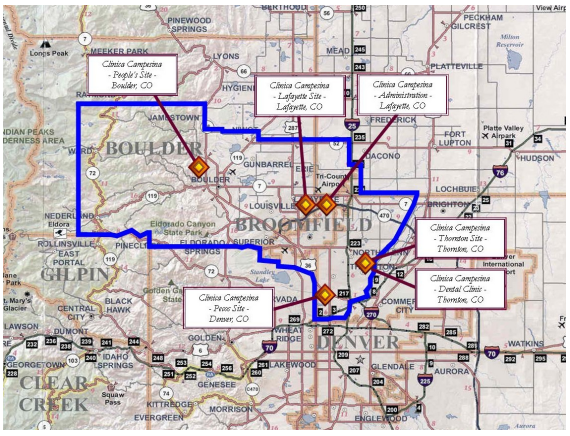
Transforming Patient Experience

Carolyn Shepherd, MD WWW.CLINICA.ORG
1/27/11



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

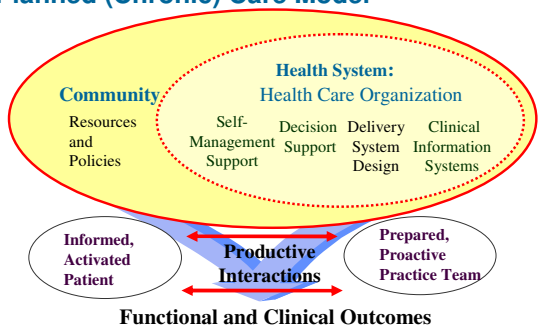
Journey

- **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

Journey

- **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
  - NCQA 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)

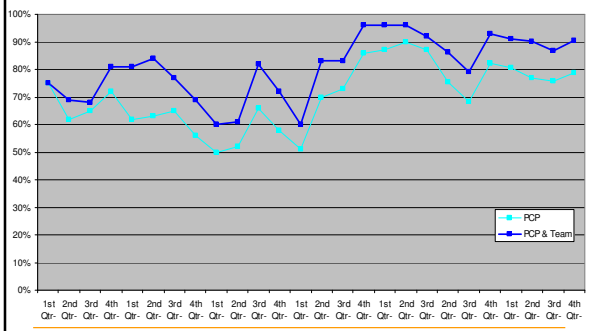
To improve patient centered-population based management.

#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

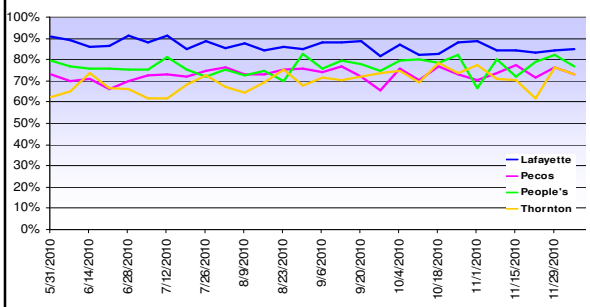
- Everyone assigned a PCP/Pod team
- Color branding for pods
- Measure continuity every three months
- Measure panel size and manage un-assigned every month
- Evaluate patient's understanding of PCP
- Key for patient activation

#1 Continuity

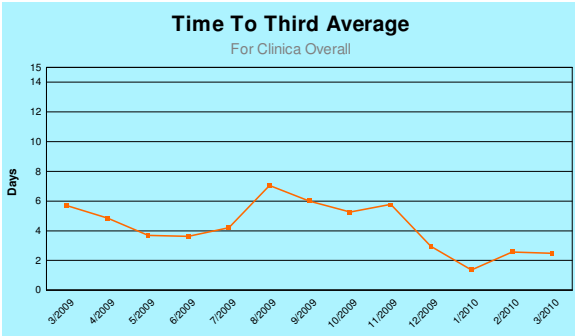


Thornton Clinic Well Child Checks
2003-2009

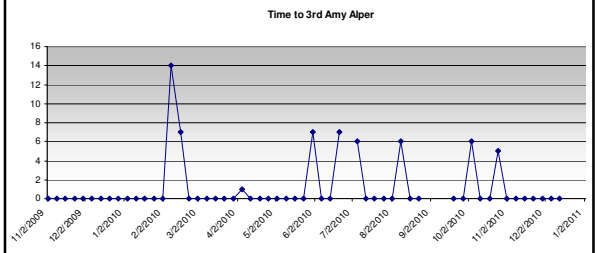
Continuity for the team



#2 Access: Time to Third



Drill down to day by day, provider by provider.



