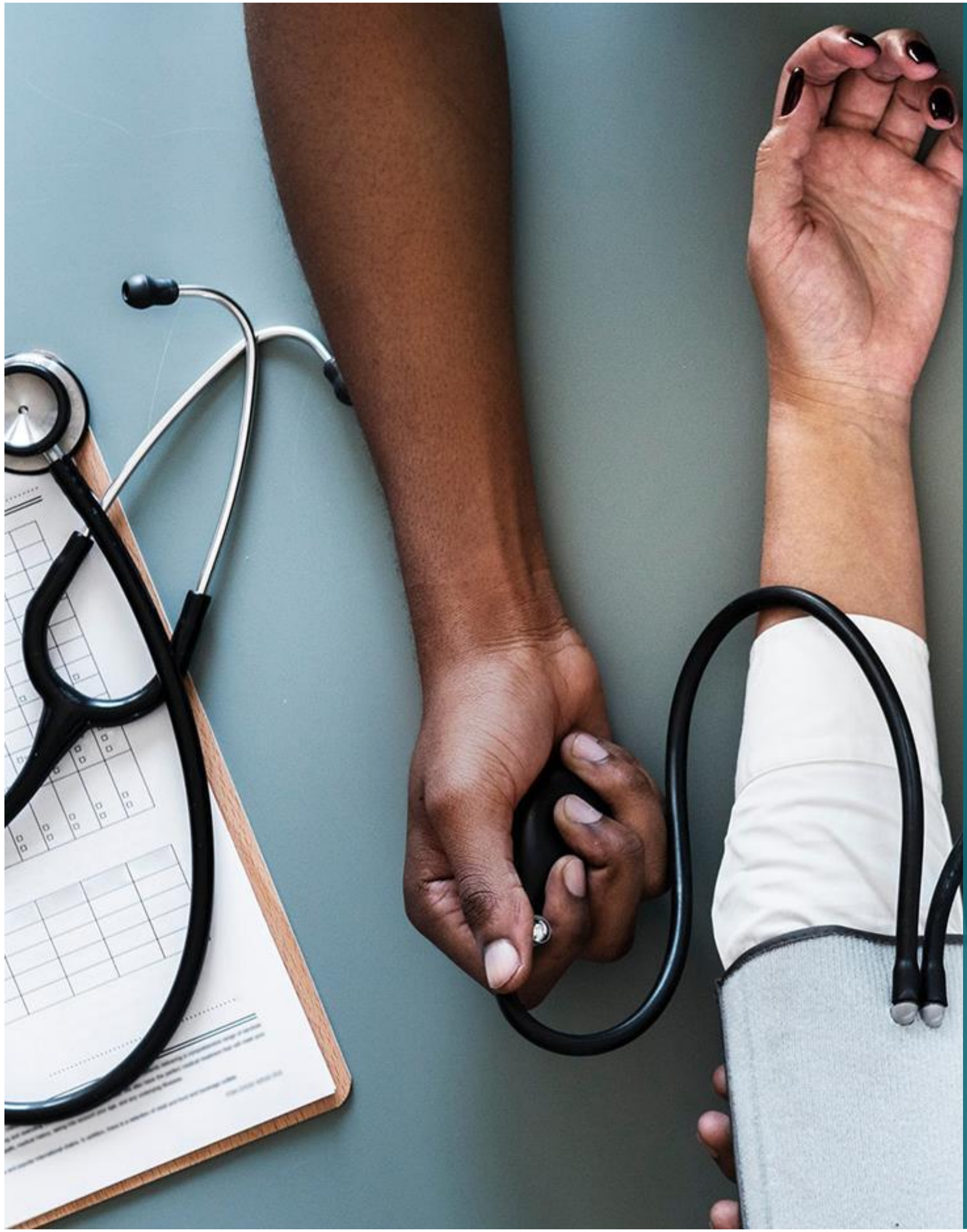
Eastern Shore Rural Health System, Inc.



