PATIENT CENTERED MEDICAL HOME

LEARNING COLLABORATIVE

POPULATION HEALTH MANAGEMENT

May 6, 2015

COMMUNITY HEALTH PARTNERSHIP

Population Management

Learning Objectives

Participants will be able to

1) Describe basic principles of population health management
2) Apply the principles to a specific health project
3) Explain how these principles align with the 2014 PCMH Standard 3: Population Management

What is Population Health Management?

There is not a widely accepted definition; however, in general population health management is an approach to health that intends to improve the health of an entire population. The population refers to a panel of patients assigned to a provider, a team, or the clinic. Delivering population-based care means providing care for all patients (or a targeted subset of patients) on the panel. By utilizing this proactive approach, we work with all patients who need care; these patients have a care gap. A care gap occurs when the patient is not up to date on routine measures or their results are of concern or are out of range. To be proactive, we contact or approach patients in the clinic even when:

- Patients do not have an upcoming appointment
- Patients have not been seen at the clinic recently
- Patients are in the clinic receiving care for an issue not related to the care gap

Why is the Population Health Management Model Important?

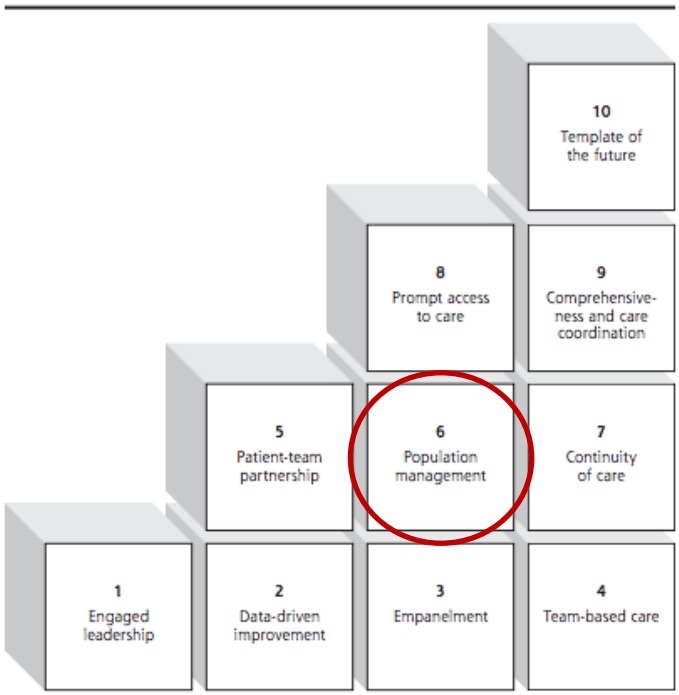
The paradigm for seeing and managing patients in our clinics has been changing dramatically in the past decade. We are moving from single encounters to multiple touches, from provider driven to team based care, from real time to discontinuous encounters, from reactive to proactive and from individual patient care to population based care.

This change has been driven by multiple forces, including financial incentives (Fee for Service to Capitation), a nationwide shortage of primary care providers, increasing knowledge about what works and what doesn't, widespread recognition of the importance of social determinants of health, and a societal need to stem the rising cost of health care.

Population Management

The Core Block of Patient Centered Medical Home

Population health has a central place in the Ten Building Blocks of Primary Care



Source: *The 10 Building Blocks of High-Performing Primary Care: Thomas Bodenheimer, MD, Amireh Ghorob, MPH, Rachel Willard-Grace, MPH and Kevin Grumbach, MD*

Building Block 6 – Population Management

UCSF's Center of Excellence for Primary Care uses this model as a road map. Tom Bodenheimer and colleagues visited several organizations that they had identified as high performing primary care sites. From these site visits they noticed that they all had ten things in common – which became the 10 building blocks of a high performing primary care. The model is viewed as a roadmap for becoming a sustainable high performing primary care organization.

