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# KP Transformation Accelerator

## Virtual Learning Session #2
## Planned Care
## Tuesday, May 22, 2018

# Today's Big Awesome Agenda

1. Opening and Data Share
2. Learning from Our Changes: Successes & Challenges
3. Deep Dive: Effective Planned Care Part 2
4. Team Report Outs
5. What's Next & Feedback Survey

# Team Report Outs

What new ideas have emerged to strengthen your projects from these virtual sessions or since the last in person meeting?

# Virtual Session Reminders

- Everyone is muted.
  - Press *7 to **unmute**
  - Press *6 to **mute**
- The session is being recorded. The slides are posted at www.careinnovations.org/accelerator-team/
- Use the chat box or unmute yourself to ask questions.

# Today's Faculty

Carolyn Shepherd

Alexis Wielunski

Tierney Giannotti

Tammy Fisher

Mary Blankson

# 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®

CHC Quality Improvement
Community Health Center, Inc.

## Care Team Protocol Examples:

- MA Standing Order (West County Health Centers, CA)
- RN Protocol-Complex Care Management (West County Health Centers, CA)
- RN Diabetes Medication Titration Protocol (Harvard Vanguard, MA)
- Nurse Management GC Test (Clinica Family Health, CO)
- Standing Orders DHK-Flu Vaccine (CDC)
- Nurse Managed Protocols in Adults with Chronic Disease (Veterans Affairs)
- Lessons Learned – MA/Nursing/PharmD Protocols (Dr. Carolyn Shepherd)

Available at: www.careinnovations.org/accelerator-team/, under the “Resource Library” Tab

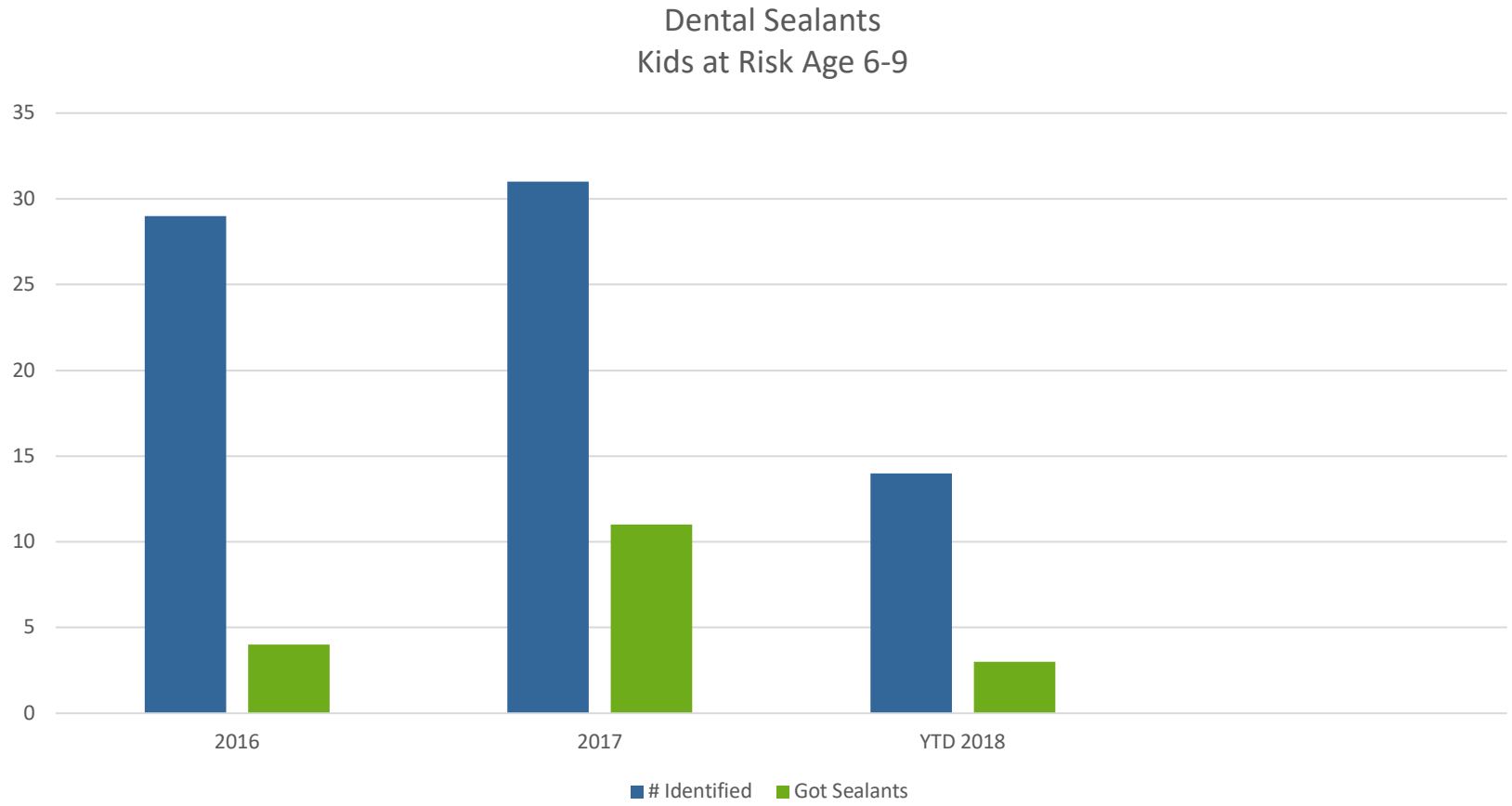
# Testing Changes & Using Data to Learn about Your Changes


