CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Practice Reporting and Transformation Meeting
February 26, 2020

Practice Report Out
CTC-RI Adult Cohort 5

A to Z Primary Care

PDSA Plan for Improving Performance Measure

Aim: To continue talking to patients about Advanced Directives and maintain our uploading into Know my health Portal. Our goal is to have 25 advance directives uploaded by January 31, 2019.

Describe your first (or next) test of change:	Person responsible:	When to be done:	Where to be done:
Our practice plans to work on educating our patients about Advanced Directives and ensuring we have returned Advanced Directives uploading into the Know My Health Portal.	Janel Kathy Mary Ellen	MCWELLNESS Visits	Office

A to Z Primary Care

PDSA Plan for Improving Performance Measure

Plan:

List the tasks needed to set up this test of change:	Person responsible:	When to be done:	Where to be done:
Our Practice plans to call the patients before appointment to encourage them to bring a copy of their Advanced Directive if they have one completed. If they do not have one completed we will mail a blank one they can have completed and bring into their appointment.	MA's Janel	Prior to appointment	Office/ phone

Prediction what will happen when the test is carried out:	Measures to determine if prediction succeeds:
I predict with encouragement and reminders we will have more patients bringing in completed copies at time of visit.	Running a report to see how many Advanced Directives were uploaded during a certain time period.

A to Z Primary Care

PDSA Plan for Improving Performance Measure

Do: When our office ran this test we ended up finding that most of our elderly population were not informed about Advanced Directives. We educated both them and their families about the document and encouraged them to have the forms filled out and returned to our office.

Study: Our measure results were about right on target as to our predictions. We mailed out the forms prior to appointments or they were given at follow up and told to return them by mail or at Medicare Wellness visit. We ran a report and 24 advanced Directives were uploaded.

Act: Overall, I think if we continue to mail out the packets and call and remind patients to bring them in on Appointment we will have a successful return rate. Being in touch with the patient to encourage them to complete the advanced directive is important for completion

Brookside Family Medical

PDSA Plan for Improving Performance Measure

Aim: As the second leading cause of cancer-related deaths in the US among men and women combined, our commitment as a practice is to promote the health of our patients and to provide the necessary education regarding preventative health measures, for each patient to maintain a healthy lifestyle. By January 2020 our goal is to reduce the amount of patient non-compliancy for colorectal screening and in return, increase the percentage of eligible patient's to be screened for colorectal cancer, by 5% from Q2 2019.

Describe your first (or next) test of change:	Person responsible:	When to be done:	Where to be done:
The practice will implement a new reporting dashboard called the HEDIS module, into their EHR. This dashboard will give the practice and providers real-time data of gaps in care and non-compliant patients. The MA's will export all non-compliant patients listed in the module, into an Excel report and filter first for patients with upcoming appointments. The MA's will then have the ability to pre-visit plan for those patient's first and then move on to active patients on the report who do not have an upcoming appointment, or did not have any appointment in 2019. The MA's will send any request to the Quality Data Analyst, to obtain records of the colorectal screening, if the patient previously had any type of colorectal screening done.	Quality Manager Medical Assistants Quality Data Analyst	Early Septembe r	Onsite

Brookside Family Medical

PDSA Plan for Improving Performance Measure

Plan:

List the tasks needed to set up this test of change:	Person responsible:	When to be done:	Where to be done:
The Quality Manager will collaborate with Eclinicalworks to implement the HEDIS Module into the practice's EHR and make sure the measures are correctly mapped, so the data is accurately picked up within the dashboard. The Quality Manager will then train each staff member, which includes, the practice manager, medical assistants and providers on each measure included in the HEDIS Module and how to successfully close each gap in care and focus on the colorectal screening measure.	Quality Manager	Early September	Onsite

Prediction what will happen when the test is carried out:	Measures to determine if prediction succeeds:
With these changes and variations our practice predicts that we will show improvement on the colorectal screening from Q2 2019 to Q4 2019, by 5%. As well as reduce the non-compliancy in our patients	The colorectal screening baseline performance measurement in Q2 2019 was 614/1,116 = 55.02%.

Brookside Family Medical

PDSA Plan for Improving Performance Measure

Do: The practice learned how to properly capture the colorectal screening in the EHR. We learned that there were some colorectal screening results in the patient's chart that weren't accurately being captured because the results weren't in the correct structured area. The practice also learned to best capture where and when the patient had a colorectal screening early on for new patient's, so we changed our new patient registration forms to include to ask patient's where and how performed their colorectal screening. The MA's were the ones to call and obtain most of the results, with the Quality Data Analyst helping to identify the non-complaint patient's by using their insurer reporting from UHC and BCBS.

Study: Since the actions were initiated in early September, the percentage of patients who received a colorectal screening increased from 55.02% in Q2 2019 to 56.08% (683/1,218) in Q4 2019, a 1.06% increase. Although the practice did not reach their goal, they did achieve improvement on this measure.

Act: The practice was understaffed during this time, with a ratio of 2 MA's to 6 providers', making it difficult for the MA's to utilize the HEDIS Module to the fullest extent. Upon seeing the results, the practice has decided to hire another full-time MA, as well as utilize the Quality Data Analyst to obtain colorectal results from the specialist.

