EHR IMPACT ON QUALITY MEASURES AND POPULATION HEALTH IMPROVEMENTS

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October 15, 2007

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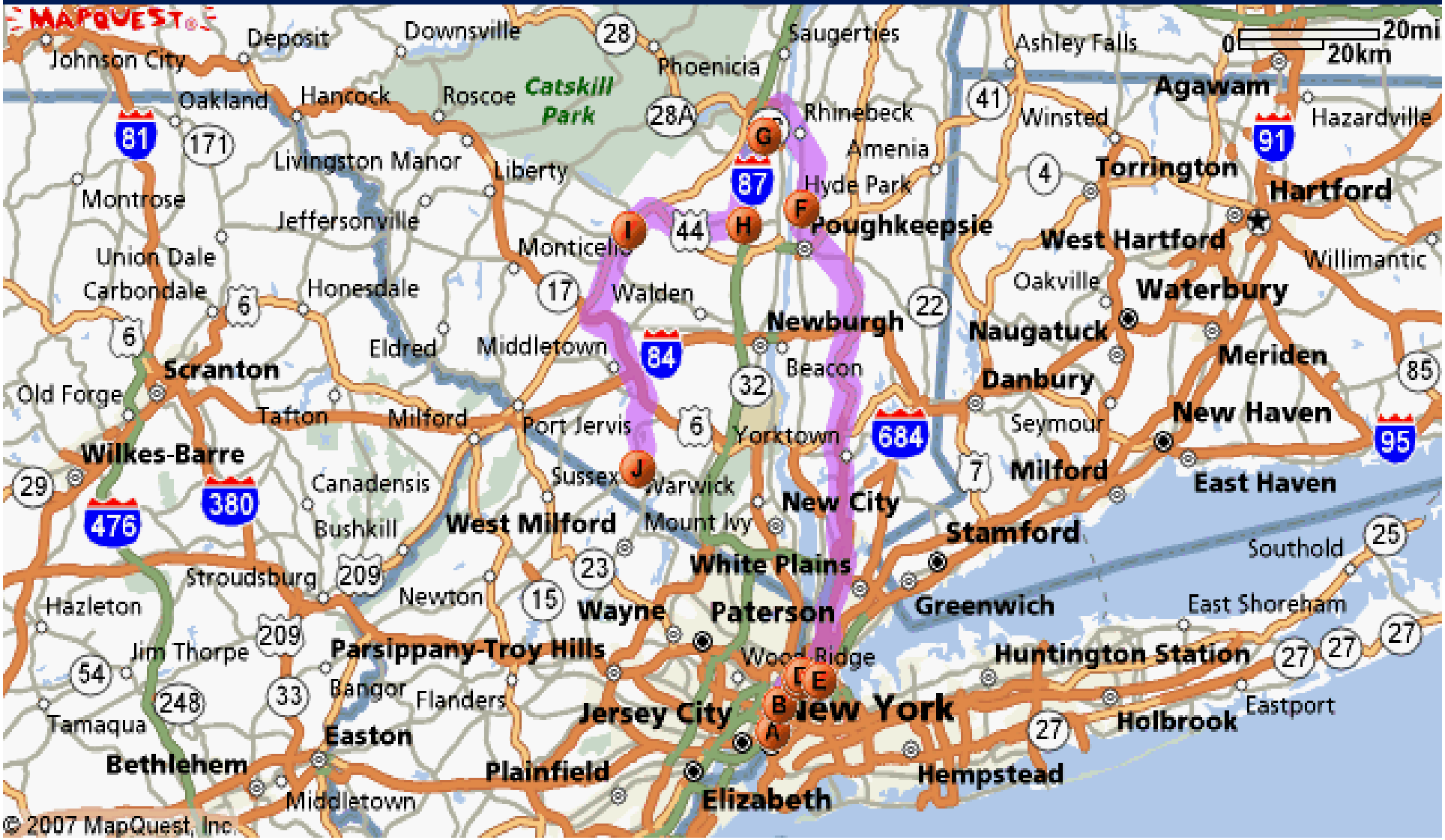
IFH AT A GLANCE



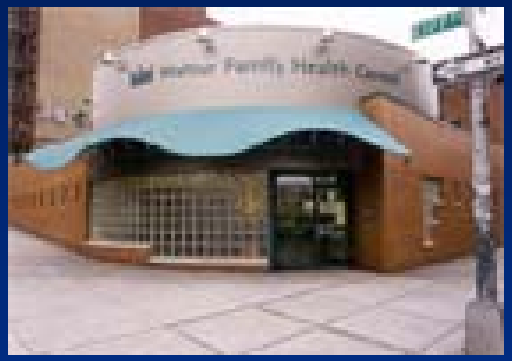
IFH AT A GLANCE

- Geographic area – Manhattan, Bronx, New Paltz, Kingston, Ellenville, Hyde Park, Port Ewen.
- 15 Community Health Centers
- One School Based Health Center
- Two FP Residency Programs
- Two Free Clinics for the Uninsured
- Two Article 31 Mental Health Sites

IFH AT A GLANCE

Sidney Hillman

Walton



Urban Horizons

Parkchester

Mount Hope

Westchester

IFH AT A GLANCE

New Paltz

Kingston

Hyde Park

Ellenville

QUALITY IMPROVEMENT DEMANDS ON CHC'S

- NATIONAL DEMANDS

National Voluntary Consensus Standards for Ambulatory Care: A Physician-focused Performance Measurement Set. The National Quality Forum has initiated 86 national voluntary consensus standards for measuring and reporting the quality of ambulatory care

NCQA: Reviews Health Plan Performance based on HEDIS. HEDIS is the performance measurement tool of choice for more than 90 percent of the nation's managed care organizations. There are over 70 different HEDIS measures ranging from review of cervical cancer screening to smoking cessation and customer satisfaction.

JCAHO: Ongoing continuous quality improvement expected.

QUALITY IMPROVEMENT DEMANDS ON CHC'S

- REGIONAL

Local Departments of Health-

HEDIS measures often used.

- LOCAL

Use of Pay-For Performance Quality incentives

by PPO's, other medical groups.

Internally Driven CQI utilized to satisfy Grant requirements.

INFORMATION TECHNOLOGY TOOLS USED TO IMPROVE QUALITY OF CARE

- Electronic decision support tools
- Utilization and sharing of reporting data
- Standardized documentation tools
- Electronic patient outreach
- CQI beyond decision support

IFH QI READINESS PRE-EHR

- Access to internal data greatly limited.
- Resource allocation limited organization- wide QI topic review to three topics per year.
- Areas covered included comprehensive HIV review, diabetes, adolescent screening for tobacco and substance abuse, postpartum care
- Interventions that worked best were those that facilitated better documentation by providers (e.g. Stamps)

IFH QI READINESS PRE-EHR

- Average time spent on chart review- 30 minutes to one hour per chart depending on the study
- Average length it took to complete Pre-EpicCare studies- three months.
- Chart reviewers were doctors and nurses at our clinics. Time spent on chart review made it more difficult for them to complete other administrative tasks.

OUTCOMES

- IFH transitioned all NYC area clinics into EpicCare between October 2002 and January 2003
- Within the first six months provider productivity matched pre-EpicCare levels.
- In 2004 and beyond, unprecedented productivity levels were noted and have been sustained.

Outcomes

- Ease of information retrieval
- Availability of reports relevant to CHCs
- Ease of development of custom reports
- Ease of running ad-hoc reports

IFH BEST PRACTICE ALERTS

PRIMARILY BASED ON HEDIS CRITERIA

PNEUMOVAX

SEASONAL FLUVAX

BREAST CANCER SCREENING

CERVICAL CANCER SCREENING

LEAD SCREENING

HGBA1C TESTING AND CONTROL

IFH BEST PRACTICE ALERTS

- OPHTHALMOLOGY CONSULTS FOR DIABETICS
- PEAK FLOW MEASUREMENTS FOR ALL ASTHMATICS
- NEPHROLOGY CONSULTS FOR PATIENTS WITH GREATER THAN 1.8 SERUM CREATININE
- LDL SCREENING
- ANNUAL RPR SCREENING IN HIV

DID THEY WORK ?

- Initial concern about the introduction of best practice alerts (BPA's) replaced by enthusiasm for the improvement seen in multiple clinical areas.
- Keys to Success- Making sure that the BPA's were accurate in capturing services rendered (e.g. There are dozens of CPT codes utilized for Cervical Cancer screening)

