



The Quality Journey: Paths to High Performance

Bureau of Primary Health Care
Grantee TA Call

June 7, 2011

BPHC/Office of Training and Technical Assistance Coordination



Learning Objectives



By the end of the call, participants should:

- Understand BPHC's approach to Quality Improvement/Performance Improvement
- Be able to describe a few contributors to high performance in health centers, based on recent research
- Be aware of training and TA resources for health centers to support Quality Improvement/Performance Improvement



Agenda



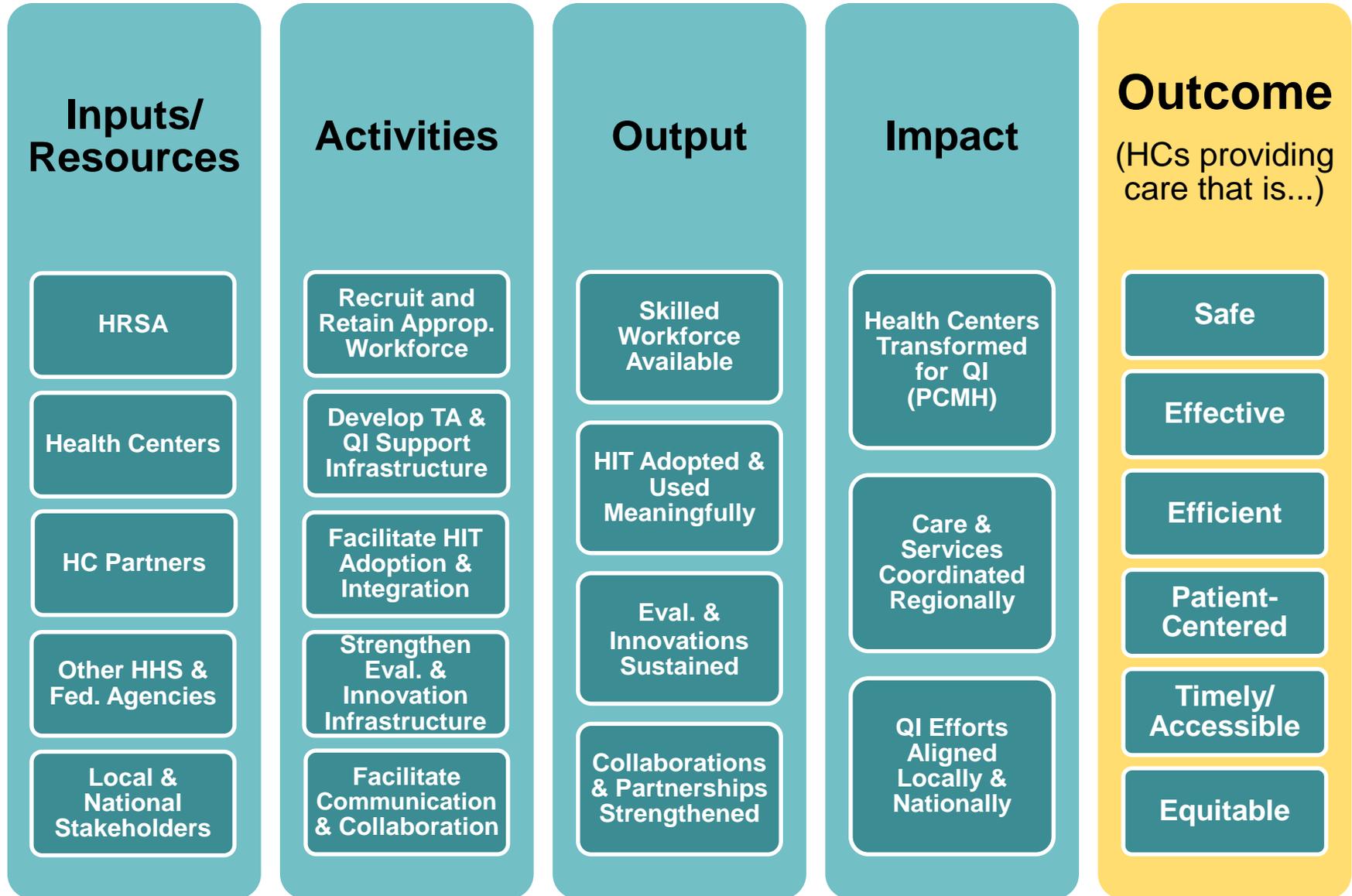
- BPHC Strategy for Quality Improvement
- Recent Research on High Performing Health Centers
- Resources and Next Steps
- Q&A Session
- Additional Opportunities to Provide Feedback



