Tips for Implementing Your Health Center Quality Improvement Program

Bureau of Primary Health Care
Health Resources and Services Administration
Department of Health and Human Services
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Replay info: 800-294-4342 passcode 6040

Introduction

- Quality is a focus area nationally and at HRSA
- Assessment of QI plans showed areas for improvement
- Invest in your QI infrastructure
  - Clinical quality and beyond
- Focus on implementation
  - This work never ends

Benefits of an Effective QI Plan

- Roadmap for HC organization
  - Leadership, focus, & prioritization
  - Efficient coordination of staff & resources
  - Better outcomes
- Satisfy external requirements
  - HRSA, State
  - Third-party quality accreditation and recognition

How Can HRSA Help?

- Support for planning and implementation of Quality Improvement strategies
  - QI Plan Learning Series
  - Further guidance
  - Resources and technical assistance
  - Third-party quality recognition
- How else can we help you with your QI plan and other quality efforts?

Office of Quality & Data Activities

- Federal Tort Claims Act deeming
  - Health centers and free clinics
  - ECRI resources
- Data collection and analysis
  - UDS, patient survey, EHB
- Health Information Technology
  - Adoption, meaningful use, health info exchange
- Quality
  - Third party quality recognition
  - Aligning technical assistance for PCMH transformation
  - CMS

Accreditation

- Effort to gain 3rd party recognition by TJC/AAAHC to ensure quality in the HCs
- In January 2011, 291 centers (25.7%) were accredited

PCMH

- The Bureau is committed to harnessing the known benefits of the patient centered medical home
- Currently, two major PCMH activities are being conducted:
  - Patient Centered Medical Health Home Initiative or PCMHHI (HRSA)
  - Advanced Primary Care Practice Medicare demo in FQHCs (CMS)

PCMHHI

- 351 NOIs, 341 are 1st time (through 2/17/11)
- NCQA has 1st 100, preparing to enter into survey recognition process
- Single application for grantee for single or multiple sites within organization
- NCQA to provide T.A. to guide through survey process
- 5 percent on-site follow up

Medicare Demo: Advanced Primary Care Practice

- Run from CMS with HRSA support
- Rolling application for up to 500 HCs, having seen >200 unique Medicare beneficiaries in past 12 months
- Will be required to achieve NCQA level III in 3 years

Technical Assistance

- To promote transformation, HRSA is working with CMS on a T.A. strategy
- Readiness assessment and gap analysis critical first step
- T.A. could include practice coaching, peer to peer learning, data/evaluation and knowledge management
- PCAs and states will have high stake, be well situated to craft T.A. delivery for grantees

Using HIT and Data in Your QI Program

- Different types of measures: clinical, patient experience, staff satisfaction, and financial domains
- UDS, patient experience surveys, dental and oral health measures, and other data sources
- Tips on useful EHB reports
- Involving Health Information Exchange goals in your QI plan

TIPS FOR IMPLEMENTING YOUR QUALITY PLAN

HRSA Quality Series #3

Jan Wilkerson, RN, CPHQ, GAPHC

“Quality is never an accident;
It is always the result of high intention, sincere effort, intelligent direction, and ***SKILLFUL EXECUTION****.*
It represents the wise choice of many alternatives.”

William A. Foster

Objectives

Participants will be able to:

- *Evaluate the FQHC's current Quality Plan*
- *Identify quality policies needed to develop and support the **quality infrastructure***
- *Determine the best **skillful execution** for your FQHC's Quality Plan*
- *Develop a formal process for **quality communication** including reporting and staff training*

QUALITY PLAN

Assessment

Assessment Criteria

- HRSA→ **FQHC program requirements** *http://bphc.hrsa.gov/about/requirements.htm*
- HRSA→ **Scope of Project**; defines the capacity of services provided by the FQHC
  http://bphc.hrsa.gov/policiesregulations/policies/index.html
- HRSA→ ***KEY HEALTH CENTER PROGRAM REQUIREMENTS*** *http://bphc.hrsa.gov/about/requirements.htm*
- FTCA requirements ***(42 CFR 51c.303(c)(1-2)***
  - *http://bphc.hrsa.gov/policiesregulations/policies/index.html*
- (Section 330(k)(3)(C) of the PHS Act, 45 CFR Part 74.25 (c)(2), (3) and 42 CFR Part 51c.303(c)(1-2))
- *The Health Care Quality Improvement Act of 1986, as amended 42 USC Sec. 11101 01/26/98*
  - *STATE Georgia Code #3910 (GA. L. 1975)*
- Accreditation requirements

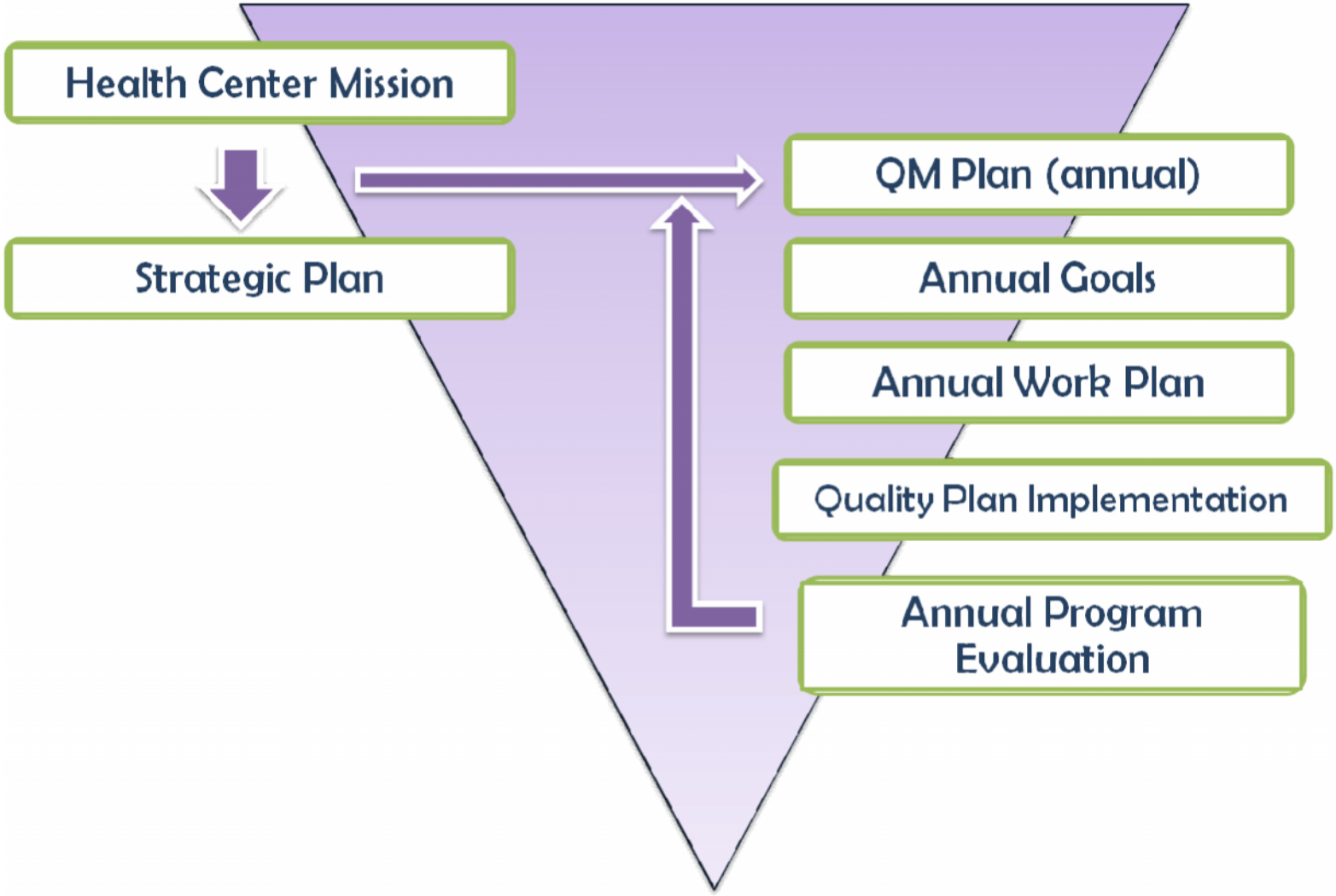
Other Considerations

Measures should include:

- Required measures
- Deficient goals/ benchmarks
- New/ revised processes
- Business Plan & Health Care Plan measures
- High volume
- High risk
- Problem-prone
- Satisfaction survey

- The FQHC's mission and Strategic Plan
- Sub-committees and workgroups
- Quality **<u>methodology</u>**
- Quality Policies
- HRSA GRANT→ Your Business Plan & Health Care Plan

Quality Management Plan Design

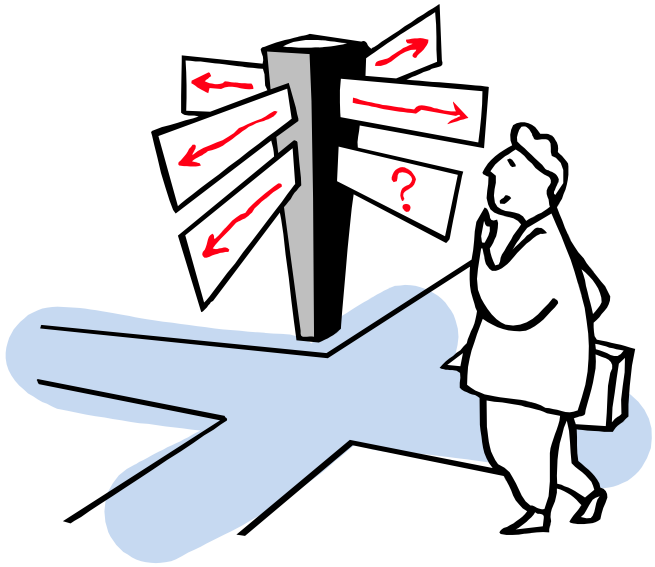


Quality Management Plan Design – diagram description

This quality management plan design depicts a triangular background with the health center mission and strategic plan flowing into the annual quality management plan. An annual program evaluation consisting of annual goals, the annual work plan, and quality plan implementation also feeds into the annual quality management plan.

