ADVANCING INTEGRATED HEALTHCARE

Practice Reporting and Transformation

Care Transformation Collaborative of R.I.

PRACTICE REPORTING AND TRANSFORMATION COMMITTEE MEETING

2/24/2021

Agenda

Topic *Presenter(s)*	Duration
Welcome & Review of Agenda Andrea Galgay and Sarah Fessler, Co-chairs	8:00-8:05AM
OHIC Measurement Specification Review *Andrea Galgay, Chief Operating Officer RIPCPC, Co-Chair*	8:05-8:20AM
PDSA Review *Susanne Campbell to facilitate*	8:20-9:05AM
Clinical Quality Report Out *Andrea Galgay, Sarah Fessler to facilitate*	9:05 -9:20AM
Looking Ahead at Health Equity *Susanne Campbell, Andrea Galgay, Sarah Fessler to facilitate*	9:20-9:30AM

OHIC Measurement Specification Review

Andrea Galgay

December 2020 CTC/OHIC Measure Specifications

Final 2021 PCMH Measure Set and Review of Practice Performance from the 2020 PCMH Measures Survey

Overarching Principles and Definitions	
Updates to Overarching Principles and Definitions:	• Updated and embedded the instructions for how to obtain HEDIS Value Set. • Added telehealth to the definition of an Active Patient for all measures. • Removed "Weight Assessment and Counseling" from the PCMH Measure Set.
Active Patients:	Patients seen by a primary care clinician of the PCMH anytime within the last 24 months Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA), and Certified Nurse Practitioner (CNP). The following are the eligible codes for determining Active Patient status: 1. CPT/HCPCS office visit codes: 99201-99205; 99212-99215; 99381 – 99387; 99391-99397; 99487; 99490; 99491; 99495-99496; G0402; G0438-G0439. 2. Eligible telephone visit, e-visit or virtual check-in codes: a. CPT/HCPCS/SNOMED codes: 98966-98968; 98969-98972; 99421-99423; 99441-99443; 99444; 11797002; 185317003; 314849005; 386472008; 386473003; 386479004. b. Any of the above CPT/HCPCS codes in 2.a. with the following POS codes: 02. c. Any of the above CPT/HCPCS codes in 2.a. with the following modifiers: 95; GT. Acceptable Exclusions: Patients who have left the practice, as determined by one or more of the following: 1. Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice 2. Patient has passed away 3. Patient cannot be reached on three consecutive occasions via phone or emergency contact person 4. Patient has been discharged according to practice's discharge policy
Outpatient Visit Criteria:	Please refer to the current year HEDIS® Outpatient Value Set.
Encounter Types:	In addition to following CPT/HCPCS code level of service guidelines to establish an eligible population, report writers should ensure encounter types are limited to include only face to face encounter types for those measures requiring a face to face encounter. Example: Depression screening: Patient turns 18 in July. In the record they have two "encounters" during the measurement year – a well visit in April and a nurse care manager phone call in August. Failure to limit encounter types correctly could result in the nurse care manager visit erroneously triggering this patient in the eligible population.

PDSA Report Out

Adolescent Health: Vicki Crowningshield

Children First: Sarah Cambridge

Drs. Concannon & Vitale: Esteisy and Melinda

North Providence Pediatrics: Capri

Ocean State Pediatrics: Jenn Castro

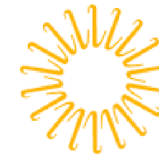
Partners in Pediatrics: Dr. Vieau

PCHC: Amy Perry

Santiago: Cristen Atehortua and Evelin Granados

Tri-County: Jennifer Papagolos

PDSA for Testing Change Adolescent Medicine (Hasbro)



Lifespan

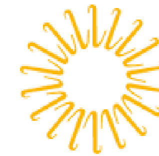
Aim: Achieve 90% completion rate for immunizations per CDC and Bright Futures guidelines (MCV, HPV, Tdap) for both adolescents age 13 and 17 in our primary care practice between Aug 2020 and Dec 2020.

Baseline Data: We had 5 patients turning 13 in the measurement year (2020), 3 (60%) of whom were up to date, and 68 patients turning 17 in 2020, 57 (84%) of whom were up to date.

Plan:

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
Run report in Kidsnet to identify the patients who are not up to date	Practice manager	.	
Outreach families of patients who are not up to date, schedule immunization visit (or well visit if due for this)	Nursing team, scheduling staff		
Nursing team notes in “Care Coordination” section of EHR if patient is due for immunization	Nursing team		
Patients come in for visits, team discusses immunizations in daily huddle, immunizations given and documented in EHR	Providers, nurses		
Re-run report in Kidsnet to identify patients who are still not up to date	Practice manager		

PDSA for Testing Change
Hasbro Adolescent Medicine



Lifespan

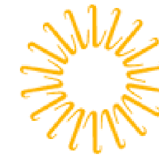
Do **Describe what actually happened when you ran the test**

Our practice manager ran the Kidsnet report, gave a list of patients/families to outreach to the nursing team, and they called to schedule patients for a visit. Since we were also working on a QI project to increase our Well Visit completion rates, the nursing team checked the EHR to see if patients were due for a well visit, and if so, helped direct them to the scheduling team to set up a well visit, and if they were not due, for a nurse visit for immunizations only.

