WEBINAR VIDEO TRANSCRIPT

Partnership for Care HIV TAC

Meaningful Approach to Quality Improvement

Edward Zuroweste, MD and Hans Dethlefs, MD

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STEVE LUCKABAUGH: Good afternoon. My name is Steve Luckabaugh, and I'd like to welcome you to the Meaningful Approach to Quality Improvement Webinar. This webinar is brought to you by the Partnerships for Care HIV Training, Technical Assistance and Collaboration Center, HIV TAC. The Partnerships for Care Project is a three year multi-agency project funded by the Secretary's Minority AIDS Initiative Fund and the Affordable Care Act.

The goals of the project are to expand provision of HIV testing, prevention, care, and treatment in health centers serving communities highly impacted by HIV, to build sustainable partnerships between health centers and their state health department, and to improve health outcomes among people living with HIV—especially among racial and ethnic minorities. The project is supported by the HIV Training, Technical Assistance and Collaboration Center, HIV TAC.

We have two speakers today. Dr. Hans Deflefs is a family physician at the One World Clinic in Omaha. Having growing up in Omaha, he attended Creighton Prep, Creighton University, and the University of Nebraska Medical Center. And he completed his family practice training in Wichita, Kansas. Prior to joining One World in 2000, he lived and worked in Honduras for three years with his wife, Andrea, and three children.

Besides providing direct patient care at One World, he serves as the medical director for an electronic health record network of nine community health centers in Nebraska, Iowa, and Texas. He is currently the president and medical director of the Omaha-based nonprofit, Chronic Care International.

And our first speaker today is Dr. Ed Zuroweste, who is a co-chief medical officer for the Migrant Clinicians Network. In this position, Dr. Zuroweste is responsible for the oversight of all of MCN's clinical activities. He was present at the first official meeting of the Migrant Clinican's Network in 1985, and has been consistently involved with the organization since that time.

Dr. Zuroweste began his work with migrants as a partner in private practice in Chambersburg, Pennsylvania. He later became the medical director of Keystone Health Center, a large migrant and community health center in Chambersburg. While tending to his administrative responsibilities, Dr. Zuroweste also maintained a full time clinical practice in family medicine and obstetrics, including full hospital privileges in pediatrics, adult medicine, and obstetrics.

In addition to his work with MCN, Dr. Zuroweste is an assistant professor of medicine at Johns Hopkins School of Medicine, where he directs an international rural health elective in Honduras. Dr. Zuroweste is also the staff physician for seven county health department tuberculosis clinics, and currently acts as the tuberculosis medical consultant for the Pennsylvania Department of Health. He is also a clinical consultant for three separate consulting firms, and serves as a locum tenens family physician for multiple sites.

Dr. Zuroweste has worked for the World Health Organization on two separate short term assignments—the first in 2009 and 2010 as a special medical consultant during the H1N1 influenza pandemic, and in 2014, as a special medical consultant with the Ebola response team in Guinea and Sierra Leone, West Africa. Please join me in welcoming Dr. Zuroweste.

EDWARD ZUROWESTE: Thank you very much, and good afternoon for those of you on the east coast—and good morning for those of you who are not on the east coast. So our objectives today—Hans and I are going to do this together. And Hans is really going to do the heavy lifting on this particular presentation today. But our objectives are to identify common pitfalls health centers encounter related to their clinical quality measures. And we're going to discuss some strategies for assessing a health center's current capacity to engage in meaningful quality improvement.

And then, we're going to finish up with a case study, which is real time with a health center in Pennsylvania who's done some excellent work on their HIV quality improvement. Unfortunately, Hans and I have nothing to disclose after 30 years or so of working in health centers. No one wants to pay us anything that we would have to disclose, so that's great.

So I'm going to start off. I think whenever we're talking about quality improvement in health centers, it's important to discuss—and I'm just going to discuss this briefly—the 16 clinical quality measures that are required of all health centers to report to the Bureau Department of Health Care. And what I'm really going to focus on is just some changes. There are five—not really very significant—changes to the 2017 reporting that all of us will have to report on.

But I just want to set this out as kind of a basis of quality in the health centers. Whenever we're talking about quality improvement in health centers, these 16 quality clinical measures really make the ground of a lot of that quality improvement activity. So to start out, these first three are the health outcomes and disparities measures. The first one hasn't changed at all. It's to report on your percentage of diabetic patients whose hemoglobin A1c levels were out of control, or over 9%. The second one is—again, hasn't changed. It's the percentage of adult patients with diagnosis of hypertension whose most recent blood pressure was under control, meaning that it was less than 140 over 90.

