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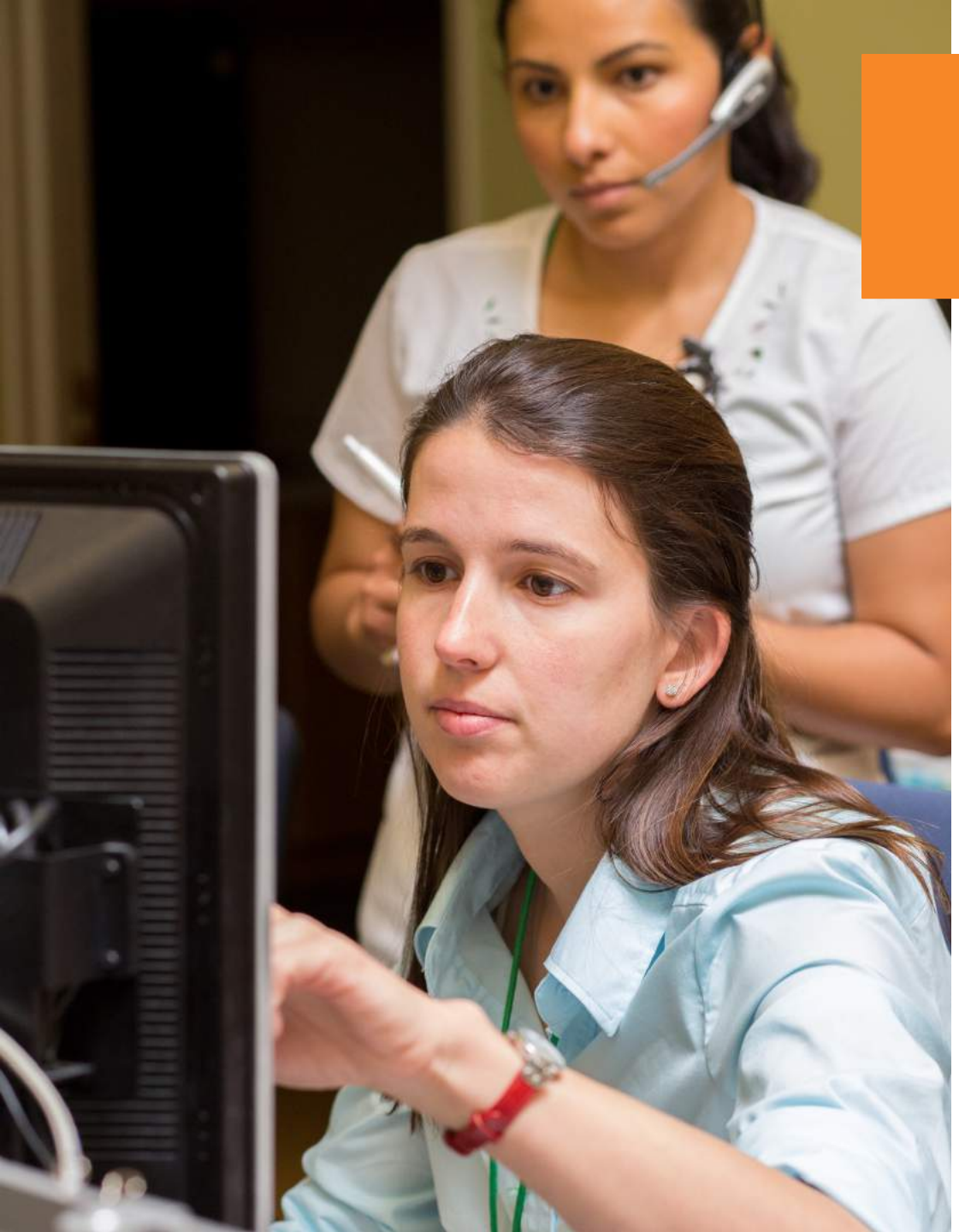
KP Transformation Accelerator

Virtual Learning Session #1
Planned Care
Tuesday, May 1, 2018



Today's Big Awesome Agenda

1. Opening
2. Learning from Our Changes: Successes & Challenges
3. Deep Dive: Effective Planned Care Part 1
4. Reflection & What's Next

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

Tierney Giannotti

Mary Blankson

Alexis Wielunski

Tammy Fisher

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

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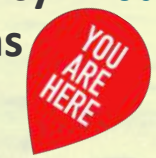
RPCC
Regional Primary Care Coalition

KAISER PERMANENTE®

Community Health Center, Inc.

Where are we in our Transformation Accelerator journey?

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



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

Transformation Accelerator Assessment for Community Health Centers

[Health Center Name]

Item #	Scoring level	Level D			Level C			Level B			Level A			Your Score	Comments Comment as needed to help explain your score (e.g., unusually high or low scores)
		1	2	3	4	5	6	7	8	9	10	11	12		
	I. Leadership & Culture (Adapted from BBPCA & BCCQ Assessment)														
1	Senior leaders	…are focused on short-term business priorities.			…visibly support and create an infrastructure for quality improvement, but do not commit resources.			…allocate resources and actively reward quality improvement initiatives.			…support continuous learning throughout the organization, review and act upon quality data, and have a long-term strategy and funding commitment to explore, implement and spread quality improvement initiatives.				
2	Strategic Planning	…is conducted for the organization but does not not address care delivery transformation (OR VBC). The Board of Directors has not yet discussed care delivery transformation (OR VBC).			…does not not address care delivery transformation (OR VBC). The Board of Directors has discussed the movement toward care delivery transformation (OR VBC).			…includes objectives for progress toward care delivery transformation (OR VBC). The Board of Directors has a clear strategy for care delivery transformation (OR VBC).			…includes initiatives for care delivery transformation (OR VBC) that are currently underway and there is measureable progress towards objectives.				
3	Clinic leaders	…intermittently focus on improving quality.			…have developed a vision for quality improvement, but no consistent process for getting there. Quality Improvement process includes setting clear aims and measures for improvement areas, regularly using PDSAs to test changes, documenting PDSAs and sharing results broadly.			…are committed to a quality improvement process, and sometimes engage teams in implementation and problem solving.			…consistently champion and engage clinical teams in improving patient experience care, clinical outcomes, and appropriate use of resources.				
4	Senior leaders (engagement)	…mainly work in their own offices and rarely interact with			…intermittently focus on improving quality and			… interact with front line staff around issues of strategy,			…frequently interact with front line staff around issues of				

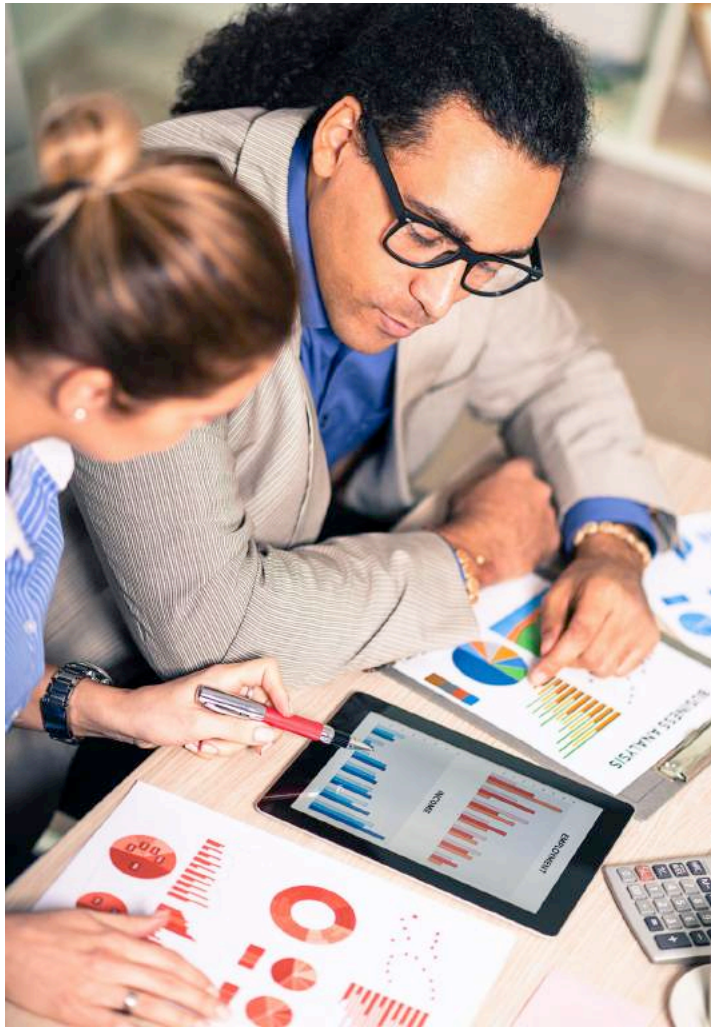
Testing Changes & Using Data to Learn about Your Changes

