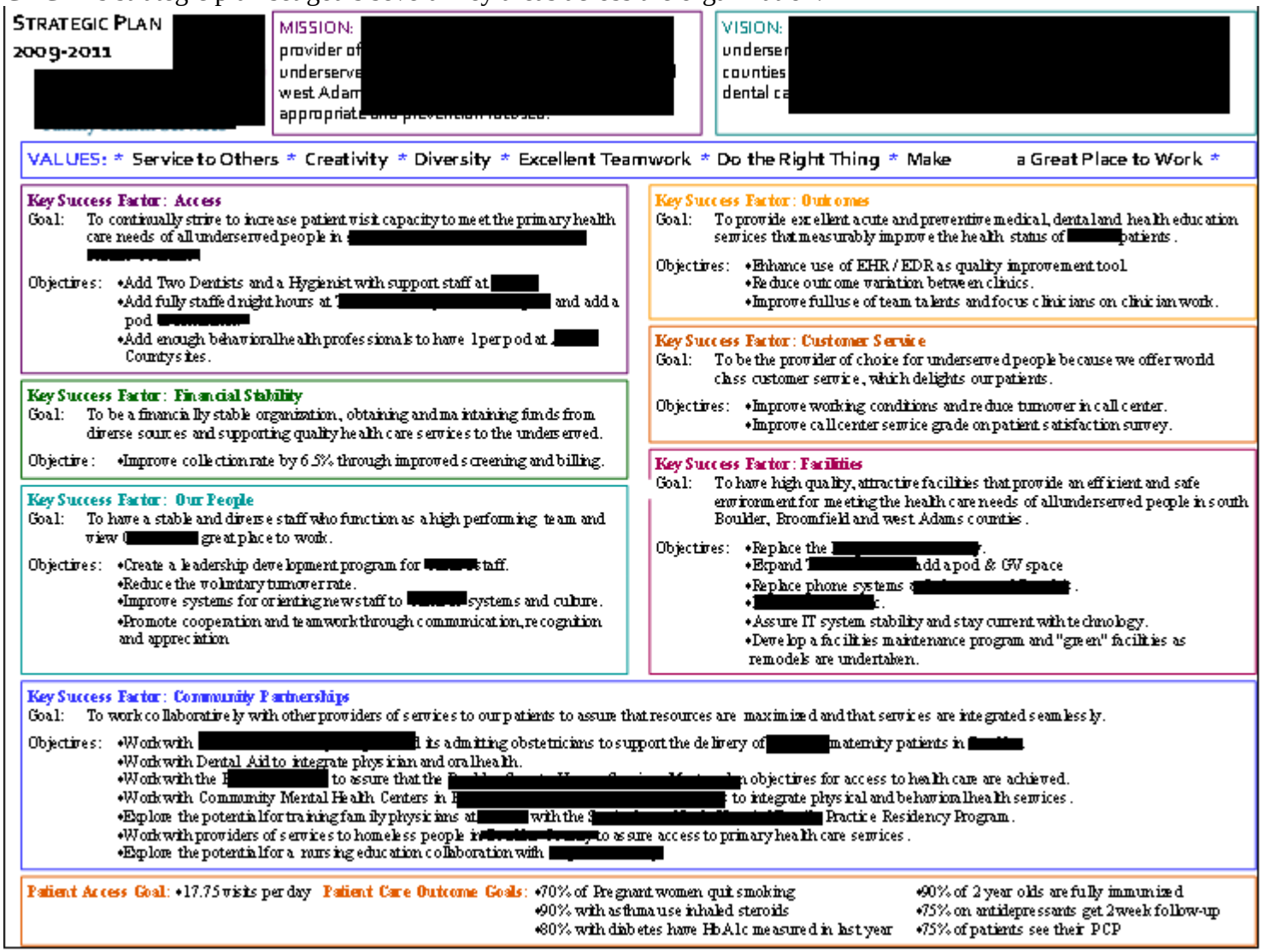
PPC 8: PERFORMANCE REPORTING AND IMPROVEMENT
Element D: Setting Goals and Taking Action

Item 1: Set goals based on measurement results in Elements A and B

CHC-A's strategic plan set goals several key areas across the organization.



STRATEGIC PLAN
2009-2011
[redacted]

MISSION:
provider of [redacted]
underserve [redacted]
west Adam [redacted]
appropriate [redacted]

VISION:
underser [redacted]
counties
dental ca [redacted]

VALUES: * Service to Others * Creativity * Diversity * Excellent Teamwork * Do the Right Thing * Make a Great Place to Work *

Key Success Factor: Access
Goal: To continually strive to increase patient visit capacity to meet the primary health care needs of all underserved people in [redacted]

Objectives:
- Add Two Dentists and a Hygienist with support staff at [redacted]
- Add fully staffed night hours at [redacted] and add a pod [redacted]
- Add enough behavioral health professionals to have 1 per pod at [redacted] County sites.

Key Success Factor: Financial Stability
Goal: To be a financially stable organization, obtaining and maintaining funds from diverse sources and supporting quality health care services to the underserved.

Objective:
- Improve collection rate by 6.5% through improved screening and billing.

Key Success Factor: Our People
Goal: To have a stable and diverse staff who function as a high performing team and view [redacted] great place to work.

Objectives:
- Create a leadership development program for [redacted] staff.
- Reduce the voluntary turnover rate.
- Improve systems for orienting new staff to [redacted] systems and culture.
- Promote cooperation and teamwork through communication, recognition and appreciation

Key Success Factor: Outcomes
Goal: To provide excellent acute and preventive medical, dental and health education services that measurably improve the health status of [redacted] patients.

Objectives:
- Enhance use of EHR / EDR as quality improvement tool.
- Reduce outcome variation between clinics.
- Improve full use of team talents and focus clinicians on clinician work.

Key Success Factor: Customer Service
Goal: To be the provider of choice for underserved people because we offer world class customer service, which delights our patients.

Objectives:
- Improve working conditions and reduce turnover in call center.
- Improve call center service grade on patient satisfaction survey.

Key Success Factor: Facilities
Goal: To have high quality, attractive facilities that provide an efficient and safe environment for meeting the health care needs of all underserved people in south Boulder, Broomfield and west Adams counties.

