# Telling Your Transformation Story: Understanding Progress, Documenting Achievement

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MacColl Institute at
Group Health Cooperative

# Objectives

- Understand the importance of being able to demonstrate progress
- Provide examples of how sites demonstrate progress and document achievements

# Why report on a set of measures for PCMH Transformation?

- To demonstrate to the Board, leaders, staff, patients & families that great care is being provided in a timely manner
- To identify opportunities for further improvement
- To become recognized as a Medical Home
- To become eligible for additional funding and resources through Meaningful Use, P4P programs, demonstration programs, grants, etc.

# Where to start? Engaged Leadership

- Do administrative and clinical leaders expect data reports on a routine basis?
- Do leaders dedicate resources, including staff to collect data and report measures?
- Does the organization have a systematic approach to access accurate data and produce reports that demonstrate progress towards PCMH?
  - 80% of sites indicated they had an EMR during the application process

# Quality Improvement Strategies

- Formal model of quality improvement
- Establish & monitor metrics to evaluate improvement efforts and outcomes; ensure all staff members understand the metrics for success
- Obtain feedback from patients/families about their healthcare experience
- Ensure that all are involved in improvement activities, including patients and families
- Optimize the use of health information technology

# Example: Measure Set for PCMH

| Dimension of Quality | System-Level Measure | Example of System-Level Measure | System-Level Goal |
|---|---|---|---|
| Patient-Centeredness | Patient satisfaction score | % of patients responding "highly satisfied" to "Overall, how satisfied are you with your care?" | 70% |
| | Patient experience score | % of patients responding "My care team gives me exactly the help I want (and need) when I want (and need) it." | 75% |
| Efficient | Reduce avoidable ED visits | % reduction in % of patients receiving care in the Emergency Dept | 5% reduction |
| | Reduce inpatient admissions/readmissions | % reduction in % of patients w CHF or asthma who had an inpatient stay | 5% reduction |
| Effective | All or none measures for prevention | % of eligible patients who received all recommended preventive cancer screenings: colorectal, cervical, breast, etc. | 90% |
| | Diabetes and hypertension outcome measures | % of eligible diabetes patients who have HbA1c<7% | 80% |
| Timely | Follow-up appointment after hospital within 5 days | % of hypertensive patients who have BP<140/90 | 85% |
| | Access to specialty care within 7 days | % of patients who were able to schedule appts within 7 days | 95% |
| | 24/7 access | % of appts after 5:00 pm during weekdays and on weekends | 25% |
| Equitable | Assure migrant workers and family members have equal access to care. | % of migrant workers or family members who receive all recommended immunizations | 75% |

**From page 10 of the Engaged Leadership Implementation Guide.**

# Minimal Measurement Expectations for the SNMHI

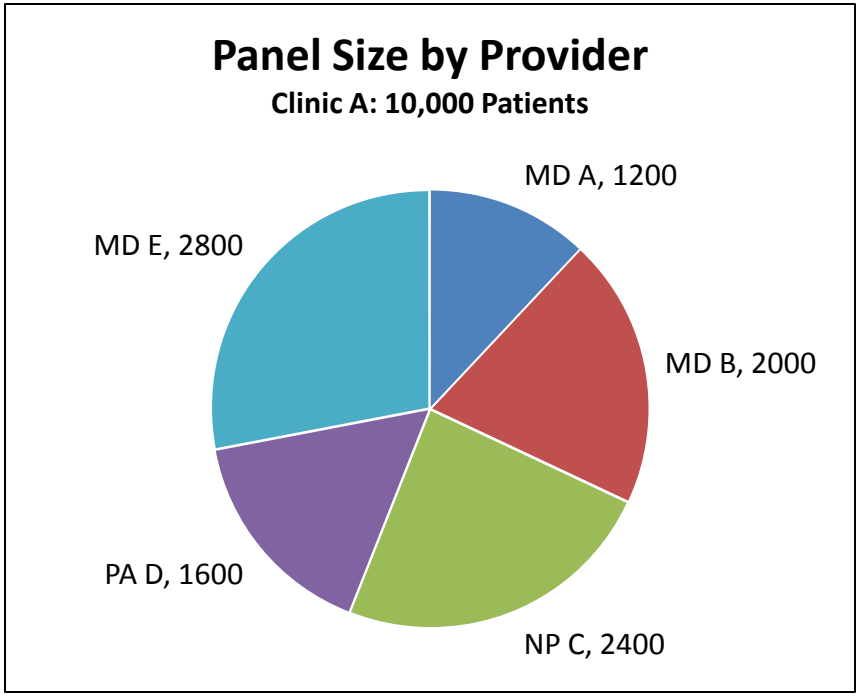
- Six measures in four domains:
  - Clinical Quality (Chronic Care, Prevention & Wellness)
  - Practice Transformation (Continuity, Access, Patient Experience)
  - Provider/Staff Satisfaction
  - Understanding Patterns of Emergency Department Utilization
- Run charts displaying at least quarterly data over time
- Goals documented on run charts