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)**

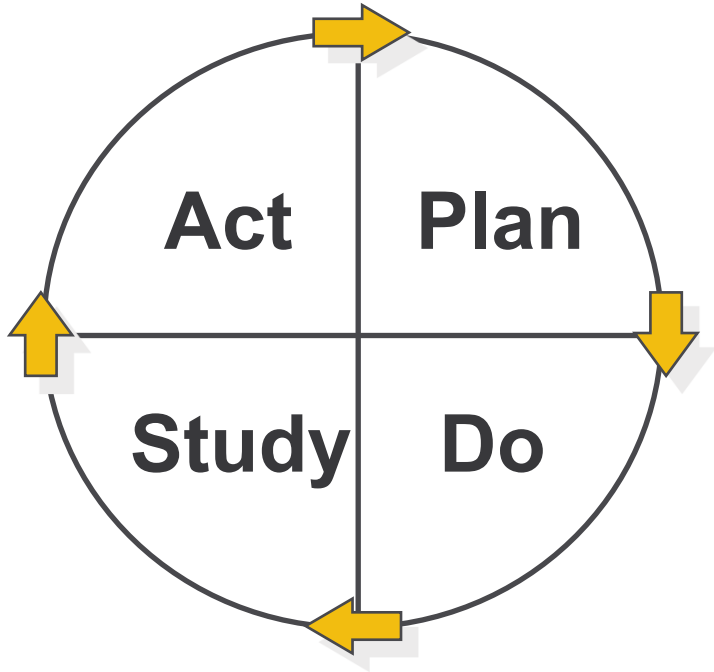
3. What changes can we make that will result in an improvement? **(Change – come from drivers)**



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)% patients screened
2) % of patients outreached that were screened
3) Percent of patients screened at visit

Aim

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

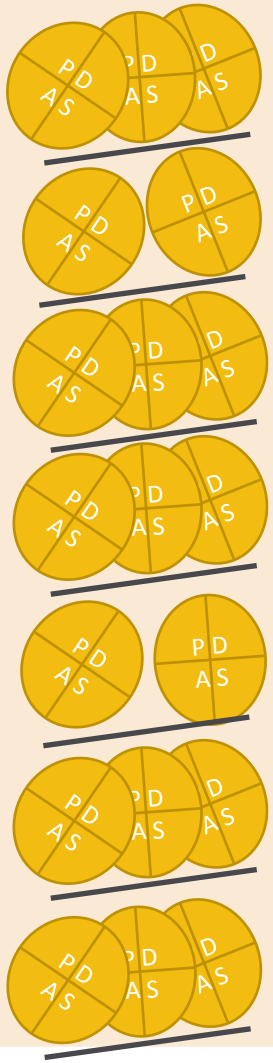
Primary Drivers

- 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

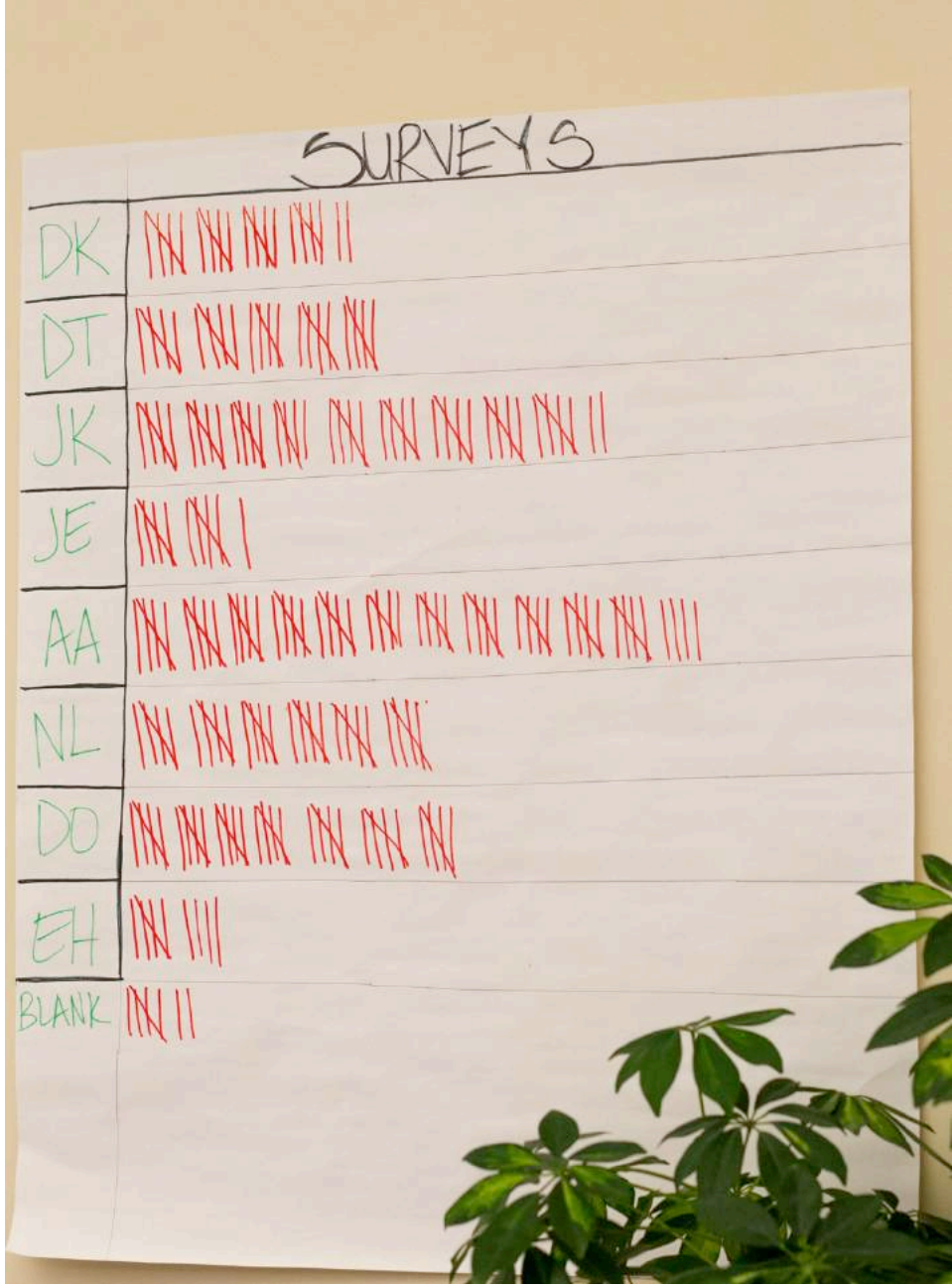


- Who didn't get it and why – check weekly or more
- % of patients successfully reached
- % of patients with scheduled appointments
- % of patients that showed for appointments
- % of patients captured in reports – validate via medical charts
- Staff experience using the protocols

PDSA measures

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



FAMILY AND MEDICAL COUNSELING SERVICE, INC.

