Division of TennCare

STATE OF TENNESSEE

PCMH: Monitoring Data & Process Improvement

7/27/18

Presented by: Rick Walker, Coach Lead, PCMH CCE

Today's Agenda:

1) Monitoring Data for Opportunities

2) Process Measurement

3) Process Improvement

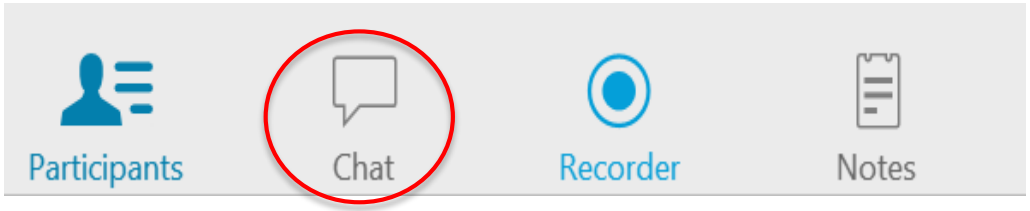
4) Facilitated Discussion
   a) Best Practices, Challenges and Novel Ideas

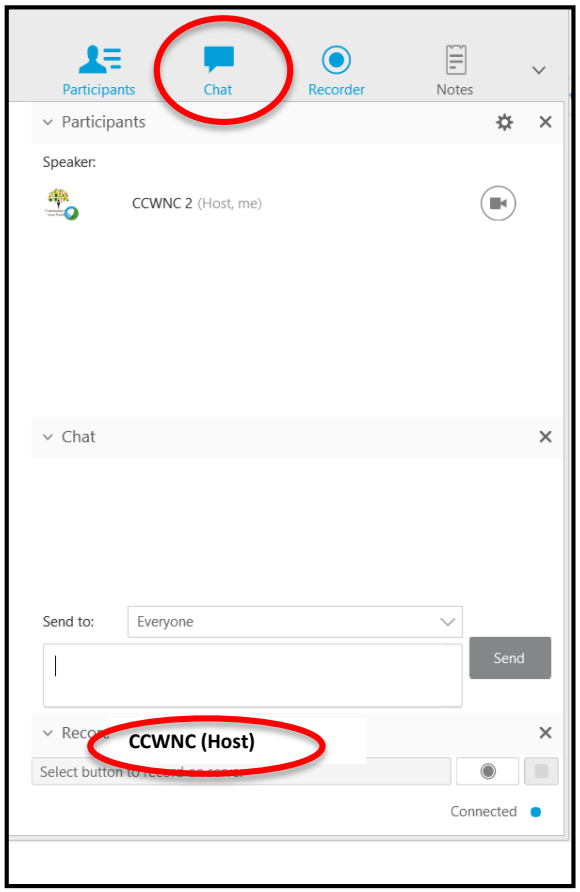
5) Wrap-up

Introduction to the webinar

Chat box during the presentation:

- Send to the Host
  - BEST PRACTICES
  - CHALLENGES
  - NOVEL IDEAS
  - QUESTIONS





Quick Review: PCMH 2017 Terminology

Today's Concepts:

QI : Performance Measurement & Quality Improvement

AC : Patient-Centered Access and Continuity

Monitor Data for Opportunities

- **QI 01 (Core):** Monitors at least five clinical quality measures across the four categories. (Must monitor at least 1 measure of each type)
  - A. Immunization measures
  - B. Other preventive care measures
  - C. Chronic or acute care clinical measures
  - D. Behavioral health measures
- **QI 02 (Core):** Monitors at least two measures of resource stewardship. (Must monitor at least 1 measure of each type)
  - A. Measures related to care coordination
  - B. Measures affecting health care costs
- **QI 03 (Core):** Assesses performance on availability of major appointment types to meet patient needs and preferences for access.
- **QI 04 (Core):** Monitor patient experience
- **QI 05 (1):** Assesses health disparities using performance data stratified for vulnerable populations. (Must choose one from each section)
  - A. Clinical Quality
  - B. Patient Experience

Monitor Data for Opportunities

QI 01 (Core): Monitors at least five clinical quality measures across the four categories. (Must monitor at least 1 measure of each type)

- **Immunization measures – Examples:**
  - Influenza vaccine during flu season
  - Pneumonia vaccine for patients over 65
  - HPV vaccine for children 9 – 12 years
- **Other preventive care measures – Examples:**
  - Mammograms for women 40-69 years
  - Colorectal screening for patients 50 – 75 years
  - Lead screening for all newborns by age 2
  - Anemia screening for children 12 – 30 months

Monitor Data for Opportunities

QI 01 (Core): Monitors at least five clinical quality measures across the four categories. (Must monitor at least 1 measure of each type)

- **Chronic or acute care clinical measures – Examples:**
  - Patients with diabetes who have been seen in the past 6 months
  - Patients with persistent asthma who are on an appropriate asthma controller medication
  - Patients with ADHD who have been seen in the past 6 months
- **Behavioral health measures – Examples: (NEW for 2017)**
  - Patients with major depressive disorder who have had a suicide risk assessment
  - Children with ADHD that have been prescribed a new ADHD medication and have had a follow up appointment within 30 days.

TN

Monitor Data for Opportunities

QI 02 (Core): Monitors at least two measures of resource stewardship. (Must monitor at least 1 measure of each type).

- **Measures related to care coordination – Examples:**
  - Medication Reconciliation at Transition of Care visit (MU)
  - Summary of Care record provided when patient transfers to another provider or is referred (MU)
- **Measures affecting health care costs – Examples:**
  - Prescribing generic medications versus brand-name medications

Monitor Data for Opportunities

QI 03 (Core): Assesses performance on availability of major appointment types to meet patient needs and preferences for access.

- Consistently review the availability of major appointment types
  - urgent care appointments
  - new patient appointments
  - routine exams
  - follow-up appointments
- A common approach to measuring appointment availability against a standard is to determine the third next available appointment for each appointment type.

Example – 3rd next available appointment

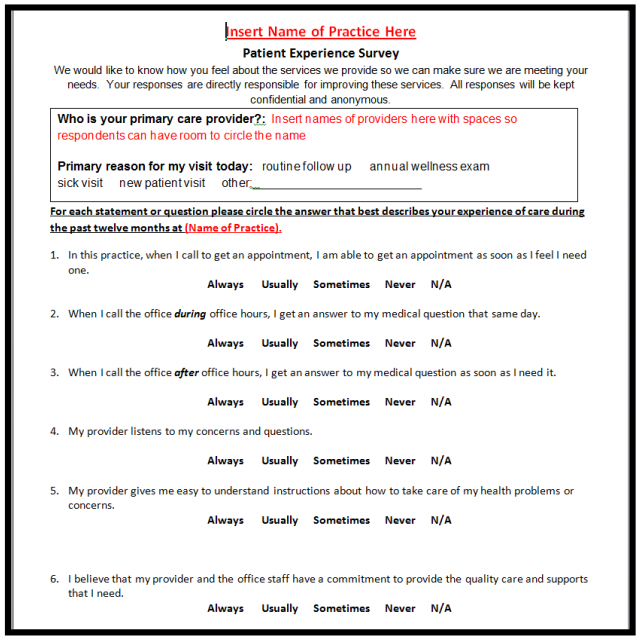
Provider	New Well Check	Established Well Check	New Sick Visit	Established Sick Visit	Follow Up VIsits
Dr. Strange	5/10/18 5/15/18 5/21/18	5/10/18 5/11/18 5/17/18	5/10/18 5/11/18 5/14/18	5/10/18 5/11/18 5/14/18	5/10/18 5/15/18 5/17/18
Dr. Pepper	5/9/18 5/15/18 6/16/18	5/9/18 5/11/18 5/15/18	5/9/18 5/11/18 5/14/18	5/9/18 5/11/18 5/14/18	5/9/18 5/11/18 5/14/18
PA System	5/9/18 5/10/18 5/11/18	5/9/18 5/10/18 5/11/18	5/9/18 5/10/18 5/11/18	5/9/18 5/10/18 5/11/18	5/9/18 5/10/18 5/11/18

Monitor Data for Opportunities

QI 04 (Core): Monitors Patient Experience through:

A. Quantitative Data (Pt. Satisfaction Survey)

B. Qualitative Data



Insert Name of Practice Here

Patient Experience Survey

We would like to know how you feel about the services we provide so we can make sure we are meeting your needs. Your responses are directly responsible for improving these services. All responses will be kept confidential and anonymous.

Who is your primary care provider?: Insert names of providers here with spaces so respondents can have room to circle the name

Primary reason for my visit today: routine follow up annual wellness exam sick visit new patient visit other:_____

For each statement or question please circle the answer that best describes your experience of care during the past twelve months at (Name of Practice).

1. In this practice, when I call to get an appointment, I am able to get an appointment as soon as I feel I need one.

   Always Usually Sometimes Never N/A

2. When I call the office ***during*** office hours, I get an answer to my medical question that same day.

   Always Usually Sometimes Never N/A

3. When I call the office ***after*** office hours, I get an answer to my medical question as soon as I need it.

   Always Usually Sometimes Never N/A

4. My provider listens to my concerns and questions.

   Always Usually Sometimes Never N/A

5. My provider gives me easy to understand instructions about how to take care of my health problems or concerns.

   Always Usually Sometimes Never N/A

6. I believe that my provider and the office staff have a commitment to provide the quality care and supports that I need.

   Always Usually Sometimes Never N/A

Monitor Data for Opportunities

QI 05 (1): Assesses health disparities using performance data stratified for vulnerable populations.

- Examples of possible vulnerable populations are people at risk because of:
  - Financial circumstances (below poverty level)
  - Residence (remote or substandard housing)
  - Age (teenagers or post-retirement population)
  - Personal characteristics (immigration status, ethnicity)
  - Functional/developmental status (quadriplegia, autism)
  - Ability to communicate effectively (non-English speaking, illiterate)
  - Chronic illness (due to high burden of care)

Monitor Data for Opportunities

QI 05 (1): Assesses health disparities using performance data stratified for vulnerable populations. (must choose one from each section)

- **Clinical Quality**
  - HPV vaccine by gender (girls typically greater than boys)
  - Colon cancer screening by insurance type
- **Patient Experience**

  Ensure that your survey asks questions to identify vulnerability, such as:
  - Age
  - Insurance type
  - Employment status
  - Primary language
  - Education Level

Performance Measurement

- All eCQMS (electronic Clinical Quality Metrics) are clearly defined by CMS
  - You can find this info on the CMS website by searching Clinical Quality Measures

eMeasure Title	**Preventive Care and Screening: Influenza Immunization**		
eMeasure Identifier (Measure Authoring Tool)	147	**eMeasure Version number**	6.1.000
NQF Number	0041	**GUID**	a244aa29-7d11-4616-888a-86e376bfcc6f
Measurement Period	January 1, 20XX through December 31, 20XX		
Measure Steward	PCPI(R) Foundation (PCPI[R])		
Measure Developer	American Medical Association (AMA)		
Measure Developer	PCPI(R) Foundation (PCPI[R])		
Endorsed By	National Quality Forum		
Description	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization		
Copyright	Copyright 2015 PCPI(R) Foundation and American Medical Association. All Rights Reserved.		
Disclaimer	The Measures are not clinical guidelines, do not establish a standard of medical care, and have not been tested for all potential applications.		

Is your EHR certified? Check here: https://chpl.healthit.gov/#/search

Performance Measurement

What now?