“…we’re on our way
We’ve only just begun **…**”
The Carpenters

PLANNING FOR SUCCESS



Infrastructure

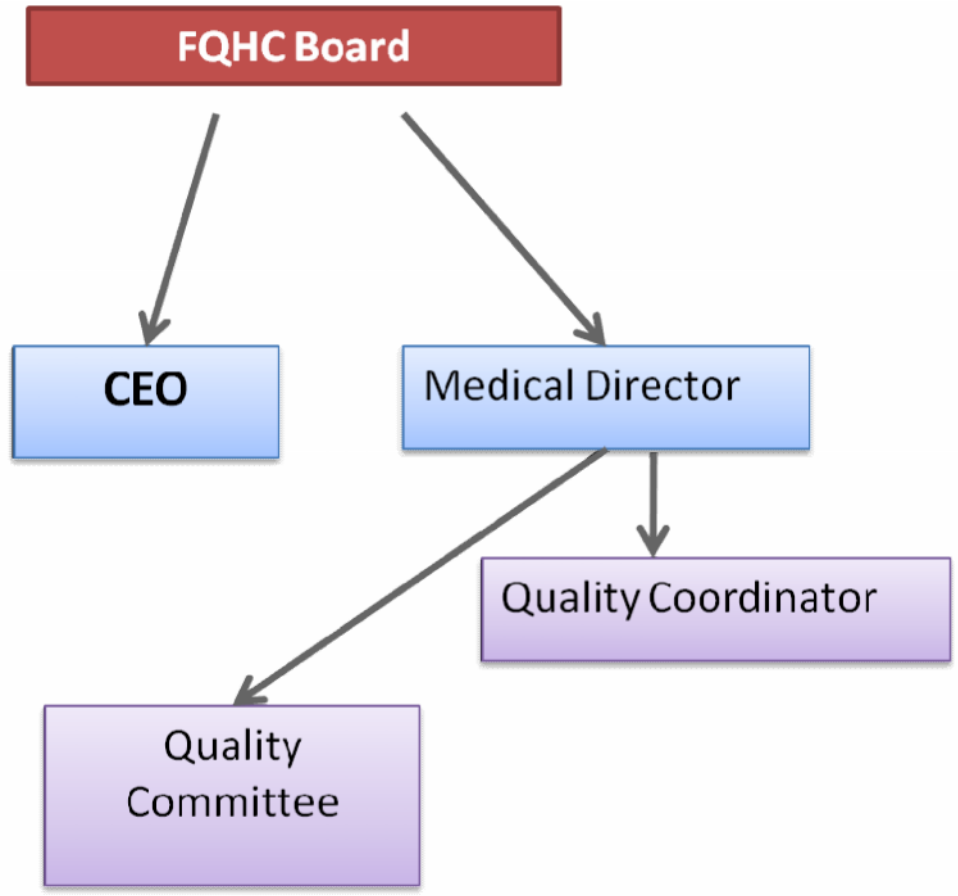
Quality Infrastructure

Quality Infrastructure – diagram description

This flowchart depicts three horizontal layers, each with three components flowing from left to right. The top row consists of, from left to right, quality skills, team management, and meeting management. The middle row consists of policies, communication, and reporting/data management. The bottom row consists of leadership, dedicated resources, and accountability.

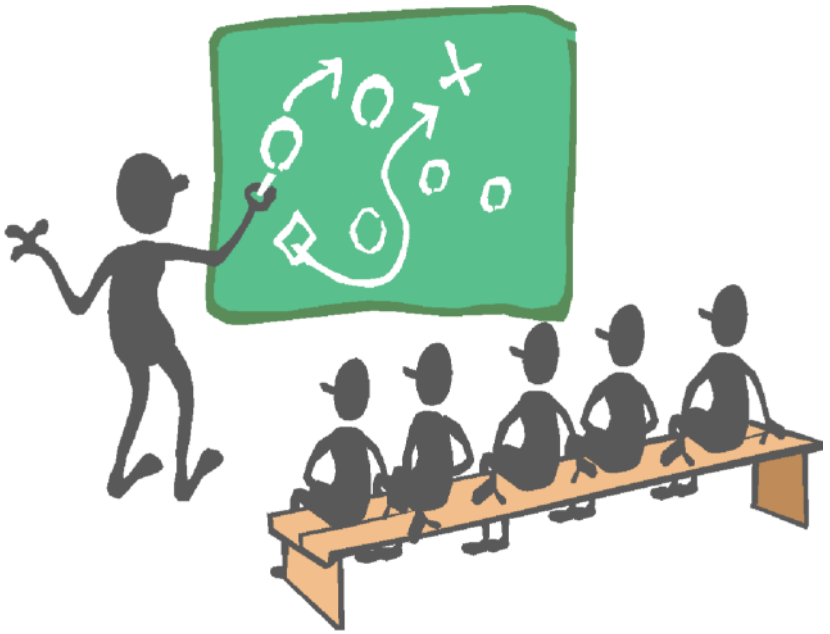
Quality Accountability & Authority

- Responsibility for Quality begins with Board
- Board authorizes CEO to provide resources to support quality program
- Board assigns responsibility for quality program to Medical Director & Quality Committee
- Day-to-day activities usually assigned to Quality Coordinator



Quality Function

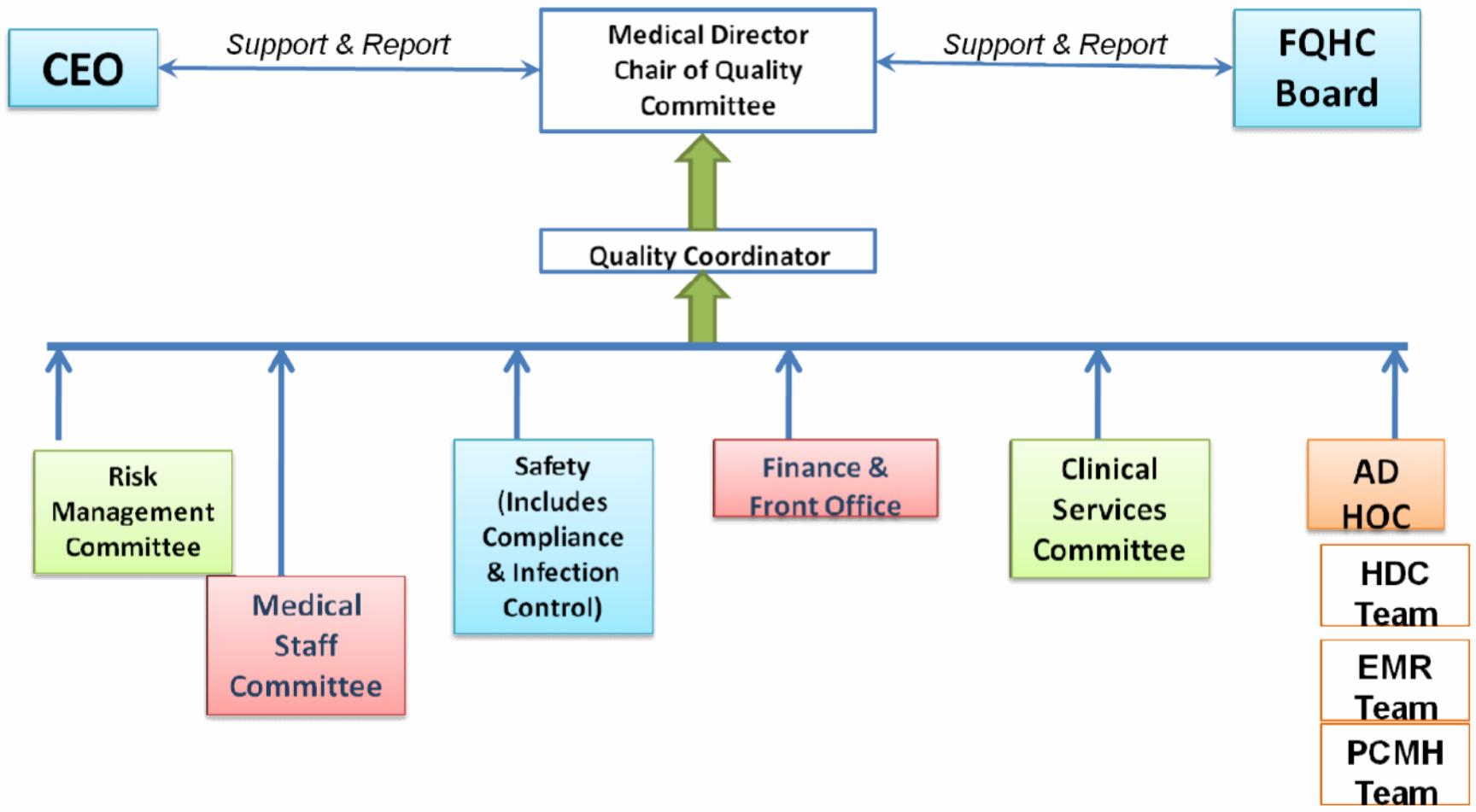
- Ongoing [continuous]:
  - **monitoring,**
  - **evaluation,** and
  - **improving processes.**
- It is a **patient-driven** philosophy and process that focuses on
- **preventing problems** and
- **maximizing quality of care.**