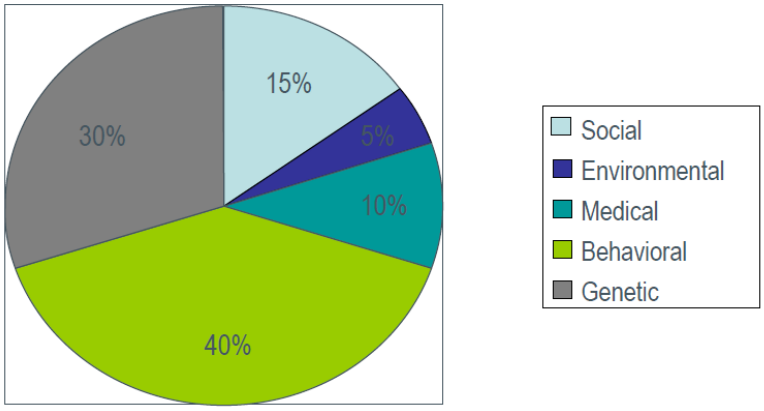
Block 6 uses teams to share the care to manage patient health needs within the clinic. There are 3 functions involved with population management: 1.panel management, 2. health coaching, and 3. complex care management. Registries are created and used to identify **care gaps** for groups of patients in the practice. This method allows the patient to receive more comprehensive care and health coaching to support patient behavior change.

Pathways to Improving Population Health

Health is affected by five factors – genetics, social circumstances, environmental exposures, behavioral patterns and health care. When it comes to reducing early deaths, medical care has a relatively minor role in improving the health of patients.

Determinants of Health and Their Contribution to Premature Death

Schroeder, NEJM 357; 12



Why Population Based Care Is Important to NCQA

The new standards have an emphasis on:

- Care management: Focus on high-needs populations. Expectation to address socioeconomic drivers of health and poorly controlled or complex conditions.
- Enhanced emphasis on team-based care: Collaboration with patients as part of the care team
- Alignment of improvement efforts with the Triple Aim: Practice must show that they are working to improve across all 3 domains of the Triple Aim.

NCQA's PCMH Standard 3: Population Health Management **(MUST PASS ELEMENT)**

- Intent of the entire standard is the practice uses health assessment and evidence-based decision support to complete patient information and clinical data to manage their entire patient population.
    1. Element 3A – Patient Information *(Capturing patient demographic information via electronic system)*
    2. Element 3B – Clinical Data *(Capturing patient clinical information via electronic system)*
    3. Comprehensive Health Assessment *(Identifying patient's health risks)*
    4. Use Data for Population Management *(Using the above 3 to proactively identify populations of patient to remind them of needed care)*

5. Implement Evidence-Based Decision Support *(Using tools to help manage the health of the patients identified in 4)*

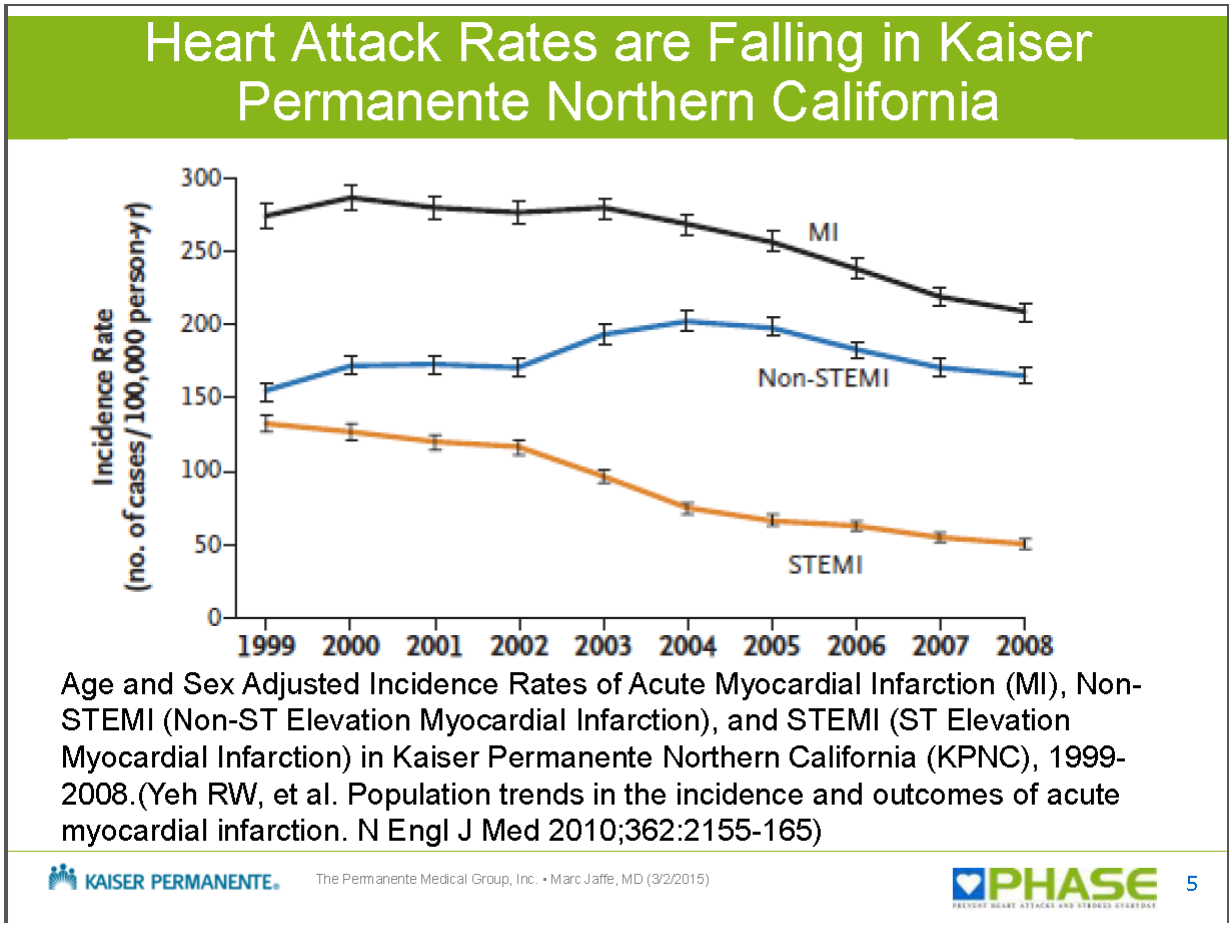
A Model for Population Health Management

