Goals for Today

• Identify Successful Components of Quality Collaboratives
• Establish consensus on CQCH’s Framework and Priorities
• Identify Shared Strategies and Activities to Support CQHC’s Framework
• Identify Gaps in Current Performance
• Plan for Upcoming CQCH Activities
Starling Advisors

We work nationally with Health Centers, Networks, and PCAs to answer the question:

“What changes, if any, do we need to make to insure a role in providing high-quality, comprehensive primary care under Health Reform?”

STRUCTURING SUCCESSFUL QUALITY COLLABORATIVES
Health Center Leadership in QI

- Long history of engaging in QI initiatives
- Builds upon the FQHC model of team-based, patient centered model of care
- Enabled by Health IT and EHR data

Successful QI Collaboratives

- Clear vision and purpose
- Defined roles and responsibilities
- Active participation and accountability
- Engaging health center leadership
- Standardized practices
- Sharing of best practices and learnings
Clear Vision:
CQCH Mission Statement

The Center for Quality in Community Health is a network of Community Health Centers and partners that supports a continually evolving health care system by sharing information and expertise to facilitate learning, support quality improvement and develop leadership. Through the use of timely, relevant data, the Center for Quality in Community Health promotes collaboration, sustainability, cost effectiveness and healthier communities in Tennessee.

Defining Roles:
The Role of CQCH

✓ Convene providers, QI teams, and stakeholders
✓ Prioritize performance goals
✓ Establish data standards
✓ Provide technical assistance to Health Center practices as needed
✓ Provide analysis on performance benchmarks
✓ Provide forums for education and best practice sharing
✓ Seek and facilitate additional partnerships and opportunities
Defining Roles:  
The Role of Health Centers

- Provide QI leadership at the practice level
- Create a Health Center QI plan
- Ensure data integrity and capture into the EHR and other data systems
- Implement QI strategies at the practice level (i.e. care teams, empanelment, rapid cycle testing, etc.)
- Integrate patient engagement strategies to that support QI plan
- Share data and best practices
- Align practice-level efforts with Collaborative goals

Discussion

- What does the CQCH Mission mean to you?
- What more would you add to strengthen the focus and priorities?
- How do the roles of CQCH and the Health Centers support the CQHC’s Mission?
CQCH Participation and Accountability

- Deliberate alignment with HCCN goals
- Demonstrate commitment to CQCH efforts
- Clinical performance reporting and data sharing
- Participation in CQCH events and activities
- High performers should expect to share their best practices and Health Centers who aren’t meeting benchmarks should seek out support from Health Center peers

Participation and Accountability: Alignment with HCCN Project

- Quarterly reporting of clinical measures
  - Percentage of patients with diabetes that have HA1c≤9
  - Percentage of patients diagnosed with hypertension that are controlled with readings <140/90
- CQCH activities support HCCN project success
- Establishes a foundation for future QI collaboration and data sharing
Participation and Accountability: Clinical Performance and Reporting

- Health Centers demonstrate data accuracy and completeness
- Collaboration to build a trusted “network wide” data set
- Ongoing evaluation of opportunities to use clinical data to improve the position and perception of Health Centers to external stakeholders

Participation and Accountability: Effective Health Center QI Teams

- **Clinical Leader**
  - Has enough authority to test and implement a change and to deal with issues that arise.
  - Understands both the clinical implications of proposed changes and the consequences such a change might trigger in other parts of the system.

- **Technical Expertise**
  - Someone who knows the subject intimately and who understands the processes of care.
  - A QI expert who can provide technical support by helping the team determine what to measure, assisting in design of measurement tools, and providing guidance on collection, interpretation, and display of data.

- **Day-to-Day Leadership**
  - The driver of the project, assuring that tests are implemented and overseeing data collection.
  - Must understand not only the details of the system, but also the various effects of making change(s in the system.

- **Project Sponsor**
  - Executive authority who can provide liaison within the organization.
  - Link to senior management and the strategic aims of the organization.
  - Provide resources and overcomes barriers on behalf of the team, and provide accountability for the team members.
  - Not a day-to-day participant but regularly reviews the team’s progress.