Quality Committee Members

- Chair – Medical Director or ***Physician*** designee
- QI Coordinator (facilitator)
- Risk/ Compliance-Safety Coordinator
- Medical Staff
- Clinical Staff
- Finance
- Front Office
- Medical Records
- In-house Lab Staff
- All departments / services represented
- All sites represented

Quality Committee:
Sub-Committees/Workgroups



Quality Committee:
Sub-Committees/Workgroups

Hierarchy Diagram Description

- Top Level: there is support/reporting responsibility between the Medical Director(Chair of the Quality Committee) and both the CEO and FQHC Board.
- Middle Level: Quality Coordinator supports the Medical Director)
- Bottom Level: Supporting the Quality Coordinator is the Risk Assessment Committee, the Medical Staff Committee, Safety (Including the compliance and infection control), Finance & Front Office, the Clinical Services Committee, and Ad Hoc (HDC team, EMR team, PCMH team)

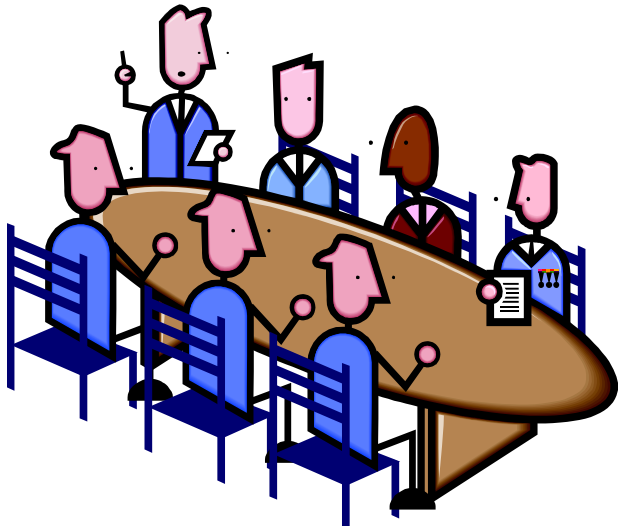
Quality Committee:

Sub-Committees/ Workgroups

- ⇨ Medical Staff Committee – *privileging, peer review*
- Safety
- Compliance
- Infection Control
- ⇨ Risk Management
- Utilization Management
- ⇨Finance (Business Plan)
- ⇨Work groups – HDC Teams or other Quality Initiatives
- EMR Work group
- Clinical Work group
- Ad Hoc work groups

⇨ Indicates necessary regardless of FQHC size

QUALITY COMMITTEE



Role & Responsibility

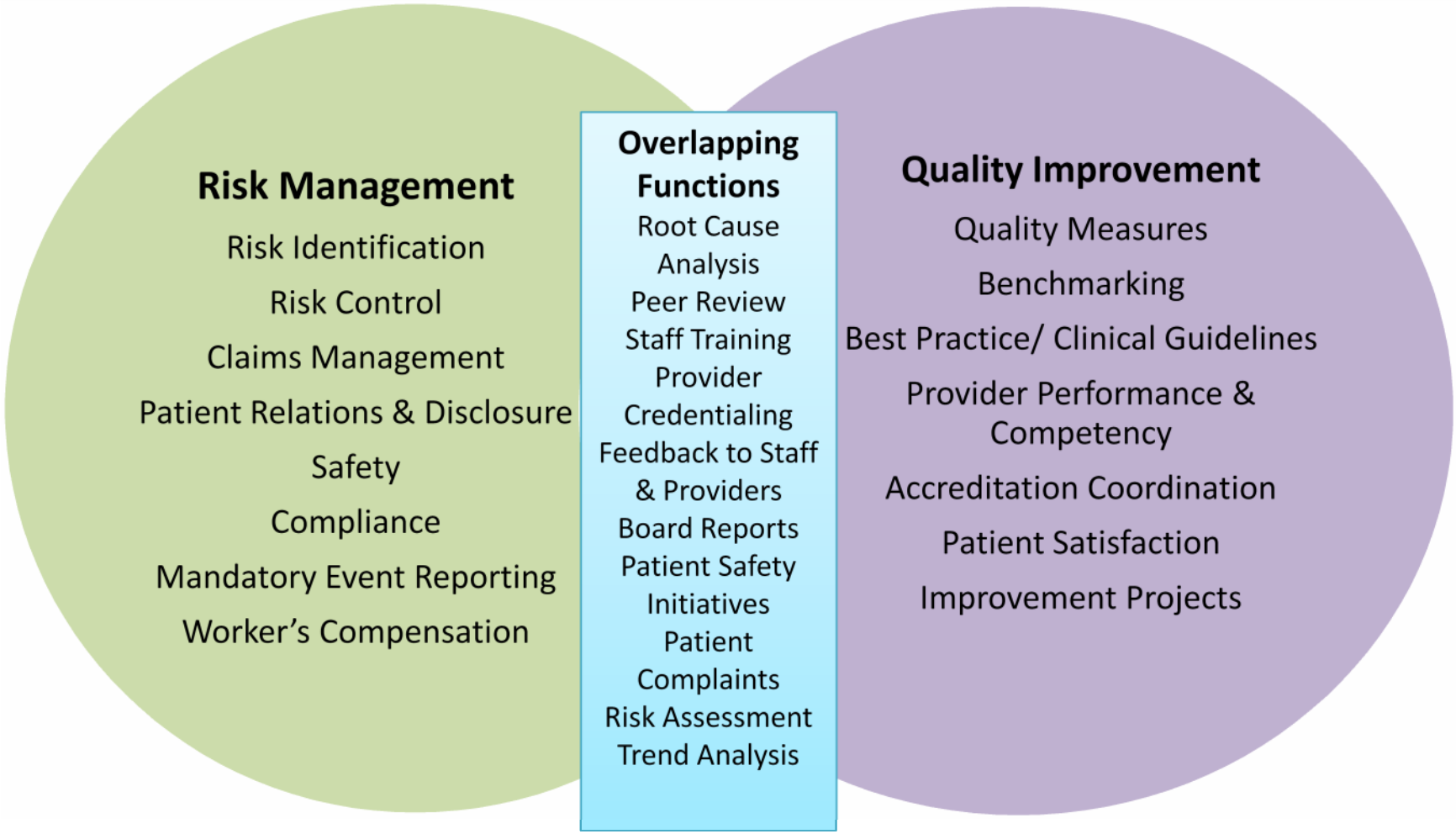
Expectations of the Quality Committee

- Prioritizing current quality initiatives and activities
- Quality assessment and planning and annual program evaluation
- Subcommittee and team chartering, with accountability & reporting followed up by the QC
- The ongoing monitoring, evaluation, and improvement of processes and system.
- With a patient-driven philosophy and process that focuses on preventing problems and maximizing quality of care.

