Health Center Field Example

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Quality Improvement Director

MOUNTAIN PEOPLE'S HEALTH COUNCILS INC.

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Proudly serving the healthcare needs of the people of Scott and surrounding counties in TN for more than 40 years.

Total Patients Served: 12,411

UDS Measure	National	Mountain People's
Colorectal	42%	59%
Cervical	53%	47%
HTN	60%	89%
BMI	61%	99%
Depression	67%	97%
Diabetes	32%	23%

POPULATION HEALTH MANAGEMENT INTERVENTIONS

- ✓ Generate population health management reports (i2i Population Health) to identify patients who are due for cervical, breast, or colorectal cancer screening.
- ✓ Reports are created daily; reviewed by provider and care team during morning huddle.
- ✓ Huddle reports flag patients due for screenings (cancer and other).
- ✓ Generate monthly reports for provider/care team showing performance relative to other teams; includes individualized list of patients in need of outreach.
- ✓ Rely heavily on our QI program in making sure that clinical staff are aware of the screening guidelines for cervical, breast, and colorectal cancer screenings.

CARE MODEL

- ✓ Huddle Reports drive cancer screening activities
  - ✓ During intake nurses address cancer and other screenings and provide patient education.
  - ✓ If needed, nurses obtain information on care obtained outside the health center; request records.
- ✓ Referral Department conducts follow up to obtain consult reports and closing of referral loop.
- ✓ If patient is willing, providers generally close screening gaps while patient is in the health center; otherwise, follow-up visit scheduled while patient is still in the office.
- ✓ For patients in need of colorectal cancer screening, test kits provided to patients while they are in the office; follow-up outreach done the nurse working with provider who ordered the test; follow-up reminder to return test kit is done via phone, as needed. If nurse is unable to reach patient by phone, a letter is sent.

PARTNERSHIPS

- ✓ Teamed up with the Knoxville Comprehensive Breast Center; mobile mammography unit comes to health centers centralized location several times throughout the year.
- ✓ Able to schedule up to 21 of our patients each time they visit. We have scheduled this once a month for the 2023 year. This has been a huge success for our patients.
- ✓ Work with managed care organizations to obtain lists of patients with gaps in care; coordinate outreach so that patient is not contacted twice.

SYSTEMS APPROACH EXTENDS TO OTHER SCREENINGS: Hypertension Management

- ✓ Blood pressure is obtained for every patient at every primary care visit.
  - Re-check if abnormal; reported to provider
  - Follow-up scheduled (e.g., in 1-2 weeks or every 2 weeks) until controlled
  - Set blood pressure goals with patient
  - Provide patient education
  - Refer to cardiologist, as needed
  - Refer to behavioral health, as needed, for stress, anxiety, and depression management
  - Connect to in-house care management services, as needed

- ✓ All staff involved in direct patient care are properly trained in obtaining the accurate blood pressure measurements.

- ✓ Follow and practice the American Heart Association guidelines.