Clinical Performance Improvement – Advancing Excellence in Care

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HIMSS GEORGIA Chapter

Clinical Performance Improvement

Objectives

- Overview of Clinical Performance Improvement
- Provide Case Studies and Examples of Clinical Performance Improvement
- Provide Insights and Lessons Learned on the Journey

Clinical Performance Improvement is an ongoing journey, not a destination.

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Clinical Performance Improvement

Defined

***Clinical Performance Improvement**: An approach to the continuous study and **improvement** of the processes of providing **healthcare** services to meet the needs of patients and others.*

- The process involves setting goals, implementing systematic changes, measuring outcomes, and making subsequent appropriate **improvements**.
- Performance improvement involves collecting and reporting data on clinical processes and outcomes.
- Measuring key clinical performance indicators can create buy-in for transformative workflows that improve or enhance care processes over time.

Clinical Performance Improvement

Goals

- The goal of performance improvement is to
  - Enhance and improve the outcomes of care,
  - To ensure patient safety,
  - To increase the efficiency of patient care and related processes,
  - To reduce costs
  - To reduce risks and liability

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Prescriptions for Excellence in
HEALTH CARE

A COLLABORATION BETWEEN JEFFERSON MEDICAL COLLEGE AND ELI LILLY AND CO.

Improving Clinical Performance in Hospitals: A Difficult Challenge for Leaders

By Walter H. Ettinger, MD, MBA

The Challenge Facing Hospital Leaders

Over the next decade, hospitals will need to make significant improvements in clinical performance—the safety, effectiveness, and efficiency of medical care—in order to satisfy the demands of patients, regulators, and insurers. Hospital governance boards and administrators will need to lead changes in systems, work processes, organizational culture, infrastructures, and the collective behaviors of physicians and other staff in order to spur the high levels of performance that will be required.

2008

- *Over the next decade, hospitals will need to make significant improvements in clinical performance–the safety, effectiveness, and efficiency of medical care–in order to satisfy the demands of patients, regulators, and insurers.*

Clinical Performance Improvement

Focus

Clinical Performance Improvement has become a focus

- Medicaid and Medicare Meaningful Use
- Medicare Physician Quality Reporting Systems (PQRS)
- Patient Center Medical Home (PCMH)
- Quality Improvement Networks/Quality Improvement Organizations (QIN/QIO)
- Transforming Clinical Practice Initiative (TCPI) & Practice Transformation Networks (PTN)
- Quality Payment Program (QPP) both Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)
  - Medicare Shared Shavings Track I (most ACOs)
  - CPC+
  - Medical Home Model
- Commercial Payors
- Network of Quality Improvement and Innovation Contractors (NQIIC)

Test of Change Model

Worksheet for Testing Change

GOAL:

Practice: _____ **Date:** _____

Every goal will require multiple smaller tests of change

Plan

Describe your first (or next) test of change	Person Responsible	When to be done	Where to be done

List the tasks needed to set up this test of change	Person Responsible	When to be done	Where to be done
1. 2. 3. 4. 5.			

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
1. 2. 3. 4.	1. 2. 3. 4.

Do Describe what actually happened when you ran the test of change

Study Describe the measured results and how they compare to the predicted results

Act Describe what changes to the plan will be made for the next cycle from what you learned

This material was prepared by GMCF, for Alliant Quality, the Medicare Quality Innovation Network – Quality Improvement Organization for Georgia and North Carolina, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. 11SOW-GMCFQIN-A1-14-02

- PDSA model simple and easy to scale
- Readily available
- Can be utilized at all levels
- Quantifiable
- Provides the vehicle for the journey

Clinical Performance Improvement

Snapshots of the Journey……

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Opportunity to work with two Rural Health Centers (RHCs)

Goals

- Identify and provide physician practices located in high burden prediabetes and Type 2 Diabetes counties across the state with access to advanced clinical dashboards to improve health outcomes.
- Work with practices and their EHR vendor to implement systems for provider reminders to schedule referrals to evidence-based programs such as the National Diabetes Prevention Program (DPP) or the Diabetes Self-Management Education and Support Program (DSMES).
- Assist practices in developing protocols and clinical support systems that will work to identify and engage vulnerable populations, understand the performance of health interventions on health outcomes and reduce costs.
- Provided these practices with access to tools, techniques and business intelligence to improve diabetes care and management.