Key Aspects & Functions of Quality Management

- ☑ Policies & Procedures
- ☑ Medical Record
- ☑ Clinical Protocols
- ☑ Tracking Systems
- ☑ Trend identification that impact systems and processes
- ☑ Quality Planning
- ☑ Credentialing
- ☑ Peer Review
- ☑ Privileging
- ☑ Compliance
- ☑ Safety
- ☑ Risk Management

Overlapping Functions



Adapted from ECRI Institute

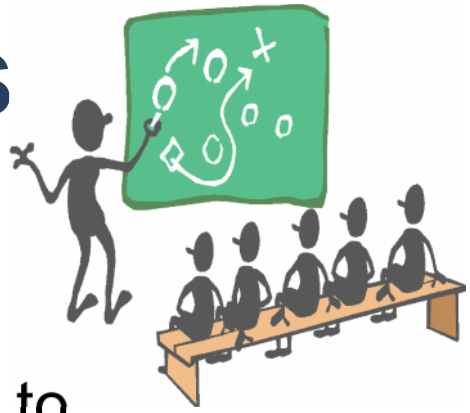
Overlapping Functions – diagram description

- **Left Oval " Risk Management"**
  - Risk Identification
  - Risk Control
  - Claims Management
  - Patient Relations & Disclosure
  - Safety
  - Compliance
  - Mandatory Event Reporting
  - Worker's Compensation

- **Right Oval "Quality Improvement"**
  - Quality Measures
  - Benchmarking
  - Best Practice/ Clinical Guidelines
  - Provider Performance & Competency
  - Accreditation Coordination
  - Patient Satisfaction
  - Improvement Projects

- **Center Square/Overlap**
  - **Overlapping Functions**
  - Root Cause Analysis
  - Peer Review
  - Staff Training
  - Provider Credentialing
  - Feedback to Staff & Providers
  - Board Reports
  - Patient Safety Initiatives
  - Patient Complaints
  - Risk Assessment
  - Trend Analysis

Skills for Quality Teams



- ✓ Confidential nature of quality improvement
- ✓ Understanding of the Quality Plan and policies to support the quality program
- ✓ Know their role and responsibilities as a team member and as *a leader/ cheerleader of quality*
- ✓ Engaged as process “owners” for the organization…not just my corner of it
- ✓ PDSA methodology & Care Model understanding
- ✓ Understanding data and measurement
- ✓ Knowledge of process improvement
- ✓ Basic toolkit – graphs, auditing, required measures

Team Skills

- Team ground rules
- Patient focus – NOT personal focus
- Working together to improve the processes of the organization
- Communicating in an effective manner
- Willingness to learn and grow

Examples of useful feedback

Describe the specific behavior or incident—don't use labels or make judgments

Say this	instead of this
"When you don't do your assignments…"	"When you're irresponsible…"
"It bothers me that you don't let the team have more say in decisions."	"When you act like a little dictator…"
"When you don't speak up, I'm not sure what you're thinking."	"It's obvious you don't care about the team because you don't speak up in our meetings."

Don't exaggerate

Say this	instead of this
"I'm impressed with your work on the customer hotline the past two days."	"Your work is always better than anyone else's."

24 Preparing to Be an Effective Team Member

Examples of Useful Feedback Picture Description

Describe the specific behavior or incident- don't use labels or make judgments:

- **Say** "When you don't o your assignments…" **instead of** "When you're irresponsible…"
- **Say** "It bothers me that you don't let the team have more say in decisions" **instead of** "When you act like a little dictator…"
- **Say** "When you don't speak up, I'm not sure what you're thinking" **instead of** "It's obvious you don't care about the team because you don't speak up in our meetings."

Don't exaggerate

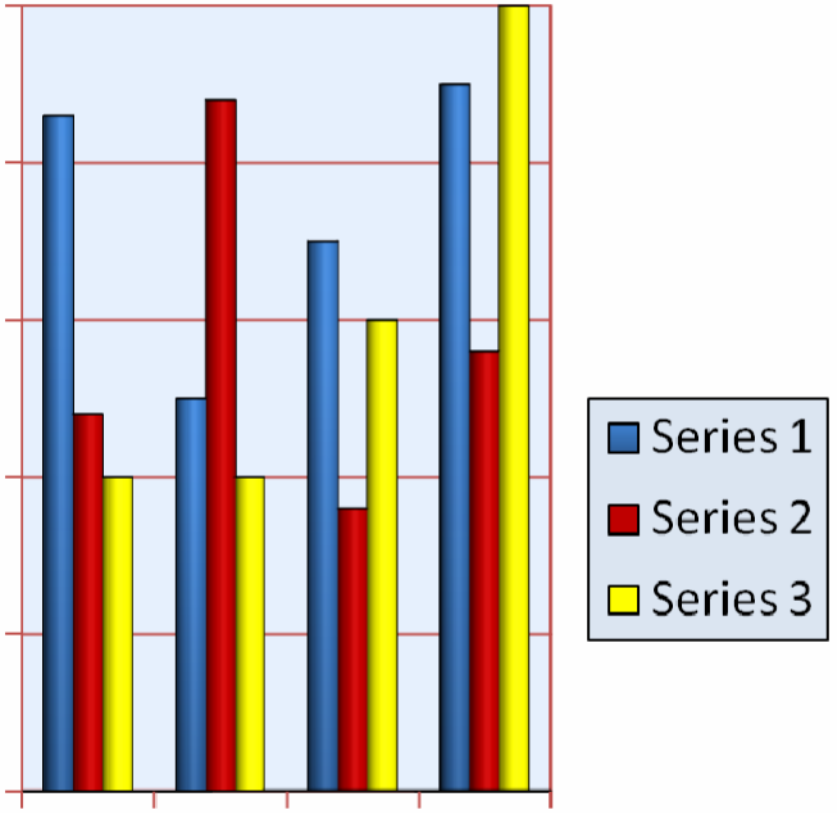
- **Say** "I'm impressed with you work on the customer hotline the past two days" **instead of** "Your work is always better than anyone else's."

Meeting Skills

- Agendas
- Minutes (no PHI – ever)
- Staying on point
- Start and end on time – regardless of who is/isn't there
- 100-mile rule (no interruptions/ cell phones)
- Accountability from the group for assigned tasks

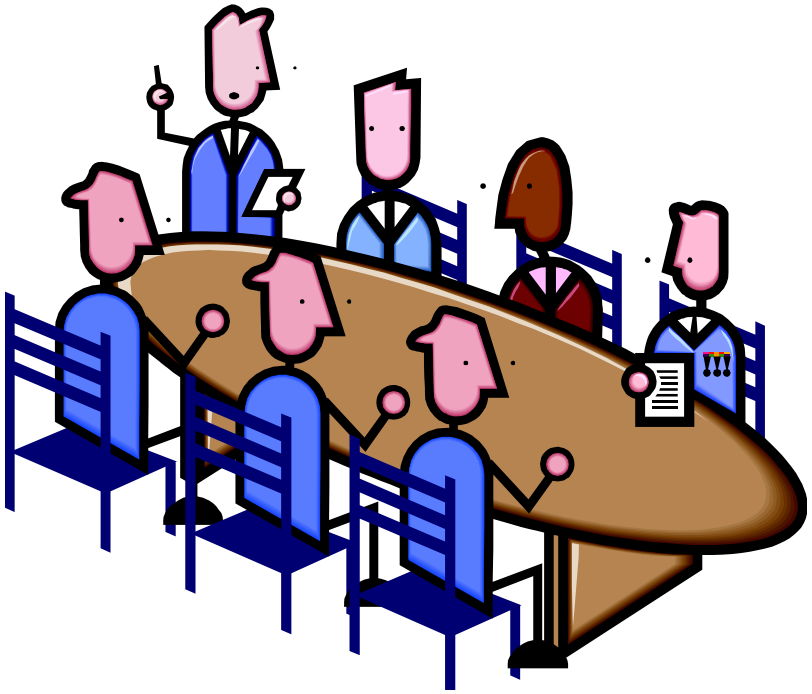
Templates and examples available upon request and in GAPHC Quality Manuals- http://*www.gaphc.org*