Source: Institute for Healthcare Improvement
Challenges with Engaging Health Center Leadership

- While QI is a fundamental component of new care delivery models, it is often **not directly** supported through reimbursement
- Internal “cheerleading” for time for QI and resources can be challenging
- Health Center stability plays a role in Leadership’s willingness to adopt QI
- While QI often leads to cost savings/revenue gains, initially it may require financial outlays
- Competing priorities (as always)

Strategies for Engaging Health Center Leadership

- Clearly articulate the goals and benefits of the QI vision
- Effectively create a link between QI and larger organizational priorities
- Be prepared to provide details about changes to staffing allocations and other costs
- Bring partners to the table who can help carry the message
- Communicate transparently
- Tailor the message appropriately
- Use data and benchmarking to show impact
- Offer solutions to challenges and “pain points”
- Identify an effective and trusted executive sponsor
Discussion

• How has your Health Center leadership supported the development of QI at your organization?
• What strategies have you used to keep leadership engaged?
• What more would you like to see leadership take on with regard to QI at both the Health Center and the CQCH level?

Standardized Practices

• Data and reporting
• Data validation and management
• Workflows and clinical guidelines
• Care planning tools and templates
Sharing of Best Practices and Learnings

• Change management
• Quality improvement techniques (i.e. aim setting, building effective care teams, PDSAs, empanelment, etc.)
• Care coordination and care planning
• QI Team logistical planning and coordination
• Patient engagement
• Using data effectively to measure impact and outcomes
• What else?

Exercise: Quality Improvement Team Effectiveness

• Use the worksheet to answer the questions for both “Team Functioning” and “Team Effectiveness” (2 sided handout)
• Work either on your own or with your QI Team members (your choice!)
• Spend 10 minutes noting your Health Center’s strengths and challenges
• Share thoughts and reflections with the group
Recap: Establishing a Statewide QI Collaborative in TN

1. Clearly identify CQCH’s purpose and priorities
2. Prioritize QI goals and activities
3. Support Health Center implementation of QI
4. Share best practice, data findings, and outcomes
5. Seek opportunities to build capacity and support for QI
6. Will require efforts at both the “collaborative” level and at the Health Center level

IDENTIFYING QI GAPS: THE IMPORTANCE OF DATA
Benchmarking: Defined

A standardized method for collecting and reporting critical operational data in a way that enables relevant comparisons among the performances of different organizations or programs, usually with a view to establishing good practice, diagnosing problems in performance and identifying areas of strength.

Benchmarking gives the organization (or the program) the external references and the best practices on which to base its evaluation and to design its working processes.


Our Working Definition

Evaluating clinical, financial, and operational data in comparison to defined or emerging best-practices in order to identify areas of strength and weakness.

Comparing the data of networks of Health Centers, individual Health Centers, and care teams within Health Centers to best-practices to inform us of where to apply resources to impact positive change.
Types of Benchmarking

- Internal benchmarking – comparing departments/groups within an organization
- External benchmarking
  - Competitive benchmarking – comparing to direct competitors
  - Functional benchmarking – seeking best in class and using as a comparison
  - Generic benchmarking – comparing to unrelated entities (e.g. comparing customer satisfaction to hotel industry)

Example of a Benchmarking Report

These bars represent an individual provider’s performance (internal benchmarking)
Example of a Benchmarking Report

This line represents the 90th percentile for all CHC providers statewide (competitive benchmarking).

Example of a Benchmarking Report

This line represents the minimum expectation: the statewide average (functional benchmarking).
## Characteristics of Benchmarking

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Use credible comparisons to support realistic improvement goals</td>
<td>Compare to top performing Health Centers, for example, compared to private practice</td>
</tr>
<tr>
<td>2. Benchmarking should be contained within QI activities, not a separate exercise</td>
<td>Use benchmark data to evaluate performance when selecting PDSA cycles and evaluating progress</td>
</tr>
<tr>
<td>3. Drill down, as necessary, to support basic risk adjustment</td>
<td>Compare the average a1c for a Health Centers homeless patients to statewide average for homeless patients</td>
</tr>
<tr>
<td>4. Use benchmarks to guide further exploration into process</td>
<td>Don’t simply ask “can we do as well as X?” but “what does X do to get its results?”</td>
</tr>
<tr>
<td>5. Incorporate benchmarks into organizational expectations / goals</td>
<td>Our goal is to be at the 90th percentile in preventing low birth weight</td>
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### USING BENCHMARKING IN QUALITY IMPROVEMENT
Best Practice for Using Data Internally

Benchmarking and Quality Improvement

- Determine what to study
- Pick appropriate reference points
- Ensure “apples to apples” comparison
- Drill down to find root causes
- Set organizational goals
- Communicate results
- Evaluate improvement over time

1. Determine what to study

As a Health Center leader:
- Use common English when setting your goal
- Communicate the goal and secure buy-in
- Identify appropriate measures that support your statement
- Is your goal realistic and attainable?
- Will you support the resources necessary to achieve your goal?
- Is there a business case for achieving it?