Data

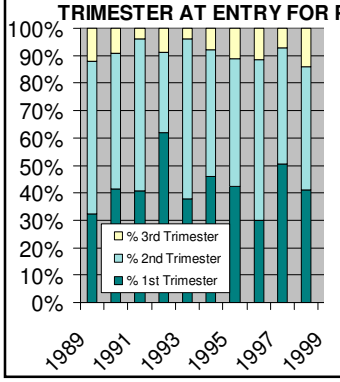
Panel Size Report

Provider	Pod	FTE	Current Number of Patients	Goal (w/factor)	2010-3 Panel (adjusted)	2010-4 Panel (adjusted)	Over (Under)
Lafayette							
Hinman, Julie	Purple	0.91	1077	1092	1,132	1,137	45
Keenan, Chris	Purple	0.50	683	600	681	711	111
Mitchell, Susan	Purple	0.75	985	900	1,035	1,016	116
Obrien, Daniel	Purple	0.80	785	960	760	812	(148)
Shepherd, John C	Purple-Gen	0	6	0	2	6	6
Boysen, Eric	Red	0.55	468	660	414	428	(232)
Funk, Karen	Red	0.60	808	720	831	829	109
Johnson, Jennifer	Red	0.60	867	720	921	901	181
Kamer, Mary	Red	0.65	885	780	901	884	104
Monyok, Eileen	Red	0.68	809	816	795	794	(22)
Unassigned	No PCP		23		30	26	N/A
Total - Lafayette		6.04	7420	7248	7,530	7,572	270

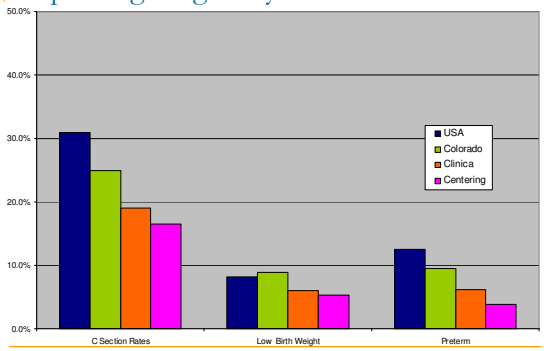
GOAL= less than 4% of patients unassigned

29/7420 = 0.4%

#2 Access to Care



Improving Pregnancy Outcomes:



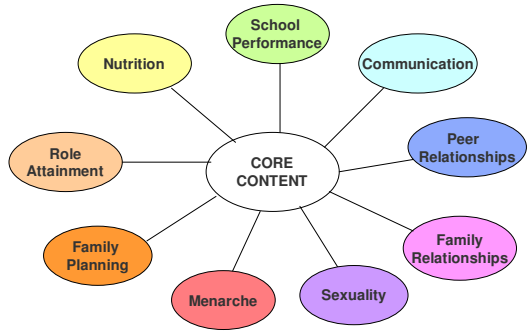
2009 Data

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



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."

Amy -

My 2¢ worth: I was feeling more confident about treatment here when you refused our youngest group member more meds. The few times I've been in the group w her, she has seemed very sedated (not today), and I've been really puzzled about why that was not being addressed.

Education Vs. Facilitation

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

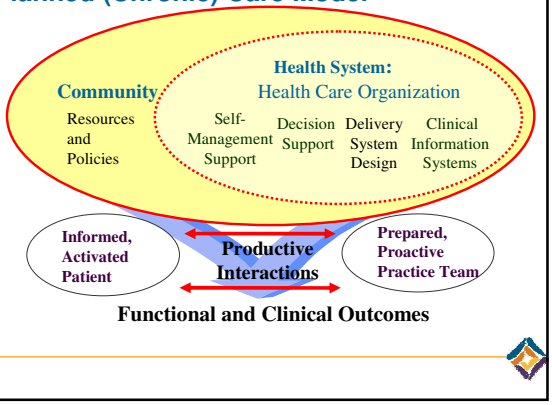
- Leader is conductor
- Patient directed
- Use content threads
- Patients offer answers and support
- Peer opinion
- Personal experience
- Care based on patient self assessment

"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



#4 It Takes a Team

Population Based Management

It takes a team!