And the third measure also has not changed—percentage of births less than 2,500 grams to health center patients. And these three have been consistent through many, many years. And most health centers are not having any trouble reporting on these three measures.

The next are outreach and quality of care indicators. The first one hasn't changed at all. It's the percentage of pregnant women who begin their prenatal care in the first trimester. The second one is the percentage of children who received age-appropriate vaccines on or before their second birthday. In this one, we flip-flopped back and forth over last few years. A couple of years, we did the third birthday, but we're back to second birthday. And this is the second or third year now that we're reporting on all children who had the appropriate vaccines by their second birthday.

The third one has changed a little bit this year. And we're making it a little more complicated for folks. The measure is the percentage of women age 21 to 64 who receive one or more tests to screen for cervical cancer in the last three years. And what they've retained is that they retained that part. So it's women who are actually 23 to 64 who had cervical cytology performed in 2017, or the two years prior to the measurement period—so 2015 and '16. What they've added is—just to complicate our lives—is to really get up to date, and that is women aged 30 to 64 who had cervical cytology and the HPV co-testing performed in 2017, or the four years prior.

So if you had the combination of a Pap smear and an HPV and they are negative, then women between ages of 30 and 64 only have to have this done every five years. So that makes for a real challenge if some of your women are only getting Pap smears, and some of your women are getting both—that it's going to take a pretty sophisticated query to pull out this particular indicator.

And the next one is the percentage of patients aged 2 to 17 who had a visit during the current year, had a BMI and had counseling for both nutrition and for physical activity during the measurement year. And that has not changed at all. So that's your pediatric patient, your BMI.

Next, we go to the adult BMI one. And that one has changed this year. And the change was that last year and the year before, they had put in parameters for over the age of 65, your BMI could have been a little higher. But they've taken that back out now. And so they've deleted separate parameters for patients aged 65. And now, it's just the normal parameters, age 18 and up. If your BMI is less than 18.5 or over 25, then you should have counseling done.

The next one is the patients age 18 and older who are screened for tobacco and receive cessation counseling. That one has not changed at all. And that one seems to be one of the easiest ones that all of our health centers have. I think we've done a good job at having other people other than the clinicians asking those questions. So either the triage medical assistant, or the nurse who's oftentimes doing a lot of that work.

And the next one is the percentage of patients age 18 and older who are discharged alive with acute myocardial infarction or coronary artery bypass or PTCA, who had the diagnosis of ischemic vascular disease and had documentation of aspirin or another anti-thrombotic. And they've changed that this year to get rid of the anti-thrombotic. Instead, it's anti-platelet. Some

people are actually using Coumadin for this measure. And so now, it's just aspirin or other anti-platelet medications. So that's the change in this particular one.

The next measure is the percentage of patients age 50 to 75 who had appropriate screening for colorectal cancer. So that can either be a colonoscopy every 10 years, a flex sig every five years, along with annual fecal occult blood testing or just annual fecal blood testing. And that one hasn't changed. In this one, I just want to point out—I do a lot of operational site visits all over the country. And this one, we're doing really poorly on all over the country. And there's been a lot of innovative things that health centers have done to try to get this number up.

And I think it's a real tragedy that we're having so much trouble with colorectal cancer screening, because it's a great screening tool. And if we pick colorectal cancer up early, it's very easy to treat. However, if we don't pick it up, it can—as we all know—be very deadly. And maybe during the question and answer period, I could give a couple examples of a colorectal cancer screening. I'll just throw one on right now.

One great one I just heard recently was that in a health center that had a lot of Hispanic patients, they had outreach workers who were working in the waiting room. And they had a project called Poop On Demand, where they literally were going out in the waiting room for patients who hadn't had colorectal screening and asking them if they felt like they might be in the mood to have a bowel movement. And if so, they were doing their colorectal screening—their fecal occult blood testing—right there at that time in the bathroom of the waiting room. Just a very innovative way to look at this one.

Some of the newer measures—and the one is really more pertinent for you folks at this HIV call—is the patients whose first ever HIV diagnosis was made by the health center staff. And if so, they should be seen for follow-up within 90 days of that first ever diagnosis. So that's the only measure out of the 16 that's related to HIV.