Study **Describe the measured results and how they compared to the predictions**

We found that 13 patients turned 13 in 2020 when we re-ran our reports, and 8 (62%) of them were up to date. This is a slight increase from 60% at baseline. Among those turning 17, of which there were 56, 61 (92%) were up to date. This was a slight improvement from 84% at baseline. Because we are a small practice, and our age range is 10 to 26, we often have patients joining and leaving our practice, even in a short period. This may have affected our results.

PDSA for Testing Change
Hasbro Adolescent Medicine



Lifespan

Study **Describe the measured results and how they compared to the predictions - CONTINUED**

We also noted that in looking at which immunizations were more likely to be missing versus others, the HPV vaccine was more likely to be missing than MCV or Tdap. This may be due to parental vaccine hesitancy related to the fact that HPV is sexually transmitted.

Act **Describe what modifications to the plan will be made for the next cycle from what you learned**

We plan to begin running immunization reports on a monthly basis, and continuing to outreach patients/families that are not up to date. As our well visit rates improve (hopefully!) related to our Well Visit QI project, we anticipate this will have a positive effect on our immunization rates, as these immunizations are routinely reviewed at well visits. However, COVID has led many families to delay or defer well care, or request telemedicine visit, which make immunization completion more challenging. We will continue to counsel families on the importance of all immunizations. Interestingly, many of our providers have noted that conversations about the COVID vaccine have come up during discussions of other vaccines, and these conversations are largely positive and allow providers to provide anticipatory guidance and address questions and misconceptions about the COVID vaccine.

PDSA for Testing Change Children First

Quality Improvement Plan for Immunization

Goal: To increase Immunization rates and catch up immunization schedules of patients who missed well visits due to Covid 19 pandemic.

Baseline Data: Will be collected from Kidsnet and Epic reports generated by RIPCPC. Lists will be complied as adolescent combination, HPV, School entrance and Infant combination.

Patient Engagement: Once lists are established we will search for people with scheduled visits and add a note to that visit, that they are due for vaccines. If patient does not have a scheduled appointment staff will reach out to patient to schedule a visit with physician or nurse/ma. Once lists have been worked by phone we will give a 2 week response window, if there has been no response there will be a mailing sent to home address. Reports will be run monthly and will be compared to previous list.

PDSA for Testing Change Children First

Patient Engagement: CONTINUED

We have made it so we see Physical Exams starting at 8:45am to 2:15pm so that well visits and sick visits are separated. We also offer vaccine only appointments during this time and early Saturday mornings before patients start. I have found that, patients' being uncomfortable in the office is one of the largest barriers for families during this time as they do not want their children exposed to sick patients.

We are now also starting to expand time for well visits as parents are returning to work. We will not cancel a scheduled time if cannot move up to Well hours, but will work day to day schedules so that if there is afternoon appointments that need to be kept for well that the rooms will be separated in afternoon each physician will have 2 sick rooms and 2 well rooms that no sick patients will be in that day.

All immunization records will be checked for patients on list and updated with Kidsnet registry if not correct.

PDSA for Testing Change Children First

QIP Immunization

One strategy we listed to improve our numbers was to remove any transferred or deceased patients from the active Patient list in the Kidsnet registry. This proved to be overwhelming as it gives a list of all patients which was upwards of 4000 patients. We needed a way to streamline and find patients that had not been here in more than a year. RIPCPC provided us with an overdue physical list which gave us a great starting point to narrow down our patient list. The list gave us anyone overdue for their yearly physical and had no appointment booked for the future. When there was no appointment scheduled, we then went to the chart to see if a record release had been scanned in. After doing some investigation we could then remove those patients from the active patient list.

The Overdue physical list was helpful in other ways as well. Parents seemed more willing to book a physical appointment and come in for that then for "just a vaccine visit". The list also gave us the next scheduled appointment, so we were able to go to appointment notes to flag that they needed a catch-up vaccine or were due for a vaccine.

PDSA for Testing Change Children First

QIP Immunization CONTINUED

Phone calls to patients were hit or miss; If we were able to get a parent on the phone they would usually book and appointment at that time, on the other hand we had less success of an appointment being scheduled if we had to leave a message.

As we worked through the list if there was no response to messages left or they did not schedule at time of call we would send a letter. There was little response to generic letters. One of the employees suggested sending a letter with a scheduled appointment and to give them the option to call and reschedule if this did not work for them. The scheduled appointment letter yielded more appointments being scheduled and more vaccines given then the generic letter. Some patients kept and came to the scheduled appointment and some people called to make new appointments because they did not want to miss their scheduled appointment and then time did not work for them that we had provided.

