CCI | CENTER FOR CARE INNOVATIONS

KP Transformation Accelerator

In-Person Learning Session #3
Tuesday, July 24, 2018
Center for Total Health | Washington, D.C.

Today's Big Awesome Agenda

1. Overview of KPTA Shared Advocacy Project

2. Team Project Lightning Rounds

3. Data Governance to Optimize Data for Population Health Management

4. Case Study

5. Data Analytics Capability Assessment and Action Planning

6. Lunch

7. Using Data to Drive Population Health Activities

8. Team Time & Next Steps

Materials and slides for today's learning session are available at:

https://www.careinnovations.org/accelerator-team/

CCI
CENTER FOR CARE INNOVATIONS

Population Health

Data Analytics

Innovation & Design Thinking

Technology Solutions

Delivery System Reform

Community-Centered Care

ABOUT   PROGRAMS   GET INVOLVED

The Resource Center

STAY UP-TO-DATE!

Transformation Accelerator Support Portal

OVERVIEW   UPDATES & CALENDAR   PROGRAM RESOURCES   RESOURCE LIBRARY   TEAMS & PARTNERS

Today's Faculty

SA Kushinka

Jerry Lassa

Boris Kalikstein

Who is in the room?

Health Center Teams

Mary's Center

GREATER BADEN MEDICAL SERVICES
Primary and Preventive Health Care

FAMILY AND MEDICAL COUNSELING SERVICE, INCORPORATED · FMCS we care

CCI health & wellness services

LA CLÍNICA DEL PUEBLO

Support Partners & Faculty

CCI CENTER FOR CARE INNOVATIONS

RPCC Regional Primary Care Coalition

KAISER PERMANENTE®

Where are we in our Transformation Accelerator journey?

Phase 1 → Program Launch	Phase 2 → Team-Based Care	Phase 3 → Planned Care	Phase 4 → Data Analytics	Phase 5 → Population Health	Program Ends: December 2018
April 2017 Convening	**October 2017 Learning Session**	**February 2018 Webinar**	YOU ARE HERE		Coaching Ends
August 2017 Webinar	December and January Site Visits	Shared Advocacy Project Begins	**July 2018 Learning Session**	**October 2018 Learning Session**	**Final Reports Due**
Coaching Begins	**Progress Report Submitted**	**May 2018 Virtual Learning Sessions**			
Project Charters & Driver Diagrams Submitted		**Progress Report Due**			

Regional Primary Care Coalition

Kaiser Permanente Transformation Accelerator Shared Project

July 24, 2018

RPCC

Regional Primary Care Coalition
Building Knowledge, Catalyzing Action

An active collaboration and learning community of local funders, primary care coalitions representing over 50 safety-net providers and community-based organizations serving residents of National Capital Region.

RPCC is committed to advancing regional partnerships, policies and practices that

- Improve health care access and quality.
- Build integrated systems of care.
- Address the underlying determinants of health.
- Reduce health disparities.
- Promote health equity.
- Create healthy, safe and thriving communities for all residents across the National Capital Region.

Transformation Accelerator
Shared Project

Purpose

- To build a framework for collaboration among Prince George's County Community Health Centers.

- Educate policy-makers and community leaders about the role and contribution of Community Health Centers.

Participants

- Executive Directors or designated representatives from CCI Health and Wellness, Family and Medical Counseling, Greater Baden, La Clinica del Pueblo and Mary's Center.

Shared Project Goals

- Create a shared impact statement and common "ask" for Prince George's County policy-makers and elected officials.

- Increase Health Center participation in health planning processes and advocate for policies and programs that will improve the health of County residents.

- Educate County Executive and County Council members about the contributions of the Community Health Centers and advocate for support for health services for the uninsured and policies that improve the health and well-being of all County residents.

- Develop strategies to address key health concerns in Prince George's County.

Why is this important now?

- Of 24 Maryland Counties, Prince George's County is ranked 14th in health outcomes and 22nd in availability of clinical services.

- There are significant health disparities experienced by the Hispanic community and portions of the African American population.

- There is increased recognition that these disparities are associated with inequities that include: access to care, income, education level, and immigration status.

- Community Health Centers and hospital community benefits have brought significant health resources into the County.

- Collaboration and better coordination promotes more efficient use of resources and enhances efforts to address health needs in under resourced communities.

- Partnerships with state and local health departments, community leaders and other stakeholders are essential to creating a comprehensive approach to improving the health of all Prince George's County residents.

Accomplishments

- Created a briefing paper on the *Prince George's County Health Care Landscape*.

- Developed a consensus advocacy position proposing a program to establish a primary health care program for the uninsured.

- Conducted meetings with Councilmember Danielle Glaros to promote a children's health program.

- All Health Centers participated in Prince George's County's inaugural Health Equity Forum.

- Health Centers met with the Chief Health Officer to request inclusion in health planning and propose a program for providing primary health care services for uninsured County residents.

Next Steps

- Increase opportunities to collaborate with the Health Officer and DOH staff.

- Conduct briefings for current and newly elected County Council members.

- Meet and brief the newly elected County Executive.

- Strengthen the framework for the Prince George's County Community Health Center Collaboration so that it continues forward.

How You Can Help!

- Document progress related to health care access, health screening and quality health care.

- Collect and share patient stories that demonstrate success—improvements in health outcomes, patient engagement, overcoming barriers and engagement with the community.

- Recommend collaborative strategies to improve patient care and maximize our collective impact on the health and well-being of Prince George's County residents.

⚡ Team Project Sharing: Story Boards

Lightning Rounds

1. Greater Baden Medical Services

2. La Clínica Del Pueblo

3. Mary's Center

4. CCI Health & Wellness Services

5. Family and Medical Counseling Service, Inc.

Story Board Components

- Your core team

- Aims and measures

- Primary drivers and changes

- Data visuals such as run charts, graphs, or tables

- Learnings and challenges

Team Project Sharing: Lightning Rounds

Greater Baden Medical Services

Team Members

- Debra Apperson CRNP, Quality Director, Project Team Lead

- Nicola Henry DDS, Dental Lead

- Guadalupe Limerick, Dental Assistant

- Tameka Heard, Clinical Medical Assistant

- Dr. Tanya Morgan, Population Health

- Levyi Centeno, Patient/Community Educator ad hoc

Aims and Measures

Project Aim: To increase the number of children age 6-9 years of age identified with moderate to high caries risk that receive dental sealants on their first permanent molars by 10 percent in the next 12 months.

Measures:

- The number of children 6 – 9 years of age who complete a dental visit and are identified as moderate to high risk for dental caries each month.

- The number of children 6 – 9 years of age who are identified as moderate to high risk for dental caries and receive a dental sealant each month.

Drivers and Changes

- *Primary drivers we have identified are parent valuing dental sealant for child and providing affordable sealants for all*

- Parent valuing dental sealant for child
  - Waiting room education
  - Access to same day appointments

- Affordable sealants
  - Referring children to check Medicaid eligibility
  - Seeking funding for uninsured

Data

Dental Sealants
Kids at Risk Age 6-9

■ # Identified ■ Got Sealants
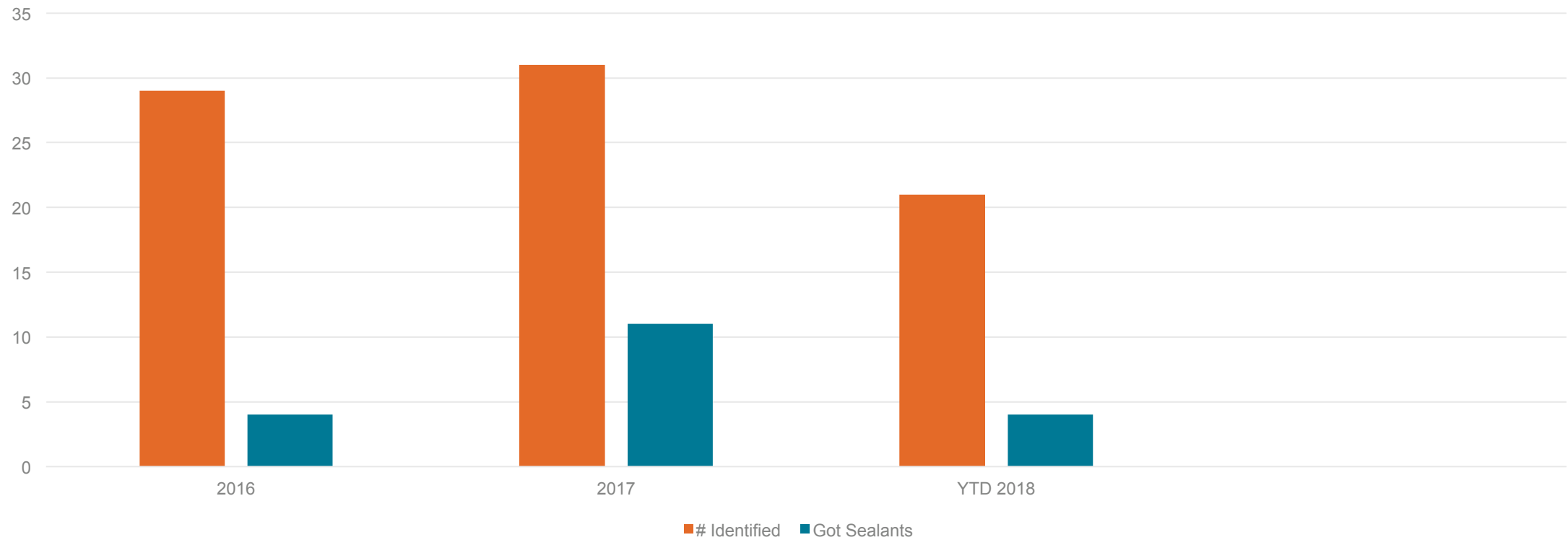
Learning and Challenges

- If we could do one thing differently it would be to have weekly meetings to look at real time sealants and evaluate factors affecting them getting done or reason they were not done.

  - Use our "Best Practice" from above to generate more improvement

  - Quickly identify factors impacting meeting goal and make course corrections more quickly using PDSA model

SESSION OBJECTIVES

Define data governance and identify the types of problems that signal a need for it

Describe key roles and structures needed to address data problems

Develop an Action Plan to use data governance practices and build capability in your organization

LEARNING OBJECTIVES

Define data governance and identify the types of problems that signal a need for it

Describe key roles and structures needed to address data problems

Develop an Action Plan to use data governance practices and build capability in your organization

IF DATA GOVERNANCE IS THE ANSWER, WHAT'S THE QUESTION?