**Measurement Plan describing 6 measures due March 15th.**

# Empanelment

## Panels Assigned

Able to report the distribution of patients that have selected or been assigned to a care team or provider, adjusted for demographics (age, gender, risk) and provider FTE





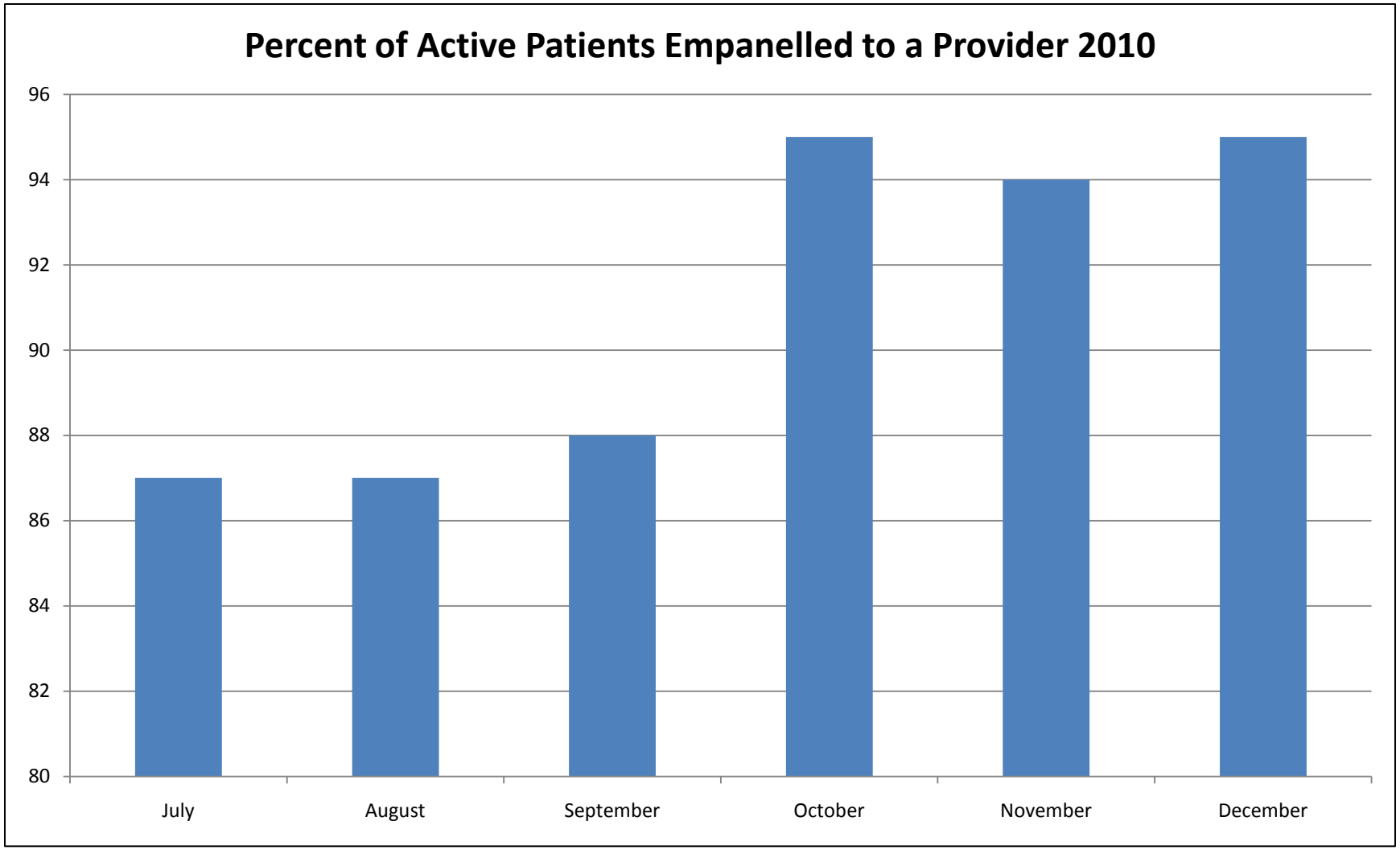
1. Shah A, Stadtlander M. Building Better Care "Empanelment." 1st ed. Portland, OR; Multnomah County Health Dept, December 2009.

2. Safety Net Medical Home Initiative. Brownlee B, Sirlin S, Virden N, Van Borkulo N. Empanelment Implementation Guide Part 2: Assigning and Managing Panels in the Patient-Centered Medical Home. 1st ed. Burton T, ed. Seattle, WA: The MacColl Institute for Healthcare Innovation at the Group Health Research Institute and Qualis Health, February 2011.