PDSA for Testing Change Children First

QIP Immunization CONTINUED

Our office plan as Covid hit was to have set times for Well visits and Sick visits separates. As parents started to return to work and children returned to a more structured school day this was not working as well for people's schedules. We therefore expanded times for well visits. We had to increase screening protocols and separate rooms for sick vs well. This opened more availability and number of visits in a day which in turn gave more opportunities for vaccine review for more patients.

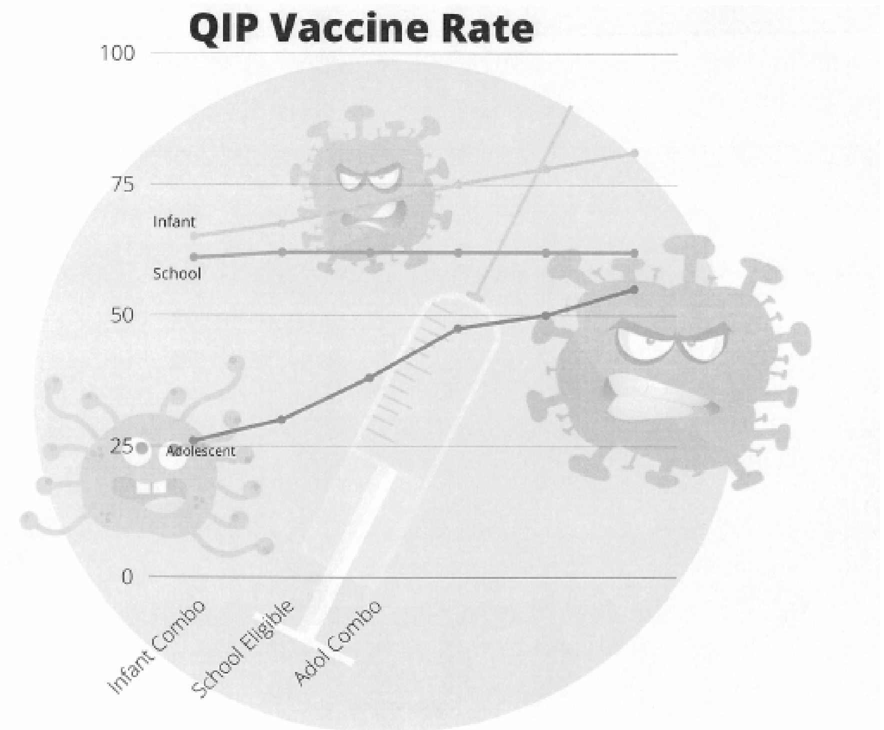
I feel that in all areas we increased except in the HPV Immunization which is consistent at about 30%. We did not track HPV as it seemed to stay consistently at 30 percent for the age group. Kidsnet numbers are skewed because we do not offer at 11yr we offer at 12 yr physical. The reasoning behind this is that there has been a lot of push back for the HPV vaccine and getting it with other vaccines parents have been uncomfortable with. We discuss at the 11 yr physical at length and then give parents a year to decide. If requested at the 11 yr or between 11 yr and 12 yr physical, we will administer as well. This proved hard to track and so I did not include data. All other vaccine categories we did have improvement in.

PDSA for Testing Change Children First

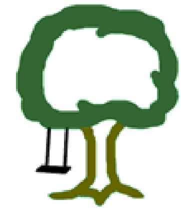
QIP Immunization CONTINUED

I feel that we found some excellent strategies to improve immunization rates across the board.

This project also rose awareness of vaccines and their importance throughout the office.



PDSA for Testing Change
Drs. Concannon & Vitale, LLC



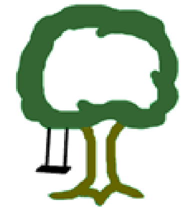
Aim: Increase physicals / well child visits (post COVID) through April 2020 – Dec 2020

Plan:

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
1. Review pts due for physicals / well child checks 2. Call to schedule 3. Mail letters if no returned call	Care Coordinator / Medical Secretaries	During Office hours	Offiice

Predict what will happen when the test is carried out	Measure to determine if prediction succeeds
Will increase our in office physicals & WCC's and close our gaps in care.	

PDSA for Testing Change
Drs.Concannon & Vitale, LLC



Do **Describe what actually happened when you ran the test**

We were able to get a hold of a lot of pts/parents and schedule visits.

Study **Describe the measured results and how they compared to the predictions**

We increased our patient visits for physicals / WCC's and closed a lot of gaps in care for the year.

Act **Describe what modifications to the plan will be made for the next cycle from what you learned**

We will do another cycle and hope to get the numbers up even further by the end of the year.

PDSA for Testing Change
North Providence Pediatrics

Aim: To reach 90% immunization rate, especially for MMR before kindergarten

***Plan*: Plan the test, including a plan for collecting data.**

Questions and predictions:

- Will we reach 90%. What is our rate for immunizations, currently? We predict we will vaccinate more than last period.
- Will every patient that needs a vaccine be scheduled?

Who, what, where, when:

- All children 2m and up. Focusing on 4yr and 12m old.

