Leveraging People Processes, and Technology to Improve Quality Outcomes

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HCN LEARNING SESSION
Warm Up Questions

Where is your organization on your QI journey?

1. How many of you use a consistent QI strategy?

2. How many of you have QI coaching capacity either at your health center or provided through your network?

3. How many of you know what the CDS 5 Rights are?
The QI Trifecta

Successful QI Projects are Win–Win–Wins

Health Center Leaders/Broader Safety Net
- Better clinical and business results
- Accountability
- Scalable QI approaches

Expanded Care Team
- Efficient workflow/information flow
- Better clinical outcomes

Patients
- Excellent experience
- Better health
- Lower Cost

Win!

Source: Adapted from TMIT Consulting, LLC
Core Success Principle

People
- Partner Solicitation/Selection
- Stakeholder Engagement
- Team Preparation & Training
- Transformation Culture
- QI Coaching
- Peer Learning Opportunities
- Financial Incentives

Technology
- Population Management Data Reporting & Analytics
- Web-based Collaborative Workspace
- Other HIT Systems & Tools (EHRs, Registries, CDS, HIE)

Processes
- Analyze Workflows/Identify Improvement Opportunities
- Design/Configure Interventions
- Measure and Benchmark
- Standardize Workflows
- Spread Successful practices

Source: Adapted from IHI
Getting the Most out of People (Laying the Foundation)
Health Center/HCCN Roles:

- Communicate and Coordinate
- Project Design & Management
- QI Coaching
- Query, Validate, Report Data

HCCN Role: Convener
Stakeholder Engagement & Building a Solid People Foundation

**Leadership**
- Is there a business case?
- Is there alignment with strategic priorities?

**Providers**
- Is there a clinical champion?
- Are patients assigned to a provider panel and confirmed with the provider?

**QI Team**
- Does the team include QI, HIT, Clinical, and Operations?
- Do they have the resources, time and meeting space needed?

Bandwidth  Stability  Team Preparation/Training  Transformation Culture
The Power of Face-to-Face Kick Offs

"Ok, now that I have you all here..."
Have a QI Strategy

✓ Systematic
✓ Standard Framework
✓ Common Language
✓ Alignment

Health IT-Enabled QI Approach
Lean
Model for Improvement
Getting the Most out of Processes
**Health IT-Enabled QI Approach**

1. What are we trying to improve and what is our baseline performance?
2. What activities impact our performance and provide improvement opportunities?
3. What are we currently doing (and not doing) to support key decisions, actions, & communication?
4. How might we improve to get better results?

**Goal:** Optimally support data gathering, decisions, actions, communications at critical opportunities to improve care processes → improve outcomes

Source: TMIT Consulting, LLC
Project Partners

- 4 HCCNs
- 5 States
- 11 Health Centers
- Target: Adults ages 18-85 (200,000+ patients)

HCCN
PCA/HCCN

Central Valley Health Network (CA)
Health Center Partners of Southern California
Kentucky Health Center Network (KY/AR/TN)
Missouri Quality Improvement Network (MO)
Project Purpose

Purpose

Year 1

- Improve detection and diagnosis of hypertensive patients “hiding in plain sight” at health centers
- Get the true hypertension population denominator right

Year 2

- Improve awareness and control of HTN, and ultimately, health outcomes

Get the true hypertension population denominator right
**Year 2**
- Set ambitious target: 10% ↑ in BP control
- Apply HTN Control Change Package
- Deploy change strategies in each focus area.

**Year 1**
- Workflow for undiagnosed HTN
- Engage patients in care
- Timely diagnosis

Undiagnosed HTN Change Package: [http://mylearning.nachc.com/diweb/fs/file/id/229350](http://mylearning.nachc.com/diweb/fs/file/id/229350)

HTN Control Change Package: [http://millionhearts.hhs.gov/Docs/HTN_Change_Package.PDF](http://millionhearts.hhs.gov/Docs/HTN_Change_Package.PDF)
What Are We Trying To Improve? How Are We Doing Today?