**With assistance from Tantau & Associates and the Institute of Healthcare Improvement**

# Outside In

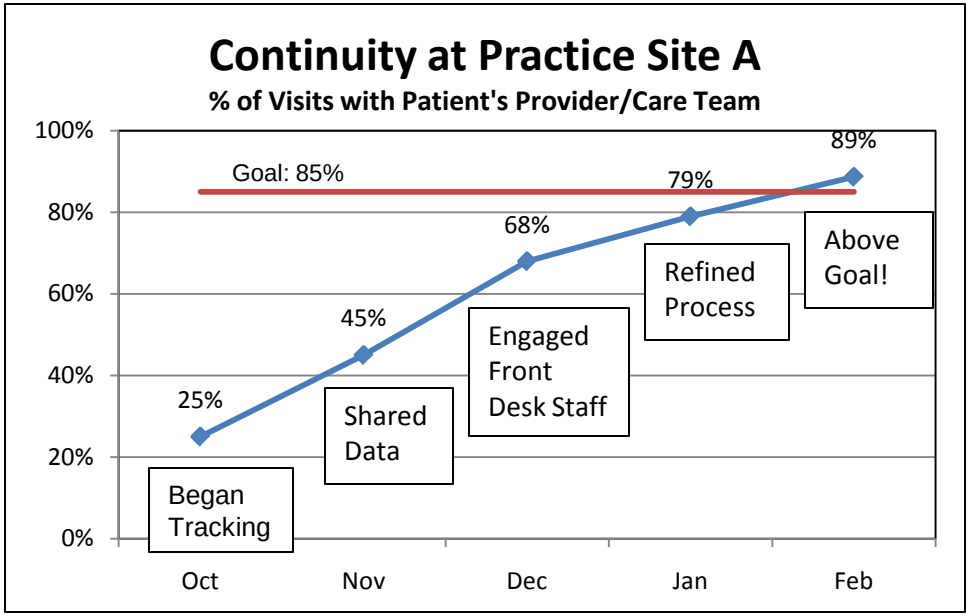

Percent of Active Patients Empanelled to a Provider 2010
96
94
92
90
88
86
84
82
80
July
August
September
October
November
December

# Continuous, Team-based Healing Relationships

**Continuity Tracking Worksheet: February 2011**

| | | Patient's Provider Visit | | Patient's Team Visit | | Continuity by Provider Team | | Other Provider or Team Visit | | Urgent Care Visit | ED Visit |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Provider | Total Visits to Primary Care | # | % | # | % | # | % | # | % | # | # |
| A | 100 | 75 | 75% | 15 | 15% | 90 | 90% | 10 | 10% | 5 | 12 |
| B | 150 | 125 | 83% | 10 | 7% | 135 | 90% | 15 | 10% | 50 | 75 |
| C | 200 | 195 | 98% | 5 | 3% | 200 | 100% | 0 | 0% | 0 | 0 |
| D | 185 | 100 | 54% | 75 | 41% | 175 | 95% | 10 | 5% | 45 | 5 |
| E | 250 | 125 | 50% | 60 | 24% | 185 | 74% | 65 | 26% | 25 | 25 |
| Total | 885 | 620 | 70% | 165 | 19% | 785 | 89% | 100 | 11% | 125 | 117 |

Based on July 2010 data submissions, 31 of the 65 sites (nearly 50%) are reporting on a continuity measure.




Safety Net Medical Home Initiative. Coleman K, Reid R. Continuous and Team-Based Healing Relationships Implementation Guide: Improving Patient Care Through Teams. 1st ed. Burton T, ed. Seattle, WA: The MacColl Institute for Healthcare Innovation at the Group Health Research Institute and Qualis Health, June 2010.