Objectives:
- Replace the [redacted].
- Expand [redacted] add a pod & GV space
- Replace phone systems [redacted].
- [redacted].
- Assure IT system stability and stay current with technology.
- Develop a facilities maintenance program and "green" facilities as remodels are undertaken.

Key Success Factor: Community Partnerships
Goal: To work collaboratively with other providers of services to our patients to assure that resources are maximized and that services are integrated seamlessly.

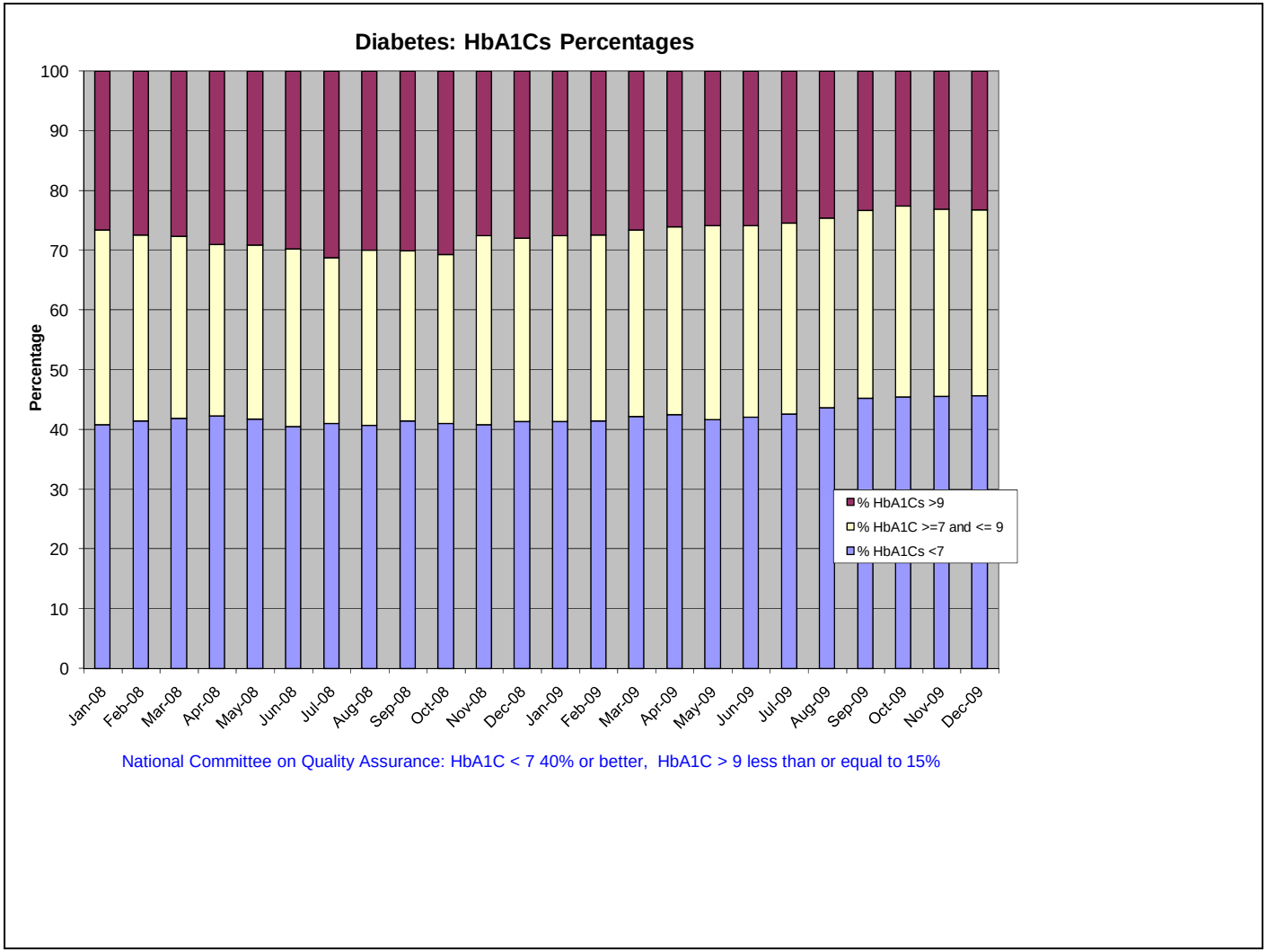
Objectives:
- Work with [redacted] its admitting obstetricians to support the delivery of [redacted] maternity patients in [redacted].
- Work with Dental Aid to integrate physician and oral health.
- Work with the [redacted] to assure that the [redacted] objectives for access to health care are achieved.
- Work with Community Mental Health Centers in [redacted] to integrate physical and behavioral health services.
- Explore the potential for training family physicians at [redacted] with the [redacted] Practice Residency Program.
- Work with providers of services to homeless people in [redacted] to assure access to primary health care services.
- Explore the potential for a nursing education collaboration with [redacted]

