Partnerships for Care

HIV TAC TEAM

A Meaningful Approach to Quality Improvement

Presenters:
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Speakers:

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Objectives

- Identify common pitfalls health centers encounter related to the clinical quality measures.
- Discuss strategies for assessing a health center's current capacity to engage in meaningful quality improvement.
- Through case studies, evaluate different approaches to clinical quality improvement using the clinical quality measures.

Disclosure Statement

Faculty: Hans Dethlefs, MD and Ed Zuroweste, MD

Disclosure: We have no real or perceived vested interests that neither relate to this presentation nor do we have any relationships with pharmaceutical companies, biomedical device manufacturers, and/or other corporations whose products or services are related to pertinent therapeutic areas.

Health Outcomes and Disparities

- Percentage of diabetic patients whose HbA1c levels are > 9 percent
- Percentage of adult patients with diagnosed hypertension whose most recent blood pressure was less than 140/90
- Percentage of births less than 2,500 grams to health center patients

Outreach/Quality of Care Indicators

- Percentage of pregnant women beginning prenatal care in first trimester
- Percentage of children who have received age appropriate vaccines on or before their 2nd birthday
- Percentage of women age 21-64 who received one or more tests to screen for cervical cancer in last 3 years
- Percentage of patients age 2 - 17 who had a visit during the current year and who had Body Mass Index (BMI) documentation, counseling for nutrition, and counseling for physical activity during the measurement year

Outreach/Quality of Care Indicators

- Percentage of patients age 18 years or older who had their Body Mass Index (BMI) calculated at the last visit or within the last six months and, if they were overweight or underweight, had a follow-up plan documented
- Patients age 18 and older (1) screened for tobacco use AND (2) received cessation counseling intervention or medication if identified as a tobacco user one or more times in the measurement year or prior year

Outreach/Quality of Care Indicators

- Percentage of patients age 18 years and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous transluminal coronary angioplasty (PTCA), or who had a diagnosis of Ischemic Vascular Disease (IVD), and who had documentation of use of aspirin or another antithrombotic during the measurement year
- Percentage of patients age 50 to 75 years who had appropriate screening for colorectal cancer (includes colonoscopy ≤ 10 years, flexible sigmoidoscopy ≤ 5 years, or annual fecal occult blood test)

New Measures

- Patients whose first ever HIV diagnosis was made by health center staff between October 1 and September 30 and who were seen for follow up within 90 days of that first ever diagnosis
- Patients aged 12 and over who were (1) screened for depression with a standardized tool and (2) had a follow-up plan documented if patients were considered depressed

Quality of Care Indicators

- Percentage of patients 5-64 years of age identified as having persistent asthma and were appropriately prescribed medications during the measurement period
- Percentage of patients aged 18 and older with a diagnosis of CAD who were prescribed a lipid lowering therapy
- Children aged 6-9 years, at moderate to high risk of caries, who received a sealant on a first permanent molar

