Pre-Visit Planning: Using Data and Optimizing Care Team Roles
Today’s Webinar Agenda

1. Welcome and Introductions
2. Pre-Visit Planning and Why it Matters
3. The CHC, Inc. Model of Pre-Visit Planning
4. CCI Health & Wellness: Improving Cervical Cancer Screening through Pre-Visit Planning
5. Q&A and Closing
Our Faculty

Carolyn Shepherd
Tierney Giannotii
Mary Blankson
Kameela Clark
Marcela Cámpoli
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—KP Transformation Accelerator

**Primary Prevention**
- Prevention of disease and promotion of wellness
  - Dental sealants
  - Cervical cancer prevention
  - Improving access

**Secondary Prevention**
- Prevention of complications caused by disease
  - HIV primary care
Why focus on Planned Care?

Exhibit 2. Health Care System Performance Rankings

<table>
<thead>
<tr>
<th>Category</th>
<th>AUS</th>
<th>CAN</th>
<th>FRA</th>
<th>GER</th>
<th>NETH</th>
<th>NZ</th>
<th>NOR</th>
<th>SWE</th>
<th>SWIZ</th>
<th>UK</th>
<th>US</th>
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<tr>
<td>OVERALL RANKING</td>
<td>2</td>
<td>9</td>
<td>10</td>
<td>8</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>6</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Care Process</td>
<td>2</td>
<td>6</td>
<td>9</td>
<td>8</td>
<td>4</td>
<td>3</td>
<td>10</td>
<td>11</td>
<td>7</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Access</td>
<td>4</td>
<td>10</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>7</td>
<td>5</td>
<td>6</td>
<td>8</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Administrative Efficiency</td>
<td>1</td>
<td>6</td>
<td>11</td>
<td>6</td>
<td>9</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>8</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Equity</td>
<td>7</td>
<td>9</td>
<td>10</td>
<td>6</td>
<td>2</td>
<td>8</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Health Care Outcomes</td>
<td>1</td>
<td>9</td>
<td>5</td>
<td>8</td>
<td>6</td>
<td>7</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>10</td>
<td>11</td>
</tr>
</tbody>
</table>

1=best of eleven countries    11=worst of the eleven countries

Mirror, Mirror: How the US Health Care System Compares Internationally at a Time of Radical Change, The Commonwealth Fund, July 2017
## Why Focus on Planned Care?

<table>
<thead>
<tr>
<th>2016 UDS</th>
<th>US</th>
<th>Maryland</th>
<th>KPTA</th>
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<tbody>
<tr>
<td>Cervical Cancer Screening</td>
<td>54</td>
<td>50</td>
<td>62</td>
</tr>
<tr>
<td>First Molar Sealants</td>
<td>49</td>
<td>57</td>
<td>28</td>
</tr>
<tr>
<td>Asthma controller meds</td>
<td>87</td>
<td>90</td>
<td>91</td>
</tr>
<tr>
<td>CAD-Lipid lowering therapy</td>
<td>80</td>
<td>84</td>
<td>82</td>
</tr>
<tr>
<td>IVD-Anti-platelet therapy</td>
<td>78</td>
<td>82</td>
<td>80</td>
</tr>
<tr>
<td>Controlled HTN</td>
<td>64</td>
<td>62</td>
<td>60</td>
</tr>
<tr>
<td>HgbA1c&gt;9</td>
<td>16*</td>
<td>28</td>
<td>35</td>
</tr>
</tbody>
</table>

*National diabetes data from 2014
Why Focus on Planned Care?

