Inspiring Primary Care: Lessons From The Field

Maine Quality Counts
February 5, 2015
Objectives for this presentation

Objectives For CME:
• Understand key elements to successful optimization of teams in primary career
• Explore Strategies for developing and sustaining team resiliency and optimization
• Acknowledge crucial link between optimizing team-based care and delivery of effective care coordination

My personal objectives for today:
• To share my optimism about the vitality and health of primary care
• To focus on the innovations that are advancing that health and vitality and leading to better, safer, more patient satisfying care
• To identify strategies for these innovations—borrowing brilliant ideas, trial and error, exhausting all other solutions, and making changes stick.
Key Concepts For Today’s Talk

• Change begins at the frontline, clinical microsystem level—supported by experts in workflow redesign

• Data unites us, anecdotes inspire us, and workflows guide us

• We need to manage the space between visits, not just within visits

• By any means—delivering the health promotion/prevention intervention activities in primary care that our patients need

• Building community: face to face, electronically, and across practices: Everyone matters: the on-stage and the off-stage players
Elements of Transformation In Primary Care -

Innovation #1:
Health Insurance Coverage! Medicaid and QHPs

Innovation #2:
Team based care with defined roles and accountability

Innovation #3:
Fully integrated behavioral health and primary care

Innovation #4:
Actionable, data driven care and workflows

Innovation #5:
Clinical microsystem/mesosystem based performance improvement

Innovation #6:
Redefining the interface between primary and specialty care

Innovation #7:
Training the next generation of PCPs/Teams to a high performance model

Innovation #8:
Engaging people where they live/work/play/pray/study
Federally Qualified Health Centers (FQHCs)
• Nation’s largest safety net setting
• Located in designated high need communities
• Caring for more than 23 million patients annually
• More than 90% of Centers now on electronic records

CHC Profile:
• Founding Year - 1972
• Primary Care Hubs – 13; 218 sites
• Active patients; 130k
• on-site specialties: psychiatry, podiatry, chiropractic, dietetics
• Specialty access by e-Consult

Elements of Model
• Fully Integrated teams
• Fully integrated EMR
• PCMH Level 3
• SBHC and WYA programs

INNOVATIONS
• Postgraduate Training Programs
• Weitzman Research Institute
• National Cooperative Agreements

Foundational Pillars
1. Clinical Excellence
2. Research & Development
3. Training the Next Generation
CHC’s Educational, Technical & Innovation Projects

**CHC Projects:**
- ★ Residency Program
- Project ECHO®
- ▲ eConsults
The LEAP Project

The Primary Care Team: Learning from Effective Ambulatory Practices

Capturing and Sharing Innovative Practices in Primary Care Delivery

After a year of intensive, cross-country site visits to exemplary primary care practices, The Primary Care Team: Learning from Effective Ambulatory Practices (LEAP) project is exploring how those workforce models can be replicated and adopted by practices across the country. The LEAP project previously selected the 31 practice sites for their innovative workforce strategies. At a meeting in Seattle in late October 2013, leaders from all 31 sites convened to share best practices and lessons learned. The LEAP project is fostering a Learning Community of the sites, an online destination for others to converse and share best practices, and developing a toolkit to distill their invaluable insights for others’ use.

The “exemplar” practices represent a variety of settings, practice configurations, sizes and locations. They include private practices, large health systems, and community health centers; they represent 20 states; and they include settings as varied as rural Colorado, inner-city New York, and Portland, Ore.

In 2014, LEAP is hosting a six-part webinar series among the project’s participants to solicit more information on how to best utilize the primary care workforce. Topics will include ways that primary care can change the cultures of care in communities and practices dealing with issues of
The LEAP Project

- Identify innovative primary care practices that can serve as models for improving efficiency and quality of the healthcare workforce.
- Collect data on innovations and change processes, best practices
- Develop a toolkit for broad dissemination
- Create a learning community among exemplar sites
- Identify up to 30 exemplar sites
The LEAP Project

Identify innovative primary care practices that can serve as models for improving efficiency and quality of the healthcare workforce.

