QUALITY OF CARE IN THE AMBULATORY SETTING

Melissa Lee, MD NYCH+H / Kings County

GREATER NEW YORK HOSPITAL ASSOCIATION & UNITED HOSPITAL FUND

CLINICAL QUALITY FELLOWSHIP PROGRAM

Objectives

- To define “excellent” primary care
- To understand standardized metrics for high quality primary care
- To explore ambulatory care data sets and identify “care gaps” and “opportunities”
- To visualize ambulatory quality improvement in action

Quality in Ambulatory Care

- Define excellent primary care
- Measure high quality primary care
- Examine care gaps- opportunities
- Utilize data to drive change and quality improvement

When poll is active, respond at **pollev.com/elinakats025**

Text **ELINAKATS025** to **22333** once to join

What do PCPs do?

Clinical Care

Preventive Care

Behavioral Health Screening

Long-Term Services and Supports

Coordination of Care and Services

Start the presentation to see live content. For screen share software, share the entire screen. Get help at **pollev.com/app**

What would inspire you to recommend your PCP to a family member?

Start the presentation to see live content. For screen share software, share the entire screen. Get help at **pollev.com/app**

Primary Care? What Matters Most?

- Location
- Insurance
- Word of Mouth
- Ease of scheduling
- Relationship with provider
- Comfort with office staff

- Yelp reviews
- Dr. Google
- Zoc Doc
- Online ratings
- US News and World Report
- New York Magazine

The Donabedian Model for Quality of Care

STRUCTURE	PROCESS	OUTCOME
Physical and organisational characteristics where healthcare occurs	Focus on the care delivered to patients e.g. services, diagnostics or treatments	Effect of healthcare on the status of patients and populations

Primary Care? What Matters Most?

Structure	Process	Outcome
• What % providers are using an EHR? • How many board-certified PCPs are there? • What's the ratio of providers to patients (panel size)?	• How are individuals screened for colon cancer? • How does the practice perform medication reconciliation?	• What are the results of the CAHPS patient experience survey? • What % of patients have diabetes in control?

Which primary care practice would you choose?

Practice A	Practice B
Structure	Structure
Process	Process
Outcome	Outcome

Quality in Ambulatory Care

- Define excellent primary care
- Measure high quality primary care
- Examine care gaps- opportunities
- Utilize data to drive change and quality improvement

Health **E**ffectiveness **D**ata **I**nformation **S**et

HEDIS/CAHPS/HOS Measures Required for HP Accreditation—Medicare

HEDIS MY 2021 (Reporting Year 2022); CAHPS MY 2020 (Reporting Year 2021); HOS MY 2020 (Reporting Year 2021)

***Note:** The **weight** column indicates the weight of the item (maximum value = 3) in the overall score calculation.*

	Measure Name	Display Name	Weight
PATIENT EXPERIENCE			
Getting Care			
	Getting Needed Care (Usually + Always)	Getting care easily	1.5
	Getting Care Quickly (Usually + Always)	Getting care quickly	1.5
Satisfaction With Plan Physicians			
	Rating of Personal Doctor (9 + 10)	Rating of primary care doctor	1.5
	Rating of Specialist Seen Most Often (9 + 10)	Rating of specialists	1.5
	Coordination of Care (Usually + Always)	Coordination of care	1.5
Satisfaction With Plan and Plan Services			
	Rating of Health Plan (9 + 10)	Rating of health plan	1.5
	Rating of All Health Care (9 + 10)	Rating of care	1.5
PREVENTION			
Cancer Screening			
BCS	Breast Cancer Screening—Total	Breast cancer screening	1
COL	Colorectal Cancer Screening—Total	Colorectal cancer screening	1
Other Preventive Services			
FVO	Flu Vaccinations for Adults Ages 65 and Older	Flu shots for adults ages 65 and older	1
PNU	Pneumococcal Vaccination Status for Older Adults	Pneumonia shots for adults ages 65 and older	1
TREATMENT			
Respiratory			
PCE	Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	Steroid after hospitalization for acute COPD	1
	Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	Bronchodilator after hospitalization for acute COPD	1
Diabetes			
CDC	Comprehensive Diabetes Care—Blood Pressure Control (<140/90)	Blood pressure control (140/90)	3
	Comprehensive Diabetes Care—Eye Exams—Total	Eye exams	1
	Comprehensive Diabetes Care—HbA1c Control (<8%)	Glucose control	3
SPD	Statin Therapy for Patients With Diabetes—Received Statin Therapy	Patients with diabetes—received statin therapy	1
	Statin Therapy for Patients With Diabetes—Statin Adherence 80%	Patients with diabetes—statin adherence 80%	1

Press Ganey Patient Experience Survey

During this visit, did this provider explain things about your child's health in a way that was easy to understand?

- O Yes, definitely
- O Yes, somewhat
- O No

During this visit, did this provider listen carefully to you?

- O Yes, definitely
- O Yes, somewhat
- O No

YOUR CHILD'S CARE FROM THIS PROVIDER ON 08/31/2021

13. Wait time includes time spent in the waiting room and exam room. During this visit, did your child see this provider **within 15 minutes** of his or her appointment time?
    - O Yes
    - O No
14. During this visit, did this provider explain things about your child's health in a way that was easy to understand?
    - O Yes, definitely
    - O Yes, somewhat
    - O No
15. During this visit, did this provider listen carefully to you?
    - O Yes, definitely
    - O Yes, somewhat
    - O No
16. During this visit, did you talk with this provider about any health questions or concerns you had about your child?
    - O Yes
    - O No → **If No, go to #18**
17. During this visit, did this provider give you easy to understand information about these health questions or concerns?
    - O Yes, definitely
    - O Yes, somewhat
    - O No
18. During this visit, did this provider seem to know the important information about your child's medical history?
    - O Yes, definitely
    - O Yes, somewhat
    - O No
19. During this visit, did this provider have your child's medical records?
    - O Yes
    - O No
20. During this visit, did this provider show respect for what you had to say?
    - O Yes, definitely
    - O Yes, somewhat
    - O No
21. During this visit, did this provider spend enough time with your child?
    - O Yes, definitely
    - O Yes, somewhat
    - O No
22. Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?
    - O 0 Worst provider possible
    - O 1
    - O 2
    - O 3
    - O 4
    - O 5
    - O 6
    - O 7
    - O 8
    - O 9
    - O 10 Best provider possible
23. Would you recommend this provider's office to your family and friends?
    - O Yes, definitely
    - O Yes, somewhat
    - O No

CLERKS AND RECEPTIONISTS AT THIS PROVIDER'S OFFICE

24. During this visit, were clerks and receptionists at this provider's office as helpful as you thought they should be?
    - O Yes, definitely
    - O Yes, somewhat
    - O No
25. During this visit, did clerks and receptionists at this provider's office treat you with courtesy and respect?
    - O Yes, definitely
    - O Yes, somewhat
    - O No

ALL YOUR CHILD'S CARE IN THE LAST 3 MONTHS

These questions ask about **all your child's** health care. Include all the providers your child saw for health care in the last 3 months. Do **not** include the times your child saw a dentist.

