# Enhancing Outcomes with Quality Improvement (QI)

**October 29, 2015**

HUSKY HEALTH CONNECTICUT

Connecticut Person-Centered Medical Home

# Learning Objectives

- Introduce Quality Improvement (QI)
- Explain Clinical Performance Person-Centered Medical Home (PCMH) Measures
- Implement
  - The Model for Improvement
  - Use of the Model
  - Using Workflows & Electronic Health Records
  - Case Example
- Monitor QI Improvements

# Quality Improvement Introduction

- Federal, state and local officials, as well as other stakeholders, are all encouraging providers and practices to utilize QI continuously

- Quality improvement is a central focus in health care delivery today
  - Preventing medical errors
  - Reducing readmission rates
  - Improving care coordination

# QI Process

- Evaluate measures based on data/reports
- Stratify data by race and ethnicity
  - Assess for health equity improvement
- Identify disparities for areas of improvement
- Choose and define QI project
  - Assess workflows for potential improvements
  - Choose realistic, attainable and measurable goal
  - Establish timeline for implementation and achievement of goal
- Complete QI project to implement improvement
- Assess for goal achievement
- Sustain improvement

***The QI process is cyclical and continuous, never stagnant***

# QI Goals

- Realistic: Relevant to your practice and your patient population
  - e.g. implement daily huddles with staff to review patients that are scheduled to be seen that day
- Attainable: Determine appropriate time frame to achieve the goal
  - e.g. can we increase our annual well visits for eligible patients by 5% in the next six months?
    - Choose one preventive service
    - Will implementing morning huddles and scheduling visits when patients are at the practice lead to desired result?
- Measureable: Include specific measurable data
  - e.g. to increase annual well visits by 5% in the next six months

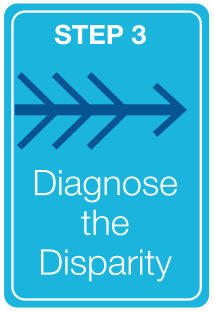
# QI Framework


Link

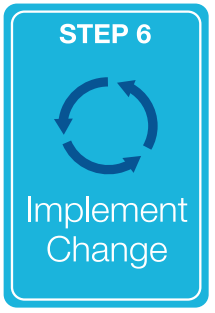

Design


Create


Secure




Diagnose




Implement

# QI Data to Reduce Disparities*

- Stratify by race, ethnicity and/or language
- Data should be easy to collect
  - Registries and practice Electronic Health Records (EHR)
  - Health plan data from reports on HUSKY Health Provider Portal
- Determine quality gap between patient populations
  - Where do disparities exist?
  - What is the magnitude of those disparities?

* *"Using Data to Reduce Disparities & Improve Quality"* from the Robert Wood Johnson Foundation; part of the **Assisting Health Equity with Quality Improvement: Part Two Toolkit** located on the Pathway to PCMH Health Equity page of the HUSKY Health provider website

# National Performance Measures

| Priority Area | Measure Description |
|---|---|
| **Asthma** | Use of appropriate medications |
| **Diabetes** | Percentage of patients with most recent A1c level >9.0% (poor control) |
| **Heart disease** | Coronary artery disease: beta blocker treatment after a heart attack |
| **Screening** | Breast cancer screening<br>Colorectal cancer screening |
| **Prenatal care** | Prenatal screening for HIV<br>Prenatal anti-D immune globulin |
| **Mental health** | Antidepressant medication management |
| **Immunization** | Childhood immunization status<br>Flu shots for adults aged 50 to 64 |
| **Prevention** | Tobacco use assessment and cessation intervention |
| **Patient experience** | Ambulatory Consumer Assessment of Health Care Providers and Systems (ACAHPS) |
| *Click on link to see full report | http://www.qualityforum.org/Publications/2008/03/National_Voluntary_Consensus_Standards_for_Ambulatory_Care%E2%80%94Measuring_Healthcare_Disparities.aspx |

