Using Data to Positively Impact Community Health

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Our Mission is to Provide Excellent, Comprehensive Healthcare to the Residents and Visitors of Wallowa County.
Winding Waters Clinic – Enterprise

• Wallowa County Profile
  – 7,045 people in 3,145 square miles (2.2 people per square mile)
• Health Care Services Profile
  – Local 22 bed Critical Access Hospital, mental health services, 3 primary care clinics
  – 66 miles from the next nearest hospital
  – 104 miles from the nearest cardiology office (no interventional cath lab)
• Winding Waters Clinic Profile
  – 3 Clinician FTEs (4 MDs, 2 NPs and 1 PA)
  – 4.88 Care Team FTE
  – 12,000 visits in 2013
  – Moved into new Office Space 7/1/12
• Patient Profile
  – 3200 active patients
  – 30% of patients over 65
  – 97% Caucasian
  – 42% Medicare, 27% Medicaid, 5% Uninsured
Using Data to Positively Impact Community Health

Health Literacy and Diabetes Intervention Projects funded in part by the Health Resources Services Administration Office of Rural Health Policy Small Provider Quality Improvement Grant

Health Literacy and Diabetes Intervention Projects implemented in partnership with Wallowa County Mental Health, Northeast Oregon Network, and Eastern Oregon University Health and Wellness Department
Winding Water Clinic Change Process

1. Idea Mandate Workflow Change
2. Person Initiating Change
3. Discuss Topic Prioritize Topic Create A3
   - Present at Exec/Ops Mtg Proposal to group 3-5 days before mtg A3 revised as needed
     - Pilot Project Roll Out
     - All Clinic Roll Out
     - Denied or More Detail Needed
   - Present at QI Meeting Proposal to group 3-5 days before mtg A3 revised as needed** A3 Posted
     - Present at BO/Provider/FO/PAC/CCT mtgs Proposal to group 3-5 days before mtg A3 revised as needed** A3 Posted
     - Go Live published in monthly newsletter Final A3 posted in Back Office for 1 month A3 added to procedure book
Newest Vital Sign (NVS) Workflow

A3 – The Newest Vital Sign

The Newest Vital Sign (NVS)

NVS is a point-of-care literacy assessment tool to be used in primary care offices to assess literacy levels of patients. We are required to have a literacy assessment on file for HRSA grant for all RCM pts.

NVS divides patients into 3 categories:
- Score of 0-1 suggests high likelihood (50% or more) of limited literacy.
- Score of 2-3 indicates the possibility of limited literacy.
- Score of 4-6 almost always indicates adequate literacy.

Capstone project for EOU Health and Resident Graduate student:
10 week project starting April 1, 2014. 5-6 days of clinical time to complete the project (40-50 hours). Kiah Jones (see newsletter for bio) will be focusing on Health Literacy in a rural population. She will compare literacy levels of those with uncontrolled chronic conditions to a baseline cross-sectional sample of WWC patients.

Her primary supervisor will be Randi Movitch. Her day-to-day help and guide will be Kathy Norman, who is very involved in the health literacy piece and will be working with other RN students and staff on the assessment of health literacy levels of our written materials.

Kiah will start 4/1/2014. She will have access to EPIC and will be taught how to check appointments, watch dots, read appointment notes and update the problem list per this A3. She will present her progress, her experience with using NVS with our patients, and her final report (including WWC health literacy statistics) at monthly staff meetings as she is able.

Winding Waters Patients – Uncontrolled Chronic Conditions:
Initial assessment: DM population for whom Randi is providing RCM services.

Long term goal: Data on literacy level (NVS results) recorded in EPIC for all WWC patients with DM and \( \text{\textcape} \).

Kiah gets list of patients from Randi, creates a tracking list (notebook that she leaves at clinic) so that she can ensure that she screens all HRSA study patients.

Kiah will check appointments to determine if RCM patients have an upcoming visit planned during her 10 weeks. If so she will arrange so that the visit coincides with a day that she and Randi are both working.

Winding Waters Patients – Comparison Data:
Initial assessment: Random cross-sectional sampling of patients.

Long term goal: Data on literacy level (NVS results) recorded in EPIC for all WWC patients.

Kiah notifies Johna and Jessie of the days she will be working in clinic. Johna and Jessie will notify FO and BO staff.

MAS working on days Kiah is present will discuss in am huddle that Kiah is working that day and may do literacy assessments on some of the day’s patients.
Data to Measure Health Literacy

• Show Eastern Oregon University Health and Wellness Student NVS Poster

• Show Eastern Oregon University Health and Wellness Student PEMAT Poster
A3 – WWC Diabetes Panel Management

RN Care Manager (NCM) runs diabetes registry from Epic Workbench

NCM stratifies list per the established criteria into categories of patients to be seen: Now, 3 months, 6 months.

Diabetic Treatment Criteria attached

Visit Now
HgA1c > 7 or > 8 if > 80 yrs
LOV > 3 months ago
BP > 140/80
LDL > 100

Visit 3 months
HgA1c > 7
LOV > 6 months ago
BP > 130/80
LDL > 100

Visit 6 months
HgA1c = 6.5 - 6.9
BP > 130/80
LDL < 100

NCM sends out Diabetes Care Team introduction to patients not meeting standards of care.
(Diabetes Care Team Intro Letter on drive)

NCM calls registry patients as a f/u to intro letter. If not on recall for appropriate timeframe, schedule appointment to see their Team on day NCM and PCP in clinic.