CCAP – Primary Care Partners

PDSA Plan for Improving Performance Measure

Aim: Improve health outcomes for patients 18-75 years of age with diabetes and improve their quality of care by improving the screening rate for eye disease (retinopathy) by patient identification, outreach, referral, accurate documentation of results and follow up treatment for annual ophthalmology examinations. Target goal: 34% by January, 31,2019 but ultimately OHIC/CTC goal of 51% by October, 2021.

Describe your first (or next) test of change:	Person responsible:	When to be done	Where to be done
Design a logistical and electronic work flow for abstraction of eye exam results into Nextgen's E.H.R. using the baseline measure for CMS131.	Cori Robinson	5/17/19	PCP/All sites

CCAP – Primary Care Partners

PDSA Plan for Improving Performance Measure

Plan:

List the tasks needed to set up this test of change:	Person responsible:	When to be done:	Where to be done:
Study the definitions of the quality measure CMS 131.	Clinical PI team/ CR	9/18	PCP/All sites
Establish Baseline compliance=18%.	Clinical PI team/ CR	1/19	PCP/All sites
Review and analyze reports with clinical leadership of community eye doctors to assess results reporting in the various consultation reports.	Kwetkowski/ Westrick	1/19	PCP/All sites
Provide medical terminology training to staff on the condition, definitions and interpretations.	Kwetkowski/ Westrick/Robinson	3/19	PCP/All sites
Determine the Workflow procedures within Nextgen to document the abstracted results.	Operations team/HIT	4/19	PCP/All sites
Finalize/approve final workflow for abstraction of eye exams.	C.Robinson	5/19	PCP/All sites
Measure compliance and develop and exception report to outreach patients.	CR/ClinicalPI	8/19	PCP/All sites