Though we have made progress, we are not where we need to be:

• The patients come with their own agenda
• Lack of time in the visit
  • Rushed practitioners can’t follow guidelines
  • Teams lack time & data to prepare for the visit
  • Lack of time to build relationships
• Patients not-yet-engaged
• Lack of care coordination and planned care
  • Lack of active follow-up
Planned Care and the Chronic Care Model

• Titer to the patient need
• Identify high-risk patients
• Use point-of-care reminders
• Enable planned interactions
• Clinicians stay focused on patient’s agenda

Evidence on the Chronic Care Model in the new millennium. Health Aff. 2009;28(1):75-85
Coleman K, et al
**Useful Data to Facilitate Planned Care**

Clinica Family Health Services
Lafayette, Colorado

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CarePlanner

<table>
<thead>
<tr>
<th>PCP</th>
<th>Status</th>
<th>Active</th>
<th>Ages</th>
<th>M</th>
<th>Active Problem List</th>
</tr>
</thead>
<tbody>
<tr>
<td>Farrell, E</td>
<td></td>
<td></td>
<td>57</td>
<td></td>
<td>04/04/2014 Farrel, E</td>
</tr>
</tbody>
</table>

**Alerts**

- **Past Due - Diabetes Eye Exam**
- **Past Due - Yearly Substance Risk Screening (SBIRT)**
- **Past Due - Self Management Goal (Diabetes, Hypertension, Anticoagulation)**
- **Past Due - CRC Screen**
- **Due Now - INR**
- **Abnormal Body Mass Index**

**Appointments**

- Appt on 04/25/2014 at 08:20AM for BRG Follow Up And INR with Farrel, Edward
- Appt on 04/25/2014 at 08:20AM for BRG Follow Up And INR with Thornton Charlotte Riccotich PedPharmD

**Active Medications**

<table>
<thead>
<tr>
<th>Start Date</th>
<th>Stop Date</th>
<th>Brand Name</th>
<th>Generic Name</th>
<th>Dose</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/08/2014</td>
<td>01/08/2015</td>
<td>HUMULIN R</td>
<td>INSULIN REGULAR, HUMAN</td>
<td>100 unit/mL</td>
<td>30 units SQ TID before meals and sliding scale</td>
</tr>
<tr>
<td>01/08/2015</td>
<td>01/08/2015</td>
<td>METOPROLOL TARTRATE</td>
<td>METOPROLOL TARTRATE</td>
<td>100 mg</td>
<td>take 1 tablet by oral route 2 times every day with meals</td>
</tr>
<tr>
<td>10/22/2013</td>
<td>10/21/2014</td>
<td>WARFARIN SODIUM</td>
<td>WARFARIN SODIUM</td>
<td>5 mg</td>
<td>take 2 tablet by oral route every day</td>
</tr>
<tr>
<td>08/30/2014</td>
<td>08/29/2014</td>
<td>HUMULIN N</td>
<td>HUMULIN N</td>
<td>100 unit/mL</td>
<td>inject 120 units by subcutaneous route every morning and 100 units every evening</td>
</tr>
<tr>
<td>08/23/2013</td>
<td>08/23/2014</td>
<td>ALBUTEROL SULFATE HFA</td>
<td>ALBUTEROL SULFATE</td>
<td>90 mcg</td>
<td>Inhal 1 - 2 Puffs by INHALATION route every 4 - 6 hours as needed</td>
</tr>
<tr>
<td>08/16/2014</td>
<td>08/17/2014</td>
<td>GLUCOSEPHORUS</td>
<td>METFORMIN HCL</td>
<td>1000 mg</td>
<td>1 tablet twice daily</td>
</tr>
<tr>
<td>08/16/2014</td>
<td>08/16/2014</td>
<td>AMLODIPINE BESYLATE</td>
<td>AMLODIPINE BESYLATE</td>
<td>10 mg</td>
<td>take 1 tablet by oral route every day</td>
</tr>
<tr>
<td>07/02/2013</td>
<td>07/02/2014</td>
<td>CRESTOR</td>
<td>ROSUVASTATIN CALCIUM</td>
<td>40 mg</td>
<td>take 1 tablet by oral route every day (stop Friday)</td>
</tr>
<tr>
<td>05/13/2013</td>
<td>05/12/2014</td>
<td>FUROSEMIDE</td>
<td>FUROSEMIDE</td>
<td>80 mg</td>
<td>take 1 tablet by oral route every 2 times every day</td>
</tr>
<tr>
<td>05/07/2013</td>
<td>05/08/2014</td>
<td>METOLAZONE</td>
<td>METOLAZONE</td>
<td>5 mg</td>
<td>take 1 tablet (5MG) by oral route every day</td>
</tr>
</tbody>
</table>

