

# PPC 8: PERFORMANCE REPORTING AND IMPROVEMENT

## Element D: Setting Goals and Taking Action

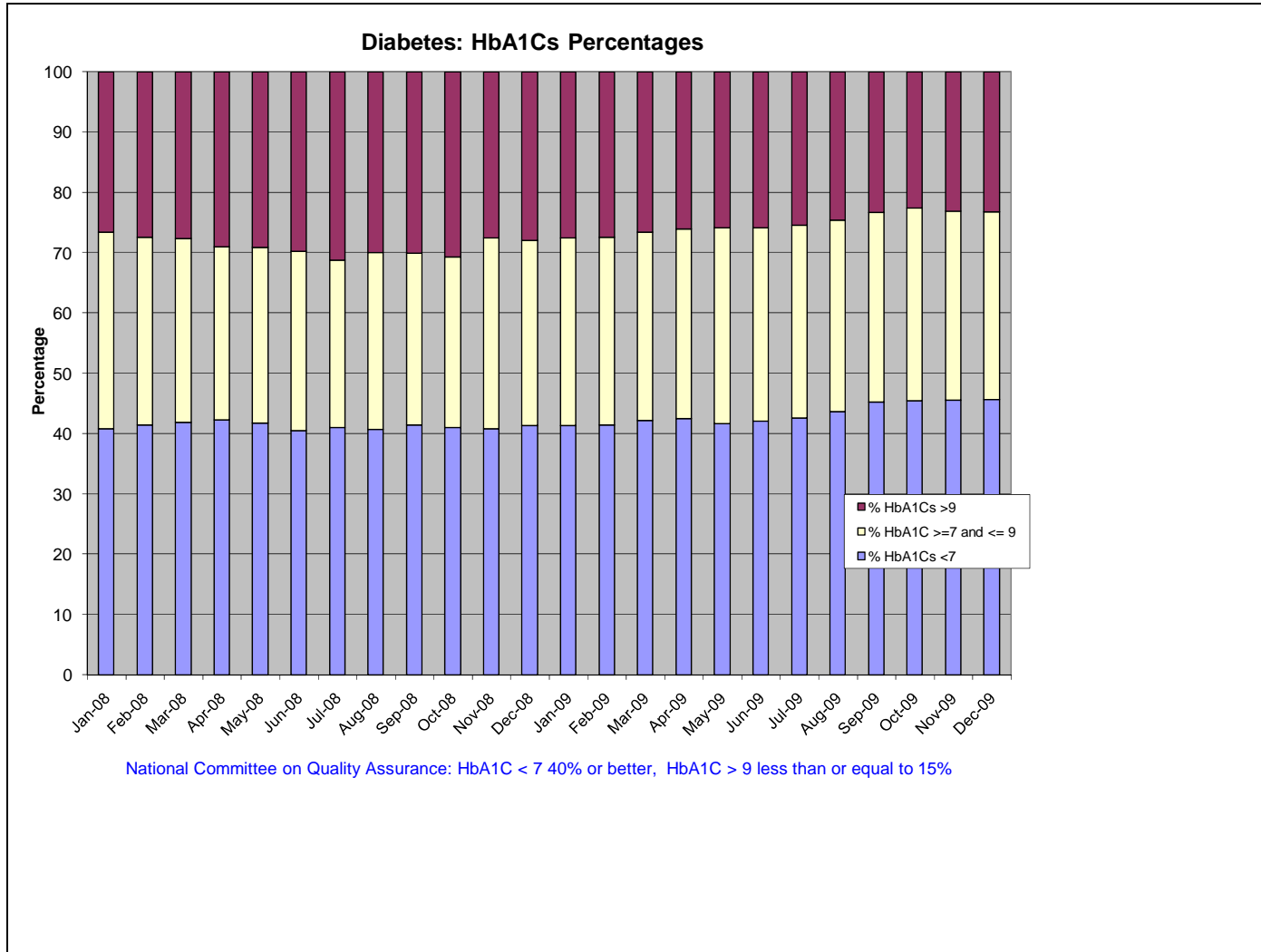
### Item 1: Set goals based on measurement results in Elements A and B