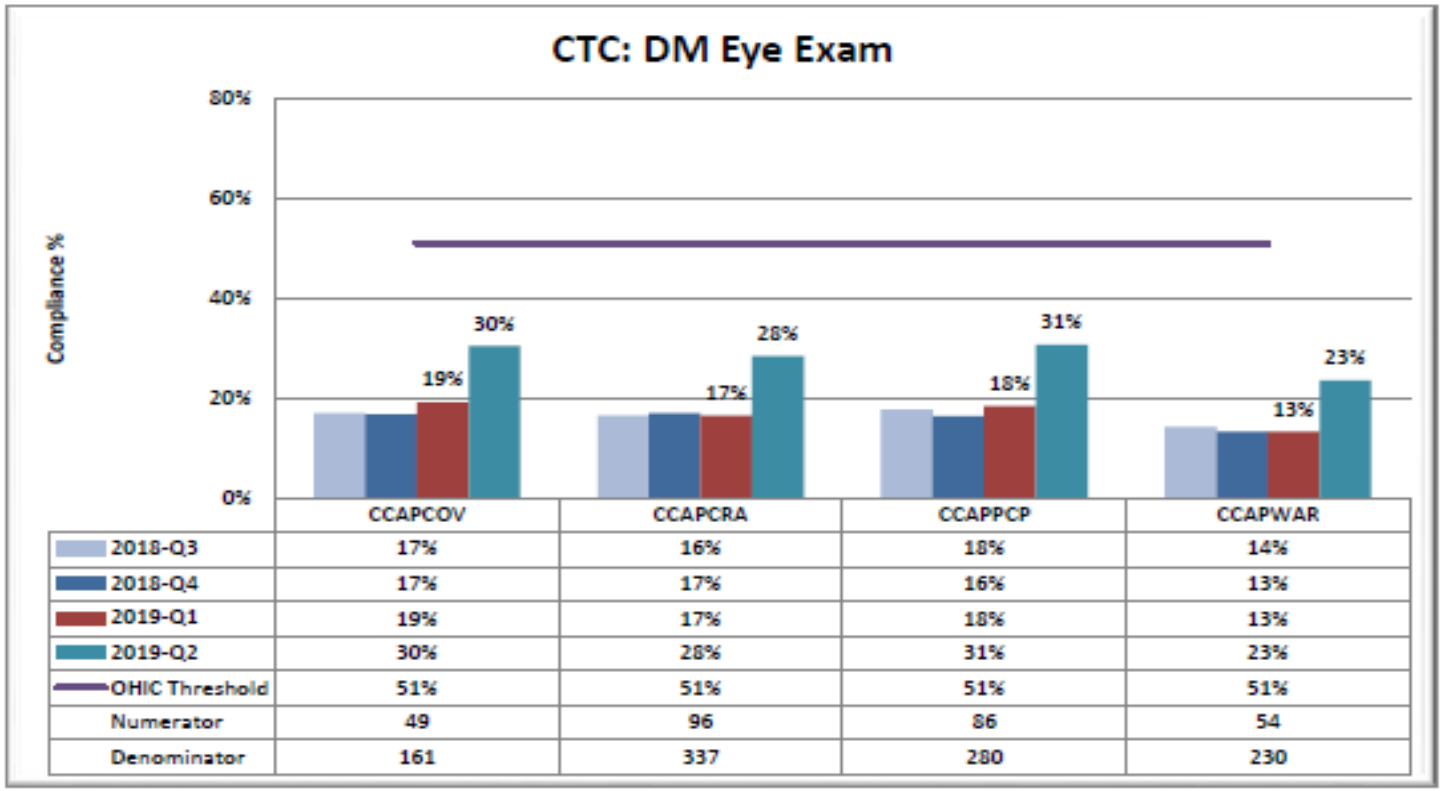
CCAP – Primary Care Partners

PDSA Plan for Improving Performance Measure

Prediction what will happen when the test is carried out:	Measures to determine if prediction succeeds:
Improved documentation of results and identification of patient in need of an annual exam.	CMS131- Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam in the 12 months prior to the measurement period.

Do:

Quarter 2, 2019 results for CCAP Primary Care Partners equal a 13% increase since Quarter 1, 2018.



	CCAPCOV	CCAPCRA	CCAPPCP	CCAPWAR
2018-Q3	17%	16%	18%	14%
2018-Q4	17%	17%	16%	13%
2019-Q1	19%	17%	18%	13%
2019-Q2	30%	28%	31%	23%
OHIC Threshold	51%	51%	51%	51%
Numerator	49	96	86	54
Denominator	161	337	280	230

CCAP – Primary Care Partners

PDSA Plan for Improving Performance Measure

Study: Introduction of a solid workflow for abstraction and documentation within the electronic health record has demonstrated significant initial results which is very consistent with the predictions and previous documentation improvement attempts with other measures.

Act: Using the outreach report (exception report), navigators will develop letters, telephone scripts and other reminders to incentivize patients to schedule an eye examination. Collaborative agreements with eye professionals will be pursued to achieve completion of examinations and documentation for approximately 194 patients by roughly 2.5% increase monthly.

EBCAP - Barrington

PDSA Plan for Improving Performance Measure

Measure 1: **Measure Affecting Health Care Costs – 3 or more Hospitalizations** **QI 09**	1. Measure selected for improvement; reason for selection	Reason: To reduce the number of patients with 3 or more hospitalizations.
	2./3. Baseline performance measurement; numeric goal for improvement	Baseline Start Date: 7/1/17 Baseline End Date: 6/30/2018 Baseline Performance Measurement (% or #): 22.0% (84/382) – Number of patients with 3 or more hospitalizations. Numeric Goal (% or #): 15%
	4. Actions taken to improve and work toward goal; dates of initiation	During weekly staff meetings the new internal workflow was discussed regarding all patients with 3 or more hospitalizations. NCMs will contact patients within 48 hours post-discharge, perform medication reconciliation and engage patients in care management activities to reduce hospital utilization. Date Action Initiated: 7/1/2018 In August of 2018 new Care Management Dashboard was implemented to monitor our high-risk patients in Hospitals.
	5. Remeasure performance (QI 12)	Start Date: 7/1/2018 End Date: 6/30/2019 Performance Re-Measurement (% or #): 4.6% (23/494)
	6. Assess actions; describe improvement.	Several interventions that involve multiple factors like patient needs assessment, medication reconciliation, patient education, arranging timely outpatient appointments, and providing telephone follow-up, have successfully reduced readmission rates by 17.4%

Lincoln Primary Care

PDSA Plan for Improving Performance Measure

Aim: As the second leading cause of cancer-related deaths in the US among men and women combined, our commitment as a practice is to promote the health of our patients and to provide the necessary education regarding preventative health measures, for each patient to maintain a healthy lifestyle. By January 2020 our goal is to reduce the amount of patient non-compliancy for colorectal screening and in return, increase the percentage of eligible patient's to be screened for colorectal cancer, by 5% from Q2 2019.

Describe your first (or next) test of change:	Person responsible:	When to be done:	Where to be done:
The practice will implement a new reporting dashboard called the HEDIS module, into their EHR. This dashboard will give the practice and providers real-time data of gaps in care and non-compliant patients. The MA's will export all non-compliant patients listed in the module, into an Excel report and filter first for patients with upcoming appointments. The MA's will then have the ability to pre-visit plan for those patient's first and then move on to active patients on the report who do not have an upcoming appointment, or did not have any appointment in 2019. The MA's will send any request to the Quality Data Analyst, to obtain records of the colorectal screening, if the patient previously had any type of colorectal screening done.	Quality Manager Medical Assistants Quality Data Analyst	Early September	Onsite

Lincoln Primary Care

PDSA Plan for Improving Performance Measure

Plan:

List the tasks needed to set up this test of change:	Person responsible:	When to be done:	Where to be done:
The Quality Manager will collaborate with Eclinicalworks to implement the HEDIS Module into the practice's EHR and make sure the measures are correctly mapped, so the data is accurately picked up within the dashboard. The Quality Manager will then train each staff member, which includes, the practice manager, medical assistants and providers on each measure included in the HEDIS Module and how to successfully close each gap in care and focus on the colorectal screening measure.	Quality Manager	Early September	Onsite

Prediction what will happen when the test is carried out:	Measures to determine if prediction succeeds:
With these changes and variations our practice predicts that we will show improvement on the colorectal screening from Q2 2019 to Q4 2019, by 5%. As well as reduce the non-compliancy in our patients.	The colorectal screening baseline performance measurement in Q2 2019 was 127/2,120 = 5.99%.

