Quality Improvement in Chronic Disease Management in Underserved Populations-
Community Heath Centers and Neighborhood Healthcare

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Neighborhood Healthcare
Escondido, California

14th Annual Community Health Center Symposium
Orange County, California
March 6, 2015
Disclosures

* None, unfortunately- but I keep an open mind !
Goals:

∗ To describe Community Health Centers in San Diego County

∗ To outline challenges to population health improvement and chronic disease management in CHCs

∗ To describe progress in CDM and Population Health in SD County

∗ To outline the tools used by one CHC to improve CDM and Population Health

∗ To stimulate thought about the future of Quality Improvement Implementation in local Community Health Centers
Quality in CHCs

* Talk plan: large → small; System → point of care
  * Consortium level activities
  * Health Center–wide activities and partnerships
  * Individual provider activities, tools, and assistance
Community Health Centers in San Diego County- the ‘Safety Net’

* 17 not-for-profit private 501c3 organizations plus IHS
* >120 sites
* >900,000 patients served annually
* >2,000,000 encounters annually
* >650 Medical Staff
* No county hospital in SD
* No county (primary or specialty) clinics in SD
* Geographic managed care for MediCaid
* Border county, 180,000 undocumented immigrants with no health insurance possibilities
Community Health Centers in San Diego County - the ‘Safety Net’

- Patient Characteristics:
  - Undocumented
  - Non-English-speaking or ESL
  - Cultural differences
  - Foreign-born
  - <200% FPL (99% in most CHCs)
  - Low Health literacy
  - Low general literacy
  - Strong beliefs in ‘folk’ medicine
  - Access to questionable meds and dispensing across border and within US
Local SD Payer Environment for CHCs

- PCP cap initially
- **PPS rate bottom line/per visit payment model**
- Lack of P4P (0.4% of budget at NHC)
- Lack of QM incentive
- Reducing hospitalization/ER → saves money elsewhere
- Little knowledge of HEDIS among clinics or providers
- Data exchange for lab/encounter data an issue
  - LabCorp encounter data to health plan ~0
- UDS reporting
- ‘Messenger Model’ HMO contracting; 1 contract: 1 clinic
Recent Council of Community Clinics Advances

- EMR adaptation
  - eCW
  - NextGen
  - AllScripts
  - Sage/Intergy
- Pop-iq
- Beacon/SDHC
PATIENT EDUCATION
- Resources
- Learning About Diabetes
- Road to Health Toolkit

MEDICATION COMPLIANCE
- Modified Morisky Scale (MMS)
- RCMAR: Measurement Tools
- Concurrent and Predictive Validity of a Self-reported Measure of Medication Adherence
- Medication Adherence Flowsheet

SELF-MANAGEMENT
- Partnering in Self-Management Support: A Toolkit for Clinicians
- Diabetes Initiative

BEST PRACTICES
- Measure Up Pressure Down Flow Chart
- HSAG Cardiac Health Disparities
- HSAG-Cardiac SIP_Overview
- KP Diabetes Guidelines
- Diabetes Mellitus Management Clinical Practice Guidelines Flow Chart
- "I Heart You!"
ALLHeart as an example of consortium-level Quality Improvement effort

- DM age 50+
- Tracking:
  - ALL use (med bundle) Rx, not dispensing data
  - Clinical measures:
    - BP, A1C test and results, Tobacco use/counselling, Self Management, LDL test and results, etc
  - No CV incident data
- Provider and staff education
- Targeted interventions in select clinics of their own design
- Kaiser Community Benefit funded
- Followed ALL effort
- Spread to SoCal/Central Valley
ALL HEART Clinics by County

Imperial County
- Clinicas de Salud del Pueblo

Los Angeles County
- Northeast Valley Health Corporation
- Eisner Pediatric & Family Medical Center
- Central City Community Health Center
  (Sites also in Orange County & Riverside)
- St. John’s Well Child
- Valley Community Clinic

Riverside County
- Community Health Systems, Inc.
- Riverside County Clinics

San Diego County
- Imperial Beach Health Center
- Vista Community Clinic
- Neighborhood Healthcare
- North County Health Services
- San Ysidro Health Center
ALL HEART Patients to Date
ALLHeart Results

