Division of TennCare

STATE OF TENNESSEE

PCMH: Evidenced Based Care

10/16/18

Presented by: Rick Walker, Coach Lead, PCMH CCE

Presenter

Rick Walker
Coach Lead for the state of Tennessee PCMH/THL Initiative

Today's Agenda:

11:00 – 11:45 am

- Evidence Based Care

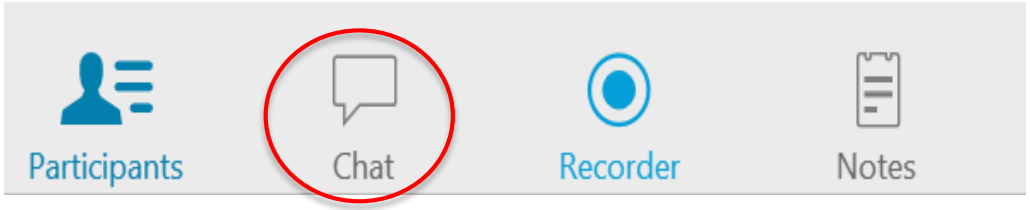
11:45am – 12:00pm

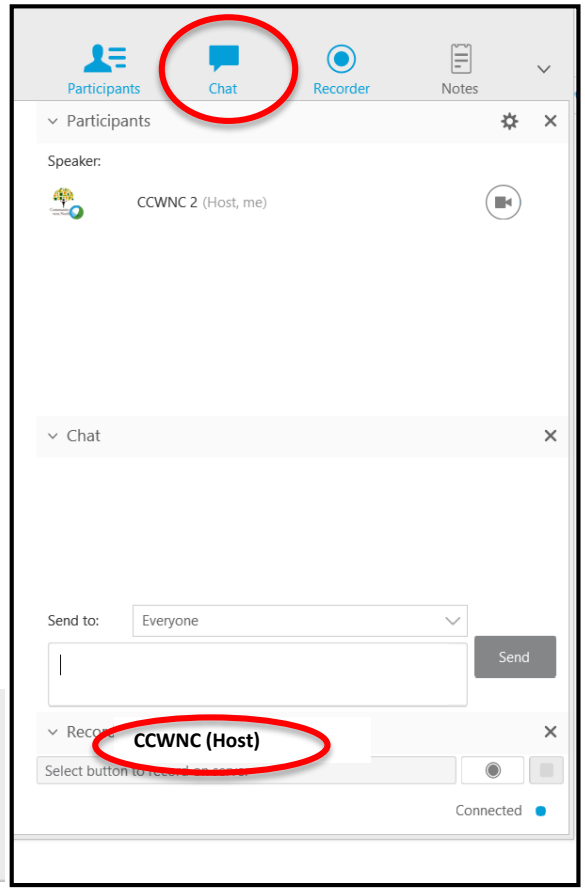
- Facilitated Discussion
  - Best Practices, Challenges and Novel Ideas

Introduction to the webinar

Chat box during the presentation:

- Send to the Host
  - BEST PRACTICES
  - CHALLENGES
  - NOVEL IDEAS
  - QUESTIONS





Quick Review: PCMH 2017 Terminology

Today's Concepts:

KM : Knowing and Managing Your Patients

CC: Care Coordination and Care Transitions

Evidence-Based Care

Evidence-Based Care

KM11 (core): Identifies and addresses population-level needs based on the diversity of the practice and the community. Demonstrate at least 2:

A. Target population health management on disparities in care
B. Address health literacy of the practice
C. Educate practice staff in cultural competence

KM12 (core): Proactively and routinely identifies populations of patients and reminds them, or their families/caregivers, about needed services (practice must report at least 3 categories)

A. Preventative care services
B. Immunizations
C. Chronic or acute care services
D. Patients not recently seen by the practice

Evidence-Based Care

KM20 (core): Implements clinical decision support following evidence-based guidelines of care of (Practice must demonstrate at least 4 criteria):

A. Mental Health condition
B. Substance use disorder
C. A chronic medical condition
D. An acute condition
E. A condition related to unhealthy behaviors
F. Well child or adult care
G. Overuse/appropriateness issues

CC3 (2 credits): Uses clinical protocols to determine when imaging and lab tests are necessary. www.choosingwisely.org

CC5 (2 credits): Uses clinical protocols to determine when a referral to a specialist is necessary.

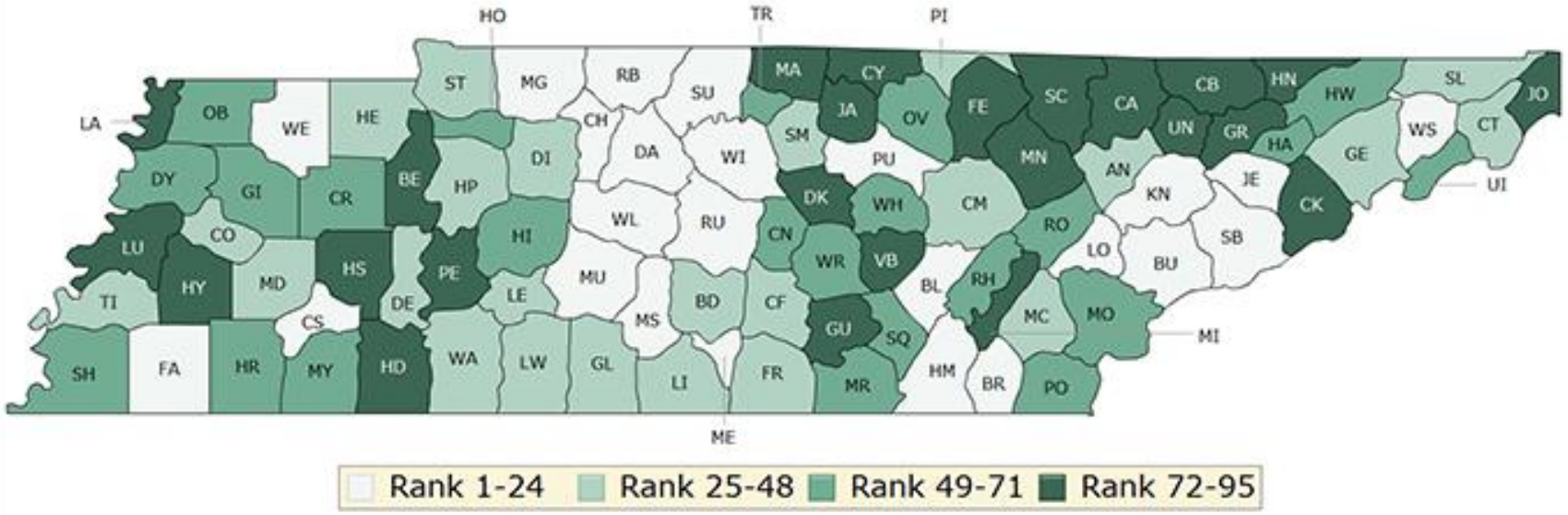
Train Staff on Population Management

KM11 (1 Credit): Identifies and addresses population-level needs based on the diversity of the practice and the community (demonstrate at least 2)

