Chronic Disease Management in Underserved Populations - Mission Impossible?

Jim Schultz, MD, MBA, FAAFP, DiMM
Chief Medical Officer
Neighborhood Healthcare
Escondido, California

LA University of Best Practices
August 2015
Audience Response

* Chose One:
  * A- UCLA
  * B- USC
  * C- Other
Evidence-based response

<table>
<thead>
<tr>
<th>Year</th>
<th>University</th>
<th>Rank</th>
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<tbody>
<tr>
<td>2012</td>
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<td>2014-15</td>
<td>UCLA</td>
<td>3-0 (LA)</td>
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Goals:

* To describe Community Health Centers in San Diego County

* To outline challenges to population health improvement and chronic disease management in CHCs

* To describe progress in CDM and PopHealth in SD County

* To outline the tools used by one CHC to improve CDM and PopHealth
Which EMR do you use for outpatient care?

1: EPIC
2: Cerner/Clarity
3: NextGen
4: Allscripts
5: Vista or Vista open source variation
6: eClinicalWorks
7: Other
Does your EMR have a usable registry function built in?

1: Yes
2: No
3: Unsure
Do you provide real time population or panel clinical quality data to your medical staff?

1: Yes, multiple measures
2: Yes, one or two measures
3: No
4: What are you smoking?
What percentage of the physician compensation is based on clinical quality metrics?

1: more than 50%
2: 25-50%
3: 10-25%
4: < 10%
5: 0%
Is providing real time actionable clinical data to your medical staff at the point of care a priority in your organization?

1: Yes, and it is happening
2: Yes, but unable to do it yet
3: Yes but searching for funding/ROI
4: No
5: What is that?
Community Health Centers in San Diego County- the ‘Safety Net’

- 17 not-for-profit private 501c3 organizations plus IHS
- >120 sites
- >900,000 patients served annually
- >2,000,000 encounters annually
- >650 Medical Staff
- No county hospital in SD
- No county (primary or specialty) clinics in SD
- Geographic managed care for MediCaid (6→8 Plans)
- Border county, 180,000 undocumented immigrants with no health insurance possibilities
Local SD Payer Environment

- PCP cap (in theory) for 80% of patients
- **PPS rate bottom line/per visit payment model**
- Lack of P4P (0.4% of budget at NHC)
- Lack of QM incentive
- Reducing hospitalization/ER→ saves money elsewhere
- Little knowledge of HEDIS among clinics or providers
- Data exchange for lab/encounter data an issue
  * Labcorp encounter data to health plan ~0
- UDS reporting
- ‘Messenger Model’ HMO contracting; 1 contract: 1 clinic
Council of Community Clinics

35 Years of Leadership to the Healthcare Community
CCC sites

CCC SERVICE AREA & CLINIC SITE LOCATIONS
Quality Work in CHCs
How does Quality happen in a CHC?

* Dedicated mission-driven medical staff
* Dedicated mission-driven frontline and back office staff- TEAM
* Finding innovative ways to get things done (that don’t cost a lot)
* Get a little help from your friends- Using other resources to fill the gaps
* Share selflessly, steal shamelessly (‘identify best practices’)
* Do the right thing AND doing things right (even if no business case)
Recent Council of Community Clinics Advances

- Pop-iq
- Beacon/SDHIE
- EMR adaptation
  - NextGen
  - eCW
  - Allscripts
  - OpenVista
  - Sage/Intergy/Greenway
Pop-iq: Org-level metrics
QM Department (Lynn Farrell, Nicole Howard, Eleanor Alcones, Henry Tuttle)
Grant writer
CCHN TSO
  * EMR hosting
  * Data support
  * SDHC/Beacon interface (HIE)
Council of Community Clinics

- ALLHeart as an example of consortium-level Quality Improvement effort
  - DM age 50+
  - Tracking:
    - ALL use (med bundle)
      - Rx, not dispensing data
    - Clinical measures:
      - BP, A1C test and results, Tobacco use/counselling, Self Management, LDL test and results, etc
    - No CV event data
  - Provider and staff education
  - Targeted interventions in select clinics of their own design
  - Kaiser Community Benefit funded
  - Followed ALL effort
“An aspirin a day will help prevent a heart attack if you have it for lunch instead of a cheeseburger.”
ALL HEART Clinics by County

Imperial County
- Clinicas de Salud del Pueblo

Los Angeles County
- Northeast Valley Health Corporation
- Eisner Pediatric & Family Medical Center
- Central City Community Health Center
  (Sites also in Orange County & Riverside)
- St. John’s Well Child
- South Central
- Valley Community Clinic