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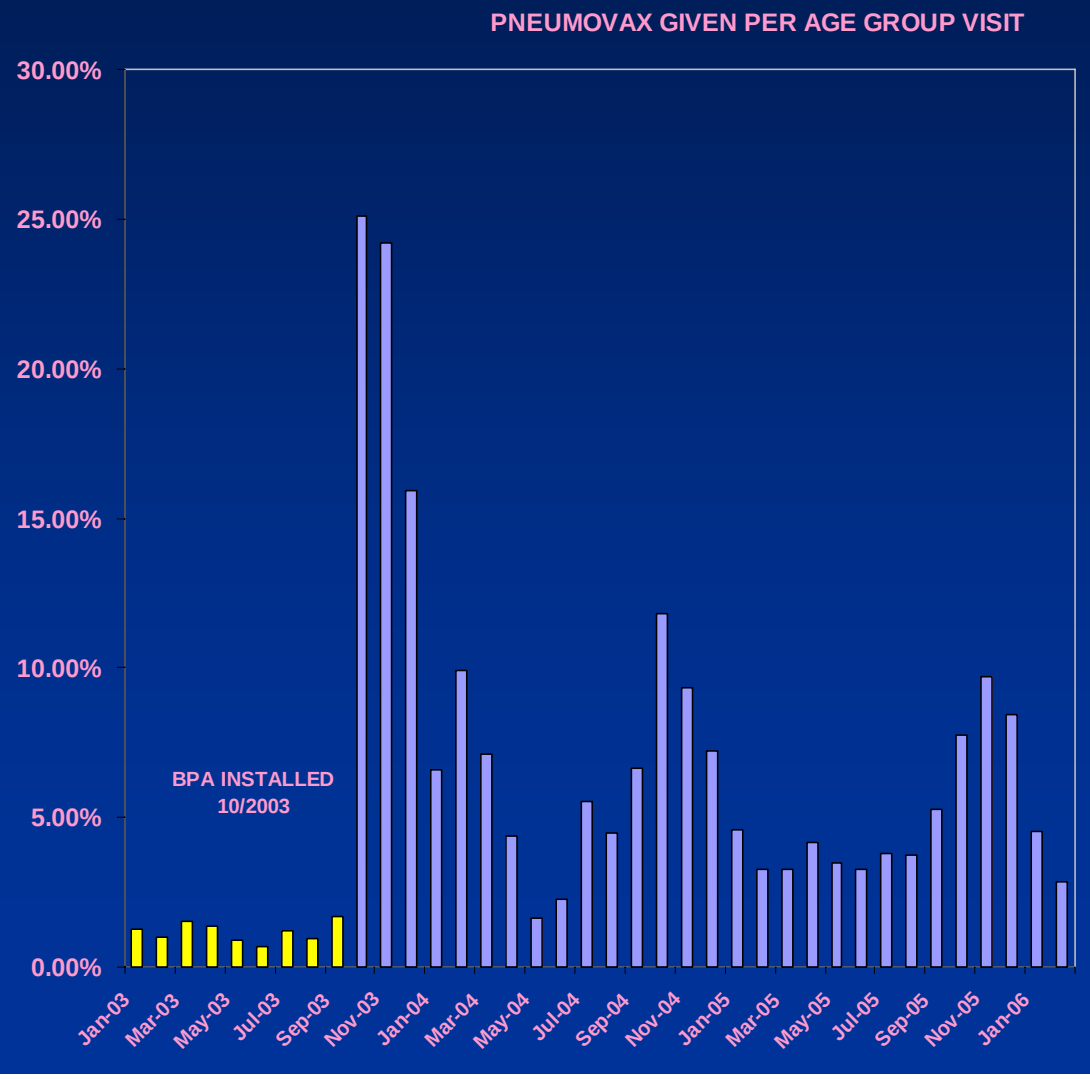
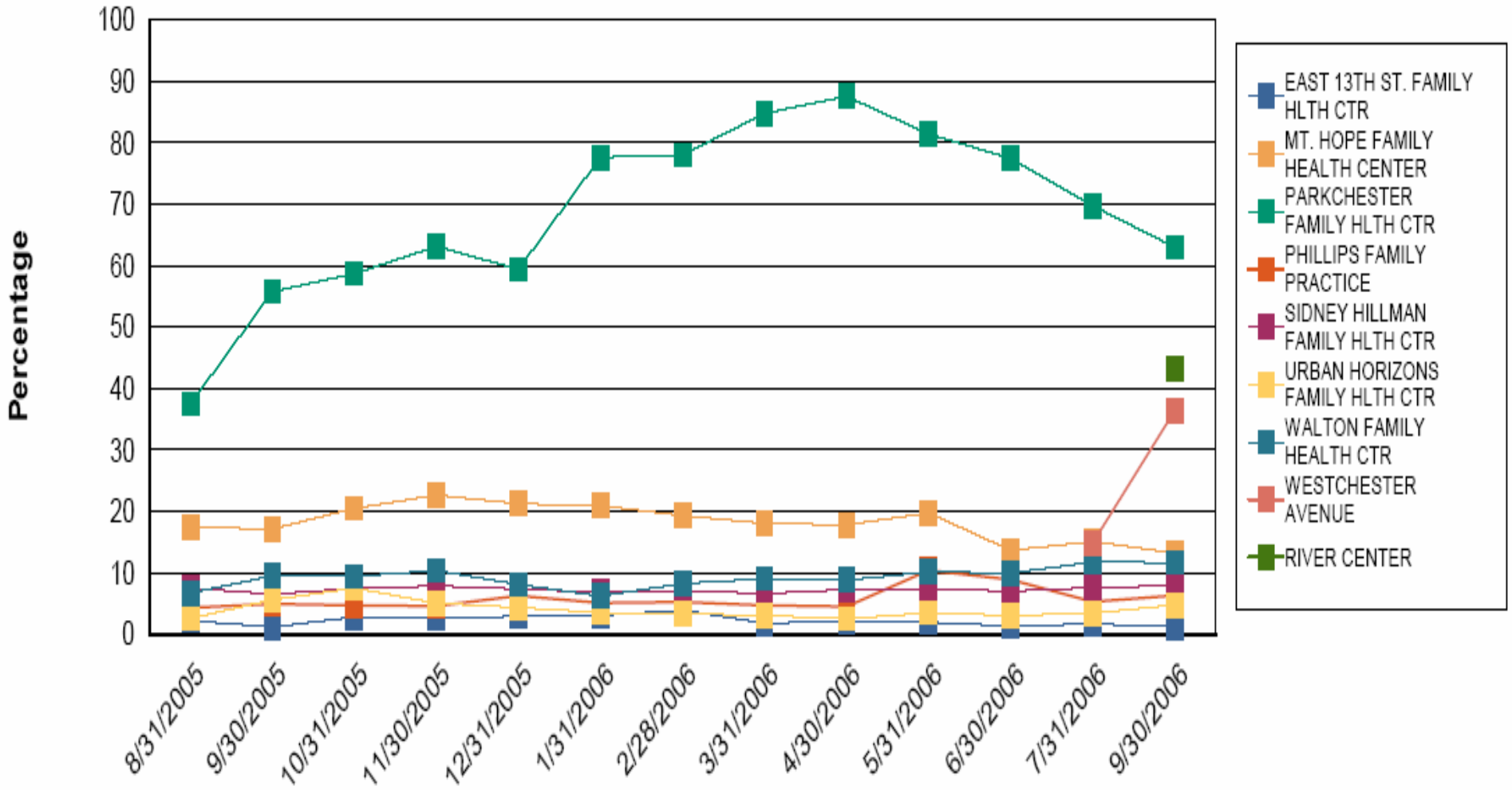
PNEUMOVAX



Depression Screen with PHQ2



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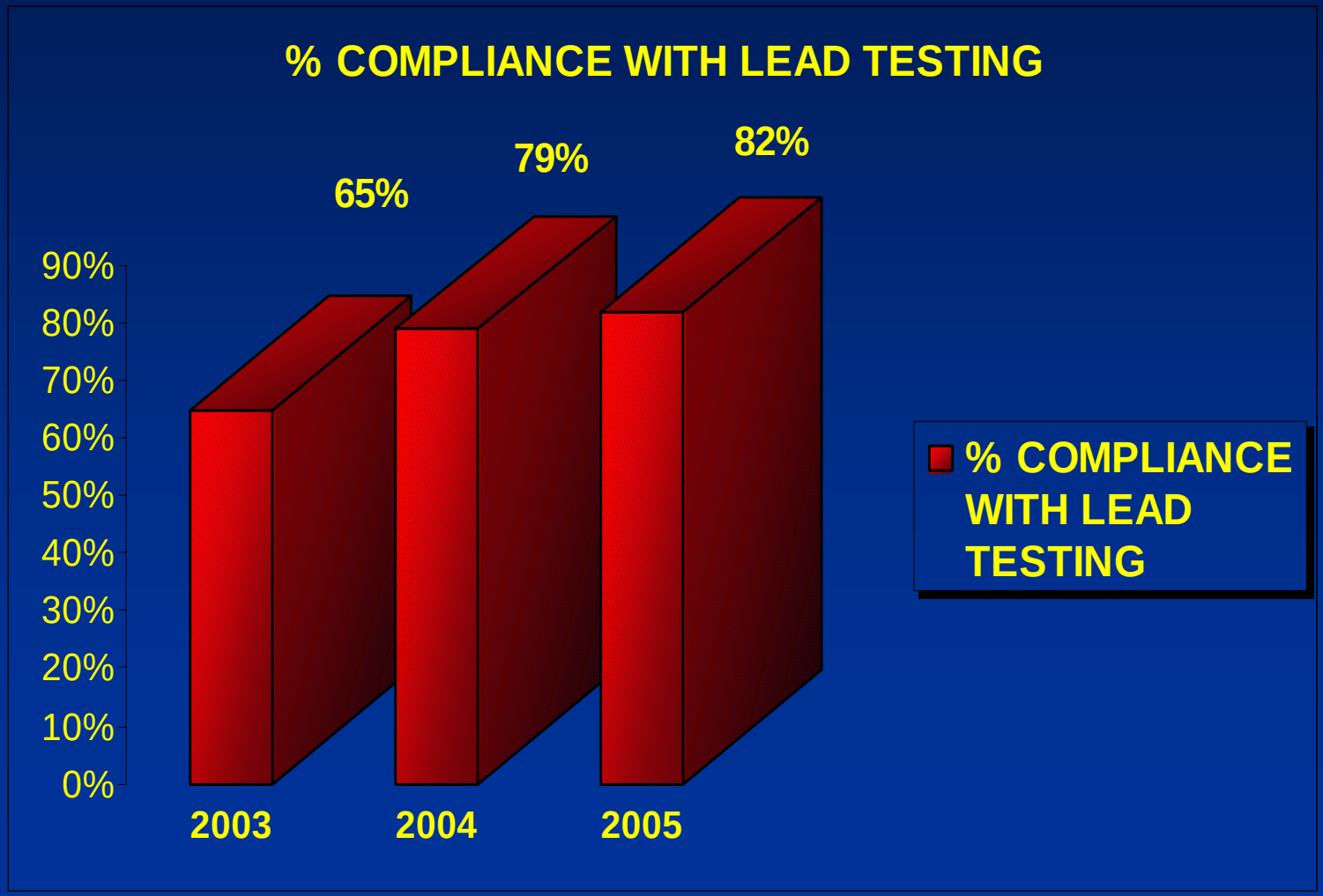
LEAD TESTING IN TWO YEAR OLDS