GREATER BADEN
MEDICAL SERVICES
Primary and Preventive Health Care

# Greater Baden Medical Services, Inc.

**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.**

GREATER BADEN MEDICAL SERVICES
Primary and Preventive Health Care




GREATER BADEN MEDICAL SERVICES
Primary and Preventive Health Care

| | | | April 2018 |
|---|---|---|---|
| Dental Visits and Sealants | 2017 | 2018 Goal | YTD Number of Dental Visits |
| 6-9 Year Olds who had a Dental Visit | 163 | 235 | 217 |
| | | | YTD % Dental Sealants |
| Moderate to High Risk for Caries and had a Sealant | 29% | 39% | 28% |

GREATER BADEN MEDICAL SERVICES
Primary and Preventive Health Care

## Changes to Date

- Same Day Appointments for Dental
- Dental Sealant Posters

# Next Steps

# Planned Care Review

## Part 2

Carolyn Shepherd

KP Transformation Accelerator

5/22/18

# 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

**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**

Completed / Opportunities (%Completed)

| Provider | Cervical Cancer | Breast Cancer | Colon Cancer | Diabetes A1c | Diabetes Retinopathy | Diabetes Foot Exam | Asthma Control Med | Asthma ACT | CAD Lipid Med | IVD Aspirin | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Agency Average | 44/678 (6.5%) | 92/400 (23.0%) | 47/461 (10.2%) | 74/113 (65.5%) | 0/80 (0.0%) | 5/55 (9.1%) | 1/8 (12.5%) | 194/448 (43.3%) | 2/8 (25.0%) | 2/9 (22.2%) | |
| [redacted] | 0/0 | 0/0 | 0/0 | 0/0 | 0/0 | 0/0 | 0/0 | 5/10 (50.0%) | 0/0 | 0/0 | |
| | 0/16 (0.0%) | 2/6 (33.3%) | 3/8 (37.5%) | 0/0 | 0/0 | 0/0 | 0/1 (0.0%) | 11/11 (100.0%) | 0/0 | 0/0 | 1 |
| | 4/21 (19.0%) | 4/10 (40.0%) | 8/15 (53.3%) | 1/2 (50.0%) | 0/1 (0.0%) | 0/1 (0.0%) | 0/0 | 7/8 (87.5%) | 0/0 | 0/0 | 2 |
| | 0/9 (0.0%) | 0/10 (0.0%) | 0/5 (0.0%) | 0/2 (0.0%) | 0/1 (0.0%) | 0/1 (0.0%) | 0/0 | 0/5 (0.0%) | 0/0 | 0/0 | |
| | 1/8 (12.5%) | 3/7 (42.9%) | 0/10 (0.0%) | 2/2 (100.0%) | 0/2 (0.0%) | 0/2 (0.0%) | 0/0 | 3/12 (25.0%) | 0/0 | 0/0 | 1 |
| | 0/4 (0.0%) | 0/1 (0.0%) | 1/1 (100.0%) | 0/0 | 0/0 | 0/0 | 0/0 | 1/2 (50.0%) | 0/0 | 0/0 | |
| | 0/22 (0.0%) | 1/14 (7.1%) | 1/13 (7.7%) | 1/5 (20.0%) | 0/4 (0.0%) | 0/4 (0.0%) | 0/0 | 1/9 (11.1%) | 0/0 | 0/0 | 1 |