ALLHEART Clinical Measures
October 2013 - September 30, 2014

N=37,339

- Statin
- BP <140/90
- ACE/ARB
- Statin and ACE/ARB

CCHN Total

High Center

Low Center

NCQA Mcaid Average

ALLHT Target

Adding new clinics/patients over time

Not a cohort of pts followed longitudinally
### ALLHeart Results- QI Project CHCs

<table>
<thead>
<tr>
<th></th>
<th>% Statin</th>
<th>% BP &lt;140/90</th>
<th>ACE/ARB</th>
<th>Statin &amp; ACE/ARB</th>
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<tr>
<td>QI Project Clinics</td>
<td>75%</td>
<td>74%</td>
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<td>60%</td>
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<td>Non QI Project Clinics</td>
<td>54%</td>
<td>61%</td>
<td>68%</td>
<td>45%</td>
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<td>October 2013 Rept</td>
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<td>65%</td>
<td>52%</td>
<td>45%</td>
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“An aspirin a day will help prevent a heart attack if you have it for lunch instead of a cheeseburger.”
HYPERTENSION CONTROL
DATA BY CLINIC ORGANIZATION-Poplq or individual reports
Measurement Year: March 31, 2013 – February 28, 2014

N = 67,241

BP Controlled
Low Center
High Center
HEDIS 2013
Molina 2013
Goal
HYPERTENSION CONTROL
Summary Data- PopIQ
Blood Pressure < 140/90 - PopIQ

12/12: 58%
N=42,000

9/14: 65%
N=48,000
PopIQ: Data Analytics & Data Aggregation

6 CHCs’ data- Diabetics

Source: Aggregated data from 6 pilot clinics from PopIQ Population Health Intelligence Tool
PopIQ

* For consideration: could these be a tool used by:
  * Other Health Centers?
  * Other Consortia?

* Already in place/up and running at CCC-SD
PopIQ: Org-level and site-level metrics
QM Department (Lynn Farrell, Nicole Howard, Henry Tuttle)
Grant writer and grant funding (in CCC case, mostly Kaiser community benefit and specific program $ now)
CCHN TSO
  * Emr hosting
  * Data support
  * SDHC/Beacon interface
  * PopIQ registry
Neighborhood Healthcare

2015 stats:
12 sites/2 counties
65,000 patients
260,000 visits
18,000 BH only visits
>40 medical providers

8 primary care sites, all PCMH-accredited except new Menifee
(5 with embedded BH; 1 rural with outside agency)

1 BH ‘only’ site with some primary care

3 dental sites

women’s health ‘only’ sites now primary care sites with integrated BH
New Menifee site 03/2014
Neighborhood Healthcare

- Private non-profit corporation, licensed by CA Dept. of Health Services
- Federally Qualified Health Center (‘FQHC’, ‘330’ clinic)
- Volunteer Board of Directors, consumer representation
- Discounted sliding fee scale for cash patients ($35)
- Evening and Saturday hours
- Employed MDs, NPs and PAs; dentists, psychiatrists, psychologists, psych NPs, midwives
- Staff cultural competence reflects patient demographics
- NCQA PCMH (1, 2, and 3 sites)
- Limited specialty care, no inpatient or SNF care

www.nhcare.org
NHC- Providing Quality Health Care Since 1969

* Medical, dental and behavioral health services to 65,000 people annually in 260,000 visits.
* ~500 employees, Annual Budget $42 million
* 80 full and part time clinical staff licensed/board-certified in family medicine, internal medicine, pediatrics, prevention, geriatrics, sports medicine, psychology, psychiatry, general dentistry, pediatric dentistry, and others.

www.nhcare.org
Neighborhood Healthcare

Grants & Contracts: 1%
Managed Care: 36%
Medi-Cal: 26%
Medicare: 6%
Private Insurance: 1%
Public Insurance: 18%
Self Pay: 12%

Legend:
- Blue: Grants & Contracts
- Green: Managed Care
- Orange: Medi-Cal
- Yellow: Medicare
- Teal: Private Insurance
- Light Blue: Public Insurance
- Purple: Self Pay
Setting the Stage: Quality CAN Happen

DM with BP < 140/90: 79%

HTN with BP < 140/90: 70%

CRC Screening: 63% (2/28/15)

DM with A1c > 9: 12%

DM with A1c > 9 or not done: 22%
How does Quality happen in a CHC?