Lincoln Primary Care

PDSA Plan for Improving Performance Measure

Do: The practice learned how to properly capture the colorectal screening in the EHR. We learned that there were some colorectal screening results in the patient's chart that weren't accurately being captured because the results weren't in the correct structured area. The practice also learned to best capture where and when the patient had a colorectal screening early on for new patient's, so we changed our new patient registration forms to include to ask patient's where and how performed their colorectal screening. The MA's were the ones to call and obtain most of the results, with the Quality Data Analyst helping to identify the non-complaint patient's by using their insurer reporting from UHC and BCBS.

Study: Since the actions were initiated in early September, the percentage of patients who received a colorectal screening increased from 5.99% in Q2 2019 to 39.68% (900/2,268) in Q4 2019, a 33.69% increase. The practice achieved improved performance on this measure.

Act: After achieving success on this measure, the practice will continue with the plan of action. The only change to be made is to utilize the quality data analyst more thoroughly to obtain the results. The MA's will send a "telephone encounter" to the analyst after the patient's appointment on where and when the patient had screening done, so the data analyst can easily obtain.

Massasoit Internal Medicine

PDSA Plan for Improving Performance Measure

Aim: Currently, 15% of patients are keeping appointments for a follow up visit after going to the ER. With additional outreach from MAs, based on more frequent checking of current care and adherence to new workflow, we predict that in the six months from Aug. 31 2019 to Jan. 31 2020, an additional 30% of patients will schedule and keep appointments."

Describe your first (or next) test of change:	Person responsible:	When to be done:	Where to be done:
Revise workflow to assure daily contact with patients recently d/c from ED. Create telephone dialogs for MA's to use when calling patients.	Misty	9/1/2019	Office

Massasoit Internal Medicine

PDSA Plan for Improving Performance Measure

Plan:

List the tasks needed to set up this test of change:	Person responsible:	When to be done:	Where to be done:
Adhere to workflow. Check Current Care website twice a day instead of once a day. Assign one MA to make calls and educate them on the project. Use certain telephone dialogs to encourage patients to schedule and keep appointments.	MA-Michelle Misty	9/1/19 to 1/15/20	Office Online

Prediction what will happen when the test is carried out:	Measures to determine if prediction succeeds:
I predict that 30% of our patients will schedule an appointment and be seen by a Provider.	Analyzing the ER tracking sheet and identify when and if the patient was seen.

Massasoit Internal Medicine

PDSA Plan for Improving Performance Measure

Do:

- It gave the Practice an opportunity to schedule patients' Annual visits while we made contact to schedule ER f/u.
- It would have been better to give more days for the patients to come in. Maybe prior to 15 days.
- Staff started to use phone call scripts for other types of appointments as well.
- Patients expressed such gratitude when we called to f/u and offer appt.

Study:

There were 56% of patients that kept appointment for ER f/u.
Numerator =89
Denominator =160

Act:

Create a generic letter reminding patients to "Call Us First" before going to Emergency Room.

Michelle Van Nieuwenhuize, M.D., LLC

PDSA Plan for Improving Performance Measure

Aim: Improve colon cancer screening rate to over 70% compliance in my practice.

Plan:

List the tasks needed to set up this test of change:	Person responsible:	When to be done:	Where to be done:
Each patient will be asked by the medical staff when the last colonoscopy was completed and the gastroenterology provider that performed it. If it is not in the chart the medical staff will request this record and have it faxed to our office. At each physical the colonoscopy history will be taken and if it has been done but not documented in a fashion that will be captured it will be entered in the computer so this data can be captured. If the patient has not been screened, we will investigate the barriers for this screening and perhaps offer other options for screening. Hand out information on colon cancer screening.	Michelle VanNieuwenhuize, M.D. and Lisa Parascandolo, NCM (data analysis)	7/1/2019 to 12/31/2019	Office

Michelle Van Nieuwenhuize, M.D., LLC

PDSA Plan for Improving Performance Measure

Plan:

Prediction what will happen when the test is carried out:	Measures to determine if prediction succeeds:
I think the practice will have better data about colon cancer screening and hopefully we will have improved colon cancer screening rate.	The practice will compare my quarterly data sent to CTC 7/2019 to the data after the change 1/2020 which is collected directly from my EMR report function

Do: *What issues or unexpected events did you encounter?*

Sometimes it was difficult to get reports sent from providers who have retired

Feedback and observations from the participants:

Some patients who are new to the practice do not even remember who did their colonoscopies.

Sometimes patient records where difficult to obtain.

Michelle Van Nieuwenhuize, M.D., LLC

PDSA Plan for Improving Performance Measure

Study: 7/1/2019 Colon cancer screening was 255/541 or 47.1 %
12/31/2019 colon cancer screening was 420/527 or 79.7 %
Our predictions were correct. We have a screening rate over 70 percent.