**Diabetes - High Risk**

<table>
<thead>
<tr>
<th>Systolic</th>
<th>Diastolic</th>
<th>Eye Exam</th>
<th>Foot Exam</th>
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</thead>
<tbody>
<tr>
<td>120</td>
<td>86</td>
<td>02/03/11</td>
<td>02/23/13</td>
</tr>
</tbody>
</table>

**Anthocoagulation**

- **Indication(s):** 71110-OTH PULMONARY EMBOLISM & INFARCTION
- **Therapy Start:** 01/01/1997
- **Therapy Duration:** Lifelong
- **INR:** 4/24/2014 - 2.3, 3.21/2013 - 3.9, 3/7/2014 - 2.20
- **Goal Range:** 3.00 - 4.00
- **Risk:** Low

**Open Referrals**


**Future Labs**

- 06/20/2013 - scheduled MRI, cervical spine, w/o contrast:
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. Patient engagement
Planned Care: a key component of high quality care

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

**Aim**

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

**Primary Drivers**

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

**Secondary Drivers**

**PDSA Test Cycles**
Want to learn more?


• Coleman K, Austin BT, Brach C, Wagner EH. Evidence on the Chronic Care Model in the new millennium. Health Aff. 2009;28(1):75-85


• Safety Net Medical Home Initiative Planned Care Organized, evidence-based care

• Improvingprimarycare.org Do the Work Planned Care Module
POLL: What are your greatest challenges with pre-visit planning?

• Hard to get data from current systems
• Roles not clearly defined
• Lack of agreement on evidence-based guidelines and protocols
• Unclear workflows
• Not trusting that others can get the work done
• Other (please chat this in to the chat box)
Planned Care
at
Community Health Center, Inc.

Mary Blankson, DNP, APRN, FNP-C
Chief Nursing Officer
Tierney Giannotti, MPA
Senior QI Manager of Population Health
Background: Planned Care at CHC

• Why was change needed?
  • Cumbersome process
  • Involved searching in multiple different locations of the EHR
  • Time spent prepping for no-shows
  • Lack of prep patients booked same day or as walk ins
  • Focus only on 8-10 planned care items
Planned Care Dashboard (PCD) Purpose

• 2014: CHCI implemented the PCD to:
  • Improve overall efficiency of patient visits by:
    • Anticipating the needs of patients
    • Supporting the work of MAs

• PCD lists:
  • Preventive care services /screenings
  • Evidence based care for chronic illnesses
  • unaddressed or open items in the health record

Currently: there are 40 measures on the PCD
**Aims**

- Improve Screening Mammogram rates by 10% in a 12 month period

**Primary Drivers**

- Delivery System Design
- Decision Support
- Clinical Information System
- Patient Engagement
- Partner Radiology Centers
- Resources for the Uninsured

**Secondary Drivers**

- E-huddle vs. Morning huddle
- Assign Responsibility/Measure Success
- Standing Orders/Templates
- SDOH/Barriers Assessment
- Care Coordination / Community Linkages to care
- Pathway for Access to Care

**PDSA Test Cycles**
Breast Cancer Screening: Area for Improvement

- Result is an Operations Team was initiated including Medical Records and Referral Department staff to understand why the rates are not higher
  - Team flow mapped current process
Breast Cancer Screening: Area for Improvement

- Result is an Operations Team was initiated including Medical Records and Referral Department staff to understand why the rates are not higher
  - Team flow mapped current process
<table>
<thead>
<tr>
<th>Aims</th>
<th>Primary Drivers</th>
<th>Secondary Drivers</th>
<th>PDSA Test Cycles</th>
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<tr>
<td><strong>Improve Screening Mammogram rates by 10% in a 12 month period</strong></td>
<td>Delivery System Design</td>
<td>E-huddle vs. Morning huddle</td>
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</tr>
<tr>
<td></td>
<td>Decision Support</td>
<td>Assign Responsibility/Measure Success</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical Information System</td>
<td>Standing Orders/Templates</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient Engagement</td>
<td>SDOH/Barriers Assessment</td>
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<td></td>
<td>Partner Radiology Centers</td>
<td>Care Coordination/Community Linkages to care</td>
<td></td>
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<tr>
<td></td>
<td>Resources for the Uninsured</td>
<td>Pathway for Access to Care</td>
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</table>
**Aims**