A. **Target Population Health Management (PHM) on disparities in care**
B. **Educates practice staff on health literacy**
C. **Educates practice staff in cultural competence**

A. Target PMH on disparities in care

How Counties Rank for Health Outcomes



A. Target PMH on disparities in care cont.

	Healthiest TN County	Least Healthy TN County	AI/AN	Asian/PI	Black	Hispanic	White
Premature Death (years lost/100,000)	3,800	14,400	3,700	3,400	11,200	4,000	8,800
Poor or Fair Health (%)	12%	23%	32%	N/A	21%	18%	18%
Poor Physical Health Days (avg)	3.5	5.4	N/A	N/A	4.2	3.5	4.3
Poor Mental Health Days (avg)	3.8	5.3	N/A	N/A	4.7	3.8	4.3
Low Birthweight (%)	6%	10%	8%	8%	14%	7%	8%

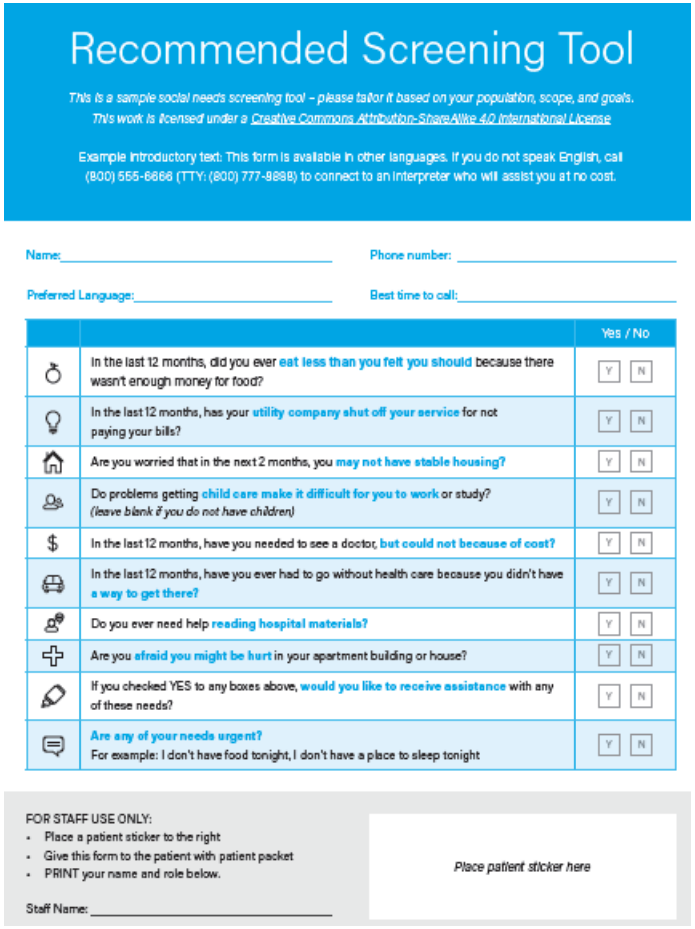
A. Target PMH on disparities in care cont.

Children without health insurance

Location	Data Type	2009	2010	2013	2014	2015	2016
Memphis	Number	15,000	11,000	13,000	10,000	12,000	9,000
	Percent	8%	7%	8%	6%	8%	5%
Nashville - Davidson	Number	8,000	9,000	9,000	11,000	6,000	8,000
	Percent	6%	7%	7%	8%	5%	6%

A. Target PMH on disparities in care cont.

Addressing Social Determinants



Recommended Screening Tool

This is a sample social needs screening tool – please tailor it based on your population, scope, and goals.
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Example introductory text: This form is available in other languages. If you do not speak English, call (800) 555-6666 (TTY: (800) 777-9898) to connect to an interpreter who will assist you at no cost.

Name:_____ Phone number:_____

Preferred Language:_____ Best time to call:_____

		Yes / No
	In the last 12 months, did you ever **eat less than you felt you should** because there wasn't enough money for food?	Y N
	In the last 12 months, has your **utility company shut off your service** for not paying your bills?	Y N
	Are you worried that in the next 2 months, you **may not have stable housing?**	Y N
	Do problems getting **child care make it difficult for you to work** or study? *(leave blank if you do not have children)*	Y N
$	In the last 12 months, have you needed to see a doctor, **but could not because of cost?**	Y N
	In the last 12 months, have you ever had to go without health care because you didn't have **a way to get there?**	Y N
	Do you ever need help **reading hospital materials?**	Y N
	Are you **afraid you might be hurt** in your apartment building or house?	Y N
	If you checked YES to any boxes above, **would you like to receive assistance** with any of these needs?	Y N
	Are any of your needs urgent? For example: I don't have food tonight, I don't have a place to sleep tonight	Y N

FOR STAFF USE ONLY:
- Place a patient sticker to the right
- Give this form to the patient with patient packet
- PRINT your name and role below.

Staff Name:_____

Place patient sticker here

- Social Needs Screening Toolkit

www.healthleadsusa.org

- PRAPARE

www.nachc.org

B. Educates practice staff on health Literacy

- Health literacy is *our* problem, not the patients
- Avoid Making Assumptions About Language Preferences or Literacy Level
- Plain, non-medical language: Use common words when speaking to patients
- Slow down: Speak clearly and at a moderate pace.
- Teach-back: Confirm patients understand what they need to know and do by
- asking them to teach back directions.
- Improve written communication
- Improve self-management and empowerment
- Improve supportive systems

B. Educates practice staff on health Literacy What, Why, and How? (cont.)

What is Health Literacy?

- Health literacy is defined as the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions
- Why must we assess?
- And how do you assess Health Literacy?