FMCS CARE TEAM: PATRICIA GRIMES, MIA THOMPSON, WENONA POSEY AND LATASHA CURRIE

PRESENTER : ANGELA WOOD

PROJECT AIM & DRIVERS

AIM

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

Primary Drivers

- Access/Appointment Availability
- Community Relationships

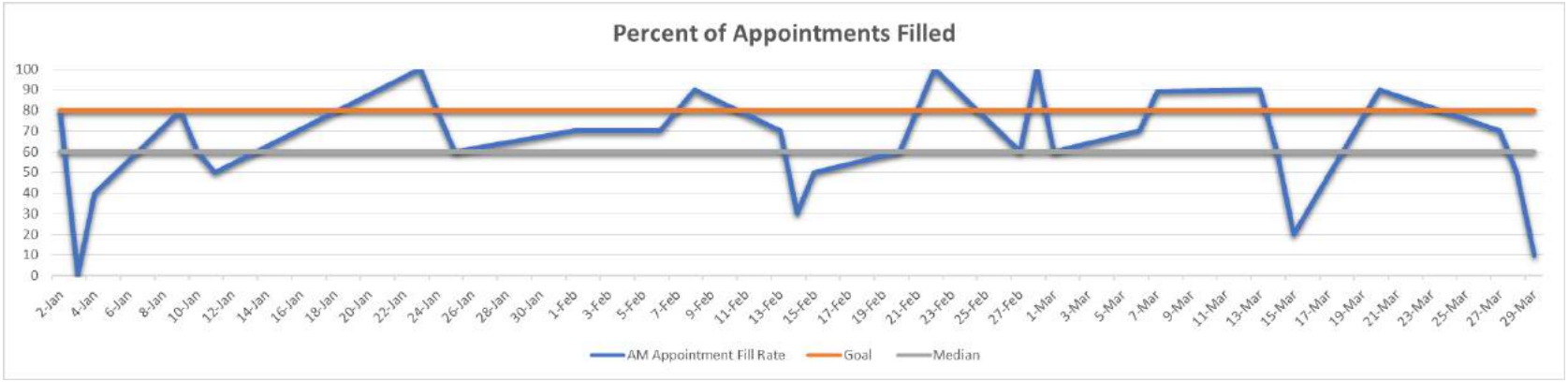
SECONDARY MEASURE

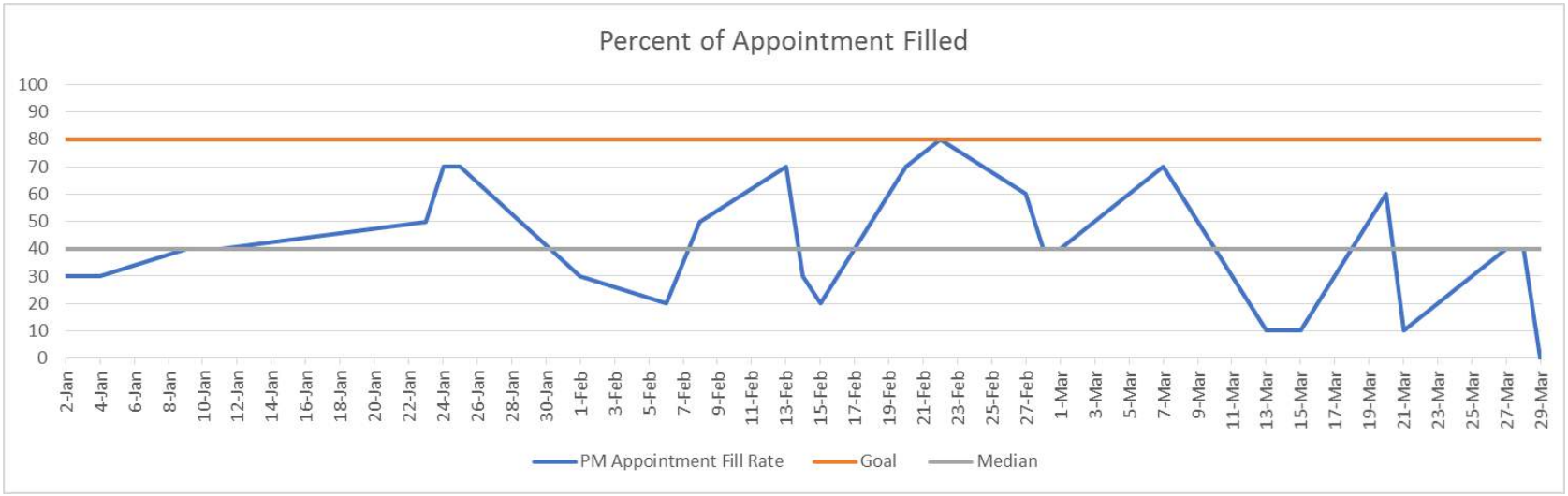
- To maintain a daily appointment filled rate of 80%.
  - Numerator: The number of filled appointment slots
  - Denominator: The number of available appointments

CHANGES IMPLEMENTED

- **Change 1:** FMCS modified the medical scheduling template changing to a standard 20 minute slot for all appointments.
- **Change 2:** FMCS increased the hours that we are open at the MD slot by one hour.
- **Change 3:** FMCS opened clinic on one Saturday to determine need and interest from the consumer base.
- **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.

DATA


Percent of Appointments Filled
100
90
80
70
60
50
40
30
20
10
0
2-Jan 4-Jan 6-Jan 8-Jan 10-Jan 12-Jan 14-Jan 16-Jan 18-Jan 20-Jan 22-Jan 24-Jan 26-Jan 28-Jan 30-Jan 1-Feb 3-Feb 5-Feb 7-Feb 9-Feb 11-Feb 13-Feb 15-Feb 17-Feb 19-Feb 21-Feb 23-Feb 25-Feb 27-Feb 1-Mar 3-Mar 5-Mar 7-Mar 9-Mar 11-Mar 13-Mar 15-Mar 17-Mar 19-Mar 21-Mar 23-Mar 25-Mar 27-Mar 29-Mar
AM Appointment Fill Rate
Goal
Median


Percent of Appointment Filled
100
90
80
70
60
50
40
30
20
10
0
2-Jan 4-Jan 6-Jan 8-Jan 10-Jan 12-Jan 14-Jan 16-Jan 18-Jan 20-Jan 22-Jan 24-Jan 26-Jan 28-Jan 30-Jan 1-Feb 3-Feb 5-Feb 7-Feb 9-Feb 11-Feb 13-Feb 15-Feb 17-Feb 19-Feb 21-Feb 23-Feb 25-Feb 27-Feb 1-Mar 3-Mar 5-Mar 7-Mar 9-Mar 11-Mar 13-Mar 15-Mar 17-Mar 19-Mar 21-Mar 23-Mar 25-Mar 27-Mar 29-Mar
PM Appointment Fill Rate
Goal
Median

KEY LESSONS LEARNED

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

1. Patients in the service area seem to prefer the morning session.
2. The addition of the later hour in the evening has not yielded additional patient volume

WHAT'S NEXT

- Expanding available morning hours
- Piloting another Saturday
- Expansion of outreach efforts and community awareness activities
- Improved relationships with third party payers
- On-going review of program data