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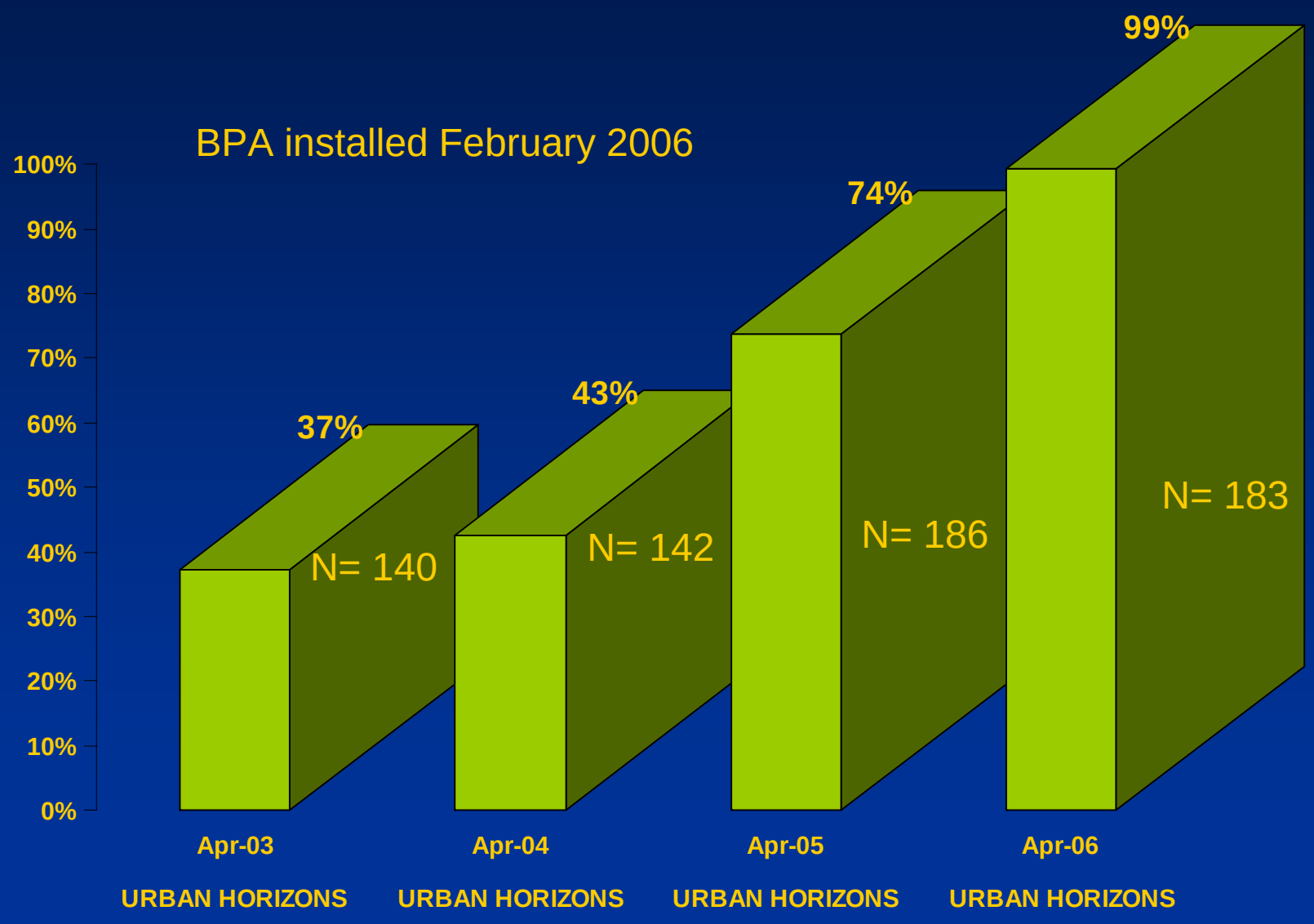
PPD Screening of HIV Patients
Urban Horizons 15 Month Reports



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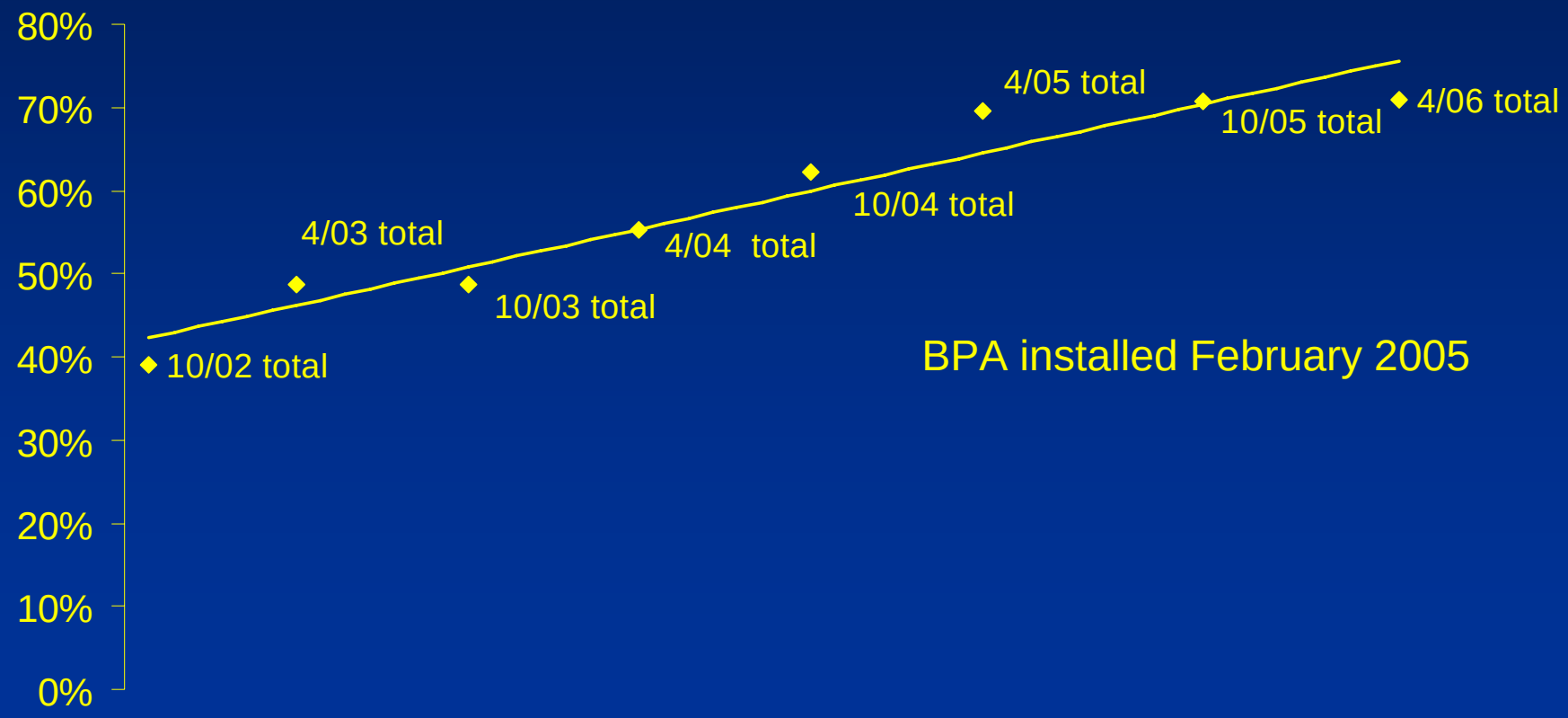
RPR TESTING IN HIV PATIENTS ACROSS ALL IFH SITES



15 month blocks starting from 10/02 to 4/06

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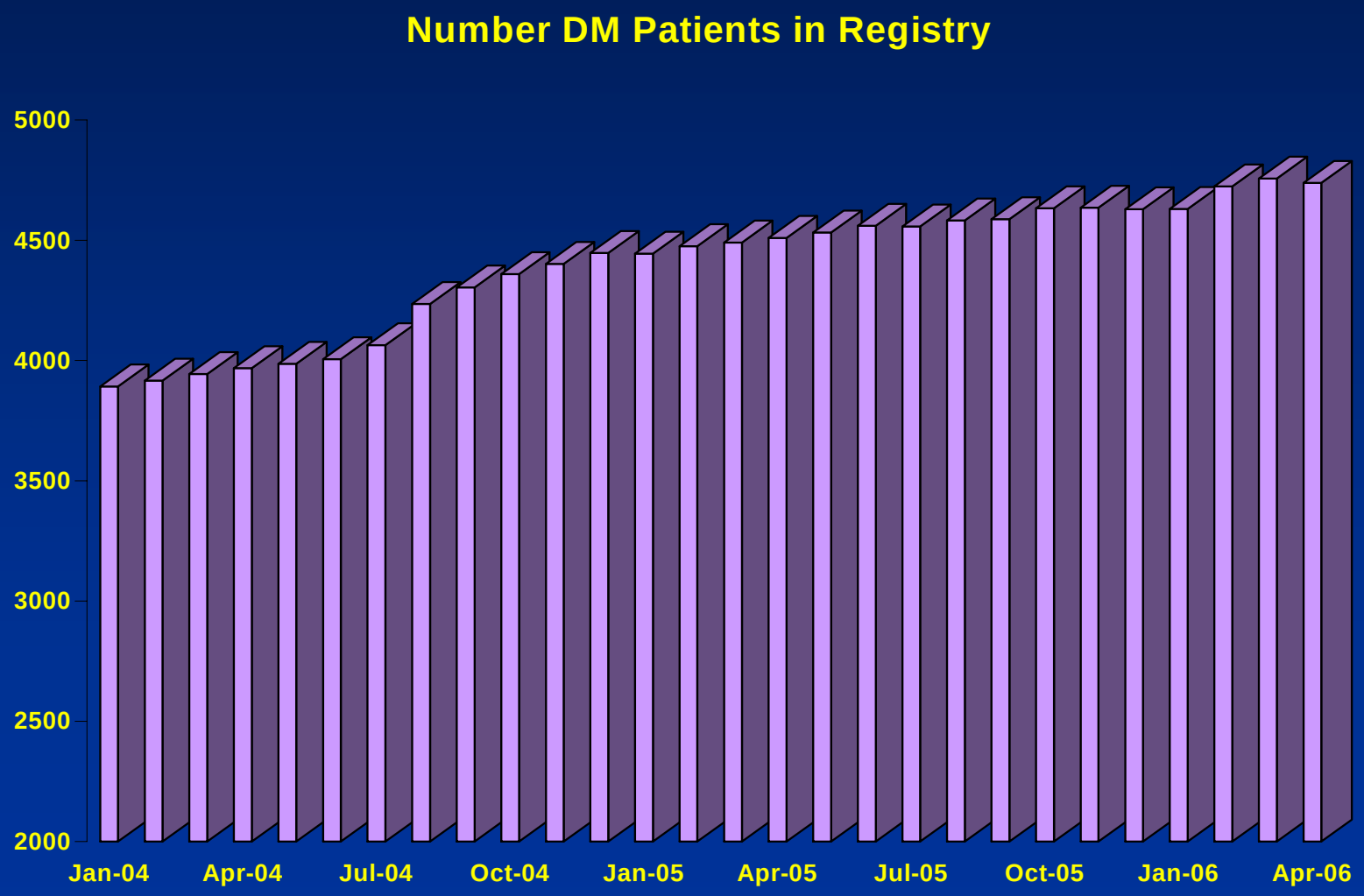
DIABETIC ROLLING 12 MONTH AVERAGE REPORTS



