Population Health for Front Line Providers: A data-driven approach to Quality Improvement

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December 6, 2018

Healthier Washington Practice Transformation Support Hub

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The Healthier Washington Practice Transformation Support Hub

- An investment of Healthier Washington managed by the Washington State Department of Health
- Helps practices successfully move to whole-person, patient-centered care

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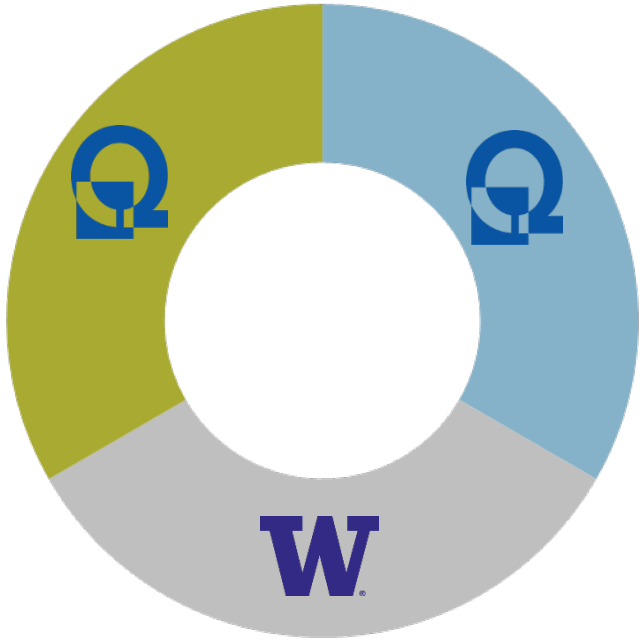
The Hub: A Four-year, State Innovation Model (SIM) Testing Grant

- Three separate contracts, funded by DOH
- Qualis Health provides Practice Coaches and Regional Connectors programs
- Web Resource Portal offered through partnership with UW Department of Family Medicine Primary Care Innovation Lab



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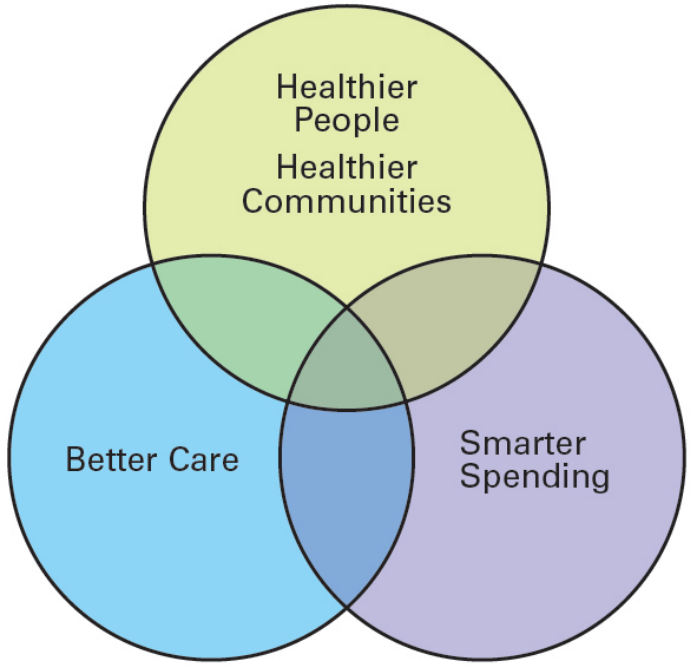
Hub Goals

Help Providers to:

- Integrate physical and behavioral health
- Move from volume-based to value-based care
- Improve population health through clinical and community linkages



Triple Aim

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Goals for this session

Understand how to use data to:

- Define a population and a quality aim for that population
- Measures gaps between current performance the goal for the population
- Design workflow changes to improve outcomes
- Evaluate whether those changes are actually working

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The Happy Valley Clinic Clinicians are not Happy

- 3 MDs, 2 NPs, & 1 PA face penalties for below average glycemic control, BP, and eye exams in adults with diabetes
- Provider meeting to decide on action
  - MAs call patients not seen in 6 months
  - Report showing our patients are sicker
  - Address co-morbidities including depression
  - More 1-hour planned diabetes visits
- Follow up meeting focuses on depression in diabetes – but that makes it seem overwhelming
- What is going on?