- Select your measures for each PCMH category
- Pull your current performance data from the EHR

Measures
CMS 2 - Preventive Care and Screening: Screening for Depression and Follow-Up Plan
CMS 22 - Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
CMS 50 - Closing the Referral Loop: Receipt of Specialist Report
CMS 61 - Preventive Care and Screening: Cholesterol - Fasting Low Density Lipoprotein (LDL-C) Test Performed
CMS 62 - HIV/AIDS: Medical Visit
CMS 64 - Preventive Care and Screening: Risk-Stratified Cholesterol -Fasting Low Density Lipoprotein (LDL-C)
CMS 65 - Hypertension: Improvement in Blood Pressure
CMS 68 - Documentation of Current Medications in the Medical Record
CMS 69 - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
CMS 74 - Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists
CMS 75 - Children Who Have Dental Decay or Cavities
CMS 77 - HIV/AIDS: RNA Control for Patients with HIV
CMS 117 - Childhood Immunization Status
CMS 122 - Diabetes: Hemoglobin A1c Poor Control
CMS 123 - Diabetes: Foot Exam
CMS 124 - Cervical Cancer Screening

Performance Measurement

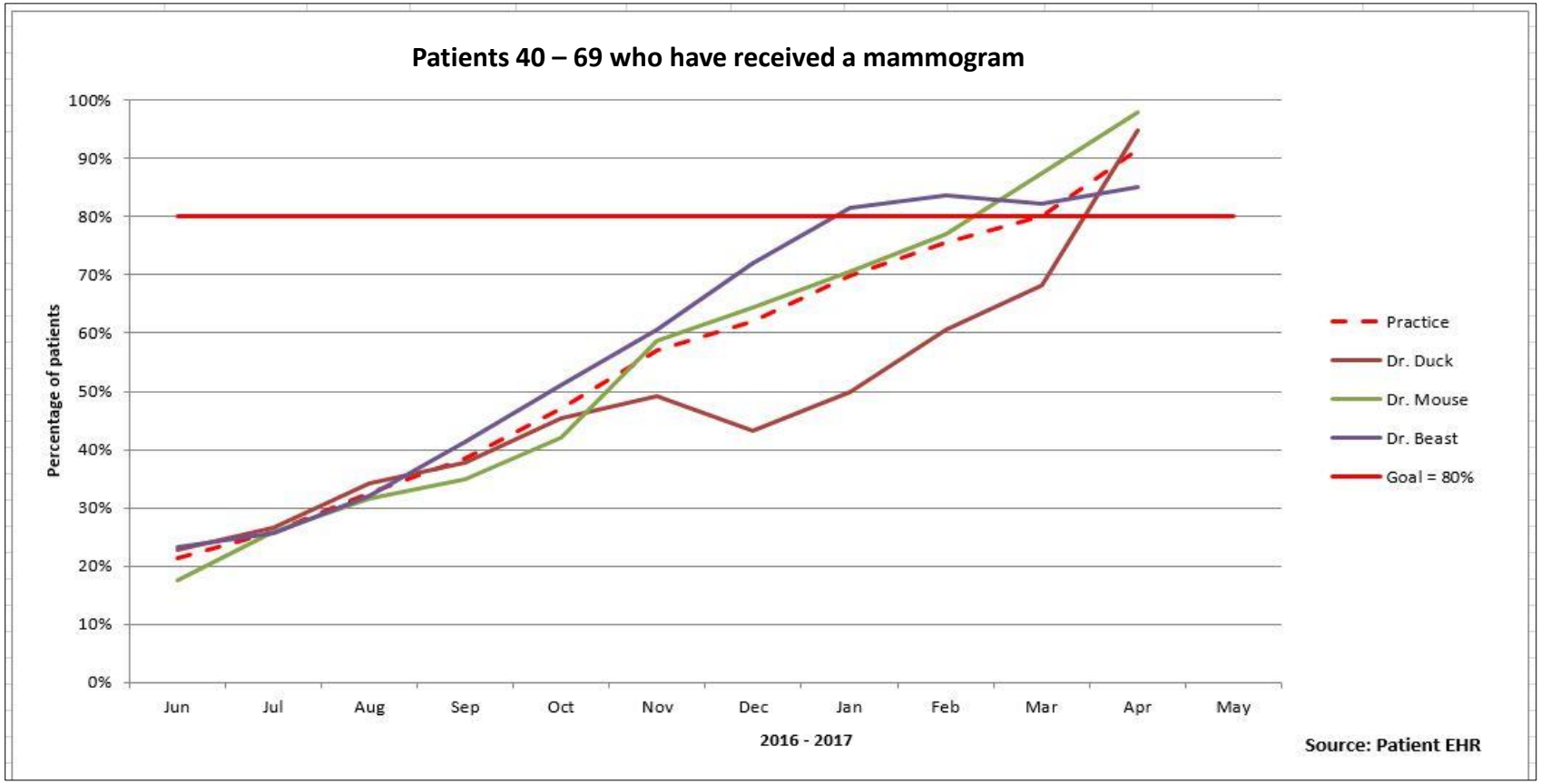
Enter your data in an Excel spreadsheet…

Patients 40-69 who have received a mammogram

		Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
	Numerator	105	127	159	189	230	279	304	342	370	392	448	#N/A
	Denominator	490	490	490	490	490	490	490	490	490	490	490	#N/A
Practice		**21.4%**	**25.9%**	**32.4%**	**38.6%**	**46.9%**	**56.9%**	**62.0%**	**69.8%**	**75.5%**	**80.0%**	**91.4%**	**#N/A**
	Numerator	30	35	45	50	60	65	57	66	80	90	125	#N/A
	Denominator	132	132	132	132	132	132	132	132	132	132	132	#N/A
Dr. Duck		**22.7%**	**26.5%**	**34.1%**	**37.9%**	**45.5%**	**49.2%**	**43.2%**	**50.0%**	**60.6%**	**68.2%**	**94.7%**	**#N/A**
	Numerator	25	37	45	50	60	84	92	101	110	125	140	#N/A
	Denominator	143	143	143	143	143	143	143	143	143	143	143	#N/A
Dr. Mouse		**17.5%**	**25.9%**	**31.5%**	**35.0%**	**42.0%**	**58.7%**	**64.3%**	**70.6%**	**76.9%**	**87.4%**	**97.9%**	**#N/A**
	Numerator	50	55	69	89	110	130	155	175	180	177	183	#N/A
	Denominator	215	215	215	215	215	215	215	215	215	215	215	#N/A
Dr. Beast		**23.3%**	**25.6%**	**32.1%**	**41.4%**	**51.2%**	**60.5%**	**72.1%**	**81.4%**	**83.7%**	**82.3%**	**85.1%**	**#N/A**
	Numerator	35	45	50	66	73	80	90	110	120	150	160	#N/A
	Denominator	170	170	170	170	170	170	170	170	170	170	170	#N/A
Dr. Mermaid		**20.6%**	**26.5%**	**29.4%**	**38.8%**	**42.9%**	**47.1%**	**52.9%**	**64.7%**	**70.6%**	**88.2%**	**94.1%**	**#N/A**
Goal = 80%		80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%

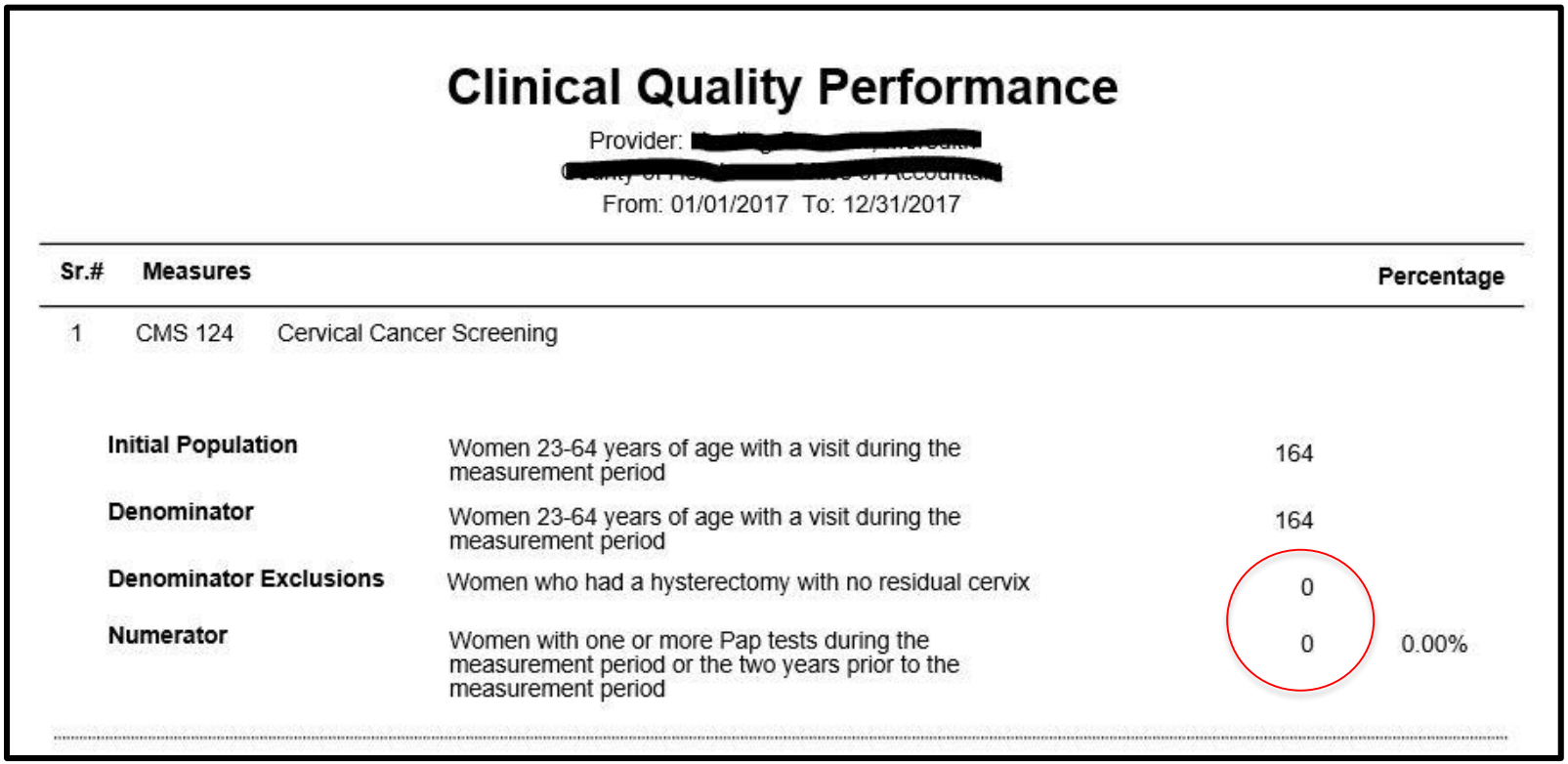
Performance Measurement

Build your dashboard…create a run chart!



Performance Measurement

Not a perfect world…



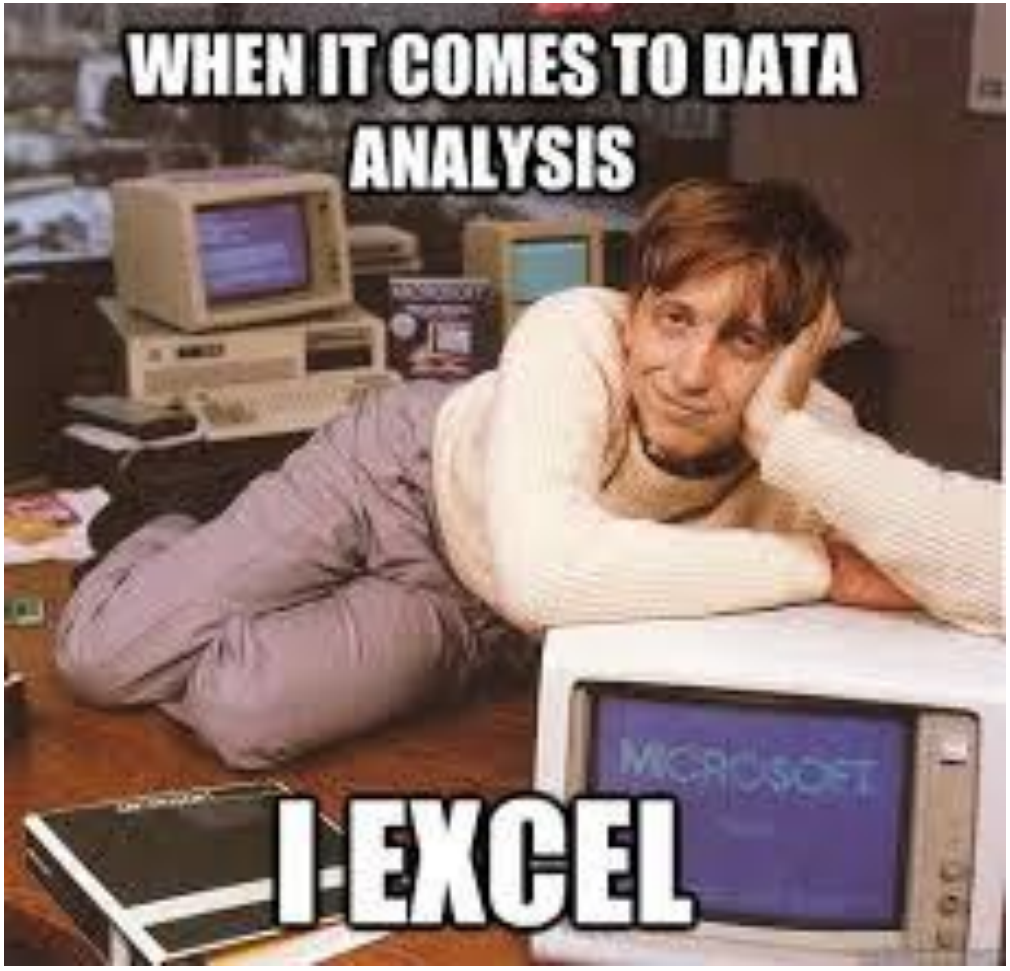
Clinical Quality Performance

Provider: [redacted]

From: 01/01/2017 To: 12/31/2017

Sr.#	Measures			Percentage
1	CMS 124	Cervical Cancer Screening		
	Initial Population	Women 23-64 years of age with a visit during the measurement period	164	
	Denominator	Women 23-64 years of age with a visit during the measurement period	164	
	Denominator Exclusions	Women who had a hysterectomy with no residual cervix	0	
	Numerator	Women with one or more Pap tests during the measurement period or the two years prior to the measurement period	0	0.00%