- Improve Access to Quality Health Care and Services
 - New Access Points
 - Patient-centered medical/health home development
 - Clinical performance improvement
- Strengthen the Health Workforce
 - Workforce recruitment and retention
 - Meaningful use adoption
- Build Healthy Communities and Improve Health Equity



BPHC QI Strategy Framework





BPHC Quality Initiatives



- **Quality Improvement Program Policies**
 - QI Plan Assessment and Framework
 - FTCA Application Process
 - Draft Quality Improvement PIN & Report to Congress
- **Clinical Performance Improvement**
 - UDS Summary and Trend Reports
 - Public Private Partnerships
 - Clinical Quality Forums
 - Best Practices/High Performers
- **Adoption and Meaningful Use**
- **National Quality Recognition**

Among Health Center Patients:

- 67.3% entered prenatal care in the first trimester
- Rate of low birth weight babies (7.3%) continues to be lower than national estimates (8.2%)
- 68.8% of children received all recommended immunizations by 2nd birthday
- 63.1% Hypertensive Patients with Blood Pressure \leq 140/90
- 70.7% Diabetic Patients with HbA1c \leq 9
- \$600 Total Cost per Patient
- \$131 per Medical Visit



For more information: <http://www.bphc.hrsa.gov/about/performanceasures.htm>

Source: Uniform Data System, 2009



Health Center Patient Survey Calendar Year 2009



- **Over 80%** reported the overall quality of services received at the health center were “**excellent**” or “**very good.**”
- **Over 80%** reported that they were “**very likely**” to **refer friends and relatives** to the health center.
- **Over 75%** reported the main reason for “going to the health center for healthcare instead of someplace else” was because it was **convenient** (28%), **affordable** (25%), and provided **quality healthcare** (22%).



Clinical Performance Improvement Monitoring Quality of Care



Uniform Data System (UDS) Clinical Measures

Current Measures

- Low birth weight babies
- Entry into prenatal care
- Childhood immunization
- Pap tests
- Adult hypertension (blood pressures)
- Adult diabetes (HbA1c levels)

Proposed for 2011

- MU Alignment of Immunization, HTN & DM measures
- Child & adolescent weight assessment & counseling
- Adult weight screening & follow up
- Tobacco use assessment & counseling
- Asthma therapy (pharmacologic)



Adoption and Meaningful Use of HIT



- **Goal: 100% of Health Centers meaningfully use a certified EHR system**
- **Where are we?**
 - Baseline data collection – EHR questions in UDS, HCs participating in HCCNs
 - Other data sources – REC program, GW Survey, CDC NAMCs survey
- **Strategy**
 - HRSA Training/TA – webinars, workshops, tool kits, etc
 - HCCNs/PCAs/National Cooperative Agreements
- **Partnerships/Collaborations**
 - CMS EHR Incentive Program
 - ONC REC Program, State HIE Program, Beacon Communities, Community College Program



National Quality Recognition



- **Goal: 100% of Health Centers receive national quality recognition**
- **Where are we?**
 - Accreditation
 - Patient Centered Medical Home Recognition
- **Strategy**
 - Accreditation Initiative/PCMH Initiative
 - CMS Medicare APC Demo
 - QI/PCMH Transformation Grants
 - Training/Technical Assistance

Achieving Excellence in Community Health Centers

**Presented at: Health Resources and Services Administration (HRSA),
Bureau of Primary Health Care (BPHC),
Grantee Enrichment Technical Assistance Call**

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Texas Association of Community Health Centers (TACHC)**



Presentation Outline

- Introduction
- Study Methods
- Study Findings
- Conclusions, Strengths and Limitations