26. In the last 3 months, did your child **take any** prescription medicine?
    - O Yes
    - O No → **If No, go to #28**
27. In the last 3 months, how often did you and anyone on your child's health care team talk about all the prescription medicines your child was taking?
    - O Never
    - O Sometimes
    - O Usually
    - O Always

Press Ganey Patient Experience Survey

YOUR CHILD'S CARE PROVIDER

Please answer these questions with the Provider named in the first question of this survey in mind.

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Concern the care provider showed for your questions or worries	O	O	O	O	O
2. Explanations the care provider gave you about your child's problem or condition	O	O	O	O	O
3. Care provider's efforts to include you in decisions about your child's care	O	O	O	O	O
4. Care provider's discussion of any proposed treatment (options, risks, benefits, etc.)	O	O	O	O	O
5. Likelihood of your recommending this care provider to others	O	O	O	O	O

Comments (describe good or bad experience): ____________________

OVERALL ASSESSMENT

	very poor 1	poor 2	fair 3	good 4	very good 5
1. How well the staff worked together to care for your child	O	O	O	O	O
2. Likelihood of your recommending our practice to others	O	O	O	O	O

Comments (describe good or bad experience): ____________________

Healthfirst Quality Assurance Reporting Requirements

Appendix XVII – PHSP Quality Rating Measures

QUALITY RATING MEASURES
HEDIS MEASURES
Access and Preventive Care
Annual Dental Visit (2–18 yrs.)
Breast Cancer Screening
Cervical Cancer Screening
Childhood Immunizations – Combo 3
Chlamydia Screening (16–24 yrs.)
Colorectal Cancer Screening
Controlling High Blood Pressure
Immunizations for Adolescents – Combo 2
Timeliness of Prenatal Care
Postpartum Care
Well-Child Visit (first 30 months of life)
Child and Adolescent Well-Care Visits
Weight Assessment and Counseling for Children and Adolescents
Chronic Care Management
Asthma Medication Ratio (5–64 yrs.)
Diabetes Care: Eye Exam
Diabetes Care: Poor HbA1c Control
HIV Comprehensive Care: Viral Load Suppression
Use of Spirometry Testing in the Assessment and Diagnosis of COPD
Behavioral Health
Antidepressant Medication Management
Initiation and Engagement of Alcohol and other Drug Dependence Treatment
Initiation of Pharmacotherapy upon New Episode of Opioid Dependence
Adherence to Antipsychotic Medications for Individuals with Schizophrenia
Diabetes Screening for People with Schizophrenia or Bipolar Disorder using Antipsychotic Medications
Follow-up After Discharge from the Emergency Department for Alcohol or other Drug Dependence (7days)
Follow-up after Discharge from the Emergency Department for Mental Illness (7 days)
Follow-up after Hospitalization for Mental Illness (7 days)
Follow-up for Children Newly Prescribed ADHD Medication
Metabolic Monitoring for Children and Adolescents on Antipsychotics
AVOIDING ADMISSIONS AND READMISSIONS
PQI: Adult Composite
PQI: Pediatric Composite
MEDICATION ADHERENCE AND USE MEASURES
Statin Therapy for Persons with Cardiovascular Disease (80% adherence)
ENROLLEE SATISFACTION MEASURES
Getting Care as Needed
Rating of Health Plan
Customer Service and Information

Preventive Care Standards

Guidelines for Documentation

Chlamydia Screening in Women	Sexually active women 16–24 years of age should be screened for chlamydia annually.	Medical record documentation must include both: • Date the test was performed • Result of test
Colorectal Screening	Patients 50–75 years of age should have 1 or more screening(s) done: 1. Fecal occult blood (FOB) in the year 2. Flexible sigmoidoscopy in the last 5 years 3. Colonoscopy in the last 10 years 4. CT colonography in the last 5 years 5. FIT-DNA test in the last 3 years	Documentation in the medical record must include both: • A note indicating the date the colorectal cancer screening was performed • The results or finding
Comprehensive Diabetes Care	For patients 18–75 years of age with diabetes: 1. 1 or more HbA1c test(s) in the year. Result should be < 8 % 2. A screening for diabetic retinal disease in the year for members with diabetic retinopathy and every 2 years for members without diabetic retinopathy by an optometrist or ophthalmologist 3. Annual nephropathy screening: a. Therapy with ACE inhibitor/ARB b. A test for microalbuminuria or documentation of existing macroalbuminuria or nephropathy 4. Blood pressure control (< 140/90 mm/Hg)	Medical record documentation must include all the following: • Note that the HbA1c, nephropathy screening, dilated retinal eye exam, and BP checks were performed • Date performed • Results of the tests
Controlling High Blood Pressure	Document BP reading every visit for patients 18 years of age and over. BP reading is considered controlled: • 18–85 years of age whose BP was < 140/90 mm Hg.	Documentation in the medical record must include both: • Date the visit occurred • BP reading

Quality in Ambulatory Care

- Define excellent primary care
- Measure high quality primary care
- Examine care gaps- opportunities
- Utilize data to drive change and quality improvement

PATIENT EXPERIENCE

Press Ganey Survey

Section Performance

SORT BY: Default
SELECT: Standard

Peer Group: National Sites
CAHPS Section/Domain Level N=1695 | PG Overall N=3924

● Top Box Score < 50th Percentile 75th - 89th Percentile 50th - 74th Percentile >= 90th Percentile

