Primary Care Quality Improvement Toolkit

December 2011

Annual COPC QI Reports Memo

Required Annual Reports
PCC Scope of Service Statement
Annual QI Plan
Annual PCQI Summary Report
Annual PCQI Summary Presentation

PCQI Tools
PCQI Reporting Calendar
Clinic QI Committee Calendar
QI Committee QI Minutes Template
Meeting Evaluation Questions
Data Collection Plan

Compliments of:
SFDPH Community Oriented Primary Care and
Performance Improvement & Patient Safety Department

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
COMMUNITY ORIENTED PRIMARY CARE
1380 HOWARD, 4TH FLOOR
SAN FRANCISCO, CA 94103

To:	**PCQI Committee Members, COPC Management Team Members**
From:	**Lisa Golden, MD, Judith Sansone, RN – Co-Chairs of Primary Care Quality Improvement Committee**
Subject:	**Annual Reports from COPC Health Centers to PCQI Committee**
Date:	**December 15, 2011**
cc:	Lisa Johnson, La Phengrasamy, Amy Petersen

Reporting Requirements

Requirements for annual COPC Health Center Reports to the PCQI Committee have been updated. Hospital, health center and medical services regulations require that proactive and systematic processes be in place to measures, assess and improve patient safety and care.

Annually, Health Centers must submit a report that includes:

- ☑ Updated Scope of Service Statement
- ☑ QI Plan
  - Plan must reflect where health center leadership will focus and direct QI efforts for *coming* year
  - Plan must be aligned with strategic priorities of the agency and overall department
- ☑ Annual Summary of QI Activities
  - Summary reflects outcomes of *previous year's* QI efforts; must include quantitative results of improvement activities
  - Health Center must report on progress towards Quality Council Goals

Submission of Reports

In order for COPC to maintain compliance with Rules and Regulations of the CPC Service and SFGH Quality Management / PIPS committee, clinics must submit reports as scheduled. Annual Reports are to be submitted to PCQI Co-Chairs electronically at the time of annual presentation.

PCQI Presentation to Peers

Presentations of QI Plan and outcomes of past years' efforts are made to the PCQI committee according to the PCQI Reporting calendar.

The purpose of an annual presentation to members of the PCQI committee is to highlight and share with colleagues lessons learned or best practices adopted at your health center that contributed to improved care across our network of primary care clinics.

PCQI TOOLKIT TABLE OF CONTENTS

COPC HEALTH CENTER NAME
ADDRESS
San Francisco, CA ZIP

SCOPE OF SERVICES STATEMENT - TEMPLATE

2012

Text in red is meant to assist you to provide information for Scope of Services Statement.
Text in black is required language for COPC Scope of Service Statement.

I. Goal Statement: Cut and paste your health center's mission statement

The mission of XXXXXXX Health Center is to

II. Scope of Service: Bullet Points are examples, insert the services offered at your health center

Primary health care services for acute and chronic medical problems of children, adults and geriatric patients

- Social Services
- Referral and liaison with adult and pediatric Mental Health Services
- Referral and liaison with Health at Home services
- Chronic Disease management program
- Group Medical Visits
- Healthy Living Groups
- Nurse-led diabetes educational classes
- Family planning services
- Pregnancy testing
- Prenatal care (including high-risk prenatal consultations and deliveries and SFGH)
- Clinical Pharmacy Services
- Podiatry Visits
- Nutritionist services on site
- WIC nutrition counseling and supplemental food program
- Child Health and Disability Prevention examinations (CHDP Program)
- Immunizations (for adults and children)

III. Major Treatment Diagnoses

Obtain data from COPC Report Registry. Go to CHN Primary Care Reports > 02_Utilization_Patient_Chars > Pt_Chars_Util > Choose fiscal year and then health center. Report Top 10 diagnosis

Top 10 Diagnoses for FY_____

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

IV. Care Providers (include FTE)

Obtain data from Report Registry > COPC Management Team > Staffing FTE and Ratios

Medical Director	__ FTE (e.g. 1.0)
MD	__ FTE (e.g. 2.3)
NP	__ FTE
Podiatrist	__ FTE
Behaviorist	__ FTE
Nurse Manager	__ FTE
RN	__ FTE
MEA	__ FTE
HW	__ FTE
Translator	__ FTE
Phram D.	__ FTE

V. Administrative, Clerical and other Staff (include FTE)

Principal Clerk	1.0 FTE
Sr. Clerk Typist	(Vacant – position frozen)
Medical Records Technician	__ FTE
Sr. Eligibility Worker	__ FTE
Eligibility Worker	__ FTE
Porter	__ FTE

VI. Educational Requirements

Below are standard disciplines and educational requirements. Add any other disciplines and list related requirements for your health center (e.g. acupuncturist)

a. PHYSICIANS

Current California MD license, Board certified or Board Eligible in Primary Care, Annual Update classes and certification (CPR, Health and Safety, Infection Control)

b. NURSE PRACTITIONERS

Current State licensure as Registered Nurse. Current State Nurse Practitioner Certificate. Annual Update classes and certification (CPR, Health and Safety, Infection Control)

c. REGISTERED NURSES

Current State licensure as Registered Nurse (Public Health Nurses must have PHN certificate). Annual Update classes and certification (CPR, Health and Safety, Infection Control)

d. LCSW (Licensed Clinical Social Worker)

Current State licensure as LCSW.

VII. Delivery of Care

Provide healthcare delivery information for your health center. Expand or edit text in red to reflect your health center's protocols.

