Integrating Population Health Management into Primary Care
Planned Care Infrastructure

**In-Reach**
- In-Reach Workflow (i.e. planned care activities that occur the day of the visit)
  - Daily Huddles
  - Patient check in
  - Encounter visit

**Outreach**
- Outreach Workflow (i.e. planned care activities that occur in between visits)
  - Phone calls to patients
  - Letters to patients
  - Secure emails
  - Text messages

**Planned Care Meeting (PCM)**
- Weekly gathering of a primary care team to review population health registries and assign planned care interventions among the care team members
Dual Strategy: In-reach and Outreach

- *Integration of Population Health into the work adds incredible power*
- *This strategy is what we use across all of Primary Care now at Cambridge Health Alliance*
- *Huddles help organize the work of the day when the team sees patients*
- *Team Meetings happen weekly to think about and organize the work around patients who are NOT coming in and make sure they are also getting the care they need*
- *This is a paradigm shift*
- *This new work needs to be funded and new team roles need to be created*
In Between Visits

Team meetings

Outreach

- Tracking registries eg. mammo, colon screenings, HTN
- Every team member has a “panel”

Follow up and care coordination with provider guidance

Provide appropriate patient education
Planned Care Meetings

• PCM Objective: provide care at a panel level
• Meetings are meant to review a panel of patients, not 1-2 patients
• Coordinated development of action plans by care teams for targeted patient cohorts; some actions include:
  – Send a staff message to remind a team member to schedule a visit with PCP, PA, RN, BH, Pharmacy, LPN, etc.
  – Phone call to update PHQ-9, care plan, ADHD check-in
  – Perform a change in medications
  – Update HM, problem list, etc.
  – Perform a referral to CCM, Specialty, community resources, etc.
  – patient attribution and panel management
• Recommended PCMs typically occur weekly and last 30 mins.

<table>
<thead>
<tr>
<th></th>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer Screening &amp;</td>
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<tr>
<td>Follow Up</td>
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<tr>
<td>Diabetes &amp; Hypertension</td>
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<td>Complex Care</td>
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<td>Depression</td>
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<td>Complex Care</td>
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</tbody>
</table>
PCM Sample Workflow: Diabetes

**Before PCM**
- MAs identify/review patients who need A1c tests
- RNs identify/review patients with high A1c
- PCP identify/review patients who require care plans

**At PCM**
- Care team meets to review DM patients
- Team agrees on patients who require outreach for tests, A1c follow ups, or care plans
- Snapshot, HM, etc. updated as needed
- Team reviews quality dashboard

**After PCM**
- Teams deploy actions agreed during PCM
  - Schedule a visit
  - Phone encounter to update a care plan, PHQ-9, etc.
  - Change medications
  - Process referrals
  - Etc.
- OPCC monitors and supports team

**Epic Report Used:**
My Loc Pts w/ Diabetes

**Operational Strategy:**
- Agree on care actions for patients in need
- Deploy & monitor planned care actions
### PCM Sample Workflow: Hypertension

**Before PCM**
- **MAs** identify/review patients who need a **BP test**
- **RNs** identify/review patients with **high BP**

**At PCM**
- Care team meets to review **HTN patients**
  - Team agrees on patients who require outreach for tests, BP follow ups, or other
  - Snapshot, HM, etc. updated as needed
  - Team reviews quality dashboard

**After PCM**
- Teams deploy actions agreed during PCM
  - Schedule a visit
  - Phone encounter to update a care plan, PHQ-9, etc.
  - Change medications
  - Process referrals
  - Etc.
- **OPCC** monitors and supports team

**Epic Report Used:**
*My Loc Pts w/ Hypertension*

**Operational Strategy:**
- **Agree on care actions for patients in need**
- **Deploy & monitor planned care actions**
Operational Strategy:
- Deploy & monitor planned care actions

Operational Strategy:
- Agree on care actions for patients in need

Operational Strategy:
- Deploy & monitor planned care actions

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### PCM Sample Workflow: CCM

#### Before PCM
- CCM identify/review pipeline of CCM patients

#### At PCM
- Care team meets to discuss CCM patients
- CCM reviews pipeline:
  - Pts. referred to CCM
  - Pts. in CCM care
  - Pts. soon to be discharged from CCM
  - Pts. at risk who yet to be referred to CCM
  - Etc.

#### After PCM
- Teams deploy actions agreed during PCM
  - Schedule a visit
  - Phone encounter to update a care plan, PHQ-9, etc.
  - Change medications
  - Process referrals
  - Etc.

