Idaho Patient Centered Medical Home (PCMH) Webinar – (March 2, 2016) Transcription

Date: March 2, 2016 **Time:** 8:00am to 4:30pm
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Notes

Today's presentation will be from the Idaho Patient Centered Medical Home Learning Collaborative and it is on PCMH Standard three from National Committee for Quality Assurance (NCQA); Population Health Management.

For the NCQA 2014 PCMH Standard, three is Population Health Management. Important areas from this are:

- Patient information
- Clinical data
- Comprehensive health assessment, and then, for the Must Pass element;
- Using that data for population management, as well as;
- Implementing evidence-based decision support

Population-based healthcare is difficult because it relies on the collection and analysis of data on individuals from across large groups, as well as then tailoring that information to the individual. So, there is really an art of providing your person patient-centered compassionate, comprehensive care to each patient, and at the same time, applying the science for larger populations to try to improve care for all patients.

In this slide, you can see how the primary care office, engaging in the care of the patient, is gathering information that, piece-by-piece, goes back into a data repository and is used to help identify and improve outcomes for a larger population of patients that are similar to your individual patients. This collection of data, putting it into the database in a meaningful way, analyzing it, helps us to identify and care for populations as a whole. It is your interaction with each patient in adding that data that is critical to helping the overall process.

The Licensed Nursing Assistant (LNA) practice needs to use an electronic system to record patient information. The information, specifically, that they are talking about is identified in factors one through 13. The data needs to be implemented into your electronic medical record (EMR) in a way that is structured and searchable; each piece of data is structured and searchable, for more than 80 percent of the patients that you see. Factors are mostly things such as age, gender, ethnicity, and can also include other factors like record of previous visits.

The second element looks at clinical data and, again, uses the electronic system with functionality in factors six and seven, and records the information for factors one through five and eight to eleven as structured, searchable data. One through five and eight to eleven with structured searchable data points are common chart elements such as; problem lists, allergies, using tobacco, family history. Six is the body mass index (BMI) and seven is growth charts, most commonly used in children.

In the third area that they are looking for, as far as collection from the practices, is that there is information that would be obtained via comprehensive health assessment that is put into the chart in a way to help inform and understand overall health risks and information about patients and families. This information needs to be collected and updated regularly and it should include the following list of items.

Section D is where we begin to look at using data for population management. So, taking what we have learned and the hole around certain populations, as well as the information around our individual practice patients, and where they intersect, and try to help inform a better plan to care for those individuals.

So at least annually, the practice should proactively identify a group of patients and set about the business of either reminding them, or the family or caregivers of needed care based on what we know about them from their information, their clinical data, and health assessments. With again, discreet searchable data points that you have inputted for them. And, around what evidence-based guidelines say, based off the population health guides that have been applied to them.

So that it can be two different preventative care services, or two different immunizations, at least three different chronic or acute care services. It should include patients not recently seen by the practices, and monitoring medication or alerts would be a part of this.

So we talk about population health, we really talk a lot about registry. Registry helps us to organize and work through lists of patients and to pull them together. Registry is critical; we have to have up-to-date information so that we can contact people that we make for our list as well as our understanding of referral for services for those individuals.

Registry can help us to identify who needs attention. It can be high-risk individuals in need of immediate attention, or people who are not following up with their outlined plan of care. Or people that have been in a plan of care, but we have not noticed improvement, or them reaching the goals that we would hope that they would have achieved with the amount of time that they had been involved in the plan of care. It should also identify a particular caseload of patients that need additional support, and it can create reminders for clinicians and managers, and prioritize calls or tasks for them.

Registries facilitate communication, consultation, and care coordination. It helps to select the specific chronic disease or a cohort of patients with interventions that are most likely to have the greatest effect to improve the management of a chronic disease. So you should choose the initiative most likely to have a significant impact and use both to focus your educational efforts.

Some ways that you can create a disease registry is you can look through claims data for patients to get historic diagnoses from prior clinic visits or clinics outside of primary care providers. You can also use your lab to look at results or certain tests that would be ordered only for people with certain types of chronic conditions.