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

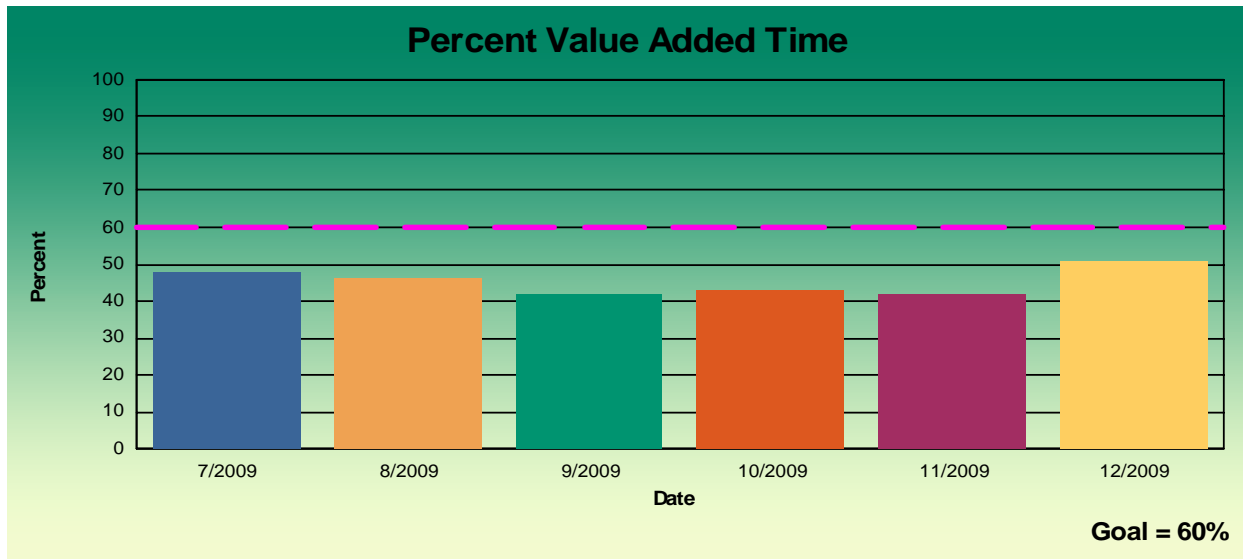
<b>STRATEGIC PLAN</b> <b>2009-2011</b>	<b>MISSION:</b> provider of underserved west Adams appropriate and prevention services.	<b>VISION:</b> underserved counties dental care
<b>VALUES: * Service to Others * Creativity * Diversity * Excellent Teamwork * Do the Right Thing * Make a Great Place to Work *</b>		
<b>Key Success Factor: Access</b> Goal: To continually strive to increase patient visit capacity to meet the primary health care needs of all underserved people in [redacted]. Objectives: <ul style="list-style-type: none"> <li>•Add Two Dentists and a Hygienist with support staff at [redacted]</li> <li>•Add fully staffed night hours at [redacted] and add a pod [redacted]</li> <li>•Add enough behavioral health professionals to have 1per pod at [redacted] Counties sites.</li> </ul>	<b>Key Success Factor: Outcomes</b> Goal: To provide excellent acute and preventive medical, dental and health education services that measurably improve the health status of [redacted] patients. Objectives: <ul style="list-style-type: none"> <li>•Enhance use of EHR / EDR as quality improvement tool</li> <li>•Reduce outcome variation between clinics.</li> <li>•Improve full use of team talents and focus clinicians on clinician work.</li> </ul>	
<b>Key Success Factor: Financial Stability</b> Goal: To be a financially stable organization, obtaining and maintaining funds from diverse sources and supporting quality health care services to the underserved. Objective: <ul style="list-style-type: none"> <li>•Improve collection rate by 6.5% through improved screening and billing.</li> </ul>	<b>Key Success Factor: Customer Service</b> Goal: To be the provider of choice for underserved people because we offer world class customer service, which delights our patients. Objectives: <ul style="list-style-type: none"> <li>•Improve working conditions and reduce turnover in call center.</li> <li>•Improve call center service grade on patient satisfaction survey.</li> </ul>	
<b>Key Success Factor: Our People</b> Goal: To have a stable and diverse staff who function as a high performing team and view [redacted] great place to work. Objectives: <ul style="list-style-type: none"> <li>•Create a leadership development program for [redacted] staff.</li> <li>•Reduce the voluntary turnover rate.</li> <li>•Improve systems for orienting new staff to [redacted] systems and culture.</li> <li>•Promote cooperation and teamwork through communication, recognition and appreciation.</li> </ul>	<b>Key Success Factor: Facilities</b> 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: <ul style="list-style-type: none"> <li>•Replace the [redacted].</li> <li>•Expand [redacted] add a pod &amp; GV space</li> <li>•Replace phone systems at [redacted].</li> <li>•[redacted].</li> <li>•Assure IT system stability and stay current with technology.</li> <li>•Develop a facilities maintenance program and "green" facilities as remodels are undertaken.</li> </ul>	
<b>Key Success Factor: Community Partnerships</b> 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: <ul style="list-style-type: none"> <li>•Work with [redacted] in admitting obstetricians to support the delivery of [redacted] maternity patients in [redacted]</li> <li>•Work with Dental Aid to integrate physician and oral health.</li> <li>•Work with the [redacted] to assure that the [redacted] objectives for access to health care are achieved.</li> <li>•Work with Community Mental Health Centers in [redacted] to integrate physical and behavioral health services.</li> <li>•Explore the potential for training family physicians at [redacted] with the [redacted] Practice Residency Program.</li> <li>•Work with providers of services to homeless people in [redacted] to assure access to primary health care services.</li> <li>•Explore the potential for a nursing education collaboration with [redacted]</li> </ul>		
<b>Patient Access Goal:</b> •17.75 visits per day <b>Patient Care Outcome Goals:</b> •70% of Pregnant women quit smoking    •90% of 2 year olds are fully immunized •90% with asthma use inhaled steroids    •75% on antidepressants get 2 week follow-up •80% with diabetes have HbA1c measured in last year    •75% of patients see their PCP		

