Improving Quality Through Community Partnerships

Nichole Wright| 05.14.2012

Health Care & Housing Are Human Rights

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

There's only so much we can take on!

Our Goal:

Working together to positively impact population health by using the patient centered medical (health) home model!

Partnership

How we started

- Identified the area we had some 'control over'
- Contracted an outside facilitator
- 3 Major Health providers
  - Regional Hospital
  - Free Clinic (also the managers of the Homeless Program)
  - Federally Qualified Health Center
- Strategic planning process: what is going on in the community?
  - How are people accessing services?
  - What gaps are there?
  - What challenges do we currently face?
- Develop a structure to address areas of concern

Structure

Carrying out the plan by leveraging resources

- Establish an oversight committee
- Develop task groups
  - HIT/Data Measures – Development of a scorecard to track each organizations progress. Separate and combined.
  - Communication/Outreach – Community Education, and outreach on resources
  - Finance – Set a budget, identify resources, track spending
  - Integrated Care Management – Partnering to provide CM to each organization
- Each task group develops goals and action plans to meet the overall goal
- Develop reporting structure

Partnership Goals

- NCQA Recognition for all 3 Organizations
  - Achieved by April 2012
- Improved access to primary care services/resources
- Strengthened local capacity to serve the underserved
- Improved health status of the community
- Sustainable PCHH Network
- Increased collaboration
- Preparation for health reform

System Quality Improvement

HIT/DATA
Scorecard
EMR
LACIE
Chronic Care Measures

Care Mgmt
Best Practices
Transparency
CHL
Case Conference

COMMUNICATION

SCORECARD

		Reporting Source	BMK--90th %ile	Stretch Goal--75th %ile	BMK Source	FY 12 Goal	Jul-11
Exceptional Customer Service	**Population Administration**						
	Number of Patients in CAN Population	EHS/Cerner					
	Medicaid Population in CAN Population	EHS/Cerner					
	Self Pay Population in CAN Population	EHS/Cerner					
	# of Unique Patients Case Managed	CM Tick Sheet				300	143
	Patient Experience with Care						
	Access to Care/Ease of Scheduling	CHL	93%	90.5%	PG	88%	85.0%
	Courtesy of Registration Staff	CHL	94%	93.0%	PG	92%	88.0%
	Friendliness/Courtesy of Care Provider	CHL	96%	95.5%	PG	95%	98.0%
	Shared Decision Making	CHL	94%	93.0%	PG	92%	87.0%
	Is the CM effective in working with you to meet your health care needs	CHL	80%		Geisinger		88.0%
	How satisfied are you with the CM responding to your concerns	CHL	83%		Geisinger		84.5%
	Overall Satisfaction Rating	CHL	93%		PG	90%	88.6%
Learn, Grow and Innovate	**Lowering Healthcare Cost / Utilization**						
	Total PCHH Encounters	TSI/EHS	29,810.0	15% Increase 34,281.5		10% Increase >2,735.58	3,773
	Average ED Encounters	TSI	1,180	10% Increase 1,062		5% Decrease < 1,121	1,372
	Average IP Encounters	TSI	279	10% Decrease 251		5% Decrease < 265	282
	Average Readmissions	TSI	17.31%	10% Decrease 15.58%		5% Decrease < 16.44%	18.51%
	Average Urgent Care Encounters	TSI	346	10% Decrease 299		5% Decrease <329	282
	NCQA Self Management						
	CAN Diabetics with established self-management goal	EHS/Cerner	100%				
	SOC Compliance						
	Smoking Status Inquiry Completed	EHS/Cerner	100%				
	Smoking Cessation Education Provided	EHS/Cerner	76%				

Goal Attainment

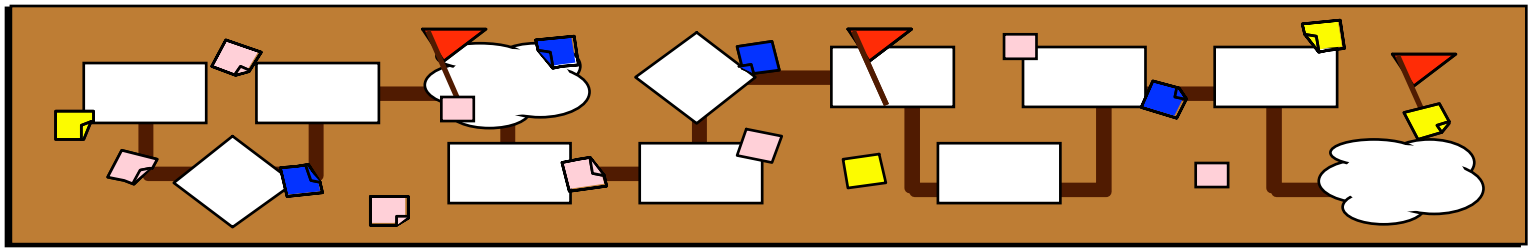
- Standardization Across Environments
- High level care coordination & communication
- Reduced barriers to care
- Reduced inappropriate utilization of the ER
- Enhanced delivery system based on needs
- Accountability for quality
- Addressing the Social Determinants of Health through comprehensive care
- Improved standardization for chronic care (including pain)

