South Carolina Department of Health and Human Services
CHIPRA Quality Demonstration Grant
Going where no man has gone before
What is QTIP?

- A partnership between DHHS, SC AAP, USC Institute for Families in Society, SCORE, Care Evolution and Thomson Reuters
- An outpatient pediatric quality improvement initiative
- A Federal CHIPRA Quality Improvement Demonstration Grant
  - Electronic Health Records and their impact on quality
  - Usefulness of the CHIPRA QI indicators
  - Statewide innovation in the development of learning collaboratives and improvement in behavioral health
- A mechanism to meet ABP Part IV requirements and NCQA certification
- An opportunity for South Carolina Pediatricians to have some control and input into the rapid changes impacting us in our offices
The South Carolina grant has four key goals:

- **Quality**: demonstrate that newly-developed quality indicators can be successfully utilized in pediatric practices;

- **Technology**: share key clinical data through a statewide electronic quality improvement network;

- **Innovation**: develop a physician-led, peer-to-peer quality improvement network; and

- **Pediatrics**: expand the use of pediatric medical homes to address mental health challenges of children in our state.
Focus of SC Grant

QUALITY

– Use federal government’s 25 quality indicators as the primary benchmark for measuring quality
– Pursuit of National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) certification by all participating practices.
– Utilization of Learning Collaboratives and the “Plan, Do, Study, Act” quality improvement cycle
Focus of SC Grant

TECHNOLOGY

– Providing primary care physicians with HIT tools that will allow them to track their patients outcomes

– Technology and the generated reports will allow the practices to compare their performance to others.
Focus of SC Grant

INNOVATION

– Providing behavioral health tools to primary care physicians
  • standardized mental health screening tools,
  • academic detailing and
  • coordination with mental health providers).

– Increasing linkage of organizations and resources with practices to provide additional resources.

– Statewide Learning Collaboratives integrate and support all QTIP initiatives.
Focus of SC Grant

PEDIATRICS

– Selection of pediatric medical homes of a heterogeneous mix
– Expanding the mental health services available in a pediatric setting
– Establishing a quality improvement team within the pediatric medical home setting to implement and review quality measures.
Participating Practices

- Little River
- BJCHS- Port Royal
- The Childrens Center Greenwood
- Sumter
- East Carolina-Florence
- Beaufort Pediatrics
- AnMed Pediatrics Anderson
- Palmetto Pediatrics-Okatie

- Barnwell Pediatrics
- Carolina Pediatrics Cheraw
- Stono Pediatrics
- Rock Hill Pediatrics
- Carolina Pediatrics-Col.
- Palmetto Pediatrics-Col.
- Sandhills Pediatrics
- MUSC Pediatrics
- USC Pediatrics
- CPM Greenville
What’s Innovative about QTIP?

• Comprehensiveness of the learning collaborative effort: Acute Care, Chronic Care, Preventive Care, Mental Health, Obesity, Chronic Care Management, Asthma

• Electronic Data Sets: Real time measurement

• Degree of grassroots control, individual pediatricians and their staff, the true experts, decide what they want to work on

• Credit with the ABP and NCQA
What’s NCQA?

• National Committee for Quality Assurance
• 2011 PCMH standards
• Modest stipend for those practices meeting level 2 or greater in last years of project
• Will discuss in greater detail later
NCQA Medical Home Standards: 2C

Practice conducts and documents a comprehensive health assessment for all patients to understand their risks and needs of information that includes the following:

- 1. Family/social/cultural characteristics
- 2. Communication needs (vision/hearing)
- 3. Medical history of patient and family
- 4. Advance care planning (N/A for pediatric practices)
- 5. Depression screening for patients with chronic conditions using a standardized tool
- 6. Behaviors (smoking, nutrition, physical activity, dental care) and family risk factors (e.g. second hand smoke)
- 7. Patient and family mental health/substance abuse (stress, alcohol, prescription drug abuse or illegal drug use, maternal depression)
- 8. Developmental/autism screening using a standardized tool (N/A for adult practices)
- 9. Depression screening for adolescents using a standardized tool (N/A for adult practices)
Developmental Screening

- Baseline data: How many developmental screens are you currently performing? (96110 codes?, 10 chart audits of 18month well child visits? By Practitioner? Where do you record in the chart positive screen referrals)
The practice adopts and implements evidence-based guidelines for:

1. First clinically important condition
2. Second clinically important condition
3. Third clinically important condition

One of the conditions selected by the practice must be a condition related to unhealthy behaviors (e.g. obesity) or a mental health or substance abuse condition.

