The Super Charged Registry: Inreach and Outreach Tools

The Mojo of Population Health Management

The 4th National Medical Home Summit

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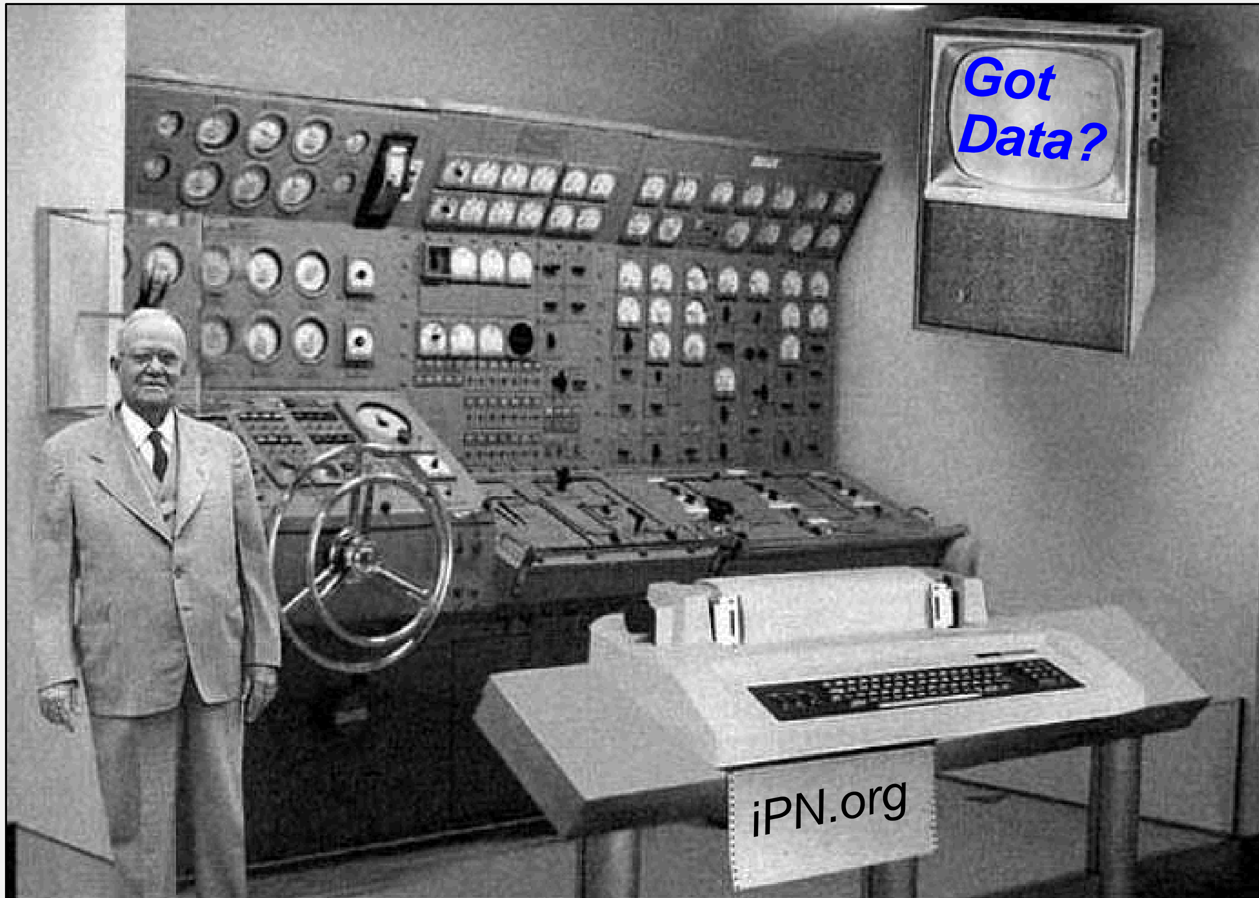
Philadelphia, 27 Feb 2012

Beyond the EHR:



…analytics-powered insight.