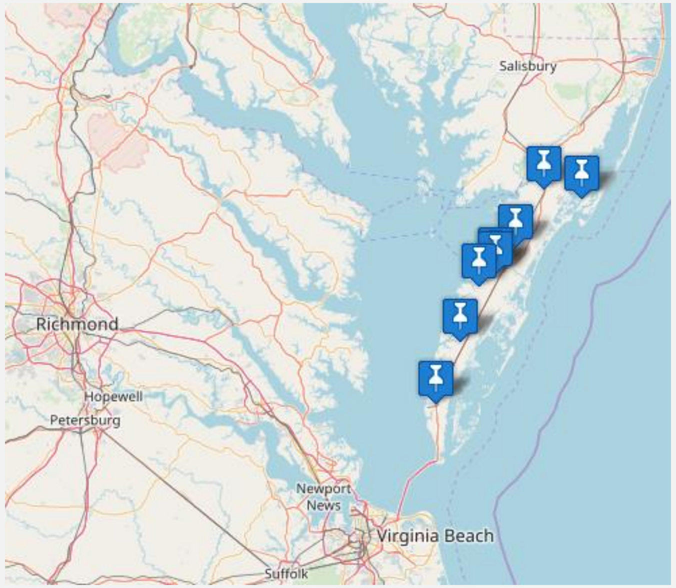
Quality over Quantity

Mike Zodun, Chief Information Officer

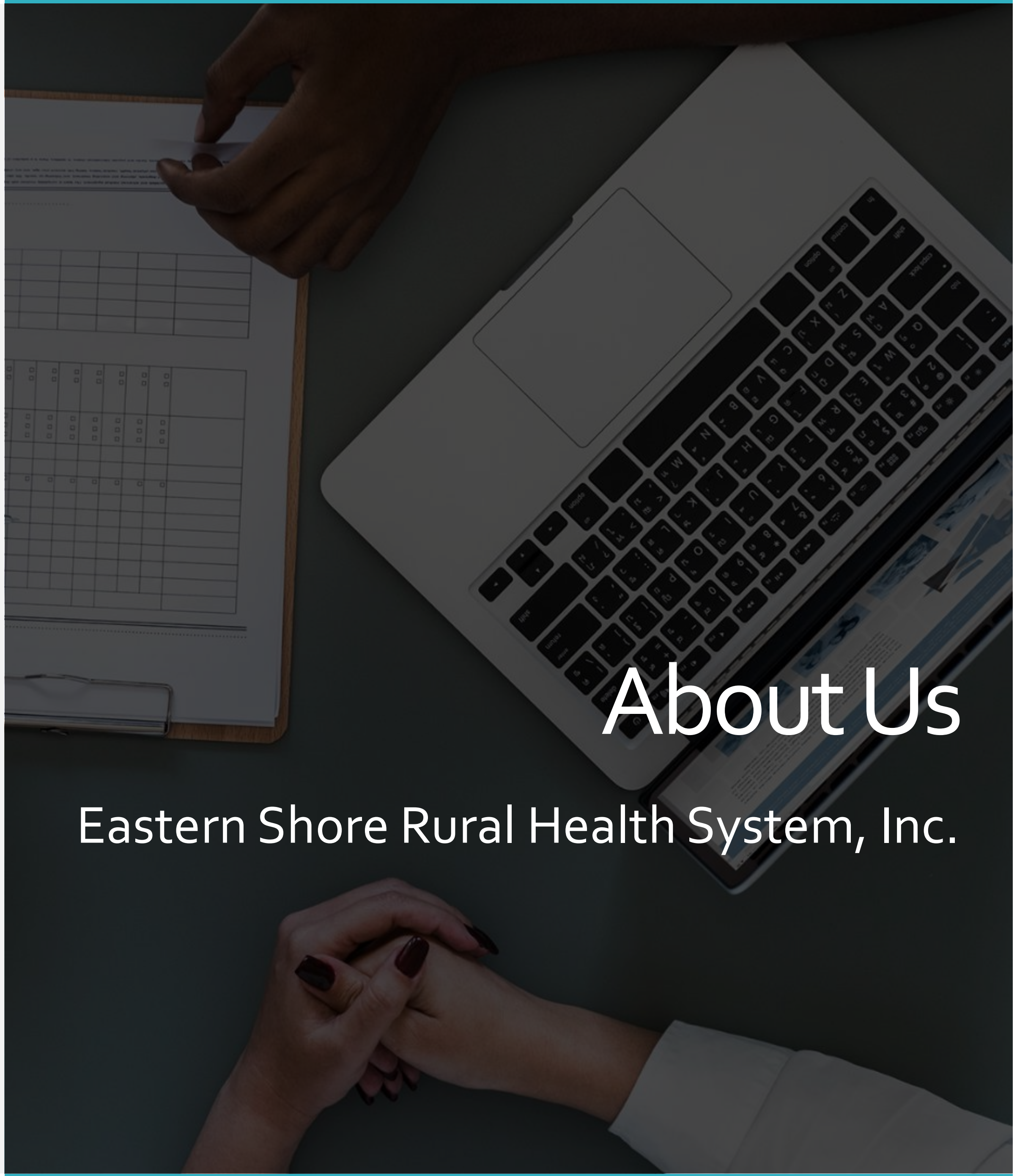
Jennifer Tyler, Chief Clinical Informatics Officer