Quality Methodology



Data Management & Analysis

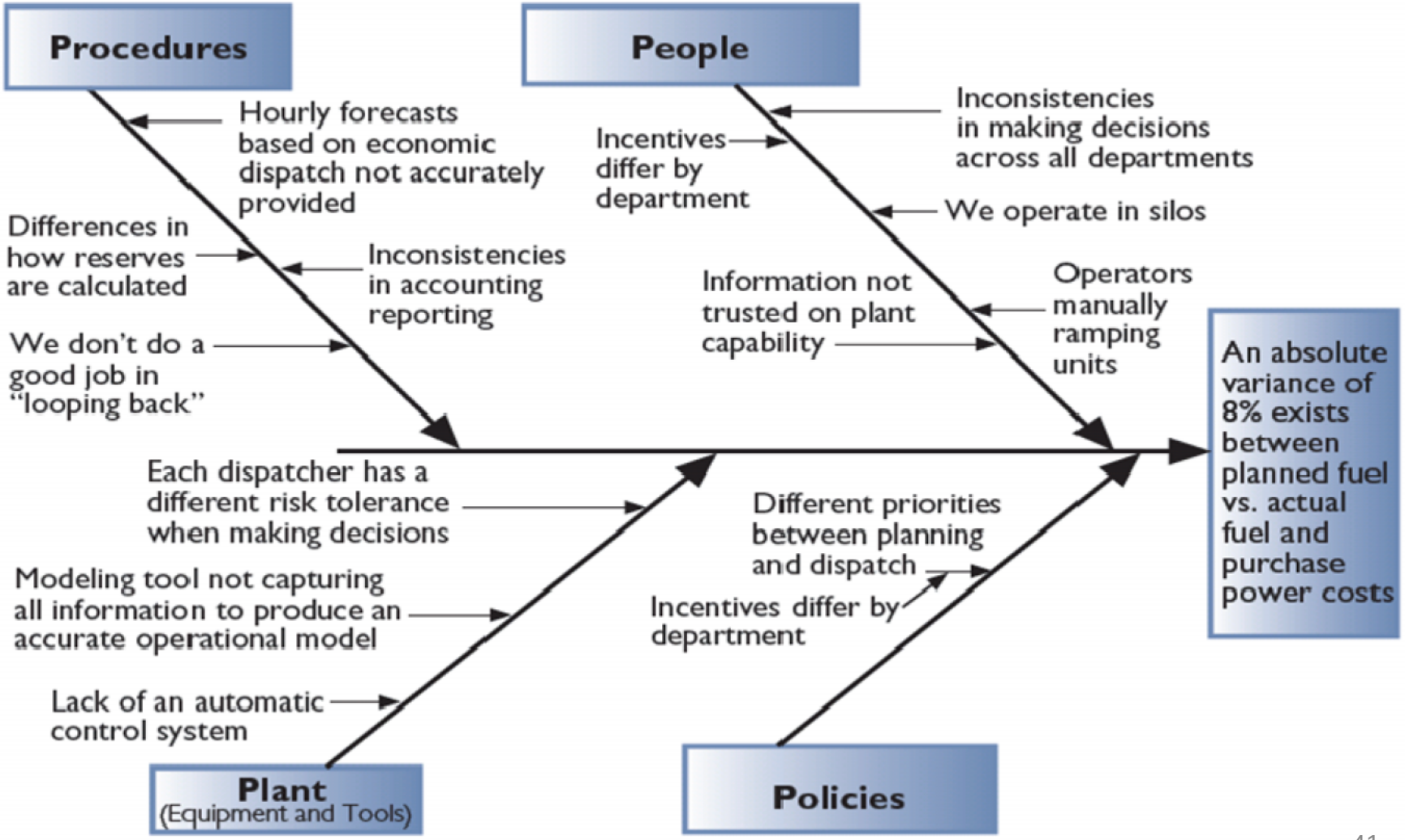
Brainstorming



Cause & Effect/Fishbone

Variance to Plan

From GOAL/ QPC Memory Joggers



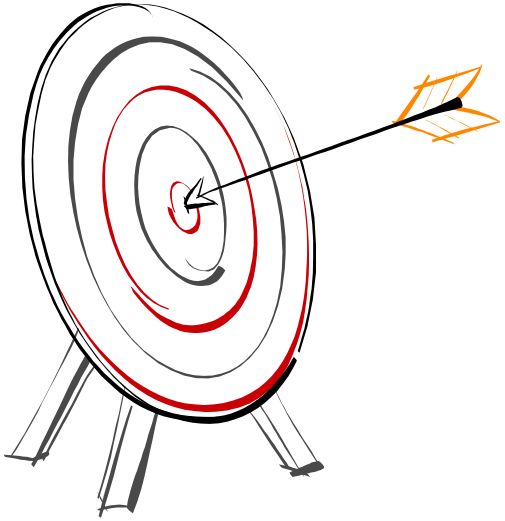
Fishbone Diagram/Cause and Effect Schematic – diagram description

The issue being examined in this example is “an absolute variance of 8% exists between planned fuel vs. actual fuel purchase power costs.” There are four main branches that feed into the overall process that leads to the outcome of interest, the variance between planned versus actual fuel purchase costs. At the top left, there are procedures of interest: hourly forecasts based on economic dispatch not accurately provided, inconsistencies in accounting reporting, differences in how reserves are calculated, and we don’t do a good job in ‘looping back.’ The next main branch at the top right is people, which includes inconsistencies in making decisions across all departments, we operate in silos, operators manually ramping units, information not trusted on plant capacity, and incentives differ by department. At the bottom, the branch called “plant” (equipment and tools) includes lack of an automatic control system, modeling tool not capturing all information to produce an accurate operational model, and each dispatcher has a different risk tolerance when making decisions. The last branch is policies, which includes incentives differ by department, which feeds into different priorities between planning and dispatch.

Improving Processes

From The Team Handbook

Benchmarking & Goals



- National Benchmark
- State Benchmark
- *http://www.hrsa.gov/data-statistics/health-center-data/StateData/index.html*

- FQHC previous year(s)
- FQHC previous audits current year

- Performance Goal
- Pre-set Trigger?

Using and Managing Data

Reporting

Confidentiality

- Protected & Privileged
- The Health Care Quality Improvement Act of 1986, as amended 42 USC Sec. 11101 01/26/98. *Note each state has legislation defining confidentiality and protection for individuals carrying out quality improvement activities*
- Specific requirements for maintaining confidentiality in the organization Signed Attestation = Policy
- Excellent way to remind everyone of the importance of protecting Confidentiality
- Some accreditation agencies require it
- At minimum, Board, QI staff and Quality Committee members, place in HR file

QUALITY INFRASTRUCTURE

Policies & Processes

Policy Templates

available as part of GAPHC Quality Manuals http://*www.gaphc.org*

Policy Number	***Policy Name***	***Summary***	***Regulatory or Standard Related to Policy***	***Rev. Date***
QM-101	QM Program	Describes the organization's quality program to comply with organizational needs, regulatory requirements and accreditations.	HRSA, FTCA http://bphc.hrsa.gov/policiesregulations/policies/index.html	
QM- 102	Quality Committee	Describes the organization's Quality Committee roles and responsibilities.	HRSA, FTCA http://bphc.hrsa.gov/policiesregulations/policies/index.html ***O.C.G.A. § 31-7-15*** [Ga. Code #3910 (GA. L. 1975)]	
QM-103	Quality Minutes	Defines the content, format and storage of quality committees' agenda and minutes, and QM staff responsibilities.	***O.C.G.A. § 31-7-15*** [Ga. Code #3910 (GA. L. 1975)]	
QM-104	Conflict of Interest	Defines conflict of interest for quality activities and provides an attestation sheet.		
QM- 105	Confidentiality	Defines confidentiality for quality activities and provides and confidentiality agreement.	***O.C.G.A. § 31-7-15*** [Ga. Code #3910 (GA. L. 1975)]	
QM-106	Chartering Sub-Committees	Defines the process for chartering sub-committees and ad hoc committees/ teams from the Quality Committee		

Chart description

The headings of the columns are policy number, policy name, summary, regulatory or standard related to policy, and rev. date. The row labels are QM-101, QM-102, QM-103, QM-104, QM-105, and QM-106. The corresponding policy names for these categories, from beginning to end, are QM program, quality committee, quality minutes, conflict of interest, confidentiality, and chartering sub-committees. The corresponding summary comments in the summary column for these categories, from beginning to end, are describes the organization's quality program to comply with organizational needs regulatory requirements and accreditations, describes the organization's quality committee roles and responsibilities, defines the content format and storage of quality committee's agenda and minutes and QM staff responsibilities, defines conflict of interest for quality activities and provides an attestation sheet, defines confidentiality for quality activities and provides and confidentiality agreement, and defines the process for chartering sub-committees and ad hoc committees/teams from the quality committee. The corresponding regulatory or standard related to policy for these categories, from beginning to end, are HRSA FTCA http://bphc.hrsa.gov/policiesregulations/policies/index.html, HRSA FTCA http://bphc.hrsa.gov/policiesregulations/policies/index.htmlO.C.G.A. § 31-7-15 [Ga. Code #3910 (GA. L. 1975)] , O.C.G.A. § 31-7-15 [Ga. Code #3910 (GA. L. 1975)] , blank cell, O.C.G.A. § 31-7-15 [Ga. Code #3910 (GA. L. 1975)] , and the bottom cell is blank. The revised date column is blank.

Policy Templates

available as part of GAPHC Quality Manuals http://*www.gaphc.org*

Policy Number	***Policy Name***	***Summary***	***Regulatory or Standard Related to Policy***	***Rev. Date***
QM-107	QM Plan (Program Description)	Defines the process, timeline, approvals of the Quality Plan and provides a template.	HRSA, BPHC & FTCA; BPHC PIN 98-23, PIN 2001-16, & PIN 2002-22; (42 CFR 51c.303(c)(1-2)	
QM-108	QM Program Workflow	Defines the workflow and approval process for the quality management program.	HRSA, BPHC & FTCA; BPHC PIN 98-23, PIN 2001-16, & PIN 2002-22; (42 CFR 51c.303(c)(1-2)	
QM-109	QM Work Plan Development	Defines the process, timeline, approvals of the Quality Work Plan and provides a template.	HRSA, BPHC & FTCA; BPHC PIN 98-23, PIN 2001-16, & PIN 2002-22; (42 CFR 51c.303(c)(1-2)	
QM-110	Quality Methodology	Defines and describes the method QM staff will use/ direct during all quality projects and programs.		
QM-111	System Improvement: Care Model	Provides the template and defines the components for developing these programs using a tested model.	http://www.ihi.org	
QM-112	QM Program Evaluation	Provides template, rationale for annual development, provides for annual review & required approvals		
QM-113	Policy Development, Review & Approval	Defines how policies will be developed, reviewed, revised and approved, with templates.		

