

<b>Alliance</b>	<b>Source of Ambulatory Data</b>	<b>Level of Public Reporting</b>	<b># Of Measures or Conditions</b>	<b>Degree of public interest in data</b>	<b>Type of Data Reported</b>
<b>Cleveland</b>	<b>Provider (EMR and Charts)</b>	<b>Practice sites</b>	<b>9 ambulatory measures with 2 composite standards; 1 condition</b>	<b>High</b>	<b>Ambulatory</b>
<b>Detroit</b>	<b>Health Plan</b>	<b>Physician Organization</b>	<b>24 ambulatory measures; 8 conditions 37 hospital measures</b>	<b>Moderate</b>	<b>Ambulatory Inpatient HCAHPS</b>
<b>Puget Sound</b>	<b>Health Plan</b>	<b>Clinic</b>	<b>24 ambulatory measures; 8 conditions 47 hospital measures</b>	<b>High</b>	<b>Ambulatory Inpatient HCAHPS Health plans</b>
<b>Wisconsin</b>	<b>Provider</b>	<b>Physician Group</b>	<b>18 ambulatory measures; 3 Care Categories 37 hospital measures</b>	<b>Moderate</b>	<b>Ambulatory Inpatient HCAHPS (thru Hospital Association) Health plans</b>



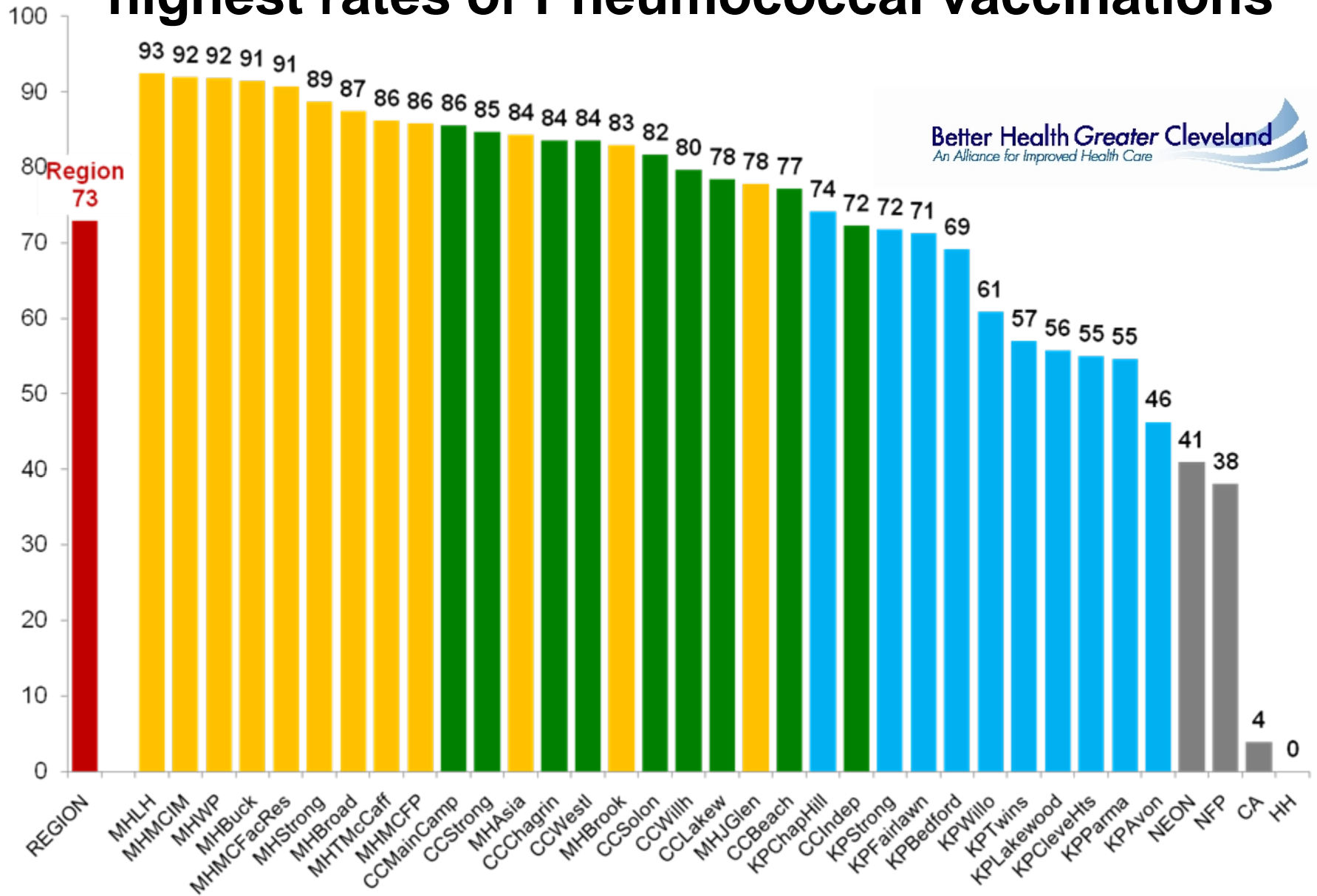
1. Interrogate the data

2. Identify and verify replicable best practices

3. Share what worked



# In 2007-08, MetroHealth's sites had the highest rates of Pneumococcal vaccinations





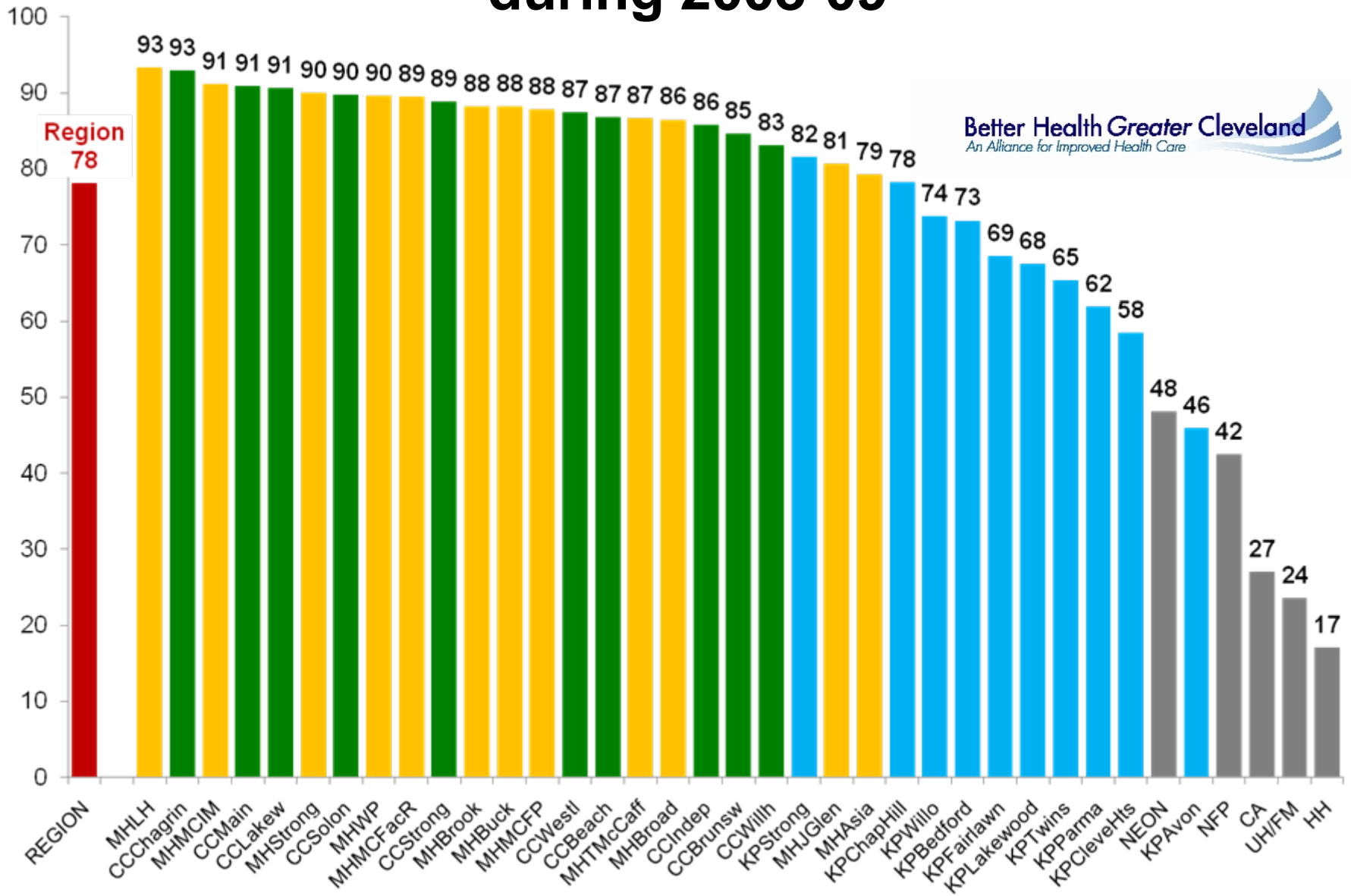
# MetroHealth's nurses solved the vaccine problem...