Patient Access Goal: •17.75 visits per day

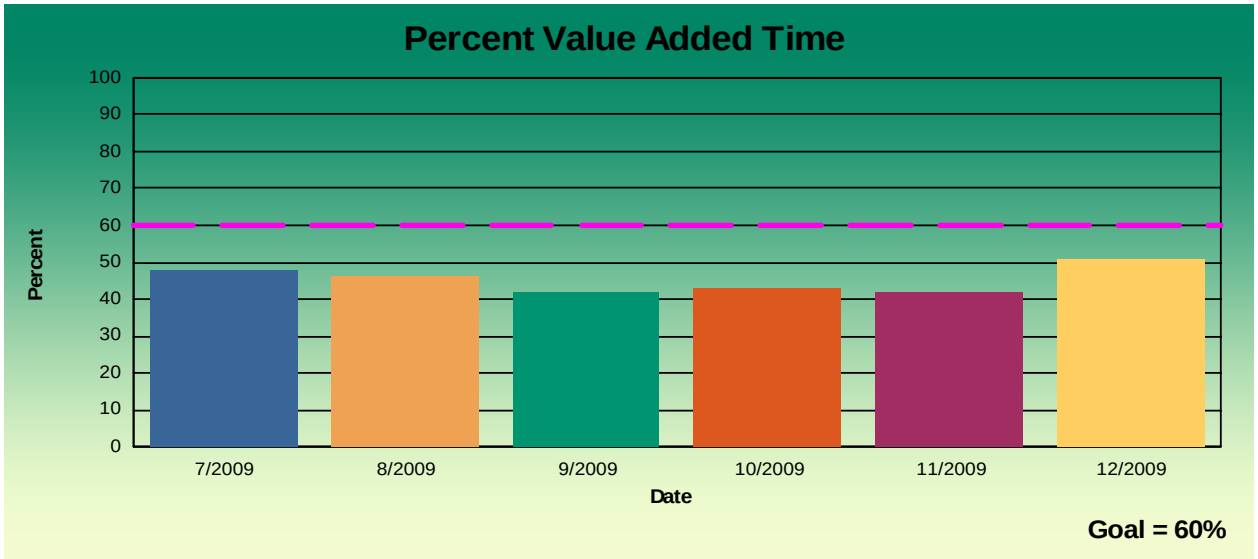
Patient Care Outcome Goals:
- 70% of Pregnant women quit smoking
- 90% with asthma use inhaled steroids
- 80% with diabetes have HbA1c measured in last year
- 90% of 2 year olds are fully immunized
- 75% on antidepressants get 2 week follow-up
- 75% of patients see their PCP

For diabetes, we have set goals based on the Health Disparities Network and NCQA measures.

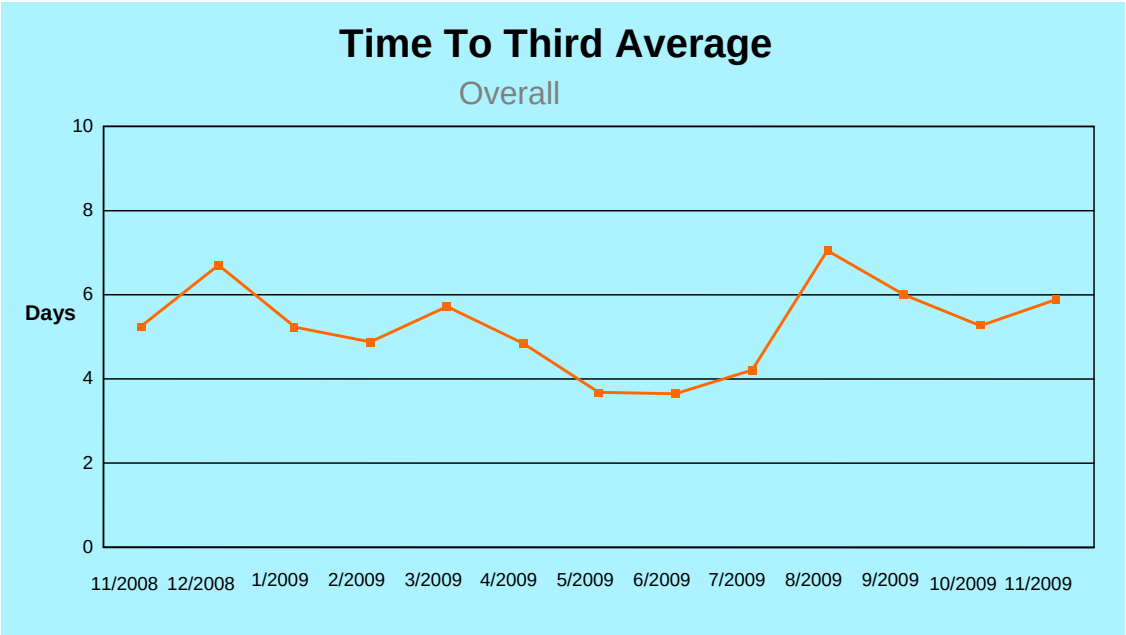
Diabetes Registry Measures/Goals:	Average A1c < 8% 40% of patients have A1cs < 7%	90% of patients have two A1cs in the last 12 months	40% of patients with last BP < 130/80 70% of patients with last LDL < 100	<12% of patients are current smokers	90% of patients have an annual foot exam 90% of patients have an annual eye exam	70% of patients have an annual self-management goal documented



Our value added time measure is set at 60%, which is based on a time study performed by XXXXX Foundation for Medical Care for Medicare's DOQ-IT program.