Riverside County
- Community Health Systems, Inc.
- Riverside County Clinics

San Diego County
- Imperial Beach Health Center
- Vista Community Clinic
- Neighborhood Healthcare
- North County Health Services
- San Ysidro Health Center
ALL HEART Patients to Date
ALLHEART Clinical Measures
July 2014 - June 2015
N=35,423

Adding new clinics/patients over time
Not a cohort of pts followed longitudinally
### ALLHeart Results - QI Project CHCs

<table>
<thead>
<tr>
<th></th>
<th>% Statin</th>
<th>% BP &lt;140/90</th>
<th>ACE/ARB</th>
<th>Statin &amp; ACE/ARB</th>
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<tbody>
<tr>
<td><strong>QI Project Clinics</strong></td>
<td>75%</td>
<td>74%</td>
<td>75%</td>
<td>60%</td>
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<tr>
<td><strong>Non QI Project Clinics</strong></td>
<td>54%</td>
<td>61%</td>
<td>68%</td>
<td>45%</td>
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<tr>
<td><strong>October 2013 Rept</strong></td>
<td>65%</td>
<td>52%</td>
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<td>45%</td>
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# Diabetes Population Blood Pressure < 140/90

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<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>0.00%</td>
<td>63.86%</td>
<td>66.57%</td>
<td>66.18%</td>
<td>71.30%</td>
<td>0.00%</td>
<td>0.00%</td>
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</table>

July 2014 – June 2015

N= 34,434

- **Network Goal**
- **HP 2010 Goal**
Hypertension patients in Control - Last BP < 140/90

JULY 1, 2014 – JUNE 30, 2015 HTN NETWORK

N= 55,425
HYPERTENSION CONTROL
DATA BY CLINIC ORGANIZATION-PopIQ or individual reports
Measurement Year : March 31, 2013 – February 28, 2014
N= 67,241
Pop-IQ

- Data aggregator/Reporting tool
- Disparate EMR data
- Down to site-level detail only
- Network tool as opposed to point of care tool
PopIQ: Data Analytics & Data Aggregation

Average HbA1c

- HbA1c < 7
- HbA1c > 9
- LDL < 100
- LDL > 130

Source: Aggregated data from 9 clinics from PopIQ Population Health Intelligence Tool
PopIQ: Hypertension, Blood Pressure < 140/90

Source: Comparison data from 9 clinics from PopIQ Population Health Intelligence Tool

HP2020 Target (61%)
PopIQ: Blood Pressure < 140/90, Diabetes

Source: Comparison data from 9 clinics from PopIQ Population Health Intelligence Tool
PopIQ: DM, Blood Pressure < 140/90

Source: ALL Heart Program comparison data from 9 clinics using PopIQ Population Health Intelligence Tool
DM, age >= 50, last BP < 140/90
Be There San Diego
Preventing Heart Attacks & Strokes

Heart Attack and Stroke Free Zone
What measures will be collecting for 2015-2016?

**Primary Measures**

- DM: BP < 140/90 mmHg
- CVD: BP < 140/90 mmHg
- HTN: BP < 140/90 mmHg

**Secondary Measures**

- DM: HbA1c I < 8.0%*
- DM: HbA1c ≥ 9.0%
- DM: LDL-C < 100 mg/dL
- CVD: LDL-C < 100 mg/dL

*Slide courtesy Allen Fremont, MD, Rand Corp*
Some measures will be stratified by age, gender, zip code in 2015-2016

<table>
<thead>
<tr>
<th>Measures</th>
<th>Patient Subgroups &amp; Stratification</th>
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</thead>
<tbody>
<tr>
<td>* DM: BP&lt;140/90 mmHg</td>
<td>➢ Age Group</td>
</tr>
<tr>
<td>* CVD: BP &lt;140/90 mmHg</td>
<td>□ 18 – 64 years old</td>
</tr>
<tr>
<td>* HTN: BP&lt;140/90 mmHg</td>
<td>□ 65 – 85 years old</td>
</tr>
<tr>
<td>* DM: LDL-C Control &lt;100 mg/dL</td>
<td>➢ Gender</td>
</tr>
<tr>
<td>* CVD: LDL-C &lt;100 mg/dL</td>
<td>□ Male</td>
</tr>
<tr>
<td></td>
<td>□ Female</td>
</tr>
<tr>
<td></td>
<td>➢ Zip Code (selected measures only)</td>
</tr>
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Estimated 2014 Blood Pressure Control Rates by Quarter & Group