<table>
<thead>
<tr>
<th>Target</th>
<th>Current Performance on Target</th>
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Patient-specific Activities

During Office Visit

- Not Visit Related
- Before Patient Comes to Office
- Daily Care Team Huddle
- Check-in/Waiting/Rooming
- Provider Encounter
- Encounter Closing
- After Patient Leaves Office

Population-oriented Activities

Outside Encounters [Population management]

Foundational Work

"Activities that are foundational to current patient-specific and population management activities and/or planned enhancements - e.g., staff training, policies and procedures, EHR tool development, etc."

## Outpatient Worksheet (Simplified)

**What Are We Trying To Improve? How Are We Doing Today?**

<table>
<thead>
<tr>
<th>Target</th>
<th>Current Performance on Target</th>
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</tr>
</tbody>
</table>

**Current Information flow**

<table>
<thead>
<tr>
<th>Potential Enhancements</th>
<th>Not Visit Related</th>
<th>Before Patient Comes to Office</th>
<th>Daily Care Team Huddle</th>
<th>Check-in/Waiting/Rooming</th>
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Source: TMIT Consulting LLC
Coaching for Workflow Mapping

Start with the Current State:

• **Make it a team effort**, from the front desk to the providers
  - People are always surprised:
    - they assume they do things they actually don’t
    - they don’t know they do things they actually do, OR
    - they think they know who does what, but actually don’t

• **Techniques**:
  - Talk through the process as a team
  - Have someone role play a patient and physically go through the process

• **Blanks are okay**! Don’t feel compelled to put something in every block – a blank is an indicator of a gap or where to focus enhancements.

Source: NACHC with TMIT Consulting, LLC
Coaching for Workflow Mapping

Then Focus on the Enhanced State (Identify Potential Enhancements):

- Make it a team effort
- Look for gaps and weak areas in your current state
- Write down all of the possible enhancements, even if they involve resources not currently available
- Apply the Clinical Decision Support (CDS) 5 Rights framework – consider who, what, when, where, how dimensions

Source: NACHC with TMIT Consulting, LLC
To improve targeted care processes/outcomes, CDS interventions must provide:

- **the right information**
  - e.g., evidence-based guidance, actionable, response to clinical need... [what]
- **to the right people**
  - consider entire care team, including the patient... [who]
- **through the right channels**
  - EHR, population management system, smartphones, patient portal... [where]
- **in the right formats**
  - documentation tools, data dashboards, registries, order sets, alerts... [how]
- **at the the right times**
  - for decision-making or action... [when]
CDS Examples

Source: NACHC Million Hearts Project, and Information Workflow Optimization for Colorectal Cancer Screening Project, 2015
Choosing Change Strategies (Prioritizing Enhancements)

- Consider **importance/impact**
- Consider **feasibility**:
  - Effort
  - Time
  - Cost

<table>
<thead>
<tr>
<th>Low feasibility</th>
<th>High feasibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low importance</td>
<td>High importance</td>
</tr>
<tr>
<td>1. Don’t bother!</td>
<td>3. Get creative to increase feasibility.</td>
</tr>
<tr>
<td>2. Don’t do it if it takes resources from cells 3 &amp; 4.</td>
<td>4. A no-brainer – Do it!</td>
</tr>
</tbody>
</table>