Introduction to Preventing Heart Attacks and Stroke Everyday (PHASE)

The PHASE program has been in place in the Kaiser system since 2005. By creating a protocol for identifying and managing their patients at risk for cardiovascular events, and by tracking their management strategies, Kaiser was able to demonstrate a hugely significant decrease in the incidence of heart attack and stroke in their patients. The number needed to treat patients in order to prevent morbidity and mortality in the PHASE program is impressive and worth doing for all of our patients.

We are going to use the All Heart Phase program as an example of population health management for our consortium. We will be able to apply similar strategies to all future health improvement projects. (We will also be meeting PCMH 2014 standards for NCQA certification.)

- 1.Video: www.youtube.com/watch?v=Rz3V44Du2tQ



Team Charter

The Team Charter provides an initial orientation toward the activities of the team, that is, the design of a new process or an improvement of an existing process.
See Appendix A for Charter Tool

Introduction to Panel Management

What is panel management?

Panel management refers to the proactive way in which we do population-based care. First, patients who need care are identified and then steps are taken to address these needs. Electronic medical records (helpful, but not a requirement to do panel management) and patient registries are involved in the identification process.

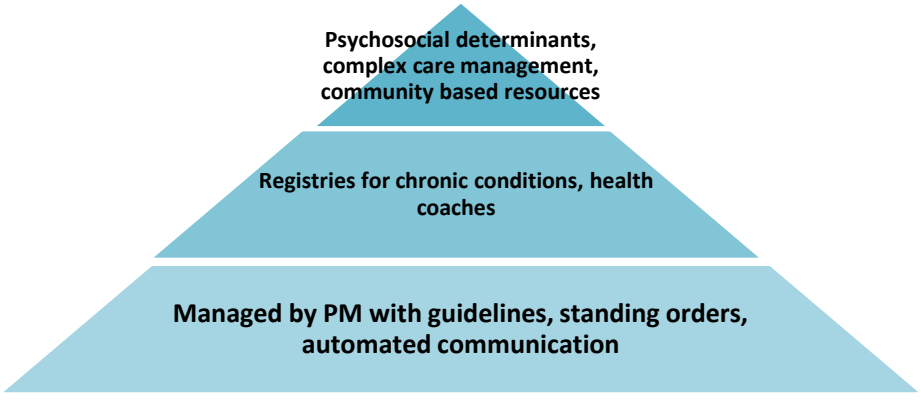
The Registry

The registry is a database that extracts patient health care information from health records. Effective panel management relies on the availability of accurate and complete information in a patient registry. The registry can be used to track patients assigned to providers, teams or a clinic. Searching the registry informs clinics about performance measures by identifying patients with care gaps:

- Patients who are overdue for mammograms, pap smears, HbA1c or LDL blood tests, or eye exams
- Patients who are not in control of HbA1c, LDL, or blood pressure
- Patients who need health coaching or more extensive planned visits with a RN or pharmacist.