Clinica Campesina

Diabetic Outcomes

Thursday, December 2, 2010

Drury, Michelle L

Total Patients	68		
HbA1c Control			
One HbA1c (In the last 365 days)	68	Percent	100.00
Two (or more) HbA1c in Last 12 months (> 90 Days Apart)	60	Percent	88.24
Average HbA1c (Last test)	7.29		
HbA1c > 9.0% (poor control)	5 /68	Percent	7.35
HbA1c control < 7.0%	29 /68	Percent	42.65
Blood Pressure Control			
Blood Pressure control <140/90 mm Hg	51/ 68	Percent	75.00
Blood Pressure control <130/80 mm Hg	26 /68	Percent	38.24
Cholesterol Control			
One LDL (In the last 365 days)	60	Percent	88.24
LDL >= 130mg/dl (poor control)	7 /60	Percent	11.67
LDL <100mg/dl	40 /60	Percent	66.67

Diabetes Registry Workflow

Aim: To provide quality evidence based care to our patients with Diabetes.

Aim: To maintain a comprehensive and accurate registry of our patients with Diabetes in order to perform appropriate and timely care.

Diabetes Registry Measures/Goals:	Average A1c <8% 40% of patients have A1cs <7%	90% of patients have two A1cs in the last 12 months	40% of patients with last BP < 130/80 70% of patients with last LDL < 100	<12% of patients are current smokers	90% of patients have an annual foot exam 90% of patients have an annual eye exam	70% of patients have an annual self-management goal documented

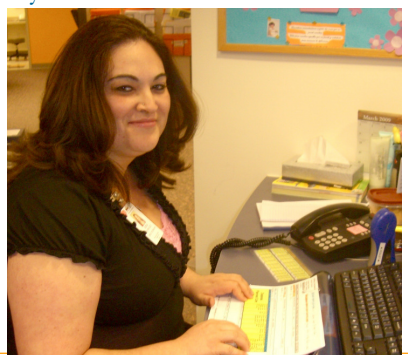
	Actions					
Operations	Print off Diabetes registry and workflow the first Tuesday of every month.					
Case Manager	Review registry for last visit, risk stratification, foot exam, eye exam, A1c, lipids, blood pressure, and self-managment goal. **Note:** For patients who do not have information populated in the flowsheet, CM will open NextGen and determine if patient is actually a diabetes patient. Alert clinical team to patients on huddle report.					
	High Risk	**Blood Pressure**	**Lipids**	**Eye Exam**	**Self-Management**	**Group Visits**
	If Hgb A1c > 9, follow up every month. If Hgb A1 c >7 but <9 follow up should be at least every 3 months. If HgbA1c <7 follow up should be every three to six months	If blood pressure <130/80 use other risk factors to determine follow up needs. If BP > 130/80 follow up at least every month.	If LDL <100 use other risk factors to determine follow up needs. If LDL >100 but less than 130 follow up should be at least every three months. If LDL > 130 follow up should be at least once a month.	Add patients without annual eye exam to wait list for eye clinic. Contact patient when slot opens with date of clinic.	Monitor patients on registry for annual goal. Reponsible for connecting with patient to set goal when in for a visit.	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 • MHP schedule availability Call pts and schedule for DM GV as needed
Provider	Review the flowsheet every visit and enter any new data. Review registy 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.					
Front Desk	Schedule individual diabetes appointment with PCP for list of patients determined by the CM (patients not in Group Visits)					

Aim: To maintain a comprehensive and accurate registry of our patients with Diabetes in order to perform appropriate and timely care.

Diabetes Registry Measures:	Average A1c / % of patients have A1cs < 7%	% of patients with two A1cs in the last 12 months	% of patients with last BP < 130/80 / % of patients with last LDL < 100	% of patients are current smokers	% of patients have an annual foot exam / % of patients have an annual eye exam	% of patients with an annual self-management goal documented

	Actions
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 Dyastolic 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 HgbA1c <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.

Registry Work for the Team



Meaningful Use

Clinica Campesina
Diabetic Registry
Clinica Pecos
Pecos - Red
Russell MD, Amy
High Risk

