Monthly Population Health Management Sessions to Boost Quality Improvement Initiatives

2017 Symposium on the Future of Complex Care
Gallery of Promising Practices

PROMISING PRACTICE OVERVIEW

Marin Community Clinics (MCC) designates protected population health management time for care teams at all clinic sites from 8:15-9:00 a.m. every second Wednesday of the month. The Quality Improvement department creates population health activities for adult and pediatric provider groups (sometimes women’s health and OB groups as well) ahead of time to maximize the use of these short work sessions. The QI department also uploads relevant patient lists to a secure shared drive prior to the sessions. Activity outlines and expectations are e-mailed to care teams the day prior to the planned work sessions. During the sessions, provider/MA teamlets work through their lists together, using the activity outline as a guide. Teamlets are reminded and encouraged to use best practices related to the quality measure(s) being targeted and are free to enlist the entire care team (RNs, Patient Navigators, Front Office, Medical Records) to plan care and outreach to patients.

AIM

To improve clinical outcomes for MCC patients, particularly those in high risk groups such as the PHASE population (18-75yo with DM or ASCVD), by facilitating evidence-based care via population health management/panel management at the care team level on a regular, consistent basis.

MEASURES

Activities have focused on a variety of clinical quality measures, including those below. Focus measures are selected strategically in response to performance trends or to support a targeted quality improvement initiative or program (ex. QIP, UDS, PHASE).

1. Hypertension control for PHASE patients
2. A1C testing and control for diabetic patients
3. Aspirin, Statin and ACEI/ARB prescribing for PHASE patients
4. Lab monitoring for patients on ACEI/ARB or diuretics
5. Colorectal cancer screening
6. Breast cancer screening
7. Immunizations for children under 2yo
8. Use of controller medications for patients with persistent asthma

Sample Activity Outlines

NOTABLE RESULTS TO DATE

- For 2017 Quarter 2, MCC met or exceeded the RCHC average and the HEDIS 90th percentile for the following PHASE measures: Diabetes A1C control, Diabetes Blood Pressure Control, Statin and ACE/ARB Prescription rates for Diabetics.

- MCC recorded their strongest performance to date for the 2016-2017 Partnership QIP cycle, including achieving FULL POINTS at one of our clinical sites.

LESSONS LEARNED

Providing protected and consistent QI time for providers and staff and designing structured population health management activities, complete with relevant and manageable corresponding patient lists, creates a culture of QI, advances principles of team-based care, and provides team time to plan for outreach and in-reaching patients overdue or not at goal for a variety of clinical measures. Guided activities allow MCC’s QI department to draw attention to specific measures when needed and to highlight and disseminate best practices and standardized workflows to all of our 5 clinic sites and numerous care teams simultaneously. Population health management activities also encourage providers to better understand the relevance of various QI measures and to help validate data and elucidate the drivers that influence our performance in many clinical areas.