Survey Type	Section	n	Top Box Score	Percentile Rank
CAHPS	Physician Comm Quality	362	95.82%	60
CAHPS	Office Staff Quality	360	88.14%	10
CAHPS	Access to Care 3 month	363	74.24%	24
CAHPS	Care Coordination	363	64.97%	9
PG	Access	367	58.81%	7
PG	Moving Through Your Visit	348	49.68%	4
PG	Nurse/Assistant	346	59.91%	1
PG	Care Provider	372	74.31%	8
PG	Personal Issues	359	65.69%	2
PG	Overall Assessment	366	68.88%	5

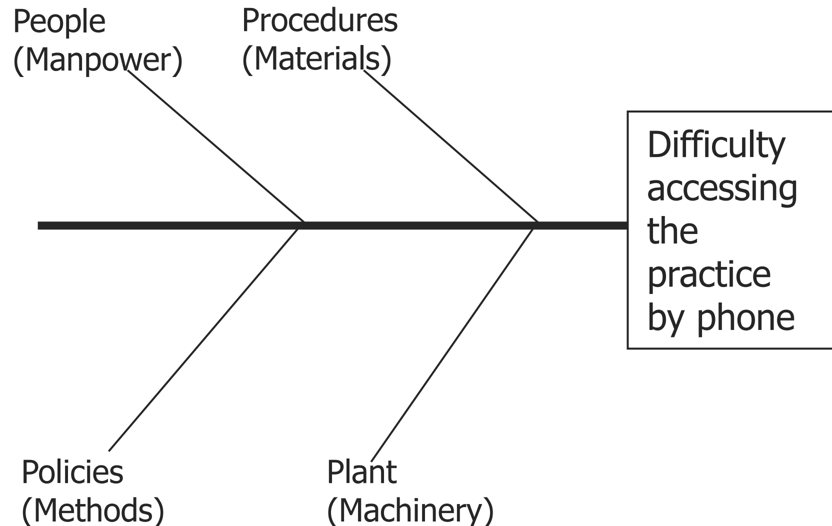
0% 20% 40% 60% 80% 100%

▲ Positive ▼ Negative

Survey Type	Sections/Domains	Items	Current n	Percentile Rank	Current Period (Q1 2023)	Previous Period (Q4 2022)	Change	
CAHPS	Global Items	Recommend this provider office	361	68	95.01%	90.25%	4.76%	▲
CAHPS	Global Items	Rate provider 0-10	361	40	88.64%	88.46%	0.18%	▲
CAHPS	Physician Comm Quality	Provider expl in way you understand	362	50	95.58%	94.02%	1.56%	▲
CAHPS	Physician Comm Quality	Provider listen carefully to you	360	62	96.94%	94.47%	2.48%	▲
CAHPS	Physician Comm Quality	Give easy to understand instruction	351	57	95.44%	94.95%	0.49%	▲
CAHPS	Physician Comm Quality	Know important info medical history	360	72	95.28%	93.22%	2.06%	▲
CAHPS	Physician Comm Quality	Show respect for what you say	361	46	96.68%	95.34%	1.34%	▲
CAHPS	Physician Comm Quality	Spend enough time with you	362	49	95.03%	91.91%	3.11%	▲
CAHPS	Office Staff Quality	Clerks/receptionists helpful	358	10	86.03%	89.74%	-3.71%	▼
CAHPS	Office Staff Quality	Clerks treat with courtesy/respect	359	10	90.25%	93.59%	-3.34%	▼
CAHPS	Access to Care 3 month	Right away appt as soon as needed	178	29	91.01%	87.50%	3.51%	▲

Data: Patient Experience

After an 18-month period without much data from the Press Ganey/CAHPS survey, your patient experience officer emails these survey findings. Of note, Access to Care metrics reveal patients are having difficulty contacting their primary care team by phone. Calls to the practice are routed to an offsite call center and messages are sent to EPIC "pools" (front desk, clinical support) at the operator's discretion. Clerical and nursing staff monitor the "pools" and forward messages to providers throughout the day, using the electronic health record.



PREVENTIVE CARE

Colon Cancer Screening

Healthfirst Members Missing Services List

Measures 2023	PHSP	MCR	Grand Total
After Visit Survey - Wait Time		89	89
After-Visit Survey - Ease of Scheduling	61	63	124
Breast Cancer Screening	172	118	290
Care of Older Adults: Medication Review		878	878
Cervical Cancer Screening	429		429
Chlamydia Screening - (16-24)	21		21
Colorectal Cancer Screening	488	317	805
Controlling High Blood Pressure	454	931	1385
Diabetes Care: HbA1c In Control	375	449	824
Follow-Up After Emergency Department Visit for Alcohol & Other Drug Dependence (7) (Servicing Provider)	24		24
Follow-Up After Emergency Department Visit for Mental Illness (7) (Servicing Provider)	62		62
Follow-Up for Multiple Chronic Conditions		74	74
Initiation and Engagement of Substance Use Disorder Treatment: Engagement (Servicing provider)	153		153
Medication Adherence for Cholesterol (Rolling 12)		213	213
Medication Adherence for Hypertension (Rolling 12)		142	142
Medication Adherence for Oral Diabetes Medications (Rolling 12)		74	74
Grand Total	**2239**	**3348**	**5587**

