KP Transformation Accelerator
In-Person Learning Session #2
Thursday, March 22, 2018
Center for Total Health | Washington, D.C.
Today’s Big Awesome Agenda

1. KPTA Assessment
2. Learning from Our Changes
3. Effective Planned Care Part 1
4. Lunch
5. Effective Planned Care Part 2
6. Testing Changes and Learning from Data
7. Reflection & What’s Next
Today’s Faculty

- Alexis Wielunski
- Carolyn Shepherd
- Tierney Giannotti
- Tammy Fisher
- Maggie Jones
- Mary Blankson
Who is in the room?

Health Center Teams

Support Partners & Faculty
Where are we in our Transformation Accelerator journey?

Phase 1 ➔ Program Launch

April 2017 Convening

August 2017 Webinar

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

March 2018 Learning Session

Progress Report Due

Phase 4 ➔ Data Analytics

June 2018 Webinar

July 2018 Learning Session

Phase 5 ➔ Population Health

September 2018 Webinar

October 2018 Learning Session

Program Ends: December 2018

Coaching Ends

Final Reports Due
KP Transformation Accelerator Clinic Assessment

March 22, 2018

Center for Community Health and Evaluation
www.cche.org
Goals of assessment

- Assess changes to clinic capacity that occur during the course of the program
- Use assessment results to inform technical assistance
- Promote dialogue at the clinics about internal capacity and potential areas for improvement
Assessment domains

**Supportive leadership & culture**
(e.g., engaged executive & clinical leadership)

**QI infrastructure**
(e.g., culture of quality, structure, goals for QI efforts)

**Data-based decision making**
(e.g., use of performance measures, registry/panel level data, use of EHR)

**Team-based care**
(e.g., roles of staff, standing orders, training practices)

**Access to care**
(e.g. enhanced access, 24/7 access)

**Panel/population management**
(e.g., empanelment, proactive care, self-management support)
Working session: Complete the assessment

- 20 minutes to begin assessing your clinic’s current level/capacity with these building blocks
- We are here for support & to answer questions
- Submit your team’s completed assessment by end of day
- Looking forward: Assessment will be completed again at the end of the program
Learning from Our Changes
Activity Steps

1. Health centers will pair up.

2. Discuss your worksheets for 15 minutes. Give feedback: I like, I wish, I wonder.

3. We will do 3 rotations, with 10 minutes per rotation. Each team will have a chance to talk with 3 other teams.
Round One
Round Two
Round Three
Team Time
Team Time

Report Out
Planned Care Review
Part 1
Carolyn Shepherd
KP Transformation Accelerator
3/22/18
Planned Care Definition

Organized patient-focused care that is based on scientific evidence, planned in advance of the visit and delivered so that the team optimizes the health of every person on their panel.
Planned Care Model: A Remedy for Poor Outcomes
“What needs to be different?”

• Visit time is limited
• Inadequate ability to identify gaps in care
• Lack of clear team goals for the visit
• Data not transformed to useful tools
Road Map: Chronic (Planned) Care Model

Community
- Resources and Policies

Health System/ Healthcare Organization
- Self-Management Support
- Delivery System Design
- Decision Support
- Clinical Information Systems

Informed and Activated Patient

Prepared and Proactive Care Team

Productive Interactions

Improved Outcomes
Delivery System Design

• Focus on the patient to meet needs

• Build core primary care teams

• Build expanded teams

• Use alternative visit models
Delivery System Design, cont.

- Optimize operational systems

- Outreach and population management

- **Pre-visit planning huddle** with the core team

- Assure all (and only) indicated care is offered to the patient
Decision Support

• Adopt evidence-based guidelines
• Use protocols and standing orders
• Team and clinician education
• Patient and family health literacy
• Access to electronic resources in EHR
• Virtual library
Clinical Information Systems

- Efficiently generate care gap reports
- Recall and reminder systems
- In-reach and Out-reach tools (registries)
- Sculpting the care path
- Performance improvement data
- PDSA library
- Clinical measures by org/site/team/clinician
Patient Self-Management

• Create shared care plan and assure follow-up

• Effective self-management support

• Health care information access

• Personal Health Record

• Patient and family engagement in service design
Community Support and Policies

• Develop and optimize partnerships

• Advocacy to add/change policies

• Address Social Determinants of Health
Clinica Family Health Services Planned Care Example

SQL Server Reporting Services
Home > Reports > Collaborative Learning > Peer Review Reports

- PEER Review Deceased Chronic Pain 3_10 HD
- PEER Review Expired Patients by Month 3_10 HD
- PEER Review HTN 2-23-10 CS
  Report to evaluate management of HTN patients for PEER Review.
Where to Start?