Slide courtesy Allen Fremont, MD, Rand Corp
Estimated 2014 Blood Pressure Control Rates by Quarter & Insurance Type

Slide courtesy Allen Fremont, MD, Rand Corp
Estimated 2014 Patients with Newly Controlled Blood Pressure by Quarter & Insurance

Slide courtesy Allen Fremont, MD, Rand Corp
Estimated 2014 Pts w/ Blood Pressure Control

Slide courtesy Allen Fremont, MD, Rand Corp
Where we are now

- Quarterly or biannual reporting to BT team, fewer data gaps
  - Manual process, BT team requests, PGs prepare & send files
- Some comparisons of group performance & tracking of pooled results, comparability issues persist.
- Groups in process of implementing bundled therapy for Hypertensive & other CVD risk groups
- Obtained CMMI, CDC grants with some funds to upgrade data infrastructure!
Neighborhood Healthcare

2014 stats:
12 sites/2 counties
65,000 patients
245,000 visits
18000 BH only visits

>40 medical providers

9 primary care sites, all PCMH-accredited except new Menifee (5 with embedded BH; 1 rural with outside agency)

1 BH site- 4 Psychiatrists (2FP/Psy, 1 IM/Psy); 4 PhD, 2 ‘other’

3 dental site
New Menifee site 03/2014
* Private non-profit corporation, licensed by CA DHS
* Federally Qualified Health Center (‘FQHC’, ‘330’ clinic)
* Volunteer Board of Directors, consumer representation
* Discounted sliding fee scale for cash patients ($35)
* Evening and Saturday hours
* Employed MDs, NPs and PAs; dentists, psychiatrists, psychologists, psych NPs, midwives, 1 Chiropractor
* Staff cultural competence reflects patient demographics
* NCQA PCMH level 2/3
* Limited specialty care, no inpatient or SNF care

www.nhcare.org
NHC- Providing Quality Health Care Since 1969

- Medical, dental and behavioral health services to 65,000 people annually in 245,000 visits.
- 450+ employees, Annual Budget $48 million
- 100 full and part time clinical staff licensed/board-certified in family medicine, internal medicine, pediatrics, geriatrics, sports medicine, psychology, psychiatry, geropsych, general dentistry, pediatric dentistry, chiropractic and others.

www.nhcare.org
Neighborhood Healthcare
FY 2016 Budget -- Revenue by Category
TOTAL REVENUE = $49,676,159
(excludes revenue from capital)

- Medi-Cal: 65.1%
  - Medi-Cal = 17.8%
  - Mgd Care Medi-Cal = 47.3%
- Medicare: 6.6%
  - Medicare = 2.8%
  - Mgd Care Medicare = 3.8%
- Private Insurance: 0.4%
  - Private Insurance 0.2%
  - Mgd Care Commercial 0.1%
  - Mgd Care Covered CA $ 0.1%
- County, State, and Federal Grants & Contracts: 16.3%
- Contract Rx Program: 6.5%
- Other Income: 2.4%
- Sliding Scale Patient Payments: 1.5%
- Donations: 0.7%
Neighborhood Healthcare
FY 2016 – Patient Care Revenue
PATIENT CARE REVENUE = $37,613,809

- Medi-Cal: 85.9%
- Sliding Scale Patient Payments: 2.0%
- Medicare: 8.8%
- County, State, and Federal Grants & Contracts: 2.8%
- Private Insurance: 0.5%
- County, State, and Federal Grants & Contracts: 2.8%
Neighborhood Healthcare
FY 2016 Budget – Patient Visit Mix
PATIENT VISITS = 278,215
Neighborhood Healthcare

Expenses –
Patient Care vs. Administrative Support

Direct Services 83.4%

Administrative Costs 15.9%

Fundraising 0.7%
Setting the Stage: Quality CAN Happen

8/21/15:
DM with BP < 140/90: 83%
HTN with BP < 140/90: 77%
ALL: 66-75%
DM with A1c > 9: 12%
DM with A1c > 9 or not done: 22%
Breast Ca screen: 71%
Cervical Ca screen: 74%
Chronic Care Model (CCM)

- Health System
  - Clinical Information Systems
  - Decision Support
  - Delivery System Design
  - Self-Management Support

- Health Care Organization
  - Informed, Activated Patient
  - Prepared, Proactive Practice Team
  - Improved Outcomes
  - Productive Interactions

- Community
  - Resources & Policies

Slide from E. Wagner
CDM in Underserved - PCMH

The TransforMED Patient-Centered Model
A Medical Home for All

A continuous relationship with a personal physician coordinating care for both wellness and illness:
- Mindful clinician-patient communication: trust, respect, shared decision-making
  - Patient engagement
  - Provider/patient partnership
  - Culturally sensitive care
  - Continuous relationship
  - Whole person care

