REDWOOD HEALTH COMMUNITY COALITION

Serving Sonoma, Napa, Marin & Yolo Counties

RCHC/RCCO

Sharing Promising Practices: Marin Community Clinics

Monthly Quality Improvement Activities

Categories: ☐ Clinical Practice ☒Operations ☐Compliance ☐ Finance

Aim:

To improve PHASE clinical quality measures (A1c, and BP control) through designating monthly QI time for care teams at all sites with a structured activity designed to improve population health management (usually panel management).

Target Population:

MCC health center patients with a special focus on PHASE eligible patients ages 18-75 (diagnosed with DM and/or ASCVD).

Promising Practice Overview:

Marin Community Clinics (MCC) schedules designated QI time for care teams at all clinics from 8:15-9:00 a.m. every second Wednesday of the month. The Medical Lead for Quality Improvement designs a population health activity for the adult and pediatric provider groups (sometimes women's health and OB groups as well). On the Tuesday before the scheduled QI time, relevant patient lists are uploaded to a shared drive and activity instructions are e-mailed to the providers, nurses and clinical leadership in case they would like to review the activity and/or get started early for the most ambitious team members. Providers and MAs are now accustomed to going to their e-mails and diving in to the activities during the designated time. MCC leadership encourages provider/MA teamlets to work together through their lists and involve the RNs, navigator teams, front office and other staffing groups as needed. The activity sheets include instructions for teams and outline expectations so that teams are using the same approach at the same time.

Measures:

MCC's clinical quality measures for diabetic patients (BP control and A1c control) improved from 2015 Q3 to 2017 Q2. MCC's clinic assessment results also demonstrated advancements in capacity to engage in team based care from baseline in November 2015.

Pre-existing infrastructure:

Prior to 2017, MCC did not provide protected QI time with planned population health management activities for clinical staff.

Changes:

Since establishing these monthly activities in January 2017, MCC's QI leadership has found that panel management activities are very high value, liked by providers and provide the QI department the ability to highlight priorities as they come up and change. For example, in the Spring, they took a break from PHASE and honed in on the QIP measures. This designated time has also facilitated sharing of best practices across sites. See the companion documents for examples of the activities.

Results:

MCC's clinical quality measures for PHASE improved since quarter 3 of 2015; improved 9% on controlled blood pressure for patients with hypertension from 69% in Q3 2015 to 78% in Q2 2017, improved 30% on controlled HgbA1c from 46% in 2015 Q3 to 76% in Q2 2017. Additionally, MCC's clinic assessments show an increase in capacity to engage in team-based care advancing towards the following: 1) non-physician care team members perform key clinical service roles that match their abilities and credentials, 2) providers and clinical support staff consistently work with the same provider/clinical support staff person almost every day.

Conclusions:

Providing protected and consistent QI time for providers and staff and designing structured population health management activities including the preparation of relevant patient lists creates a culture of QI, advances principles of team-based care, and provides team time to plan for outreaching and in-reaching patients overdue or not at goal. Structured activities allow MCC's QI department to focus on specific measures when needed, such as QIP measures during times of heightened activity.

Companion Documents:

Adult QI Panel Management Activity 1.2017
Pediatric Panel Management Asthma 2.2017
Women's Health Population Health Activity 2.2017
Pediatric Panel Management Activity 3.2017
Adult QI Panel Management 3.2017
Adult and Pediatrics QIP Activity 5.2017
Pediatrics Activity 6.2017
Adult Panel Management Activity 7.2017

Pediatric Panel Management Activity: Abnormal Weight Follow-up

March 8, 2017

This month's QI activity presents those patients in your panel whose last recorded BMI was =/>95%, who have not had a medical encounter in the past 3 months and do not have a visit scheduled within the next 4 weeks. In order to monitor progress and support patients and families, we aim for overweight and obese patients to have a visit to encourage healthy lifestyle changes periodically. For obese patients, this interval should be approximately every 3 months at maximum (see enclosed protocol). Periodic check-in can take many forms: Healthy Lifestyle Visit with PCP, RD visit or group nutrition visit, behavioral health visit, etc.