Planned Care Review
Part 1

Carolyn Shepherd

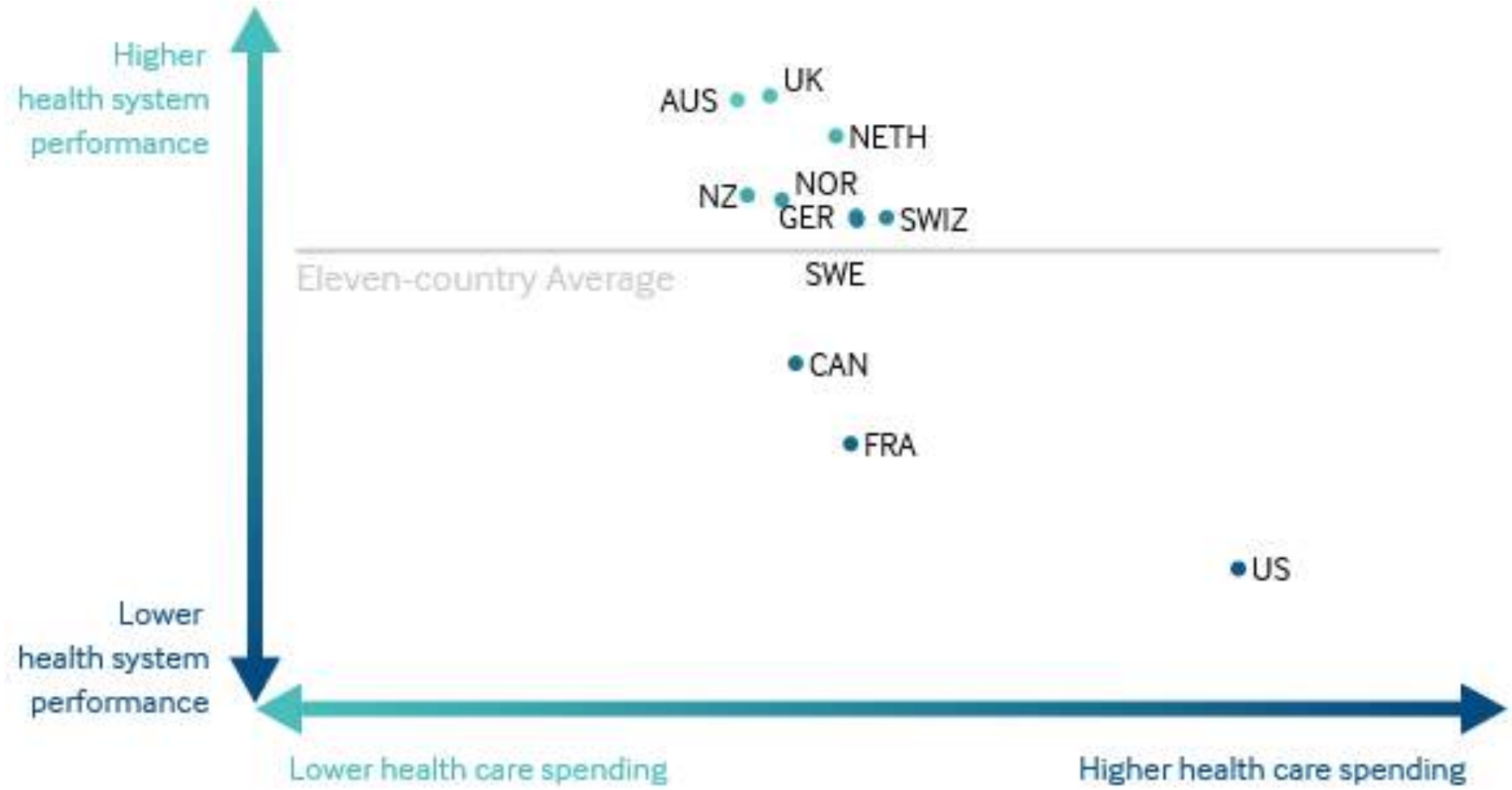
KP Transformation Accelerator

5/1/18

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.

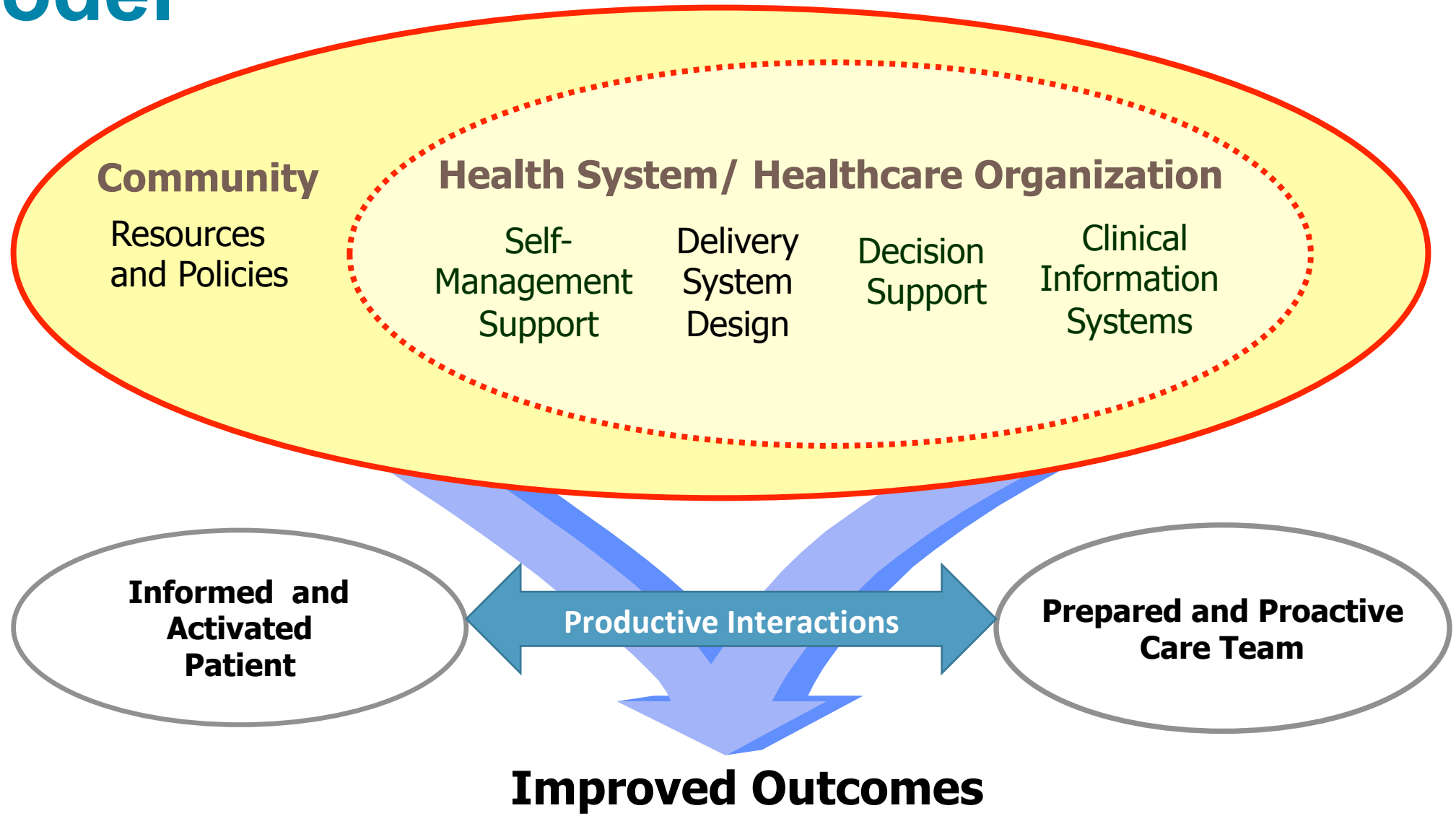
Planned Care Model:
A Remedy for Poor Outcomes