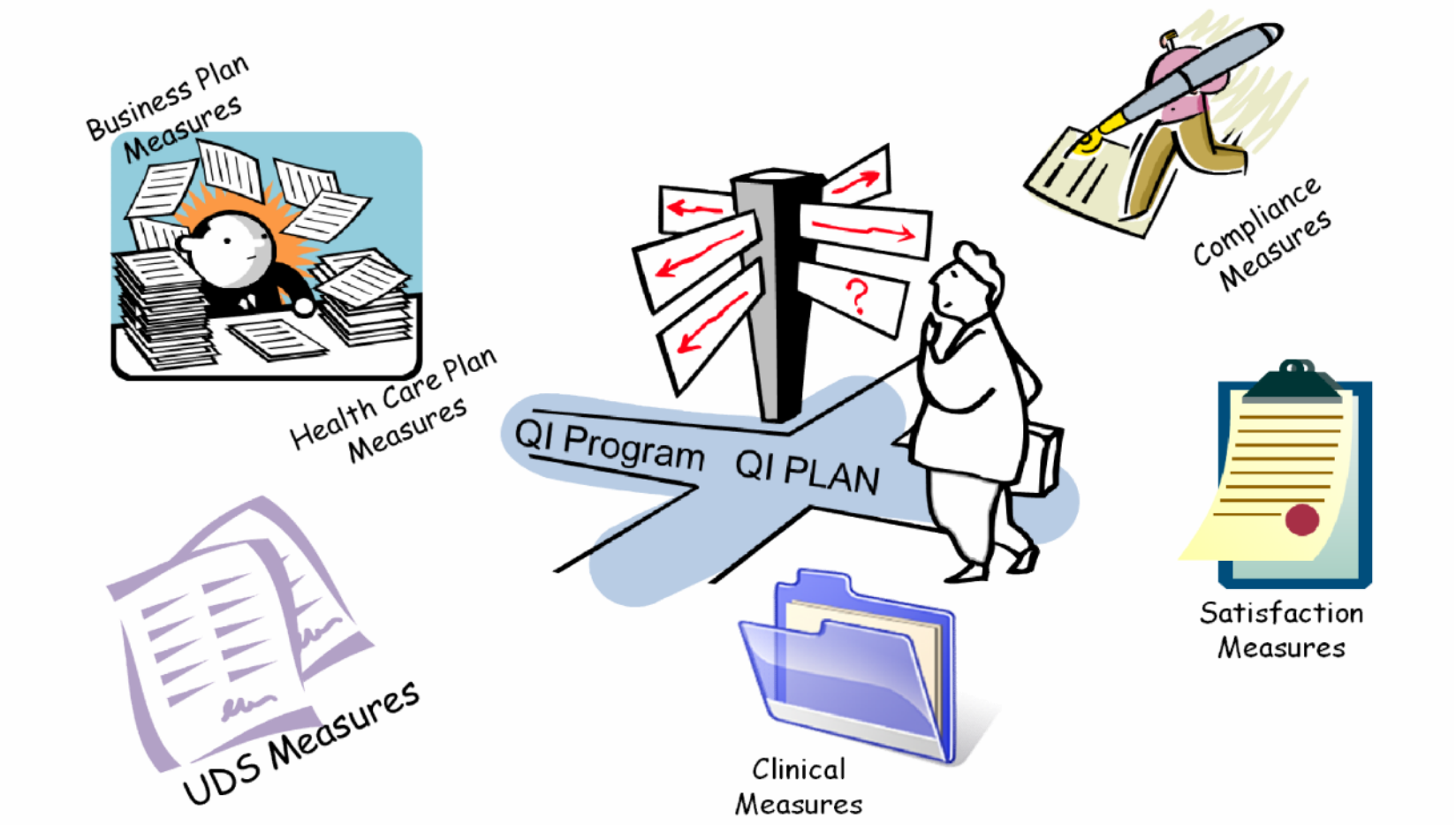
Chart Description

The headings of the columns are policy number, policy name, summary, regulatory or standard related to policy, and revised date. The row labels are QM-107, QM-108, QM-109, QM-110, QM-111, and QM-112. The corresponding policy names for these categories, from beginning to end, are QM plan (program description), QM program workflow, QM work plan development, quality methodology, system improvement care model, QM program evaluation, and policy development review and approval. The corresponding entries in the summary column for these categories, from beginning to end, are defines the process timeline approvals of the quality plan and provides a template, defines the workflow and approval process for the quality management program, defines the process timeline approvals of the quality work plan and provides a template, defines and describes the method QM staff with use/direct during all quality projects and programs, provides the template and defines the components for developing these programs using a tested model, provides template rationale for annual development provides for annual review and required approvals, and defines how policies will be developed reviewed revised and approved with templates. The corresponding regulatory or standard related to policy for these categories, from beginning to end, are HRSA BPHC & FTCA BPHC PIN 98-23 PIN 2001-16 & PIN 2002-22 (42 CFR 51c.303(c)(1-2), HRSA BPHC & FTCA BPHC PIN 98-23 PIN 2001-16 & PIN 2002-22 (42 CFR 51c.303(c)(1-2), HRSA BPHC & FTCA BPHC PIN 98-23 PIN 2001-16 & PIN 2002-22 (42 CFR 51c.303(c)(1-2), blank cell, http://www.ihi.org, and the bottom two cells are blank. The revised date column is blank.

IMPLEMENTATION

Skillful Execution

Closing The Measure Loop



Closing The Measure Loop – Diagram Description

This grouping of illustrations is titled ‘closing the measure loop.’ At the top left are business plan measures and a drawing of a man at a desk piled high with stacks of paper. At the bottom left are UDS measures with a drawing of two pieces of paper with writing on them. In the bottom center is a picture of a folder titled clinical measures. At the bottom right is a clipboard with a piece of paper on it called satisfaction measures. At the top left is a picture of a person holding an oversized pen and signing a piece of paper; it is called compliance measures. In the center is a person at a crossroads of QI program and QI plan considering which way to go.

Performance Measurement

- This section defines the technique (process of HOW) the organization improves quality. In order to be effective, the process must be systematic with continuous activities that lead to measureable improvement. Included here is:
- Indicates who will collect and analyze data
- Indicates who is accountable for collecting, analyzing and reviewing performance data results and communicating findings
- Includes strategies on how to report and disseminate results and findings; communicate information about quality improvement activities
- Describe the process to use data to develop new QI activities and address identified gaps

This section will stimulate several Quality Policies to be developed to support this document.

Performance Measurement

- Performance measurement is necessary to track progress towards the end goal of improvement.
- Steps to measure performance:
  - First, identify the critical aspects of the care and services provided
  - Second determine care and services that are:
    - ✓***High Risk***
    - ✓***High Volume***
    - ✓***Problem Prone***
- Identify indicators to measure these important aspects of care and service to determine organizational performance and identify areas for improvement

Quality Measures Workplan

HRSA Quality Performance Measures

PREVENTION				
Measure	**Definition**	**Data Gathering Plan**	**Goal**	**Notes/Comments**
1. FIRST TRIMESTER CARE	Percentage of pregnant women beginning prenatal care in the first trimester	Numerator: Number of patients who began prenatal care in the first trimester. Denominator: Number of patients who entered prenatal care during the measurement year		
3. BREAST CANCER PREVENTION	Percentage of women 50-69 years of age who had a mammogram	Numerator: One or more mammograms during the measurement year or the year prior to the measurement year. Denominator: All female patients aged 52-69 years of age at the beginning of the measurement year or year prior to the measurement year		
4. CERVICAL CANCER PREVENTION	Percentage of women 18-64 years of age who received one or more Pap tests	Numerator: One or more Pap tests during the measurement year or the two years prior to the measurement year. Denominator: All female patients age 21-64 years of age during the measurement year		

Quality Measures Workplan – chart description

This slide is a quality measures workplan It lists HRSA quality performance measures: first trimester care, breast cancer prevention, and cervical cancer prevention in three rows. The columns are titled measure, definition, data gathering plan, goal and notes/comments. The last two columns are blank. The definitions of the measures, in order, are Percentage of pregnant women beginning prenatal care in the first trimester, Percentage of women 50-69 years of age who had a mammogram, and Percentage of women 18-64 years of age who received one or more Pap tests. The data gathering plans are Numerator Number of patients who began prenatal care in the first trimester Denominator Number of patients who entered prenatal care during the measurement year; Numerator One or more mammograms during the measurement year or the year prior to the measurement year Denominator All female patients aged 52-69 years of age at the beginning of the measurement year or year prior to the measurement year; and Numerator One or more Pap tests during the measurement year or the two years prior to the measurement year Denominator All female patients age 21-64 years of age during the measurement year.