...and shared the solution with others

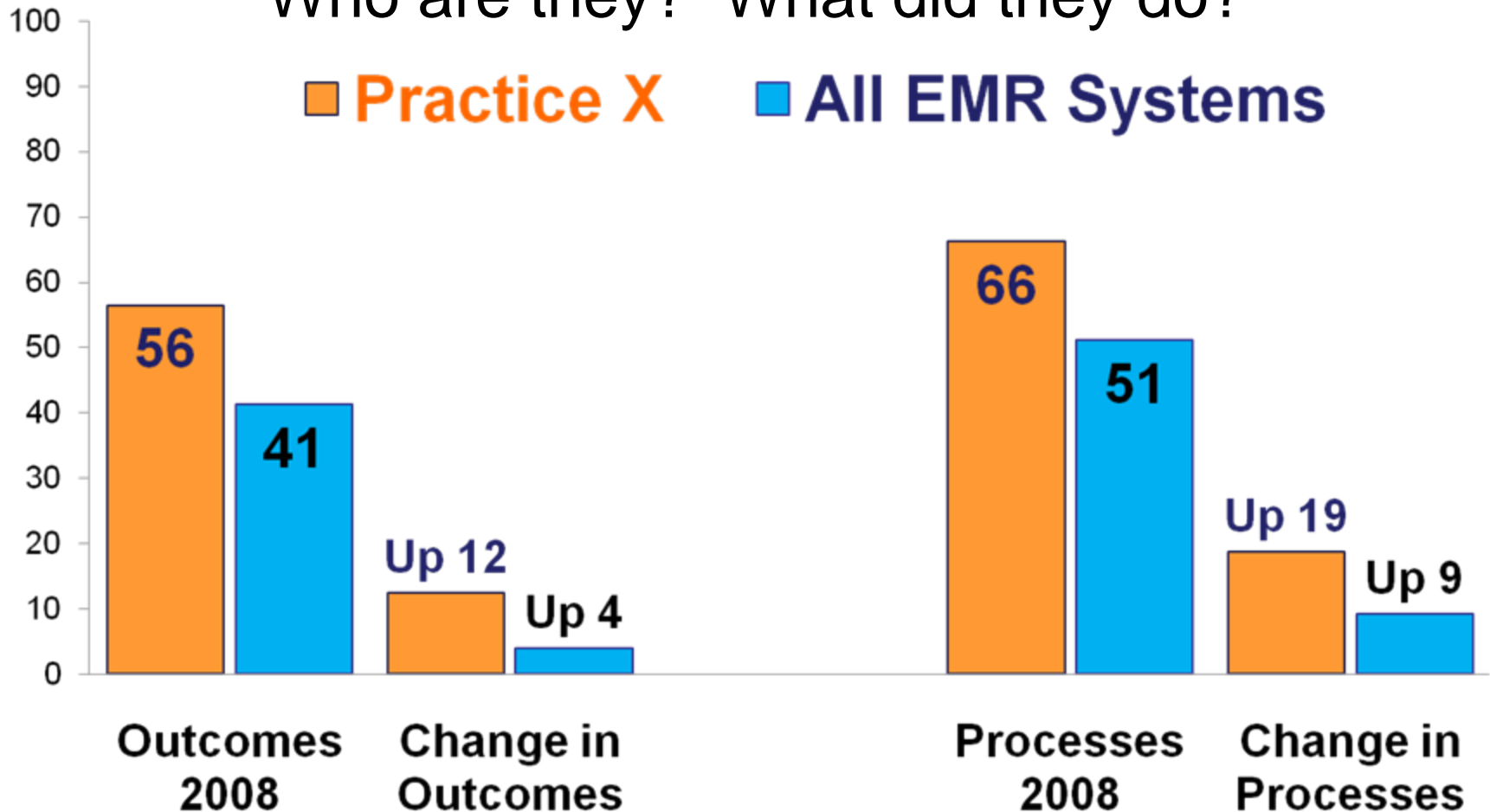
TABLE 9. PNEUMOCOCCAL VACCINATION: METROHEALTH SYSTEM'S APPROACH

Four Steps to Improving Pneumovax Rates Among Eligible Patients
<ol style="list-style-type: none"> <li>1. Use the EMR's database to identify scheduled patients who need the vaccine (using age and condition-related indications) and provide the list weekly to the clinic's receptionist.</li> <li>2. When a patient on the list checks in, the clinic receptionist provides her with a pamphlet about the vaccine.</li> <li>3. Use "standing orders" from clinic physicians to authorize nurses to offer and administer the vaccine.</li> <li>4. Nurse documents consent and vaccine administration in the patient's record.</li> </ol>

# Region-wide rates have gone up 5% during 2008-09



Practice “X” had the region’s **best** overall achievement and **improved** much more than others:  
Who are they? What did they do?





## Dr. Nicholas Dreher's primary care team faced a dilemma.

The suburban Cleveland office of Kaiser where Dr. Dreher works lost three physicians in a short time, but it still had to hit its quality metrics. So the team leadership built a team with the staff it had.

It optimized the roles of nurses, medical assistants and pharmacists and held regular meetings for the team. The practice transformed its workflow, patient interactions and follow-up so that everyone who “touched” the patient shared responsibility.

The mantra – *the culture* – became prevention, chronic disease and acute illness care for every patient at every visit. Within months, the practice had its metrics within or above target ranges - and a team that was focused on true patient-centered care.

# *Better Health's* Primary Care QI Learning Collaborative Sept. 18<sup>th</sup>, 2009

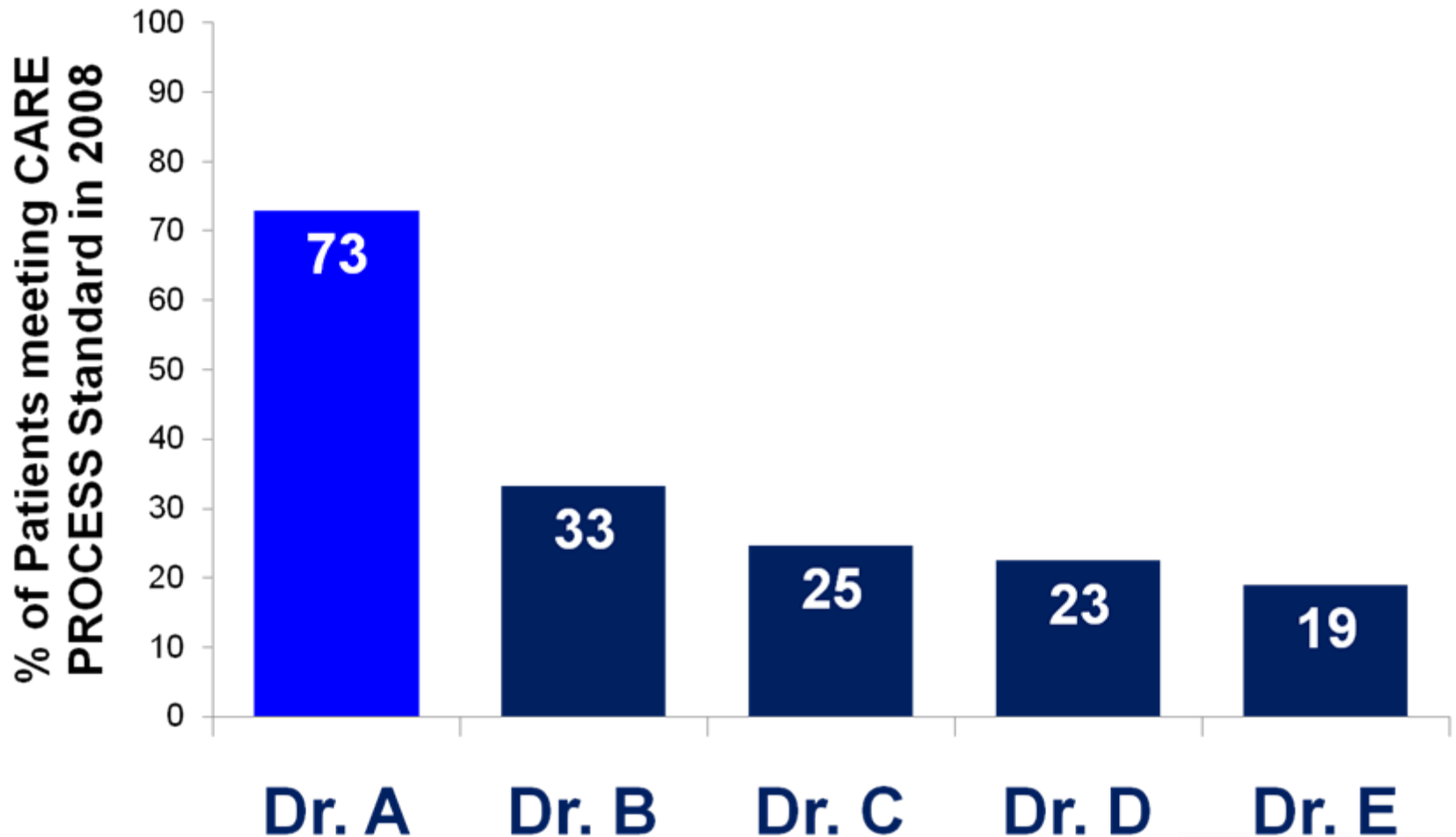


# Show and tell

Kaiser group shares  
population  
management  
expertise



Practicing in a challenging setting,  
Dr. "A" had the second highest achievement in the  
region, and improved nearly 50% from 2007.  
Who is she? What did she do?



# Changing workflow in a busy practice can be challenging.



Dr. Jim Misak, a family practice physician at one MetroHealth's community health centers, started by changing his own.

EMRs can be a great tool for managing patients, and Dr. Misak knew he'd have to change his routine to take full advantage of it. So he made it a habit to review the health maintenance field in the Epic EMR system for *every* encounter with *every* diabetic patient – even if no alert was there to grab his attention.

For each patient with diabetes, he reviewed the field and wrote orders for needed tests before the visit, so he wouldn't forget. The result was a remarkable improvement on *Better Health's* Process of Care composite standard.

Only 33% of the practice's diabetes patients met the composite standard – well below 47% regional average. But 73% of Dr. Misak's patients achieved it in 2008 -- 46% more of his patients than in 2007.



