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/
Today’s Faculty

SA Kushinka

Jerry Lassa

Boris Kalikstein
Who is in the room?

Health Center Teams

Support Partners & Faculty

- Mary’s Center
- Greater Baden Medical Services
- Family and Medical Counseling Services
- CCI Health & Wellness Services
- La Clínica del Pueblo

- CCI Center for Care Innovations
- CCI
- Kaiser Permanente
- Regional Primary Care Coalition
Where are we in our Transformation Accelerator journey?

Phase 1 ➔ Program Launch  
April 2017 Convening  
Coaching Begins  
Project Charters & Driver Diagrams Submitted  

Phase 2 ➔ Team-Based Care  
October 2017 Learning Session  
December and January Site Visits  
Progress Report Submitted  

Phase 3 ➔ Planned Care  
February 2018 Webinar  
Shared Advocacy Project Begins  
May 2018 Virtual Learning Sessions  
Progress Report Due  

Phase 4 ➔ Data Analytics  
July 2018 Learning Session  

Phase 5 ➔ Population Health  
October 2018 Learning Session  

Program Ends: December 2018  
Coaching Ends  
Final Reports Due
Regional Primary Care Coalition

Kaiser Permanente Transformation Accelerator Shared Project

July 24, 2018
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
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
---|---
2016 | 30
2017 | 30
YTD 2018 | 20
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
FUNDAMENTALS OF DATA GOVERNANCE:
A WORKSHOP FOR HEALTH CENTERS

SAFETY NET ANALYTICS PROGRAM (SNAP) LAB

A workshop for Kaiser Permanente’s Transformation Accelerator
Mid-Atlantic Region

CCI
CENTER FOR CARE INNOVATIONS
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
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 **people**, **processes**, and **techniques** for managing data.
WORKING SINGLE HANDEDLY?

ACT to address data quality issues!

“These aren’t my patients!”

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?
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
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
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
Drivers and Changes

Aim

By December 31, 2018, integrate HIV primary care into LCDDP Hyattsville site, enrolling 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 LCDDP
- Other care team scheduling
- HIV 101, Resources and Benefits
- Stigma/Safe Space Behaviors
- Shadowing/coaching for non-clinicians
- DC Care team recommit, handoff
- MD Health Department
- PCMH Patient Handoff- Blue Team

Specific Ideas to Test or Change Concepts
- Relevance of training
- Monitor staff experience
- Monitor Patient Experience
Data – Run Chart

# of HIV patients paneled with Husni

- **Days**
- **Goal Line**

Time Period:
- January
- February
- March
- April
- May
- June
- July
- August
- September
- October
- November
- December

Goal Line:
- 25 days
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
Take a break!
Team Project Sharing: Lightning Rounds
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

- 61.4%
- 78.05%
- 68.26%
- 79.01%

- 38.86%
- 21.95%
- 31.74%
- 20.99%
Data

Percent of Targeted Patients Screened for Cervical Cancer at all Mary’s Center Sites (Nov 2017 - April 2018)

Percent of Targeted Patients Screened for Cervical Cancer at Adelphi Site (Nov 2017 - April 2018)
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
SAFETY NET ANALYTICS PROGRAM LAB

Module 4: Data Governance Action Plan
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

- Reactive
- Responsive
- Proactive
- Predictive

Building a Data Driven Culture
## COMPONENTS OF THE "ACA"

### Domain: People

**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.

**Factor:** 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?

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**Scoring Level:**

- **Score:** 0-11
- **Indicators:**
  - No formal ownership within a department, staff rely on "gut feeling" 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 the organization, and held accountable for accurate, reliable, integrated data to achieve organizational goals.
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
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?

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<td>No formal ownership within departments; staff use their own initiative and rely on “gut feel” or self-defined standards of accuracy and quality.</td>
<td>Departmental data users or experts have an informally acknowledged role in assuring that data are captured consistently and accurately.</td>
<td>Clearly defined, formal roles are called out for data stewardship in some high-priority areas or departments.</td>
<td>Data stewards are present and acknowledged throughout all departments the organization, and held accountable for accurate, reliable, integrated data to achieve organizational goals.</td>
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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?
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
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?
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
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?**

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<td>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.</td>
<td>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.</td>
<td>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.</td>
<td>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.</td>
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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?

