



# PRIMARY CARE COALITION

## Promising Practices and Ideas for Cancer Plan Implementation

11/29/2011

Presented by:

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**primary care coalition**  
of Montgomery County, Maryland

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# Primary Care Coalition

**PCC** is an independent, non-profit organization that strives to provide high-quality, evidence-based, cost-effective primary care and preventive care services to low-income and uninsured Montgomery County residents. PCC achieves this through partnerships with 11 Private Safety-Net Clinics; Montgomery DHHS; 5 Community Hospitals; Community-based organizations; private medical community; local, regional, and national foundations

**Mission:** PCC will serve as the catalyst in the development and coordination of a community-based health care system that strives for universal access and elimination of health disparities for all county residents.

## **PCC serves as a Systems Integrator:**

- Administers County funded primary care initiatives for low-income, uninsured.
- Adults and Children ~ 30,000 (Montgomery Cares/Care for Kids)
- Convenes key administrative/clinical leadership in County.
- Leverages core funding provided by County.
- Provides infrastructure support: electronic health record; quality improvement initiatives; specialty care; medications; research and innovation programs.

# Mobile Medical Care, Inc.

- Founded in 1968, MobileMed's mission is to provide quality health care to the uninsured, low income, working poor and homeless in Montgomery County.
- The goals of MobileMed include:
  - the provision of free or low-cost medical care in a respectful, competent, culturally sensitive and compassionate manner;
  - patient education toward self-directed health management;
  - decrease in the need for Emergency Department medical care.
- MobileMed provides care for over 7,000 patients annually at 15 clinic sites.



# DHMH Cancer Screening Goals/Objectives



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# DHMH Cancer Screening Goals #1

Use evidence based formal improvement processes to improve cancer care screening.

- ✓ Increase clinic team knowledge of process improvement methods
- ✓ Convene monthly collaborative learning and feedback sessions
- ✓ Establish metrics
  - Increase referral and screening rates by 20%

*Every System  
Is Perfectly Designed  
To Get the Results It Is Getting*



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# Programatic Review

## Baseline

- 80% of the project team have little or no experience in process improvement
- Reasons for not screening include:
  - Forgot
  - Busy
  - Supplies not available
  - Unfamiliar with guidelines
  - Disagree with guaiac for screening
  - Services not available
- Reasons for not tracking:
  - Reports never received
  - Services not provided



# Opportunities for Improvement

Capacity and Demand

Patient Flow/Handoffs

Financing





## Model for Improvement



# Small Tests of Change

- Standardize exam rooms; hemocult slides in pre-addressed envelope
- Tracking for all breast, cervical and colorectal cancers screening and follow-up
- Data entry into CHLCare
- MA identification/preparation of cancer screening (Visit Planner)
- Increasing supply of mammograms
- Standardizing a referral process for colonoscopies
- Increasing supply of colonoscopies