Performance Measurement



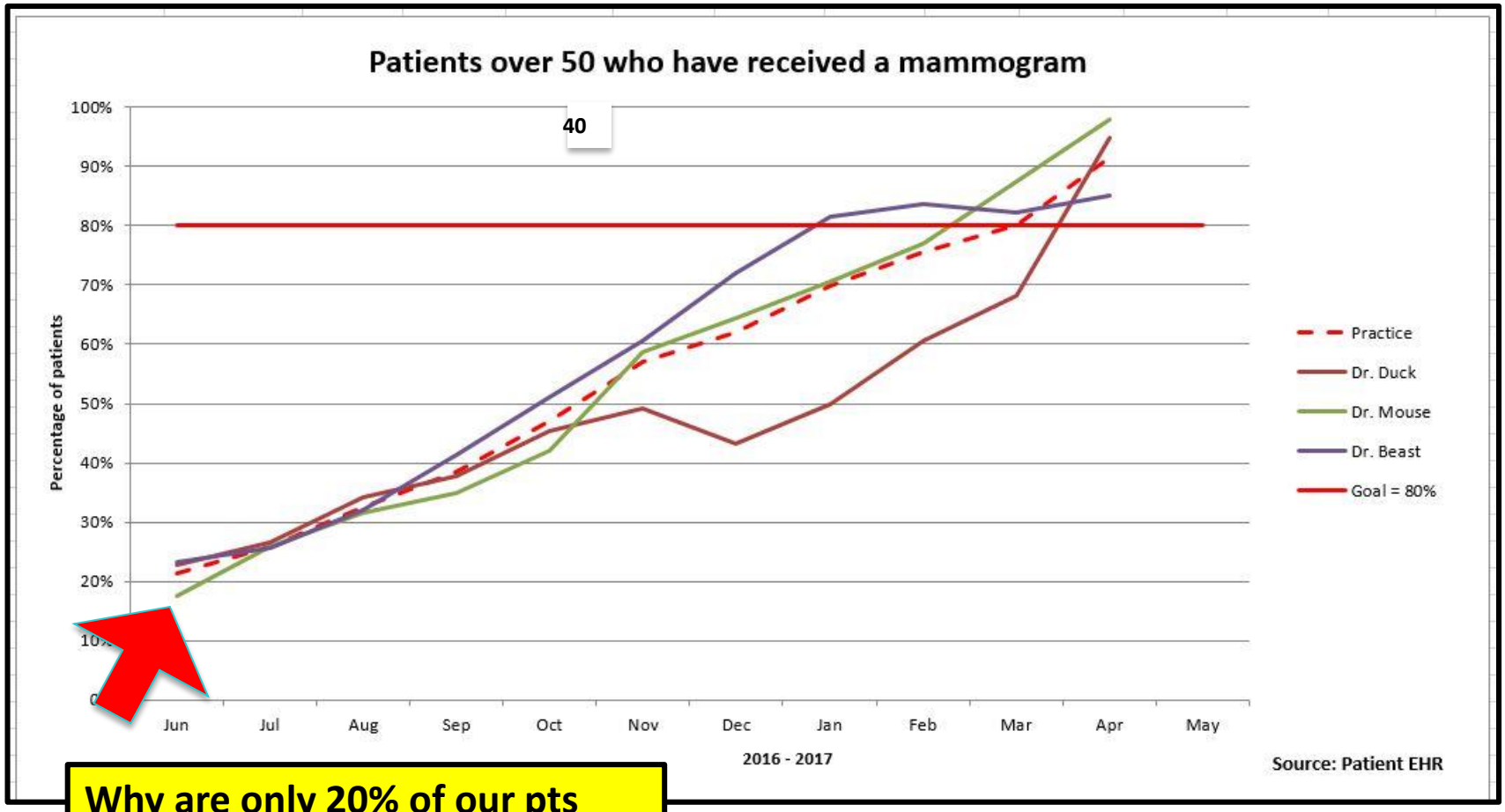
Process Improvement

- **QI 08 (core):** Sets goals and acts to improve upon at least five measures across at least three the four categories.
  A. Immunization measures
  B. Other preventive care measures
  C. Chronic or acute care clinical measures
  D. Behavioral health measures
- **QI 09 (core):** Sets goals and acts to improve upon at least one measure of resource stewardship.
  A. Measures related to care coordination
  B. Measures affecting health care costs
- **QI 10 (core):** Sets goals and acts to improve on availability of major appointments types to meet patient needs and preferences.
- **QI 11(core):** Sets goals and acts to improve on at least one patient experience measure.
- **QI 12 (2):** Achieves improved performance on at least 2 performance measures.

Process Improvement

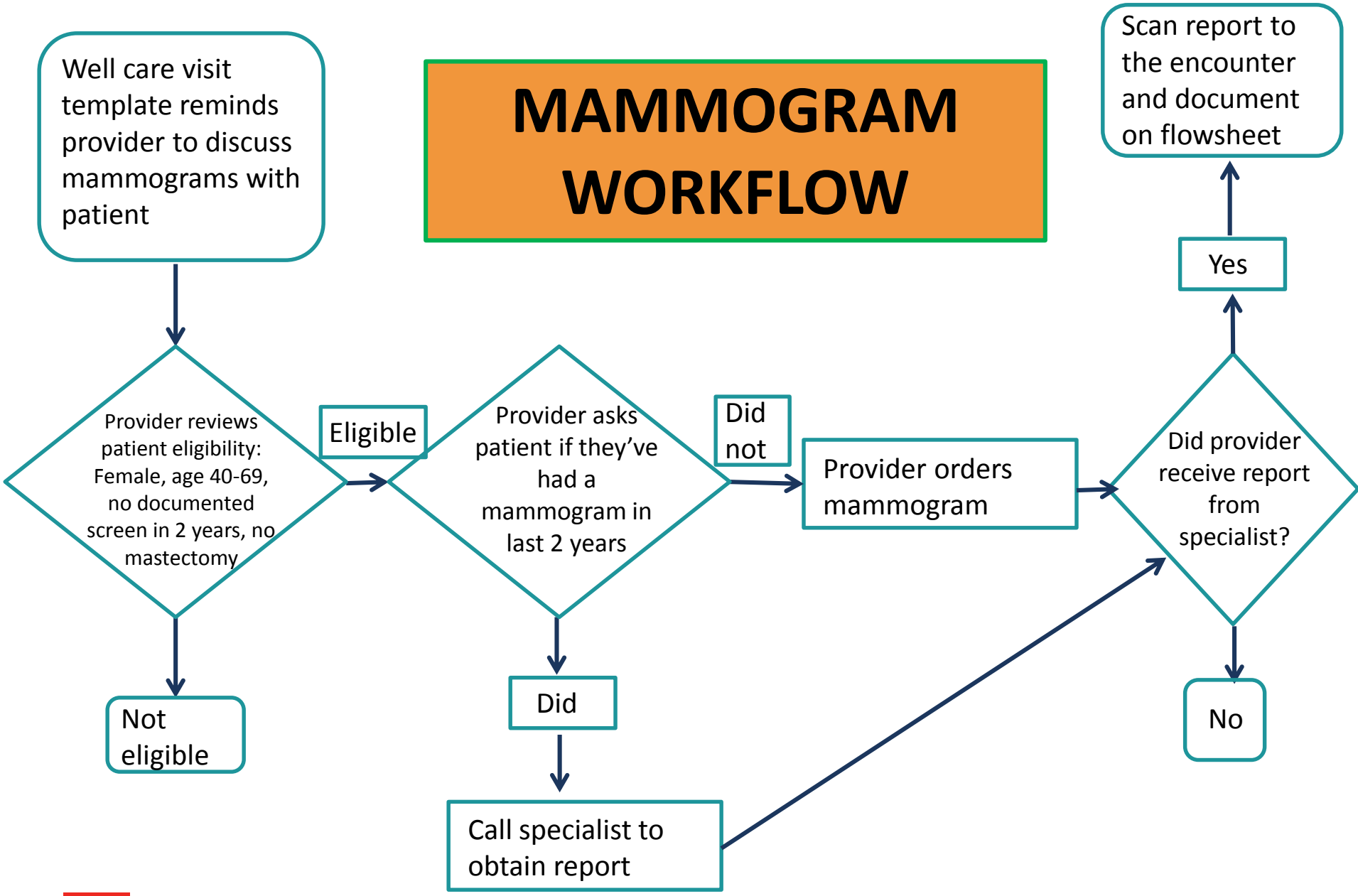
- **QI 13 (1):** Sets goals and acts to improve disparities in care or service on at least 1 measure
- **QI 14 (2):** Achieves improved performance on at least 1 measure of disparities in care or service.
- **AC 11 (core):** Sets goals and monitors the percentage of patient visits with selected clinician or team.
- **QI 18 (2):** Reports clinical quality measures to Medicare or Medicaid agency
- **Q 19 (1-2):** The practice is engaged in Value-Based Contract Agreement. (Maximum 2 credits)
  - ✓ A. Practice engages in up-side risk contract (1 credit)
  - ✓ B. Practice engages in two-sided risk contract (2 credits)

Performance Measurement

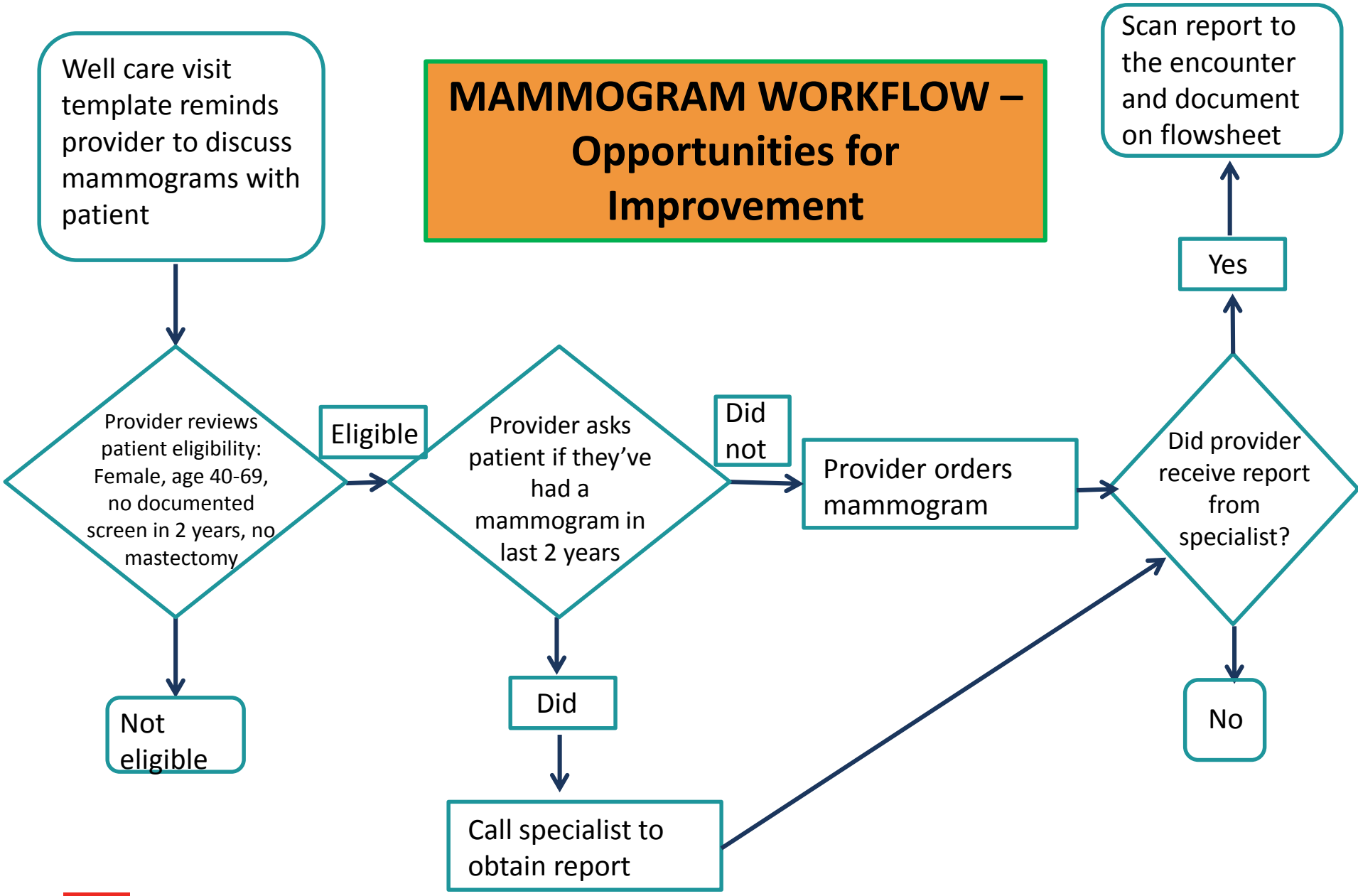


Why are only 20% of our pts getting mammograms?

