PPC 8: Performance Reporting and Improvement
Element D: Setting Goals and Taking Action

CHC-B sets goals and creates action plans as part of our annual preparation of our Federal Health Plan. Below are examples for Cardiovascular Disease, Pnuemovax, and Asthma. We have similar goals and action plans for Diabetes, Behavioral Health, Dental Treatment Completion, Pap Smears, and Mammograms.

Focus Area: Cardiovascular Disease			
Performance Measure: Percentage of adult patients with diagnosed hypertension whose most recent blood pressure was less than 140/90			
Is this Performance Measure Applicable to your Organization?	[X] Yes [_] No		
Target Goal Description	By the end of the Project Period, increase the % of adult patients with hypertension whose blood pressure is under control from 62% to 69%		
Numerator Description	Patients 18 to 85 years with a diagnosis of hypertension with most recent systolic blood pressure measurement < 140 mm Hg and diastolic blood pressure < 90 mm Hg.		
Denominator Description	All patients 18 to 85 years of age as of December 31 of the measurement year with diagnosis of hypertension and have been seen at least twice during the reporting year, and have a diagnosis of hypertension.		
Baseline Data	**Baseline Year: 2008** **Measure Type: Percentage** **Numerator: 634** **Denominator: 1005**	Projected Data (by End of Project Period)	**69%**
Data Source & Methodology	Complete registry of all patients within our Electronic Medical Record (Data run on 5/31/2008)		
Key Factor and Major Planned Action #1	**Key Factor Type:** [X] Contributing [ ] Restricting [ ] Not Applicable **Key Factor Description:** CHC-B utilizes a multidisciplinary team that includes providers, medical assistants, an RN case manager, a registered dietician, and collaborative support staff. The team utilizes patient visits, phone calls, group visits, and planned care to address items that will improve blood pressure control. **Major Planned Action Description:** CHC-B will assure on-going staff training on self-management goal setting, motivational interviewing, and providing follow-up support to patients with CVD.		
Key Factor and Major Planned Action #2	**Key Factor Type:** [X] Contributing [ ] Restricting [ ] Not Applicable **Key Factor Description:**		

	CHC-B has received a new grant to add health coaches in July, 2009. Our health coaches will work under a registered dietician and be part of the collaborative support staff. **Major Planned Action Description:** CHC-B will integrate the new health coaches into the collaborative infrastructure to provide CVD patients with the necessary education, tools, and support to successfully manage their disease.
Key Factor and Major Planned Action #3	**Key Factor Type:** [ ] Contributing [X]Restricting [ ]Not Applicable **Key Factor Description:** A key to the successful management of the CVD patient panel is correct data on clinical measures and corresponding lists of patients in need of care. CHC-B utilizes our EMR and a custom reporting package to provide this data to our teams. Our collaborative support staff make daily calls to patients to get them to come in for blood pressure checks, fasting lipid panels, LDL control, self management goals, PHQ9's. Recent changes made by our EMR vendor and staff changes and/or absences have made management of this data more stressful. **Major Planned Action Description:** CHC-B will continue to work with the EMR vendor to improve reporting and the amount of time it take to run reports. CHC-B will assure staff time for the CVD team to meet, test changes, and implement the changes system-wide. CHC-B will assure that the collaborative support team is staffed and has the patient lists to facilitate necessary care for CVD patients.
Comments	CHC-B will continue to track and report the measures from the Health Disparities Collaboratives for CVD.

Focus Area: Adult Health	
Performance Measure: Percentage of adults 65+ with pnuemovax.	
Is this Performance Measure Applicable to your Organization?	[_x] Yes [_] No
Target Goal Description	By the end of the Project Period, increase the % of adults 65+ with appropriate pnuemovax coverage to 80%.
Numerator Description	Number of adults 65+ in the “universe” with a medical visit in the last year who received a pneumovax, among those adults included in the denominator.
Denominator Description	Number of adults 65+ with at least one medical

	encounter during the reporting period, who did not have a contraindication for this specific vaccine.
Baseline Data	**Baseline Year: 2008** **Measure Type: Percentage** **Numerator: 327** **Denominator: 484** Projected Data (by End of Project Period): **80%**
Data Source & Methodology	
Key Factor and Major Planned Action #1	**Key Factor Type:** [_] Contributing [X] Restricting [_] Not Applicable **Key Factor Description:** Many patients get pnuemovax at nursing services, community shot clinics, Safeway, or out of state. **Major Planned Action Description:** CHC-B will utilize the EMR to alert the providers and medical assistants to ask about pnuemovax coverage. We will work to capture dates of pnuemovax given elsewhere. All medical staff will have access to the state immunization registry to print a patient's immunization history. CHC-B will continue to have ongoing education regarding immunization schedules for all medical staff.
Key Factor and Major Planned Action #2	**Key Factor Type:** [_] Contributing [x] Restricting [_] Not Applicable **Key Factor Description:** Many patients 65+ do not believe or know they need the pnuemovax injection. **Major Planned Action Description:** CHC-B staff will give VIS (Vaccine Information Sheet) handouts to patients telling them the importance for anyone 65+ to receive this injection. Providers will follow up during the visit and order the immunization.
Comments	

