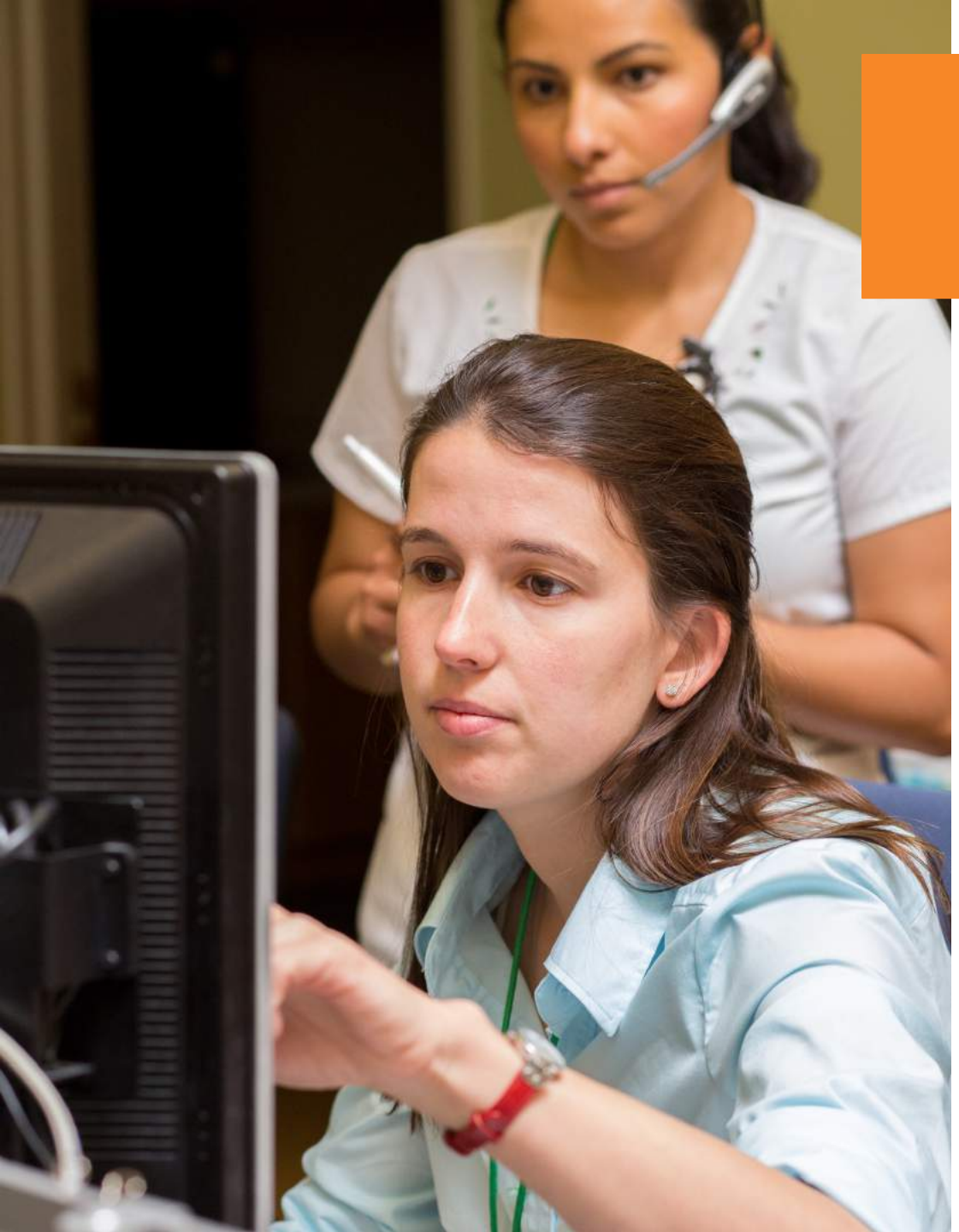
CCI
CENTER FOR CARE INNOVATIONS

KP Transformation Accelerator

In-Person Learning Session #2
Thursday, March 22, 2018
Center for Total Health | Washington, D.C.



Today's Big Awesome Agenda

1. KPTA Assessment
2. Learning from Our Changes
3. Effective Planned Care Part 1
4. Lunch
5. Effective Planned Care Part 2
6. Testing Changes and Learning from Data
7. Reflection & What's Next

Today's Faculty

Alexis Wielunski

Tammy Fisher

Maggie Jones

Carolyn Shepherd

Tierney Giannotti

Mary Blankson

Who is in the room?

Health Center Teams

Mary's Center

GREATER BADEN MEDICAL SERVICES
Primary and Preventive Health Care

FAMILY AND MEDICAL COUNSELING SERVICE, INCORPORATED
FMCS
we care

CCI health & wellness services

LA CLÍNICA DEL PUEBLO

Support Partners & Faculty

CCI
CENTER FOR CARE INNOVATIONS

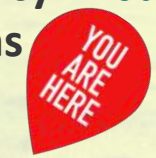
RPCC
Regional Primary Care Coalition

KAISER PERMANENTE®

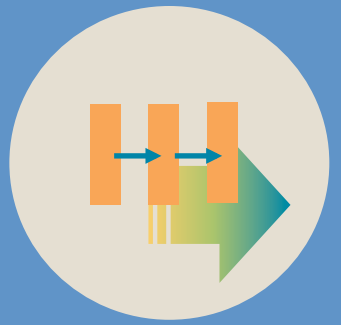
Community Health Center, Inc.

Where are we in our Transformation Accelerator journey?

Phase 1 → Program Launch	Phase 2 → Team-Based Care	Phase 3 → Planned Care	Phase 4 → Data Analytics	Phase 5 → Population Health	Program Ends: December 2018
April 2017 Convening	October 2017 Learning Session	February 2018 Webinar	June 2018 Webinar	September 2018 Webinar	Coaching Ends
August 2017 Webinar	December and January Site Visits	Shared Advocacy Project Begins	July 2018 Learning Session	October 2018 Learning Session	Final Reports Due
Coaching Begins	Progress Report Submitted	March 2018 Learning Session			
Project Charters & Driver Diagrams Submitted		Progress Report Due			



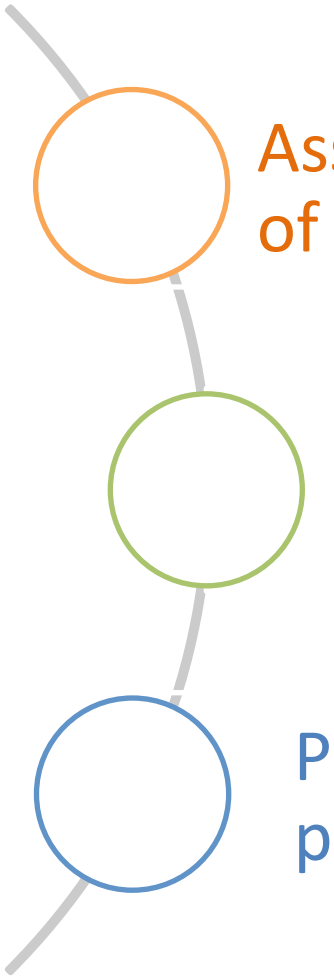
KP Transformation Accelerator Clinic Assessment



March 22, 2018

Center for Community Health and Evaluation
www.cche.org

Goals of assessment



Assess changes to clinic capacity that occur during the course of the program

Use assessment results to inform technical assistance

Promote dialogue at the clinics about internal capacity and potential areas for improvement

Assessment domains

Supportive leadership & culture

(e.g., engaged executive & clinical leadership)

QI infrastructure

(e.g., culture of quality, structure, goals for QI efforts)

Data-based decision making

(e.g., use of performance measures, registry/panel level data, use of EHR)

Team-based care

(e.g., roles of staff, standing orders, training practices)

Access to care

(e.g. enhanced access, 24/7 access)

Panel/ population management

(e.g., empanelment, proactive care, self-management support)

Working session:
Complete the assessment

20 minutes to begin assessing your clinic's current level/capacity with these building blocks

We are here for support & to answer questions

Submit your team's completed assessment by end of day

Looking forward: Assessment will be completed again at the end of the program

Questions and comments?

Maggie Jones
Associate Director
Center for Community Health and Evaluation
Part of Kaiser Permanente Washington Health Research Institute

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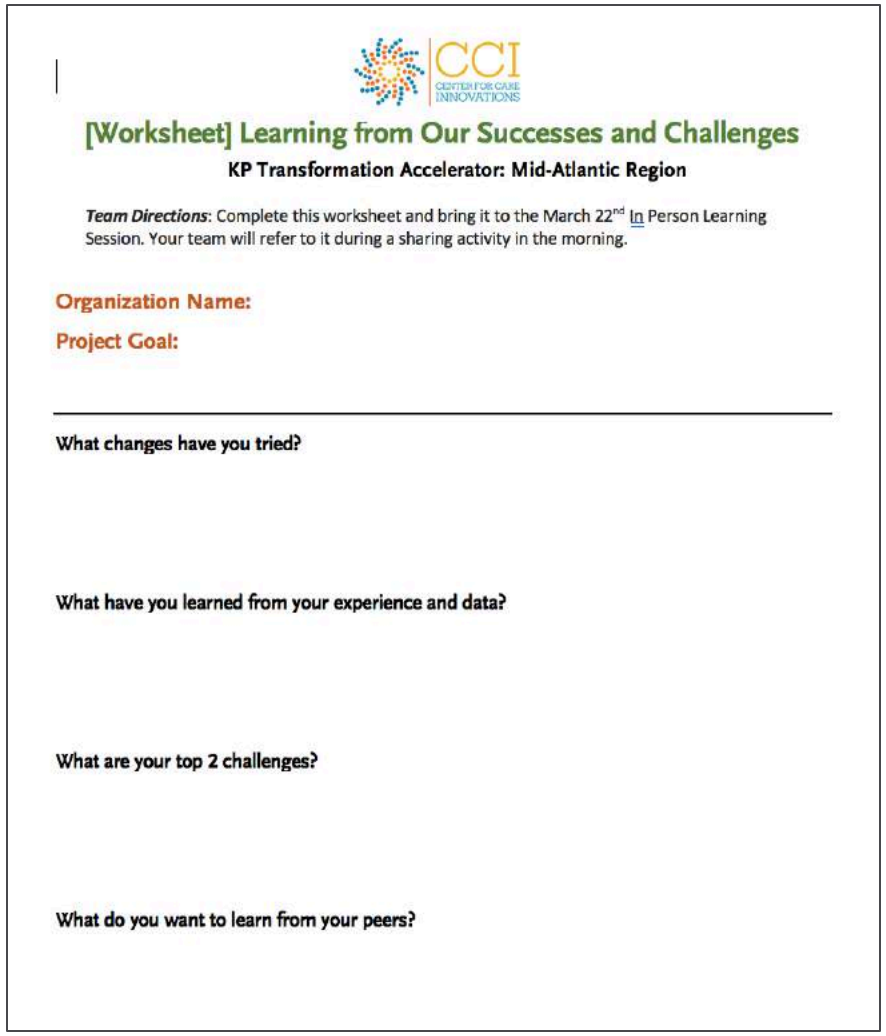
Learning from Our Changes



[Worksheet] Learning from Our Successes and Challenges

KP Transformation Accelerator: Mid-Atlantic Region

Team Directions: Complete this worksheet and bring it to the March 22nd In Person Learning Session. Your team will refer to it during a sharing activity in the morning.

Organization Name:

Project Goal:

What changes have you tried?

What have you learned from your experience and data?

What are your top 2 challenges?

What do you want to learn from your peers?

Activity Steps

1. Health centers will pair up.

2. Discuss your worksheets for 15 minutes. Give feedback: I like, I wish, I wonder.

3. We will do 3 rotations, with 10 minutes per rotation. Each team will have a chance to talk with 3 other teams.

Round One

Mary's Center

CCI health & wellness services

LA CLÍNICA DEL PUEBLO

Community Health Center, Inc.

GREATER BADEN MEDICAL SERVICES

Primary and Preventive Health Care

Round Two

Mary's Center ↔ FAMILY AND MEDICAL COUNSELING SERVICE, INCORPORATED • FMCS we care

LA CLÍNICA DEL PUEBLO ↔ CCI health & wellness services

Community Health Center, Inc. ↔ GREATER BADEN MEDICAL SERVICES — Primary and Preventive Health Care

Round Three

Mary's Center

GREATER BADEN MEDICAL SERVICES
Primary and Preventive Health Care

Community Health Center, Inc.

