

Population Health Management

2017 Symposium on the Future of Complex Care

Gallery of Promising Practices

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H2QCS30258, Health Center Controlled Networks, for \$1,500,000. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Promising Practice Overview

Management of Assigned MediCal Members for Outreach and P4P program

Management of assigned members by the various health plans has been challenging because of the EHR lacks the functionality to manage members who are not fully registered. There is insufficient data in the healthplan member list to create a record, and adding people from the list who may never end up in clinic to the EHR creates unnecessary data that must be maintained for years.

The various P4P programs require matching the membership list to the program measures, and tracking clinical progress as well as outreach to members who have not established care with the clinics.

CommuniCare developed a database and app to manage these two related data needs. The ability to monitor outreach efforts and track progress on the P4P measures has been greatly improved.

Aim

Development of a population health management tool to streamline data management and optimize limited staff time in order to target outreach and patient care.

Outreach Tools

Outreach App - P4P Tracking View

Pap		Davis	Hansen	Salud	Grand Total
1	Denominator / Still Need	190	149	297	636
2	Numerator / Done	394	307	738	1439
3	Total Patients in Measure	584	456	1035	2075
4	Total % Screened	67.5%	67.3%	71.3%	Avg: 68.7%
5	Full Points Goal %	69.9%	69.9%	69.9%	69.9%
6	# Left in Need for Full Points	14	12	-15	11
7	Half Points Goal %	63.7%	63.7%	63.7%	63.7%
8	# Left in Need for Half Points	-22	-17	-79	-118

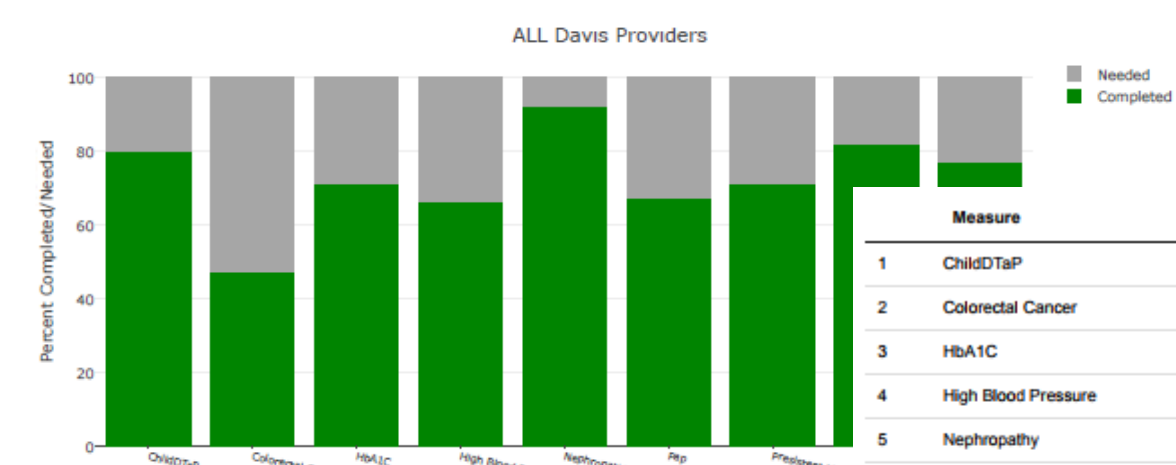
Outreach App - Upcoming Visits View

Last_Appt	Last_Appt_Type	Next_Appt	Next_Appt_Facility	Next_Appt_Start_Time	Pap	HbA1C	Retinal_Eye	High_BP	Persistent_Meds	Notes_and_Comments
2017-11-14	SAMEDAYAPP	2017-11-22	Davis Community Clinic	02:15 PM	Numerator		Denominator	Denominator		Appt 11/22/2017 with Dr. marci. notes added to CC-NAM 11/15/2017
2017-11-16	OB CPSPre	2017-11-22	Perinatal DCC	08:15 AM	Denominator					34 Wk Pregnant- Notes added to yellow sticky note for PN- NAM 11/07/2017
2016-12-30	Office Vis	2017-11-22	Davis Community Clinic	09:45 AM						CHDP appt with Dr. Soloniuk 11/22/17 notes added to CC-NAM 11/16/17
2017-10-04	DEN-EXAM	2017-11-22	Dental Davis Community Clinic	08:00 AM		Numerator	Numerator	Denominator	Numerator	BP uploaded by sayra - NAM 11/09/2017. referral started for Retinal eye 11/21/17- NAM 11/21/17
2017-11-21	OB CPSPre	2017-11-22	Perinatal DCC	03:30 PM	Denominator					Pap done 03/24/2017. uploaded 11/13/2017- NAM

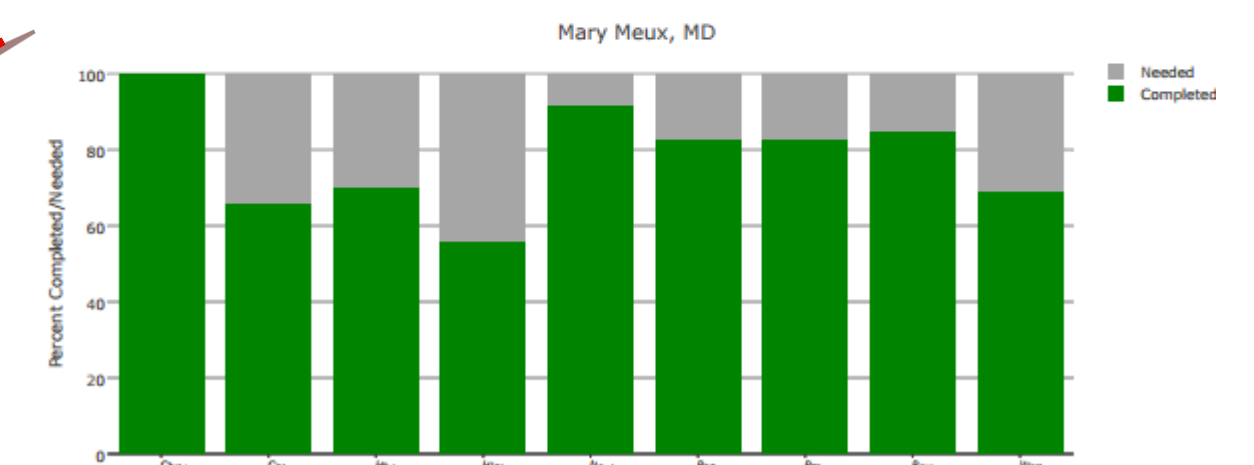
P4P Program Clinic and Provider Dashboards

