts beyond the Welcome Letter.</p>

Takeaways Continued



	What worked (successes)	What didn't work (lessons learned)
Technology-related	Our primary health plan (HPSJ) is part of this program. Other health plans will be mapped to the new Enrollment Manager roster process within a few weeks.	There were challenges with getting the other health plan membership listings in the correct format needed for proper upload into the roster program.





Next Steps

- Add 2 new health plans to the Enrollment Manager roster process, bringing our total participating percentage to 92%.
- Matching of Health Plan Roster members program, evaluate more automated options each month.
- Develop new strategies & technologies for engaging with new as well as established members – Text message campaign outreach
- Use the Enrollment Manager roster tool to understand why members leave CMC, by reaching out to those members, if they retained coverage, but are now with different organizations.
- Utilize the Enrollment Manager to facilitate appointments to improve HEDIS outcomes.



Open Door Community Health Centers

Who Are We?

- FQHC serving Humboldt and Del Norte Counties, on the far northwest coast
- 56,000 Patients seen in 2018
- 10 Family Practice Clinics plus 1 Medical Van, 3 Dental Clinics plus 1 Dental Van, and 1 OB Clinic
- EHR system is OCHIN Epic



Year 2 Project Overview

- Behavioral Health Integration with a goal of implementing evidence-based depression management.

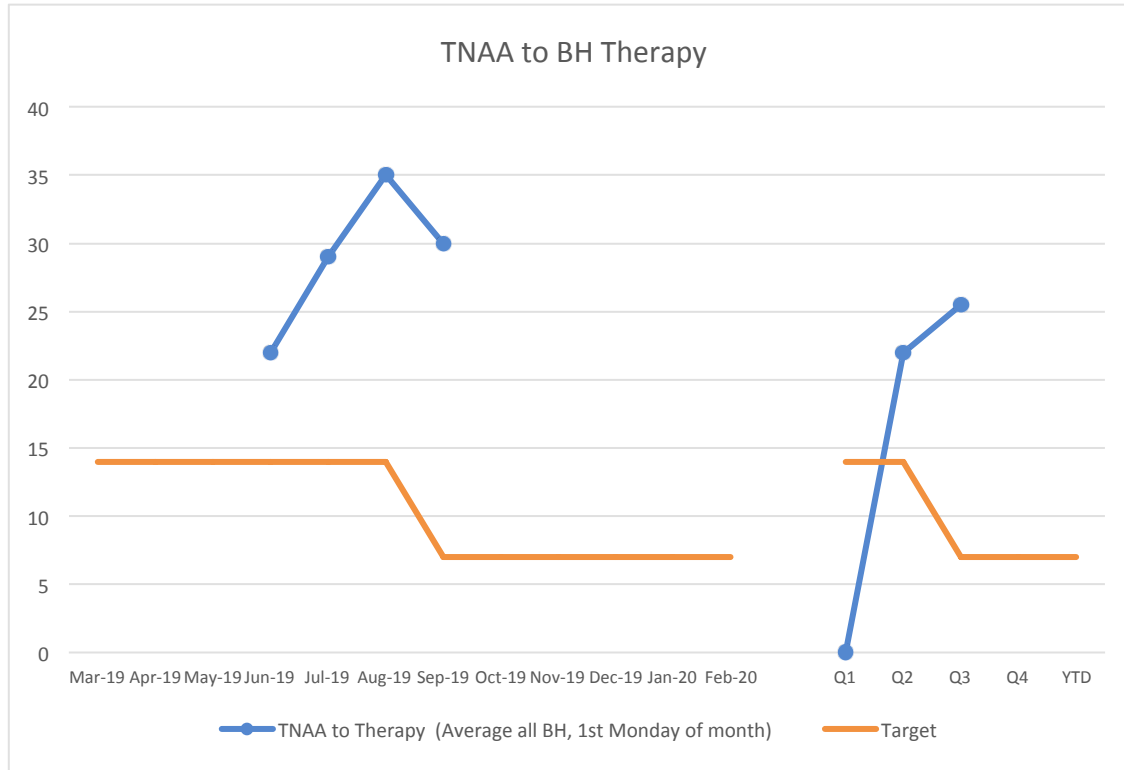
Process: Identify patients with a PHQ9 score ≥ 20 seen in the prior week.

- Share a weekly list with the BH provider on the patient's care team.
- BH provider reviews the patient's chart looking for a depression care plan.
- BH Providers fill care gaps and give feedback to care team as needed.