# ***Public Reporting: Showcasing Improvement***

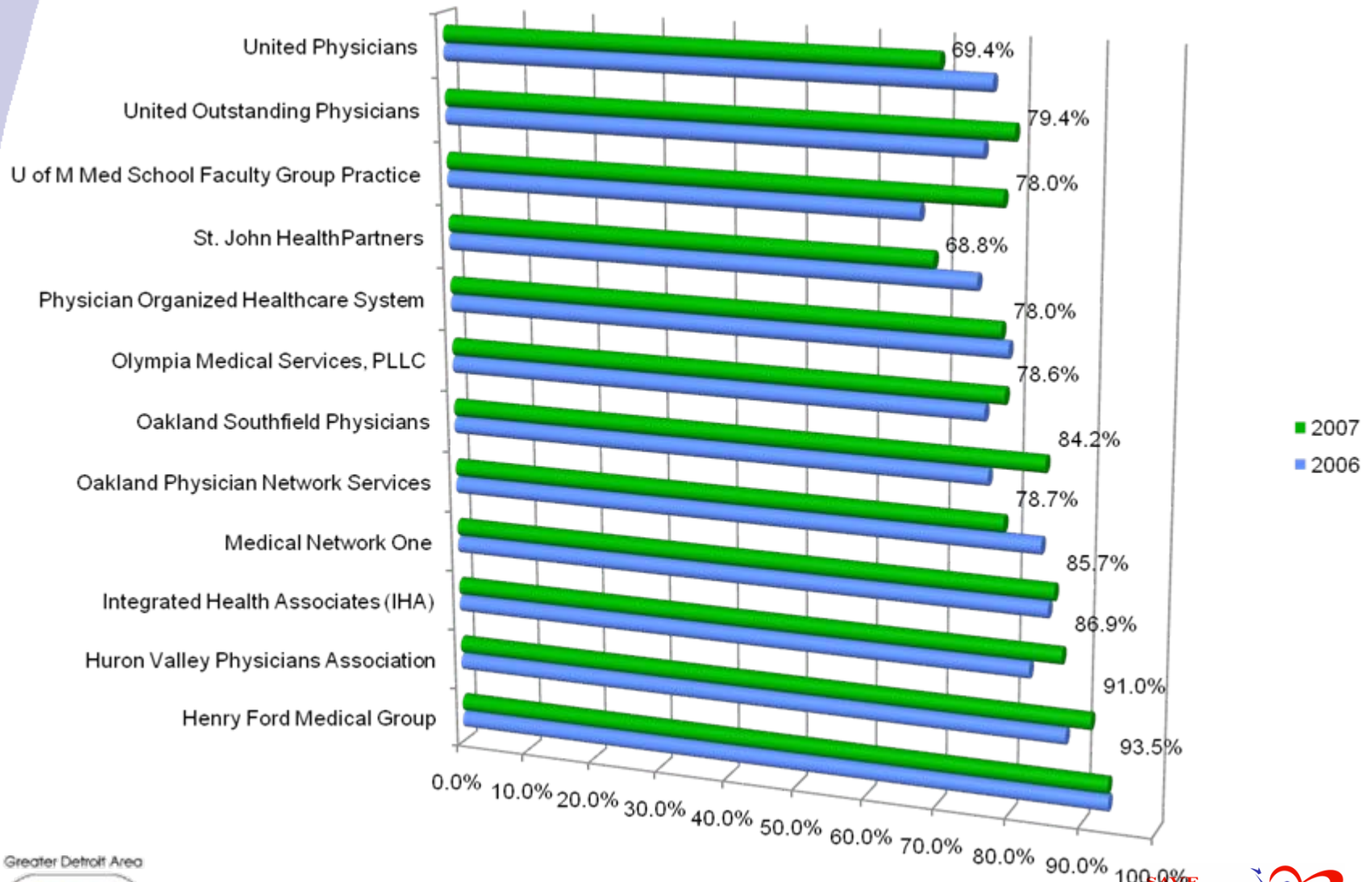
November 20, 2009

# GDAHC SLSD PO Report Updates

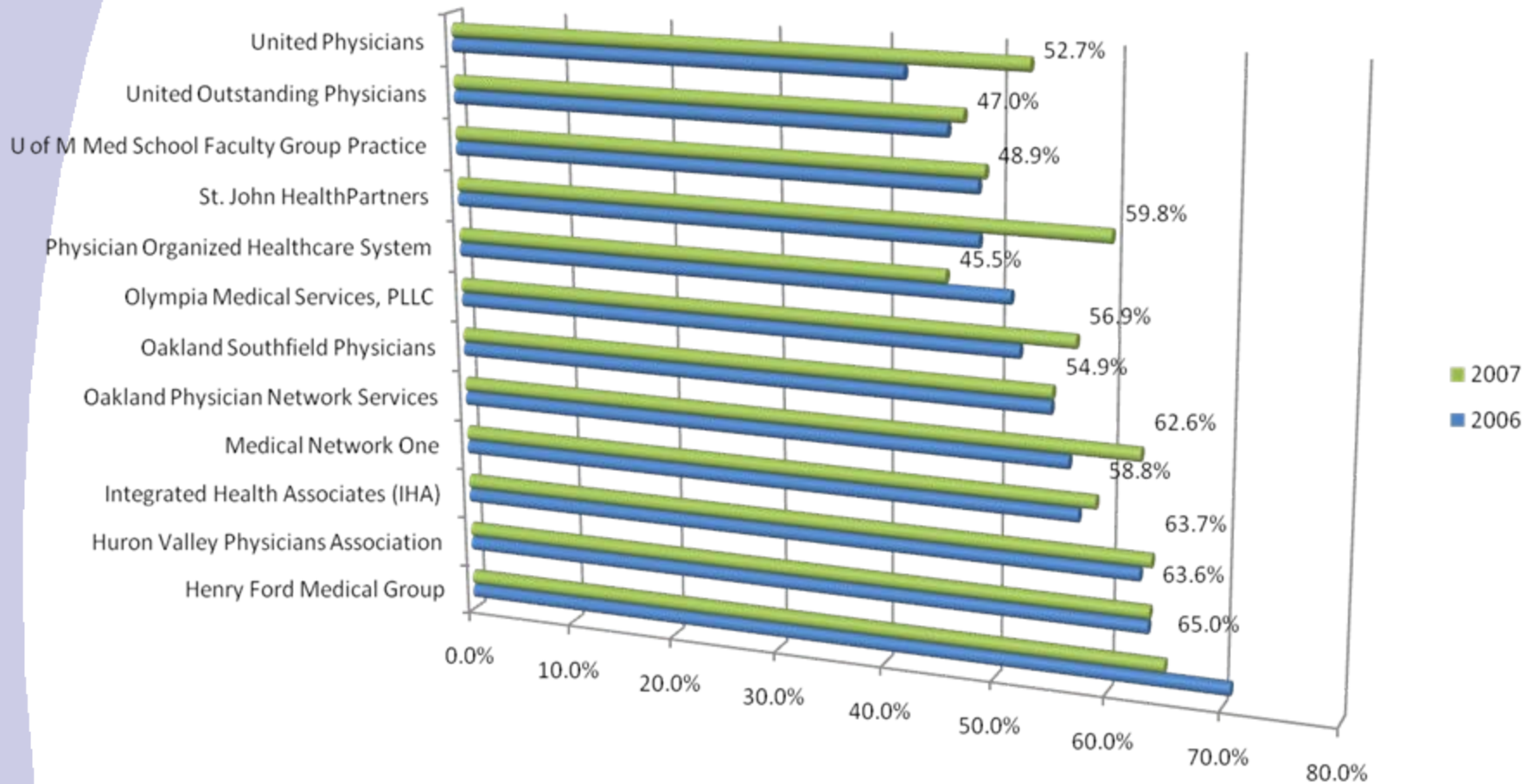
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- **On the Road to becoming an all Payer Report**
  - **2010 Commercial PO reports will include one of the region's largest self-insured employer, the University of Michigan**
  - **SLSD has successfully engaged Medicaid Health Plans**
    - **Goal is to publish PO reports in the summer of 2010**
    - **Great enthusiasm among the Medicaid Health Plans**
  - **Medicaid PO Reports will include:**
    - **Most of the HEDIS based Commercial Health Plan metrics**
    - **Lead screening measures**
    - **Race and ethnicity data**
  - **Group level reporting in beta testing phase**