MAMMOGRAM WORKFLOW



MAMMOGRAM WORKFLOW – Opportunities for Improvement



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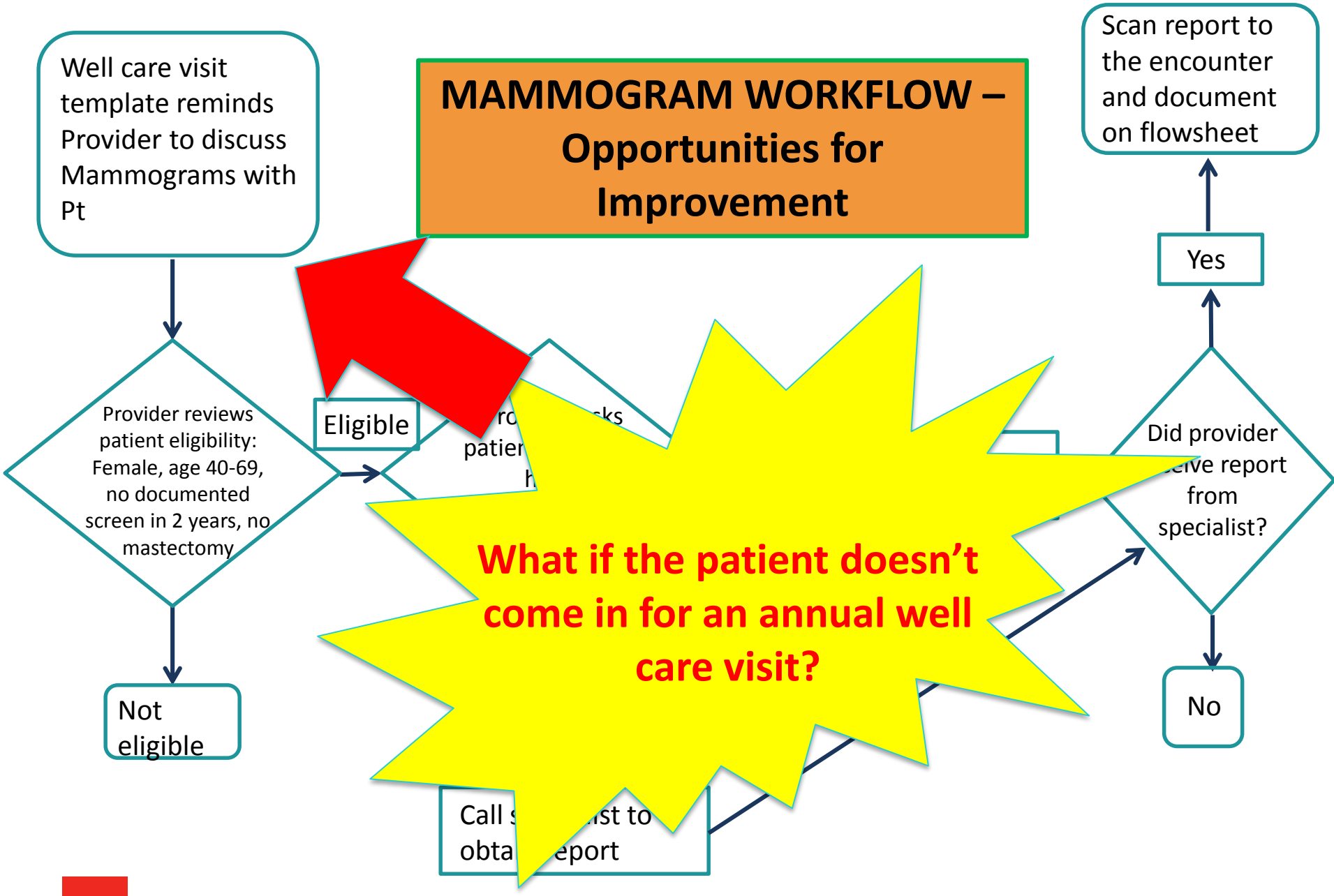

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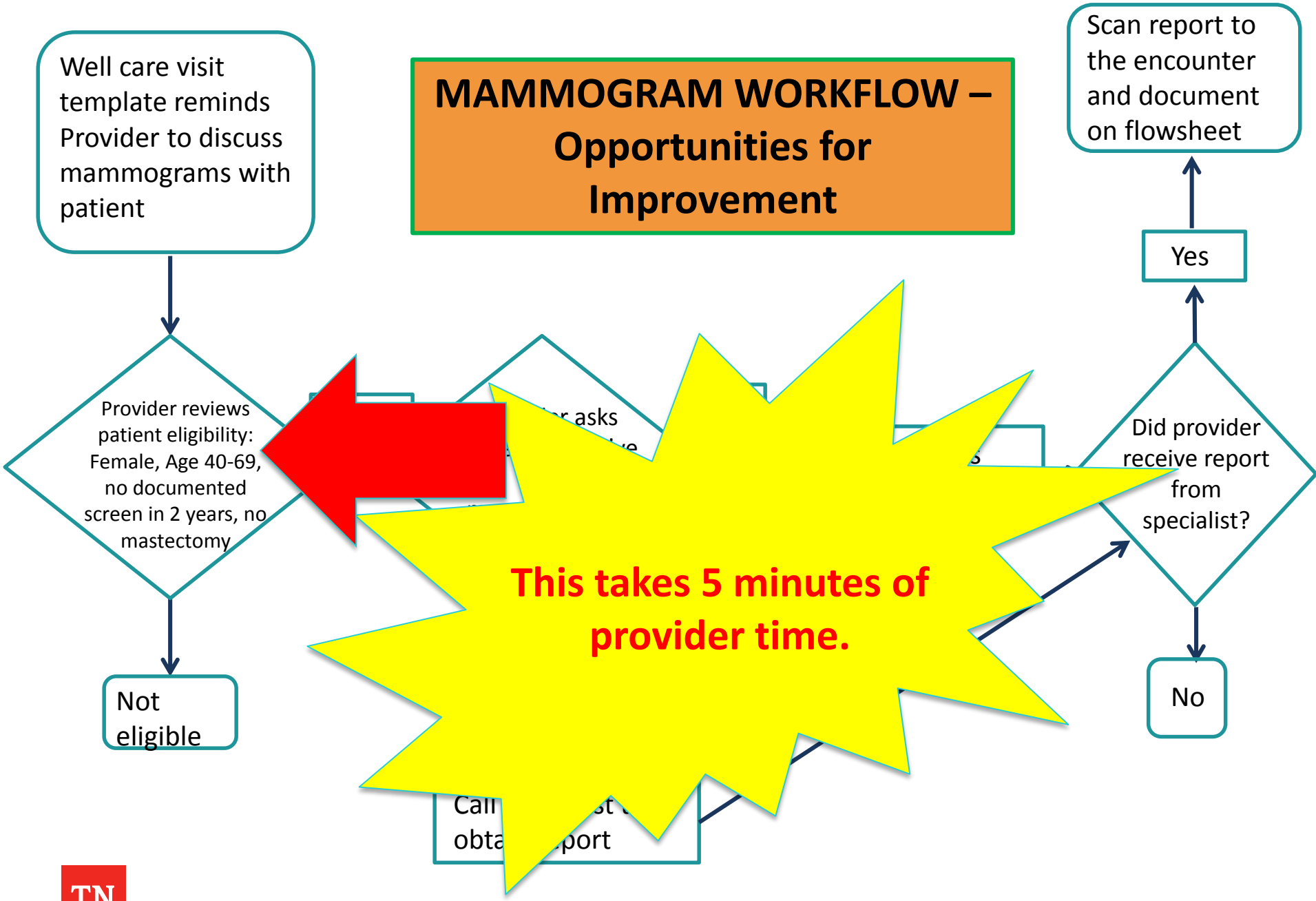

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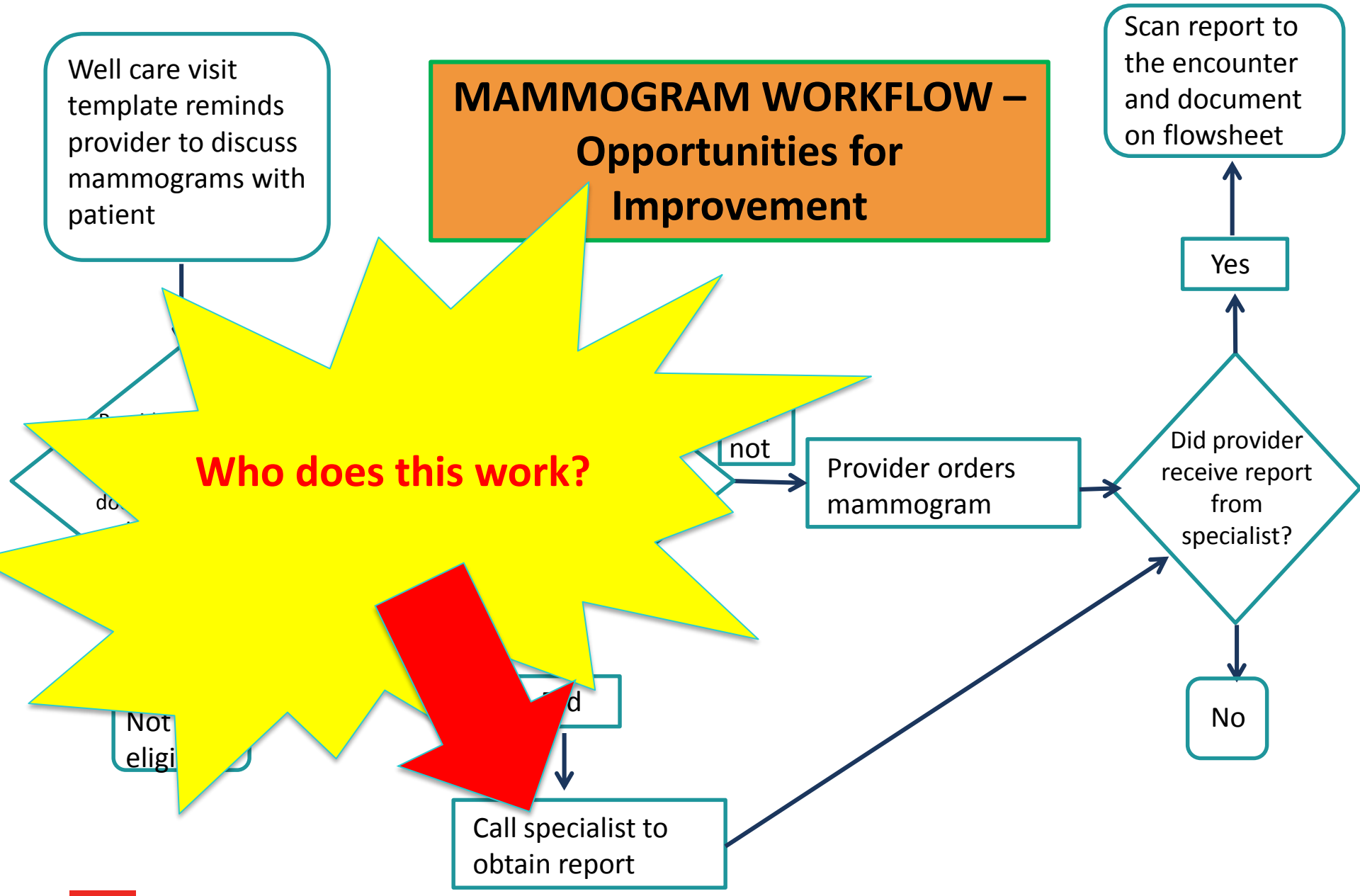