Data is the new organizational currency

Setting Context
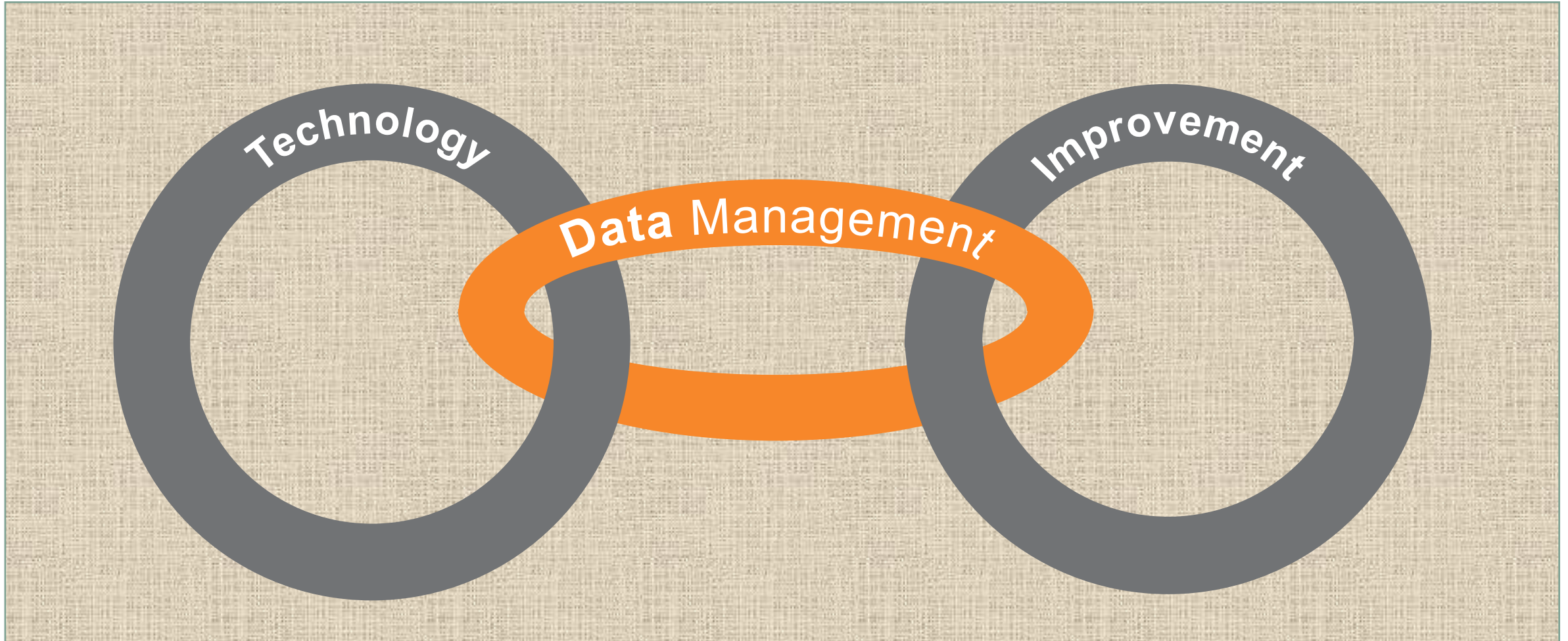
So what is data governance anyway?...
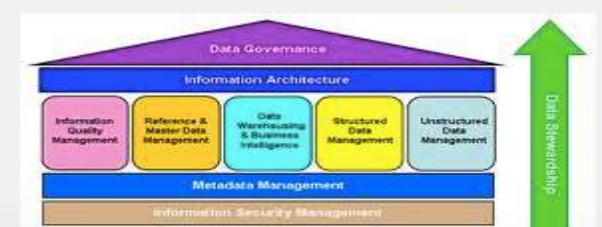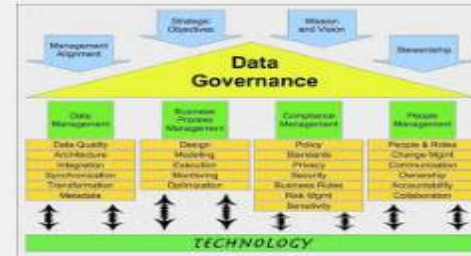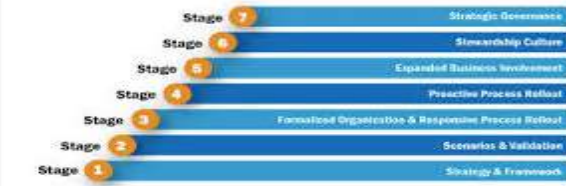
Data Governance Institute's Definition

"Data Governance is a *system of decision rights and accountabilities* for information-related processes, executed according to agreed upon models which describe who can take what actions with what information and under what circumstances, using what methods."

Data governance for the sake of data governance?

IN PLAIN ENGLISH:

Data Governance :
The <u>people</u>, <u>processes</u>, and <u>techniques</u> for managing data.

The Triple Aim of Data Governance
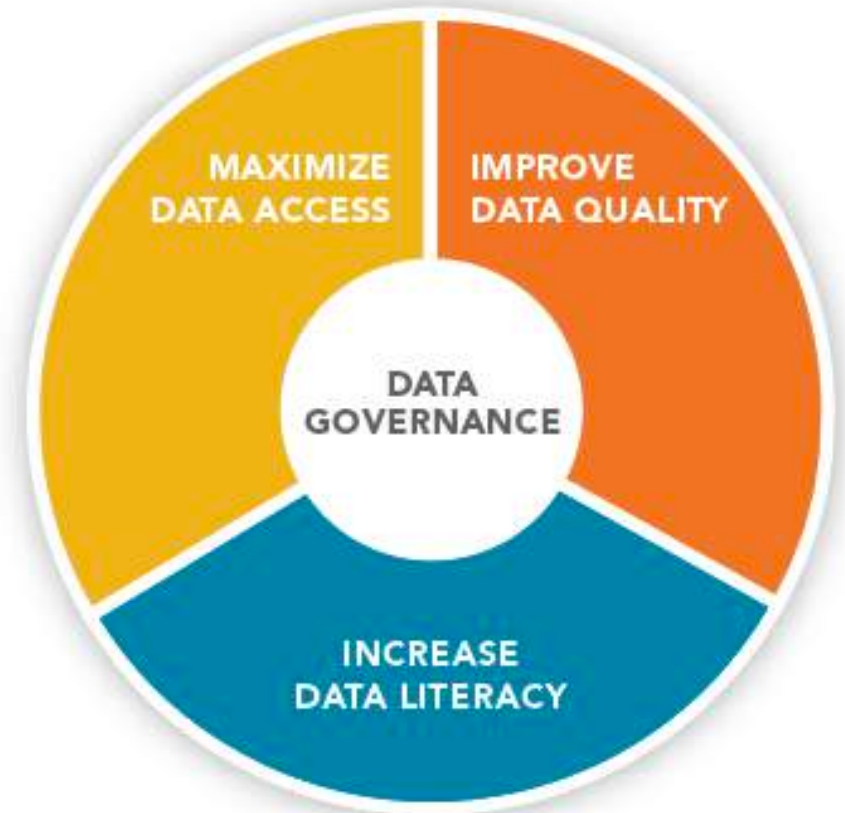
WORKING SINGLE HANDEDLY?

ACT to address data quality issues!

Not **A**ccurate   Not **C**omplete   Not **T**imely
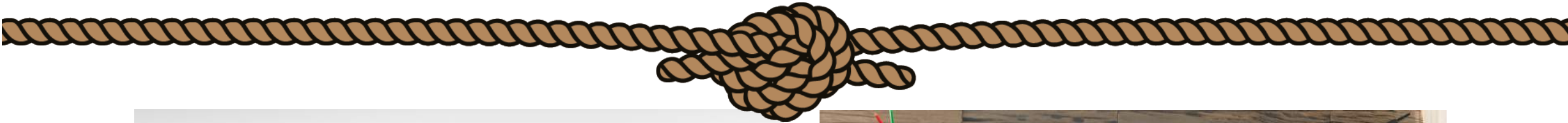
TRYING TO FIND YOUR WAY IN THE DARK?

"I'll pause for a moment so you can let this information sink in."

IN WHAT WAYS ARE YOUR HANDS TIED?

Denied access to what you need

Unable to find the right data

What Exactly is Data Governance?

PLAY VIDEO ⊃

DISCUSSION

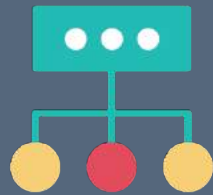## What key messages did you hear in the video?

VIDEO: KEY MESSAGES

Data Governance helps you turn data into actionable information

Data is an asset: a new organizational currency

Data Governance requires:

- People from various departments and roles
- Organization authority to set priorities and allocate resources for data related activities

Right-sizing data governance
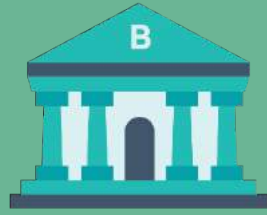
[PLAY VIDEO ➲](#)

DISCUSSION

What key messages did you hear?

VIDEO: KEY MESSAGES
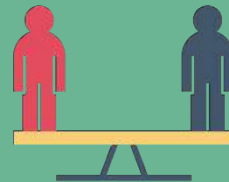
Central principles, distributed execution

Govern data to the least extent necessary to achieve the greatest common good

Govern no data until its time

Look for opportunities to create value with your data and don't create work for governance committees

Find a balance between central authority and decentralized authority

IF DATA GOVERNANCE IS THE ANSWER…

THE QUESTION IS:

Does your organization have issues with data quality, data literacy or data access?

GROUP ACTIVITY

What types of data issues keep bubbling up for our organization?

Are our data related issues more centered around any one dimension of the triple aim of data governance (quality, literacy, access/use)?

What do we see as the most pressing data problem?

What elements of data governance do we already have and how well are they working?

"Without data you're just another person with an opinion."

W. EDWARDS DEMING

⚡ Team Project Sharing: Lightning Rounds

Storyboard KPTA Learning Session

July 24, 2018

La Clinica del Pueblo – KPTA Core Team

- Marlene Fuentes, Director of Clinical Operations
- Catalina Sol, Chief Programs Officer
- Ricardo Fernandez, Chief Medical Officer
- Claudia Husni, Physician
- Kenia Garay, Patient Care Coordinator
- Palmyr Cardenas, Patient Care Coordinator
- Melanie Lugo, Care Coordinator
- Nelson Cruz, Health Educator/Navigator
- Lucy DeOliveira, Director of Nursing/CM
- Axel Reyes, Sexual Health Program Manager

LA CLÍNICA DEL PUEBLO

Aims and Measures

AIMS

- By December 31, 2018, integrate HIV primary care into LCDP Hyattsville site, paneling a minimum of 25 patients with Dr. Husni.

- By December 31, 2018, provide culturally competent, interdisciplinary, HIV care services to Limited English Proficient (LEP) patients living with HIV at our Hyattsville site.
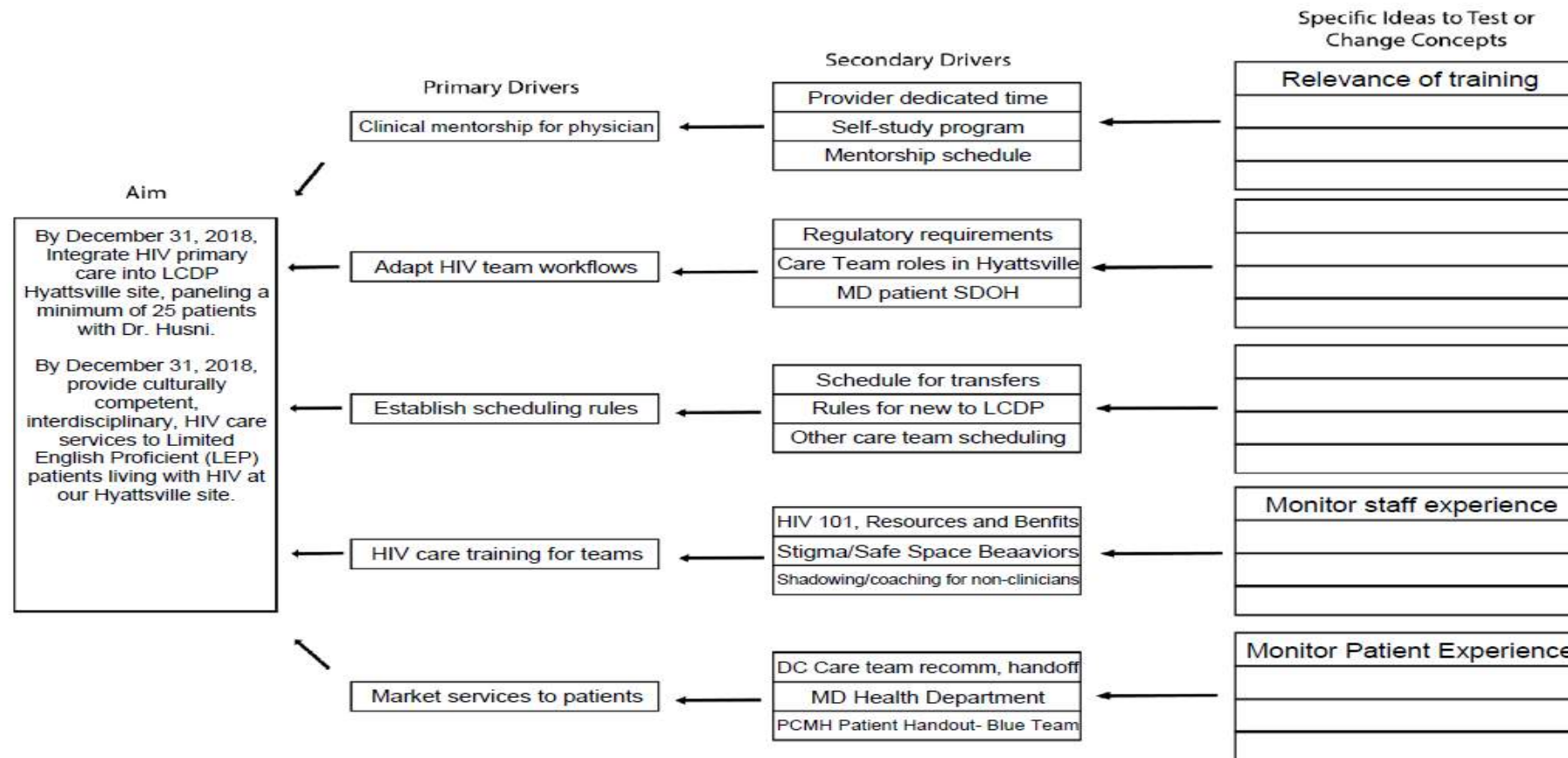
Measures