- Start with an AIM
- Develop a driver diagram using the planned care model as a framework
- Prioritize PDSAs for testing process changes
- Apply the 6 steps
- Apply learning to this and other aims to build momentum for change
Planned Care: a key component of high quality care

Planned Care: 100% patients receive all & only indicated care

Aim

Primary Drivers
- Delivery System Design
- Decision Support
- Clinical Information Systems
- Patient Engagement
- Community Support and Partners

Secondary Drivers
- 1. Core team huddles
- 1.2. Assign the delivery of key services
- 3. Protocols and standing orders
- 4. Identify services required by evidence-based guidelines
- 6. Create patient specific data on services due
- 6. Partner with patient to plan follow up
- Leverage partnerships to expand services

PDSA Test Cycles
Six Steps to Providing Planned Care

1. Identify the common services required by evidence-based guidelines

2. Assign the delivery of key services to specific staff and ensure that they are trained

3. Use protocols and standing orders to allow staff to act independently

4. Efficiently generate patient-specific data on services that are due

5. Huddle with the core practice team and review patient before clinic sessions

6. Ensure patient engagement and follow up
Six Steps to Providing Planned Care

1. Identify the common services required by evidence-based guidelines

Questions:

• What moves CHC, Inc. to take on a measure?

• How does your organization decide which evidence-based guidelines to follow?

• Who is involved in these decisions?
# Clinical Expectations

<table>
<thead>
<tr>
<th>Clinical Expectations</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lung Cancer (USPSTF)</strong></td>
<td>Asymptomatic adults aged 55 to 80 years who have a 30 pack year smoking history and currently smoke or have quit within the past 15 years. Screen annually with low dose Computed Tomography until the patient has not smoked for 15 years.</td>
</tr>
<tr>
<td><strong>STD Screening (USPSTF/CDC)</strong></td>
<td></td>
</tr>
</tbody>
</table>
- **Gonorrhea & Chlamydia**: Screen sexually-active women age 24 years and younger and in older women who are at increased risk for infection. Retest approximately 3 months after treatment (CDC).  
- **Syphilis**: Screen non-pregnant adults and adolescents who are at increased risk for syphilis (MIS, positive HIV) and (Men under age 25, race/ethnicity, geography, incarceration, and sex work) |
| **HIV Screening (CDC)** | HIV screening may be offered to patients ages 13–64 at least once. |
| **HCV Screening (USPSTF/CDC)** |  
- HCV screening for persons at high risk for infection (past or current injection drug use, blood transfusion before 1992, long-term hemodialysis, born to an HCV-infected mother, incarcerated, intranasal drug use, unregulated tattoo, and other percutaneous exposures).  
- One time screening in individuals born between 1945-1965. |
| **HBV Screening (USPSTF/CDC)** | HBV screening (periodic) for persons at high risk for infection (those from countries with a high prevalence of HBV infection, HIV-positive, injection drug users, household contacts of persons with HBV, and men who have sex with men). |
| **Depression Screening – adolescents (AAP/USPSTF)** | Annual depression screening for adolescents ages 12 and above. |
| **Depression Screening – adults (USPSTF)** | Annual depression screening for adults ages 18 and above. |
| **Intimate Partner Violence Screening (USPSTF/AAP)** | Screen women of childbearing age for intimate partner violence (IPV), such as domestic violence, and provide or refer women who screen positive to intervention services. For women aged 15 and above:  
- HITS questionnaire on initial screen  
- HARP questionnaire annually |
| **Developmental Screening (AAP)** | See Pediatric section. |
| **Vaccinations** | |
| **HPV Vaccine (ACIP)** | Female patients: offered/given to patients ages 11-26 years.  
Male patients: offered/given to ages 11-26.  
Male patients with risk factors: offered/given until age 26.  |
| **Tetanus booster (ACIP)** | Adult patients: 1 dose given at least once; 1 dose every 10 years thereafter.  
Pregnant women: 1 dose given during each pregnancy. |
| **Influenza (ACIP)** | Offered/given during the last flu season for indicated patients (chronic illness, age 65+, etc.). |
Six Steps to Providing Planned Care

2. Assign the delivery of key services to specific staff and ensure that they are trained

Questions:

• How do your sites determine who is the staff member completing or responsible for each action?

• How do you train your teams, confirm understanding and measure impact/success?
# Tool for PCD: Mammograms

<table>
<thead>
<tr>
<th>PCD Item</th>
<th>Patient Population</th>
<th>How Often</th>
<th>What MA/LPN Does (or other clinical staff)</th>
</tr>
</thead>
</table>
| Breast Cancer Screening   | Women age 50 to 74   | Every 24 months | - Ask the patient if she has had a mammogram in past 24 months. If yes, complete Non ROI ROI and send to the facility where she got it done and order a “Mammogram Outside” (via Manage Orders) [MA].  
  - If she had not had one, order a mammogram using DI.  
    - Order DI = Mammogram – Bilateral Screening [MA]  
    - Mammogram – Bilateral Diagnostic [Prov]  
    - Mammography screening with U/S –Hospital specific [MA/Prov]  
  - If she declines, order a “Mammogram Declined” (via Manage Orders) [MA] with provider permission or [Prov].  
  - Once results come in: Results checked as “Received”, “Collection Date” entered and “Attached” [MA] or Medical Records  
  - DI Result “Reviewed” [Prov]. |
## Medical Assistant Performance Appraisal