Plan for collecting data:

- We will run a report to see what percentage we are currently at. We will improve from the percentage. We will run who needs to come in and call to make sure they are scheduled.

PDSA for Testing Change
North Providence Pediatrics

Do **Describe what happened. What data did you collect? What observations did you make?**

Called patients to inform/schedule vaccine appt. to keep up to date. We learned that one was on the fence and that 2 others on the list no longer came to the practice.

Study **Analyze the results and compare them to your predictions. Summarize and reflect on what you learned:**

We learned to keep up with patient data/KIDSNET for most accurate list and that some patients need more reassurance.

Act **Based on what you learned from the test, make a plan for your next step. Determine what modifications you should make – adapt, adopt, or abandon:**

Constant follow up

PDSA for Testing Change: Ocean State Pediatrics

Project: Cancelled Appointments due to COVID19 Pediatric Immunization Improvement Initiative

Aim: To identify all patients whose appointments were cancelled due to the start of the COVID19 pandemic between 3/15/2020 and 5/31/2020 then reschedule these cancelled appointments with a goal to improve our well child appointment rate to pre-COVID19 numbers.

Baseline Data: Cancelled appointment data: Initial report on 06/01/2020 showed that there were 1,616 patient appointments cancelled between 03/15/2020 and 05/31/2020.

PDSA for Testing Change: Ocean State Pediatrics

Project: Cancelled Appointments due to COVID19 Pediatric Immunization Improvement Initiative

Plan:

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
The NCM will run report through EMR (Athena) to find all cancelled WCC appointments between 03/15/2020-05/31/2020	Jennifer	June 1-7, 2020	**In office**
The NCM will manually go through list to identify patients who have not rescheduled their cancelled WCC appointments	Jennifer	June 8-30, 2020	**In office**
The front reception staff will contact those families/patients who have not rescheduled their previously cancelled WCC appointments yet	Front reception staff	July-August 2020	**In office**
The NCM will monthly run reports to identify patients still missing WCC appointments	Jennifer	Last week of August, September, October, November 2020	**In office**
The NCM will re-run report of cancelled appointments to determine the amount of appointments that have been rescheduled	**Jennifer**	**December 2020**	**In office**

PDSA for Testing Change: Ocean State Pediatrics

Project: Cancelled Appointments due to COVID19 Pediatric Immunization Improvement Initiative

Plan:

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
Goal is to have 95% of cancelled appointments rescheduled before December 2020	NCM will be able to either rerun report or manually go through each patient's chart on list to determine if their appointment has been rescheduled

Do: Describe what actually happened when you ran the test:

Initial report from 06/01/2020 showed 1,616 patient appointments cancelled between 03/15/2020-05/31/2020.

***Study*: Describe the measured results and how they compared to the predictions:**

- Recheck on 06/24/2020 showed 250 patient appointments had not been rescheduled yet (15.5% of original 1,616)
- Recheck on 08/27/2020 showed 105 patient appointments had not been rescheduled yet (6.5% of original 1,616)
- Recheck on 10/20/2020 showed 39 patient appointments had not been rescheduled yet (2.4% of original 1,616)
- Recheck on 11/24/2020 showed 24 patient appointments had not been rescheduled yet (1.5% of original 1,616)
- Recheck on 12/16/2020 showed 10 patient appointments had not been rescheduled yet (0.6% of original 1,616)

PDSA for Testing Change: Ocean State Pediatrics

Project: Cancelled Appointments due to COVID19 Pediatric Immunization Improvement Initiative

Act: **Describe what modifications to the plan will be made for the next cycle from what you learned (Describe your sustainability plan):**

Less than 1 month following the studied period of 3/15/2020-5/31/2020, 84.5% of the initial 1,616 cancelled appointments had already been rescheduled. This was mainly due to active rescheduling of cancelled appointments by our front reception staff and parents calling to reschedule. The subsequent follow up numbers were reflective of weekly/monthly outreach by the NCM to individuals who had not yet rescheduled their appointments. For those who were hesitant to come to the office, most were reassured after hearing about the updated office workflow and COVID19 precautions. The remaining 0.6% by December who had not yet rescheduled had been outreached at least 3 times and their PCP was informed. These patients will continue to be followed into 2021 with a goal of scheduling their appointment.

PDSA for Testing Change: Ocean State Pediatrics

Project: MMR Vaccinations Pediatric Immunization Improvement Initiative

Aim: To identify all patients who are Kindergarten age and are missing an MMR dose, then schedule appointments to vaccinate those missing an MMR dose with a goal to improve our MMR vaccine rate to pre-COVID19 numbers.

Baseline Data: MMR vaccine data: According to Kidsnet, as of 12/31/2019 we had 419 patients who were Kindergarten aged and of those, 404 had received both MMR vaccine doses (15 patients missing MMR vaccine; ~96.4% of kindergarten ready patients had received both MMR doses).