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Improving Quality

Background

Washington County Family Practice in Sandersville has 3 providers – 2 MD's and an NP.

Family Practice

Did you wake up with a sore throat this morning, or did your child wake up with an earache?

You know if you call for an appointment to see the doctor it might be several days, or even next week before there will be an appointment available? Having to wait a few days or a week to schedule a routine appointment is understandable, but when you're feeling sick from a bug or the flu…you want help right away. The folks at Washington County Family Practice understand this.

If you need to see a doctor for a cold, or a sore throat, or a stomach virus, you don't want to spend all day in the waiting room. You want to pop in an exam room, let the doctor take a look at you, prescribe you a course of treatment and then send you on your way home and back to your comfy bed.

Give us a call at **552-9000**, tell us your symptoms and we'll work as hard as we can to get you in to see the doctor that very day.

This won't be the time for a routine office visit to get a refill for your prescription, or a yearly physical, you'll have to come back another day for that But we will get you in and out as soon as possible for the symptoms you're experiencing that day.

Our clinic is open from 8:30 am to 5:30 pm, Monday through Friday. We are closed for lunch every day from 12pm to 1pm. New patients are being accepted. Washington County Family Practice is a part of Washington County Regional Medical Center.

Remember: YOUR health IS our Business

The practice is located in Sandersville, near the Washington County Regional Medical Center. The practice is part of Optim Healthcare which is an IPA with several rural FQHC as well as hospitals.

EHR Vendor- Azalea Health
No Lab Interface

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Demographics on the Practice and their Diabetic Patients

Information Requested	Data
Number of unique patients in the practice	1360
Total patient visits for one year period	4516
Number of patients diagnosed with diabetes	256
Number of patients diagnosed with pre-diabetes **	3
Number of patients with uncontrolled diabetes *	132
Number of Referrals to Diabetic Education or CDC lifestyle prevention program for patients with uncontrolled diabetes	Unable to determine the number of referrals by A1c results
Number of Referrals to Diabetic Education or CDC lifestyle prevention program for patients diagnosed as “pre-diabetic”	Unable to determine the number of referrals by A1c results

* Uncontrolled diabetes is determined by HgbA1c >9

** Pre-diabetes is determined by HgbA1c between 5.7 and 6.4

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Current Practice Workflows

- All HgbA1c tests are performed at Washington County Regional Medical Center which is next door to the practice
- Lab results are scanned into the EHR
- GoodRx is recommended for patients who have trouble affording medication
- Diabetic patients who are extremely out of control are referred to an endocrinologist in Dublin which is almost an hour drive
- Nutrition counseling is available to patients only during the lunch hour at the hospital cafeteria.
- Information on diabetes is provided to patients. The source of the education is obtained from the UGA Extension.

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Limiting Factors

- No local diabetic education classes in Sandersville
- Lack of resources (Specialist, educational opportunities) in rural area
- No lab interfaces to the EHR system
- Internet availability is limited in the rural areas

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Educational Opportunities from Georgia DPH

1. Diabetes Self-Management Classes – this option requires an RN, registered dietician, diabetes educator or pharmacist on staff. DPH has the policy and procedure manuals for this class. There would have to be a Test Class. This option is not limited as to who attends though it is geared to patients who have been diagnosed with Diabetes.

2. CDC evidence-based class. There is no requirement for RN or other licensed medical professional. A life-coach could lead the class. This option is for those patients who have a pre-diabetic diagnosis or who are at risk for developing diabetes. This is a year-long class (16 weekly sessions, then 6 monthly sessions - 24 sessions in all). DPH recommends at least 15 enrollees in this class. Five individuals must complete the program for a successful completion of this class.

