4) A Population Health Management Strategy to Improve Quality Outcomes in Primary Care – FINALIST

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PROJECT DESCRIPTION

We implemented a new Population Health Management program in its primary care practices in order to improve chronic disease management and delivery of preventive services for over 160,000 primary care patients. Three key strategies enabled the effort's success:

(1) Primary Care defined their own, more clinically relevant quality measures- The organization defined its own, more clinically relevant quality measures for diabetes, hypertension, atherosclerotic cardiovascular disease, and cancer screenings. The first strategy involved moving away from Healthcare and Effectiveness Data and Information Set (HEDIS) measures that had been used in previous pay-for-performance contracts. Primary Care, along with Partners Population Health Management, defined its own, more clinically relevant quality measures for diabetes, hypertension, atherosclerotic cardiovascular disease, and cancer screenings. For example, in place of the HEDIS Hypertension measure, patients met the measure if:

- Their average blood pressure over the past 18 months was well-controlled or they were already on three anti-hypertensive medications.

Performance targets were set at low target of 2% improvement above the previous year's baseline and a high target reflective of the highest observable performance rate for a specific measure. By setting two targets, emphasis was placed on overall quality improvement rather than achievement of an absolute target.

(2) The launch of TopCare 2.0, a patient disease and preventive care management registry: TopCare provides a framework for population management outside of the office visit. TopCare provides a framework for population management outside of the office visit. Patient registries exist for diabetes, hypertension, cardiovascular events and three cancer screening registries (breast, colon, cervical). TopCare served as the data source to measure performance on quality outcomes.

(3) Piloting a team of population health coordinators (PHC), which included population management huddles at 8 primary care practices. These eight practices were assigned a PHC who was embedded in the practice and whose role was to primarily manage TopCare and address all associated administrative tasks. This included appointment scheduling, ordering overdue laboratory testing, and obtaining home blood pressure values. The other remaining eleven primary care practices were provided a part-time quality consultant who provided training and support to existing practice staff in adoption of TopCare; practice staff remained responsible for managing the administrative tasks.

Some of the TopCare features used by the PHCs included:

- Tracking points of contact made to patients such as patient education, appointment reminders and/or assistance with social services. TopCare allowed users to input date of last contact and schedule the next contact date.
- Coordinating care referrals between users. The PHC could refer a patient via TopCare to a diabetes educator who would then accept, reject or forward the referral to another provider.

Extracting data to create lists for discussion with the PCP. The PHC might assemble a list of patients scheduled for visits the following week or a list of patients with uncontrolled diabetes.

OUTCOMES ACHIEVED

- Met low targets for all (9) ambulatory quality measures.
- Increased provider satisfaction on quality outcome management in primary care
- A 5 percentage point improvement on the number of hypertension patients who have had a blood pressure check within the past six months and whose blood pressure is well controlled.
- A 9 percentage point improvement on the number of atherosclerotic cardiovascular disease patients who are either on a high dose statin or have an LDL < 100.
- More than a 5 percentage point improvement on the number of diabetic patients with a hemoglobin A1c < 9.
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- 90 percent of patients are up to date on their recommended breast and cervical cancer screenings.

LESSONS LEARNED

- An embedded Population Health Coordinator in the primary care practice yields higher performance for quality outcomes.
- Quality measures that make clinical sense and have targets based on improvement result in greater physician and clinical staff engagement.
- An accurate real-time disease population electronic tool is absolutely necessary to manage chronic and preventive care for all primary care patients so that no one falls through the cracks.