1. Institute of Medicine: Ten Attributes of Health Literate Health Care Organizations
2. Agency for Healthcare Research & Quality: Health Literacy Universal Precautions Toolkit
3. Alliance for Health Reform Toolkit

Health Literacy Skills

A patient with health literacy skills will be able to:

1. Communicate health problems to their providers and understand health information
2. Read prescription bottles and understand treatment regimens
3. Read and understand warning labels to recognize potentially life-threatening complications from medications
4. Implement self-care strategies and manage their health at home
5. Read and understand health insurance forms, informed consent, and public assistance applications

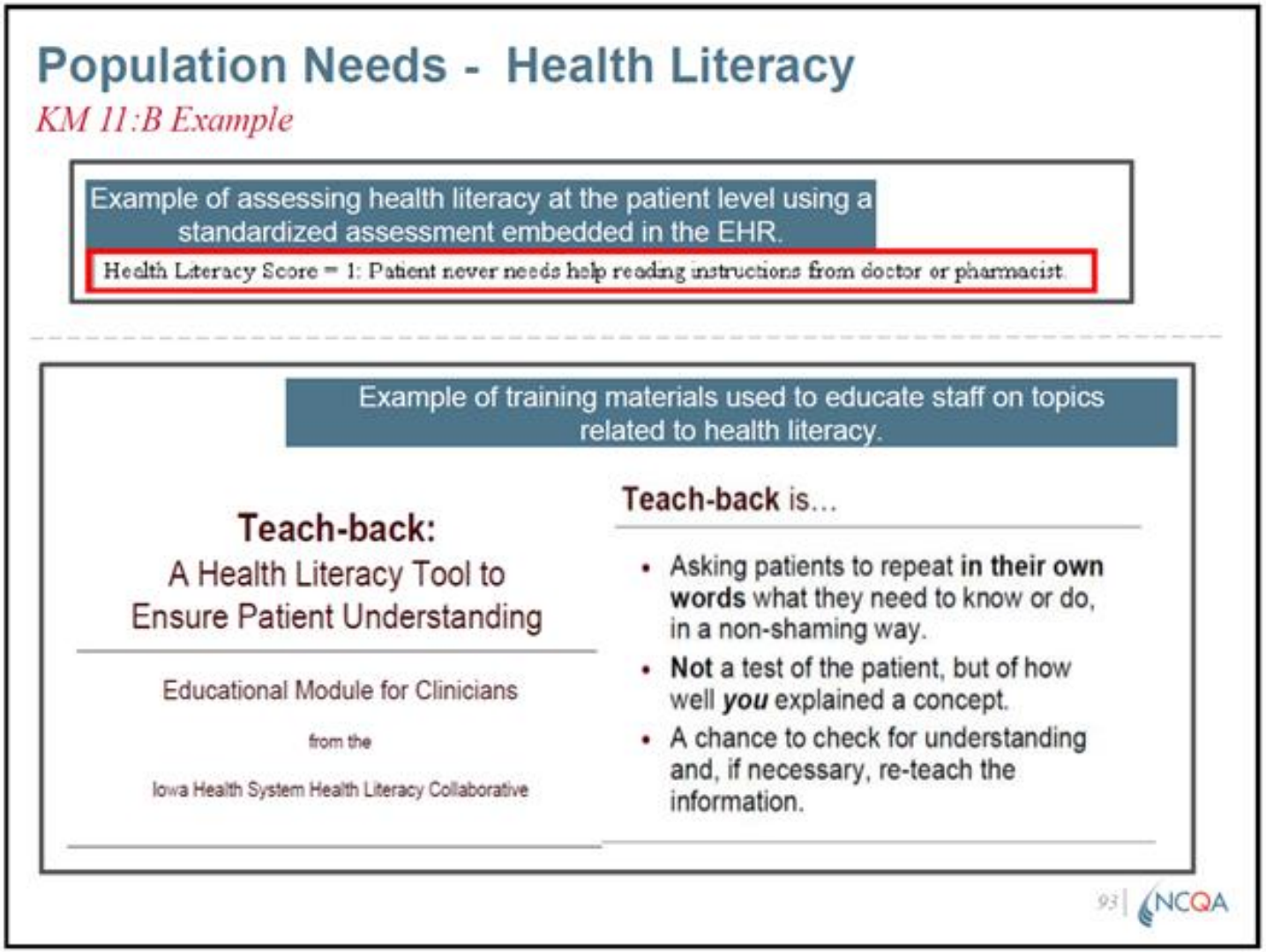

...AND IF THIS IS ALL TOO CONFUSING, WE RECOMMEND LOGGING ONTO OUR WEB SITE AT WWW.MEDICARE.GOV QUESTIONS?
WHAT THE IS A WEB SITE?
MEDICARE Rx DRUG PLAN
CALL BUTTERBALL HOTLINE
CORRECTION:
EARLY BIRD SPECIALS
WORM FRONT
1-90
ONE FROM COLUMN A
ONE FROM COLUMN B
OPTION X
OPTION Y
OPTION Z
CARLSON

Improved Communication

Teach-back

1. Ensuring agreement and understanding about the care plan is essential to achieving adherence
2. “We don’t always do a great job of explaining our care plan. Can you tell me in your words how you understand the plan?”
3. Some evidence that use of teach-back is associated with better diabetes control