# Appropriate Med Use for Upper Respiratory Infections

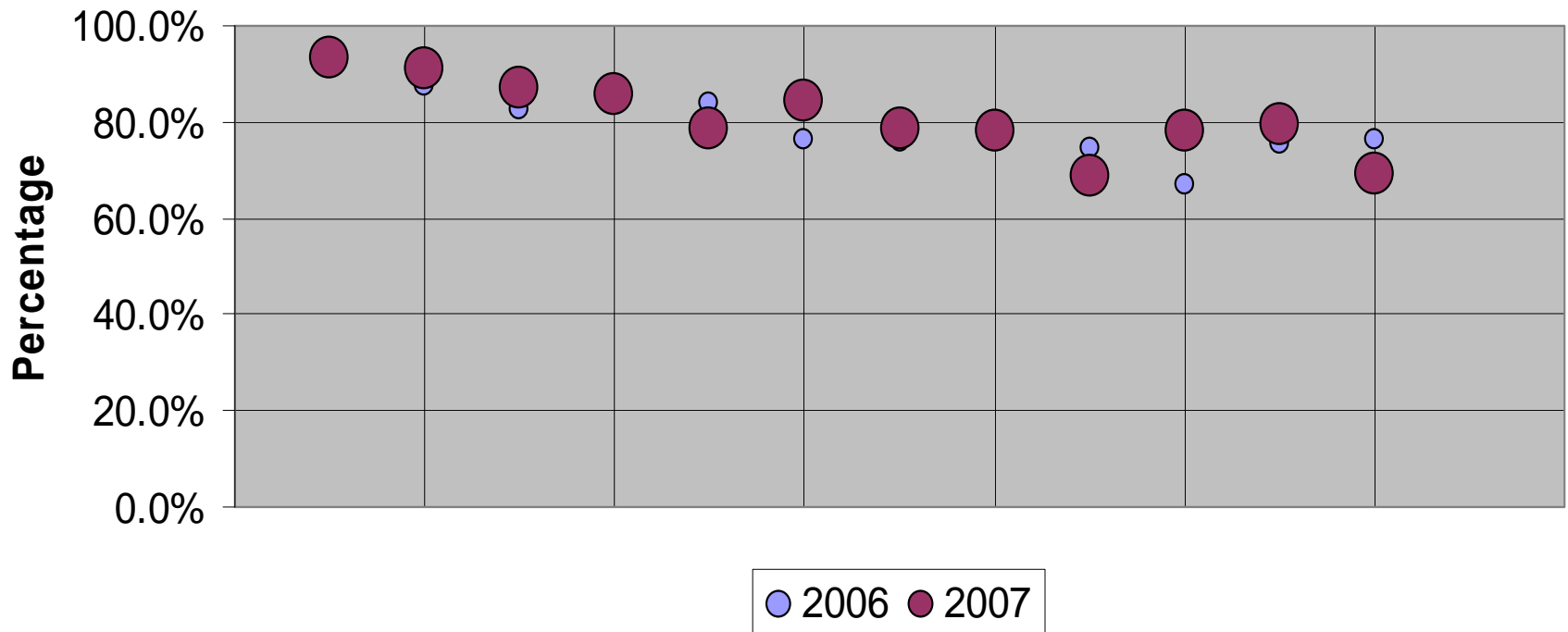


# Colon Cancer Screenings



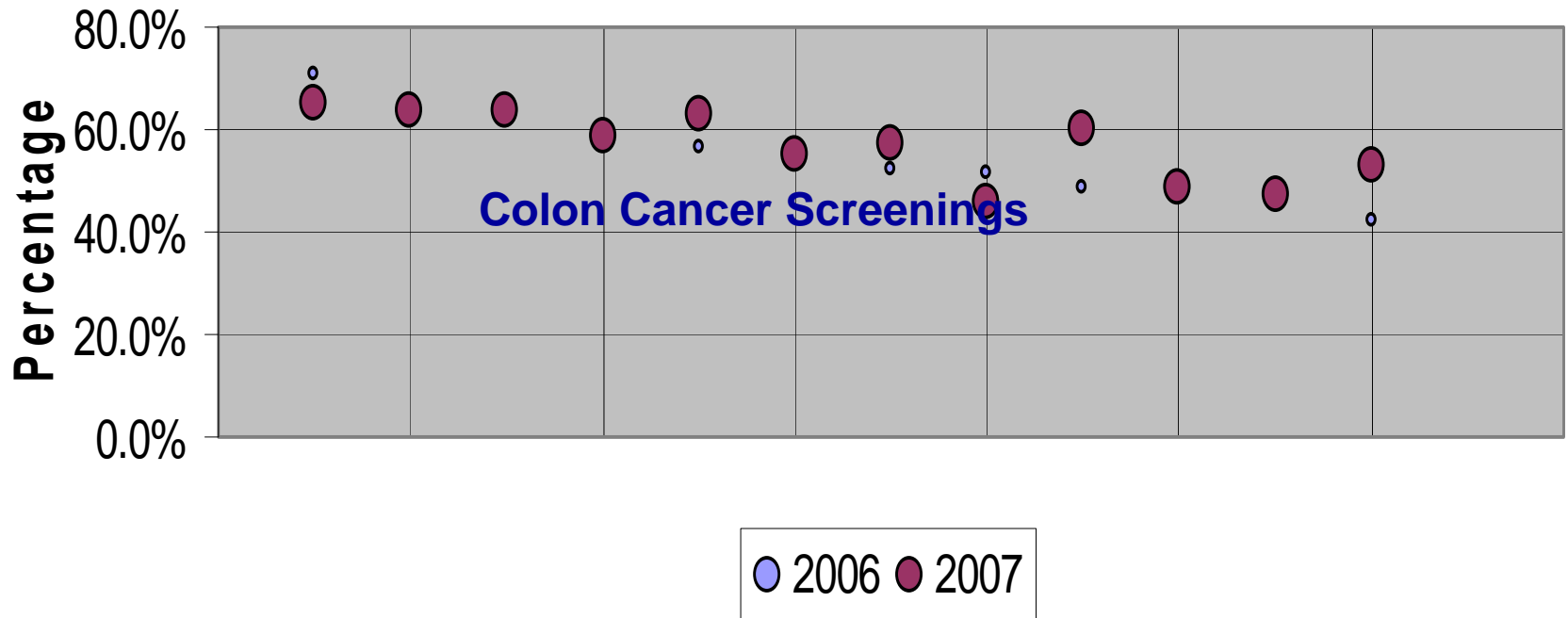
# Appropriate Med Use for Upper Respiratory Infections

## Appropriate Med Use for Upper Respiratory Infection



# Colon Cancer Screenings

## Percentage of Colon Cancer Screenings



# “Observations from the Data” Report

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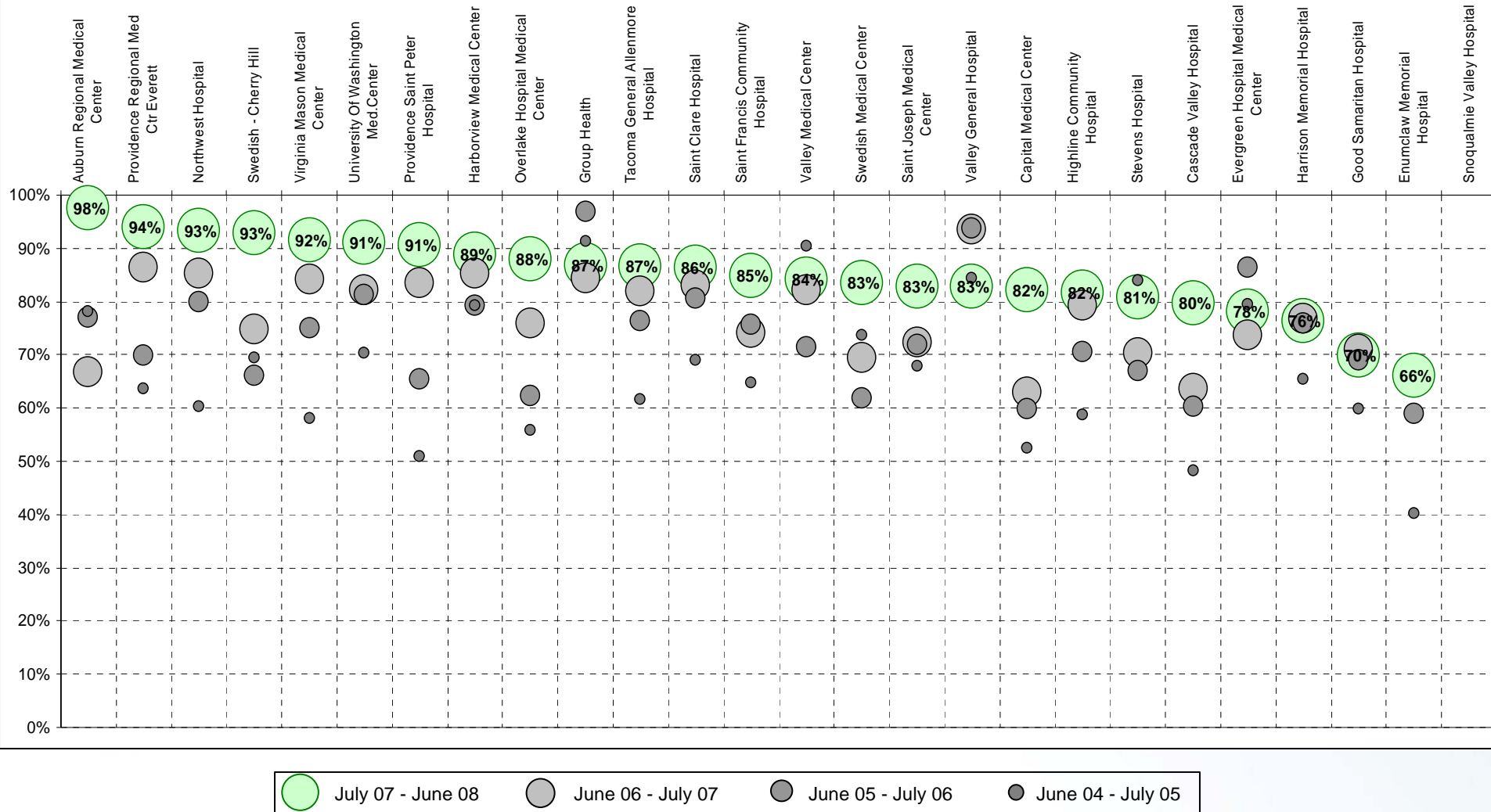
- **“Observations from the Data” Report**
  - **Review progress on reported performance measures over time**
  - **Identify gaps and opportunities**
  - **Help focus stakeholder attention on important issues relevant to performance/quality improvement**
  - **Distribution to SLSD stakeholders, including POs and posted on the SLSD website**

- ✓ *Community Checkup* Report
  - ✓ Hospitals
  - ✓ Medical groups
  - ✓ Health plans
- ✓ Hospitals: quarterly update from public sources
- ✓ Medical groups: 2x in 2008, 1x in 2009, next in 2010
- ✓ Health plans: 1x in 2009, next will be 2010