- Improve Screening Mammogram Ordering by 10% in a 12 month period

**Primary Drivers**

- Delivery System Design
- Decision Support
- Clinical Information System
- Patient Engagement
- Partner Radiology Centers
- Resources for the Uninsured

**Secondary Drivers**

- E-huddle vs. Morning huddle
- Assign Responsibility/Measure Success
- Standing Orders/Templates
- SDOH/Barriers Assessment
- Care Coordination/Community Linkages to care
- Pathway for Access to Care

**PDSA Test Cycles**

- [APSDAPSDAPSDAPSDAPSDAPSDAPSD]

*Community Health Center, Inc.* Where health care is a right, *not a privilege*, since 1972.
**Aims**

- Improve Screening Mammogram Ordering by 10% in a 12 month period

**Primary Drivers**

- Delivery System Design
- Decision Support
- Clinical Information System
- Patient Engagement
- Partner Radiology Centers
- Resources for the Uninsured

**Secondary Drivers**

- E-huddle vs. Morning huddle
- Assign Responsibility/Measure Success
- Standing Orders/Templates
- H/Bed/Discharge
- Care Coordination / Community Linkage to care
- Access to care

**PDSA Test Cycles**

- A
- P
- S
- D
- A
- P
- S
- D
- A
- P
- S
- D
- A
- P
- S
- D
- A
- P
- S
- D
Steps in Planned Care for MAs

- Open EHR
- Open PCD
- Select PCP
- Review PCD alerts
- Take action
Open Planned Care Dashboard & Select Provider

Parameters

- Provider
- ApptRange
  - Today
- ControlNo
- ApptTime
  - All
**Planned Care Dashboard Display**

**Provider Name**

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

**Contact Us!**

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

**ALERTS**

<table>
<thead>
<tr>
<th></th>
<th>Last Date</th>
<th>Due Date</th>
<th>Value</th>
<th>Notes</th>
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<tbody>
<tr>
<td>DM Retinopathy</td>
<td>Never Done</td>
<td>Never Done</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 of</td>
<td>Never Done</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlamydia Screen</td>
<td>Never Done</td>
<td>Never Done</td>
<td></td>
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<tr>
<td>Depression Screening</td>
<td>11/15/2016</td>
<td>11/15/2017</td>
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**Bubbles**

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<tr>
<th>Bubbles</th>
<th>#</th>
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<tbody>
<tr>
<td>TE</td>
<td></td>
</tr>
<tr>
<td>RX</td>
<td></td>
</tr>
<tr>
<td>Doc</td>
<td>2</td>
</tr>
<tr>
<td>Lab</td>
<td></td>
</tr>
</tbody>
</table>

**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

ID

Community Health Center, Inc.  Where health care is a right, not a privilege, since 1972.
## Split Screen: PCD and EHR

<table>
<thead>
<tr>
<th>Patient</th>
<th>PCP and Visit Info</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ALERTS</td>
</tr>
<tr>
<td></td>
<td>Last Date</td>
</tr>
<tr>
<td></td>
<td>WHO CANDIDATE</td>
</tr>
<tr>
<td></td>
<td>Needs Flu Vaccine 2017-2018</td>
</tr>
<tr>
<td></td>
<td>Body Mass Index</td>
</tr>
<tr>
<td></td>
<td>SBIRT</td>
</tr>
<tr>
<td></td>
<td>Bubbles</td>
</tr>
<tr>
<td></td>
<td>TE</td>
</tr>
<tr>
<td></td>
<td>RX</td>
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<tr>
<td></td>
<td>Doc</td>
</tr>
<tr>
<td></td>
<td>Lab</td>
</tr>
</tbody>
</table>