"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



Delivery System Design

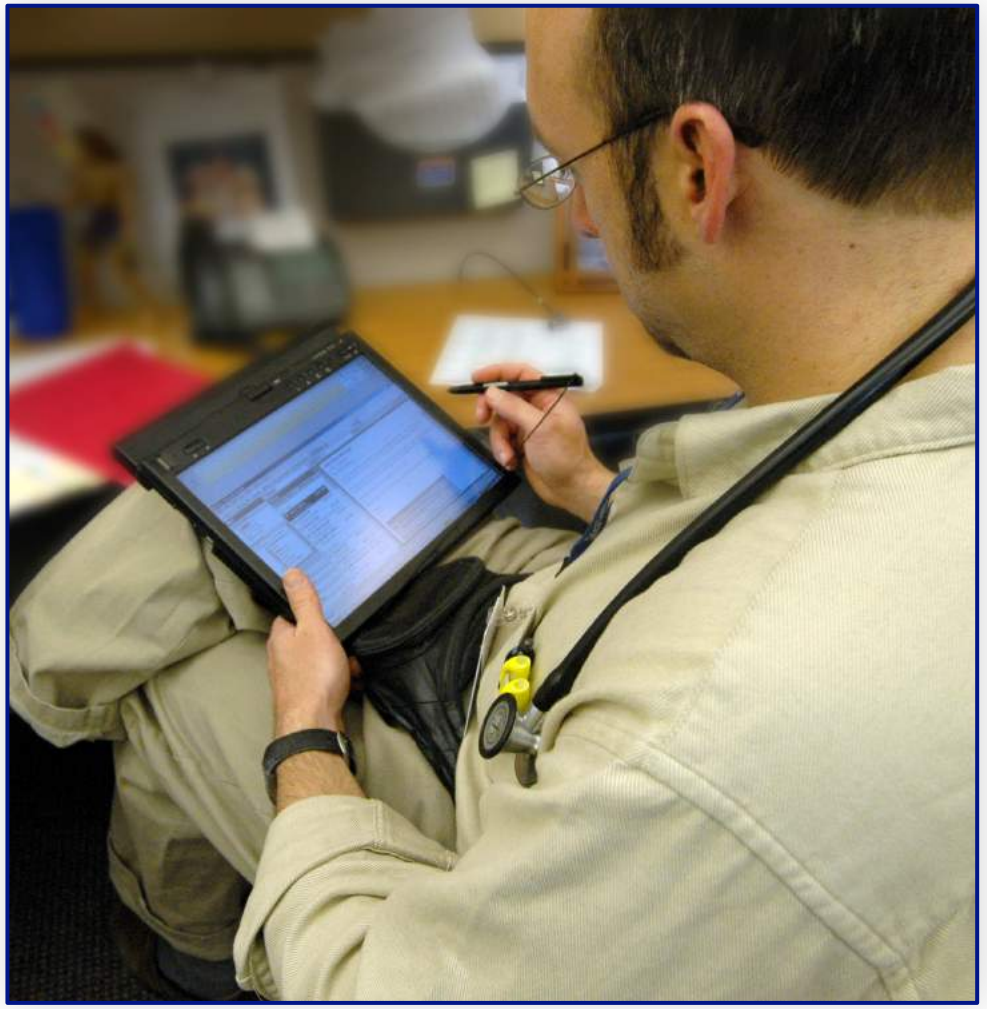
- Focus on the patient to meet needs
- Build core primary care teams
- Build expanded teams
- Use alternative visit models

Delivery System Design, cont.

- Optimize operational systems
- Outreach and population management
- **Pre-visit planning huddle** with the core team
- Ensure all (and only) indicated care is offered to the patient