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

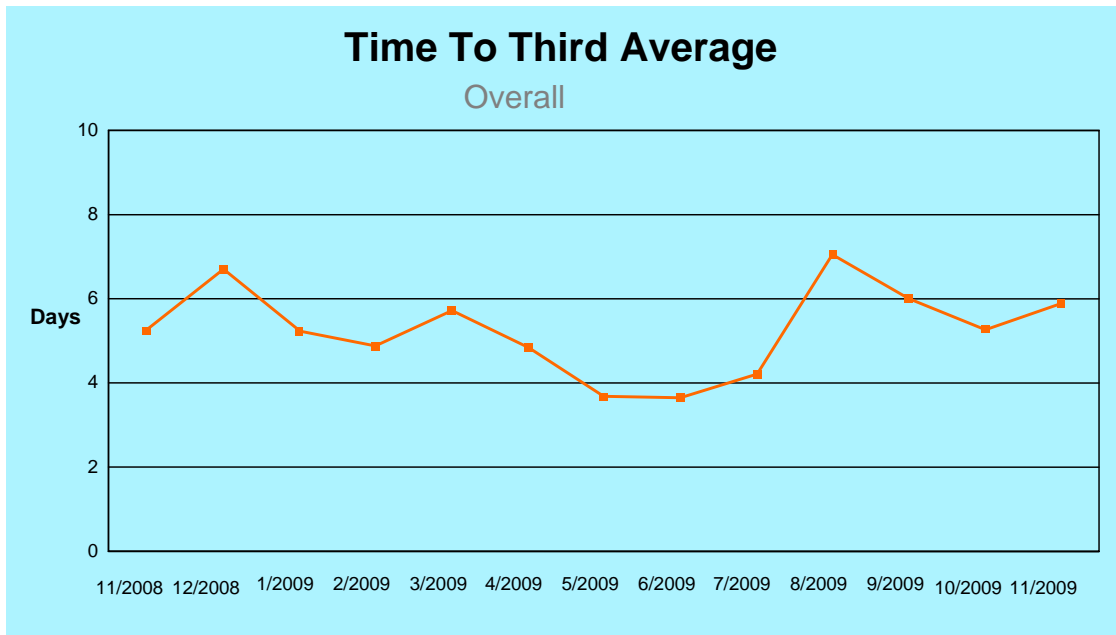
<b>Diabetes Registry Measures/Goals:</b>	Average A1c < 8%	90% of patients have two A1cs in the last 12 months	40% of patients with last BP < 130/80	<12% of patients are current smokers	90% of patients have an annual foot exam	70% of patients have an annual self-management goal documented
	40% of patients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



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.

**PDSA: Cycle for Learning and Improvement** id

Date Created:   Is the PDSA completed? Date Completed:   Should PDSA be disseminated?

Title:   On hold/ended?

category: 

- Advanced Access
- Behavioral Health
- Billing
- Business Intelligence
- Call Center
- Clinical**
- Dental
- Finance
- Financial Screening
- Front Desk
- Group Visits

First Name:  Last Name:

Job Title: 

- billing staff
- call center manag
- call center staff
- clinic director
- clinic medical dire**
- Clinical Report An

Site: 

- Admin
- All clinics

Supervisor First:  Last:

**PLAN**

**Plan: Describe the issue**

1. Lack of action and engagement in DM planned care.
2. Inefficient use of huddle time to address DM registry issues.
3. Lack of staff confidence in acting on DM registry.