- Identify up to 30 exemplar sites
- Collect data on innovations and change processes, best practices
- Create a learning community among exemplar sites
- Develop a toolkit for broad dissemination
Major Findings from Site Visits

Sites have well-developed core teams surrounded by an extended team with care managers, pharmacists, behavioral health, etc.

Sites perform planned care, population management, care management, and medication management well.

Lay-persons and flow staff play key patient care roles in most practices.
Building a Primary Care Team

Learn how expanding roles, increased training and using standing orders can develop trust, teamwork and efficiencies in your practice.
“Every Patient has a Team!”
Care that is Comprehensive and Population Focused

- Medical
- Dental
- Prenatal
- Pharmacy
- Nursing
- BH

- Nutrition
- Diabetes education
- Chiropractic
- Podiatry
- Remote retinal screening
- MBMSR
The Components of Team Integration

- Leadership
- Workflow
- Data
- Pod
- People
Integration of Systems and Technology

Integrated Scheduling System

• Call any CHC number and connected to same scheduling agent
• Medical, dental, therapy and psychiatry services all scheduled through one system
• All Recalls visible at all points of contact

User Alerts

Before I assist you with your other item/Appointment I see you have some recalls – can we schedule you for these appointments today? PSA make note of recall appointment needed so you can book appointment

Megan Testnovo Recalls

Only Schedule highlighted recalls. Make sure to schedule on or after the due date.

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<th>Description</th>
<th>Recall Reason</th>
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<td>TEST *MED Rx Recall</td>
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</tr>
<tr>
<td>6/2/2015</td>
<td>*BH Recall Psychiatry</td>
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</table>

Patient Information

- Patient Name: Megan Testnovo
- Birth Date: 8/1/1990
- Age: 25 years old
- Patient Balance: $35.00
- Patient Id: 295134
- Frequent ER: Recent Hospitalization

Medical

- CHC Site: Middletown Medical
- PCP: Service MD, Kerian FP (F)
- Nurse: Caitlin Greenslade
- MA: Jariha Martinez
- Assign To: Caitlin Greenslade
- Last Physical: 3/16/2013

Behavioral Health

- CHC Site: Norwalk
- Therapist: Kathryn Carhart, PsyD
Integrated at the level of the pod, the data, the care, and the leadership
# Medical Assistants Planned Care Dashboard

<table>
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<tr>
<th>Patient</th>
<th>PCP Name</th>
<th>Adult Weight Screen and Edu</th>
<th>Smoker Intervention</th>
<th>Breast Cancer Screen</th>
<th>Cervical Cancer Screen</th>
<th>Colon Cancer Screen</th>
<th>Child Immun</th>
<th>DM A1c Control</th>
<th>Asthma Control Med</th>
<th>CAD Lipid Med</th>
<th>IVD Aspirin</th>
<th>HTN Control</th>
<th>Bubbles</th>
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<tbody>
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**Next Medical Appointment:** 1/21/2016 4:26:00 PM

**Last Dental Visit:** 9/3/2013

**Sex:**

**Age:**

**ALERTS**

- Needs Flu Vaccine 2015-2016
- Cervical Cancer Screening: Never Done, Never Done
- Smoking Assessment: Never Done, Never Done
- Body Mass Index: Never Done
- ACT: Never Done, Every Visit
- Chlamydia Screen: Never Done, Never Done
- Depression Screening: 7/21/2011, 7/21/2012
- HIV Screen Needed: Once, 13-64 yrs old
- SBIRT: Never Done, Yearly, 18+ yrs old

---

<table>
<thead>
<tr>
<th>Patient</th>
<th>PCP Name</th>
<th>Adult Weight Screen and Edu</th>
<th>Smoker Intervention</th>
<th>Breast Cancer Screen</th>
<th>Cervical Cancer Screen</th>
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<th>DM A1c Control</th>
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**Next Medical Appointment:** 1/21/2016 4:40:00 PM

**Last Dental Visit:** 6/11/2008

**Sex:**

**Age:**

**ALERTS**

- Breast Cancer Screening: 12/18/2013, 12/18/2014
- Body Mass Index: 12/30/2015, 28.41 Needs Education
- SBIRT: Never Done, Yearly, 18+ yrs old