CCI health & wellness services

FAMILY AND MEDICAL COUNSELING SERVICE, INCORPORATED
FMCS we care

LA CLÍNICA DEL PUEBLO

Team Time

Report Out

Planned Care Review
Part 1

Carolyn Shepherd

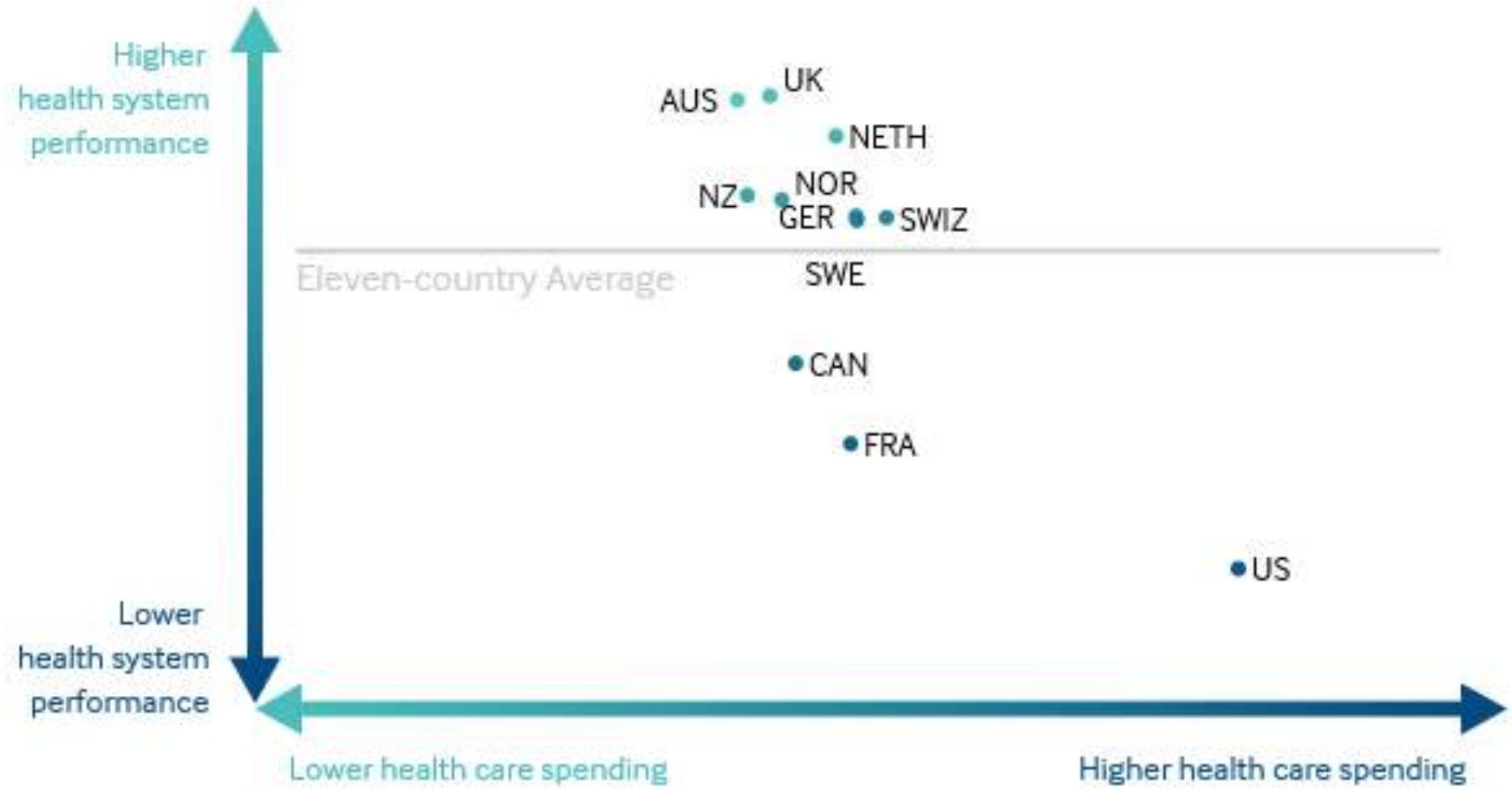
KP Transformation Accelerator

3/22/18

Planned Care Definition

Organized patient-focused care that is based on scientific evidence, planned in advance of the visit and delivered so that the team optimizes the health of every person on their panel.

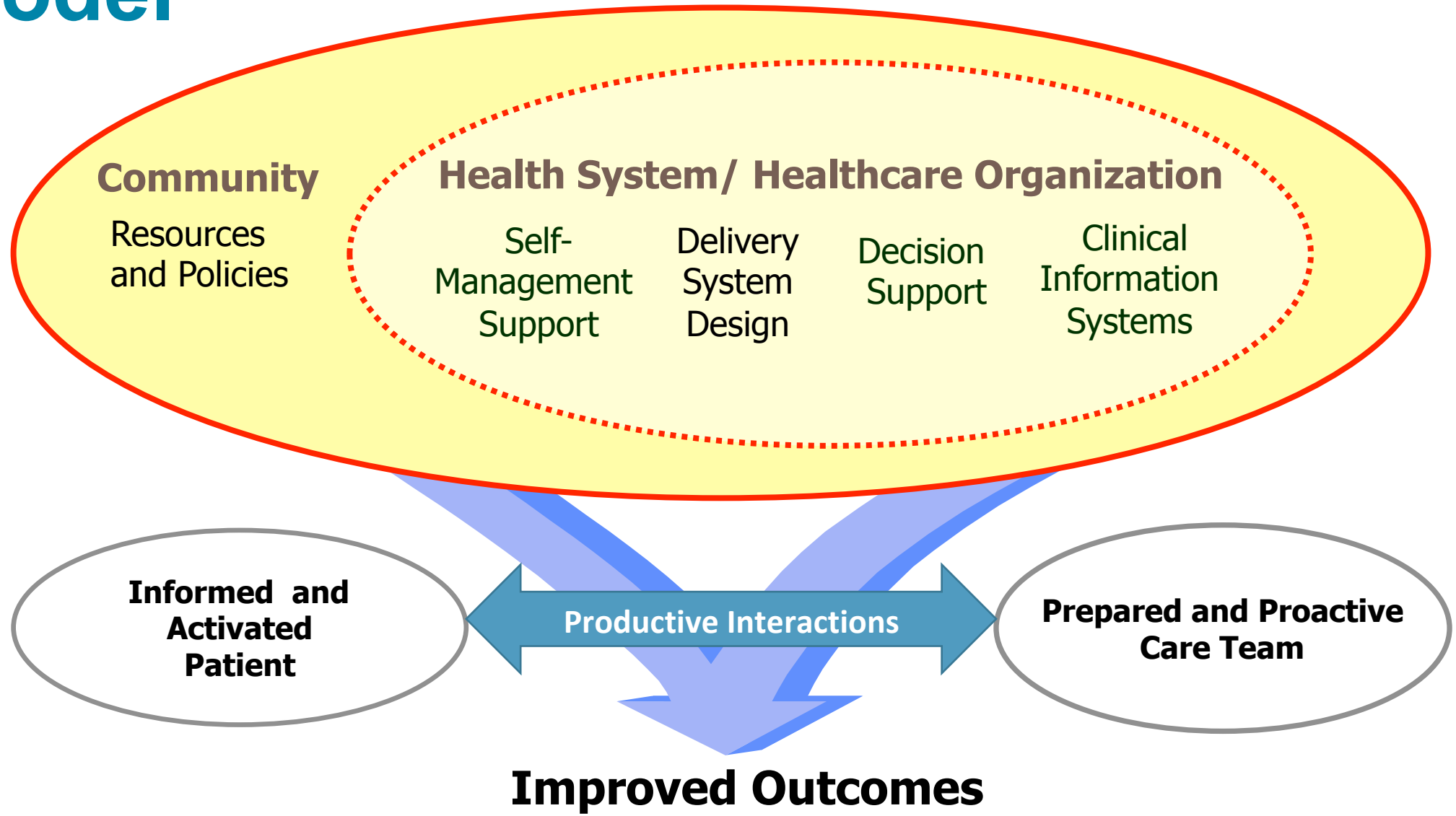
Planned Care Model:
A Remedy for Poor Outcomes



"What needs to be different?"

- Visit time is limited
- Inadequate ability to identify gaps in care
- Lack of clear team goals for the visit
- Data not transformed to useful tools

Road Map: Chronic (Planned) Care Model



Delivery System Design

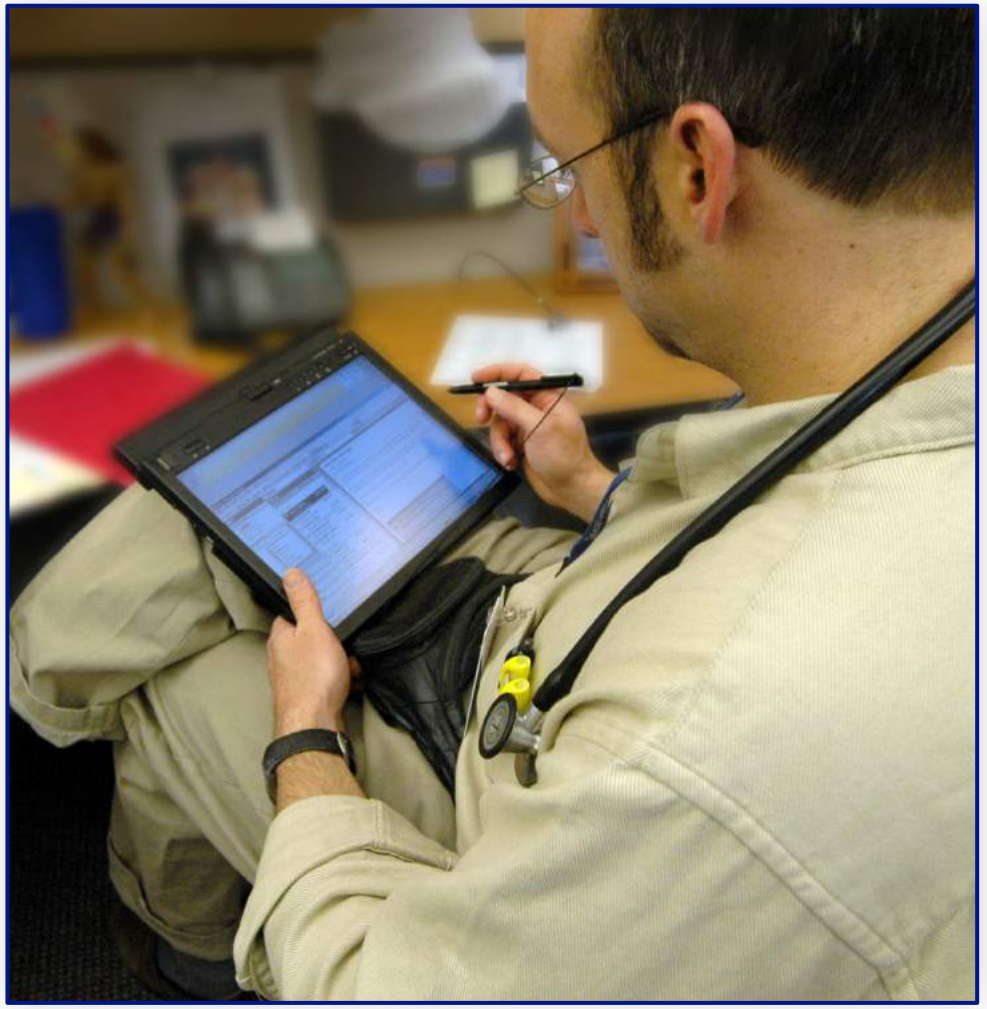
- Focus on the patient to meet needs
- Build core primary care teams
- Build expanded teams
- Use alternative visit models

Delivery System Design, cont.

- Optimize operational systems
- Outreach and population management
- **Pre-visit planning huddle** with the core team
- Assure all (and only) indicated care is offered to the patient

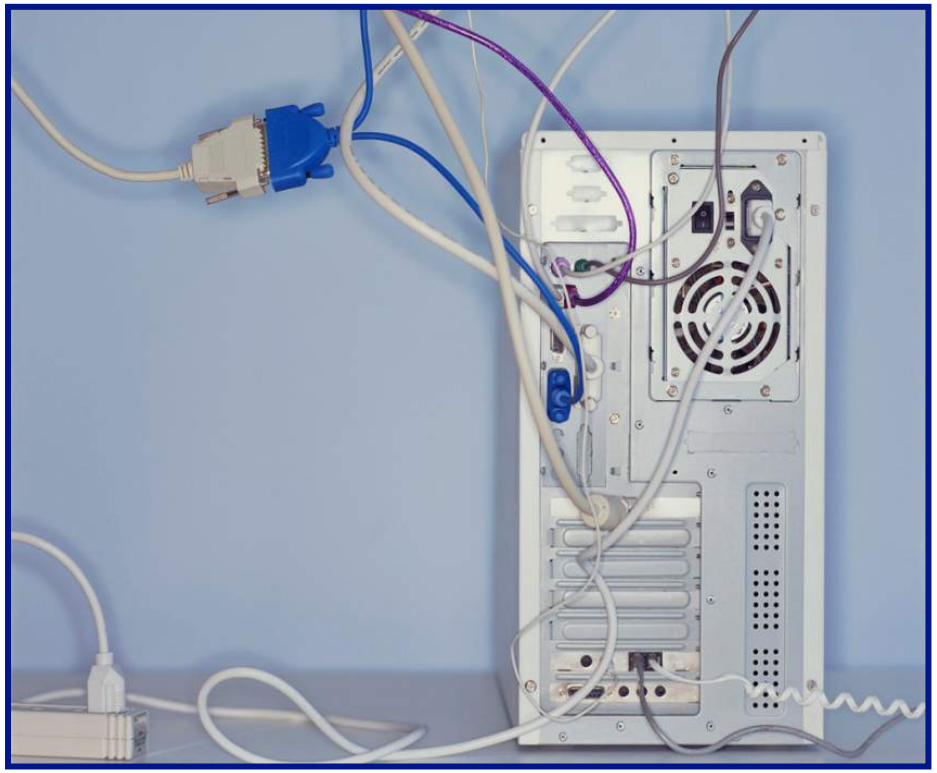
Decision Support

- Adopt evidence-based guidelines
- Use protocols and standing orders
- Team and clinician education
- Patient and family health literacy
- Access to electronic resources in EHR
- Virtual library



Clinical Information Systems

- Efficiently generate care gap reports
- Recall and reminder systems
- In-reach and Out-reach tools (registries)
- Sculpting the care path
- Performance improvement data
- PDSA library
- Clinical measures by org/site/team/clinician



