Using Data for Quality Improvement

Lander Cooney, MS
CEO of Community Health Partners
Office Hour
August 31, 10:30 AM -12:00 PM PT / 1:30 PM-3 PM ET
Using Data for QI
(and everything else)

Lander Cooney, CEO
Community Health Partners, Inc.
Lander Cooney, CEO

- From: Kansas (originally), now Bozeman, MT
- Love to: ski, bike, bake zucchini bread

You?

- Where are you from?
- Something you’d like to discuss today?
“The more you learn, the more acutely aware you become of your ignorance.”

Peter Senge, *The Fifth Discipline*
Community Health Partners, Inc.

- FQHC started in 1997, rural/frontier, ~120 employees
- Medical, dental, behavioral health, pharmacy, and educational programming
- Served 10,600 patients for over 39,000 visits in 2010
- Participated in DM, CVD, Depression, ARMC, Oral Health, Self-Management Support, Patient Safety Collaboratives
- Live on NextGen EHR since April 2009
- Currently applying for NCQA PCMH recognition
History of Measurement at CHP

The Technical Story…….

► Balanced Scorecard
► Strategic Plan
► PECS
► EMR
History of Measurement at CHP

The Engagement Story.......

► Asked what does engagement *really* mean?
► Link Strategic Plan to Daily Work
► In response to *Are We Making progress*
Baldrige Gap Survey (*www.nist.gov/baldrige*)
....and research
Strategic Plan – 2010—12 GOALS & OBJECTIVES

Goal Area
Goal: Engage staff, board, and clients in pursuit of mission
Objectives:
1.0 Ensure clients get “what they needed” every time.
2.0 Retain focus on staff engagement and programming
3.0 Foster board proficiency in understanding CHP quality and services.

Goal Area
Goal: Assure access to medical, dental and educational services.
Objectives:
1. Improve UDS percentile in medical and maintain in dental.
2. Enhance educational connections in all service areas.
3. Expand behavioral health, pharmacy and dental access.
4. Explore expansion possibilities beyond current service area.

Goal Area
Goal: Ensure adequate financial resources to offer programs
Objectives:
1.0 Maintain focus on payer sources that support programming.
2.0 Grow responsibly, ensuring resources to sustain programs.
3.0 Market CHP programs to maintain/increase funds and services.

Goal Area
Goal: Address root causes of poor health
Objectives:
1.0 Ensure the connection of clients and services that attend to education, income, housing, and self-efficacy.
2.0 Foster school success/educational advancement.
3.0 Spread thinking about root causes at all presentation opportunities and in marketing materials.

Goal Area
Goal: Measure outcomes in line with mission.
Objectives:
1.0 Create measurement/change system that attends to all strategic priorities.
2.0 Focus on system redesign.
3.0 Capitalize on Next Gen possibilities.

Goal Area
Goal: Reduce disparities through strong partnerships
Objectives:
1.0 Create referral partnerships that ensure access to medical, dental and educational services.
2.0 Spread CHP’s vision through new and current partnerships.
3.0 Participate in local and regional collaborations that enhance health and wellbeing.

MISSION
To Enhance Community Health and Wellbeing through:
• Innovative programming
• Strong partnerships
• Improved outcomes

VISION
100% Access, 0% Disparity
How does it all fit together?
Our Model

- 85 current measures (27 retired measures since Feb 2010)
- Data gathered by staff and EMR
- Facilitated by a Data Guru (analyst)
- Guided to be fully aligned with MVV
- “Drive up” measures from team level to organizational level
- Shared among staff, teams and board
Our Model (cont’d)

► “Formal” measures (weekly or monthly) to teams and/or site directors and/or the Board of Directors
► “Informal” measures gathered ad hoc for PDSA development or just to answer questions:
  ▪ Which providers are seeing the most new patients?
  ▪ What days of the week have the highest phone call demand?
  ▪ How many vasectomies did Dr. S do last year?
Measurement Wall
Why Invest the Time, Energy, Effort?

► Achieving our mission
► Know where process improvement needed
► Hire the best, bring out their best
► People do better work when they know where to focus their efforts
Why Invest . . .

- Helps us manage by fact
- Human development – our most important contribution
- Side benefits – reduced turnover, higher engagement, increased productivity
Culture is Key!

► **Management** approach
  - Facilitation
  - Coaching
  - Change Management
  - Communication techniques
  - Team work experts

► **Transparency** of Data, Plans and Problem Solving
  (staff get to question, solve, come up with other ideas)

► Energized, engaged, and informed **Staff**
Where are we now?

► Measurement continues to be topic at each staff meeting, continuing engagement
► Retiring and revitalizing measures as they level off or change in priority
► Staff engagement numbers increased over measurement timeframe from 4.2 to 4.65!
► Turnover decreased from 31.9% (2007) to 15% (2009) to 6% (2010).
Questions?
Data Nuts and Bolts

► Don’t be afraid of Low tech options
► Use run charts
► Build EVERYONE’S capacity to use data
► Embed data everywhere
Data Collection Tools

- Sometimes low tech is perfect
- Visual management is important (we think)
- Excel, Access, Crystal, SQL
- EMR???
Why Run Charts?

► AKA line graphs. . . Show process performance **over time**
► Graphically display shifts, trends, cycles **over time**
► Identify problems (trend away from desired results)
► OR recognize REAL improvements (or positive deviants) to CELEBRATE!
Run charts tell great stories…
Other graphical displays. . .
Build Capacity to Use Data

► “I hate math!”
► Mini measurement summits
► New employee orientation
► Early successes
► Champions and gurus
RUN CHARTS 101
Data Question for Discussion:

Why might the following statement be misleading? "Last year the average days in accounts receivable was 79.6 days."
Here are two different run charts that show an average of 79.6 days in a/r.
Patient/Client Survey Time!!!!!

Patient Satisfaction surveys will be distributed to patients/clients during the week of August 22nd. This is one of CHP’s Organizational Measures and we consider it a very important patient-centered measure.

Please make sure each patient/client has an opportunity to complete the survey and ask for help if they have questions.

If you find the secret of getting LOTS of patients to complete the surveys please share it with everyone!!!!!!!!!!!!

This is how many surveys were collected the last two times—let’s at least meet those same numbers:

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Thanks so much for your help!!!!

Linda Hults
Organization Data Analyst
Embed Data Everywhere

► Use it for decision making
► Use it for celebrating
► Put it in front of people in every way you can think of – email, print, website, whatever. Make it the default.
So how is this opening doors to PCMH?
PCMH Change Concepts

1. Empanelment
2. Engaged Leadership
3. Continuous and Team-Based Healing Relationships
4. Quality Improvement
5. Patient-Centered Interactions
6. Enhanced Access
7. Care Coordination
8. Organized Evidence-Based Care

(Safety Net Medical Home Initiative – http://www.safetynetmedicalhome.org)
PCMH - A

PcMH Quarterly Assessment

- Empanelment
- Relationships
- Pt Ctrd Interactions
- Engaged Leadership
- QI
- Access
- Care Coordination
- Evidence-based Care

Nov-10: [Graph Data]
Apr-11: [Graph Data]
Nov Aver: [Graph Data]
Apr Aver: [Graph Data]
Discussion...

► What measurement challenges are your teams facing?
► What would you like to do differently with measurement?
► How is EMR helping or hindering teams with measurement?
► How are your teams with transparency?
► How hard is it to connect measures to MVV?
Thank you!

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