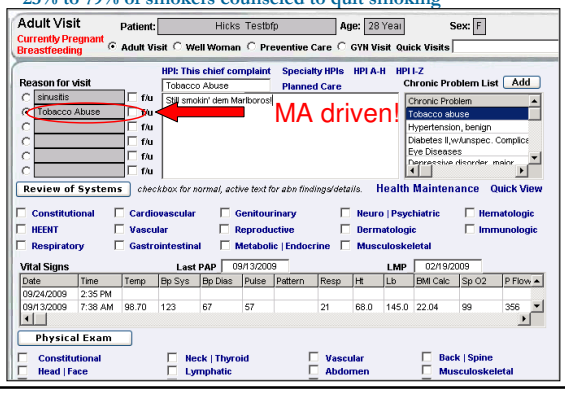
Last Name	First Name	DOB	Visit	BP Sys	BP Dias	Tobacco	Eye Exam	SM Goal	Foot Exam	LDL Date	LDL	A1c Date	Value
	Bonnie	/1952	11/13/2008	122	80	Current	08/01/2007	11/13/08	05/15/2008	04/03/2008	59		
Group Visit	No											11/13/2008	7.80
												09/04/2008	8.00
												07/17/2008	8.00
	Angelica	/1975	03/26/2009	115	69	Never		12/11/08	03/26/2009	02/15/2008	90		
Group Visit	Yes											03/26/2009	8.90

Last Name	First Name	DOB	Visit	BP Syst	BP Dias	Tobacco	Eye Exam	SM Goal	Foot Exam	LDL Date	LDL	A1c Date	Value
Diabetes Planned Care Ruler			If more than six months, make appt Otherwise, see BP, LDL & A1c rules	If above 130, appt every month	If above 80, appt every month	If current smoker, CM to review for Tobacco Cessation counseling	If not within one year, put on list for DM Eye Exam GV	If not within one year, CM to set goal with patient	If not within one year, make appt	If not within one year, make appt	If above 130, appt every month. If 100-130, appt every 3 months	If not within 3 months, make appt (6 months okay if last value less than 7.0)	If above 9, appt every month. If 7.0 - 9.0, appt every 3 months. If below 7.0, appt every 6 months
												12/19/2008	7.60
	Teresita	/1974	03/26/2009	110	72	Never	10/10/2008	1/30/09	10/16/2008	01/30/2009	75		
Group Visit	Yes											03/26/2009	10.00
												01/29/2009	7.50
												12/11/2008	7.90

03/30/2009 **High Risk:** Last A1c >= 7 **Medium Risk:** Last A1c > 5 Months **Low Risk:** Last A1c <7 and < 5 Months Page 1 of 5

Improved Quality Takes a Team:

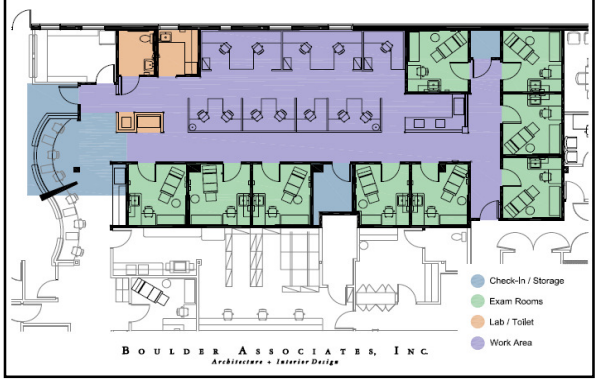
23% to 79% of smokers counseled to quit smoking



Who is on the team?

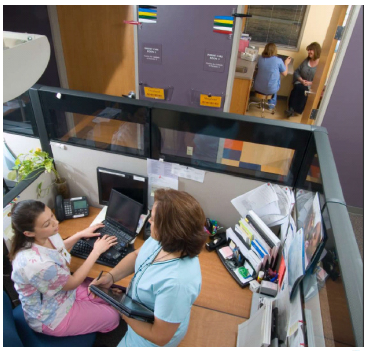
- 3 FTEs of Provider
- 3 FTEs of Medical Assistant
- 1 Nurse Team Manager
- 1 Case Manager
- 1 Behavioral Health Professional
- 2 Front Desk
- 1 Medical Records
- ½ Referral Case Manager