Patient Self-Management

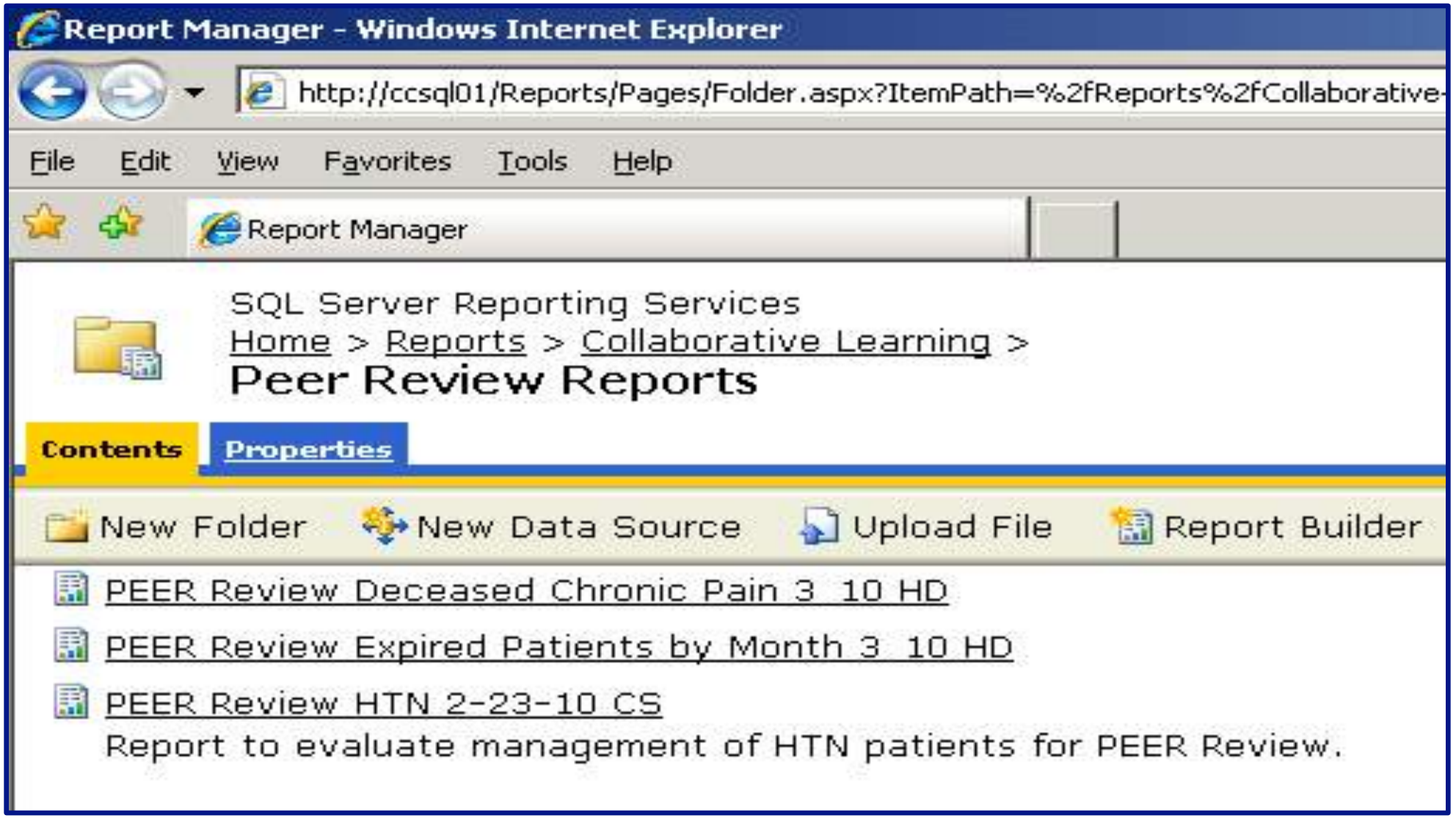
- Create shared care plan and assure follow-up
- Effective self-management support
- Health care information access
- Personal Health Record
- Patient and family engagement in service design

"Do you want the pill, the suppository, the patch or the app?"

Community Support and Policies

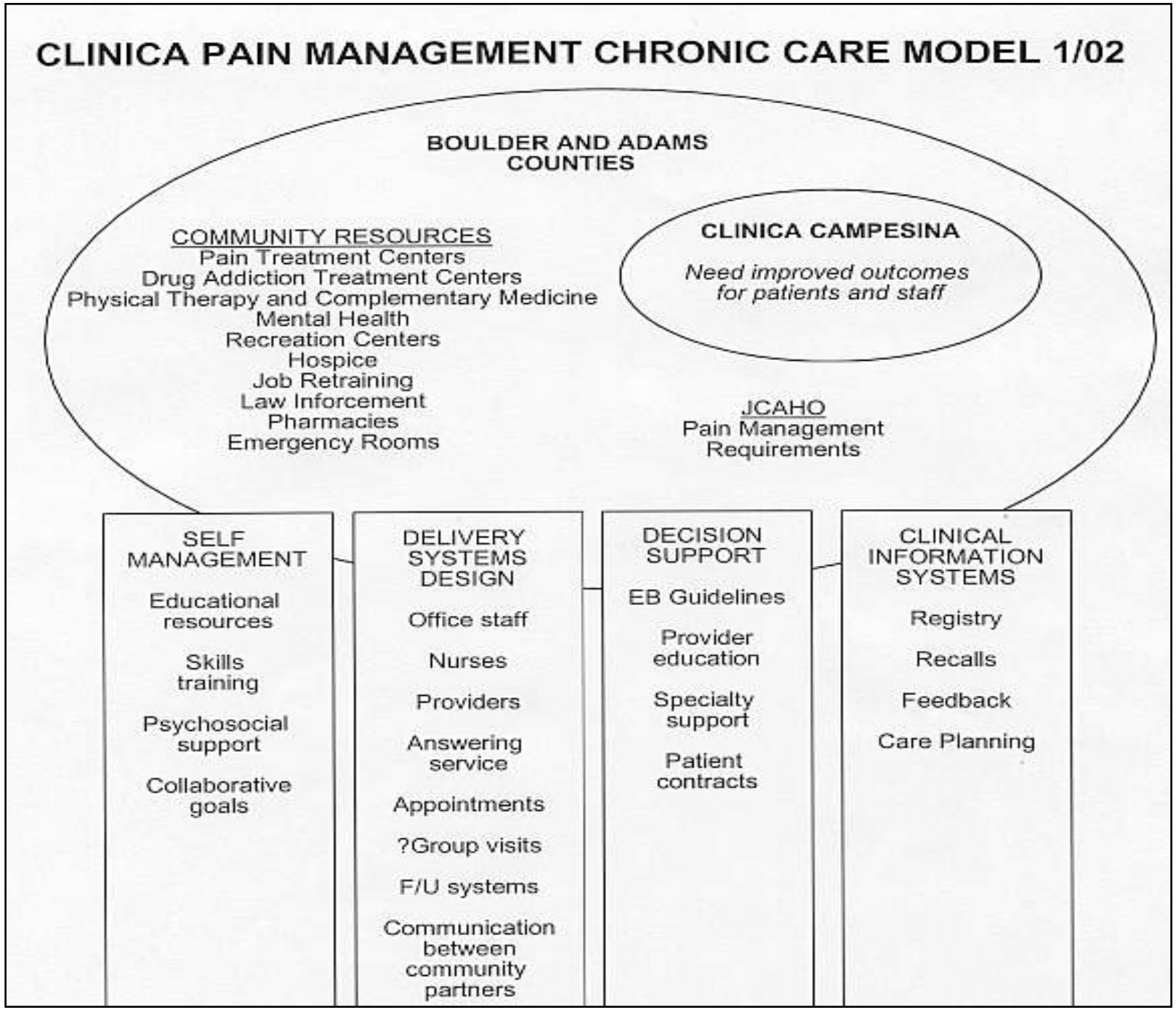
- Develop and optimize partnerships
- Advocacy to add/change policies
- Address Social Determinants of Health

Clinica Family Health Services Planned Care Example

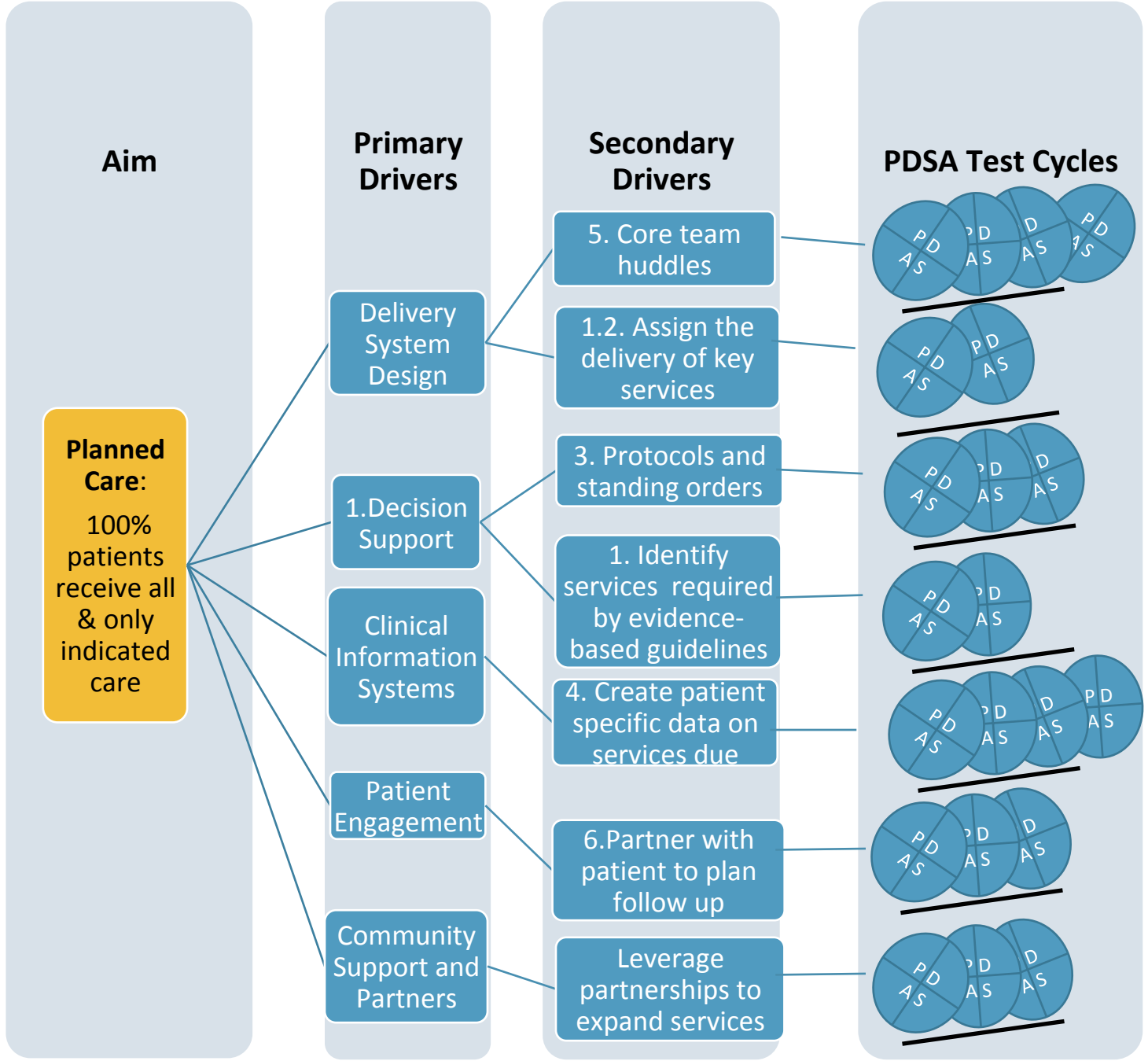


Where to Start?

- Start with an AIM
- Develop a driver diagram using the planned care model as a framework
- Prioritize PDSAs for testing process changes
- Apply the 6 steps
- Apply learning to this and other aims to build momentum for change



Planned Care: a key component of high quality care



Six Steps to Providing Planned Care

1. Identify the common services required by evidence-based guidelines
2. Assign the delivery of key services to specific staff and ensure that they are trained
3. Use protocols and standing orders to allow staff to act independently
4. Efficiently generate patient-specific data on services that are due
5. Huddle with the core practice team and review patient before clinic sessions
6. Ensure patient engagement and follow up

Six Steps to Providing Planned Care

1. **Identify the common services required by evidence-based guidelines**

<u>Questions:</u>

- What moves CHC,Inc. to take on a measure?
- How does your organization decide which evidence-based guidelines to follow?
- Who is involved in these decisions?

Clinical Expectations

Lung Cancer (USPSTF))	Asymptomatic adults aged 55 to 80 years who have a 30 pack year smoking history and currently smoke or have quit with in the past 15 years: Screen annually with low dose Computed Tomography until the patient has not smoked for 15 years.
STD Screening (USPSTF/CDC)	• **Gonorrhea & Chlamydia:** Screen sexually active women age 24 years and younger and in older women who are at increased risk for infection. Retest approximately 3 months after treatment (CDC). • **Syphilis:** Screen non-pregnant adults and adolescents who are at increased risk for syphilis (MSM, positive HIV) and (Male under age 29, race/ethnicity, geography, incarceration, and sex work)
HIV Screening (CDC)	HIV screening been done/offered to patients ages 13-64 at least once.
HCV Screening (USPSTF/CDC)	• HCV screening for persons at high risk for infection (past or current injection drug use, blood transfusion before 1992, long-term hemodialysis, born to an HCV-infected mother, incarceration, intranasal drug use, unregulated tattoo, and other percutaneous exposures. • One time screening in individuals born between 1945-1965
HBV Screening (USPSTF/CDC)	HBV screening (periodic) for persons at high risk for infection (those from countries with a high prevalence of HBV infection, HIV-positive, injection drug users, household contacts of persons with HBV, and men who have sex with men. CDC link-HBV prevalence by country: http://wwwnc.cdc.gov/travel/yellowbook/2016/infectious-diseases-related-to-travel/hepatitis-b
Depression Screening – adolescents (AAP/USPSTF)	Annual depression screening for adolescents ages 12 and above.
Depression Screening – adults (USPSTF)	Annual depression screening for adults ages 18 and above.
Intimate Partner Violence Screening (USPSTF/ACOG)	Screen women of childbearing age for intimate partner violence (IPV), such as domestic violence, and provide or refer women who screen positive to intervention services. For women aged 14 and above: • HITS questionnaire on initial screen • HARK questionnaire annually
Developmental Screening (AAP)	See Pediatric section.
Vaccinations	
HPV Vaccine (ACIP)	Female patients: offered/given to patients ages 11-26 years. Male patients: offered/given to ages 11-21. Male patients with risk factors: offered/given until age 26.
Tetanus booster (ACIP)	Adult patients: Tdap given at least once; Td every 10 years thereafter. Pregnant women: Tdap given during each pregnancy.
Influenza (ACIP)	Offered/given during the last flu season for indicated patients (chronic illness, or age 0-4, 50+).