- Clinical Quality Measures

- # of clients

- # of visits

- $$ revenue generated

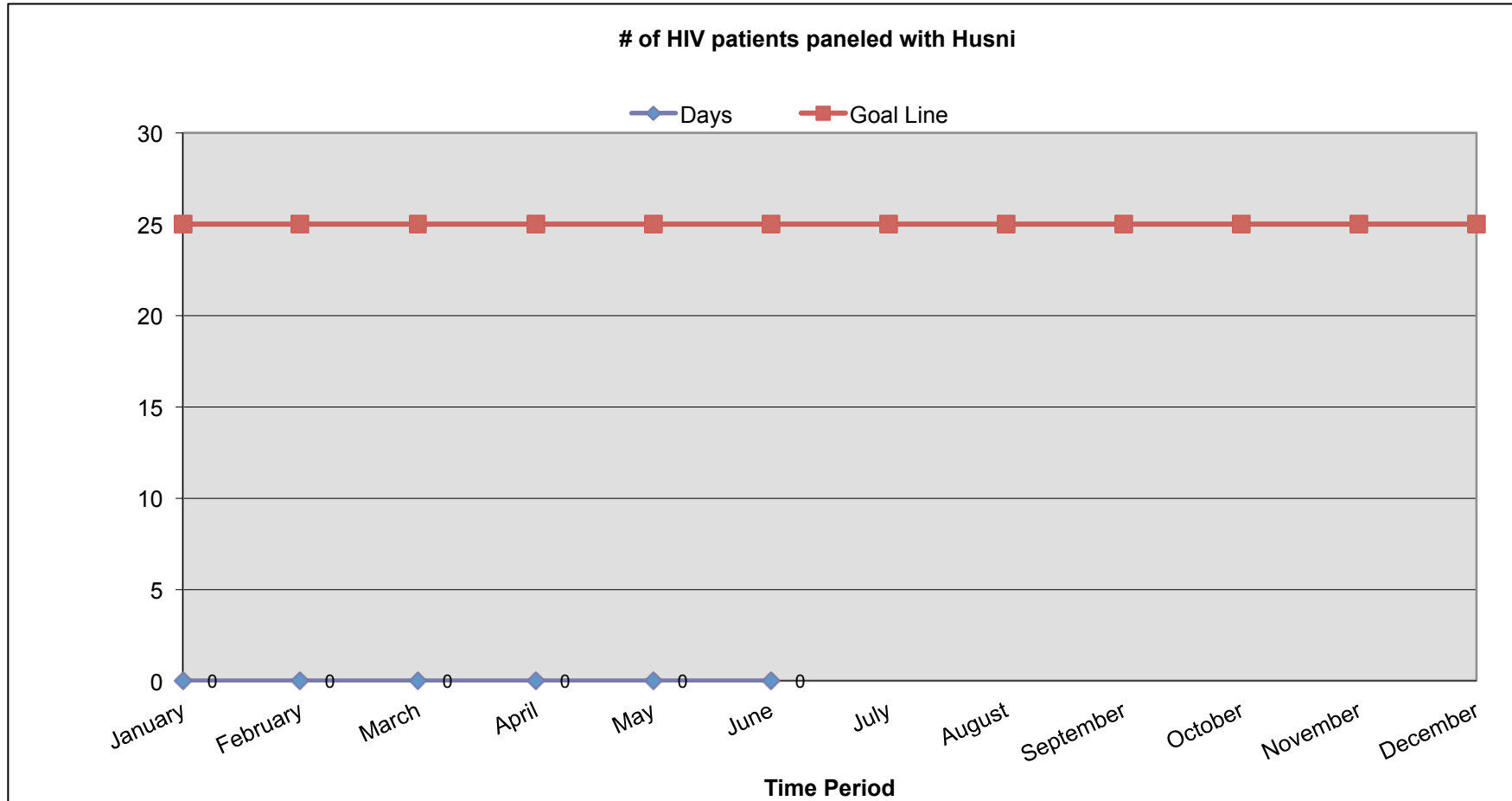- Patient Experience

- Staff Experience

LA CLÍNICA DEL PUEBLO

Drivers and Changes

Aim

By December 31, 2018, Integrate HIV primary care into LCDP Hyattsville site, paneling a minimum of 25 patients with Dr. Husni.

By December 31, 2018, provide culturally competent, interdisciplinary, HIV care services to Limited English Proficient (LEP) patients living with HIV at our Hyattsville site.

Primary Drivers

- Clinical mentorship for physician
- Adapt HIV team workflows
- Establish scheduling rules
- HIV care training for teams
- Market services to patients

Secondary Drivers

- Provider dedicated time
- Self-study program
- Mentorship schedule

- Regulatory requirements
- Care Team roles in Hyattsville
- MD patient SDOH

- Schedule for transfers
- Rules for new to LCDP
- Other care team scheduling

- HIV 101, Resources and Benfits
- Stigma/Safe Space Beaaviors
- Shadowing/coaching for non-clinicians

- DC Care team recomm, handoff
- MD Health Department
- PCMH Patient Handout- Blue Team

Specific Ideas to Test or Change Concepts

- Relevance of training

- Monitor staff experience

- Monitor Patient Experience

LA CLÍNICA DEL PUEBLO

Data – Run Chart

# of HIV patients paneled with Husni

Learning and Challenges

- Started with Hyattsville staff only, then integrated key staff from DC site

- Exploring staff expectations and concerns key to shaping project trajectory

- Reports help to catch unexpected events

- Time and Competing Demands

LA CLÍNICA DEL PUEBLO

Take a break!

⚡ Team Project Sharing: Lightning Rounds

Mary's Center

Mary's Center

Ashley Harris, MD, MHS
Cancer Screening Champion

Alis Marachelian, MPH
Senior Director Community Health
Initiatives & Strategic Alliances

Dara Koppelman RN, BSN, BA
Chief Nursing Officer

Nathalie Gonzalez, MPH
Senior Manager of Quality and
Outcomes

Rosa Goyes
Associate Director Community Health
Education, Training & Research

We have a multidisciplinary core team made up of members with different perspectives who contribute to this project.

Aims and Measures

- Improve cervical cancer screening rates at our Prince George's County, MD site from baseline 75% to 82.5%.

    – Strategy: To identify, develop and implement and point of care system to identify care gaps for patients.
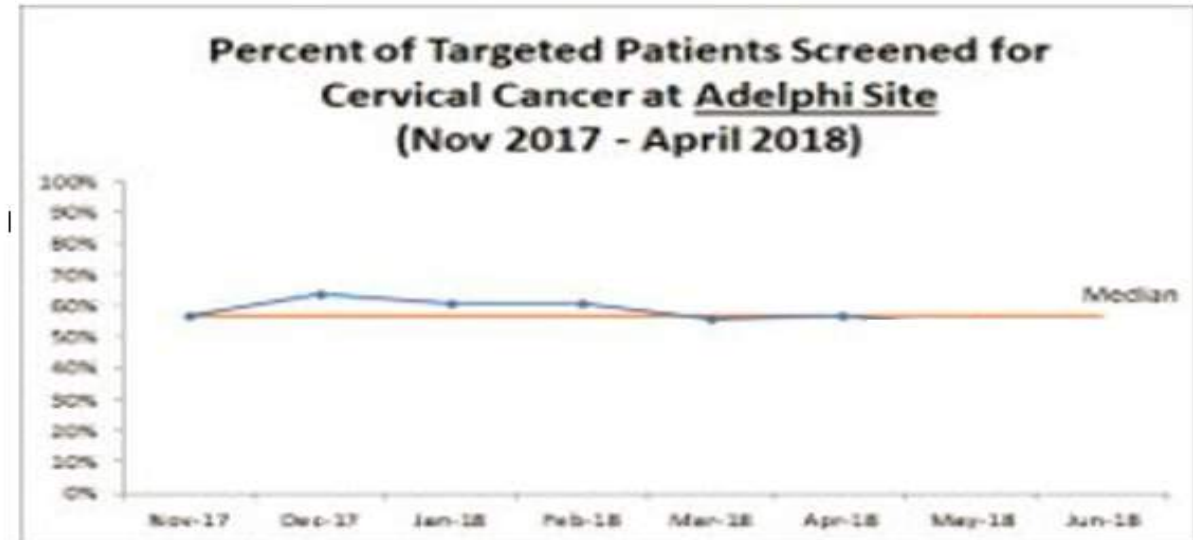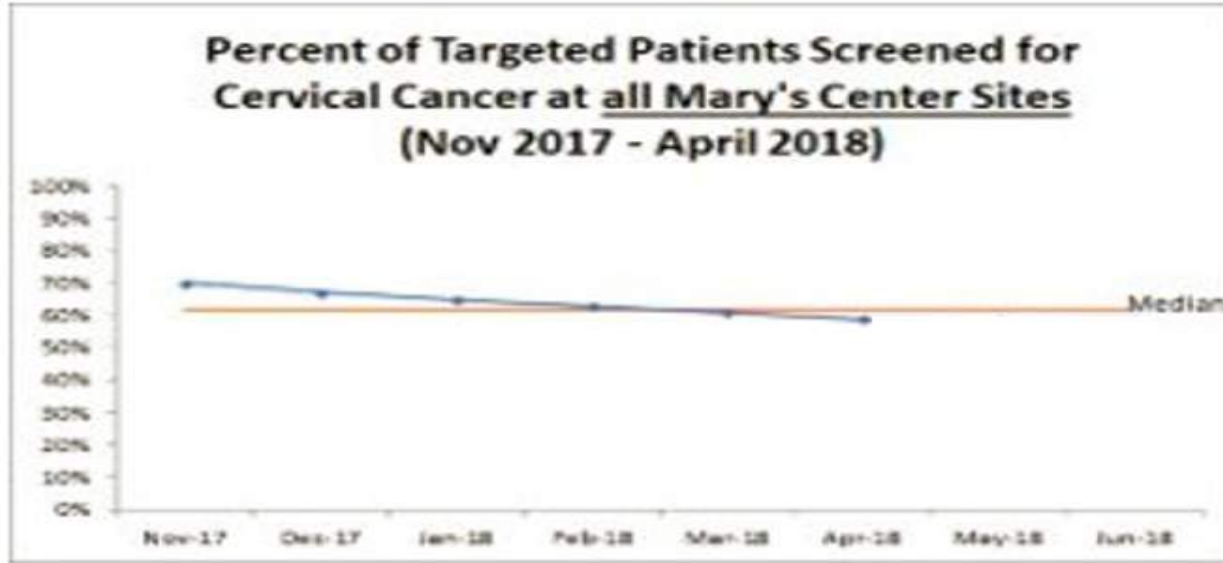
Drivers and Changes

