The Power of Science + Art: Pairing Data with Patient-centered Care Strategies to Make Your Patient Populations Healthier

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Welcome to The Future

WHAT’S IN YOUR WAY?
Why use data and measurement?

- Identify areas for improvement - separating what you think is happening from what’s really happening
- Knowing your population, not just your patients - establishing a baseline and allowing for periodic monitoring
- Determining whether changes lead to improvements instead of just change
- Reinforcing behaviors that lead to improvement
- Comparing and sharing performance with others
Barriers to Putting Data into Action

- Don’t know where or how to get data/info
- Data kept at levels above frontlines
- Lack of interest - focused on the trees not the forest, putting out fires
- Defensiveness
- Incorrect data collection and/or interpretation of data results
CAUTION

THIS SIGN HAS
SHARP EDGES

DO NOT TOUCH THE EDGES OF THIS SIGN

ALSO, THE BRIDGE IS OUT AHEAD
If you don’t think you have a quality problem with your data, you haven’t looked at it yet.
The Five Stages of Data Grief

- Denial
- Anger
- Bargaining
- Depression
- Acceptance
What motivates us?

- FAQ: how to engage front line and organization individuals/systems to work together?
- What motivates us?
  - Autonomy
  - Mastery
  - Purpose
  - DRIVE: The surprising truth about what motivates us
Communication: part of effective, evidence-based leadership we often forget

WHY

HOW

WHAT
“Working at Starbucks would be better.”
Benjamin Crocker, MD, October 3, 2007

“I look forward to going to work each day. I’m loving it!”
Benjamin Crocker, MD, July 13, 2011

Source: Sinskey et al., Ann Fam Med May/June 2013 vol. 11 no. 3 272-278
## Interventions to Improve Chronic Care

<table>
<thead>
<tr>
<th>Quality Improvement Strategy</th>
<th>No. of Trials</th>
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<td>Team Changes</td>
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<td>Electronic Patient Registry</td>
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<td>Facilitated Relay of Clinical Information</td>
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<td>Continuous Quality Improvement</td>
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<tr>
<td>All Interventions</td>
<td>66</td>
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</tbody>
</table>

![Graph showing the difference in postintervention HbA1c](image)

Characteristics of Team Based Care
Facilitators of Team Based Care
Technical Problems

• Problem is clear
• Expert/leader provides solution
• Solutions easy to accept

Adaptive Challenges

• Problem hard to acknowledge
• The team must provide the solution
• Solution requires difficult change
PDSA Includes STUDY and ACT

Step 1: Plan
Plan a change

Step 2: Do
Try it out on a small scale

Step 3: Study
Observe the results

Step 4: Act
Refine the change as necessary
“Be sure to always celebrate your successes and learn from missteps. A low failure rate means you aren’t being ambitious enough in your change initiatives.”

– Dr. Ken Carlson
How to make sharing data throughout the practice work

- **Laugh and Celebrate** - What are the best practices we have and how can we replicate those best practices?
- **Go Beyond “Performance” Metrics** to understand what’s really important
- **Share, share, share - Data Trumps Opinion** - if it’s a matter of opinion, then my opinion counts more than anybody’s.
- **Focus on Next Steps**
- **Create Time and Opportunities for Reflection**
"People will forget what you said, people will forget what you did, but people will never forget how you made them feel.” - Maya Angelou
Oregon Health Authority | PATIENT CENTERED
PRIMARY CARE HOME PROGRAM

- Patient & Family Centered
- Comprehensive
- Coordinated
- Continuous
- Accessible
- Accountable
PCPCH Core Attributes

ACCESS TO CARE
Be there when I need you.

ACCOUNTABILITY
Take responsibility for making sure I receive the best possible health care.

COMPREHENSIVE WHOLE PERSON CARE
Provide or help me get the health care and services I need.

CONTINUITY
Be my partner over time in caring for my health.

COORDINATION AND INTEGRATION
Help me navigate the health care system to get the care I need in a safe and timely way.

PERSON AND FAMILY CENTERED CARE
Recognize that I am the most important member of my care team - and that I am ultimately responsible for my overall health and wellness.
Using Data to Improve Access

“Health Care team, be there when we need you”

Pediatric Clinic, medium-size:

- **Problem:** inadequate in-person appointment access
  - needed more clinicians seeing patients, but no space
  - “booked out” several weeks
  - high “no show” rate
  - wanted to expand hours but didn’t have staff for all days of the week

- **Action:** Brief patient survey regarding access, one question asked about which hours/days would be best.