# NCQA Standard 6: Elements

- Element A: Measure Performance
- Element B: Measure Resource Use and Care Coordination
- Element C: Measure Patient/Family Experience
- Element D: Implement Continuous Quality Improvement
  - ***Must Pass Element***
- Element E: Demonstrate Continuous Quality Improvement
- Element F: Report Performance
  - Share performance data reports using measures from Elements 6A, 6B and 6C
- Element G: Use Certified EHR Technology

# Crosswalk of DSS Child/Adolescent PCMH Performance Measures and 2014 NCQA PCMH Standard

| Child/Adolescent PCMH Measures | Measure Source | 2014 NCQA Crosswalk | CHNCT Available Reports (Provider Portal) |
|---|---|---|---|
| Well-Child Visits in the First 15 Months of Life [1] | HEDIS Measure W15 | 6A1,2,4*<br>6D1,2**<br>6E1,2~ | **Care Analyzer:** Provider Effectiveness Report and Provider Detail Report<br>**Secure Provider Portal:** Child Well-Care Visits - Gaps in Care |
| Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life[1] | HEDIS Measure W34 | 6A1,2,4*<br>6D1,2**<br>6E1,2~ | **Care Analyzer:** Provider Effectiveness Report and Provider Detail Report<br>**Secure Provider Portal:** Child Well-Care Visits - Gaps in Care |
| Adolescent Well-Care Visits [1] | HEDIS Measure AWC | 6A1,2,4*<br>6D1,2**<br>6E1,2~ | **Care Analyzer:** Provider Effectiveness Report and Provider Detail Report<br>**Secure Provider Portal:** Child Well-Care Visits - Gaps in Care |
| Annual Dental Visit (ages 2 - 21) | HEDIS Measure | 6A2,4*<br>6D1,2,7**, 6E1,2~ | **Care Analyzer:** HEDIS Module - Summary Report and Detail Report |
| Asthma Patients (ages 2 – 20) with One or More Asthma-Related Emergency Room Visits [1] | Retired 2013 CHIPRA Measure (#20) | 6A3,4*<br>6B2<br>6D3,4,7**, 6E1,3~ | **Secure Provider Portal:** ED Utilization Report |
| Rate of ED visits per 1,000 member month. Ages 0-19 | CHIPRA ED Measure (#18/AMB-CH) | 6B1,2<br>6D3,4<br>6E3~ | **Care Analyzer:** HEDIS Module - Summary Report and Detail Report<br>**Secure Provider Portal:** ED Utilization Report |
| Developmental Screening In the First Three Years of Life [1] | CHIPRA Measure (#8/DEV-CH) | 6A2,4*<br>6D1,2* *<br>6E1,2~ | **Care Analyzer:** HEDIS Module - Summary Report and Detail Report<br>**Secure Provider Portal:** Child Well-Care Visits - Gaps in Care |
| Medication Management for People (ages 5-18) with Asthma [1] | HEDIS Measure ASM | 6A3,4*<br>6B2<br>6D1-4,7**, 6E1-3~ | **Care Analyzer:** HEDIS Module - Summary Report and Detail Report<br>**Secure Provider Portal:** Pharmacy Claims Report |
| PCMH CAHPS Survey | | 6C2,3, 6D5,6**<br>6E1,4~ | CAHPS being sent for CY 2014<br>Annual Provider Profile Report |

[1] Health Equity Measure selected by DSS
* Measure may be used once for Element 6A
** Measure may be used once for Element 6D
~ Measure demonstrates results tracked over time, assesses effects and achieves improved performance if used for Element 6A, 6B or 6C.

