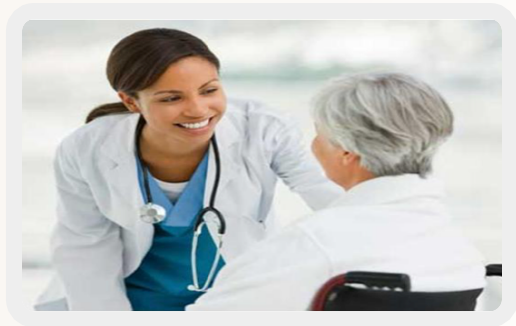


Integrating Population Health Management into Primary Care



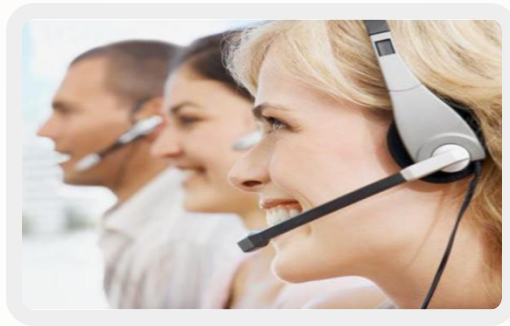
Planned Care Infrastructure

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.

Week 1	Week 2	Week 3	Week 4
Cancer Screening & Follow Up	Diabetes & Hypertension	Depression	Complex Care