**CCM monitors and supports team**

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**Epic Report Used:**
- My Loc Pts w/ CCM - Active
Planned Care; Meeting Participants & Outreach Flow (draft) Sabrina G. Losandie 10/07/15

**Diabetes**
- Outreach by: MA 1
  * A1C > 8 and above = RN
- MD
- PA
- RN
- MA: 1
- Pharmacy
- PMR: WCC outreach

**Depression**
- Outreach by: RN & BH care partner
- MD
- PA
- RN
- BH care partner
- *RN & BH care partner meet weekly
- MA: outreach admin time
- PMR: WCC outreach

**Hypertension**
- Outreach by: MA 2a
  * BP 140/30 and above = RN
- MD
- PA
- RN
- MA 2a
- Pharmacy
- PMR: WCC outreach

**Immunizations**
- Outreach done by: LPN & RN
- MD
- PA
- RN
- MA 2a
- Pharmacy
- PMR: WCC outreach

**Asthma/ADHD**
- Outreach by: MA 2a
  * Care plan needed = RN
- MD
- PA
- RN
- MA 2a
- PMR: WCC outreach
- *Asthma list for pedi ready
- *Asthma adult list needed

**Well Child**
- Outreach by: PMR
- MD
- PA
- RN
- MA: outreach admin time
- PMR: WCC outreach

**Routine/Abnormal MAMMOs**
- Outreach by: MA 1
- MD
- PA
- RN
- MA 1
- PMR: WCC outreach

**Routine/Abnormal COLONs**
- Outreach by: MA 2b
  * Team based outreach
- MD
- PA
- RN
- MA 1
- PMR: WCC outreach

**Routine/Abnormal PAPs**
- Outreach by: MA 2a
  * Team based outreach
- MD
- PA
- RN
- MA 2a
- PMR: WCC outreach

**Controlled Substances & Watch List & CCM**
- Outreach by: RN
- MD
- PA
- RN
- Pharmacy
- MA: outreach admin time
- PMR: WCC outreach

*All information is subject to change
*Temporary site receptionists will perform outreach to previous USFH providers; patient reassigned to another USFH PCP and cleaning up and clearing data in RWB
Tools

IT platform is EPIC with integrated registries
Additional reporting available monthly with metrics by PCP team at each site across the entire organization

Expectation is that these are used by the teams to manage their outreaches and care manage their panel to goal
Outreach is onerous in our population, with phone numbers and addresses (and country!) changing frequently
The Shared Care Plan

My Care Plan:

1. My goals to improve my health: ***

2. My healthcare team's goals: ***

3. My strengths and supports to meet my goals: ***

4. Challenges to meeting my goals: {BARRIERS FOR BRIEF CARE PLAN:16120::"need more support"}

5. My healthcare team: ***


7. My confidence that I can follow my Action Plan: {Numbers; 1-10:17898}
Health Maintenance

<table>
<thead>
<tr>
<th>Topic</th>
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<tbody>
<tr>
<td>TETANUS (16 AND OVER)</td>
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<tr>
<td>LIPID SCREENING</td>
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<tr>
<td>HEP B HIGH RISK VACCINE EVAL (ONCE)</td>
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<tr>
<td>PHQ-9</td>
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<tr>
<td>AWQ Questionnaire</td>
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<td>PAP SMEAR</td>
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<tr>
<td>HPV SCREENING</td>
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<tr>
<td>PHYSICAL EXAM (AGE 40-49)</td>
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<td>MAMMOGRAPHY 9/8/2014 (DISCU.) 1/29/2016 (APPT...)</td>
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<tr>
<td>ABNORMAL RAD RESULT 1 YR F/U 4/1/2015 (APPT...)</td>
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<tr>
<td>HEALTH CARE PROXY 6/9/2020</td>
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<tr>
<td>HIV SCREENING 7/31/2014 (NOT...)</td>
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</tbody>
</table>

TO-DO list for the patient's health care
EPIC Diabetes Registry: Reporting Workbench

★ REAL TIME!!!

★ ONE report with all the information you would need!!!

★ Reporting Workbench is in EPIC, you can go directly into the chart by clicking on the patient once and then clicking.

★ MORE detailed information can be found here!!!
How do we sustain the team-based model of care?

- Engaged Leadership who provides consistent messaging
- Strong Team relationship
- Consistent team scheduling
- Communication across team members
- Regular meetings
- Well defined roles/expectations
- Celebrations/accomplishments
Continuous Staff Training