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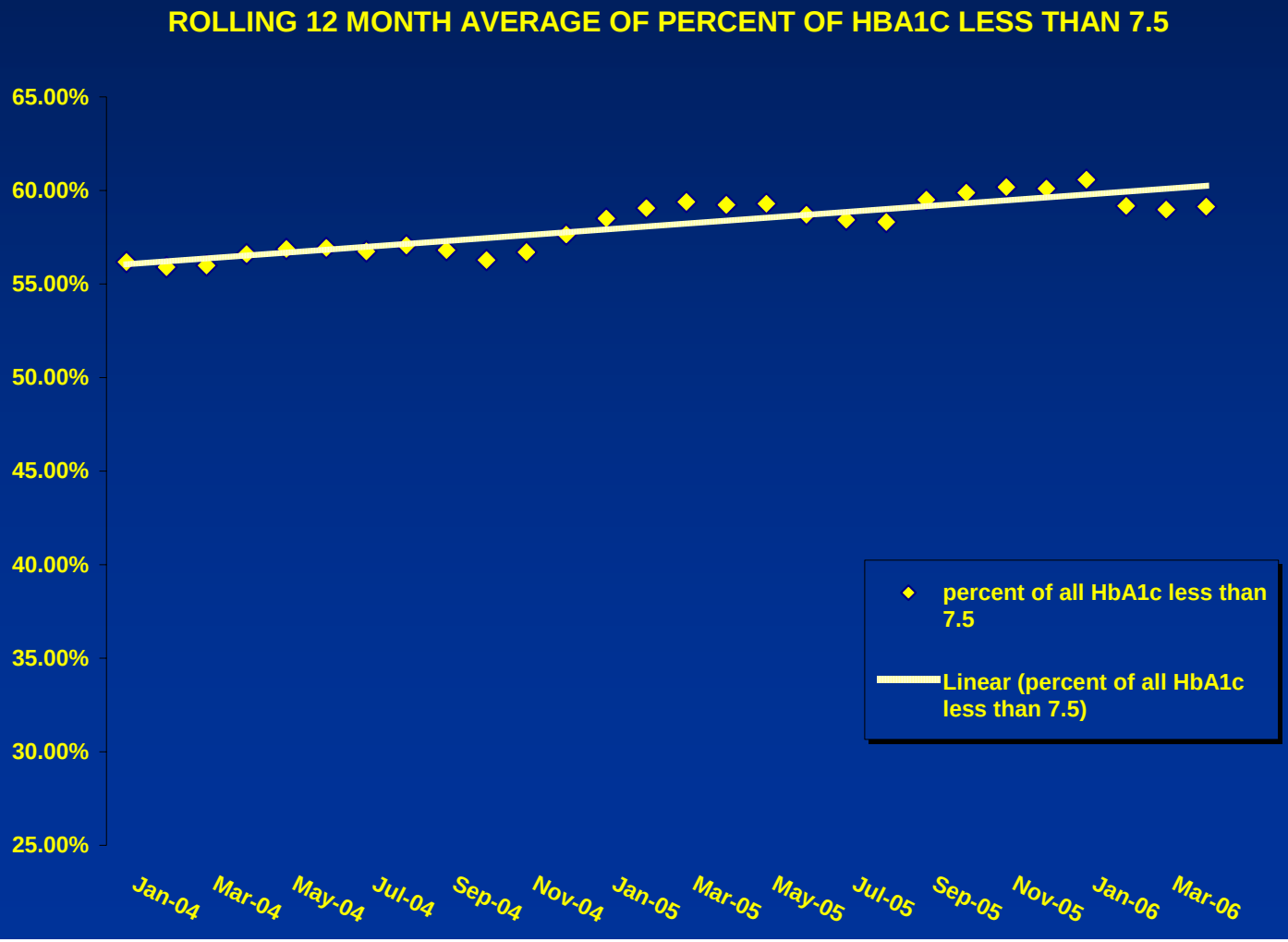

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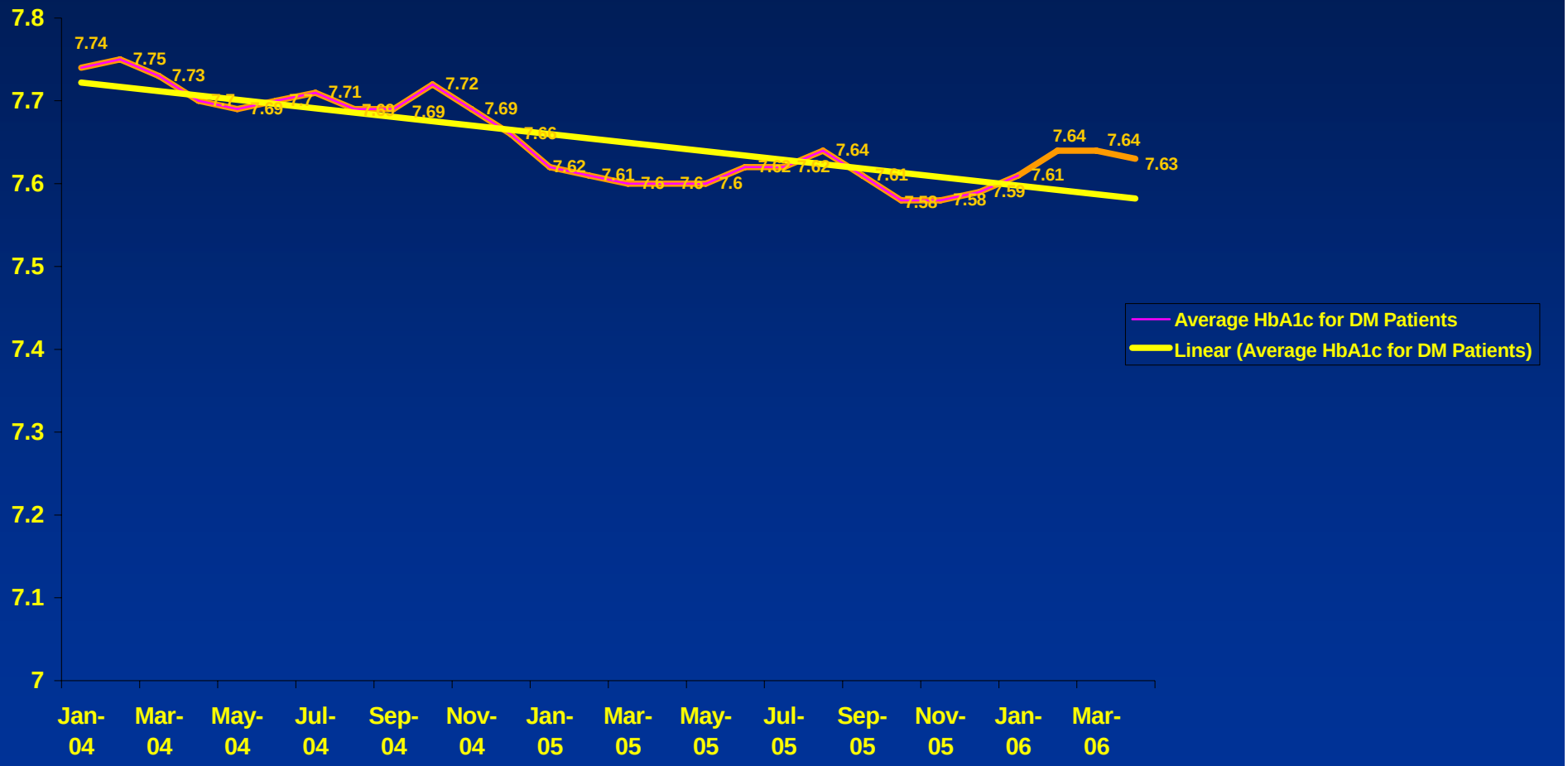
Average HbA1c for DM Patients