**MA Performance Appraisal Data: Agency and Site Average and Your Rate**

**Time Period:** 7/1/2016-6/30/2017

**MA Name:**

### Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Agency Average</th>
<th>Meriden Average</th>
<th>Your Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression Screening</td>
<td>81.4%</td>
<td>87.9%</td>
<td></td>
</tr>
<tr>
<td>Smoking Assessment</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>Colon Cancer Screening</td>
<td>61.2%</td>
<td>63.7%</td>
<td></td>
</tr>
<tr>
<td>AIC</td>
<td>83.0%</td>
<td>80.3%</td>
<td></td>
</tr>
<tr>
<td>Literacy in Social History</td>
<td>51.1%</td>
<td>50.0%</td>
<td></td>
</tr>
<tr>
<td>Initial appointments documented</td>
<td>32.7%</td>
<td>39.3%</td>
<td></td>
</tr>
<tr>
<td>Chaperone for all well women visits</td>
<td>60.8%</td>
<td>84.1%</td>
<td></td>
</tr>
<tr>
<td>SOGI</td>
<td>90%</td>
<td>93%</td>
<td></td>
</tr>
<tr>
<td>PEDS Screening</td>
<td>58.7%</td>
<td>71.2%</td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td>78.7%</td>
<td>83.7%</td>
<td></td>
</tr>
<tr>
<td>Child BMI Percentile</td>
<td>99.7%</td>
<td>99.3%</td>
<td></td>
</tr>
<tr>
<td>Child Weight Education</td>
<td>85.6%</td>
<td>91.9%</td>
<td></td>
</tr>
<tr>
<td>Asthma -ACT</td>
<td>78.9%</td>
<td>72.1%</td>
<td></td>
</tr>
<tr>
<td>Adult BMI</td>
<td>58.6%</td>
<td>96.3%</td>
<td></td>
</tr>
<tr>
<td>Adult Weight Education</td>
<td>73.4%</td>
<td>70.5%</td>
<td></td>
</tr>
<tr>
<td>Chlamydia</td>
<td>33.3%</td>
<td>30.8%</td>
<td></td>
</tr>
<tr>
<td>Planned Care Dashboard</td>
<td>630</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SBIRT</td>
<td>45%</td>
<td>77%</td>
<td></td>
</tr>
</tbody>
</table>

### Key:
- Red box indicates the site average is statistically significantly lower than the agency average.
- Green box indicates the site average is statistically significantly higher than the agency average.
## Complex Care Management Dashboard: Eligible Patients

<table>
<thead>
<tr>
<th>Patient ID</th>
<th>2 ER Visits in Last 12 Mths.</th>
<th>Hosp. Last 12 Mths.</th>
<th>DM</th>
<th>HTN</th>
<th>Asthma</th>
<th>4 Chronic Cond.</th>
<th>Smoking Status</th>
<th>BP</th>
<th>Age</th>
<th>Sex</th>
<th>CC Start Date</th>
<th>CC End Date</th>
<th>SMG Date</th>
<th>Action Item</th>
<th>Action Item Due Date</th>
<th>Last PCP Visit</th>
<th>Last Dental Visit</th>
<th>Last Bill Visit</th>
<th>Portal Enabled</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1234</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>never smoker</td>
<td>112/75</td>
<td>11</td>
<td>45</td>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1/10/2017</td>
<td>9/10/2017</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5678</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>never smoker</td>
<td>100/74</td>
<td>100</td>
<td>31</td>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1/10/2017</td>
<td>9/10/2017</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>never smoker</td>
<td>112/75</td>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1/10/2017</td>
<td>9/10/2017</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>never smoker</td>
<td>123/75</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1/10/2017</td>
<td>9/10/2017</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3/23/2017</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>smoker, current status unknown</td>
<td>126/82</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1/10/2017</td>
<td>9/10/2017</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>former smoker</td>
<td>142/80</td>
<td>142</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1/10/2017</td>
<td>9/10/2017</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>former smoker</td>
<td>128/76</td>
<td>128</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1/10/2017</td>
<td>9/10/2017</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>smoker, current status unknown</td>
<td>154/75</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1/10/2017</td>
<td>9/10/2017</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>smoker, current status unknown</td>
<td>106/87</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1/10/2017</td>
<td>9/10/2017</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>former smoker</td>
<td>121/53</td>
<td>121</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1/10/2017</td>
<td>9/10/2017</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Complex Care Management Dashboard: Enrolled Patients

