Clinica Patient Population

- 170,000 visits
  - Physical Health
  - Behavioral Health
  - Dental
  - Homeless
  - Pharmacy
- 40,000 active patients
- 50% uninsured
- 40% Medicaid
- 56% < Poverty
- 98% <200% of Poverty
Clinica Family Health Services
- 46 Physical Health Provider Positions (67)
- 13 Behavioral Health Providers
- 4 Dental Providers
- Clinics in the Homeless Shelter and Safehouse
- 2 Full Pharmacies, 2 Pharmacy Outlets, School of Pharmacy
- Total Staff of 320
- Admit to 3 community hospitals
- Community EHR

Journey
- **1998**: joined the IHI Chronic Care Collaborative
- **2000**: Delivery system redesign (The Big 3)
  - access
  - office efficiency through transition to teams
  - alternative visits
- **2001-2004**: planned care approach to quality improvement
  - Asthma, depression, chronic pain
  - Preventative health care
  - Redesign architectural layout to support team care
- **2004-2010**: spread innovation and sustaining our improvements.
  - Visit model
  - Behavioral Health Integration
  - Other chronic illnesses-ADHD, Bipolar Patients…
  - Safety-anticoagulation program CU School of Pharmacy
  - Implemented EHR
  - NCCQA Level 3 PCMH
- **Future**: Patient Activation
  - More behavioral health and dental services
  - Care across the continuum
  - Improve patient activation
  - Portal and the Digital Divide
  - ACO and Payment reform
Planned (Chronic) Care Model

Key Redesign Initiatives (The Big 6)

To improve patient centered-population based management.

#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
- Color branding for pods
- 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

Thornton Clinic Well Child Checks 2003-2009

Continuity for the team

#2 Access: Time to Third

Time To Third Average
For Clinics Overall
Drill down to day by day, provider by provider.

Data

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<thead>
<tr>
<th>Panel Size Report</th>
<th>2010 3</th>
<th>2010 4</th>
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GOAL: less than 4% of patients unassigned
29/7420 = 0.4%

#2 Access to Care
Improving Pregnancy Outcomes:

Group Visit Outcomes
- Diabetic more process outcomes
- Low birth weight rates are lower
- Breast feeding initiation is higher
- Patient satisfaction is higher
- Staff satisfaction is higher

Teen Parent group
Parenting Girls Group Content Threads

- Nutrition
- School Performance
- Communication
- Role Attainment
- Family Planning
- Menarche
- Sexuality
- Peer Relationships
- Family Relationships

Chronic Pain Group Visit-Team

“Some unbelievable group moments:
2 patients have completely gotten off meds in the last 2 months and are a source of admiration for the group who are wanting to know all about how they did it.
There was only one bitching and groaning about why he had to be in the group—and others were calling him on his stuff. After 3 months, it was working close to the way in which we envisioned.”

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
“In dialogue people become observers of their own thinking”

Teamwork Visualization
- SETS the intervals for blood thinner monitoring?
- DECIDES intervals for patients with diabetes?
- SELECTS the vaccines to be given?
- DECIDES to arrange a diabetes retinal screening?
- ORDERS the mammograms?
- INITIATES diabetes foot testing?
- FINDS patients with asthma?
- DECIDES intervals for children with ADHD?
- DECIDES intervals for a patient with depression?
- ADMINISTERS SBIRT screening?

Planned (Chronic) Care Model

- Informed, Activated Patient
- Prepared, Proactive Practice Team
- Functional and Clinical Outcomes

- Community
  - Resources and Policies
- Self-Management Support
- Decision Support
- System Design
- Information Systems
- Delivery
- Clinical Information Systems

- Health System:
  - Health Care Organization

- Interactions
Population Based Management  It takes a team!

Clinica Campesina
Diabetic Outcomes

Thursday, December 2, 2010

Duty, Michele L

Total Patients
60

HbA1c Control

One HbA1c (in the last 365 days)
58
Percent 100.00

Two or more HbA1c in Last 12 Months
59
Percent 98.33

Average HbA1c (last 12 months)
7.26

HbA1c > 9.0% (poor control)
5
Percent 7.69

HbA1c control <= 7.0%
29.66
Percent 49.17

Blood Pressure Control

Blood Pressure control <=140/90 mm Hg
57
Percent 95.00

Blood Pressure control >130/80 mm Hg
59
Percent 98.33

Cholesterol Control

One LDL (in the last 365 days)
54
Percent 90.00

LDL > 150mg/dL (poor control)
7
Percent 11.67

LDL < 150mg/dL
40
Percent 66.67

#4 It Takes a Team

It takes a team!
### Registry Work for the Team

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### Diabetes Planned Care Ruler

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Improved Quality Takes a Team:
23% to 79% of smokers counseled to quit smoking

Who is on the team?

- 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
Team Based Care

#5 Information Technology

The Journey to Find Data

MEANINGFUL USE!
UDS Two Year Old Immunizations

Goal: 90% of 2 Year Olds Immunized

Meaningful Data for Meaningful Change

Clinica Campesina - All Sites 2 Year Old Immunization Rates

The Problems We Know About
Patient Activation

#6 The Holy Grail

What self-management support isn’t...

- Didactic patient education
- Sage on the stage
- You should…
- Finger wagging
- Lecturing
- Waiting for patients to ask for help

Patients need to be involved in self care activities and their own health assessment
How to emphasize the patient’s role

- Simple messages from the primary care provider:
  “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.”
- Consistent approach

Models of Patient Activation

- Perceived Self-Efficacy
- Motivational Interviewing
- Readiness for Change
- 5 As
- Solution Focused Brief Treatment
5 As

Steps in Self-Management Support

- Collaborative goal setting
- Identification of barriers and challenges
- Personalized problem-solving
- Follow-up support
Perceived Self-Efficacy

Not at all confident | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 Very confident

---

Key Redesign Initiatives (The Big 6)

#1 Continuity
#2 Access
#3 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
#4 Improved care delivery model
- Choice of group care or one-on-one visits DM, WCC, ADHD...
- Telephonic care, secure email, patient portal...
#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

---

Clinica Lessons Learned

- Put the patients first
- Find ways to add the patients voice
  - Choose threads
  - On teams
  - Scan comment
  - Media
- Start small but start!
- Optimize the team-hold on to the good, out with the bad
Clinica Lessons Learned

- Use the QI tools that work
  - Chronic care model,
  - The IHI Model for improvement
  - Sequential learning with PDSAs
  - Short and small test cycles followed by spread
- Make improvement a system characteristic
- Free up leaders to innovate and “spin the fly wheel faster”
- Measure data over time
  - You don’t need a double blinded RCT to get better