Teach-Back


Population Needs - Health Literacy
KM 11:B Example
Example of assessing health literacy at the patient level using a standardized assessment embedded in the EHR.
Health Literacy Score = 1: Patient never needs help reading instructions from doctor or pharmacist
Example of training materials used to educate staff on topics related to health literacy.
Teach-back:
A Health Literacy Tool to Ensure Patient Understanding
Educational Module for Clinicians
from the
Iowa Health System Health Literacy Collaborative
Teach-back is…
• Asking patients to repeat in their own words what they need to know or do, in a non-shaming way.
• Not a test of the patient, but of how well you explained a concept.
• A chance to check for understanding and, if necessary, re-teach the information.
93
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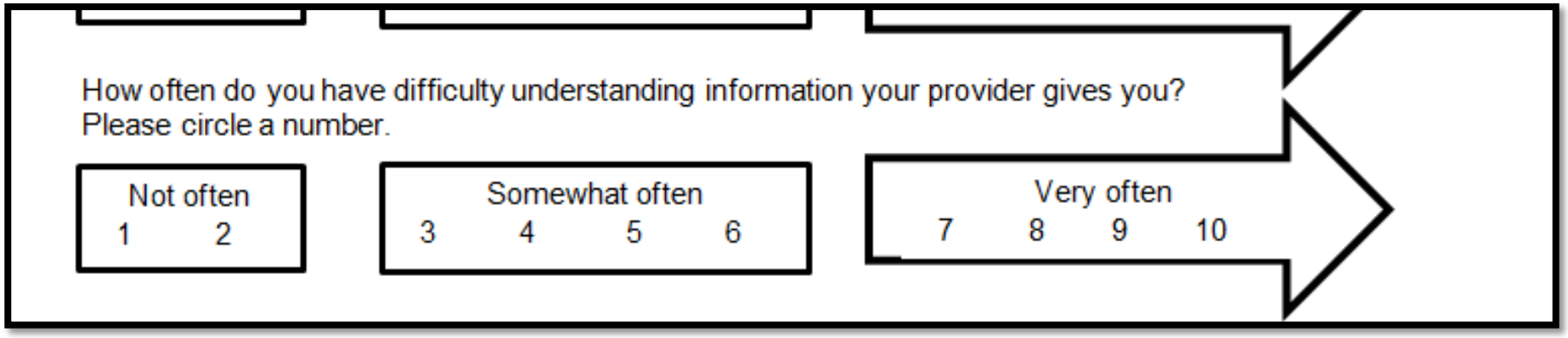
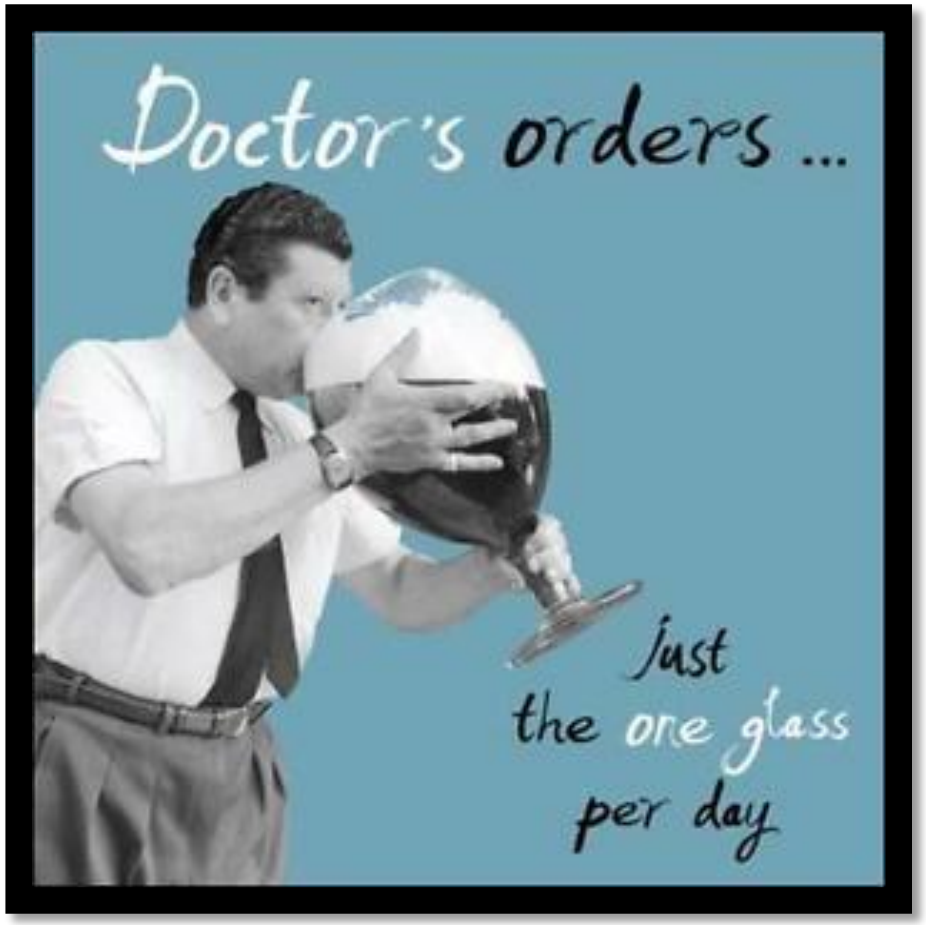
Teach-Back

Here is an example of what we have seen some practices add to the bottom of their goal setting sheet.



Teach-Back



Cultural Competence

- Cultural competence is the ability to understand, communicate with and effectively interact with people across cultures
- Cultural competence encompasses:
  - Being aware of one's own world view
  - Developing positive attitudes toward cultural differences
  - gaining knowledge of different cultural practices and world views

Resources for Cultural Competency

- IHI, AAP, AAFP, AHRQ
- MCOs
- Other health care training schools, resources, etc.
- The library is a great resource to learn about your particular community and the various cultures that abide

Provide Evidence-Based Care

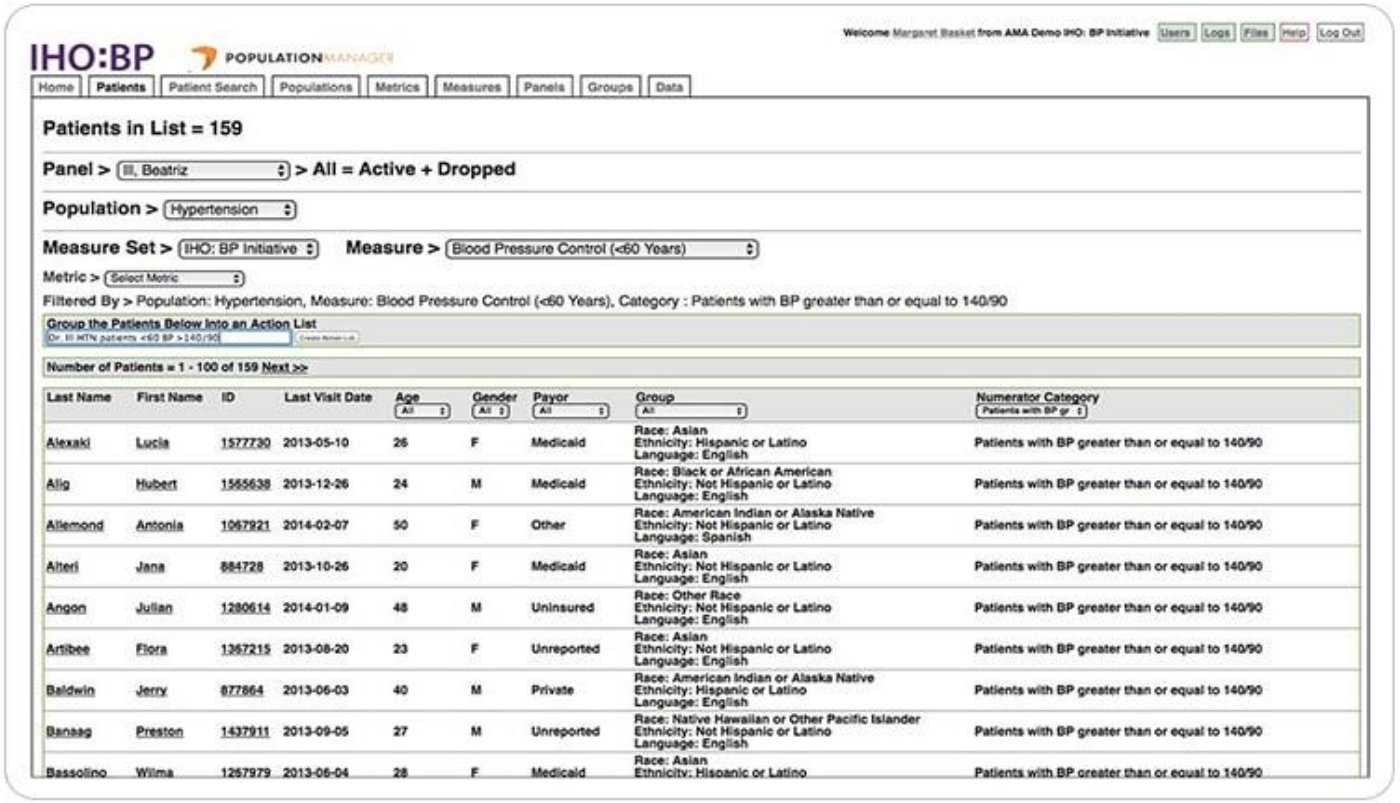
KM12 (core): Proactively and routinely identifies populations of patients and reminds them, or their families/caregivers about needed services (practice must report at least 3 categories)