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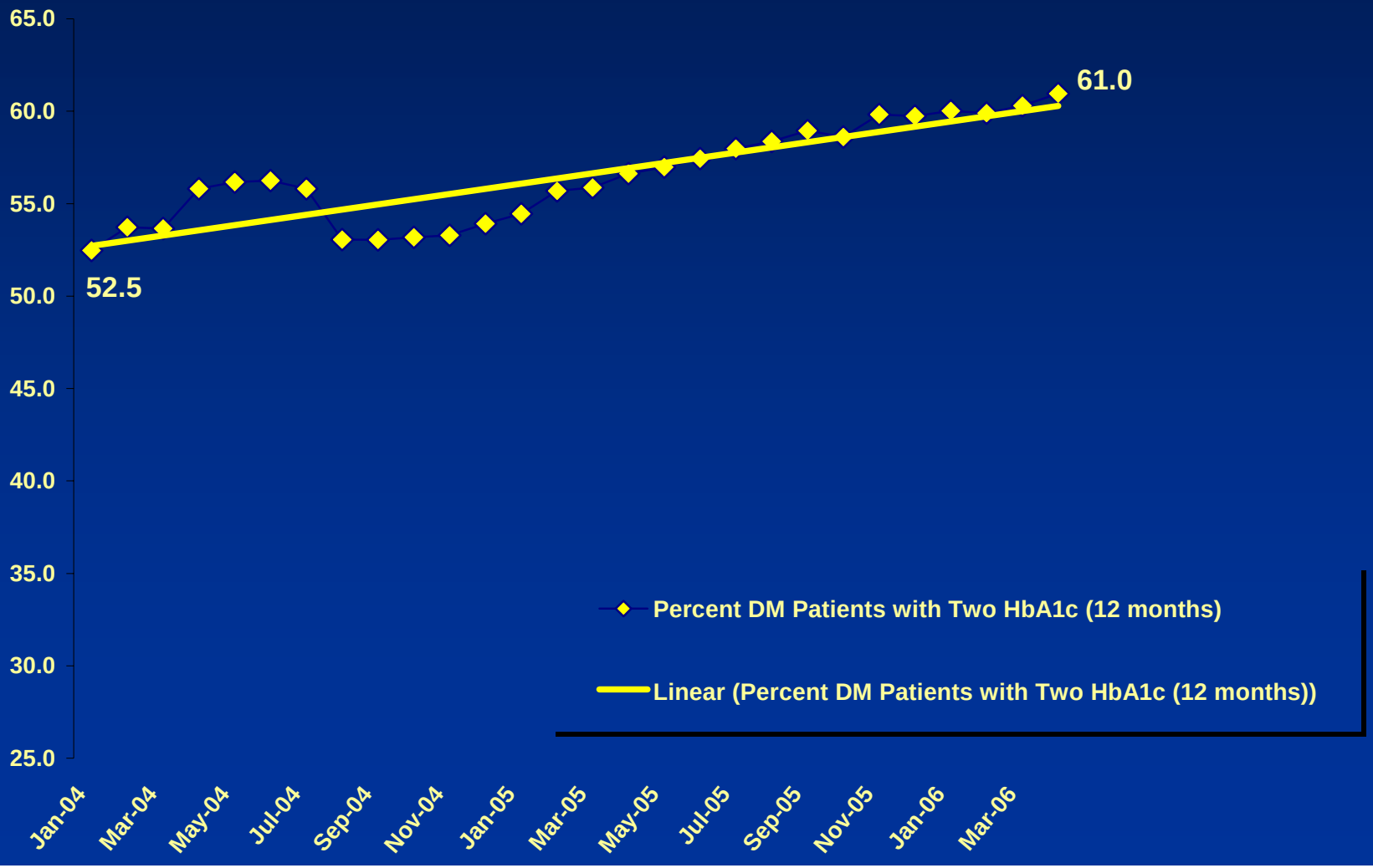
HEMOGLOBIN A1C TESTING RATES (TWO A1C)

PERCENT OF DIABETICS WITH TWO HGBA1C IN 12 MONTHS



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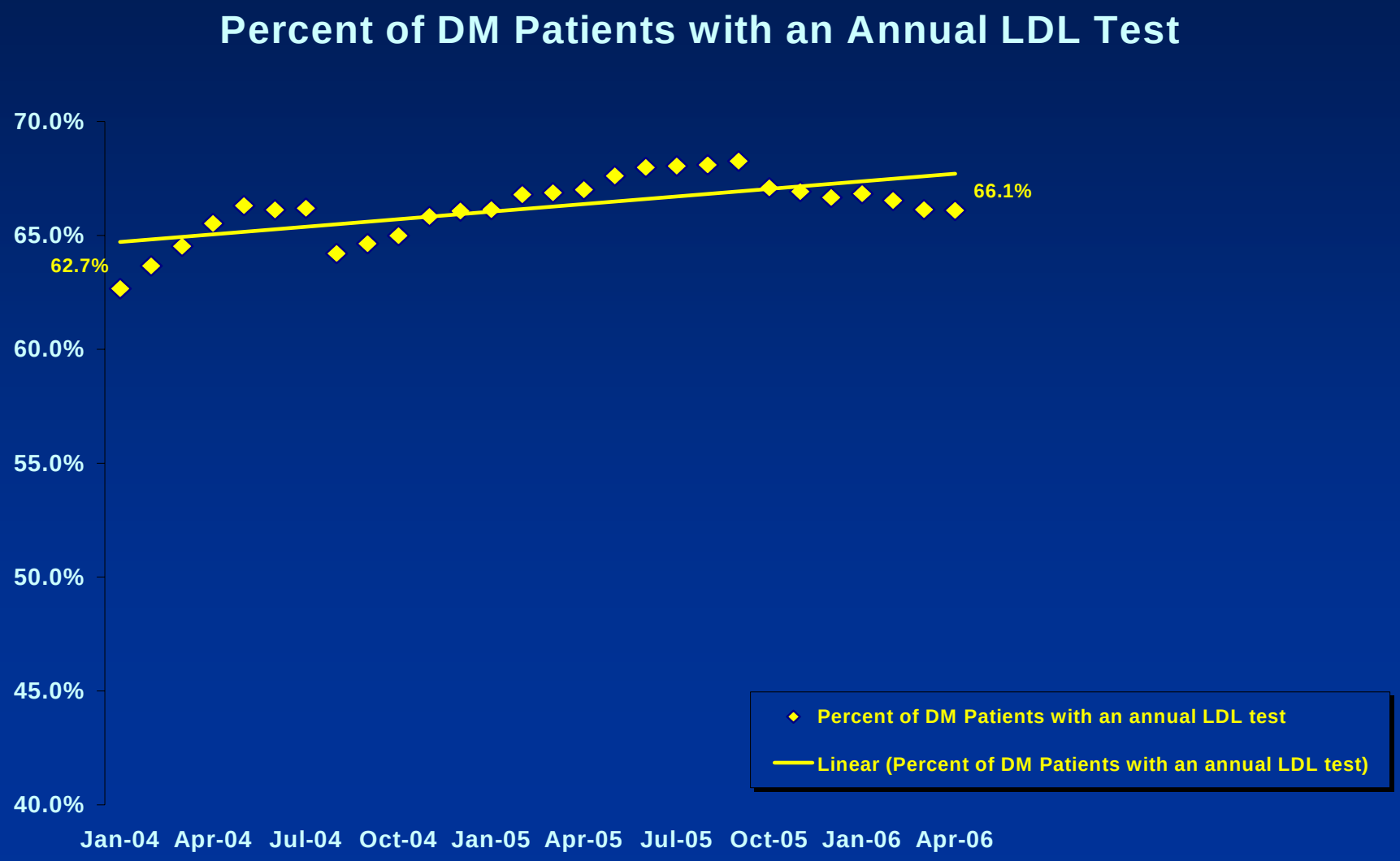
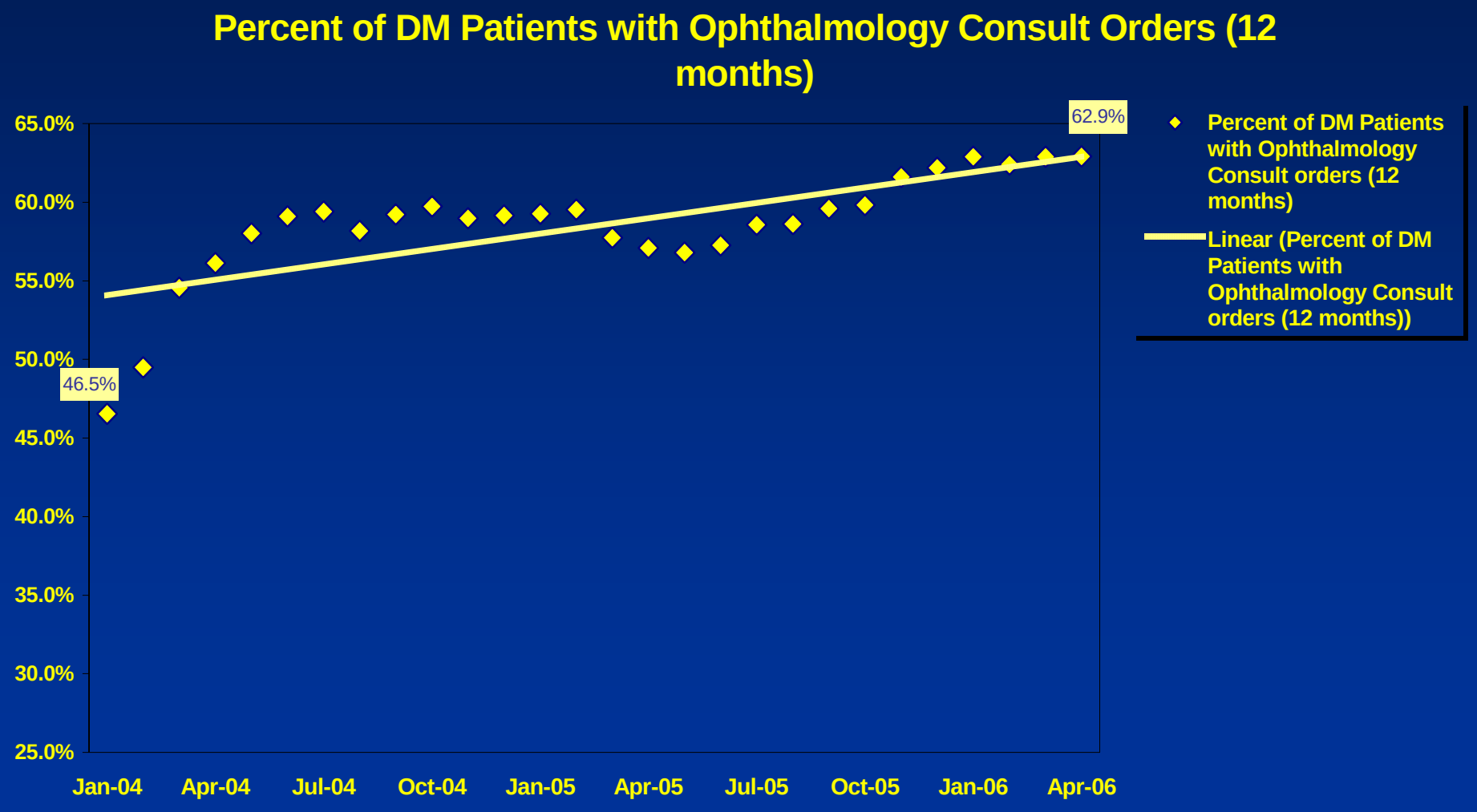
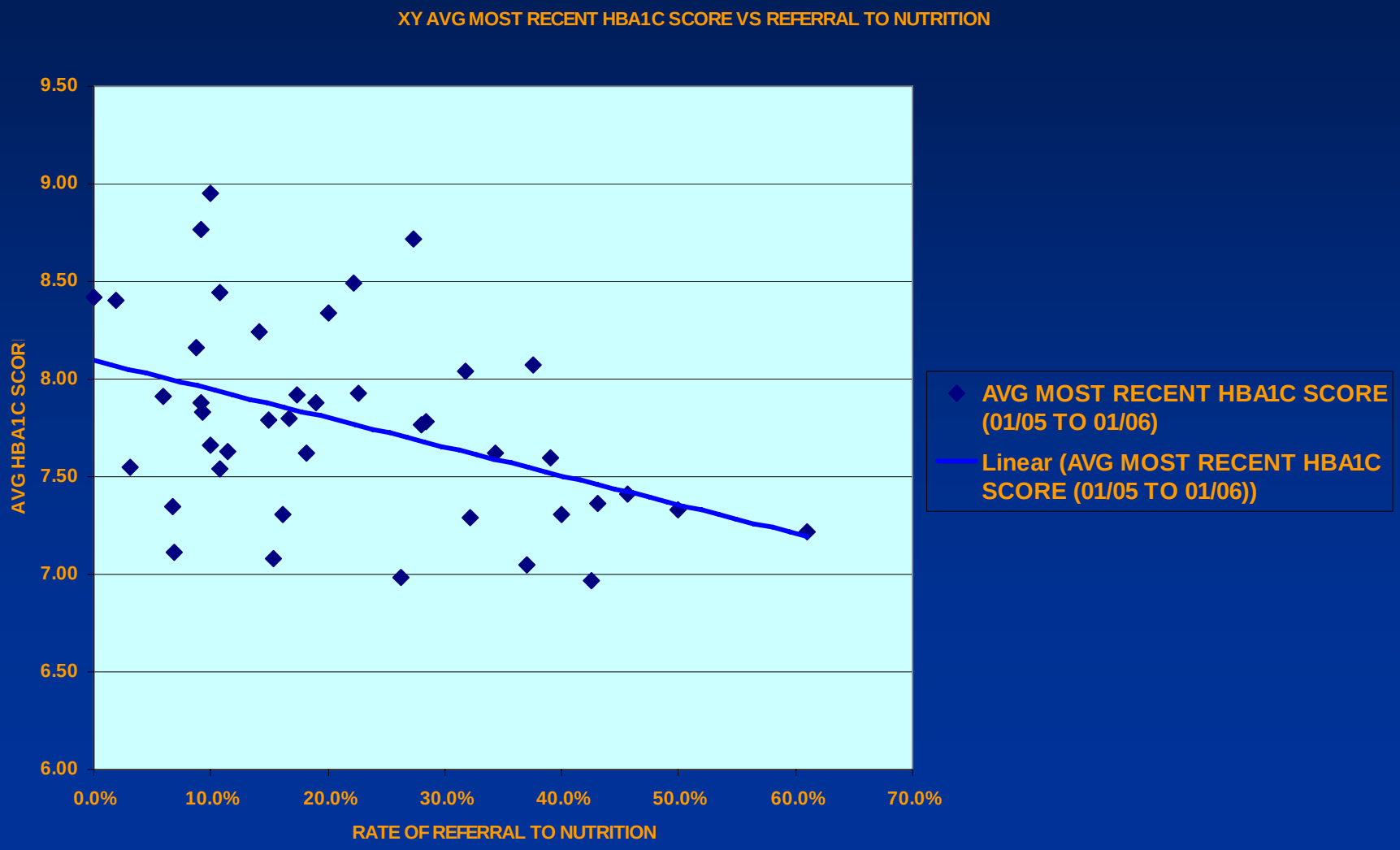
% OF DIABETIC PATIENTS WITH AN ANNUAL LDL TEST