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Opportunities for EHR Enhancement

- Lab interface from Washington County Regional Medical Center to Azalea Health
  - Dependent on approval by Optim Healthcare
  - There is a cost for the interface
- Patient Portal
- Referral Process (Limitation of EHR)

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Next Steps

- Implement the CDC evidence-based class
- Implement patient portal
- Improve referral process so that referrals to the CDC evidence-based class can be tracked and referral loop can be closed

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Improving Quality

Practice B The practice has 2 MD's and 3 NP's and 1 PA

EHR vendor – Azalea Health

HgbA1c tests are performed in the practice and entered manually into the EHR.
No Lab interface

Diabetic education is provided by the pharmacists at IHS pharmacy - 150 S Leroy Street in Metter, GA

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Demographics on the Practice and their Diabetic Patients

Information Requested	Data
Number of Unique Patients	21,300
Total of Patient Visits for one year period	10,384
Number of Patients Diagnosed with Diabetes	1,140
Number of Patients Diagnosed as Pre-diabetic **	200
Number of patients with Uncontrolled Diabetes *	180
Number of Referrals to Diabetic Education or CDC lifestyle prevention program for patients with uncontrolled diabetes	Not able to determine the number of referrals
Number of Referrals to Diabetic Education or CDC lifestyle prevention program for patients diagnosed as "pre-diabetic"	Not able to determine the number of referrals

* Uncontrolled diabetes is determined by HgbA1c >9

** Pre-diabetes is determined by HgbA1c between 5.7 and 6.4

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Current Practice Workflows

- Diabetic education is provided by IHS pharmacy in Metter. The owner/pharmacist, Dean Stone, provides a monthly diabetes class that is open to the public. The program has been certified by the American Association of Diabetic Educators (AADE).
- The practice performs all HgbA1c within the practice.
- Diabetic patients are seen every 3 months.
- The front desk call patients to remind them of appointments
- Patients are given information about the Diabetic Education classes

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Limiting Factors

- Transportation is an issue for many patients
- There is no follow-up process on attendance at diabetes education classes
- There is no lab interface
- The HgbA1c results are entered manually into the EHR

Opportunities for Improvement of Practice Referral Workflow

- Implement a structured workflow for referral to diabetic education at IHS pharmacy.
  - Referral entered into the EHR
    - Allows for follow-up for diabetic and pre-diabetic patients
    - Allows for IHS pharmacy to have information (name, address) on patients who have been referred for diabetes education
    - Allows for IHS pharmacy to close the referral loop when the patient attends the monthly class

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Next Steps

- Implement PDSA cycle on entering a referral into the EHR
- Notify IHS pharmacy of patients referred
  - This can be a monthly list
- IHS pharmacy returns a list of Practice B patients who attend the monthly diabetic education class to close the referral loop

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USRetina's QI Journey

- 350 Retina Specialty practices across the nation
- 1500 physicians
- Partnered with a QIO
- Opt In Approach
- Designated a USRetina Lead to work with the QIO and practices
- Identified common measures and retina specific measures for standardization
- Conducted web based training sessions
- Conducted site visits
- Leveraged USRetina Analytics Platform

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USRetina Standardized Measures

- Closing the Referral Loop: Receipt of Specialist Report (Quality ID: 374) – TCPi Core Metric
- Documentation of Current Medication in the Medical Record (Quality ID: 130, NQF: 0419) – TCPi Core Metric
- Controlling High Blood Pressure (Quality ID: 236, NQF: 0018) – TCPi Core Metric
- Diabetes: Hemoglobin A1c Poor Control (Quality ID: 001, NQF:0059) – TCPi Core Metric
- Diabetes: Eye Exam (Quality ID: 117, NQF: 0055) – QPP Suggestion
- Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care (Quality ID: 019, NQF: 0089) – QPP Suggestion
- Diabetic Retinopathy: Documentation of Presence of absence of macular edema and level of severity of retinopathy (Quality ID: 018, NQF: 0088) – QPP Suggestion

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Lessons Learned

- Not all QIOs are created equal
- QIOs portal was a technical disadvantage
  - Standardized Spreadsheet template
  - Data pulled from analytics platform but still required manual upload and some manual manipulation
  - Rigid architecture
  - Lack of ability to integrate
- Larger practices participate in health systems quality program
- Other practices participated via IRIS instead through the QIO
  - IRIS had it's own challenges
- Limited participation overall
- EMRs really struggled

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Questions

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Closing Remarks

- Buy-in – consider the audience/team, leadership (people barriers)
- Technology barriers (EHRs, Internet, Interfaces, Integration, HIE)
- Utilize a standard, formal process
- Determine workflows utilizing the EHR and thus the reporting capabilities

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Continue the Journey

Thank You!

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