PCMH User Group Highlights 08/25/16

Slides from presentations are attached to email and on website (slides and highlights under PCMH User Group)

Kelly Saxton from NPO demonstrated the NPO community registry dashboards and discussed practice workflow and answered questions. This was a highly engaged interactive meeting.

Please see ***DASHBOARD PRESENTATION FINAL*** (the presentation) and ***DASHBOARD SCREENSHOTS*** *(a user guide with screenshots)* attached to the email.

NPO Population Clinical Quality Dashboard (NPO)

- Provides the most recent (within 3 weeks) comprehensive view on ***how the practice is performing*** with the management of the patient population on a physician and practice level and up to the community level.
    - Identifies opportunity to review processes from providers doing well on measures to *improve the process* for providers where opportunity exists.
- Includes data accessible from a facility or provider office for connected practices and BCBSM and ACO claims (claims data can be used as a starting point in conversation with patient to collect information to close care gap). These external data sources can be filtered on/off as desired.

Best practices: *Ideas about how the practice can use the Clinical Quality Dashboard in the practice workflow.*

Example 1: PCMH: Planned Visit and ensuring care gaps/information obtained in preparing for the visit has been entered in the structured data field.
Practice Manager:

- Access Clinical Quality Data weekly.
- Generate a weekly report to identify patients scheduled for physicals.
- Obtain the dashboard ***gap in care report*** using the names provided in the weekly report.
- Export to an Excel Spreadsheet
    - Identifies patients who may not have a lab order to complete prior to the visit.
    - Contact patient to remind them of labs to be completed prior to the visit.
    - A1C > 9, Care manager can be alerted to expect the provider to ask the patient be seen, hopefully on the day of the visit.
    - Research immunization records, diabetic eye exam records, specialist referral notes ensuring all have been entered *in the structured data field as possible*.
    - Prepare for the visit identifying the gaps in care.

Example 2: Provider/Designated person can access ***the patient level dashboard*** during or before the point of care:

- Accessing graphs for trends in A1C, Cholesterol, BP, etc.
- Confirming all HEDIS measures have been completed.
- Assuring that counseling for nutrition and physical activity have been addressed and is in a structured data field appearing in blue.
- Applying the filter to determine if Claims measures have been updated.

What are the Barriers to using the NPO Community Registry?

1. Not enough time or unsure how to incorporate in practice flow.
   Please contact NPO for a one on one appointment.

2. Mapping issues
   Immediately contact Ed or Kelly to make them aware.

3. Too much information.
   Attendees were asked what information they would like to see. Ed and Kelly will follow-up and some changes requested have already been implemented to minimize unnecessary information.

Questions:

1. When the Dashboard is refreshed will the *Date of Service* and *historical data* be accessible?
   Yes, for example if historical colorectal data has been entered software will look for it.

2. Will the data be pulled from templates?
   The note has to be locked and in a structured data field to be pulled into the registry.

3. If the EMR is locked and an update occurs, will the registry update all at once?
   Yes, if information not updated it may be a mapping issue. Let NPO know and we will take a screen shot prior and after the update.

4. If patients have been excluded from the practice EMR why are they still showing up in the community registry dashboard? (Even the practice test patients show up which result in inaccurate performance). ***Kelly to investigate***

5. I see Hysterectomy as an exclusionary and it has been entered before with BCBSM. Why does it keep showing up? ***You will have to <u>Push a code</u> through once per year.***

6. What is the time period of the measures? ***HEDIS measures are typically based on a calendar year.***

<u>2016 Meeting Dates – all meetings from 11:30 AM – 1PM:</u>

- <u>Sept 29, Thursday</u>
  - Group Visits – **CHC Fort Gratiot** will be discussing their **group visit process**. This practice won 2015 MiPCT Most Improved Pediatric Practice:

    2015 MiPCT Best Practice Winner Success Story; CHC Fort Gratiot Wins Most Improved Pediatric Practice

    According to Deepa Nandamudi, LMSW/ACSW, Complex Care Manager for CHC Fort Gratiot, there are several factors that made a difference in their practice. First, they have a dedicated process and staff focuses on closing gaps in care. The office staff diligently follows up with parents by phone and via letters. Each visit, regardless of the reason for the visit is used as an opportunity to close gaps in care.

    Additionally, ED calls are made to patients who visit the ED to remind them of extended access hours and arrange a follow-up visit, if appropriate.

    They also utilize data to identify opportunities for improvement. Data analysis indicated that the most frequent driver of ED visits was constipation. Discussion with parents found that they didn't know what to do when their child was in pain, or how to prevent constipation. The practice offered a group visit that included how to prevent constipation (e.g., with a high fiber diet that is appealing to kids), and offered information on what to do if constipation reoccurs. Care Managers and physicians identified patients who could benefit from this group visit. The group visit was held at a convenient time for parents (from 5:30 to 7:30) and was a hit! As a result, group visits are now conducted for asthma, nutrition, and ADHD.

    Another factor is that the Care Managers are centrally located but huddle once a week to discuss cases. Moreover, one Care Manager is a social worker and has good relationships with community mental health

agencies and behavioral health resources. Community resources are monitored and published on their website and in a hardcopy binder. All employees are trained on community resources and there are good relationships with local agencies. The practice helps the agencies by documenting activity for funders, so that they can provide it to their funders as evidence of use.

There are a few hints that they would like to pass on to other practices. The whole team must know they play important roles and that others depend on them. Connect your offices with community resources. Define and document processes. Create standard work and expectations. Use your data to find out what your issues are. Add a midlevel or increase your after-hours schedule if needed.

CHC Fort Gratiot hopes that the information provided here will benefit care managers, practice staff, and leadership throughout the state of Michigan as they work to provide quality care management for their patients.

- October 26, Wednesday
  - To be determined

PLEASE NOTE: If you plan to attend the next meeting either in-person or telephonically, please either email kelliott@npoinc.org or call NPO at 231-421-8505 to RSVP. After we receive your RSVP, we send you an Outlook appointment. Please bring in parking garage tickets for validation.