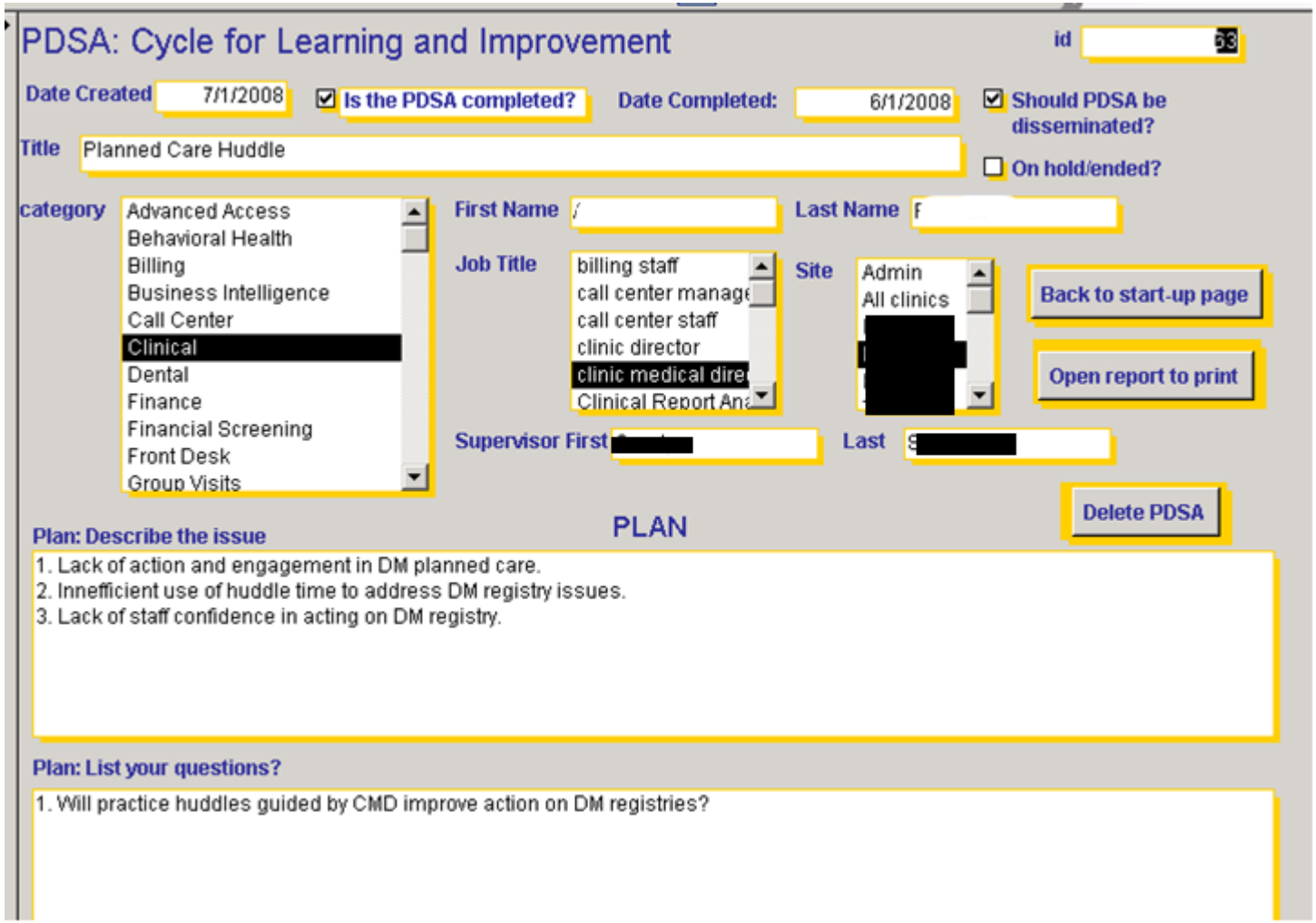


Time to third goal is to have same day access.



Item 2: Take action where identified to improve performance

For our diabetes population, we worked with Providers at the Pod level using the PDSA model to improve outcomes. Provider received their data on a monthly basis. We created Provider champions on each Pod who would then help the other Providers on their team with their diabetes outcomes. All our PDSAs are stored in a PDSA database for institutional memory and spread. Below is a screen shot of the PDSA with our diabetes population, outcome measures and a screen shot of our diabetes flowsheet in the EMR.



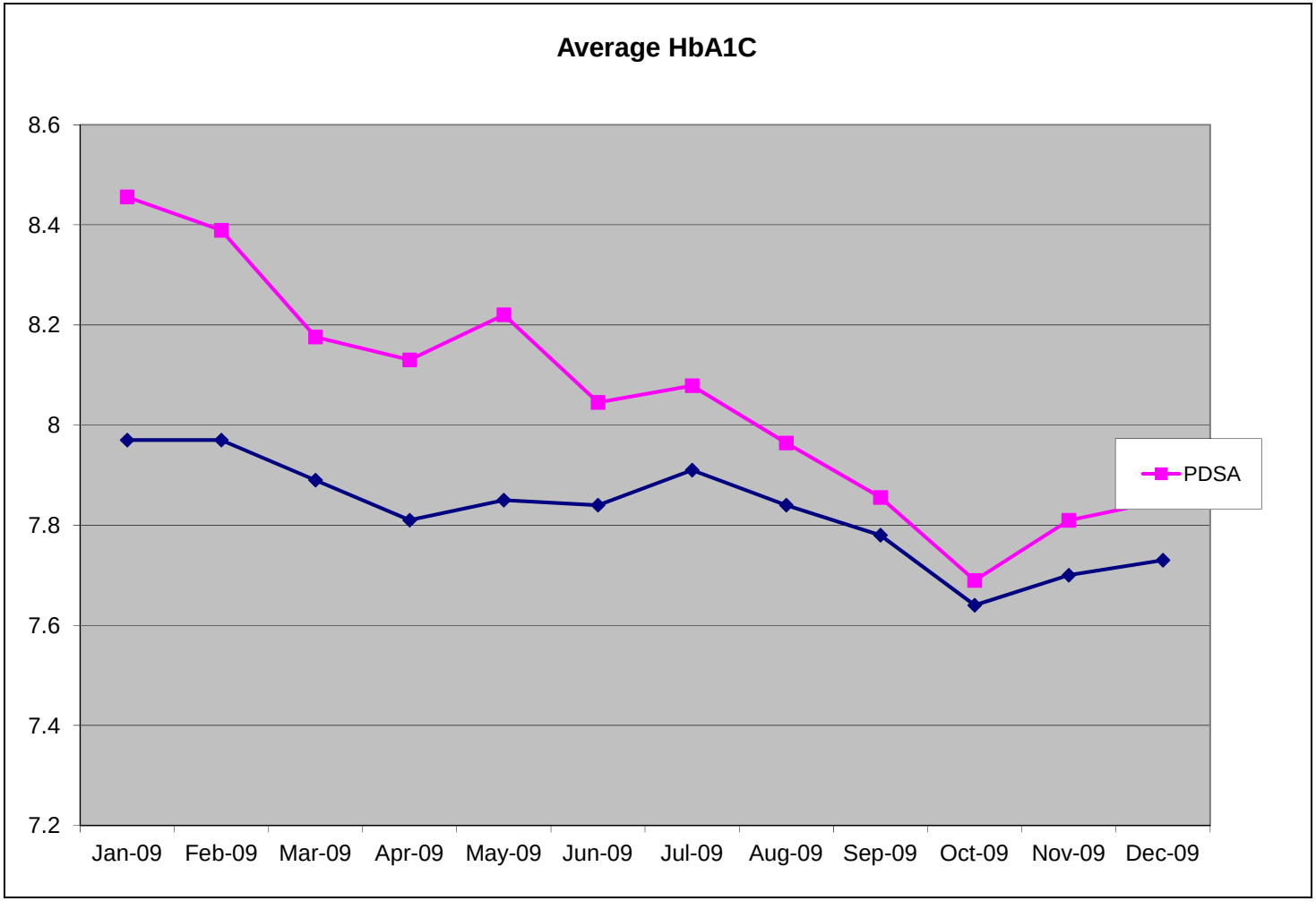
Plan for change:		Plan for data collection:	
who:	Lead (full time) physicians on the Pods, NTM, case manager, MA	**who:**	CMD -me and admin assistant
what:	Huddle using , MA DM template training tool, DM outcomes report, DM registry management guide, And DM registry. CMD to assist in helping team	**what:**	Benchmark outcomes fo rthe pod and individual providers involved
when:	1st week of july then monthy	**when:**	Benchmark data collected June 30th.
where:	On the Pods	**where:**	Pecos