Architecture to Support Teams



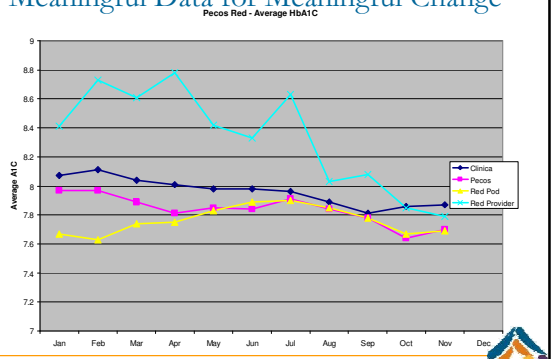
Team Based Care

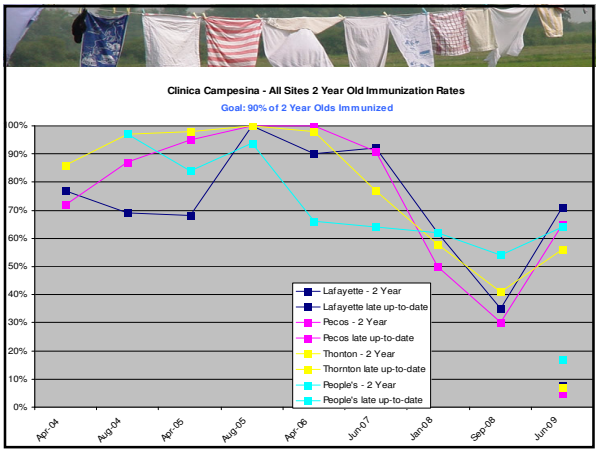
#5 Information Technology



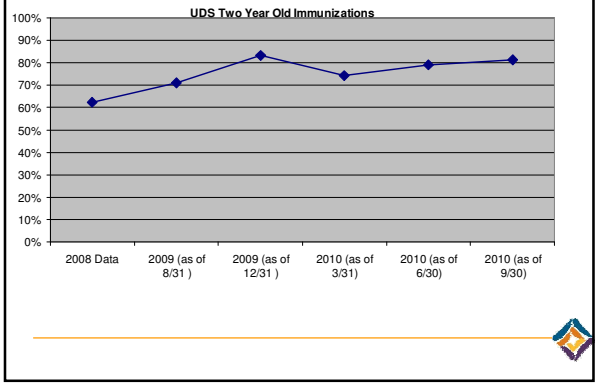
The Journey to Find Data

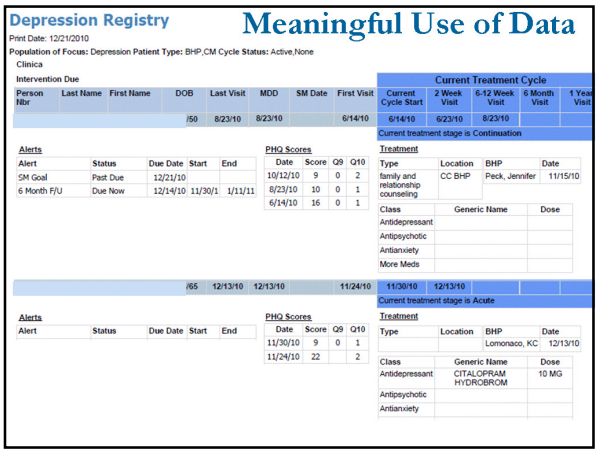
Meaningful Data for Meaningful Change

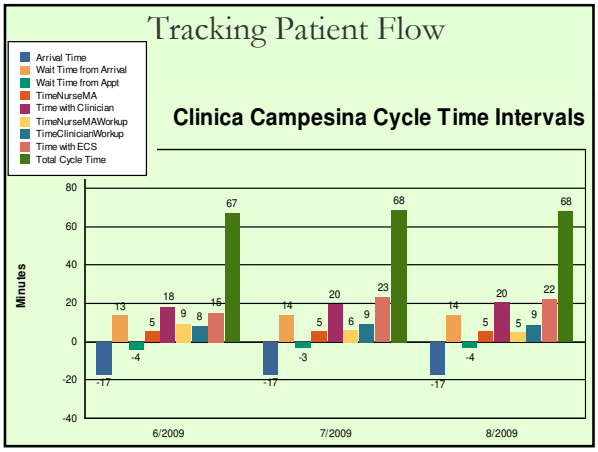


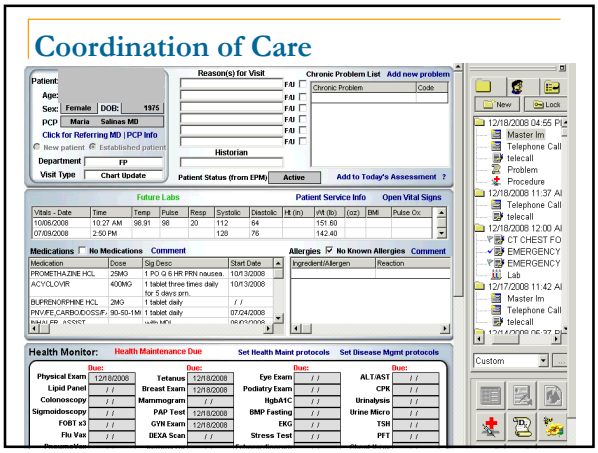


The Problems We Know About




Depression Registry
Meaningful Use of Data
Print Date: 12/21/2010
Population of Focus: Depression Patient Type: BHP,CM Cycle Status: Active,None
Clinica
Intervention Due
Current Treatment Cycle
Person Nbr
Last Name
First Name
DOB
Last Visit
MDD
SM Date
First Visit
Current Cycle Start
2 Week Visit
6-12 Week Visit
6 Month Visit
1 Year Visit
/50
8/23/10
8/23/10
6/14/10
6/14/10
6/23/10
8/23/10
Current treatment stage is Continuation
Alerts
Alert
Status
Due Date
Start
End
5M Goal
Past Due
12/21/10
6 Month F/U
Due Now
12/14/10
11/30/1
1/11/11
PHQ Scores
Date
Score
Q9
Q10
10/12/10
9
0
2
8/23/10
10
0
1
6/14/10
16
0
1
Treatment
Type
Location
BHP
Date
family and relationship counseling
CC BHP
Peck, Jennifer
11/15/10
Class
Generic Name
Dose
Antidepressant
Antipsychotic
Antianxiety
More Meds
/65
12/13/10
12/13/10
11/24/10
11/30/10
12/13/10
Current treatment stage is Acute
11/30/10
9
0
1
11/24/10
22
2
Lomonaco, KC
12/13/10
CITALOPRAM HYDROBROM
10 MG


Tracking Patient Flow
Clinica Campesina Cycle Time Intervals
Arrival Time
Wait Time from Arrival
Wait Time from Appt
TimeNurseMA
Time with Clinician
TimeNurseMAWorkup
