

Transparent Measurement & Monitoring

Measurement (Data) is the cornerstone of QI in Care Delivery

- How do you know how you are doing ?...are you doing what you *intend* to do ?
- How do you know if changes result in improvement ?
- Need some “data”need to be able to do assessment...

Measuring & Using Data

- is part of “what we do” in medicine all the time
 - In our patient care we measure and use data to diagnose and manage treatment
 - BP, weight, ECG, EMG, Ejection Fraction, BMD, lesion size, etc.
 - Hemoglobin, WBC, A1c, TSH, ESR, Creatinine, Sodium, ALT etc.
 - In our research we measure and use data to determine Effectiveness of a new test or treatment
 - BMD and/or reduction in rate of fractures
 - LDL and/or cardiac events or death
 - Cr and/or need for renal replacement

Measurement (Data) is the cornerstone of QI in Care Delivery

Separates what is *thought* to be happening from
what is *really* happening

Example:

“I am a good endocrinologist & care a lot about keeping my patients with diabetes as healthy as possible. I order UMA on my patients routinely as part of their recommended care”

UMA data: 27% of my patients with diabetes had a UMA checked in past year

Use of Data (measurements)

- Establishes a baseline (*a low scores is ok*)
- Indicates whether changes lead to improvements
- Reduces continuation of ineffective changes
- Allows monitoring to ensure that improvements are sustained
- Allows comparisons of performance across sites (benchmarking)

That UMA data...

- Baseline 27% (*Benchmark for UMA = 80%*)

- Establishing a Benchmark

- The **average** of all scores

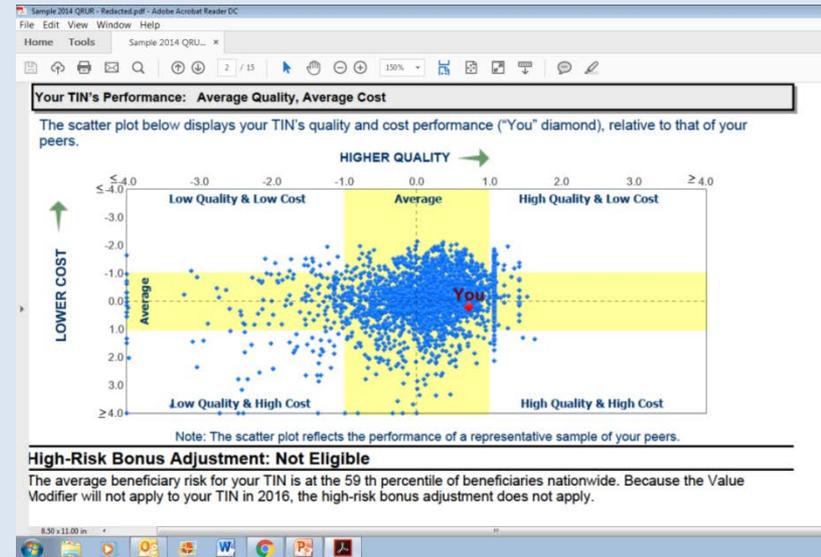
- Example: Medicare cost data on utilization report

- The **average of the top performers** (*achievable*)

