Pediatric Weight Management

Partners in Excellence – Preventive

CentraCare™

Provider

CentraCare Health

Contact

Dane Nelsen | 320-251-2700 x54134
dane.nelsen@centracare.com

Challenge

In the U.S., approximately seventeen percent of children and adolescents ages 2-19 years have obesity. In 2018, Centracare had 4,300 pediatric patients above the 85th BMI percentile. Children with obesity are five times more likely to have obesity as adults. Factors contributing to obesity such as physical inactivity and inadequate nutrition are also related to chronic health conditions like high blood pressure, diabetes, and heart disease. Furthermore, there was a gap in treatment options for pediatric patients with obesity in central Minnesota.

Process for change

- We developed Pediatric Weight Management (PWM), an interdisciplinary, family-based, behavior-intensive program based at the local YMCA for community children. Goals include:
  - Improved weight status and cardiovascular and metabolic risk factors
  - Psychosocial improvements, cognitive skill and academic performance improvements, and physical functioning improvements
- PWM provides care individually or in a group by physicians, dietitians, psychologists, exercise specialists, social workers and nurses.

Results

- Data reflects improvement in pediatric mental health, social determinants, and parental, familial, and social environment relationships.
- Patients report less screen time, more physical activity, more family meals, greater offerings of fruits and vegetables, and less sugar-sweetened beverages.
- At initial consult, over half of children reported baselines of insulin resistance and elevated liver enzymes, while one third reported significant risk of heart disease. Within three months of enrollment, clinical data reflected BMI stabilization.

Adoption considerations

- Although the YMCA location results in higher overhead, it supports follow-through, participation and compliance with each recommended care plan, as well as sharing of resources.

Recommendations for sustaining the gains

- Continue to progress shared medical appointments (SMA) as they are effective at establishing parent-to-parent interactions, exposing families to new disciplines, and surrounding kids with a cohort of peers.
- Addressing biases associated with obesity requires ongoing medical team education and advocacy for addressing obesity.

HealthPartners®

Improving Immunization Errors

Partners in Excellence – Preventive

CentraCare™

Provider
CentraCare Pediatrics

Contact
Becky Baldwin | 320-251-2700 x50349
becky.baldwin@centracare.com

Challenge
From October 2018 to June 2019, there were eight reported errors related to immunizations in the pediatric clinic. These errors were due to various issues, including wrong vaccine, wrong order, and wrong person. The pediatric clinic felt a need for change.

Proccess for change
Our general goal was to reduce the number of errors, with an end goal of near zero errors. To accomplish this, we implemented scanning functionality to use when administering immunizations. This scanning acts as a double check to the order that was placed by the provider. A provider orders the vaccines, the nurse then checks the provider order, and brings the vaccines and scanner to the patient exam room. The nurse checks the patient's name, scans the vaccines, and then preps them to be given to the patient. When the scanning occurs, the EMR system makes sure what was scanned is a match to what the provider ordered.

Results
- Zero errors in the first two months of the project.
- This process change has also made an improvement in nurse time spent on immunizations and improved efficiency.

Adoption considerations
- What types of errors were happening?
- Current nursing workflow.
- Overall cost of implementation.

Recommendations for sustaining the gains
- Our EMR system generates a report to show usage of the scanners and near misses.
- Leadership shadowing and observation of the process to ensure nurses are compliant.

HealthPartners®

CentraCare Colorectal Cancer Screening Improvement for Patients of Color

Partners in Excellence – Preventive

CentraCare™

Provider
CentraCare Health

Contact
Phil Opatz | 320-251-2700 ext 76740
phil.opatz@centracare.com

Challenge
In September of 2018, CentraCare had an overall colorectal cancer screening rate of 78.2%, while patients of color were screened at a rate of 49.6%. This disparity clearly needed to be addressed.