A. **Preventative Care Services**
B. **Immunizations**
C. **Chronic or acute care services (Report/List and Outreach materials or *KM 13)**
D. **Patients not recently seen by the practice**

- *KM 13: Elective criteria- Using evidence-based care guidelines, the practice demonstrates excellence in benchmarked/performance-based recognition program (This is the NCQA HSRP or DRP recognition program)

Example of Registry

FIGURE 2. Snapshots of patients with out of range results in a sample POC registry



IHO:BP POPULATIONMANAGER

Welcome Margaret Basket from AMA Demo IHO: BP Initiative | Users | Logs | Files | Help | Log Out

Home | Patients | Patient Search | Populations | Metrics | Measures | Panels | Groups | Data

Patients in List = 159

Panel > Ill, Beatriz **> All = Active + Dropped**

Population > Hypertension

Measure Set > IHO: BP Initiative **Measure >** Blood Pressure Control (<60 Years)

Metric > Select Metric

Filtered By > Population: Hypertension, Measure: Blood Pressure Control (<60 Years), Category : Patients with BP greater than or equal to 140/90

Group the Patients Below into an Action List

Number of Patients = 1 - 100 of 159 Next >>

Last Name	First Name	ID	Last Visit Date	Age	Gender	Payor	Group	Numerator Category
Alexaki	Lucia	1577730	2013-05-10	26	F	Medicaid	Race: Asian Ethnicity: Hispanic or Latino Language: English	Patients with BP greater than or equal to 140/90
Alig	Hubert	1565638	2013-12-26	24	M	Medicaid	Race: Black or African American Ethnicity: Not Hispanic or Latino Language: English	Patients with BP greater than or equal to 140/90
Allemond	Antonia	1067921	2014-02-07	50	F	Other	Race: American Indian or Alaska Native Ethnicity: Not Hispanic or Latino Language: Spanish	Patients with BP greater than or equal to 140/90
Alteri	Jana	884728	2013-10-26	20	F	Medicaid	Race: Asian Ethnicity: Not Hispanic or Latino Language: English	Patients with BP greater than or equal to 140/90
Angon	Julian	1280614	2014-01-09	48	M	Uninsured	Race: Other Race Ethnicity: Not Hispanic or Latino Language: English	Patients with BP greater than or equal to 140/90
Artibee	Flora	1367215	2013-08-20	23	F	Unreported	Race: Asian Ethnicity: Not Hispanic or Latino Language: English	Patients with BP greater than or equal to 140/90
Baldwin	Jerry	877864	2013-06-03	40	M	Private	Race: American Indian or Alaska Native Ethnicity: Hispanic or Latino Language: English	Patients with BP greater than or equal to 140/90
Banaag	Preston	1437911	2013-09-05	27	M	Unreported	Race: Native Hawaiian or Other Pacific Islander Ethnicity: Not Hispanic or Latino Language: English	Patients with BP greater than or equal to 140/90
Bassolino	Wilma	1257979	2013-06-04	28	F	Medicaid	Race: Asian Ethnicity: Hispanic or Latino	Patients with BP greater than or equal to 140/90

Patient Outreach

Knowing and Managing Your Patients

KM 12: Example

MRN/Pat Name	Pat Acct No	Pat Type	Hospital Service	Patient Area Code	Patient 2015 2 2016	2014 Cases	Address
		Ou	C ADULT HEALTH CENTER		1	0	
		Ou	C ADULT HEALTH CENTER		1	0	
		Ou	C ADULT HEALTH CENTER		1	0	
		Ou	C ADULT HEALTH CENTER		1	0	
					1	0	
					1	0	
					1	0	
					1	0	
					1	0	

Dear Patient

Our records indicate you have not been to the office recently.

Please phone the office at (973) 555-5555 to schedule your appointment with ABC Health Center.

For the visit to be as beneficial as possible, we will need your help in preparing for it.

Your participation is vital for good health. Thanks for taking care of yourself and helping to prepare for your visit.

Please bring your current medications list to your checkup. And be prepared to discuss your healthcare goals.

Sincerely,
ABC Health Center

97 | NCQA

Adult Annual Registry Schedule

	Who	Jan	Feb	March	April	May	June	July	August	Sept	Oct	Nov	Dec
Women age 40-69 who have not had a mammogram in 2 years				■			■			■			■
Patients who have not a flu vaccine during flu season											■	■	■
Patients age 65+ who have not had a pneumonia vaccine				■			■			■			■
Patients 50-75 who have not had colorectal cancer screening				■			■			■			■
Patients with Diabetes who have not been seen in the past 6 months		■			■			■			■		
Patients with Diabetes who have not had a foot exam in the past year		■			■			■			■		
Patients with Diabetes who have not had an eye exam in the past year		■			■			■			■		
Patients with Diabetes who have not had nephropathy screening in the past year		■			■			■			■		
Patients with Major Depressive Disorder who have not had a PHQ-9 in the past 3 months			■			■			■				
Patients who have not had a well care visit in the past 2 years		■	■	■	■	■	■	■	■	■	■	■	■
Patients who have not had an office visit in the last 3 years		■	■	■	■	■	■	■	■	■	■	■	■

Pediatric Annual Registry Schedule

A	B	C	D	E	F	G	H	I	J	K	L	M	N
	Who	Jan	Feb	March	April	May	June	July	August	Sept	Oct	Nov	Dec
ADHD patients w/o visit in last 6 months		■	■	■	■	■	■	■	■	■	■	■	■
15 mo old w/o Anemia screening		■	■	■	■	■	■	■	■	■	■	■	■
Patients under 2 yo with UTI, no US				■			■			■			■
Persistent asthmatics no controller, seen in last 6 months					■					■			
Persistent asthmatics not seen in past 6 months					■					■			
Asthmatics w/o flu vaccine										■	■	■	■
Asthmatics not classified in the past year, but seen in the past 2 years					■					■			
11-12 yo w/o MCV					■								
4-5 yo w/o WCC					■								
10-12 yo w/o Tdap					■								
Infants w/o metabolic screen (weekly)		■	■	■	■	■	■	■	■	■	■	■	■
Infants w/o hearing screen (weekly)		■	■	■	■	■	■	■	■	■	■	■	■
Radiology regestries (xray, us, mri, ct) (weekly)		■	■	■	■	■	■	■	■	■	■	■	■

Clinical Decision Support

KM 20 (core) Implements Clinical Decision support following Evidence-Based guidelines for care of:

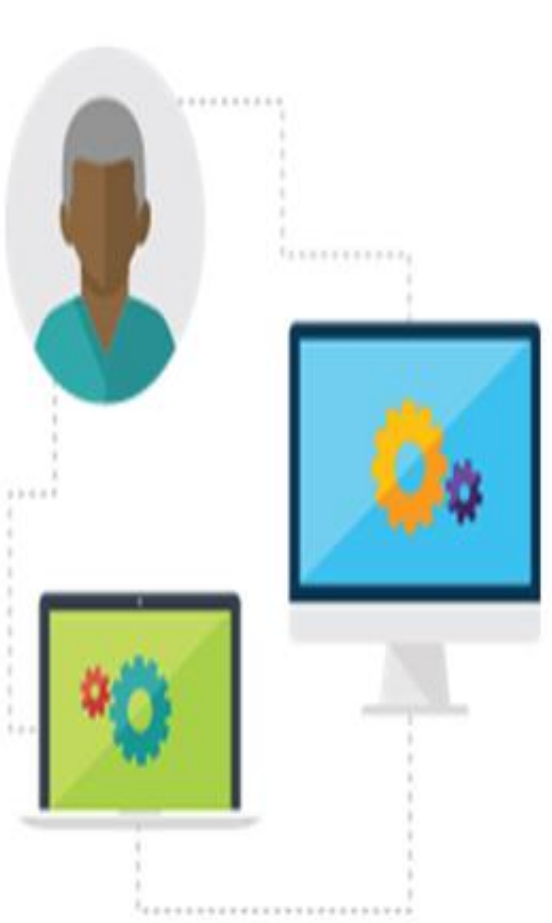
(Practice must demonstrate at least 4 criteria)

A. Mental Health
B. Substance Use Disorder
C. A Chronic Medical Condition
D. An Acute Condition
E. A condition related to unhealthy behaviors
F. Well Child or Adult Care
G. Overuse/appropriateness issues

What is Clinical Decision Support?

- Clinical decision support (CDS):

Technologies that assist physicians at the point of care using evidence-based guidelines in making timely and informed decisions in providing care, such as computerized alerts, condition-specific order sets, documentation templates, and diagnostic support.



Case 1 - Jimmy S.

- 2 years ago 6 year old Jimmy was diagnosed with asthma. He is now 8 and arrived for his routine well child visit.
- The nurse arrives, gathers information and updates patient's chart.
- Provider arrives and is presented with a template of tasks to be completed during a 8-year well child exam.
- Computer notifies the provider that the discharge summary from a recent ER visit is available for review.
- Mom reports that a recent health insurance change with an increased copay is making it hard for them to afford Jimmy's medication.
- Between visits, the EHR sends a reminder by patient portal to Jimmy's mom to schedule him for a flu shot.

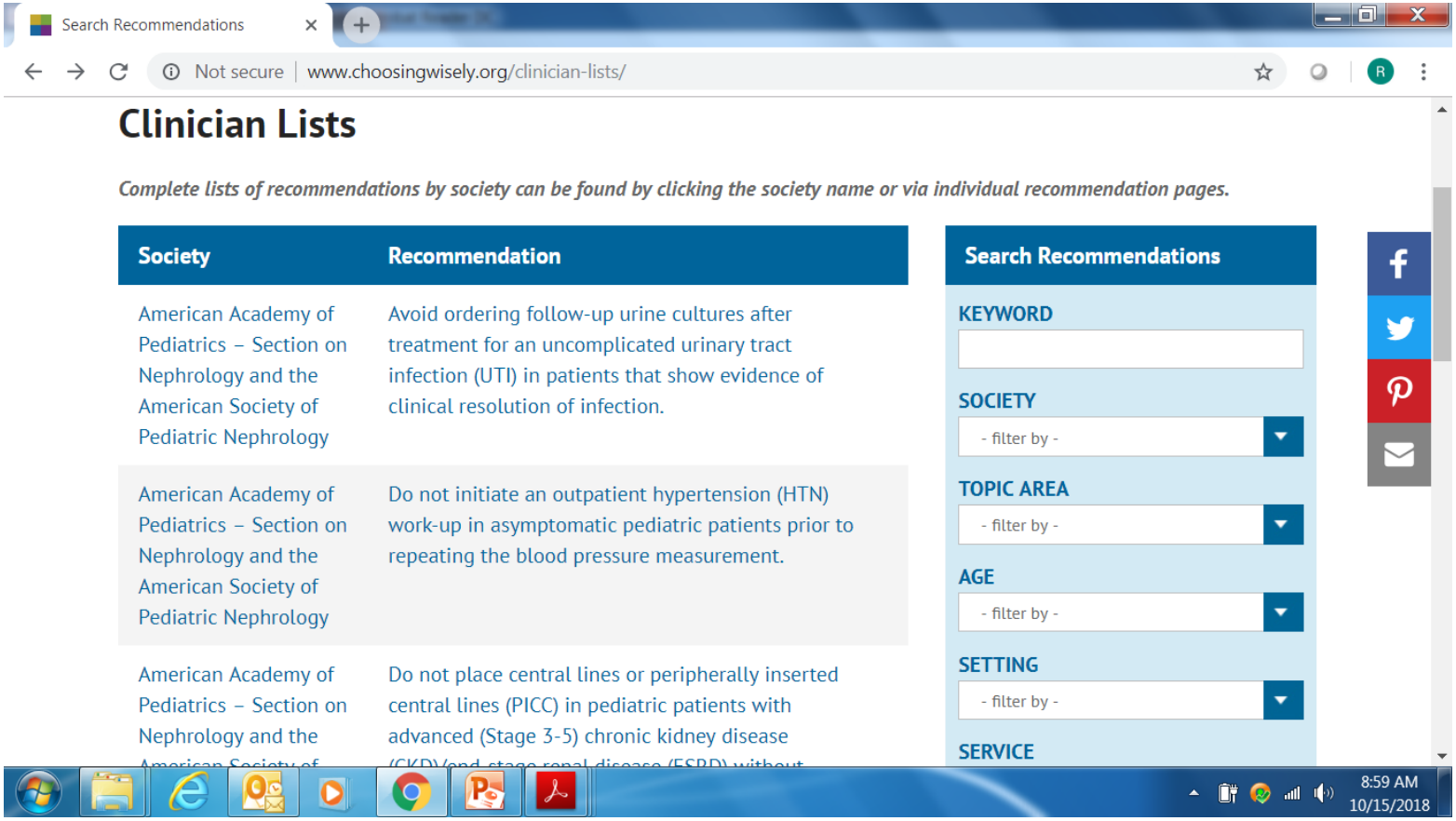
Clinical Decision Support cont.