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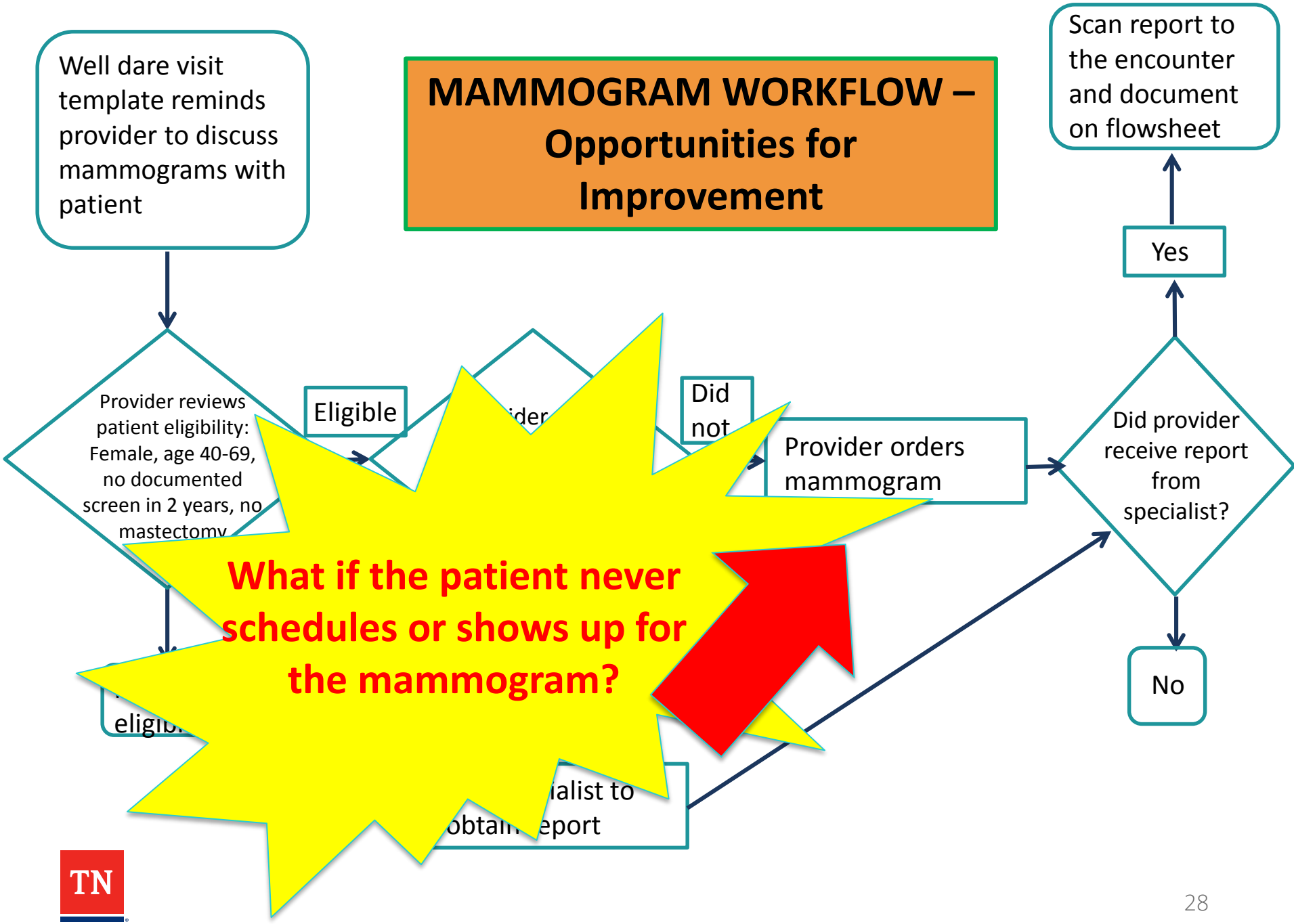

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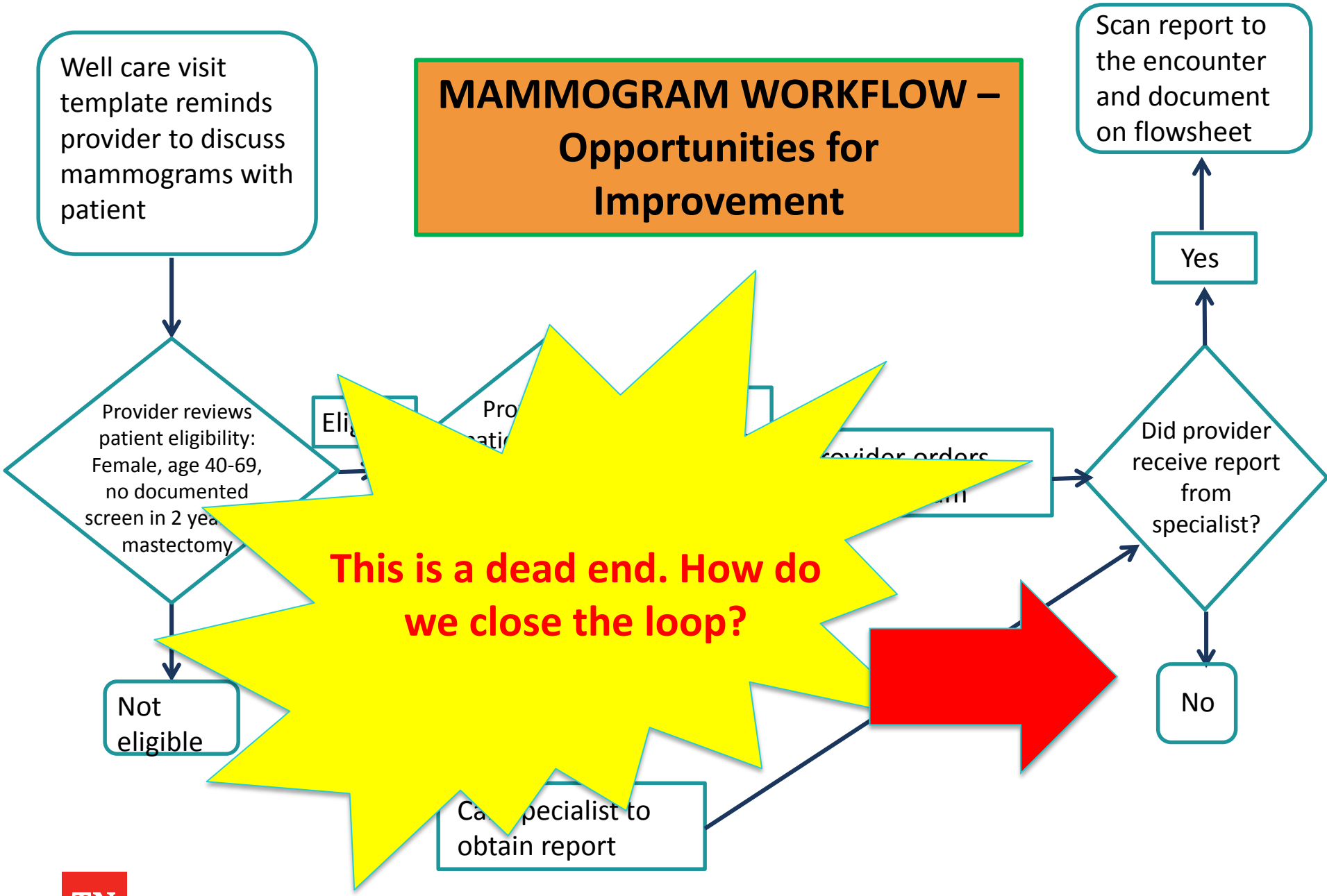

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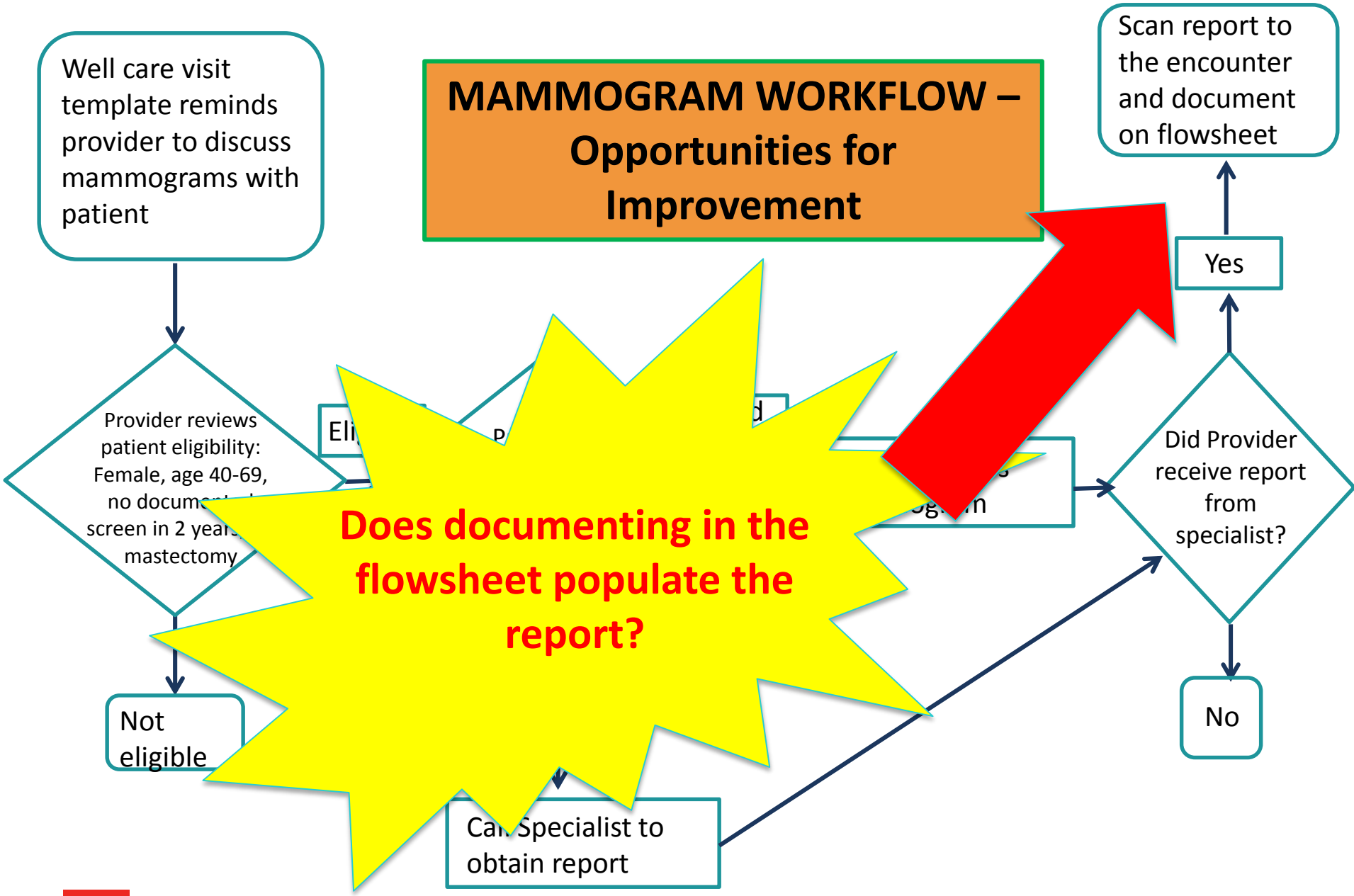
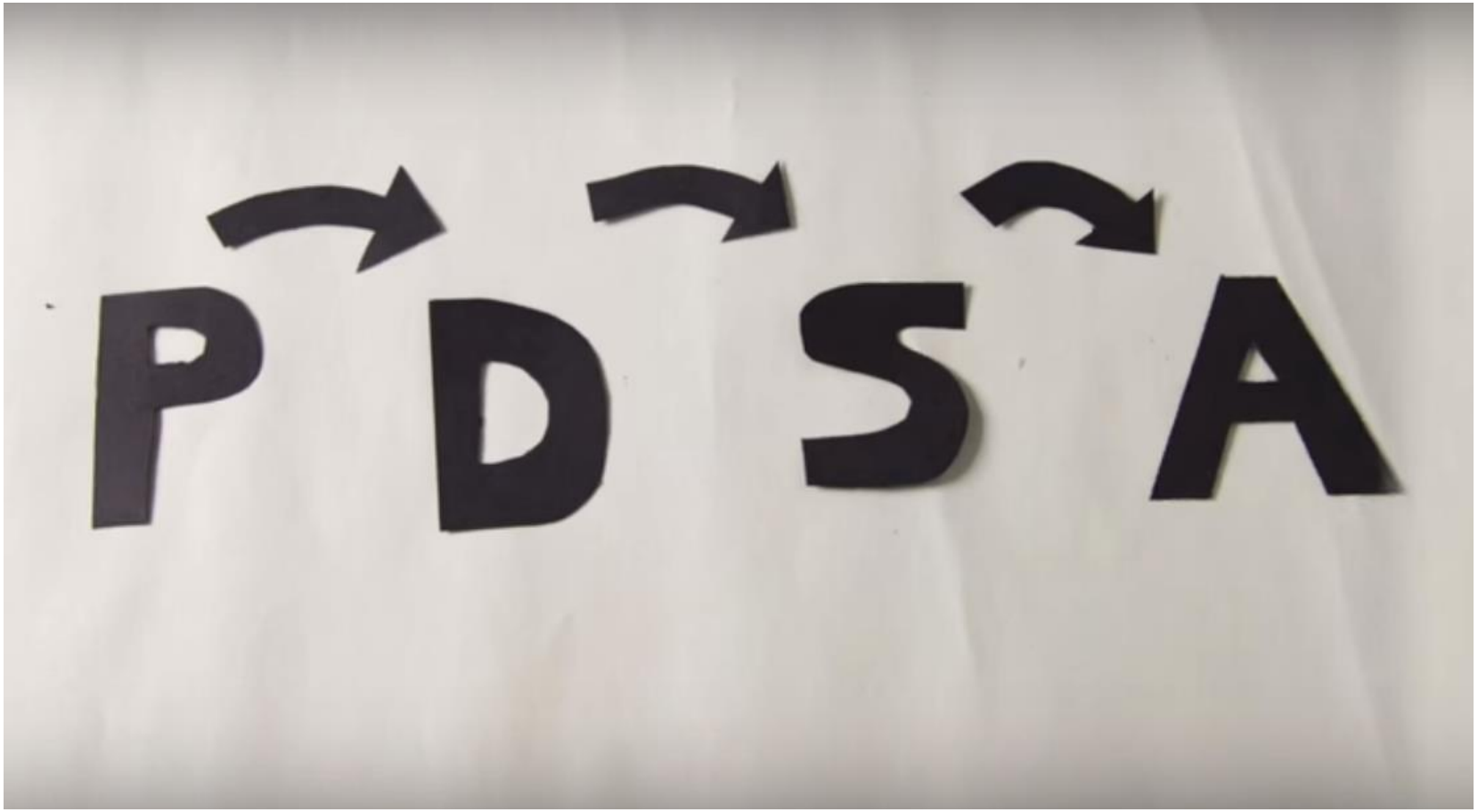