IMPACT:
NCQA recognition for Social Welfare Board

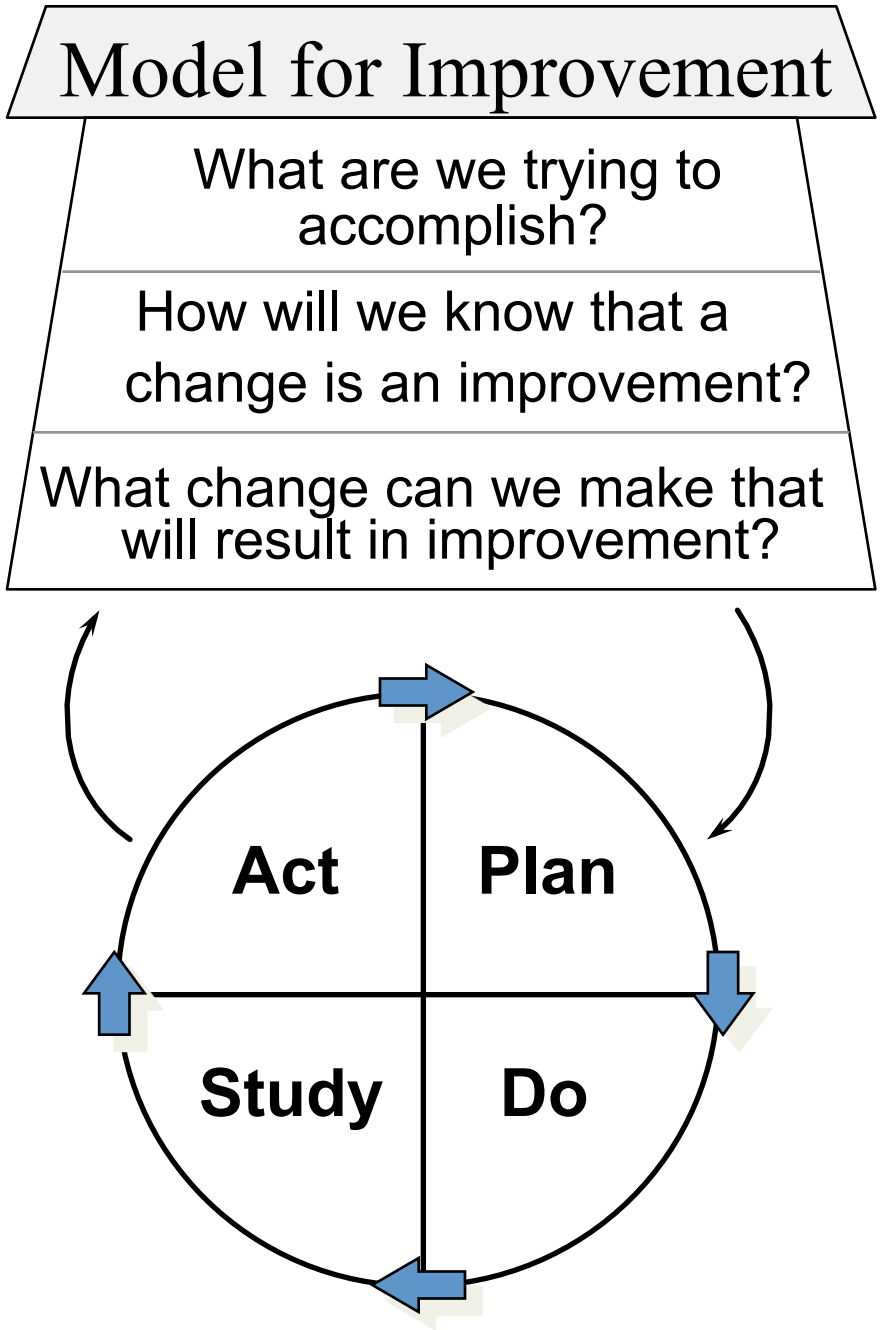
- All processes are reviewed, evaluated & enhance
- Serves as a reliable seal to consumers & healthcare organizations that…
  - Clinic provides quality medical care
  - Continuity of patient care enhanced
  - Standardizes care according to best practices
  - Clinic is well managed
- Increases credibility with potential funders

Tools and Resources

Process/Flow Mapping



- Shows the “Big Picture”
- Describes a process as it works today; an “as-is” model
- High touch, low-tech
- Identifies gaps, strengths, opportunities, bottlenecks, and waste
- Captures the complexity and disconnects of key operational issues
- Identifies outside areas involved in the process