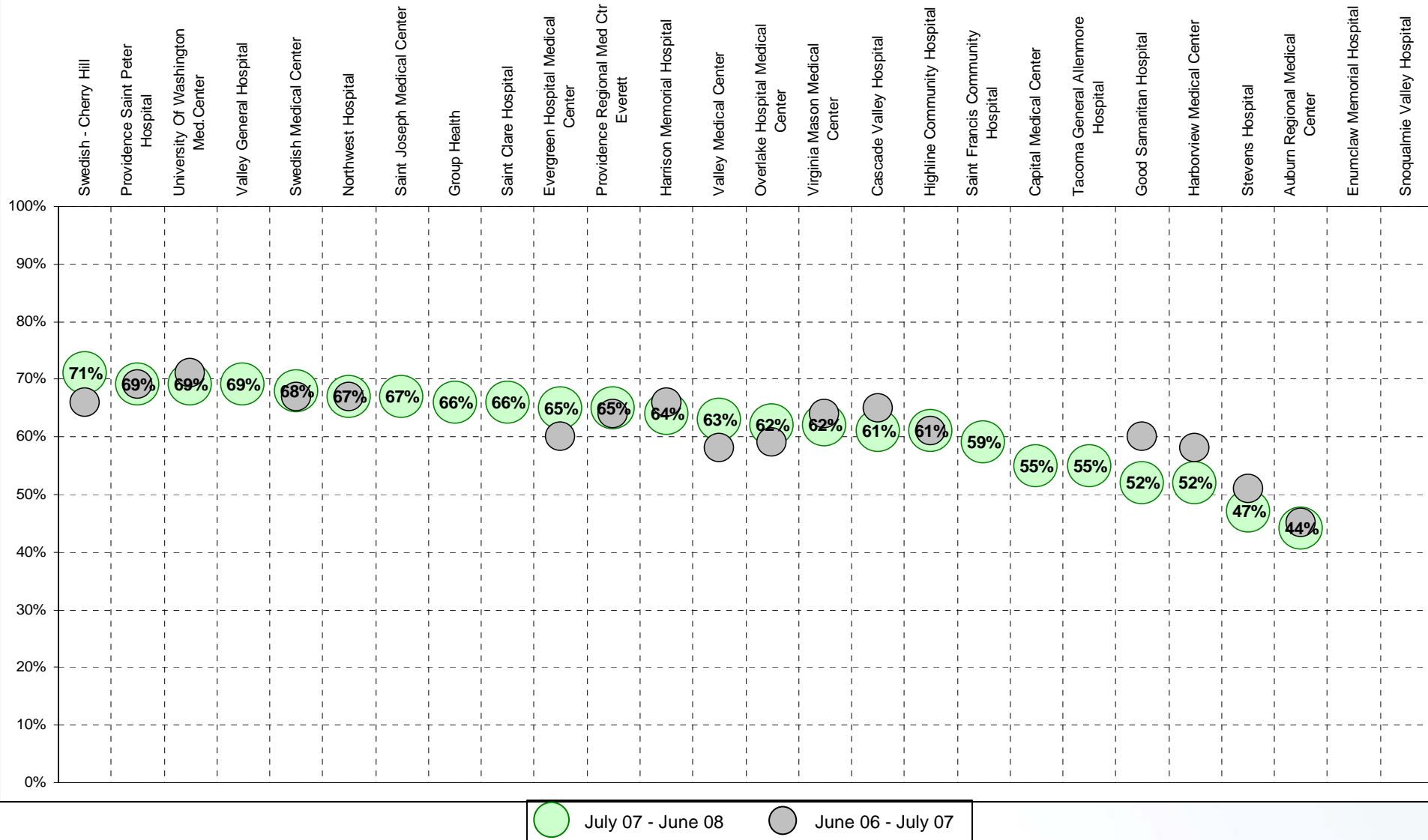


[www.WACommunityCheckup.org](http://www.WACommunityCheckup.org)

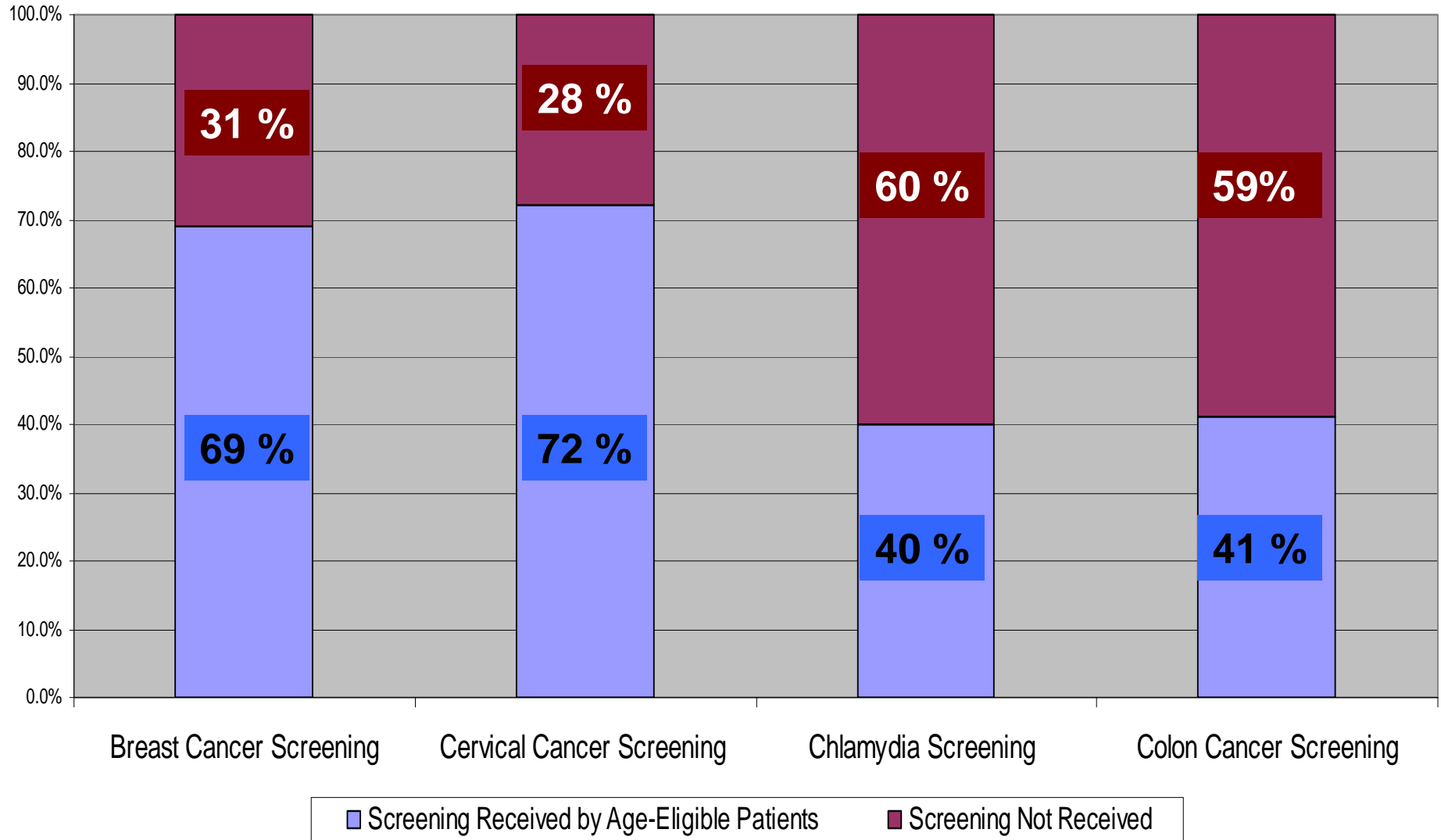
# Hospitals Over Time: Heart Failure Care