PLAN – DO – STUDY – ACT



BMJ Video Series PDSA 101

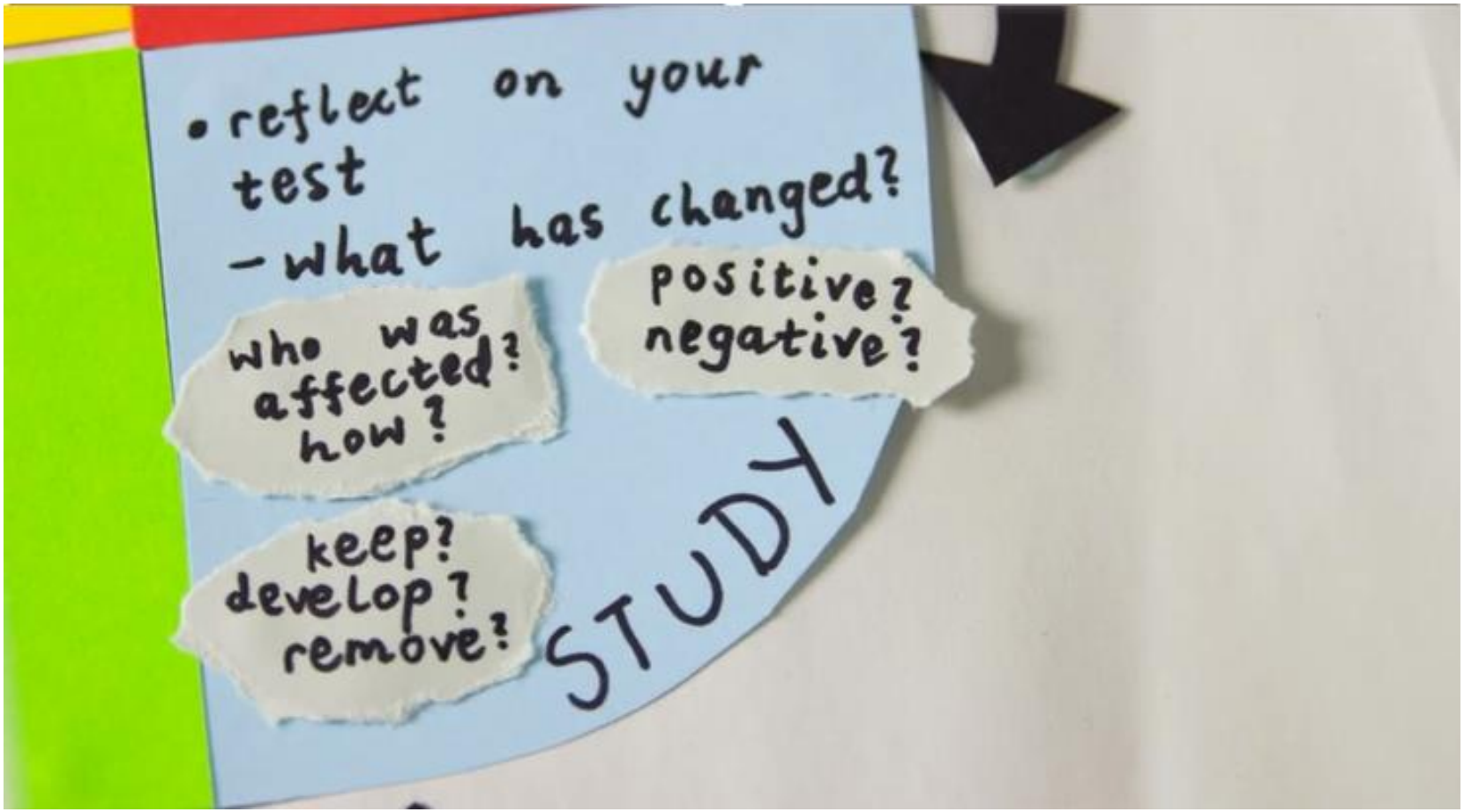
PLAN


data?
feedback?
PLAN
•identify issue
•what could change?
•what will happen?
teamwork?
communication?

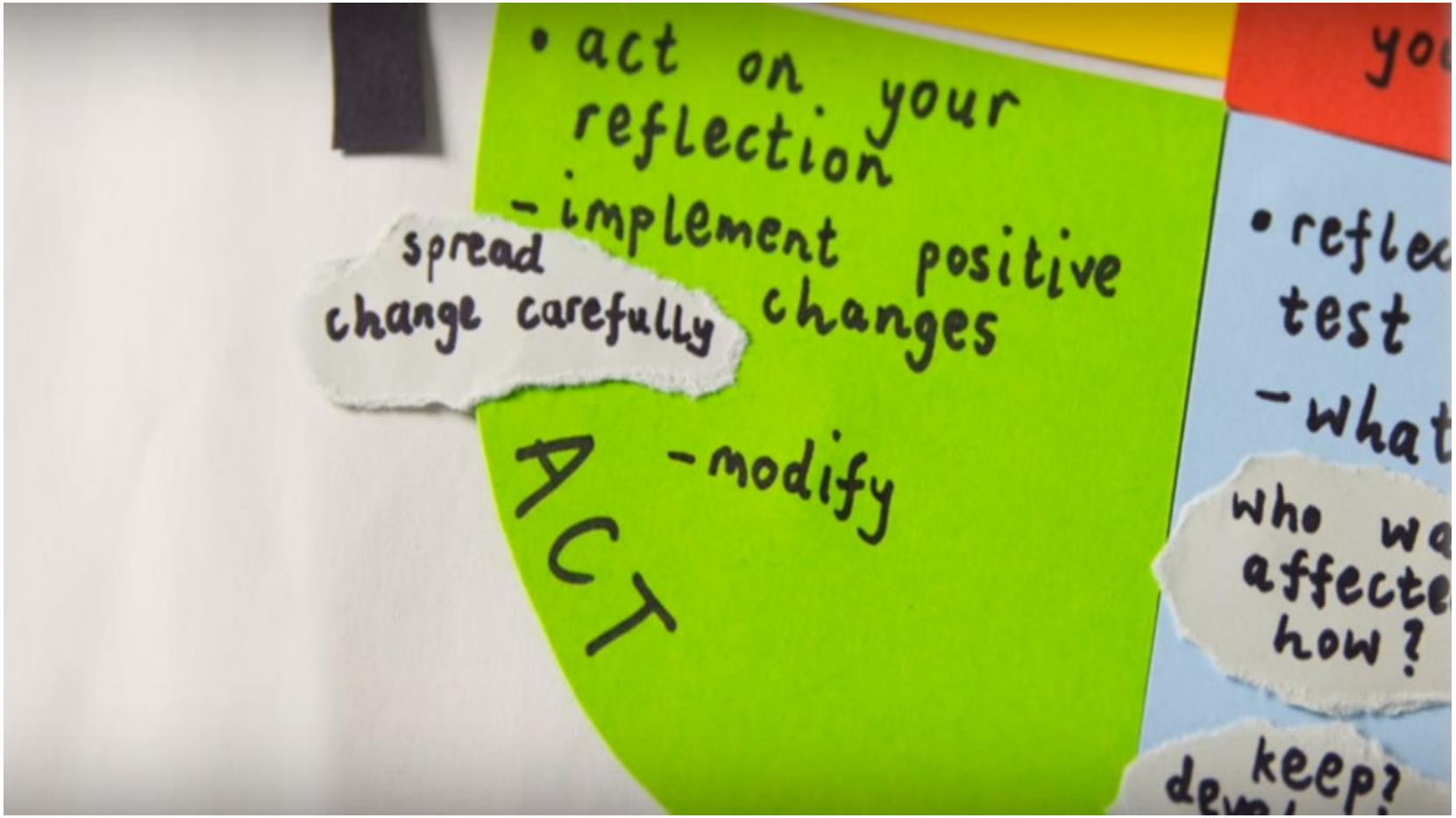
DO


back?
-fy
ppen?
DO
• test your idea
- prepare
- start small
- monitor your progress
training? resources?
start with small group

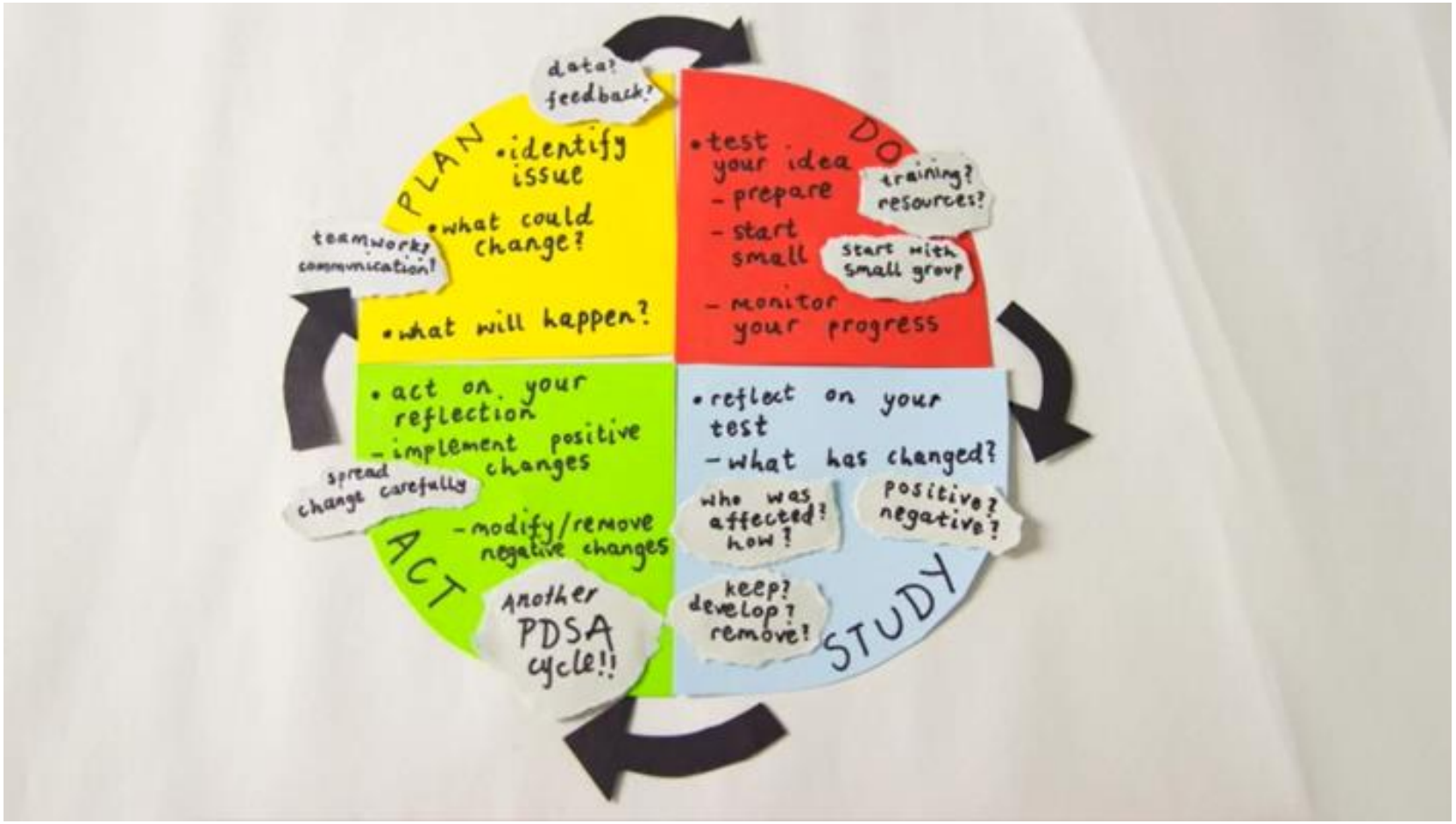
STUDY


• reflect on your test
– what has changed?
positive?
negative?
who was affected? how?
keep? develop? remove?
STUDY