Framework: The Care Model

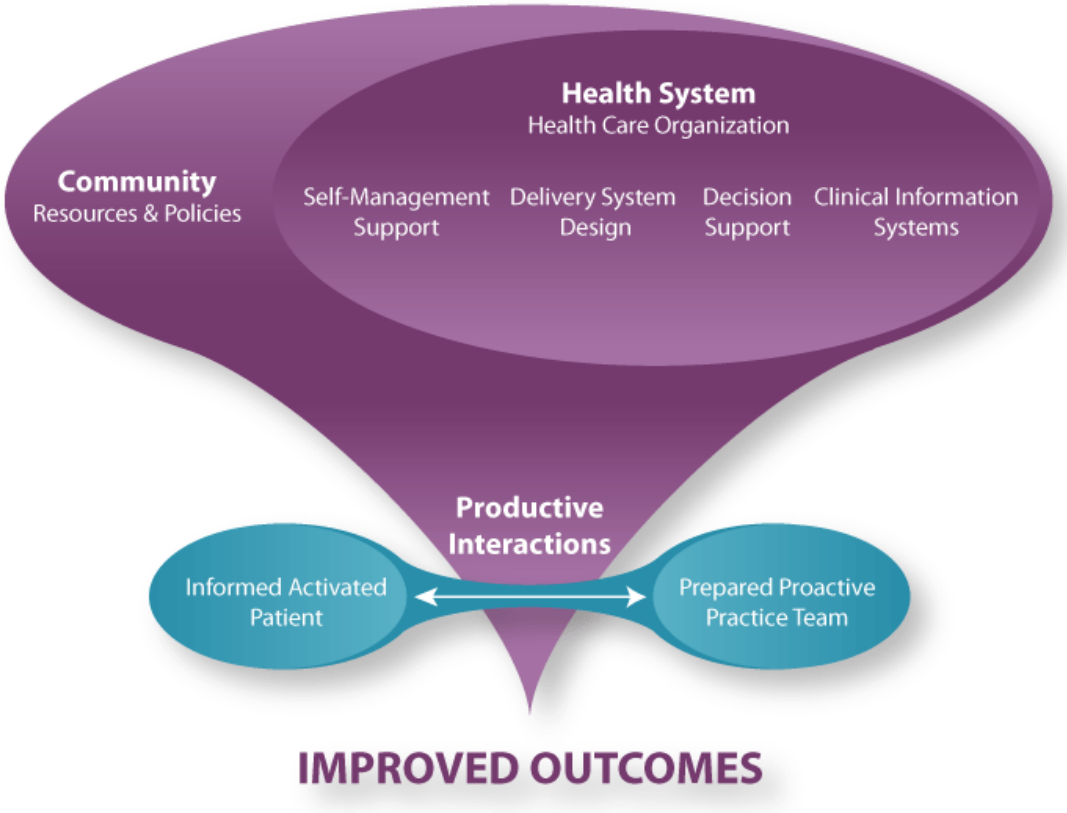
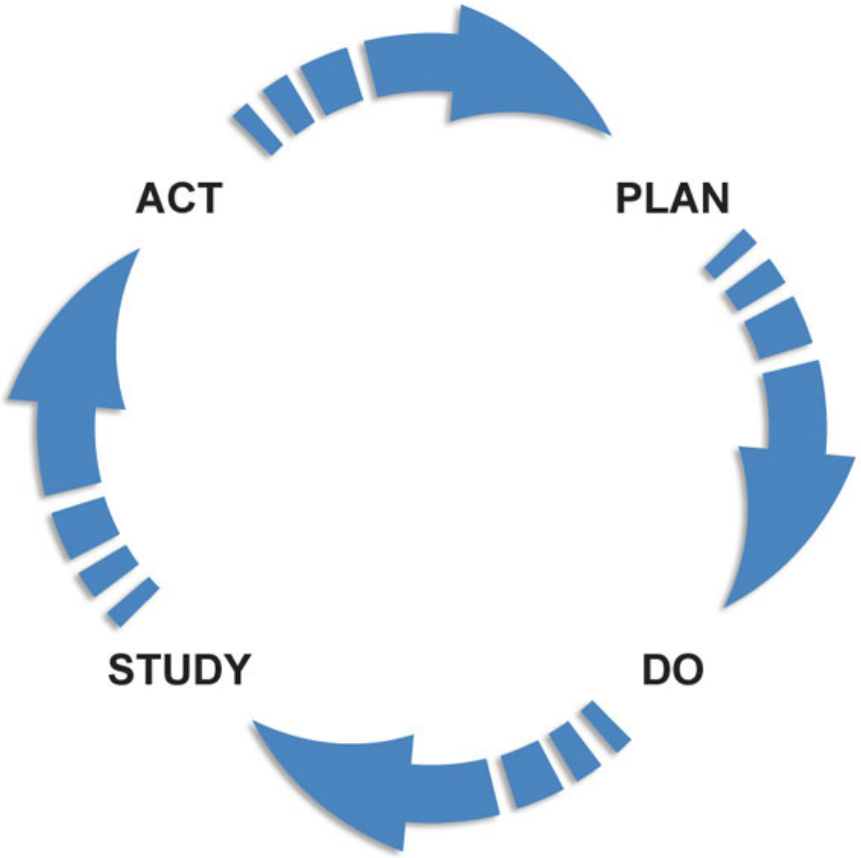


