Data Mining and Sharing across Organizations

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Vice President, Quality Improvement
Background

• MOC Program is embedded in Quality Division
• Infrastructure includes Performance Improvement Coordinators, Program Coordinator
• Scoped number of QI projects that support Enterprise level Quality goals
• Focus: Primary Care Physicians
• Large geographic footprint, 100 practice locations
• Common EHR platform
• Enterprise DataWarehouse
• 2016 transition to physician compensation plan that incorporates 10% to quality/patient satisfaction
Discussion Point #1

How are Portfolio Sponsor organizations using internal data to identify performance gaps?
Ambulatory Appropriate Care (QCC)

- Baseline: 82%
- Target: 85%
- Stretch: 88%
- Actual: 85.7%

**Favorable**
Metrics | Colon Cancer

- HEDIS 75th Percentile (65.6%) Stretch
- HEDIS 50th Percentile (57.5%) Target
- HEDIS 25th Percentile (50.5%)
Projects are open to Carolinas HealthCare System physicians and CHS-affiliated facilities. To view a project, click the name of the project below.

**Asthma**
- Assessment of Daytime & Nighttime Symptoms
- Controller Medication for Persistent Asthma
- Electronic Asthma Action Plan
- Influenza Vaccine
- Spirometry
- Inhaled Corticosteroids

**Diabetes**
- Hypertension BP < 140/90
- LDL <100
- Diabetes - Hgb A1c < 9%
- Nephropathy Assessment
- Retinal Eye Exam

**Heart Failure**
- ACE/ARB for LVSD (EF < 40%)
- Beta Blocker for LVSD (EF < 40%)
- Assessment for LVS Function

**Prevention**
- Breast Cancer Screening
- Colorectal Cancer Screening
- Cervical Cancer Screening
- Healthy Weight/BMI

**CAD/IVD**
- Complete Lipid Profile
- LDL Lowering Profile
- Anti-Platelet Therapy

**Telemedicine**
- PICU
Discussion Point #2

• How are we evaluating the impact of portfolio activities?
Discussion Point #3

- How can information be shared for cross organizational QI efforts including aggregate analysis, trending and reporting formats
# Metrics Reporting-Physician Goals

<table>
<thead>
<tr>
<th>CHSMSG Primary Care Quality Performance Report - FM, IM &amp; Endo</th>
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<tbody>
<tr>
<td>Current Snapshot - by Practice</td>
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<tr>
<td>Reporting Period: Monthly Snapshots for Current Year</td>
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<td>Report Run Date: 2/2/15</td>
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## CHARLES W RHODES MD

**CABARRUS FAMILY MED PROSP / CURTIS R PREIK MD**

Data as of: 02/01/2015

Number of patients to move listed underneath the percentage.
Number of patients to move listed underneath the percentage in ()

<table>
<thead>
<tr>
<th>Providers</th>
<th>Diabetes</th>
<th>Prevention and Safety</th>
<th>Goals Total</th>
<th>Goals Met</th>
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<td>A1C &lt; 8%</td>
<td>BP &lt; 140/90</td>
<td>LDL &lt; 100</td>
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# Providers Included in Measure: 7
# Providers Meeting Target: 4
% Providers Meeting Target: 57.1%
Diabetes - Blood Pressure 140 90

Global Aim

Improve the care of diabetic patients.

Specific Aim

Increase the percent of diabetic patients (ages 18-75 years) with blood pressure readings ≤ 140/90 documented in Health Maintenance to 20% of the baseline by the end of the improvement cycle.

Project Description

The provider will identify (0) diabetic patients (ages 18-75 years) with documented blood pressure readings ≤ 140/90 in Health Maintenance within the past 12 months from the patients with blood pressure readings in the office. The focused population are diabetic patients (ages 18-75) in the Carolinas Healthcare System Internal Medicine & Family Medicine physician panel. Blood pressure readings completed at the office will automatically be documented in Health Maintenance. Normalized blood pressure readings or home readings will not count towards the measure. This will serve as the baseline for the provider’s project. The benchmark for blood pressure readings ≤ 140/90 was set at 30% based on the Agency for Healthcare Research and Quality (AHRQ) National performance goal. During the next two weeks, the provider will track data with the QI coach to identify patients who have had a provider encounter during the past four weeks. Cycle 1: During the next two weeks, provider will work with the QI coach to identify and employ the strategies listed below. The provider will track the progress for 12 months and ensure that the provider’s project is completed.

Key Driver Diagram – Diabetic Blood Pressure Control

Outcome Measures:

- % diabetic patients within age range with documented BP reading ≤ 140/90 within the past 12 months

Process Measures:

- % diabetic patients within age range with documented BP reading ≤ 140/90 within the past 12 months/total # diabetic patients within age range that presented to practice within cycle 3.2 35

Balancing Measures:

- Cycle time during exams
- Time spent by clinical staff members collecting reports

Diabetic Blood Pressure Control - Projects (Completed)
Discussion Point #4

• What investments are your organizations making to advance performance reporting?

• What pain points are your organizations trying to address?
Physician Level View

Diabetes Stop Light Dashboard
Back Workbook

Visualize

Patient requiring attention: Last Hgb A1C > 9 or 
lowest Hgb A1C Date > 365 days ago

Recall Level
- High
- High/Med
- Medium
- Medium/Low
- Low
- Ok

A1C Ranges
- < 7
- 7 - 8.0
- 8 - 10.0
- > 10.0
- None

Last Visit Date Ranges
- < 90 days
- < 180 days
- < 365 days
- ≥ 365 days

Last A1C Date Ranges
- < 90 days
- < 180 days
- < 365 days
- ≥ 365 days

Provider: BASTABIAN MILSYV ME

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<th>Next Schedule</th>
<th>Last Hgb A1C</th>
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Carolina HealthCare System