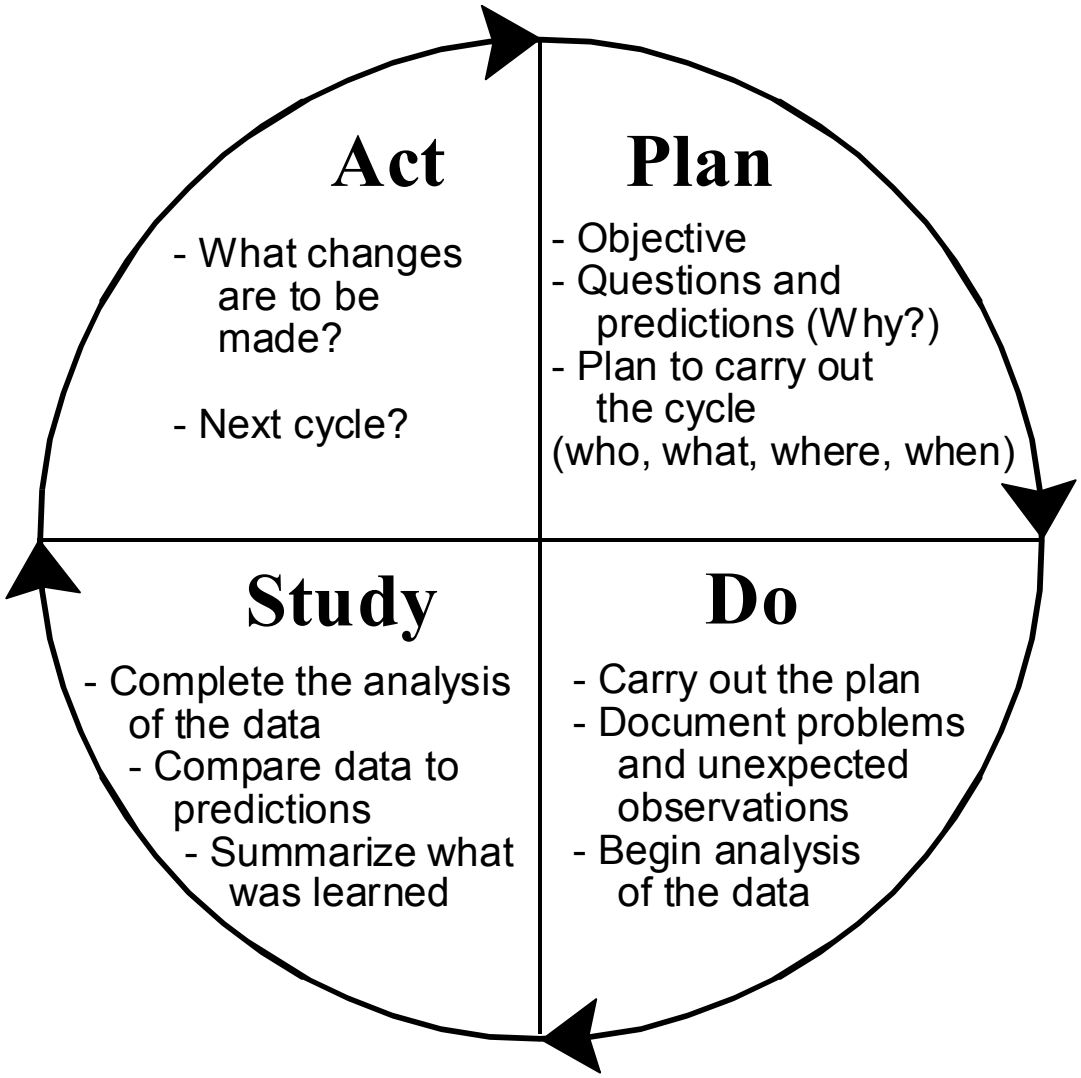
Tools you already have…

- Goals that define excellent practice; Care Model
- Description of Key Measures
- Change Concepts and Ideas organized by elements of the Care Model