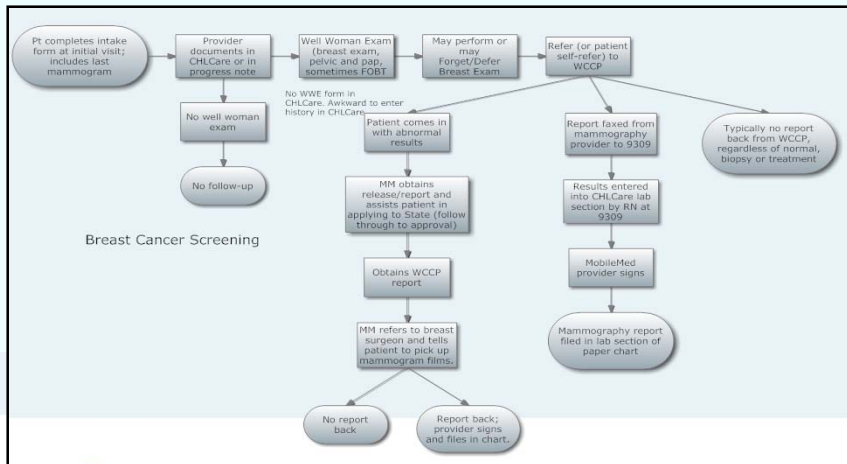
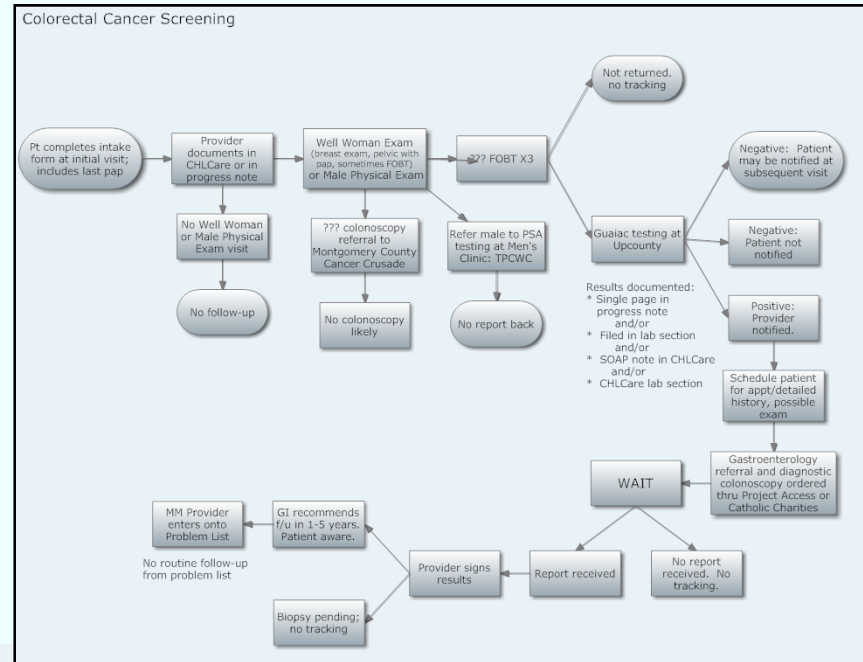
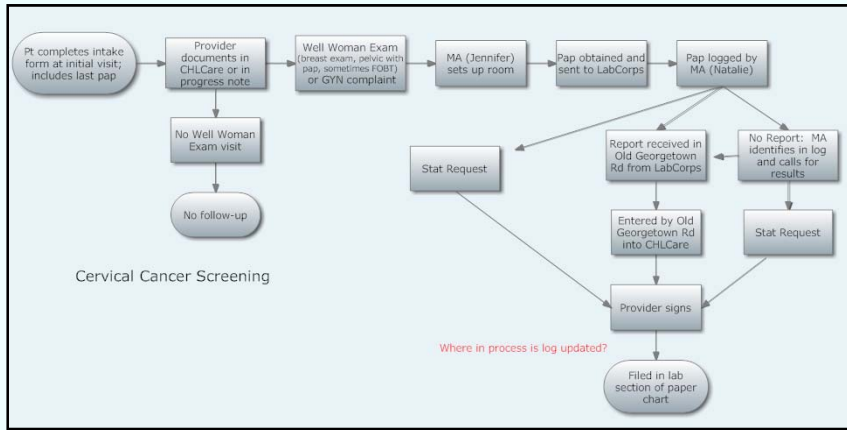
## DHMH Cancer Screening Goals #2

Establish provider driven referral, follow up and tracking system that is well-integrated into clinic workflow.

- ✓ Conduct gaps analysis on current clinic breast, cervical, and colorectal cancer screening processes
- ✓ Establish clinic guidelines for screening for all three cancers
- ✓ Determine supply and demand for screening
- ✓ Establish process for provider reminders
- Reduce cycle time from referral to screening and screening to diagnosis



# Process Mapping



# Mobile Med-Germantown Supply and Demand Grid

## Breast Cancer Screening

Women Age 40-64 seen in CY 2010	Need: 65% of total women*	Mammogram Resources
628	408	CRA: 300 WCCP: Unknown

## Cervical Cancer Screening

Women Age 40-64 seen in CY 2010	Need: 79% of total women*	Cervical Screening Resources
628	496	Pap completed in clinic. Unlimited

## Colorectal Screening

Women and Men Age 50-64 seen in CY 2010	Need: HEDIS Commercial Mean 61%*	Colorectal Resources
595	363	FOBT: Unlimited Colonoscopy: TBD (273Montgomery County)

\*HEDIS benchmarks for calendar year 2009, as reported in NCQA's 2010 State of Healthcare. Colorectal is the only screening of the three that is not reported separately for Medicaid Plans.