<table>
<thead>
<tr>
<th>Patient ID</th>
<th>DEX Visits in Last 12 moths.</th>
<th>Hosp. Last 12 moths.</th>
<th>DMI</th>
<th>HTN</th>
<th>Asthma</th>
<th>Chronic Cond.</th>
<th>Smoking Status</th>
<th>Age</th>
<th>Sex</th>
<th>C.C. Start Date</th>
<th>C.C. End Date</th>
<th>Action Item</th>
<th>Action Item From Dec Date</th>
<th>Last PCP Visit</th>
<th>Last Dental Visit</th>
<th>Last EM Visit</th>
<th>Portal Enabled</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/7/2017</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>smoker, current status unknown</td>
<td>119/82</td>
<td>55.0</td>
<td>F</td>
<td>2/5/2018</td>
<td>RN Care Coordination</td>
<td>3/2/2018</td>
<td>2/18/2018</td>
<td>9/20/2017</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>10/21/2017</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>never smoker</td>
<td>119/72</td>
<td>42.0</td>
<td>F</td>
<td>12/2/2017</td>
<td>RN Care Coordination</td>
<td>3/2/2018</td>
<td>12/27/2017</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5/27/2017</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>never smoker</td>
<td>121/75</td>
<td>54.0</td>
<td>F</td>
<td>2/15/2018</td>
<td>Staff Management Goal</td>
<td>3/2/2018</td>
<td>12/5/2017</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Six Steps to Providing Planned Care

3. Use protocols and standing orders to allow staff to act independently

Questions:

• Do you (and if so, how do you) use clinical decision support to assist with following evidence-based guidelines?

• What advice do you have for standing orders?
Planned Care Dashboard Display

**Provider Name: ID**

**Data as of: 1/23/2018**

**Contact Us!**

**Appointment Range**
- Display only patients with an upcoming appointment within the selected range.
- In Compliance
- Out of Compliance
- In Progress
- Not in Denominator

**Data Legend**
- 3/15/2015: A date indicates that a Due Date is upcoming or has past.

<table>
<thead>
<tr>
<th>Patient</th>
<th>PCP and Visit Info</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alerts</th>
<th>Last Date</th>
<th>Due Date</th>
<th>Value</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>DM Retinopathy</td>
<td>Never</td>
<td>Never</td>
<td></td>
<td>Ordered in last 30 days.</td>
</tr>
<tr>
<td>ACT</td>
<td>5/30/2017</td>
<td>Every Visit</td>
<td>25</td>
<td>&gt;19 is good control</td>
</tr>
<tr>
<td>HPV</td>
<td>Done</td>
<td>Never</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlamydia Screen</td>
<td>Never</td>
<td>Never</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression Screening</td>
<td>11/15/2016</td>
<td>11/15/2017</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Bubbles**
- TE
- RX
- Doc 2
- Lab

**Provider Name**

Next Medical Appointment: 1/24/2018 9:00:00 AM

Sex: F
Age: 19.0

Last Dental Visit: 8/28/2017

Reason for Visit: ED F/U Pregnancy
What about at your clinic?

1. Evidence-based guidelines
2. Assign key work to specific staff
3. Use protocols and standing orders

Team time: 30 minutes

Reflect on what you’ve heard and discuss what you plan to change/apply given your current-state assessment.

• Do you need to add a driver?
• Have ideas emerged for a driver or PDSA around planned care?
<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1</td>
<td>Quality and Analytics</td>
</tr>
<tr>
<td>Table 2</td>
<td>Clinicians</td>
</tr>
<tr>
<td>Table 3</td>
<td>Senior Leadership (COO, CMO, CNO)</td>
</tr>
<tr>
<td>Table 4</td>
<td>Operations and Finance</td>
</tr>
<tr>
<td>Table 5</td>
<td>Care Team Staff</td>
</tr>
</tbody>
</table>
Planned Care Review
Part 2
Carolyn Shepherd
KP Transformation Accelerator
3/22/18
Six Steps to Providing Planned Care

4. Efficiently generate patient-specific data on services that are due

Questions:

• What tools do you use to support your teams to prevent missed opportunities for patients?

• How do you follow through on the care plan and measure success currently? In 1 year, what in this process do you hope to improve?

• Do you focus on these items only when patients come to the clinic, or do you have care gap reports that are worked separately from the visit?
# Missed Opportunities Dashboard