Individual

Team/Organizational

○ Team time moments: Huddles and team meetings
○ Grand Rounds
○ Annual Competency and skills review
○ New Initiatives
○ IT upgrades
<table>
<thead>
<tr>
<th>Introduction to Team Based Care</th>
<th>What is a team</th>
<th>Roles of Team Members</th>
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<tr>
<td>• Introduction to Team Based Care 1.0</td>
<td>• Teamwork with 1.0 (all pages)</td>
<td>• Roles of Team Members 2.0</td>
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<tr>
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<td>• Getting Started Forming Teams 1.0</td>
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<tr>
<th>Previsit</th>
<th>Visit</th>
<th>Post or Between Visit</th>
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</thead>
<tbody>
<tr>
<td>• Ambulatory Visit Forms 1.0</td>
<td>• Day of visit 1.0</td>
<td>• Between visit 1.0</td>
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<tr>
<td>• How to Access the Daily Med List 1.0</td>
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<tr>
<td>• Previsit Pocket 1.0</td>
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<tr>
<td>• Previsit 1.0</td>
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<thead>
<tr>
<th>Care Plans</th>
<th>Planned Care</th>
<th>Hospital and ED Discharge Follow up</th>
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<tbody>
<tr>
<td>• Care Plan Training 2.0</td>
<td>• Planned Care Meeting Guide 2.0</td>
<td>• Hospital Discharge 2.0</td>
</tr>
<tr>
<td>• Why Make Care Plans 2.0</td>
<td></td>
<td>• Hospital Discharge 3.0</td>
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<td>• Updating Care Plans 2.0</td>
<td></td>
<td>• ED and Discharge Follow up Letter</td>
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<td>• Care Plans FAQ 2.0</td>
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<thead>
<tr>
<th>Chronic Disease Management</th>
<th>Complex Care Management</th>
<th>Huddles</th>
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</thead>
<tbody>
<tr>
<td>• Chronic Disease Management 1.0</td>
<td>• Complex Care Program 2.0</td>
<td>• Huddles 1.0 (all pages)</td>
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<tr>
<td>• Diabetes Chronic Care Management 1.0</td>
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<td>• What is the difference between a huddle and team meeting 1.0</td>
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<td></td>
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<td>• Huddle Strategies and Checklist 1.0</td>
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<td>• Huddle Care Plan for today 1.0</td>
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<td>• Huddle Assessment Tool</td>
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<td>• Huddle Assessment Tool 1.0</td>
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<td>• Huddle Evaluation Checklist for Leadership 1.0</td>
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<tr>
<th>Dealing with Different People</th>
<th>Appendix</th>
<th>Care Team Training 1.0</th>
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<tbody>
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<td>• Dealing with Different Types of People 1.0</td>
<td>• Appendix 1.0</td>
<td>• Building Teams in Primary Care Toolkit 1.0</td>
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Welcome to your wiki library!
You can get started and add content to this page by clicking Edit at the top of this page, or you can learn more about wiki libraries by clicking How To Use This Library.

What is a wiki library?
WikiWiki means quick in Hawaiian. A wiki library is a document library in which users can easily add any page. The library grows organically by linking existing pages together or by creating links to new pages. If a user finds a link to an uncategorized page, he or she can follow the link and create the page.

In business environments, a wiki library provides a low-maintenance way to record knowledge. Information that is usually traded in e-mail messages, gleaned from hallway conversations, or written on paper can instead be recorded in a wiki library, in context with similar knowledge.
The Importance of Continuous Training

- Investment
- Confidence
- Competency
- Morale
- Efficiency
- Identify need for additional training
- Reduce Variation
# Huddling & Team Satisfaction

<table>
<thead>
<tr>
<th>Workforce Perception</th>
<th>Total N</th>
<th>% Frequent Huddlers who strongly agree/agree</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall, I am satisfied with my current job</td>
<td>351</td>
<td>62%</td>
<td>0.0087</td>
</tr>
<tr>
<td>I would recommend this practice as a great place to work</td>
<td>277</td>
<td>64%</td>
<td>0.0023</td>
</tr>
<tr>
<td>People in my care team operate as a real team</td>
<td>354</td>
<td>63%</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>
Union Square Family Health Center

Provider satisfaction at 95\textsuperscript{th} percentile (2015) and 98\textsuperscript{th} percentile (2018)
Patient satisfaction at 98\% for likelihood to recommend practice
Staff satisfaction at 80\textsuperscript{th} percentile (2015) and 85\textsuperscript{th} percentile (2018)

- 100\% participation in surveys for providers and staff
- Every patient seen gets an invitation to review the practice by email (multi-lingual)
## Burnout (not!)

<table>
<thead>
<tr>
<th>Question</th>
<th>Union Square</th>
<th>Benchmark</th>
<th>Gap to Benchmark</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>% Positive</td>
<td>% Negative</td>
<td>% Positive</td>
</tr>
<tr>
<td>#1 I feel emotionally exhausted by my work.**</td>
<td>54.5%</td>
<td>18.2%</td>
<td>39.3%</td>
</tr>
<tr>
<td>#2 I feel overwhelmed by my workload.**</td>
<td>54.5%</td>
<td>9.1%</td>
<td>43.3%</td>
</tr>
<tr>
<td>#3 I feel detached from my patients.**</td>
<td>45.5%</td>
<td>9.1%</td>
<td>75.3%</td>
</tr>
<tr>
<td>#4 The work I do every day does not have a meaningful impact.**</td>
<td>36.4%</td>
<td>9.1%</td>
<td>76.7%</td>
</tr>
<tr>
<td>#5 I feel burned out.**</td>
<td>45.5%</td>
<td>9.1%</td>
<td>52.1%</td>
</tr>
</tbody>
</table>

** Indicates a negatively worded question. With negatively worded questions the % Positive indicates the desired response on the response scale. For negatively worded questions % positive accounts for the Disagree/Strongly Disagree responses.
¿QUESTIONS?