Percent of DM Patients with Ophthalmology Consult Orders



LINEAR REGRESSION OF AVG HBA1c SCORE VS REFERRAL TO NUTRITION



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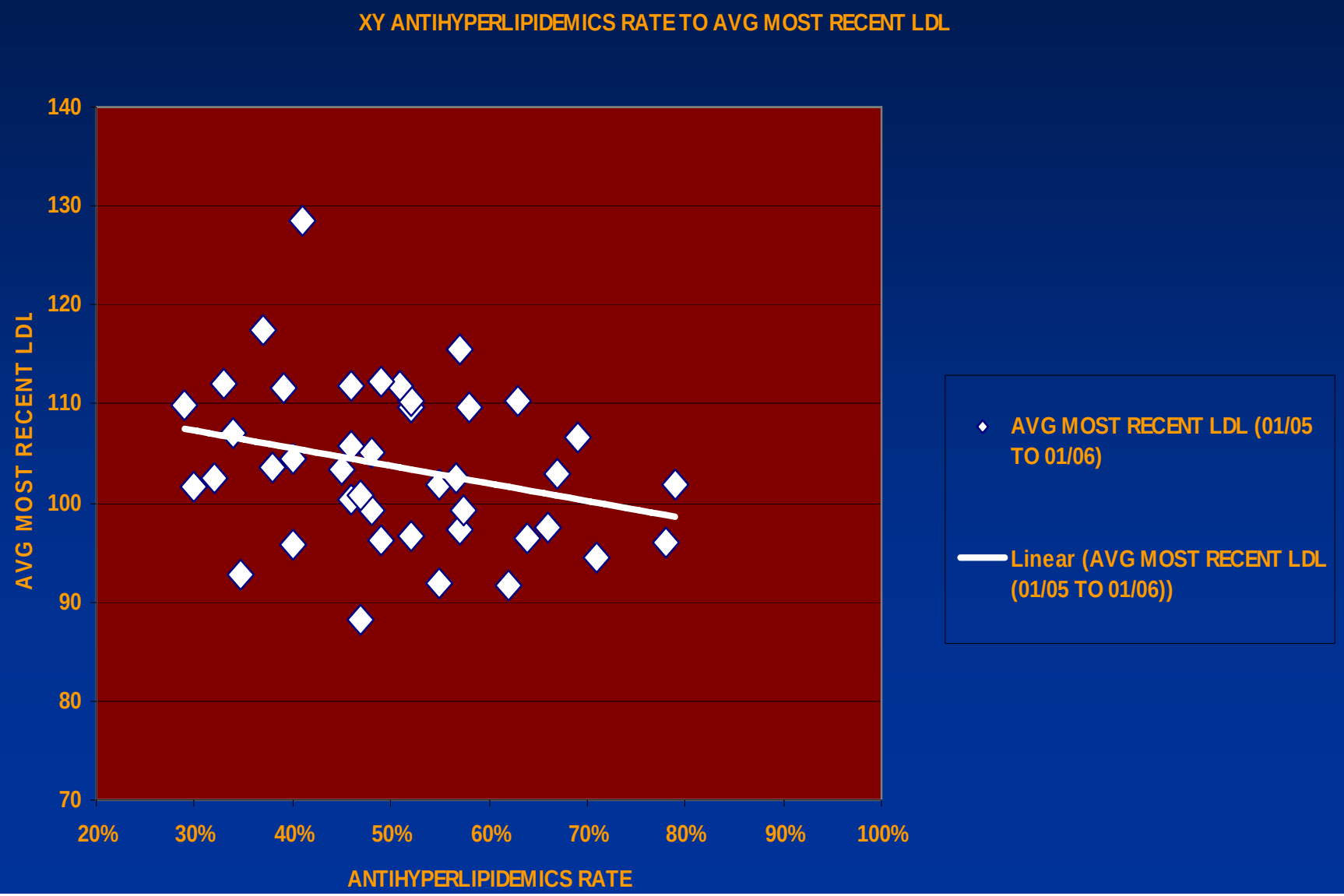
XY GRAPH OF MOST RECENT LDL IN DIABETICS AND PROVIDER SPECIFIC RATE OF UTILIZATION OF ANTIHYPERLIPIDEMICS