Activity:

Please review your list of patients that meet the above criteria. The attached report is sorted by PCP (see tabs at the bottom of the page). For each patient, decide on an action that is best suited to the patient. Some potential actions are listed below and can be performed with the help of your MA or RN:

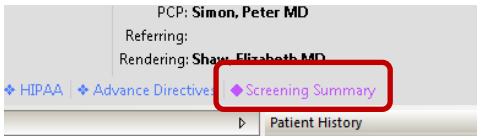
- Call parent to schedule a Healthy Lifestyle Visit (can task MA or FO)
    - Order labs and task MA to inform the family to have them done before the visit if needed
- Schedule for individual health educator, individual dietician counseling or in pediatric nutrition group (can task MA or RD)
- Mail a letter asking parent to call for a visit to check-in about weight and lifestyle. Consider enclosing a copy of the pediatric newsletter, The Upbeat Monthly. (Can draft letter and task HIMS to print and mail)
- Call parent to schedule a WCC (if last visit date was over 1 year ago, they are due)
- Refer to an outside program/agency

Hints/Notes:

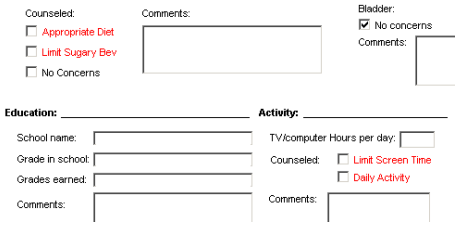
- Some providers lists are very LONG (especially those of well establish pediatricians). In this case, you will likely not be able to take action on every patient. Consider prioritizing based on age, BMI, date of last visit or by patients most familiar to you who you feel would be receptive to outreach or referral.
- Take note of the circumstances that lead to the patient being "lost to follow-up". Was a follow-up visit not scheduled, missed, cancelled, etc.? If you notice pattern of contributing factors, please share so that we can address systems issues and common challenges.
- While you are in patient charts, double check that obesity has been added to the chronic problem list and that obesity labs are up to date.
- Do you have a best practice that works well for your patients? Please share (email Dr. Shaw or Dr. Hessel)!!

- Please recall the following new(ish) features in NextGen to make documenting healthy lifestyle counseling in the EHR more streamlined. These features can be used for any visit type.

  - Distribution of the Pedi Nutrition Newsletter (Upbeat Monthly) can be documented by MAs and providers in the **Screening Summary** by checking the box next to "Nutrition Newsletter Given". This box will clear at every new encounter, but the date stamp in "Last Given" box will carry forward so that care teams can avoid handing out newsletters for the same month.



  - Nutrition and activity assessment and counseling can be documented in the **Peds Social Hx** template from the pediatric SOAP template



Please email questions/comments/feedback to eshaw@marinclinic.org

Adult Panel Management Activity

Wednesday, July 12, 2017

PHASE is back!!

We know you missed it so at long last, we are circling back to our PHASE panel management work this month. As a reminder, PHASE (Preventing Heart Attacks and Strokes Every Day) is a population health initiative aimed at making sure that our patients at highest risk for cardiovascular events get the evidence based care they need to prevent these events. Here are a few updates:

- Patient enrollment: PHASE enrollment is expanding to include ALL MCC patients, age 18-75, who are PHASE eligible. After 2 years of PHASE work, we are ready to offer the program to all of our eligible patients. This means that patients that have been individually removed from the program in the past will return. We believe that all patients, no matter how challenging, deserve the benefits of PHASE. Our panel management approach means that care teams can individualize the approach to patients based on their needs and preferences.
- Updated enrollment lists: Although we will resume our PHASE work, the official enrollment lists for provider are still in progress. We will notify care teams when the lists are finalized and available on the P-drive.
- Algorithm update: Attached is a newly revised DM management algorithm from RCHC. A revised "PHASE on a Page" algorithm is forthcoming.

Activity:

This month we will work on panel management for uncontrolled PHASE DM patients. Attached are lists of PHASE patients with most recent A1C >8. The lists are separated by site and are available on the P-drive as well at P:\PHASE\PHASE OUTREACH_RECALL MASTER LISTS\Uncontrolled A1C. Please review your list with your MA and make a plan to address these patients. Consider the following options:

- Schedule a follow-up appointment (task FO)
- Order updated labs (task MA or Care Navigator)
- Refer to Dietician or Health Educator
- Refer to DM classes in San Rafael
- Task RN for medication reconciliation
- Refer to stress management
- Refer to Care Navigation team for help with social variables (transportation, food access, etc)

Also take a look at BP control and whether appropriate patients are on the 3 core PHASE medications: ASA, Statin and ACEI/ARB

Happy PHASING!!