**ID**
- Sex: M
- Age: 44.0

**Next Medical Appointment:**
- 1/24/2018 10:00:00 AM

**Last Dental Visit:**
- Never Done

**Reason for Visit:**
- Flu meds

### Office Visits

<table>
<thead>
<tr>
<th>Visit Type</th>
<th>Appt Time</th>
<th>Patient Name</th>
<th>P/R</th>
<th>Reason</th>
<th>Sex</th>
<th>Age</th>
<th>Visit St</th>
<th>Arr Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>09:40 AM</td>
<td>Patient Name</td>
<td>DP</td>
<td>&quot;MED PCP Recall - HP. WCC&quot;</td>
<td>F</td>
<td>6M 5D</td>
<td>ARR</td>
<td>09:50 AM</td>
</tr>
<tr>
<td>Est MD 20'</td>
<td>10:00 AM</td>
<td></td>
<td>DP</td>
<td>suboxone JS</td>
<td>M</td>
<td>23 Y</td>
<td>ARR</td>
<td>10:01 AM</td>
</tr>
<tr>
<td>Est MD 20'</td>
<td>10:00 AM</td>
<td></td>
<td>DP</td>
<td>&quot;MED PCP Recall - HP. HCV End of Tx f/u; Inhaler effi&quot;</td>
<td>M</td>
<td>52 Y</td>
<td>ARR</td>
<td>09:47 AM</td>
</tr>
<tr>
<td>Est MD 20'</td>
<td>10:40 AM</td>
<td></td>
<td>DP</td>
<td>f/u appt</td>
<td>M</td>
<td>25 Y</td>
<td>ARR</td>
<td>10:41 AM</td>
</tr>
<tr>
<td>Est MD 20'</td>
<td>11:00 AM</td>
<td></td>
<td>DP</td>
<td>f/u catre--cdd</td>
<td>M</td>
<td>47 Y</td>
<td>ARR</td>
<td>10:56 AM</td>
</tr>
<tr>
<td>Est MD 20'</td>
<td>11:20 AM</td>
<td></td>
<td>DP</td>
<td>f/u</td>
<td>M</td>
<td>50 Y</td>
<td>ARR</td>
<td>11:01 AM</td>
</tr>
<tr>
<td>Est MD 20'</td>
<td>11:40 AM</td>
<td></td>
<td>DP</td>
<td>suboxone JS</td>
<td>M</td>
<td>59 Y</td>
<td>ARR</td>
<td>11:48 AM</td>
</tr>
<tr>
<td>24 Hour Ap</td>
<td>02:00 PM</td>
<td></td>
<td>DP</td>
<td>f/u on diabetic regimen s/p d/c from YNHH 1/19/2018</td>
<td>F</td>
<td>2M 27D</td>
<td>ARR</td>
<td>01:52 PM</td>
</tr>
<tr>
<td>Est MD 20'</td>
<td>02:40 PM</td>
<td></td>
<td>DP</td>
<td>excessive coughing, s/p ER d/c for uti</td>
<td>F</td>
<td>2M 27D</td>
<td>ARR</td>
<td>02:03 PM</td>
</tr>
</tbody>
</table>
## 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>
<tbody>
<tr>
<td>Breast Cancer Screening (turns red 3 months prior to due date)</td>
<td>Women age 50 to 74</td>
<td>Every 24 months</td>
<td>• Ask the patient if she has had a mammogram in past 24 months. If yes, complete Non ROI RQI and send to the facility where she got it done and order a “Mammogram Outside” (via Manage Orders) [MA]</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• If she had not had one, order a mammogram using DI.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Order DI = Mammogram – Bilateral Screening [MA]</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Mammogram – Bilateral Diagnostic [Prov]</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Mammography screening with U/S –Hospital specific [MA/Prov]</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• If she declines, order a “Mammogram Declined” (via Manage Orders) [MA] with provider permission or [Prov]</td>
</tr>
<tr>
<td>(yellow for 30 days once the mammogram has been ordered or declined)</td>
<td></td>
<td></td>
<td>• Once results come in: Results checked as “Received”, “Collection Date” entered and “Attached” [MA] or Medical Records</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• DI Result “Reviewed” [Prov]</td>
</tr>
</tbody>
</table>
Missed Opportunities

