Transformation to Increase Value

*Effective Team-based Care*

October 19, 2017

Carolyn Shepherd, M.D.
KPTA Transformation Goals

Quadruple Aim

• Better Outcomes
• Better Experience
• Lower Costs
• Joy in Work

Value-Based Care

Value = patient outcomes + experience cost
KPTA: Transformation Goals

Increasing Value Based Care:
• Assuring delivery of comprehensive care
• Improving physical health prevention
• Improving oral health prevention
• Expanding delivery of primary care services
• Leveraging technology to increase access to care
Making Transformation Work
Value Based Care: Diabetes

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System Wide changes:

**Engaged leadership at all levels**
Clear vision, and goals, adaptive leadership style extending population health beyond medical and into the community

**Robust data systems, measurement and reporting**
Financial/operational analytics, clinical informatics, performance monitoring, data for clinical decision making, data for addressing social determinants of health, data sharing and monitoring across sectors of the community

**Training and knowledge management**
Institutes, programs, training for using stories for building patient-clinician relationship, assessing vulnerabilities and resilience

**Continuous improvement and innovation**
Improvement methodology, human centered design training, and clear plan for spread and scale

**Community partnerships**
Tools for building collaboration to identify and engage community partners
Build Systems That Work: LEAP
High Performing Primary Care Teams

TEAM WORK

Build the Team

Build Team Culture

TASK WORK

Do the Work

Excellent Performance of Critical Functions
KPTA PGC Framework

- Accelerate Sustained Transformation
- Delivering High Value Care
- Improving Systems of Care
- Leveraging High Performing Teams
- Optimizing Teamwork and Taskwork

Community Health Center, Inc. Where health care is a right, not a privilege, since 1972.
Inter-professional Team Based Care at the Community Health Center Inc.

Veena Channamsetty, MD Chief Medical Officer
Mary L. Blankson, DNP, APRN, FNP-C Chief Nursing Officer
CHC Profile
- Founding year: 1972
- Primary care hubs: 14; 204 sites
- Annual budget: $105M
- Staff: 1,000
- Patients/year: 100,000 (est. 2017)
- Visits/year: 550,000
- Specialties: onsite psychiatry, podiatry, chiropractic
- Specialty access by e-Consult to 15 specialists

Elements of Model
- Fully Integrated teams and data
- Integration of key populations
- Data driven performance
- “Wherever You Are” approach

Weitzman Institute
- QI experts; national coaches
- Project ECHO®— special populations
- Formal research and R&D
- Clinical workforce development

THREE FOUNDATIONAL PILLARS
1. Clinical Excellence
2. Research and Development
3. Training the Next Generation
The Components of Integration

- Evaluation
- Training
- Workflow/Processes
- Facilities/Systems
- Leadership Structure
Interdisciplinary Leadership

4 Clinical Chief positions:
- Chief Medical Officer
- Chief Nursing Officer
- Chief of Behavioral Health
- Chief Dental Officer

Leadership Support
- Executive Mentoring
- Interdisciplinary Chief Meetings
- Leadership Meetings

Collaboration/Integration among departments
- QI Projects/Microsystem work
- Clinical Initiatives/Policies

PCMH/UDS/Clinical Quality
Interdisciplinary Leading

Onsite Clinical Directors
- OSMD
- Nursing Managers
- OSBHD
- OSDD

Collaboration/Integration among departments
- Integrated Microsystems
- Integrated Care Meetings
- Clinical/Pod “Huddles”

Leadership Support
- Leadership Skills Training
- Leadership Meetings
Interdisciplinary Pods that Promote Team-Based Care
Facilities: One Corridor Care

- Exam rooms and therapy rooms
- Reducing stigma of seeing behavioral health provider – no longer sent “over there”
- Seamless transition between medical and behavioral health
The Interdisciplinary Team

POD design

- 2 Medical Providers
- 1 Registered Nurse
- 2 Medical Assistants
- 1 Behavioral Health Clinician
- Additional members: podiatrist, dietician, Pharm-D, chiropractor, CDE
- Student/Trainees
Care that is Comprehensive: IPCP Team

- Medical
- Dental
- Prenatal
- Nursing
- Pharmacy
- BH

Additional on-site specialties:
- Nutrition
- Diabetes education
- Chiropractic
- Podiatry
- Retinal screening
Role of the Provider

• Clinical Leader/Responsible
• Clinical Management
  • Support planned care
  • Evidence based care delivery
  • Care coordinate with team
• Empower the Team
• Leverage the Team
• Engage in the Team
Role of the Medical Assistant

- Planned Care
- Delegated Ordering
- Panel Management
- Scanning/Faxing/handling of incoming faxes
- Retinal Camera Operation
- QI/Microsystem Participants
Domains of RN Nursing Practice at CHC, Inc.