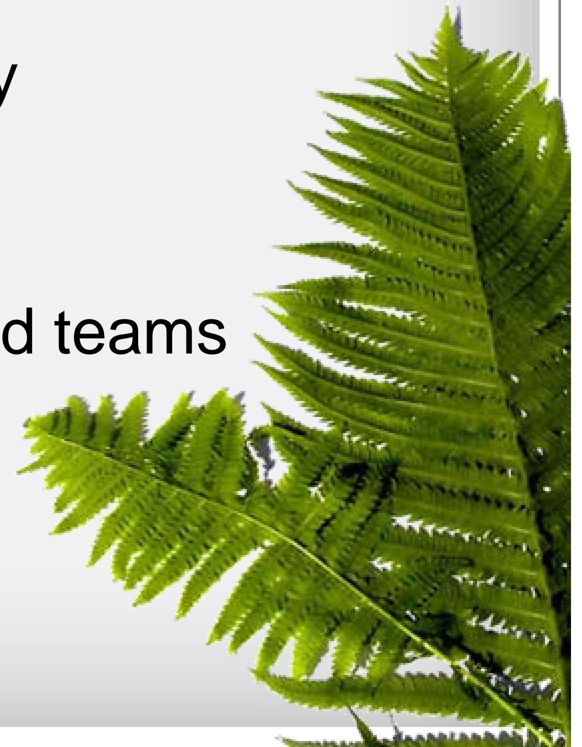
Advanced Registries: thoughts on design and function…

Outreach tools (Registries):

- Population health literacy
- Population health accountability

Inreach tools (Pre-visit planning):

- Prepared, informed, empowered teams
- Efficient teamwork



What if…?

What if the moment you walked into your primary care team's office, *everyone really knew you* and was ready to meet your needs?

What if your health was as *important to your care team between visits* as it was when you were in the office?

What if, at every visit for healthcare, your *provider was relaxed, seemed to have plenty of time to listen, understand and to connect*?

What if, after an office visit, you *consistently felt better informed and more capable* —even energized—to promote your own health?

Registry Impact: Population Health

- Primary Care Team continuity
- Walking the talk of evidence based care
- Demonstrable performance (chronic care, prevention and screening)
- Hot Spotter competency
- Making Transitions of Care safe and efficient
- Moving beyond patient-centered: person-centered
- Patient activation (self management) as priority

OUTREACH tools (Registries):

Population Health literacy and accountability

"What should the tool really do?"

- Patient empanelment—chronic care, prevention, screening, TOC
- Risk stratification, Hot Spotters
- Rules-based alerts
- Actionable—meaningful alerts, standing orders
- Activate teamwork and team members
- Centered on patients, not conditions
- Prospective—informed about patients' care appointments
- Promote PCP continuity
- Care team communication tool
- Never touch providers' hands…

Anatomy of an ultimate registry…the Outreach Tool

Print Date: 2/4/2012

			Chronic Disease					
Name	**ACO**	**Next Appt**	**Diabetes**	**Depression**	**Tobacco**	**Hypertension**	**Transition of Care**	**Self Management**
Esmeralda	X	02/17/2012-WCC						
		Appt on 02/17/2012 at 10:20AM for WCC with					Past Due - HRA	
James				X	X	X		X
						Past Due - Last BP >= 140/90		Past Due - SM Goal
Fred				X	X		X	X
				Due Now - 2 Week F/U			1 ER Visit(s) in last 30 days - Last Visit on	Past Due - SM Goal
Jorge	X		X			X		
			Past Due - Eye Exam Past Due - BP >== 140/90 Past Due - DM Visit Due Now - LDL Lab Due Now - Foot Exam			2 Wks - Last BP >= 140/90		
Marta	X	02/10/2012-RE				X		
		Appt on 02/10/2012 at 09:40AM for RE with				Past Due - Last BP >= 140/90 04/01/2012 - HTN Visit	Past Due - HRA	

Planned Care Registry Outreach

Print Date: 2/9/2012

Total Patients: 2511		Group Visits	Outreach Details			
Person Nbr	Name	Group Visits	Date Reviewed	Comments	Attempt	Status
1234567	Healthy, Jane	X				
		Diabetes				

Planned Care Out Reach

Add new comment

Comment

Call attempt: 1st Call

Call status: Left message

Comment:

High risk pt—called to remind re GV next wk. GHJ

Add Close

Continued…

PC

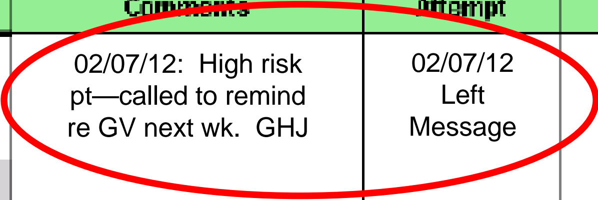
C K

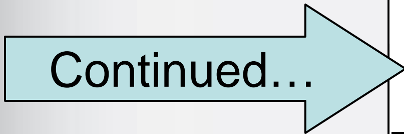
Appt on 02/15/2012 at 09:00AM for DIA with Bezdek Benage, Kimberly