Visit Dates	11/06/2007								
Blood Pressure (Sys/Dias)	/	/	/	/	/	/	/	/	/
Weight - lbs									
BMI	NaN	NaN	NaN	NaN	NaN	NaN	NaN	NaN	NaN

**Laboratory**

HgbA1c (Every 6 months)									
LDL (Annually)									
MicroAlbumin screening (Annually)									
lab type									
value									

**Preventative Goals**

Pap Smear (If normal, every 3 years for women > 18)			Mammogram (If normal, every 2 years for women > 40)			Clinical Breast Exam (If normal, Annually)	
Tetanus (Every 10 years)			Influenza (Annually for age > 50)			Pneumovax (For patients > 65)	
Colorectal Screening (FOBT annually, Flex Sig every 5 yrs, Double Contrast Barium every 5 yrs, OR Colonoscopy every 10 yrs for patients for age > 50)							
Diabetic Foot Exam (Annually)			Retinal Eye Exam (Annually)				

**Education**

Diabetic Classes	Class 1	Class 2	Class 3	Class 4	DSME Completed		
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**Other Clinical Encounters**

Done

# DHMH Cancer Screening Goals #3

Expand scope of current cancer screening patient navigation to include all three cancers.

- ✓ Train clinic staff on patient navigation
- ✓ Increase the use of CHLCare electronic tools to improve care coordination
- ✓ Explore enhancements to CHLCare to support patient navigation and care coordination (Care-2-Care and reports)



# Care2Care Patient Navigation Tool

**Care2Care Connect is a convenient, efficient and customizable workflow solution that helps care coordinators decide where to focus resources, better coordinate care, integrate data within the workflow and plan appropriate interventions.**

**The module:**

- **Consolidates the data needed to effectively coordinate the care for a patient.**
- **Helps identify gaps in health care.**
- **Integrates with external systems.**
- **Tracks interventions and care coordination time.**
- **Reduces your administrative workload and duplication of effort to drive down administrative costs.**





# CHLCare Reminder

The Reminder popup is divided in to 2 sections:

The top section is for adding a new reminder or modifying and existing one

The lower section is for completing an existing reminder

The screenshot shows a web browser window with the URL <https://chlcare.community-healthlink.org/index.php/main/Referral/view/981>. The page title is "Patient: Simpson, Homer P23 #78829, Age 62". The browser's address bar shows "ClearHealth : Patient" and "community-healthlink.org". The page content includes a navigation menu with "Patient", "Diagnosis", "Admin", "Case Management", "Reports", "Patient Data", "Summaries", and "Admin". Below the navigation menu are sections for "Demographics" and "Criticals". The main content area displays a "Add/Complete Reminder" popup window. The popup window has a title bar with a close button (X). The main content of the popup is divided into two sections. The top section is titled "Add/Complete Reminder" and contains a dropdown menu for "New Reminder", a text input field for "Enter Reminder data", a "Reminder Type" dropdown, a "Due Date" date picker set to "11/14/2011", and an "Assigned to User" dropdown set to "Joseph, Mary". Below these fields is a "Reminder Detail" text area and a "Save" button. The bottom section is titled "Complete this Reminder" and contains a "Completion Reason" text input field, a "Date Completed" date picker set to "11/14/2011", and a "Completion Notes" text area. Below these fields is a "Mark Complete" button. The popup window also has a "Close Popup" link in the bottom right corner.



# New Reports

- Number of Patients with Referrals -
- Number of Patients with Referrals who Completed Lab Tests -
- Number of Patients with Comp Tests Regardless of Referrals -
- Number of Patients Referred Who Completed Lab Tests Within 60 Days -
- CycleTime Between EncDate SpecReceDate -
- Number of Patients with completed Lab Tests by Result Value & Flag Code -