Primary Drivers

- **Identification of gaps in care**- Point of Care Alerts
- **Clinical guidelines** – updated cervical cancer screening policy
- **Workflows** – mapped current workflows, will update after piloting new systems.
- **Patient Engagement** – Health Passport, outreach efforts

Data

Jan-Mar 2018
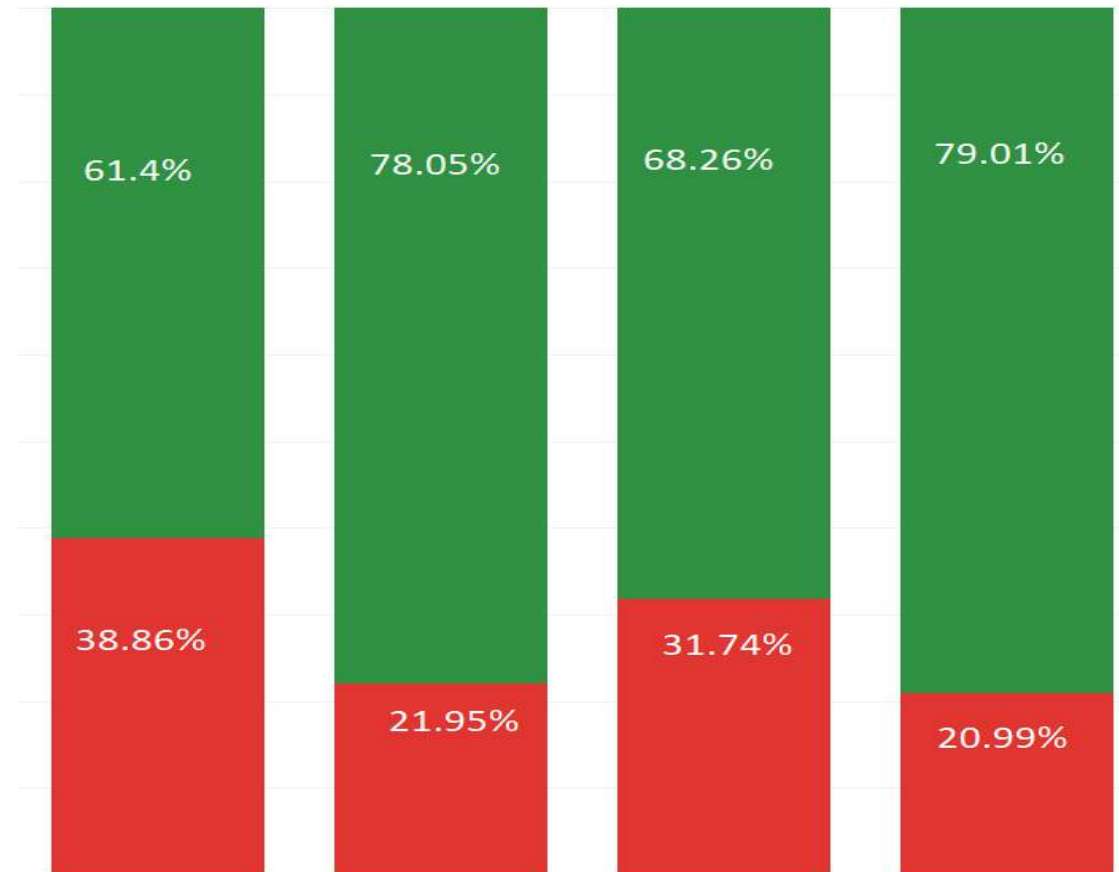
Data

Learning and Challenges

- If you could do one thing over, what would you do differently?

  - Creating manuals of past reports
  - Saving explanations of how initial data was pulled with along with raw data

Case Study

FUNDAMENTALS OF DATA GOVERNANCE:
A WORKSHOP FOR HEALTH CENTERS

SAFETY NET ANALYTICS PROGRAM LAB

Module 4: Data Governance Action Plan

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SESSION OBJECTIVES

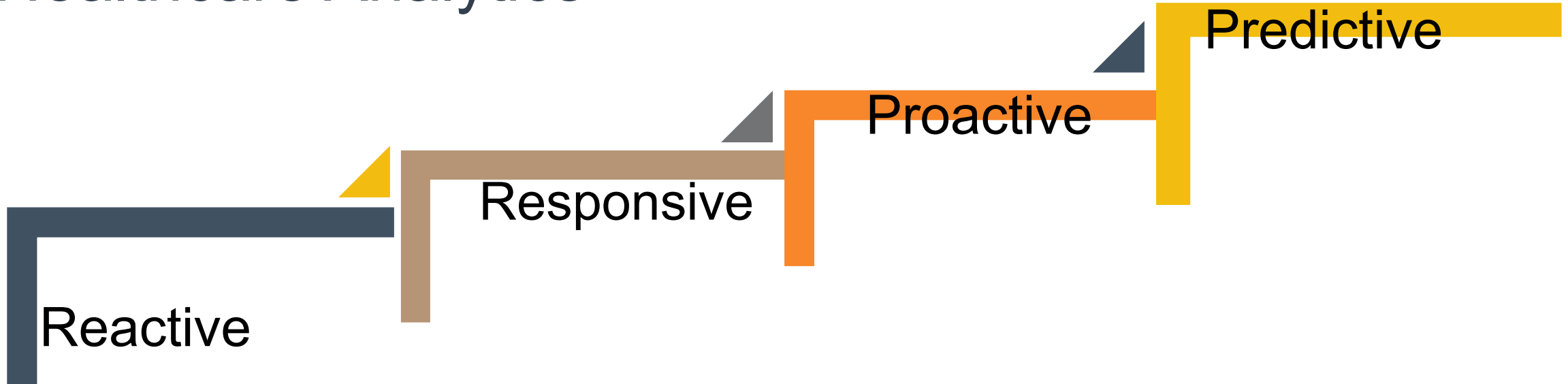Define data governance and Identify the types of problems that signal a need for it

Describe key roles and structures needed to address data problems

Develop an action plan to use data governance practices and build capability in your organization

A ROADMAP FOR BUILDING CAPABILITY

Healthcare Analytics

Predictive

Proactive

Responsive

Reactive

Building a Data Driven Culture

COMPONENTS OF THE "ACA"

Domain

Factors

Indicators

Scoring Level

PEOPLE Capability Levels	Reactive	Responsive	Proactive	Predictive
Data Stewardship: The role of the "data steward" may be formally defined or informally recognized and is typically the "go to" person within a department or site for all the queries/issues and usability of the data. Data stewards ensure the data is complete, accurate, and timely and that it is useful to the department or site in measuring performance and making improvement.				
1B. To what extent are departmental staff identified as being responsible for defining data requirements and ensuring departmental or project based data quality and effective use?	No formal ownership within departments, staff use their own initiative and rely on "gut feel" or self-defined standards of accuracy and quality.	Departmental data users or experts have an informally acknowledged role in assuring that data are captured consistently and accurately.	Clearly defined, formal roles are called out for data stewardship in some high-priority areas or departments.	Data stewards are present and acknowledged throughout all departments the organization, and held accountable for accurate, reliable, integrated data to achieve organizational goals.

SCORE	0	1	2	3	4	5	6	7	8	9	10	11

ACTION PLAN

Data Stewardship

INSTRUCTIONS FOR BUILDING THE ACTION PLAN
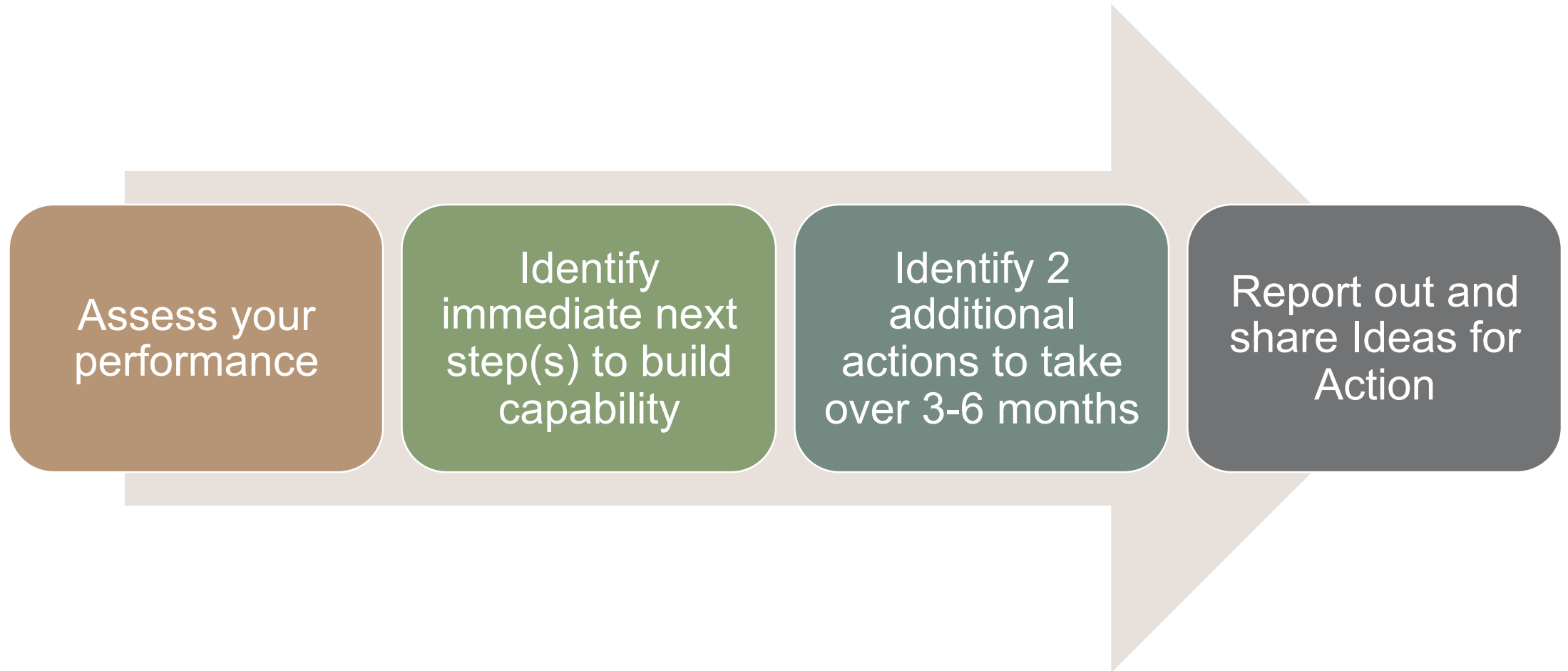
Assess your performance

Identify immediate next step(s) to build capability

Identify 2 additional actions to take over 3-6 months

Report out and share Ideas for Action

1. DATA STEWARDSHIP

The role of the data steward is to ensure that data are accurate, complete and timely and support the end users needs.

- *To what extent have staff been identified as being responsible for defining data requirements and ensuring departmental or project based data quality and effective use?*

Reactive	Responsive	Proactive	Predictive
No formal ownership within departments; staff use their own initiative and rely on "gut feel" or self-defined standards of accuracy and quality.	Departmental data users or experts have an informally acknowledged role in assuring that data are captured consistently and accurately.	Clearly defined, formal roles are called out for data stewardship in some high-priority areas or departments.	Data stewards are present and acknowledged throughout all departments the organization, and held accountable for accurate, reliable, integrated data to achieve organizational goals.
0	1	2	3	4	5	6	7	8	9	10	11

DATA STEWARDSHIP

The role of the data steward is to ensure that data are accurate, complete and timely and support the end users' needs.