**Plan: List your questions?**

1. Will practice huddles guided by CMD improve action on DM registries?

[Back to start-up page](#) [Open report to print](#) [Delete PDSA](#)

**Plan for change:**

**who:** Lead (full time) physicians on the Pods, NTM, case manager, MA

**what:** Huddle using , MA DM template training tool, DM outcomes report, DM registry management guide, And DM registry. CMD to assist in helping team

**when:** 1st week of july then monthly

**where:** On the Pods

**Plan for data collection:**

**who:** CMD -me and admin assistant

**what:** Benchmark outcomes fo rthe pod and individual providers involved

**when:** Benchmark data collected June 30th.

**where:** Pecos

**DO**

- Carry out the change or test
- Collect data/ benefit analysis

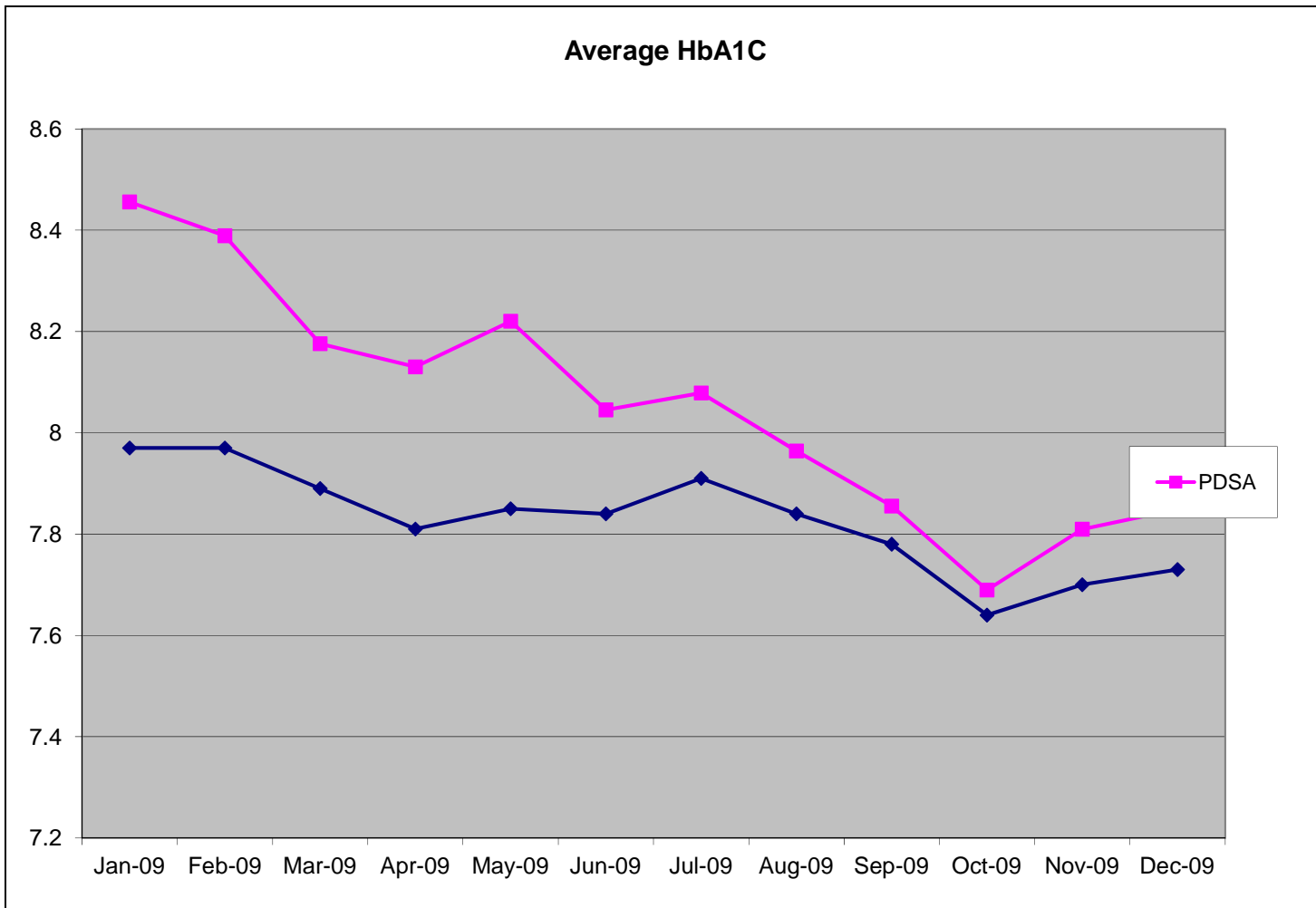
Huddles completed with each Pod/ Physician team.