And we're going to talk about some other measures that you can be doing when Hans talk about the health center that gave us a lot of information towards the end of this presentation. And then, the next one is patients age 12 and over who were screened for depression with a standardized tool and had a follow-up plan documented if the patient was considered depressed. And that one has changed also, because apparently, some health centers were doing the PHQ2. And then as their follow-up plan, they were just doing a PHQ9. So a PHQ9 is no longer permitted for filling this measure as a follow-up. You actually have to have counseling as a follow-up if you have a positive screen for depression.

The next one is a percentage of patients 5 to 64 who have been identified as having persistent asthma and appropriately prescribed medication. This one has changed a little bit. In the past, it said that they had to have received a prescription for their asthma medicine. And now, the asthma medicine has to have been prescribed.

The next one is percentage of patients aged 18 and older with the diagnosis of coronary artery disease who were prescribed a lipid lowering therapy—that hasn't changed. And the one children ages six to nine at moderate risk for caries who received sealants on their first permanent molars, that one has not changed either. And I think at this point in time, I'm going to turn it over to Hans.

HANS DETHLEFS: Good morning. Thanks for going through those measures. I was taking notes as you went through, since we have to adjust our EHR based on measure definition changes. So I appreciate your highlighting the differences.

So my work primarily is seeing patients as a family doctor in our clinic. But over time, I've certainly developed a passion for population care and health, and how to utilize data to help facilitate improved health of our patient populations. And so I think to begin with as kind of a foundation, what I'd say is when you are saying we need to make an improvement in our clinic, we need to make a change, it's important to have a couple of things in place before you go any further.

One is a framework for how are you going to change, how are you going to improve things, as it relates to any given clinical measure. And the framework that's been used for chronic disease for the last 20 years has been what is called the care model. And when you consider here's an HIV area of improvement that we want to approach—or any other area—I think it's helpful to say, OK, of these areas enclosed in the care model, how are we addressing each one of them?

So just looking at the general diagram, you can see the rubrics on the left is what community partnerships and relationships will we need to help us be successful, since it's oftentimes hard to do everything within a health center—since patients spend the better part of their lives out of the health center. Within the health system, there are four areas that we talked about changing. Above all those areas, we talk about health care organization or senior leadership—which is to say, if you don't have buy-in from the people who make the major money decisions and organizational decisions at your clinic, you're going to have a hard time with long-term success.

The four categories of particular change that a team who wants to improve things goes about include—one, self-management support. So by way of example, if you are working with someone with smoking cessation, giving them the opportunity to express what success and failures they've had in the past, and what next concrete steps they might want to take that fit with their life. And so taking it out of just pure education and really getting into the role of the patient, as far as the primary caregiver for their own health.

Delivery system design speaks about how do you operate within your clinic to operate efficiently, and make sure that you're not missing any steps that are important in the process of quality improvement—by way of example for diabetes, for A1cs at our health center, we have a point-of-care machine—I think a lot of health centers do.

And a particular thing is that when a health system checks in a diabetic patient, if they're due for an A1c we always say, OK, the first thing you do as part of check-in is to get the drop of blood and get the A1c going, because it takes six minutes. And then, by the time you're done checking the patient in, the A1c is ready to go. And the provider can have that right when they walk in the door, as opposed to I've checked the patient in, they're ready for the provider. Now, I'll get the A1c running, and now they need to get six minutes into an encounter without having that information, which is going to shape their conversation. So that's an example of a good delivery system design element.

Decision support speaks to having specialty support and resources that help you make good decisions. And so by way of example, we have a hepatitis C improvement project at our health center. And we have a clinical pharmacist who does a lot of the management of it, and who guides us on therapeutic decisions with regards to what medication makes most sense in what patient.

And then, the final element—which is perhaps the most complex—is clinical information systems. So what data systems, what computer systems do you have in place to track what you're doing so that in the end, you can have good reports to show which way you're moving the needle—and also, something that fits well within the workflow as far as data capture in the course of your processes.

And so when you attend to all of those elements for any particular change related to a chronic condition, the hope is that in the end, you will have an informed activated patient, a proactive care team, and then the result of very productive interactions and improved outcomes.