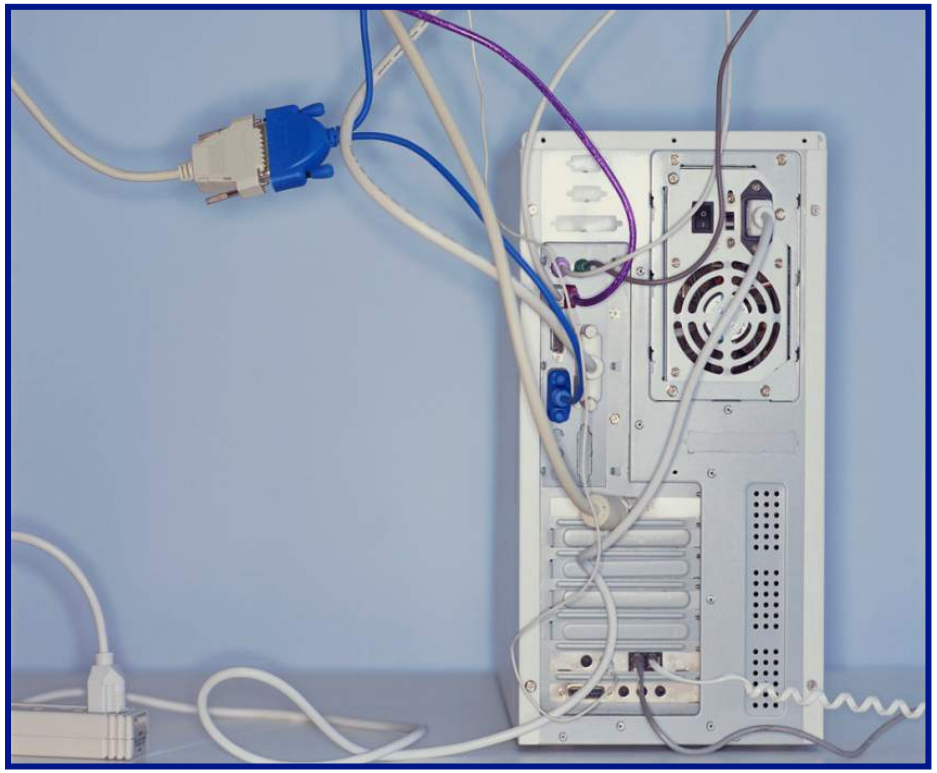
Decision Support

- 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

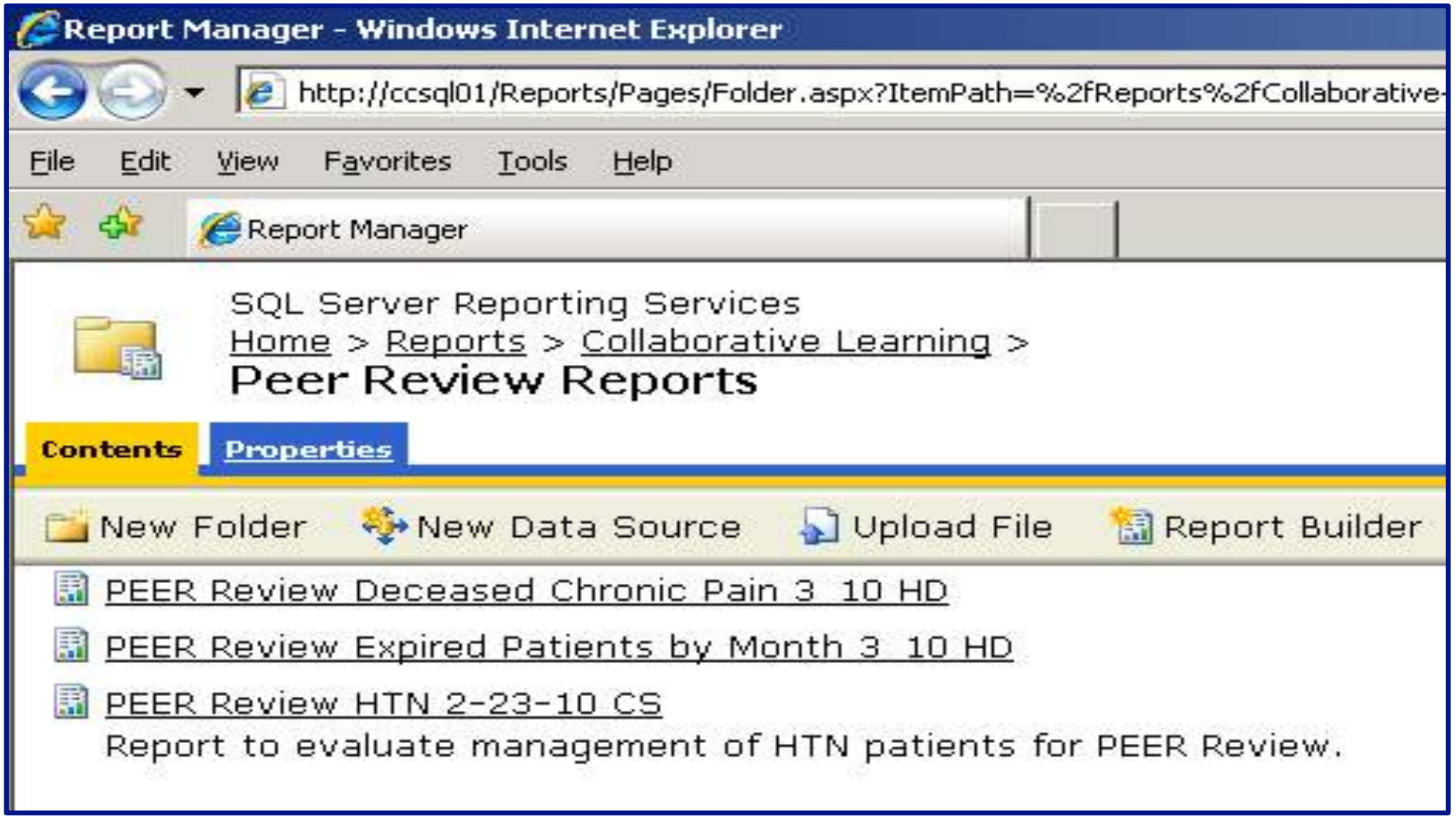
- Create shared care plan and assure follow-up
- Effective self-management support
- Health care information access
- Personal Health Record
- Patient and family engagement in service design

"Do you want the pill, the suppository, the patch or the app?"

Community Support and Policies

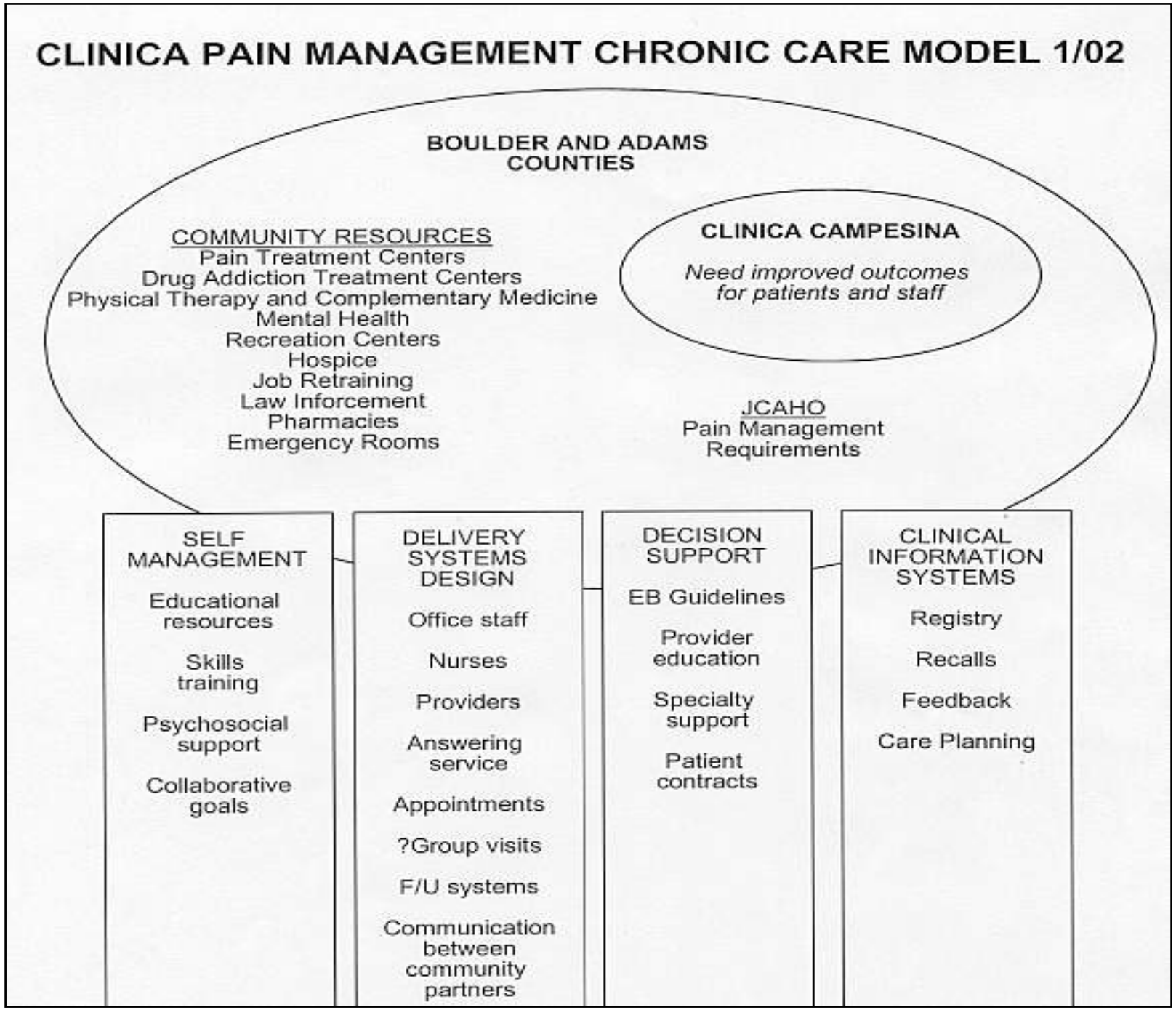
- Develop and optimize partnerships
- Advocacy to add/change policies
- Address Social Determinants of Health