See Benchmark report: P:\Committees\O R D \CPDSA\IPDSA support documents\IPDSA #63 Planned Care Huddle June-08

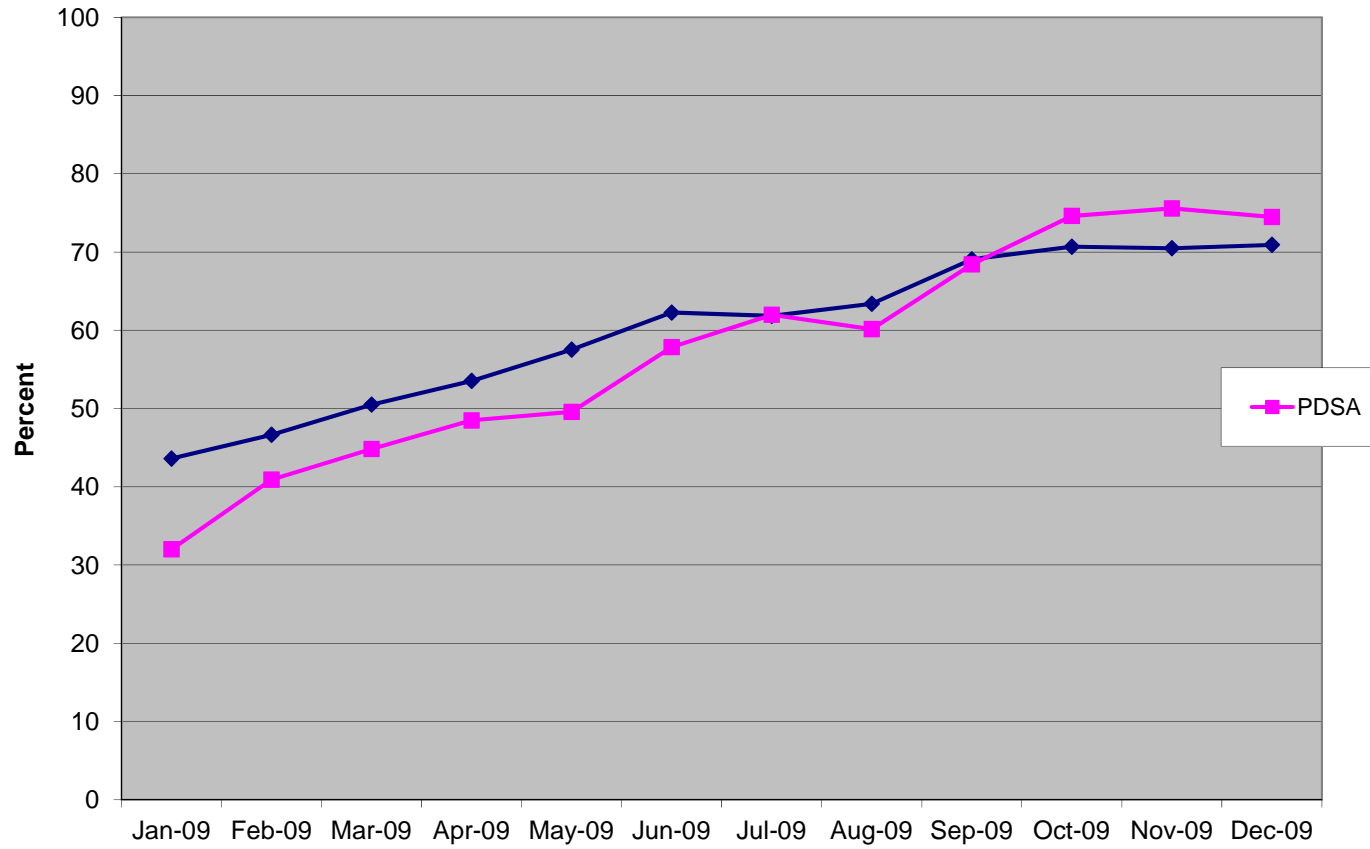
**STUDY**

- Complete data analysis
- Summarize what was learned

All results areas on DM improve over the 7 month study period



### Annual Self-Management Goal



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

**Diabetes Flwsheet IPN**

**Diabetes Mellitus Diagnosis** Diabetes mellitus 250

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**Vital Signs**

Height  in  cm  measured this encounter  
 carried forward from last encounter

Last Measured / /

Weight  lb  kg

BMI

? BP Goal for DM 130 Syst 80 Diast

BP Sitting  Syst  Diast **Excluded**

Pulse

**Upload Vital Signs**

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**Smoking** Smokes?  Current  Never  Former Type