**Courtesy of Tantau & Associates and the Institute of Healthcare Improvement**

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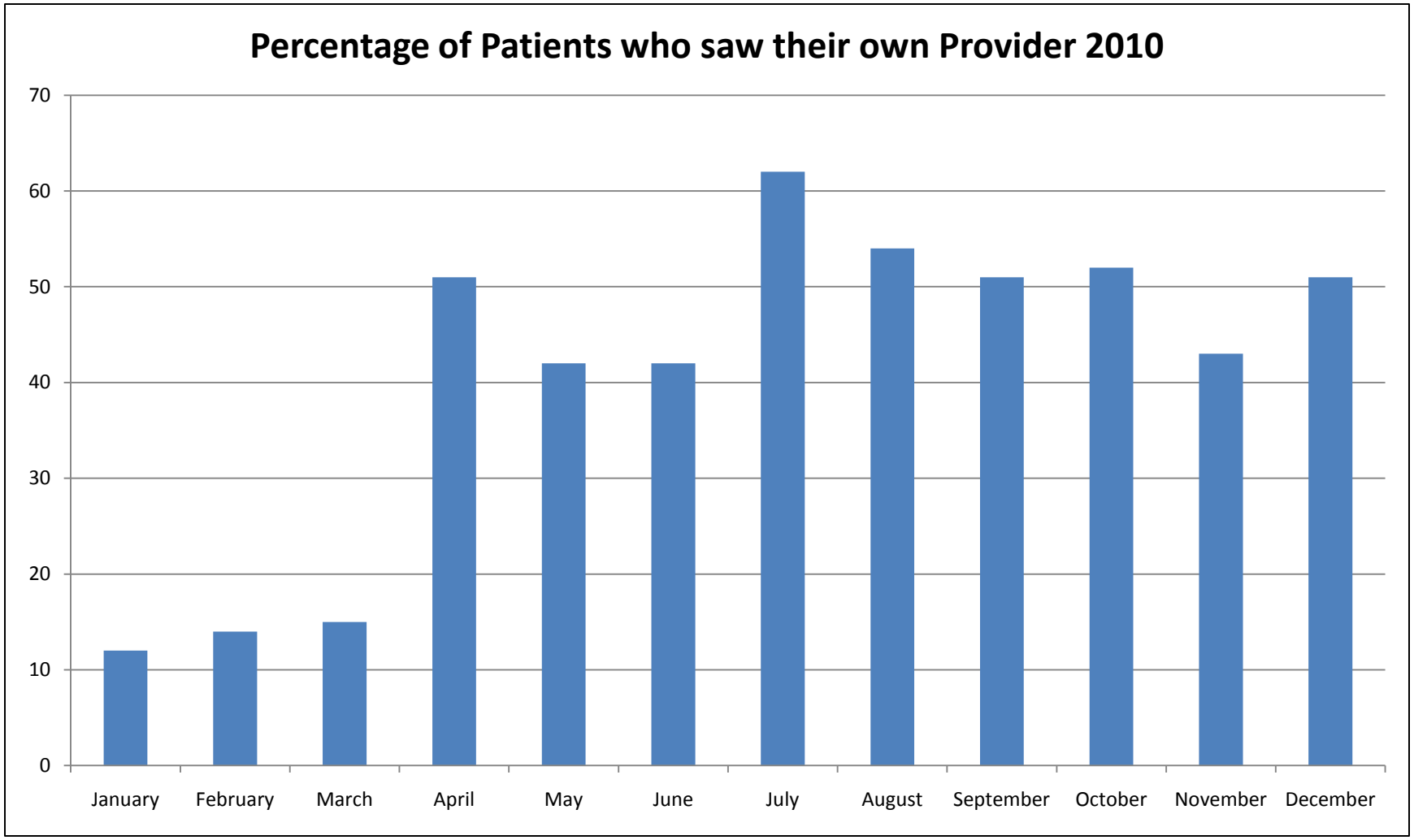

Percentage of Patients who saw their own Provider 2010
70
60
50
40
30
20
10
0
January
February
March
April
May
June
July
August
September
October
November
December

# Patient Centered Interactions

## Patient Satisfaction

- Patient Satisfaction Questionnaire (PSQ-18)

## Patient Efficiency

- Average Patient Wait Time
- Survey Question:

When you visit your doctor's office, how often is it well organized, efficient, and does not waste your time?