## Missed Opportunity Report

**Week of 1/7/2018**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Cervical Cancer</th>
<th>Breast Cancer</th>
<th>Colon Cancer</th>
<th>Diabetes A1c</th>
<th>Diabetes Retinopathy</th>
<th>Diabetes Foot Exam</th>
<th>Asthma Control</th>
<th>Asthma ACT</th>
<th>CAD Lipid Med</th>
<th>IVD Aspirin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency Average</td>
<td>44/678 (6.5%)</td>
<td>02/400 (23.0%)</td>
<td>47/481 (10.2%)</td>
<td>74/113 (65.5%)</td>
<td>0/80 (0.0%)</td>
<td>5/55 (91.1%)</td>
<td>1/8 (12.5%)</td>
<td>1/448 (43.3%)</td>
<td>2/8 (25.0%)</td>
<td>2/9 (22.2%)</td>
</tr>
<tr>
<td>0/16 (0.0%)</td>
<td>0/0</td>
<td>0/0</td>
<td>0/0</td>
<td>0/0</td>
<td>0/0</td>
<td>0/5</td>
<td>0/0</td>
<td>0/0</td>
<td>0/0</td>
<td></td>
</tr>
<tr>
<td>4/21 (19.0%)</td>
<td>4/10 (40.0%)</td>
<td>8/15 (53.3%)</td>
<td>1/2 (50.0%)</td>
<td>0/1 (0.0%)</td>
<td>0/1 (0.0%)</td>
<td>0/7 (87.5%)</td>
<td>0/0</td>
<td>0/0</td>
<td>0/0</td>
<td></td>
</tr>
<tr>
<td>0/9 (0.0%)</td>
<td>0/10 (0.0%)</td>
<td>0/5 (0.0%)</td>
<td>0/2 (0.0%)</td>
<td>0/1 (0.0%)</td>
<td>0/1 (0.0%)</td>
<td>0/5 (0.0%)</td>
<td>0/0</td>
<td>0/0</td>
<td>0/0</td>
<td></td>
</tr>
<tr>
<td>1/8 (12.5%)</td>
<td>3/7 (42.9%)</td>
<td>0/10 (0.0%)</td>
<td>2/2 (100.0%)</td>
<td>0/2 (0.0%)</td>
<td>0/2 (0.0%)</td>
<td>3/12 (25.0%)</td>
<td>0/0</td>
<td>0/0</td>
<td>0/0</td>
<td></td>
</tr>
<tr>
<td>0/4 (0.0%)</td>
<td>0/1 (0.0%)</td>
<td>1/1 (100.0%)</td>
<td>0/0</td>
<td>0/0</td>
<td>0/0</td>
<td>1/2 (50.0%)</td>
<td>0/0</td>
<td>0/0</td>
<td>0/0</td>
<td></td>
</tr>
<tr>
<td>0/22 (0.0%)</td>
<td>1/14 (7.1%)</td>
<td>1/13 (7.7%)</td>
<td>1/5 (20.0%)</td>
<td>0/4 (0.0%)</td>
<td>0/4 (0.0%)</td>
<td>1/9 (11.1%)</td>
<td>0/0</td>
<td>0/0</td>
<td>0/0</td>
<td></td>
</tr>
</tbody>
</table>
## Integrating Nursing into Behavioral Health & Dental

### Agency Overview

**BAM**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Enfield</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td>-</td>
<td>3</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Clinton</td>
<td>5</td>
<td>12</td>
<td>2</td>
<td>-</td>
<td>7</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>Danbury</td>
<td>3</td>
<td>10</td>
<td>14</td>
<td>1</td>
<td>14</td>
<td>20</td>
<td>9</td>
</tr>
<tr>
<td>Enfield</td>
<td>4</td>
<td>7</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Groton</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Hartford</td>
<td>12</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Meriden Dental</td>
<td>20</td>
<td>20</td>
<td>17</td>
<td>-</td>
<td>17</td>
<td>20</td>
<td>17</td>
</tr>
<tr>
<td>Meriden Mental Health</td>
<td>19</td>
<td>52</td>
<td>23</td>
<td>3</td>
<td>52</td>
<td>36</td>
<td>33</td>
</tr>
<tr>
<td>Middletown</td>
<td>44</td>
<td>54</td>
<td>54</td>
<td>3</td>
<td>48</td>
<td>74</td>
<td>43</td>
</tr>
<tr>
<td>New Britain</td>
<td>41</td>
<td>58</td>
<td>46</td>
<td>8</td>
<td>54</td>
<td>51</td>
<td>44</td>
</tr>
<tr>
<td>New London</td>
<td>24</td>
<td>49</td>
<td>38</td>
<td>6</td>
<td>50</td>
<td>54</td>
<td>38</td>
</tr>
<tr>
<td>Norwalk</td>
<td>15</td>
<td>2</td>
<td>15</td>
<td>-</td>
<td>20</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td>Old Saybrook</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>-</td>
<td>8</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Stamford</td>
<td>14</td>
<td>22</td>
<td>12</td>
<td>-</td>
<td>25</td>
<td>33</td>
<td>24</td>
</tr>
<tr>
<td>Waterbury</td>
<td>3</td>
<td>16</td>
<td>6</td>
<td>1</td>
<td>17</td>
<td>8</td>
<td>17</td>
</tr>
</tbody>
</table>
## Integrating Nursing into Behavioral Health & Dental

### Table 1: Patient Information

<table>
<thead>
<tr>
<th>Patient</th>
<th>Provider and Visit Info</th>
<th>ALERTS</th>
<th>Last Date</th>
<th>Due Date</th>
<th>Value</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Needs Flu Vaccine 2017-2018</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>SBIRT</td>
<td></td>
<td></td>
<td>Never</td>
<td>Yearly, 18+ yrs old</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Body Mass Index</td>
<td>11/30/2017</td>
<td></td>
<td>30.72</td>
<td>Needs Education</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HTN</td>
<td>11/30/2017</td>
<td></td>
<td>150/89</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>DM Retinopathy</td>
<td>Never</td>
<td>Never</td>
<td>Done</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table 2: Patient Information

<table>
<thead>
<tr>
<th>Patient</th>
<th>Provider and Visit Info</th>
<th>ALERTS</th>
<th>Last Date</th>
<th>Due Date</th>
<th>Value</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>DM Retinopathy</td>
<td>Never</td>
<td>Never</td>
<td>Done</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Notes
- DM Retinopathy: Needs follow-up and monitoring.
- Body Mass Index: Normal range.
Six Steps to Providing Planned Care

5. Huddle with the core practice team and review patient before clinic sessions

Questions:

• What items do you focus on in the huddle and why?