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Making Sense out of the Clinicians' Dilemma

- These are excellent clinicians providing high quality care in a difficult environment
  - Small-to-medium sized setting
  - Challenging patients
  - Changing incentive system
- They are "jumping to solutions"
- Each solution has arguments for & against
- The solutions tend to be provider-centric
- Although one could try any of the solutions it is unlikely that everyone would agree on whether it was a good idea or not

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A practice coach offers a way forward

- The clinic chief brings a practice coach with QI experience to the next meeting
- She offers a data-driven way forward and guidance to navigate this new terrain
- The group decides that depression in people with diabetes is the barrier they want to tackle to improve diabetes care and avoid financial penalties for poor outcomes

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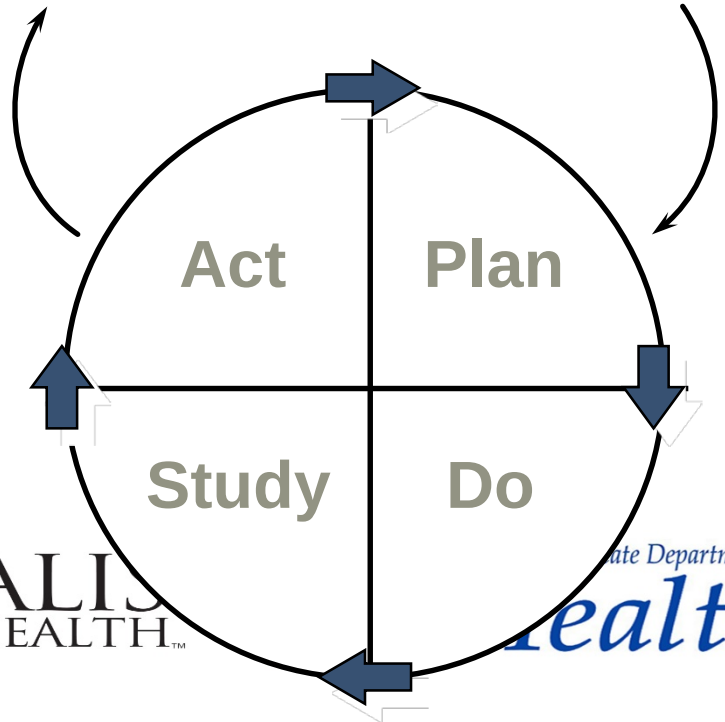
Model for Improvement

What are we trying to accomplish? — Aims

How will we know that a change is an improvement? — Measures

What change can we make that will result in improvement? — Change Ideas



The Improvement Guide: A Practical Approach to Enhancing Organizational Performance. G. Langley, K. Nolan, T. Nolan, C. Norman, L. Provost.

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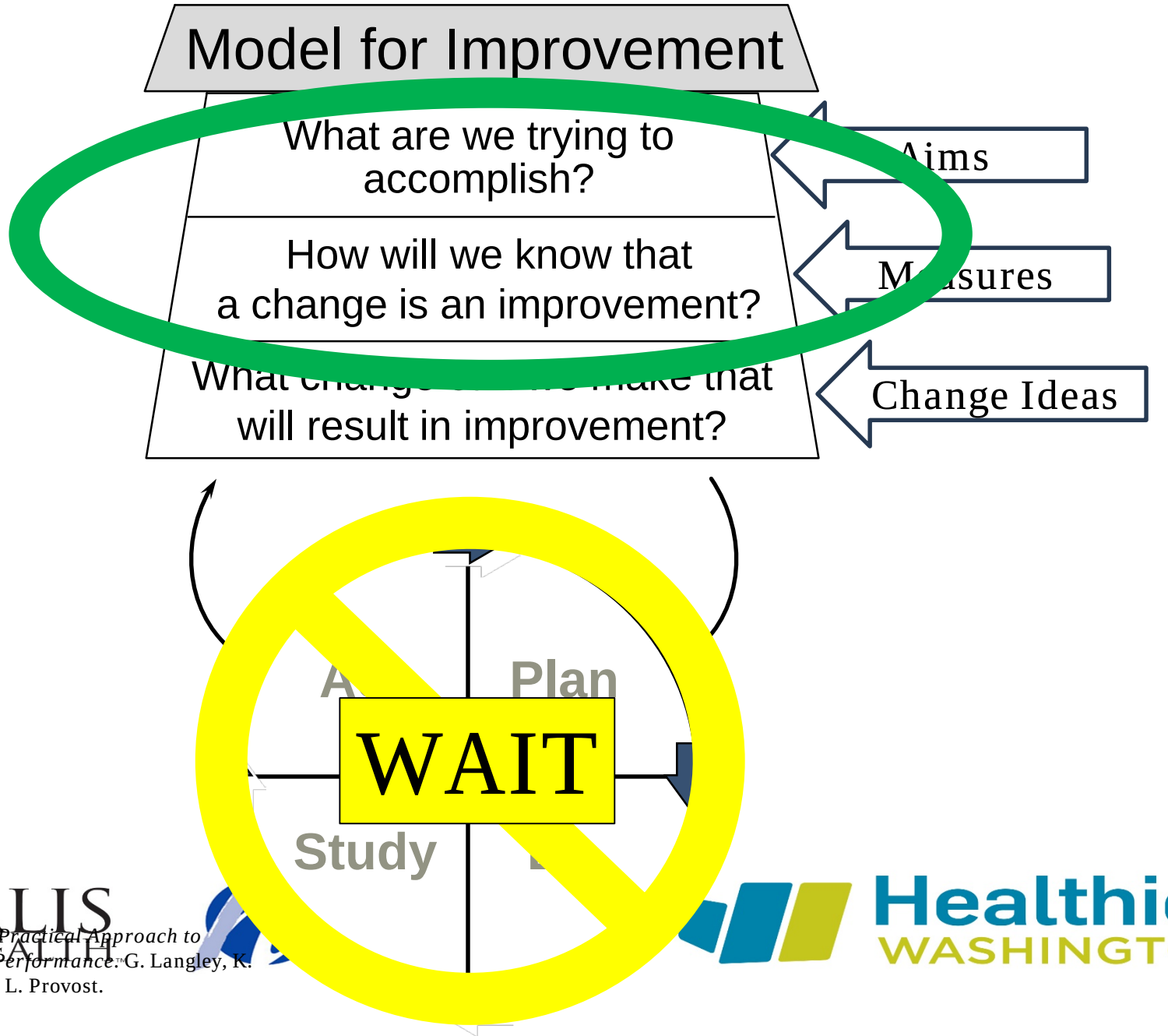

