Population Health

Strategies for Improving Outcomes & Patient Engagement

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Learning Objectives

• Lessons learning in the journey of improving population health
• How to improve health outcomes for large populations using a “Metric Champion”
• Critical team member roles and responsibilities
About Us

FQHC in Southern Oregon with 19 locations:

• 5 primary care centers
• 1 women’s health center
• 1 large dental clinic
• 1 mobile health center
• 12 School Based Health Centers
Our Staff

• Approximately 400 FTE
  • 37 medical providers
  • 13 mental health providers
  • 11 dentists
OUR SYSTEMS

- **EPIC** *(medical & dental electronic record system)*
- **Tableau** *(data visualization and business intelligence software)*
Our Patients

2017 by the numbers

Patients served: 29,736
Total patient visits: 147,365

Patient insurance:
- Private insurance: 12%
- Medicaid: 53%
- Medicare: 6%
- Uninsured: 29%

Patient income:
- Above low-income threshold*: 23%
- Below low-income threshold*: 77%

Patient age:
- 18-64: 64%
- 0-17: 27%
- 65+: 8%

Race:
- White: 83%
- Other races: 17%

Ethnicity:
- Non-Latino: 62%
- Latino: 28%

Special populations:
- Homeless: 4,778
- Agricultural workers: 3,104
- Veterans: 898
- Public housing residents: 934
Our Beliefs About Quality

- Quality is everyone’s job
- Training on quality improvement tools is critical for every team member
Our Evolution of Population Health Management
Aligning Objectives & Sharing Best Practices

• What are the biggest challenges in:
  • Addressing care gaps at the time
  • Addressing care gaps between visits
  • For patients who are not engaged in care

• What best practice are you most proud of in addressing one of these three challenges?
The Basics

- New to Electronic Health Records
- Reporting from (EHR) on 4 measures
- Did not trust our data and had no idea how to use it to drive performance
- Data available at the organization level only
Getting Traction

• More robust reporting – 8 measures!
• Data available at organization, clinic and provider level
• Panel Manager
• Version 2.0 of tools:
  • Huddles
  • Visual Display Boards
  • Chart Scrubbing
  • Check-out Pass
Getting Traction – Panel Manager

Measures shown for report dates from July 2017 to December 2018
Getting Traction - Improvement Tools
Getting Traction - Improvement Tools

Visual display boards create focus
Getting Traction - Improvement Tools

Adult Hypertension Population Management

Standard Workflow

Hypertension Standing Order PC 101.47 9.17.2015

Run HTN Report → Outreach Call → Schedule → RN Visit → Medication Adjustment → Patient Follow Up Visit

How To Run HTN Outreach List

1. Type HTN in search bar
2. Select Dashboard HTN Patient and click Edit
Checkout passes improved communication and increased accountability.
Group Discussion

- Have your teams utilized any of the improvement tools discussed?
- What improvement tool has helped your team the most?
- What will you bring back to your team related to improvement tools?
Hitting Our Stride

- Payor Partnerships
- Making Data Meaningful
- Risk Stratification & Care Planning
- Metric Champions
Hitting Our Stride – Payor Partnerships

- Negotiate:
  - Quality incentives
  - Creative collaborations
Hitting Our Stride – Making Data Meaningful

HOW TO SAVE A LIFE

COLORECTAL CANCER SCREENING

Colorectal cancer will cause:
- About 50,260 deaths in 2017
- Imagine all of the people of Ashland and Grants Pass dying from one cancer.

Colorectal cancer is the:
- #2 Cause of cancer deaths for Men
- #3 Cause of cancer deaths for Women
- Lifetime risk of colorectal cancer
  - 1 in 21 for men and
  - 1 in 23 for women.

For the US in 2017 there will be:
- 95,520 new cases of colon cancer
- 39,910 new cases of rectal cancer

That could be 2 of us in this room.

Teach how to do it and why we do it
Hitting Our Stride – Risk Stratification
Hitting Our Stride – Metric Champions
<table>
<thead>
<tr>
<th>Which metric would your team like to improve upon?</th>
<th>Colorectal Cancer Screening</th>
</tr>
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<tbody>
<tr>
<td>Why is this measure important to us and to our patients?</td>
<td>CRC screening can and will save lives. Our nursing director will develop an engaging training on what colorectal cancer is, how we can prevent it, and makes the content real by giving examples that are relatable.</td>
</tr>
</tbody>
</table>
| Describe the measure in a simple way. | - We are focused on all adults ages 50-75 years of age.  
- We will exclude patients with a diagnosis of colorectal cancer or a history of total colectomy.  
- Patients must have one of the following: FIT test in the last 12 months, flexible sigmoidoscopy within the last 5 years or a colonoscopy within the last 10 years. |
| - Who is included in the denominator?  
- Are there exclusions?  
- What does it take to meet the metric and land in the numerator? | |
| Create standard work using a high-level overview. Consider: | In the office (Team A will test this process)  
MA sends chart day before appt → MA discuss screening during robing process and place order in EMR → provider give the fit kit to the patient and communicate importance → lab tech follow up with patients who have pending fit kit orders.  
Outreach for gaps in care (Team B will test this process)  
Panel manager run report for pt due for CRC screening → MA place order for fit kit → panel manager mail fit kit → panel manager call patient to discuss fit kit. |
| - Who will do what, and when?  
- How is the work captured in the electronic health record?  
- Which team members will test the standard work? | |
| Share the knowledge: | Metric champion will coordinate with nursing director and provide standard work training after the “why” behind the metric has been provided.  
Metric champion will ask team member for feedback at huddles and answer any questions.  
Metric champion will report out regarding improvement on the metric at monthly team meetings and provide updates at huddles on the process. |
| - When will standard work training be provided? By whom?  
- How can team members give feedback about what is working?  
- When will performance be discussed? | |
Group Activity

Use the Metric Champion Worksheet to develop a plan for your team.
On avg, how many days does it take for the patient to become “non-compliant”?

- Patient no longer meets metric, HTN uncontrolled
  - AVG time 62 days

- Patient meets metric, HTN controlled
  - AVG time 11 days (standard work, protocols)

- Patient new or has not been seen in >24 months
  - AVG time 62 days

- Patient seen, dx w/HTN not meeting metric
Questions? Comments? Ideas?
Thank you!

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