* Dedicated mission-driven medical staff
* Dedicated mission-driven frontline and back office staff
* Finding innovative ways to get things done (that don’t cost a lot)
* Using other resources to fill the gaps
* Share selflessly, steal shamelessly (‘identify best practices’)
* Do the right thing AND doing things right (even if no business case)- need healthy finances and an enlightened CEO
Chronic Care Model (CCM)

- Community
- Resources & Policies
- Health System
- Health Care Organization
- Clinical Information Systems
- Decision Support
- Delivery System Design
- Self-Management Support
- Informed, Activated Patient
- Prepared, Proactive Practice Team
- Productive Interactions
- Improved Outcomes

Slide from E. Wagner
CDM in Underserved- PCMH
How to get better population quality?

* Workflow changes
* Adequate support staff (number, quality, training)
* Innovation (NHC=‘Mikey’)
* Ruthless removal of ‘tasks below license’
* Data:
  * Credible
  * Actionable
  * To the right people
  * At the right time
* Accountability/Individual Reward- ‘Future State’
How to get better population quality?

- Workflow changes
- Adequate support staff (number, quality, training)
- Innovation Ruthless removal of ‘tasks below license’
- Data:
  - Credible
  - Actionable
  - To the right people
  - At the right time
NHC QM Efforts- Workflow changes

- BPHC Disparities Collaboratives
  - PDSA cycles
  - Depression screening and intervention
- Pt Flow redesign
- Project Dulce- intensive RN CDE-led diabetes management program, inception 2000
  - Dulce group medical appts
    - pain mgmt groups, asthma groups
- BH integration
- ALLHeart→ ALL (Kaiser Grant through CCC)
- EHR 2010 (eClinicalWorks)
- PCMH, MU
Workflow changes: Pt flow redesign

- Roger Coleman and Associates
- Eliminate unnecessary steps in workflow based on data and ‘value-added’ concept
- Patient-centered- bring services to the patient vs. assembly-line model (7-9 stops → 4 stops)
- Rapid cycle improvement/PDSA model of rapid change
- 2 MAs per fte MD or NP/PA
- Huddles/pre-visit planning
- Results:
  - Cycle time
    - 114 → 47 minutes scheduled
    - 144 → 67 minutes walkin
    - These data still a part of site and org dashboards
  - Improved patient satisfaction
Workflow changes:
Individual Reports - Huddles

Neighborhood Healthcare
Valley Parkway Care Transformation Report Card
December 2013

Valley Parkway Electronic Medical Visit Summaries
Period for: 12/01/2013-12/31/2013
Standard: 75%

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<th>Area</th>
<th>Betty Brown</th>
<th>Jean Miller</th>
<th>Larissa Vishtell</th>
<th>Linda Laverdiere</th>
<th>Patricia Christie</th>
<th>Site</th>
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<tbody>
<tr>
<td>Percentage</td>
<td>67.50%</td>
<td>85.55%</td>
<td>75.09%</td>
<td>85.07%</td>
<td>94.15%</td>
<td>81.46%</td>
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Valley Parkway Pre-Visit Planning (Huddles)
Period for: 12/01/2013-12/31/2013
Standard: 75%

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<th>Area</th>
<th>Betty Brown, NP</th>
<th>Jean Miller, FNP</th>
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<th>Linda Laverdiere, NP</th>
<th>Patricia L Christie, MD</th>
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<tbody>
<tr>
<td>Percentage</td>
<td>94.62%</td>
<td>90.75%</td>
<td>87.24%</td>
<td>89.04%</td>
<td>76.24%</td>
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How to get better population quality?- Support Staff

* Workflow changes
* **Adequate support staff (number, quality, training)**
  * 2 MAs/ MD
  * **Team:**
    * MD or NP/PA
    * 2 MA
    * part of RN or MA Panel Manager- doing proactive care/pop management activities
    * part of Referral Coordinator (MA-level)
    * (part of PSR)
  * Recently started: Pharmacy MTM (grant-funded pilot started Nov 2014)
    * MTM Team: PharmD, PharmD Resident (free!), MA
  * Experimenting with: Team= 1 MD, 3 mids, 7 MA, RN Panel Manager
  * Experimenting with: Pharmacist MTM
* Innovation
* Ruthless removal of ‘tasks below license’
* Data:
  * Credible
  * Actionable
  * To the right people
  * At the right time
How to get better population quality?