Crosswalks are part of the Assisting Health Equity with Quality Improvement: Part Two Toolkit

# Crosswalk of DSS Adult PCMH Performance Measures and 2014 NCQA PCMH Standard

| Adult PCMH Measures | Measure Source | 2014 NCQA Crosswalk | CHNCT Available Reports (Provider Portal) |
|---|---|---|---|
| Comprehensive Diabetes Care - LDL Screening [1] | HEDIS Measure CDC Component | 6A3,4*<br>6D1,2,7**<br>6E1,2~ | **Care Analyzer:** Provider Effectiveness Report and Provider Detail Report<br>**Secure Provider Portal**: Adult Diabetes Screening Tests - Gaps in Care |
| Comprehensive Diabetes Care - Eye Exam [1] | HEDIS Measure CDC Component | 6A3,4*<br>6D1,2,7**<br>6E1,2~ | **Care Analyzer:** Provider Effectiveness Report and Provider Detail Report |
| Cholesterol Management for Patients With Cardiovascular Conditions - LDL Screening [1] | HEDIS Measure CDC Component | 6A2,3*<br>6D1,2,7**<br>6E1,2~ | **Care Analyzer:** Provider Effectiveness Report and Provider Detail Report<br>**Secure Provider Portal:** Adult Diabetes Screening Tests - Gaps in Care |
| Post-Admission Follow-Up Within Seven Days of an Inpatient Discharge [1] | DSS Custom Measure | 6B1,2<br>6D3,4,7**<br>6E1,3~ | **Secure Provider Portal:** Inpatient Claims Report and Inpatient Daily Census Report |
| ED Usage | HEDIS Measure | 6B1,2<br>6D3,4,7**<br>6E3~ | **Care Analyzer:** HEDIS Module - Summary Report and Detail Report<br>**Online Secure Provider Portal:** ED Utilization Report |
| Medication Management for People (ages 19 – 64) with Asthma [1] | HEDIS Measure ASM | 6A3,4*, 6B2<br>6D1-4,7**<br>6E1-3~ | **Care Analyzer:** HEDIS Module - Summary Report and Detail Report<br>**Secure Provider Portal:** Pharmacy Claims Report |
| Follow-Up within 30 Days After New Behavioral Health Diagnosis and Rx [1] | DSS Custom Measure | 6B1<br>6D3,4,7**<br>6E1,3~ | Annual Provider Profile Report |
| PCMH CAHPS Survey | | 6C2,3<br>6D5,6**<br>6E1,4~ | CAHPS being sent for CY 2014<br>Annual Provider Profile Report |
| Readmission Rate - 30 days after discharge | DSS Custom Measure | 6B1,2<br>6D3,4,7**<br>6E3~ | **Secure Provider Portal:** Inpatient Claims Report and Inpatient Daily Census Report<br>Annual Provider Profile Report |

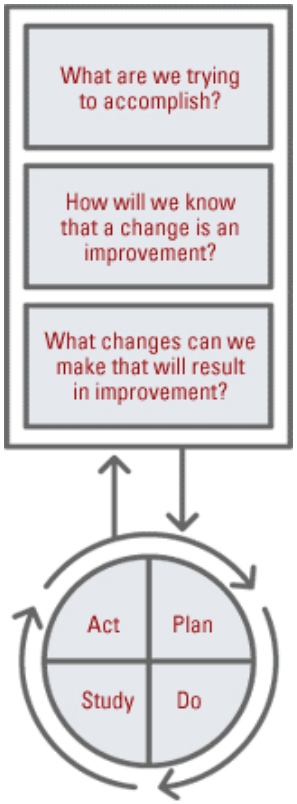
# Diagnose the Disparity

- Relate to health measures
- Improve results
- Share results
- Utilize Health Information Technology (HIT)
- Reduce disparities

# Best Practice QI Model

## Plan-Do-Study-Act (PDSA)

- Identify potential areas for improvement
- Map out the chosen improvement and define goal
- Implement a change to achieve desired outcomes
- Test, evaluate and/or adapt to ongoing changes