So once you have the conceptual framework—so we're working within the care model. Here's the particular change we want to make, and looking at the different elements of the care model. The second piece of change is having a change model. And so PDSA is, I think, a pretty well-understood and broadly used change concept and model. But I oftentimes see it used as just kind of a phrase to say we're making a change, without actually digging down to the details in your change processes and utilizing it the way it's intended.

So I'll give you an example of where a PDSA would have been a good thing. In our work in the Dominican Republic, we have a program for diabetes. And we have a recent med school grad who's doing a retinal photo project for us. And so he is in the Dominican Republic and needs to take photos of each or our patient's eyes. And so he created a data entry form that he could use to capture the key answers to questions from the patients, and historical ailments from the patient's eye health when he's doing the photos.

And so he made a couple hundred copies of the form and then got two days into taking photos, and was completely frustrated with this form because he was missing several key elements. And where he would have been better off is to say, OK, I've got a new form. I think this is going to do the job. I'm going to print five of them, try five patients. And if it's good, then I'll make 200 copies. If it's not, I will tweak it, make five more copies, and after five more patients, decide

whether I need to go through the cycle of plan what I'm going to do, doing it, evaluating the results, and then acting on it again. And there are so many areas in health care where we're tempted to implement rather than test first. And so it's always better to test on small scale first.

When you've got your conceptual framework, you have your change model and you're going to be faithful to it. Then, perhaps next setup step is to make sure that you have buy-in from the right people, and that you have a well-defined scope. It's oftentimes the case that a team forms and it just works in perpetuity and never ends, even though the team should have been together for three months or six months until a defined change was made, and then disband or change focus.

At the beginning of things, you need to say, OK, what's our time frame? Who's our team? Get senior leadership buy-in, get input from providers, and get guarantee of resources both time and whatever else—needed space and equipment—from your senior leader. And then, I always recommend they have someone from IT on the team. Because IT with clinical information systems is going to be a big part of what you're going to have to utilize to be successful, both in data capture, and then reporting.

When we talk about who to have at the table as far as setting the foundation, most health centers have some forum which is a good place to tap into. And so an annual provider retreat is an example. Or if you have a biweekly provider meeting, to start planting the idea of what you want to do early on, and getting feedback early on allows you to have something that's well-designed to be able to spread it more easily because it's something that everyone's had a bit of say in already.

I'm just going to go through an example of one of our UDS measures that we've used internally as a clinic, as something that we've done a focused change process on, and walk through the elements of it. And so the adult weight screening and follow-up is one that most people don't do too well on as a baseline, but is one that with pretty discrete changes, can be one where you have a lot of success.

And so the first part is to really understand the definition well. And at UDS, sometimes they put out definitions that are a little bit obscure or have twists to them where it's hard to grasp the nuances. And so this one is a little bit like that, where you're in the denominator if you're 18 years and older. And you're in the numerator if you had a BMI and it was normal and it was documented, or if you had an abnormal BMI that was documented and you had an appropriate plan.

The trick is one—understand the definition, but then two—understand, well, how are we going to translate that into our EHR, into our charting system? And what constitutes credit. And so for us, we said, well, we have a place where we document self-management goals. And so we will consider a self-management goal that we've set in the past as counting, if it contains any one of a number of words strings like weight, or diet, or exercise. And we will also now—going

forward—add something where we can—for each self-management goal—give it a category like diabetes, or asthma, or in this case, weight management.

And so for reporting purposes, we're able then to go back and say, OK, let's look at old self-management goals and see which ones we should get credit for. And going forward, let's add the ability to be a little bit more precise and label them as weight management.

Someone—usually, your IT people—need to understand the names of fields and where data is going to be put, both for where you should capture things, and then where things should be reported from. So where you put in your height and your weight, and does it always generate a BMI, which is an essential first part for this particular measure.

In talking about kind of the areas of the care model, self-management is a cornerstone, and so for us, this measure really begs for paying attention to self-management and self-management goal-setting. And so this is a screenshot of where we put our self-management goals over time. And we've designed it to be able to capture stage of readiness, any barriers, and then for any particular goal, goal progress over time.

And back in the days of just using paper, we really struggled because someone would have a self-management form that you would fill out. And it would get buried in the chart. And it was hard over time to readdress and track any particular self-management goal. So it was just at the first one. But after that, things got messy.

For clinical information systems—personally—for population health, I think there's two areas that are essential as relates to improving the quality of your population's health. One is good reporting, so you know what's going on with your population. But prior to that is good electronic indicators of whether a patient is in need of a service or not. And I call those clinical reminders. And they're called different things in different electronic health records.