Essential member of the primary care team and interprofessional activities
(1) RN supports (2) primary care providers/panels

Key functional activities:
- Patient education and treatment within provider visits
- Independent Nurse Visits under standing orders
- Delegated provider follow up visits using order sets
- Self management goal setting and care management
- Complex Care Management; coordination and planning
- Telephonic Advice and Triage via dedicated triage line
- Quality improvement leaders, coaches, and participants
- Leaders and participants in research
- Clinical mentoring of RN students; Supervision and mentoring of Medical Assistants
Nursing Standing Orders

- Uncomplicated UTI
- Vulvovaginal candidiasis
- Comprehensive diabetes visit with retinal screening
- Pupil dilation
- Titration of basal insulin
- Pedi & adult vaccines
- TB DOT
- Bronchodilator testing in spirometry
- Tobacco cessation
- Emergency contraception
- Pregnancy testing
- Orders for emergency situations
RN Complex Care Management

- Comprehensive didactics for Complex Care Management
  - Transition Care, Medication Reconciliation, CHF, DM, Pediatric Asthma, COPD, Psych, Motivational Interviewing, Chronic Pain, Addiction, HIV/HCV, Self Management Goal Setting
  - Care Plan/Zone Sheet development & Self-Management

- EHR Templates
  - Structured Intakes/Follow up
  - Nursing Informatics/Outcome Measures
  - Dashboards (Population Management)

- Community Engagement
  - Data Sharing
  - ICMs
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New filter option
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**Self-Management Goal Details**

- **Patient ID:** [Patient ID]
- **2 ER Visits in Last 12 Mths.** [2 ER Visits in Last 12 Mths.]
- **Hosp. Lost 12 Mths.** [Hosp. Lost 12 Mths.]
- **DM** [DM]
- **ITN** [ITN]
- **Asthma & Chronic Cond.** [Asthma & Chronic Cond.]
- **Smoking Status** [Smoking Status]
- **A1C** [A1C]
- **BP** [BP]
- **Age - Sex** [Age - Sex]
- **CC Start Date** [CC Start Date]
- **CC End Date** [CC End Date]
## Planned Care Dashboard

### Patient Information:
- **Sex:** F
- **Age:** 12.0
- **Last Dental Visit:** 9/11/2006
- **Reason for Visit:** Initial/physical w/ twin brother

### ALERTS:
- **VARNISH CANDIDATE**
  - Last Date: [Redacted]
  - Due Date: [Redacted]
  - Value: Fluoride

- **Depression Screening**
  - Last Date: [Redacted]
  - Due Date: [Redacted]
  - Value: [Redacted]

### Patient Information:
- **Sex:** F
- **Age:** 63.0
- **Last Dental Visit:** 5/5/2016
- **Reason for Visit:** Pre-op

### ALERTS:
- **WHO CANDIDATE**
  - Last Date: [Redacted]
  - Due Date: [Redacted]

- **Needs Flu Vaccine 2016-2017**
  - Last Date: [Redacted]
  - Due Date: [Redacted]

- **DM Foot Exam**
  - Last Date: 7/24/2015
  - Due Date: 7/24/2016

### Bubblus
- **TE:** 1
- **RX:** [Redacted]
- **Doc:** [Redacted]
- **Lab:** [Redacted]
What is MA Panel Management?

- Recurring biweekly (40 min) dedicated time will be scheduled for Panel Management activities
  - Medical Assistant Reviews
    - Diabetes Dashboard
    - HTN Dashboard
    - Opioid Dashboard
    - Missed Opportunities Dashboard
  - Nurse-led Complex Care Management Panel Review
    - Provider & Nurse
    - Care Coordination Dashboard
Goals & Outcomes of MA Panel Management

• The goal of MA Panel Management is to:
  • Re-connect patients who are overdue for f/u back to the clinical team
  • Ensure that uncontrolled patients are adhering to defined treatment plans
  • Ensure all planned care associated with HTN, DM and chronic Opioid treatment have been completed