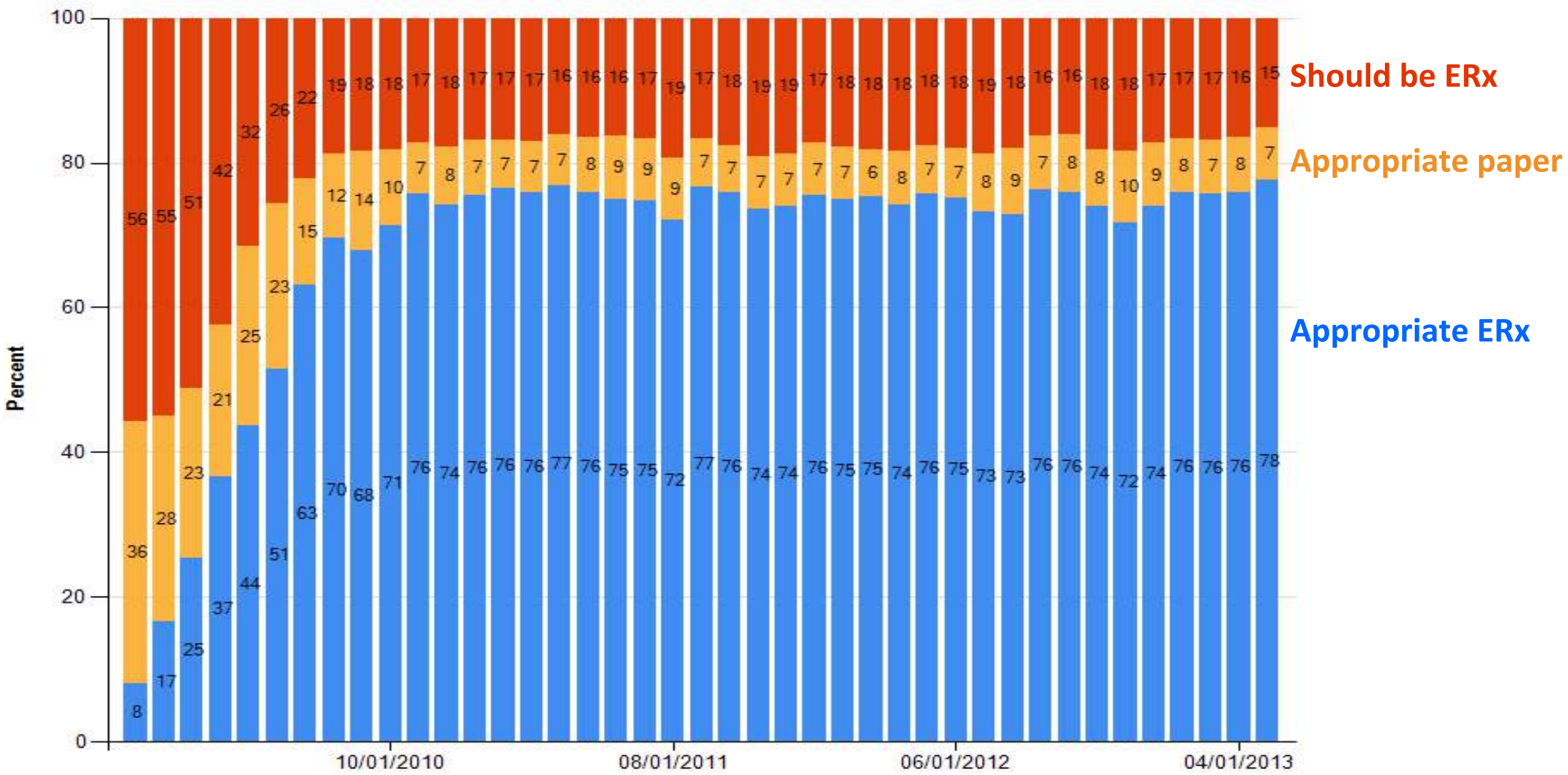
Six Steps to Providing Planned Care

2. Assign the delivery of key services to specific staff and ensure that they are trained

<u>Questions:</u>

- How do your sites determine who is the staff member completing or responsible for each action?
- How do you train your teams, confirm understanding and measure impact/success?

Outcomes-ERx Clinica



Tool for PCD: Mammograms

PCD Item	Patient Population	How Often	What MA/LPN Does (or other clinical staff)

Breast Cancer Screening (turns red 3 months prior to due date)
 	
(yellow for 30 days once the mammogram has been ordered or declined)
	Women age 50 to 74	Every 24 months	• Ask the patient if she has had a mammogram in past 24 months. If yes, complete Non ROI ROI and send to the facility where she got it done and order a "Mammogram Outside" (via Manage Orders) [MA]
			
			• If she had not had one, order a mammogram using DI.
			
			  • Order DI = Mammogram – Bilateral Screening [MA}
			  • Mammogram – Bilateral Diagnostic [Prov]
			  • Mammography screening with U/S –Hospital specific [MA/Prov]
			
			• If she declines, order a "Mammogram Declined" (via Manage Orders) [MA] with provider permission or [Prov]
			
			• Once results come in: Results checked as "Received" , "Collection Date" entered and "Attached" [MA] or Medical Records
			
			• DI Result "Reviewed" [Prov]

Medical Assistant Performance Appraisal

MA Performance Appraisal Data: Agency and Site Average and Your Rate

Time Period: 7/1/2016-6/30/2017

MA Name: _____

Measure	Agency Average	Meriden Average	Your Rate
Depression Screening	81.4%	87.9%	
Smoking Assessment	100.0%	100.0%	
Colon Cancer Screening	61.2%	63.7%	
A1C	83.0%	80.3%	
Literacy in Social History	51.1%	56.0%	
Initial appointments documented	32.7%	39.5%	
Chaperone for all well women visits	60.8%	81.4%	
SOGI	90%	96%	
PEDS Screening	58.7%	71.2%	
HIV	78.7%	83.7%	
Child BMI Percentile	99.7%	99.3%	
Child Weight Education	85.6%	91.9%	
Asthma -ACT	78.9%	72.1%	
Adult BMI	98.6%	98.3%	
Adult Weight Education	73.4%	70.5%	
Chlamydia	33.3%	30.8%	
Planned Care Dashboard	630		
SBIRT	45%	77%	

Key:

Red box indicates the site average is statistically significantly lower than the agency average.

Green box indicates the site average is statistically significantly higher than the agency average.

MA Performance Appraisal Data: Agency and Site Average and Your Rate

Time Period: 7/1/2016-6/30/2017

MA Name: _____

Measure	Agency Average	New Britain Average	Your Rate
Depression Screening	81.4%	77.2%	
Smoking Assessment	100.0%	100.0%	
Colon Cancer Screening	61.2%	64.7%	
A1C	83.0%	85.7%	
Literacy in Social History	51.1%	49.6%	
Initial appointments documented	32.7%	30.6%	
Chaperone for all well women visits	60.8%	41.8%	
SOGI	90%	92%	
PEDS Screening	58.7%	70.3%	
HIV	78.7%	83.0%	
Child BMI Percentile	99.7%	99.7%	
Child Weight Education	85.6%	87.8%	
Asthma -ACT	78.9%	89.2%	
Adult BMI	98.6%	98.8%	
Adult Weight Education	73.4%	72.2%	
Chlamydia	33.3%	29.6%	
Planned Care Dashboard	630		
SBIRT	45%	71%	

Key:

Red box indicates the site average is statistically significantly lower than the agency average.

Green box indicates the site average is statistically significantly higher than the agency average.

Complex Care Management Dashboard: Eligible Patients

Patient ID	2 ER Visits in Last 12 Mths.	Hosp. Last 12 Mths.	DM	HTN	Asthma	4 Chronic Cond.	Smoking Status	A1C	BP	Age - Sex	CC Start Date	CC End Date	SMG Date	Action Item	Action Item Due Date	Last PCP Visit	Last Dental Visit	Last BH Visit	Portal Enabled
							unknown												
[redacted]							never smoker	13.7	137/86	31.0 - M						10/10/2017		11/11/2016	No
							never smoker		100/74	31.0 - F						10/23/2017	2/3/2018	9/2/2015	Yes
		1/21/2018					never smoker	11	112/68	45.0 - F						1/6/2018		8/1/2017	Yes
							smoker, current status unknown	6.1	139/76	58.0 - F						1/23/2018	5/13/2010	9/14/2016	Yes
							smoker, current status unknown	5.6	126/82	22.0 - F						11/9/2017	9/26/2016	1/24/2018	No
		3/23/2017					never smoker	5.3	142/86	75.0 - M						1/2/2018	6/10/2013		No
							former smoker	5.5	128/76	34.0 - M						11/9/2017	1/15/2013	11/8/2016	Yes
							smoker, current status unknown	5.8	124/75	50.0 - F						1/3/2018	9/13/2016		No
							smoker, current status unknown	11.2	186/97	55.0 - F				fu	3/8/2018	12/18/2017			No
							former smoker	5.8	131/63	45.0 - F						2/5/2018	6/1/2011	3/22/2006	No

Complex Care Management Dashboard: Enrolled Patients

Patient ID	2 ER Visits in Last 12 Mths.	Hosp. Last 12 Mths.	DM	HTN	Asthma	4 Chronic Cond.	Smoking Status	A1C	BP	Age - Sex	CC Start Date	CC End Date	SMG Date	Action Item	Action Item Due Date	Last PCP Visit	Last Dental Visit	Last BH Visit	Portal Enabled
[redacted]		1/7/2018					smoker, current status unknown		116/60	55.0 - F	2/5/2018			RN Care Coordination	3/2/2018	2/16/2018		9/20/2017	No
							never smoker	11.8	116/79	42.0 - F	12/9/2017		1/16/2018 2:20:00 PM	RN Care Coordination	3/2/2018	12/27/2017			Yes
							never smoker	7.8	121/75	54.0 - F	2/16/2018		2/16/2018 9:20:00 AM	Self Management Goal	3/2/2018	12/6/2017			Yes
		10/31/2017					never smoker	10.6	96/55	48.0 - F	8/15/2016					11/3/2017		4/11/2017	Yes
							never smoker	9.5	134/88	51.0 - M	2/1/2018			Self Management Goal	2/26/2018	1/25/2018		8/24/2017	No
							never smoker	6.9	146/77	77.0 - M	2/19/2018			Self Management Goal	3/5/2018	10/26/2017		1/9/2013	Yes
		5/27/2017					never smoker	8.8	120/72	48.0 - F	10/31/2016		6/12/2017 10:00:00 AM	RN Care Coordination	3/14/2018	11/17/2017		9/22/2015	Yes
							never smoker	10	143/80	48.0 - F	2/15/2018			DM	3/1/2018	1/24/2018		2/15/2018	Yes
							never smoker	6.9	162/98	55.0 - M	5/19/2017			RN Care Coordination	3/1/2018	2/7/2018			No
							former smoker	5.7	124/73	59.0 - F	2/2/2018			Self Management Goal	2/23/2018	1/3/2018		6/10/2014	No

Six Steps to Providing Planned Care

3. Use protocols and standing orders to allow staff to act independently

Questions:

- Do you (and if so, how do you) use clinical decision support to assist with following evidence-based guidelines?
- What advice do you have for standing orders?

Planned Care Dashboard Display

Provider Name

Data as of : 1/23/2018

Contact Us!

Appointment Range	Data Legend	
Display only patients with an upcoming appointment within the selected range.	In Compliance Out of Compliance Order in Progress Not in Denominator	3/15/2015 A date indicates that a Due Date is upcoming or has past.

Patient	PCP and Visit Info
ID Sex: F Age: 19.0	Provider Name Next Medical Appointment: 1/24/2018 9:00:00 AM Last Dental Visit: 8/28/2017 Reason for Visit: ED F/U Pregnancy

ALERTS	Last Date	Due Date	Value	Notes
DM Retinopathy	Never Done	Never Done		Ordered in last 30 days.
ACT	5/30/2017	Every Visit	25	>19 is good control
HPV	Done of	Never Done		
Chlamydia Screen	Never Done	Never Done		
Depression Screening	11/15/2016	11/15/2017		

Bubbles	#
TE	
RX	
Doc	2
Lab	

What about at your clinic?

1. **Evidence-based guidelines**
2. **Assign key work to specific staff**
3. **Use protocols and standing orders**

Team time: 30 minutes

Reflect on what you've heard and discuss what you plan to change/apply given your current-state assessment.

- Do you need to add a driver?
- Have ideas emerged for a driver or PDSA around planned care?