- If a data steward has not been identified, who is the logical choice?
- If a data steward has been identified, what is working and what are the opportunities?
- Is there an opportunity to expand the concept to other departments and specialties?

IDEA SHARE

Data Stewardship

IDEAS FOR ACTION

Data Stewardship

Executive Director set clear expectations for data stewardship throughout the organization but especially at orientation.

Assigned staff in each department to be data stewards; they ensure data quality, accessibility of data, set data/reporting priorities and support improvement of measures in their department.

Medical Director took on the role of data steward to prioritize the data and information requests that were overwhelming analysts; assigned "deputies" by specialty care (DM, HTN)

Defined the role, skills and competencies of data stewardship and incorporated it into every job description in the organization. ("We are all data stewards").

RESOURCES & TOOLS

Data Steward Responsibilities

- DG Handbook p. 16

2. DATA GOVERNANCE

Data governance refers to the processes and structures in place to oversee and manage the data strategy, data and information needs, conflicts, definitions and gaps within an organization. The purpose of data governance is to improve data quality, increase data literacy, and maximize data use to achieve organization goals.

- *To what extent are data issues and opportunities prioritized, resourced, and managed within your organization?*

Reactive	Responsive	Proactive	Predictive
Motivated individuals or groups within a department take ownership of their priority data needs and do what they can within their control; IT generally makes most data decisions.	Teams are formed to address data management for one-off initiatives when a problem or new clinical/business case requires it and depends on the project team to execute.	A formal data governance project management structure is emerging in the organization to ensure that priority goals and objectives can be met and the data needed is available.	Cross-functional team(s) meets regularly to ensure that data definitions and data requirements are integrated, standardized and documented, and data access is optimized both across the organization and with external partners.
0	1	2	3	4	5	6	7	8	9	10	11

IDEA SHARE

Data Governance

IDEAS FOR ACTION

Data Governance

Use monthly QI committee meeting to raise and prioritize data quality issues, in effect building a data governance structure.

Develop (and share) a tool to enable prioritization of analytics efforts and resource allocation. Transparency is key to democratic data governance.

Re-convene EHR team as a data governance committee with cross department representation.

Place a standing agenda item on the Executive Committee meeting for setting priorities, resolving competing data requests, setting access and security policies and lobbying for resources.

Use established data governance councils to more proactively strategize about how to collect and use data. Staff can pitch data requests (e.g., to show how they aligned with the strategic goals and how the benefits of collecting data would outweigh costs).

RESOURCES & TOOLS

Data Governance Charter
- DG Handbook pg 10-12

Data Governance Committee Agenda
- DG Handbook pg 13

Governance Policies and Procedures
- DG Handbook pg 19 - 21

3. DATA QUALITY

Data Quality refers to the trustworthiness of data used in the organization for decision-making and the efforts to ensure accuracy, completeness, and timeliness.

- *To what extent does your organization ensure accurate data across the organization?*

Reactive			Responsive			Proactive			Predictive		
Not a priority. Most efforts are focused on cleanup and individual intervention; data quality review does not occur with rigor or regularity in the organization.			Data quality reviews occur within selected teams, departments or sites but the efforts are usually one-time efforts and not sustained on an ongoing basis.			Departmental data quality tracking reports are produced on a regular basis and are integrated and aligned across the organization; common errors are assessed and training occurs to address them.			Data collection and aggregation is highly automated with built-in data quality checks and exception reports; measures of data quality (e.g., % accuracy) prioritize and inform ongoing data quality efforts and trace errors to individuals for training.		
0	1	2	3	4	5	6	7	8	9	10	11

IDEA SHARE

Data Quality

IDEAS FOR ACTION

Data Quality

Provide new staff with orientation on inputting quality data, data standards and data stewardship.

Create guidelines and processes for data input and quality to increase trust in data.

Document data definitions for key performance metrics and share on enterprise site (e.g. SharePoint) so that everyone had a definitive reference.

IDEAS FOR ACTION, CONTINUED

Data Quality

Use analytics tools to generate quarterly data accuracy reports (missing data, obvious incorrect/out-of-range data, etc.).

Hold 1:1 meeting with care teams to engage them being part of the solution to data problems.

One health center incorporated a data quality segment into all standard reporting forums (QI, department meetings, etc.).

RESOURCES & TOOLS

HITEQ Center -Data Quality Checklist

4. DATA-DRIVEN CULTURE

A data-driven culture refers to an organizational climate that embraces use of data in achieving organization goals and making positive change through continues improvement in all areas.

- *To what extend does the organization promote data literacy and require supporting data to make decisions?*

Reactive	Responsive	Proactive	Predictive
The focus of data and information management is mostly on accurate historical data and retrospective reporting.	Data and information is available and used by department heads, but not uniformly required when making operational decisions or changing strategy.	Data and information is used by managers and leaders on a regular basis, is pushed down and across the organization, and is required to support business cases and key decisions.	Data-driven decisions are pervasive in the organization at all levels. Line staff knows how their day-to-day actions affect performance metrics and achievement of goals. Data literacy is a hallmark of the organization.

0	1	2	3	4	5	6	7	8	9	10	11

IDEA SHARE

Data-Driven Culture

IDEAS FOR ACTION

Data-Driven Culture

Leaders must communicate and model data-driven behavior. Try doing a simple cost benefit analysis on data projects to get their attention.

Develop site and provider level scorecards to make measures more relevant to teams and individuals. The more people can see their actions reflected in metrics, the more engaged they'll be.

Utilize platforms like SharePoint to post reports that all staff can see; more sophisticated systems can allow users to select from drop down menus by site, department and provider to easily access their data.

Produce reports in ways that users can easily identify what action they need to take (e.g., screening rate plus number of screenings to reach goal).

RESOURCES & TOOLS

Communication Roles & Responsibilities

- DG Handbook pg 18

Training and Data Literacy Plan

- DG Handbook pg 22

THE DAY IN REVIEW:

- Data are an asset.
- Virtually all data issues can be mapped back to the Triple Aim of Data Governance.

MAXIMIZE DATA ACCESS

IMPROVE DATA QUALITY

DATA GOVERNANCE

INCREASE DATA LITERACY

THE DAY IN REVIEW:
ESSENTIAL ROLES AND STRUCTURES
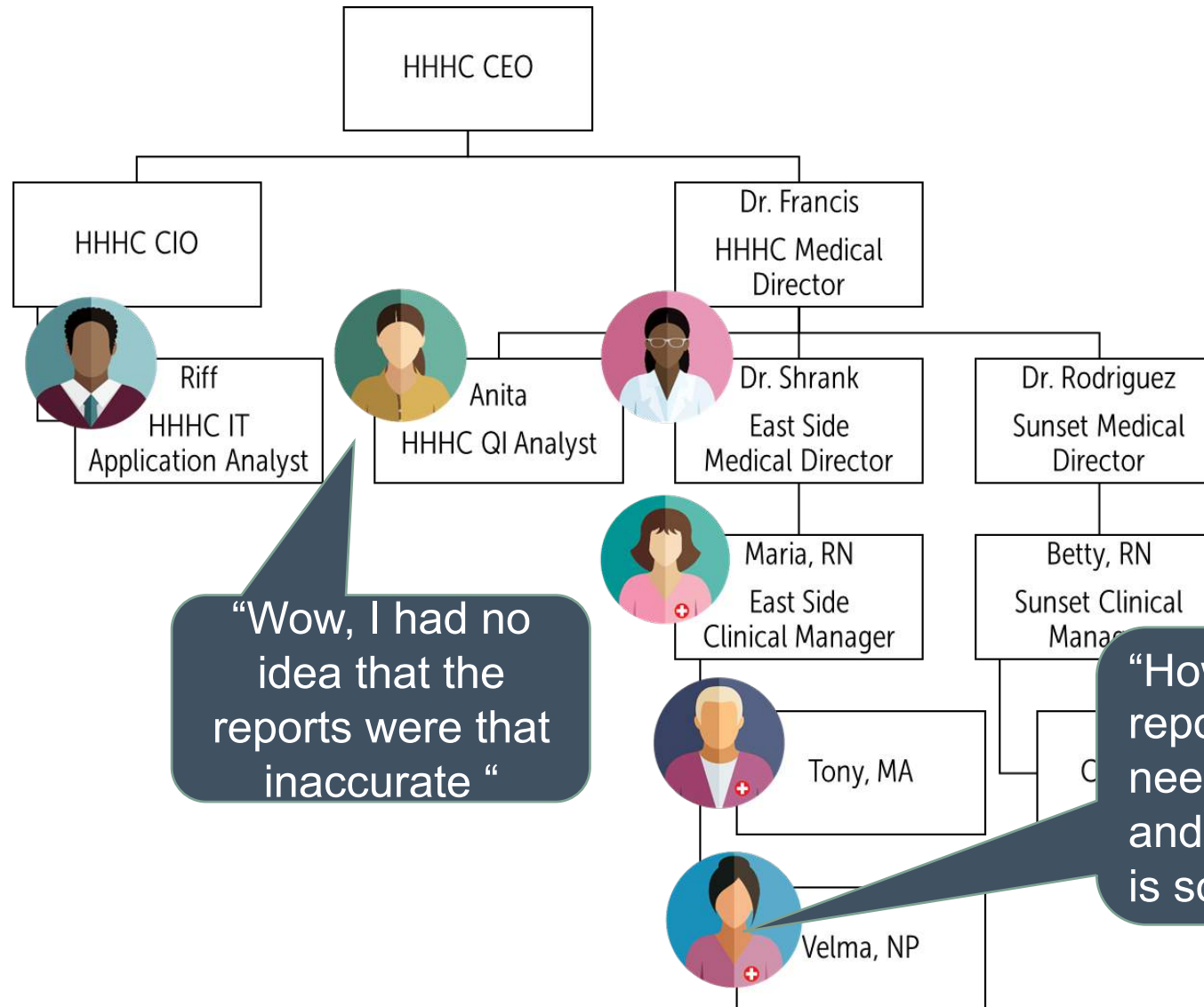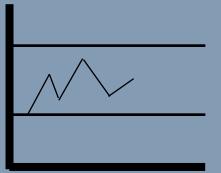
THE DAY IN REVIEW: MODULE 4
IT'S A JOURNEY

Healthcare Analytics

Reactive

Responsive

Proactive

Predictive
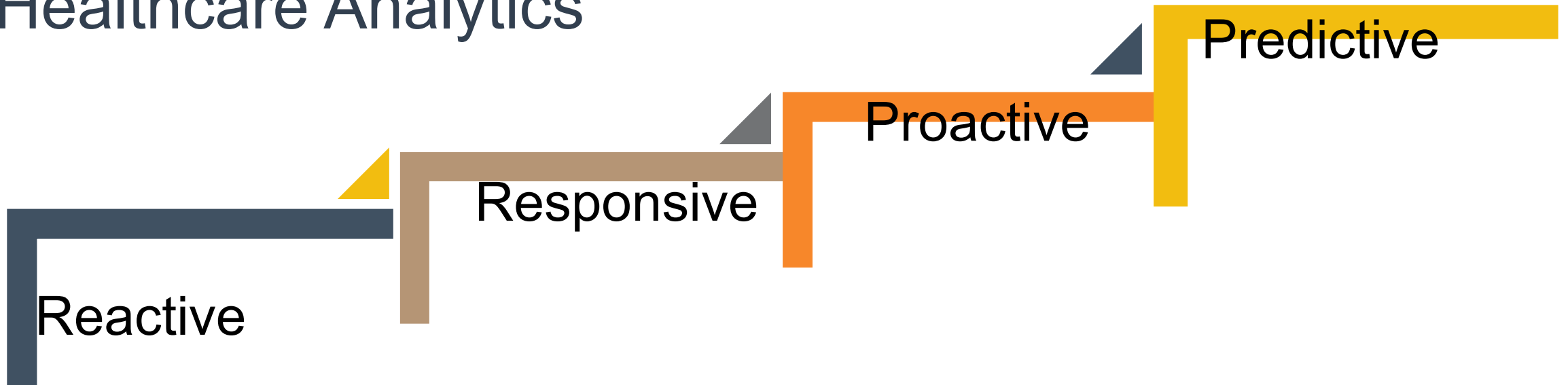
Building a Data Driven Culture

HOW DO I KNOW IF WE'RE DATA DRIVEN?