Practice-Based Care Team
- Provider leadership
- Shared vision and mission
- Effective communication
- Task designation by skillset
- Nurse Practitioner/Physician Assistant
- Patient participation
- Family involvement options

Practice-Based Services
- Comprehensive care for both acute & chronic conditions
- Prevention screening and services
- Surgical procedures
- Ancillary therapeutic and support services
- Ancillary diagnostic services

Practice Management
- Cost/Benefit decision-making
- Revenue enhancement
- Optimized coding & billing
- Personnel/HR management
- Facilities management
- Optimized office design/redesign
- Change management

Care Coordination
- Community-based resources
- Collaborative relationships
  - Emergency Room
  - Hospital care
  - Behavioral health care
  - Maternal care
  - Pediatric care
  - Pharmacy
  - Case Management
  - Care Transition

Health Information Technology
- Electronic medical records
- Patient access to information
- Disease management
- Population-based disease management
- Population health management registry
- Practice Web site

Quality and Safety
- Evidence-based best practices
- Medication management
- Patient satisfaction feedback
- Clinical outcomes analysis
- Quality improvement
- Risk management
- Regulatory compliance

Find out more at www.TransforMED.com
How to get better population quality?

* Workflow changes
* Adequate support staff (number, quality, training)
* Innovation (NHC=‘Mikey’)
* Ruthless removal of ‘tasks below license’
* Data:
  * Credible
  * Actionable
  * To the right people
  * At the right time
* Accountability/Individual Reward- ‘Future State’
How to get better population quality?

* **Workflow changes**
  * Adequate support staff (number, quality, training)
  * Innovation Ruthless removal of ‘tasks below license’
  * Data:
    * Credible
    * Actionable
    * To the right people
    * At the right time
NHC QM Efforts- Workflow changes

- Pt Flow redesign
- Project Dulce- intensive RN CDE-led diabetes management program, inception 2000
- Dulce group medical appts
  - pain mgmt groups, asthma groups
- Disparities collaborative (depression screen and rx)
- BH integration
- EHR 2010
- PCMH, MU
- AllHeart→ ALL (Kaiser grant through CCC)
Workflow changes: Pt flow redesign

- Roger Coleman and Associates
- Eliminate unnecessary steps in workflow based on data and ‘value-added’ concept
- Patient-centered- bring services to the patient vs. assembly-line model (7-9 stops → 4 stops)
- Rapid cycle improvement/PDSA model of rapid change
- 2 MAs per fte MD or NP/PA
- Huddles/pre-visit planning
- Results:
  - Cycle time
    - 114 → 47 minutes scheduled
    - 144 → 67 minutes walkin
  - Improved patient satisfaction
Workflow changes:
Individual Reports - Huddles
How to get better population quality?- Support Staff

* Workflow changes
* Adequate support staff (number, quality, training)
  * 2 MAs: 1 MD
  * Team: MD or NP/PA; 2 MA; part of RN or MA Panel Manager; part of Referral Coordinator (MA-level); part of PSR
* Pharmacy MTM:
  * Complex pts
  * Polypharmacy
  * Hospital follow up
  * Adherence issues
* Experimenting with: Team= 1 MD, 3 mids, 7 MA, RN Panel Manager
* Innovation
* Ruthless removal of ‘tasks below license’
* Data:
  * Credible
  * Actionable
  * To the right people
  * At the right time
How to get better population quality? - Innovation

- Workflow changes
- Adequate support staff (number, quality, training)

* Innovation
  * And leveraging others’ innovations
  * Ruthless removal of ‘tasks below license’
  * Data:
    * Credible
    * Actionable
    * To the right people
    * At the right time
Innovation: Project Dulce

* RN CDE-led chronic disease management program

* Key features:
  * Started ~1999 with Dr. Nick/ECC
  * RN-led
  * BH available
  * MD/NP/PA involvement on med changes/lab interpretation/exam
  * Self management skills
  * Patient education and activation
  * Care coordination (scheduling, labs, referrals, PCP consultation, foot exams)
  * Proactive office encounter (huddles, previsit planning)
  * **Single stable point of contact (health coach) for the patient**
Cost savings estimates for Dulce Model: (~$/QALY, 2006 $)

- **Uninsured:** $10,000
- **County Medical Services:** $25,000
- **Medicaid:** $45,000
- **Commercial:** $70,000