2018 Virginia Rural Collaborators Conference

Virginia Rural Health Association – Lexington, VA



- Federally Qualified Health Center
- Migrant Health Center
- 9 Fixed Locations –(5 Medical, 4 Dental) and 4 Portable Dental
- 35 Medical Providers, 12 Dental Providers
- ~32,000 patients (2017)
- ~115,000 Medical Visits (2017)
- ~13,000 Dental Visits (2017)



About Us

Eastern Shore Rural Health System, Inc.

The Transformation of Healthcare

Quantity

- How many patient can we see today?

Quality

- How can I help my population?

Today's Focus

Identify

Identify strategies to prepare you for transformations from quantity to quality

Target

Determine what to collect

Align and Measure

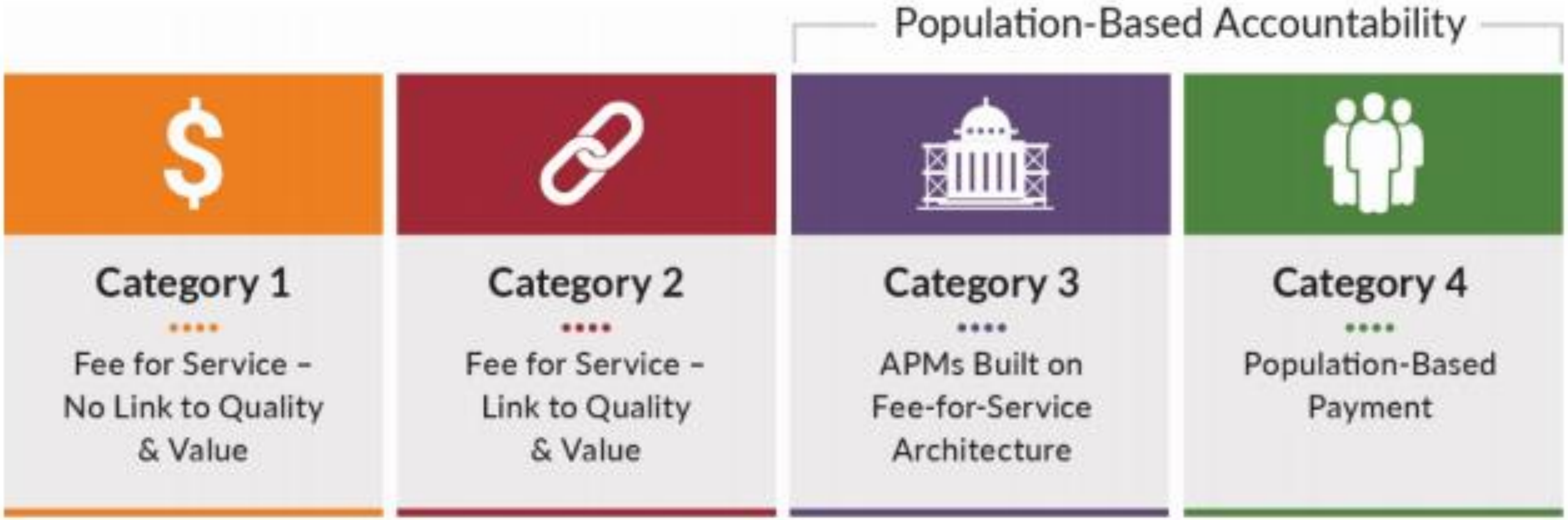
Implement changes and monitor performance

Share best practices

Categories of Value Based Payment

- CMS "Alliance to Modernize Healthcare" (CAMH)

Figure 1: APM Framework (At-a-Glance)



Source: Alternative Payment Model (APM) Framework and Progress Tracking Work Group

Measurement

- Where have we been?
- Where are we going?
- Where do we need to be?
- Who is looking?
- What are we required to do?
- What *should* we do?
- What happens if I do what I say I will do?