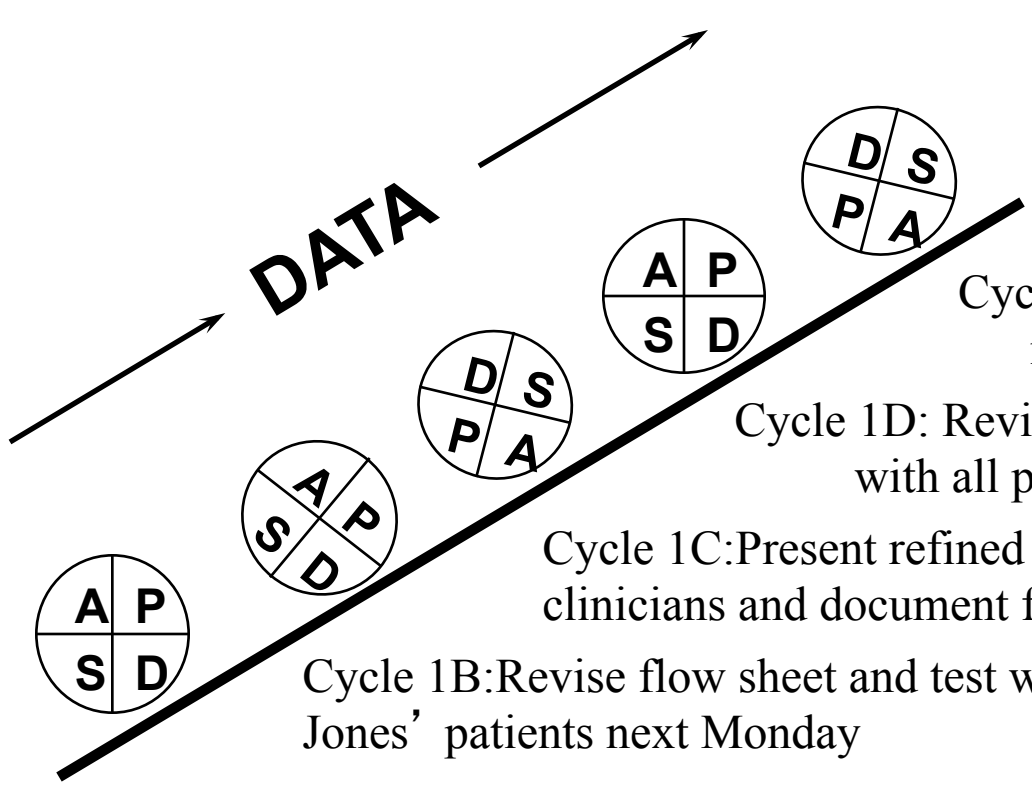
The PDSA cycle provides the means to apply, adapt and implement the change concepts in your practice.

Institute for Healthcare Improvement
www.ihi.org

The PDSA Cycle for Learning and Improvement



Objective: Improve decision support by using a flow sheet that incorporates evidence-based guidelines



Improved Decision Support

Cycle 1E: Implement and monitor the standards

Cycle 1D: Revise and test flow sheet with all patients for one week

Cycle 1C:Present refined flow sheet to all 3 clinicians and document feedback

Cycle 1B:Revise flow sheet and test with all of Dr. Jones' patients next Monday

Cycle 1A:Adapt flow sheet stolen shamelessly at LS 3 and test with one of Dr. Jones' patients

Use of flow sheet will improve care to known standards

Tips

- Be sure to keep a log of previous PDSA Cycles tested in the organization
- Intent of PDSA cycle is rapid cycle test of change
- Pilot small changes prior to implementing organization wide
- Involve staff members that will be impacted by the change in the design and testing of the potential change

- Principles of Redesign™ Developed by Coleman and Associates in 1998
- Developed to help teams quickly construct redesign models
- Twelve principles that have been utilized by successful redesign teams
- Resources and tools available for download
- Website: http://patientvisitredesign.com/index.html

Safety Net Medical Home Initiative

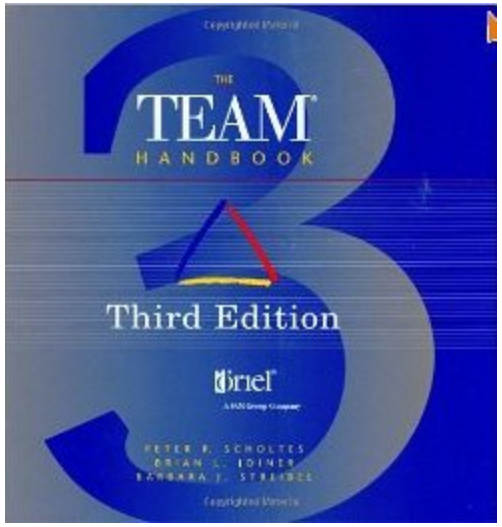
QUALIS HEALTH

THE COMMONWEALTH FUND

MacColl Institute at
Group Health Cooperative

- **Implementation Guides Based on Eight Key Change Concepts**
  - Empanelment
  - Team Based Healing Relationships
  - Patient Centered Interactions
  - Engaged Leadership
  - **QI Strategy**
  - Enhanced Access
  - Care Coordination
  - **Organized, Evidenced Based Care**

- Implementation Guides and Webinars can be downloaded free of charge at: www.safetynetmedicalhome.org/change-concepts



- *The Team Handbook Third Edition*
- *http://www.amazon.com/The-Team-Handbook-Third-Edition/dp/1884731260#_*

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