- **Outcomes:** Result data shared with “run charts” in break room:
  - improved “third next available” appointment
  - decreased “no show” rate
  - Wed PM/Sat. AM clinics fully utilized, lower ER visits

Clinic is now doing CAHPS survey to continually assess patient/family access.
Accountability - “QI”

“Take responsibility for making sure we receive the best possible healthcare”

Family Medicine clinic – medium-sized

- **Problem:** Complex patient population, clinicians/staff felt they weren’t meeting needs

- **Actions:**
  - Visited a clinic doing “medical home” work
  - Staff hired/trained to work in “medical home model”
  - Clinic begins measuring, tracking, and sharing a variety of clinical data – displayed on a white board in “nursing station” area.
  - Each team chooses one metric they want to improve, use “Plan, Do, Study, Act” (PDSA) cycles.

- **Outcomes:** Data helps staff “understand why changes in care are needed” and helps them feel good when improvement occurs - diabetes foot screening (46% → 67%), % of women getting mammograms (<50% → over 80%).
Comprehensive Whole Person Care

“Provide or help us get the health care information and services we need”

Family Medicine clinic – small

- **Problem:** clinicians overwhelmed with workload, preventive care provided only at “annual visits” which patients often miss

- **Actions:**
  - Reviewed roles, trained staff on age-appropriate preventive screening
  - **Any** scheduled patient visit: the MAs “scrub” the records, review the health maintenance alerts
  - Standing order protocols allowing recommended preventive screening tests or vaccination orders to be “teed up” by the MA
  - Staff outreach to patients to close “gaps” in recommended preventive care

- **Outcomes:** Improvement in all preventive care data measures (colon/breast/cervical cancer, childhood/adult vaccines)
Continuity

“Be our partner over time in caring for us”

Internal Medicine clinic – medium-sized

- **Problem:**
  - clinicians work “part time” in clinic
  - schedules overlap
  - lack of in-person access for “over-paneled” providers
  - coverage issues

- **Actions:**
  - Reviewed continuity numbers, importance of continuity
  - Formed functional TEAMS to provide better cross-coverage/access
  - Patients informed of teams/team-members
  - Measure/share team continuity numbers monthly

- **Outcomes:** Clinic feels care improved, they “know” each other’s patients better, >80% continuity, improved patient experience (survey)
Coordination and Integration - Proactive, Rather than Reactive Care

“Help us navigate the health care system to get the care we need in a safe and timely way”

Internal Medicine clinic – medium-sized

- **Problem:**
  - complex patient population
  - high ER use
  - high “no show” rates

- **Actions:**
  - Risk stratified patients
  - Hired dedicated RN “care coordinator” to work with highest risk patients
  - Worked with hospital to use shared “care plans”
  - Hospital tracked/shared ER use

- **Outcomes:** 50% reduction in ER visits + total costs of ER care, Improved Access/Process “quality” measures
Patient & Family centered Care

“Recognize that we are the most important part of the care team and that we are ultimately responsible for our overall health and wellness”

Family Medicine clinic – medium-sized

- **Problem:**
  - complex patient population
  - clinicians feel much of “health” is out of their control

- **Actions:**
  - Produced/reviewed demographic/disease population data
  - Confirmed diabetes, chronic pain were key issues
  - Initiated “peer” group visits, staff education around goal setting, motivational interviewing
  - Tracked data for diabetes, chronic pain (medication/functional levels)

- **Outcomes:** Improved diabetes control, stable pain levels but improved functionality, slightly decreased “scheduled” medication use
Figure 1: PCPCH % Utilization Change vs. Non-PCPCH Primary Care Sites
(* = p<.05)
PCPCH Site Visits: The First Year, Key Learning

- **Variability and Patterns**
  - Near universal need for “help” – near universal “good things”
  - Small/medium-sized clinics working together
  - Larger organization difficulty engaging front lines

- **Common barriers**
  - Finances, resources, FFS billing system
  - EHR
  - Workforce/staff limitations
  - Low adaptive reserve: Lack of support, feeling “alone”, ”change fatigue”

- **Common characteristics of successful/substantial transformation**
  - Motivation
  - Collaborative learning and support
  - Frontline staff/clinician involvement, communication, data-sharing
  - Multi-disciplinary staff involved in improvement
Opportunities to help clinics transform to and sustain robust Patient-Centered Primary Care:

- “Practice Enhancement Specialist”/Peer-mentor support around site visits
- Patient Centered Primary Care Institute (PCPCI.ORG)
- Collaborative learning opportunities
- CCOs + Transformation Center/Innovator Agents
Thank You - DISCUSSION

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