Quality Calendar

	Measure	Goal %	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1	Prenatal care of patients who delivered during the current year including:		x				x			x			x	
	a) Trimester of first known visit ,		x				x			x			x	
	b) Deliveries preformed by CHC provider,		x				x			x			x	
	c) Birth weight < 1500 grams/ 1501- 2499 grams/> 2500 grams		x				x			x			x	
2	Childhood Immunizations: number of children who have received required vaccinations that had their 2nd birthday during measurement year.		x			x				x				x
3	Number of female patients aged 21-64 who have had at least one PAP test performed during the measurement year OR during one of the previous two years.			x				x			x			x
4	Hypertension> Percentage of patients >18 years with diagnosis of hypertension whose blood pressure was <140/90 at the time of the last reading.				x			x			x			x
5	Diabetes> Total Number of patients >18 years with diagnosis of diabetes Type I or II					x				x				x
	a) Patients with HBA1c <7%					x				x				x
	b) Patients with HBA1c >7%					x				x				x
	c) Patients with HBA1c equal to or less than 9%					x				x				x
	d) Patients with HBA1c >9%					x				x				x
6	Satisfaction Survey Patient			x							x			
7	UDS Measures are collected annually		x											
8	Dental Measure			x			x			x			x	
9	Behavioral Health Measure			x			x			x			x	

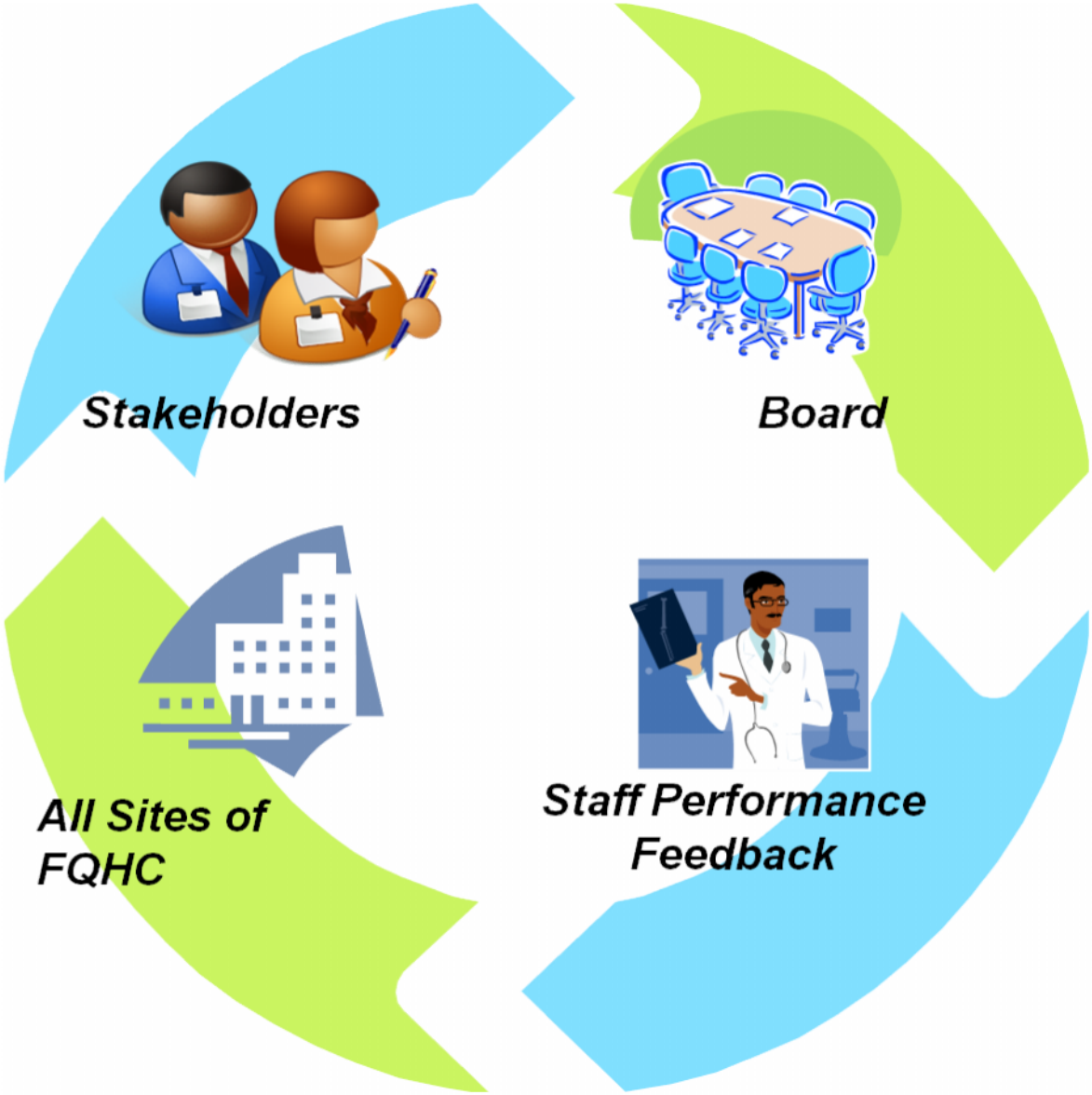
Quality Calendar – chart description

This slide depicts a chart that is a quality calendar. The columns are measure and goal percentage, followed by each month of the year in order. The measures are Prenatal care of patients who delivered during the current year including a) Trimester of first known visit, b) Deliveries preformed by CHC provider, and c) Birth weight < 1500 grams/ 1501- 2499 grams/> 2500 grams. Childhood Immunizations: number of children who have received required vaccinations that had their 2nd birthday during measurement year. Number of female patients aged 21-64 who have had at least one PAP test performed during the measurement year OR during one of the previous two years. Hypertension> Percentage of patients >18 years with diagnosis of hypertension whose blood pressure was <140/90 at the time of the last reading. Diabetes> Total Number of patients >18 years with diagnosis of diabetes Type I or II, a) Patients with HBA1c <7%, b) Patients with HBA1c >7%, c) Patients with HBA1c equal to or less than 9%, d) Patients with HBA1c >9%. Satisfaction Survey Patient, UDS Measures are collected annually, dental measure, and behavioral health measure. There are x marks placed in various months to indicate when each measure will be used.

QUALITY

Communication

Quality Communication



Quality Measure/Indicator Chart

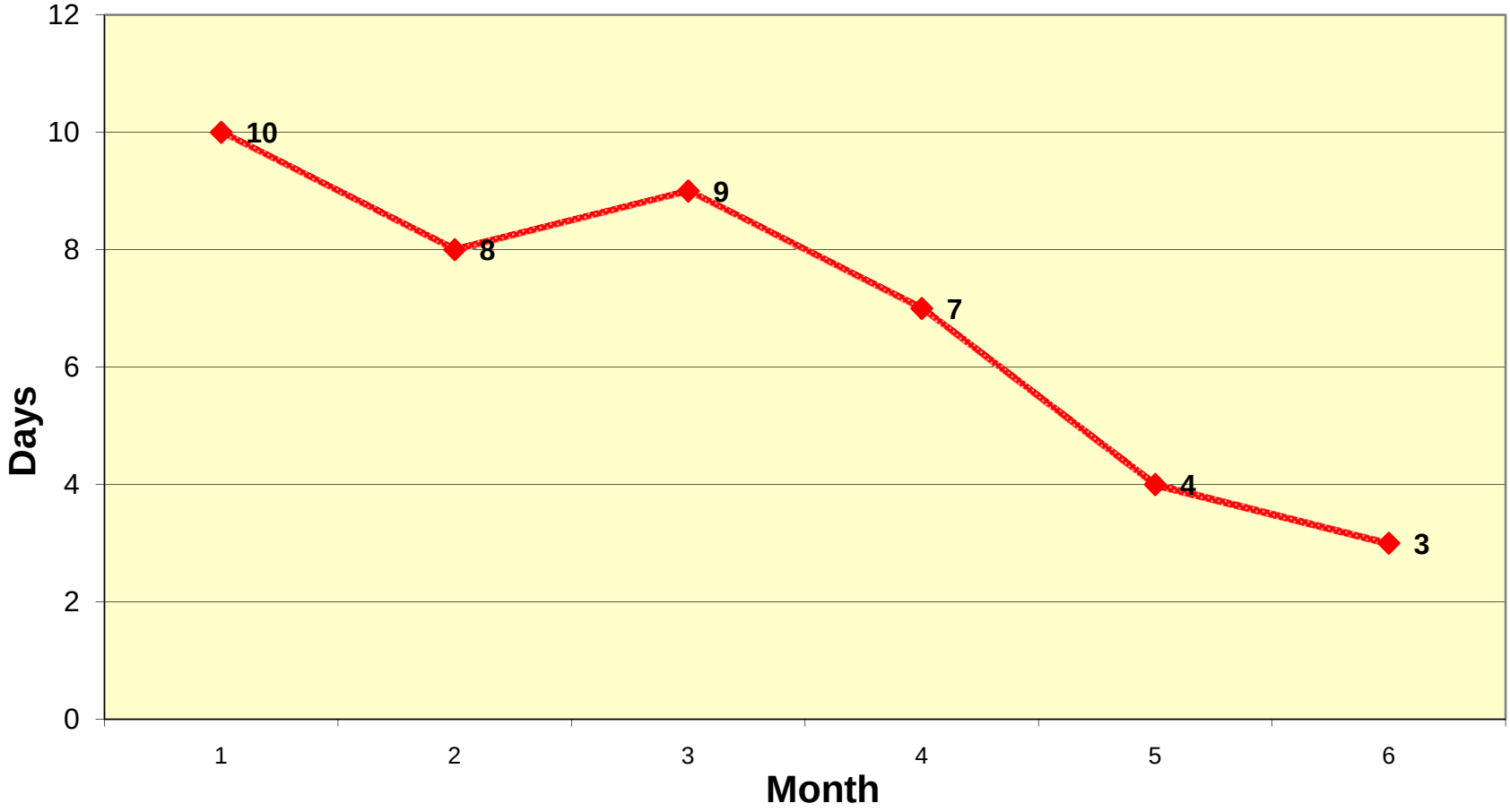
Template available upon request jwilkerson@gaphc.org

Report Frequency	Quality Measure / Indicator	Totals with Numerator	Denominator	Percentage	National Benchmark	Last Report Results	Organizational GOAL	Comments
	UDS CLINICAL MEASURES REQUIRED ALL FQHC							
REPORT BI-MONTHLY FEB (100% PER UDS Report) / APRIL / JUNE / AUG / OCT / DEC	*Children fully immunized on their 2nd birthday*			#DIV/0!				
	Children and adolescents aged 2-17 with a BMI percentile			#DIV/0!				
	Documented Pt. counseling on nutrition and physical activity documented for the current year			#DIV/0!				
	Adult patients aged 18 and overwith (1)BMI charted and (2) follow-up plan documented if patients are overweight or underweight			#DIV/0!				
	Documented Pt. counseling on nutrition and physical activity documented for the current year			#DIV/0!				
	Adult women (age 24 –64) with a "current" Pap test during measurement year or prior two years (2009 – 2010)			#DIV/0!				
	Number of patients age 18 years and older who were queried about tobacco use one or more times within 24 months.			#DIV/0!				