Planned Care Registry Outreach

Print Date: 2/9/2012

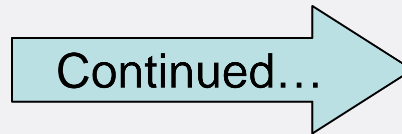
Total Patients: 2511		Group Visits	Outreach Details			
Person Nbr	Name	Group Visits	Date Reviewed	Comments	Attempt	Status
1234567	Helthy, Jane	X	Manage Comments	02/07/12: High risk pt—called to remind re GV next wk. GHJ	02/07/12 Left Message	
		Diabetes GV				





Patient Demographics							
PCP	Phone	Language	DOB	Last Visit	Last Payer	ACO	Next Appt
C Keenan	303 555 1234 c	English	01/15/62	02/06/2012 Bulkacz, A-GV	Clinica CICP N Sliding Scale		02/13/2012-GV, 02/14/2012-DEd, 02/15/2012-DIA
			Age: 50				Appt on 02/13/2012 at 05:20PM for GV with Jensen, Lauren Kindscher, Appt on 02/14/2012 at 02:40PM for DEd with Botero, Maria, Appt on 02/15/2012 at 09:00AM for DIA with Bezdek Benage, Kimberly

Chronic Disease			
Diabetes	**Depression**	**Tobacco**	**Hypertension**
X	X	X	
Past Due - HgbA1c, Lipids, DIA GV	Due Now - 1 Year PHQ	1 Wk - Assessment 1 Wk - Counseling	



Transition of Care	Self Management	Prenatal
x	X	
1 ER Visit(s) in last 30 days - Last Visit on 02/07/2012	Due – Self Mnmt Goal	

Pre-Visit Plan Impact: Practice transformation

- Essential tools of meta-teamwork
- Top of license, “load balancing” the clinical work, flattening the hierarchy
- Informed, efficient workflows
- Enhanced communication (playbook)
- Meaningful work
- The huddle (pre-visit planning) made easy
- Powering triple aim performance (all and only…)
- Proactive “person-centered” care

INREACH Tools (Pre-Visit Planning):

Prepared, informed, efficient teamwork

“What should the tool really do?”

- The daily playbook for team-based care—chronic conditions, prevention, screening, transitions of care
  - Focal point for efficient and effective Pre-Visit Planning
- Actionable—meaningful alerts, standing orders
- Centered on patients, not conditions
- Rules-based alerts
- Prospective—informed about patients’ care appointments
- Anticipatory of Patient needs—refills, near-term EBM “due’s”
- Promotes PCP continuity

A Huddle Playbook…the Outreach Tool

Person Nbr	Patient Name	PCP	Phone Number	Age	Gender	Last Visit	ACO	Next Appt
1234567	**Helthy, Jane**	Keenan, Chris	303 555-1234 cell	57	F	02/08/2012 Keenan, C		Appt on 02/08/2012 at 02:40PM for BRF with Keenan, Chris

Alerts

Tobacco - Current Tobacco User

Past Due - Eye Exam

Past Due - SM Goal

02/23/2012 - BP >= 140/90

03/01/2012 - Last BP >= 140/90

1 ER Visit(s) in last 30 days

Last BMI was 28.76 on 02/01/2012

Past Due – Mammo

Past Due - Flu Vaccine

Last Counseled

4/1/2011

Active Medications

Brand Name	Start Date	Stop Date	Qnty
ASPIRIN EC	8/30/2010	[illegible]/2020	30
CHLORPROPAMIDE	1/23/2012		365
METFORMIN HCL	1/23/2012	2/21/2012	60
LEVOTHYROXINE SODIUM	1/23/2012	1/21/2013	90
PRAVASTATIN SODIUM	1/23/2012	1/21/2013	90
OXYCODONE-ACETAMINOPHEN	2/1/2012	2/28/2012	56
PROMETHAZINE HCL	2/1/2012	3/1/2012	60

Active Problem List

Date	DX Code	DX Description
4/5/2011	250.02	DM, uncomplicated, type II, uncontrolled
6/22/2009	V58.69	High risk medication
1/25/2008	272.4	Hyperlipidemia, unspec.
4/5/2011	401.9	Hypertension, essential NOS
9/9/2010	276.1	Hyposmolality/hyponatremia
1/25/2008	244.9	Hypothyroidism, unspec.
6/10/2011	715.80	Osteoarthrosis multiple sites,