But early on, we spent a lot of time working on a good clinical reminder system that then is flexible to take on any of the EDS measures or other quality measures, and say when—at the point of care—do we need to remind the care team of a particular service. And so for us, if a patient has an abnormal BMI and they haven't had a self-management goal in the last six months, then we're prompted with a clinical reminder that BMI is abnormal.

Once you get to the point of data capture, you've done your self-management goal, you've recorded it—it's a weight management type. And regardless of whatever quality measure you're looking at, the next phase is to say, OK, can we report on this? And is it accurate?

And so it's not just a report that say, OK now, we'll just do our UDS report. It's really saying, well, we need a few reports to help us look at this. And the first one is just to say, give me a list of all my patients who should be in a denominator. Give me a list of those who are in the numerator. And let me manually check 10, 20, or 30 of them to see if indeed, the report is

giving me the data that I think it should, or if there's a logic error in the report—as often happens in first iterations of reports.

Just yesterday, I was at a health center in Iowa. And for this exact measure, one of their very sharp nurses who does auditing like that says, well, no. There's something wrong with your report, because look at this patient. And the patient didn't have a clinical reminder for BMI abnormal. But they did show up on the report as not going to the numerator. They were on the denominator. And the reason was the BMI was exactly 25. And a reminder only shows up if it's greater than 25. But the report looks at greater than or equal to 25. And so that's a needle in the haystack kind of thing. But the reality is that with reports, there's often several needles that need to be worked through before you say, OK, this report is good to go.

So along the same lines, as far as the kinds of reports that you need to support your effort, are good audit reports. And so this report says, well, let's look at data anomalies where we might have patients who had an extra digit put in on their weight or missed a digit on their height. And they have a BMI of less than 10 or greater than 200. And I've had one patient with a BMI of 2,000 something. And needless to say, before you go in the room, you're a little bit skeptical. And I think the only way that would be possible is if the person were a living pancake that weighed 500 pounds.

And it's a common thing for data entry mistakes to happen. And what this highlights for us when this happens is maybe we need some way to control the data entry so that you can't possibly put in variant values like that.

The final output—once you're confident about what you're reporting on for us—is a provider report card. And so to be able to tell each of our providers, here's how many patients that belonged to you that you had in your denominator. Here's how many you had in your numerator, and here's your score. And then, to use that as a training opportunity to say, well, do you know where you need to capture the data? And sometimes, it's a question of, oh, I didn't know that. Or it's the need to develop a new habit of documentation.

But I think I would suggest that a better step sometimes—besides really working with your providers—is to do a better job of documentation, which I hear at all the health centers that I visit, people asking me, how can we work with our providers to act in a better—so for this particular goal, right now in my clinic, I'm doing a change effort on being more productive, since I'm a little bit on the slow side.

And so part of that is getting everything off my plate that I can that would be equally well-handled by someone else on my team. And so I've developed a form that my health assistants can use to query people about their weight and weight management efforts, and then work with them on helping to set self-management goals. And so now my health assistants are setting my self-management goals for BMI. And when I go in the room, it's already set. And I can just briefly applaud the patient on the particular goal, or weigh in on it—if you will—so that the patient is more likely to actually act on it.

Towards the end of the process, really, what you're hoping for is something that, if you walk away from it and come back two years later, there's still a well-oiled effective process in place. And so you need to compare your baseline values to your final or benchmark values, document the lessons learned, identify any building blocks that you put in place to help with that particular measure—because they can help you with the next measure—and make sure you close communication loops with staff, providers, senior leadership, your board. And make sure that you use that opportunity to evaluate was our reporting infrastructure adequate.

If you've done something well, it should appear in job descriptions—like my PSA with the assistance, setting a self-management goal—that should appear in their—not job description—in their training manual, as far as whatever new health system is trained on, so that when I walk away from this, any new health assistant coming to the organization would just do this as part of their routine.

Our particular clinic, we have a sundry of clinical quality measures that we put on or provide a report card now—the BMI just being one of them. And we didn't build them all at once. We said, OK, let's—as a provider group—decide what is our next biggest priority. And then, we focus on that for a period of time. Once we feel like we're good to go, then the next one. And we've done that over a course of years. And the final output of all that is, one—having a lot of measures that we're tracking over time and we're able to tell providers about their performance on, but then two—now, we have a lot of building blocks in place so that when a new quality measure comes down the pike, we're able to absorb it, and already have a lot of tools that are going to help us—in shorter order—make good headway on that particular measure.