Focus Area: Asthma	
Performance Measure: Percentage of asthma patients whose ED/Urgent Care visits decrease.	
Is this Performance Measure Applicable to your Organization?	[X] Yes [_] No
Target Goal Description	By the end of the Project Period, the % of asthmatic

	patients who had ED/Urgent Care visit in the last 6 months will be <5%
Numerator Description	Number of patients with a diagnosis of asthma who had an ED/Urgent Care visit in the past 6 months among those patients included in the denominator.
Denominator Description	Number of patients with a diagnosis of asthma, who have been seen in the clinic at least once during the reporting year and do not meet any of the exclusion criteria
Baseline Data	**Baseline Year: 2008** **Measure Type:Percentage** **Numerator: unknown** **Denominator:671** Projected Data (by End of Project Period): **5%**
Data Source & Methodology	
Key Factor and Major Planned Action #1	**Key Factor Type:** [x] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** CHC-B utilizes a multidisciplinary team that includes providers, medical assistants, a RN case manger, a registered dietician, and collaborative support staff. The team utilizes patient visits, phone calls, group visits, and planned care to address items that will decrease ED/Urgent Care visits. **Major Planned Action Description:** CHC-B will continue to use a provider champion team to hold monthly asthma meetings. During these meetings the team will do PDSA's to test ideas and implement changes system wide.
Key Factor and Major Planned Action #2	**Key Factor Type:** [] Contributing [x] Restricting [_] Not Applicable **Key Factor Description:** Patients deny asthma diagnosis and/or refuse to take medications as directed. **Major Planned Action Description:** CHC-B has established EMR reminders and tracking for staff to address with patient at each visit. The above standards will be audited in our Quality Improvement process.
Key Factor and Major Planned Action #3	**Key Factor Type:** [_] Contributing [x_] Restricting [_] Not Applicable **Key Factor Description:** EMR has helped in identifying many more patients that the old method of sending charts to data entry.

	Major Planned Action Description: CHC-B collaborative support staff will call and send letters monthly to get patients in for their routine asthma appointments. CHC-B will utilize established EMR tracking and reminders/alerts to ensure self management goals are set, appropriate labs are obtained, and patients are on the right type of medications. CHC-B will also utilize the Health Educator/Registered Dietician and Health coaches to change behavior/lifestyles.
Comments	CHC-B will continue to report all asthma measures to the Health Disparities Collaboratives.

We also create alerts and forms in our system to prompt staff to collect data and address items with patients to improve performance of individual physicians or the practice as a whole. An example of an alert for an influenza vaccination is below:

The workflow to improve this measure calls for the staff member to:

1. Offer the injection to the patient if the alert is on the chart
2. Or document in the form the date the patient received the injection elsewhere
3. Or document the patient's refusal at this time. Refusal does not improve the performance on the measure but proves that we are addressing the need with the patient.

This form prompts the staff to ask about the flu shot and allows for documentation if the patient received it elsewhere or refuses.

FOR SENIORS 65 & OVER

Do GERIATRIC DEPRESSION SCREEN yearly for pts 65+. (See Tab Above)

PTS OVER 65 NEED A FLU SHOT YEARLY

Reported A Recent FLU SHOT **Date REQUIRED* | Y | Onset

Pt Refused Flu Shot Today | Y | Onset

ALL PATIENTS OVER 65 NEED ONE PNEUMOVAX IN LIFETIME

Reported A PNEUMOVAX *Date REQUIRED* | Y | Onset

Pt Refused Pnemo Today | Y | Onset

We have customized forms created to provide decision support and to prompt a more systematic workflow and treatment. This form prompts staff to collect all the required data for our Diabetes measures:

Medcin Entries 1 | Foot Exam | Outline View

Self-management goal setting in the past 12 months.

- Patient Goals
- Decrease Cholesterol
- Begin Regular Exercise
- Maintain Regular Exercise
- Test Blood Sugars And Bring In Results
- Decrease Weight By ___ (lbs#oz)
- Keep Fasting Blood Sugar Under ___
- Cut Smoking To ___ Packs Per Day (packs/day)

Dilated eye exam in the past 12 months

- Fundoscopic Exam w Dilated Pupils (Performed today) **DATE REQUIRED | Y | Onset
- Recent Medical Examination By An Ophthalmologist (History of) **DATE REQUIRED | Y | Onset

Influenza vaccine in the last 12 months.