Some information in a registry may be entered electronically from a laboratory or from the electronic medical record, for example, patient demographic information, diagnoses, and lab values such as HbA1c and LDL cholesterol. Other information may need to be entered by someone in the clinic, for example, blood pressure, weight, and BMI.

The Panel Pyramid



Base tier (largest): Managed by panel manager with guidelines, standing orders and automated communication.

Middle tier: Registries are used for chronic conditions and health coaches are utilized

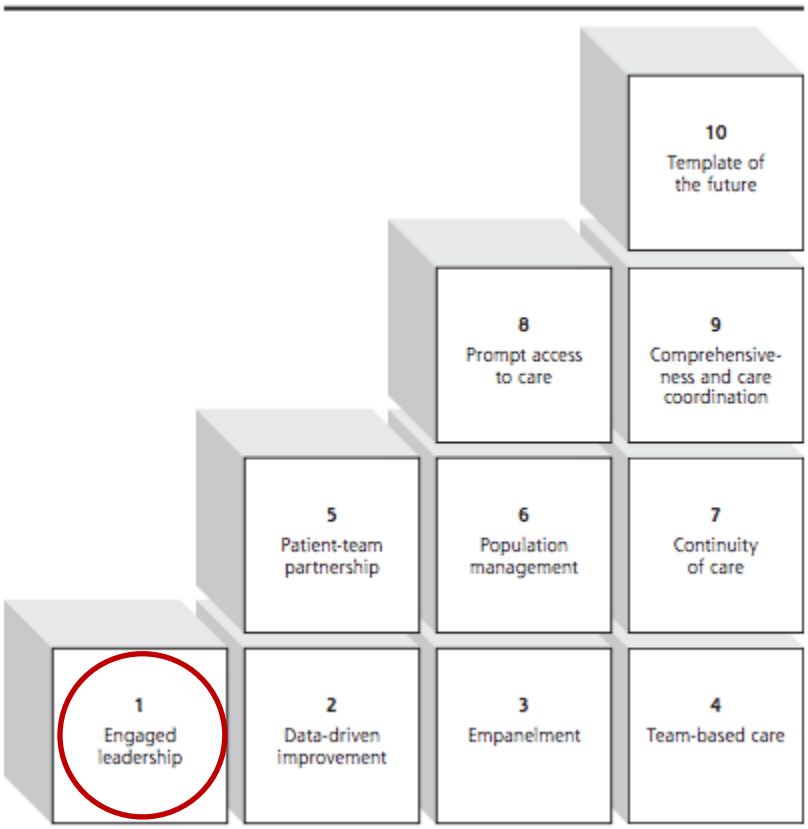
Top tier: Psychosocial determinants are evaluated, complex care management takes place and patients are linked to community based resources.

Care Team Coordination

How do we fit team-based care and care coordination into the clinic

Making teams work both for patients and for staff requires much more than co-locating a group and giving them a name like “Team 1” or “the Red Pod.” It requires changes to daily operations, like scheduling and visit planning. And, it requires changes in human resources policies, job descriptions, and performance expectations. It requires access to basic health information technology so that team members can truly share in the care for an established panel of patients. Choosing to organize a practice into teams requires senior leadership, buy-in, and real resources.