Please email quality@marinclinic.org with questions or comments

Adult QI Panel Management Activity

March 8, 2017

ACTIVITY: Continue work on outreach and panel management for PHASE patients. Updated PHASE Outreach lists for March can be found in the **P-drive PHASE folder** in the subfolder labelled "PHASE Outreach_Recall lists". Lists are separated by site and sorted by PCP.

a. A1C testing: Can be championed by MAs. MAs can order DM labs with standing orders and call patients to notify them. Patients w/o a visit in past 6 months should have a visit scheduled. Refer/enroll in our DM classes (especially if new dx, poor understanding of disease or near A1C goal). **Update: A "needs labs" letter is being added to the document library in the coming days. This generic letter can be mailed to patients along with printed lab orders when they are due and cannot be reached by phone. The letter asks patients to update their contact info if needed.**
b. HTN Management: Have FO schedule shared HTN visits for these patients. Titrate and bring patients back until they are at goal!! Alternatively, ask your Pod RN to call patients for a med compliance check-in and med reconciliation if you sense medication adherence is an issue.
c. A1C Control: Refer to DM classes, partner with your Pod RN to titrate insulin by phone or refer to RD. Also consider BH referrals or stress management classes.
d. Needs Statin: Included in this list is information on whether patients are taking ASA and an ACEI or ARB as well. Develop a plan to intervene on these patients and please share your successes!! **All PHASE patients should be on ASA, a moderate-high intensity statin and an ACEI/ARB unless contraindicated**

***Document your plans/interventions/outreach attempts in a communication labelled "PHASE" so that PHASE efforts can be easily identified and reviewed in the future

***__Hey NOVATO Care Teams__: Consider outreaching to your English-speaking PHASE patients for the Nutrition Orientation Group Visit, held on the 1st Wednesday of each month. Other sites, stayed tuned!!

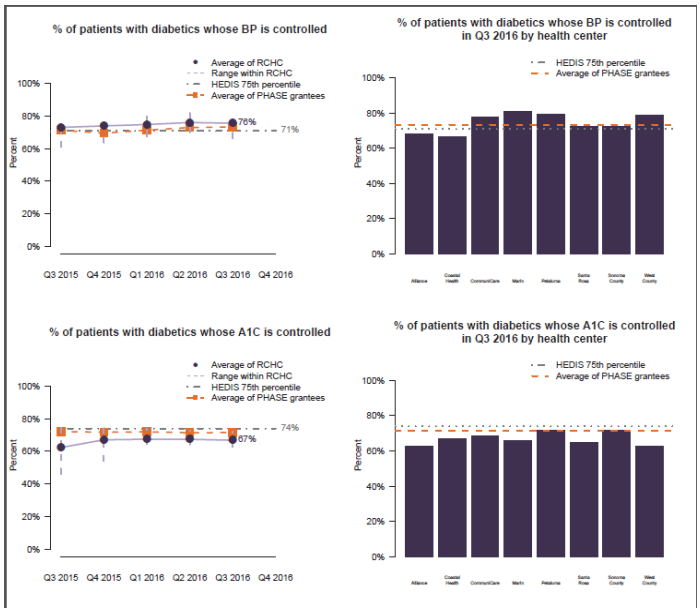
BEST PRACTICES FROM THE FIELD:

- Task yourself or your MA or RN from a patient's chart with a due date in the future as a reminder to follow-up an outreach call or check in on lab status, etc.
- Create your own patient lists in excel by copying and pasting your patients from the master lists. Save your personal lists in a folder on the P-Drive labelled with your name. Add a column or 2 for shared documentation (ex. Date 1st call made, 2 week fu done, etc) and access the list along with your care team to work on it together over time.

REMINDER: Patients are automatically removed from the PHASE program every quarter if they have an "Outside PCP" documented or they have not been in for a visit in >18 months. If you would like an individual patient removed sooner, please e-mail eshaw@marinclinic.org. Any enrollment changes will be reflected in the next month's outreach lists.