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What are we trying to accomplish?

- All diabetes patients will be evaluated yearly & treated to target for depression
- 70% of diabetes patients will have a BP < 140/90, HbA1c < 8, dilated retinal exam
- Data definitions:
  - "Patients with diabetes" – a list of people with diabetes on the problem list
  - Evaluated for depression: PHQ-2/9
  - Target for for depression treatment: PHQ-9 < 5, or 50%
  - BP, HbA1c, Dilated Retinal Exam using results reporting

Wait, you say. What if we're a BHA?

The aim statement will be different

- All of our diabetes patients will be evaluated yearly to makes sure
  - Every patient will have a primary care provider who is managing their diabetes
  - Every patient will have had a visit with their primary care provider in the past 6 months
  - > 70% will have a blood pressure < 140/90

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How will we know a change is an improvement?

Agreeing on an aim statement using data definitions makes measurement easier

Metric for Medicine: Percent of population with:

- PHQ-2/9 done in past year
- PHQ-9 < 10, < 5
- BP checked in the past 6 months
- BP < 140/90
- HbA1c checked in the past 6 months
- HbA1c < 9, or < 8
- Dilated retinal exam in the past year

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How will we know a change is an improvement?

Metric for Behavioral Health: Percent of population with:

- A primary care provider managing the diabetes
- A visit with the primary care provider within 6 months
- BP < 140/90

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How do we do that?

Registry options: (They're all imperfect)

- An Excel spreadsheet
- Patient List functionality in EHR exported to Excel
- Canned Reports from EHR (from vendor)
- Custom queries from EHR data
- 3rd party registry/business intelligence software from vendor such as PrimeMD, i2i, Crimson, etc

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What Information Does the Registry Contain?

- For Medicine:
  - Name of Patient & other identifiers
  - Date and value of last PHQ-2/9, BP, HbA1c, Dilated Retinal Exam, other diabetes tests
- For Behavioral Health
  - Name of Patient & other identifiers
  - Name of PCP/Clinic and date of last visit
  - Date and value of last BP

