Evidence-Based Technical Assistance

Unlocking the Black Box:
Supporting practices to transform

Portland, OR
July 16, 2013
Why do you work with practices? What are you hoping to achieve?
Percentage of medical students choosing primary care specialties

Source: The Impending Collapse of Primary Care Medicine and Its Implications for the State of the Nation’s Health Care
A Report from the American College of Physicians
What's Threatening Primary Care?

- Changing demography and practice content, increasing demand
- Greater care complexity and lower provider self-efficacy
- Working harder just to keep up

### Chronic Conditions Per Medicare Beneficiary

<table>
<thead>
<tr>
<th># of conditions</th>
<th>% of beneficiaries</th>
<th>% of expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>18</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>19</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>21</td>
<td>11</td>
</tr>
<tr>
<td>3</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>4</td>
<td>12</td>
<td>21</td>
</tr>
<tr>
<td>5</td>
<td>7</td>
<td>63%</td>
</tr>
<tr>
<td>6</td>
<td>3</td>
<td>63%</td>
</tr>
<tr>
<td>7+</td>
<td>2</td>
<td>95%</td>
</tr>
</tbody>
</table>

Source: Partnership for Solutions
Greater Care Complexity

Preventive Care
7.4 hours

+ Evidence-based Care
10.6 hours

Quality of Current Primary Care

Of patients with major chronic illnesses receive recommended care.

Of people leave the doctor’s office without understanding what their physician said.

Of doctors perceive “people with chronic conditions usually receive adequate medical care.”

Can the primary care home help?
What’s the impact of a primary care home on getting patient needs met?

Percent of adults who say they get the care they need when they need it.

Source: The Commonwealth Fund Survey of Americans 18-64, June 2007
# Initial High Quality Meta-Analysis Suggests Improvement

<table>
<thead>
<tr>
<th>Outcome of Interest</th>
<th>Studies (N=17)</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient &amp; Caregiver Experience</td>
<td>7</td>
<td>Improvements (strength: moderate)</td>
</tr>
<tr>
<td>Staff Experience</td>
<td>3</td>
<td>Improvements (strength: low)</td>
</tr>
<tr>
<td>Care Processes</td>
<td>6</td>
<td>Improvements (strength: moderate)</td>
</tr>
</tbody>
</table>

PCMH Trial Results

<table>
<thead>
<tr>
<th>Outcome of Interest (N= 17)</th>
<th>Risk Ratio</th>
<th>Lower – Upper Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Patient Admissions (n=5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Patients</td>
<td>0.98</td>
<td>0.86-1.12</td>
</tr>
<tr>
<td>Older Adults</td>
<td>0.96</td>
<td>0.84-1.10</td>
</tr>
<tr>
<td>ED Admissions (n=3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Patients</td>
<td>0.93</td>
<td>0.72-1.20</td>
</tr>
<tr>
<td>Older Adults</td>
<td>0.81</td>
<td>0.67-0.98</td>
</tr>
</tbody>
</table>

PCMH Observational Study Results

Group Health: 29% ↓ ED visits 11% ↓ ACS admissions
Geisinger: 8% ↓ ED visits 28% ↓ Medicare admissions
CCNC: 8% ↓ ED visits 18% ↓ Medicaid kids w/ asthma admissions

## How will we get from here to there?

<table>
<thead>
<tr>
<th>Today’s Care</th>
<th>Patient Centered Primary Care Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>My patients are those who make appointments to see me.</td>
<td>Our patients are those who are in the team’s panel of patients, whether they make appointments or not.</td>
</tr>
<tr>
<td>Care is determined by today’s problem and time available today.</td>
<td>Care is determined by a proactive plan to meet health needs, with or without visits.</td>
</tr>
<tr>
<td>Care varies by scheduled time and memory or skill of the provider.</td>
<td>Care is standardized according to evidence-based guidelines.</td>
</tr>
<tr>
<td>I know I deliver high quality care because I’m well trained.</td>
<td>We measure our quality and make rapid changes to improve it.</td>
</tr>
<tr>
<td>Patients are responsible for coordinating their own care.</td>
<td>A prepared team of professionals coordinates all patients’ care.</td>
</tr>
<tr>
<td>It’s up to the patient to tell us what happened to them.</td>
<td>We track tests and consultations, and follow up after ED and hospital visits.</td>
</tr>
<tr>
<td>Clinic operations center on meeting the doctor’s needs.</td>
<td>An interdisciplinary team works at the top of our licenses to serve patients.</td>
</tr>
</tbody>
</table>

How do we support transformation into primary care homes more effectively?
Formula illustrating the way in which knowledge systems combine to produce improvement.