Image source: Community Care of North Carolina

Change Method: PDSA



Maximize Buy-in & Limit Scope

- Input from providers and senior leadership on their top priority from UDS
- Senior leadership commitment
  - Resources
  - Community connections
- Cross departmental team including IT
- Well defined goal with set meeting schedule and timeline
- Early assessment of needs and strengths

Step 1: Select Measure as part of our annual provider retreat

Table 6B Sec F - Adult Weight Screening and Follow Up

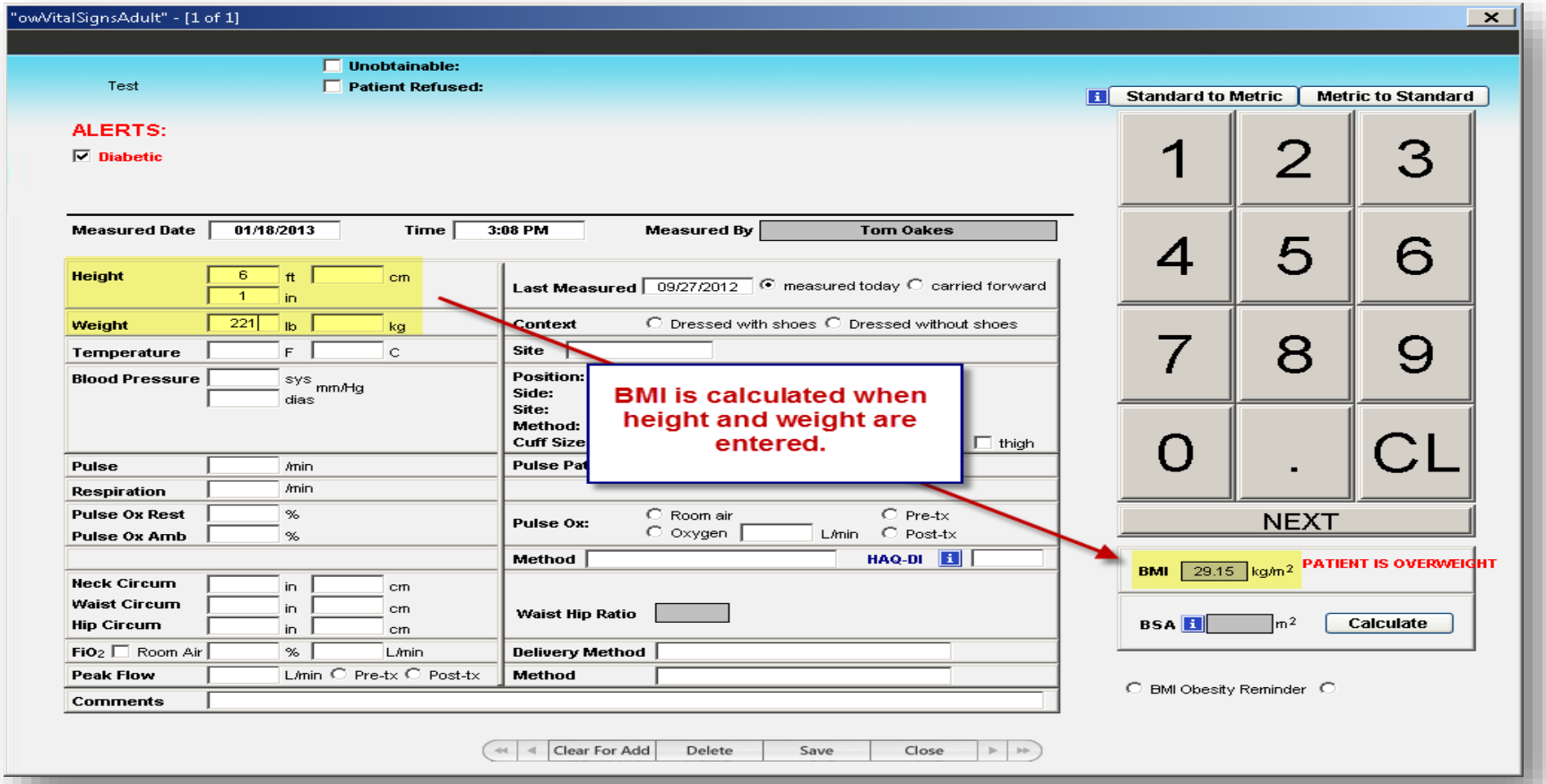
SECTION F – ADULT WEIGHT SCREENING AND FOLLOW-UP				
ADULT WEIGHT SCREENING AND FOLLOW-UP		TOTAL PATIENTS AGED 18 AND OLDER (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS WITH BMI CHARTED AND FOLLOW-UP PLAN DOCUMENTED AS APPROPRIATE (c)
13	MEASURE: Patients aged 18 and older with (1) BMI charted *and* (2) follow-up plan documented *if* patients are overweight or underweight			