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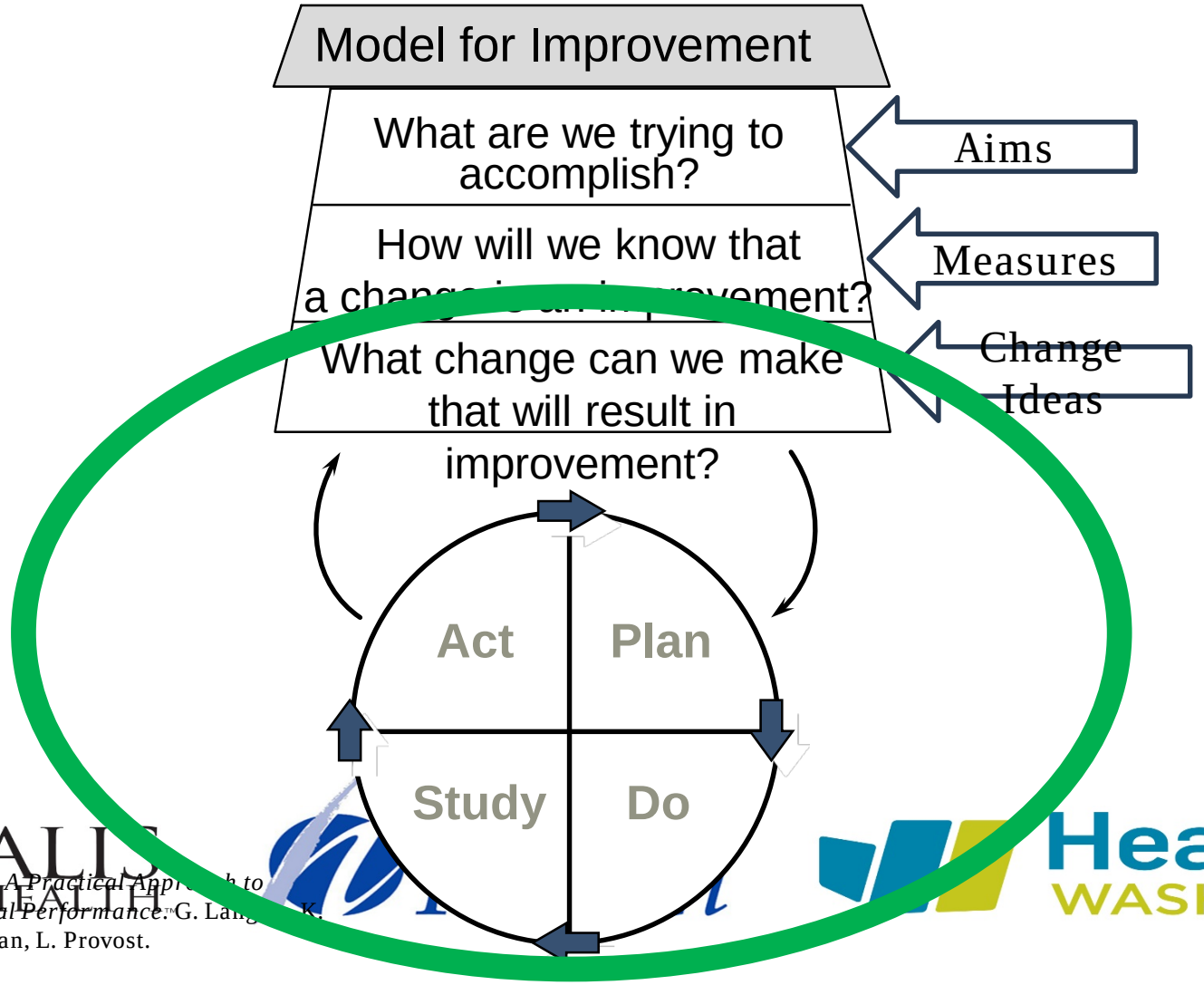
Now we can turn our attention to all those great ideas for things that may result in improvement



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Making changes that will result in improvement

- Workflow changes impact clinical decisions made for individual patients one at a time
- Data-driven workflow changes for improvement follow a set structure
  - Gathering data required to make a decision
  - Providing an evidence-based framework for the person making the decision
  - A standard approach to determine if the decision had the desired effect
- Notice we're not standardizing the decisions, just way they are made

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Adding Tasks to a Primary Care Workflow

- Step 1: Understand the current state workflow
- Step 2: Decide on the clinical decisions to be inserted into a future state
  - Necessary information for each decision
  - Necessary decision support for each decision
  - Follow up to gauge impact of individual decisions
- Step 3: Design future state to include
  - Who will gather/organize the necessary information
  - What the decision support needs are needed
  - How the follow up will be structured