Clinica Family Health Services Planned Care Example

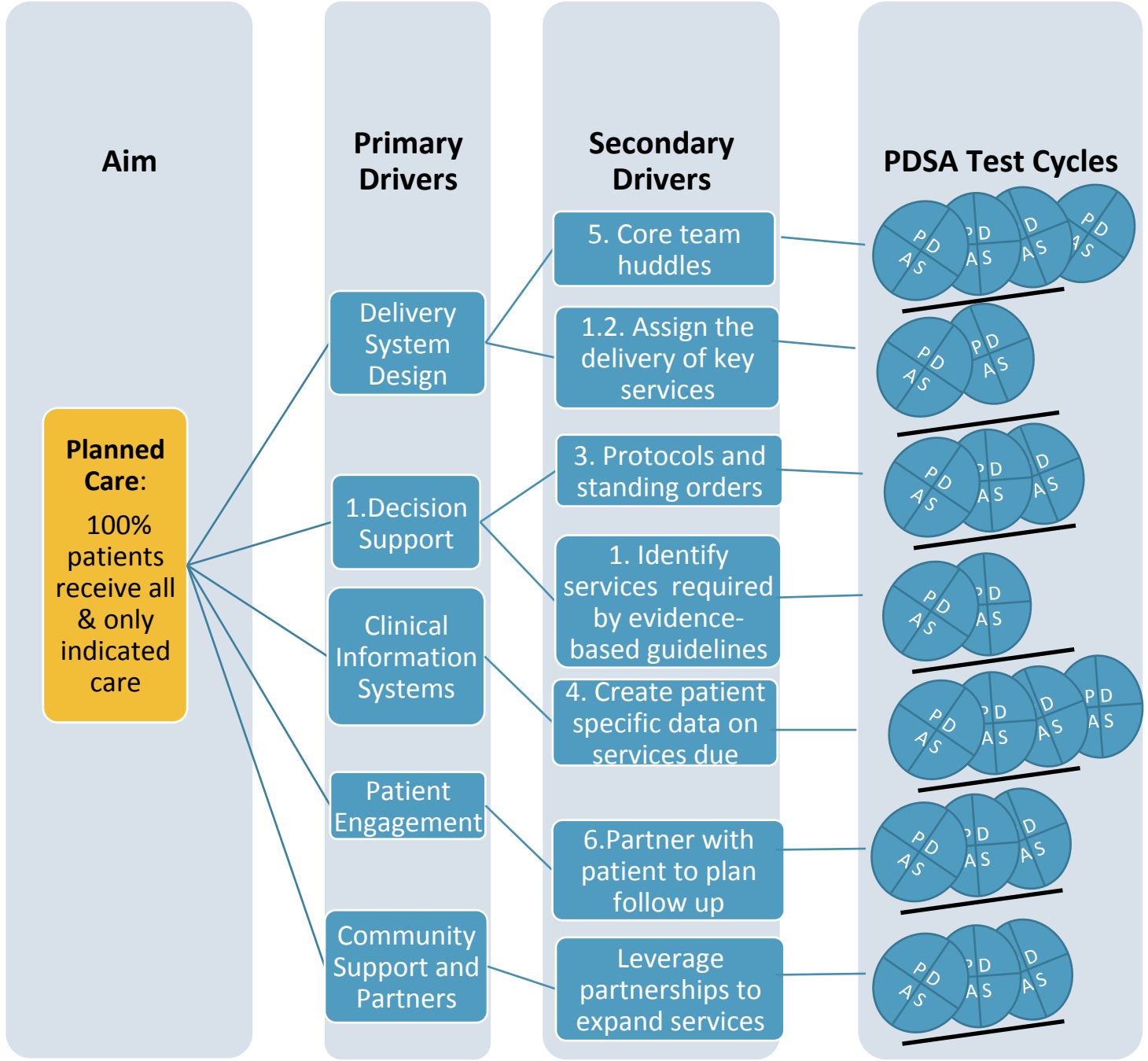


Where to Start?

- 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



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**

<u>Questions:</u>

- 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

Lung Cancer (USPSTF))	Asymptomatic adults aged 55 to 80 years who have a 30 pack year smoking history and currently smoke or have quit with in the past 15 years: Screen annually with low dose Computed Tomography until the patient has not smoked for 15 years.
STD Screening (USPSTF/CDC)	• **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 (MSM, positive HIV) and (Male under age 29, race/ethnicity, geography, incarceration, and sex work)
HIV Screening (CDC)	HIV screening been done/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, incarceration, 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. CDC link-HBV prevalence by country: http://wwwnc.cdc.gov/travel/yellowbook/2016/infectious-diseases-related-to-travel/hepatitis-b
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/ACOG)	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 14 and above: • HITS questionnaire on initial screen • HARK 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 11-21. Male patients with risk factors: offered/given until age 26.
Tetanus booster (ACIP)	Adult patients: Tdap given at least once; Td every 10 years thereafter. Pregnant women: Tdap given during each pregnancy.
Influenza (ACIP)	Offered/given during the last flu season for indicated patients (chronic illness, or age 0-4, 50+).

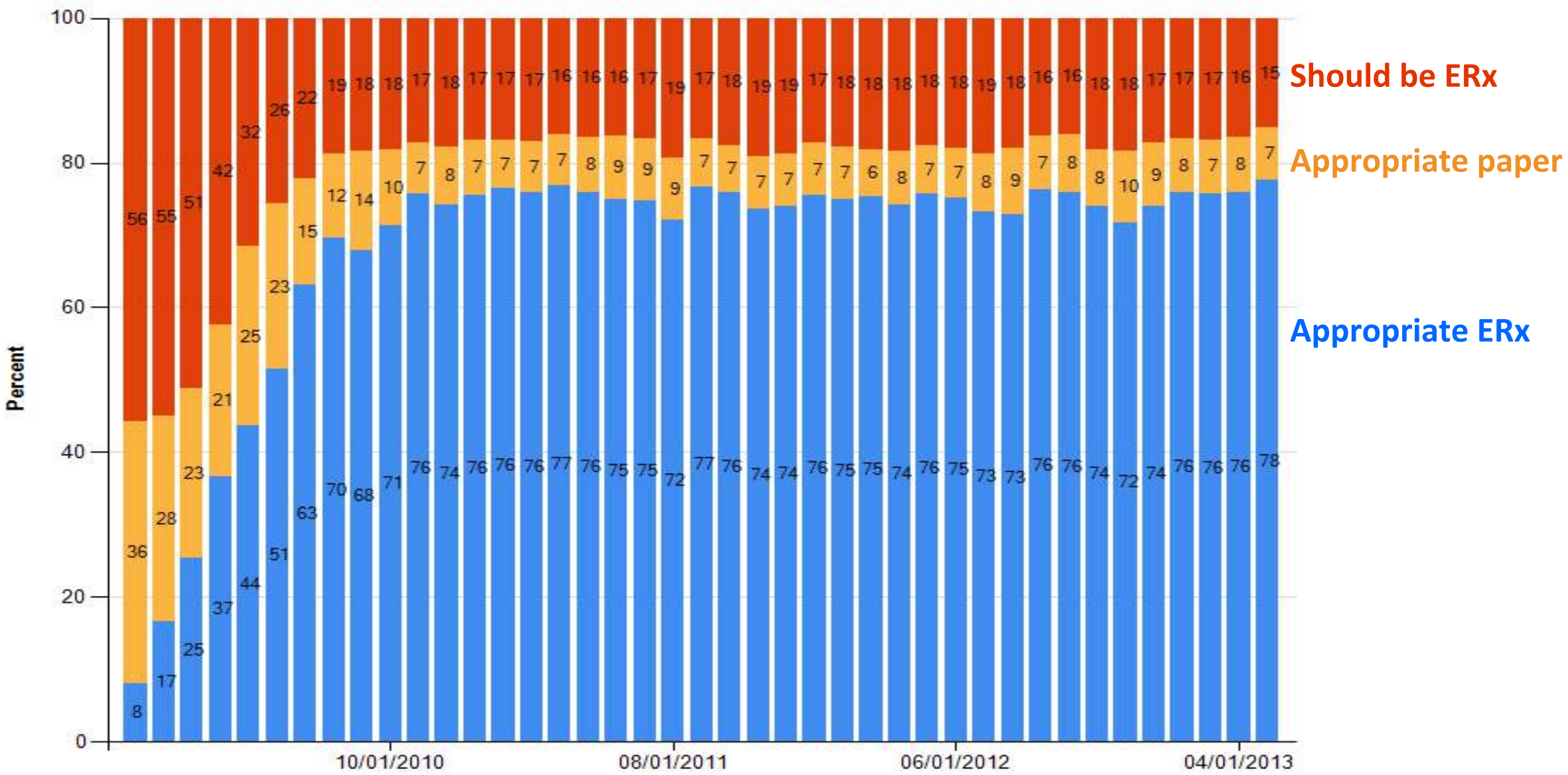
Six Steps to Providing Planned Care

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

<u>Questions:</u>

- 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?