• Are there things you currently don’t huddle on that you wished you could? Are there things that you currently do in the huddle that you wish were automatic?
Six Steps to Providing Planned Care

6. Ensure patient engagement and follow up

Questions:

• How do you support patients to be part of the care team and engage in the work of closing their own care gaps?

• What are common barriers that you identify for your patients?
“Every Patient has a Team!”
Managing Care Gaps

**Scenario A:** Lists of 3,00 patients with systolic BPs between 140-150 sent out Nurse Managers for dissemination. Instructions included:

1. Nurse to review list of patients with the PCP and discuss the approach for each (e.g., medication titration, referral to RD, BH smoking cessation group).

2. Nurse to call each patient and follow through with the plan discussed with the PCP. Also, nurse asked to complete other actions (order home BP monitor, enroll in CCM, complete med rec).

**Scenario B:** Telephone encounters sent directly through the EHR to providers whose patients (n=100) are not on an inhaled corticosteroid. Instructions included verifying diagnosis, prescribing medication if appropriate.
What about at your clinic?

4. Efficiently generate patient specific information care gaps
5. Huddle on each patient before clinic session
6. Ensure patient engagement and follow up

Team time: 30 minutes
Reflect on what you’ve heard and discuss what you plan to change/apply given your current-state assessment.
• Do you need to add a driver?
• Have ideas emerged for a driver or PDSA around planned care?
Testing Changes & Using Data to Learn about Your Changes
Three Key Questions

1. What are we trying to accomplish? (Aim – main outcome measure)

2. How will we know that a change is an improvement? (Measure – process and balancing measures that link to changes)

3. What changes can we make that will result in an improvement? (Change – come from drivers)
What do we mean by “changes”?

Model for Improvement: Large System Change

To get to Big Change, we need many Small Tests of Change – use the PDSA Cycle
Monthly Measures
1) % of patients screened
2) % of patients outreached that were screened
3) Percent of patients screened at visit

### Planned Care:
**Aim**
Increase percent of women 23-64 screened for CCS from 55% to 75%

### Primary Drivers
- **Delivery System Design**
- **Decision Support**
- **Clinical Information Systems**
- **Patient Engagement**
- **Community Support and Partners**

### Secondary Drivers
- Core team huddles
- Assign the delivery of key services
- Protocols and standing orders
- Identify services required by evidence-based guidelines
- Create patient specific data on services due
- Partner with patient to plan follow up
- Leverage partnerships to expand services

### PDSA Test Cycles
- Who didn’t get it and why – check weekly or more
- % of patients successfully reached
- % of patients with scheduled appointments
- % of patients that showed for appointments
- % of patients captured in reports – validate via medical charts
- Staff experience using the protocols

---

**CENTER FOR CARE INNOVATIONS** | **58**
Collecting data for learning: use PDSAs

• Quick measures
• Just enough data to provide signal
• Quantitative and qualitative data
• Data is easily retrievable – same day or a week at most
Example: Missed Opportunity Report

Most common reasons for no pap

- Not sure
- MD didn’t know screen was needed
- Patient said lab was done
- Patient refusal
- Patient didn’t appear on huddle report
Use IT to Support Organizational Learning

PDSA Database

Cycle for Learning and Improvement

Add New PDSA
View all PDSA entries
Search PDSA entries

Sort by site
- Admin
- All clinics
- Federal Heights
- Lafayette
- Pecos
- People’s

Sort by category
- Finance
- Financial Screening
- Front Desk
- Group Visits
- HR
- Immunizations
- IT
- Master Planning/Scheduling
- Medications/Pharmacy
- Obesity
- Other
- Panel Management
- PCMH/MU

PDSA w/incomplete act section
Incomplete PDSA
PDSA w/incomplete study section
Completed PDSA

Clinica Family Health Services
## Use IT to Support Organizational Learning

<table>
<thead>
<tr>
<th>Category</th>
<th>Title</th>
<th>First Name</th>
<th>Last Name</th>
<th>Site</th>
<th>Date entered</th>
<th>completed?</th>
<th>Date completed</th>
<th>Disseminated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open PDSA</td>
<td>Group Visits Group Visits for Sports Physicals</td>
<td>Beth</td>
<td>Versaw</td>
<td>People’s</td>
<td>7/10/2009</td>
<td>✓</td>
<td>7/30/2009</td>
<td>✓</td>
</tr>
<tr>
<td>Open PDSA</td>
<td>Group Visits Financial incentives to increase attendance at CDSM group</td>
<td>Mary</td>
<td>Fahynski</td>
<td>Lafayette</td>
<td>3/27/2008</td>
<td>✓</td>
<td>5/1/2008</td>
<td>✓</td>
</tr>
<tr>
<td>Open PDSA</td>
<td>Group Visits Share our Strength – Operation Frontline</td>
<td>Anne</td>
<td>Hansen</td>
<td>Thornton</td>
<td>10/26/2008</td>
<td>✓</td>
<td>12/1/2008</td>
<td>✓</td>
</tr>
</tbody>
</table>
Collecting data to measure impact on AIM: use run charts

• Make performance of the process visible

• Determine if change is an improvement by comparing data before and after test
  
  o Aggregate measures alone do not lead to predictions about future performance or insights to explain past variations
  
  o Displaying data over time allows us to make informed predictions, and thus manage effectively

• Determine if holding the gain
Example 1: Average CABG Mortality

Before and After the Implementation of a New Protocol

Conclusion – The protocol was a success!