ACT

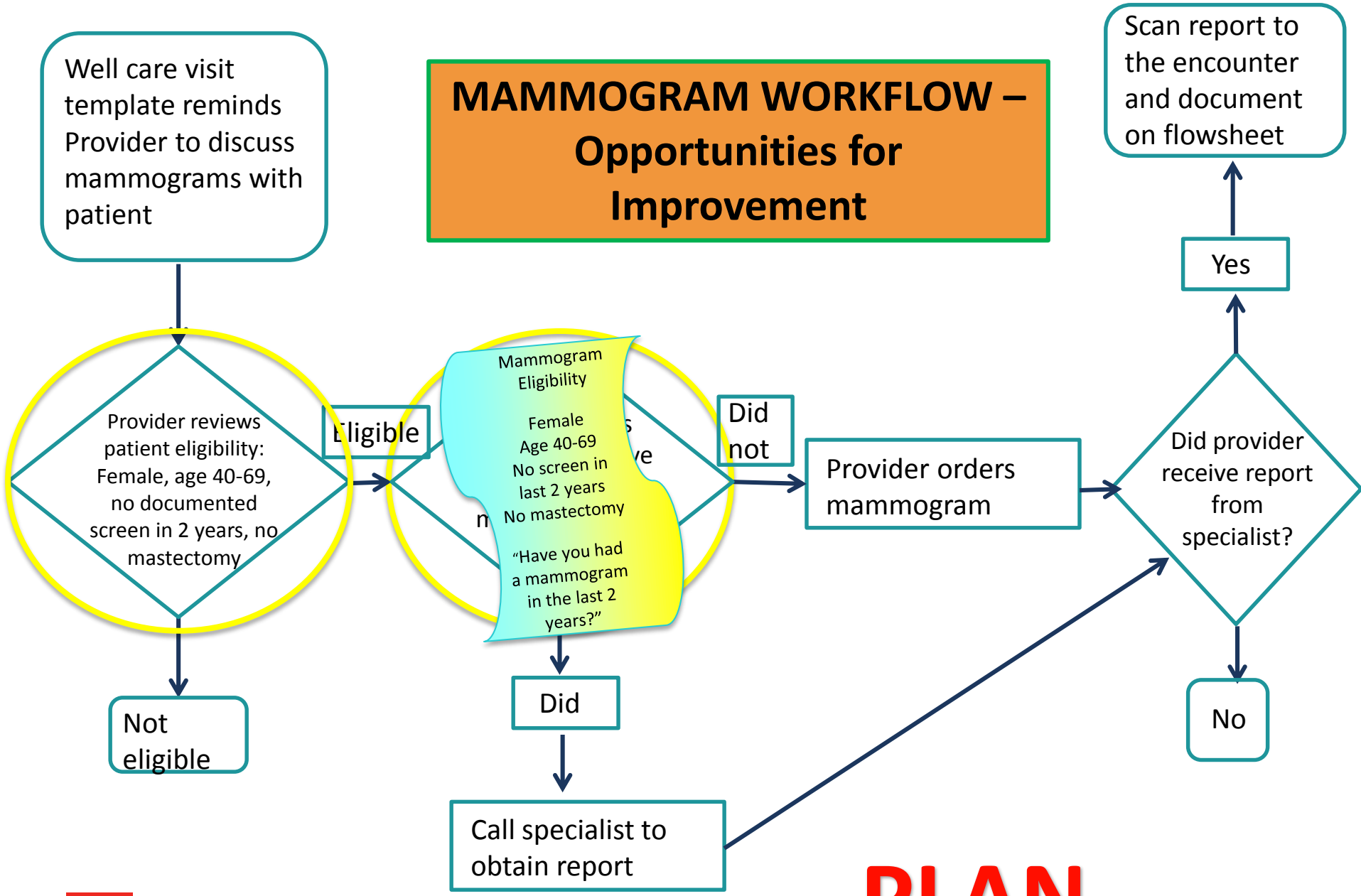

• act on your reflection
- implement positive changes
spread change carefully
- modify
ACT
• reflec
test
- what
who
affecte
how?
keep?

PDSA Cycle (BMJ Video)



BMJ Video Series PDSA 101

MAMMOGRAM WORKFLOW – Opportunities for Improvement



PLAN

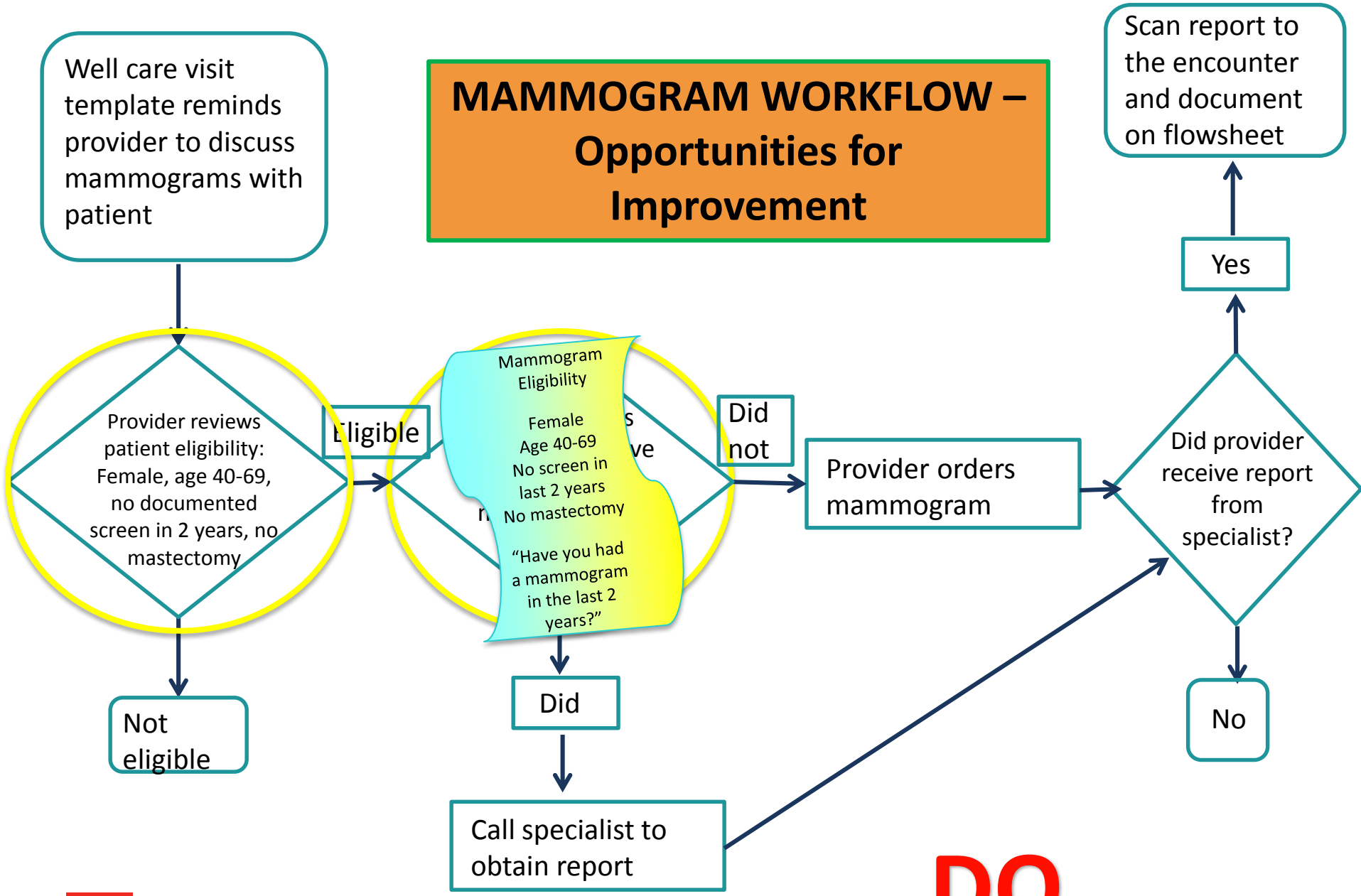
Document the PDSA

NCQA PCMH Quality Measurement and Improvement Worksheet

Practice Name: **World's Best Practice** ***Date Completed:***

Measure 1: **MAMMOGRAPHY BREAST CANCER SCREENING**	1. Measure selected for improvement; reason for selection	*Reason:* Only 20% of our eligible patients receive mammograms every 2 years.
	2./3. Baseline performance measurement; numeric goal for improvement *(QI 03)*	*Baseline Date*: June 2018 *Baseline Performance Measurement (% or #):* 20% *Numeric Goal (% or #):* **80%**
	4. Actions taken to improve and work toward goal; dates of initiation *(QI 10)* *(Only 1 action required)*	*Action*: *Date Action Initiated*: *Additional Actions*:
	5. Remeasure performance *Note: Continuing QI is encouraged, but is not required for QI 10.*	*Performance Re-measurement (% or #):*
	6. Assess actions; describe improvement. *Note: Continuing QI is encouraged, but is not required for QI 10.*	

MAMMOGRAM WORKFLOW – Opportunities for Improvement



DO

Document the PDSA

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	4. Actions taken to improve and work toward goal; dates of initiation *(QI 10)* *(Only 1 action required)*	*Action*: MA to review chart for eligibility criteria. If patient meets criteria and no mammogram report is in the chart MA asks the patient "Have you had a mammogram in the past 2 years?" *Date Action Initiated*: June 15, 2018 *Additional Actions*:
	5. Remeasure performance *Note: Continuing QI is encouraged, but is not required for QI 10.*	*Performance Re-measurement (% or #):*
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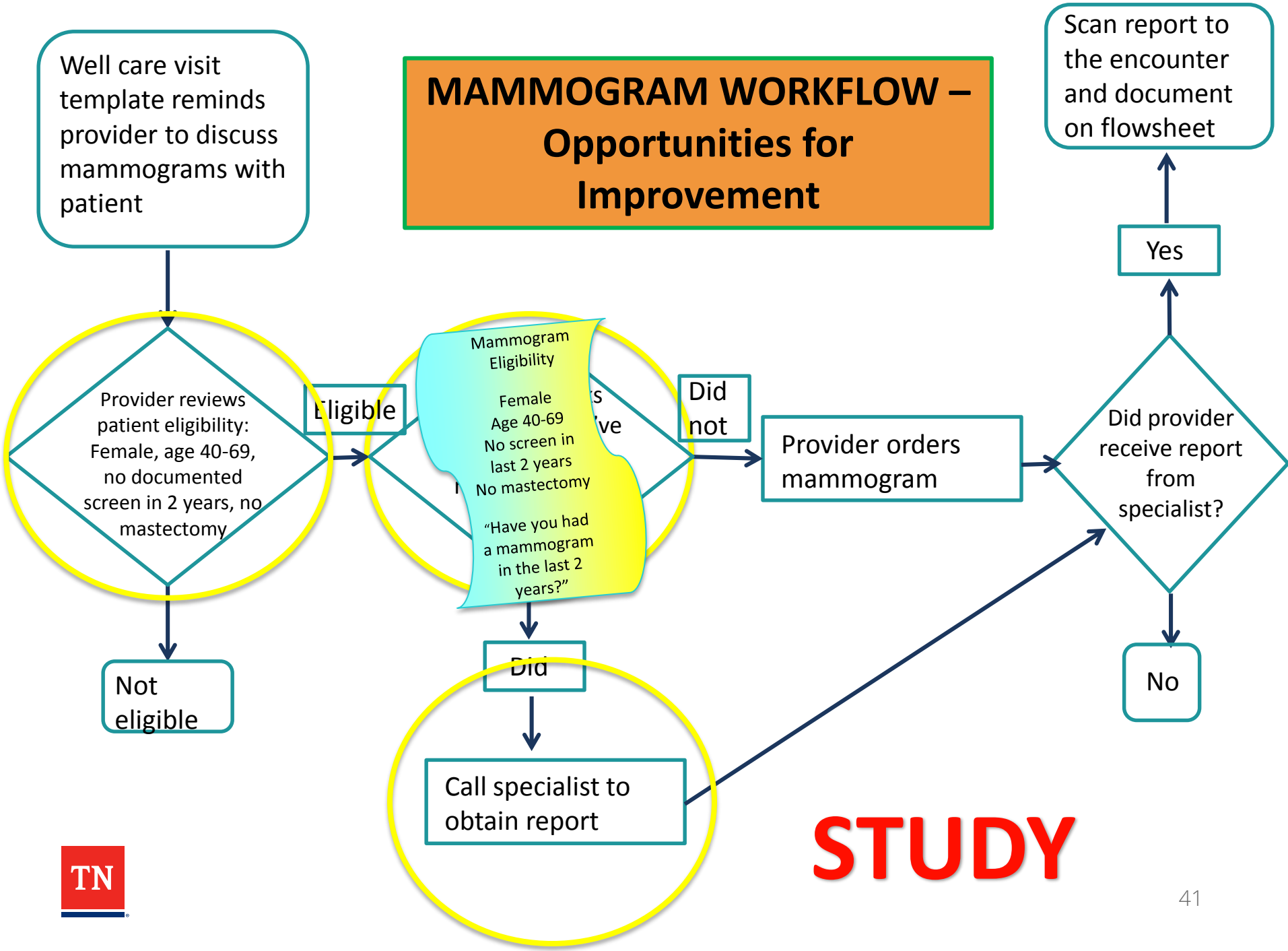
MAMMOGRAM WORKFLOW – Opportunities for Improvement



