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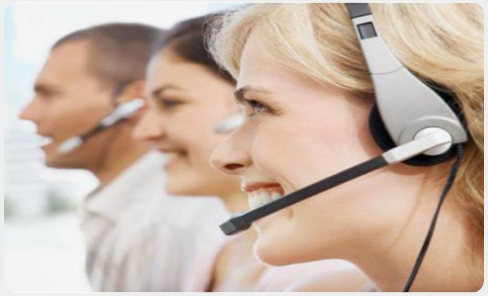
Integrating Population Health Management into Primary Care

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

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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

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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

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PCM Sample Workflow: Hypertension

1 Before PCM

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

Epic Report Used:
My Loc Pts w/ Hypertension

2 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

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

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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

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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 wkly
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 pedi 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: ***

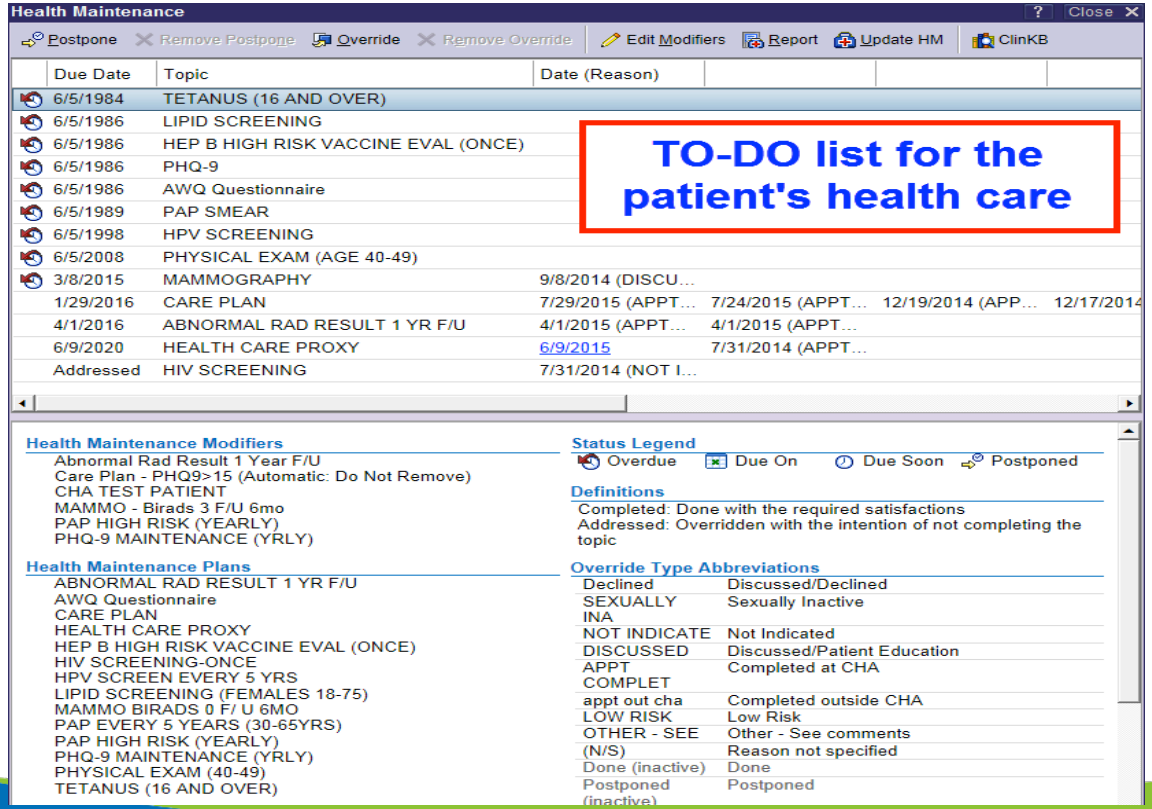
4. Challenges to meeting my goals: {BARRIERS FOR BRIEF CARE PLAN:16120::"need more support"}