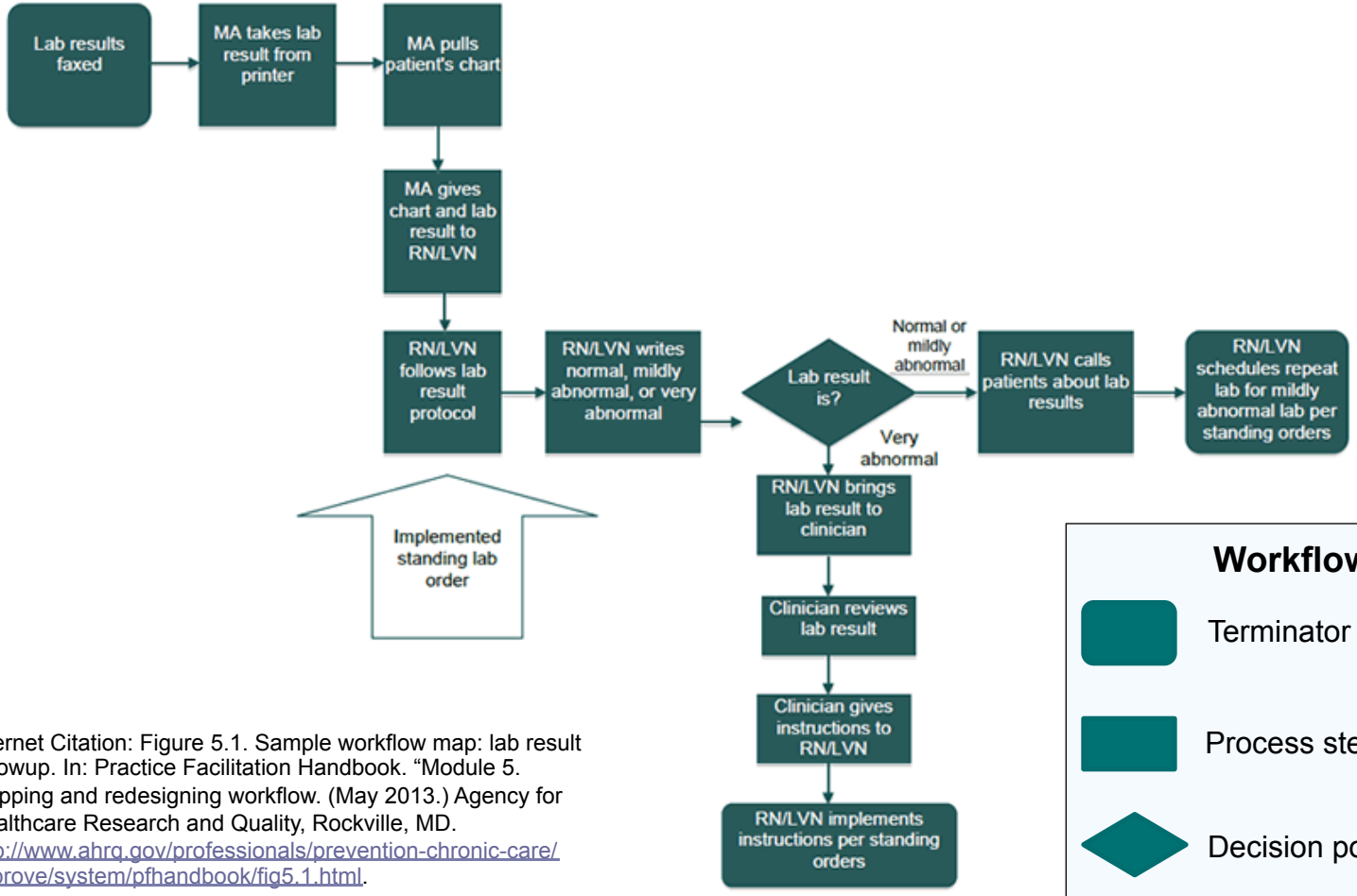

The Model for Improvement was developed by Associates in Process Improvement . Graphic provided courtesy of Cambridge, Massachusetts: Institute for Healthcare Improvement; [2015]. (Available on www.IHI.org)

# Plan-Do-Study-Act (PDSA)

# Using Workflows for QI

- Workflows consist of connected steps to accomplish a collective action or goal
- EHR information can be used to:
  - Measure workflow effectiveness and accomplish the goal
- Identify and prioritize quality issues and efficiency gains

# QI Process
# Sample Workflow Map




**Workflow Shape Key**

- Terminator – start or stop a workflow
- Process step - action/work
- Decision point – workflow branch

Internet Citation: Figure 5.1. Sample workflow map: lab result followup. In: Practice Facilitation Handbook. "Module 5. Mapping and redesigning workflow. (May 2013.) Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/fig5.1.html.