- (notes - Patient agenda and planned care agenda)
# 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:**

<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>A1C</td>
<td>83.0%</td>
<td>80.3%</td>
<td></td>
</tr>
<tr>
<td>Literacy in Social History</td>
<td>51.1%</td>
<td>56.0%</td>
<td></td>
</tr>
<tr>
<td>Initial appointments</td>
<td>32.7%</td>
<td>39.5%</td>
<td></td>
</tr>
<tr>
<td>documented</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chaperone for all well</td>
<td>60.8%</td>
<td>81.4%</td>
<td></td>
</tr>
<tr>
<td>women visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOGI</td>
<td>90%</td>
<td>96%</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>98.6%</td>
<td>98.3%</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.

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

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Orders for Mammograms 2010-2017

Mammograms Ordered

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>58%</td>
</tr>
<tr>
<td>2011</td>
<td>67%</td>
</tr>
<tr>
<td>2012</td>
<td>66%</td>
</tr>
<tr>
<td>2013</td>
<td>64%</td>
</tr>
<tr>
<td>2014</td>
<td>72%</td>
</tr>
<tr>
<td>2015</td>
<td>70%</td>
</tr>
<tr>
<td>2016</td>
<td>71%</td>
</tr>
<tr>
<td>2017</td>
<td>74%</td>
</tr>
</tbody>
</table>
**Aims**

- Improve Screening Mammogram rates by 10% in a 12 month period

**Primary Drivers**

- Delivery System Design
- Decision Support
- Clinical Information System
- Patient Engagement
- Partner Radiology Centers
- Resources for the Uninsured

**Secondary Drivers**

- E-huddle vs. Morning huddle
- Assign Responsibility/Measure Success
- Standing Orders/Templates
- SDOH/Barriers Assessment
- Care Coordination / Community Linkages to care
- Pathway for Access to Care

**PDSA Test Cycles**
Breast Cancer Screening Completed

Mammograms Completed

Percent of Patients with Mammogram Completed

- 32% in 2010
- 40% in 2011
- 39% in 2012
- 37% in 2013
- 45% in 2014
- 42% in 2015
- 44% in 2016
- 43% in 2017
Breast Cancer Screening: Area for Improvement

- Result is an Operations Team was initiated including Medical Records and Referral Department staff to understand why the rates are not higher
  - Team flow mapped current process
Breast Cancer Screening: Area for Improvement

- Result is an Operations Team was initiated including Medical Records and Referral Department staff to understand why the rates are not higher
  - Team flow mapped current process
PDSA

Our team is conducting this PDSA to see if this small change will affect the number of mammogram results that are properly attached to the order and "count".

**PLANNING THE PDSA**

<table>
<thead>
<tr>
<th>Task</th>
<th>By Whom</th>
<th>Week of</th>
<th>Where (Site, Pod, Team, Etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtain buy-in from Chief Nursing Officer</td>
<td>Jen B</td>
<td>2/16/2018</td>
<td>Meriden - Aislinn's providers</td>
</tr>
<tr>
<td>Inform Referrals and Indexing</td>
<td>Hayley H</td>
<td>after Jen talks with Mary</td>
<td>Danbury - Maribel's providers</td>
</tr>
<tr>
<td>Team of the PDSA</td>
<td></td>
<td>2/19/18</td>
<td>Meriden - Aislinn's providers</td>
</tr>
<tr>
<td>Implement PDSA</td>
<td>Aislinn and Maribel</td>
<td>2/26/2018</td>
<td>Danbury - Maribel's providers</td>
</tr>
</tbody>
</table>

**DO - POST PDSA**

<table>
<thead>
<tr>
<th>Task</th>
<th>Challenges</th>
<th>Successes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hayley sends all mammogram Dis for providers A, B, C and D to Aislinn and Maribel</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Baseline Data**