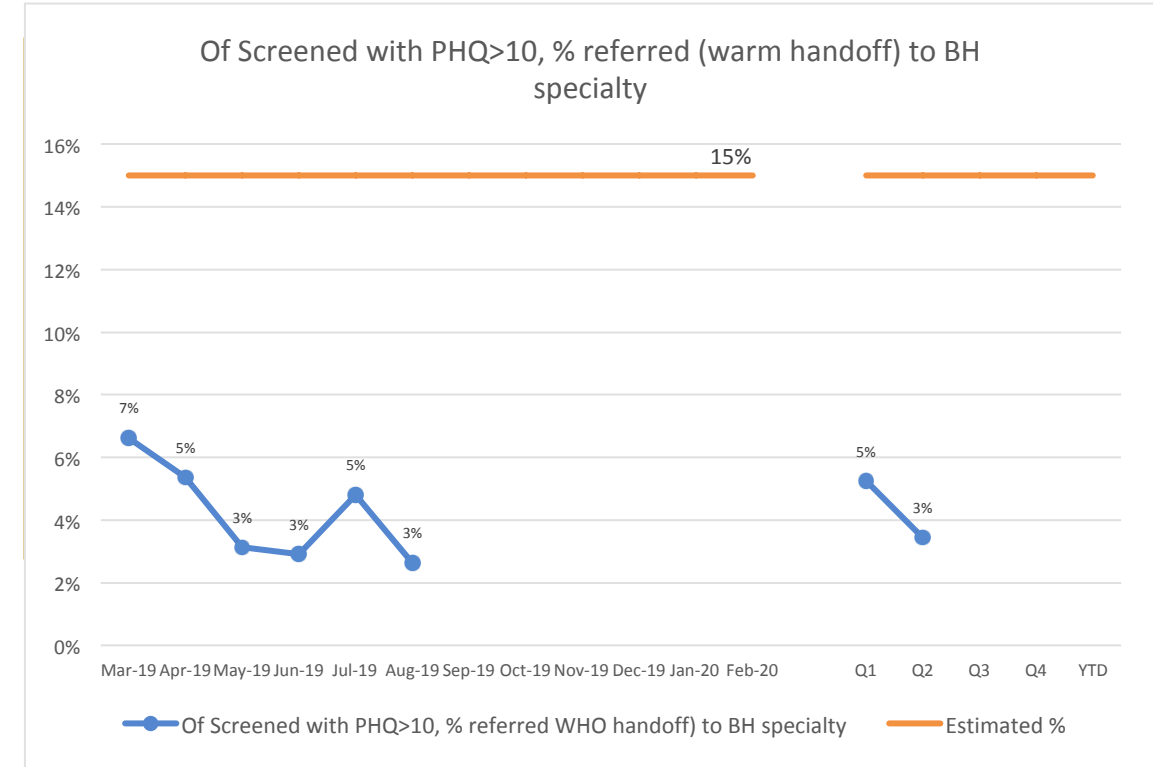
Outcome: The patient's severe depression was addressed in the visit most of the time.

- $>70\%$ of patients were already connected with a therapist and/or were on anti-depressants.
- $<10\%$ of patient's depression was not addressed because the result was not entered in the chart and/or the provider did not notice it during the visit.
- The need for good communication between care team members was made clear.

Results



- TNAA was not calculated for BH Providers until June 2019.



- There are fewer warm handoffs for patients with a positive PHQ9 than expected.

Takeaways

	What worked (successes)	What didn't work (lessons learned)
People-related	90% of BH providers were willing and able to complete the chart reviews. They also found it useful and clinically important work.	10% of the BH providers were unwilling/unable to review charts so QI department staff is reviewing those patient's charts and referring questions to a designated BH provider.
Process-related	The process has been rolled out to all sites.	BH providers
Technology-related	Reports were developed to identify patients with a PHQ9 ≥ 20 .	The reports don't filter out patients already connected with a BH provider or was on anti-depressants.

- BH-Medical provider data integration showed good potential.

- BH workflows and data collection lack consistency.



Next Steps

In the next few months:

- Train Medical Assistants on the importance of entering the PHQ9 before the provider enters the room and/or communicating the score if it's over 10.
- Add the patient's outside BH therapist information as a provider on their Care Team.
- Pilot post-visit chart reviews and medication follow-up calls with MFT interns.
- Re-survey BH Providers about their relationship with the Care Teams.

In 2020:

- Increase the post-visit chart review to include patients with a PHQ9 over 15 (rather than over 20).
- Leverage use of the Depression Registry.
- Learn and implement best practices for treating to remission.