American Society for Clinical Pathology Example:

- Testing Adult patients w/Diabetes and/or hypertension for CKD

- Don’t request just a serum creatinine to test adult patients with diabetes and/or hypertension for Chronic Kidney Disease (CKD); use the Kidney Profile (serum Creatinine with eGFR and urinary albumin-creatinine ratio.)
- Use the National Kidney Foundation (NKF) updated evidence-based Kidney Profile test to evaluate patients for CKD with the following common tests to more effectively assess kidney function.
- “Spot” urine for albumin-creatinine ratio (ACR) to detect albuminuria
- Serum creatinine to estimate glomerular filtration rate (GFR) using the CKD EPI equation

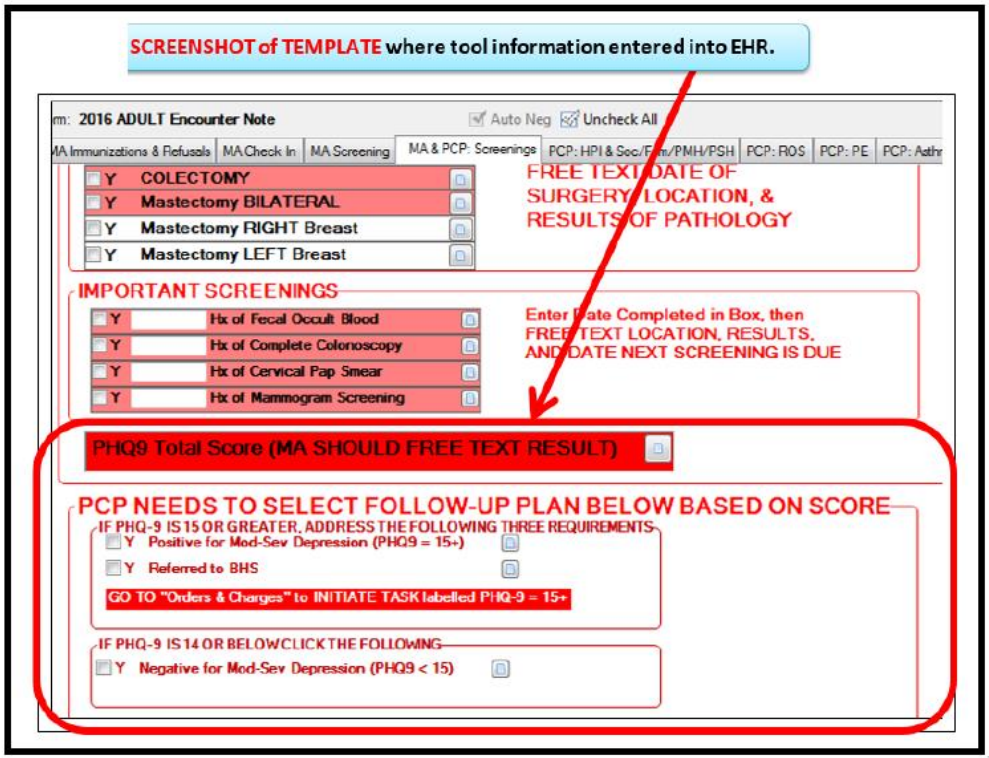
Clinical Decision Support (cont.)
Choose Wisely