LUNCH

Table 1	Quality and Analytics
Table 2	Clinicians
Table 3	Senior Leadership (COO, CMO, CNO)
Table 4	Operations and Finance
Table 5	Care Team Staff

Planned Care Review
Part 2

Carolyn Shepherd

KP Transformation Accelerator

3/22/18

Six Steps to Providing Planned Care

4. Efficiently generate patient-specific data on services that are due

Questions:

- What tools do you use to support your teams to prevent missed opportunities for patients?
- How do you follow through on the care plan and measure success currently? In 1 year, what in this process do you hope to improve?
- Do you focus on these items only when patients come to the clinic, or do you have care gap reports that are worked separately from the visit?

Missed Opportunities Dashboard

Missed Opportunity Report

Week of 1/7/2018

Completed / Opportunities (%Completed)

Provider	Cervical Cancer	Breast Cancer	Colon Cancer	Diabetes A1c	Diabetes Retinopathy	Diabetes Foot Exam	Asthma Control Med	Asthma ACT	CAD Lipid Med	IVD Aspirin	
Agency Average	44/678 (6.5%)	92/400 (23.0%)	47/461 (10.2%)	74/113 (65.5%)	0/80 (0.0%)	5/55 (9.1%)	1/8 (12.5%)	194/448 (43.3%)	2/8 (25.0%)	2/9 (22.2%)	
[redacted]	0/0	0/0	0/0	0/0	0/0	0/0	0/0	5/10 (50.0%)	0/0	0/0	
	0/16 (0.0%)	2/6 (33.3%)	3/8 (37.5%)	0/0	0/0	0/0	0/1 (0.0%)	11/11 (100.0%)	0/0	0/0	1
	4/21 (19.0%)	4/10 (40.0%)	8/15 (53.3%)	1/2 (50.0%)	0/1 (0.0%)	0/1 (0.0%)	0/0	7/8 (87.5%)	0/0	0/0	2
	0/9 (0.0%)	0/10 (0.0%)	0/5 (0.0%)	0/2 (0.0%)	0/1 (0.0%)	0/1 (0.0%)	0/0	0/5 (0.0%)	0/0	0/0	
	1/8 (12.5%)	3/7 (42.9%)	0/10 (0.0%)	2/2 (100.0%)	0/2 (0.0%)	0/2 (0.0%)	0/0	3/12 (25.0%)	0/0	0/0	1
	0/4 (0.0%)	0/1 (0.0%)	1/1 (100.0%)	0/0	0/0	0/0	0/0	1/2 (50.0%)	0/0	0/0	
	0/22 (0.0%)	1/14 (7.1%)	1/13 (7.7%)	1/5 (20.0%)	0/4 (0.0%)	0/4 (0.0%)	0/0	1/9 (11.1%)	0/0	0/0	1

Integrating Nursing into Behavioral Health & Dental

Agency Overview

BAM

Patients by City and Day

	Wednesday 2/21/2018	Thursday 2/22/2018	Friday 2/23/2018	Saturday 2/24/2018	Monday 2/26/2018	Tuesday 2/27/2018	Wednesday 2/28/2018
Bristol	2	5	2	-	3	10	3
Clinton	5	12	2	-	7	2	15
Danbury	3	19	14	1	14	20	9
Enfield	4	7	-	-	-	-	3
Groton	3	5	5	-	4	2	5
Hartford	12	3	3	2	5	3	2
Meriden Dental	20	29	17	-	17	20	17
Meriden Mental Health	19	52	23	3	52	36	33
Middletown	44	54	54	3	48	74	43
New Britain	41	58	46	8	54	51	44
New London	24	49	38	6	50	54	38
Norwalk	15	2	15	-	20	10	16
Old Saybrook	4	4	5	-	8	7	5
Stamford	14	22	12	-	25	33	24
Waterbury	3	16	6	1	17	8	17

Integrating Nursing into Behavioral Health & Dental

Patient	Provider and Visit Info
[redacted] Sex: F Age: 34.0	New Britain Dental Appointment: 2/22/2018 9:00:00 AM

ALERTS	Last Date	Due Date	Value	Notes
Needs Flu Vaccine 2017-2018				
SBIRT	Never Done			Yearly, 18+ yrs old
Body Mass Index	11/30/2017		30.72	Needs Education
HTN	11/30/2017		150/89	

Patient	Provider and Visit Info
[redacted] Sex: M Age: 45.0	New Britain Mental Health Appointment: 2/22/2018 9:30:00 AM

ALERTS	Last Date	Due Date	Value	Notes
DM Retinopathy	Never Done	Never Done		

Bubbles	#
TE	3
RX	
Doc	
Lab	1

Six Steps to Providing Planned Care

5. Huddle with the core practice team and review patient before clinic sessions

Questions:

- What items do you focus on in the huddle and why?

- Are there things you currently don't huddle on that you wished you could? Are there things that you currently do in the huddle that you wish were automatic?

Six Steps to Providing Planned Care

6. Ensure patient engagement and follow up

Questions:

- How do you support patients to be part of the care team and engage in the work of closing their own care gaps?
- What are common barriers that you identify for your patients?

"Every Patient has a Team!"

Managing Care Gaps

Scenario A: Lists of 3,00 patients with systolic BPs between 140-150 sent out Nurse Managers for dissemination. Instructions included:

1. Nurse to review list of patients with the PCP and discuss the approach for each (e.g., medication titration, referral to RD, BH smoking cessation group).

2. Nurse to call each patient and follow through with the plan discussed with the PCP. Also, nurse asked to complete other actions (order home BP monitor, enroll in CCM, complete med rec).

Scenario B: Telephone encounters sent directly through the EHR to providers whose patients (n=100) are not on an inhaled corticosteriod. Instructions included verifying diagnosis, prescribing medication if appropriate.

What about at your clinic?

4. **Efficiently generate patient specific information care gaps**
5. **Huddle on each patient before clinic session**
6. **Ensure patient engagement and follow up**

Team time: 30 minutes

Reflect on what you've heard and discuss what you plan to change/apply given your current-state assessment.

- Do you need to add a driver?
- Have ideas emerged for a driver or PDSA around planned care?

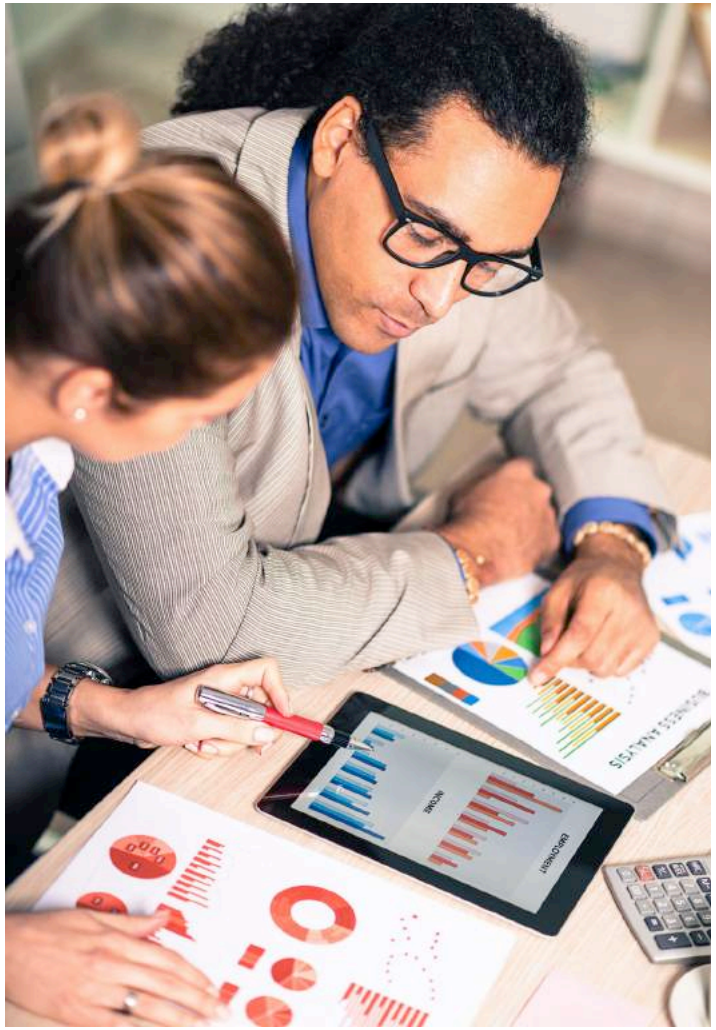
Testing Changes & Using Data to Learn about Your Changes

Three Key Questions

1. What are we trying to accomplish? **(Aim – main outcome measure)**

2. How will we know that a change is an improvement? **(Measure – process and balancing measures that link to changes)**

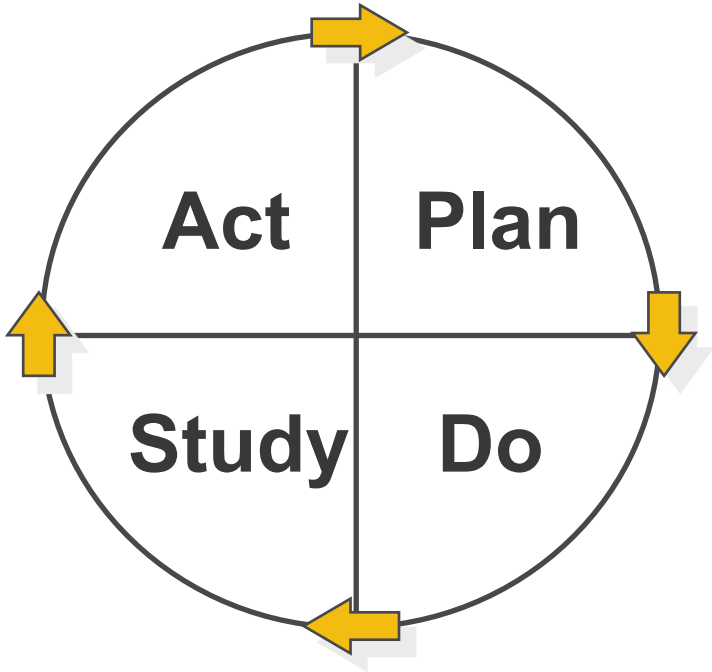
3. What changes can we make that will result in an improvement? **(Change – come from drivers)**



What do we mean by “changes”?

Model for Improvement: Large System Change

To get to Big Change, we need many Small Tests of Change – use the PDSA Cycle



Monthly Measures
1)% patients screened
2) % of patients outreached that were screened
3) Percent of patients screened at visit

Aim

Planned Care: Increase percent of women 23-64 screened for CCS from 55% to 75%

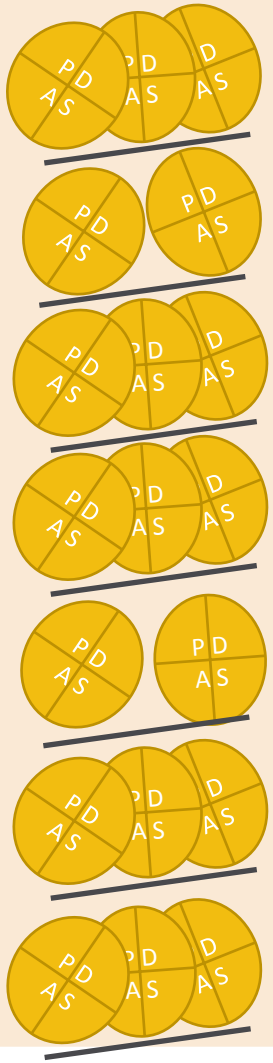
Primary Drivers

- Delivery System Design
- Decision Support
- Clinical Information Systems
- Patient Engagement
- Community Support and Partners

Secondary Drivers

- Core team huddles
- Assign the delivery of key services
- Protocols and standing orders
- Identify services required by evidence-based guidelines
- Create patient specific data on services due
- Partner with patient to plan follow up
- Leverage partnerships to expand services