*Health Services Research: Health Research and Educational Trust*

DOI: 10.1111/j.1475-6773.2007.00701.x

HbA1c Prior to Dulce 1:1 (n=78)
HbA1c Prior to GMV (n=78; p<0.001)
HbA1c after 6 months (n=55; p<0.05)
HbA1c after 12 months (n=55, p<0.05)
HbA1c after 18 months (n=24; p<0.05)
HbA1c after 24 months (n=22; p<0.05)
Innovation

George Hayes, CRR - Scripps Whittier Institute

Primary Care retinal photography
How to get better population quality? **DATA!!!!**

- Workflow changes
- Adequate support staff (number, quality, training)
- Innovation
- Ruthless removal of ‘tasks below license’

**Data:**
- Credible
- Actionable
- To the right people
- At the right time
NHC Data Journey: EMR

- 2010 implementation of eClinicalWorks (eCW)

- Data lag: 1 year +
- Validation period: 1 year +
- Registry function
  - BridgeIT
  - Home-grown registry
  - **eCW alerts:** point-of-service data with low annoyance quotient
  - i2i
5 stages of grief (Kubler-Ross):

- **Denial** - ‘the data are wrong’; ‘it’s not my patients’
  - Remedy: only show good easily-verifiable data

- **Anger** - ‘damn you, they aren’t my pts’; ‘I don’t practice cookbook medicine’;
  - Remedy: only show good easily-verifiable data

- **Bargaining** - ‘if I had some help on this’; ‘my pts are the sickest so of course my numbers are bad’; ‘I get all the new out-of-control pts’
  - Remedy: good data with good benchmarks- local and regional/national, similar practices eg. CHC vs. CHC

- **Depression** - ‘boy I really suck’; ‘my system is set up to sabatoge me’; ‘my MAs are no bueno’
  - Remedy: give tools and workflow changes that make doing the right thing easy; get help at appropriate license level; don’t penalize right away for poor performance

- **Acceptance** - ‘ok how do we make it better’; ‘MAs, let’s be the top by the end of the month’
  - Remedy: more of the above; continued emphasis; emphasize saving lives and preventing morbidity (and cost in some systems)
Data Grief Stages 6 and 7?

- **Data overload**
  - Providers burn out trying to be #1 in everything, drive their team crazy, start focusing on the numbers over actual clinical quality, start pt dumping/cherry picking
  - Remedy: only emphasize a few things at a time; reward for one or two priority areas; reward whole team

- **Apathy**
  - Too much data, people revert back to concentrating on individual pt care
  - Feel futility at times- moving the result takes effort and time
  - Remedy: give the population/prevention tasks to others (RNs + data analysts, midlevels dedicated to specific roles, advanced MAs in conjunction with their team under protocols, health coaches, etc)
Point-of-Service Data
CVD Risk calculated (ASCVD)
A1c
LDL
MAb/creat
Foot exam
Retina screen
ALL meds
ASA
BP control
Statin
CRC screen
Breast Ca screen
Cervical Ca screen
Depression screen
Alcohol screen
Immunizations due today/declined
Tobacco use/counselling due
HIV done ever
Visit summary printed (MU)
eRxsent (MU measure)
eCW Alerts app

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<tr>
<th>Alert</th>
<th>Stats</th>
<th>Pend</th>
<th>Inreach</th>
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<td>(age:63)</td>
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<tr>
<td>DM, CVD, HTN, 10y CVD risk:</td>
<td>24.4 %</td>
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<tr>
<td>A1C:</td>
<td>8/12/14</td>
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<tr>
<td>LDL:</td>
<td>4/20/15</td>
<td>62</td>
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<tr>
<td>Microalb:</td>
<td>7/20/15</td>
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<td>Foot exam:</td>
<td>7/20/15</td>
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<td>Optho:</td>
<td>8/21/15</td>
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<td>10/20/14</td>
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<td>Alcohol:</td>
<td>7/13/15</td>
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<tr>
<td>Imms due:</td>
<td>None</td>
<td></td>
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<tr>
<td>Imm refused: Tdap</td>
<td></td>
<td></td>
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<tr>
<td>Tobacco:</td>
<td>Assessed</td>
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<tr>
<td>HIV:</td>
<td>none</td>
<td></td>
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Updated: minutes ago
Don’t wait for the patient to show up- identify the needs and go get them!