PDSA for Testing Change: Ocean State Pediatrics

Project: MMR Vaccinations Pediatric Immunization Improvement Initiative

Plan:

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
NCM will run reports through Kidsnet and EMR (Athena) to find all patients who are kindergarten age and who are missing a MMR dose (don't have a complete 2-dose series)	Jennifer	July 2020	**In office**
NCM will manually go through list to identify patients who need to schedule an appointment for the missing MMR vaccine/WCC appointment	Jennifer	July 2020	**In office**
NCM and front reception staff will contact patients to schedule appointments	Jennifer/ Front reception staff	July-August 2020	**In office**
NCM will re-run reports monthly to find any patients still missing an MMR dose and schedule an appointment	**Jennifer**	**Monthly**	**In office**

PDSA for Testing Change: Ocean State Pediatrics

Project: MMR Vaccinations Pediatric Immunization Improvement Initiative

Plan:

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
Reports will show an increase in patients who are kindergarten aged and are missing MMR vaccine due to cancelled appointments because of the COVID19 pandemic between April - June 2020	After increasing appointment availability in summer 2020 and outreach by office staff, MMR rates will improve toward pre-pandemic numbers.

Do: **Describe what actually happened when you ran the test**

Initial data from 12/31/2019 showed of the 419 Kindergarten aged patients, 404 had received both MMR doses (96.4%)

PDSA for Testing Change: Ocean State Pediatrics

Project: MMR Vaccinations Pediatric Immunization Improvement Initiative

Study: **Describe the measured results and how they compared to the predictions:**

- According to Kidsnet on 7/15/2020, of the 473 total K-aged patients, 450 had received both MMR doses (95.1%)
- According to Kidsnet on 8/15/2020, of the 475 total K-aged patients, 454 had received both MMR doses (95.6%)
- According to Kidsnet on 9/16/2020, of the 467 total K-aged patients, 456 had received both MMR doses (97.6%)
- According to Kidsnet on 10/15/2020, of the 472 total K-aged patients, 458 had received both MMR doses (97%)
- According to Kidsnet on 11/15/2020, of the 476 total K-aged patients, 467 had received both MMR doses (98.1%)
- According to Kidsnet on 12/15/2020, of the 476 total K-aged patients, 467 had received both MMR doses (98.1%)

Act: **Describe what modifications to the plan will be made for the next cycle from what you learned (Describe your sustainability plan):**

We saw a decrease in our K-aged MMR rate after the COVID19 pandemic started in March 2020 (reflected in the July/August MMR rates). We were able to outreach the patients due for their MMR vaccine and schedule appointments before December (went from 23 patients missing vaccines to 8). Rate increased from 95.1% to 98.1% and is above our 12/31/2019 baseline of 96.4%. The barriers to some patients coming in for their visit were personal preference to not come into the office due to the pandemic (even with our updated office procedure and protocol) and deferral of the vaccine for non-COVID reasons.

PDSA for Testing Change Partners in Pediatrics

Partners in Pediatrics

Aim: To improve our rates of adherence to routine preventative visits as recommended and outlined by AAP.

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
Will we be able to realize (or exceed) our previous (prior to COVID pandemic) rates of well child check visits.	All staff	Over next 6 months	Phone calls followed by in office visits

Plan:

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
• Obtain report of all missed well checks from 3/1/2020 through 6/30/2020	Andrea (RIPCPC)	July 2020	RIPCPC
• Call each family to notify of overdue well check and outline safety precautions in place in office. Address concerns of family as needed.	Jessica	Weekly	Phone
• Schedule appointments as soon as possible for in office well checks	Em	PRN	Phone
• Review and update report on 1st of month every other month.	Andrea/ Courtney	Every other month	RIPCPC or office

PDSA for Testing Change
Partners in Pediatrics

Partners in Pediatrics

Plan: CONTINUED

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
I predict we will be able to capture at least 80% of missed appointments	Compare percentage of missing well checks at beginning of initiative to percentage missing at end of project

Do **Describe what actually happened when you ran the test**

We ran our first report in July and found that we had 154 patients missing / behind on well checks. By October we were down to 74 and by November we were down to 49. In January we were back up to 51 patients missing well checks, which is only 67% of our initial number and I had hoped to get to 80%. We were able to book another 19 of these patients for well checks in the following weeks so if these show up, we will be at 79%

PDSA for Testing Change
Partners in Pediatrics

Partners in Pediatrics

Study **Describe the measured results and how they compared to the predictions**

Our results are not as good as I had hoped they would be at this point. However, I could not have predicted the severity of the pandemic in the winter months. This clearly contributed to our overall numbers. I am pleased with the plan and we will continue to track / follow missing appointments on an every other month basis.

Act **Describe what modifications to the plan will be made for the next cycle from what you learned**

We will continue to follow these reports but will do so every other month. The process is more streamlined now so it is easier to "scrub" the lists. we will switch to every other month as monthly leaves us with too many redundancies.

PDSA for Testing Change
Providence Community Health Centers

Aim: The goal of this project is to improve MMR Vaccines to be at a goal of 90% the rate in 2019, by end of Quarter 4, 2020.