# Hospitals Over Time: Patient Experience

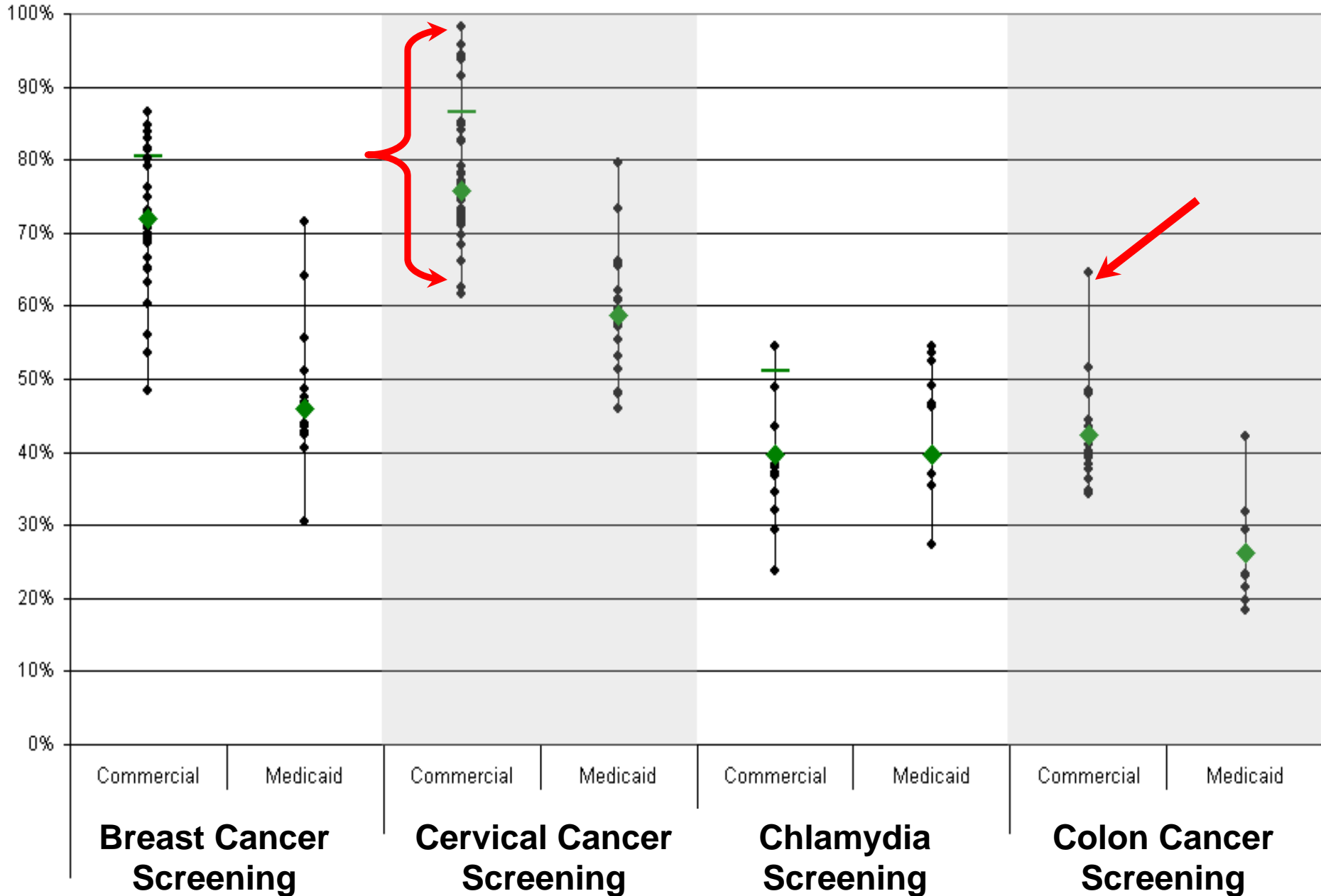


# Room for Improvement: Gaps in Preventive Services in the 5-County Puget Sound Region (July 2009)



● Medical Group Rates    ◆ Regional Average    — National Top 10%

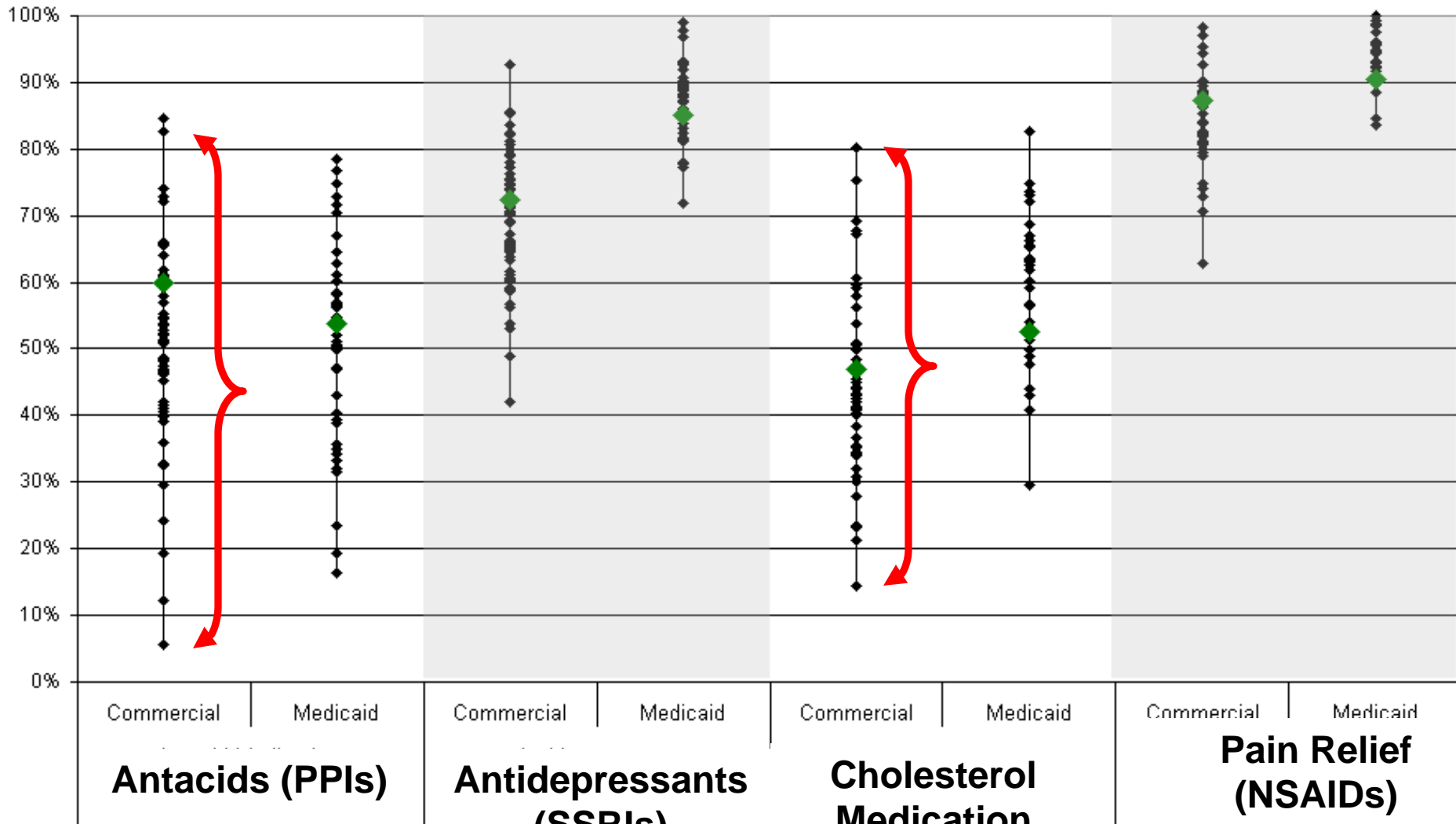
# Medical Groups: Preventive Services



# Medical Groups: Generic Drug 'Fill Rate'

• Medical Group Rates    ◆ Regional Average

### Use of Generic Drugs: Commercial and Medicaid Results



Commercial    Medicaid  
**Antacids (PPIs)**

Commercial    Medicaid  
**Antidepressants (SSRIs)**

Commercial    Medicaid  
**Cholesterol Medication**

Commercial    Medicaid  
**Pain Relief (NSAIDs)**

# *Collaboration. Accountability. Action.*

Diane Stollenwerk

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## Types of Data

- Ambulatory Care
  - EMR, charts, and administrative claims
  - Spring and autumn reporting cycle
- In-patient Care
  - WCHQ value metric with quadrant display
  - Public sources: CMS, Joint Commission, Leapfrog
  - Wisconsin Hospital Association reports additional data
- Health Plans
  - HEDIS
  - CAHPS