New skills:
- Data/data analysis
- Prioritization of a lot of need
- Proactive pt activation/education for preventive care

How financed
- LIHP funding for population management and PCMH
- Health Plan: very little funding
- CHC payment model a handicap

Best example CRC screen

Key finding: team responsibility for screening and monitoring (not JUST the MD)
Partners: KP, C4, PASD, LabCorp
- Minimum funding from C4
- LabCorp donated FIT tests
Pt identified needing CRC screen:
- during visit via eCW alerts app
- proactively using registry
FIT test given
Tests tracked by Panel Managers
- Pt contacted if kit not returned in 2 wks
Results tracked monthly
- Reported to sites, med staff, QM, BOD periodically
Positive tests: free colonoscopy by Kaiser via Project Access San Diego
Positive Biopsies:
- Kaiser-donated surgery, imaging, specialty consult/Rx plan
- PASD arranges for donated oncology eval, XRT if needed, ChemoRx if needed
CRC-In reach

- The daily huddle
**In reach**

- Identifying Patients due for CRC Screening
- eCW Alert app developed by Dr. Kulin Tantod

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<th>Alerts</th>
<th>Checklist</th>
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<td>Tobacco:</td>
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<td>eRx:</td>
<td>Not sent</td>
</tr>
<tr>
<td>Updated:</td>
<td>14 hours ago</td>
</tr>
<tr>
<td>Ready:</td>
<td>none</td>
</tr>
</tbody>
</table>
Outreach

* Identifying Patients due for CRC Screening
* Data registry developed by Dr. Kulin Tantod
Hypertension and Diabetes efforts at NHC
Neighborhood Healthcare ALLHeart Project

- Project: Increase the number of ALLHEART patients on both medications
  - RN protocol
  - MD education video
  - Added to alerts app if not on ACE/ARB & Statin
  - Added to medical staff clinical measures dashboard
  - Monitoring overall performance monthly
  - ASCVD Risk Calculator embedded in alerts app with hyperlink to reference
How are we doing? BP Control, UDS

% of Hypertensives with Controlled BP

- UDS Measure: Hypertension
- Data Source: BridgeIT Reports
- Denominator: Total # of patients age 18-85 with a diagnosis of hypertension, were first diagnosed point before 6/30 of the measurement year, AND had at least two medical visits during the measurement year.
- Numerator: # patients from denominator whose last systolic blood pressure was less than 140 mmHg.

Exclusions: pregnant patients and patients with end stage renal disease.

Neighborhood Healthcare 2013 UDS Clinical Performance Measures

- 65% - California
- 64% - National
- 64% - NHcare2012
- 67% - NHcare2013

Healthy People 2020: 61.20%

8/24/15
NHC/CCC HTN Protocol October 2013

CCHN Adult Hypertension Treatment Algorithm

**Preferred**

ACE-Inhibitor/Thiazide Diuretic
- Lisinopril/HCTZ (Advise as needed)
- 20/25 mg X 1 daily
- 20/25 mg X 2 daily
- Pregnancy Potential: Avoid ACE inhibitors

Thiazide Diuretic
- Chlorothalidone 12.5 mg → 25 mg
- HCTZ 25 mg → 50 mg

Calcium Channel Blocker
- Add amiodipine 5 mg X 1 daily → 5 mg X 1 daily → 10 mg X 1 daily
- If not in control in 2-4 wks. on max dose, consider medication non-adherence before going to the next step.

Spironolactone otherwise Beta Blocker
- If on thiazide AND eGFR ≤ 60 ml/1.73 m² AND K < 4.5 Add spironolactone 12.5 mg daily → 25 mg daily
- Otherwise Add atenolol 25 mg daily → 50 mg daily (keep heart rate > 55)
- Consider medication non-adherence. Use the non-adherence tool in POINT.
- Consider simvastatin if taking amiodipine. Simvastatin maximum dose is 20 mg.
- Consider interfering agents (e.g., NSAIDs, excessive alcohol)
- Consider white coat effect. Consider BP checks by medical assistant (e.g., two checks with 2 readings each, 1 week apart)
- Consider discontinuing lisinopril/HCTZ and changing to chlorothalidone 25 mg plus lisinopril 40 mg daily
- Consider additional agents (hydrochlorothiazide, reserpine, minoxidil)
- Consider stopping atenolol and adding diltiazem to amiodipine, keeping heart rate > 55.
- Avoid using clonidine, verapamil or diltiazem together with a beta blocker. These heart-rate slowing drug combinations may cause symptomatic bradycardia over time.
- Consider secondary etiologies.

1. Includes essential hypertension, MD and Stage 1-3 CKD, CVA, TIA; excludes CAD, Heart Failure, Stage 4 CKD, and pregnancy.
2. ACE-inhibitors are contraindicated in pregnancy and not recommended in most child-bearing age women.
3. NNT = number needed to treat or prevent one event maintaining hypertension control for at least 5 years.