- Example: National Healthcare Quality report

- A **desired goal**

- Example: NCQA benchmark for medication reconciliation



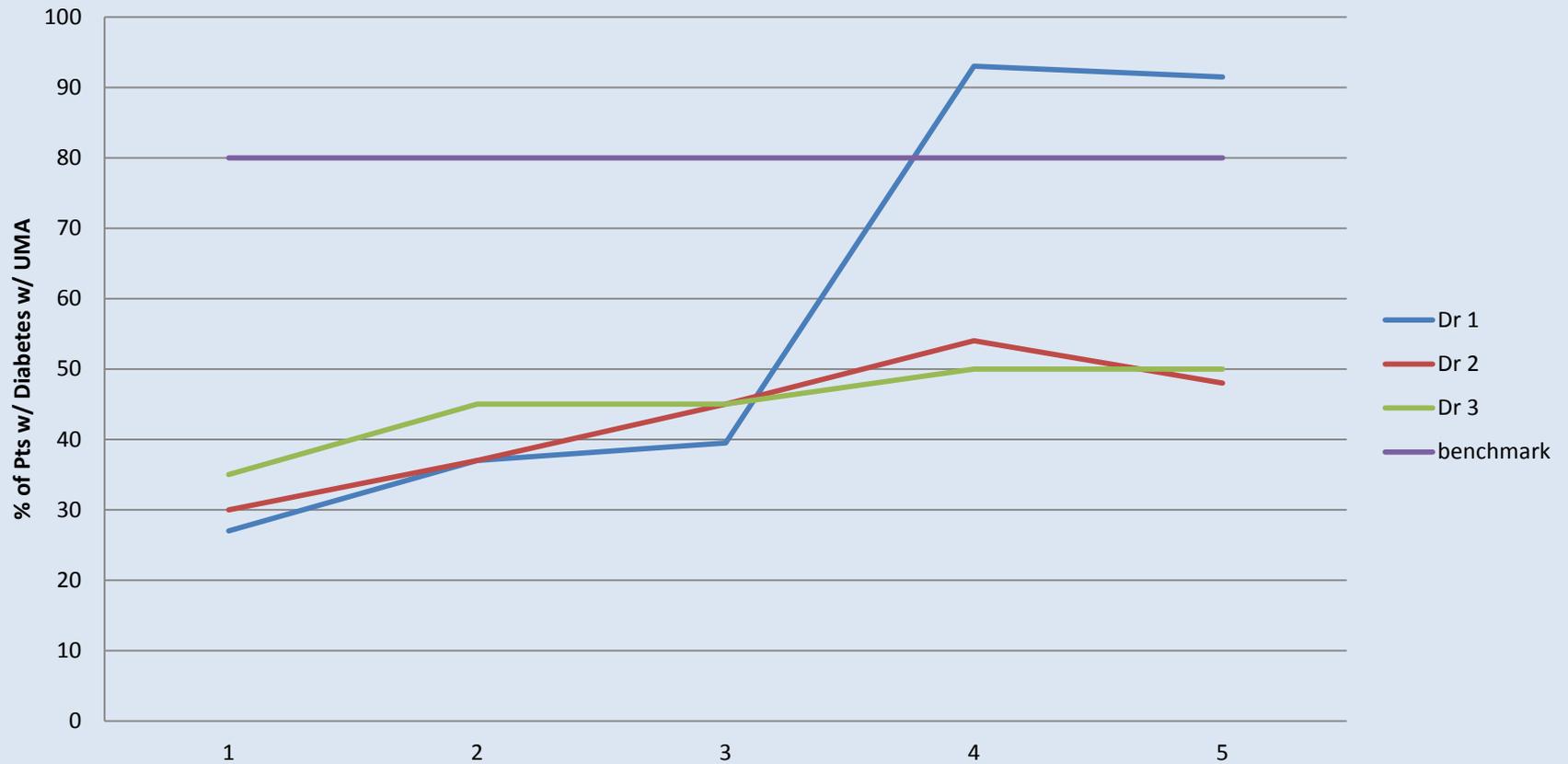
That UMA data...

- Baseline 27% (*Benchmark for UMA = 80%*)
- I “tried harder” → 37%
- Started using a registry & team care → 39.2%
- Expected greater improvement
 - Did “root cause analysis” (the 5 whys)
 - New approach (check the HIE, if no UMA there, order)
 - Better results → 92.8%



Sharing Data: *Transparency*

Diabetes UMA Data



Best Practice

A technique or methodology that,
through experience and research,
has proven to reliably lead to
a desired result



SHARING
INFORMATION &
BEST PRACTICES

Types of Data

Quantitative Data

- Frequency of No Show appointments
- Number of patients getting immunizations
- Wait time for appointment
- Frequency of ED visits
- Number of women getting mammograms
- In-patient bed days

Qualitative Data

- Patient feedback/ experience of care (*“ I feel like s/he explains things thoroughly so I can understand”*)
- Staff satisfaction (*“I feel underutilized”*)
- Clinician satisfaction (*“I feel overloaded and unheard”*)
- Observations

Common Types of Performance Measures

- Quality of Care
 - Structure
 - Staff (e.g. OR team members, mental health clinic team members)
 - Equipment / space /assessment tools
 - Process (linked to better patient outcomes)
 - Hepatitis C: Screening for HCC in patients with cirrhosis
 - VTE prophylaxis (perioperative)
 - Smoking assessment & cessation counselling
 - Outcome measures (sum of all structures & processes)
 - Psoriasis: response to oral systemic or biologic therapy
 - Response to Antidepressant medication at 6 months
 - Surgical site infection
 - Refraction after cataract surgery (planned vs final)

Structure allows Process, Process drives Outcome
vs “Random” effects

Measures serve as indicators to let us know if we are on track

Analogy

- The Ski Racer



Structural elements:

- The Skier
- The Equipment
- The Snow

Process:

- Training schedule
- Race prep
- Speed
- Turn techniques

Outcome:

- Winning...or Not

Does the skier, the equipment and training and techniques consistently produce wins (good outcome) or not

