Quality Improvement

Allison Palmer, PCMH CCE, CHES
SHIP Quality Improvement Specialist
Getting Started

- Consider what reports you can access
  - If you don’t have a report you can’t quantify your improvement
  - NCQA is looking for **quantitative data**
- Choose SMART
  - Specific
  - Measurable
  - Attainable
  - Realistic
  - Time bound
1. **Immunization measures:**
   - Childhood Immunization Status: Obtain from EMR or IRIS
   - [https://www.ncqa.org/hedis/measures/childhood-immunization-status/](https://www.ncqa.org/hedis/measures/childhood-immunization-status/)

2. **Other preventive care measures:**
   - Mammogram Rates: obtain from EMR reports
   - [https://www.ncqa.org/hedis/measures/breast-cancer-screening/](https://www.ncqa.org/hedis/measures/breast-cancer-screening/)

3. **Chronic/Acute care measures:**
   - HbA1C control (<8.0%)
   - [https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/](https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/)

4. **Behavioral Health measures:**
   - Depression Screening
SET GOALS for 3 of the 4 Measures

1. Immunization measures:
   ✓ Immunization Status: “We aim to improve our rates by 5% by the end of February.”

2. Other preventive care measures
   ✓ Mammogram Rates: “We aim to improve our rates by 5% by the end of the quarter.”

3. Chronic/Acute care measures:
   ✓ HbA1C “We aim to improve our rates by 10% by the end of the second quarter.”

4. Behavioral Health measures:
   ✓ Depression Screening: “We aim to have 75% of our patients screened by the March 1, 2019.”
1. Immunization measures:
   ✓ Childhood Immunization: “We will gather a report from IRIS, send a reminder, and call to follow up with all patients who are not up to date. (Meets B)

2. Other preventive care measures
   ✓ Mammogram Rates: “During the month of October, we will use a standardized script to call all patients who are due for their screening.” (Meets A)

3. Chronic/Acute care measures:
   ✓ HbA1C: “We will send out postcards reminders to patients with uncontrolled HbA1C measures and get them in with care coordinator to set patient centered goals.” (Meets C)

4. Behavioral Health measures:
   ✓ Depression Screening: “We will implement a new template that screens for depression at the beginning of January, 2019.” (Meets KM03)
What gets improved, gets rewarded!

Need to improve rates on 2 measures from QI08, QI09, or QI11)
QI02

Step 1: Gather Quality Measures From EHR Reports

1. Measures related to care coordination
2. Measures affecting health care costs

<table>
<thead>
<tr>
<th>GUIDANCE</th>
<th>EVIDENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice reports at least two measures related to resource stewardship, including a measure related to health care cost and a measure related to care coordination. When pursuing high-quality, cost-effective outcomes, the practice has a responsibility to consider how it uses resources.</td>
<td>Report</td>
</tr>
</tbody>
</table>
Example 1:

- Closing the referral loop: Receipt of specialist report:
  - Numerator: Measure is satisfied if the referring provider receives a report from the provider to whom the patient was referred.
  - Denominator: Patients with at least one referral and at least one office visit during the past 12 months.
- **Tie in CC04: C. guidelines for tracking referrals with this measures**

Example 2:

- Perform medication reconciliation for patients transferred from another setting of care or provider – Measure identifies relevant encounters and transitions of care during the last 12 months in which medication reconciliation occurs with patient and families.
  - Numerator: Measure is satisfied by reconciling the patient’s medications
  - Denominator: Measure includes all transfers of care during the last 12 months, which are defined as a new patient visit or the first encounter after receiving a consult note.
Q102
B. Measures Related to Health Care Costs

Performance Measurement & Quality Improvement
Q102 B: Example

(Generic Medication Cost Saving)

<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Saving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Losart/Hctz</td>
<td>36,036</td>
<td>36,736</td>
</tr>
<tr>
<td>Norco</td>
<td>35,016</td>
<td>35,021</td>
</tr>
<tr>
<td>Zithromax</td>
<td>36,796</td>
<td>36,765</td>
</tr>
<tr>
<td>Benzonatate</td>
<td>35,600</td>
<td>35,604</td>
</tr>
<tr>
<td>Flonase</td>
<td>35,084</td>
<td>35,083</td>
</tr>
<tr>
<td>Naproxen 500mg</td>
<td>40,992</td>
<td>40,992</td>
</tr>
<tr>
<td>Depakote ER 200mg</td>
<td>34,735</td>
<td>34,735</td>
</tr>
<tr>
<td>Metformin 500mg</td>
<td>20,200</td>
<td>20,200</td>
</tr>
<tr>
<td>Neuronitin 600mg</td>
<td>12,000</td>
<td>12,000</td>
</tr>
<tr>
<td>Hydroxychloroquin</td>
<td>1,825.00</td>
<td>1,825.00</td>
</tr>
</tbody>
</table>
Set a goal for both measures!