Salud Para La Gente

Working Together for a Healthy Community



Salud Para La Gente

Who We Are

- Founded in 1978 as a single free clinic offering healthcare primarily to farmworkers living and working on California's Central Coast (Santa Cruz County & North Monterey County)
- Became a Federally Qualified Health Center in 1995
- 11 sites of which five are clinics and six are school-based health centers.
- 93 providers serving ~27,000 patients, 75% of whom are non-English speaking
- EHR system: Greenway Intergrity EHR



Year 2 Project Overview



- Project Description & Goal: Improve data transparency by developing population health reports for care teams to take action on regarding measures aligned with the organization's strategic goals.
- We will start by improving one preventive screening measure (colorectal cancer screening) as an example.
 - Process measure: By 3/5/19, develop monthly reports on colorectal cancer screening data at several levels: agency-wide data; by Care Team pods; and by individual provider.
 - Outcome measure: To improve organizational performance on UDS measures, Salud Para La Gente will improve colorectal cancer screening from 41% up to 55% by 12/31/19.

Results: Process Measure

CRC SCREENING DATA BY POD: CDV

Screening Rate		
Numerator	Denominator	%
86	243	35%
189	328	58%
253	407	62%

Ordering Rate		
Numerator	Denominator	%
125	243	51%
235	328	72%
290	407	71%

Providers by Pod

Wolbers	Esparza
Smith	
Bui-Duy	
Aleman	Steiny
	Contini
Coldwater	Harlamoff
	Ruiz-Ruelas

How many more pts to meet agency goal?
48
0
0

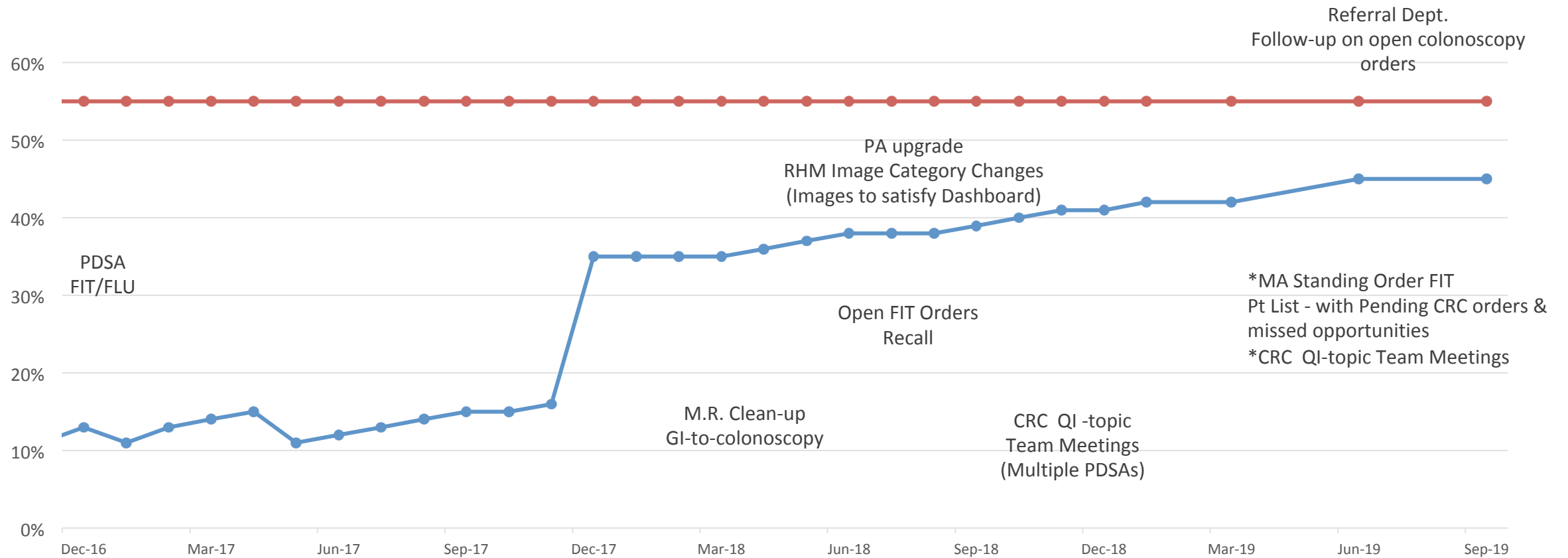
Reporting Methodology:
Reporting period: 12 Months (2/23/2018-2/22/2019)
Age Criteria: Patients aged 50-75 years old

- An example of data shared by pod during team meeting
- Providers appreciated knowing ordering vs screening (completion) rate
- Humanizing the numbers—very helpful, especially paired with patient-specific lists of those who didn't have screening ordered yet