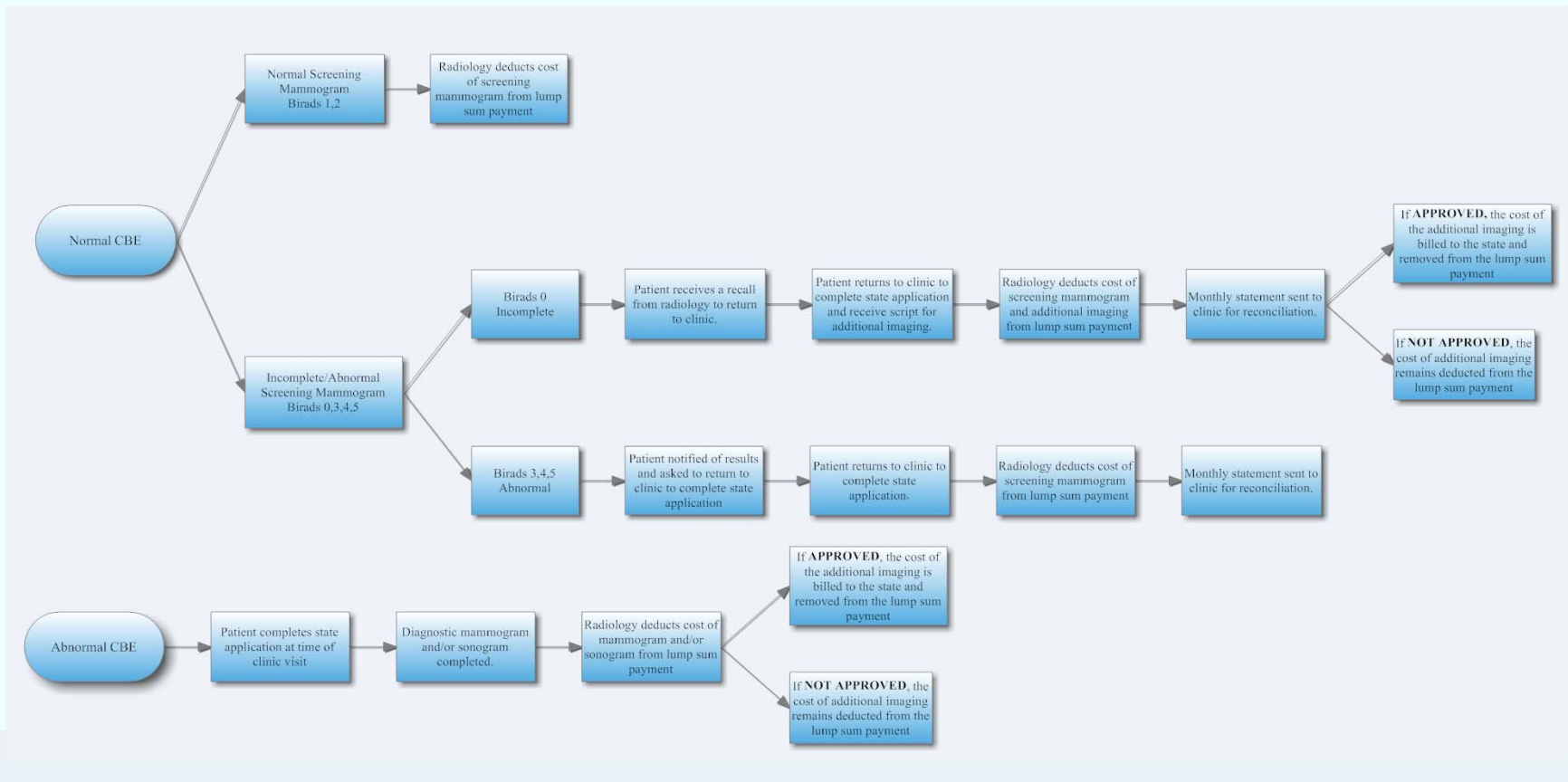
# DHMH Cancer Screening Goals #4

Provide a plan for sustainability and spread to all Montgomery Cares clinics.

- Improve alignment and cost leveraging with Montgomery County programs
- Develop plan to spread what was learned in this grant to other clinics
- Obtain funding to support spreading this program