- What does my organization want to achieve?
- What does quality mean to you?
- What does productivity mean to you?
- How will this impact my organization?

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Data Driven Quality

Collect/Enter

Extract/Analyze

Visualize

Share

Utilize

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Step 1: Core Measures

Identification and Focus

Goals and Objectives

- Identify clinical priorities
- Identify operational priorities
- Identify financial priorities

- How can we achieve a balance between all three areas?

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Step 2: Focus on Culture

Continuous Quality Improvement

Culture Shift – Continuous Quality Improvement

Quality

Staff

Define quality as the standard of excellence

Everyone contributes to success

Mid-Office / Providers

Point of care tools, feedback, best practices

Teaching patients about the importance of quality

Administration

Training, Data Sharing, Performance Improvement / Quality Assurance, Patient Engagement

Case Mgmt. / Care Coord.

Target populations, Close gaps in care, direct outcomes, compliance

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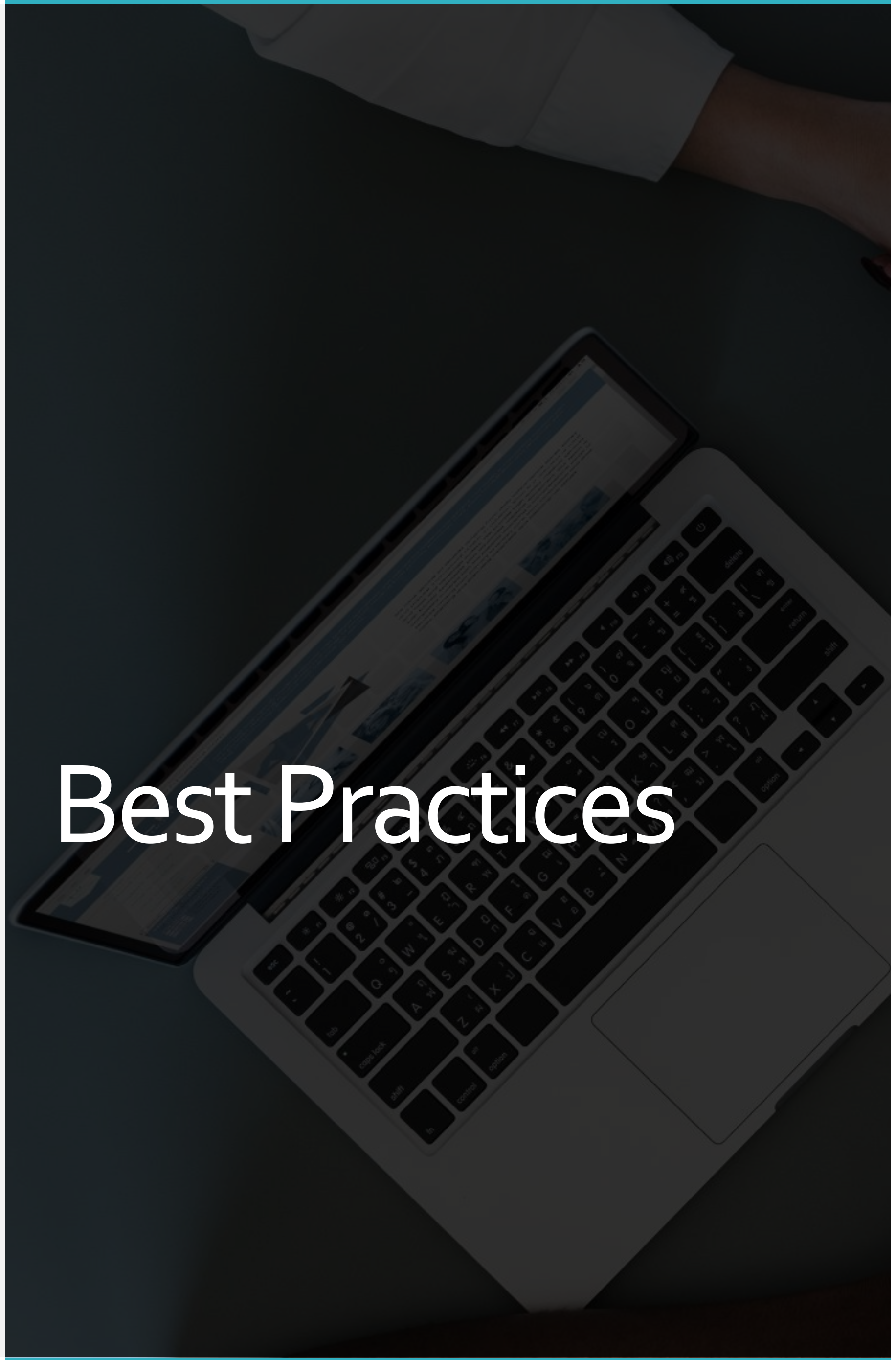
Step 3: Align and Measure