Study Aims

1. Identify community health centers (CHCs) that perform especially well on care quality and cost
2. Pinpoint operational practices associated with high performing CHCs



Study Background

- Performance varies within all provider types
 - High and low performers of all types
- Understanding which providers perform especially well is key to system-wide improvements
- CHCs positioned to play key role in health reform
 - Know little about cost; nothing about variation
- Study designed in this context

IOM 2001

Berwick et al. 2003



Methods Overview

- Claims analysis to identify high performing CHCs
- Case studies to understand operational drivers of high performance



Claims Analysis

- Data and Sample
 - California (CA), Massachusetts (MA), Texas (TX)
 - Medicaid Analytic Extract Files (MAX); Uniform Data System (UDS)
 - Beneficiaries whose usual source of care was a CHC
- Measures and Analysis
 - Quality and cost measures
 - Regression analysis controlling for covariates (e.g., health status)
- Results
 - Determine CHC performance *relative to other CHCs in same state*
 - Identify high performing (“above average”) CHCs in each state



Performance Measures

Quality Measures*

1. Well child visits (0 to 15 months)
2. Well child visits (3 to 18 year olds)
3. Timely prenatal care
4. Timely post-partum care
5. Avoidable hospitalizations
6. Avoidable ER use

Cost Measures

1. Outpatient services (including pharmacy and labs)
2. Inpatient services (including ER)
3. Total services (inpatient and outpatient combined)

* Adapted from Healthcare Effectiveness Data Information Set (HEDIS) and Billing 2003.



Case Studies

- Sample and Data
 - Select high performers (N=8)
 - Site visits and key informant interviews (administrators, clinical department heads, etc)
- Interview guides
 - Patient-Centered Medical Home (PCMH) elements
 - Other social supports for patients
- Analysis
 - Code interviews
 - Identify common operational practices across sites



Findings



1. Facilitate Care Access

- Extend operating hours
- Manage patient appointments
 - Prompt patients for upcoming visits
 - Conduct active follow-up for missed appointments
- Invest in wait-time reduction strategies
 - Open scheduling, walk-in centers, reduce no-show rate
 - Enhance ability to meet same-day appointment requests



2. Manage Referral System

- Referral relationships with specialists
 - Proximity of public hospital key (when available)
 - Dedicated staff to build relationships also key
- Centralize and expand referral staff functions
 - Secure and schedule
 - Track and follow up
 - Manage and flag negative reports



3. Support Providers

- Use care team model
 - Extensive use of non-physician staff (LVNs, MA, etc.) to support clinical function
- Actively integrate clinical and support services
 - Pods and other physical groupings
 - Proximity
 - Morning “huddles”
- Provide decision-support
 - Prompts at point of care about appropriate services



3a. Provider Support *Examples*

- Small rural CHC with electronic health records still relies on support staff (nurse health educator) to develop daily “cheat sheet” (decision-support) for providers. Low tech but effective.
- Medium-sized urban CHC facilitates integration of clinical and support/social services by defining dual role for LVNs who work part-time as case manager (track at-risk patients) and part-time as nurse (seeing patients).
- Several site emphasized use of standing orders where possible (e.g., foot exams, UTIs)



4. Support Patients

- Target services to high risk groups
 - Case managers and health educators key
- Secure sustainable funding
 - Funders with vested interest (e.g., hospitals, universities) more reliable than traditional funders (e.g., grants)
- Provide link to community services
 - Enrollment in safety-net programs, job training, etc.
 - Helps facilitate medical “homeness”



4a. Patient Support *Examples*

- CHC participating in P4P managed care contract, staffs case managers (LVNs) to manage patients with chronic disease and ensure evidence-based guideline compliance. Increased revenue offsets cost of case managers.
- Medium size urban CHC adopted mobile HIT that allows outreach workers to determine eligibility, schedule appointments in field, and patient navigation
- Medium size urban CHC designed health coaching program, where MAs review medications and orders with patients after visit, and follow up 1-2 weeks later



4a. Patient Support *Examples*

(continued)

