UHA POPULATION HEALTH UPDATE

Purpose: This update is intended to help providers inform and shape improvements to Population Health Management and Clinical Quality Measures processes and programs.

IMPORTANT UPDATES FOR THE WEEK ENDING MARCH 18, 2016

Direction and Current State

We are embarking on an effort to develop a comprehensive and standardized approach to clinical quality improvement within UHA

Project Charter for RPIW #1:

- In-scope
  - Back office flow
  - Pre-visit processes
  - Front Desk processes
  - Epic Enhancements
  - Preliminary Outreach
  - Care Pathways for Diabetic Management, HTN, and Lipids
- Out of Scope
  - Care Coordination

Voice of the Patient Session - conducted on 2/22 with the Patient & Family Advisory Counsel at Collaborative Primary Care in Los Gatos.

- **Lessons on Value**-
  - Very interested in Population Health Management and how it could change the face of healthcare
  - Would select a MD who offered the development of a total patient care plan & support services that assisted with care plan execution over a MD who does not
  - Should educate patients in overall concept of Population Health Management and the value of closing quality care gaps to engage and build patient accountability
    - i.e. in-office posters, charts with "lives saved" due to screening, reader boards in lobby

- **Lessons on Engagement, how do we motivate and activate partnerships with patient to close gaps-**
  - NO PAMPHLETS! Overwhelming agreement that this is not effective and leaves patient feeling as if the physician doesn't care
  - Health fairs, in-clinic education, fun challenges or activities
  - MyHealth push notifications- could use this in a multitude of ways including DUE reminders of labs, injections, medication management, and procedures. Also leverage to send short educational messages regarding condition and motivational messages to "stay on-track"
  - SEAL-THE-DEAL if you engage a patient in attending to a care gap then seize the moment and do so. i.e. colonoscopy then recommend a physician who can perform and help schedule the appointment before the patient leaves the office.
  - "Hover to Discover" connect patient to meaning of lab results by allowing them to hover over the result to see a pop-up that explains how to interpret and next steps. Push notification may also be leveraged to encourage follow-up if needed.

- **Lessons on Care Teams/Care Coordinators**-
  - Idea very well received. Group loved the idea of having someone who could help you maneuver the complexity of the system but guiding principles of this position would be:
    - Meeting assigned care team should not be a separate appointment but occur at time of MD appointment or concurrent with appointment (not another day)
    - Know Me- create a personal connection so I feel accountable to not only my personal health but to Care Team.

- Be familiar and know my story. When reaching out to me, know my unique plan. Patients do NOT want to have to explain who they are, their health story, or their care plan. You contacted them, know their needs.

Getting Data Collection Right!- A series of working sessions to focus on the 4 major inputs of data capture which support the Population Health :

- Capture of "Outside Data"
  - New Practice Onboarding – standard abstraction protocol for key data
  - New Patient Onboarding – standard (focused!) "patient records request"
- Capture of Data "Hidden" in Epic
  - Media File – one time chart review/abstraction
  - Care Everywhere – one time and prn chart review and abstraction
- Prospective Document Management
  - Centralized Process – Direct feed>HIMS abstraction
  - Local Process – Quick Abstractor
- Visit Documentation
  - Facilitation – make work of "data collection" a by-product of clinical work
  - Standard Work – provider/staff training on key input locations for key data

By identifying gaps early we are better able to utilize participant time at the RPIW more effectively.

What's Next?

- Communication Plan. We have taken partnership with Margaret Grumley, Branding & Communications Manager to develop ongoing plans for project communication to stakeholders within UHA that will include monthly updates to the East Bay Leadership team.
- Pilot Site RPIWs and implementation: March 21st-23rd
- Pilot Site Implementation Week starting March 28th at Alameda Family Physicians and Collaborative Primary Care.

Recognition & Gratitude:

- Thank you to all clinics that participated in process walks!
- Thank you Dr. Richard Sankary, Dr. Karen Sharpe, and Dr. Michael Zimmerman from the project MGT team for guiding, advising, and shaping outcomes at the Current State Mapping event!
- Thank you to Dr. Richard Sankary and team for focus & development of Care Pathways!
- Thank you to AFP & CPC for partnership in process walks and data collection!
- Thank you to Dr. John Carper & Dr. Angela Stapleton for dedicated work in data sessions!
- Thank you to Dr. Angela Stapleton, Dr. Rachel Seaman, Aman Lail, and the staff of Collaborative Primary Care for hosting the Voice of the Patient focus group with their PFAC team!
- Thank you to Dr. Michael Zimmerman for guidance & support regarding Population Health Dashboard & data abstraction!
- Thank you to Alameda Family Physicians and Collaborative Primary Care for being our pilot sites ☺

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