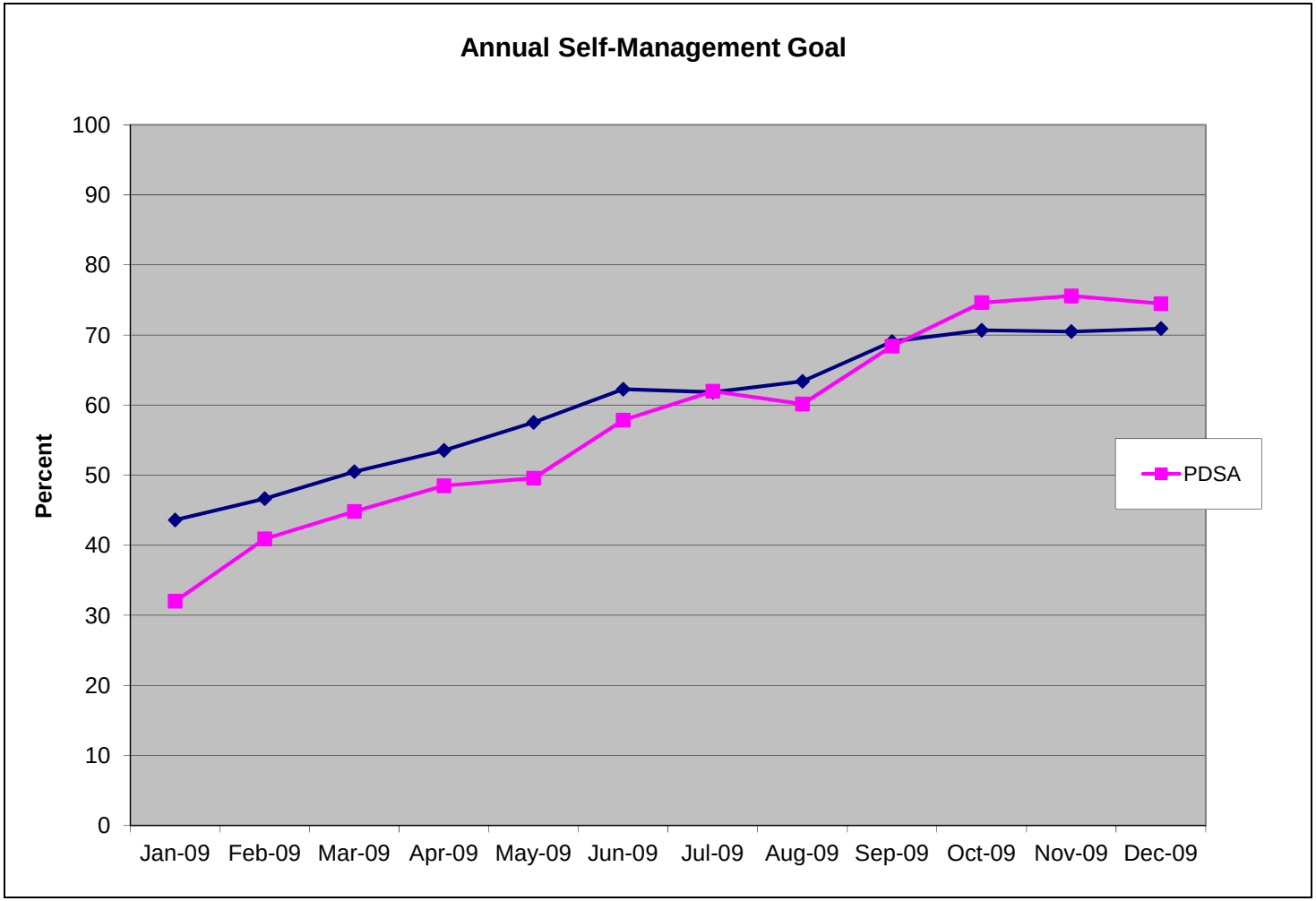
DO

- Carry out the change or test **- Collect data/ benefit analysis**	Huddles completed with each Pod/ Physician team. See Benchmark report: P:\Committees\O R D C\PDSA\PDSA support documents\PDSA #63 Planned Care Huddle June-08