# Financing Strategy



# Metrics



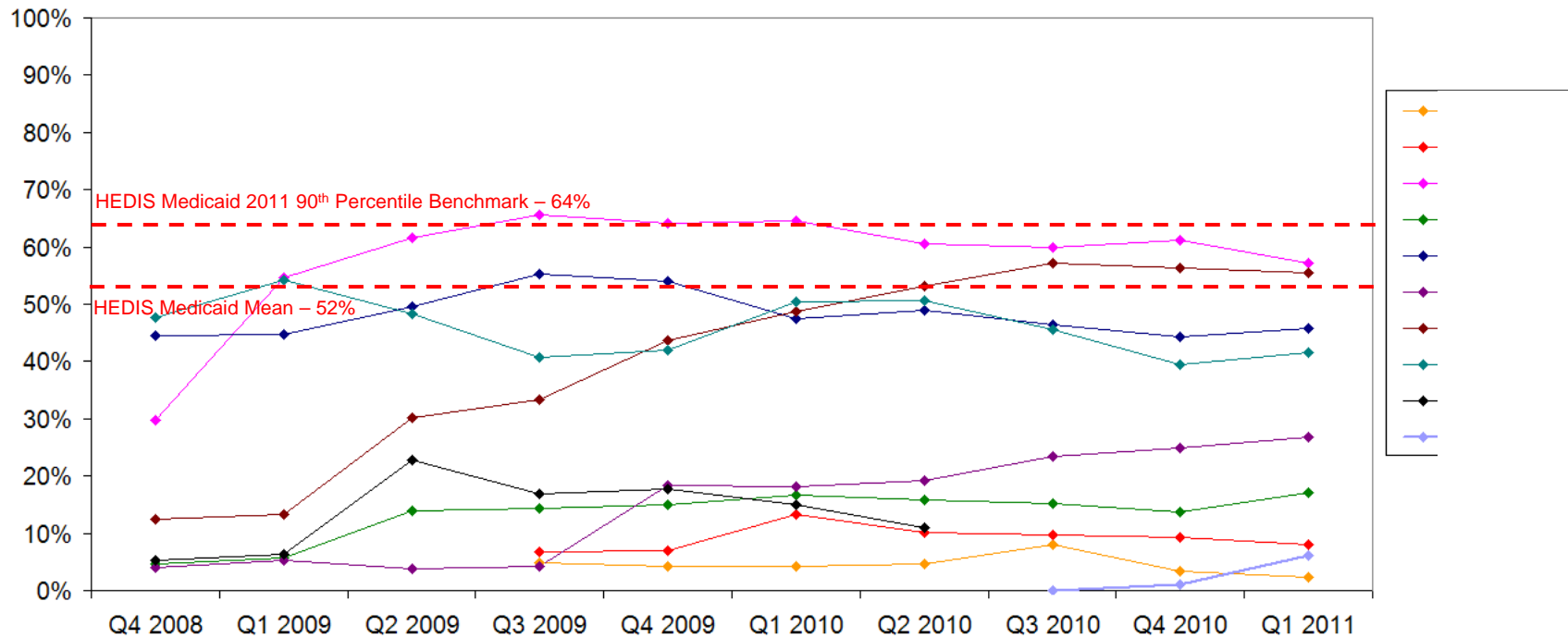
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# Patients with Breast Cancer Screening 40+