This action has captured the true patient data and has made conversation about colonoscopy or alternate colon cancer screening easier in the practice. We have had may patients that were opposed to having a colonoscopy who have been screened with Cologuard.

I think this will cause more screening in the future that may have been avoided by patients due to procedure fear.

Act: We will continue to collect this data at each physical and engage in conversation about barriers to having colon cancer screening.

Nardone Medical Associates

PDSA Plan for Improving Performance Measure

Aim: Implement a Colorectal Cancer Screening practice initiative to increase screening rates from the baseline of 20.95% (measurement period 07/01/2018-6/30/2019) to 30% by 9/30/19. Increasing Colorectal Cancer Screening propaganda and awareness will ensure more patients will complete their routine screening.

Plan:

List the tasks needed to set up this test of change:	Person responsible:	When to be done:
Display culturally appropriate brochures in patient areas to encourage patients to talk to providers about screening.	NCM	During check-in
Display culturally appropriate posters in patient rooms	NCM	07/01/2019
Flag patients for the provider that are overdue for a colonoscopy during pre-visit planning.	Medical Assistant	Pre-Visit
Provide patients over the age of 45 with pamphlets regarding the importance of routine colorectal cancer screening upon check in.	Front Desk Secretary	During check-in
Provide a list of free or low -cost colorectal screening services upon check in.	Front Desk Secretary	During check-in
Provide evidence -based guidelines for colorectal cancer screening including risk assessments and educational tools to support cancer screening.	Provider, Support Staff	During visit

Nardone Medical Associates

PDSA Plan for Improving Performance Measure

Plan:

Prediction what will happen when the test is carried out:	Measures to determine if prediction succeeds:
More patients will complete routine colorectal cancer screenings then would normally have without the screening initiative, therefore improving screening rates from the 20.95% baseline to 30%.	Review Colorectal Screening rates for Quarter 3 (10/01/2018-09/30/2019) against the baseline of 20.95% from Quarter 2 (07/01/18-06/30/19)

Do: The cycle was carried out as planned and Quarter 3 data demonstrated a Colorectal Screening rate of 22.85% among active patients 51 to 75 years of age at the end of the measurement period, who received an acceptable colorectal screening during the identified lookback period (See CTC/OHIC Measure Specifications).

Study: It was predicted that Colorectal Cancer Screening rates would increase from the baseline of 20.95% to 30% by 9/30/2019. As of October 15, 2019, the rate was calculated at 22.85%, even though we did not obtain our goal; we did note a quarterly improvement.

Act: The plan was not as successful as predicted; however, we did see an improvement from our initiative. We anticipate for the next cycle, to send out postcard mailers to patients' that are overdue for colorectal screenings.

Nardone Medical Associates

PDSA Plan for Improving Performance Measure

Study: It was predicted that Colorectal Cancer Screening rates would increase from the baseline of 20.95% to 30% by 9/30/2019. As of October 15, 2019, the rate was calculated at 22.85%, even though we did not obtain our goal; we did note a quarterly improvement.

Act: The plan was not as successful as predicted; however, we did see an improvement from our initiative. We anticipate for the next cycle, to send out postcard mailers to patients' that are overdue for colorectal screenings.

Ocean State Primary Care of Coventry

PDSA Plan for Improving Performance Measure

Aim: By January 2020 our goal is to reduce the amount of patient non-compliancy for colorectal screening and in return, increase the percentage of eligible patient's to be screened for colorectal cancer, by 5% from Q2 2019.

Describe your first (or next) test of change:	Person responsible:	When to be done:	Where to be done:
The practice will implement a new reporting dashboard called the HEDIS module, into their EHR. This dashboard will give the practice and providers real-time data of gaps in care and non-compliant patients. The MA's will export all non-compliant patients listed in the module, into an Excel report and filter first for patient's with upcoming appointments. The MA's will then have the ability to pre-visit plan for those patient's first and then move on to active patients on the report who do not have an upcoming appointment, or did not have any appointment in 2019. The MA's will send any request to the Quality Data Analyst, to obtain records of the colorectal screening, if the patient previously had any type of colorectal screening done.	Quality Manager Medical Assistants Quality Data Analyst	Early September	*Onsite

Ocean State Primary Care of Coventry

PDSA Plan for Improving Performance Measure

Plan:

List the tasks needed to set up this test of change:	Person responsible:	When to be done:	Where to be done:
The Quality Manager will collaborate with eClinicalworks to implement the HEDIS Module into the practice's EHR and make sure the measures are correctly mapped, so the data is accurately picked up within the dashboard. The Quality Manager will then train each staff member, which includes, the practice manager, medical assistants and providers on each measure included in the HEDIS Module and how to successfully close each gap in care and focus on the colorectal screening measure.	Quality Manager	Early September	*Onsite

Prediction what will happen when the test is carried out:	Measures to determine if prediction succeeds:
With these changes and variations our practice predicts that we will show improvement on the colorectal screening from Q2 2019 to Q4 2019, by 5%. As well as reduce the non-compliancy in our patients.	The colorectal screening baseline performance measurement in Q2 2019 was 211/467 = 45.18%.