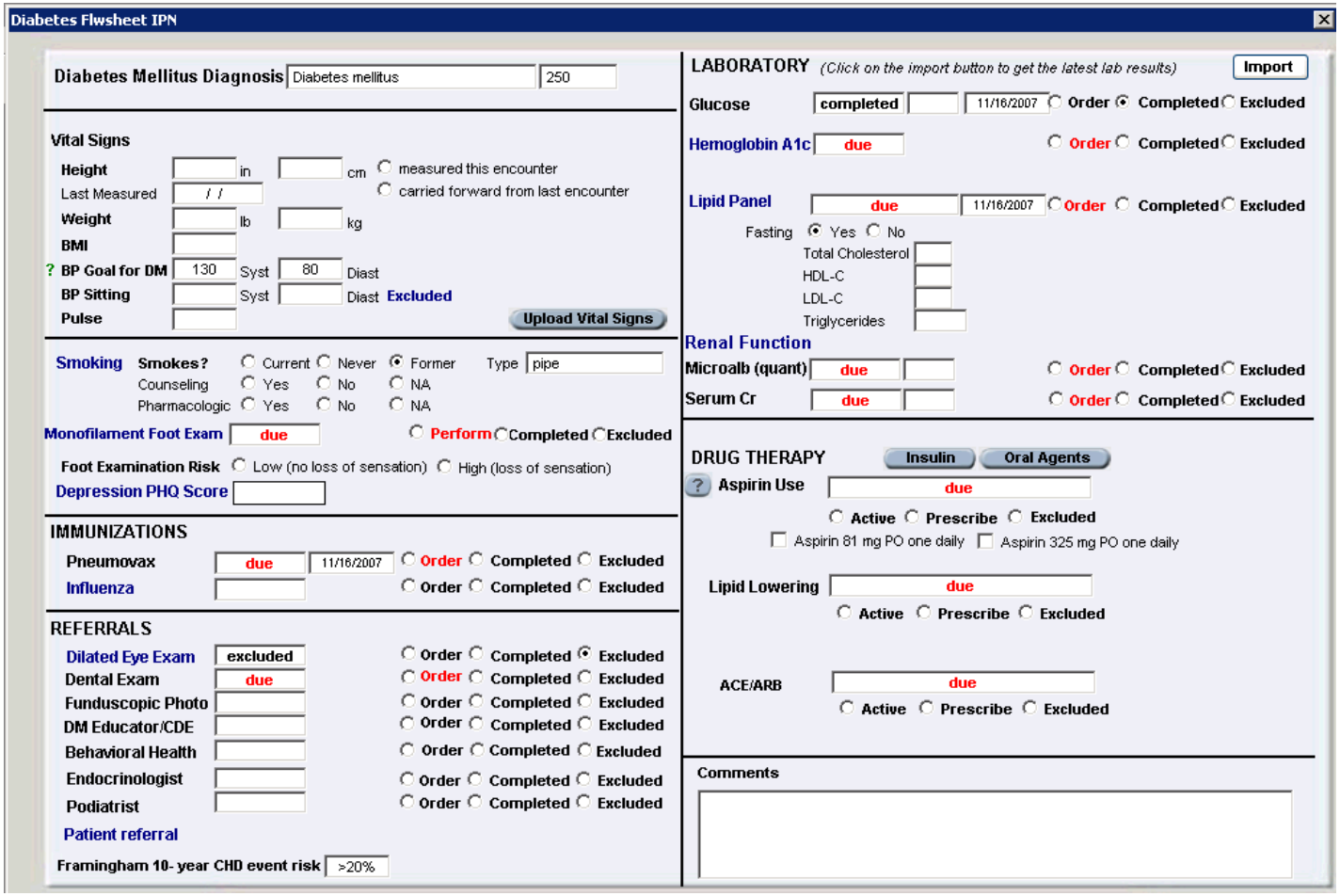
STUDY

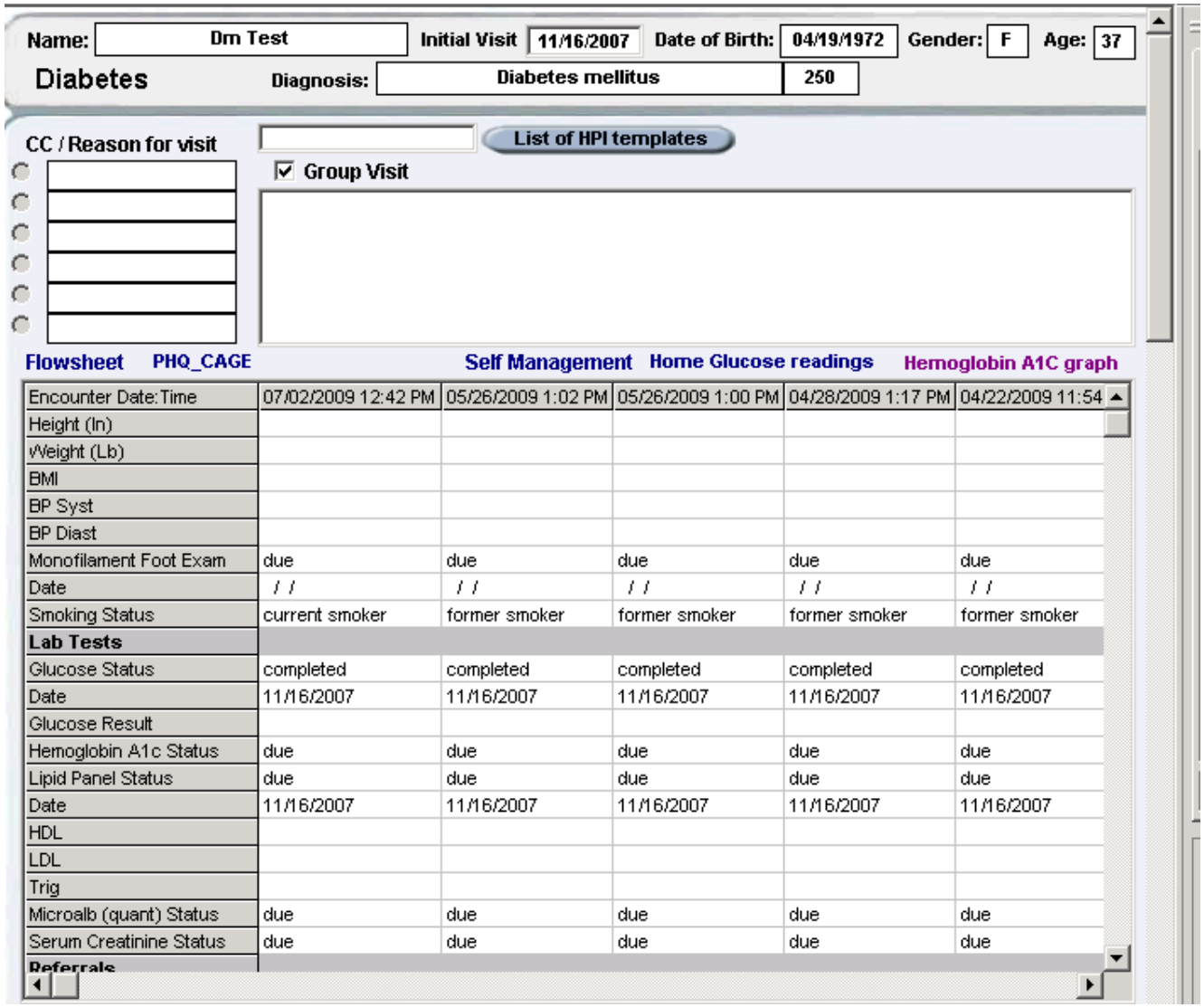
-Complete data analysis **-Summarize what was learned**	All results areas on DM imporve over the 7 month study period