Female patients age 40+ with a mammogram in the past 2 years

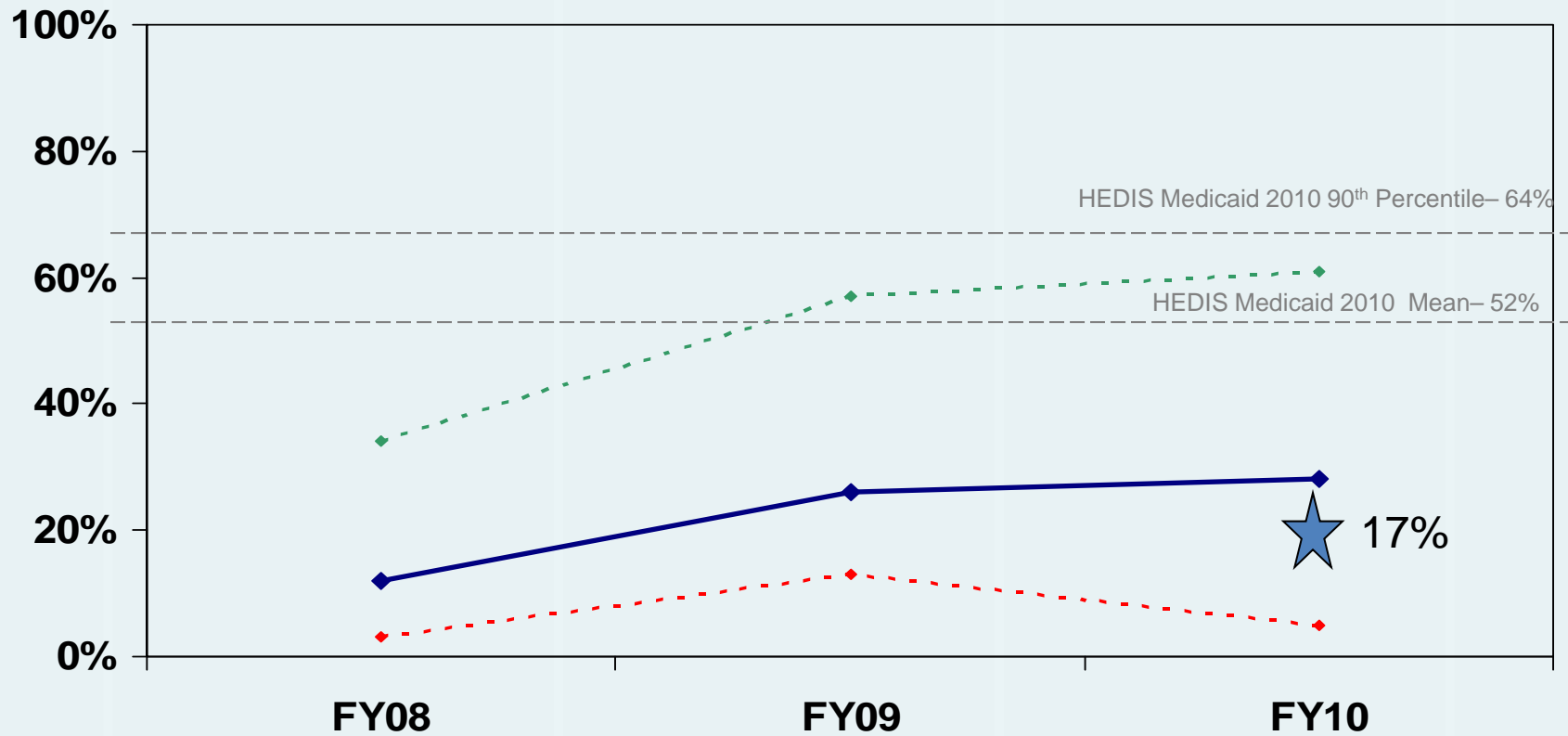
C37

	Q4 2009			Q1 2010			% change	Q2 2010			% change	Q3 2010			% change	Q4 2010			% change	Q1 2011			% change
	num.	den.	%	num.	den.	%		num.	den.	%		num.	den.	%		num.	den.	%		num.	den.	%	
	2	48	4%	2	47	4%	2.1%	3	65	5%	8.5%	5	63	8%	72.0%	2	60	3%	-58.0%	1	43	2%	-30.2%
	5	71	7%	12	91	13%	87.3%	14	139	10%	-23.6%	18	185	10%	-3.4%	20	216	9%	-4.8%	18	223	8%	-12.8%
	317	494	64%	325	503	65%	0.7%	324	535	61%	-6.3%	330	550	60%	-0.9%	300	491	61%	1.8%	281	491	57%	-6.3%
	155	1030	15%	162	969	17%	11.1%	171	1087	16%	-5.9%	149	983	15%	-3.6%	121	880	14%	-9.3%	152	893	17%	23.8%
	226	418	54%	191	403	47%	-12.3%	206	420	49%	3.5%	199	428	46%	-5.2%	208	469	44%	-4.6%	223	487	46%	3.2%
	145	789	18%	140	773	18%	-1.4%	174	906	19%	6.0%	207	885	23%	21.8%	213	857	25%	6.3%	223	835	27%	7.5%
	163	373	44%	180	369	49%	11.6%	211	397	53%	9.0%	231	404	57%	7.6%	225	399	56%	-1.4%	221	398	56%	-1.5%
	42	100	42%	54	107	50%	20.2%	71	140	51%	0.5%	62	136	46%	-10.1%	58	147	39%	-13.5%	70	168	42%	5.6%
	30	170	18%	24	161	15%	-15.5%	19	173	11%	-26.3%												
												0	124	0%		2	188	1%		16	260	6%	



Includes female patients > 40 who had a mammogram within 2 years prior to their most recent encounter