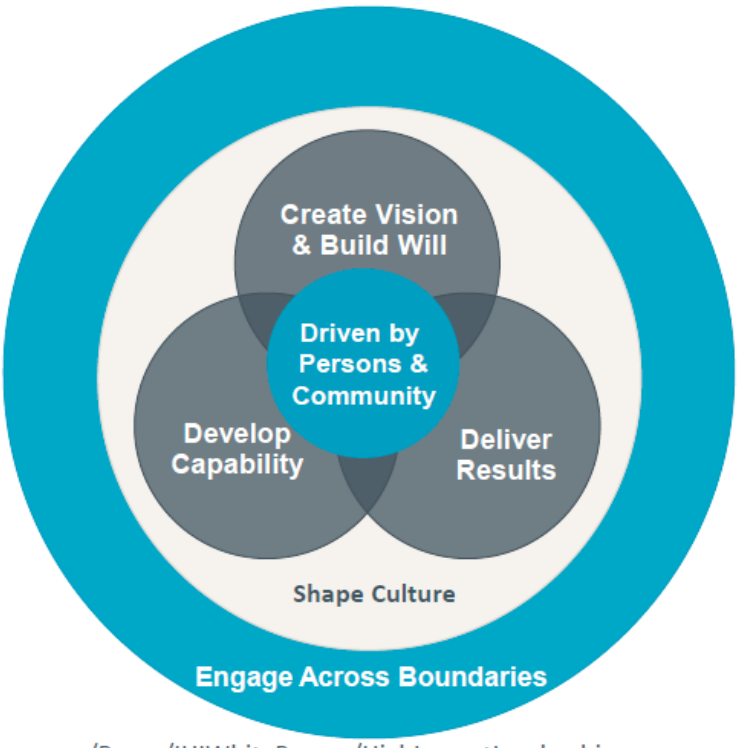
Ten Building Blocks of Primary Care



Source: *The 10 Building Blocks of High-Performing Primary Care: Thomas Bodenheimer, MD, Amireh Ghorob, MPH, Rachel Willard-Grace, MPH and Kevin Grumbach, MD*

High Impact Leadership Framework

This framework serves as a guide for where leaders need to focus efforts and resources in order to drive improvement and innovation. This framework adds three essential areas of leadership efforts: driven by persons and community; shape desired organizational culture; and engage across traditional boundaries of health care systems. Detailed information can be found at: http://www.ihi.org/resources/Pages/IHIWhitePapers/HighImpactLeadership.aspx



http://www.ihi.org/resources/Pages/IHIWhitePapers/HighImpactLeadership.aspx

Why Team Based Care Is Important to NCQA

The patient-centered medical home is a model of primary care that combines teamwork and information technology to improve care, improve patients' experience of care and reduce costs. Medical homes foster ongoing partnerships between patients and their personal clinicians, instead of approaching care as the sum of episodic office visits. Each patient's care is tended to by clinician-led care teams that coordinate treatments across the health care system. A growing preponderance of research confirms that medical homes can lead to higher quality, lower costs, and higher patient and provider satisfaction.

NCQA PCMH 2014 Standards 2D: The Practice Team

The practice uses a team to provide a range of patient care services by:

1. Defining roles for clinical and nonclinical team members.
2. Identifying the team structure and the staff who lead and sustain team based care.
3. Holding scheduled patient care team meetings or a structured communication process focused on individual patient care. **(CRITICAL FACTOR)**
4. Using standing orders for services
5. Training and assigning members of the care team to coordinate care for individual patients.
6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change.
7. Training and assigning members of the care team to manage the patient population.
8. Holding scheduled team meetings to address practice functioning.
9. Involving care team staff in the practice's performance evaluation and quality improvement activities.
10. Involving patients/families/caregivers in quality improvement activities or on the practice's advisory improvement activities or on the practices advisory council.

Models of Panel Management

There are two models of panel management

1. **Specialized Panel Manager Model:**
    a. One of two people, usually MA's, are trained to be full or half-time panel managers. During their panel management time they do not do medical assisting. The panel manager is responsible for panel managing all patients in the clinic
2. **Teamlet Model:**
    a. Every MA is trained as a panel manager and every MA spends part of their time doing panel management. Each clinician is paired with an MA – who is also a panel manager - in a 2 person team called a teamlet. The teamlet, not just the clinician, is responsible for a panel of patients. The responsibility of the MA/panel manager is to provide in-reach and out-reach only for that panel of patients.

Tasks that May be Assigned to a Panel Manager

- Enter data into the registry (like blood pressures) and keep the registry up to date
- Review the registry on a regular basis to identify patients with care gaps
- Call and send letters and lab slips to patients who need lab work done
- Make appointments for follow up, eye exams, mammograms, pap smears, etc.
- Work with clinicians to review patients' medications and contact patients to intensify medications based on the clinician's orders
- Identify patients who need lifestyle and medication counseling

Who can be a Panel Manager

Although many clinics have a registry available, often the registry is not used to its full capacity because there is not a dedicated person assigned to work the registry. Ideally, a clinic team member (for example, a medical assistant) is trained to be a Panel Manager. Panel managers should be given protected time to work the registry and review it on a regular basis in order to identify care gaps, enter data and to identify and contact patients who need care. To keep the registry up to date and registry searches accurate, the Panel Manager may be tasked with entering patient information such as blood pressure or weight.