Care plans can help as well. Your Health Risk Assessment (HRA) should help. The EMR is a good source of information, as well as pharmacy data, the meds that are only used

with certain conditions again, very helpful to create registry. And you can use old manual registries to help to inform your new registry. All of these areas should be combined into your electronic health record to create registry.

Here is an example of a paper tracking, or a manual paper registry. You can get this from your mental health provider and it collects information based on information as well as visit information, consultations, and screening scores.

Here is an example of using Excel to track. One of the advantages of using a program like Excel is that information could be filtered or sorted based on scores or percentages versus certain things.

In this example, you can see a registry that was a mental health registry, where you can see subsets of patients in this registry. This registry, if you look down at the bottom, includes uninsured veterans and their family members, non-children, and older adults. This tells me about the population looked at. Then, from that group, that subset, they are looking at specific scores and patients that are identified most at risk, based on that screening are highlighted, and the registry is able to split those people to create a list for the care manager for outreach.

When we use registries for outreach, there are things that are crucial to have in place for it to be effective. You should make sure that you have a method for contacting your patient, and the electronic health record (EHR) should have a record of the preferred method of contact.

It is also really important to understand what language the contact's information should go out in. What language, spoken language, information should go into, as well as written language. Do not make the assumption that the person has spoken and written language preferences are the same. Sometimes people can speak in the language but they cannot read in the language. And it is easier for them, for example, to get information in English and they know someone who can read English and then translate it into their language for them. So make sure you ask in both areas.

Make sure that the letter is going to be opened by the patients, so try not to make it look like a bill. Keep your message and tone positive, attempt to engage them in your process, and educate them about coming in to give assistance around it, whatever area you want to work on. It should be easy for them to understand and respond to. Try to leverage the technology that you have the contact pages and provide services to improve care. It helps the patient overcome fears to get the services they need and how they need it.

Include in the letter, multiple missing services in the same letter or call. So do not send out a barrage of email events, letters, but rather, incorporate it all into one; missed referrals, missed lab, missed appointments, those types of things, as well as clear instructions on how to get to those services and who to contact. Try to provide at least two numbers for the person to call, the two persons they can contact and not general call the office, because then you call the office and the person answering does not know who they should contact. It can become overwhelming and problematic to try to get back to the right person for them.

You may want to attach different reminders of different types of year. So, for example,

tying into a month like October where it is breast cancer awareness. You send the reminder to a group, and also remind them to get their mammogram if that is appropriate, or flu season to get their flu shots. Maybe New Year's to tie into resolutions around better health or a person's birthday where they are more motivated, perhaps, to incorporate a healthier lifestyle.

Also, for staff, make sure you have a clear understanding of how many attempts you will use to contact these persons. There should be two different methods that are used; so typical is two phone calls, then a letter. But should be that the opportunity is more than one methodology to reach the individual. And decide how much time and effort to invest and track issues with incorrect phone numbers and addresses.

You should also stagger times so that the two phone calls would be done, maybe one in the evening and one in the morning, to try to accommodate people who may be at work. You may also want to create a "do not call" list based on patient or clinician request for that as well.

Some other considerations are your ability as a clinic to handle these additional phone calls. If you set up a more robust calling in, or reaching in, for information as well as how to make sure the people get to the right person. Consider when and how patients may obtain the service without an actual office visit or a face-to-face with clinicians. So, “If I want a flu shot, can I come in and do I need to be seen?” Communicate with other facilities and specialists of the effort so they can be prepared as well.

It is best to provide a script for staff to respond to patient calls, and in particular, calls in special situations like the deceased patient's family member, or patients who are not eligible for programs, or are not up-to-date on their new work-ups or what they need.

It is a practice if you can implement standing orders and standardize your workflow. It is helpful in accommodating a surge of patients around particular instances, back to school patient flows or other times when you maybe get additional people in. Other type of standing orders and workflow standardizations for common presentations by patients can be helpful as well.