# Breast Cancer Screening ( $\geq 40$ )



—◆— All Clinics    - - -◆- - - Lowest Clinic    - - -◆- - - Highest Clinic



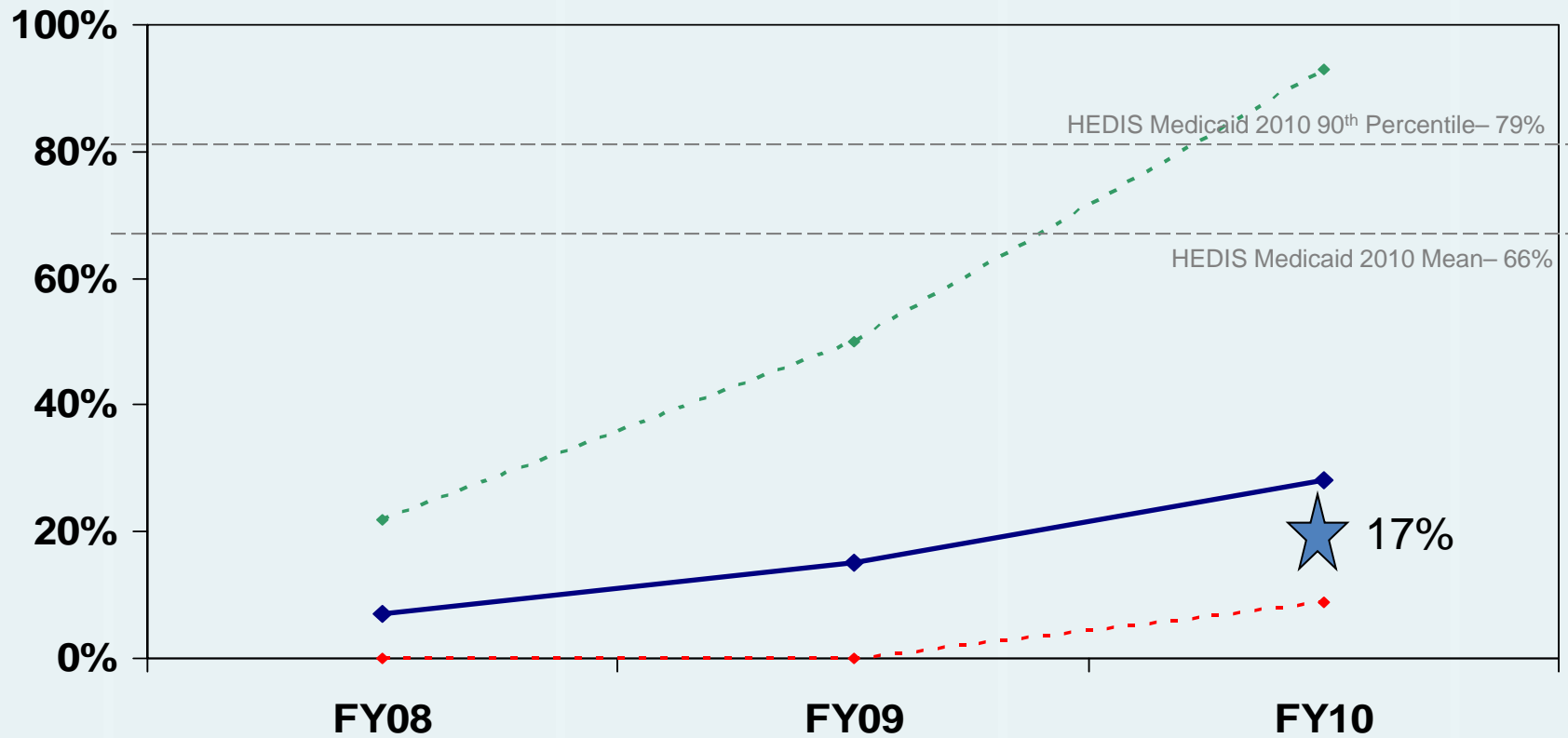
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Includes patients who had a mammogram within 2 years prior to their most recent encounter