Data Denial — You distrust data and avoid using it

Data Indifferent — You don't care about data and have no need for it

Data Informed — You use it only when it supports your opinions or decisions

Data Driven — You use it to shape and inform all your decisions
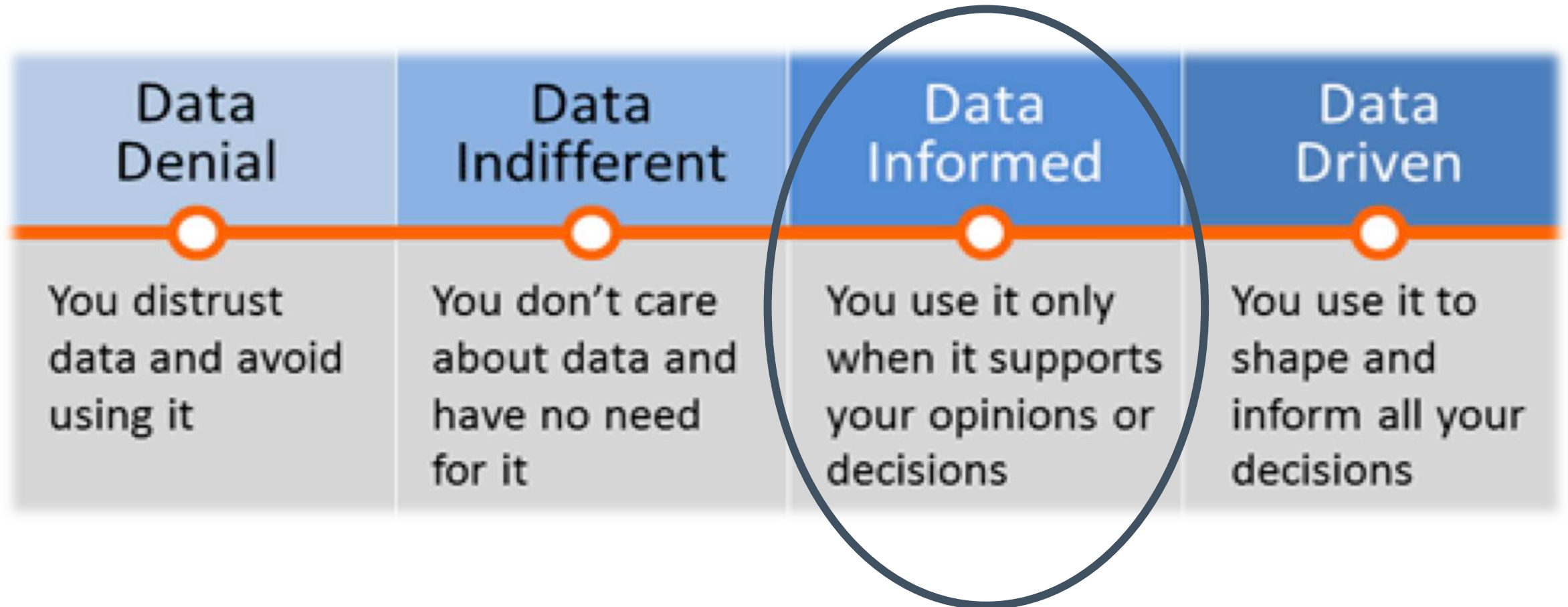
Lunch
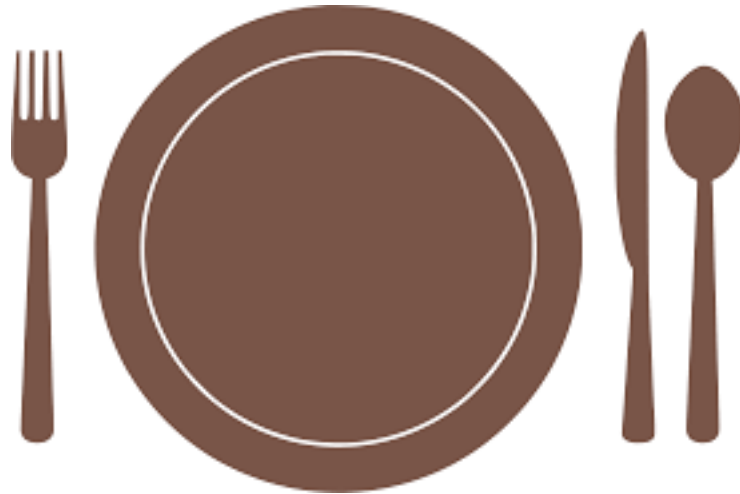
Team Project Sharing: Lightning Rounds

KPTA Storyboard

CCI Health & Wellness Services
Greenbelt

10,000
economically disadvantaged/homeless/disabled
state medical assistance coverage or uninsured

Claudia Guevara
Health Center Manager

Services
Prenatal, Reproductive Health, Family Planning,
(Preventive Cancer Screenings, Nutrition Counseling, Centering)

Transformation Goals

from 78% to 85%
preventive cervical cancer screenings
Patients (21-29 yrs) by July 2018

Screening Guidelines
Approved July 2017

Org. goal
Increase the percentage of patients 21 to 29 years of age who had a preventive cervical cancer screening (Cytology or PAP) within the past 3 years from 78% to 85% by the end of FY18.

Project outcome
To ensure that women beginning at the age of 21 are receiving there pap's every 3 years if results are normal and yearly if results are abnormal.

Primary Driver (1)
Having a more efficient way of tracking when women are due for Pap's

Primary Driver (2)
Protocol for abnormal Pap's to be standard for all CCI.

Secondary Driver (1)
Make sure to get results if patient received Pap smear elsewhere and Verify that each patient eligible for annual Pap gets in for an appointment.

Secondary Driver (2)
Verify the workflow for MA's once a patient results are abnormal.

Ideas to test
Add a pop up for patient who is due for a Pap, or need results from last pap.

Ideas to test
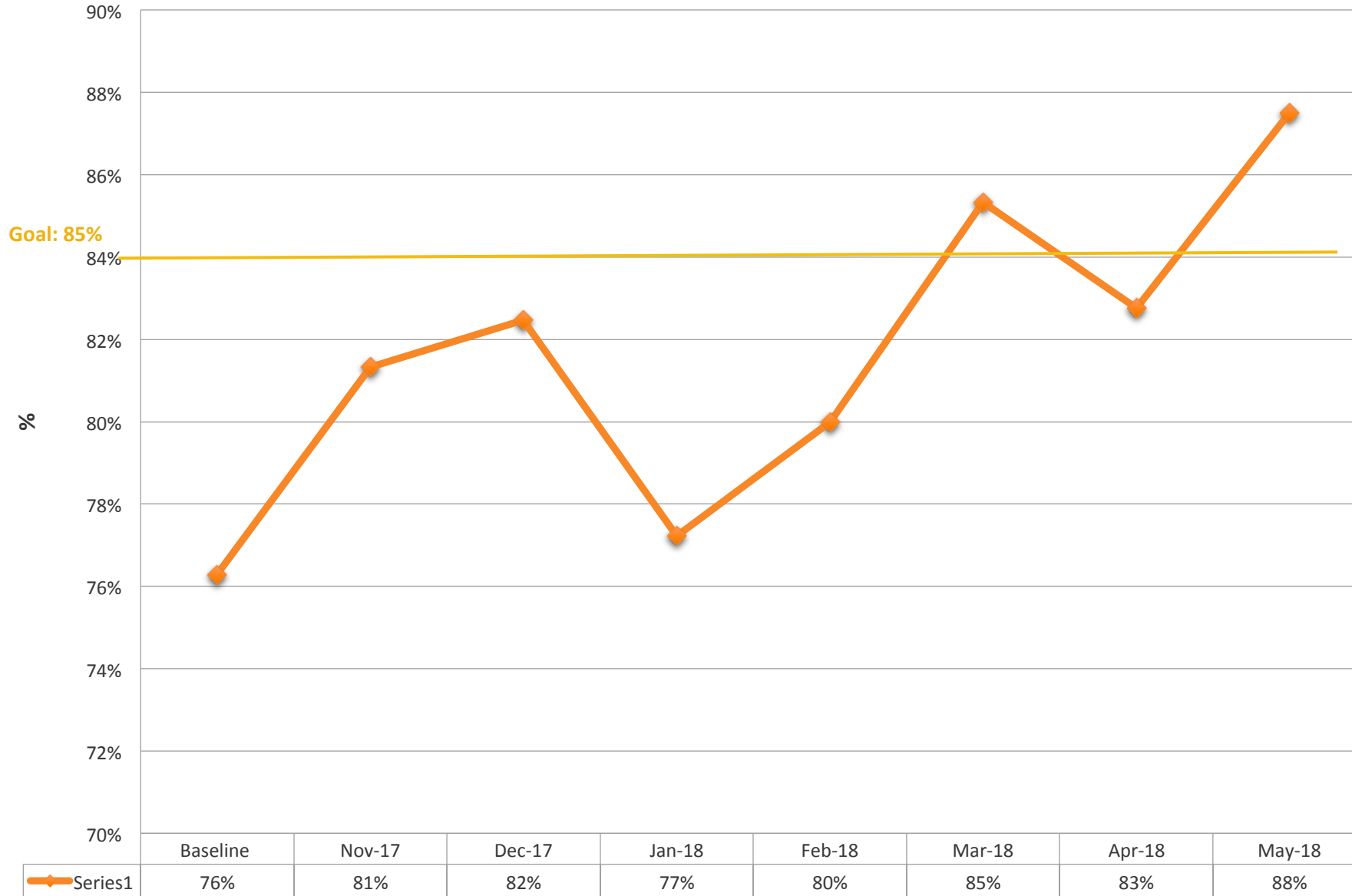Work with LabCorp and i2i to receive reports on abnormal labs.

Driver Diagram

January, 2018

CCI - Cervical Cancer Screening   Greenbelt - FY2018

Goal: 85%

%

	Baseline	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Series1	76%	81%	82%	77%	80%	85%	83%	88%

Project Measures

- ✓ Data Management
- ✓ Management Transition

Challenges

- ✓ Data Management
- ✓ Huddle Reports
- ✓ Flags and Alerts
- ✓ Patient recall process
- ✓ Lab results
- ✓ Abnormal results

Lessons Learned

I Got a Fever...

Boris Kalikstein

Pivotal Moment Consulting

The purpose for measurement

- What the problem we're trying to solve?

  - The guy has a fever…how do we know, we measured

- Act on the data

  - Provide more cowbell

How do we identify problems?

- Acute exacerbation

- Patient tells us

- Receive some piece of information

- I know what my patient needs

Why measure, I know my patients

"It takes 7.4 hours per working day to provide all recommended preventive care to a panel of 2,500 patients, plus 10.6 hours to manage all chronic conditions adequately"

I don't even KNOW you.

I have a small panel of patients

- Detailed measurements is not for me
  - I only have 50 diabetic patient on my panel
  - I have taken care of them for years

- Ask yourself
  - When were they last seen?
  - What were there last 3 A1C values? Were they trending in the right direction?
  - When was the last foot exam? (73,000 amputations per year – CDC)
  - When was the last eye exam? (1 in 3 have diabetic retinopathy – CDC)
  - Etc.

Let's play a game

Please memorize this string of numbers

1 – 914 – 191 – 81 – 93 – 919 – 4 – 5

Take no more than 15 seconds…

Say the numbers in order

1 – 914 – 191 – 81 – 93 – 919 – 4 – 5

YOU WANT TO TRUST YOUR MEMORY?