STUDY

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Measure 1: **MAMMOGRAPHY BREAST CANCER SCREENING**	1. Measure selected for improvement; reason for selection	*Reason:* Only 20% of our eligible patients receive mammograms every 2 years.
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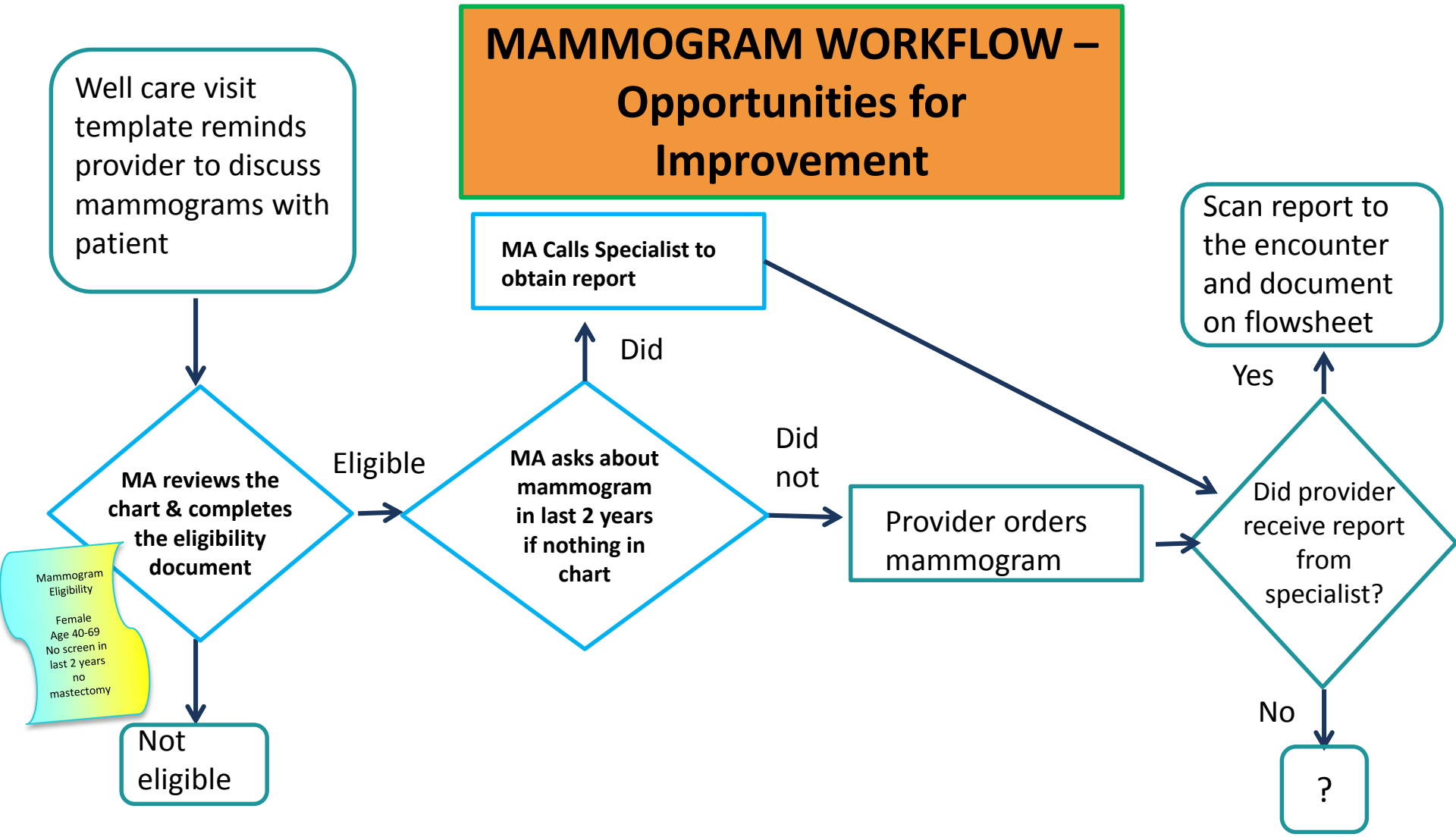
	4. Actions taken to improve and work toward goal; dates of initiation *(QI 10)* *(Only 1 action required)*	*Action*: MA to review chart for eligibility criteria. If patient meets criteria and no mammogram report is in the chart MA asks the patient "Have you had a mammogram in the past 2 years?" *Date Action Initiated*: June 15, 2018 *Additional Actions*: MA determined that she could easily call for a report from the specialist as part of the new process.
	5. Remeasure performance *Note: Continuing QI is encouraged, but is not required for QI 10.*	*Performance Re-measurement (% or #):*
	6. Assess actions; describe improvement. *Note: Continuing QI is encouraged, but is not required for QI 10.*	

MAMMOGRAM WORKFLOW – Opportunities for Improvement



ACT

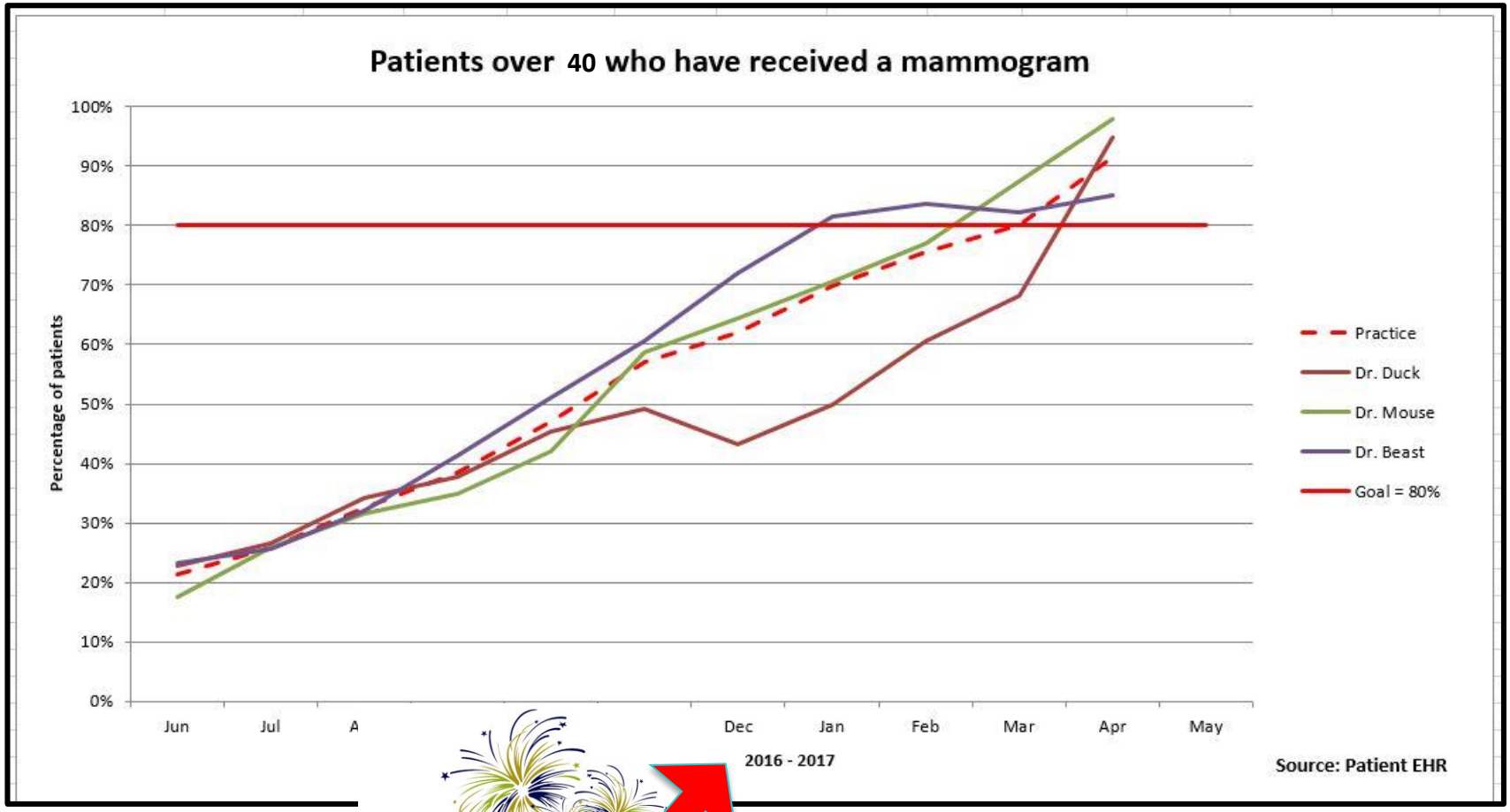
Document the PDSA

NCQA PCMH Quality Measurement and Improvement Worksheet

Practice Name: **World's Best Practice** ***Date Completed:***

Measure 1: **MAMMOG-RAPHY BREAST CANCER SCREENING**	1. Measure selected for improvement; reason for selection	*Reason:* Only 20% of our eligible patients receive mammograms every 2 years.
	2./3. Baseline performance measurement; numeric goal for improvement *(QI 03)*	*Baseline Date*: June 2018 *Baseline Performance Measurement (% or #):* **20%** *Numeric Goal (% or #):* **80%**
	4. Actions taken to improve and work toward goal; dates of initiation *(QI 10) (Only 1 action required)*	*Action*: MA to review chart for eligibility criteria. If patient meets criteria and no mammogram report is in the chart MA asks the patient "Have you had a mammogram in the past 2 years?" *Date Action Initiated*: June 15, 2018 *Additional Actions*: MA determined that she could easily call for a report from the specialist if the patient could tell her which specialist ordered the mammogram.
	5. Remeasure performance *Note: Continuing QI is encouraged, but is not required for QI 10.*	Process Measure: Monitor 10 charts/week for 6 weeks to ensure process does not change . Look to see that MA is reviewing eligibility, asking the question about recent mammogram as appropriate and calling for results when needed. Outcome Measure: Quarterly review of % of eligible patients receiving mammograms every 2 years. Start with Oct-Dec quarter. *Performance Re-measurement (% or #):*
	6. Assess actions; describe improvement.	

Performance Measurement



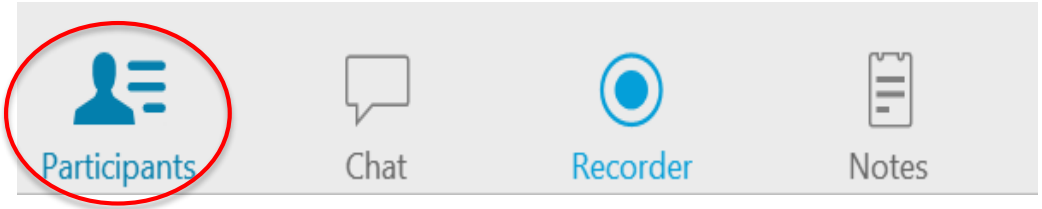
CELEBRATE Success!

Collaborative Discussion

- BEST PRACTICES
- CHALLENGES
- NOVEL IDEAS
- QUESTIONS

HOUSEKEEPING

- The host will read comments from the chat box
- Please raise your hand to engage in discussion – we will unmute you when we call your name.
- Please lower your hand when you are finished speaking



Next Session

Evidence-Based Care
and
Access to Care

Next Session

Provide Evidence-Based Care

- **KM 12 (core):** Proactively and routinely identifies populations of patients and reminds them, or their families/caregivers about needed services (practice must report at least 3 categories)
  - Preventive care services
  - Chronic or acute care services
  - Patients not recently seen by the practice
- **KM 20 (core):** Implements clinical decision support following evidence-based guidelines for care of: (Practice muster demonstrate at lease 4 criteria):
  A. Mental health condition
  B. Substance use disorder
  C. A chronic medical condition
  D. An acute condition
  E. A condition related to unhealthy behaviors
  F. Well child or adult care
  G. Overuse/appropriateness issues
- **CC 03 (2):** Uses clinical protocols to determine when imaging and lab tests are necessary
- **CC 05 (2):** Uses clinical protocols to determine when a referral to a specialist is necessary

Train Staff on Population Management:

- **KM11 (core):** Identifies and addresses population-level needs based on the diversity of the practice and the community. Demonstrate at least 2.
  A. Target population health management on disparities in care
  B. Address health literacy of the practice
  C. Educate practice staff in cultural competence

Next Session

Access to Care:

- **AC2 (core):** Provides same-day appointments for routine and urgent care to meet identified patients' needs.
- **AC3 (core):** Provides routine and urgent appointments outside regular business hours (generally considered 8-5 M-F) to meet identified patients' needs
- **AC4 (core):** Provides timely clinical advice by telephone.
- **AC5 (core):** Documents clinical advice in patient records and confirms clinical advice and care provided after-hours does not conflict with patient medical record.
- **AC6 (1):** Provides scheduled routine or urgent appointments by telephone or other technology supported mechanisms.
- **AC7 (1):** Has a secure electronic system for patients to request appointments, prescription refills, referrals and test results.
- **AC8 (1):** Has a secure electronic system for two-way communication to provide timely clinical advice

Contact Info

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