## Patient Experience

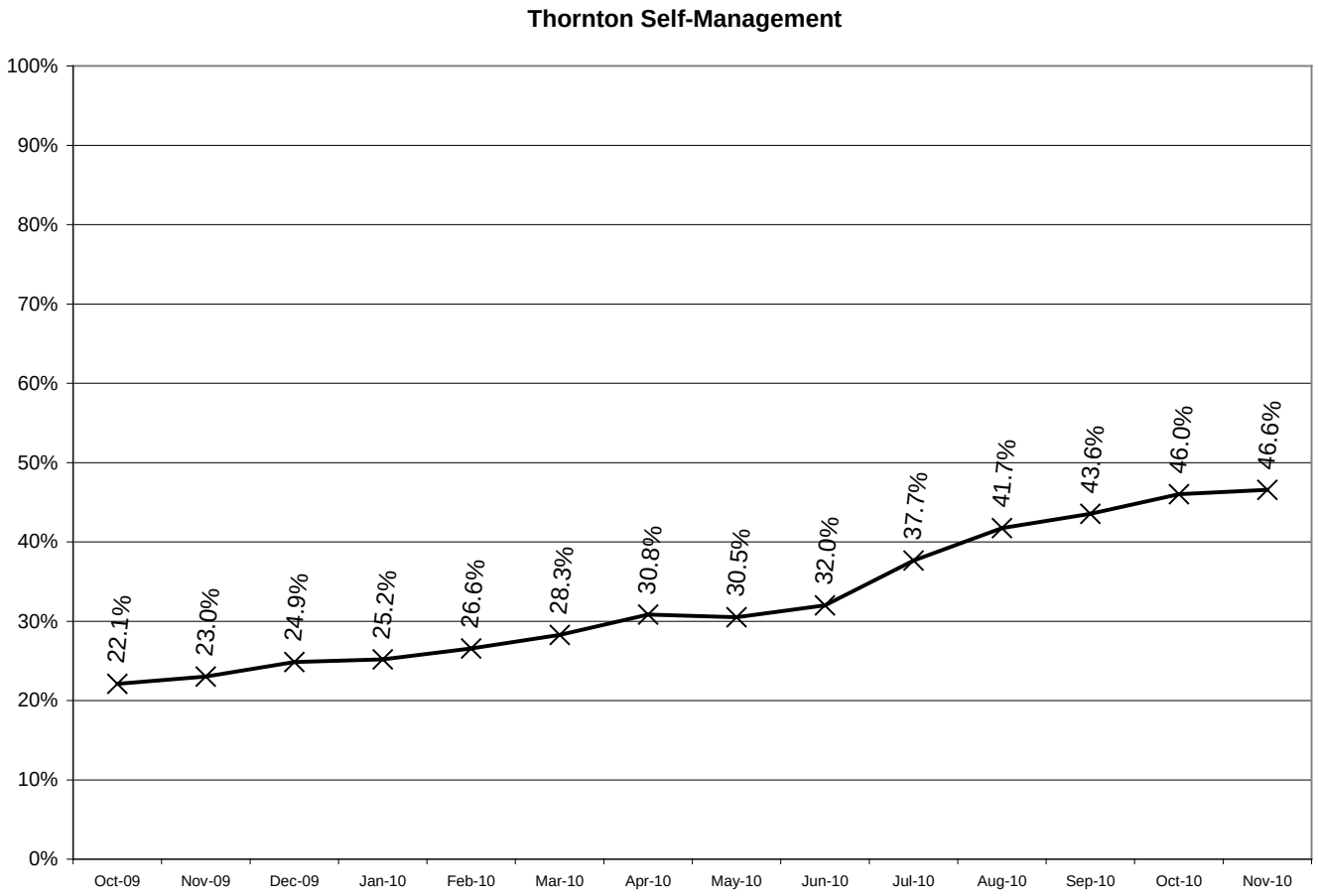
- PCR Patient Experience of Care Survey
- CAHPS-Ambulatory Care Survey
- www.howsyourhealth.org
- Walk-arounds or Focus Groups

## Patient Activation

- % of patients with a self-mgmt goal
- Patient Activation Measure (PAM) Survey

Safety Net Medical Home Initiative. Schaefer J, Coleman K, Morales L, and Brownlee B. Patient-Centered Interactions Implementation Guide, Part 1: Measuring Patient Experience. 1st ed. Seattle, WA: The MacColl Institute for Healthcare Innovation at the Group Health Research Institute and Qualis Health, June 2010.

# Thorton
## Clinica Family Health Services



# Potential Measures supporting other Change Concepts

## ENHANCED ACCESS

- Measures of telephone access
- Measures of walk-in access/wait times
- 3rd next available appointment
- No show rates
- % of patients who had an ED visit during office hours for a non-traumatic event