Adult QI Panel Management Activity: PHASE

Wednesday, January 11, 2017



BACKGROUND: We have made great strides toward achieving PHASE treatment goals for our patients at highest risk for heart attacks and strokes at MCC! Recently MCC was recognized by Redwood Community Health Coalition for achieving the highest rate of BP control among diabetic patients out of the eight local participating community health centers. WAY TO GO!!

Our next goal is to maintain our amazing efforts around HTN management while improving blood sugar control for our diabetic patients. As you can see, we fall in the middle of the pack for A1C control in diabetics when compared to our neighbors.

ACTIVITY: Outreach lists for PHASE patients needing A1C testing (no test in past 6 months) or improved A1C control (last A1C>8) have been updated and added to the PHASE folder in the P-drive. Lists can be found in the subfolder labelled "PHASE Outreach_Recall lists" and are separated by site and organized by PCP. Lists are also included in this email.

1. Care teams should review their "NeedsA1C" and "Uncontrolled A1C" January 2017 lists together. If you would like to modify or reformat the excel lists to make them more useful (i.e. add columns to track calls or interventions), please save a copy to your desktop or U-drive folder first.
2. Work together to strategize a care team approach to these two patient groups. See the attached sample workflow for A1C testing recall or develop your own strategy. For A1C Control, try to think beyond a one-size-fits-all appointment recall approach. The beauty of panel management is that you know these patients well! Consider the following steps in lieu of, or in addition to, an appointment.
    a. Refer/enroll in our DM classes (especially if new dx, poor understanding of disease or near A1C goal)
    b. Ask RN or MA to call patient to check on medication adherence (if patient has a pattern of non-adherence or other barriers to compliance)
    c. Ask your RN to titrate up qHS long acting insulin by 2-4 units weekly over the phone until patient achieves goal fasting blood sugars (requires regular FBS monitoring and logging by patients)
3. Document your plans/interventions/outreach attempts in a communication labelled "PHASE" so that PHASE efforts can be easily identified and reviewed in the future

Adult and Pediatrics QI Activity, May 10, 2017

QIP Panel Management

Adult and Pediatric Providers:

This month we will continue our work on QIP outreach (see attached QIP summary if you are still confused about what the QIP program is and why it's so important). When looking at the QIP outreach lists that are attached, keep in mind that these lists are posted on the P-drive by the QI department at the beginning of the QIP season to guide outreach. It is the responsibility of each individual site to update these lists as we march through the months leading up to the QIP deadline, June 30th. Some sites (ex. San Rafael) rarely update their QIP lists on the P-drive. In this case, it might be better to check in with your buddy or lead MA to ask for copies of the current list(s) they are using for QIP outreach. These may be saved on individual desktops or in paper form.

Please focus on the following topics this month:

- Colon Cancer Screening (**ADULT**): Please see the attached Colon Cancer Screening QIP Outreach list for your clinic site. This is a list of all of the patients we are focusing on for CCS QIP outreach. Notice that there may be helpful notes in the "Outreach" Columns about what has been done so far to communicate with these patients. Please talk to your MA about any additional outreach work that has happened that may not be reflected in the notes. (FYI, notes get updated in these "shared" QIP lists on the P-drive only periodically by the clinic PSC or lead MA. Many MAs keep their own paper lists as they work on outreach).
    - If there are patients you think might benefit from a reminder call from YOU, please plan to call them. These may be patients you saw recently and know have a FIT order pending. **A call from you, their PCP, may encourage them to complete the test** more promptly. Similarly you may see notes in the outreach comments for patients that have declined testing. Sometimes a phone call from their PCP can make these patient re-consider their decision to accept the test.
    - If there are patients on the list with upcoming appointments, make a pre-visit plan with your MA to take the following steps:
        - Order the FIT test and **DISTRIBUTE A FIT KIT WITH THE ORDER** during the visit.
        - Ask your MA to use the **MCC FIT brochures** (attached and available in the clinics) to explain the kit to the patient. Most MAs have been trained on FIT KIT health coaching. If your MA has not been trained or doesn't feel confident coaching patients about the FIT kit, please instruct them to contact their MA supervisor to arrange for training. If you need more brochures printed, please contact your clinic director or quality@marinclinic.org
        - Consider sending the patient home with a blue **"Get FIT" silicon bracelet** as a reminder to complete the test. Tell the patient to wear the bracelet until they complete and return their FIT Kit. Bracelets are also a good way to remind

patients who have a pending kit at home to complete and return it. Bracelets should be available somewhere in your clinic—they might be hiding! Ask your MA or clinic director to help you find them.