- Large urban CHC received grant to train community residents as MAs who now assist CHC providers to deliver culturally competent care
- Recruit and train undergraduates from local university to support and advocate for pregnant mothers throughout pregnancy
- Medium size urban CHCs serving predominantly non-English speaking patient population has translators and cancer navigators based at and funded by hospital



5. Effect Performance Improvement

- Measurement good but not sufficient
 - All report UDS quality measures
 - Some use data for care improvement
- Be in a learning mode
 - Understand and act on information
 - Practice re-design and on-going assessment key
- Pay for performance (P4P)
 - Mainly around productivity measures
 - Quality being considered



5a. Quality Improvement Examples

- Performance monitoring found diabetic foot exam rate low. Efforts and inquiry eventually attributed low rates to “providers don’t like to do foot exams.” Trained MA and nurses to do exams and rates improved.
- In response to high no show rate, patient survey found cost of care a barrier. CHC adopted more pro-active payment plan policy. At another site, incentive program developed around no-show rate reduction.
- In response to low mammography rates, CHC conducted more health education fairs and started mammography van.



Conclusions, Strengths and Limitations



Conclusions

- Drivers of performance reflect core PCMH elements
 - Extensive systems to facilitate care access
 - Comprehensive management of referrals
 - Integration of clinical and support staff
 - Robust and targeted patient supports
 - Pro-active performance improvement programs
- One-size-does-not-necessarily-fit-all
 - Specific strategies within core elements may look different for different patient populations and practices



Conclusions (cont.)

- CHCs valued member of delivery system
- Era of performance reporting upon us
 - Much to be learned from high and low performers
- CHC contributions outside study scope
 - Care for uninsured, access
 - Important to capture and study



Strength and Limitations

- Strengths
 - Mixed methods
 - Large and diverse case study sample
- Limitations
 - Generalizability of findings
 - Performance based on Medicaid FFS patients only
 - Five-year lag between claims data and site visits



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Research Team

- Project Directors
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- Additional Site Visit Staff
 - Jenna Sirkin and Walter Leutz
 - John Capitman and Diana Traje (CVHPI*)

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Thank You

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The Quality Journey: Next Steps



- BPHC Resources and Next Steps
 - Current Resources
 - Resources in Development
 - Future Plans
- Related Work and Resources of NCA Partners
 - NACHC
 - Capital Link



Selected Resources – BPHC



- BPHC Technical Assistance Website
<http://bphc.hrsa.gov/technicalassistance/index.html>
 - Links to TA resources in areas of Needs Assessment, Services, Management & Finance, and Governance
- HRSA Patient-Centered Medical/Health Home Initiative
<http://bphc.hrsa.gov/policiesregulations/policies/pal201101.html>
- Health Center Site Visit Guide
<http://bphc.hrsa.gov/policiesregulations/centerguide.html>
 - Includes self-assessment questions and resources for performance improvement



BPHC – Future Resources



- Case Studies in Development
 - UDS Data Analysis
 - Project Officer Feedback

- Additional Resources
 - Share your Feedback and “Success Stories”



NACHC: Exploration of Great Community Health Centers

- Literature Reviews, Focus Groups, Interviews
- 6 Attributes of Great CHCs:
 - Patient-centeredness
 - Partnership and linkage
 - Focus on outcomes
 - Patient care is managed
 - The right people are selected and retained
 - Clinical practice follows evidence-based practice
- Next Steps
 - Develop resources and tools (e.g., observation template to assess elements of greatness)

<http://www.nachc.com/magazine-article.cfm?MagazineArticleID=186>



Capital Link

- Study for California HealthCare Foundation
- Examining relationship between operational and staffing patterns and health center financial success
- Financial data, UDS data, case studies
- Results will be disseminated via:
 - Report
 - Case studies
 - Training and TA at local, regional, national levels





Thank You



Thank you for participating in today's call on
The Quality Journey: Paths to High Performance.

Please share your feedback & success stories with Lisa Wald
in OTTAC (lwald@hrsa.gov):

- Was this call helpful to you?
- What additional resources would further your work towards improved performance?
- Do you have a “success story” to share with others?