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<td>The focus of data and information management is mostly on accurate historical data and retrospective reporting.</td>
<td>Data and information is available and used by department heads, but not uniformly required when making operational decisions or changing strategy.</td>
<td>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.</td>
<td>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.</td>
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### 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.
“Wow, I had no idea that the reports were that inaccurate.”

“How are all the reporting and data needs being managed and prioritized? There is so much going on.”
THE DAY IN REVIEW: MODULE 3
INCREASING DATA LITERACY

1. Data/Analysis Focus Aligned with Strategy
2. Balanced Measures
3. Data Quality
4. Trending of Data
5. Use of Targets or Goals
6. Self Service
7. Advanced Analysis Techniques
THE DAY IN REVIEW: MODULE 4
IT’S A JOURNEY

Healthcare Analytics

Building a Data Driven Culture

Reactive

Responsive

Proactive

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

Work with LabCorp and i2i to receive reports on abnormal labs.
CCI - Cervical Cancer Screening

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<th>Series1</th>
<th>Baseline</th>
<th>Nov-17</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Mar-18</th>
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<tr>
<td></td>
<td>76%</td>
<td>81%</td>
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Goal: 85%
✓ Data Management
✓ Management Transition
Lessons Learned

- Data Management
- Huddle Reports
- Flags and Alerts
- Patient recall process
- Lab results
- Abnormal results
Boris Kalikstein
Pivotal Moment Consulting
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
- Acute exacerbation

- Patient tells us

- Receive some piece of information

- I know what my patient needs
“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”
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.
Please memorize this string of numbers


Take no more than 15 seconds…
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
CASE STUDY
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
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<th>Monday</th>
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<tr>
<td>Week #1</td>
<td>Frencal</td>
<td>Chronic Pain</td>
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<td>EHP Dep</td>
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<td></td>
<td>Dep</td>
</tr>
<tr>
<td>Week #2</td>
<td>ADHD</td>
<td>Diabetess (11th)</td>
<td>CM Dep</td>
<td>EHP Dep</td>
<td>Green PR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Dep</td>
</tr>
<tr>
<td>Week #3</td>
<td>Frencal</td>
<td>HIV</td>
<td>CM Dep</td>
<td>EHP Dep</td>
<td>Red PR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Missing Pap</td>
<td></td>
<td></td>
<td>Dep</td>
</tr>
<tr>
<td>Week #4</td>
<td>Coumadin</td>
<td>Diabetess (11th)</td>
<td>CM Dep</td>
<td>EHP Dep</td>
<td>ORANGE PR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Dep</td>
</tr>
</tbody>
</table>
### Diabetes Planned Care Ruler

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>DOB</th>
<th>Visit</th>
<th>BP Syst</th>
<th>BP Diast</th>
<th>Tobacco</th>
<th>Eye Exam</th>
<th>SM Goal</th>
<th>Foot Exam</th>
<th>LDL Date</th>
<th>LDL</th>
<th>A1c Date</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bonnie</td>
<td></td>
<td>/1952</td>
<td>11/13/2008</td>
<td>122</td>
<td>80</td>
<td>Current</td>
<td>08/01/2008</td>
<td>11/13/08</td>
<td>05/15/2008</td>
<td>04/03/2008</td>
<td>69</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Notes:
- **High Risk**
- **Group Visit**
- **BP Syst**: If above 130, check every month.
- **BP Diast**: If above 80, check every month.
- **Tobacco**: If current smoker, refer for Tobacco Cessation counseling.
- **Eye Exam**: If not within one year, set up for DM Eye Exam OY.
- **SM Goal**: If not within one year, make apt.
- **Foot Exam**: If not within one year, make apt.
- **LDL**: If above 130, check every month.
- **A1c Date**: If not within 3 months, make apt. 6 months okay if last value less than 7.0.