Initial Work-Up for Newly Diagnosed HTN

Thorough history and physical including BMI, BP in both arms, listening for subclavian and renal bruits, retinal exam, etc. If not done within the past year, check CRP, fasting BMP, LFT, lipid panel, TSH, UA, EKG. There is room for an echocardiogram unless EKG is abnormal or there is a physical exam abnormality such as an SS, murmur, etc.
How are we doing? BP Control/DM/ALL

**DM <140/90: 83% (3329/3999)**

**HTN: 77% (6693/8713)**

65% on 3/16/14

DM >50 on ACE/ARB + Statin:
75% on 10/9/14 (2458/3269)
70% on 3/16/14
How are we doing? BP Control

As of 3/10/14
How are we doing? BP Control
As of 2/5/15
How are we doing? DM BP control
Getting Quality Data to the Medical Staff

- MDs are competitive
- Data + support ➔ moving the curve
NHC Physician-level Interactive Real Time Quality Detail - panel level detail

Detailed, Individual real time, Peer-normative, Actionable, Trending
### On-demand Quality Data - Actionable Data

#### Reports [ANONYMIZED]

<table>
<thead>
<tr>
<th>Patient</th>
<th>Provider</th>
<th>Last apt</th>
<th>Next apt</th>
<th>Dx CVD risk</th>
<th>BP</th>
<th>ATC</th>
<th>On Ace/Statin</th>
<th>Needs</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith, John 251142, age:72</td>
<td>Schultz, James</td>
<td>Jun 20, 2015</td>
<td>Jul 16, 2015</td>
<td>DM HTN 30.3%</td>
<td>154/77</td>
<td>May 1, 2015</td>
<td>11.6</td>
<td>May 1, 2015</td>
<td>Pt named BPA1, LDL  called pt to ask regarding BP she stated unable to come in for HTN due to hns/26/15 ebma</td>
</tr>
<tr>
<td>Smith, John 285323, age:60</td>
<td>Schultz, James</td>
<td>Dec 5, 2014</td>
<td>Jan 13, 2015</td>
<td>DM 9.8%</td>
<td>129/86</td>
<td>Jul 16, 2014</td>
<td></td>
<td>FIT  called left voice mail, need to verify care, thma 01/29/15</td>
<td></td>
</tr>
</tbody>
</table>

- Click any column to generate recall list
- All recall items identified - one-call hits all items
### Outreach

- Identifying Patients due for CRC Screening
- Data registry developed by Dr. Kulin Tantod

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**Reports [ANONYMIZED]**

<table>
<thead>
<tr>
<th>Patient</th>
<th>Provider</th>
<th>Last appt</th>
<th>Next appt</th>
<th>Dx</th>
<th>CVD risk</th>
<th>BP</th>
<th>A1C</th>
<th>Needs</th>
<th>Notes</th>
</tr>
</thead>
</table>
| Smith, John  
26912.1, age:78  
CHG (CCI CAL-MEDICONECT) MEDICARE HMO | Chen, Margaret | Apr 18, 2015 | Aug 17, 2015 | DM | HTN 71.1% | 170/77 | 9.8 | May 27, 2015 | appt on 01/09/15 with PD, needs an appt w/pcp 12/26/14 ebmo |
| Smith, John  
269485, age:58  
Molina Medi-Cal Elm | Coleson, Pamela | Feb 26, 2015 | Jul 20, 2015 | DM | HTN 49.4% | 147/87 | 11 | Jun 12, 2015 | 7/20/15 w/Coleson. |
| Smith, John  
250855, age:77  
Medi-Cal FQHC Elm | Schiff, Karin | Mar 2, 2015 | Jun 5, 2015 | DM | HTN 48.7% | 138/71 | 9.5 | Feb 5, 2015 | appt 1/19/15, 12/26/14 ebma |
| Smith, John  
119240.1, age:72 | Ede, Kekoa | Jul 23, 2015 | Sep 8, 2015 | DM | HTN 42.8% | 132/66 | 9.7 | May 28, 2015 | Pt has appt on 01/13/15 with Dr. Ede 1/6/15 ebma |
## Leveraging Competitive Nature