TimeClinicianWorkup
Time with ECS
Total Cycle Time
Minutes
80
60
40
20
0
-20
-40
6/2009
7/2009
8/2009


Coordination of Care
Patient:
Age:
Sex:
Female
DOB:
1975
PCP
Maria
Salinas MD
Click for Referring MD | PCP Info
Department
FP
Visit Type
Chart Update
Reason(s) for Visit
Chronic Problem List
Add new problem
Chronic Problem
Code
Historian
Patient Status (from EPM)
Active
Add to Today's Assessment
Future Labs
Patient Service Info
Open Vital Signs
Medications
No Medications
Comment
Allergies
No Known Allergies
Health Monitor:
Health Maintenance Due
Set Health Maint protocols
Set Disease Mgmt protocols
Physical Exam
Lipid Panel
Colonoscopy
Sigmoidoscopy
FOBT x3
Flu Vax
Tetanus
Breast Exam
Mammogram
PAP Test
GYN Exam
DEXA Scan
Eye Exam
Podiatry Exam
HgbA1C
BMP Fasting
EKG
Stress Test
ALT/AST
CPK
Urinalysis
Urine Micro
TSH
PFT

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

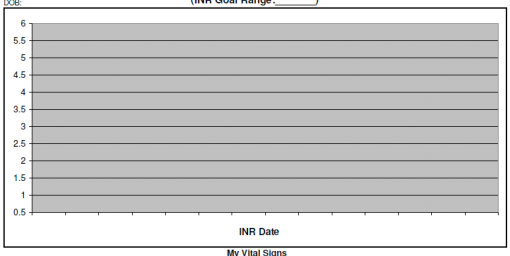
- Simple messages from the primary care provider:

  "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

Group Visit Start Date:
Patient Name:
DOB:

My INR Graph
(INR Goal Range:_____)



My Vital Signs

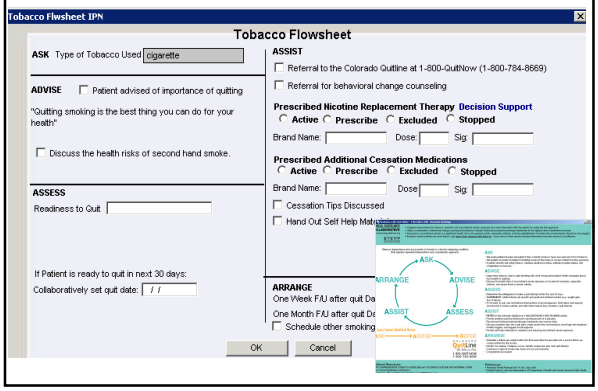
	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Pulse									
Blood Pressure									
Respiration									
INR									
Confidence*									

*Confidence Scale: From 1-10, please rate how confident you are that you can manage your blood thinner therapy?

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

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