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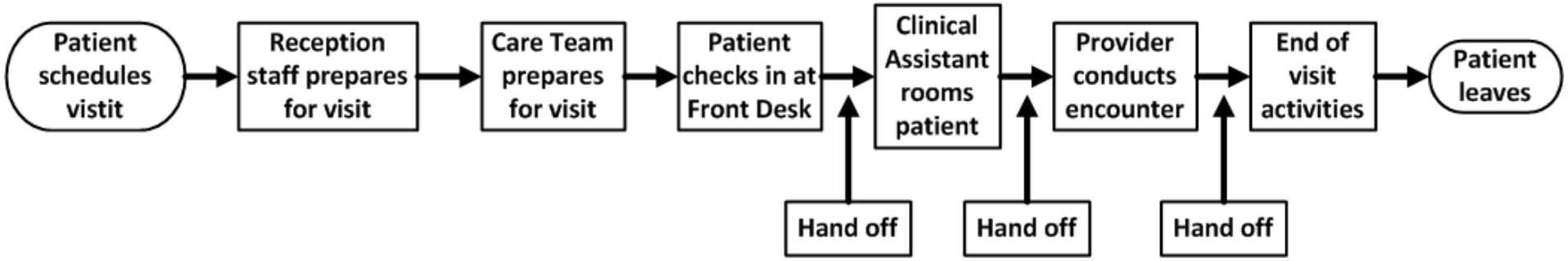
Current State



- All primary care visits follow this general framework
- There is a similar framework for behavioral health visits

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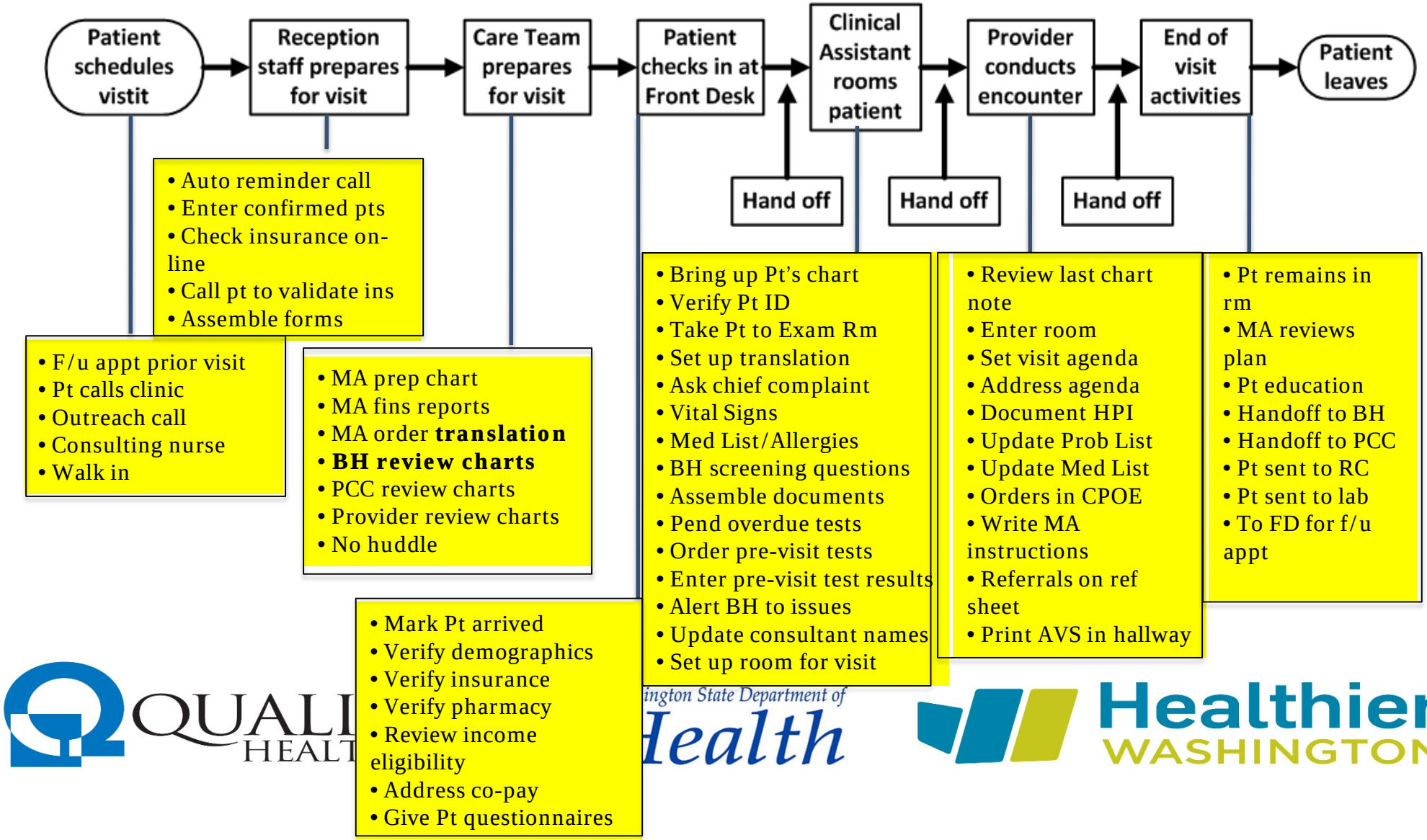
Current State



