Utilizing a Registry for Health Care Management: A Team Perspective

Linda Follenweider MS PhDc FNP
Commercial Disclosure

I have no relevant financial relationships to disclose prior to presenting

I do not intend to discuss off-label uses of FDA-approved products
Learning Objectives

Identify key concepts of a registry to incorporate population health into daily practice

Utilize key concepts and strategies for team based care with the use of a registry

Describe key concepts of care management delivery and how it differs from traditional health care delivery and case management
Change is hard enough; transformation to a PCMH requires epic whole-practice re-imagination and redesign.

It is so much more than a series of incremental changes.
Transformation includes:

- New scheduling
- New access
- New coordination
- New types of visits
- Incorporating population medicine
- Bringing evidence to point of care
- More point of care services
- Redefining patient visit
- New coordination with other parts of the healthcare system
- QI at point of care
- Team based care
- Changes in practice management
- Changes in roles
- New strategies for patient engagement
- Multiple uses of new information systems and technology
- Response to patient events outside of the clinical setting
- Outcomes based staffing

Adapted from Initial Lessons Learned from the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home ANNALS OF FAMILY MEDICINE MAY/JUNE 2009
NCQA The Standards

The PCMH 2011 program’s six standards align with the core components of primary care.

PCMH 1: Enhance Access and Continuity
PCMH 2: Identify and Manage Patient Populations
PCMH 3: Plan and Manage Care
PCMH 4: Provide Self-Care and Community Support
PCMH 5: Track and Coordinate Care
PCMH 6: Measure and Improve Performance
Essential to the PCMH

1. Access During Office Hours
2. Use Data for Population Management
3. Care Management
4. Support Self-Care Process
5. Track Referrals and Follow-Up
6. Implement Continuous Quality Improvement

Pick one to start when your team returns......
Care Management Process

• patient-centered,
• team-implemented
• outcomes-focused
Example CM Domains

1. Disease Specific Care
2. Utilization
3. Health Care Maintenance/ Prevention and Well Episodic Care
Team based care

The coordination of activities and the distribution of tasks/responsibilities among clinical team members, consistent with their license and skills, to meet the patient's needs.

Each team member is expected to work at the top of his or her license and/or skill set.
What is the staff and skill mix?

- Highest level of skills and licensure
  
  Trust

  Training

- New Roles for licensed and unlicensed
- Accurate evaluation that is outcomes focused
- Local leadership
- Value over volume

HEALTH MANAGEMENT ASSOCIATES

May 31, 2012
Where does typical care occur?

In the clinic
In the exam room
Access during Office Hours

• Front desk and appointments
• Is it possible to be seen the same day?
• Other opportunities...
  • Introduction to the PCMH
  • Outstanding labs for scheduled appointments
  • Missed appointment follow up
  • Screening
Screening

Depression Screening Tool
Patient Health Questionnaire (PHQ-2)

*Over the past 2 weeks, have you often been bothered by:*
1. Little interest or pleasure in doing things? Yes No
2. Feeling down, depressed, or hopeless? Yes No

If the patient responded “yes” to either question, follow-up using the PHQ-9, a nine-item, self-administered questionnaire
Registry

A software system that houses, organizes and track patient data to plan individual patient visit and conduct population health management.
2 levels of Panel Management

• assume responsibility for the health of all the patients in their panels, whether or not the patients seek care.

• changes the day-to-day function of the medical practice and require a staff person to periodically review the clinical registry, to identify care gaps (deficiencies in preventive or chronic condition care), and to arrange for patients to address those care gaps.
2 purposes of Panel Management

• to improve preventive and chronic condition care for a population of patients and
• to redistribute work in the primary care practice so that practitioners have more time for complex functions that require their level of knowledge and skill.
Use Data for Population Management (NCQA)

Practices uses patient data and evidence-based guidelines to generate lists and remind patients about needed services:

1. At least three different preventive care services**
2. At least three different chronic care services**
3. Patients not recently seen by the practice
4. Specific medications
Panel management

1. Outreach and In-reach
   1. Who
   2. What
   3. When
   4. Where
   5. How

May 31, 2012
<table>
<thead>
<tr>
<th><strong>Clinic Flow</strong> Factors</th>
<th><strong>Day of Care</strong></th>
<th><strong>Printing Patient Visit Summary</strong> Forms (VPS)</th>
<th><strong>Patient Visit Summary</strong> Forms (VPS)</th>
<th><strong>Acting on the Searches</strong></th>
<th><strong>Receiving the Searches</strong></th>
<th><strong>Entering Data</strong></th>
<th><strong>Who</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>When</td>
<td>Who will print the VPS forms to prepare for the visit/teams huddle?</td>
<td>When will the VPS forms be printed?</td>
<td>Who will receive the search/report lists?</td>
<td>When will the designated receiver access the reports?</td>
<td>Where will the information be received? (ex. daily, weekly)</td>
<td>Where will the information be received? (ex. designated area for the staff to work)</td>
</tr>
<tr>
<td>Where will the VPS forms be placed? (ex. Sorted by provider with a barcode)</td>
<td>Where will the information be entered? (ex. Consider space and equipment location/limitations)</td>
<td>Once the information is captured on the VPS form, who is designated to enter the data into i2Tracks registry?</td>
<td>Where will the information be entered? (ex. Real time, daily, weekly)</td>
<td>When will the information be entered into i2Tracks? (ex. Daily, weekly, monthly)</td>
<td>Who will act on the VPS form? (ex. Who performs the outreach? Use mail, phone calls?)</td>
<td>Where will the information be entered? (ex. Daily, weekly, monthly)</td>
<td>When will the VPS forms be printed?</td>
</tr>
<tr>
<td>Consider physical location, equipment.</td>
<td>Where in the clinic area will outreach be performed?</td>
<td>Where will the information be entered? (ex. Consider space and equipment location/limitations)</td>
<td>Where will the information be entered? (ex. Real time, daily, weekly)</td>
<td>Where will the information be entered? (ex. Daily, weekly, monthly)</td>
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Outreach