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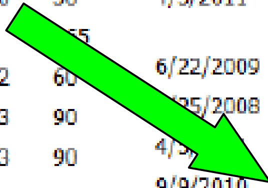
PRAVASTATIN SODIUM	1/23/2012	1/21/2013	90
OXYCODONE-ACETAMINOPHEN	2/1/2012	2/28/2012	56
PROMETHAZINE HCL	2/1/2012	3/1/2012	60
CLONAZEPAM	2/8/2012	3/6/2012	28
METOPROLOL TARTRATE	2/8/2012	3/23/2012	180



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1/25/2008	244.9	Hypothyroidism, unspec.
6/10/2011	715.80	Osteoarthrosis multiple sites, not specified as ge
1/25/2008	733.00	Osteoporosis, unspec.
1/25/2008	278.02	OVERWEIGHT

Diabetes - High Risk

Systolic	Diastolic	Eye Exam	Foot Exam	A1c Date	A1c Value
160	100	10/01/09	4/5/11	1/23/2012	8.8
				10/10/2011	7.7
				6/10/2011	8.4

Group Visit: No

Depression - Intervention Due

Cycle Start	2 Week	6-12 Week	6 Month	1 Year	Last BHP Seen	Date Seen
12/6/2011	12/22/2011				Shannon, Rachel	8/31/2010

Current treatment stage is **Acute**

PHQ Date	Score	Q9	Q10
12/6/11	21	2	3
10/22/10	9	0	2
8/31/10	12	0	1

Therapy Type	Therapy Location

Medication Class	Generic Name	Dose
Antidepressant		
Antipsychotic		
Antianxiety	CLONAZEPAM	

PCMH line-up: just how important are Inreach and Outreach tools ("advanced registries")?

Directly impact **all 6 Standards** and **20 of the 27 Elements**:

1G: Practice Team

2D: Use Data for Population Management

3C: Care Management (Huddle)

4A: Self Management

5A: Test Tracking

6C: Continuous Quality Improvement

Practice transformation—really?

Advanced Registries as the soul of primary care…reinvented:

1. Healthcare Value IT—mining the database gold for population health literacy
2. Engaged Learning Organization—powering team-based care
3. Community Benefit—transparent, market relevant and accountable

Really!

Powering the Planned Care Model

Community

Resources and Policies

Health System

Health Care Organization

Self-Management Support

Delivery System Design

Decision Support

Clinical Information Systems

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

IMPROVED OUTCOMES

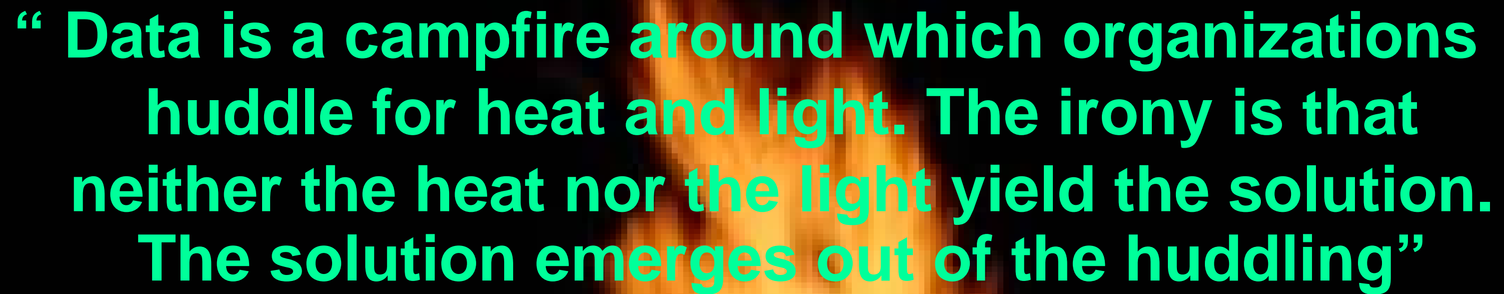
What if…?

What if a busy PCP schedule was *12 patients/ day*?

What if each PCP was supported by a team of 2 MAs?...and that the *MAs did as much clinical care* as the provider?

What if pre-visit planning (huddling) was the *key to a relaxed day and superior population-based care*…and technology was a *gateway not a barrier to effective and efficient huddling*?

What if, aside from indicated physical exams and Pap smears, PCPs *never did prevention, screening or routine chronic care* management?...but could prove that the care their panel of patients received was in the 90th percentile nationally?



“ Data is a campfire around which organizations huddle for heat and light. The irony is that neither the heat nor the light yield the solution. The solution emerges out of the huddling”

--Stolen shamelessly from the 2009 Vancouver IHI Office Summit--

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