Ocean State Primary Care of Coventry

PDSA Plan for Improving Performance Measure

Do: The practice learned how to properly capture the colorectal screening in the EHR. We learned that there were some colorectal screening results in the patient's chart that weren't accurately being captured because the results weren't in the correct structured area. The practice learned to best capture where and when the patient had a colorectal screening early on for new patient's, so we changed our new patient registration forms to include to ask patient's where and how performed their colorectal screening. The MA's were the ones to call and obtain most of the results, with the Quality Data Analyst helping to identify the non-complaint patient's by using their insurer reporting from UHC and BCBS.

Study: Since the actions were initiated in early September, the percentage of patients who received a colorectal screening increased from 45.18% in Q2 2019 to 62.88% (293/466) in Q4 2019, a 17.7% increase. The practice achieved improved performance on this measure.

Act: After achieving success on this measure, the practice will continue with the plan of action. The only change to be made is to utilize the quality data analyst more thoroughly to obtain the results. The MA's will send a "telephone encounter" to the analyst after the patient's appointment on where and when the patient had screening done, so the data analyst can easily obtain.

Ocean State Primary Care of Westerly

PDSA Plan for Improving Performance Measure

Aim: By January 2020 our goal is to reduce the amount of patient non-compliancy for colorectal screening and in return, increase the percentage of eligible patient's to be screened for colorectal cancer, by 5% from Q2 2019.

Describe your first (or next) test of change:	Person responsible:	When to be done:	Where to be done:
The practice will implement a new reporting dashboard called the HEDIS module, into their EHR. This dashboard will give the practice and providers real-time data of gaps in care and non-compliant patients. The MA's will export all non-compliant patients listed in the module, into an Excel report and filter first for patients with upcoming appointments. The MA's will then have the ability to pre-visit plan for those patient's first and then move on to active patients on the report who do not have an upcoming appointment, or did not have any appointment in 2019. The MA's will send any request to the Quality Data Analyst, to obtain records of the colorectal screening, if the patient previously had any type of colorectal screening done.	Quality Manager Medical Assistants Quality Data Analyst	Early September	*Onsite

Ocean State Primary Care of Westerly

PDSA Plan for Improving Performance Measure

Plan:

List the tasks needed to set up this test of change:	Person responsible:	When to be done:	Where to be done:
The Quality Manager will collaborate with Eclinicalworks to implement the HEDIS Module into the practice's EHR and make sure the measures are correctly mapped, so the data is accurately picked up within the dashboard. The Quality Manager will then train each staff member, which includes, the practice manager, medical assistants and providers on each measure included in the HEDIS Module and how to successfully close each gap in care and focus on the colorectal screening measure.	Quality Manager	Early September	*Onsite

Prediction what will happen when the test is carried out:	Measures to determine if prediction succeeds:
With these changes and variations our practice predicts that we will show improvement on the colorectal screening from Q2 2019 to Q4 2019, by 5%. As well as reduce the non-compliancy in our patients.	The colorectal screening baseline performance measurement in Q2 2019 was 946/2,187 = 43.26%

Ocean State Primary Care of Westerly

PDSA Plan for Improving Performance Measure

Do: The practice learned how to properly capture the colorectal screening in the EHR. We learned that there were some colorectal screening results in the patient's chart that weren't accurately being captured because the results weren't in the correct structured area. The practice also learned to best capture where and when the patient had a colorectal screening early on for new patient's, so we changed our new patient registration forms to include to ask patient's where and how performed their colorectal screening. The MA's were the ones to call and obtain most of the results, with the Quality Data Analyst helping to identify the non-complaint patient's by using their insurer reporting from UHC and BCBS.

Study: Since the actions were initiated in early September, the percentage of patients who received a colorectal screening increased from 43.26% in Q2 2019 to 53.96% (1,138/2,109) in Q4 2019, a 10.7% increase. The practice achieved improved performance on this measure.

Act: After achieving success on this measure, the practice will continue with the plan of action. The only change to be made is to utilize the quality data analyst more thoroughly to obtain the results. The MA's will send a "telephone encounter" to the analyst after the patient's appointment on where and when the patient had screening done, so the data analyst can easily obtain.

PCHC - Randall Health Clinic

PDSA Plan for Improving Performance Measure

Aim: To increase access for new patients.
A long wait has been a determent to many patients for entering into care. Randall Square as the newest PCHC clinic believed that there can be a more streamlined way for patient to obtain a PCP and begin accessing Primary care. Recognizing that all team members must be involved in creating access and understanding its significance.

Plan:

List the tasks needed to set up this test of change:	Person responsible:	When to be done:	Where to be done:
-Have a dedicated phone line for new patients -Complete a quick registration into our EMR -Schedule same day appointment -Creation of a daily news sheet that let's each team know how many appointments were filled daily.	Call center staff and Randall Square staff-Front desk supervisor, HCD & AHCD	January 2019 and ongoing	through telephone access then in person completion of registration at clinic day of appointment

PCHC - Randall Health Clinic

PDSA Plan for Improving Performance Measure

Do: Randall has been tracking access and new patient volume from 1/22019 through 7/31. The results have been amazing .2, 394 new patients have accessed care at Randall. Since opening two years ago the total new patient volume has exceeded 4, 444 new patients.