Process for change
CentraCare and Exact Sciences partnered to implement a Care Gap Project, in which CentraCare and Exact Sciences staff worked together to reach out to patients of color who had never been screened for colorectal cancer. We focused on Family Health Center, the CentraCare clinic with the most patients of color and which has historically had lower rates of colorectal cancer screening. Two hundred thirteen patients who had never been screened were identified. Letters were sent to these patients, followed by phone calls and discussions with providers during office visits. Translators from Family Health Center followed up with the patients as necessary.

Results
- Of the 213 patients identified in September of 2018, 55 have since been screened for colorectal cancer, for a success rate of 26%.
- Family Health Center's overall colorectal cancer screening rate for patients of color went from 35.3% in September of 2018 to 45.7% through July of 2019, helping drive the overall system rate from 49.6% to 55.6% in that same period.

Adoption considerations
- While the majority of the outreach occurred outside of the clinic by CentraCare and Exact Sciences staff, it was crucial to have the support and cooperation of clinic providers and nurses to encourage patients to get screened.
- This engagement creates momentum for promotion of screening to patients that were not on the list of those outreached.

Recommendations for sustaining the gains
- We recommend and will continue to try various outreach approaches (mail, phone, MyChart) and educating all patients on the various options, e.g. Cologuard, FIT and colonoscopy.

HealthPartners®

Direct Scopes: Removing Barriers to Colorectal Cancer Screening

Partners in Excellence – Preventive

SANFORD HEALTH

Provider

Sanford Health – Worthington

Contact

Tiffany Johnson | 605-333-7360
tiffany.johnson@sanfordhealth.org

Challenge

According to the Centers for Disease Control (2016), one quarter of adults aged 50-75 have never been screened for colorectal cancer. Sanford Health established a Performance Improvement Goal for Colorectal Screening to be greater than 80% by 2018. Our community's population has many people who speak very little (if any) English, which creates a significant language barrier. We have become proficient in the use of interpreters in order to convey the importance of getting screened for colorectal cancer.

Process for change

Our goal was to decrease the length of time from scheduling to completion of colonoscopy. To do this we:

- Created a universal screening form and customized dot phrases for direct scopes.
- Implemented universal prep for colonoscopies for surgeons.
- Created blocks in surgery schedule for direct scopes for same day scheduling.
- Provided standard education.

Results

- Our colorectal cancer screening rates increased from 67.7% to 71.5% in calendar year 2018.
- Within the first six months of implementing our changes, 47 screening colonoscopies were scheduled.

Adoption considerations

- Know and understand your current process and known barriers (with potential solutions) prior to implementing this process.
- Support and understanding from all staff is crucial to carry out this work.

Recommendations for sustaining the gains

- Continue current process and workflow as we have seen our rates continue to rise through 2019.
- Integrate mammography screenings and Dexa-scans to colorectal cancer screening workflow.

HealthPartners

Adolescent Depression Screening

Partners in Excellence – Preventive

INTEGRITY HEALTH NETWORK

Provider

Integrity Health Network

Contact

Teri Shelton | 218-722-8802 x116
tshelton@ihnhealth.com

Challenge

Depression is the leading cause of disability in the United States. Children and adolescents with Major Depressive Disorder (MDD) typically have functional impairments in their school or work performance, as well as in their interactions with families and peers. MDD in children and adolescents is strongly associated with recurrent depression in adulthood, other mental disorders, and increased risk for suicidal ideation, suicide attempts, and suicide completion. (Source: United States Preventive Service Task Force).

Integrity Health Network did not have a standardized workflow for screening adolescents for depression or coordinating care for these patients.

Process for change

- Integrity Health Network clinics implemented a process to screen all adolescents for depression using the Patient Health Questionnaire for Adolescents (PHQ-A) at their annual preventive visit.
- Care Coordination and Follow-up was initiated based on severity score. All patients scoring a 5 or higher are assigned a designated care coordinator who will conduct targeted follow-up, referral tracking, education and crisis intervention if needed.

Results

- In the first 9 months of the project, 1,026 adolescents were screened for depression.
- Of those 1,026 patients, 473 received care coordination and additional mental health services.
- 5 of those patients qualified for immediate crisis intervention.