<table>
<thead>
<tr>
<th>Describe the data you have</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the source of the data?</strong> Data from CHN lists patients who had a mammogram but for whom CHC does not have the result.</td>
<td>818 (patients with a mammogram completed that are not &quot;counting&quot; in CHC's system.)</td>
<td>1661 (patients with a mammogram completed according to CHN)</td>
</tr>
<tr>
<td><strong>What is the timeframe for the data?</strong> Last 12 months</td>
<td>A record review of 100 of these 818 revealed that 28% are in the EHR but not counting because they are not attached/documented correctly.</td>
<td></td>
</tr>
<tr>
<td><strong>What is the data measuring?</strong> Patients with a mammogram completed for whom the test is in the record but not attached and documented correctly.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Future Work

- Consider interventions involving patient navigation
- Identify reasons patients are not going for mammograms, once the data are clean
- Analyze data to identify high performing sites and/or providers to uncover any best practices
- Analyze data to identify areas of lower performance and provide supports as needed

Summary: There are dozens of PDSAs that can be performed on this one measure!
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
Transformation Goals

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

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

Screening Guidelines
Approved July 2017
Pre-Visit Planning
### Pre-Visit Planning

#### Patient ID & Name

<table>
<thead>
<tr>
<th>Time</th>
<th>Provider</th>
<th>Resource</th>
<th>Type</th>
<th>Patient</th>
<th>Age</th>
<th>Sex</th>
<th>Language</th>
<th>Race</th>
<th>PCP</th>
<th>Acuity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:10 AM</td>
<td>June CRNP, Linda</td>
<td>June CRNP, Linda</td>
<td>WWE</td>
<td>[Redacted]</td>
<td>31</td>
<td>F</td>
<td>Spanish</td>
<td>White</td>
<td>Mba NP, Chibuzor</td>
<td>0.95</td>
</tr>
<tr>
<td>Reason: parpap arr 800 216 ba History (12 Mo): No Shows: 2 Canceled: 1 Visits: 1 ER: 0 Admits: 0 Last Visit DR: Mba NP, Chibuzor</td>
<td>Outstanding Referrals: 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last Pap: LMP: Smoker: No Framingham Risk Factor:</td>
<td>0.01%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Due: Procedure / Referral: SBIRT Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:10 AM</td>
<td>Shields NP, Caroline</td>
<td>Shields NP, Caroline</td>
<td>Visit 20</td>
<td>[Redacted]</td>
<td>26</td>
<td>F</td>
<td>English</td>
<td>Patient Declined</td>
<td>Khan DMD, Fatima</td>
<td>1.9</td>
</tr>
<tr>
<td>Reason: 800 0up pp History (12 Mo): No Shows: 0 Canceled: 3 Visits: 17 ER: 0 Admits: 0 Last Visit DR: Shields NP, Caroline</td>
<td>Outstanding Referrals: 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last Pap: 8/15/2017 LMP: Smoker: No Framingham Risk Factor:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Due: Procedure / Referral: SBIRT Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:30 AM</td>
<td>June CRNP, Linda</td>
<td>June CRNP, Linda</td>
<td>New Patient Planning Visit</td>
<td>[Redacted]</td>
<td>37</td>
<td>F</td>
<td>Spanish</td>
<td>Patient Declined</td>
<td>Shields NP, Caroline</td>
<td>1.9</td>
</tr>
<tr>
<td>Reason: is aware she need to bring parpap and id arr 815am, ecg method consult 2/16 ba</td>
<td>History (12 Mo): No Shows: 0 Canceled: 0 Visits: 0 ER: 0 Admits: 0 Last Visit DR: Outstanding Referrals: 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last BMI: 32.57 (10/30/14)</td>
<td>Weight Change (6 Mo): Last BP: 151/94 (10/30/14) Last PHQ:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Lessons Learned
Lessons Learned