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Managing Depression in Adults with Diabetes

- Gathering information:
  - Identify patients with diabetes
  - Determine date and value of last screen
  - Perform screening if due
- Making an evidence-based decision:
  - PHQ-9 score today
  - Current and past treatment
  - Patient preference
- Follow-up:
  - Algorithm for phone/in-person follow up
  - Referral and referral tracking

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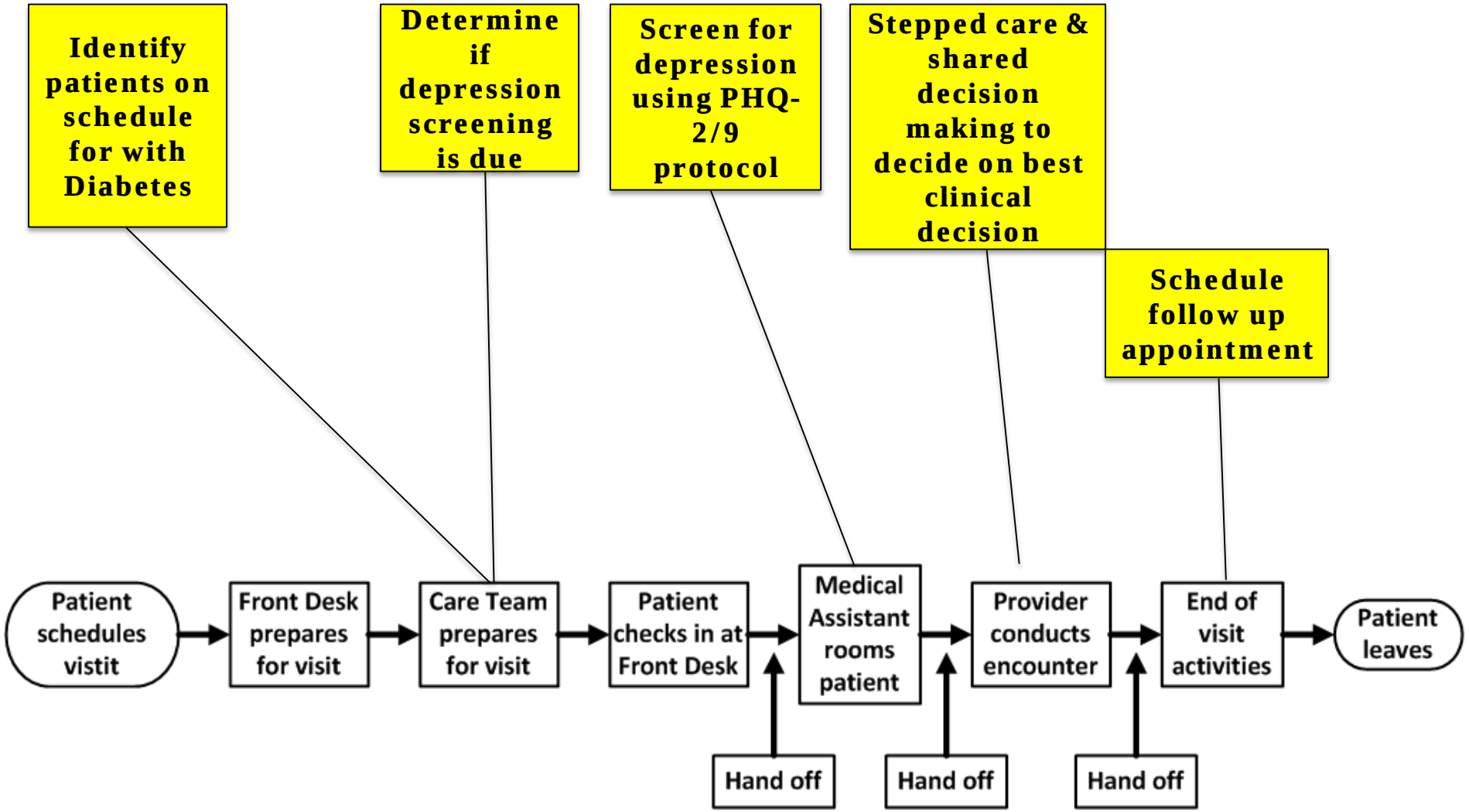

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How do you PDSA that?