Adoption considerations

- Providers must use the same standardized screening tool.
- Care Coordination must be determined. This could include hiring staff or utilizing existing staff.
- Proper tracking and follow-up within the EMR must be determined and trained.

Recommendations for sustaining the gains

- Scores and follow-up treatment is reported to the network on a quarterly basis.
- Treatment and care coordination is tracked in the patient chart.
- Care coordinators work follow-up lists to ensure all patients receive necessary follow-up care within the office or from outside mental health staff.

HealthPartners®

CentraCare's Collaboration with Local Legislation to Pass T-21

Partners in Excellence – Preventive

CentraCare™

Provider

CentraCare Health

Contact

Dane Nelsen | 320-251-2700 x54134
dane.nelsen@centracare.com

Challenge

Each year in Minnesota, tobacco use is responsible for more than 6,300 deaths and more than $3 billion in preventable health care costs. Alarmingly, 95 percent of addicted adult smokers started before the age of 21. Simply stated, too many kids are using tobacco. In fact, 55,000 Minnesota students will use tobacco this year, which is no surprise giving how heavily and effectively the tobacco industry markets to youth.

Smoking costs Minnesota billions of dollars, including more than $3 billion in excess health care costs annually. That's $593 for every person in the state. Smoking hurts low-income and diverse communities most. Death from smoking-related diseases is higher among African-Americans than in the general population.

Process for change

- Raise the legal age to purchase tobacco products, including electronic delivery systems, to 21 years old. Increasing the tobacco age will prevent 30,000 Minnesota kids from becoming smokers over the next 15 years.
- Reduction in initiation rates has proven impact on overall smoking prevalence. This improves overall health by reducing smoking and other tobacco product-related health effects. Furthermore, it will reduce secondhand smoke exposure.

Results

After 22 months of intense collaboration with numerous community partners and leaders, including the county sheriff, local substance abuse coalition, public health, county attorney's office, educators and statewide technical assistance agencies, a county-wide tobacco licensing policy was passed to increase the legal age to purchase tobacco to age 21.

Adoption considerations

Facilitating T-21 legislation will require changing the hearts and minds of communities served. Significant barriers include the age of maturity and the "right" to use tobacco, and an unfair playing field for local retailers.

Recommendations for sustaining the gains

We will continue to host conversations with local elected officials about supporting and passing policies at the city and state level.

HealthPartners®

Completion of breast cancer screening in congruence with primary care appointments

Partners in Excellence – Preventive

HealthPartners®
Stillwater Medical Group

Provider

Stillwater Medical Group – HealthPartners

Contact

Sonya K. Steiner | 651-275-3318
Sonya.K.Steiner@lakeview.org

Challenge

There was a decrease in breast cancer screening rates in our clinic. Women were not completing the recommended screening (mammogram) when they scheduled their primary care appointment or thereafter.

Process for change

The initial goal was to increase the rate of scheduled mammograms when the patient called to schedule an office visit. The broader goal was to increase our overall mammogram screening rate for women based on MN Community Measurement guidelines. We executed an A3 process improvement project involving access, radiology, clinical staff, and clinicians. As a result, scripting was added for call center colleagues when women called in for an appointment. The script included supportive messaging from primary care and referenced the date of their last mammogram. We also expanded the mammography calendar to allow scheduling from 3 months to 12 months to capture those patients who needed to schedule a future mammogram.

Results

- We saw a 37% increase in mammogram appointments made through the call center when women called to make an office visit.
- The overall mammography screening rate including over 8,600 patients improved from 79.91% to 83.92% over a 2-year period.

Adoption considerations

- It was critical to engage the call center staff to acknowledge and embrace the important role they have in the care of our patients.
- There was a high need for educating all staff around the need for women to complete mammograms and our measures of success.
- Easy available access to routine and same day mammograms was crucial.

Recommendations for sustaining the gains

- Focus on goals communicated through staff meetings, daily visual management, monthly data review and observation audits.
- Focus on assisting women to schedule their mammogram at any time during their visit.
- Commitment to continue process improvement.

HealthPartners®