Results: Outcome Measure



Colorectal Cancer Screening



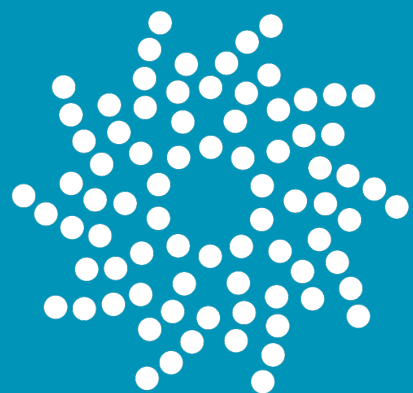
Takeaways



	What worked (successes)	What didn't work (lessons learned)
People-related	<ul style="list-style-type: none"> - Population Health Analyst as our data point person: tracking data, creating reports using consistent methodology including: <i>"How many patients needed to achieve agency goal?"</i> - Creating care team pods allowed us to present more specific data 	<ul style="list-style-type: none"> - Running 6 PDSAs at the same time generates a lot of data for a small reporting team of 2! - Operational support is key to help execute and follow-up on PDSAs—Family Practice does not yet have a Program Manager
Process-related	<ul style="list-style-type: none"> - Used team meetings to structure PDSA cycles 	<ul style="list-style-type: none"> - Limited accountability to staff involved b/c there was little to no follow-up due to lack of bandwidth and operational support
Technology-related	<ul style="list-style-type: none"> - We had to merge several reports together to create actionable data that we present at team meetings - Practice Analytics gives us baseline numbers, then we fine-tune further 	<ul style="list-style-type: none"> - Small details matter: if Med Records doesn't label colonoscopy image with correct attributes, it does not "count" in our dashboard - Not all of our systems align: our Dashboard runs independent of our Health Reminders

Next Steps

- Currently planning QI for 2020
- Will try to limit to 1 PDSA per site/departament
- Continue to fine-tune data: the role of “non-established” patients & engaging them in primary care
- Discussing how to visually present data to front-line staff (providers & support staff)
 - Individual provider reports on paper? Bulletin boards updated monthly with QI progress?
 - Long-term plan: create a home-grown data warehouse to customize reports and allow users to generate specific reports for ideal data transparency



CCI

CENTER FOR CARE
INNOVATIONS

Questions?



December Convening

Location, Objectives, Faculty, & Pre-Work



Location & Details

When/Where

- Thursday, December 5 from 8:30am-6pm (includes happy hour & networking from 5-6pm)
- Hilton Oakland Airport Hotel
- **Register at:**
<https://www.eventbrite.com/e/population-health-learning-network-session-3-tickets-69769397145>

Who Should Attend

- Each organization should plan to send the core team participating in the PHLN network.
- Due to the size of the cohort, we are asking that each organization limit their attendance to five team members.

Session Objectives

By the end of the learning session, you will have:

1. Connected with peers to advance your population health management capabilities **by sharing best practices and lessons learned** across PHLN domains.
2. Strengthened your year two projects by **infusing new ways of thinking and problem-solving challenges** through peer dialogue and exchange.
3. Moved from experimentation and testing to **building a culture around population health management**.
4. Identified key steps for **sustaining and spreading** population health capabilities throughout your organization.



Highlights:

- Sharing Lessons Learned from the PHLN: Storyboard Galley
- FishBowl Activity: Building a Culture around Population Management
- Affinity Groups: In-Person Time
- Sustaining Population Health Activities Beyond the PHLN
- PHLN Connections: Virtual Site Visits
- Celebratory Happy Hour & Continued Networking

Key Faculty



CCI will be reaching out to your teams to make requests for you to share during the December convening.

What's Next?

Check out the PHLN Program Website for Details and Links

Team To-Dos

- ❑ Due Oct. 30: Progress Report
- ❑ By Nov. 8: Register for December In-Person Learning Session
- ❑ Due Nov. 22: Team Storyboard Slides for Learning Session – *more details and template to come soon!*

PHLN Learning Events

- ❑ Nov. 12, 12-1pm: Change Management Webinar
- ❑ Dec. 5, 8:30am-5pm: In-Person Learning Session
- ❑ Coaching: Through the end of January 2020

<https://www.careinnovations.org/phln-portal/activities/>





Thank you!

For questions contact:

Megan O'Brien
Senior Program Manager, Value-Based Care
Center for Care Innovations
mobrien@careinnovations.org

Jerry Lassa
Metrics Advisor
Data Matt3rs
jerry.lassa@datamatt3rs.com