PDSA Test Cycles

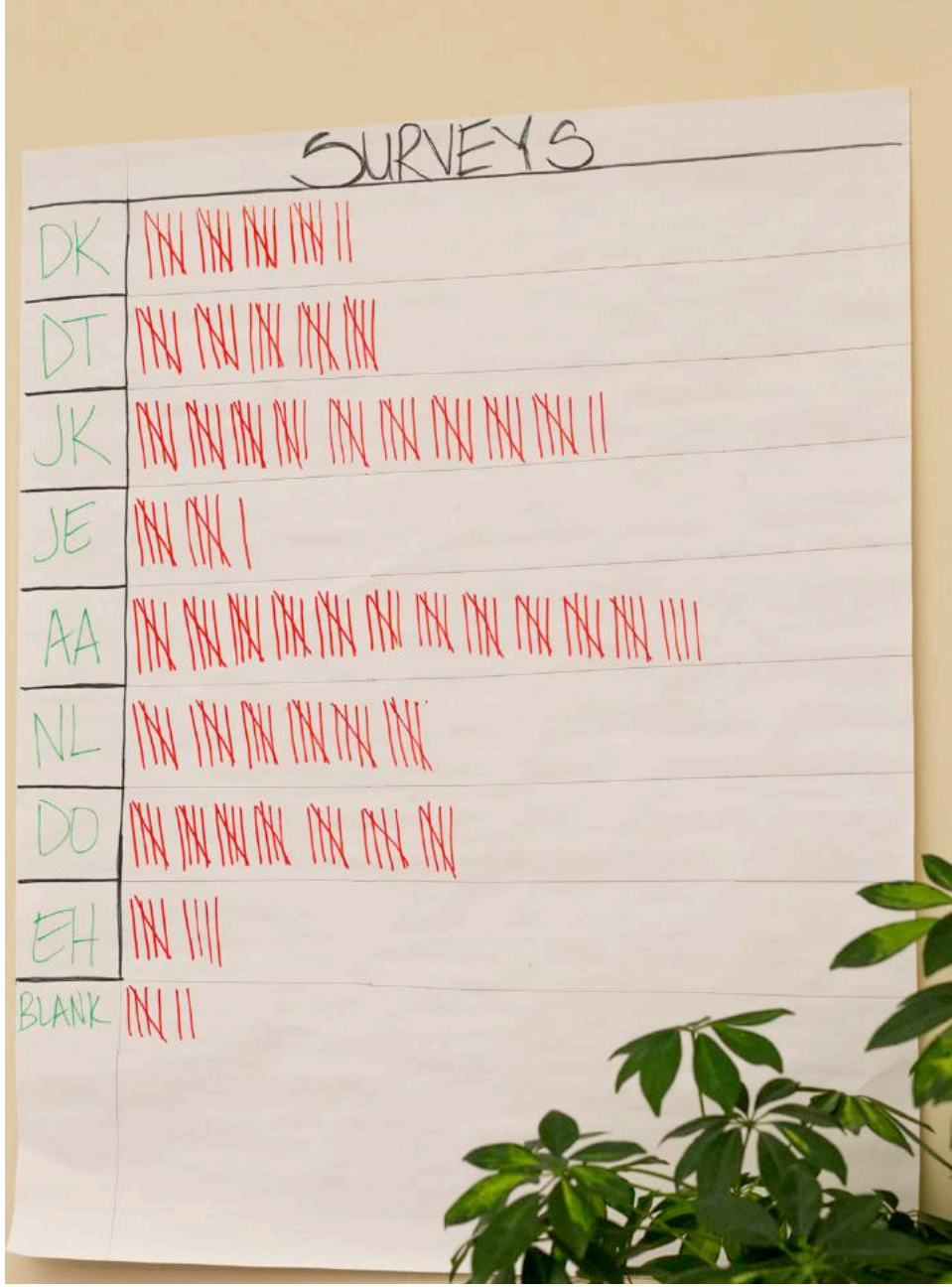


- Who didn't get it and why – check weekly or more
- % of patients successfully reached
- % of patients with scheduled appointments
- % of patients that showed for appointments
- % of patients captured in reports – validate via medical charts
- Staff experience using the protocols

PDSA measures

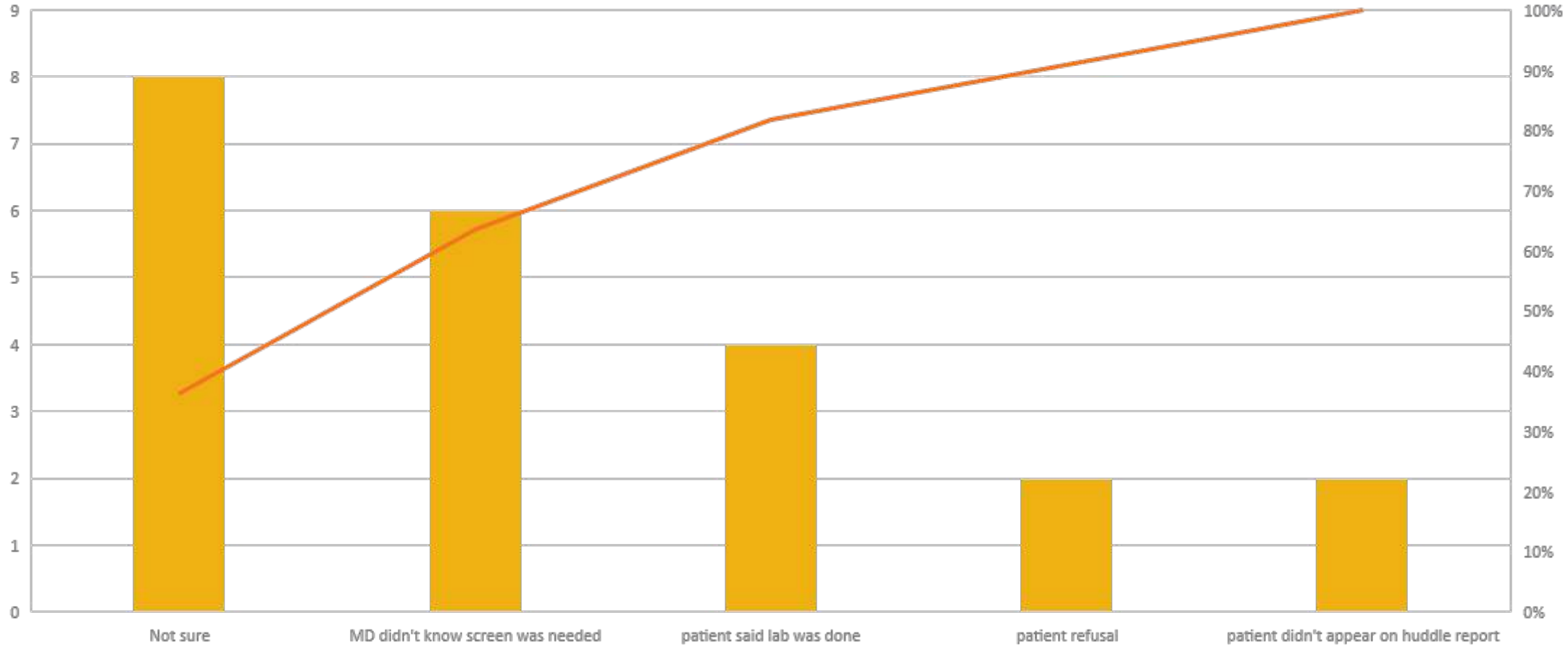
Collecting data for learning: use PDSAs

- Quick measures
- Just enough data to provide signal
- Quantitative and qualitative data
- Data is easily retrievable – same day or a week at most

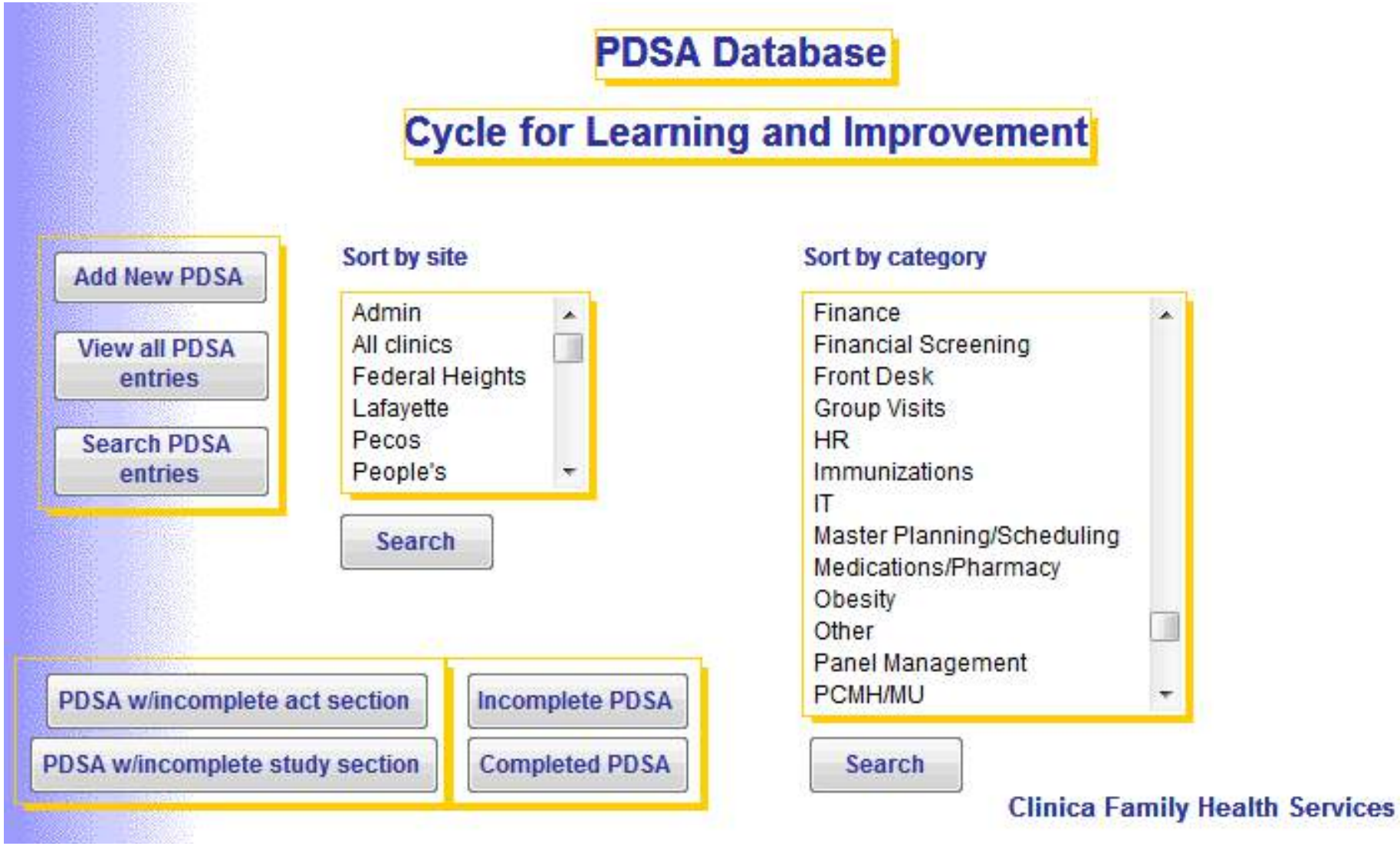


Example: Missed Opportunity Report

Most common reasons for no pap



Use IT to Support Organizational Learning

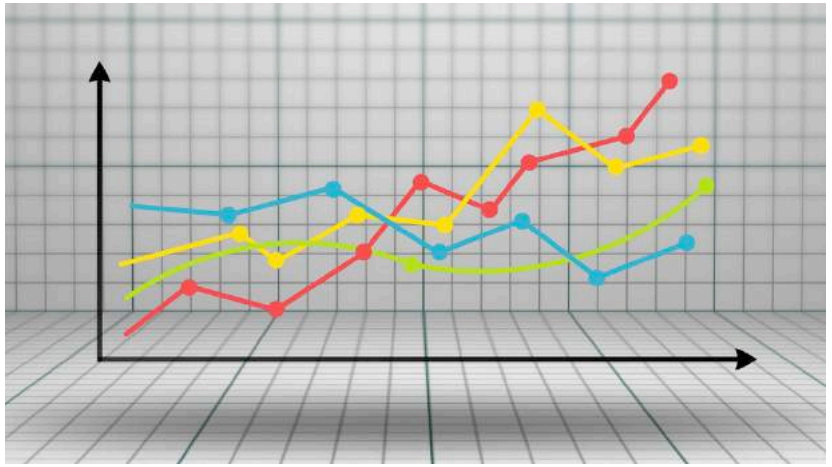


Use IT to Support Organizational Learning

File | Home | Create | External Data | Database Tools

	Category	Title	First Name	Last Name	Site	Date entered	completed?	Date completed	Disseminati
Open PDSA	Group Visits	Centering Patient Recruitment	Judy	Troyer	Pecos	10/9/2008	☑	9/1/2009	☑
Open PDSA	Group Visits	Cold/Flu Cluster Visit III	Judy	Detweiler	Pecos	2/4/2008	☑	3/1/2008	☑
Open PDSA	Group Visits	Cold/Flu Cluster Visit II	Judy	Detweiler	Pecos	1/7/2008	☑	2/4/2008	☑
Open PDSA	Group Visits	Group Visits for Sports Physicals	Beth	Versaw	People's	7/10/2009	☑	7/30/2009	☐
Open PDSA	Group Visits	Geriatric New patient group	Amy	Russell	Pecos	10/8/2008	☑	1/15/2009	☐
Open PDSA	Group Visits	Patient Specific New Patient Group Visits	Judy	Detweiler	Pecos	7/25/2008	☑	10/20/2008	☐
Open PDSA	Group Visits	Financial incentives to increase attendance at CDSM group	Mary	Faltynski	Lafayette	3/27/2008	☑	5/1/2008	☐
Open PDSA	Group Visits	New Patient Group Visit for all Clinicians	Victor	Montour	Thornton	3/4/2008	☑	6/1/2008	☐
Open PDSA	Group Visits	Back Pain Group Visit	Martina	Paiz	Thornton	3/4/2008	☑	3/11/2008	☐
Open PDSA	Group Visits	New Patient Group Visit	Victor	Montour	Thornton	11/1/2007	☑	12/1/2008	☐
Open PDSA	Group Visits	Cold & Flu cluster spread & having CCA schedule	Rebecca	Ballantyne	People's	10/1/2009	☐	3/25/2010	☑
Open PDSA	Group Visits	Share our Strength – Operation Frontline	Anne	Hansen	Thornton	10/26/2008	☐	12/1/2008	☐