1. We aim to improve our rates of closing the referral loop by 10% by the end of the 2nd quarter.

2. We aim to decrease our health care costs by improving our rates by decreasing our readmission rates by 10%.
QI03

Step 1: Assess Appointment Types

### 3rd Next Available Appointment

<table>
<thead>
<tr>
<th>Date</th>
<th>Standard</th>
<th>Provider 1</th>
<th>Provider 2</th>
<th>Provider 3</th>
<th>Provider 4</th>
<th>Provider 5</th>
<th>Provider 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/2/2016</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
<td>30</td>
<td>35</td>
</tr>
<tr>
<td>5/1/2016</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
<td>30</td>
<td>35</td>
</tr>
<tr>
<td>5/6/2016</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
<td>30</td>
<td>35</td>
</tr>
<tr>
<td>6/1/2016</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
<td>30</td>
<td>35</td>
</tr>
<tr>
<td>6/6/2016</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
<td>30</td>
<td>35</td>
</tr>
<tr>
<td>6/11/2016</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
<td>30</td>
<td>35</td>
</tr>
<tr>
<td>7/1/2016</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
<td>30</td>
<td>35</td>
</tr>
</tbody>
</table>

### QI 03 (Core) Appointment Availability Assessment

Assesses performance on availability of major appointment types to meet patient needs and preferences for access.

<table>
<thead>
<tr>
<th>GUIDANCE</th>
<th>EVIDENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients who cannot get a timely appointment with their primary care provider may seek out-of-network care, facing potentially higher costs and treatment from a provider who does not know their medical history. The practice consistently reviews the availability of major appointment types (e.g., urgent care, new patient, routine exams, follow-up) to ensure that it meets the needs and preferences of its patients, and adjusts appointment availability, if necessary (e.g., seasonal changes, shifts in patient needs, practice resources). A common approach to measuring appointment availability against standards is to determine the third next available appointment for each appointment type.</td>
<td></td>
</tr>
<tr>
<td>• Documented process AND Report</td>
<td></td>
</tr>
</tbody>
</table>

*Documented process only*
Step 2: Set Goals to Improve Quality Measures (from QI03)

1. Example:
   1. We plan to reduce our 3rd next available rate from 5 days to 2 days by the end of the 2nd quarter.
Step 1: Gather Patient Experience Feedback

- **Quantitative**
  - Survey monkey
  - 3rd party
  - End of patients visit
  - Determine how often
    - (annually, quarterly, bi annually, etc.)

- **Qualitative**
  - State Evaluator patient surveys
  - Phone call surveys
  - Patient comment boxes
What are your patients saying about
- Access
- Communication
- Coordination
- Whole person- self management

As a team:
- Review results
- Decide what needs to be improved
- Create a plan of improvement until next patient survey
Other ways to help with QI plans:

- Quality Meetings
- Set measures for the month/quarter or year
- Use education and reminders in your monthly/quarterly meeting
- Track measures- quality dashboard
  - (Meets QI15, QI16)

<table>
<thead>
<tr>
<th>GUIDANCE</th>
<th>EVIDENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice provides individual clinician or practice-level reports to clinicians and practice staff. Performance results reflect care provided to all patients in the practice (relevant to the measure), not only to patients covered by a specific payer. The practice may use data that it produces or data provided by affiliated organizations (e.g., a larger medical group, individual practice association or health plan).</td>
<td>• Documented process AND Evidence of implementation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GUIDANCE</th>
<th>EVIDENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice shares individual clinician or practice-level reports with patients and the public. Reports reflect the care provided by the care team. Performance results reflect care provided to all patients in the practice (relevant to the measure), not only to patients covered by a specific payer. The practice may use data that it produces or data provided by affiliated organizations, such as a larger medical group, individual practice association or health plan.</td>
<td>• Documented process AND Evidence of implementation</td>
</tr>
</tbody>
</table>
Examples: Measure of the Month

1. January - Respiratory Health (Asthma & Smoking Cessation)
2. February - Heart Attack/CAD
3. March - Depression
4. April - Hypertension
5. May - Obesity/Weight Screening
6. June - Diabetes
7. July - Accident Prevention
8. August - Childhood Immunization
9. September - Oral Health
10. October - Women’s Health
11. November - Men’s Health
12. December - Cancer Prevention