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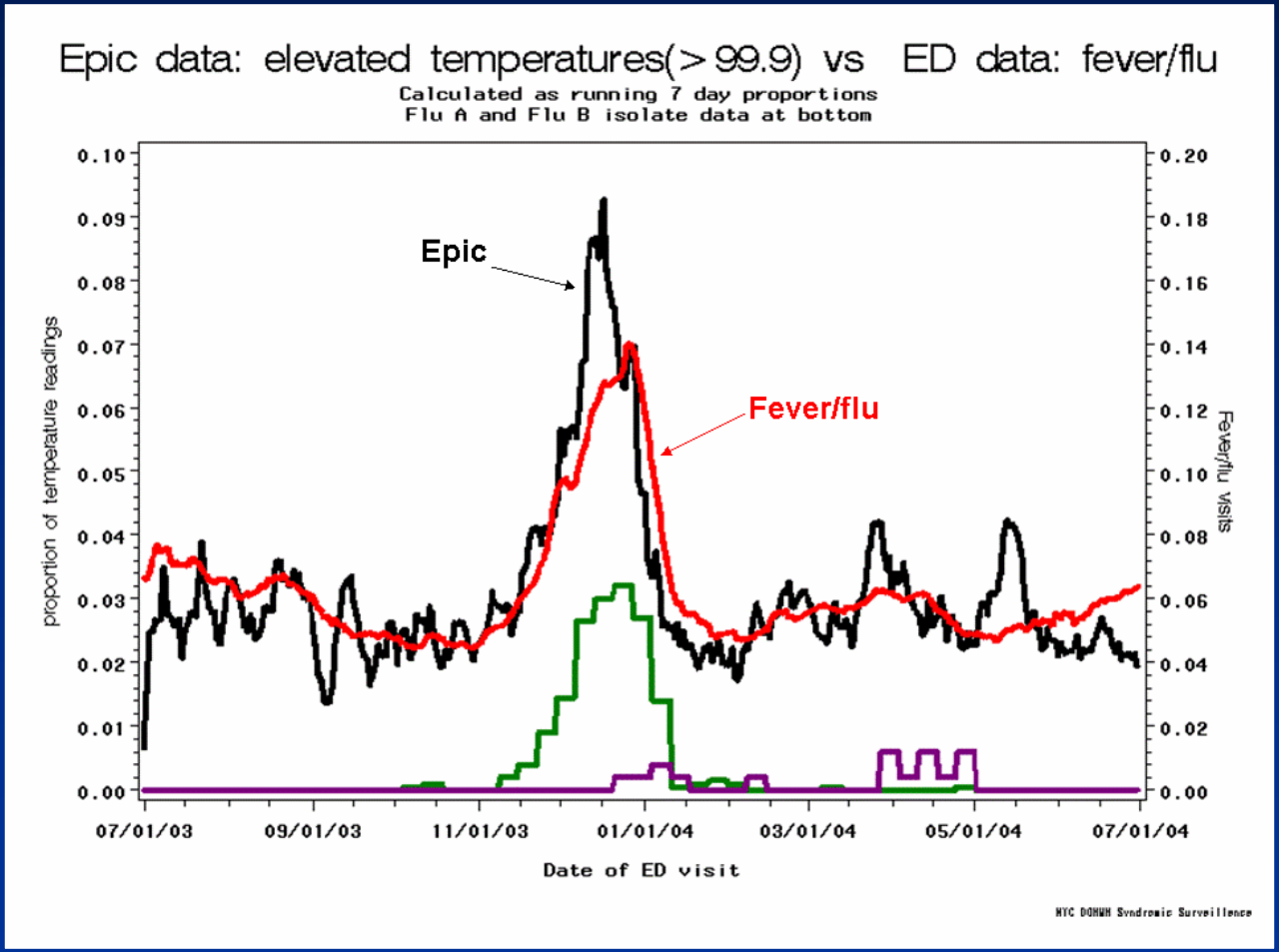
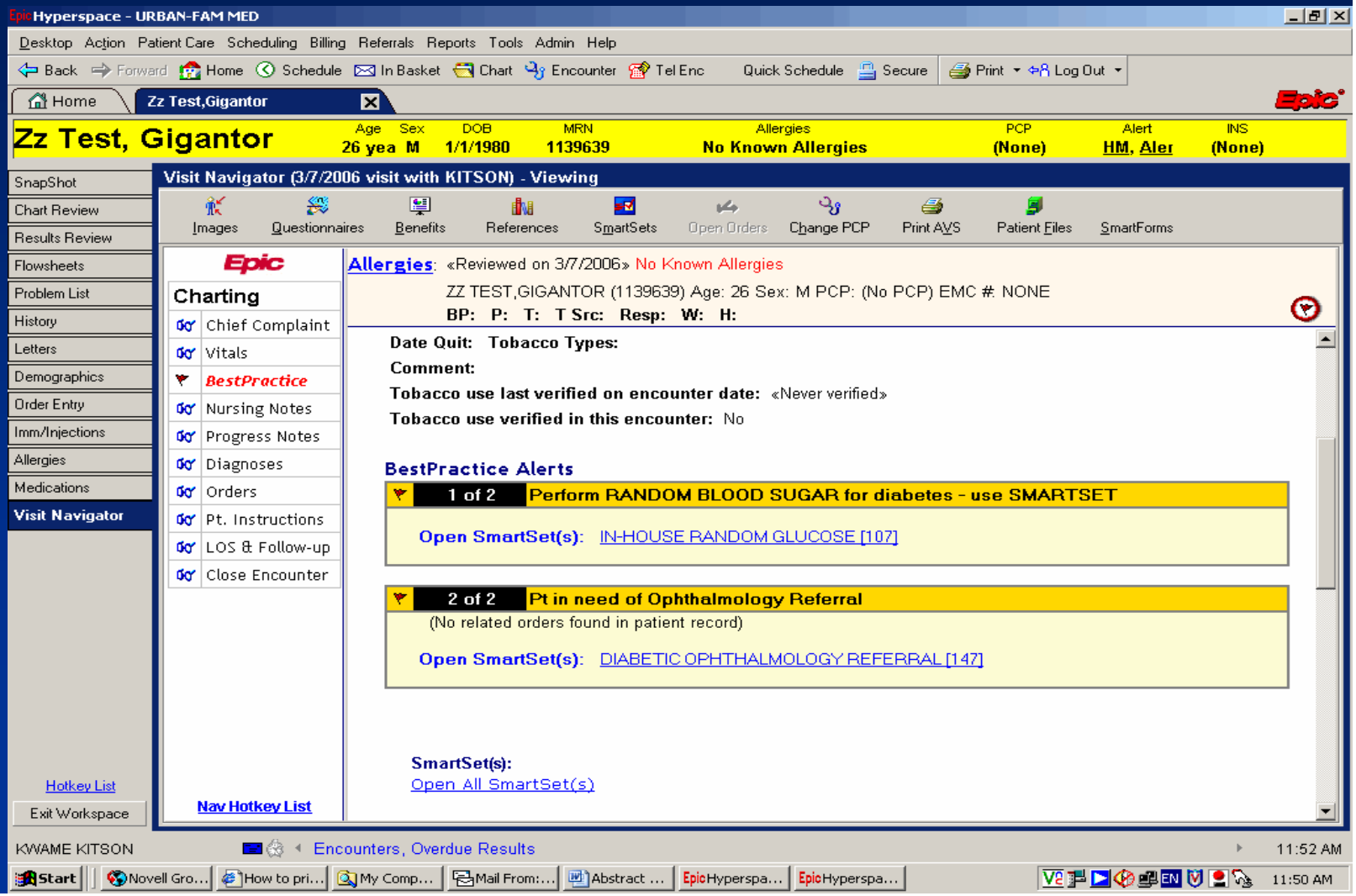
Syndromic Surveillance