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
Expand Face-to-Face visits for outreach to children due for immunizations ages 4-6.	Operations	07/13/2020-12/31/2020	Olneyville, Randall, Chafee, Prairie, Central and Capitol

Plan:

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
Pediatric Opportunity Report Creation	AE Data Team	7/01/2020	AE Team
Pediatric Opportunity Report Validation	AE Data Team	7/15/2020	AE Team
Training of care teams on use of report to identify immunization gaps	AE Med Director	8/01/2020	AE Team
Distribution of daily pediatric opportunity report to care teams	AE Data Team	8/15/2020	AE Team
Use of Pediatric Opportunity Report to identify immunization gaps	Care Team	8/15/2020	Clinic
Calls to patients' caregivers to schedule Pediatrician follow-up to include immunizations	Care Team	8/15/2020	Clinic

PDSA for Testing Change

Providence Community Health Centers

Plan: CONTINUED

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
I predict we will be able to capture at least 80% of missed appointments	Compare percentage of missing well checks at beginning of initiative to percentage missing at end of project

PDSA for Testing Change
Providence Community Health Centers

Do **Describe what actually happened when you ran the test**

In July, the Community Health Advocates surveyed 21 families enrolled in case management to discuss access to care and potential barriers to getting their children immunized during the COVID-19 pandemic. Questions included: overall experience with telehealth visits, access to masks, childcare and transportation. We also asked what type of assistance and/or resources they would need in order to bring their child to the health center to catch up on their immunization.

Parents/caregivers suggested the following:

- "Bring both children at the same time"
- "Do a physical on the phone rather than coming into the clinic"
- "Provide a ride to their appointment"

In September, we also added the MMR immunization gap to our existing pediatric outreach report. Care teams used this outreach list to prioritize patients based on risk level and open gaps in care to get them in for their immunizations

PDSA for Testing Change
Providence Community Health Centers

Study **Describe the measured results and how they compared to the predictions**

All sites met the goal of the PDSA and are within 10% of the 2019 MMR rates and 4/6 sites improved their MMR immunization rates compared to 2019!

	12/31/2019	7/15/2020	12/15/20	1/15/21
CHAFEE	80.56	70.34	78.08	78.08
PRAIRIE	79.73	71.27	78.65	82.83
OHC	80.18	74.23	80.4	83.33
CAPITOL	83.33	79.59	83.73	85.65
CENTRAL	84.27	80.37	85.52	86.43
RANDALL	90	83.95	88.7	88.79
Source: Kidsnet				

PDSA for Testing Change

Providence Community Health Centers

Act **Describe what modifications to the plan will be made for the next cycle from what you learned**

It was suggested that we leverage technology (texting/patient portal) to reach more patients, instead of using staff time to call patients. It was also suggested that we create an ad hoc nurse led clinic to focus just on immunizations, offer drive up vaccinations and/or offer immunizations at our Express clinic.

Chafee shared that for their site in particular, their MMR immunization rate fell slightly in 2020 due to limited capacity for outreach because of staff shortages and providers schedules already being booked with overdue physicals.

PDSA for Testing Change
Santiago Pediatrics

Aim: *Santiago Pediatrics joined forces with Harp (Home Asthma Response Program) in December 2019. HARP is an evidence-based asthma intervention designed to reduce preventable asthma emergency department visits and hospitalizations among high risk pediatric asthma patients. HARP is a part of the regional New England Asthma Innovation Collaborative (NEAIC). In Rhode Island, HARP is a partnership between the Rhode Island Department of Health, Hasbro Children's Hospital, Saint Joseph's Health Center, and Thundermist Health Center.*

Our site identifies children with a diagnosis of Asthma and refers to HARP. ***Our goal is to refer a total of 30 patients*** *by December 2020, at a rate of 2-3 patients per month. The HARP model utilizes a Certified Asthma Educator (AE-C) and a Community of Health Worker (CHW) to conduct three intensive sessions that: Assess patients' asthma knowledge and triggers exposure, provide intensive asthma*

self-management education, deliver cost-effective supplies to reduce home asthma triggers and improve quality and experience of care. Referring patients to the HARP program follows our direction in providing quality care while helping to reduce ER rates, and increase patient satisfaction

PDSA for Testing Change
Santiago Pediatrics

Describe your first (or next test of change) :	Person responsible	When to be done	Where to be done
Obtain high risk lists from HARP that include BCBS patients.	Dora		**Via email**
Identify patients in the practice, birth to 17 years old, that can be referred to the program. NO more than 2-3 per month as required by HARP	Providers & staff	December 2019	**Pull reports and/or identify at visits**
Review process with all staff and referral form.			**Staff meeting**

PDSA for Testing Change
Santiago Pediatrics

Plan

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
Lower ER Visits	**Number of ER visits**
Improve overall patient health	**The frequency of office visits due to asthma**

PDSA for Testing Change
Santiago Pediatrics

Do: Describe what actually happened when you ran the test.

Patients were selected from the high risk list, based on severity of their Asthma symptoms and visits to the ER.