NCM makes appointment or forwards patient to front desk.

NCM scrubs next day's schedule and puts warm handoff/PAM needed in appointments notes.

Front desk schedules with PCP, note in appointments "warm handoff to Randi for DM care management. If patient has already had WH from PCP, then put on NCM schedule and note in appointments "to switch to provider."
In morning NCM to huddle with all teams. Review Warm Handoffs and NCM visits who will be switched to provider schedule.

If on NCM schedule she will do vitals, review allergies, and meds. Reviews CBG logs and standards of diabetes care. Conducts diabetes physical exam. Make referrals, labs, order meds and supplies.

NCM changes patient to provider schedule to take over encounter note and bill accordingly. Turns dot red to consult with PCP regarding Standards of Care Plan and Goals.

NCM will do a WH to Health Coach and/or make a referral for future visit.

Front desk will give patient PAM, if not given NCM, Health Coach or Team member (PCP, MA or FO) will give at initial Diabetic Team appointment or every 3 months. The team member will score the PAM and put in Problem list under Screening. If unable to score, then put date PAM given under Screening. Place in PAM box and NCM will enter into the spreadsheet and put score under Screening.

Weekly meeting with Health Coach and NCM to review patients who have been referred

NCM participates in monthly colored team meetings to discuss panel management of diabetes patients.

Measures of success:
Meeting Standards of Care
Quality of Care
Efficiency
Continuity
Financial Stability
Dashboard Reports to Team

Most Recent HgA1c Result
PCP = WWFMC

<table>
<thead>
<tr>
<th>HgA1c Category</th>
<th>Count</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>HgA1c &lt;7</td>
<td>69</td>
<td>57.5%</td>
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<tr>
<td>HgA1c 7-8</td>
<td>28</td>
<td>23.3%</td>
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<tr>
<td>HgA1c 8-9</td>
<td>5</td>
<td>4.2%</td>
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<tr>
<td>HgA1c &gt;9</td>
<td>16</td>
<td>13.3%</td>
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<tr>
<td>Not Administered</td>
<td>2</td>
<td>1.7%</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>120</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

- % Clinic Ave = 80.8
- FM Portland Ave = 72.7
- % Target = 95.0

Graph showing HgA1c results over time from June 2013 to August 2014.
Meaningful Use Analysis from EHR to influence workflows

The data shown for this provider is not valid for attestation because the quality measure summary data was calculated before the reporting period had concluded and the objective measure summary data is not valid.

### Quality Measures

<table>
<thead>
<tr>
<th>Clinical Process/Effectiveness</th>
<th>Denom</th>
<th>Num</th>
<th>Performance Rate**</th>
<th>Excl</th>
<th>Excep</th>
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<tbody>
<tr>
<td>CMS-122: Diabetes: HbA1c Poor Control</td>
<td>45</td>
<td>13</td>
<td>28.9%</td>
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<td>CMS-123: Diabetes: Foot Exam</td>
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<tr>
<td>CMS-127: Pneumonia Vaccination Status for Older Adults</td>
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<td>109</td>
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<td>CMS-163: Diabetes: LDL Management And Control</td>
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<td>CMS-165: Controlling High Blood Pressure</td>
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<td>76</td>
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Meaningful Use Analysis from EHR to influence workflows

<table>
<thead>
<tr>
<th>Objective Measures</th>
<th>Q4 '13</th>
<th>Q1 '14</th>
<th>Q2 '14</th>
<th>Q3 '14</th>
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<tr>
<td>Enter Orders Using CPOE (Patients)</td>
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<td>Prescribe Medications Electronically</td>
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<td>Record Patient Demographics</td>
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<td>Record Vitals, BMI, and Growth Charts (2014)</td>
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<td>Order Lab Tests with Structured Results</td>
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## Patient Feedback for their Care Teams

### Composites - Achievement Scores

<table>
<thead>
<tr>
<th>Category</th>
<th>WINDWC Score</th>
<th>Oregon Score</th>
<th>Oregon Low Benchmark</th>
<th>Score</th>
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<tr>
<td>Access</td>
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<td>82.1%</td>
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<td></td>
<td>87.5%</td>
<td>74.0%</td>
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<td>Communication</td>
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<td></td>
<td>97.2%</td>
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<tr>
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<td>39.1%</td>
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<td>41.4%</td>
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<td>Office Staff</td>
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<td>93.2%</td>
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<td>649</td>
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<td>Shared Decision Making</td>
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<td>61.1%</td>
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<td></td>
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<td>56.0%</td>
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<td>Adult Behavioral</td>
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<td>33.7%</td>
<td></td>
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<td>246</td>
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<td></td>
<td>36.6%</td>
<td>26.5%</td>
<td></td>
<td></td>
<td>649</td>
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</tbody>
</table>

Worse | Percent of members reporting satisfaction | Better

*Statistically significantly higher/lower than Oregon*
Thank you!!!!

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