PCM Sample Workflow: Diabetes

1

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

Epic Report Used:
My Loc Pts w/ Diabetes

2

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

Operational Strategy: Agree on
care actions for patients in need

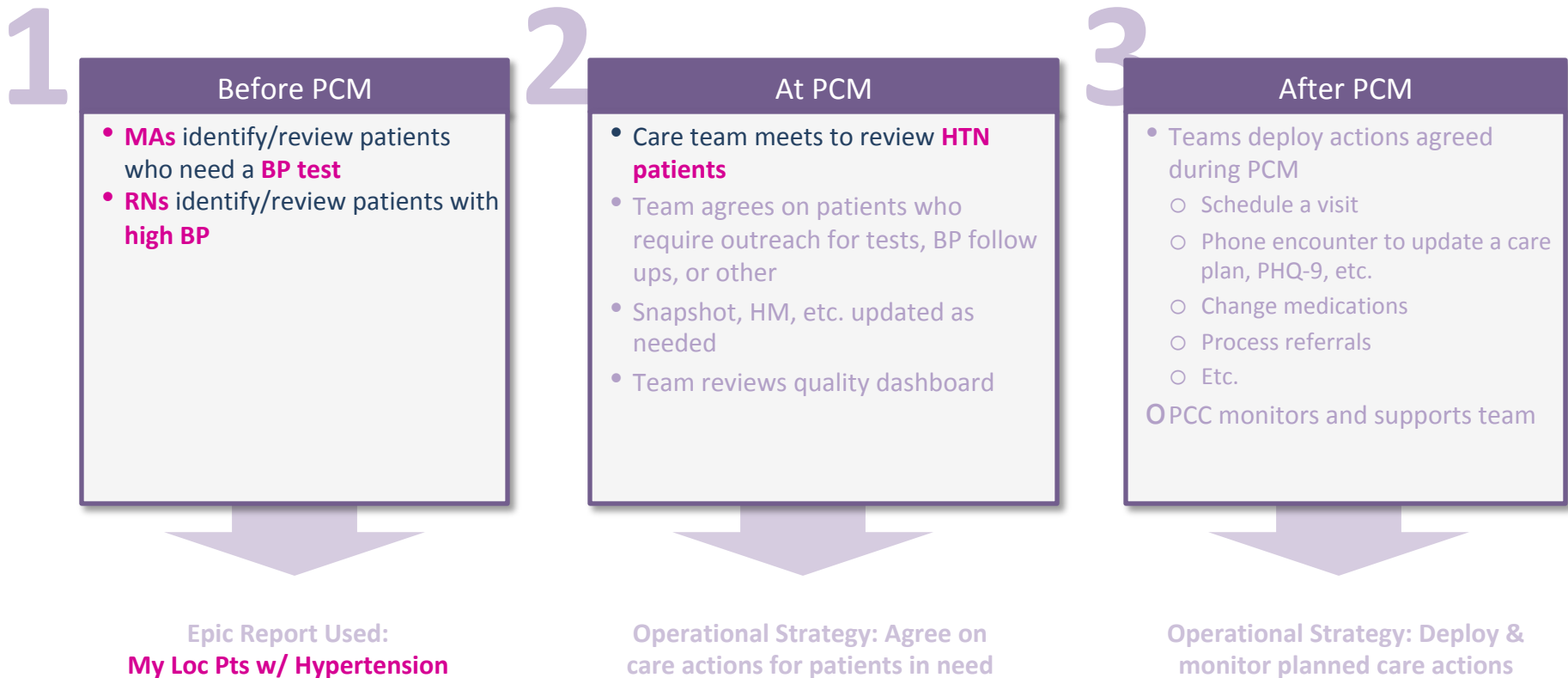
3

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.
- PCC monitors and supports team

Operational Strategy: Deploy &
monitor planned care actions

PCM Sample Workflow: Hypertension



PCM Sample Workflow: CCM

1

Before PCM

- CCM identify/review pipeline of CCM patients

Epic Report Used:
My Loc Pts w/
CCM - Active

2

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.

Operational Strategy: Agree on
care actions for patients in need

3

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

Operational Strategy: Deploy &
monitor planned care actions

Planned Care; Meeting Participants & Outreach Flow (draft) Sabrina G. Lozandieu 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 wkl
MA: outreach admin time
PMR: WCC outreach

Hypertension

Outreach by: MA 2a

*BP 140/90 and above = RN

MD
PA
RN
MA 2a
Pharmacy
PMR: WCC outreach

****HTN PROJECT:
Esmie, Nordia, Mirna & Ludy

Immunizations

Outreach done by:

LPN & RN

RN
LPN
*Will meet to discuss
monthly

Asthma/ADHD

Outreach by: MA 2a

*care plan needed = RN

MD
PA
RN
MA 2a
PMR: WCC outreach
*TBA ADHD lists
*Asthma list for pedj ready
*Asthma adult list needed

Well Child

Outreach by: PMR

MD
PA
RN
PMR
MA: outreach admin time

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 2b
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 outreaches to previous USFH providers; patient reassignments 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:** ***
- 6. My Action Plan:** {ACTION PLAN FOR BRIEF CARE PLAN:16121::"keep my appointments"}
- 7. My confidence that I can follow my Action Plan:** {Numbers; 1-10:17898}

Health Maintenance

Health Maintenance

Postpone

Remove Postpone

Override

Remove Override

Edit Modifiers

Report

Update HM

ClinKB

	Due Date	Topic	Date (Reason)		
	6/5/1984	TETANUS (16 AND OVER)			
	6/5/1986	LIPID SCREENING			
	6/5/1986	HEP B HIGH RISK VACCINE EVAL (ONCE)			
	6/5/1986	PHQ-9			
	6/5/1986	AWQ Questionnaire			
	6/5/1989	PAP SMEAR			
	6/5/1998	HPV SCREENING			
	6/5/2008	PHYSICAL EXAM (AGE 40-49)			
	3/8/2015	MAMMOGRAPHY	9/8/2014 (DISCU...		
	1/29/2016	CARE PLAN	7/29/2015 (APPT...	7/24/2015 (APPT...	12/19/2014 (APP... 12/17/2014
	4/1/2016	ABNORMAL RAD RESULT 1 YR F/U	4/1/2015 (APPT...	4/1/2015 (APPT...	
	6/9/2020	HEALTH CARE PROXY	6/9/2015	7/31/2014 (APPT...	
Addressed		HIV SCREENING	7/31/2014 (NOT I...		

Health Maintenance Modifiers

Abnormal Rad Result 1 Year F/U

Care Plan - PHQ9>15 (Automatic: Do Not Remove)

CHA TEST PATIENT

MAMMO - Birads 3 F/U 6mo

PAP HIGH RISK (YEARLY)

PHQ-9 MAINTENANCE (YRLY)

Health Maintenance Plans

ABNORMAL RAD RESULT 1 YR F/U

AWQ Questionnaire

CARE PLAN

HEALTH CARE PROXY

HEP B HIGH RISK VACCINE EVAL (ONCE)

HIV SCREENING-ONCE

HPV SCREEN EVERY 5 YRS

LIPID SCREENING (FEMALES 18-75)

MAMMO BIRADS 0 F/ U 6MO

PAP EVERY 5 YEARS (30-65YRS)