Before you can begin benchmarking, you must establish a goal for the exercise:

“As an organization, perform in the 90th percentile or higher in the treatment of diabetes”

Benchmarking should be about setting aspirational goals, but don’t be afraid to start small.
2. Pick Appropriate Reference Points

As a Health Center leader:
✓ Since the goal of benchmarking is to study quality improvement more closely, starting with realistic comparisons makes sense.
✓ We will discuss the value of working together across Health Centers in our next training, but an excellent starting point for dissemination of best-practice is benchmarking across like organizations.
✓ You can include more than one benchmark in your reporting:
  ✓ Internal (Best internal care team)
  ✓ Statewide (Best statewide care team)
  ✓ National center of excellence (American Diabetes Association)

It may or may not be appropriate to use national performance benchmarks when evaluating your own performance.

Key factors like insurance status, economic status, education levels, and other social determinants might make it inappropriate.

3. Ensure Apples to Apples

As a Health Center leader:
✓ Make sure you have discretely defined the numerator and the denominator for your measure
✓ Ensure all mappings are done effectively – be proactive in identifying where quality of data is the cause of poor performance reports
✓ Do not pre-aggregate or group data if at all possible – it makes it impossible to work backwards and understand shifts

The value proposition of benchmarking breaks down if we cannot compare the same measurement in the same way.

This ties us back to our first training where we talked about the importance of sourcing clean and accurate data.
4. Drill down to find root causes

As a Health Center leader:

- Set the expectation that you wish to see performance at a variety of levels:
  - Organization
  - Site
  - Department
  - Location
  - Care team

- Establish a core team who is empowered to ask the next, difficult question about performance

Benchmarking is an effective way to quickly answer key questions about performance:

- Are we underperforming as an organization?
- If so, is it a universal problem?
- Or are a small number of groups/care teams holding us back?

5. Set organizational goals

As a Health Center leader:

- Set a limited number of goals for improvement in any one time period.
- Inform your goals with a benchmark, but make them specific, measurable, attainable, realistic, and timely.
- The benchmark tells you when it may be time to focus elsewhere (diminishing returns)

Benchmarks are very helpful in finding areas of less than desirable performance.

It is important to differentiate a benchmark from a stated goal.

Benchmark: "Less than 6% of births below 2,500g"

Organizational goal: "Within one year, improve from 9.2% to 8.0% the percentage of births below 2,500g"
6. Communicate results

Data is an organizational asset. It cannot meet its ultimate purpose and usefulness if it is not shared broadly.

Securing commitment to improvement often requires us to cast a bright light on the areas of our performance we like the least.

Competition is a powerful force.

As a Health Center leader:

✓ Ensure every contributor to performance sees their own data and comparisons to benchmarks

✓ Answer hard questions early:
  ✓ Will we un-blind data?
  ✓ Where does performance against expectations fit in overall performance evaluation?

7. Evaluate improvement over time

While we may break data down to communicate it most effectively, the optimal end-state is to align all contributors with the goals of the organization.

Celebrate success. Don’t be afraid to talk about failure.

Make it a routine part of communication to share the progress you’ve made.

As a Health Center leader:

✓ Make it a part of routine communication to share the organization’s progress against QI goals

✓ Consider communicating goals more broadly (Board, community, patients)
Pulling it Together: Case Study

Benchmarking:

• Nationally, statewide associations of Health Centers are seeing value in working together on benchmarking exercises
• This is a story of how many states are making data work for overall improvement

Creating competition and a platform for sharing best practice is helping groups of health centers improve overall performance through the dissemination of best practice.

Statewide by Health Center (Example)
Statewide by Health Center

These organizations need to look deeper into root causes

Here are my best practices.

We are underperforming as a State.

Site 22: By Provider

These results would suggest I have a programmatic issue.