Other challenges

- Data is too hard to get

- It's not accurate

- It's not timely

- It's not actionable

- I have too much to do already

Clinica Family Health

CASE STUDY

What's the problem we are trying to solve?

- Provide excellent quality of care for our patients to prevent further spread of disease, focus on prevention and makes lives better

- To do this, we needed to understand our population of patients

Incremental Change

Sunday	Monday	Tuesday		Friday	Saturday
Week #1	Prenatal Chronic Pain Pap Mngt CM D	CM Dep BHP Dep Blue PR Dep			
Week #2	ADHD Coumadin Diabetes(half)	CM Dep BHP Dep Green PR Dep			
Week #3	Prenatal HTN Missing Pap	CM Dep BHP Dep Red PR Dep			
Week #4	Coumadin Diabetes(half)	CM Dep BHP Dep Orange PR Dep			

Guided Decision Making

High Risk

Last Name	First Name	DOB	Visit	BP Sys	BP Dias	Tobacco	Eye Exam	SM Goal	Foot Exam	LDL Date	LDL	A1c Date	Value
	Bonnie	/1952	11/13/2008	122	80	Current	08/01/2007	11/13/08	05/15/2008	04/03/2008	59		

Group Visit No

												11/13/2008	7.80
												09/04/2008	8.00
												07/17/2008	8.00

Last Name	First Name	DOB	Visit	BP Sys	BP Dias	Tobacco	Eye Exam	SM Goal	Foot Exam	LDL Date	LDL	A1c Date	Value
	Angelica	/1975	03/26/2009	115	69	Never		12/11/08	03/26/2009	02/15/2008	90		

Group Visit Yes

| | | | | | | | | | | | | 03/26/2009 | 8.90 |
| | | | | | | | | | | | | 12/11/2008 | 9.50 |

Last Name	First Name	DOB	Visit	BP Syst	BP Dias	Tobacco	Eye Exam	SM Goal	Foot Exam	LDL Date	LDL	A1c Date	Value
Diabetes Planned Care Ruler			If more than six months, make appt. Otherwise, see BP, LDL & A1c rules	If above 130, appt every month	If above 80, appt every month	If current smoker, CM to review for Tobacco Cessation counseling	If not within one year, put on list for DM Eye Exam GV	If not within one year, CM to set goal with patient	If not within one year, make appt	If not within one year, make appt	If above 130, appt every month. If 100-130, appt every 3 months	If not within 3 months, make appt (6 months okay if last value less than 7.0)	If above 9, appt every month. If 7.0 - 9.0, appt every 3 months. If below 7.0, appt every 6 months

| | Teresita | /1974 | 03/26/2009 | 110 | 72 | Never | 10/10/2008 | 1/30/09 | 10/16/2008 | 01/30/2009 | 75 | | |

Data rich but information poor

- Having an EMR and collecting data does not translate into action

- EMRs
  - Thousands of data points

  - Visually aggregates the data points on EMR screens

  - Providers and teams mentally evaluate the data to convert it into information that drives patient care
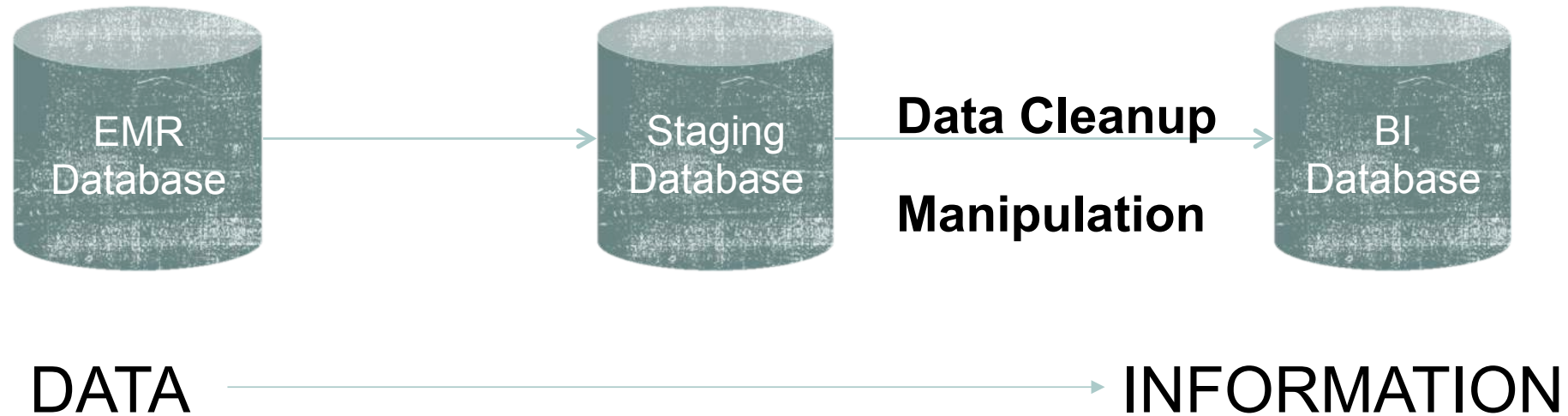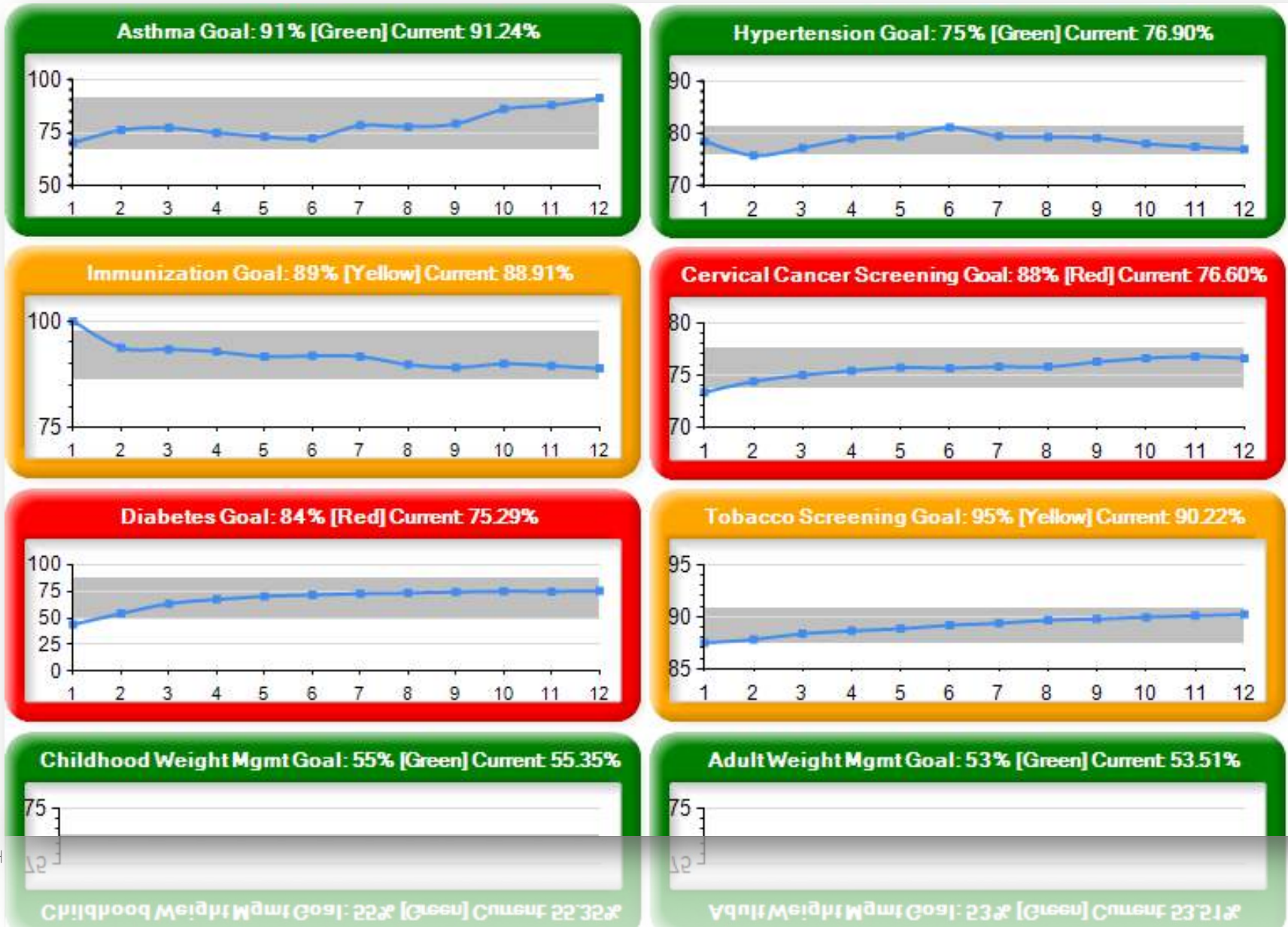
Data vs. Information

PARIS
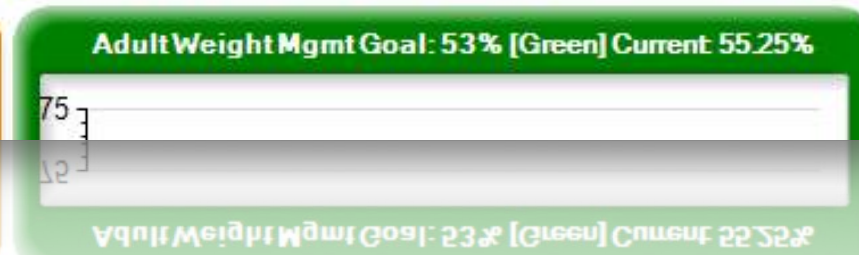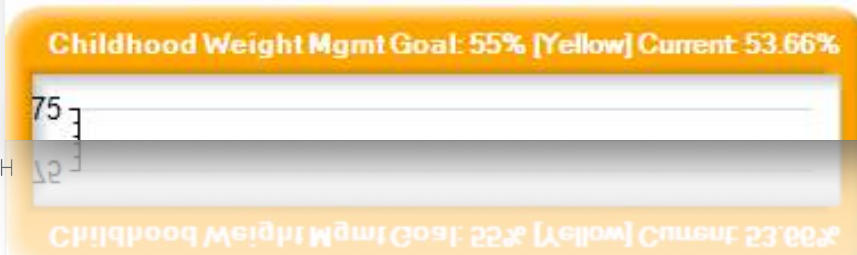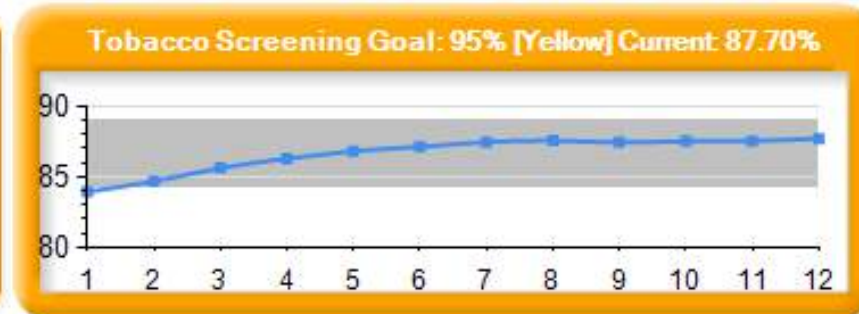IN THE
THE SPRING