- If there are patients on your list that have had positive FIT tests in the past and have been referred to GI, please make plans to get the colonoscopy records or update the referral to GI. **DO NOT ORDER REPEAT FIT TESTS FOR PATIENTS WITH A POSITIVE FIT IN THE PAST.**

- Well Child Checks (**PEDI**): Please see the attached Well Check QIP Outreach list for your site. This is a list of all of the patients we are focusing on for WCC QIP Outreach. Notice that there may or may not be notes in the "Outreach" Columns about what has been done so far to communicate with these patients. Talk to your MA about any additional outreach work that has happened that may not be reflected in these notes. (FYI, notes get updated in these "shared" QIP lists on the P-drive only periodically by the clinic PSC or lead MA. Many MAs keep their own paper lists as they work on outreach).
  - First and foremost, **we recognize that ACCESS IS THE BIGGEST ISSUE** for this measure and that that is largely out of your control. Some sites are more impacted than others. If you are at an impacted site and would like to add a WCC clinic shift to a day you do or do not normally work, or a Saturday, please let your clinic director know. While appreciated, this is not required.
  - Other Panel Management Tactics:
    - **If you recognize patients that tend to no-show, or you know have barriers (transportation)**, on the list with upcoming appointments, consider calling them personally to encourage them to come to their WCC appointment and consider asking your navigator or MA to call about helping with transportation.
    - If you recognize patients on your list that you know have upcoming non-WCC appointments scheduled for simple issues, plan to complete the WCC at that upcoming visit.
  - Don't get discouraged! **Even if you can't schedule patients before June 30th, go ahead and schedule them at some point in the future**. The QIP program will be changing its submission deadline to January 1st starting in 2018, so these patients will count for our next QIP submission. In addition, it will help get these patients on a summer WCC schedule and summer tends to be a lower volume and higher access time for pediatrics historically.

Quality Improvement Activity

June 14, 2017

Pedi Providers:

Psst …have you seen the new Clinical Quality Dashboard?! Things look a little different this month, as we have retired some measures and added new ones. This month's activity is to become acquainted with the new dashboard and start to strategize around the new measures. The dashboard is attached. Here are the highlights:

- **A1C Testing has been removed**. (However, A1C testing continues to be reflected on the teamlet level A1C control dashboards.)
- **Breast Cancer Screening has been added** (i.e. mammogram q2 years, 50-74yo). This will become a Partnership QIP measure starting in 2018, so time to start focusing on improving our rates now. Please see the Adult/WH Activity for details.
- **Pediatric Abnormal Weight Assessment has been removed**. The MCC standard of addressing abnormal weight at every visit remains. Please continue to distribute the monthly Pedi newsletter, refer to the dietician (and the Eat, Play, Grow class in Novato), and refer back to the PCP when appropriate. Also, please document nutrition and physical activity counseling in the Pedi Social Hx template when you have discussed these items.
- **Childhood Immunization Status-Combo 3 has been added**. This is a current UDS measure and will be a Partnership QIP measure in 2018. This measure really raises the bar (or maybe the BARR;) for immunization rates. Requirement is for children to have received ALL of the following vaccines by their 2nd birthday: 4 Dtap, 3 IPV, 1 MMR, 3 HiB, 3 HepB, 1 VZV, 4 PCV, 1 HepA, 2 Rota, 2 Flu. This will require using every opportunity to give catch-up vaccines and keeping kids up to date with well child checks.