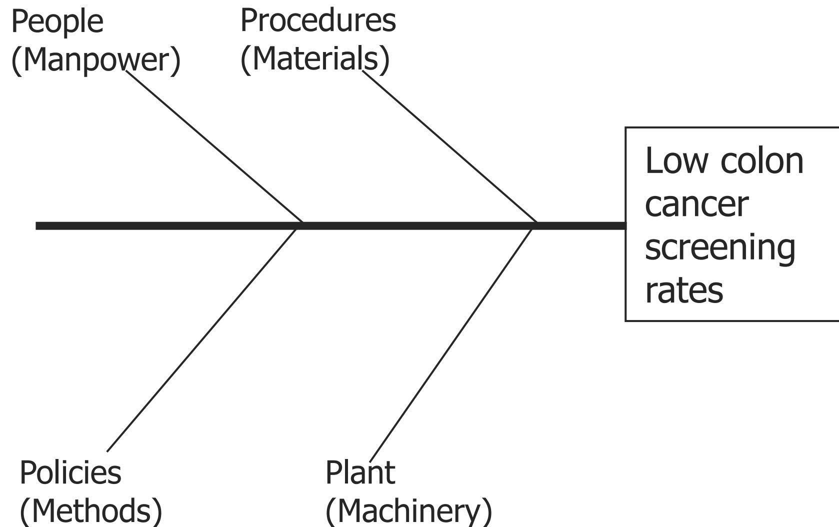
Measure	LOB	Mar Rate	Apr Rate	May Rate	Num / Den	To Reach Rating or	Current Rating	TIER 1	# Members to Target	TIER 2	# Members to Target
Total	Total						3.5				
Breast Cancer Screening*	MCR	48%	53%	57%	(196/346)		1.0	90%	115		
Controlling High Blood Pressure*	MCR	1%	19%	31%	(239/760)	423	1.0	80%	369	87%	423
Diabetes Care: HbA1c In Control*	MCR	0%	30%	49%	(163/331)	139	2.0	81%	89	91%	139
Diabetes Care: Eye Exam*	MCR	37%	46%	56%	(184/331)		1.0	87%	104		
Care of Older Adults: Medication Review*	MCR	1%	52%	71%	(450/633)		1.0	98%	171		
Colorectal Cancer Screening*	MCR	65%	74%	75%	(485/651)		3.0	88%	89		
90 Day Fills for Adherence Medications*	MCR		69%	69%	(3013/4368)	N/A	N/A	60%	Meets	80%	
								94%	Meets		
Medication Adherence for Oral Diabetes Medications: First Fill	MCR	0%	0%	0%	(0/149)		N/A				
Med Reconciliation Post-Dsg	MCR	0%	8%	24%	(9/38)	27	1.0	82%	23	94%	27
Q1 Focus - 90-Day Fills Conversion	MCR	11%	17%	20%	(60/298)	N/A	N/A				
Q1 Focus Med Reconciliation Post-Dsg	MCR			24%	(9/38)	Meets	N/A				
Statin Therapy for Patients with Cardiovascular Disease	MCR	64%	86%	95%	(21/22)		4.0	97%	1		
Measures Specific Bonus Measures	% to Tier Bonus										
HEDIS Measures	% to 5 Star Rating										

Colorectal Cancer Screening

- March 65%, April 74%, May 75%
- Num/Den (485/651)
- Star rating 3.0
- Tier 1 88% (89 members to target)

Data: Preventative Screening

Your practice manager sends you the latest practice data on colon cancer screening according to your largest payer. Generally, PCPs identify eligible patients and offer colonoscopy referral, or an annual fecal immunochemical test (FIT) distributed in person during the visit. Colonoscopies are difficult to schedule due to COVID and many visits last year were telephonic/video. The Kaiser approach of mailing birthday cards with fecal immunochemical tests has piqued your interest.



CHRONIC ILLNESS MANAGEMENT

Hypertension Control

Population Health Dashboard

NYC HEALTH+ HOSPITALS | POPULATION HEALTH

Population Health Dashboard: Kings County

Chronic Disease

Diabetes Control (March 2023)
Patients with Diabetes: HbA1c < 8.0%
66.6%

Depression Treatment (Q1 2023)
Adults enrolled 70+ days in CC for Depression who improved: PHQ-9 < 10 or 50% reduction from baseline
55.4%

Hypertension Control (March 2023)
Patients with Hypertension: Controlled representative home/clinic BP
75.7%

Asthma Controller RX (March 2023)
Patients with Asthma Controller inhaler Rx in last 6mo
41.2%

HIV Viral Load Suppression (Mar 2023)
Percent of HIV patients who were virally suppressed (<200 copies/mL)
85.6%

Immunizations

COVID-19 Vaccination (March 2023)
Primary care patients seen in the month with at least one dose of a COVID-19 Vaccine
66.6%

Flu Vaccination (Month of March 2023)
Patients ages 2+ seen in Primary Care in the last month who are up to date on flu vaccine: '22-23 flu season
48.6%

Pediatric Immunizations (Mar 2023)
Patients with completed vaccination series: *Epic and CIR*
91.0%

Smoking Cessation Intervention (Mar 2023)
Patients who received an intervention in last 12 months (if current smoking tobacco user)
36.7%

NEW

Adult Obesity Intervention (Mar 2023)
Primary care patients with obesity who received 1+ intervention in last 12 months
41.2%

Social Determinants of Health

NEW

Social Needs Screening Yield (Mar 2023)
Primary care patients who screened positive for 1+ social need in past year
41.9%

High Risk Patients (Year Ending Mar 2023)
Adults at high risk (top 5%) of acute care utilization in the next year
4,652 patients

Access to Care

In Clinic Appointments (March 2023)
% In Clinic Appointments
87.8%

Average Panel Size (March 2023)
Adult Medicine patients per 1 Direct Care FTE
1,062 patients

Appointment Availability (Mar 2023)
UPDATED: Median days to Third Next Available Appt TNAA-New: Adult Medicine
11 days

Facility

Kings County

Meet our other tools

Encounter Insights Dashboard

Measure Explorer Dashboard

Pediatric and Adolescent Dashboards

Homelessness Dashboard

Pop Health Explorer

Measure	LOB	Mar Rat	Apr Rat	May Rat	Num / Den	To Reach Rating or	Current Rati	TIER 1	# Members to Target	TIER 2	# Members to Target
Total	**Total**						**3.5**				
Breast Cancer Screening*	MCR	48%	53%	57%	(196/346)		1.0	90%	115		
Controlling High Blood Pressure*	MCR	1%	19%	31%	(239/760)	423	1.0	80%	369	87%	423
Diabetes Care: HbA1c In Control*	MCR	0%	30%	49%	(163/331)	139	2.0	81%	89	91%	139
Diabetes Care: Eye Exam*	MCR	37%	46%	56%	(184/331)		1.0	87%	104		
Medication Adherence for Hypertension*	MCR	95%	94%	94%	(418/445)	Meets	5.0	93%	Meets		
Medication Adherence for Hypertension: First Fill	MCR	0%	0%	0%	(0/311)		N/A				
Medication Adherence for Oral Diabetes Medications*	MCR	95%	93%	94%	(249/266)	Meets	5.0	94%	Meets		
Medication Adherence for Oral Diabetes Medications: First Fill	MCR	0%	0%	0%	(0/149)		N/A				
Med Reconciliation Post-Dsg	MCR	0%	8%	24%	(9/38)	27	1.0	82%	23	94%	27
Q1 Focus - 90-Day Fills Conversion	MCR	11%	17%	20%	(60/298)	N/A	N/A				
Q1 Focus Med Reconciliation Post-Dsg	MCR			24%	(9/38)	Meets	N/A				
Statin Therapy for Patients with Cardiovascular Disease	MCR	64%	86%	95%	(21/22)		4.0	97%	1		