☑ Data Management
Lessons Learned

✓ Data Management
✓ Patient recall process
Lessons Learned

✓ Data Management
✓ Patient recall process
✓ Lab results
Lessons Learned

✓ Data Management
✓ Patient recall process
✓ Lab results
✓ Abnormal results
KPTA In-Person Session: Planned Care
Thursday, March 22nd | 8:45am – 4:00pm
Center for Total Health | Washington, DC

Register Now
Pre-Work – Due March 9th

• Complete the worksheet and sent to alexis@careninnovations.org

• Reach out to Alexis, Tammy, or Carolyn if you have questions

• CCI will print copies for you to reference during the learning session

[Worksheet] Learning from Our Successes and Challenges
KP Transformation Accelerator: Mid-Atlantic Region

Team Directions: Complete this worksheet and send it to alexis@careninnovations.org by Friday, March 9th. CCI will print and bring copies to the March 22nd In Person Learning Session for reference by your team.

Organization Name:
Project Aim:

1. What changes have you tried to help you achieve your aim?
   For each change, please share whether you are still testing (change is being tested with a few patients and/or with a few providers, for example) or have implemented the change (you’re doing the change most of the time with most patients and providers at the pilot site).

2. What have you learned from doing these changes?
   How are patients, staff, clinicians experiencing these changes? Please give us a glimpse of the data you have collected.

3. What are your top 2 challenges in achieving your aim?

4. What do you want to learn from your peers to help you reach your aim?
Got to:
www.careinnovations.org/accelerator-team/
Current Updates

Read below for all the most current program announcements, reminders, and newly posted resources. Be sure to bookmark this page and check back regularly so that you don’t miss a thing!

WEBINARS & EVENTS

Webinar: Planned Care. February 28, 2-3pm ET. Pre-Visit Planning: Using Data and Optimizing Care Team Roles. Register here.

Optional: Team-Based Care Webinar Series. March 1, 8. Optional team-based care webinars delivered by CHC, Inc. and the Weitzman Institute’s Clinical Workforce Development. More information here.

In-Person Learning Session: Planned Care. March 22, Center for Total Health. Pre-work due March 9th. Complete this worksheet and email to Alexis. Use this example as a template.

In-Person Learning Sessions. Save the Dates! July 24 and October 10. The 2nd and 3rd in-person learning sessions will be held at the Center for Total Health in Washington, D.C.

NEW RESOURCES

KEY DATES

- 2nd Installment Release, January – February 2018
- Webinar: Planned Care, February 28, 2018
- In-Person Convening, March 22, 2018
- Progress Report #2 Due, May 15, 2018
- In-Person Convening, July 24, 2018
- In-Person Convening, October 10, 2018
- Final Financial & Narrative Report Due, December 31, 2018
Program Resources

Documents & Templates

- Program Overview
- Reporting
  - Progress Report Form – December 2017
  - Charter for improvement (CFI) Template
  - Budget template
Program Resources

Learning Sessions & Site Visits

Transformation Accelerator: Informational Webinar
AUG 9, 2017 - CENTER FOR CARE INNOVATIONS

This webinar detailed the program structure, expectations, and timelines in the Accelerator program.

Learning Session #1: Learning, Reflecting, and Applying
CLICK FOR MORE DETAILS.

Serve the People Site Visit
CLICK FOR MORE DETAILS.

Community Health Center, Inc.
CLICK FOR MORE DETAILS.

Documents & Templates

PROGRAM OVERVIEW
Program and Funding Overview

REPORTING
Progress Report Form – December 2017
Charter for improvement (CFR) Template
Budget template
Program Resources

Learning Sessions & Site Visits

Documents & Templates

Program Overview
- Program and Funding Overview

Reporting
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- Charter for Improvement (CFI) Template
- Budget template

Handouts
- Agenda
- Faculty Biographies
- Team-Based Care Reflection Worksheet
- Driver Diagram Toolkit

Presentations
- Full Slide Deck
- Introduction & Closing Slides
- Driver Diagrams
- Team-Based Care Framework
- Leveraging Team-Based Care
THANK YOU!

Carolyn Shepherd  Tierney Giannotii  Mary Blankson  Kameela Clark  Marcela Cámpoli