Analogy

- The Ski Racer



Structure:

- The Skier
- The Equipment
- The Snow

Structure Measure

- % time had correct wax on skis

Process:

- Training schedule
- Race prep
- Speed
- Turn techniques

Process Measure

- % time meeting training targets

Outcome:

- Winning...or Not

Does the skier, the equipment and training and techniques consistently produce wins (good outcome) or not

Intermed. Outcome Measure

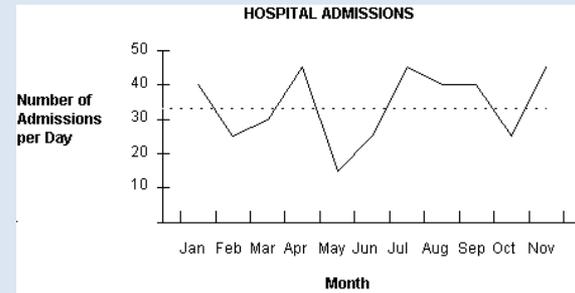
- Completing the race

Outcome Measure

- Place in the finish (time)

Common Types of Performance Measures

- Utilization (measure of activity) (not good or bad per se, but can be tied to quality: e.g. appropriate use criteria)
 - Number of MRI exams
 - ED visits
 - In-patient bed days/LoS
- Appropriate Use measures (*activity tied to evidence of benefit or lack of benefit*) (also called “efficiency measures”)
 - Underuse
 - BMD screening in women >65
 - Overuse
 - Head CT for low risk trauma or headache
 - Low back imaging
 - Misuse
 - Wrong site surgery



Common Types of Performance Measures

- Patient Experience/Satisfaction/Report of Care
 - Communication/Information
 - Hepatitis C: Discussion & Shared Decision Making Surrounding Treatment Options
 - Caring/Compassion
 - Wait Times

What makes Data Meaningful ?

- Needs to be “**actionable**” (something you can do something about)
- Needs to be related to something that matters (*the “Why”*):
 - patient outcomes
 - patient experience
 - practice burden
 - business model/sustainability
 - Costs (e.g. to generate shared savings, as part of a “system” (bundled payment, episode of care, ACO))

Using Data to Drive Care

- What do you want to improve?
- What is your starting point (measurement)?
- Use QI methods to plan change for improvement
- Use data to see if change is effective or not
 - *Set a goal or benchmark to aim for*
- Include entire team in the process
 - Explain the WHY, commit to the WHY (*shared vision*)
- Share data with team
 - *Create a “data wall” or a dashboard*
- Learn from everything and everyone

Examples of use of data in Care Delivery

- My practice
 - Getting necessary information on referred patients: use of Care Coordination Agreement (CCA)
 - Baseline survey showed at least 50% of referrals had critical information missing
 - Was the CCA having any effect ?
 - MD did the audit of adequate vs not adequate (based on an established set of criteria)
 - Tracked on excel spreadsheet, reviewed by entire team
 - Initially no change in the information we received
 - Used “the 5 Why’s”
 - We changed the wording on our cover letter

Referral Form for referral to **Western Slope Endocrinology**

PLEASE SHARE THIS WITH YOUR PHYSICIANS, NPs AND PAs

We want to provide you with value-added and appropriate assistance with your **ENDOCRINOLOGY referrals**. Please note the requested information. Feel free to use your own referral form but please do include as much of the information as possible to help us expedite your patient's referral.

Providing a summary of the issues necessitating referral or a clinical question will help us ensure that we address the appropriate concerns and also will help us triage the referral.

Every referral request is reviewed by the staff and our physician upon receipt.

We may ask that you do some additional testing prior to referral to prevent delay or to further define the process for your patient.

We want to be sure that you and your patient get the advice and assistance to care that is requested. We are working to align our referral response to meet those aims. We will do our best to tie into any CARE PLAN that has been established for the patient and to outline any endocrine care plan or action plan items. As we all know, this is a work in progress for all of us and please feel free to let us know if there are additional items or a different format that would be of more help to you in coordinating the care of our common patients.