Step 2: Interpret Measure
(In the context of your data / charting system)

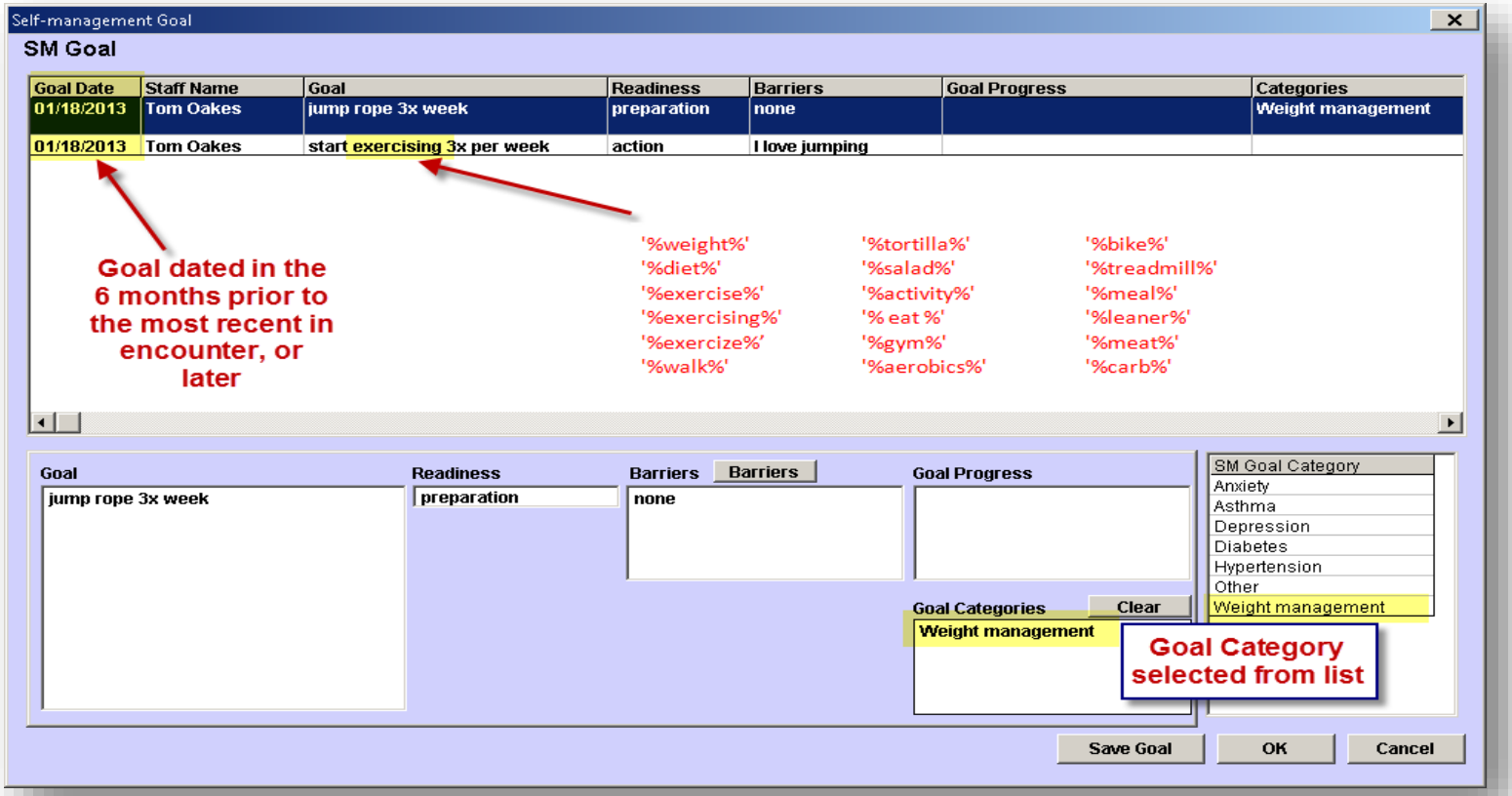
BMI Documentation	BMI is calculated for patients in NextGen when height and weight are documented. The BMI used for the numerator of this report is that which was captured at the last (most recent) encounter during the reporting period, or in the six (6) months preceding that visit. There is an inherent assumption that patients are seen in an environment where vitals equipment is present.
SM Goal Documentation	Self Management Goals regarding weight management that are documented in the EHR qualify a patient for the numerator of this measure. SM Goals that contain one or more of the following keywords will be picked up as satisfying the numerator. '%weight%' '%tortilla%' '%bike%' '%diet%' '%salad%' '%treadmill%' '%exercise%' '%activity%' '%meal%' '%exercising%' '% eat %' '%leaner%' '%exercize%' '%gym%' '%meat%' '%walk%' '%aerobics%' '%carb%' The "%" is a wildcard character, meaning the text between will be found anywhere in the Goal. In addition, using the SM Goal category "Weight Management" will qualify the SM Goal for the numerator. The SM Goal must have a goal date that is after 6 months prior to the most recent encounter. For instance, if a patient's most recent encounter during the reporting period is September 15, the SM Goal must be dated on or after March 15 of that year. See screenshots below.
Exclusions: pregnant and terminally-ill patients	Pregnancy is determined as having an OB visit in the last 90 days.