Study: All four steps in the plan have been in place since August 2019
Randall Square has been able to intake more new patients than any other PCHC location in history. We believe that having the ability to schedule same day appointments is key to getting and keeping people engaged in care. The ability to have a separate phone queue for new patients to access has contributed to that success and our tracking appointments through a daily newsletter filled keeps staff on the same page.

PCHC – Randall Health Clinic

PDSA Plan for Improving Performance Measure

Study:

As of 11/30/19 the number of new patients seen at Randall Square for the year was 3,398

- Patients choose new patients line even when they are established. This artificially increases the amount of new patient calls and may prevent some folks from getting through for an appointment.
- New patient queues are not adequately staffed- answer rate is between 60-70 % of all calls- in comparison individual clinics answer rate for all appointment/questions between 80-90%.
- New patients who were routed through the new patient only queue and wanted an appointment that day were able to get one over 60% of the and another 15% for following day to accommodate patient request. Staffing directly affect the ability to intake new patients, with no surprise, shortages negatively affecting access.

Act: Randall will continue to implement all ongoing processes with revisions to balance entry for new patients and increase access for new patient by expansion of hours.

Richard VanNieuwenhuize, M.D.

PDSA Plan for Improving Performance Measure

Aim:

Specific: All patients age 18 and older.
Measurable: Depression screening, 90% patients screened.
Achievable: Make sure that at any visit patient screening is within 1 year.
Relevant: Every patient must be screened.
Time Specific: 07/01/2019-01/31/2020.

Plan:

List the tasks needed to set up this test of change:	Person responsible:	When to be done:	Where to be done:
Every patient encounter- be sure that a depression screening is up to date within 1 year- and address change in mood at any type of appointment, such as sick visit, if applicable.	Nurse Care Manager	07/01/2019-01/31/2020.	Data will be extracted in a report in EHR.

Prediction what will happen when the test is carried out:	Measures to determine if prediction succeeds:
Every patient will be screened, depression screening rate will be at least 90%.	If goal of 90% of patients screened is not met, decision will be made on how to implement screening into patient encounters to satisfy goal.

Richard VanNieuwenhuize, M.D.

PDSA Plan for Improving Performance Measure

Do: As of 2019-Q2 clinical depression screening 77.2% of patients were screened. Prior baseline was 62.4%. As change was implemented with PDSA(07/31/2019-01/31/2020) 1217 patients were screened, 145 patients were excluded based on criteria (CMS2v7, NQF- 0418 Community/Population Health). Out of the 1072 patients to be screened, 963 patients were screened (89.8%).

Study: Our goal was for 90% of patients seen during time period to be screened for depression. 89.8% of patients were screened, meeting goal +/-.2%.

Act: We will continue to monitor depression screening at every patient encounter, and if not completed within 12 months, the patient will be screened. Our goal is to be sure every patient is screened.

Prospect CharterCARE

PDSA Plan for Improving Performance Measure

COPD Treatment: **Long-Acting Beta Agonist (LABA) with inhaled corticosteroids (ICS) AND long acting muscarinic agonist (LAMA) medications**	1. Measure selected for improvement; reason for selection	Patients with a diagnosis of COPD and currently being treated with a combination of Long-Acting Beta Agonist (LABA) with inhaled corticosteroids (ICD) AND long acting muscarinic agonist (LAMA) medications are eligible to be switched to Trelegy. Switching current treatment (LABA/ICS and LAMA) to Trelegy can provide patients with improvements in cost and as a result, improved adherence.
	2./3. Baseline performance measurement; numeric goal for improvement	Baseline Start Date: August 31, 2019 Baseline End Date: August 31, 2019 Baseline Performance Measurement (% or #): 24 eligible patients identified; Numeric Goal (% or #): 25% or 6/24 patients in total

Prospect CharterCARE

COPD Treatment: **Long-Acting Beta Agonist (LABA) with inhaled corticosteroids (ICS) AND long acting muscarinic agonist (LAMA) medications**	4. Actions taken to improve and work toward goal; dates of initiation	1. Prospect pharmacist educates primary care staff regarding benefits of Trelegy vs LABA/ICS/LAMA 2. Prospect pharmacist conducts chart review to confirm potentially eligible patients. 3. Prospect pharmacist reviews patient specific clinical criteria with primary care provider. 4. Prospect pharmacist reviews clinical criteria with pulmonologist if applicable. 5. Prospect pharmacist phone outreaches to patient to review the advised change in medication regimen. 6. Prospect pharmacist communicates patient response to prescribing physician and/or pcp. 7. Medication order submitted to applicable pharmacy. 8. Ongoing patient education provided. 9. Continually reassess/ maintain contact with patient. Date Action Initiated: September 1, 2019
	5. Remeasure performance	24 patients were originally identified in the numerator but upon further scrutiny of the variables, the numerator was adjusted to 4 patients. All 4 were converted to Trelegy for a performance rate of 100%.
	6. Assess actions; describe improvement.	This documentation is specific to CCMA Lincoln and the related CTC-RI milestone requirements. However, the Trelegy PDSA was conducted across Prospect, CharterCARE.