DIABETES BEST PRACTICE ALERT SCREENSHOT



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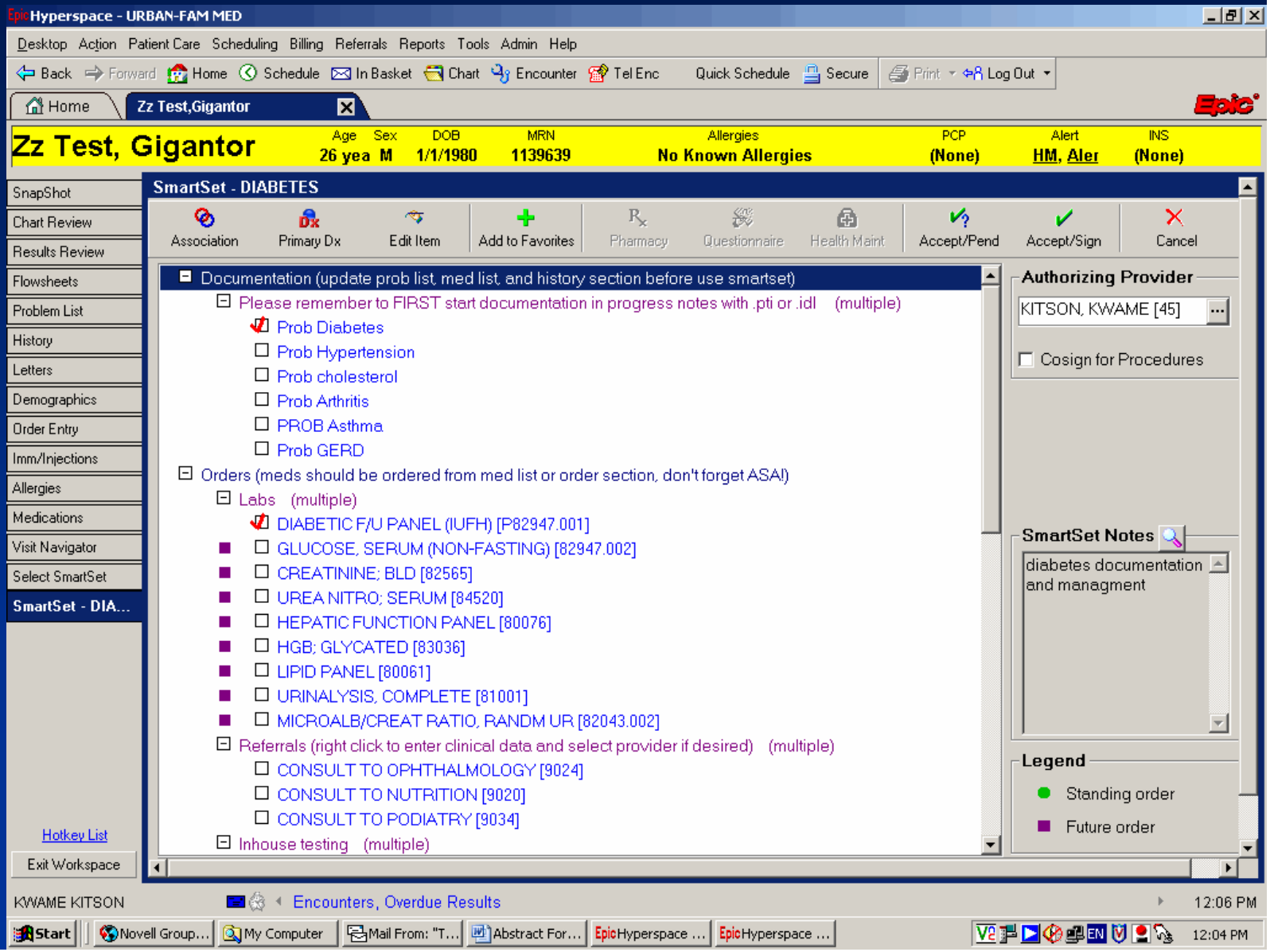
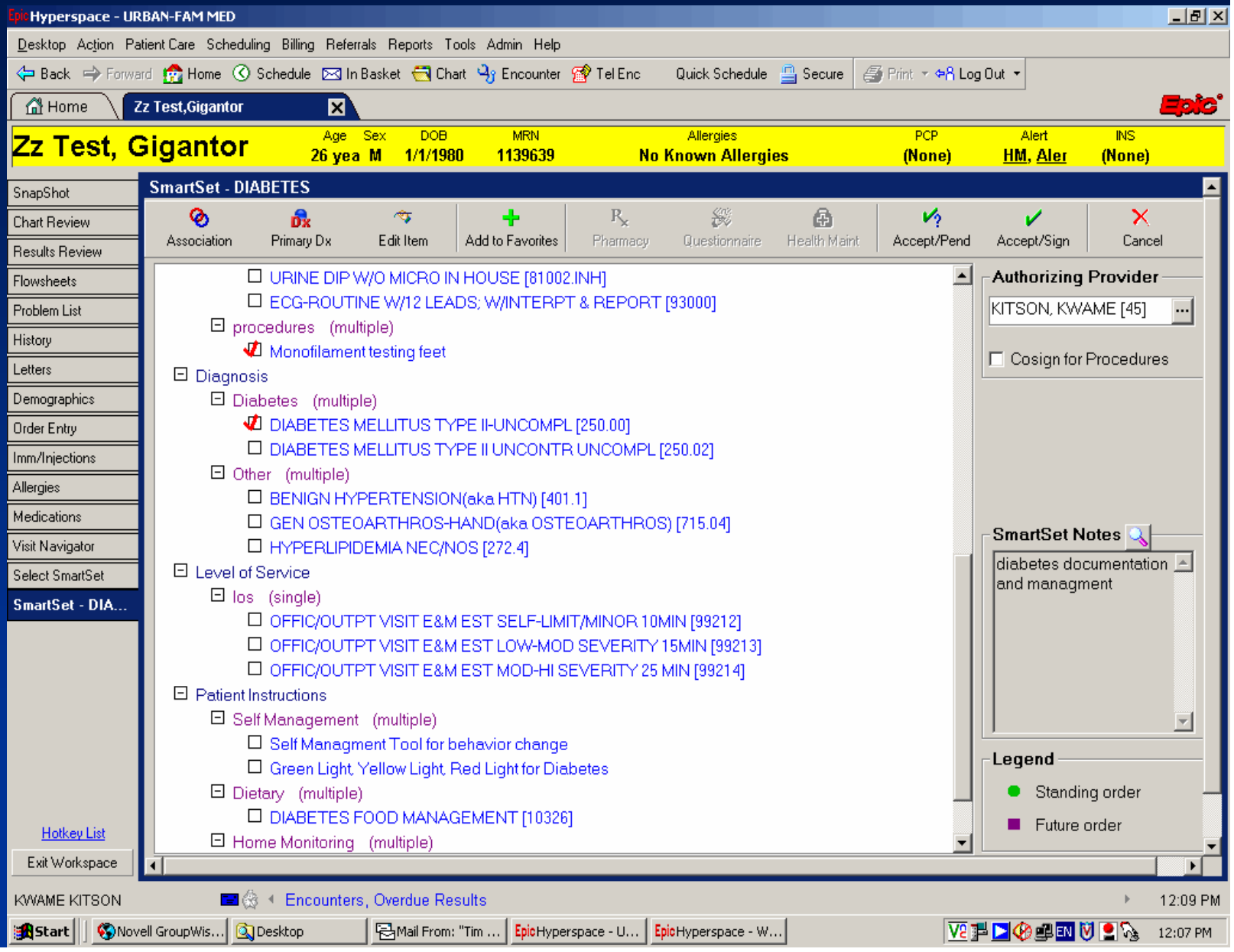
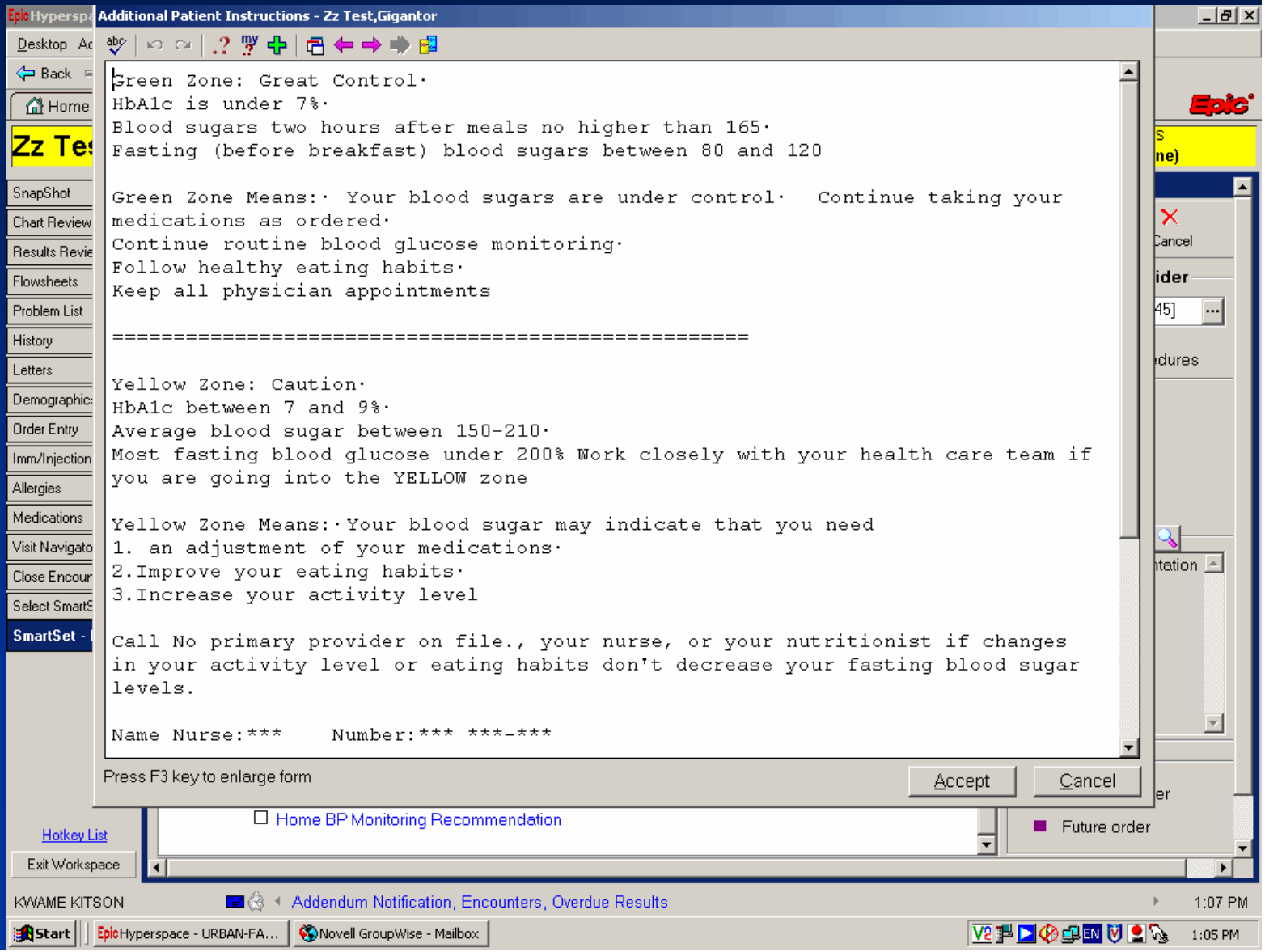
DIABETES SMARTSET SCREENSHOT



DIABETES SMARTSET SCREENSHOT



DIABETES SELF MANAGEMENT TOOL SCREENSHOT



ELECTRONIC PATIENT OUTREACH

- 2.0 FTE Outreach/CQI support personnel
- Initially funded by the great gains received from managed care pay for performance incentives
- Now also funded in part by grants for various projects.

ELECTRONIC PATIENT OUTREACH

- Telephonic and Mail Outreach are done to 20,000 plus patients per year.

TYPES OF OUTREACH

- Targeted outreach based on internal reporting data.
- Outreach based on mid-year QARR eligible reports
- Outreach to patients assigned to our practices that have never accessed care.
- Outreach to patients who are no-shows for their specialty appointments/procedures.

ELECTRONIC PATIENT OUTREACH

Major new grant funded CQI outreach effort in 2008 will involve utilizing risk scores for various types of cancer and targeting cancer screening outreach on a risk adjusted basis.

	LAST_VISIT_DATE	AGE	AGE_SCORE	LAST_TOBAC	tobacco score	BMI	BMI_SCORE	ALCOHOL_OZ_PER_WK	ALCOHOL_SCORE	_SCORE
zzzzzz11	8/13/2007	79	6	Quit	1	31.74	2	4.9	1	10
zzzzzz12	8/6/2007	81	6	Quit	1	32.05	2	1.5 - 2	1	10

CQI BEYOND ELECTRONIC DECISION SUPPORT

- Clinical measures reach nadir point.
- CQI efforts now refocused on clinical and operational areas that impact patient care.
- Overall goal = Total Quality Management by getting all functional areas and clinical sites involved in local active CQI
- “Back To The Basics” – Re-examining workflow processes.

CQI BEYOND ELECTRONIC DECISION SUPPORT