* Workflow changes
* Adequate support staff (number, quality, training)
* **Innovation**
  * And leveraging others’ innovations
* Ruthless removal of ‘tasks below license’
* Data:
  * Credible
  * Actionable
  * To the right people
  * At the right time
* RN CDE-led chronic disease management program

* Key features:
  * Started ~1999 with Dr. Nick/ECC
  * RN-led
  * BH available
  * MD/NP/PA involvement on med changes/lab interpretation/exam
  * Self management skills
  * Patient education and activation
  * Care coordination (scheduling, labs, referrals, PCP consultation, foot exams)
  * Proactive office encounter (huddles, previsit planning)
  * **Single stable point of contact (health coach) for the patient**
Cost savings estimates for Dulce Model: (~$/QALY, 2006 $)

Uninsured: $10,000

County Medical Services: $25,000

Medicaid: $45,000

Commercial: $70,000

Health Services Research: Health Research and Educational Trust
DOI: 10.1111/j.1475-6773.2007.00701.x

Project Dulce Group Medical Visits

Analysis of change in HbA1c over time

- HbA1c Prior to Dulce 1:1 (n=78)
- HbA1c Prior to GMV (n=78; p<0.001)
- HbA1c after 6 months (n=55; p<0.05)
- HbA1c after 12 months (n=55; p<0.05)
- HbA1c after 18 months (n=24; p<0.05)
- HbA1c after 24 months (n=22; p<0.05)
How to get better population quality? DATA!!!!

- Workflow changes
- Adequate support staff (number, quality, training)
- Innovation
- Ruthless removal of ‘tasks below license’

Data:
- Credible
- Actionable
- To the right people
- At the right time
NHC Data Journey: EMR

* 2010 implementation of eClinicalWorks (eCW)

* Data lag: 1 year +
* Validation period: 1 year +
* Registry function
  * eCW built in- a loser!
  * BridgeIT
  * Home-grown registry +
  * **eCW alerts:** point-of-service data with low annoyance quotient
  * I2i
  * Now PopIQ and SDHC
5 stages of grief (Kubler-Ross):

- **Denial** - ‘the data are wrong’; ‘it’s not my patients’
  - Remedy: only show good easily-verifiable data
- **Anger** - ‘damn you, they aren’t my pts’; ‘I don’t practice cookbook medicine’;
  - Remedy: only show good easily-verifiable data
- **Bargaining** - ‘if I had some help on this’; ‘my pts are the sickest so of course my numbers are bad’; ‘I get all the new out-of-control pts’
  - Remedy: good data with good benchmarks- local and regional/national, similar practices eg. CHC vs. CHC
- **Depression** - ‘boy I really suck’; ‘my system is set up to sabotage me’; ‘my MAs are no bueno’
  - Remedy: give tools and workflow changes that make doing the right thing easy; get help at appropriate license level; don’t penalize right away for poor performance (if ever)
- **Acceptance** - ‘ok how do we make it better’; ‘MAs, let’s be the top by the end of the month’
  - Remedy- more of the above; continued emphasis; emphasize saving lives and preventing morbidity (and cost in some systems)
**Data overload**

- providers burn out trying to be #1 in everything, drive their team crazy, start focusing on the numbers over actual clinical quality, start pt dumping/cherry picking
- Remedy: only emphasize a few things at a time; reward for one or two priority areas; reward whole team; med staff determines areas of focus

**Apathy**

- too much data, people revert back to concentrating on individual pt care
- Feel futility at times- moving the result takes effort and time
- Remedy: give the population/prevention tasks to others (RNs + data analysts, midlevels dedicated to specific roles, advanced MAs in conjunction with their team under protocols, health coaches, etc)
CVD Risk calculated
A1c
LDL
MAb/creat
Foot exam
Retina screen
ALL meds
ASA
BP control
Statin
CRC screen
Depression screen
Immunizations due today
Tobacco use/counselling due today
HIV done ever
Visit summary printed (MU measure)
eRx sent (MU measure)
Last INR > 1 month ago
Missed opps
eCW Alerts app