1 Generalisable scientific evidence
2 Particular context
3 Measured performance improvement

4 + 5

Source: Batalden P B , and Davidoff F Qual Saf Health Care 2007;16:2-3
Safety Net Medical Home Initiative – www.safetynetmedicalhome.org
+Patient Centered Primary Care Home Core Attributes 2011

*The Building Blocks of High -Performing Primary Care: Lessons from the Field. Rachel Willard & Tom Bodenheimer. April 2012.
# Interventions to Improve Chronic Care

<table>
<thead>
<tr>
<th>Quality Improvement Strategy</th>
<th>No. of Trials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team Changes</td>
<td>26</td>
</tr>
<tr>
<td>Case Management</td>
<td>26</td>
</tr>
<tr>
<td>Patient Reminders</td>
<td>14</td>
</tr>
<tr>
<td>Patient Education</td>
<td>38</td>
</tr>
<tr>
<td>Electronic Patient Registry</td>
<td>8</td>
</tr>
<tr>
<td>Clinician Education</td>
<td>20</td>
</tr>
<tr>
<td>Facilitated Relay of Clinical Information</td>
<td>15</td>
</tr>
<tr>
<td>Self-Management</td>
<td>20</td>
</tr>
<tr>
<td>Audit and Feedback</td>
<td>9</td>
</tr>
<tr>
<td>Clinician Reminders</td>
<td>18</td>
</tr>
<tr>
<td>Continuous Quality Improvement</td>
<td>3</td>
</tr>
<tr>
<td>All Interventions</td>
<td>66</td>
</tr>
</tbody>
</table>

![Graph showing the difference in postintervention HbA1c % for various interventions.](image)

Learning Collaboratives

30%

Transform
Drop Out
Hold Steady

Challenges Remaining

- Reaching beyond early adopters
- Try less time-intensive learning
- Target small practices
- Create supportive systems
What other peer-to-peer learning mechanisms have you tried?
practice facilitator

(prak-tis fuh-sil-i-tey-ter) n., 1. specially trained individuals who work with practices “to make meaningful changes designed to improve patients’ outcomes. [They] help physicians and improvement teams develop the skills they need to adapt clinical evidence to the specific circumstance of their practice environment” 2. focused on building permanent capacity for continuous quality improvement. 3. self management support for practices
Core of coaching

Motivation – effort brought to the task

Consultation – use of good strategies & resources

Education – knowledge & skills

Recent meta analysis (Bakerville, 2012) is encouraging – review of 38 coaching studies showed moderate but significant improvement in evidence-based care diminishing with intensity & duration of coaching support.

Study comparing PF to self-directed (Nutting et al, 2010) mixed, showing modest improvements compared to self-directed in adaptive reserve and proportion of NPD components implemented.

Yet to be published studies show value but also indicate need for additional resources in addition to facilitation to enact and sustain complex change.
Questions Remain

- intensity
  - distance
  - on-site

- duration
  - time-limited
  - ongoing

- approach
  - specialist
  - generalist

- qualifications
  - few + training
  - degree + experience
What has worked/been challenging when coaching practices?
Resources & Tools

Coaching the Patient Centered Medical Home:
Curricula & tools for coaches supporting practices to become medical homes
www.coachmedicalhome.org

Setting up a Practice Facilitation Program:
A How-to Guide on Developing and Running a Primary Care Practice Facilitation Program
www.pcmh.ahrq.gov

Implementing Patient Centered Primary Care Changes:
Implementation guides, tools & webinars from the Safety Medical Home Initiative
www.safetynetmedicalhome.org

Training:
Institute for Healthcare Improvement: www.ihi.org
Dartmouth Clinical Microsystems: clinicalmicrosystem.org
“To do things differently, we must see things differently. When we see things we haven’t noticed before, we can ask questions we didn’t know to ask before.”

-John Kelsch
Xerox
Scenario

• Please take a few minutes to read the scenario (in folder)

• When prompted, gather with the 4 – 5 people next to you and discuss

• We’ll come together to share what the groups have discussed and share tips and tricks about practice support

INSTRUCTIONS
1. Please take a few minutes to read the scenario
2. When prompted gather with the 4 – 5 people next to you and discuss
3. We’ll come together to share what the groups have discussed and share tips and tricks about practice support

You are coaching a health center in Eugene, OR that is working on measurement for quality improvement. The clinical operations manager was recently hired and would like to talk to you about starting a Quality Improvement Committee to guide efforts to improve the use of data for population management. The health center installed an EHR 3 years ago, and the staff are comfortable using it for billing and charting. Recently, the health center developed patient panels for each provider team, of which there are eight. The manager is concerned about how they will maintain their panels and keep them functioning well. He’d also like to broaden the small diabetes registry that two of the provider teams are using and report a variety of clinical process and outcomes by panel each month. He is confident providing accurate, timely data will lead to improvements in care. He wants the Quality Improvement Committee to help him with these projects.

The executive director is committed to providing great access to care and would like to see health outcomes improve. She wants to be sure the health center is a provider of choice as more folks get insurance in 2014 & 2015. She supports the manager’s focus on clinical quality improvement, but she is nervous about taking staff away from seeing patients to meet. She has already heard some complaints that patients are having more difficulty getting in for care now that there are panels, and she doesn’t want any new initiatives to push patients away.

The clinical operations manager would like your advice on several points.

1.) Who should be invited to participate in the Quality Improvement Committee?

2.) How can he make sure the executive director supports what he can already tell will be a big undertaking?

3.) Are there any pitfalls that he should be sure to prepare for or avoid as he gets started?
Additional Questions

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