Average HbA1C
8.6
8.4
8.2
8
7.8
7.6
7.4
7.2
Jan-09
Feb-09
Mar-09
Apr-09
May-09
Jun-09
Jul-09
Aug-09
Sep-09
Oct-09
Nov-09
Dec-09
PDSA


Annual Self-Management Goal
Percent
100
90
80
70
60
50
40
30
20
10
0
Jan-09
Feb-09
Mar-09
Apr-09
May-09
Jun-09
Jul-09
Aug-09
Sep-09
Oct-09
Nov-09
Dec-09
PDSA

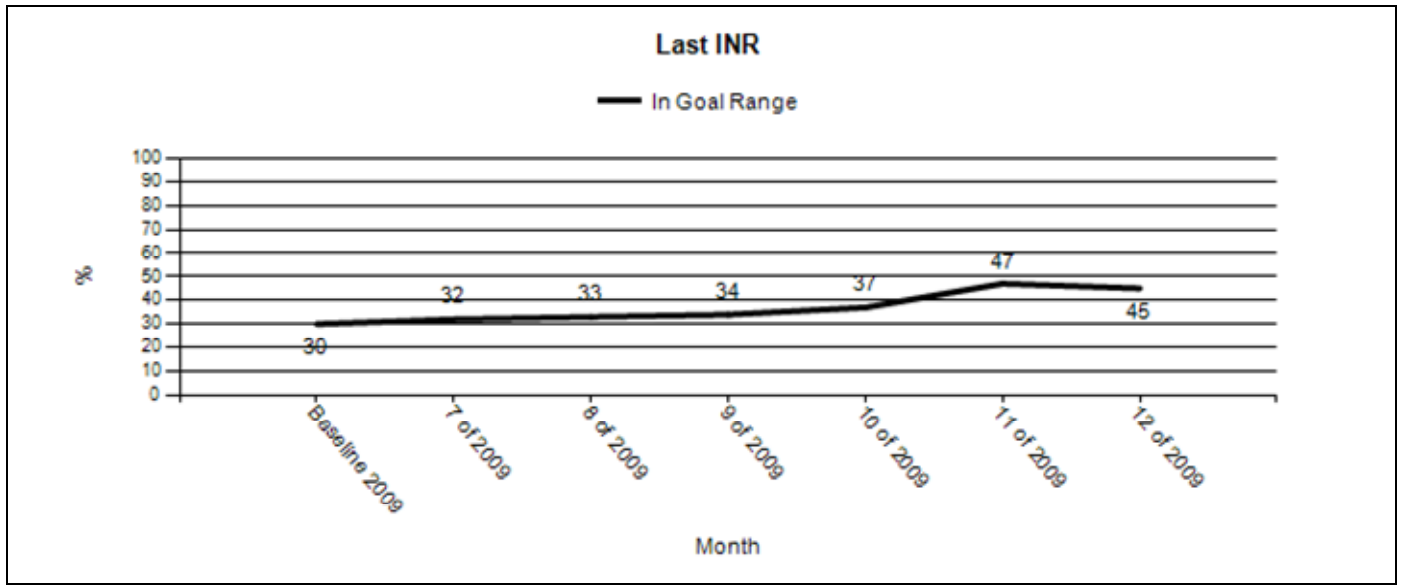
Our EMR has a flowsheet and decision support built in for our planned care conditions.