# Utilization of HIT

- Implements quality improvement within your entire patient population
- Allows you to track the referral process
- Improves administrative process efficiency in support of care delivery
- Strengthens communication and coordination among health care providers managing a patient's continuum of care

# QI Process Example: *Evaluate a Measure*

- Adult Quality Measure
- Link quality and equity
  - Adult ages18-75 with diagnosis of Type 1 or Type 2 diabetes who received at least one HgA1c screening during the measurement year
- Report baseline
  - Electronic Health Records
    - White Males vs. Hispanic Males
    - Ages 18-75 who have received at least one HgA1c screening during the measurement year
    - Run a previous 6-12 months report, stratified by race and ethnicity, what does the data show?

# QI Process Example: *Identify Disparities*

- Stratify data obtained for measure by race and ethnicity
- Example data disparity results:
  - 55% compliance with this measure for White Males
  - 45% compliance with this measure for Hispanic Males
  - There is a 10% disparity gap between White Males and Hispanic Males

# QI Process Example: *Identify a Goal*

- Use identified disparities to choose and set a goal
  - The data indicates a 10% disparity gap between two of the practice population groups
  - Goal is to improve compliance of annual HgA1c screening in all Adult Males ages 18-75 and reduce disparity

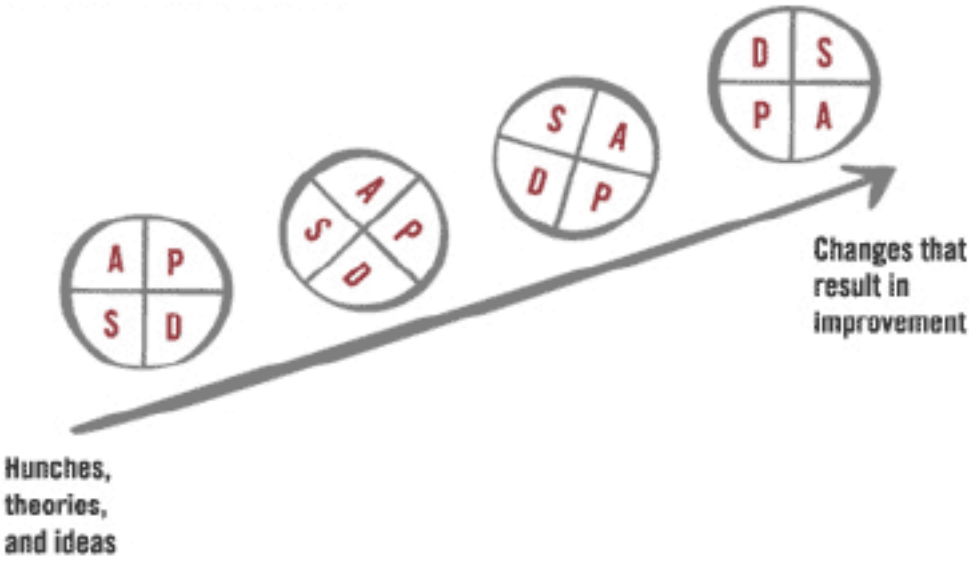
# QI Process Example: *Project Definition*

Increase compliance by 25% among all adult males and reduce disparity between White and Hispanic males by 50% within 6 months by assessing and addressing barriers to care for target population

- Realistic
  - Develop and implement new assessment beginning November 2015
  - Establish individualized patient plans for compliance
  - Establish follow up program to assess for and reinforce compliance
- Attainable
  - Reasonable for practice to implement in defined timeframe
  - Estimate impacts and expected results for defined timeframe
- Measurable
  - Evaluate reports beginning May 2016 and compare to baseline
  - 68.75% target compliance for White Males
  - 65.31% target compliance for Hispanic Males