Counseling  Yes  No  NA

Pharmacologic  Yes  No  NA

**Monofilament Foot Exam**  **due**  Perform  Completed  Excluded

**Foot Examination Risk**  Low (no loss of sensation)  High (loss of sensation)

**Depression PHQ Score**

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**IMMUNIZATIONS**

**Pneumovax**  **due** 11/16/2007  Order  Completed  Excluded

**Influenza**   Order  Completed  Excluded

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**REFERRALS**

**Dilated Eye Exam**  **excluded**  Order  Completed  Excluded

**Dental Exam**  **due**  Order  Completed  Excluded

**Funduscopy Photo**   Order  Completed  Excluded

**DM Educator/CDE**   Order  Completed  Excluded

**Behavioral Health**   Order  Completed  Excluded

**Endocrinologist**   Order  Completed  Excluded

**Podiatrist**   Order  Completed  Excluded

**Patient referral**

**Framingham 10-year CHD event risk** >20%

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**LABORATORY** (Click on the import button to get the latest lab results) **Import**

**Glucose**  **completed** 11/16/2007  Order  Completed  Excluded

**Hemoglobin A1c**  **due**  Order  Completed  Excluded

**Lipid Panel**  **due** 11/16/2007  Order  Completed  Excluded

Fasting  Yes  No

Total Cholesterol

HDL-C

LDL-C

Triglycerides

**Renal Function**

**Microalb (quant)**  **due**  Order  Completed  Excluded

**Serum Cr**  **due**  Order  Completed  Excluded

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**DRUG THERAPY** **Insulin** **Oral Agents**

? **Aspirin Use**  **due**

Active  Prescribe  Excluded

Aspirin 81 mg PO one daily  Aspirin 325 mg PO one daily

**Lipid Lowering**  **due**

Active  Prescribe  Excluded

**ACE/ARB**  **due**

Active  Prescribe  Excluded

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**Comments**



Name:  Initial Visit:  Date of Birth:  Gender:  Age:

**Diabetes**      Diagnosis:      

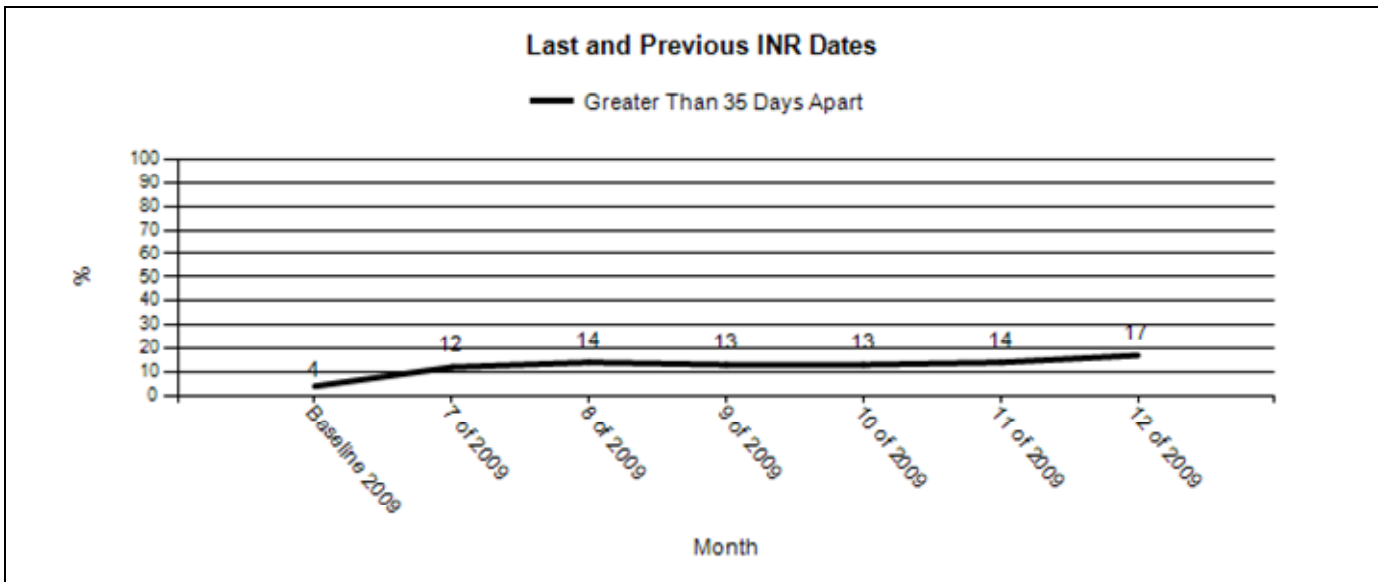
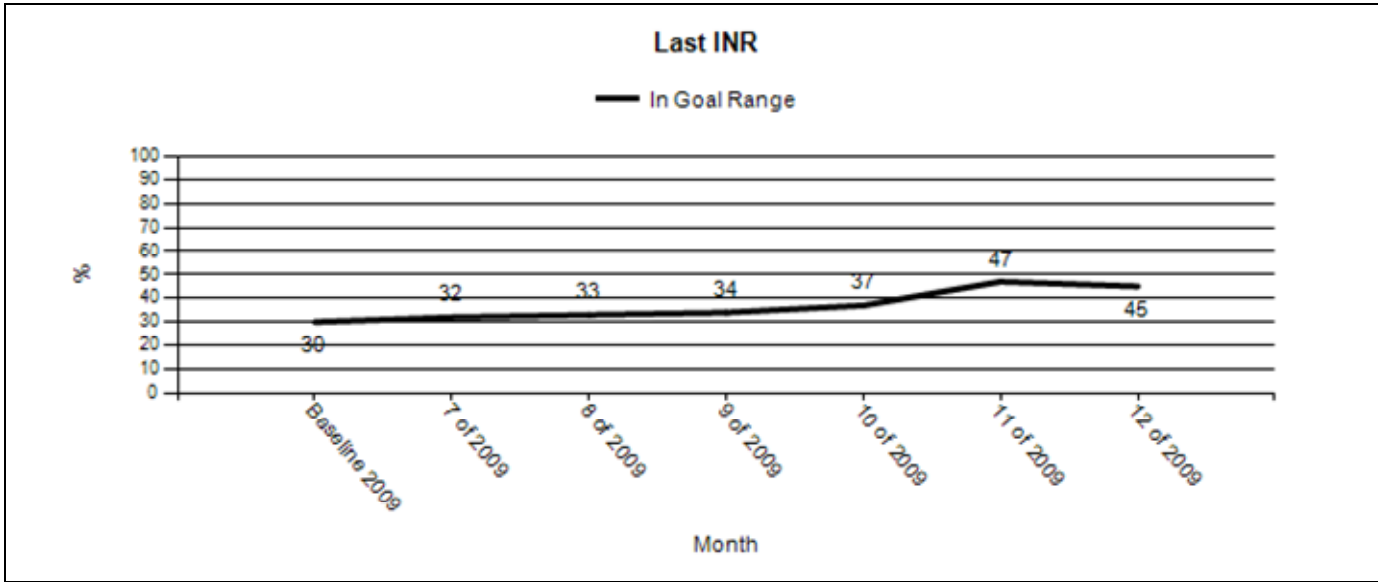
CC / Reason for visit:  [List of HPI templates](#)