• Are all rooms/sites set up to perform screening?
• Do all providers understand importance?
• Are clinical support staff operating differently?
Site 22: Run Chart

Real Life Example

- The State of Iowa Wellness Plan pays ACOs $4PMPM to coordinate care.
- This care coordination payment is predicated on hitting a SINGLE measure of performance:
  - 50% of all attributed patients must have a complete Health Risk Assessment within the calendar year
Exercise: Analyzing QI Gaps

Review benchmark data for 2 clinical measures (HTN Controlled Blood Pressure, Diabetes Controlled AbA1c) and Discuss the following:

1. How do we fare as a “network” relative to state and national benchmarks?
2. What challenges might we face with data capture and validation?
3. What challenges might we face with clinical workflows?
4. What are the best practices we should prioritize for each measure?
5. What should our “network level” goals be for clinical performance?
6. How will we document our progress and success in meeting these goals?
WHAT MORE CAN OUR DATA DO FOR US?

New Types of Data, New Expectations

“Total Cost of Care”  
Claims Data  
Population Health Management/Risk Stratification  
Risk Adjustment  
Patient Engagement and Satisfaction Data  
Transition of Care Data  
Data Use for Care Planning  
Data and Performance Transparency  
Patient Attribution and Empanelment
Discussion: Risk Adjustment

- Risk adjustment is unnecessarily complicated
- The process of adjusting risk is its own type of benchmarking
- Risk adjusting quality outcomes is essential to understand the actual story of what is occurring
- You are encouraged to read this interesting piece entitled “Explaining Health Reform: Risk Adjustment, Reinsurance, and Risk Corridors”

Risk Adjustment: Definition

- “Risk adjustment” is too widely used a term to select one standard definition
- Therefore I am proposing our own:
  
  “Risk adjustment is the process of statistically modifying an outcome measurement (quality or cost related) to account for inherent, uncontrollable aspects of a population”
Risk Adjustment: Our Best Example

The “benchmark” for a well controlled population of people living with diabetes is an average A1c < 7.0%.

Clinic A
Average A1c = 6.64%

Clinic B
Average A1c = 7.32%

Not so fast...

• Type 1 diabetes is harder to control, because it requires self-regulation of insulin via injection

Clinic A
Average A1c = 6.64%
% type 1 = 20%, average = 7.6%
% type 2 = 80%, average = 6.4%

Clinic B
Average A1c = 7.32%
% type 1 = 80%, average = 7.5%
% type 2 = 20%, average = 6.2%

• Clinic B is ACTUALLY BETTER at managing both Type 1 and Type 2 diabetes!
Risk Adjustment: Our Best Example
Let’s “risk-adjust” Clinic B to Clinic A’s population...

• Simply take a weighted average that gets us to a level playing field...

<table>
<thead>
<tr>
<th>Clinic A</th>
<th>Clinic B</th>
</tr>
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<tbody>
<tr>
<td>Average A1c = 6.64%</td>
<td>Average A1c, type 1 = 7.5% x 20% type 1 +</td>
</tr>
<tr>
<td>% type 1 = 20%, average = 7.6%</td>
<td>Average A1c, type 2 = 6.2% x 80% type 2 = 6.46%</td>
</tr>
<tr>
<td>% type 2 = 80%, average = 6.4%</td>
<td></td>
</tr>
</tbody>
</table>

• After risk-adjustment, Clinic B is a better performer in caring for populations of people with diabetes.

Risk Adjustment and CHCs

• Health Centers care for an inherently risky population
• There is virtually no data on the actual risks of these patients
• Just like in our diabetes example, we could, for example, risk adjust for things like homeless status, education level, English language proficiency, and many, many other social determinants of health
• This will become increasingly important as we learn to tell the story of our value
Final Thoughts on Future Data Use

• What you are doing today lays the foundation for more complex uses of data and analysis
• Standardizing data and data reporting will remain critical
• Think about what can be put in place to work together to improve the quality and efficiency of data acquisition and use

NEXT STEPS FOR CQCH
Upcoming Learning Sessions and Technical Assistance

- CQCH Steering Committee—meets 3rd Tuesday of every month (next meeting: 11/17 at 10AM)
- TPCA Monthly Clinical Webinars—convened 2nd Tuesday of every month at 11AM (next sessions: 10/20, 11/10, 12/8)
- EHR Users Groups
  - i2i—Meets the 4th Wednesday at 2PM (next meeting 10/28)
  - NextGen—Meets every other month on the 4th Monday at 10AM (next meeting 11/16)
- TPCA Clinical Team Site Visits (2x/year)
- CQCH Collaborative Meetings (2x/year)

Agenda Planning for Next CQCH Collaborative Meeting

- Which topics should be included?
- Who should attend?
- Which follow up items/deliverables from today should be included?
- When and where will the meeting take place?
Reflections on Today’s Session

Thank you!