Ecow, Andrew (age: 59)
DM, 10y CVD risk: Insufficient data

A1C: none
LDL: none
Microalbumin: none
Foot exam: none
Optic: none
A.L.R.: Asa Statin Ace/Arb
CRC: none
PHQ2/9: 12/20/2009
Imms due: Flu
Tobacco: Assessed
Visit sum: Not printed
eRx: Not sent
Updated: 0 seconds ago
Population Management

- Don’t wait for the patient to show up- identify the needs and go get them!
- New skills:
  - Data/data analysis
  - Prioritization of a lot of need
  - Proactive pt activation/education for preventive care
- How financed
  - LIHP funding for population management and PCMH
  - Health Plan: very little funding
  - CHC payment model a handicap
- Best example CRC screen
- Key finding: team responsibility for screening and monitoring (not JUST the MD)
- Problem: Reimbursement
Organization Wide Trend

% CRC screened

21% → 51% in 1 yr

63%

2/28/15
Colorectal Cancer Screening Project

- Partners: KP, C4, PASD, LabCorp
  - Minimum funding from C4
  - LabCorp donated FIT tests
- Pt identified needing CRC screen:
  - during visit via eCW alerts app
  - proactively using registry
- FIT test given
- Tests tracked by Panel Managers
  - Pt contacted to return or pick up another kit if lost
- Results tracked monthly
  - Reported to sites, med staff, QM, BOD periodically
- Positive tests: free colonoscopy by Kaiser via Project Access San Diego
- Positive Biopsies:
  - Kaiser-donated surgery, imaging, specialty consult/Rx plan
  - PASD arranges for donated oncology eval, XRT if needed, ChemoRx if needed
CRC-In reach

- The daily huddle
Point-of-Care

- Identifying Patients due for CRC Screening
- eCW Alert app developed by Dr. Kulin Tantod
Outreach

- Identifying Patients due for CRC Screening
- Data registry developed by Dr. Kulin Tantod
### Active Usable Registry

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<th>Description</th>
<th>Notes</th>
<th>Status</th>
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<td>6.2</td>
<td>5/28/2014</td>
<td>Y/N</td>
<td>11/14/2014</td>
</tr>
</tbody>
</table>

**Patient Details**

**Suppress for:**
- (not suppressed)
- 1 week
- 2 weeks
- 1 month
- 3 months
- 6 months
- 1 year
- Forever

**Note:**
- Appt. 01/12/2015

**Patient Details**

**Suppress for:**
- (not suppressed)
- 1 week
- 2 weeks
- 1 month
- 3 months
- 6 months
- 1 year
- Forever

**Note:**
- Appt. 01/12/2015

**OK Cancel**
Hypertension and Diabetes efforts at NHC
Neighborhood Healthcare+ALLHeart

- **Project:** Increase the number of ALLHeart DM >=50 patients on both medications
- **Summary:** Med bundle including ACE/ARB + Statin (+/- ASA) reduces morbidity and mortality in DM patients (even if not treating to a target goal BP/A1C/LDL)

- RN protocol (In Progress)
- MD education video
- Added alerts app if not on ACE/ARB & Statin
- Added to medical staff clinical measures dashboard
- Monitoring overall performance monthly
- ACA/ASCVD Risk Calculator embedded in EHR/shows in alerts app
1st step: Lisinopril/HCTZ
How are we doing? BP Control, UDS

Neighborhood Healthcare 2013 UDS Clinical Performance Measures

% of Hypertensives with Controlled BP

UDS Measure: Hypertension
Data Source: BridgeIT Reports
Denominator: Total # of patients age 18-85 with a diagnosis of hypertension, were first diagnosed by the practice at some point before 6/30 of the measurement year, AND had at least two medical visits during the measurement year.
Numerator: # patients from denominator whose last systolic blood pressure was less than 140 mm Hg AND

