Monthly Population Health Management Sessions to Boost Quality Improvement Initiatives

2017 Symposium on the Future of Complex Care
Gallery of Promising Practices

PROMISING PRACTICE OVERVIEW

Marin Community Clinics (MCC) designates protected population health management time for care teams at all clinic sites from 8:15-9:00 a.m. every second Wednesday of the month. The Quality Improvement department creates population health activities for adult and pediatric provider groups (sometimes women's health and OB groups as well) ahead of time to maximize the use of these short work sessions. The QI department also uploads relevant patient lists to a secure shared drive prior to the sessions. Activity outlines and expectations are e-mailed to care teams the day prior to the planned work sessions. During the sessions, provider/MA teamlets work through their lists together, using the activity outline as a guide. Teamlets are reminded and encouraged to use best practices related to the quality measure(s) being targeted and are free to enlist the entire care team (RNs, Patient Navigators, Front Office, Medical Records) to plan care and outreach to patients.

AIM

To improve clinical outcomes for MCC patients, particularly those in high risk groups such as the PHASE population (18-75yo with DM or ASCVD), by facilitating evidence-based care via population health management/panel management at the care team level on a regular, consistent basis.

MEASURES

Activities have focused on a variety of clinical quality measures, including those below. Focus measures are selected strategically in response to performance trends or to support a targeted quality improvement initiative or program (ex. QIP, UDS, PHASE).

- Hypertension control for PHASE patients
- A1C testing and control for diabetic patients
- Aspirin, Statin and ACEI/ARB prescribing for PHASE patients
- Lab monitoring for patients on ACEI/ARB or diuretics
- Colorectal cancer screening
- Breast cancer screening
- Immunizations for children under 2yo
- Use of controller medications for patients with persistent asthma

Sample Activity Outlines

Adult Panel Management Activity

Wednesday, July 12, 2017

PHASE is back!!

We know you missed it so at long last, we are circling back to our PHASE panel management work this month. As a reminder, PHASE (Preventing Heart Attacks and Strokes Every Day) is a population health initiative aimed at making sure that our patients at highest risk for cardiovascular events get the evidence based care they need to prevent these events. Here are a few updates:

- Patient enrollment: PHASE enrollment is expanding to include ALL MCC patients, age 18-75, who are PHASE eligible. After 2 years of PHASE work, we are ready to offer the program to all of our eligible patients. This means that patients that have been individually removed from the program in the past will return. We believe that all patients, no matter how challenging, deserve the benefits of PHASE. Our panel management approach means that care teams can individualize the approach to patients based on their needs and preferences.
- Updated enrollment lists: Although we will resume our PHASE work, the official enrollment lists for provider are still in progress. We will notify care teams when the lists are finalized and available on the P-drive.
- Algorithm update: Attached is a newly revised DM management algorithm from RCHC. A revised "PHASE on a Page" algorithm is forthcoming.

Activity:

This month we will work on panel management for uncontrolled PHASE DM patients. Attached are lists of PHASE patients with most recent A1C >8. The lists are separated by site and are available on the P-drive as well at P:\PHASE\PHASE OUTREACH_RECALL MASTER LISTS\Uncontrolled A1C. Please review your list with your MA and make a plan to address these patients. Consider the following options:

- Schedule a follow-up appointment (task FO)
- Order updated labs (task MA or Care Navigator)
- Refer to Dietician or Health Educator
- Refer to DM classes in San Rafael
- Task RN for medication reconciliation
- Refer to stress management
- Refer to Care Navigation team for help with social variables (transportation, food access, etc)

Also take a look at BP control and whether appropriate patients are on the 3 core PHASE medications: ASA, Statin and ACEI/ARB

Happy PHASING!!

Please email quality@marinclinic.org with questions or comments

Pediatric Panel Management Activity: Asthma Diagnostic Accuracy

Wednesday, February 8, 2017

Background: Last month we worked on making our asthma diagnoses more specific and adding appropriate asthma diagnoses to our patients' problem lists in an attempt to more accurately identify our persistent asthmatics. In review, asthma management is a UDS measure for both adults and children:

Percentage of patients 5-64 years of age with a diagnosis of persistent asthma and who were appropriately prescribed medication* during the measurement period.

- Received a prescription for or were using an inhaled corticosteroid, or
- Received a prescription for or were using an acceptable pharmacological agent, specifically inhaled steroid combinations, anti-asthmatic combinations, antibody inhibitor, leukotriene modifiers, mast cell stabilizers, or methylxanthines.

We also know that our persistent asthmatics are more susceptible to complications of influenza and that influenza activity this year has been very high.

Activity: This month we will do a panel management activity to review the charts of our persistent asthmatics. Attached is a report of pediatric patients aged 5-17 with a diagnosis of persistent asthma in their problem list (this report should be more accurate after last month's activity). The list is organized by pediatric provider. Please review the charts of your persistent asthmatic patients and ensure that each patient:

a. has a current prescription of a controller medication and a rescue medication, with a spacer or nebulizer if needed
b. has received a flu vaccine this season

Please make a plan to contact families of patients who need medications updated or flu shots. Interventions can be as simple as scheduling MA visits for flu vaccines, sending medication refills, or scheduling appointments to review asthma treatment plans. The purpose of panel management is to make individualized plans for the patients you know well.

Notes:

- This is a great time to review with your MA and care team what information to collect when rooming an asthmatic patient, tools to use to classify asthma (peak flow, Asthma Control Test, etc) and any brief health coaching topics that may be helpful with asthma patients (inhaler use, spacer use)

ACTIONS TAKEN/WORKFLOW

- In Fall 2016, Executive Leadership at MCC prioritized Quality Improvement by protecting 50 minutes per month for clinical care teams to undertake population health management/panel management work
- Monthly Workflow:
  1. QI Department reviews Clinical Quality Dashboards and current QI initiatives/projects and decides on adult and pediatric focus measures for the 2nd Wednesday QI Activity
  2. Medical Lead for QI devises and outlines a population health management activity the targets the focus measure(s)
  3. QI Analysts/Coordinators create and upload relevant patient lists to a secure shared drive (usually separated by clinical site and sorted by PCP)
  4. 2nd Tuesday of the Month: QI Department e-mails activity outlines to providers, MAs and RNs
  5. 2nd Wednesday of the Month, 8:10-9am: MA/Provider teamlets review and work on the activities together, tasking additional care team members as needed.
  6. Following the activities, the QI department elicits and reviews feedback from care teams to identify data validation concerns and any systems issues or areas of confusion.

NOTABLE RESULTS TO DATE

- For 2017 Quarter 2, MCC met or exceeded the RCHC average and the HEDIS 90th percentile for the following PHASE measures: Diabetes A1C control, Diabetes Blood Pressure Control, Statin and ACE/ARBI Prescription rates for Diabetics.
- MCC recorded our strongest performance to date for the 2016-2017 Partnership QIP cycle, including achieving FULL POINTS at one of our clinical sites.

LESSONS LEARNED

Providing protected and consistent QI time for providers and staff and designing structured population health management activities, complete with relevant and manageable corresponding patient lists, creates a culture of QI, advances principles of team-based care, and provides team time to plan for outreaching and in-reaching patients overdue or not at goal for a variety of clinical measures. Guided activities allow MCC's QI department to draw attention to specific measures when needed and to highlight and disseminate best practices and standardized workflows to all of our 5 clinic sites and numerous care teams simultaneously. Population health management activities also encourage providers to better understand the relevance of various QI measures and to help validate data and elucidate the drivers that influence our performance in many clinical areas.