Pedi Activity: Review the new dashboard with your MA and Pod Teams and strategize about how to approach the new vaccine measures. A list of children who are not up-to-date with 4 Dtaps at 18 months (a proxy for children at risk for missing the full Combo 3 IZ measure at age 2) is attached to help you understand the volume of kids we are missing and to provide examples to peruse. The list is separated by site, organized by PCP. Here are some reminders and thinking points for guidance:

- Remember that the **expectation is to check for outstanding vaccine needs in NextGen, and CAIR if necessary, at EVERY VISIT**. When possible, catch-up vaccines should be given. At minimum, a follow-up appointment should be made for any outstanding vaccines and the reason they weren't given during the current visit should be documented
- **When the NextGen IZ record is not up-to-date with information from CAIR, that vaccine info must be manually entered into the NextGen Immunization template**. All of our reporting depends on NextGen, so if it happened but isn't documented in the EHR, we don't get credit! Make a plan TODAY with your MA and Pod team about how this should get done. Some options:
    - MA updates NextGen during Pre-visit prep

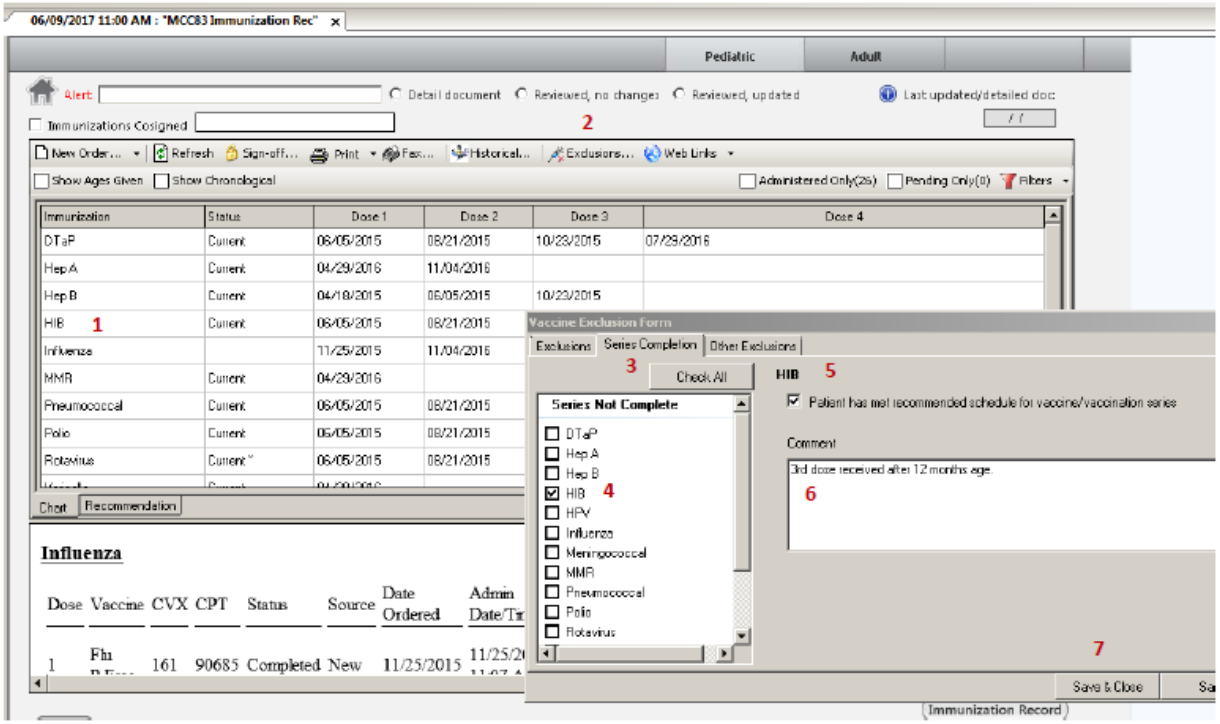
- MA updates NextGen during the visit
- CAIR reports that need to be manually entered into NextGen are collected by the MA or Pod and entered during down time.
- MA send themselves a task for patients that need IZs update in NextGen and enters the info during downtime.