PAP HIGH RISK (YEARLY)

PHQ-9 MAINTENANCE (YRLY)

PHYSICAL EXAM (40-49)

TETANUS (16 AND OVER)

Status Legend

Overdue

Due On

Due Soon

Postponed

Definitions

Completed: Done with the required satisfactions

Addressed: Overridden with the intention of not completing the topic

Override Type Abbreviations

Declined

Discussed/Declined

SEXUALLY

Sexually Inactive

INA

NOT INDICATE

Not Indicated

DISCUSSED

Discussed/Patient Education

APPT

Completed at CHA

COMPLET

appt out cha

Completed outside CHA

LOW RISK

Low Risk

OTHER - SEE

Other - See comments

(N/S)

Reason not specified


Done (inactive)

Done

Postponed

Postponed


(inactive)


CHA Cambridge Health Alliance

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 **

Patient	DOB	PCP	A1C: Last A1C Dt	Last PHQ9	G9 Last Date	Alb/Cr	Alb/Cr Dt	LDL	Last LDL Dt	Last BP Dt	Last BP Date	Sys	Dia	Exam Due	ED Count	Last w/ Me	Next w/ Me	Tobacco Use	MyC:lass	Care Pt Status	Benefit Plan	Allergy List
Chamberlin, Marshall R.	6.8	4/18/2015	0	12/4/14	5 ug/tng	5/22/2014	120	12/4/2014	4/23/2015	4/27/15	145	82	11/26/2015	04/27/2015	Never	✓				MEDICARE PPO BLUE	LISINDAPRIL	
Chamberlin, Marshall R.	7.1	4/23/2015	16	4/23/15	6 ug/tng	7/18/2014	60	9/23/2014	4/23/2015	4/23/15	93	57	3/23/2016	3	04/23/2015	Never	✓			EVERCARE		
Chamberlin, Marshall R.	7.6	11/25/2014	0	12/6/13	5 ug/tng	1/25/2014	113	11/25/2014	11/25/2014	11/25/14	125	57	1/23/2014		11/25/2014	06/11/2015	Quit	✓		HARVARD PILGRIM HCMO		
Chamberlin, Marshall R.	7.7	5/16/2014	4	12/6/13	11 ug/tng	1/30/2013	98	1/17/2014	7/2/2014	7/2/14	148	85	11/1/2014		07/02/2014	Quit	✓			MEDICAID		
Chamberlin, Marshall R.	5.6	11/28/2014	0	11/28/14	6 ug/tng	6/6/2014	134	1/2/2014	11/28/2014	11/28/14	100	72	12/29/1993	3	11/28/2014	05/21/2015	Quit	✓		MEDICAID-PCC	SULFA ANTIBIOTICS, PREGABALIN, TRAMADOL	
Chamberlin, Marshall R.	7.6	2/23/2015	2	11/24/14	24 ug/tng	5/1/2014	90	11/24/2014	2/27/2015	2/27/15	140	82	2/23/2016	1	02/23/2015	Never	✓			MEDICAID		
Chamberlin, Marshall R.	8.8	4/6/2015	0	4/6/15			42	4/6/2015	4/6/2015	4/6/15	140	60	4/6/2016	1	04/06/2015	Never	✓			NEIGHBORHOOD HPMO		
Chamberlin, Marshall R.	8.8	4/24/2015	8	12/11/14	9 ug/tng	2/26/2015	71	12/11/2014	4/24/2015	4/24/15	124	80	2/7/2016	1	04/24/2015	05/26/2015	Never	✓		CELTICARE CAREPLUS	ASPIRIN	
Chamberlin, Marshall R.	6.6	4/17/2015	4	11/5/14	105 ug/tng	7/21/2014	32	4/21/2014	4/17/2015	4/17/15	140	86	11/3/2015		11/05/2014	Never	✓			NAPROXEN		
Chamberlin, Marshall R.	6.9	9/26/2014	1	9/26/14	5 ug/tng	9/26/2014	85	9/26/2014	9/26/2014	9/26/14	117	74	10/12/2013		09/26/2014	Never	✓			SELF PAY		