---

**Last Date**

**Due Date**

**Value**

**Notes**

- Ordered in last 30 days
- Needs Education
- Yearly, 18+ yrs old
### Actionable Data Complex Care Dashboard

#### Care Coordination

**Borgonos MD, Ovanes-FP**

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### BH Dashboard

**Report Run Date 1/21/2016 10:24:22 AM**

**Patients seen in last 18 Months: 192**

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<th>Initial CarePlan</th>
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<th>Last Discharge</th>
<th>Last PHQ</th>
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<th>Fluoride Varnish due</th>
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**WHO Candidates for New London Medical**

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<tr>
<th>ControlNo</th>
<th>Appt Start</th>
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<th>Resource Name</th>
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<tbody>
<tr>
<td></td>
<td>10:00:00 AM</td>
<td>10:20:00 AM</td>
<td>Pens APRN, Diana FP</td>
<td>Arrived</td>
<td>BH Diagnosis</td>
</tr>
<tr>
<td></td>
<td>10:40:00 AM</td>
<td>11:00:00 AM</td>
<td>Smith MD, Stephen FP</td>
<td>Arrived</td>
<td>Last PHQ &gt;= 15</td>
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<td></td>
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<td>11:00:00 AM</td>
<td>Guarin APRN, Natalie FP</td>
<td>Scheduled</td>
<td>BH Diagnosis</td>
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<tr>
<td></td>
<td>11:00:00 AM</td>
<td>11:20:00 AM</td>
<td>Doenwalt MD, Hartmut-FP</td>
<td>Arrived</td>
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<tr>
<td></td>
<td>11:20:00 AM</td>
<td>11:40:00 AM</td>
<td>Ruiz MD, Alan FP</td>
<td>Scheduled</td>
<td>BH Diagnosis</td>
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## Integrating Care: Bringing Care to the Patient

![Image of care integration dashboard]

### Tillman Varnish Project

**Middletown**

10/7/2015

<table>
<thead>
<tr>
<th>Next Appt</th>
<th>Facility</th>
<th>Resource</th>
<th>Controlno</th>
<th>Age</th>
<th>Insurance</th>
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Integration of communication: internal consults

- Instant access to health services via messaging service while with patients facilitating:
  - Immediate and seamless warm-hand offs to BH
  - Transition to nursing for controlled substances
  - Transition to dental hygienist for dental treatment
  - Behavioral health crisis calls handled by large regional groups of providers
## Interdisciplinary Care Initiatives

<table>
<thead>
<tr>
<th>Initiative</th>
<th>BH</th>
<th>Medical</th>
<th>Nursing</th>
<th>Dental</th>
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Domains of RN Primary Care Nursing Practice

Essential member of the primary care team

(1) RN supports (2) primary care providers/panels

Key activities: pod/team nursing care, complex management, systems leadership

- Patient education and treatment within provider visits
- Independent Nurse Visits under standing orders
- Delegated provider follow up visits using order sets
- Self management goal setting and care management
- Care Coordination and complex care management
- Telephonic Advice and Triage via dedicated triage line
- QI/clinical microsystems leaders, coaches, and participants
- Leaders and participants in research
- Clinical mentoring of RNs, Medical Assistants, and students
RN Complex Care Management

- Comprehensive training for Complex Care Management (CCM)
  - Skills: Transition Care, Medication Reconciliation, Motivational Interviewing, Self Management Goal Setting
  - Content: CHF, DM, Asthma, COPD, HIV, Hep C
  - Support: Project ECHO Case-Based consults
  - Planning: Interdisciplinary with medical and behavioral health

- CCM Tools
  - Structured EHR Templates
  - Dashboards
  - Scorecard

- Community Engagement
  - partnerships
  - Agreements
Interdisciplinary Leadership

Clinical Chief positions are peers:

- Chief Behavioral Health Officer
- Chief Dental Officer
- Chief Medical Officer
- Chief Nursing Officer