Robert Carrellas, M.D.

PDSA Plan for Improving Performance Measure

Aim: Improve depression screening screenings by 10%

Describe your first (or next) test of change:	Person responsible:	When to be done:	Where to be done:
Re-design work flow to improve depression screening rates. Sue to changes within the practice, staff have noted Depression screening documentation decreased.	Ashley, Susan	September 2019	office

Robert Carrellas, M.D.

PDSA Plan for Improving Performance Measure

Plan:

List the tasks needed to set up this test of change:	Person responsible:	When to be done:	Where to be done:
• Hold staff meeting to discuss current workflow for annual exams • Develop work flow changes to assist in increasing the depression screenings. • Develop a laminated checklist of items to document and place in each exam room for the MD to review.	Ashley, Sue, Susan, Dr. Carrellas	September 2019	office

Prediction what will happen when the test is carried out:	Measures to determine if prediction succeeds:
Increase in depression scores from 76% to 86% by January 2020	Depression screening and follow-up reports

Do: Beginning in September 2019, the office staff began monthly meetings to review workflows which include performing the depression screening during the extended wellness visits. Reminders of required documentation were placed in each exam for easy access of screenings and testing to be performed at each visit. The office staff also began proactively monitoring last physical exam date and contacting patients for the annual physical exam each year to prevent lapses in annual exams.

Robert Carrellas, M.D.

PDSA Plan for Improving Performance Measure

Study: The measured result for January 2020 was 80% for depression screening. The depression screening rate at the beginning of the PDSA cycle in August 2019 was 76%. The practice was unable to reach our predicted goal of 86%. One barrier noted was challenges of getting patients scheduled within 12 months for their next physical (patients may have had annual exams 13-14 months apart versus 12 months apart).

Act: The practice plans to focus on scheduling future annual exams within 12 months to avoid patients falling out of the 12 month period as the depression screen is primarily completed at annual exams and as needed. The office manager has begun to go through each month for the prior year to identify patients who will be coming up from their physical exams and providing outreach to schedule the exams in a timely manner.

Wayland Medical Associates

PDSA Plan for Improving Performance Measure

Aim: Improve a1c percentage.

Describe your first (or next) test of change:	Person responsible:	When to be done:	Where to be done:
Test using care team education regarding documentation and the checklist, we hope to improve our a1c percentage	NCM, PharmD, MA	Starting August 2019 Ongoing	office

Plan:

List the tasks needed to set up this test of change:	Person responsible:	When to be done:	Where to be done:
• We needed to plan our test including the collection of data. NCM will meet with DM patients in need of managed a1c . MA's will prep all annual physicals. MD's will order Q3 months. • *Initial Measurement Period: 7.1.19-7.31.19 =* ***Goal =*** *50% 10.1.2019-12.31.2019 = 30%*	NCM, MA, MD	Beginning August, 2019 ~ ongoing protocol at OV and F/U as needed	office

Wayland Medical Associates

PDSA Plan for Improving Performance Measure

Plan:

Prediction what will happen when the test is carried out:	Measures to determine if prediction succeeds:
Although every member of the care team must work together to monitor labs are completed q 3 months, it is the NCM and MA who will carry the primary responsibility; we predict some resistance as staff are concerned about the length of checklist for quality metrics. We predict that eCW is not capturing this measure at all times, due to documentation in various places within patient chart. We predict the percentage of patient compliancy with a1c testing will improve with additional staff education and the addition of NCM offices located within the patient exam room hallways.	I am happy to report one of our MA's has offered to work directly with our NCM and Pharmacist to assure results are uploaded into the system and DM patients due for testing have orders in-hand as they are escorted to our in-house lab Staff continues to work pre-visit checklist, allowing capture of measure at each OV

Wayland Medical Associates

PDSA Plan for Improving Performance Measure

Do:

- Nancy met with the 3 medical providers, 2 NCMs and 1 pharmacist to discuss this metric and the other quality metrics that must be addressed. Discussion to adopt workflow which will allow patient's with uncontrolled a1c to be walked to the NCM office for nutrition counseling and follow up a1c education. Standing lab orders will be added to patient chart for NCM to access and print with future date for tracking.
- Education on how to place standing order with future date within eCW was taught to NCM and Pharmacist.
- Education for MA's on requirements for tracking and lowering a1c levels in DM patients. Discussion and training on best practices for pre-visit planning was given to MA's

Study:

Follow-Up Measurement Period: 10.1.19-12.31.2019 = 30%
Results better than Goal of 50%

Act:

Despite best efforts to help patients actually get BW done, compliancy continues to be a barrier. Office is evaluating purchasing A1c machine for immediate testing at OV. This will allow immediate results and increase compliancy.