Michigan Primary Care Transformation Project

Patient Registry and Population Health Management

4.22.15

MiPCT
Michigan Primary Care Transformation
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Topics for Today's Webinar

- Patient Registry and Population Health Management Overview
  - Marie Beisel MSN,RN, CPHQ, UMHS Care Management Resource Center Project Manager
- Gaps in Care Process Management in the Primary Care Setting, University of Michigan Health System
  - Jan Pund RN-BC, UMHS Educational Nurse Coordinator, Complex Care Navigator Ypsilanti Health Center

Objectives

- Describe features of a patient registry
- Explain the use of gaps in care reports in the primary care practice
- Describe the MiPCT care manager's role in closing gaps in care
- Identify elements of a work flow designed to close gaps in care in a primary care practice

Patient Registry

- Goal: Enable providers to manage their patients both at the population level and at point of care through use of a comprehensive patient registry.

- Definition: A patient registry is a database that enables population-level management in addition to generating point of care information, and allows providers to view patterns of care and gaps in care across their patient population. A registry contains several dimensions of clinical data on patients to enable providers to manage their population of patients.

Reference: BCBSM PGIP Patient Centered Medical Home and Patient Centered Medical Home Neighbor Domains of Function, Interpretive Guidelines 2014-2015 V1.0

What a Registry Should Be

- quick to implement
- simple to use
- organized by patient; responsive to disease populations
- contain only data relevant to clinical practice
- when necessary, make data entry simple and efficient
- easy to update from other automated data sources
- assist with internal and external performance reporting
- guide clinical care ***first***, measurement ***second***!

Adapted from Improving Chronic Illness Care; www.improvingchroniccare.org

Registry Features

- Provides access to lab data, test results, and across settings in your system
- Guidelines and prompts are included for needed services
- Identify populations and subpopulations of patients

Adapted from Improving Chronic Illness Care; www.improvingchroniccare.org

Registry Features

- Allows stratification of patients
  - complexity, disease severity for care management services
- Captures all critical clinical information
- Captures outcomes by practice, physician

Adapted from Improving Chronic Illness Care; www.improvingchroniccare.org

Registry Goal

Goal: Enable providers to manage their patients both at the population level and at point of care through use of a comprehensive patient registry.

- Improve patient outcomes
  - Close gaps in care
- Report the practices quality metrics
  - Monitor the population level performance over time of the practice and physician organization

Reference: BCBSM PGIP Patient Centered Medical Home and Patient Centered Medical Home Neighbor Domains of Function, Interpretive Guidelines 2014-2015 V1.0

Use of the Registry

- Create population-specific reports
- Facilitate external reporting requirements
- Create dashboard reports of the practice as a whole
  - Quality metric reports – to identify benchmarks and performance of the practice with meeting the identified goals
  - How is the practice doing with closing the gaps in care?

Adapted from Improving Chronic Illness Care; www.improvingchroniccare.org

Reminders

Timely reminders for physicians, office team and patients

Registry - Reminders

The registry has electronic prompts which are designed to support evidence-based patient care

Prompts can be delivered:

- At the time of visit
- Through population reports
- Via exception reports
  - subset of patients requiring active management refers to those patients with particular chronic illness management needs

Adapted from Improving Chronic Illness Care; www.improvingchroniccare.org

Sample Registry Report

PO	Practice	Provider	MRN	Name	A1C >8	New this Month	Last A1C Date	Last A1C
					A1C>8	*NEW	2014-04-03	9.5
					A1C>8	*NEW	2014-04-23	10.1
					no	*NEW	2014-10-17	6.4
					no	*NEW	2014-04-09	7.4
					A1C>8	*NEW	2014-08-09	8.4
					A1C>8	*NEW	2014-09-19	8.9
					A1C>8	*New	2014-09-26	10.7

Populations and Sub-populations

Relevant for proactive care

Population Health Management

- Goal of Population Health Management: Keep a patient population as healthy as possible, minimizing the need for expensive interventions such as emergency department visits, hospitalizations, imaging tests, and procedures.
  - Focus on
    - High risk patients who generate the majority of health costs
    - Systematically addressing the preventive and chronic care needs of every patient

Reference: Population Health Management: A Road map for Provider-Based Automation in a New Era of Healthcare; Institute for Health Technology Transformation 2012

Population-Based Care

- Goal: Maximize the health outcomes of a defined population
- Efforts are made to assure that all relevant members of a population receive needed services
- Use registry for *planning* office visits and patient outreach