Measures Specific Bonus Measures	% to Tier Bonus
HEDIS Measures	% to 5 Star Rating

Controlling High Blood Pressure

- March 1%, April 19%, May 31%
- Num/Den (239/760)
- 423 to reach 5 star rating (currently 1 star)
- 369 patients to Tier 1 Bonus
- 423 patients to Tier 2 Bonus

NYC HEALTH+ HOSPITALS | POPULATION HEALTH

Hypertension Control: Provider List (March 2023)

	Denom	Rate
NYC H+H	95,126	75.7%
Kings County	11,626	75.7%

NOTE: If the provider list shows as "None", you must select a specific facility on the Hypertension Dashboard before clicking the "Provider List" icon.

Kings County: Blood Pressure Control for Patients with Hypertension by **General PCP (March 2023)**

Provider	Denom	Rate
	555	85%
	543	85%
	517	79%
	513	89%
	495	78%
	488	74%
	477	74%
	410	84%
	399	63%
	353	80%
	329	90%
	304	81%

Month

March 2023

Provider Type

Supervising PCP

General PCP

Provider

Sort By

# of Pts

Sort Order

Descending

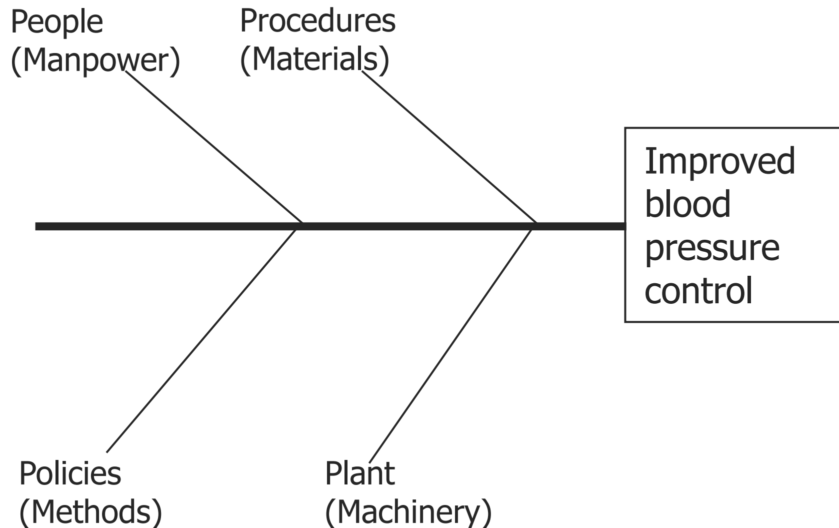
Patient List

NEW

View Measures by **Demographics**

Data: Chronic Illness Management

Your healthcare system has an amazing population health dashboard, easily accessible from every desktop. You download a report of blood pressure control by primary care provider. All providers meet weekly for a PCP meeting. Interdisciplinary care teams meet monthly with their practice "group". How will you spark creativity/competition, identify and spread best practices to drive change?