---

**Clinica Family Health**

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- 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
EMR Database  →  Staging Database  →  Data Cleanup Manipulation  →  BI Database

DATA  ⟷  INFORMATION
# Planned Care Registry Outreach

## REPORT SPECIFICATIONS

### SHOWING PATIENTS WITH DIABETES ALERT(S)

<table>
<thead>
<tr>
<th>Total Patients: 55</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Person Nbr</th>
<th>Patient Details</th>
<th>Visits and Appointments</th>
<th>Outreach Details</th>
<th>Patient Care Alerts</th>
</tr>
</thead>
<tbody>
<tr>
<td>842791</td>
<td>Dryden, Kevin</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DOB:** 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**
<table>
<thead>
<tr>
<th>Person Nbr</th>
<th>Patient Name</th>
<th>POPF Status</th>
<th>Phone Number</th>
<th>Age/DOB</th>
<th>Gender</th>
<th>Last Visit</th>
<th>ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td>842791</td>
<td>POPF: Dryden, Kevin</td>
<td>Medicaid FQHC</td>
<td>49 Year(s)</td>
<td>M</td>
<td>11/16/2016</td>
<td>Dryden, K</td>
<td>X</td>
</tr>
</tbody>
</table>

**Alerts**
- Past Due - Diabetes Eye Exam
- Past Due - Diabetes Foot Exam
- Past Due - LDL (Cholesterol) Lab
- Past Due - Last A1c > 9 on 11/16/2016
- Past Due - High Blood Pressure > 140/90 (Diabetes, )
- Past Due - Immunizations (Past Due - 1 dose Td Vaccine, )

**Active Problem List**
- 11/16/2016 - Alcohol-induced chronic pancreatitis
- 11/16/2016 - Continuous chronic alcoholism
- 06/17/2014 - Alcoholism - 305.90
- 06/17/2014 - Iron deficiency anemia - 283.9
- 06/17/2014 - Megaloblastic anemia - 285.70
- 06/17/2014 - Pancreatitis - 577.0
- 06/17/2012 - Diabetes type 2, uncontrolled - 250.92

**Active Medications**
- Start Date | Stop Date | Prescribed Elsewhere | Brand Name | Generic Name | Dose | Instructions |
- 12/2/2016  | 12/20/2016 | | TRUE TRACK | SURE COMFORT | PEN NEEDLE, DIABETIC | 30 gauge X 5/16 | Inject 10 U of Levemir SQ HB |
- 12/2/2016  | 12/14/2016 | | TRUE TRACK | TRUE TRACK TEST STRIP | BLOOD SUGAR DIAGNOSTIC | | use 1 strip by in vitro route 1-2 times every day as needed to monitor blood glucose |
- 12/2/2016  | 12/14/2016 | | THIN LANCETS | THIN LANCETS | LANCETS | | Injected by MD (Insulin Pen, Combo Route) route 1-2 times every day for injecting blood sugar |
- 12/20/2016 | 06/20/2016 | | WAVESENSE PRESTO | WAVESENSE PRESTO | BLOOD-GLUCOSE METER | | Take 1 by injection route 3 times every day for 35 days. Cheek blood sugar TID |
- 11/10/2016 | 11/11/2016 | | LEVEMIR | LEVEMIR FLIXOTEN | INSULIN DETEMIR | 100 units/mL | Inject 10 Unit by a subcutaneous route every morning |
- 11/10/2016 | 11/11/2016 | | LIGINOPIL | LIGINOPIL | INSULIN ASPART | 5 mg | Take 1 tablet by oral route every day |
- 11/16/2015 | 11/11/2016 | | NOSOLOG FLOPEN | NOSOLOG FLOPEN | BLOOD-GLUCOSE METER | 100 units/mL | Inject by subcutaneous route per prescriber's instructions. Insulin dosage requires individualization. Use 1 by topical route every day for glucose monitoring |

**Diabetes - High Risk**
- Systolic | Diastolic | Eye Exam | Foot Exam | A1c (Last 3) |
- 140 | 80 | 11/16/2015 - 11.5 | 03/16/2015 - 11.6 | 08/14/2014 - 14.6 |

**Group Note No**

**Open Referrals**

**Future Labs**

**Diagnostics**
- 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?
Take a break!

![Exercise and Coffee](image-url)
Team Project Sharing: Lightning Rounds
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 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.
**PRIMARY MEDICAL MD Slots Filled Report**

- 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.
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.

TOP IDEAS TO TAKE BACK

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

ORGANIZATION NAME: ________________________________

COHORT CONNECTIONS

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

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. 

4. 

5.
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