Implement change, monitor, and measure

Best Practices



Pre-Visit Planning

- Pre-visit planning (Huddle Sheets)
  - Determine the gaps in care before the patient is in the building
  - Focus on what you can accomplish, make steps to ensure follow ups for others
    - Standing orders
    - Referrals
    - Ancillary Services (health educator, outreach coordinator, pharmacy assistance, financial assistance)
    - Release of information forms
    - Return appointments for items not completed today

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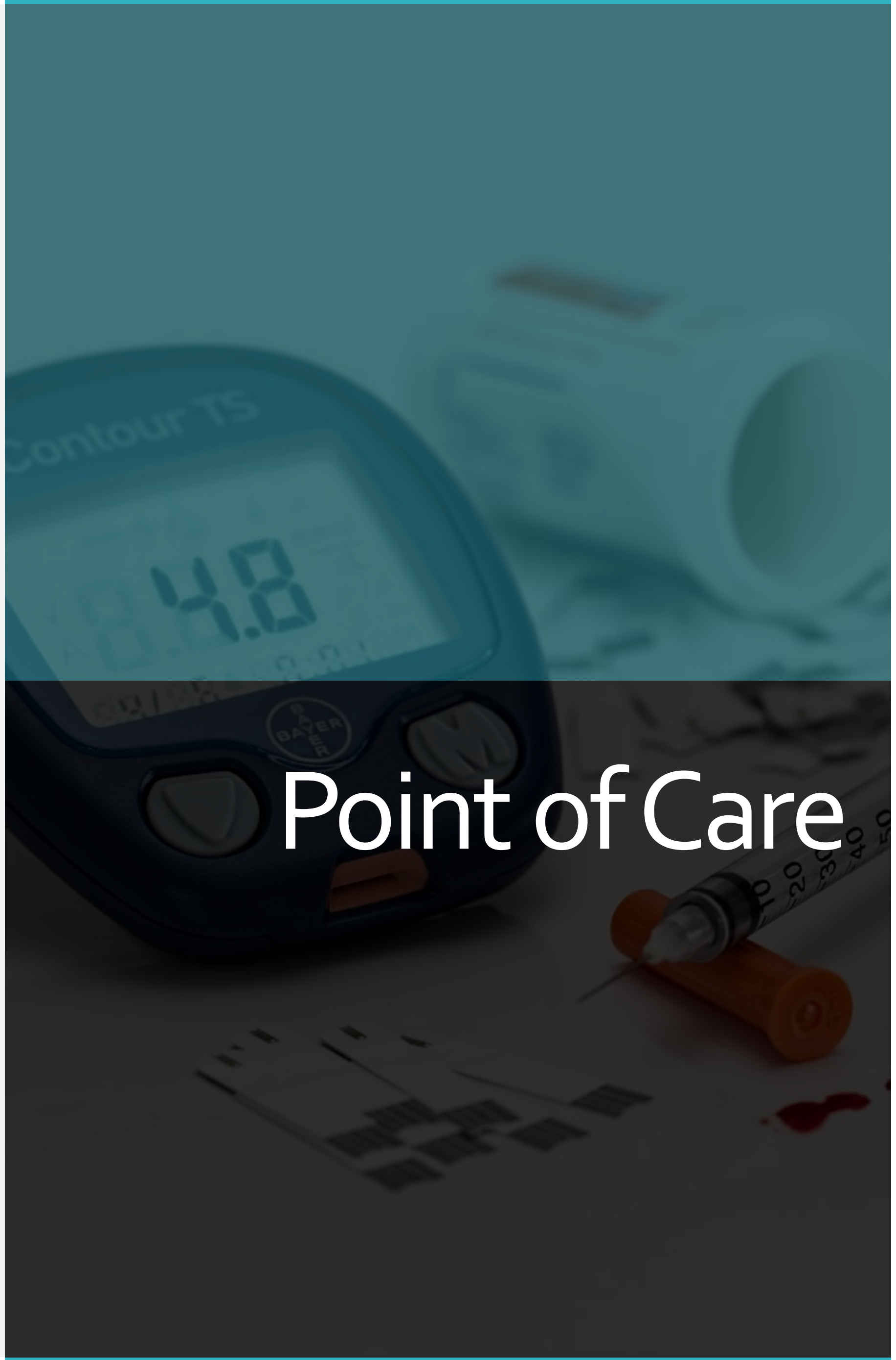
Point of Care