A 20% drop in the average mortality!

Source: Robert Lloyd, IHI
Example 1: Average CABG Mortality

Before and After the Implementation of a New Protocol

Source: Robert Lloyd, IHI
Percent of ER patients with chest pain seen by a cardiologist within 10 min

<table>
<thead>
<tr>
<th>Week</th>
<th>Date</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3-Oct</td>
<td>88%</td>
</tr>
<tr>
<td>2</td>
<td>10-Oct</td>
<td>88%</td>
</tr>
<tr>
<td>3</td>
<td>17-Oct</td>
<td>94%</td>
</tr>
<tr>
<td>4</td>
<td>24-Oct</td>
<td>71%</td>
</tr>
<tr>
<td>5</td>
<td>1-Nov</td>
<td>88%</td>
</tr>
<tr>
<td>6</td>
<td>8-Nov</td>
<td>73%</td>
</tr>
<tr>
<td>7</td>
<td>15-Nov</td>
<td>78%</td>
</tr>
<tr>
<td>8</td>
<td>22-Nov</td>
<td>67%</td>
</tr>
<tr>
<td>9</td>
<td>29-Nov</td>
<td>69%</td>
</tr>
<tr>
<td>10</td>
<td>6-Dec</td>
<td>87%</td>
</tr>
<tr>
<td>11</td>
<td>13-Dec</td>
<td>83%</td>
</tr>
<tr>
<td>12</td>
<td>20-Dec</td>
<td>68%</td>
</tr>
<tr>
<td>13</td>
<td>3-Jan</td>
<td>83%</td>
</tr>
<tr>
<td>14</td>
<td>10-Jan</td>
<td>70%</td>
</tr>
<tr>
<td>15</td>
<td>17-Jan</td>
<td>73%</td>
</tr>
<tr>
<td>16</td>
<td>24-Jan</td>
<td>76%</td>
</tr>
<tr>
<td>17</td>
<td>31-Jan</td>
<td>78%</td>
</tr>
<tr>
<td>18</td>
<td>7-Feb</td>
<td>79%</td>
</tr>
<tr>
<td>19</td>
<td>14-Feb</td>
<td>84%</td>
</tr>
<tr>
<td>20</td>
<td>21-Feb</td>
<td>89%</td>
</tr>
<tr>
<td>21</td>
<td>28-Feb</td>
<td>95%</td>
</tr>
<tr>
<td>22</td>
<td>6-Mar</td>
<td>95%</td>
</tr>
<tr>
<td>23</td>
<td>13-Mar</td>
<td>91%</td>
</tr>
<tr>
<td>24</td>
<td>20-Mar</td>
<td>95%</td>
</tr>
</tbody>
</table>

Week 1-12
- Avg: 80%
- Max: 94%
- Min: 67%

Week 13-24
- Avg: 84%
- Max: 95%
- Min: 70%

Source: Robert Lloyd, IHI
## Example 2: Wait Time for ER Patients

Percent of ER patients with chest pain seen by a cardiologist within 10 min

<table>
<thead>
<tr>
<th>Week</th>
<th>Date</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3-Oct</td>
<td>88%</td>
</tr>
<tr>
<td>2</td>
<td>10-Oct</td>
<td>88%</td>
</tr>
<tr>
<td>3</td>
<td>17-Oct</td>
<td>94%</td>
</tr>
<tr>
<td>4</td>
<td>24-Oct</td>
<td>71%</td>
</tr>
<tr>
<td>5</td>
<td>1-Nov</td>
<td>88%</td>
</tr>
<tr>
<td>6</td>
<td>8-Nov</td>
<td>73%</td>
</tr>
<tr>
<td>7</td>
<td>15-Nov</td>
<td>78%</td>
</tr>
<tr>
<td>8</td>
<td>22-Nov</td>
<td>87%</td>
</tr>
<tr>
<td>9</td>
<td>29-Nov</td>
<td>69%</td>
</tr>
<tr>
<td>10</td>
<td>6-Dec</td>
<td>87%</td>
</tr>
<tr>
<td>11</td>
<td>13-Dec</td>
<td>83%</td>
</tr>
<tr>
<td>12</td>
<td>20-Dec</td>
<td>68%</td>
</tr>
<tr>
<td>13</td>
<td>3-Jan</td>
<td>83%</td>
</tr>
<tr>
<td>14</td>
<td>10-Jan</td>
<td>70%</td>
</tr>
<tr>
<td>15</td>
<td>17-Jan</td>
<td>73%</td>
</tr>
<tr>
<td>16</td>
<td>24-Jan</td>
<td>76%</td>
</tr>
<tr>
<td>17</td>
<td>31-Jan</td>
<td>78%</td>
</tr>
<tr>
<td>18</td>
<td>7-Feb</td>
<td>79%</td>
</tr>
<tr>
<td>19</td>
<td>14-Feb</td>
<td>84%</td>
</tr>
<tr>
<td>20</td>
<td>21-Feb</td>
<td>89%</td>
</tr>
<tr>
<td>21</td>
<td>28-Feb</td>
<td>95%</td>
</tr>
<tr>
<td>22</td>
<td>6-Mar</td>
<td>95%</td>
</tr>
<tr>
<td>23</td>
<td>13-Mar</td>
<td>91%</td>
</tr>
<tr>
<td>24</td>
<td>20-Mar</td>
<td>95%</td>
</tr>
</tbody>
</table>