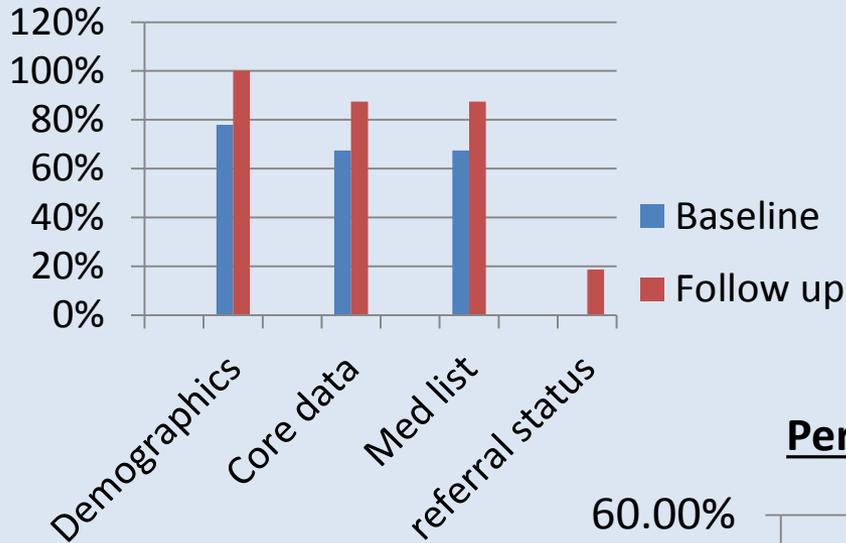
Sincerely and Thank You,

Carol Greenlee MD and the staff of Western Slope Endocrinology

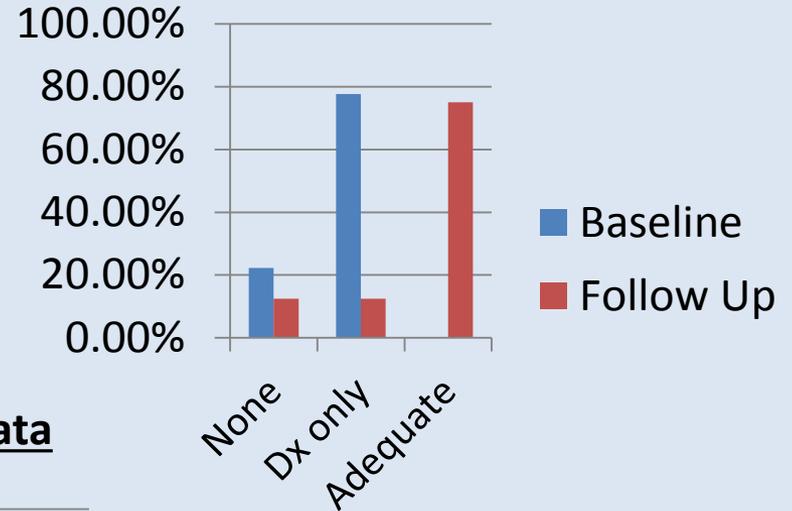
Referral Request Elements

Before & After CCA Referral Form

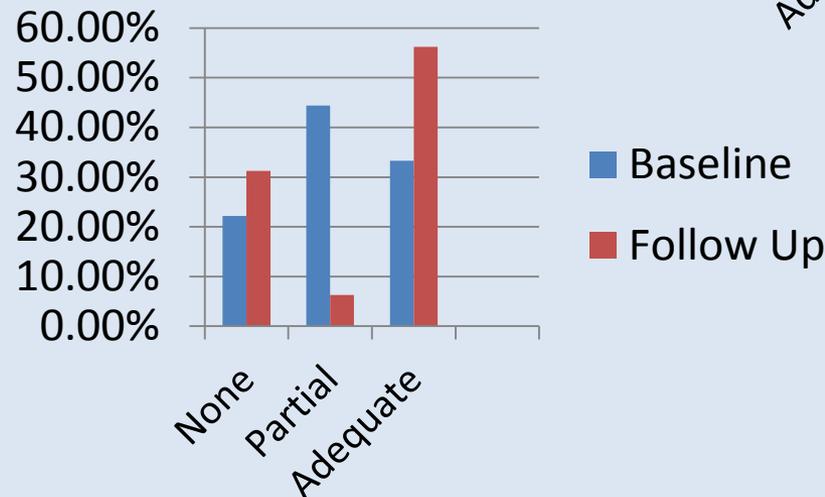
Basic Data



Clinical Question/RfR



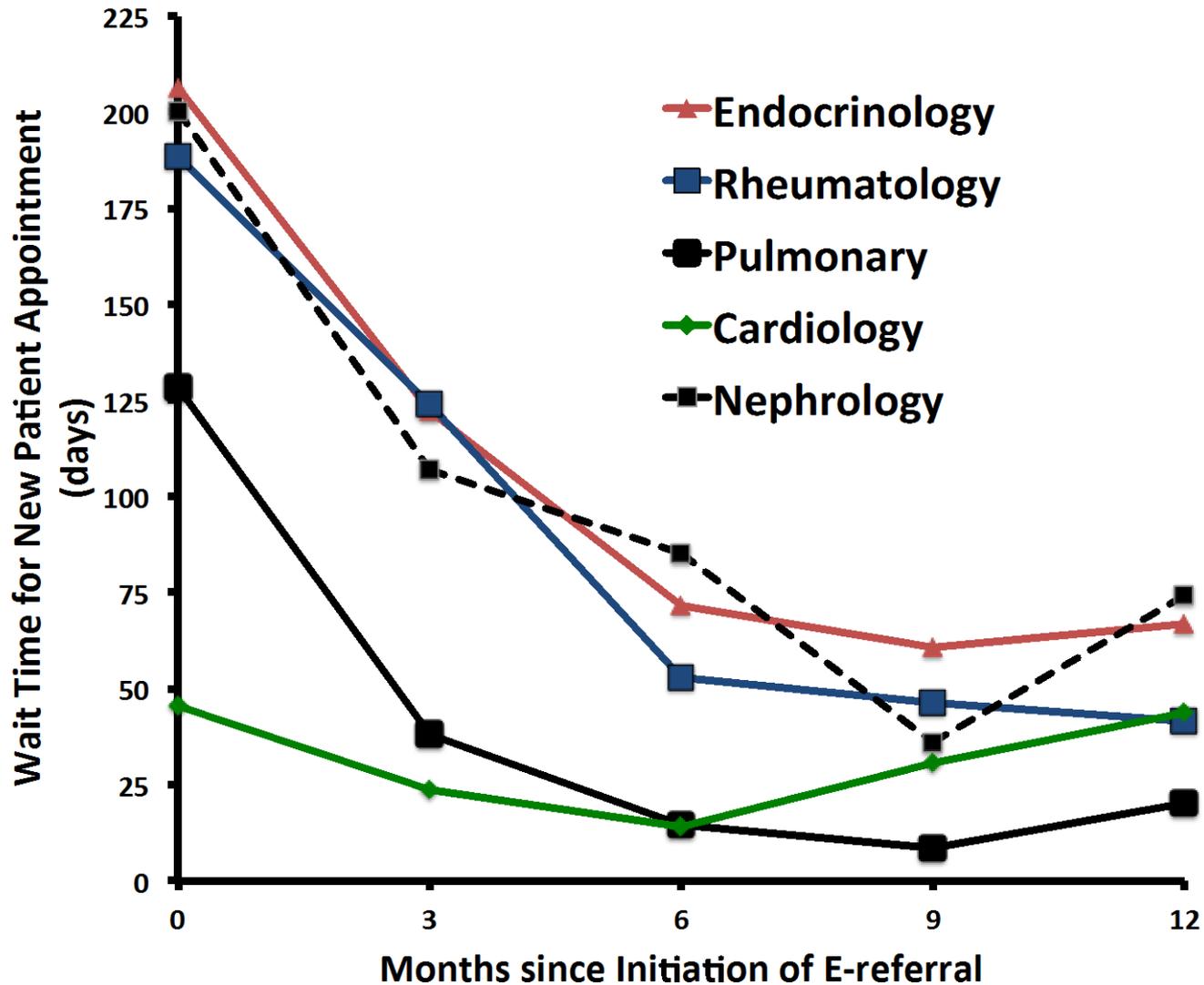
Pertinent Data



Examples of use of data in care delivery

- San Francisco General Hospital system (FQHCs)
 - Improving access (*excessive wait time* for specialty clinics):
use of an e-referral system/ process to improve
referral disposition (*“pre-consultation review”*)
 - Was this improving the wait time (delay in care/access)?

Impact on Wait Times



Courtesy E. Murphy SFGH

Use of Data (measurements)

- Let's us know “how are we doing?”
- Helps us find opportunities for improvement
 - Don't limit to measures in your EHR, be creative
- Use it for the right reason (the “Why”)
 - To improve care
 - Not data for data sake or check-the-box
- Share the results
- Set goals/ benchmarks for where you want to be
- Use to sustain achievements & plan for continued further improvement

END

Questions

1. Which quality/performance measure(s) can your practice use to help improve care for your patients?
2. What utilization measure(s) might be valuable for your practice to review & monitor to help reduce unnecessary services (ED use, Hospital admissions or readmissions, imaging, other testing, antibiotic prescriptions) and to reduce costs?
3. What other data would help you deliver care more effectively or efficiently (ideas: wait times, no show rates, patient satisfaction, etc.)

Resources

Website with tool showing specialty measures

www.QPP.CMS.gov

Network for Regional Healthcare Improvement (NRHI)

How to get and interpret your practice QRUR

Will forward links