- Questionnaires
  - Required screening (PHQ, MCHAT, Pediatric Intake)
    - KIOSK or Paper or Verbal
- Real-time tools
  - PVP work sheets
  - Hover-over or CDSS
  - Alerts (automated, manual, or entered by nurse)
- Patient Education
  - Help patients understand why we need to close these care gaps
  - “Good patient care”
  - “I’m just here for my sore throat, why are you asking if you can schedule my pap smear?”

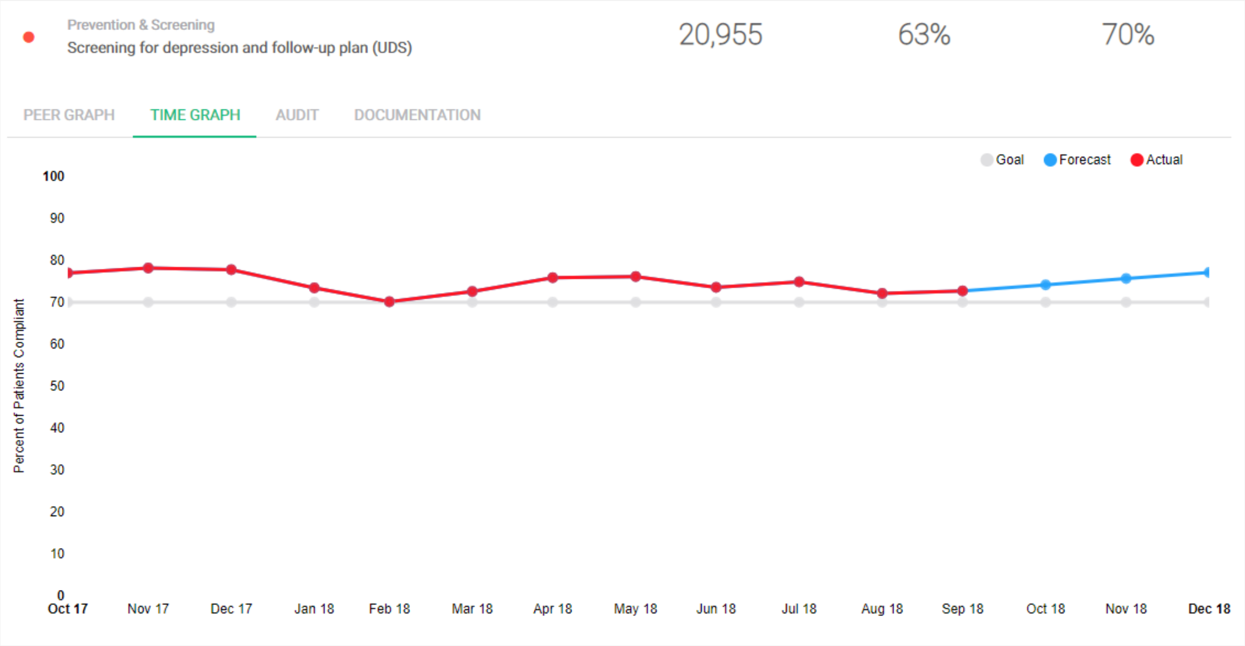


Post Visit

- Case Management
- Care Coordination
- Worklist generation
- Payor worklists / Care Gaps
- Hospital Follow Up (PCMH Requirement)

Reporting

- Share data across the organization (dashboards, reports)
- Promotes healthy competition (pun intended)
- Staff can use each other to determine best practices
- Show the trends
- Attach financial incentives (results may vary)
    - Studies have shown to do this across all level of employees, not just providers



Measure Outcomes

- Are the activities improving the health of the population?
- Are the activities improving the financial health of the organization?
- How can we continue to transform and provide the best care for our patients?