Quality Measure/Indicator Chart -chart description

This slide depicts a chart to fill in for each quality measure/indicator. The UDS clinical measures required for all FQHC are the rows: Children fully immunized on their 2nd birthday, Children and adolescents aged 2-17 with a BMI percentile, Documented Pt. counseling on nutrition and physical activity documented for the current year, Adult patients aged 18 and over with (1)BMI charted and (2) follow-up plan documented if patients are overweight or underweight, Documented Pt. counseling on nutrition and physical activity documented for the current year, Adult women (age 24 –64) with a "current" Pap test during measurement year or prior two years (2009 –2010), Number of patients age 18 years and older who were queried about tobacco use one or more times within 24 months. The columns are totals with numerator, denominator, percentage, national benchmark, lab report, organizational goal, and comments. They are all blank except the percentage column, which is filled with #DIV/0!.

3rd Available Appointment



3rd Available Appointment - graph description

This slide is a line graph depicting the time until the third available appointment. The y axis is days and ranges from zero to 12. The x axis is months and ranges from zero to 6. The values for each month in sequence are: 10, 4, 9, 7, 4, and 3.

Checklist for Creating An Effective Storyboard

Adapted from GOAL/QPC *Problem Solving Memory Jogger pgs 121-134*

ASK	☑	Check for YES
Does it describe the problem?	☑	Describe the team's task and why the project was chosen
Does it address a customer-related problem?	☑	Shows the relationship of the team's objectives to the organization's objectives
Is it eye-catching and interesting?	☑	Use photos, graphs, cartoons as appropriate – depending on the audience
Is it clear to people at all levels?	☑	Explains any abbreviations and technical terms – no jargon please! – graphics and text are apparent – easily understood
Does it logically describe the sequence of actions taken by the team?	☑	P-D-S-A cycle summaries provide logical sequencing that is understandable to the audience
Are the measures clearly depicted in graphs?	☑	Report on clear measures of success – do not expect the audience to "ASSUME" an improved outcome. Relate back to team and organizational objectives. Graphs are clear and labeled for ease of understanding. NO "busy-ness"!

Checklist for Creating An Effective Storyboard – chart description

- **Ask:** Does it describe the problem?
- **Check for YES:** Describe the team's task and why the project was chosen

- **Ask:** Does it address a customer-related problem?
- **Check for YES:** Shows the relationship of the team's objectives to the organization's objectives

- **Ask:** Is it eye-catching and interesting?
- **Check for YES:** Use photos, graphs, cartoons as appropriate – depending on the audience

- **Ask:** Is it clear to people at all levels?
- **Check for YES:** Explains any abbreviations and technical terms – no jargon please! – graphics and text are apparent – easily understood

- **Ask:** Does it logically describe the sequence of actions taken by the team?
- **Check for YES:** P-D-S-A cycle summaries provide logical sequencing that is understandable to the audience

- **Ask:** Are the measures clearly depicted in graphs?
- **Check for YES:** Report on clear measures of success – do not expect the audience to "ASSUME" an improved outcome. Relate back to team and organizational objectives. Graphs are clear and labeled for ease of understanding. NO "busy-ness"!

“Data is a lot like garbage.

You have to know what you are going to do with the stuff BEFORE you start collecting it.”

Mark Twain

Next Steps

Annual Program Evaluation

- Reference policy and format
- Summary description of mechanism
- Reporting process
- Who is responsible for developing, reviewing and approving
- Frequency – usually annually

Back to PDSA: WORK THE PLAN

Step 1:

- Develop the Quality Improvement Plan; development/ revisions are based on:
- The organization (system)
- Population & services provided
- External requirements (HRSA, accreditation)

Step 2:

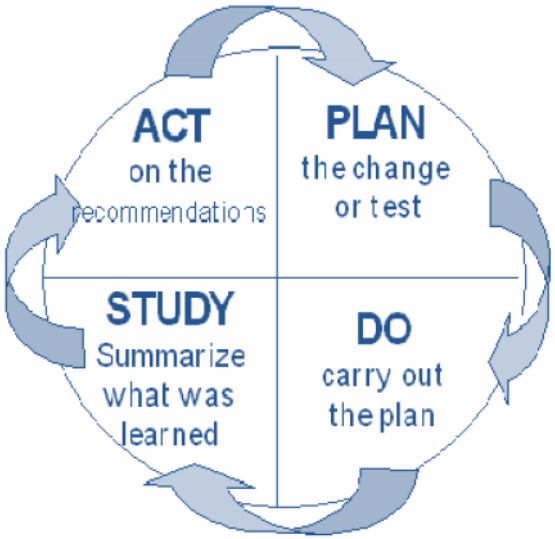
- Implement the Quality Improvement Plan
- Use the QI Plan as the roadmap for implementing an integrated quality program system-wide

Step 3:

- Evaluate the Quality Improvement Plan
- Did you do what you said you were going to do?
- Why? Why not?
- What were the results?
- How can next year be better?

Step 4:

- Act on the lessons learned to revise the Quality Improvement Plan for the next year



Quality Resources

- The Team Handbook – 3rd Edition; Scholtes/ Joiner/ Streibel : Amazon.com → *http://www.amazon.com/Team-Handbook-Third-Peter-Scholtes/dp/1884731260*
- *GOAL/ QPC Memory Joggers* *http://www.goalqpc.com/shop_products.cfm?ProductShopBy=7*
- NAHQ Guide to Quality Management, 8th edition, Handbook for Improvement, 1997 ; *http://www.nahq.org/*
- HRSA Quality Matrix – Performance Measures *http://www.hrsa.gov/healthit/coremeasures.html*
- *GAPHC Quality Management Plan Template & Manuals , Jan Wilkerson, RN, CPHQ; http://www.gaphc.org*

Quality Resources

- NCQA- *http://www.ncqa.org/tabid/1196/Default.aspx*
- IHI *http://www.ihi.org/IHI/Results/WhitePapers/*
- AHRQ *http://www.ahrq.gov/clinic/epcix.htm*
- Institute for Clinical Systems Improvement *http://www.icsi.org/*
- *UDS Manual*, -HRSA; *http://www.hrsa.gov/data-statistics/health-center-data/reporting/2010manual.pdf*
- NACHC – http://*www.nachc.org ; Information Bulletin #15: Using Information Technology to Improve Quality*
- *UDS Benchmark National & State: http://bphc.hrsa.gov/healthcenterdatastatistics/index.html*

Measures Resources

Use nationally [standardized] developed measures, rather than developing your own

- HRSA Clinical Quality Performance Measures
  http://www.hrsa.gov/healthit/coremeasures.html
  Healthy People (2010 & 2020)
  http://www.healthypeople.gov/About/
- National Forum *http://www.qualityforum.org/*
- Agency for Healthcare Quality & Research
  http://www.ahrq.gov/
- NCQA HEDIS® Measures
  http://www.ncqa.org/tabid/59/Default.aspx

Resources

- FTCA for Health Centers:
  http://bphc.hrsa.gov/FTCA/

- FQHC PIN & PALS:
  http://bphc.hrsa.gov/policiesregulations/policies/index.html

Investigating An Out Of Control Process: Questions to Ask

1. Was a new collection tool/ method used?
2. Were all staff consistent in collection method?
3. Is process affected by new or significant change in environment?
4. Is process affected by predictable conditions?
5. Any new or untrained staff involved in the process during measurement period?
6. Change in resource for input to the process?
7. Is process affected by employee fatigue?
8. Has there been a change in policy/procedure?
9. Is process adjusted frequently?
10. Did sample come from different parts of the process?
11. Are new employees afraid to report?

Discussion and Questions

- Please share your quality improvement successes, challenges, and training and technical assistance needs
- Contact your HRSA Project Officer or the Office of Quality and Data at OQDcomments@hrsa.gov or (301) 594-0818