Source: Robert Lloyd, IHI
Run Charts

• Display ordered sequence of data and provide running record over time
• Can be used for any data that are sequenced over time (trending)
• Require no statistics
• Visually illustrate progress toward goal
• Allow us to detect signals of improvement or degradation in a process over time

Run Chart Anatomy

Source: Richard Scoville, PhD

Annotations tell the story

Title names the measure

Appropriate Scale:
- Data fills most of scale

2/5 Project Start = baseline data collected

2/6 New data system, no data available

6/6 New triage procedure

Per Cent Patients who "Walk Away" from ED

2005
Feb
Aug
Feb
Aug
Feb
Aug
Feb
Feb
05
06
00
05
00
07
07
00
## Run Chart: Cervical Cancer Screening

![Run Chart](chart.png)

<table>
<thead>
<tr>
<th>Month</th>
<th>CCS Rate</th>
<th>Goal</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>55</td>
<td>75</td>
<td>58.5</td>
</tr>
<tr>
<td>February</td>
<td>55</td>
<td>75</td>
<td>58.5</td>
</tr>
<tr>
<td>March</td>
<td>53</td>
<td>75</td>
<td>58.5</td>
</tr>
<tr>
<td>April</td>
<td>56</td>
<td>75</td>
<td>58.5</td>
</tr>
<tr>
<td>May</td>
<td>57</td>
<td>75</td>
<td>58.5</td>
</tr>
<tr>
<td>June</td>
<td>57</td>
<td>75</td>
<td>58.5</td>
</tr>
<tr>
<td>July</td>
<td>60</td>
<td>75</td>
<td>58.5</td>
</tr>
<tr>
<td>August</td>
<td>61</td>
<td>75</td>
<td>58.5</td>
</tr>
<tr>
<td>September</td>
<td>60</td>
<td>75</td>
<td>58.5</td>
</tr>
<tr>
<td>October</td>
<td>62</td>
<td>75</td>
<td>58.5</td>
</tr>
<tr>
<td>November</td>
<td>63</td>
<td>75</td>
<td>58.5</td>
</tr>
<tr>
<td>December</td>
<td>63</td>
<td>75</td>
<td>58.5</td>
</tr>
</tbody>
</table>
Understanding Variation

All data demonstrate variation

• Sources of variation
  - People, methods, environment, materials, measurements
  - Methods: measuring, collecting, analyzing, interpreting

• Two types of variation
  - Random / Common cause
  - Non-random / Special cause

Your turn!

• What big change do you want to test next within planned care?

• Which primary driver does it address?

• Shrink the change into one small PDSA?

• Documentation is important! Document the PLAN
  o What assumptions/hypothesis do you have?
  o Who will do what and by when?
  o How will you measure the change?
  o Who and how will data be collected?
  o How will you display it?

• Partner up, share your PDSA
Planned care is organized patient-focused care that is based on scientific evidence, planned in advance of the visit and delivered so that the team optimizes the health of every person on their panel.

The **six steps** to providing planned care are:

1. Identify the **common services** required by evidence-based guidelines
2. **Assign the delivery** of key services to specific staff and ensure that they are trained
3. Use **protocols and standing orders** to allow staff to act independently
4. Efficiently generate **patient-specific data** on services that are due
5. **Huddle** with the core practice team and review patient before clinic sessions
6. Ensure **patient engagement** and follow up

Test and measure impact of your changes using run charts

In Summary ....
Inspiration Disco
What’s Next?

Coaching with Tammy & Carolyn

Progress Report
Due: May 15

Webinar
Date TBA

Learning Session
July 24th
Transformation Accelerator Support Portal

Transformation Accelerator Support Center

HELLO, TEAM MEMBERS!

This is the support center for participants of the KP Transformation Accelerator program. Program updates, report due dates, resources and more will be posted to this website. This website is managed by Center for Care Innovations.

For more information about KP Transformation Accelerator, please visit the program page.

KPTA Website

Live Tour!
Practical Considerations for Applying the New Hypertension Guidelines in Practice

Thursday, March 29th, 2018
11am Pacific /2pm Eastern

A webinar with Dr. Mike Rakotz of the American Medical Association
Thank you!