And this is my advertising slide. Working with an electronic health record with nine health centers, what I am constantly reminded about is how complex it is, and that it's not something that a single isolated health center can do well by itself over time because of all the changes in meaningful use, new measures constantly, and just the complex structure that all EHRs represent. It's really a good thing to partner with the organization with the same electronic health record. And there's a lot of existing health center control networks to be able to be a little bit more agile with what you're able to do on the IT end, because that's an essential cornerstone of any quality improvement efforts that you might want to make. And I'll turn it back to Ed.

EDWARD ZUROWESTE: Great, Hans. Thanks, that was a great overview. And so what we thought for you folks, what we'd like to do is talk now more specific about quality improvement in HIV. And so we reached out, we looked around the country to the health centers that were doing a good job with HIV. And we came across Family First Health Center, which is in York, Pennsylvania. And I've had the privilege of knowing the CEO there, Jenny English, for over 20 years. I actually hired her when I was the chief medical officer of a health center as our first behavioral health professional. She's a social worker by training. And then, she became the COO of our health center. And then eventually, she took over as the CEO of Family First.

And Family First is just a great organization in south central Pennsylvania. You can see there where it's located. They have several sites. And this past year, the organization was awarded the National Quality Center award for measurable improvements in HIV care in 2016.

So what we did, we reached out to them and asked them several questions about what they are currently doing in quality related to their HIV patients. And so Hans is going to now present the results of what we found out from that inquiry to them, just within the last week or so. So this is hot off the press. Hans, I'm giving it back to you.

HANS DETHLEFS: Great, yeah. So we realized that everyone who's joined us on the call is interested in particular in HIV quality improvement. And the reality is that every measure, every condition has a lot of nuances that make it unique. But at the same time, there's a lot of commonality with regards to if you've done one area of quality improvement, what you've done is build a toolset that enables you for the next area of quality improvement.

And so Family First had 596 patients in 2016. And their current panel is 544. It's important to mention this number, because if they were focusing on a particular area of improvement—generally, what we'd recommend is, well, don't do it with 544 patients, do it with one provider's patient. Or do it with a set group of 20 patients. Just because as you try to stay faithful to a PDSA type model, that's virtually impossible to do when you have a very large patient panel that you're trying to impact, at least, at the beginning.

Family First did kind of a stepwise—let's pick a measure. And in my experience, what happens when you say, oh, let's pick five measures—or that sort of thing—is that you don't do anything well because it takes a lot of effort and resources to change one measure. And so I personally am—as we've said—that doing things sequentially as far as numbers and measures is a better approach. So they started in 2015 or '16 with the process measure of retention of clients in medical care. And that had a side effect of helping them with the outcome measure of an improved viral load suppression.

And I think Ed and I were chatting yesterday. And his experience in working with health centers is that oftentimes, if you focus on a process measure to begin with, it has kind of a natural secondary benefit toward a corresponding outcome measure.

EDWARD ZUROWESTE: And if I can just jump in there—this is a really great example of really looking too, to see if you decide to work on a process measure, then you really want to find out—is there going to be some outcome measure from that? Because a process measured without a good outcome really probably is not worth your while. So this is really a great example. They got more clients in. So if they got more clients in and had much fewer lost to follow-up, obviously, those people then were staying on their meds. And if they stayed on their meds, then they improved their viral load suppression. So this is really a great example of working on one area, but then looking at the other area to see how it was impacted by that process measure. So I think this is an excellent example of what they did.

HANS DETHLEFS: Yeah, yeah. And I think a lot of times, you'll notice in the UDS measures by way of example, there's primarily outcome measures. But some of them call for better processes as well. And so in 2017, they moved onto the next measure of trying to improve access to dental care for their patients, and then in 2018, added on co-morbidity of HIV—which is treatment of hepatitis C.

I sent Family First a list of 10 questions. One of those were what were your challenges? And they highlighted, well, keeping track of so many performance measures is a challenge—one, because oftentimes, there are subtle differences in measures across organizations. So HERSA has its measures working with a campaign and En+ Care, that had its measures. They had previously their own internal measures. And so how to minimize the number of reports and workflow changes you need to make, when there's subtle differences on what essentially the same measure.