• The expected outcome of MA Panel Management is to:
  • Improved rates of HTN & DM control
  • Improved rates of Planned Care completion
  • Improved adherence to defined treatment plans
# Figure 1. Diabetes Dashboard by Provider

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Dental Integration

- Patient Centered Home (Dental Patients are Medical Patients)
- Fluoride Varnish (Hygienists in Pods)
- Provide Oral Health Education and try to establish Dental Home
- Prenatal Packages (Part of our Dental team)
- Referring patients for Smoking Cessation
Ensures access to integrated, quality specialty care for 5 key groups with highest burden of, and risk for, HIV who experience barriers to comprehensive, respectful and safe care.

- Men who have sex with men
- Transgender people
- People who inject drugs
- (Recently) incarcerated
- Sex workers

Services:

- HIV screening, prevention, and treatment
- HCV screening, prevention and treatment
- STI screening, prevention and treatment
- Buprenorphine maintenance therapy for opioid use disorder
- Homeless care services
- LGBTQ health
What are we doing at CHC?

Routine HIV testing – 86% compliance rate across the agency
PrEP (Pre-Exposure Prophylaxis) – daily medication assistance to reduce the transmission risk of HIV
PEP (Post Exposure Prophylaxis) – medication assistance to reduce risk of HIV transmission after exposure
Risk Reduction Counseling - Reduce patient risk for HIV or transmitting HIV through education of risk
HIV Treatment and Care - HIV Treatment from your primary care provider at your healthcare home
What are we doing at CHC?

Routine Hep C Testing for Baby Boomers - 64% compliance rate for patients born between 1945-1965
Hepatitis C Treatment and Care – Care and treatment for patients by their PCP in their medical home

• Participant in HIV/HCV 1.5 million HRSA grant to increase cure rate for co-infected patients.
• Lead Contributor to the Statewide Hepatitis C Task Force
• Lead Contributor of the National Hepatitis C Roundtable
### CHC HIV Dashboard

#### HIV Dashboard

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<th>Last Medical Encounter Date</th>
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<th>Last Gonorrhea Encounter</th>
<th>PHQ Screen</th>
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CENTER FOR KEY POPULATIONS

Mission:

To ensure that every patient at CHC receives comprehensive care in a respectful manner within a safe environment.

Purpose:

To guarantee that key populations in the communities we serve have a central and cohesive focus within CHC.

https://www.chc1.com/Our-Model-Of-Care/Clinical-Excellence/Center-for-Key-Populations
What does Team Based Care look like?
Case Example in Integration
Behavioral Health Integration

Collaboration Continuum

| MINIMAL | BASIC at a Distance | BASIC On-site | CLOSE Partly Integrated | CLOSE Fully Integrated |

CHC’s Journey

- Behavioral Health from the Beginning
- Separate Buildings, Paper Charts
- Integrating Facilities, Integrated Care Record
- Innovate Practices: Changing the Way We Operate
- Next Steps
Systems and Technology

Integrated EHR

• Up-to-date patient medical and behavioral health information available.
• Pain scores and access to other data – bi-directional information sharing
• Shared Care Plans
• Electronic referral and recall process
• Collaborative Care Dashboard
Systems and Technology

Integrated Scheduling System

- Call any CHC number and connected to same scheduling agent
- Medical, dental, therapy and psychiatry services all scheduled through one system
- All Recalls visible at all points of contact
Systems and Technology and Process
Collaborative Care Dashboard

- Planned Care in Behavioral Health
- Delivery of Integrated Services

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For New Britain Medical

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Rethinking the warm hand-off process: Proactive vs Reactive

- Medical initiated warm hand-off and behavioral health initiated warm hand-off
- Staggered vs. consecutive visits – make our presence known
- Criteria:
  - No BH services and PHQ above 15
  - No BH services and BH Diagnosis
  - No BH services and chronic pain patient
Processes

- Seamless Scheduling

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## Interdisciplinary Care Initiatives

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Thank you!

Veena Channamsetty, MD  
Chief Medical Officer  
veena@chcl.com

Mary L. Blankson, DNP, APRN, FNP-C  
Chief Nursing Officer  
mary@chcl.com

Community Health Center, Inc.  
675 Main Street, Middletown, CT, 06457  
www.chc1.com