Shown to improve other preventive and chronic condition care measures.

- patients with diabetes who received letters from a panel manager reminding them to address care gaps had better process and outcome measures than patients whose physicians were responsible to close the care gaps.

- Outreach separate from physician visits has also been shown to improve colorectal cancer screening.


Other types of outreach

Utilization follow up

- ED
- Hospitalizations (obs and inpatient)
- Specialty
- SNF
In reach

“every patient, every time”

whenever a patient shows up for any problem, a team member, often a medical assistant, with access to a list of the patient’s care gaps arranges for the patient to close those gaps

(Labs, specialty, diagnostics)
Patient Visit Summary (Diabetic)

Patient ID: 1091
Name: Owens, Miguel
DOB: 1/24/1931
Sex: M
Language: ENGLISH
Home Address: 148 West Ave
Phone: 707-526-3624
PCP: Robert Wright, MD
Insurance: Medicaid Managed Care

Diabetes - Type 2: Renal Nephropathy (29)
Vascular HTN (20)

Medications: Aspirin (20), Lipid Lowerer

Alerts:
Due: Procedure / Referral: Dental Visit (20)
Due: Lab: HbA1c

Procedure / Referrals
- Dental Visit (20)
- Depression Screening (20)
- Ophthalmology Visit (20)
- Podiatry Visit (20)
- EKG (20)
- Other Notes

Edwards
- Diabetes (20)
- Med Management
- Immunizations
- Pneumovax (20)
- Tetanus (20)
- Goals
- Exercise (20)
- HbA1c (20)

Blood Pressure
- Date: 2/7/11
  - Val: 147/71
- Date: 2/18/09
  - Val: 21.31
- Date: 2/7/11
  - Val: 149/71
- Date: 2/7/11
  - Val: 130/75
- Date: 2/7/11
  - Val: 126/99
- Date: 2/7/11
  - Val: 114/82

Anticoagulant Therapy
- Date: 2/7/11
  - Dosage: 2

Attachment 1: Printed Patient Visit Summary (PVS) form for Day of Care
Day of Care

- huddles
- pre-visit preparation
- Team communication
**Alerts:**

<table>
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<tr>
<th>Due: Procedure / Referral: Dental Visit (21)</th>
<th>Due: Lab: HbA1c</th>
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**Procedures / Referrals**

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<td>10:</td>
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**Other Profile Items**

| Smoker (21) | Never | 10/10/2008 | |
| Homeless Status | | | |
| Drug Asst Program | | | |

**Blood Pressure**

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**Goals**

<p>| Exercise (21) | | |
| HbA1c (21) | | |</p>
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Visit Notes for 2/13/2012

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<th>Date</th>
<th>WT (lbs)</th>
<th>Ht (in)</th>
<th>BMI</th>
<th>T (°F)</th>
<th>BP</th>
<th>P</th>
<th>R</th>
<th>Pain Score</th>
<th>PHQ</th>
</tr>
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Health Management Associates
### Patient Visit Summary (Diabetic)

**Patient ID:** 1901  
**Name:** March, Miguel  
**DOB:** 10/25/1931  
**Sex:** M  
**Address 1:** 3637 West Ave  
**City:** Healdsburg  
**State:** CA  
**ZIP:** 94927  

**Last Visits:**  
- **Date:** 4/7/2011  
  - **Blood Pressure:** 147/71  
  - **BMI:** 6.2  
  - **Pain Score:** 8  
  - **Weight (lbs):** 30  

**Blood Pressure:**  
- **Date:** 4/7/11  
  - **Value:** 124/10  
- **Date:** 4/7/11  
  - **Value:** 124/10  
- **Date:** 4/7/11  
  - **Value:** 124/10

**BMI:**  
- **Date:** 12/18/09  
  - **Value:** 31.31  
- **Date:** 12/18/09  
  - **Value:** 7.3  

**HGB:**  
- **Date:** 12/4/10  
  - **Value:** 106  
- **Date:** 12/4/10  
  - **Value:** 106  
- **Date:** 11/22/10  
  - **Value:** 67