Adapted from Improving Chronic Illness Care; www.improvingchroniccare.org

Proactive Population Management

Gaps in Care

- Use registry reports to identify gaps
  - including both prevention and chronic disease gaps
- The evidence - based care guidelines are incorporated in the registry
  - ex. Standard of care = Patient with diabetes has an A1C every 6 months

Use of Registry

- Establish and implement processes using registry data
  - identify and reach out to patients with chronic conditions
    - due for tests, services
    - out of control parameters
  - to identify patients due for preventive services
  - conduct pre-visit planning
- Close care gaps

Practice Team Pre-visit planning

- Primary Care Providers
  - Establish Standing orders for chronic disease management
    - Parameters to follow regarding gaps in care using evidence-based guidelines
      - Chronic conditions - Recommended diagnostic tests and labs (type and frequency)
      - Preventive tests
      - Referrals to specialists
      - Schedule follow up with PCP
  - Refer patients to MiPCT Care Manager

Practice Team Pre-work: Identify Patients via Outreach and Proactive Approach

- Generate a registry report and cross-reference with MiPCT patient list
  - Identify the focus
    - Ex. Goal for diabetes control: A1C < 8

- Ex. Review the list of patients who have office visit, uncontrolled chronic condition(s), and are MiPCT eligible during daily huddle

Role of the MiPCT Care Manger in Population Management

- Role of the MiPCT Care Manager includes:
  - Closing gaps in care for patient's in his/her caseload
    - Preventive services overdue
    - Chronic Condition(s) -tests and lab work overdue, parameters out of control
  - As a member of the practice team the *MiPCT Care Manager may*
    - Receive referrals from with office staff who call and send reminder letters to MiPCT patients with over due or out of range tests to assist with identified patient barriers
    - Be a resource for office staff
    - Participate in review of current processes to close gaps in care and identify ideas to improve, as needed, processes to close gaps in care

Compilation of Team Based Care Best Practices based on Observation of MiPCT Practices

Example: Practice Team Roles and Responsibilities	
Front Office Staff	Run Registry Report Monthly; Cross reference with MiPCT list; Highlight MiPCT eligible patients on registry report; Participate in daily huddle to cross reference highlighted patient list with provider schedule for the day
Medical Assistant	Highlight MiPCT eligible patients with gaps in care; Participate in daily huddle to cross reference highlighted patient list with provider schedule for the day; Follow up with non-MiPCT patients with gaps in care and MiPCT patients identified as not appropriate for care management services (schedule tests per standing order or PCP appointment as appropriate)
Clinic / Triage Nurse	Participate in daily huddle to cross reference highlighted patient list with provider schedule for the day; Conduct outreach to non-MiPCT eligible patients identified during huddle if there are identified patient needs including closing gaps in care; Collaborate with PCP to determine treatment plan and determine needed referrals as appropriate; Communicate patient progress to PCP regularly
Care Manager	Conduct introductory phone call to MiPCT eligible patients identified during huddle; Provide care management services (close gaps in care, medication reconciliation, assess barriers, provide disease management education and resources, assist with setting self-management goals); Participate in daily huddle to cross reference highlighted patient list with provider schedule for the day; Collaborate with PCP to determine treatment plan and determine needed referrals as appropriate; Communicate patient progress to PCP regularly

EXAMPLE: Practice Team Roles and Responsibilities (continued)	
Primary Care Provider	Provide leadership and clinical expertise to the practice team; Participate in daily huddle to cross reference highlighted patient list with provider schedule for the day; Provide necessary treatment regimen changes and referrals as appropriate.
CDE	Participate in daily huddle to cross reference highlighted patient list with provider schedule for the day; Provide teaching and resources to their licensure to appropriate patients after PCP referral; Collaborate with practice team during treatment to ensure clinical goals and patient self-management goals align, close gaps in care
Pharm D	Participate in daily huddle to cross reference highlighted patient list with provider schedule for the day; Provide teaching and resources specific to their licensure after PCP referral; Collaborate with practice team during treatment to ensure clinical goals and patient self-management goals align, close gaps in care
MSW	Participate in daily huddle to cross reference highlighted patient list with provider schedule for the day; Provide resources and support specific to their licensure after PCP referral; Assist patient with accessing appropriate community resources; Support patient in setting self-management goals; Collaborate with practice team during treatment to ensure clinical goals and patient self-management goals align, including closing gaps in care
Registered Dietician	Participate in daily huddle to cross reference highlighted patient list with provider schedule for the day; Provide teaching and resources specific to their licensure after PCP referral; Collaborate with practice team during treatment to ensure clinical goals and patient self-management goals align, including closing gaps in care

Questions?