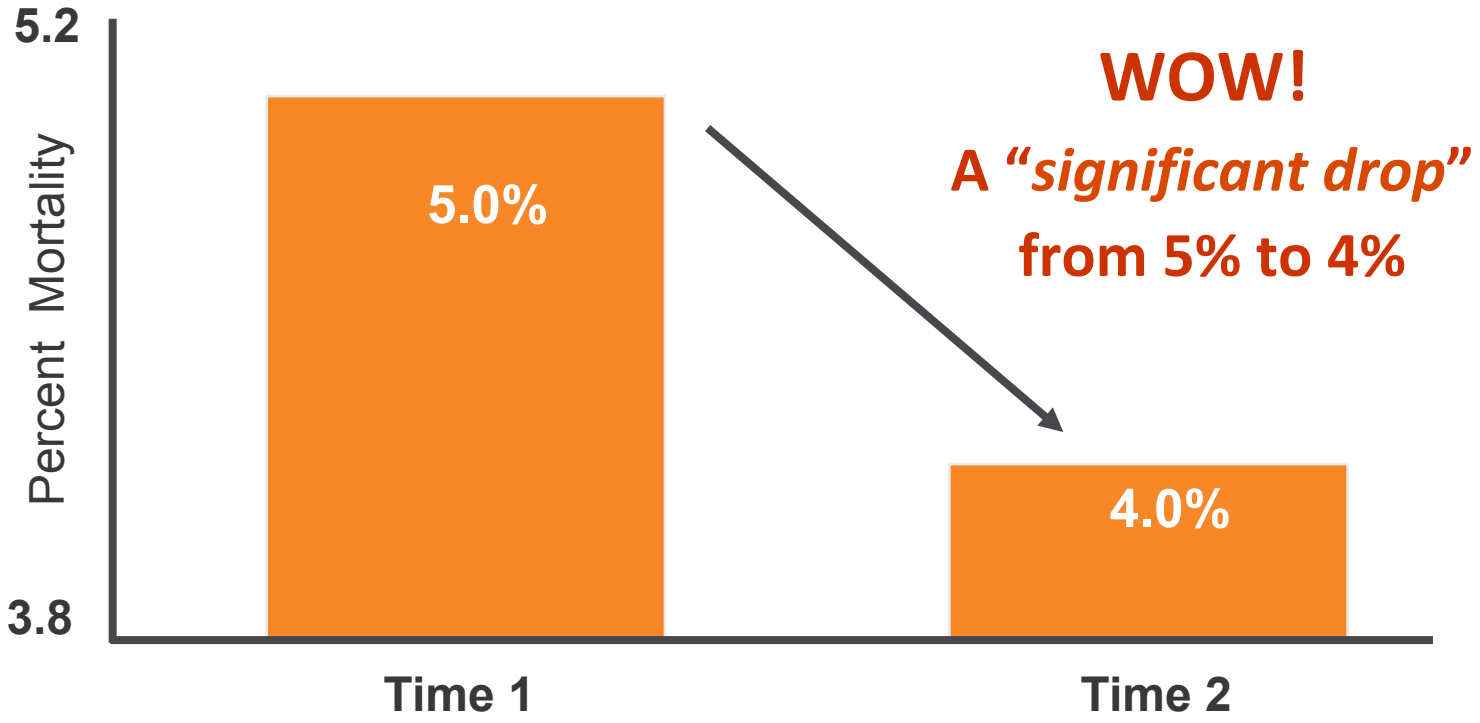
Collecting data to measure impact on AIM: use run charts



- Make performance of the process visible
- Determine if change is an improvement by comparing data before and after test
  - Aggregate measures alone do not lead to predictions about future performance or insights to explain past variations
  - Displaying data over time allows us to make informed predictions, and thus manage effectively
- Determine if holding the gain

Example 1: Average CABG Mortality

Before and After the Implementation of a New Protocol

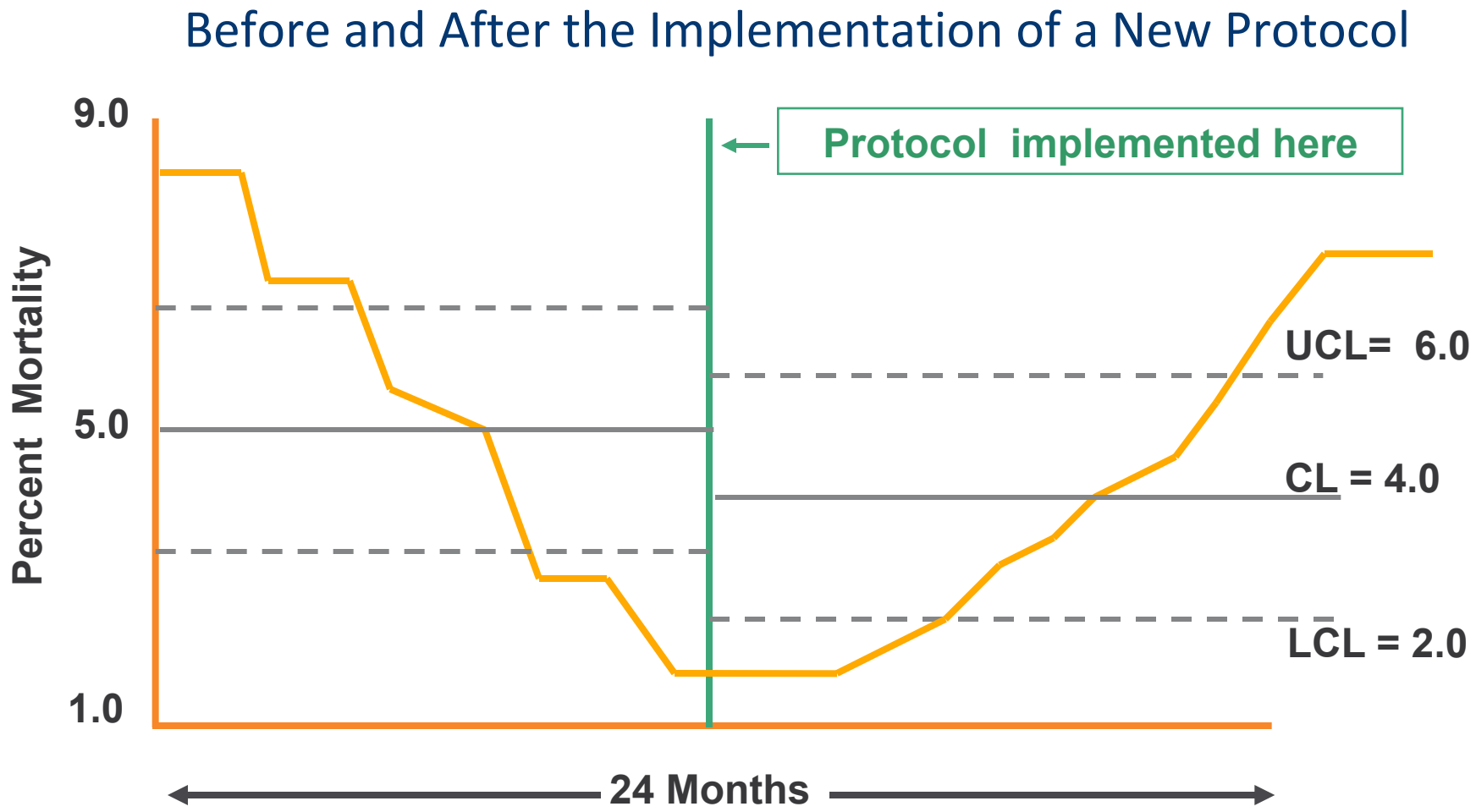


Conclusion – The protocol was a success!

A 20% drop in the average mortality!

Source: Robert Lloyd, IHI

Example 1: Average CABG Mortality



Source: Robert Lloyd, IHI

Example 2: Wait Time for ER Patients

Percent of ER patients with chest pain seen by a cardiologist within 10 min

Week	Date	Percent
1	3-Oct	88%
2	10-Oct	88%
3	17-Oct	94%
4	24-Oct	71%
5	1-Nov	88%
6	8-Nov	73%
7	15-Nov	78%
8	22-Nov	67%
9	29-Nov	69%
10	6-Dec	87%
11	13-Dec	83%
12	20-Dec	68%
13	3-Jan	83%
14	10-Jan	70%
15	17-Jan	73%
16	24-Jan	76%
17	31-Jan	78%
18	7-Feb	79%
19	14-Feb	84%
20	21-Feb	89%
21	28-Feb	95%
22	6-Mar	95%
23	13-Mar	91%
24	20-Mar	95%

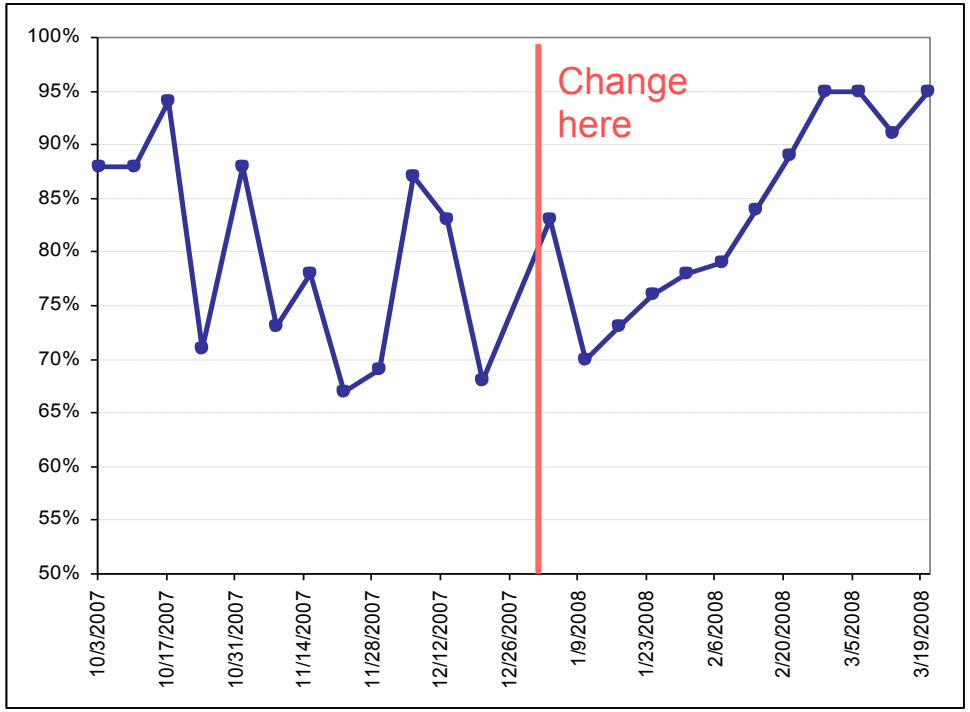
Week 1-12	
Avg	80%
Max	94%
Min	67%
Week 13-24	
Avg	84%
Max	95%
Min	70%

Source: Robert Lloyd, IHI

Example 2: Wait Time for ER Patients

Percent of ER patients with chest pain seen by a cardiologist within 10 min

Week	Date	Percent
1	3-Oct	88%
2	10-Oct	88%
3	17-Oct	94%
4	24-Oct	71%
5	1-Nov	88%
6	8-Nov	73%
7	15-Nov	78%
8	22-Nov	67%
9	29-Nov	69%
10	6-Dec	87%
11	13-Dec	83%
12	20-Dec	68%
13	3-Jan	83%
14	10-Jan	70%
15	17-Jan	73%
16	24-Jan	76%
17	31-Jan	78%
18	7-Feb	79%
19	14-Feb	84%
20	21-Feb	89%
21	28-Feb	95%
22	6-Mar	95%
23	13-Mar	91%
24	20-Mar	95%



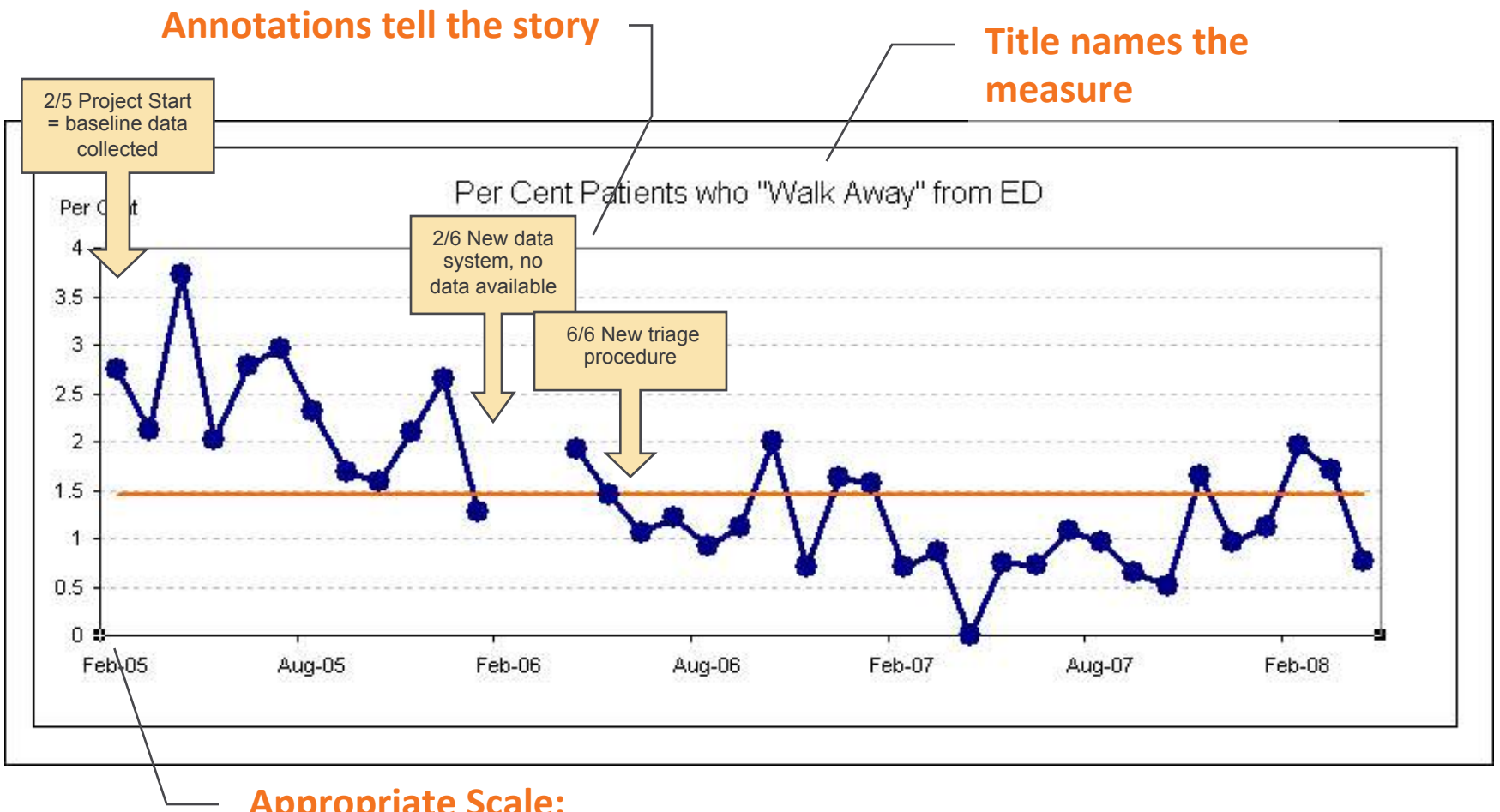
Source: Robert Lloyd, IHI

Run Charts

- Display ordered sequence of data and provide running record over time
- Can be used for any data that are sequenced over time (trending)
- Require no statistics
- Visually illustrate progress toward goal
- Allow us to detect signals of improvement or degradation in a process over time

