IV Congreso Nacional de Atención Sanitaria al Paciente Crónico

Nuevos equipos, nuevas competencias nuevas alianzas

8, 9 y 10 de Marzo 2012
Auditorio de la Diputación de Alicante (ADDA)
Transforming Patient Experience

Caring for Populations with Chronic Disease

Carolyn Shepherd, M.D.
Executive Vice President of Clinical Services
Clinica Family Health Services
3/9/2012
www.clinica.org
Clinica Family Health Services

- 206,000 visits in 2011
  - Physical Health
  - Behavioral Health
  - Dental
  - Homeless
  - Pharmacy

- 40,000 active patients
- 49% No insurance
- 47% Government
- 56% < Poverty
  - 17,480 € per year
Dr. Ed Wagner: Chronic Care Model

Health System: Clinica Family Health Services

Community
Resources and Policies

Self-Management Support
Decision Support
Delivery System Design
Clinical Information Systems

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Functional and Clinical Outcomes

Key Redesign Initiatives (The Big 6)  
To improve patient experience of care

#1 Continuity  
#2 Access  
#3 Improved care delivery model  
#4 Improved office efficiency  
#5 Improved IS design  
#6 Patient activation and self-management
#1 Continuity of Care

- Everyone assigned a PCP/Pod team
- Measure continuity every three months
- Measure panel size and manage un-assigned every month
- Evaluate patient’s understanding of PCP
- Key for patient activation
#1 Continuity of Care-Challenges

- Part time providers:
  - 50% of our staff work .6 FTE or less
- Over paneled providers
- Hospital Coverage/CME/Vacation/FMLA
- Clinic hours
- Staff understanding of continuity
#1 Continuity to #2 Access

Define Panels

Goal = <4% unassigned

## Panel Size Report

<table>
<thead>
<tr>
<th>Provider</th>
<th>Pod</th>
<th>FTE</th>
<th>Current Number of Patients</th>
<th>Goal (w/factor)</th>
<th>2011-3 Panel (adjusted)</th>
<th>2011-4 Panel (adjusted)</th>
<th>Over (Under)</th>
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<tbody>
<tr>
<td>Lafayette</td>
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<td>Hirman, Julie</td>
<td>Purple</td>
<td>0.91</td>
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<td>1092</td>
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<td>1.111</td>
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<td>600</td>
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<td>635</td>
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<td>Mitchell, Susan</td>
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<td>0.75</td>
<td>920</td>
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<td>940</td>
<td>40</td>
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<td>O'Brien, Daniel</td>
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<td>0.80</td>
<td>922</td>
<td>960</td>
<td>883</td>
<td>902</td>
<td>(58)</td>
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<td>Boysen, Eric</td>
<td>Red</td>
<td>0.55</td>
<td>653</td>
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<td>559</td>
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<td>(77)</td>
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<tr>
<td>Funk, Karen</td>
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<td>799</td>
<td>840</td>
<td>827</td>
<td>825</td>
<td>(15)</td>
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<tr>
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<td>758</td>
<td>720</td>
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<td>Kamer, Mary</td>
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<td>896</td>
<td>780</td>
<td>902</td>
<td>896</td>
<td>116</td>
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<tr>
<td>Monyok, Eileen</td>
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<td>0.68</td>
<td>804</td>
<td>816</td>
<td>782</td>
<td>793</td>
<td>(23)</td>
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<tr>
<td>Unassigned</td>
<td>No PCP</td>
<td></td>
<td>23</td>
<td>21</td>
<td>25</td>
<td>N/A</td>
<td></td>
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<tr>
<td>Total - Lafayette</td>
<td></td>
<td></td>
<td>6.14</td>
<td>7492</td>
<td>7368</td>
<td>7,476</td>
<td>7,520</td>
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</tbody>
</table>