POP
GOES THE
THE WEASEL

Warehousing

EMR
Database

Staging
Database

Data Cleanup

Manipulation

BI
Database

DATA   INFORMATION

Start with the big picture

Cascade the message
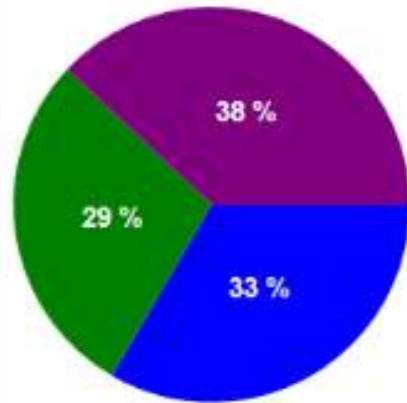
Make it manageable

Make it actionable

Planned Care Registry Outreach

REPORT SPECIFICATIONS

SHOWING PATIENTS WITH DIABETES ALERT(S)

Total Patients: 55			
Person Nbr	**Patient Details**	**Visits and Appointments**	**Outreach Details**	**Patient Care Alerts**

Dryden, Kevin				
842791	DOB: Age: 49 Preferred Contact Method: Home Phone: Day Phone: Alternate Phone: Secondary Phone: Email: Cell Phone: Language:English ACO: N Medicaid Nbr: My CLINICA Connection Status: Enrolled OB Status: Groups:	PCP: Dryden, Kevin PDP: Missing PDP Hygienist: Last Visit: 11/18/2015 Dryden, K-DIA Last WCC: Payer: Medicaid FQHC Next appt: Last Dental Visit: Next Dental Visit:	**Clinical** Date Reviewed:12/17/2015 Comments: Lvm informing pt to RCTC and schedule apt for DM. IH Call Attempt:2nd Call Call Status:Left message **Dental** Date Reviewed: Comments: Call Attempt: Call Status:	**Clinical** Past Due - Diabetes Eye Exam Past Due - Diabetes Foot Exam Past Due - High Blood Pressure > = 140/90 (Diabetes,) Past Due - Last A1c > 9 on 11/18/2015 Past Due - LDL (Cholesterol) Lab Past Due - Tdap/TD Vaccine ACO Care Team Score is 3 **Dental**

Close the loop

Person Nbr	Patient Name	PCP/ Status	Phone Number	Age/ DOB	Gender	Last Visit	ACO
842791		PCP: Dryden, Kevin Status: Active Payer: Medicaid FQHC Group Visits: My CLINICA Connection Status: Enrolled		49 Year(s)	M	11/18/2015 Dryden, K Last WCC: CarePlan Rvw:	X

Alerts	Appts	Active Problem List
Past Due - Diabetes Eye Exam Past Due - Diabetes Foot Exam Past Due - LDL (Cholesterol) Lab Past Due - Last A1c > 9 on 11/18/2015 Past Due - High Blood Pressure > = 140/90 (Diabetes,) Past Due - Immunizations (Past Due - Tdap/TD Vaccine,) ACO Care Team Score is 3		11/18/2015 - Alcohol-induced chronic pancreatitis 11/18/2015 - Continuous chronic alcoholism 06/17/2014 - Alcoholism - 303.90 06/17/2014 - Iron deficiency anemia - 280.9 06/17/2014 - Methamphetamine abuse - 305.70 06/17/2014 - Pancreatitis - 577.0 06/17/2012 - Diabetes type 2, uncontrolled - 250.02

Active Medications

Start Date	Stop Date	Prescribed Elsewhere	Brand Name	Generic Name	Dose	Instructions
12/21/2015	12/20/2016		SURE COMFORT	PEN NEEDLE, DIABETIC	30 gauge X 5/16"	Inject 10 U of Levemir SQ HS
12/21/2015	12/19/2016		TRUETRACK TEST STRIP	BLOOD SUGAR DIAGNOSTIC		use 1 Strip by In Vitro route 1 - 3 times every day as needed to monitor blood glucose
12/21/2015	12/14/2016		THIN LANCETS	LANCETS		inject by Misc.(Non-Drug; Combo Route) route 1- 2 times every day for testing blood sugar.
12/03/2015	05/29/2016		WAVESENSE PRESTO	BLOOD-GLUCOSE METER		take 1 by Injection route 3 times every day for 365 days Check blood sugar TID
11/18/2015	11/11/2016		LEVEMIR FLEXTOUCH	INSULIN DETEMIR	100 unit/mL (3 mL)	inject 10 Unit by subcutaneous route every morning
11/18/2015	11/11/2016		LISINOPRIL	LISINOPRIL	5 mg	take 1 tablet by oral route every day
11/18/2015	11/11/2016		NOVOLOG FLEXPEN	INSULIN ASPART	100 unit/mL	inject by subcutaneous route per prescriber's instructions. Insulin dosing requires individualization.
06/05/2015	06/19/2016		TRUETRACK BLOOD GLUCOSE SYSTEM	BLOOD-GLUCOSE METER		use 1 by Topical route every day for glucose monitoring

Diabetes - High Risk

Systolic	Diastolic	Eye Exam	Foot Exam	A1c (Last 3)
140	80			11/18/2015 - 11.5 03/10/2015 - 14.6 08/14/2014 - 14.6

Group Visit: No

Open Referrals	Future Labs	Diagnostics

What problem are YOU trying to solve?

- How patients qualify for cervical cancer screening? When were they last screened? How much outreach do you need to do to reach your goal?

- How many patients need dental sealants? What's the reduction of caries?

- How do you expand HIV services? Do you have a defined panel of patients? Do you know what they are due for and when in their treatment plan?

- What's my time to third? Are your templates setup to allow ease of scheduling? How are you tracking outreach? What is your schedule utilization?

Boris Kalikstein | boris@pivotalmomentconsulting.com | 720.289.9542

Pivotal Moment Consulting

pivotalmomentconsulting.com

Take a break!

Team Project Sharing: Lightning Rounds

Family and Medical Counseling Service, Inc. (FMCS)

Angela Wood

Pat Grimes

Wenona Posey

Mia Thompson

LaTasha Currie

LaDonya McClure

Who is on your core project team to support work done in the Transformation Accelerator Program?

Angela Wood,COO

Pat Grimes, NP

Wenona Posey, Clinical Office Manager

Mia Thompson, Care Coordinator

LaTasha Currie, Medical Assistant

LaDonya McClure, Billing Supervisor

Aims and Measures

FMCS Aim

To increase the number of patients receiving care at the MD site by 100% by December 2018.

FMCS Measure

To maintain a daily appointment filled rate of 80%.

> **Numerator:** The number of filled appointment slots
>
> **Denominator:** The number of available appointments

Drivers and Changes

Drivers

- Access/Appointment Availability
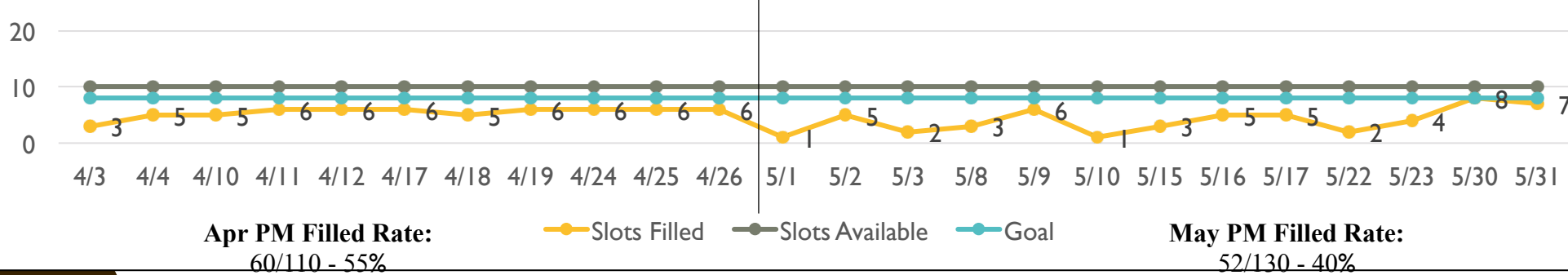- Community Relationships

Changes

- Change 1: FMCS modified the medical scheduling template changing to a standard 20 minute slot for all appointments and increased the hours that we are open at the MD slot by one hour.
- Change 2. FMCS has facilitated meeting with MCO's that we are credentialed with in MD.
- Change 3: FMCS Change 3: FMCS is opening the clinic for one Saturday per month and on Mondays.
- Change 4: FMCS put a system in place for monitoring number of available appointments each month in comparison to the number of filled appointments each month.
- Change 5: FMCS is participating in numerous community outreach events to increase awareness of our service delivery package.

DATA

Time Slots Available and Filled (AM Blocks)
Reporting Period: 4/1/18-5/31/18

Apr AM Filled Rate:
71/110- 66%

— Slots Filled — Slots Available — Goal

May AM Filled Rate:
71/120- 59%
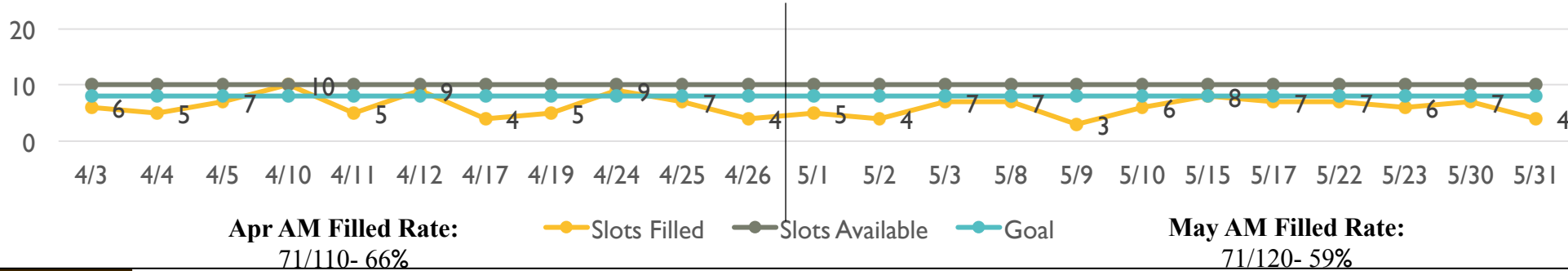
Time Slots Available and Filled (PM Blocks)
Reporting Period: 4/1/18-5/31/18

Apr PM Filled Rate:
60/110 - 55%

— Slots Filled — Slots Available — Goal

May PM Filled Rate:
52/130 - 40%

PRIMARY MEDICAL MD Slots Filled Report Summary

- Slots filled rate in the AM decreased by 7% from April to May.

- Slots filled rate in the PM decreased by 15% from April to May.

- 19% more slots are being scheduled in the AM than in the PM.

Learning and Challenges

FMCS has learned several key lessons as a result of program changes:

1. Patients in the service area seem to prefer the corning session.

2. The addition of the later hour in the evening has not yielded additional patient volume

Team Time!

Team Time Worksheet

Use this worksheet to help you plan your next steps after this learning session. Reference your driver diagrams and charters as needed. Please write legibly; CCI will be collecting this worksheet and emailing your team a scanned copy after the convening.

ORGANIZATION NAME: _____

TOP IDEAS TO TAKE BACK

What ideas do you want to take back from today's convening?

ACTIONS TO DRIVE IMPROVEMENT IN YOUR PROJECT

Define 3 to 5 activities or actions you need to take that align with your project aim, measures, and drivers. Ruthlessly prioritize!
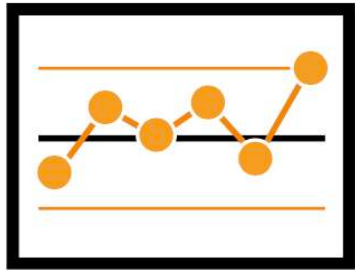
1.

2.

3.

COHORT CONNECTIONS

Please share which organizations or faculty you'd like to connect with after the convening and for what reasons.

4.

5.

KP Transformation Accelerator| July 24, 2018 Learning Session

What's Next?

Submit Monthly Data

7th of each month

Coaching with Tammy & Carolyn

Final Learning Session

October 10th

Final Report

Due: Dec. 31st

Thank you!

*Please complete the evaluation survey.

*Materials and slides for today's learning session are available at:

https://www.careinnovations.org/accelerator-team/resources/#learningsession