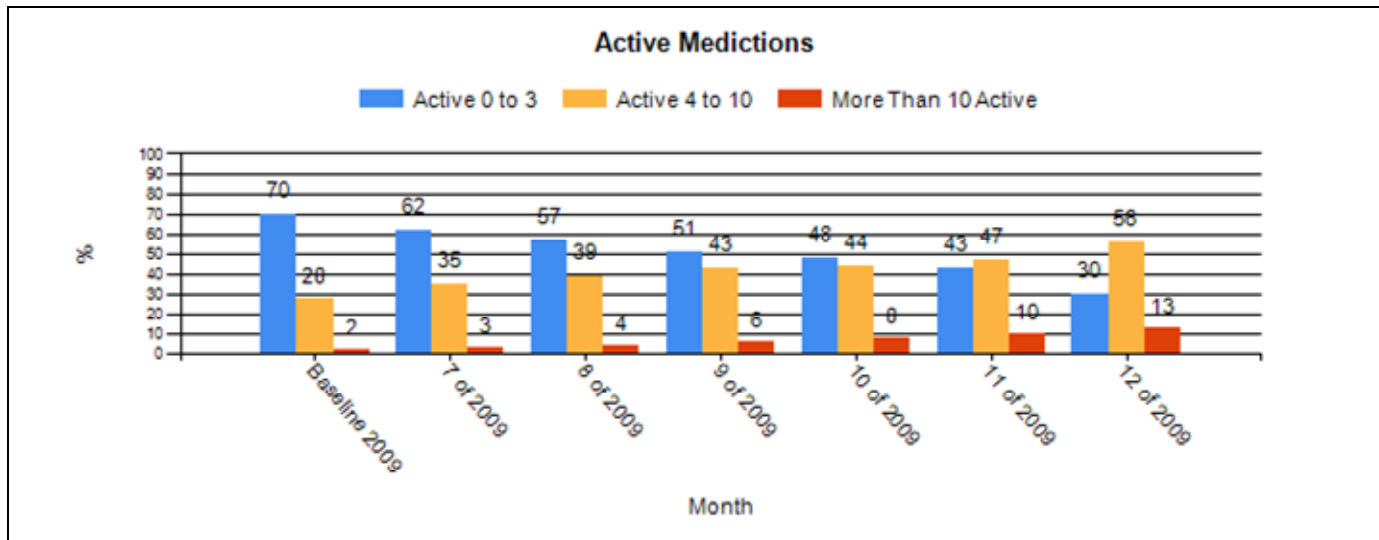
**Group Visit**

**Flowsheet**    **PHQ\_CAGE**      **Self Management**    **Home Glucose readings**    **Hemoglobin A1C graph**

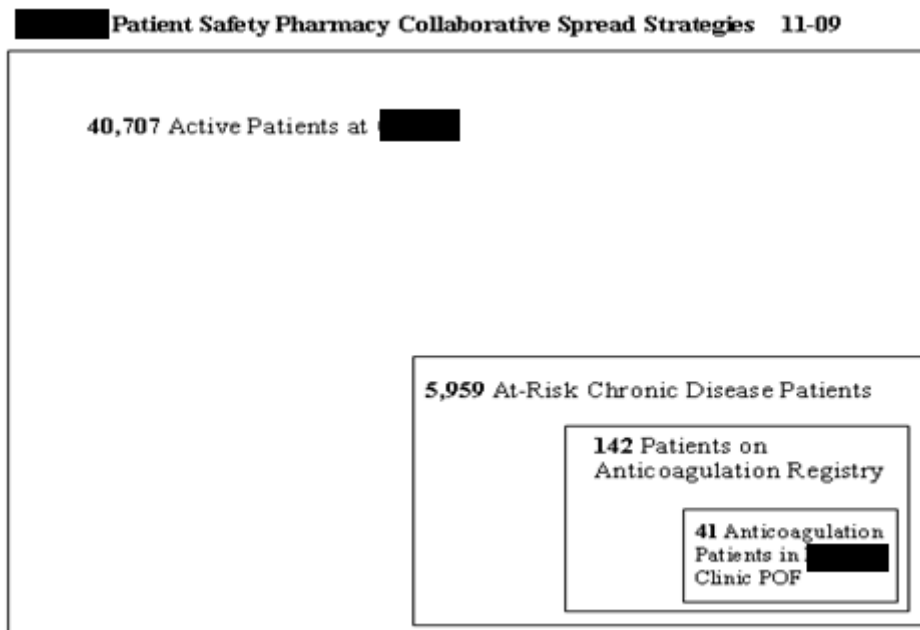
Encounter Date:Time	07/02/2009 12:42 PM	05/26/2009 1:02 PM	05/26/2009 1:00 PM	04/28/2009 1:17 PM	04/22/2009 11:54
Height (In)					
Weight (Lb)					
BMI					
BP Syst					
BP Diast					
Monofilament Foot Exam	due	due	due	due	due
Date	//	//	//	//	//
Smoking Status	current smoker	former smoker	former smoker	former smoker	former smoker
<b>Lab Tests</b>					
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
<b>Referrals</b>					

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 Collaborative 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.



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

### ANTI-COAGULATION THERAPY

Referring Physician:  Full Name:  Date of Birth:  Home Phone:  Alternate Phone:   
 Drn Test  04/19/1972  ( ) -  ( ) -

**Indications For Therapy**

Therapy started:  /  /  stopped:  /  /   
 Expected duration of therapy:   
 High Risk Alerts:

**Week One**  Change dose  
 Target Range:  .00 to  .00 Table Sizes:  3mg    Clear  
 Lab Date:  /  /  INR:  Protine:

Lab Date	INR	Protine	Sun	Mon	Tue	Wed	Thu	Fri	Sat	w/Weekly	Dosage
<input type="text"/>	<input type="text"/>	<input type="text"/>	3mg	3mg	3mg	3mg	3mg	3mg	3mg	15.00	1.50mg Su,Tu,W,Th / 3.00mg M,F,Sa
			0.5	1	0.5	0.5	0.5	1	1		
Additional Dosage											
Comments			Totals	1.50	3.00	1.50	1.50	1.50	3.00	3.00	

**Week Two**  Change dose  
 Target Range:  .00 to  .00 Table Sizes:      Clear  
 Lab Date:  /  /  INR:  Protine:

Lab Date	INR	Protine	Sun	Mon	Tue	Wed	Thu	Fri	Sat	w/Weekly	Dosage
<input type="text"/>	<input type="text"/>	<input type="text"/>								.00	
Additional Dosage											
Comments			Totals	.00	.00	.00	.00	.00	.00	.00	