### Real Time on Demand

<table>
<thead>
<tr>
<th>Provider/Clinic</th>
<th>DM, A1C&lt;9DM, BP (Goal 71%)</th>
<th>HTN (Goal 60%)</th>
<th>Cervical Ca (Goal 64%)</th>
<th>Breast Ca (Goal 77%)</th>
<th>CRC (Goal 72%)</th>
<th>Overall Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grand</td>
<td>0.39</td>
<td>0.34</td>
<td>0.51</td>
<td>-0.08</td>
<td>0.58</td>
<td>0.89</td>
</tr>
<tr>
<td>Temecula</td>
<td>0.13</td>
<td>0.41</td>
<td>0.79</td>
<td>1.01</td>
<td>-0.31</td>
<td>-0.04</td>
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<tr>
<td>El Cajon</td>
<td>0.9</td>
<td>0.11</td>
<td>0.28</td>
<td>-0.28</td>
<td>0.65</td>
<td>-0.05</td>
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<tr>
<td>Valley Parkway</td>
<td>-0.41</td>
<td>-0.16</td>
<td>-0.16</td>
<td>0.77</td>
<td>0.41</td>
<td>-0.47</td>
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<tr>
<td>Lkside Medical</td>
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<td>-0.09</td>
<td>-0.05</td>
<td>0.08</td>
<td>-0.19</td>
<td>0.17</td>
</tr>
<tr>
<td>Menifee</td>
<td>-0.62</td>
<td>0.33</td>
<td>-0.06</td>
<td>0.89</td>
<td>-0.01</td>
<td>-1.17</td>
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<tr>
<td>Elm</td>
<td>-0.35</td>
<td>0.08</td>
<td>-0.36</td>
<td>-0.61</td>
<td>0.02</td>
<td>0.32</td>
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<tr>
<td>Date BH</td>
<td>1.9</td>
<td>-4.37</td>
<td>-2.65</td>
<td>-2.06</td>
<td>-2.01</td>
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<tr>
<td>Shoukry, Cristina</td>
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<td>0.8</td>
<td>1.07</td>
<td>1.46</td>
<td>1.48</td>
<td>1.17</td>
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<tr>
<td>Patel, Rakesh</td>
<td>0.96</td>
<td>0.65</td>
<td>0.95</td>
<td>-0.39</td>
<td>1.25</td>
<td>1.26</td>
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<tr>
<td>Thiermann, Palge</td>
<td>1.57</td>
<td>1.08</td>
<td>0.91</td>
<td>0.46</td>
<td>0.62</td>
<td>0.01</td>
</tr>
<tr>
<td>Bravo, Ruth</td>
<td>-0.51</td>
<td>0.17</td>
<td>0.19</td>
<td>1.05</td>
<td>1.61</td>
<td>1.88</td>
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<tr>
<td>Tasher, Dean</td>
<td>0.93</td>
<td>-0.3</td>
<td>0.73</td>
<td>0.07</td>
<td>1.22</td>
<td>1.67</td>
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<tr>
<td>Ayon Martinez, Carlos Temecula</td>
<td>-0.02</td>
<td>0.43</td>
<td>1.24</td>
<td>0.99</td>
<td>-0.33</td>
<td>0.95</td>
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<tr>
<td>Summers, Lindsay</td>
<td>0.08</td>
<td>0.1</td>
<td>-0.02</td>
<td>0.98</td>
<td>1.38</td>
<td>0.73</td>
</tr>
<tr>
<td>Liu, Dorothy</td>
<td>1.05</td>
<td>0.78</td>
<td>0.95</td>
<td>-0.36</td>
<td>0.45</td>
<td>0.25</td>
</tr>
</tbody>
</table>
### Panel Size
- DM: A1c < 9, BP, 140/90, LDL < 100
- HTN: BP < 140/90, ALL meds
- Ca screen: colon, breast, cervical
- Antipsych meds with A1c test
- PP and prenatal visit tieliness
- Childhood IMMMIs
- Asthma on controller
- etc
Chronic disease management can be done in an underserved population; requirements:

- Committed leadership
- Dedicated staff with a unifying purpose
- Validated and trusted data delivered when it is needed
- Data analytics capability
- Prioritization process
- Leveraging community resources
- Engaged patients
- Payment model to support activities outside typical face-to-face visit
Key Concept - Data

I have the ability to quantify the unquantifiable.

That is why they call me Dogbert the quantifier.

Who calls you that?

Eight people.
A group becomes a team when each member is sure enough of himself to praise the skills of others. — Norman Shidle
Key Concept - Innovation

George Hayes, CRR - Scripps Whittier Institute

Primary Care retinal photography
Key Concept- Boldness

"You miss 100% of the shots you don't take." - Wayne Gretzky

- Michael Scott
Key Concept- Team

Erika Bazan, MA- Care Coordinator
Maria Acosta, MA
Erica Cruz, MA
Key Concept- Happy People!