23/7492 = 0.3% defects
#2 Access: Time to Third Next Appt

Drill down to the patient perspective

- Chris Keenan MD
- Daniel O'Brien MD
- Julie Hirman NP
- Susan Mitchell FNP

Days

High Leverage Changes for Access

1. Match Demand and Supply Daily
2. Reduce Backlog
3. Decrease Appointment Types and Times
4. Develop Contingency Plans
5. Reduce Demand for Visits
6. Optimize the Care Team
TRIMESTER AT ENTRY FOR PRENATAL CARE

1989 1991 1993 1995 1997 1999

% 1st Trimester
% 2nd Trimester
% 3rd Trimester

#2 Access to Care

Access to Care
#3 Improving the Care Model
#3 Care Delivery Model Clinica Group Visits

- Facilitated group process for patient activation
- Care setting in space designed for groups
- Patients invited on basis of chronic disease history and utilization patterns
- The goal is patient activation
- Patients remain in same group for continuity
Education Vs. Facilitation

• Leader is teacher
• Provider directed
• Educational topics
• Provider offers answers and support
• Expert opinion
• Educated advice
• Care based on provider assessment

• Leader is conductor
• Patient directed
• Use content threads
• Patients offer answers and support
• Peer opinion
• Personal experience
• Care based on patient self assessment
#3 Care Delivery Model Group Visit Outcomes

- Diabetics have more process outcomes
- Low birth weight rates are lower
- Breast feeding initiation is higher
- Better compliance with INR testing
- Decreased total narcotic dose
- Patient satisfaction is higher
- Staff satisfaction is higher
Chronic Care Model

Community
- Resources and Policies

Informed, Activated Patient

Health System:
- Clinica Family Health Services
  - Self-Management Support
  - Decision Support
  - Delivery System Design
  - Clinical Information Systems

Productive Interactions
- Prepared, Proactive Practice Team

Functional and Clinical Outcomes
#4 Team Based Care
#4 Team Based Care

3 FTEs of Provider
3 FTEs of Medical Assistant
1 Nurse Team Manager
1 Case Manager
1 Behavioral Health Professional
2 Front Desk
1 Medical Records
½ Referral Case Manager
#4 Team Based Care Architectural Design to Support Teams
**Aim:** To maintain a comprehensive and accurate registry of our patients with Diabetes in order to perform appropriate and timely care.

### Diabetes Registry Measures:

<table>
<thead>
<tr>
<th></th>
<th>Average A1c</th>
<th>% of patients with two A1cs in the last 12 months</th>
<th>% of patients with last BP &lt; 130/80</th>
<th>% of patients with last LDL &lt; 100</th>
<th>% of patients are current smokers</th>
<th>% of patients have an annual foot exam</th>
<th>% of patients have an annual eye exam</th>
<th>% of patients with an annual self-management goal documented</th>
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</thead>
</table>

### Operations

- Print off Diabetes registry and workflow the first Tuesday of every month.

### Front Desk

- Review registry for last visit, blood pressure, eye exam, foot exam, lipids, and A1c.
  - **Visit:** If more than six months, make appointment. Otherwise, review Blood Pressure, Lipids and A1c for follow-up guidelines.
  - **Blood Pressure:** If blood pressure <130/80 use other risk factors to determine follow up needs. If BP Systolic is >130 or BP Diastolic is >80 follow up at least every month.
  - **Eye Exam:** Add patients without eye exam in the last 12 months to wait list for eye clinic. Contact patient when slot opens with date of clinic.
  - **Foot Exam:** If no foot exam in the last 12 months, schedule an appointment.
  - **Lipids:** If LDL <100 use other risk factors to determine follow up needs. If LDL >100 but <130 follow up should be at least every three months. If LDL >130 follow up should be at least once a month.
  - **A1c:** If Hgb A1c > 9, follow up every month. If Hgb A1c > 7 but < 9 follow up should be at least every 3 months. If Hgb A1c < 7 follow up should be every three to six months.