And then staff turnover they highlight is a major impact. And a lot of our health centers in our network are smaller. The one we were visiting yesterday definitely highlighted this. They're doing a great job on blood pressure control, with around 78% of their patients were in control for blood pressure—which is phenomenal. And they described all the little things that they're doing to accomplish that. But at the end, they say, but if we lose one of our providers and get a new locum tenens and our new provider, we're going to take a major hit on our measure, just because staff turnover. In a sense, you lost a little bit of your institutional memory.

Data challenges were a big thing that they wanted to highlight. And this is why I emphasize so much—trying to be part of a network of community health centers, or if in your area there's a private network and you can use the same EHR and leverage their resources. They ended up—because of database differences—doing a lot of manual data entry. And so they had to include that in their workflows and in their job descriptions, as far as making sure that they captured the right information for their particular quality of measures.

And there's a definite phenomenon of database creep where you say, well, I can't get my EHR to do this. I'll create an access database. Or we'll use this database. And I really try to highlight for people that's not a good general strategy. You should try as much as possible to have one electronic system that does everything for you. And that requires good partnerships and a good IT department, and relationships with other organizations.

They put together an HIV QI team of eight to 10 people. And represented in that team and giving input in that team, was a much larger group, which included a consumer advisory board. So getting patients' input into workflows and their general vision, and mission, and direction. When we talk about the care model, we've already talked with HIV, their challenges around the clinical information system.

Their very first measure was very self-management support-oriented that is presenting to care. So it takes patients to actually show up for appointments. They gave us some good information on their particular workflows, which really talks to delivery system design, which is one of the

parts of the care model. And so they have a very team-based approach where it's not just a provider and a nurse, it also includes care coordinators, medical case managers, and linkage to other especially groups for decision support.

And so they talk about having huddles every Friday. So doing an effective huddle is not an easy thing to do. But one done well is a very important tool for quality improvement, and sustaining quality, improvement and having case managers as part of your team providing services at the time of the visit to let you do hand-offs—and take things off the provider's plate—is very important. You can see that they have an EHR partner with Aetna Health, and they've had to develop guidelines around prescription refills—which will be part of their delivery system design, where perhaps a nurse can have a protocol for doing refills, rather than waiting for the physician. And then, they've got a specific intake flow sheet that they use to help facilitate that new diagnosis patient in making sure that everything gets put in place in short order so as to meet the bureau's UDS measure for HIV follow-up within 90 days.

They've focused on specialty support, which we would call decision support and community partnerships. And so looking at a hospital as a partner, having a clinical pharmacist who can do counseling, nutritionists, medical case managers, behavioral health to do warm handoffs—and also, attending to what is kind of the substance abuse side of things—which is a common co-morbidity.

And then, as far as community partnerships, some sub-contracted with the hospital. They've been working with the city and the state, and also working with regional groups as far as in their area and Pennsylvania, making sure that they're plugged in and not working in isolation. So that has also helped them build a referral network of specialists that can help them do things that they're not able to accomplish in their health center.

And so that is kind of a quick run through of the general look at quality improvement with your framework, which is the care model—your change model, which is kind of a PDSA. Let's do things in small cycles of change, rather than just trying to implement a good idea from the outset, and then looking at all the pieces of those as applied to adult weight management—which is one of our measures, but then also, how Family First has done a great job of applying those same tools to do some impressive changes in their HIV care. So I think we can open it up to questions.

STEVE LUCKABAUGH: OK, we have a few minutes here. If you have a question, please type it into the questions pane on the Go To Webinar toolbar. We do have one. Do you have any further information on resources regarding strategies behind building CQI?

HANS DETHLEFS: I'll let you go first, Ed, if you want to.

EDWARD ZUROWESTE: Boy, I'm trying to think. Well, certainly, things like ECRI. The Bureau has national cooperative agreements—like the Migran Clinician Network is part of that, and NACK. And ECRI—E-R-C-I, ECRI—does a lot of quality improvement activities and has a lot of resources

on their website. That's ECRI, E-C-R-I. And they're one of the national partners, national cooperative agreements for the Bureau. And so every health center has access to them and their website. And they have lots of resources for quality improvement.

HANS DETHLEFS: And I think I'd also encourage the NACK, has a list of the health center control networks that are out there. And health center controlled networks are often EHR-centric. So if you have a particular product that you use—whether it be Epic or NexGen, or eClinicalWorks, there's about 10 out there that are common in health centers to be able to tap into a network and say, OK, so you've got the same product. You're doing the SHIB measure, the BMI measure. What are you doing as far as data capture and workflows in the EHR?