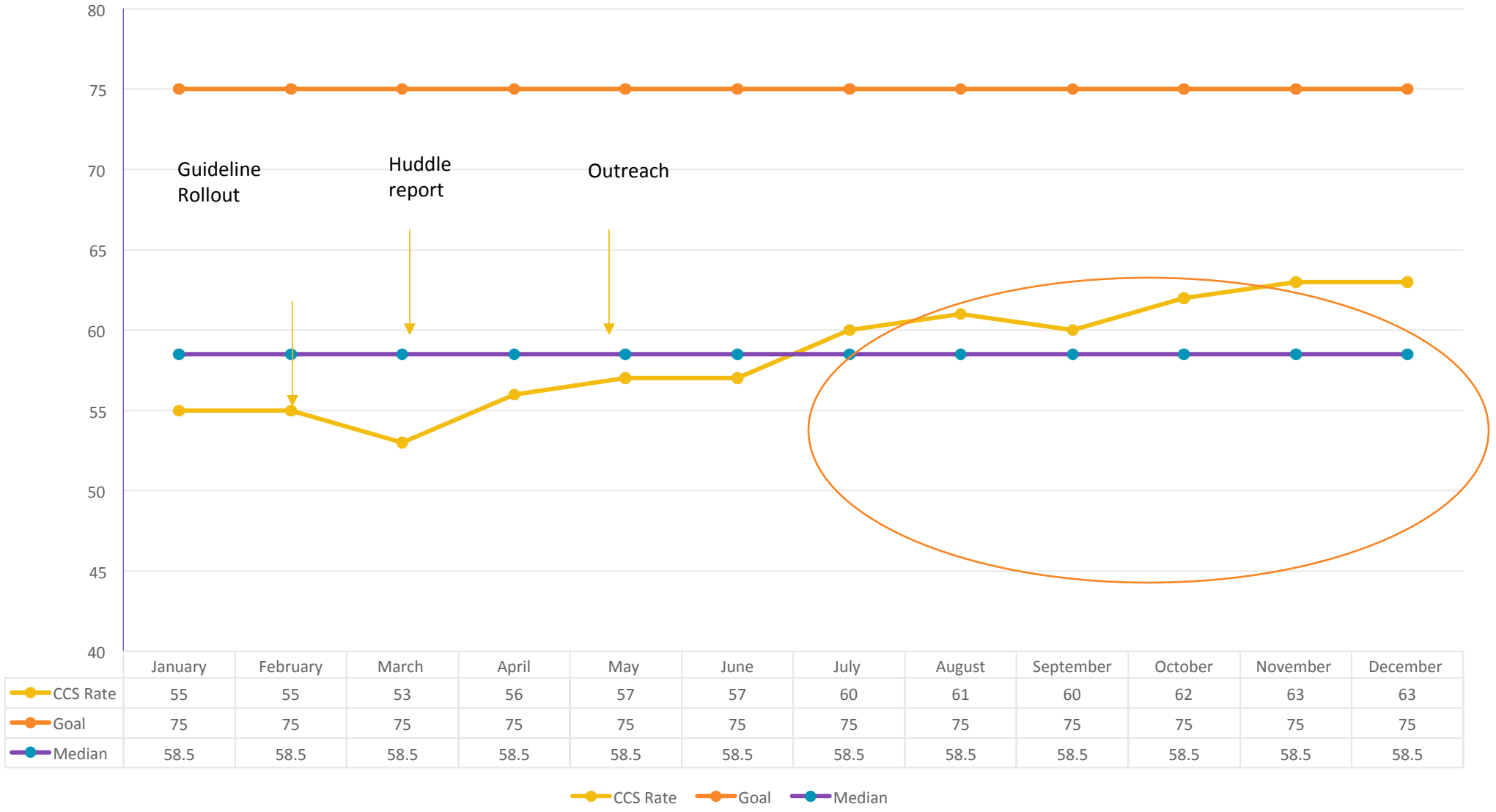
Adapted from, *NHS Scotland Tutorial Guide on Statistical Process Control*.
http://www.indicators.scot.nhs.uk/SPC/SPC.html

Run Chart Anatomy



Source: Richard Scoville, PhD

Run Chart: Cervical Cancer Screening



	January	February	March	April	May	June	July	August	September	October	November	December
CCS Rate	55	55	53	56	57	57	60	61	60	62	63	63
Goal	75	75	75	75	75	75	75	75	75	75	75	75
Median	58.5	58.5	58.5	58.5	58.5	58.5	58.5	58.5	58.5	58.5	58.5	58.5

Understanding Variation

All data demonstrate variation

- Sources of variation
  - People, methods, environment, materials, measurements
  - Methods: measuring, collecting, analyzing, interpreting
- Two types of variation
  - Random / Common cause
  - Non-random / Special cause

Adapted from, *NHS Scotland Tutorial Guide on Statistical Process Control*. http://www.indicators.scot.nhs.uk/SPC/SPC.html

Your turn!

- What big change do you want to test next within planned care?
- Which primary driver does it address?
- Shrink the change into one small PDSA?
- Documentation is important! Document the PLAN
  - What assumptions/hypothesis do you have?
  - Who will do what and by when?
  - How will you measure the change?
  - Who and how will data be collected?
  - How will you display it?
- Partner up, share your PDSA

Planned care is organized patient-focused care that is based on scientific evidence, planned in advance of the visit and delivered so that the team optimizes the health of every person on their panel.

Test and measure impact of your changes using run charts

In Summary ….

The **six steps** to providing planned care are:

1. Identify the **common services** required by evidence-based guidelines
2. **Assign the delivery** of key services to specific staff and ensure that they are trained
3. Use **protocols and standing orders** to allow staff to act independently
4. Efficiently generate **patient-specific data** on services that are due
5. **Huddle** with the core practice team and review patient before clinic sessions
6. Ensure **patient engagement** and follow up


Inspiration Disco

What's Next?

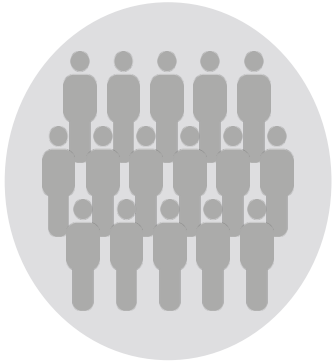
Coaching with Tammy & Carolyn

Progress Report

Due: May 15

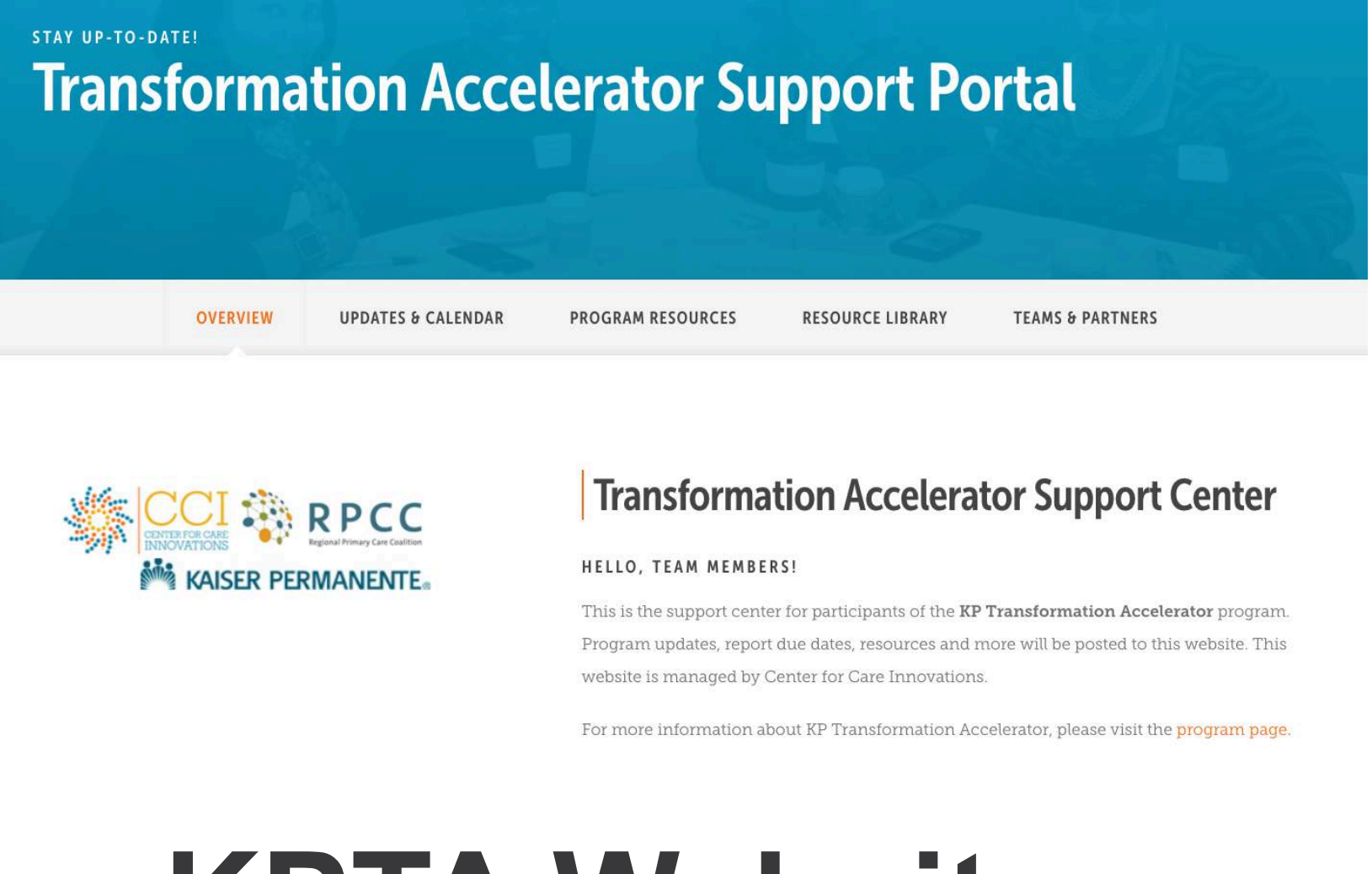
Webinar

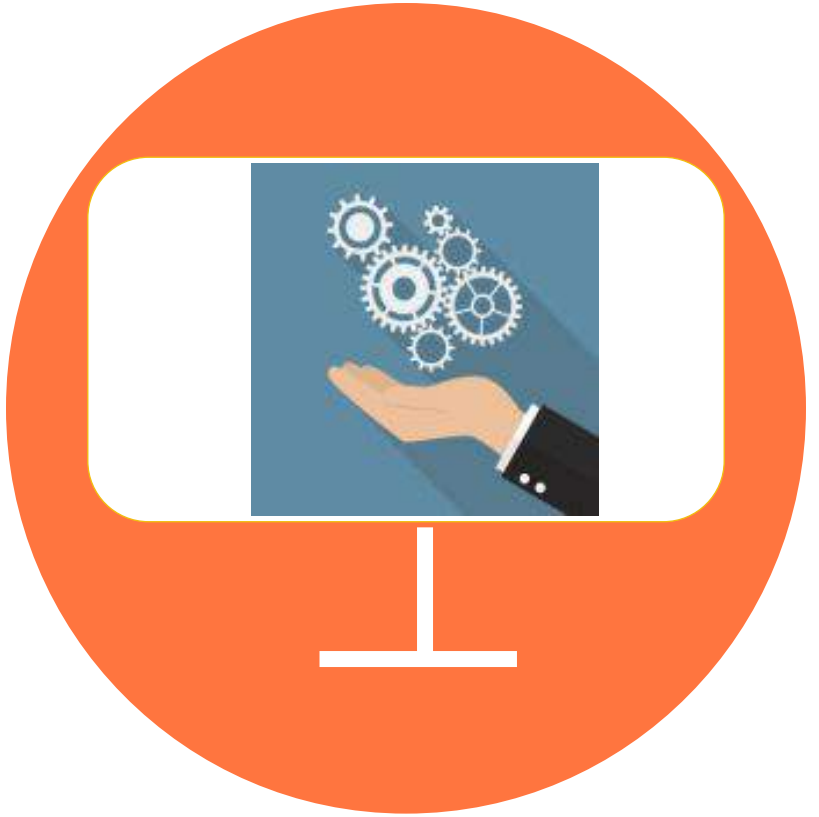
Date TBA



Learning Session

July 24th





KPTA Website

Live Tour!

Practical Considerations for Applying the New Hypertension Guidelines in Practice

Thursday, March 29th, 2018

11am Pacific /2pm Eastern

A webinar with Dr. Mike Rakotz of the American Medical Association

Thank you!