**Scoring:** Based on number of factors met; practices seeking to renew their PCMH recognition must select at least one new condition not present in their initial application.

**Documentation:** Workflow organizers or decision support tools demonstrating source of the guidelines and adoption and implementation by the practice.
Attention Deficit Disorder

• Visit follow up: Base line data: Number of patients seen in 45 days after first stimulant prescription (Use your electronic data, billing or electronic health record? 10 chart audits per practitioner?

• Cost data: Medicaid managed care provide pharm data per provider on a regular basis?

• Standardized instrument: Vanderbilt or other recorded? (96110 code as an indicator, 10 chart audits)
Requirements for ABP Part IV MOC

• 10 Chart audits at least monthly for 5 months per provider. Chart runs recorded for all 5 months

• Check for three things
  – Was there f/u within 45 days of beginning a new stimulant
  – Vanderbilt or similar
  – What meds prescribed

• At least two PDSA cycles followed to increase performance

• Practitioner must have agreed to practice wide changes and participated in a minimum of 4 contacts with QI team

• Participation with Academic detailing team
Well Child Visits

• Baseline data: Number of 15 month visits completed using electronic health record or billing data? Compare to number of newborns cared for per practitioner?

• Number of reminders sent out?
Emergency Department Usage

• Access hospital record system to count number of practice patients seen in ER one day a week? Thursday?
• Develop a strategy to educate families as to appropriate ER use? Add as a template to electronic health record? Monitor number of times ER use discussed? 10 chart audits?
PDSA Cycle Review

Francis Rushton
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<th>Model for Improvement</th>
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<th>What are we trying to accomplish?</th>
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<td>What change can we do that will result in improvement?</td>
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<td>How will we know that a change is an improvement?</td>
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Sample changes to increase referral to early intervention services

- Choose a standard screen: PEDS and Ages and Stages most common
- Screen all children for developmental delay by having nurse give screen to family when they are put in room
- Make sure Doctor reviews screen and bills 96110 Code.
Steps to improve screening rates

• Nurses place screening instrument at work up station and give to patient when they go in the exam room
• Physician must review and document in the chart that they saw and took action on the base of the screen
• Office billing sheet will be changed to add the 96110 developmental screening code so that front office builds for service and other staff is prompted to do screen.
Use of 96110 (dev. screening) code per week by provider

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The PDSA Cycle

Act
- What changes are to be made?
- Next cycle?

Plan
- Objective
- Questions and predictions (why)
- Plan to carry out the cycle (who, what, where, when)

Study
- Complete the analysis of the data
- Compare data to predictions
- Summarize what was learned

Do
- Carry out the plan
- Document problems and unexpected observations
Key Points for PDSA Cycles

• Do cycles on smallest scale possible
  – Cut your original plan in half
  – A “trial of one” is often good
  – “Failed” cycles provide learning when small

• Test over a range of conditions before implementing

• Series of tests should build on each other
Key Points for PDSA Cycles

• Consider reasons for failed tests
  – Change not executed well
  – Support processes inadequate
  – Theory / hypothesis wrong
Repeated Use of PDSAs for Implementation

**Routine use of developmental screening**

**Cycle 1:** Test how many screens doing now?

**Cycle 2:** how many screens after provider ed.

**Cycle 3:** Nurse puts screen on chart

**Cycle 4:** Reimbursement data

**Test of screen utilization**
Issues

• IRB issues
• IHI tool to measure QI progress
• NQF Standards: Feasibility, Validity, Reliability, Usability and Relevance for new measures
• IHI/ Berwick’s Triple Aim: Improved Patient Care, Better Health Outcomes, Lower Costs
• Family involvement
  – Practice level
  – Family involvement in measure selection
Issues

• Sustainability
• There is a lot that you are asking practices to do. Need focus
• Enhancing Peer Interaction
• Business Associate Agreement with sub-contractors (we believe probably in place)
• Will practice linked data be transparent?
  – Practice approval for transparency. Need to get permission from everyone
  – Firewall between grant and outside world
  – Malpractice concerns
Things we like about this project

• Tackling mental health
• Comprehensiveness of the project
• Linking the three aims: Electronic Health Records, CHIPRA Indicators, Learning Collaboratives
• Degree of support from the state
• Right mix of players