# Integrating Nursing into Behavioral Health & Dental

## Agency Overview

## BAM

### Patients by City and Day

| | Wednesday 2/21/2018 | Thursday 2/22/2018 | Friday 2/23/2018 | Saturday 2/24/2018 | Monday 2/26/2018 | Tuesday 2/27/2018 | Wednesday 2/28/2018 |
|---|---|---|---|---|---|---|---|
| Bristol | 2 | 5 | 2 | - | 3 | 10 | 3 |
| Clinton | 5 | 12 | 2 | - | 7 | 2 | 15 |
| Danbury | 3 | 19 | 14 | 1 | 14 | 20 | 9 |
| Enfield | 4 | 7 | - | - | - | - | 3 |
| Groton | 3 | 5 | 5 | - | 4 | 2 | 5 |
| Hartford | 12 | 3 | 3 | 2 | 5 | 3 | 2 |
| Meriden Dental | 20 | 29 | 17 | - | 17 | 20 | 17 |
| Meriden Mental Health | 19 | 52 | 23 | 3 | 52 | 36 | 33 |
| Middletown | 44 | 54 | 54 | 3 | 48 | 74 | 43 |
| New Britain | 41 | 58 | 46 | 8 | 54 | 51 | 44 |
| New London | 24 | 49 | 38 | 6 | 50 | 54 | 38 |
| Norwalk | 15 | 2 | 15 | - | 20 | 10 | 16 |
| Old Saybrook | 4 | 4 | 5 | - | 8 | 7 | 5 |
| Stamford | 14 | 22 | 12 | - | 25 | 33 | 24 |
| Waterbury | 3 | 16 | 6 | 1 | 17 | 8 | 17 |

# Integrating Nursing into Behavioral Health & Dental

| Patient | Provider and Visit Info |
|---|---|
| [redacted]<br>Sex: F<br>Age: 34.0 | New Britain Dental<br>Appointment:<br>2/22/2018 9:00:00 AM |

| ALERTS | Last Date | Due Date | Value | Notes |
|---|---|---|---|---|
| Needs Flu Vaccine 2017-2018 | | | | |
| SBIRT | Never Done | | | Yearly, 18+ yrs old |
| Body Mass Index | 11/30/2017 | | 30.72 | Needs Education |
| HTN | 11/30/2017 | | 150/89 | |

| Patient | Provider and Visit Info |
|---|---|
| [redacted]<br>Sex: M<br>Age: 45.0 | New Britain Mental Health<br>Appointment:<br>2/22/2018 9:30:00 AM |

| ALERTS | Last Date | Due Date | Value | Notes |
|---|---|---|---|---|
| DM Retinopathy | Never Done | Never Done | | |

| Bubbles | # |
|---|---|
| TE | 3 |
| RX | |
| Doc | |
| Lab | 1 |

# Six Steps to Providing Planned Care

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

<u>Questions:</u>

- 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**

<u>Questions:</u>

- 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 top 20 patients highest BPs per PCP panel sent out Nurse Managers for dissemination to teams. 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 are not on an inhaled corticosteroid (n=100). Instructions included verifying diagnosis or prescribing medication, if appropriate.

**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.

Test and measure impact of your changes using run charts

# In Summary ....

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

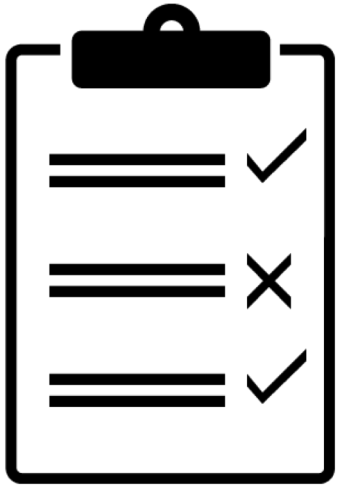
1. Identify the **common services** required by evidence-based guidelines
2. **Assign the delivery** of key services to specific staff and ensure that they are trained
3. Use **protocols and standing orders** to allow staff to act independently
4. Efficiently generate **patient-specific data** on services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

# Your turn!

What new ideas have emerged to strengthen your projects from these virtual sessions or since the last in person meeting?

# What's Next?

Coaching with Tammy & Carolyn



Baseline KPTA Assessment

Due: June 1st

Data Analytics Learning Session

July 24th

# KP Transformation Accelerator Clinic Assessment

## Repeat Assessment Due June 1st

- Complete the simplified tool at your May Team Meeting
- Think back and score where your clinic was when this program began in April 2017
- Send completed assessment to Meaghan@careinnovations.org

## Goals of Assessment

Assess changes to clinic capacity

Use results to inform technical assistance

Promote dialogue re: internal capacity & improvement areas

# Data Analytics
# KPTA In-Person Session

Tuesday, July 24th | 8:45am – 4:30pm
Center for Total Health | Washington, DC

## Register Now

# Thank you!

# *Please complete the feedback survey*

https://www.surveymonkey.com/r/HVRS2W6