From December 2019-December 2020 40 patients were referred to the St. Joseph Asthma Program, of the 40 patients 28 agreed to join the program. Progress notes from St. Joseph and our engagements with the parents indicate that parents are satisfied to have someone helping them with asthma education. The asthma action plan is updated, they make sure that patients have proper medications. The program also provides them supplies like vacuum cleaners to keep carpets clean. They contact Green and healthy homes so they can help with the removal of any mold if the home has any . 12 patients refused the program due to personal conflicts either parent's work schedule, patient's school hours or due to Covid they were nervous to let anyone in their home.

PDSA for Testing Change
Santiago Pediatrics

Study: Describe the measured results and how they compared to the predictions.

Out of the 40 referred patients, only 4 had ER visits.

Act: Describe what modifications to the plan will be made for the next cycle from what you learned.

Working closer with patients that refused the program. Helping them feel comfortable and clarifying that the program now offers home visits through video chat not only in person. We will continue with the program for this year and we will keep referring 2-3 new patients per month.

PDSA for Testing Change Tri-County

The goal for the Pediatric Immunization Improvement Program is to improve immunization rates for children which have declined based on the impact of COVID 19. Population of focus is school aged children (aged 4-6) that are in need of M-M-R as identified on KIDS NET reports. Target is for practices to achieve 90% of M-M-R on 12/31/19 report compared with 12/31/20 KIDS NET report. Plan is to be informed using feedback obtained from parents through same sample outreach questionnaire that help to identify parent/family/child needs/barriers. Plan is to be informed by practice resources ("supply") including staff availability, practice schedule (times available), time needed for appointments, supplies needed and space.

Aim: (overall goal you wish to achieve) Tri-County Health Center aims to safely provide age appropriate immunizations to children during the COVID-19 pandemic. Specifically, Tri-County aims to provide M-M-R immunizations to children aged 4-6, with a target of achieving 90% of M-M-R vaccination rate as compared to M-M-R vaccinations completed by the health center as of December 31, 2019. In December of 2019, the M-M-R vaccination rate was 84%, so our goal for this PDSA was to achieve at least 76% vaccination rate by December 2020.

PDSA for Testing Change Tri-County

Base line Data (12/31/19 KIDS NET Report MMR)

December 31, 2019 Tri-County Health Center M-M-R vaccination rate was 84%. This number is reported by KidsNet, and is used for baseline reporting. The goal is to achieve 90% of 2019 completion, or 76% M-M-R vaccination rate.

Outline your patient engagement strategy to understand patient's perspective:

In order to understand patient perspective surrounding this initiative, Tri-County will identify patients aged 4-6 that are in need of M-M-R vaccination, but who do not have appointments scheduled to complete the immunization. Community Health Workers (CHW) will attempt to contact parents or guardians of these patients via telephone communication. If CHW is successful in their attempt to contact the parent, an appointment will be scheduled for M-M-R to be administered, along with any other vaccinations that might be needed. If the parent resists scheduling an in-person appointment, the CHW will attempt to complete the Customer Experience Questionnaire to identify and resolve any barriers to care. Barriers to care will be addressed according to the individual needs of the family to maximize engagement and completion of M-M-R vaccination. Barriers may include parent concerns of bringing children into the office during the COVID-19 pandemic, lack of transportation, lack of childcare, or other concerns.

PDSA for Testing Change Tri-County

Outline your patient engagement strategy to understand patient's perspective: CONTINUED

If the CHW is unsuccessful in 3 attempts to contact the parent by phone, written communication will be mailed to the home notifying the family that the child is due for immunization, along with educational materials reiterating the importance of completing vaccinations in a timely manner.

Every goal will require multiple smaller tests of change

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
NextGen report will be run to identify patients due for M-M-R that do not have an appointment scheduled to complete the vaccination. For patients that are apprehensive of scheduling in –person visits to complete the M-M-R, CHW will administer the Customer Experience Survey to identify barriers to care. CHW will then attempt to address barriers.	Care Team members listed below.	Begin 08/01/2020	TC Health Center

PDSA for Testing Change Tri-County

Plan:

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
1. NextGen Report to identify patients. 2. Workflows established to address barriers to care. 3. Training provided to CHW on administration of Customer Experience Survey. 4. CHW's to outreach parents via phone communication. 5. Tracking of outcomes (immunizations scheduled vs not)	1. Mercedes 2. Care Team 3. Barbara, RN 4. CHW's 5. CHW's	Begin 8/1/2020	TC Health Center

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
Barriers to care will be identified and addressed, resulting in number of completed M-M-R vaccinations in children age 4-6 to increase.	-Increase in appointments scheduled for M-M-R. -Increase in completed M-M-R vaccinations.