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



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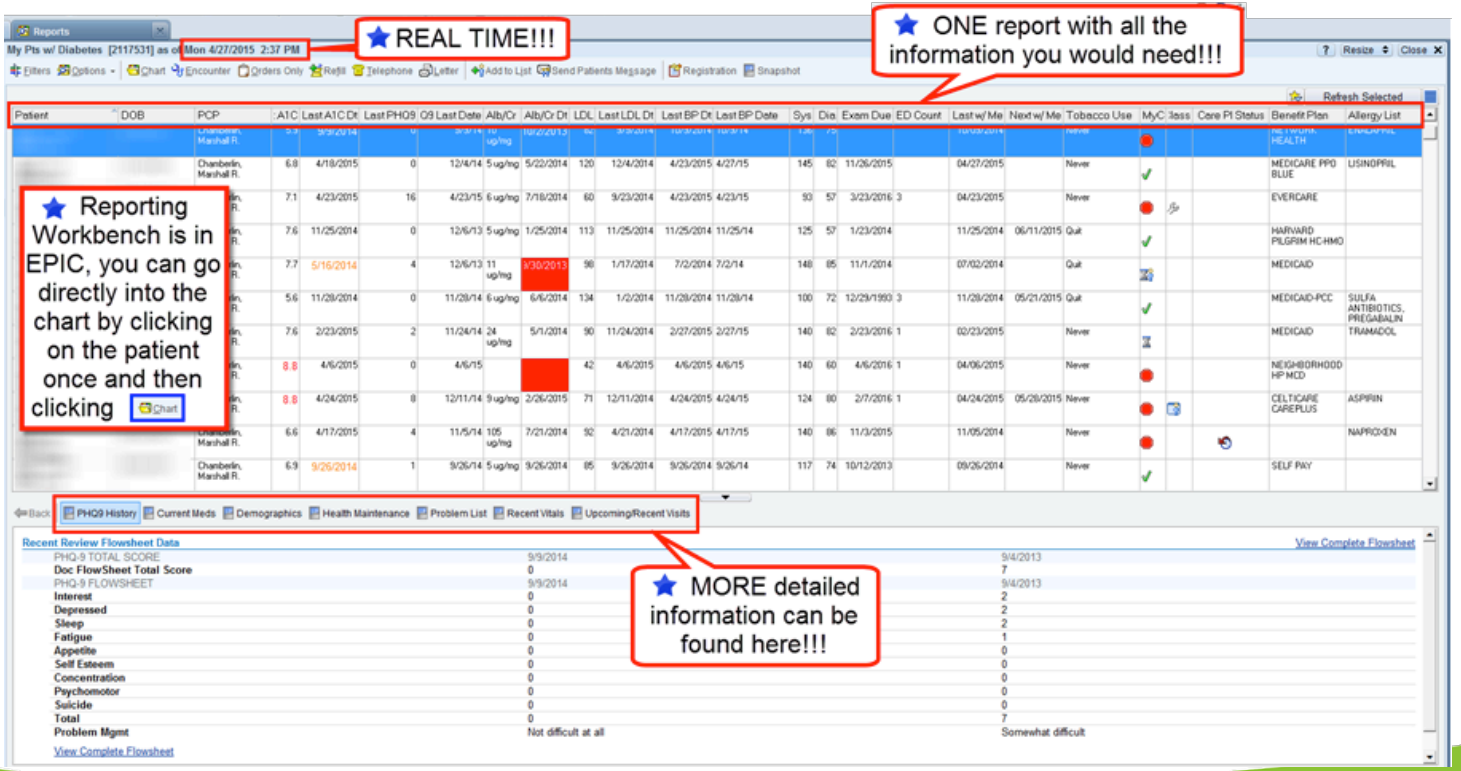
EPIC Diabetes Registry: Reporting Workbench



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

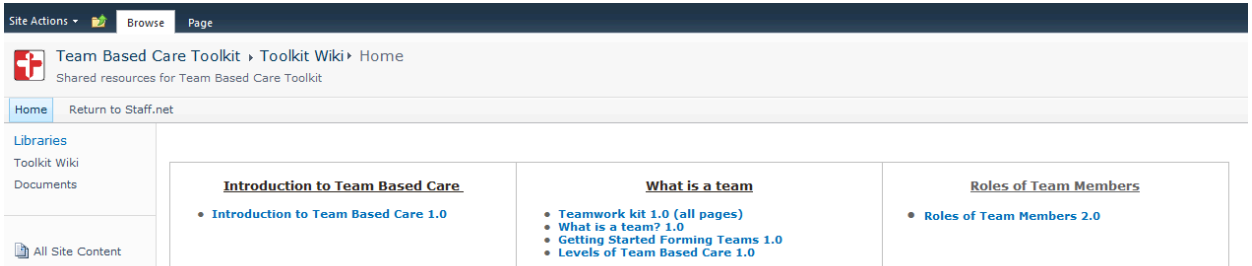
Celebrations/accomplishments

Continuous Staff Training

Individual

Team/Organizational

- Team time moments: Huddles and team meetings
- Grand Rounds
- Annual Competency and skills review
- New Initiatives
- IT upgrades



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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!)

		Union Square		Benchmark		Gap to Benchmark	
	Question	% 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?