Order Flu Vaccination

- Reported A Recent Immunization For Flu **DATE REQUIRED | Y | Onset
- Pt Refused Flu Shot Today | Y | Onset

Dental exam obtained in last 12 months.

- Seeing A Dentist **DATE REQUIRED | Y | Onset
- Teeth Absent Edentulous **DATE REQUIRED | Y | Onset

PHQ9 (screening for depression) in the past 12 months.

- Administered Psychometric Depression Scale **DATE REQUIRED | Y | Onset

One pneumococcal vaccination at any time.

Order Pneumococcal Vaccination

- Reported A Recent Pneumovax | Y
- Pt Refused Pnemo Today | Y | Onset

PF's Use This Form First

We create lots of workflows to promote consistent use of our EMR. This one was created to help staff utilize the Wait List in EHS to ensure patient access to their provider:

WAIT LISTS WORKFLOW

If you are unable to put a patient in with their provider and you have triaged the call and feel that they need to get in offer the patient to put the patient on the wait list so that the team can call them if there is a cancellation.

To put someone on a wait list:
Open Scheduling in EHS
Right click
Click add to wait list
Select patient by clicking on the ellipse button and searching for the patient. Put in appointment type and make sure that the correct provider is marked on the right. Only select 1 provider.

Under appointment date select on and leave it on today's date.
Enter the comments as to why the patient is in need of an appointment. Be specific.

WORKING WAIT LISTS

To view the wait list right click in the provider's schedule and click on view wait list.
Teams are responsible for the patients on their waiting list. Look at them throughout the day and work to get the patients seen and worked in. It is your responsibility as a team to make sure that each and every patient gets called on the wait list by the end of the day. Even if you just call

them to tell them unfortunately there were no cancellations please call tomorrow for a SDA or you can overbook them for tomorrow's day, but you have to at least call them.

Our Quality Improvement Program has many audits that are performed throughout the year and coaching/action plans are made from this data. Here is an example of a PF (medical assistant) Peer Audit. Any area scoring less than an 80% requires coaching from the supervisor:

Please put a Y for Yes or N for No or N/A for not applicable

		CHART							PAM				CK IN
PT #	DOS	Chief Complaint	Meds checked	Allergies	Vitals	PMH	Pt Alerts	Recall / Deferred	HouseAsse Updated	Relation to Guarantor	HIPPA	Ins. Scanned	Copay Collected
27327	1/21/2010	YES	YES	YES	YES	YES	YES	NO	N/A	YES	YES	YES	N/A
277	1/21/2010	YES	YES	YES	YES	YES	N/A	N/A	YES	YES	YES	YES	N/A
5982	1/21/2010	YES	YES	YES	YES	YES	YES	YES	N/A	YES	YES	YES	N/A
6652	1/21/2010	YES	YES	YES	YES	YES	NO	NO	N/A	YES	YES	YES	YES
9544	1/21/2010	YES	YES	YES	YES	YES	YES	NO	YES	YES	YES	YES	N/A
22995	1/21/2010	YES	YES	YES	YES	YES	YES	NO	YES	YES	NO	YES	N/A
25516	1/21/2010	YES	YES	YES	YES	YES	YES	NO	N/A	YES	YES	YES	N/A
27326	1/21/2010	YES	YES	YES	YES	YES	YES	NO	N/A	YES	YES	N/A	N/A

We also set goals about the number of clients we will serve for certain programs or services. The goal sheet below is posted in our restrooms each month as a "Porcelain Promotion" (a way to inform staff how we are doing on certain goals):

GOAL: 1020 Well Child Visits in 2010

2009		2010
YTD=720		YTD= 858
	1020	
	950	
	900	
	880	
	860	September=50
	840	
	820	
	810	
	800	August=363
	760	
	740	
December=24	720	
	700	
November=30	680	
October = 25	660	
	640	
September= 43	620	
	600	
	580	
	560	
	540	
	500	
	480	
August= 244	460	
	440	July= 163
	420	
	400	
	380	
	360	
	340	
	320	
July = 104	300	
	280	June= 71
	260	
June = 42	240	
	220	
	200	May=38
May = 43	180	
	160	April=43
April = 30	140	
	120	
March=41	100	March=58
	80	
February=62	60	February= 50
	40	
	20	
January= 32	0	January = 32

Did you schedule a well child visit today??

Great Job in the month of August, biggest well child month ever!! Now we need to maintain 54

Color	
Red	HOT, HOT, HOT!!! We are locked on our target!!
Yellow	Come on yellow bellies... We can do better than this!!!
Green	Better GO, GO, GO!!! We're never gonna make it!!