Outcomes-ERx Clinica



Tool for PCD: Mammograms

PCD Item	Patient Population	How Often	What MA/LPN Does (or other clinical staff)

Breast Cancer Screening (turns red 3 months prior to due date)
 	
(yellow for 30 days once the mammogram has been ordered or declined)
	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: _____

Measure	Agency Average	Meriden Average	Your Rate
Depression Screening	81.4%	87.9%	
Smoking Assessment	100.0%	100.0%	
Colon Cancer Screening	61.2%	63.7%	
A1C	83.0%	80.3%	
Literacy in Social History	51.1%	56.0%	
Initial appointments documented	32.7%	39.5%	
Chaperone for all well women visits	60.8%	81.4%	
SOGI	90%	96%	
PEDS Screening	58.7%	71.2%	
HIV	78.7%	83.7%	
Child BMI Percentile	99.7%	99.3%	
Child Weight Education	85.6%	91.9%	
Asthma -ACT	78.9%	72.1%	
Adult BMI	98.6%	98.3%	
Adult Weight Education	73.4%	70.5%	
Chlamydia	33.3%	30.8%	
Planned Care Dashboard	630		
SBIRT	45%	77%	

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

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

MA Name: _____

Measure	Agency Average	New Britain Average	Your Rate
Depression Screening	81.4%	77.2%	
Smoking Assessment	100.0%	100.0%	
Colon Cancer Screening	61.2%	64.7%	
A1C	83.0%	85.7%	
Literacy in Social History	51.1%	49.6%	
Initial appointments documented	32.7%	30.6%	
Chaperone for all well women visits	60.8%	41.8%	
SOGI	90%	92%	
PEDS Screening	58.7%	70.3%	
HIV	78.7%	83.0%	
Child BMI Percentile	99.7%	99.7%	
Child Weight Education	85.6%	87.8%	
Asthma -ACT	78.9%	89.2%	
Adult BMI	98.6%	98.8%	
Adult Weight Education	73.4%	72.2%	
Chlamydia	33.3%	29.6%	
Planned Care Dashboard	630		
SBIRT	45%	71%	

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

Patient ID	2 ER Visits in Last 12 Mths.	Hosp. Last 12 Mths.	DM	HTN	Asthma	4 Chronic Cond.	Smoking Status	A1C	BP	Age - Sex	CC Start Date	CC End Date	SMG Date	Action Item	Action Item Due Date	Last PCP Visit	Last Dental Visit	Last BH Visit	Portal Enabled
							unknown												
[redacted]							never smoker	13.7	137/86	31.0 - M						10/10/2017		11/11/2016	No
							never smoker		100/74	31.0 - F						10/23/2017	2/3/2018	9/2/2015	Yes
		1/21/2018					never smoker	11	112/68	45.0 - F						1/6/2018		8/1/2017	Yes
							smoker, current status unknown	6.1	139/76	58.0 - F						1/23/2018	5/13/2010	9/14/2016	Yes
							smoker, current status unknown	5.6	126/82	22.0 - F						11/9/2017	9/26/2016	1/24/2018	No
		3/23/2017					never smoker	5.3	142/86	75.0 - M						1/2/2018	6/10/2013		No
							former smoker	5.5	128/76	34.0 - M						11/9/2017	1/15/2013	11/8/2016	Yes
							smoker, current status unknown	5.8	124/75	50.0 - F						1/3/2018	9/13/2016		No
							smoker, current status unknown	11.2	186/97	55.0 - F				fu	3/8/2018	12/18/2017			No
							former smoker	5.8	131/63	45.0 - F						2/5/2018	6/1/2011	3/22/2006	No

Complex Care Management Dashboard: Enrolled Patients

Patient ID	2 ER Visits in Last 12 Mths.	Hosp. Last 12 Mths.	DM	HTN	Asthma	4 Chronic Cond.	Smoking Status	A1C	BP	Age - Sex	CC Start Date	CC End Date	SMG Date	Action Item	Action Item Due Date	Last PCP Visit	Last Dental Visit	Last BH Visit	Portal Enabled
[redacted]		1/7/2018					smoker, current status unknown		116/60	55.0 - F	2/5/2018			RN Care Coordination	3/2/2018	2/16/2018		9/20/2017	No
							never smoker	11.8	116/79	42.0 - F	12/9/2017		1/16/2018 2:20:00 PM	RN Care Coordination	3/2/2018	12/27/2017			Yes
							never smoker	7.8	121/75	54.0 - F	2/16/2018		2/16/2018 9:20:00 AM	Self Management Goal	3/2/2018	12/6/2017			Yes
		10/31/2017					never smoker	10.6	96/55	48.0 - F	8/15/2016					11/3/2017		4/11/2017	Yes
							never smoker	9.5	134/88	51.0 - M	2/1/2018			Self Management Goal	2/26/2018	1/25/2018		8/24/2017	No
							never smoker	6.9	146/77	77.0 - M	2/19/2018			Self Management Goal	3/5/2018	10/26/2017		1/9/2013	Yes
		5/27/2017					never smoker	8.8	120/72	48.0 - F	10/31/2016		6/12/2017 10:00:00 AM	RN Care Coordination	3/14/2018	11/17/2017		9/22/2015	Yes
							never smoker	10	143/80	48.0 - F	2/15/2018			DM	3/1/2018	1/24/2018		2/15/2018	Yes
							never smoker	6.9	162/98	55.0 - M	5/19/2017			RN Care Coordination	3/1/2018	2/7/2018			No
							former smoker	5.7	124/73	59.0 - F	2/2/2018			Self Management Goal	2/23/2018	1/3/2018		6/10/2014	No

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

Data as of : 1/23/2018

Contact Us!

Appointment Range	Data Legend	
Display only patients with an upcoming appointment within the selected range.	In Compliance Out of Compliance Order in Progress Not in Denominator	3/15/2015 A date indicates that a Due Date is upcoming or has past.

Patient	PCP and Visit Info
ID Sex: F Age: 19.0	Provider Name Next Medical Appointment: 1/24/2018 9:00:00 AM Last Dental Visit: 8/28/2017 Reason for Visit: ED F/U Pregnancy

ALERTS	Last Date	Due Date	Value	Notes
DM Retinopathy	Never Done	Never Done		Ordered in last 30 days.
ACT	5/30/2017	Every Visit	25	>19 is good control
HPV	Done of	Never Done		
Chlamydia Screen	Never Done	Never Done		
Depression Screening	11/15/2016	11/15/2017		

Bubbles	#
TE	
RX	
Doc	2
Lab	

What about at your clinic?

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

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?

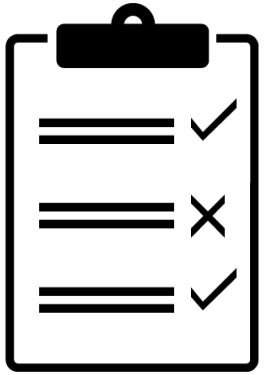
What's Next?

Progress Report

Due: May 15th

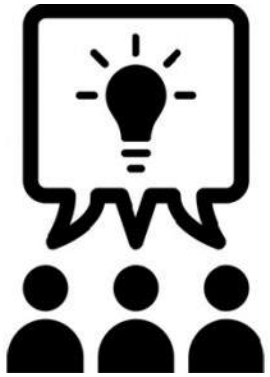
Planned Care Virtual Learning Session #2

May 22nd



Baseline KPTA Assessment

Due: June 1st



Data Analytics Learning Session

July 24th

Thank you!

Please complete the feedback survey

https://www.surveymonkey.com/r/YMK8CRB