MEDICATION ADHERENCE

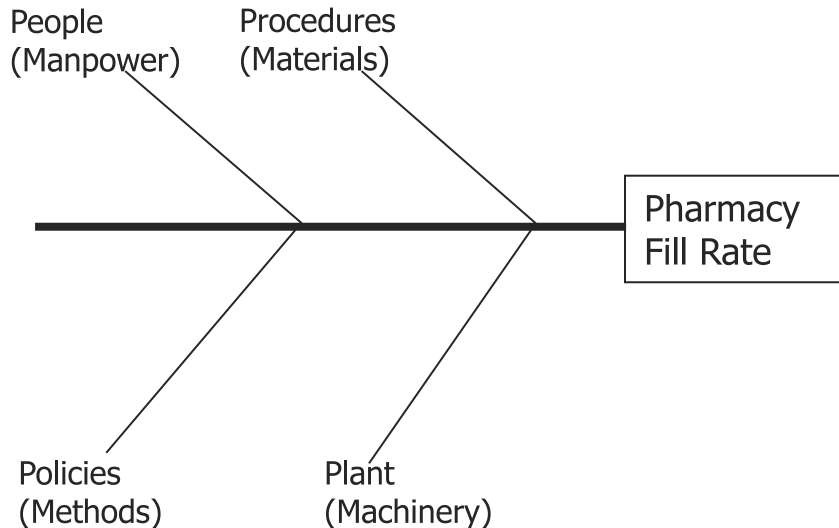
Patient Self-Management

Medication Adherence

PCPName	PharmName	PharmAddress	PharmPhone	Clm1
	BROOKDALE PHARMACY	2568 LINDEN BLVD	7184850070	2021-08-17_ALOGLIPTIN BENZOATE TAB 25 MG_30_30
	RITE AID CORPORATION	16502 BAISLEY BLVD	7185257642	2021-08-19_SACUBITRIL-VALSARTAN TAB 49-51_30_60
	RAEES PHARMACY	750 FLATBUSH AVE	7188565998	2021-08-19_ATORVASTATIN CALCIUM TAB 40 MG_30_30
	LINCOLN PLACE PHARMACY I	1135 EASTERN PKWY	7187561717	2021-08-18_ATORVASTATIN CALCIUM TAB 20 MG_30_30
	COMMUNITY A WALGREE	4915 FLATLANDS AVE	3478565852	2021-08-17_METFORMIN HCL TAB 500 MG_30_30
	COMMUNITY A WALGREE	1871 ROCKAWAY PKWY	7182510426	2021-08-20_ATORVASTATIN CALCIUM TAB 40 MG_30_30
	ROSSI PHARMACY	1891 EASTERN PKWY	7183462506	2021-08-18_ATORVASTATIN CALCIUM TAB 20 MG_30_30
	CVS PHARMACY	170-05 LINDEN BLVD	7182629533	2021-08-20_AMLODIPINE BESYLATE TAB 10 MG_30_30
	RITE AID CORPORATION	4102 CHURCH AVE	7189401579	2021-08-18_AMLODIPINE BESYLATE-BENAZEPRIL_30_30
	CVS PHARMACY	2201 NOSTRAND AVE	7186375006	2021-08-15_LOSARTAN POTASSIUM TAB 100 MG_30_30
	FINE CARE PHARMACY	1490 FLATBUSH AVE	7184218161	2021-08-17_ROSUVASTATIN CALCIUM TAB 5 MG_30_30
	PHARMACY CORPORATIO	524 CLARKSON AVE	7187741656	2021-08-18_AMLODIPINE BESYLATE TAB 10 MG_30_30
	WELLNESS CENTER PHARMACY	4015 BROADWAY	7189560060	2021-08-21_AMLODIPINE BESYLATE TAB 10 MG_30_30
	COMMUNITY A WALGREE	5001 CHURCH AVE	3475570959	2021-08-18_AMLODIPINE BESYLATE-BENAZEPRIL_30_30
	CVS PHARMACY	30 FLATBUSH AVE	7188586712	2021-08-15_ATORVASTATIN CALCIUM TAB 20 MG_30_30
	RITE AID CORPORATION	1154 CLARKSON AVE	7183456355	2021-08-15_AMLODIPINE BESYLATE TAB 5 MG_30_30
	COMMUNITY A WALGREE	1040 SAINT JOHNS PLACE	7189537150	2021-08-17_MONTELUKAST SODIUM TAB 10 MG (_30_30
	PHARMACY CORPORATIO	524 CLARKSON AVE	7187741656	2021-08-19_ATORVASTATIN CALCIUM TAB 40 MG_30_30

Data: Medication Adherence

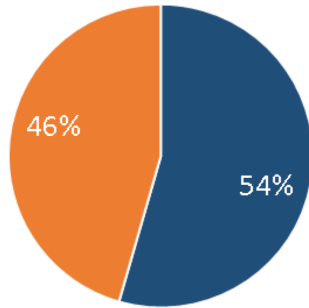
You receive documentation from a leading healthcare insurance company demonstrating gaps in medications that have not been "filled" on time by your patients. They have highlighted prescriptions written for 30 instead of 90 days. The practice started using EPIC 3 months before the first COVID wave and never was "optimized".



ACCESS TO CARE

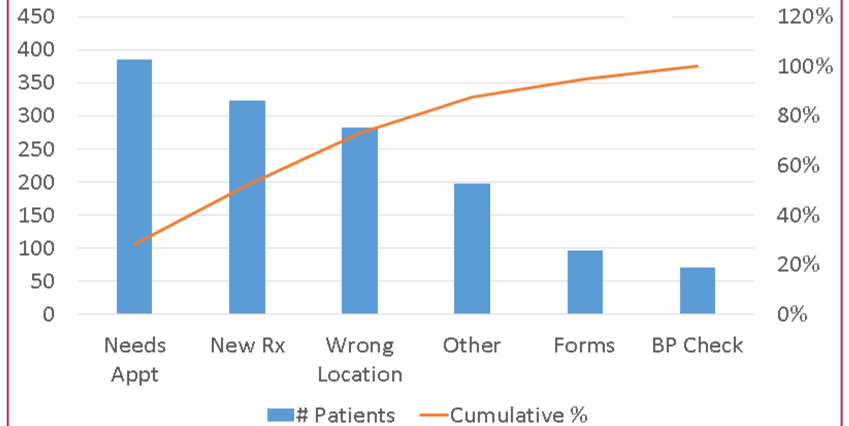
Practice Workflow

Patients Visiting Our Practice



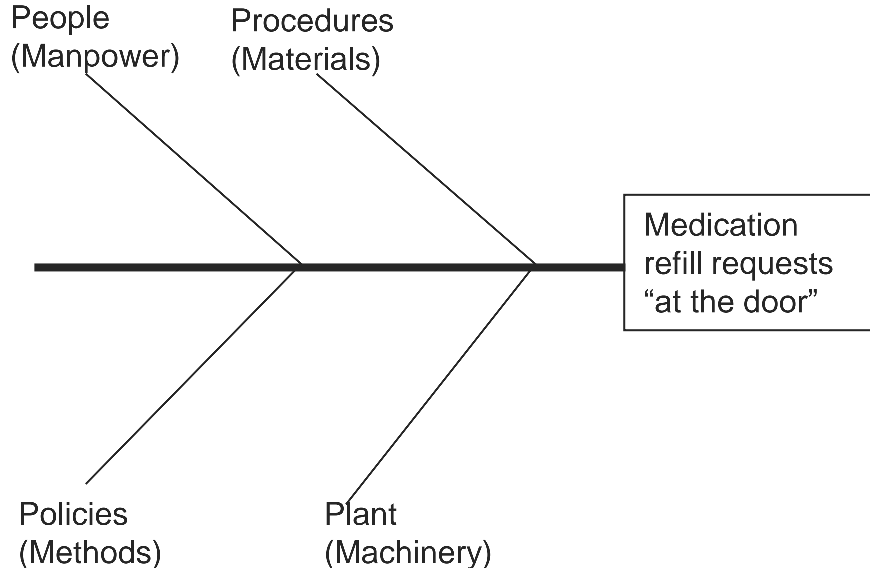
■ Without appointments (1589) ■ With appointments (1330)

Why do patients visit us without appointments?



Data: Access to Care

Every day, the registration lines in each medical "suite" are filled with both scheduled and unscheduled patients. A central info desk was created and staffed to serve those without appointments. A two-week observation period reveals that most patients want to schedule an appointment, or request medication refills. Historically, staff knock at the PCP's door to ask for meds to be refilled but you've noticed a lot of grumpy looks lately. You've been approved to rearrange staff, including a clerk, nurse, and nurse practitioner to address this problem.