PDSA for Testing Change Tri-County

Do **Describe what actually happened when you ran the test**

Community Health Workers reported that the majority of parents were agreeable to scheduling their child's appointment in the office to complete their vaccinations. For the parents that declined to schedule their child's appointment, CHW's reported that parents were apprehensive to bring children into the health centers during the COVID-19 pandemic due to

fear of exposure. Parents also reported that childcare was not available to watch other children in the home, or that transportation was a barrier. Community Health Workers were able to address barriers in some cases that led to the scheduling of appointments. Funding was allocated to address concerns such as transportation and CHW's assisted patients and families to arrange for safe and reliable sources. Patients that were apprehensive about scheduling appointments during the COVID-19 pandemic were notified via telephone communication of safety measures in place and patients were offered facial coverings and other PPE if needed at no cost.

PDSA for Testing Change Tri-County

Study **Describe the measured results and how they compared to the predictions**
Measures were identified to determine if our outreach efforts were successful. As of December 31, 2020, KidsNet data for immunizations, and specifically for M-M-R immunizations was reviewed. As of December 2020, Tri-County reported 83% M-M-R vaccination rate, achieving our goal of 90% of the M-M-R vaccination rate of December 2019 (84% completion rate of patients age 4-6). Staff were successful in many cases in addressing the concerns of family members, finding solutions to barriers to care, and to successfully scheduling in-person appointments for M-M-R vaccinations.

Act **Describe what modifications to the plan will be made for the next cycle from what you learned**
Community Health Workers found that direct contact with patients was a successful strategy in maintaining our immunization, and M-M-R completion rates. However because of the COVID-10 pandemic, staff availability fluctuated considerably from week to week. Oftentimes staff were utilized to cover shortages, or their focus was shifted to urgent and time sensitive matters, including the staffing of COVID-19 testing clinics. Going forward, Medical Assistants should be cross trained in patient outreach strategies, and be included in this workflow so that we can sustain outreach and be more consistent in this area.

PDSA for Testing Change Tri-County

Describe your sustainability plan: Personal outreach and education regarding the importance of childhood immunizations to parents and guardians was a successful approach to maintaining the rate of M-M-R immunizations for children ages 4-6. Additionally, Community Health Workers were able to address barriers to care for some parents that resulted in scheduled appointments and completed immunizations that otherwise may not have been completed. In order to sustain our rates of M-M-R completion, and childhood immunization in general going forward, we will incorporate this workflow as standard practice, and update policies and procedures accordingly. Additional staff, including medical assistants will be trained in addition to Community Health Workers. Funding specifically allocated to addressing barriers was critical to this effort. Allocating funding will continue in the short term, and will be considered on a longer basis going forward.

Clinical Data Report Out

Well Child Resources

Best practice recommendations for "patient reported" vital signs

CDC help for parents:

https://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/measuring_children.html

AAP recommendations

- "document any gaps“; identify and make a plan to "close the gaps.
- For visits that require other work, (like hearing/vision, vaccines), have a "close the gap" visit planned.
- IF there really aren't any gaps to close (other than a full exam), document in your virtual visit any gaps, the risk and a plan. For example might say "Unable to examine testicles, but patient well known to practice and has had normally descended testicles in the past 3 well visit exams. Will make a note in the chart to pay attention and document at next in person visit."

Looking Ahead at Health Equity

- *How practices capturing race, ethnicity information?*
- *What are barriers? How are practices addressing barriers?*
- *Are practices applying race & ethnicity to the clinical quality measures?*
- *If yes, what are your findings?*

Road to Equity Call for Applications

Activity	Time
Post Request for Applications	February 5, 2021
Stakeholders submit questions and CTC posts written answers	Rolling basis Submit to: deliverables@ctc-ri.org
Webinars Zoom Information: https://ctc-ri.zoom.us/j/4665707463?pwd=V2huN0VDSmtrTUY4TTNQZi9iRHZ2dz09 Meeting ID: 466 570 7463 Passcode: 646876	• March 26, 2021 (2:00-3:30pm) • April 13, 2020 (11:30-1:00pm)
Office Hour application consulting available from WE Team Zoom information: https://weintheworld-org.zoom.us/j/92177879408 Meeting ID: 921 7787 9408	• April 1, 2021 (10:00-11:00am) • April 22, 2021 (10:00-11:00am) • May 13, 2021 (10:00-11:00am)
Application due:	May 21, 2021 Submit to: deliverables@ctc-ri.org Contact person: Jazmine Mercado, Program Coordinator Cell: 401-323-1414 Email: Jmercado@ctc- ri.org
Review and Selection process	May 21, 2021-June 4, 2021
Teams notified of selection with each team member sent Participative Agreement (Adobe-sign) and Compass Assessment	June 4, 2021
Participative Agreements due back from each team member (Adobe-sign) and W-9 as applicable	Due: June 18, 2021
Accepted teams complete Compass Assessment	Due: June 18, 2021
Team participation in "Kick off "session Zoom information to follow	July 14, 2021 (1:00-5:00 pm)

ADVANCING INTEGRATED HEALTHCARE

Thank you
Stay Healthy and Safe

NEXT MEETING: MAY 26, 2021

No PR/PT meeting in March. Please join us March 12th for Breakfast of Champions, 7:30-9:00AM (Zoom)