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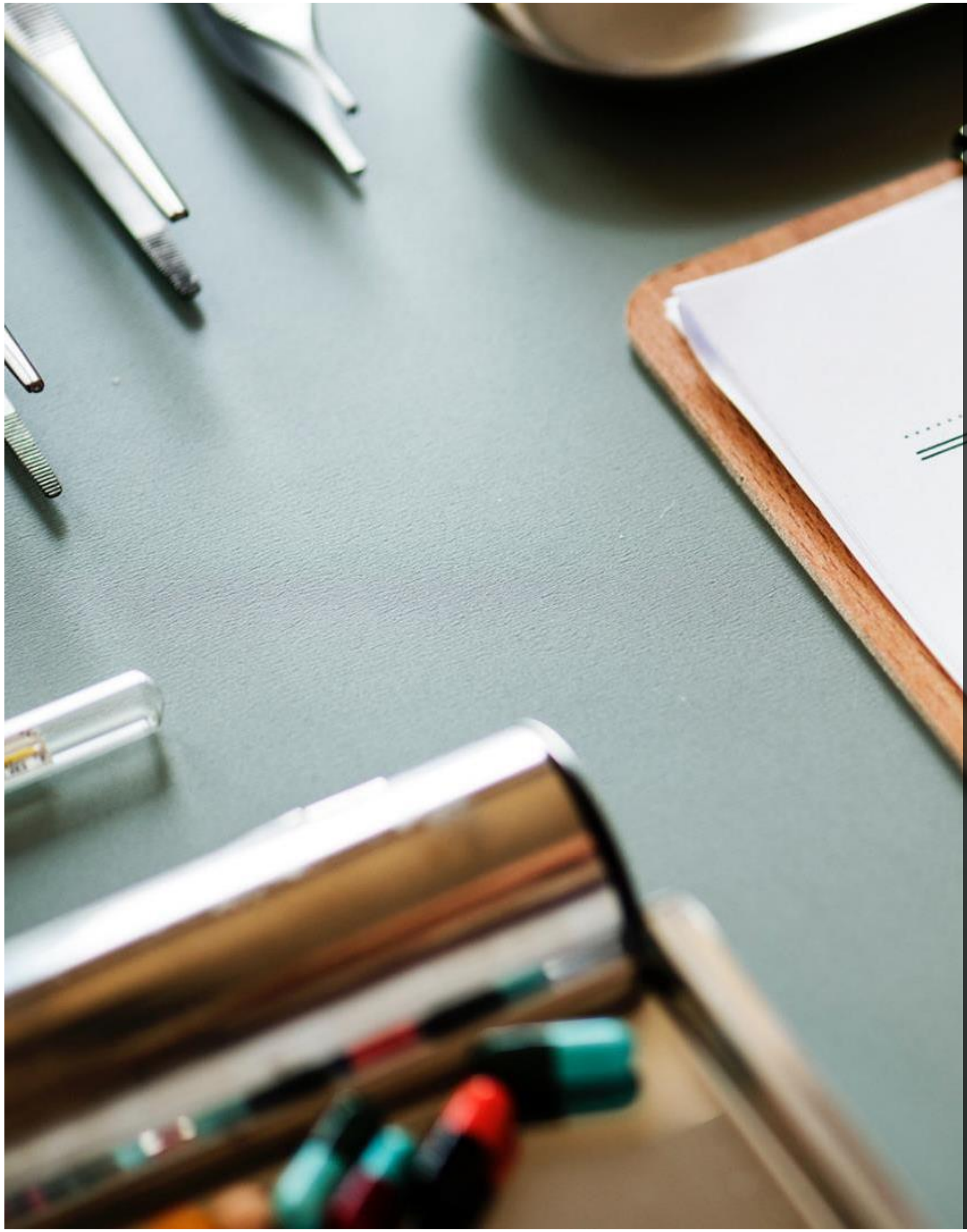

Questions?

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