**HgbA1c:**  
- **Date:** 12/4/10  
  - **Value:** 8  
- **Date:** 11/22/10  
  - **Value:** 8  
- **Date:** 10/25/10  
  - **Value:** 8

**LDL:**  
- **Date:** 12/23/10  
  - **Value:** 7.3  
- **Date:** 12/4/10  
  - **Value:** 8

**HDL:**  
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**INR:**  
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- **Date:** 11/22/10  
  - **Value:** 1  
- **Date:** 12/23/10  
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**Procedures / Referrals:**  
- **Date:** 4/10/11  
  - **Referral:** Dental Visit (23)  
- **Date:** 2/8/12  
  - **Referral:** Ophthalmology Visit (23)  
- **Date:** 1/8/2012  
  - **Referral:** Podiatry Visit (23)  
- **Date:** 10/10/2008  
  - **Referral:** EKG (23)  

**Allergies:**  
- **Due:** Procedure / Referral: Dental Visit (23)  
- **Due:** Lab: HgbA1c:

**Medications:**  
- **Diabetes:** (23)  
- **Exercise:** (23)  
- **Med Management:** (23)  
- **Immunizations:** (23)  
- **Goals:** (23)

**Notes:**  
- **Diabetes:** (23)  
- **Exercise:** (23)  
- **Med Management:** (23)  
- **Immunizations:** (23)  
- **Goals:** (23)
In-reach needs at least 3 things:

- EMR to display a screen showing up-to-date care gaps for every patient in a practice’s panel
- Medical assistants to be well trained in panel management
- Written standing orders for the medical assistants.

Ellen H. Chen, MD
Thomas Bodenheimer, MD
Panel management may play a particularly effective role in decreasing health care disparities for low-literacy, lower socioeconomic-level, limited English-proficient, and underserved racial and ethnic groups.


Plan and Manage Care

Health Management Associates
Risk Assessment

Assess and assign risk using:

• standardized assessment tools
• integrated through registry
  • lab data,
  • visit history,
  • utilization patterns,
  • disease status
• defined and specific system triggers.
Risk Response

Risk assignment activates a coordinated response by appropriate team members who are notified and mobilized through clear and defined communication of responsibilities, primarily through registry task assignments.

- Utilization
- Care gaps
- Additive/multiplicative risk flags
Multidisciplinary Action Plan

- standardized interventions
- minimum contact intervals
- evaluations
- clear outcome measures.

Van Gogh
Gravity

The CM assessment may trigger an increase or decrease in the intensity and/or level of services provided by the PCMH team.
Think differently.....

Standardized interventions may take place face to face, telephonically, through written communication, in group visits, through individual coaching or education or through other methods.

Interventions are performed by the appropriate team member.

Where is your capacity?
Care management

• a program of coordinated activities
• centered around the patient’s goals and needs.
• defined through synthesis of individual patient goals and their current health status which is ascertained by chronic disease(s) status, health-related behaviors, health care utilization and access, and health educational needs.
• The coordinated activities of the program inform each interaction between the patient and their medical home.
Risk

Risk Factors

- Modifiable
- Fixed

Treatment goal is to near-normalize the level of each risk factor
Identify High-Risk Patients

The practice does the following to identify high-risk patients:

1. Establishes criteria and a process to identify high-risk or complex patients
2. Determines the percentage of high-risk patients in the population
Care Management

1. Conducts pre-visit preparations
2. Collaborates with patient to develop care plan, including treatment goals
3. Gives patient written care plan
4. Assesses and addresses barriers to treatment goals
5. Gives patient clinical summary at relevant visits
6. Identifies patients who need more care management support
7. Follows up with patients who have not kept important appointments
Care Management

Is not restricted to or dependent on any single individual role or job function but rather depends on the coordination, communication and active participation of all team members at various defined points in the patient’s time in the PCMH.

Who leads?
Training

initiate widespread training on basic preventive and chronic condition care and role redefinition. Interpersonal skills in health coaching to explain procedures, engage patients in a culturally and linguistically concordant manner, and assist patients in navigating health care institutions.
### Patient Search Results: DM or CVD pts w HbA1c > 9 less LDL < 100 (Group: Default)

#### Search Criteria
- **Active**
- **Have Tracking Type:** 'Diabetes Tracking'
- **Have HbA1c (Value): Greater than 9 (Most Recent); Period = The last 6 month(s); Min Count = 1'
- **Not Have LDL (Value): Less than or equal to 100 (Most Recent); Period = The last 6 month(s); Min Count = 1'

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**Database:** i2itrackdemo  **User:** train1
The Patient as team member

Supporting the self care process.

• Patient Ed in disease trajectories and recognizing early signs of worsening condition
• Access/System/Follow up intervals
• Behavioral screenings
• Goal setting and action plans
• Assessing willingness to change
• Providing SMS in real time
• Motivational Interviewing
SELF-MANAGEMENT MODEL

Health Management Associates
Under health care reform, demand for services is likely to increase as the uninsured gain coverage. Given the already strained supply of primary care practitioners, it will be critical to use panel managers and other team approaches to extend the reach of primary care practitioners.