## ORGANIZED, EVIDENCE-BASED CARE

- Clinical Quality Measures
- Preventive Services Measures

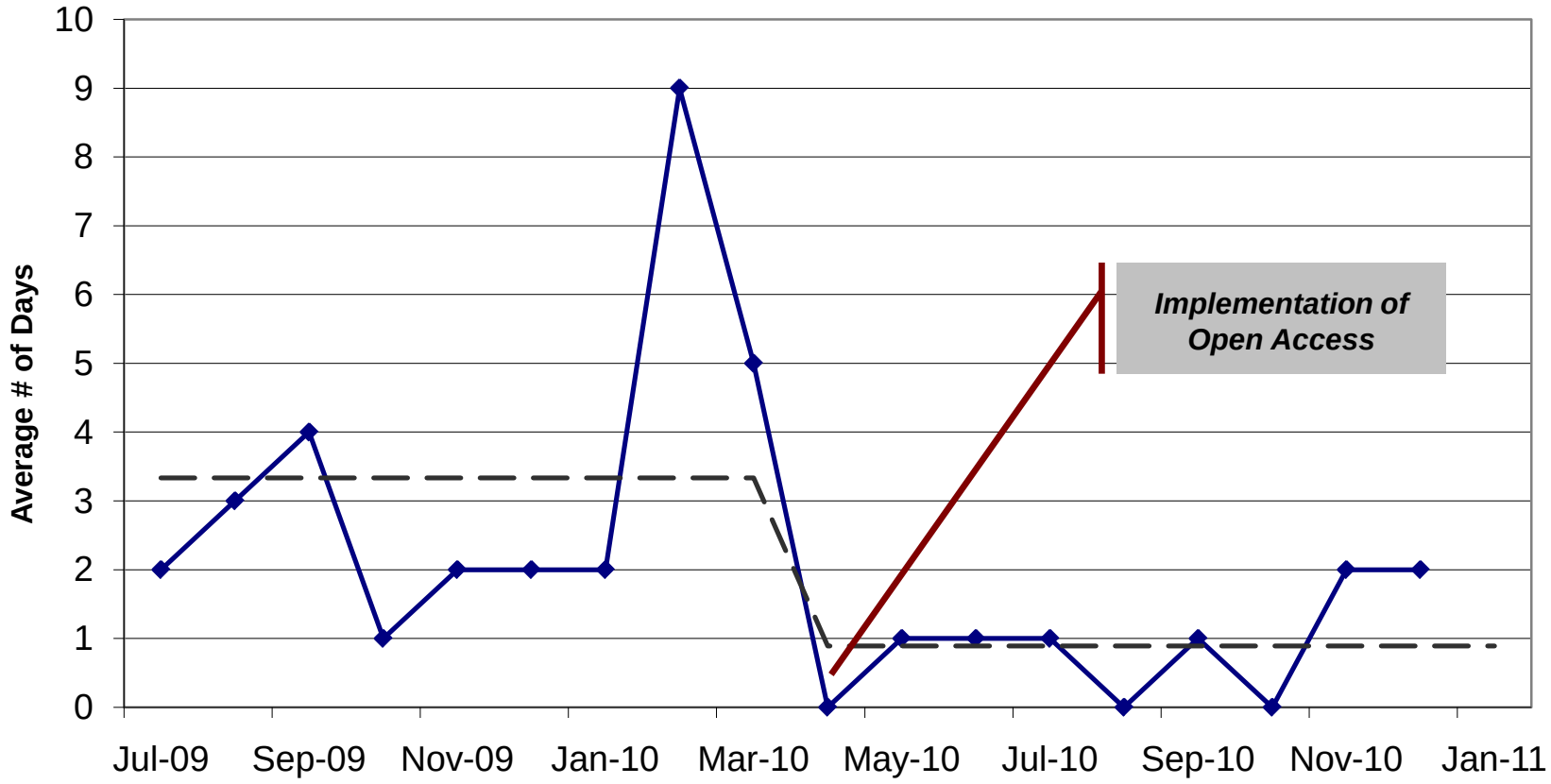
## CARE COORDINATION

- % of patients keeping referred appointments
- % of patients discharged with follow-up by PC team in X days
- % of complete information received from care providers external to the practice site, e.g., hospital, specialty care, community services, etc.
- Avoidable ED visit & inpatient admission / readmission

# Mid County Health Center
## Multnomah County Health Department

**# Days until 3rd Next Available Appointment -**
**Mid County Health Center**

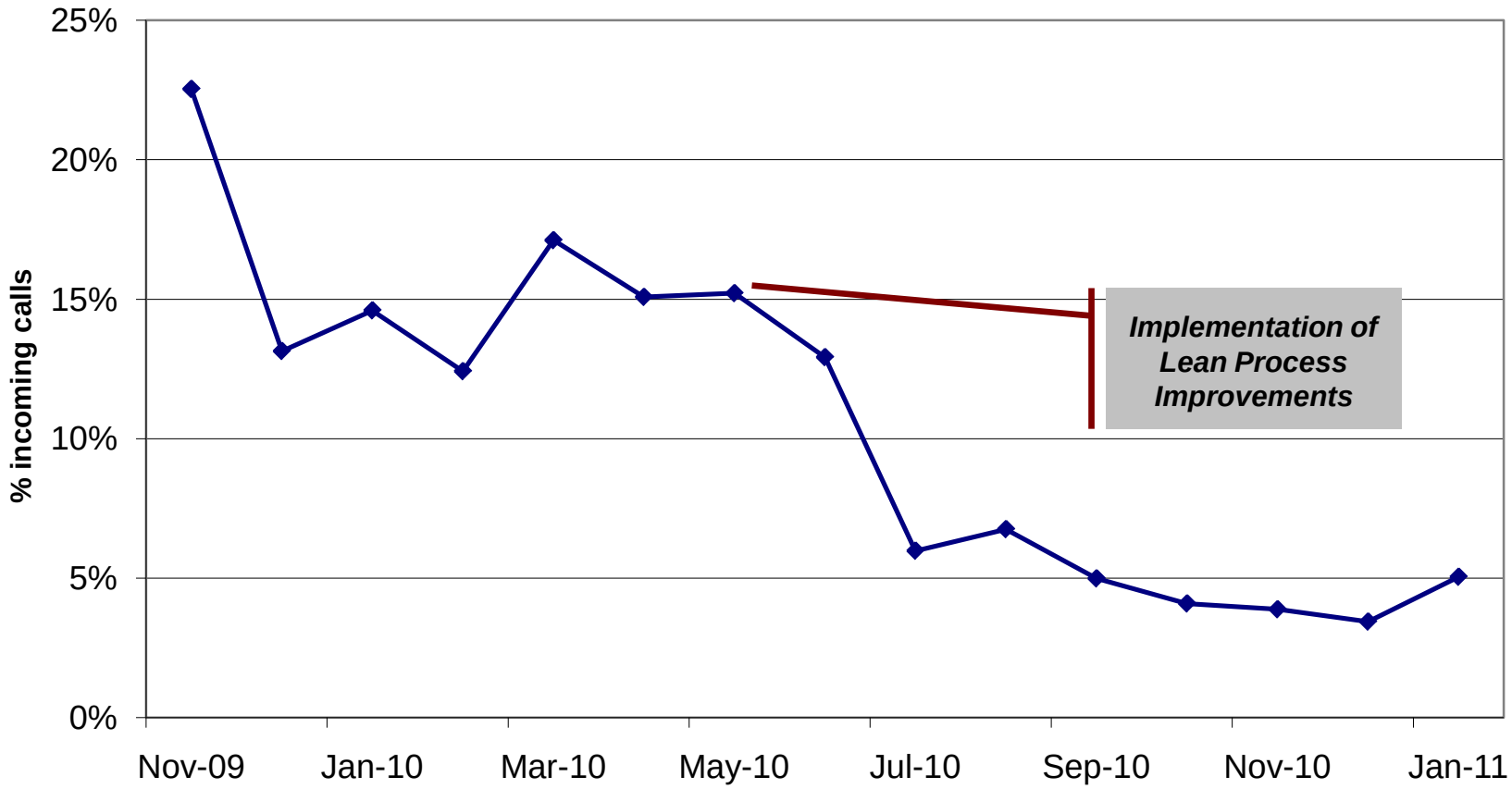
*represents the average # of days until 3 open appointments across all PCP's on Monday morning*