Training Panel Managers

Training for Panel Managers should cover:

- Using the registry and running registry reports
- Tracking and reporting panel management efforts
- Identifying care gaps according to clinical guidelines
- Health coaching to close care gaps
- Identifying exception
- Protocols to handle exceptions, titrate medications, or other responsibilities as agreed upon by the clinic and the Panel Manager
- Outreach: making calls and writing and sending letters
- Making appointments and referrals

Identifying your Team

Team Composition

- Teams can be designed in a variety of ways depending on the size and needs of the patient population and the resources of the practice. Ideally, primary care practices should be structured to respond to all common problems for which their patients seek care. Since patient populations can vary substantially in age, gender, illness patterns, and social determinants, the composition of primary care teams must also vary. For instance, social issues may be more prevalent in some practices than others, indicating the need for a social worker be an every-day team member.
- However, there are some general principles which can be applied broadly. Most successful practices are organized around an accountable clinician (usually a physician or advanced registered nurse practitioner or physician assistant) and a medical assistant dyad that interact continuously throughout the day. The MA is generally responsible for preparing the visit (e.g., making sure that external medical records are available if care has been received elsewhere), checking-in and rooming patients, and ensuring post-visit tasks are completed and patients understand the follow-up plan. Other team members are usually responsible for providing self-management support (e.g., nurse or clinical pharmacist, or health educator) or arranging other resources (e.g., social worker).
- Regardless of team composition, care must be taken to keep the team size relatively small (fewer than five to seven members) because team functioning breaks down as teams grow. Other clinic staff members, including billing staff, receptionists, computer technicians, and laboratory personnel, complement the primary care teams. Each of these staff members can play important roles in ensuring strong trusting relationships between patients and their care team. For instance, receptionists can help ensure that patients see their chosen team, reach out to them when follow-up care is needed, and remind them to bring in medications.

Identify Care Team for PHASE Project

See Appendix B for worksheet

- Write up your team and roles. What tasks need to be done and who will do them? Include each staff position and describe their role.
- Identify any patient needs that are not yet accounted for by the team. Consider ways to leverage external/community resources.

It is important that team member roles and responsibilities be clearly defined and delineated so that key tasks are neither duplicated nor neglected, and so they are delivered by the person with the right skill set.

PHASE Registry Overview

The registry is a database that extracts patient health care information from health records. Effective panel management relies on the availability of accurate and complete information in a patient registry. The registry can be used to track patients assigned to providers, teams or a clinic. Searching the registry informs clinics about performance measures by identifying patients with care gaps. Some information in a registry may be entered electronically from a laboratory or from the electronic medical record, for example, patient demographic information, diagnoses, and lab values such as HbA1c and LDL cholesterol. Other information may need to be entered by someone in the clinic, for example, blood pressure, weight and BMI.

Appendix

Appendix A

Project Charter Template

Date: Project Name:
What is the objective of the program?
How will we know a change is an improvement?
What are we trying to accomplish (outcomes/goals)?
Measurements that will be affected and guideline source: Current Level 1. 2. 3.
What changes can we make that could result in improvement? 1. 2. 3.
Initial Activities/Cycles 1. Identify your program population 2. Who should be part of the project team and what are their roles? 3. Create the project registry: What data will you need for your registry? Are standing orders needed? 4. Project process map(s): How will this be incorporated into clinic flow? 5. In/outreach plan and supporting documents: What is your enrollment strategy for the patients? 6. 7. 8.
Clinical evidence for project (The Why):

Appendix B
Team Roster Handout

Potential Team Members	Contact	Team Role
1 Name: Title:	Phone: Email:	
2 Name: Title:	Phone: Email:	
3 Name: Title:	Phone: Email:	
4 Name: Title:	Phone: Email:	
5 Name: Title:	Phone: Email:	
6 Name: Title:	Phone: Email:	
7 Name: Title:	Phone: Email:	
8 Name: Title:	Phone: Email:	
9 Name: Title:	Phone: Email:	