Exclusions: pregnant patients and patients with end stage renal disease
HTN Control - Update

HTN Control 70%
DM BP Control 79%
How are we doing? BP Control/DM/ALL

DM ≥50 on ACE/ARB + Statin:
75% on 2/28/15 (2458/3269)
70% on 3/16/14

DM <140/90: 79%
(3863/4892)

HTN:
70% on 2/28/15 (6415/9154)
65% on 3/16/14
How are we doing? BP Control

As of 3/10/14
How are we doing? BP Control

As of 10/9/14
How are we doing? DM BP control
As of 3/10/14

How are we doing? ALL

DM. 50+ on ace/erbb/statin (goal=80%)

[Bar chart showing data for various names, with percentages ranging from 0 to 100.]

Neighborhood Healthcare
Getting Quality Data to the Medical Staff

- MDs are competitive
- Data + support ➔ moving the curve
NHc Physician-level Interactive Real Time Quality Detail - panel level detail
On-demand Quality Data-

Population management plus individual provider panel management and feedback

- Click column to generate recall list
- All recall items identified - one-call hits all items
## Leveraging Competitive Nature

### Real Time on Demand

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<th>Provider/Clinic</th>
<th>DM, A1C&lt;9</th>
<th>DM, BP&lt;140/90</th>
<th>HTN, BP&lt;140/90</th>
<th>Cervical Ca</th>
<th>Breast Ca</th>
<th>CRC</th>
<th>Overall</th>
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<td>0.09</td>
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### By Measure:
- DM, A1C<9
- DM, LDL<100
- DM, BP<140/90
- DM, 50+ on ace/arb/statin
- CVD, LDL<100
- HTN, BP<140/90
- Smoking cessation
- Persistent asthma on controller
- CRC
- Breast Ca
- Cervical Ca
- Chlamydia
- Childhood Imms

### By Clinic:
- El Cajon
- Elm
- Grand
- Hickory
- Lkside Medical
- Pauma Medical
- Peds/Prenatal
- Tem Winchester
- Temecula WH

### By Provider:
- (no pcp)
- Aguey, Omar
NHC Physician-level Quality Detail - monthly reporting

- Panel Size
- DM: A1c<9, BP, 140/90, LDL <100
- HTN: BP <140/90, ALL meds
- Ca screen: colon, breast, cervical
- Antipsych meds with A1c test
- PP and prenatal visit timeliness
- Childhood IMMMIs
- Asthma on controller
- Peds Dev Delay screening 9,18,30

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<th>Wt/FIT or Colonoscopy</th>
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GOAL
- Psychiatry:
  - Gabriela Rodriguez
  - Harvey Meck
  - JUMIL H,
  - Keka Edie
  - Rhoelio Samaran

FM/Peds:
- Amy Corney
- Andrew Brown
- Betty Brown
- Bill H McCarrick
- Carlos R Ayon Martinez
- Carol L Hastan
- Caroline E. Avent
- Caroline Heiron
- Catherine Konya
- Connie Lepaet
- Cristela Shokrak
- Elizabeth Manning
- James B. Smith
- Jean Miller
- Justin E Matlitt
- Karen A. Schiff
- Kalin Tamood
- Leah R. Patrick
- Lani A. Roksana
- Omar J Aga
- Paige A. Thiermann
- Patricia J. Christo
- Paul D Brydon
- Rachel A. Butler
- Rakesh R. Patel
- Ruth Brow
- Sarah A. Russell
- Shannon S. Ragon
- Veronica Zurlage

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MTM (Pharmacist) Team

* Goal: Triple Aim goals: reduce morbidity, cost/waste, and improve pt experience by improving access and reducing unnecessary side effects
* Team: Pharmacist, PharmD PGY-2 Resident (+/- PharmD faculty member), MA
* Visits non-billable
  * Plan to add NP/PA face-to-face component later
* Grant funding for now
Chronic disease management can be done in an underserved population; requirements:

- Committed leadership
- Dedicated staff with a unifying purpose
- Validated and trusted data delivered when it is needed
- Data analytics capability
- Prioritization process
- Leveraging community resources
- Engaged patients
- **Payment model to support activities outside typical face-to-face visit**