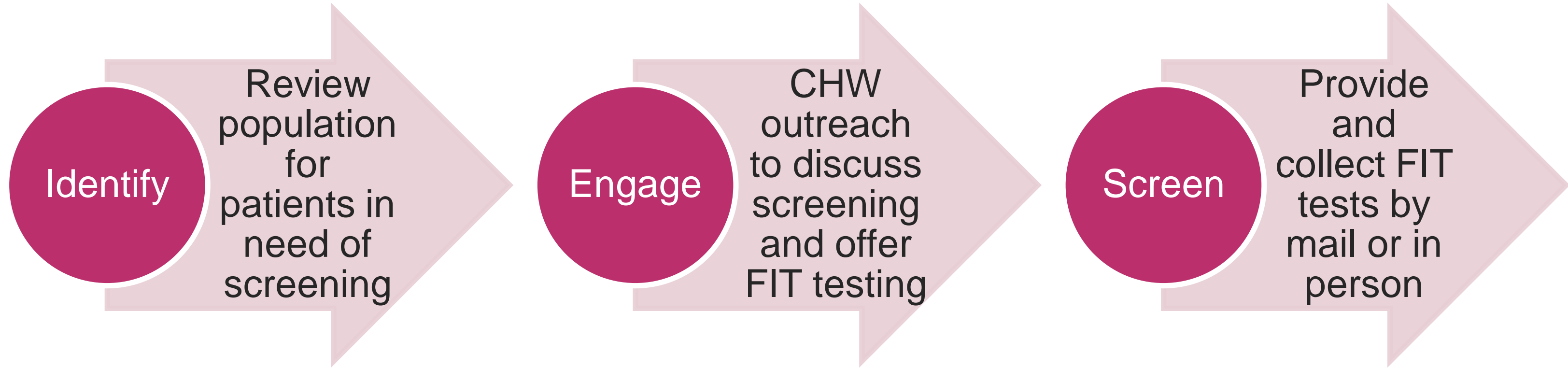


Quality in Ambulatory Care

- Define excellent primary care
- Measure high quality primary care
- Examine care gaps- opportunities
- Utilize data to drive change and quality improvement

COLON CANCER SCREENING

Preventative Health Measures


Identify
Review population for patients in need of screening
Engage
CHW outreach to discuss screening and offer FIT testing
Screen
Provide and collect FIT tests by mail or in person

Standardize the Process

Preventive Health Outreach Note

This note confirms outreach completed for the H+H CHW Corps Adult Medicine Program. Any relevant updates on program progress are included below.

General Information
CHW name and contact: @MECRED@
Patient name: @NAME@
Patient age: @AGE@
Language: ***
Patient contact: ***

Referral source: {Referral Source:45437}
PCP: @PCP@

Note Date: @TODAYDATE@

Contacted patient to discuss colorectal cancer screening.
Patient agreed to discussion: {Yes/No/Explain:40798}

Good day. My name is @MECRED@ and I'm calling from @PCP@'s office at Kings County Hospital. Our records show you're due for colon cancer screening.
Is this a good time to talk? {Yes/No/Explain:40798}

@PCP@ asked me to call to talk to you about having a stool test to prevent colon cancer or detect it at an early stage.
Would you be interested in learning more about this? (If No, make note if patient has already been screened - type of test, date, location) {Yes/No/Explain:40798}

We can mail you a FIT kit. It's a simple take-home test that checks for hidden blood in your stool, which can be an early sign of cancer.

Would you like me to mail a test to you or would you like to pick it up at our office (confirm mailing address)? {Mail:45761}

We ask our patients to return the test in one week.

I'd like to review the instructions for the test with you:
- We will provide you with a labelled plastic sampling bottle
- Place the collection paper inside the toilet bowl on top of the water
- Deposit stool sample on top of the collection paper
- Collect the sample before the paper sinks and the stool sample touches water (the paper is safe to flush down the toilet)
- Scrape the surface of the fecal sample with the sample probe and cover the grooved portion completely with stool
- Close the sampling bottle by inserting the sample probe
- Snap the green cap on tightly
- Mail the sample in the envelope provided OR drop it off at our laboratory on the first floor

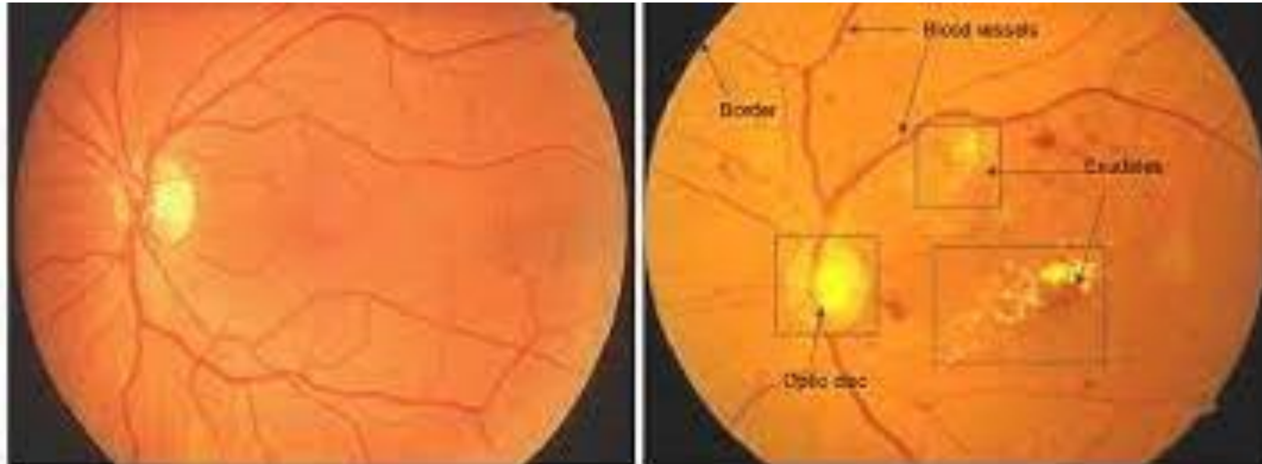
DIABETIC RETINOPATHY SCREENING

Chronic Disease Measures

Diabetic Retinopathy Screening

Measure	LOB	Mar Rate	Apr Rate	May Rate	Num / Den	To Reach Rating or Target Rate	Current Rating	TIER 1	# Members to Target
Total	Total						3.5		
Diabetes Care: Eye Exam[6]	MCR	37%	46%	56%	(184/331)		1.0	87%	104

Diabetic Retinopathy



https://www.researchgate.net/figure/Sample-retinal-fundus-images-of-a-Normal-and-b-Diabetic-retinopathy-subjects_fig2_276528880

NYC HEALTH+ HOSPITALS | GO

New TeleRetinal Screening Workflow

This tip sheet will outline the new workflow for when a PCP orders the retinal screening but it will be performed on a different day. Below are a few of the new features:

- Primary Care Provider
  - Retinal Screening tests can now be ordered in any encounter (i.e., video visit, televisits)
- PCAs
  - No longer need to **"Send Message"** to send the order to Ophthalmology reading pool

Same Day Screening

Primary Care Provider

1. In the Meds & Orders section, the primary care provider will order Retinal Screening Photo – OU – Both Eyes. It defaults to a future order. Sign the order.