Step 3: Map Pertinent Workflows

(Use to create training documents for recommended workflows)

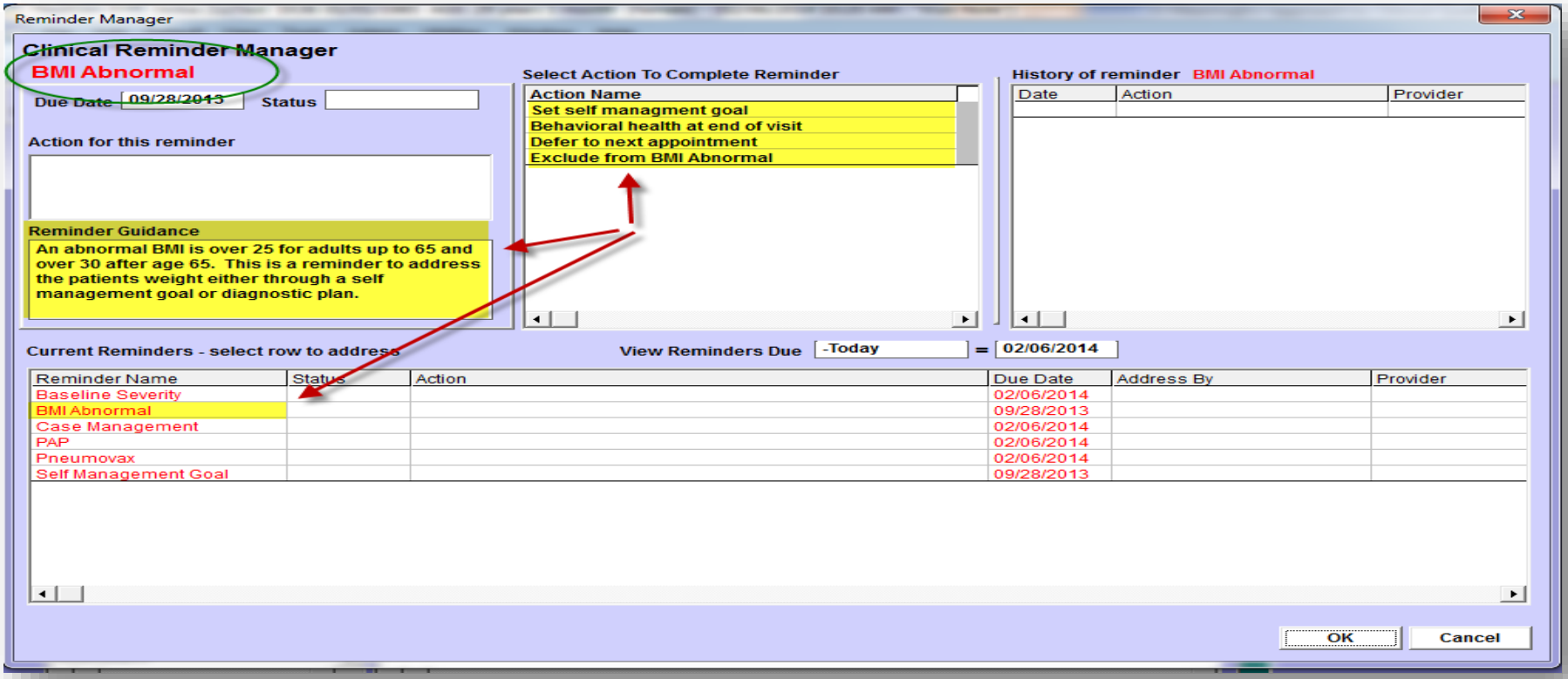


Step 3 (cont.)
(Re-train staff on workflows)



Step 4: Point of Care Clinical Reminders

(One of most important tools for clinical quality improvement – if built correctly)



Step 5: Population Report

(Used for case management and verification of report accuracy)

Patient	DOB	Person #	Age	BMI	Normal BMI	SM Goal
			32	27	No	Yes
			33	26	No	No
			66	26	Yes	No
			61	37	No	Yes
			55	36	No	Yes
			45	25	No	No
			51	25	No	No
			45	28	No	Yes
			29	37	No	Yes
			63	34	No	No

Summary For: Dethlefs MD, Henry J

Abnormal BMI with Followup Plan	275
Normal BMI Under 65 Years of age	38
Normal BMI 65 and Over	18
Numerator	331
Denominator	416
	80%

Measure PCP Definition:
Visits going back 2 years
Includes OB visits
Excludes Behavioral Health visits
Excludes Acute visits

Step 6: Audit Reports

(Used to identify bad data and issues with templates or workflows leading to it)

UDS Audit - BMI<10 or BMI>200

OneWorld Community Health Centers Inc

Those with bmi < 10 or > 200.

Period Starting: 1/1/2014
Period Ending: 1/31/2014

Patient Total: 16

Patient Name	DOB	Person #	BMI	weight_lb	height_ft	height_in
			0.00	175	0	6625
			1.47	73	0	187
			2.70	14	4	12
			4.11	163	0	167
			6.53	16	3	6
			6.58	34	5	0
			7.44	30	4	5
			7.68	157	5	60
			8.38	134	4	58
			8.50	27	3	11
			8.93	4	1	6
			9.74	5	1	7
			211.55	623	3	10
			293.72	1820	0	66
			1,489.67	58	0	5
			3,930.01	195	0	6

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Step 7: Provider Report Card

(Use transparency to leverage desire to perform well)

UDS - Adult Weight Screening Follow-up

OneWorld Community Health Centers Inc
Data from 01/01/2013 to 12/31/2013

Denominator is all patients age 18 or older during the measurement year and:
1. Had at least one medical visit during the measurement year
2. In an environment which had equipment present to measure weight and height
3. Were ever seen after their 18th birthday

Numerator is patients with Normal BMI, OR abnormal BMI (>=25 for patients under 65; >=30 for patients over 65; or < 18.5) and having a documented followup plan.