Leadership Support

- Executive Mentoring
- Interdisciplinary Chief Meetings
- Leadership Meetings
- Integrated on-boarding of new clinicians
- Policy development that is interdisciplinary
- All clinical chiefs participate in major system redesigns
The Weitzman Institute

Committed to improving primary care for underserved populations by promoting research, training, education, and innovation
Moving Knowledge, Not Patients

- **Tele-health**

- **Project ECHO:**
  Provide ongoing case based learning and consultation with an expert, multidisciplinary team

- **eConsults:**
  Provide PCPs with access to quick, useful electronic consults from specialists
Community eConsults Network

Safety Net Connect Web Based eConsult Platform

Provider’s EHR
Sample eConsult
Dermatology

Primary Care Visit: New London, CT

Consultation: 3 months old with severe scalp seborrhea and symmetrically bright red ezematoid cheeks that she scratches, protected by gloves, and generalized body atopy. refer to be seen for management of severe apparent eczema/atopy.

- Option A: Refer to Dermatology (wait time 6-9 months)
- Option B: eConsult
eConsult Response
One Day Later

**Diagnosis:** seborrheic dermatitis and atopic dermatitis.

**Recommendation:**

**Scalp:** Dermasmoothe FS oil at bedtime under occlusion over night, wash off in the morning, daily for 3 days then 2-3x/week as needed.

**Rest of body:** Hydrocortisone cream 2.5% BID to all affected area with wet dressing: warm water bath, pat skin dry gently, apply HC 2.5% to affected area, then put on wet warm cotton pajama or towel over, wrap baby with warm dry blankets over, leave it on for 30-45mintutes, then take off wet wraps, apply moisturizer cream (Aveeno, CeraVe, Vanicream, etc.) all over. Start wet wraps daily for 3-5 days, when skin improving, use medicated cream BID while decrease wet wraps to 1-2 x/week as needed.
Cardiology eConsult – Six Month Cost Savings per 10,000 pts

<table>
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<th>Description</th>
<th>Value</th>
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<tbody>
<tr>
<td>Medicaid population in intervention group:</td>
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<tr>
<td>Average cost savings per patient</td>
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<td>PMPM Estimated Savings</td>
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Reduction in F2F Visits
ECHO/Collaborative Impact Model

Increase knowledge → Change practice → Improve Patient Outcomes
Using ECHO to tackle “Hot Spots”
Frontline Involvement In Transformation & Improvement: Clinical Microsystems

- Health Disparities
- Research
- Quality Improvement
- Coaching/Training

http://quality.chcl.com
Training the Next Generation

- Dedicated Education Unit for RNs
- Postgraduate residency training for new NPs and Clinical Psychologists
- Public Health Dental Residency
- National Cooperative Agreement
Starting in January 2016, the Community Health Center, Inc. is providing education, information, and training to interested health centers in:

Transforming Teams

- **National Webinars** on the team based care model
- Invited participation in **Learning Collaboratives** to launch team based care in your health center

Training the Next Generation

- Two **National Webinar** series on developing post-grad Nurse Practitioner and Postdoctoral Clinical Psychology residency programs and successfully hosting health professions students within health centers
- Invited participation in **Learning Collaboratives** to implement these programs at your health center

Want to participate?
Email your contact information to [nca@chc1.com](mailto:nca@chc1.com) and visit [www.chc1.com/NCA](http://www.chc1.com/NCA).
Conversations on Health Care® Past Episode

MONDAY, JANUARY 4, 2016

Jeff Williams, Chief Operating Officer of Apple

This week, hosts Mark Masselli and Margaret Flinter speak with Jeff Williams, Chief Operating Officer of Apple. Mr. Williams is in charge of the tech giant's entire distribution chain and is overseeing Apple’s foray into health care with the development of the Apple Watch, Apple HealthKit and ResearchKit, which are aimed at simplifying health and medical research by leveraging participation from Apple's 700 million users around the globe.

To download a full transcript of this episode click here.

Jeff Williams
Margaret Flinter, APRN, PhD, c-FNP, FAAN, FAANP
Senior VP and Clinical Director
Email: margaret@chcl.com
Tel: 860-852-0899