★ **MORE detailed information can be found here!!!**

Recent Review FlowSheet Data

	9/9/2014	9/4/2013
PHQ-9 TOTAL SCORE	0	7
Doc FlowSheet Total Score	0	7
PHQ-9 FLOWSHEET	0	2
Interest	0	2
Depressed	0	2
Sleep	0	2
Fatigue	0	1
Appetite	0	0
Self Esteem	0	0
Concentration	0	0
Psychomotor	0	0
Suicide	0	0
Total	0	7
Problem Mgmt	Not difficult at all	Somewhat difficult

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



Libraries

[Toolkit Wiki](#)[Documents](#) [All Site Content](#)

<p><u>Introduction to Team Based Care</u></p> <ul style="list-style-type: none"> • Introduction to Team Based Care 1.0 	<p><u>What is a team</u></p> <ul style="list-style-type: none"> • Teamwork kit 1.0 (all pages) • What is a team? 1.0 • Getting Started Forming Teams 1.0 • Levels of Team Based Care 1.0 	<p><u>Roles of Team Members</u></p> <ul style="list-style-type: none"> • Roles of Team Members 2.0
<p><u>Previsit</u></p> <ul style="list-style-type: none"> • Ambulatory Visit Forms 1.0 • How to access the Daily Med List 1.0 • Previsit Packet 1.0 • Previsit 1.0 	<p><u>Visit</u></p> <ul style="list-style-type: none"> • Day of visit 1.0 	<p><u>Post or Between Visit</u></p> <ul style="list-style-type: none"> • Between visit 1.0
<p><u>Care Plans</u></p> <ul style="list-style-type: none"> • Care Plan Training 2.0 • Why Make Care Plans 2.0 • Updating Care Plans 2.0 • Care Plans FAQ 2.0 	<p><u>Planned Care</u></p> <ul style="list-style-type: none"> • Planned Care Meeting Guide 2.0 	<p><u>Hospital and ED Discharge Follow up</u></p> <ul style="list-style-type: none"> • Hospital Discharge 2.0 • Hospital Discharge RN 2.0 • ED and Discharge Follow up Letter
<p><u>Chronic Disease Management</u></p> <ul style="list-style-type: none"> • Chronic Disease Management 1.0 • Diabetes Chronic Care Management 1.0 	<p><u>Complex Care Management</u></p> <ul style="list-style-type: none"> • Complex Care Program 2.0 	<p><u>Huddles</u></p> <ul style="list-style-type: none"> • Huddles toolkit 1.0 (all pages) • What is the difference between a huddle and team meeting 1.0 • Huddle Strategies and Checklist 1.0 • Huddle Game Plan for today 1.0 • Huddle Assessment Tool • Huddle Assessment Tool 1.0 • Huddle Evaluation Checklist for Leadership 1.0
<p><u>Dealing with Different People</u></p> <ul style="list-style-type: none"> • Dealing with Different Types of People 1.0 	<p><u>Appendix</u></p> <ul style="list-style-type: none"> • Appendix 1.0 	<p><u>Care Team Training 1.0</u></p> <ul style="list-style-type: none"> • Building Teams in Primary Care Toolkit 1.0

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What is a wiki library?

Wikiwiki means quick in Hawaiian. A wiki library is a document library in which users can easily edit 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 uncreated 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

Workforce Perception	Total N	% Frequent Huddlers who strongly agree/agree	P-Value
Overall, I am satisfied with my current job	351	62%	0.0087
I would recommend this practice as a great place to work	277	64%	0.0023
People in my care team operate as a real team	354	63%	<0.0001



Union Square Family Health Center

Provider satisfaction at 95th percentile (2015) and 98th percentile (2018)

Patient satisfaction at 98% for likelihood to recommend practice

Staff satisfaction at 80th percentile (2015) and 85th 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!)

	Question	Union Square		Benchmark		Gap to Benchmark	
		% Positive	% Negative	% Positive	% Negative	% Positive	% Negative
#1	I feel emotionally exhausted by my work.**	54.5%	18.2%	39.3%	19.2%	15.2%	-1.0%
#2	I feel overwhelmed by my workload.**	54.5%	9.1%	43.3%	15.1%	11.2%	-1.9%
#3	I feel detached from my patients.**	45.5%	9.1%	75.3%	3.4%	-29.8%	5.7%
#4	The work I do every day does not have a meaningful impact.**	36.4%	9.1%	76.7%	5.3%	-40.3%	3.8%
#5	I feel burned out.**	45.5%	9.1%	52.1%	13.2%	-6.6%	-4.1%
	** 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?