MobileMed Upcounty

# Cervical Cancer Screening



—◆— All Clinics    - - -◆- Lowest Clinic    ···◆··· Highest Clinic

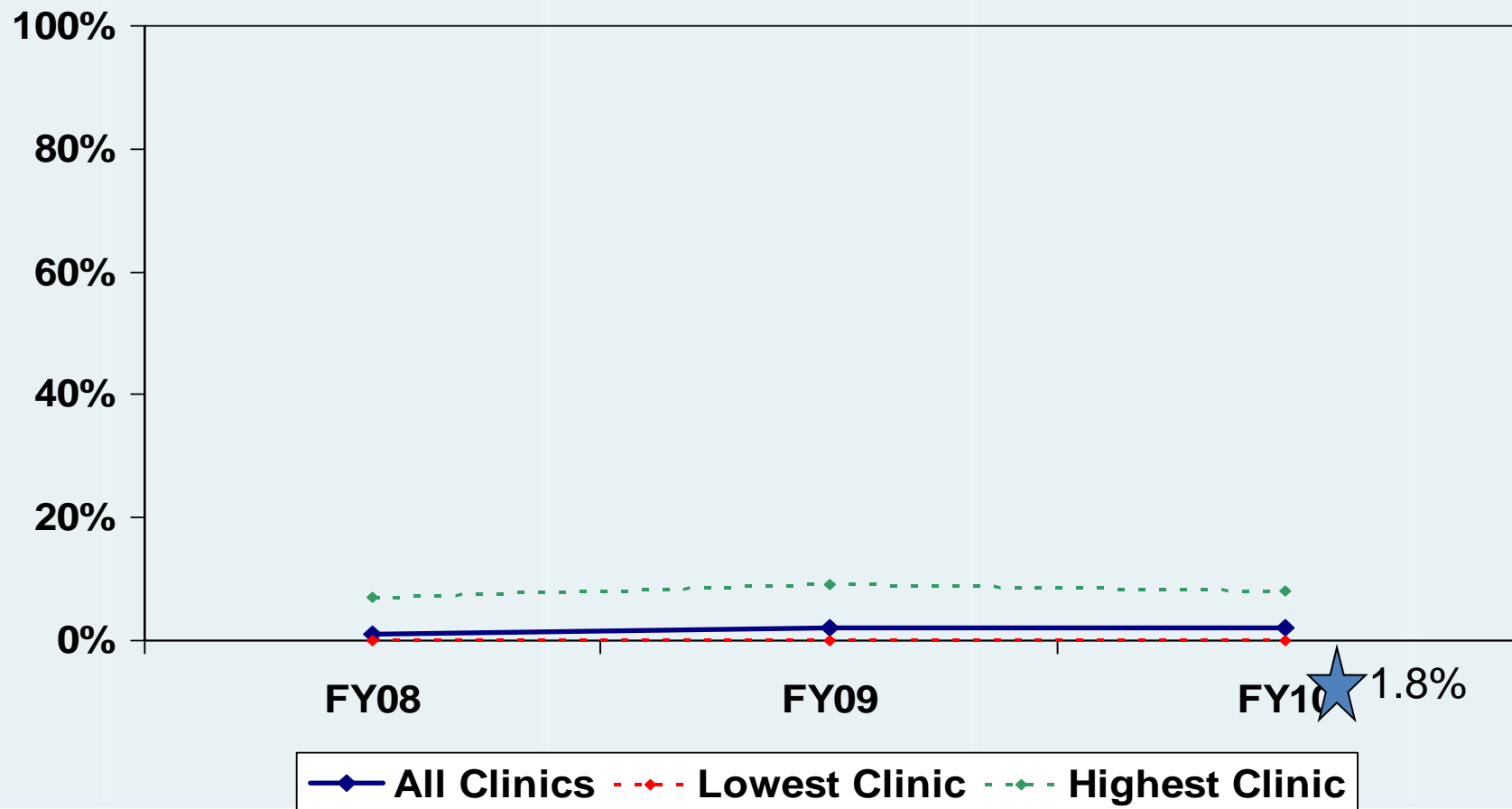


Includes patients who had a pap smear within 3 years prior to their most recent encounter.

★ MobileMed Upcounty



# Colorectal Cancer Screening



Includes patients who had a colonoscopy within 10 years, a flexible sigmoidoscopy or double contrast barium enema within 5 years, or a FOBT within 1 year of their most recent encounter.

# Data Update

Measure_Code	Measure_Category	MM-Up County Q3 2011	MM-Up County Baseline annual
C36	Denominator-Breast Cancer Screening (women 40 and older)	342	677
C37	Breast Cancer Screening (women 40 and older)	74	115
		21.64%	16.98%
C38_Cervical_Dem	Denominator-Cervical Screening	461	677
C38_Cervical	Cervical Cancer Screening	166	115
		36.01%	16.98%
C38_Colorectal_Dem	Denominator Colorectal Cancer Screening	340	638
C38_Colorectal	Colorectal Cancer Screening	40	12
		11.76%	1.88%
C36_Over50	Denominator-Breast Cancer Screening (women 50 and older)	232	
C37_Over50	Breast Cancer Screening (women 50 and older)	54	
		23.28%	



# Successes and Challenges

## Successes:

- Enthusiasm of MobileMed Staff
- Collaboration with Montgomery County partners
- Process Mapping and Model of Improvement Training
- Electronic reporting

## Challenges:

- Data collection
- Staff turnover
- Spread



# Contact Information

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