So what to do if someone has missed their appointment and they need additional blood pressure medicine to accommodate them to the next visit. Update that there is a consistent way to do that that is really helpful for all staff. Then - for population - there are some additional patient care reminders at the website on this bottom bullet as well.

Implementing here population health measures - you should always check your performance and measure your performance. So, one example of a process for outreach might be that you measure the number of reminders to calls completed and how many actually speak with the patients. You may also want to track the calls that are not completed to get a total denominator as well.

But as you improve the targeted metric over time, you may decide too, that for you to accomplish something more than just speaking with the patient but the patient actually making an appointment or setting an appointment. But again, deciding what your metric is or what your measure would be. And then share how well you are doing with staff, patients, medical neighborhood, and payers, all of these. Let everyone know.

Here is an example of a patient's report card using, again, sharing with the patient the data that is collected about that patient engages them in their health care. Here you have an example of some hypertension and diabetes goals. What is normal or expected is clearly outlined for the patient so they understand how to treat to goal and what would be best for them for goal, and where they are. The colors also help to highlight areas that are areas for improvement for them.

Here is an example of team scorecard. You can see in the first column; clinic, you look at the aggregate score across the entire clinic. And then on the far right is the goal where they would like to be so your benchmark your minimum that you set. And then in between the different teams, A, B, C, and D, they can clearly see how they are doing in relationship to their colleagues. These types of transparency and performance metrics have been shown to change behavior of providers and practices.

The next area in the standards looks at implementing evidence-based decision support. All practices should implement clinical decision support based on evidence-based guidelines. So it is a critical factor for mental health and substance use disorder. You can only score 50 percent in this element unless this factor is achieved. But also, clinical evidence-based guidelines are important for chronic conditions, acute conditions, conditions related to unhealthy behavior, well child and adult care, and then also overuse and appropriateness issues.

Evidence-based guidelines are not cookbook medicine. It is more a textbook that uses population health science and experts to look at – modifiable areas to receive the best outcomes in certain diseases or conditions. It uses patient data to determine which conditions can benefit from use of guidelines and protocols. Guidelines are available from multiple sources, and they are written to adapt to practice environments.

It is important for you to choose which guidelines that you want to be able to express what guideline you are using. It is best if it is integrated with registry reminders. The worksheets, the flowcharts, and the standing orders that you use in your EHR, embedded medical decision support like this that is the most successful. And your EHR may already have the potential for doing this, particularly around chronic diseases. You should look into that as well.

You should determine the roll of each of the team members in the implementation of these guidelines. Where they are going to reside as far as the work that they do and how it helps the overall practice to adhere. And then track progress on that. How well we adhere to the guidelines. And then also track which is the process of problem improvement, but also track your critical outcomes and see if we – since we have become to utilize these guidelines - have you seen an improvement in the outcomes?

So here is an example of some evidence-based medicine guidelines for Attention Deficit Disorder (ADD). It says initially that we will identify all children with Attention Deficit Disorder at all visits. So every time the child comes in, there is an opportunity to ask about their level of control and how well they are doing with this disorder. It could be a flag created in the EMR, it could be a manual process, and it could be triggered by any method for identification. But you, the system, should be able to say who your children are and when they come into the visit, it should be clear to everyone on the team that is seeing that this child has the additional needs for questions around this particular disorder.

The nurse or medical assistant (MA) should note any changes in height, weight, blood pressure or pulse. A clinical person should assess their medication, adherence, adverse affects, and response to treatment, as well as monitoring for any changes in core symptoms to look for other signs that may indicate Attention Deficit Hyperactivity Disorder (ADHD). Also, look how well they are functioning on their current plan of care, if there are any problems or additional areas for focus for them. That is an example of incorporating the guidelines for that particular condition.

For your team, you need to get to know your population that you choose the way you each see your patients. And select their appropriate condition targets, develop a registry, decide on your outreach functions, and address the Must Pass element for using the population management.

As you begin to integrate the evidence-based protocols into your practice, assess the critical care factors for point-of-care guidelines for mental health or substance abuse disorders.

Thank you for your attention to this presentation. And if you have any questions, please email or call your PCMH Transformation Team. Thank you.