*Please identify contact lead

Appendix C
Roles and Responsibilities of a Team during the Life of an Improvement Effort

Team Responsibilities	Team Member	Team Leader	Improvement Advisor	Subject Matter Expert	Management Sponsor
Using the charter	Accept and work toward the aim of the team	Keep the team meetings focused on charter	Use the charter to focus the team and give input to the team	Learn what the team is trying to accomplish	Work with team to reach consensus on the aim
Education and training for the team	Learn the model, tools, and teamwork principles; apply these methods and ideas	Communicate need for additional help	Teach or coach the team on improvement and teamwork methods	Assist with required education and training on the subject matter; help assess needs	Help supply resources (time, schedules, use of experts) for the team
Organizing and conducting effective meetings	Attend and participate in meetings; complete assigned tasks	Plan meetings; distribute agendas, minutes; conduct good meetings	Focus on the team decision-making process	Observe meetings and help leader and sponsor	Periodically, attend meetings and participate, if needed
Using the Plan-Do-Study-Act Cycle	Participate in planning, data collection, study, and action	Organize team activities and assignments using the cycle	Assist the team to collect and analyze data and run effective tests	Furnish knowledge about the change being tested	Allocate resources and remove barriers to help teams take action for improvement
Communicating the status and results of the team	Share experience with coworkers	Serve as liaison to others outside the team	Help leader and sponsor summarize status		Keep abreast of team progress and report status to management

Appendix D
PHASE PROJECT METRICS (DRAFT)

PHASE patient eligibility criteria: Adults 18 and over with a current or previous diagnosis of Coronary Artery Disease (Heart Disease), Diabetes Mellitus, TIA/ Cerebrovascular Accident (Stroke), Hypertension (HTN)

	Measure	Description
Demographic & Clinical Quality Measures	Enrollment in PHASE	Number/Percent of patients on PHASE protocols. A PHASE enrolled patient has been prescribed the PHASE medications and been referred to a health educator/coach
	Patient Demo-graphics	Age
		Race
		Gender
		Payer
	HbA1c Good Control	Number/Percent of PHASE enrollees with HbA1c < 8
	HbA1c Poor Control	Number/Percent of PHASE enrollees with HbA1c >9
	Lipid Control	Number/Percent of PHASE enrollees with most recent testing of LDL cholesterol ≤ 100 mg/dl.
	Blood Pressure Control	Number/Percent meeting HTN Guidelines < 140/90 mm Hg.
Lifestyle Quality Measures	Smoking Status	Smoking Status: Total number/Percent of PHASE enrollees who are current smokers
	Smoking Cessation	Number/Percent that have received counseling on smoking cessation
	Health Education	Number/Percent that have received education on lifestyles changes: 1) Exercise; 2) Diet; and 3) Weight Management
Medication Quality Measures	Aspirin Medication	Number/Percent of PHASE enrollees who have a current prescription for Aspirin.
	ACE/ARB Medication	Number/Percent of PHASE enrollees who have a current prescription for ACE/ARB.
	Statin Medication	Number/Percent of PHASE enrollees who have a current prescription for Statin.

Appendix E
Worksheet for Developing an Aim Statement

Definition

An Aim Statement is a written, measurable, and time-sensitive description of the accomplishments the Team expects to make from its improvement efforts. The Aim Statement answers the question: "What are we trying to accomplish?"

Critical Consideration

The Aim Statement should be developed with input from Senior Leadership to ensure support for the Team and alignment with the strategic goals of the organization. An organization will not improve without a clear and firm intention to do so. The performance goals should represent a challenge for the organization.

Aim Statement Components

The timeframe:

The clinical condition:

The measures:

The work:

The performance goals:

Surgical Care Improvement Project Example

During our participation in the 2008-09 Reducing Hospital Acquired Infections Collaborative, St. Elsewhere hospital will improve the care of our surgical patients. We will form an improvement team and focus on the aspects of care related to the national SCIP process of care measures. We will use the CMS and IHI change packages and ideas as resources. We will primarily use the John's Hopkins "4Es" approach to quality improvement and will conduct small-scale tests of change (PDSA cycles) with a limited number of care units/physicians at first, and then spread the successful change

strategies to the remainder of the care units/physicians. We will monitor and report monthly on our team activities, interventions, and quality measures progress. Our performance goals are 95% compliance with best clinical practice for all of the SCIP measures in all eligible patients.