# Ambulatory Care

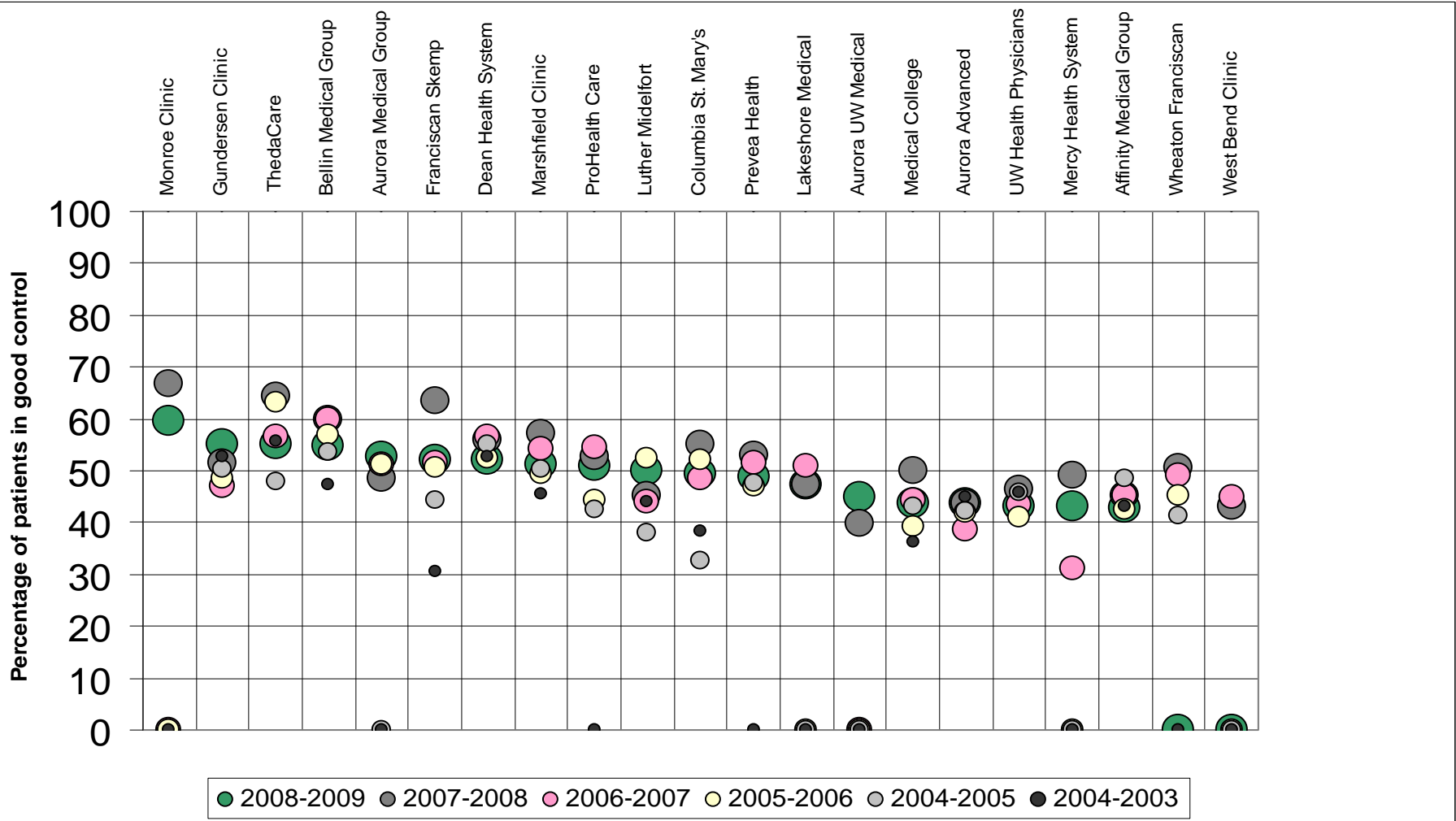
## ● Care Categories

- Chronic
- Preventive
- Episodic

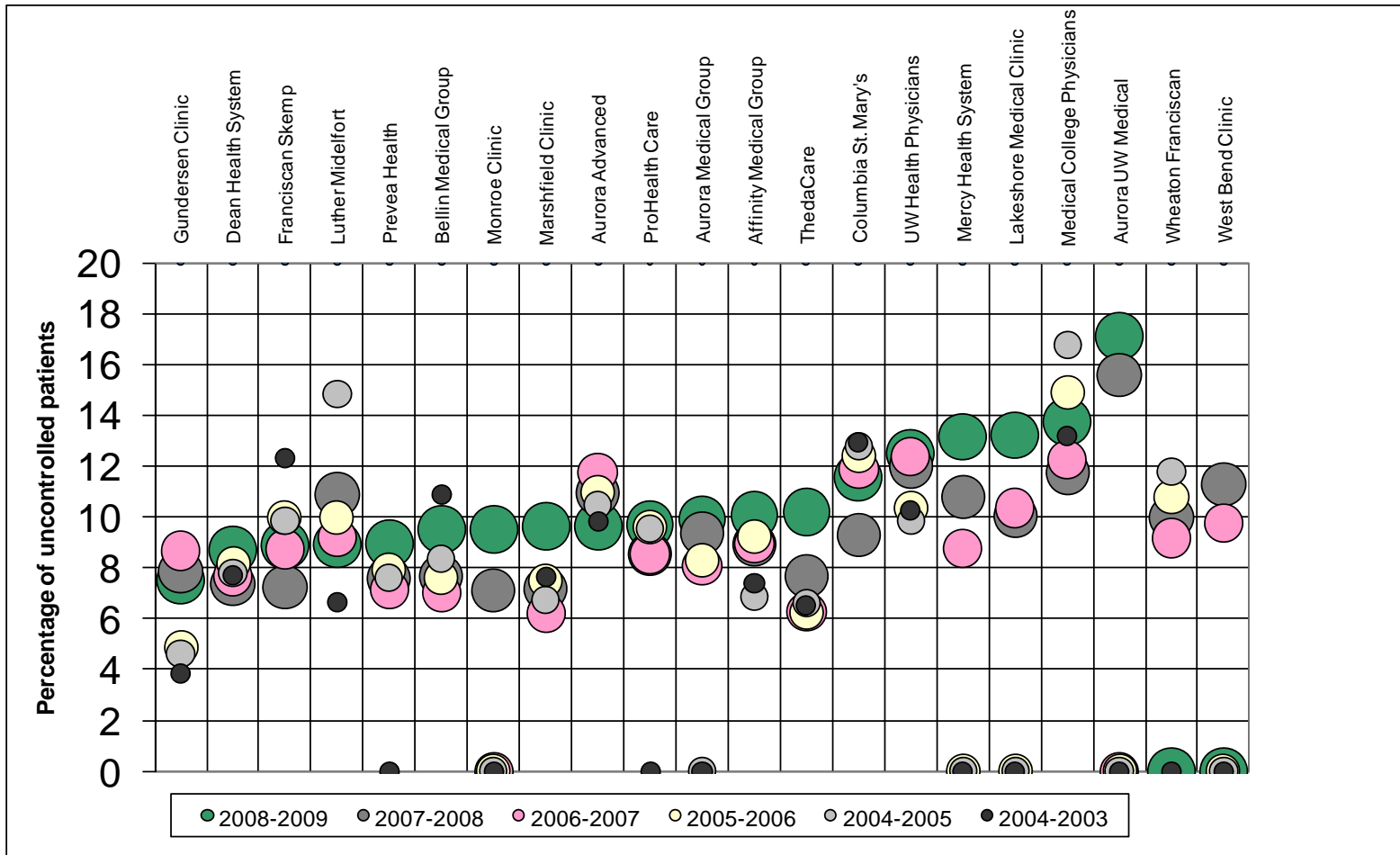
## ● Data Attributions

- Reporting at medical group level
- Includes entire patient population
- Represents all payers
  - Commercial
  - Medicare
  - Medicaid
  - Uninsured

# Diabetes: Blood Sugar (A1C) Control - Good control, less than 7.0%

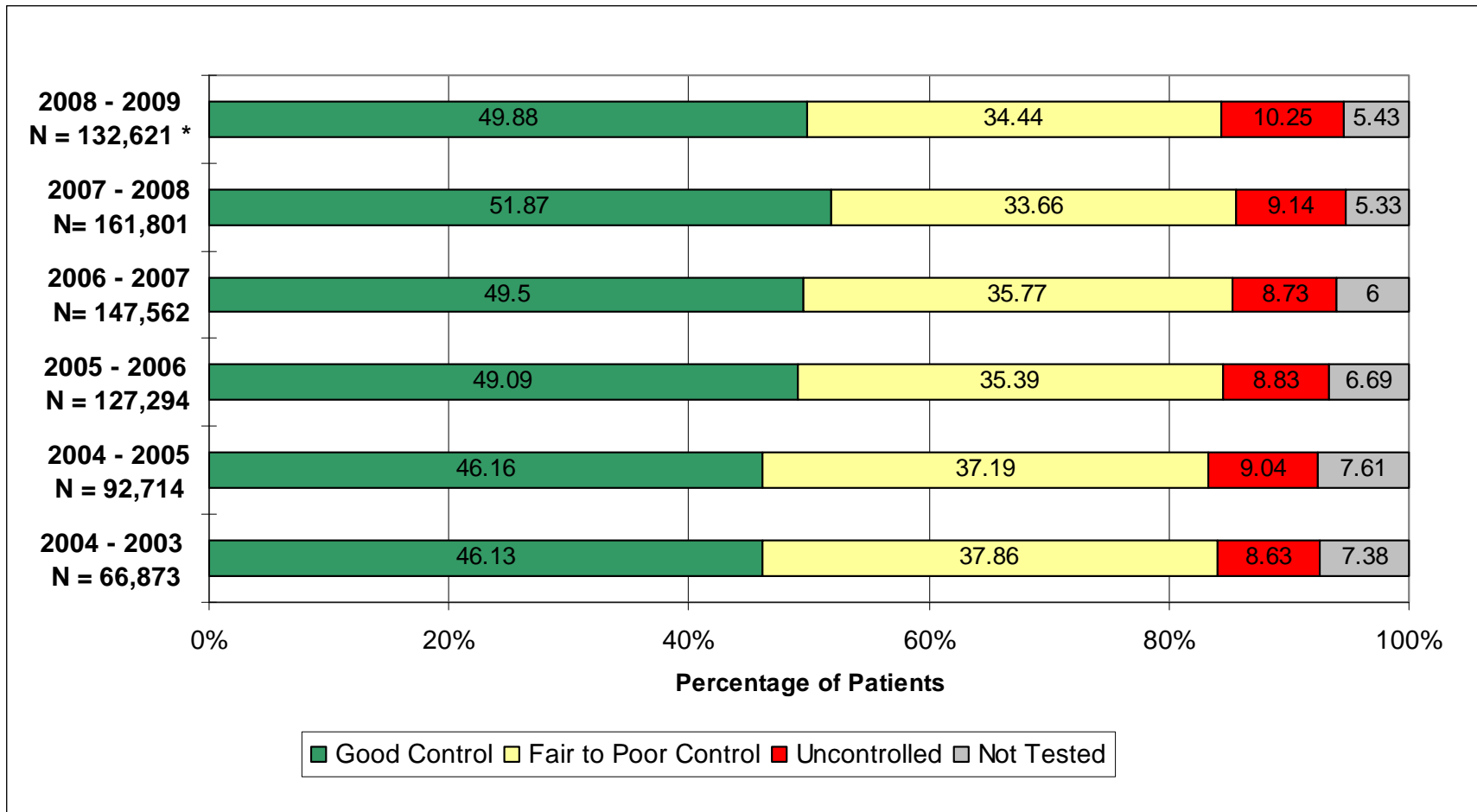


# Diabetes: Blood Sugar (A1C) Control - Uncontrolled, greater than 9%



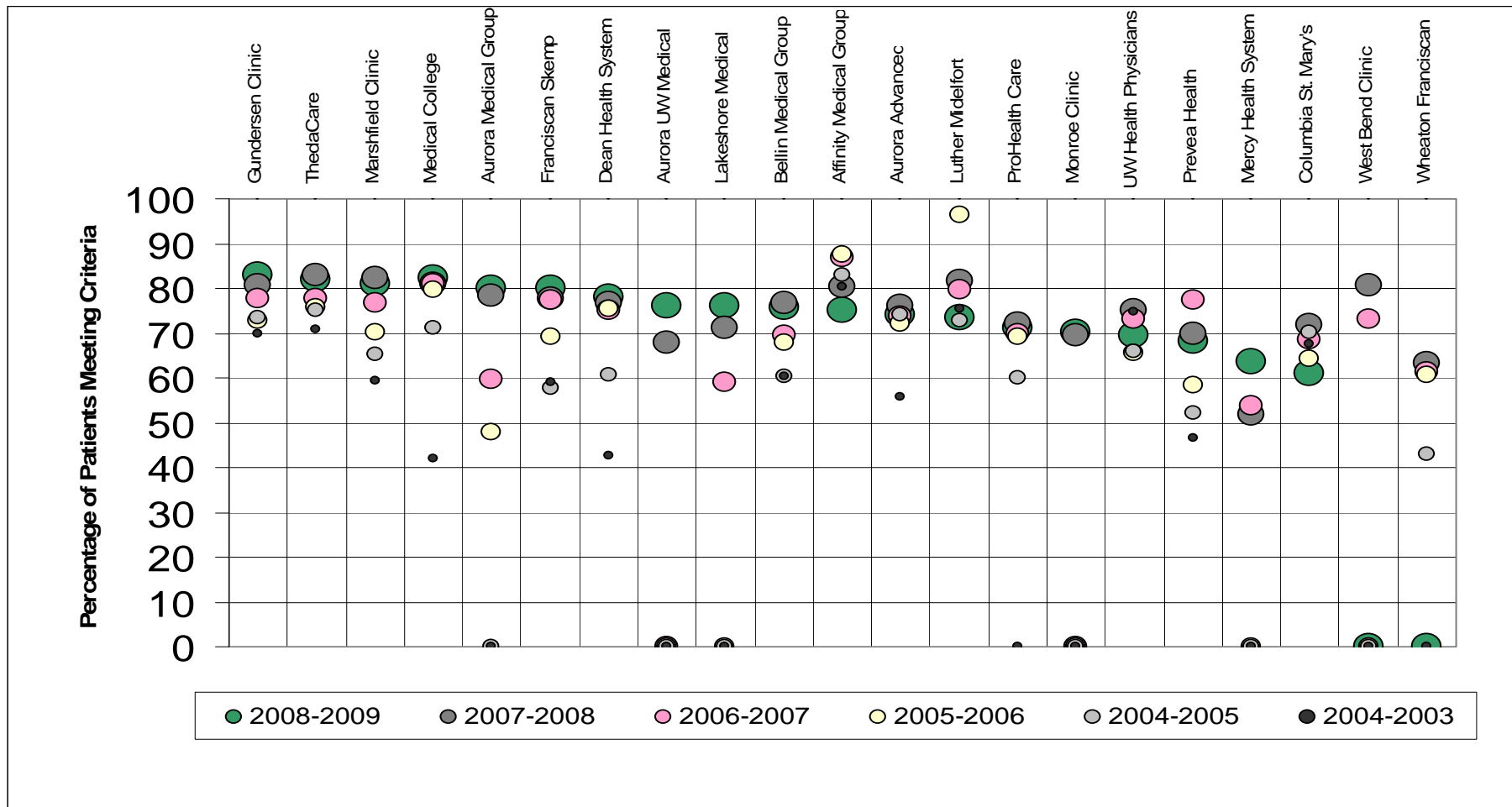
A lower percentage is the preferred target and reflects better performance with fewer uncontrolled diabetes patients.