- Pick a segment of the future state
- Identify the information required for decisions
  - Review list of patients on tomorrow's schedule
  - Scan problem list, med list, & labs each patient
  - View data display of past PHQ-2/9 dates & scores
- Flag chart if past PHQ-9 > 10; no screen 1 yr
- Try that for 1 day, and at the end of the day
  - Review how many charts were successfully flagged
  - Find out what went smoothly and what didn't
- Modify, repeat

Identify patients on schedule for with Diabetes

Determine if depression screening is due

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How did it go for the Clinicians at Happy Valley Clinic?

- They used a Patient List to dump into Excel every week
- They called patients who hadn't been in within 6 months and scheduled appointments
- They tested and adopted a future state workflow to screen all patients for depression
- Here is what happened over the next 6 months

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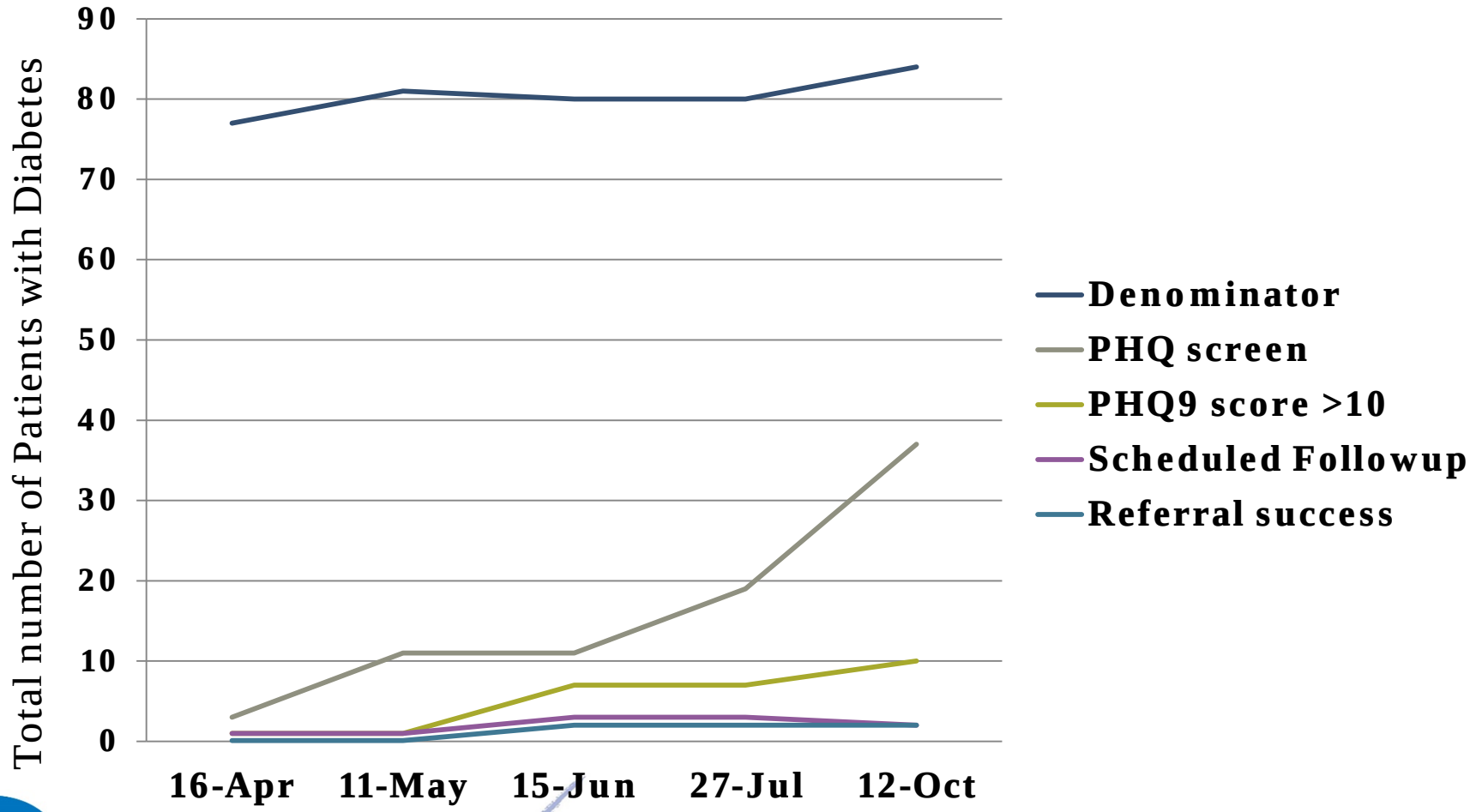
Improved Management of Depression