Measure	Completed	Needed	Grand Total	Percent Completed
1 ChildTAP	49	12	61	80%
2 Colorectal Cancer	141	160	301	47%
3 HbA1C	72	30	102	71%
4 High Blood Pressure	63	32	95	66%
5 Nephropathy	94	8	102	92%
6 Pap	394	190	584	67%
7 Persistent Meds	60	25	85	71%
8 Retinal Eye	94	18	112	82%
9 Well Child	127	38	165	77%

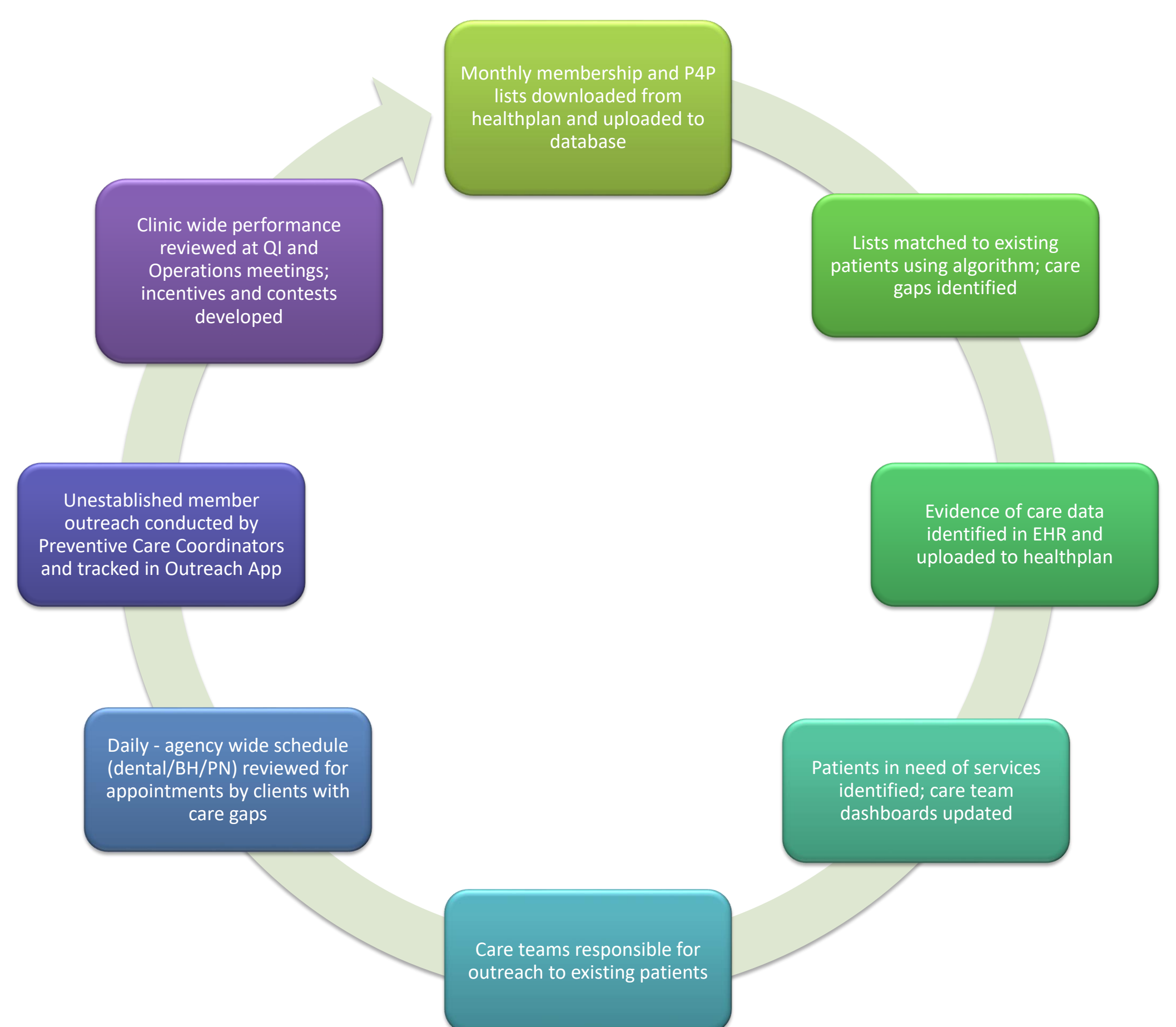
Clinic Dashboard



Provider Dashboard



Workflow



Results To Date

Improvement in ability to match healthplan assigned members to existing patients. Initial match of 60% now approaching 70% due to improved identification of patients. Significant improvement in performance on clinical quality measures.

Lessons Learned

- Availability of accurate and actionable data improves outcomes on quality metrics and patient care.
- Existing outreach measures (postcards, phone calls) ineffective. Need to develop more creative ways to connect with assigned patients.
- Unblinded provider and clinic level data spurs friendly competition.