	Denominator	Numerator	% of Patients
	4	0	**0.0%**
	209	95	**45.5%**
	386	139	**36.0%**
	61	24	**39.3%**
	16	4	**25.0%**
	20	7	**35.0%**
	19	8	**42.1%**
	636	315	**49.5%**
	176	111	**63.1%**
	167	112	**67.1%**
	1	1	**100.0%**
	25	10	**40.0%**
	144	60	**41.7%**
	1	1	**100.0%**
	416	331	**79.6%**

Step 8: Evaluate Process

- Compare your baseline to final and benchmark this against others (UDS, Healthy People 2020 etc)
- Document lessons learned
- Identify building blocks that will help with other clinical measures
- Close communication loops with staff, providers, and senior leadership
- Evaluate adequacy of reporting infrastructure

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Build a Quality Program
Measure by Measure

Monthly Provider Performance Review

If performance is favorable to the target, color the box green. If it is not favorable to the target, color the box red.

	Measurements	2013 Target	Current Numerator	Current Denominator	2013 May	2013 June	2013 July	2013 August	2013 September	2013 October	2013 November	2013 December	num	den	Year End
					Month by Month Progression										
All Patients	Productivity Current Year - All locations	1588			637	806	NR	1222	1336	1479	1334	1439			
	Productivity- Current Month - All Locations	132			123	169	204	114	114	150	122	105			
	Clinical Summaries Past Three Months	50%	153	242	31%	32%	41%	48%	64%	71%	64%	63%	1028	1969	52%
Peds Conditions	Childhood Immunizations Past 12 Months	80%	18	18	100%	100%	100%	100%	100%	100%	100%	100%	149	149	100%
	Missed Immunizations Current Month	5%	0	1	0%	0%	0%	NR	0%	NR	0%	0%	0	8	0%
	Asthma Severity Past 12 Months	78%	20	20	100%	87%	92%	100%	100%	100%	100%	100%	165	171	96%
	Asthma on ICS Past 12 Months	90%	5	5	100%	100%	100%	83%	100%	100%	100%	100%	50	51	98%
Weight Mgmt	Peds Weight Assessment Past 12 Months	65%	103	135	72%	72%	73%	73%	77%	76%	75%	76%	778	1047	74%
	Peds Diet and Exercise Current Month	45%	7	11	59%	71%	81%	82%	71%	79%	90%	64%	112	148	76%
	Adult Weight Follow-Up Past 12 Months	45%	230	344	59%	60%	58%	60%	62%	65%	65%	67%	1740	2808	62%
	Adult Weight Self-Mangement Goal Current Month	18%	12	14	69%	57%	42%	69%	53%	88%	82%	86%	106	165	64%
Tobacco	Tobacco Cessation Past 12 Months	75%	28	36	80%	79%	80%	75%	76%	76%	74%	78%	348	454	77%
	Addressed Smoking Current Month	50%	1	2	100%	100%	60%	100%	71%	60%	0%	50%	25	34	74%
Heart Disease	LDL for CAD Past 12 Months	82%	3	3	100%	100%	100%	67%	100%	100%	100%	100%	16	17	94%
	Aspirin for IVD Past 12 Months	80%	21	23	90%	90%	90%	91%	91%	91%	95%	91%	159	174	91%
	HTN < 140/90 Past 12 Months	76%	78	90	80%	79%	82%	83%	82%	94%	82%	87%	628	753	83%
Cancer Screen	Colorectal Cancer Screening Past 12 Months	38%	82	140	66%	69%	66%	67%	68%	66%	69%	68%	659	975	68%
	FOBT Ordered Current Month	39%	6	7	50%	43%	86%	100%	33%	67%	83%	86%	30	44	68%
	Pap Within 3 Years Past 12 Months	67%	121	159	75%	75%	76%	75%	79%	81%	76%	76%	1031	1344	77%
Diabetes	DM HbA1C ≤ 9 Past 12 Months	87%	68	74	84%	86%	87%	87%	85%	84%	91%	92%	523	601	87%
	DM LDL Screening Past 12 Months	73%	63	86	86%	86%	84%	83%	81%	80%	77%	73%	562	690	81%
	DM HbA1C completed last 6 Months	87%	70	86	91%	90%	86%	80%	80%	83%	80%	81%	578	690	84%
	DM Eye Exam Past 12 Months	40%	59	86	68%	65%	60%	57%	64%	64%	64%	69%	441	690	64%
	DM Hypertension Controlled Past 12 Months	76%	59	86	63%	62%	60%	61%	72%	78%	72%	69%	463	690	67%
	DM Microalbumin Past 12 Months	69%	64	86	71%	74%	73%	72%	76%	77%	79%	74%	515	690	75%
	DM LEAP Past 12 Months	68%	55	86	77%	77%	72%	69%	64%	60%	62%	64%	470	690	68%