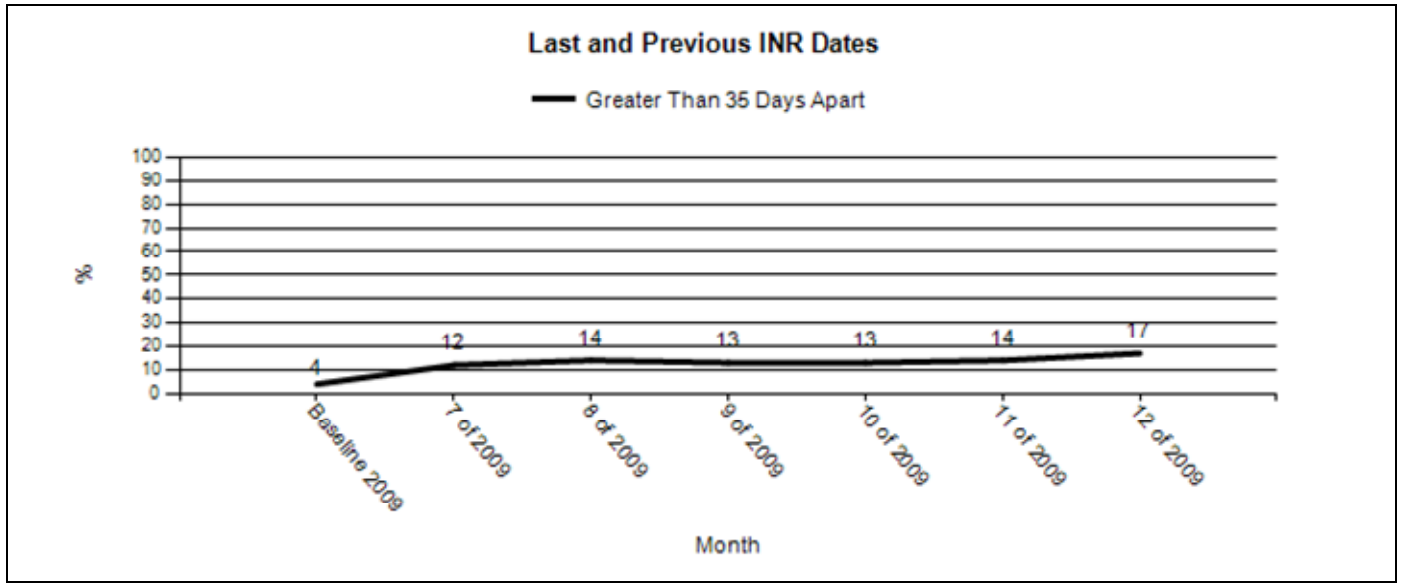


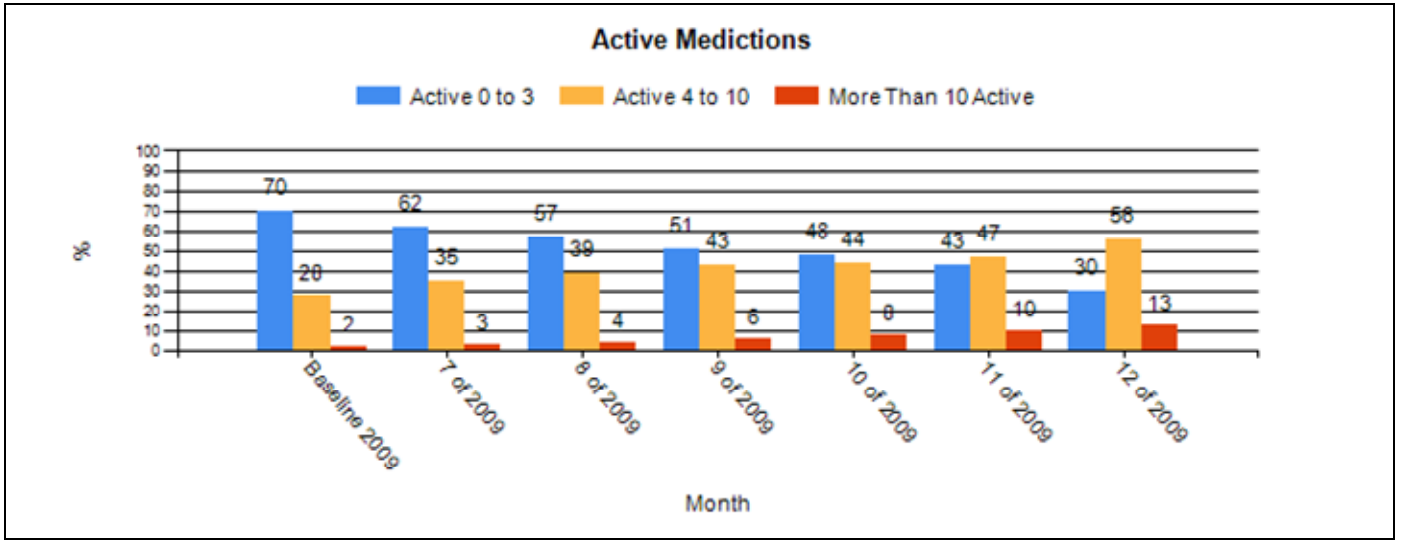


Encounter Date:Time	07/02/2009 12:42 PM	05/26/2009 1:02 PM	05/26/2009 1:00 PM	04/28/2009 1:17 PM	04/22/2009 11:54
Height (In)					
Weight (Lb)					
BMI					
BP Syst					
BP Diast					
Monofilament Foot Exam	due	due	due	due	due
Date	/ /	/ /	/ /	/ /	/ /
Smoking Status	current smoker	former smoker	former smoker	former smoker	former smoker
Lab Tests					
Glucose Status	completed	completed	completed	completed	completed
Date	11/16/2007	11/16/2007	11/16/2007	11/16/2007	11/16/2007
Glucose Result					
Hemoglobin A1c Status	due	due	due	due	due
Lipid Panel Status	due	due	due	due	due
Date	11/16/2007	11/16/2007	11/16/2007	11/16/2007	11/16/2007
HDL					
LDL					
Trig					
Microalb (quant) Status	due	due	due	due	due
Serum Creatinine Status	due	due	due	due	due
Referrals					

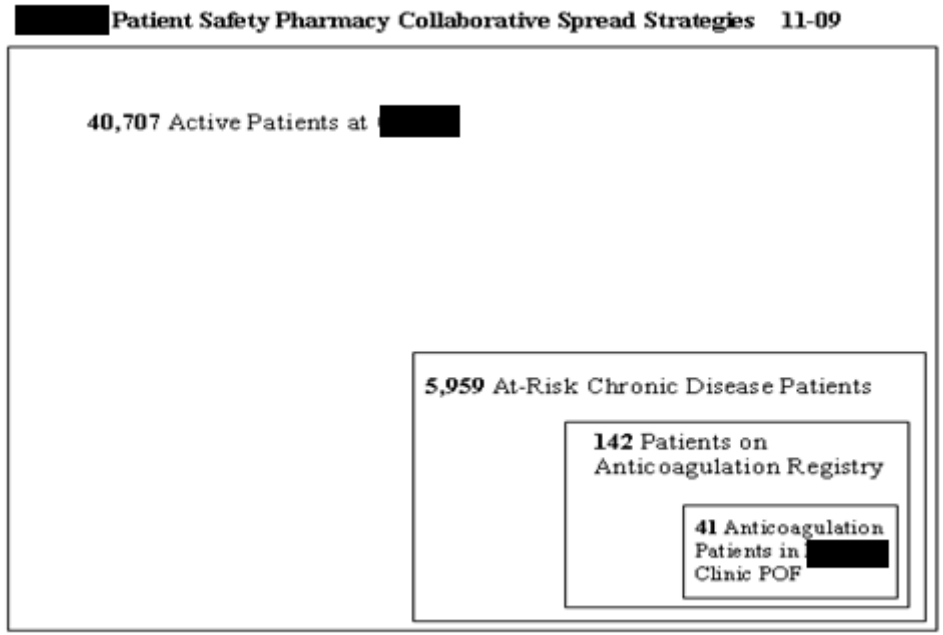
We are also working with the University of Xxxx School of Pharmacy on a Service for Anticoagulation Management Safety Project. Our Aim is to improve the care provided to patients taking Warfarin for anticoagulation therapy. We want to increase the number of patients seen at appropriate intervals; increase the number of patients who's last INR was in range and prevent complications from under or over anticoagulation. We also want to increase our patient's activation in managing their disease and medication.







Participation in the National Safety Collaboration requires a spread strategy. Our plan is to extend pharmacy services for medication therapy management from the existing population of focus to the 41 to the 142 patients on Warfarin in our organization during the two year collaborative ending September 2011.



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