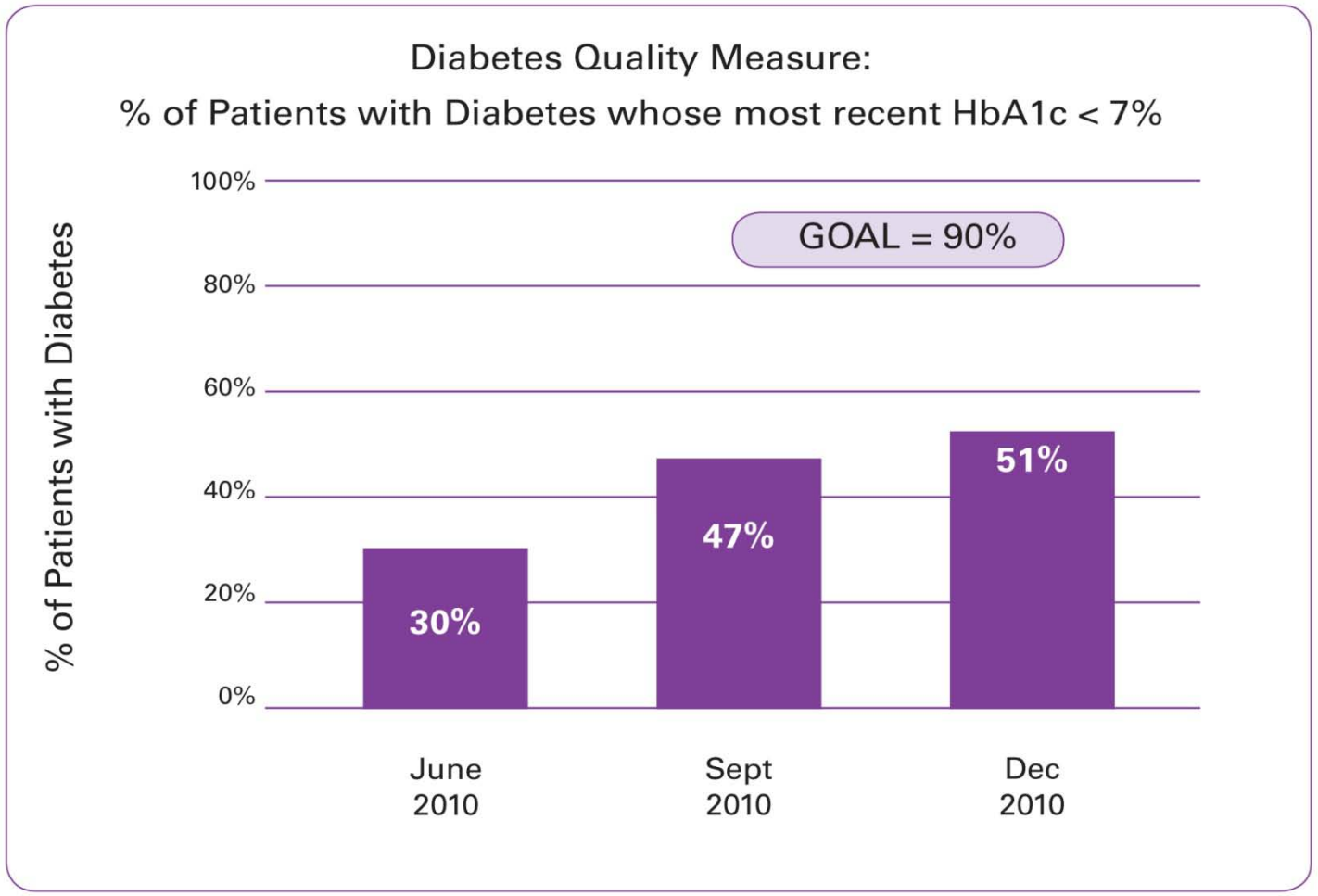
# Mid County Health Center
## Multnomah County Health Department