Appendix F
Your Aim Statement

The timeframe:

The clinical condition:

The measures:

The work:

The performance goals:

Appendix G
Engaged Leadership Checklist

The table below lists ideas of activities to engage key change leaderships in a clinical setting

Engaged Leadership Key Changes	**Key Activities:** *Ideas for how to implement this key change*	**Examples of Activities that Have Been Tested**
EL-1A: Provide visible and sustained leadership to lead overall cultural change as well as specific strategies to improve quality and spread and sustain change.	**EL-1A-1:** Ensure executive and clinical leadership demonstrates "buy-in" to the PCMH model	-Educate, promote, and discuss the PCMH model frequently at a variety of organizational meetings, so that BOD members, providers, staff, and key partners are informed and activated -Incorporate PCMH goals into organizational compliance plan or link to incentive programs; if possible, redesign compensation or bonus structure to promote the PCMH model -Inform internal and external audiences about PCMH plans, innovations, and successes using a variety of formats, i.e. clinic newsletters, local newspapers, etc. -Be visible at provider and staff meetings to support the PCMH model and actively participate in PCMH/QI team meetings -Develop and implement a PCMH Leadership Committee, which may be composed of staff members from each care team or professional group (i.e. nurses, MAs, providers) -Set organizational priority to gain PCMH recognition by external entities, i.e., NCQA, state certification, etc. -Participate in regional, statewide, and national P4P programs -Integrate the PCMH model into the organizational mission and vision -Hire staff or volunteers to support PCMH, i.e., QI /PCMH manager, "panel" manager, patient greeter, etc.
	OTHER (Add Other Key Activities)	
EL-1B: Ensure that the PCMH transformation effort has the time and resources needed to be successful.	**EL-1B-1:** Identify a central PCMH implementation team that is made up of staff members representing a variety of roles, patients, and other stakeholders	-Develop management team "go and see" activities, i.e. weekly executive team rounds and daily site management team rounds -Discuss how the team will adapt to transitioning team members (i.e. departures and new additions); consider representation from every discipline -Include patients

	EL-1B-2: Ensure resources are available to staff for PCMH transformation	-Dedicate necessary resources, i.e., to support measurement, to facilitate communication about the PCMH model, to support team building -Establish expectations with timelines for PCMH practice priorities -Assess QI training needs and act upon results -Send staff to trainings or conferences to learn about aspects to PCMH, i.e., IHI Office Practice Summit
	OTHER (Add Other Key Activities)	
EL-1C: Ensure the providers and other care team members have protected time to conduct activities beyond direct patient care that are consistent with medical home model.	**EL-1C-1:** Protect time for planning and time for reviewing data	-Allocate time for PCMH/QI Planning -Develop "standard work" activities for site management teams which focus on process improvement and best practices, i.e. develop agreements on standard templates and consistent definitions across teams and/or sites -Share data with staff on a regular basis and allocate time for discussion -Schedule all meetings during the staff work hours instead of before or after clinic hours to allow the staff to attend and not add to their work day
	EL-1C-2: Engage team members in PCMH activities	-Use visual boards and team-specific data -PDSA binder in breakroom where staff can add ideas for change -Actively share best practices for PCMH implementation across teams and clinics -Provide opportunities for staff to identify opportunities for improvement and to define action plans, e.g. staff surveys, suggestion boxes -Restructure clinic leadership and accountabilities to guide transformation work
	OTHER (Add Other Key Activities)	
EL-1D: Build the practice's values on creating a medical home for patients into staff hiring and training processes.	**EL-1D-1:** Modify new hire and orientation process to embed PCMH values	-Incorporate vision of PCMH into staff, provider, patient, and BOD member orientation -Develop staff training modules for PCMH -Modify job descriptions -Identify mentors to support new and existing employees in learning PCMH change concepts -Develop orientation materials to use with new e-learning platform -Send staff to trainings or conferences to learn about aspects to PCMH, i.e., IHI Office Practice Summit
	EL-1D-2: Engage all staff in marketing PCMH	-Collect and share stories of how PCMH has positively impacted patients and patient care -2011 All Staff meetings focused on "Telling Our Story"
	OTHER (Add Other Key Activities)	