Coaching for Choosing Change Strategies
### Completed Worksheet Example

<table>
<thead>
<tr>
<th>Not Visit Related</th>
<th>Before Patient Comes to Office</th>
<th>Daily Care Team Huddle</th>
<th>Check-in/Waiting/Rooming</th>
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<th>After Patient Leaves Office</th>
<th>Outside Encounters [Population management]</th>
<th>Foundational Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use recall “robo-call” system to remind patients with scheduled visits</td>
<td>EHR review and pre-visit planning; use huddle report to communicate chronic disease &amp; preventive screening needs to full care team.</td>
<td>VS/BP obtained and documented; repeat BP if &gt; 140/90. Red alert with abnormal results.</td>
<td>Provider reviews pertinent patient information; develops a plan of care/goal with the pt.; reviews &amp; prescribes meds; provides pt education &amp; counseling; disc F/U &amp; documents in EHR.</td>
<td>Provide self-monitoring tools, f/u on education and labs.</td>
<td>Nurse Visit for BP check as indicated.</td>
<td>Monitor and provide feedback to leadership/QI on site data elements.</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Outreach calls to check in on home monitoring and self-management</td>
<td>48-hour outreach “live” call to scheduled HTN patients; 24-hour text message reminder</td>
<td>Implement automated office blood pressure (AOBP) machines with capacity for cyclic measurement</td>
<td>Ensure providers are documenting the 2nd BP check in structured/reportable data field when the provider measures.</td>
<td>Ensure patient is scheduled for follow up appointment before leaving the office; align with patients needs (transportation/work schedule, etc.)</td>
<td>Evaluate process of renewing medication s without patient visit.</td>
<td>Obtain &amp; evaluate provider specific HTN control rate information &amp; develop feedback</td>
<td>Purchase AOBP machines with capacity for cyclic measurement.</td>
<td>-</td>
</tr>
<tr>
<td>Leverage portal to encourage patients with uncontrolled HTN</td>
<td>Add undiagnosed uncontrolled HTN to pre-visit planning.</td>
<td>Implement behavioral interviewing</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Incorporate HTN control (protocol adherence) into the Peer Review process.</td>
<td>-</td>
</tr>
<tr>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Regular staff training on accuracy of blood pressure measurement</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: content from NACHC Million Hearts Project; template from TMIT Consulting, LLC
“The worksheets gave us a clear plan [about] where we are now and where we want to be....to say this is what we’re going to do and this is our plan and these are the steps that we’re going to take to do it....”

“This CDS/QI tool...allows you the vision and the foundational aspects to be able to push [an initiative] across the whole organization and use that foundation as the basis and a guide for other projects.”
Getting the Most out of your Technology (HIT & Data)
Coach Health Centers to Produce Trustworthy Data!

Data Integrity

- Accurate/Reliable
- Verifiable
- Complete
- Retrievable
# Checklist for Validating & Analyzing Performance Measure Data

## Are the Numbers Right? (Is there Data Integrity?)

<table>
<thead>
<tr>
<th>Data Integrity Category</th>
<th>Definition</th>
<th>What to Look for</th>
</tr>
</thead>
</table>
| Verifiable              | The same result can be generated from calculating the measure or numerator/denominator using different data sources. | - Is the measure result (e.g., BP control rate) the same using your EHR management software?  
                          |                                                                           | - When you do a chart sample from the reported data, do the number of records match those reported? |
| Accurate/Reliable       | Numerators and denominators are correct, and based on the measure specifications; consistent results are generated from the same reporting tool. | Documentation Issues                                                                |
|                         |                                                                           | - Are data entered into proper EHR fields (e.g., are staff documenting the correct sequence or field vs. diastolic BP?) |
|                         |                                                                           | - Are EHR data fields free of text elements that could nullify data (e.g., systolic and diastolic BP readings is entered backwards or text in the EHR, resulting in a zero value) |

Know the difference between monitoring measures and evaluation measures!

1 or 2 measures reported monthly – use a run chart!

A comprehensive set of measures based on evaluation questions; data pulls pre- and post-intervention!
Assess Your Overall Approach in Light of the Outcome Target – Run Charts

Indicates a shift. In this case, the shift above the median indicates a significant improvement; has reached 10% improvement!

- Implemented Undx HTN CDS and Recalls
- Implemented Provider Performance Reports
- Implemented AOBP Machines
Getting the Most out of People
(Continuous Investment)
1. What is your [next] highest leverage change to achieve target?

2. How far along are you with implementation?

3. What's working/not working? How do you know? Will you change anything?

4. What are the challenges and critical success factors for change?

5. What are your next steps toward success? Do you need any additional resources/support?

Think out loud about your efforts…

Source: NACHC and TMIT Consulting, LLC
Engage the Data Creators...
...and Use Data to Engage Staff
## Assess Workforce/Care Team Roles

Are staff working to the top of their license? Are they using their time optimally?