**% of Abandoned Telephone Calls - Mid County Health Center**

*represents the proportion of calls into the clinic where patients hung up before the call was answered*



# Northview Heights
## Northside Christian Health Center



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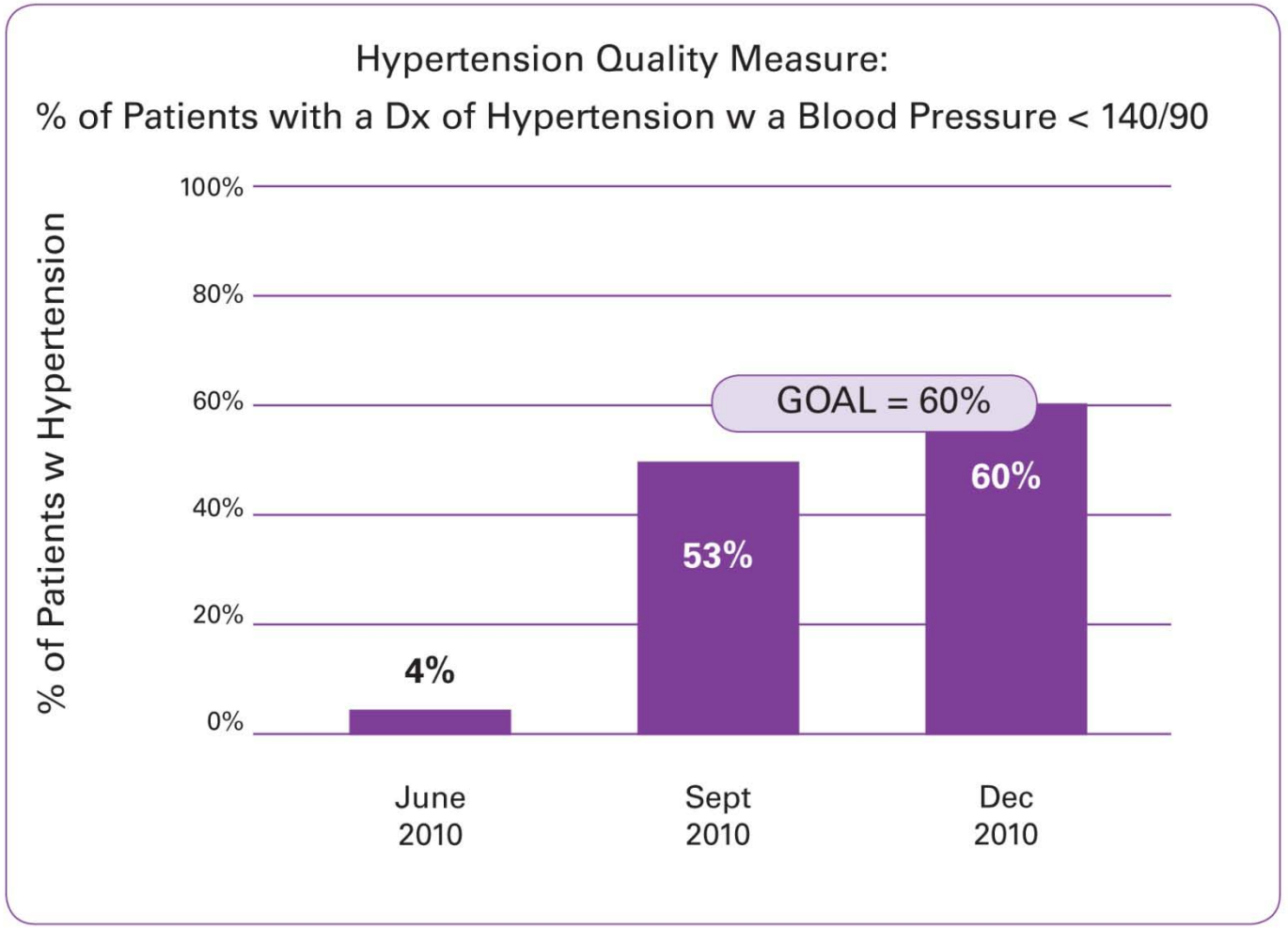

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# Data collection & Reporting are not enough…

"You can't fatten a cow by weighing it."

—Palestinian Proverb

New ideas must be continuously tested and implemented to transform your practice into a Patient Centered Medical Home!

# Thank You!



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