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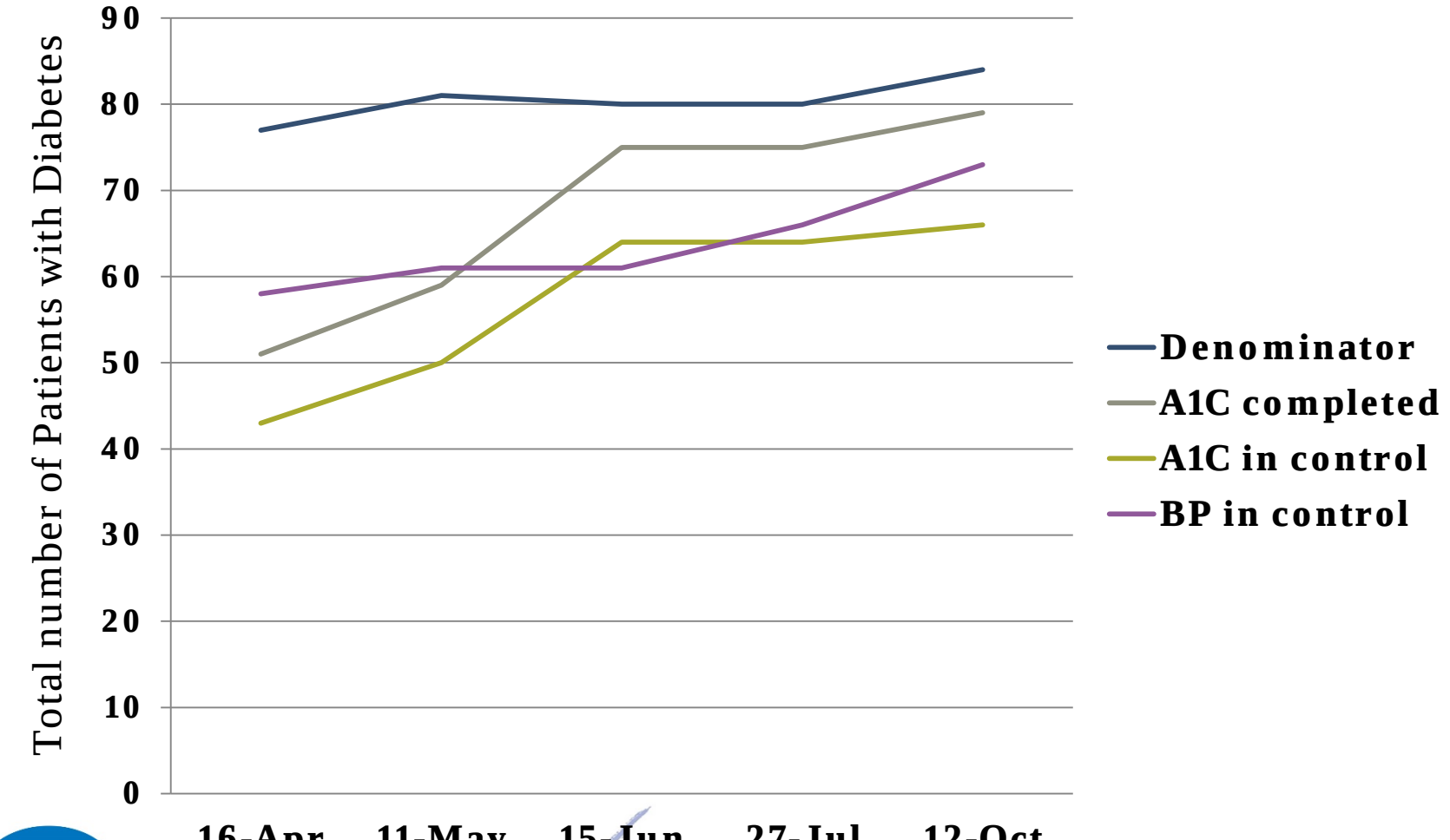
Improved Outcomes for Diabetes



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For Behavioral Health

- The approach will be set up the same
- Number of patients with diabetes
- Percent of patients who have a primary care provider managing the diabetes
- Number of patients with BP checked at last BH visit
- Percent of patients with a visit to the primary care provider within 6 months
- Percent of patients with most recent BP < 140/90

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Conclusion

- A structured data-driven approach to population health makes sense out of chaos
- The key components are:
  - A clear definition of the goal
  - Metrics that reflects things the care team can control
  - Workflow changes designed to support good decision-making process rather than specific decisions
  - Testing and modification to get it right

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Questions and Discussion

For More Information

Hub Help Desk: (206) 288-2540 or (800) 949-7536 ext. 2540 or by email HubHelpDesk@qualishealth.org.

Transformation training links and tools on the **Hub Resource Portal** website: www.waportal.org

The project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

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