- For **some patients who are on a catch up schedule, a 4th or even 3rd Hib and a 4th PCV is not recommended** – see CDC catch up schedule at link below.

https://www.cdc.gov/vaccines/schedules/hcp/imz/catchup.html

In this case, CAIR will be correct, not asking for additional doses. However, Next Gen will continue to show them as due. **You or your medical assistant can correct that in the Next Gen Immunizations Module:**

1. Click on the name of the vaccine in the grid.
2. Click on “exclusions” just above the grid.
3. Click on the tab “series completion”.
4. Check the box for the vaccine in question.
5. Check the box “patient has met recommended schedule for vaccine/vaccination series”.
6. Add a comment if you wish.
7. Save and Close



Pediatric Panel Management Activity: Asthma Diagnostic Accuracy

Wednesday, February 8, 2017

Background: Last month we worked on making our asthma diagnoses more specific and adding appropriate asthma diagnoses to our patients' problem lists in an attempt to more accurately identify our persistent asthmatics. In review, asthma management is a UDS measure for both adults and children:

> Percentage of patients 5-64 years of age with a diagnosis of persistent asthma and who were appropriately prescribed medication* during the measurement period.
>
> - Received a prescription for or were using an inhaled corticosteroid, or
> - Received a prescription for or were using an acceptable pharmacological agent, specifically inhaled steroid combinations, anti-asthmatic combinations, antibody inhibitor, leukotriene modifiers, mast cell stabilizers, or methylxanthines.

We also know that our persistent asthmatics are more susceptible to complications of influenza and that influenza activity this year has been very high.

Activity: This month we will do a panel management activity to review the charts of our persistent asthmatics. Attached is a report of pediatric patients aged 5-17 with a diagnosis of persistent asthma in their problem list (this report should be more accurate after last month's activity). The list is organized by pediatric provider. Please review the charts of your persistent asthmatic patients and ensure that each patient:

a. has a current prescription of a controller medication and a rescue medication, with a spacer or nebulizer if needed
b. has received a flu vaccine this season

Please make a plan to contact families of patients who need medications updated or flu shots. Interventions can be as simple as scheduling MA visits for flu vaccines, sending medication refills, or scheduling appointments to review asthma treatment plans. The purpose of panel management is to make individualized plans for the patients you know well.

Notes:

- This is a great time to review with your MA and care team what information to collect when rooming an asthmatic patient, tools to use to classify asthma (peak flow, Asthma Control Test, etc) and any brief health coaching topics that may be helpful with asthma patients (inhaler use, spacer use)

Women's Health Population Health Activity, February 8, 2017

Offering effective contraception is one of the key functions of our Women's Health program and we know that compared to short-acting methods, the long-acting reversible contraceptive (LARC) methods are far more effective and convenient for patients. Title X also recognizes the effectiveness of LARCs and tracks our LARC rates (see attached tables with methods broken down by site).

This month, we will begin planning and testing approaches to promote LARCs to MCC patients proactively. Attached and on the P-drive you will find a report of patients, organized by home clinic site, who have come in to receive a Depo-provera shot within the past month. These patients may be interested in LARCs given they are already receiving a hormone that is available in several LARCs (Mirena, Syla, Liletta, Nexplanon).

Please review the list and propose an idea to proactively contact some of these patients (contacting them all for this first pass is probably too ambitious) to offer a LARC method in lieu of their next depo injection. Contact can be made by phone, letter or portal and can involve your care team members. Some ideas might be offering appointments to discuss LARC methods, mailing info on LARCs to patients, planning education or health coaching on LARCs for the next Depo appointment or anything in between. You may decide to focus on patients that you think might be most receptive to a LARC based on age, etc.

To improve access for LARC placement, Campus Clinic has arranged 2 LARC only clinics in February:

-Friday 2/10 AM shift

-Friday 2/24 AM shift

To add patients to these shifts, please task the Campus GYN MA task group and they will schedule and confirm appointments

**These clinics should be reserved for patients who know they want a LARC method, not patients who need counseling only

Please pilot your idea with a small set of patients from your site (10-20) over the next month. Feel free to work together with other WH providers at your site and involve the care team if needed.

Approach this as a PDSA cycle. PDSA Observation sheets are attached to help with documentation.

Please keep any documents with PHI in a secure place in the clinic and plan to revisit your PDSA next month to review your progress.

Please document any outreach efforts made in patient charts using a communication titled "LARC Outreach". Consider reviewing Care Guidelines for any outstanding women's health maintenance needs before reaching out to patients as well.

BE CAUTIOUS WHEN OUTREACHING TO TEENS AS THEIR CONTRACEPTION USE MAY BE CONFIDENTIAL. CHECK THE STICKY NOTE FOR A CONFIDENTIAL NUMBER.

Please contact Dr. Shaw with questions/comments: eshaw@marinclinic.org