# Sustainability

- Ability to maintain and hold the gains
- Ensure continuity in improvement




Graphic provided courtesy of Cambridge, Massachusetts: Institute for Healthcare Improvement; [2015]. (Available on www.IHI.org)

# Monitoring QI Improvements through Benchmarking

Baseline performance standards for benchmarking:

- Data Reports for Federal Requirements
  - Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- NCQA-HEDIS
  - NCQA created Healthcare Effectiveness Data & Information Set (HEDIS) to set standardized performance measures
- CT Department of Social Services Measure Requirements
  - 4 custom measures defined by DSS

# Quality Performance Measures

- The defined set of measures are a combination of:
  - Nationally recognized measures from Healthcare Effectiveness Data and Information Set (HEDIS)
  - Children's Health Insurance Program Reauthorization Act (CHIPRA)
  - Custom measures approved by Department of Social Services (DSS)
- Key quality measures were selected by DSS and include:
  - Preventive care, treatment of chronic diseases and utilization of services

# PCMH Quality Measures

Pediatric Quality Measures

- Well-child visits in the first 15 months of life
- Well-child visits in the third, fourth, fifth and sixth years of life
- Adolescent well-care visits
- Percentage of eligible beneficiaries ages 1-21 with at least one dental visit during the measurement year
- Annual percentage of asthma patients (ages 2-20) with one or more asthma-related emergency department visits (Custom measure based on CHIPRA)
- Use of appropriate medications for people with asthma, with several age ranges 5-11, 12-18 and total 5-18
- Rate of emergency department visits per 1,000 member months (ages birth-19)
- Developmental screening in the first three years of life; three age breakouts: ages 1, 2, and 3 (CHIPRA measure)
- PCMH Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

# PCMH Quality Measures

Adult Quality Measures

- Adults ages 18-75 with a diagnosis of Type I or Type II diabetes who received at least one LDL-C screening during the measurement year
- Adults ages 18-75 with a diagnosis of Type I or Type II diabetes who received at least one eye screening for diabetic retinal disease in a two year period
- Cholesterol Management for Patients With Cardiovascular Conditions - LDL Screening
- Post-Admission Follow-Up Within Seven Days of an Inpatient Discharge
- Use of appropriate medications for people with asthma, with several age ranges 19-50, 51-64 and total 19-64
- Percentage of adults given a new psychiatric diagnoses, and medication, by a PCP who received a follow-up visit within 30 days (Custom measure)
- Readmission rate within 30 days after discharge (Custom measure)
- Emergency department usage
- PCMH Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

# Enhanced Fee-for-Service Payments

- The department shall make enhanced fee-for-service payments to a practice
  - Enhancements are to the current base Medicaid fee schedule, visit rate or other fee applicable to the practice
- The enhanced fee-for-service will be limited to primary care practices
- The primary care codes for which enhanced fee-for-service payments are available shall be posted on the department's website or by other means accessible to providers

For more information on the PCMH Participation Fee Differential Payments and Code List, go to http://www.huskyhealthct.org/pathways_pcmh/pcmh_postings/PCMH_Participation_Fee_Differential_Payments.pdf

# Performance-Based Supplemental Payments

- The two types of Per Member Per Month (PMPM) performance-based supplemental payments to eligible PCMH practices or providers are:
  - Performance Incentive Supplemental Payment
  - Performance Improvement Supplemental Payment

For more information on the methodology for calculating the performance payments, go to http://www.huskyhealthct.org/pathways_pcmh/pcmh_postings/PCMH_Performance-Based_Payment_Program.pdf

# Next Webinar

- Using Provider Portal Reports to Manage HUSKY Members
  - Learn to access and use reports available on the Provider Portal
  - Member data specific to your practice
    - The data foundation for identifying opportunities for QI
- Join us on Thursday, November 19th at noon

# Questions?

Thank you!