<table>
<thead>
<tr>
<th>Site</th>
<th>PCC</th>
<th>Actual FTE</th>
<th>Goal FTE</th>
</tr>
</thead>
</table>
| Elm    | Gloria C.  | 0.50 FTE Prior Auths blue pod  
0.125 FTE P4P HEP/ IHA outreach  
0.125 FTE BP/DM Care Management blue pod  
0.25 FTE CRC tracking/oversight  
0.05 FTE Childhood Obesity visits | 0.50 FTE BP/ DM Care Management blue pod  
0.25 FTE CRC tracking/oversight  
0.20 FTE P4P tracking/oversight  
0.05 FTE Childhood Obesity visits |
|        | Tomas H.   | 0.50 FTE Prior Auths pink pod  
0.20 FTE Complex care  
0.20 FTE Ca Screening outreach  
0.05 MTM Back up  
0.05 MA for Retinal exams  
0.05 FTE Childhood Obesity visits | 0.50 FTE BP/ DM Care Management pink pod  
Including MTM Back up  
0.20 FTE Transition Of Care  
0.20 FTE Complex Care  
0.05 FTE MA for Retinal exams  
0.05 FTE Childhood Obesity visits |
| Lakeside | Maria R.  | 0.50 FTE Prior Auths  
0.20 FTE BP Care Management  
0.10 FTE WI pregnancy tests  
0.10 FTE CRC tracking/oversight  
0.10 FTE P4P tracking/oversight | 0.70 FTE BP/ DM Care Management  
0.20 FTE CRC tracking/oversight  
0.10 FTE P4P tracking/oversight |
Assess Workforce/Care Team Roles

Melissa Barajas, RN/BSN/PHN
Director of Population Health
Neighborhood Healthcare
I'm not thinking about this
I'm thinking about this, but it's not a priority
This is a priority, but I don't know what to do
This is a priority and I know what to do, but I don't have time/I'm burned out/it's too costly/it's too hard
This is a priority, I know what to do, and I'm making it happen

Assess frequently – Where are your patients and care teams?

Raise Awareness
Change Attitudes/Culture
Build Skills; Train Specific Strategies
Address Barriers
Reward and Celebrate Milestones

Supports and Reinforcements

Source: NACHC and TMIT Consulting, LLC
This isn’t important considering everything else I have to do.”

Health center leadership endorses in meetings and through other communication channels

Make it part of the organization’s QI Plan

Educate about impact (show evidence)

Provide incentives/rewards (or tie to performance standards)

Source: NACHC and TMIT Consulting, LLC
“I don’t have time to do it.”

- Assign task to other care team member
- Automate or Streamline (e.g., order sets, templates, Rx favorites, standing orders)
- Provide incentives/rewards

Source: NACHC and TMIT Consulting, LLC
"I forgot to bring my medications with me."

It doesn’t seem important

I have so many other things going on, it’s hard to remember

Educate about importance: achieve control, feel better

Cues to action: Care Message or other reminders, special bag

Provide incentives/rewards (free home monitor, eligible for gift card drawing, food voucher)

Source: NACHC and TMIT Consulting, LLC
Results & Lessons Learned
Undiagnosed Hypertension Cohort
65.2% had a follow up visit; of these, 31.9% were dx w/HTN
Blood Pressure Control – NQF 0018

Stretch Goal: 10% Improvement from Baseline

You can successfully engage patients and clinicians in HTN management!

January 2015 (Baseline)   June 2016
Invest time to create buy-in of executive leadership, QI staff, operations staff, and care teams

Begin with a F2F Meeting!

Use a uniform QI strategy

QI Coaching is effective and essential!

Use the CDS 5 Rights to think about enhancing process

Accurate/trustworthy data is fundamental to providers to taking action

Use run charts to understand drivers of change and keep teams engaged with their own progress

Consider a time study on staff to ensure they are not burdened with administrative work that detracts from their ability to care for patients

Build in supports to increase uptake and sustainability of interventions
“Quality is never an accident. It is always the result of intelligent effort.”

—John Ruskin
Questions?