### Case Manager

- Review registry for risk stratification, tobacco, and self-management goal. **Note:** For patients who do not have information populated in the flowsheet, CM will open NextGen and determine if patient is actually a diabetes patient. Alert clinical team to patients on huddle report.
  - **Tobacco:** If current smoker, review for tobacco cessation counseling. Advise patient to quit at next contact.
  - **Self-Management:** Monitor patients on registry for annual goal. Responsible for connecting with patient to set goal when in for a visit.
  - **Group Visits:** Determine which patients/providers do groups. Coordinate DM group visits for pod by doing the following:
    - Determine provider availability
    - Denise’s schedule availability
    - Coordinate with NTM on support staff availability
    - BHP schedule availability
    - Call pts and schedule for DM GV as needed.

### Provider

- Review the flowsheet every visit and enter any new data. Review registry for any patients for which there are concerns and patients who are MOGE. Provide information to CM.

### MA

- Review the flowsheet every visit and enter any new data. Responsible for patients on registry who are in for visit today.

### Nurse

- Reviews copy of registry given by CM to ensure all follow-up has been completed and is accurate.
Improved Quality Takes a Team

MA driven!
Tobacco Counseling Documented
#5 Information Technology
#5 Information Technology

The Journey to Find Meaningful Data

MEANINGFUL USE!
Quality Improvement Outcomes

– Measurement to check progress towards Aims

– PDSA Study Data
  • At times very granular around process change
  • Not often reported to outside agencies
  • Define opportunities for system improvement

Institute for Healthcare Improvement (IHI) Model for Improvement
Possible Missed Immunization Opportunities

Possible Opportunities Missed Between 7/18/2011 and 8/1/2011

IT get data for PDSA cycles - Performance Improvement
<table>
<thead>
<tr>
<th>Name</th>
<th>ACO</th>
<th>Next Appt</th>
<th>Diabetes</th>
<th>Depression</th>
<th>Tobacco</th>
<th>Hypertension</th>
<th>Transition of Care</th>
<th>Self Management</th>
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<td>Esmeralda</td>
<td>X</td>
<td>02/17/2012-WCC</td>
<td></td>
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<td>Past Due - HRA</td>
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<tr>
<td></td>
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<td></td>
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<td></td>
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<tr>
<td>James</td>
<td></td>
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<td></td>
<td>Past Due - Last BP &gt;= 140/90</td>
<td></td>
<td>Past Due - SM Goal</td>
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<tr>
<td>Fred</td>
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<td>Past Due - SM Goal</td>
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<tr>
<td>Jorge</td>
<td>X</td>
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<td></td>
<td></td>
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<td>Past Due - Eye Exam</td>
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<td>Past Due - BP &gt;= 140/90</td>
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<td></td>
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<td></td>
<td></td>
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<td>Past Due - DM Visit</td>
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<td>Due Now - LDL Lab</td>
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<td>02/10/2012-RE</td>
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<td></td>
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<td>Past Due - Last BP &gt;= 140/90</td>
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<td>04/01/2012 - HTN Visit</td>
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<td>Past Due - HRA</td>
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</table>
#5 IT Improves Coordination of Care
#6 Patient Activation

NOT:

- Didactic patient education
- Waiting for patients to ask for help
- Sage on the stage
- You should...
- Finger wagging
- Lecturing
#6 Patient Activation

Emphasize the patient’s role

- Patients need to be involved in self care activities and their own self assessment

- Simple consistent messages from the primary care provider and team:

  “Diabetes is a serious condition. There are things you can do to live better with diabetes and things our medical team can do to assist you. We are going to work together on this.”
Key Patient Experience Initiatives

#1 Continuity
#2 Access
#3 Improved care delivery model
  – Choice of group care or one-on-one visits DM, CHF, ADHD, Asthma...
  – Telephonic care, secure email, patient portal...
#4 Improved office efficiency
  – Patient centered redesign of work flow
  – Collaborative co-located team approach to patient care
  – Everyone works at the top level of their license
#5 Improved IS design
  – Care teams do the right thing: when the patient is in the clinic and when they are not
  – Outcomes are real time and accurate
#6 Patient activation and self-management
Continuity References