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Health Center Controlled Networks

- In the EHR world opportunities for improvement have grown
- Leveraging these opportunities is complex and requires a close collaboration between clinicians, senior leadership, and HIT staff
- This collaboration requires a substantial investment in HIT infrastructure
- The magnitude of investment requires leveraging the pooled resources of networks

Family First Health

Jenny Englerth, CEO

Jennifer L. Moubray, Director of Community Health Programs

HIV Data

596 patients in 2016, current active patient panel of **544**

Focus Areas for CQI

2015-2016: Retention of clients in medical care (Process)

- Improved Viral Lead Suppression Measure (Outcome)
- Used In+Care campaign definitions of medical visit frequency and viral load suppression

2017: Percentage of HIV pts, regardless of age, who received at least one oral health exam by a dentist during the measurement year, based on patient self-report or other documentation (HIV/AIDS Bureau definition)

2018: Increase the number of patients receiving specialty treatment for Hepatitis C

Main Challenges

1. Keeping track of all the performance measures is a challenge.
    - Permutations of HRSA measures
    - In+Care Campaign measures
    - Internal measures
    - Sub-versions used to track disparities
    - currently monitor no less than 105 different performance measures.
2. Staff turnover can impact QI efforts, particularly provider turnover which can have a profound effect on retention in care numbers.

Data Challenges

- Our patients are served at both our agency and at a subcontracted hospital system.
- Family First Health and the subcontractor use different electronic health records, neither of which interface directly with CAREWare.
- All data must be entered manually in CAREWare on an ongoing basis, mostly through the efforts of the data manager (although medication data is entered exclusively by the program counseling pharmacist.)

HIV QI Team

HIV QI Team (8-10)

- Data manager (co-leader)
- Program Manager (co-leader)
- Medical Director
- Subcontractor Provider
- Linkage-to-Care Coordinator
- Lead Case Manager
- 2 Clinical Care Coordinators
- Eligibility Specialist
- Quality & Compliance Coordinator

Additional Input from Consumer Advisory Board

Workflows

1. Team based approach with defined roles for care (providers, clinical care coordinators, medical case managers, linkage to care coordinator, and eligibility specialist)
2. Huddle every Friday morning for one hour with entire team to review patients for past and upcoming week
3. Case managers and other supportive services staff available before, during, and after medical appointments as needed.
4. EHR- Athenahealth
5. Developed guidance around prescription refills, labs, etc. as it relates to medical appointment compliance
6. Specific intake flowsheet developed, focus on 7 day challenge for new diagnosis

Specialty Support and Community Partnerships

Specialty Support

- Referrals through subcontracted hospital
- Counseling pharmacist
- Nutritionist
- Medical case managers
- Behavioral health
- Medically-managed substance abuse support

Community Partnerships

- Subcontracted health/hospital system for outpatient health services
- City and state health departments in referrals, partner notifications, and in reaching out to patients who may have been lost to care.
- Regional QM group including other RW Part C agencies in Eastern PA.
- Extensive referral network for specialty care and support (gastroenterology, pain management and therapy, behavioral health, substance abuse services, etc.)

Thank you for participating in this Webinar.

We hope that you are able to find the information provided useful as you continue your P4C project. We ask that you take a few moments to complete the feedback survey you will receive when you close out of this webinar.

If you have any additional questions, please email us:
P4CHIVTAC@mayatech.com