# Diabetes: Blood Sugar (A1C) Control

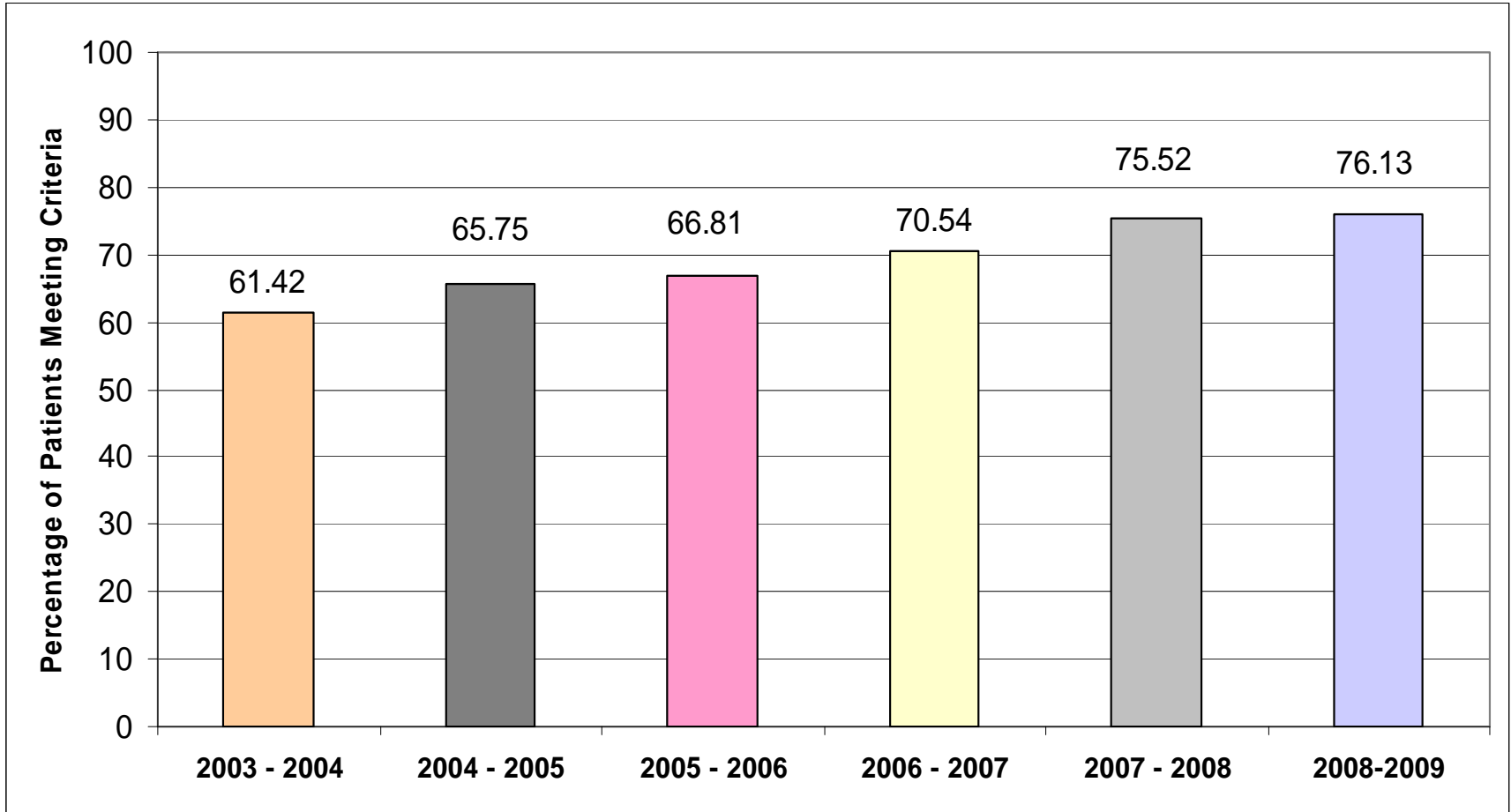


\* = Patient upper age limit was changed from 85 to 75 years with the release of 2008-2009 data.

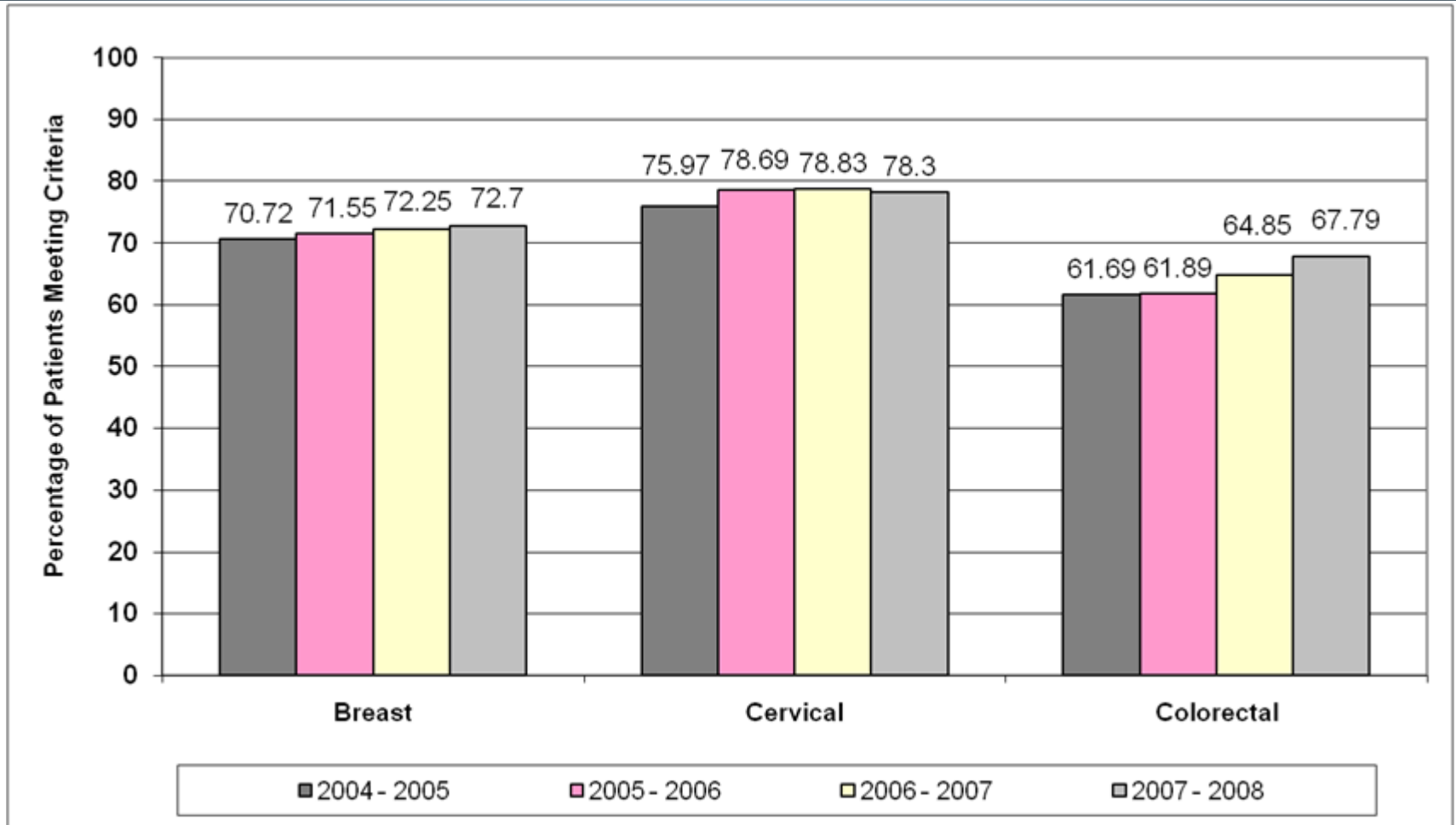
# Diabetes: Kidney Function Monitoring



# Diabetes: Kidney Function Monitoring



# Cancer Screenings



Patients with a history of cancer were no longer excluded with release of the 2007-2008 data.

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