I think oftentimes, if you can find someone who is doing similar work with the same EHR, they can actually give you some very good concrete suggestions as related to what, in particular, you're trying to improve.

STEVE LUCKABAUGH: OK, thank you. Why is your linkage to HIV care measure 90 days? Aren't most organizations now using 30 days or less, especially when the agency in question is a health center?

EDWARD ZUROWESTE: I think that's a very good question. What the Bureau of Primary Health Care through HERSA has done was try to match all of their measures to national measures. So as far as I understand, that is a national measure. And that may come down to 30 days. Certainly, 90 days—when you look at that—really is way out there. There's no question about that. But I know for sure that each of these measures—the 16 measures the Bureau has put out there, that all health centers have to report on annually—have been vetted very, very strongly with other national partners like the National Center for Quality. And so I'm sure that measure came through those kind of deliberations.

HANS DETHLEFS: Yeah, and it's a similar question to why you look at A1cs greater than nine as opposed to, say, seven. When we see a particular patient, we often say, well, we want you under seven or between seven and eight if you had diabetes for a long time. And I think part of the reason that that measure is a wider interval is one—because for diabetes, the really high risk zone is above nine. But at two, that allows you to say, well, we want to get our whole population—100% of our population—within that range. So there's no individual that you'd say, well, their goal is above nine.

And so it allows you—instead of saying, well, let's try to get 40% of our patients below seven, you can say, let's get 100% of our patients below of nine. So it lets you set your standard—your goal—higher than if it were a stricter measure, where you'd have to set it at a lower percentile.

EDWARD ZUROWESTE: Yeah.

STEVE LUCKABAUGH: OK, any suggestions for prioritizing which measures to focus on, considering all of the different funding sources and competing priorities that agencies face?

EDWARD ZUROWESTE: Yeah, that's an excellent question. I think all health centers are different. And all health centers have different populations, and strengths, and weaknesses. So what I always tell health centers are you should focus on those measures where either A, it's a high number of your patients are involved with that particular measure, or B, it's very high risk, or three, you're not doing very well and you know you could do better.

So if you kind of look at those three aspects—it's high volume, high risk, or you're really underperforming—those are the ones you should focus on. And as Hans said, oftentimes with quality, you get overwhelmed with all these measures. And so it's important to really focus on one a year and really, really do a quality improvement project on that one. And what you'll find is when you improve one quality measure, oftentimes, the systems you set up in place—and Hans, you can talk about this more, maybe—the systems you set up to improve that one measure will have a fall out and improve other measures also.

HANS DETHLEFS: Sure, yeah. And by way of example, we added a clinical pharmacist to our staff to help us with hypertension first, and now, they help us with a lot of things. They help us with the hepatitis C program, help us with polypharmacy, they help us with diabetes management. And so for areas of improvement, now we've got this resource that we can really tap into without having to start from the beginning, as we did the first time without a clinical pharmacist.

STEVE LUCKABAUGH: OK, I'm not seeing any further questions. Did you have any closing thoughts before we wrap it up?

EDWARD ZUROWESTE: Just one, that I am personally very encouraged that more health centers are now having HIV patients as a part of their overall clinical group of patients. For years and years, HIV patients were only being treated by infectious disease specialists, which really was a barrier to a lot of our patients. And since now we know HIV is a chronic illness, I think it's really great that more health centers are bringing those patients into their general population. And the more educated you folks can be, the better for your patients.

So I just congratulate all of you for stepping up to the plate. I think it's great.

HANS DETHLEFS: And I would just perhaps say that I think it's great that you're involved in quality improvement. And folks—not at all—I think quality improvement is obviously good for our population. It's great for the health center as well. It provides change and newness, and I think helps avoid burnout. And so I would encourage—from an organizational standpoint—that as much as possible as you go through change processes over time, that you involve as many staff as possible. Because it really is being part of a team like that, something that integrates you and helps you have a more positive outlook on the work that you're doing. And that helps you in the end, do a better job with patient care.

STEVE LUCKABAUGH: All right. Well, thank you for participating is today's webinar. And we hope that you're able to find the information provided useful as you continue your P4C project. Take care, everybody, and we'll see you next time.