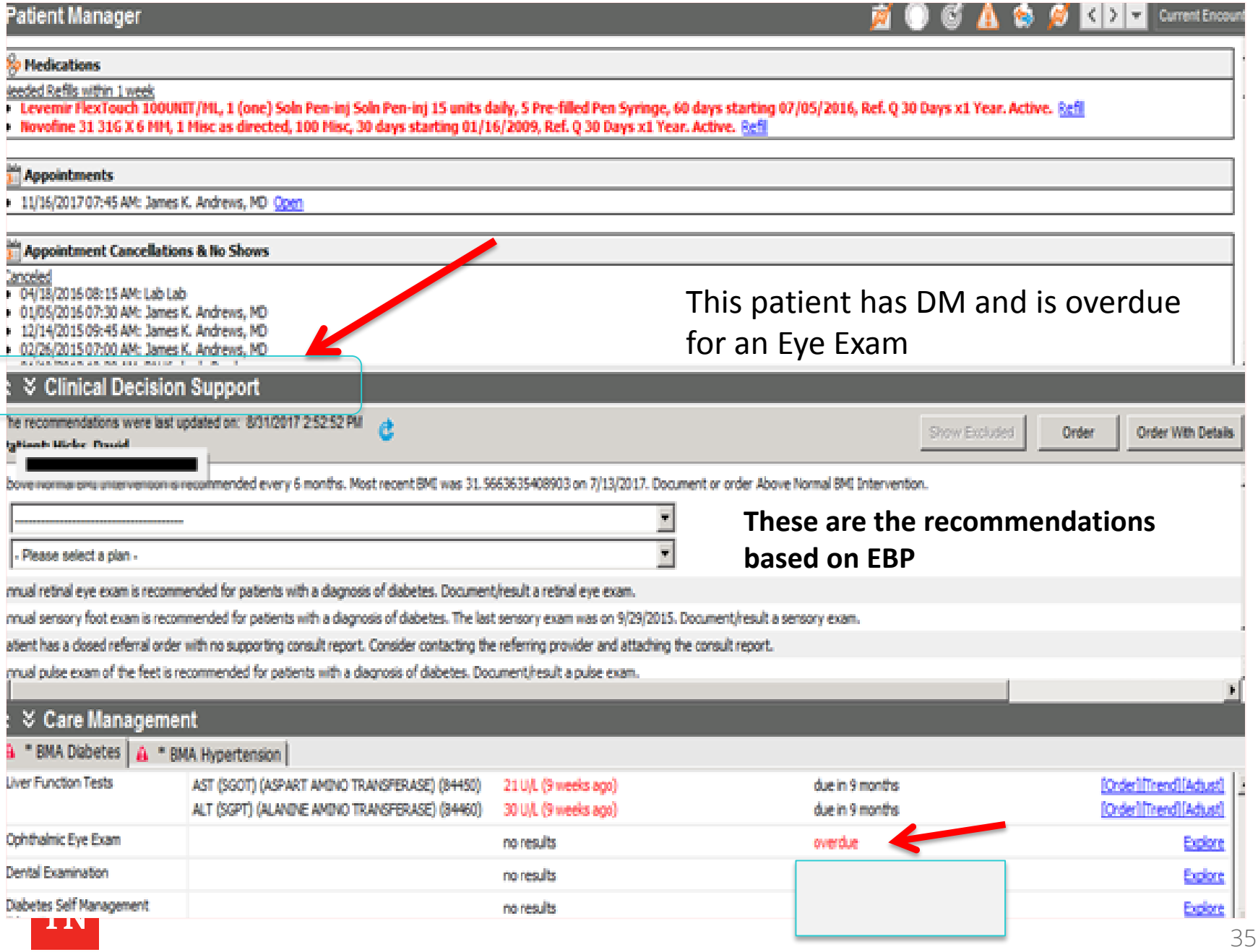
KM 20-Mental Health condition

Clinical Decision Support – Mental Health

KM 20 A: Example



104 | NCQA


Patient Manager
Medications
Levemir FlexTouch 100UNIT/ML, 1 (one) Soln Pen-inj Soln Pen-inj 15 units daily, 5 Pre-filled Pen Syringe, 60 days starting 07/05/2016, Ref. Q 30 Days x1 Year. Active. Refill
Novofine 31 31G X 6 MM, 1 Misc as directed, 100 Misc, 30 days starting 01/16/2009, Ref. Q 30 Days x1 Year. Active. Refill
Appointments
11/16/2017 07:45 AM: James K. Andrews, MD Open
Appointment Cancellations & No Shows
04/18/2016 08:15 AM: Lab Lab
01/05/2016 07:30 AM: James K. Andrews, MD
12/14/2015 09:45 AM: James K. Andrews, MD
02/26/2015 07:00 AM: James K. Andrews, MD
This patient has DM and is overdue for an Eye Exam
Clinical Decision Support
Show Excluded
Order
Order With Details
Please select a plan -
These are the recommendations based on EBP
Care Management
* BMA Diabetes
* BMA Hypertension
Liver Function Tests
AST (SGOT) (ASPART AMINO TRANSFERASE) (84450) 21 U/L (9 weeks ago) due in 9 months [Order][Trend][Adjust]
ALT (SGPT) (ALANINE AMINO TRANSFERASE) (84460) 30 U/L (9 weeks ago) due in 9 months [Order][Trend][Adjust]
Ophthalmic Eye Exam no results overdue Explore
Dental Examination no results Explore
Diabetes Self Management no results Explore

Embedding Evidence Based Guidelines into Daily Clinical Practice

1. Identify existing guidelines
2. Review guidelines and select the best one(s) for your clinical setting. Make sure they are based on the best medical evidence
3. Teach providers the basics of evidence-based medicine and guideline review
4. Have providers review and discuss guidelines to develop consensus
5. Customize guidelines for your organization, within the boundaries of the evidence
6. Use a standardized assessment to diagnose and determine disease control and risk for complications (heart, eyes, kidneys, etc.) to guide management for all patients

Embedding Evidence Based Guidelines into Daily Clinical Practice (cont.)

7. Consider conduction a baseline chart audit to benchmark your current practice against agreed upon guidelines. Agree *before* the audit which patients to include (see Clinical Information System for establishing a registry). Do NOT omit charts because a randomly selected chart is not that of a "typical" patient
8. Use flowsheets, pathways, or checklists to embed guidelines into daily practice. The guidelines include triggers for care
9. Link guidelines to the information system to provide prompts
10. Review and update guidelines for care regularly (at least yearly)
11. Remove barriers identified with previous guidelines

CC3 (2 credits): Uses clinical protocols to determine when imaging and lab tests are necessary.

- Establishes clinical protocols based on Evidence-Based guidelines, to determine when imaging and lab tests are necessary.
- May implement clinical decision supports to ensure that protocols are used (e.g., embedded in the order entry system)
- Develop Standing Orders (SO) or Standing Operating Procedures (SOP) that can be implemented for these protocols

Case 2 - Justin

- 13-year-old patient who has had sore throat, fever and swollen glands for two days, presents to your office
- On examination, he has exudative tonsillitis and tender anterior cervical nodes but no posterior cervical adenopathy
- What is his probability of having group A beta-hemolytic streptococcal (GABHS) pharyngitis?

CC3 (cont.)

SORE THROAT ENCOUNTER FORM

Patient's name: _____ Age: _____ Medical record #: _____

Data collection

Symptom	Points
☐ History of fever or measured temp >100.4°F	1
☐ Absence of cough	1
☐ Tender anterior cervical nodes	1
☐ Tonsillar swelling or exudates	1
Patient's age	
☐ <15 years	1
☐ 15 to 45 years	0
☐ >45 years	-1
Total	

Score

0 to -1 point: Strep throat ruled out (only a 2% risk).

1 to 3 points: Order rapid strep test; treat accordingly.

4 to 5 points: Diagnose probable strep throat (52% risk); consider empiric antibiotic therapy.

Suggestive findings	Diagnostic considerations
☐ Palatine petechiae or scarlatiniform rash	Probable strep throat
☐ Contact with strep infection in past 2 weeks ☐ Duration of illness <3 days	Consider strep throat
☐ Headache ☐ Petechial rash ☐ Stiff neck	Consider meningitis
☐ Hot-potato voice ☐ Sudden/severe symptoms	Consider abscess
☐ Posterior cervical adenopathy or teenager	Consider mononucleosis

Rapid strep test: ☐ Positive ☐ Negative ☐ NA

Mono spot test: ☐ Positive ☐ Negative ☐ NA

Other history: _____

_____

_____

Diagnosis

☐ Probable or confirmed strep throat

☐ Viral pharyngitis

☐ Mononucleosis

☐ Other: _____

_____

_____

Antibiotic treatment

☐ None needed ☐ Erythromycin

☐ Penicillin V potassium ☐ Azithromycin

☐ Cephalexin

Symptomatic measures

☐ NSAID ☐ 2% lidocaine gargle

☐ Sore throat spray ☐ Salt water gargles

Follow-up visit

☐ prn only

☐ _____ days

Other treatment: _____

_____

_____

☐ Patient education handout given.

CC5 (2 credits): Uses clinical protocols to determine when a referral to a specialist is necessary

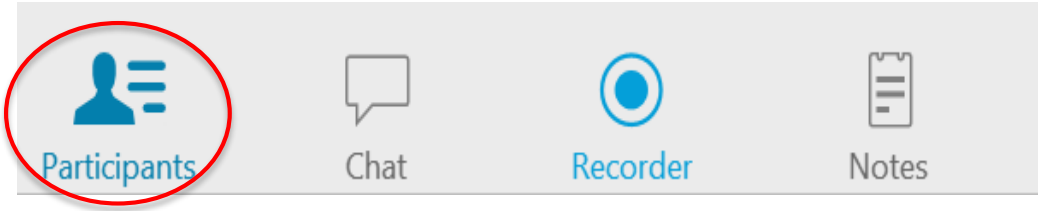
- Uses clinical protocols or decision-support tools to determine if:
  - A patient needs to be seen by a specialist
  - Care can be addressed or managed by the primary care clinician

Collaborative Discussion

- BEST PRACTICES
- CHALLENGES
- NOVEL IDEAS
- QUESTIONS

HOUSEKEEPING

- The host will read comments from the chat box
- Please raise your hand to engage in discussion – we will unmute you when we call your name.
- Please lower your hand when you are finished speaking



Next Session – December 2018

- Behavioral Health in Primary Care
- PCMH Distinction in Behavioral Health Integration

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