Retinal Screening Photo - OU - Both Eyes ✓ Accept ✗ Cancel
Status: Normal Standing Future
Expected Date: Today Tomorrow 1 Week 2 Weeks 1 Month 3 Months 6 Months Approx.
Expires: 7/29/2021 1 Month 2 Months 3 Months 4 Months 6 Months 1 Year 18 Months
Class: Clinic Perfo Clinic Performed

PCA Workflow (same workflow as before but no longer need to "send message")

1. When the patient is in the room, go to your **Inbasket.**
2. Click on **Orders.**
3. Find your patient, click on their name.
4. Click **Retinal Screening** in the upper right hand side.
5. Click **Release Order.**
6. Perform the screening using the camera.
7. In Epic, Select **Enter Result** in the Imaging and Procedures section.

Imaging and Procedures
Ordered
Enter Result
Retinal Screening Photo - OU - Both Eyes

8. Select **Testing Complete.**

Save ✓ Testing Complete ✗ Cancel

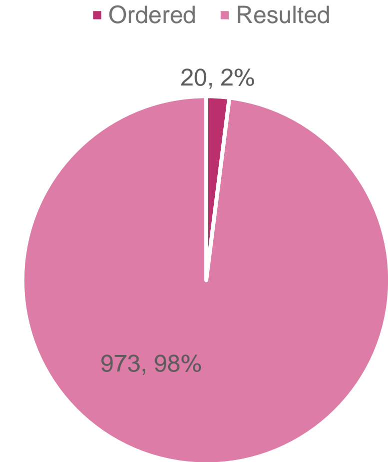
9. The test will automatically be assigned / sent to the appropriate Ophthalmology reading pool.

Data: Teleretinal Screening

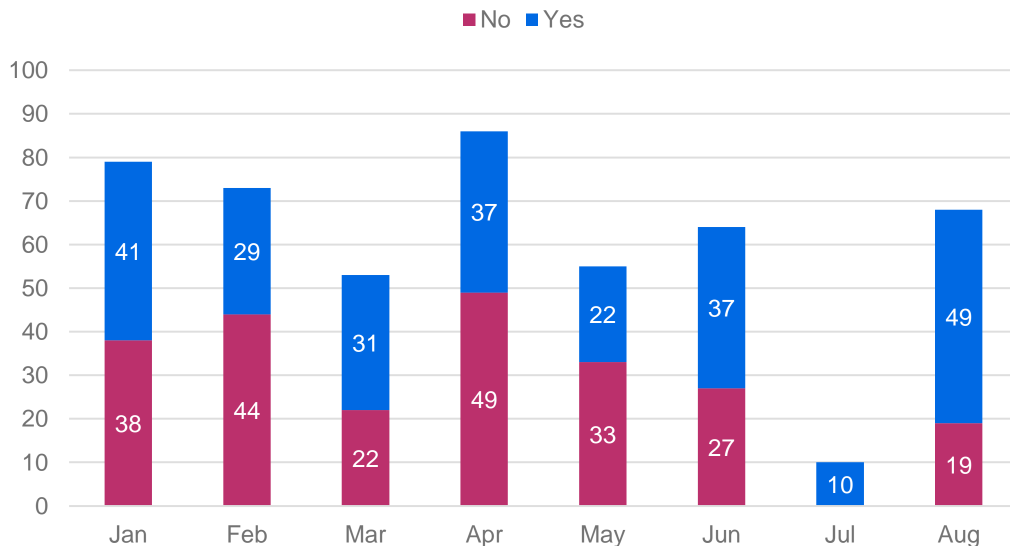
Teleretinal Status

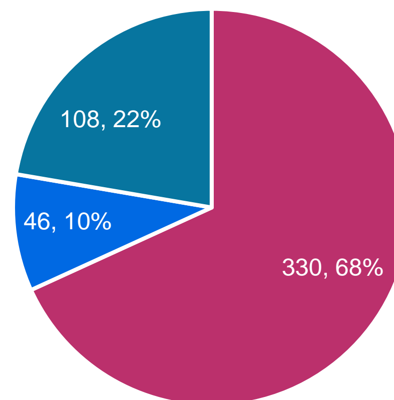
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Edited Result - FINAL	3		2				1	2
Final result	76	73	52	86	55	64	9	65
In process	19	9	59	83	122	55	111	27
Pending/Blank	6	2	4	3	1	3	1	

DFE Order Status



Data: Teleretinal Screening

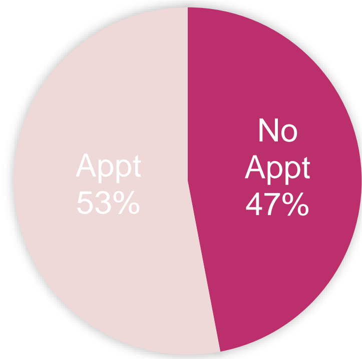




ACCESS TO CARE

Clinical Processes

Why do patients visit the info desk?



Number of Patients Visiting PAA for Reason

160
140
120
100
80
60
40
20
0

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

Rx Refill
Appointment Request
Which Suite
Answered Phone
Forms, Auth Requests
Wrong Clinic
Financial Clearance
Walk-in
Late Patient Rule

Natural Groups: Unappointed Patients

Why does this matter?

Thanks!

CQFP Faculty

Kings County Primary Care Practice & Residency Program