- Clinic days and hours of operation
  - Monday-Friday 8:30-5:00PM, closed 1-2PM
- Process for making Urgent Care appointments

- Call clinic to schedule an urgent care appointment
- Process for providing immunizations
  - Immunizations provided through regular immunization drives or scheduled by PCP
- Process for providing Diabetes Education
  - On-site Diabetes Nurse Educator provides 1:1 support by referral and group classes

VIII. Accountability

Please fill in areas with XXX and where deemed necessary, expand on roles and responsibilities of Managers/Directors at your health center

The Medical Director of XXX Health Center:

- Lead health center performance improvement and patient safety programs
- Set performance improvement priorities, determines qualifications and competencies of licensed clinical staff
- Maintain appropriate quality control programs
- Provide guidance and schedules peer reviews to ensure clear and accurate documentation of medical record
- Provide vision and leadership to motivate and direct staff of health center to achieve strategic plans of Community Oriented Primary Care (COPC) and the San Francisco Department of Public Health (SFDPH)

The Nurse Manager of XXX Health Center:

- Evaluate clinical operations and nursing/support staff resources that impact the services of health center.
- Collaborate with Medical Director on issues related to clinical operations, and on developing nursing practice guidelines.
- Responsible for professional development of health center nursing staff RNs, Medical Assistants, and Health Workers.
- Responsible for hiring, ongoing development of nursing roles, and performance appraisals of nursing staff.

The Principal Clerk of XXX Health Center:

- Supervise processing and issuing of licenses, permits and provider numbers; ensures that appropriate documentation is readied for program auditors
- Provide supervision, education and development of operations staff
- Receive and investigate grievances and other complaints about registration, medical records, and/or clerical problems as appropriate.
- Initiate/oversee requisitions for supplies, materials and work orders for office and building operations
- Responsible for handling and accounting for petty cash, collection of fees and resolving funds, including the necessary posting, calculations and recordkeeping

HEALTH CENTER ANNUAL QUALITY IMPROVEMENT PLAN – TEMPLATE

Health Center Name
ADDRESS
San Francisco, CA ZIP
YEAR 2012

Text in red is meant to assist you to provide brief descriptions for 5 core areas of QI infrastructure.
Text in black is required language for COPC QI Plans.

I. Statement of QUALITY VISION for your Health Center

Use the opening sentence of your Scope of Service document in this QI Toolkit): this is a statement of your vision for what quality at your health center would look like if it was the best it could be: your vision for what you want to create through your QI activities and structure.

II. QUALITY IMPROVEMENT INFRASTRUCTURE

A. Leadership:

1. What committee or group provides oversight and monitoring of health center QI projects and activities?
2. Describe roles and responsibilities of QI committee or group members. (List chair and committee member names and disciplines. May use graphic org chart as appendix if relevant)
    - Committee Member Name, Chair
        A. Roles and responsibilities
    - Committee Member Name, Title
        A. Roles and responsibilities
    - …
3. How often does QI Committee report to the Management Team?
4. Who represents health center at COPC Primary Care Quality Improvement Committee (PCQI)? What is their responsibility at PCQI?

The relationship of the (Health Center Name) QI committee to the PC QI committee and the SFGH Medical Staff Performance Improvement and Patient Safety Committee is described in the Rules and Regulations of the Community Primary Care Service of the SFGH Medical Staff.

B. Meeting structure description:

1. How often and for how long does the QI Committee or group meet?
2. How are decisions made?
3. Attendance requirements?
4. When does the QI Committee choose its strategic goals?

The (Health Center Name) QIC sets annual quality goals reflecting COPC-wide organizational initiatives and priority quality issues for the health center's patient population.

C. Technology/Data

1. Describe how data are used and general data capture plan for QI initiatives
2. Who is responsible for compiling data?
3. How does committee make use of existing data reports shared at PCQI or other forums?

The QIC is responsible for reviewing, analyzing, and responding to the periodic quality data reports on clinical, operational, and patient experience that are generated by Primary Care Reporting Group and COPC Administration.

III. ANNUAL QUALITY GOALS

1. **QI Project:** Name 2-4 Priority QI Projects for the year
    - Example: Increase percentage of eligible patients with colorectal cancer screening
    - If health center is focusing only on Quality Council Goals, copy into table
2. **Rationale:** Provide 1 sentence for why project chosen (i.e. Quality Council Goal, performance has decreased, of importance given patient population)
2. **Team Members:** Team leading project (e.g. communicating to staff, designing and testing PDSAs, collecting and reporting data)
    - Most QI teams are 4-8 staff who represent functions related to improvement aim
3. **Aim Statement:** Include project AIM statement
    - Example: By December 2012, ABC Health Center will achieve 70% of eligible patients screened for colorectal cancer.
4. **Baseline Data:** Provide baseline data – where you are at start of project
5. **Data Sources:** What data sources will the team use to track project progress?
6. **Frequency of Reporting:** How often to review data (i.e. weekly, monthly quarterly, etc)

QI Project	*Rationale*	*Team Members*	*Aim Statement*	*Baseline Data*	*Data Source/s*	*Frequency of Reporting*
1.						
2.						
3.						
4.						

IV. STAFF INVOLVEMENT

Describe plan to involve staff in the quality improvement program

A. Communication plan:

1. What are ways QI Committee, Management Team or other designee keeps entire health center staff abreast of QI work? (i.e. monthly newsletter or email update, DataWall with run charts, QI projects reviewed at staff meeting as standing agenda item, minutes of the QIC meetings circulated to all staff, etc.)
2. Who is responsible for communication plan described above?

B. Staff Education plan:

I. How does health center orient staff to quality improvement concepts and methods?
II. Who is responsible for providing or linking staff to education opportunities

V. EVALUATION OF QUALITY IMPROVEMENT PROGRAM

A. Evaluation of Quality projects

1. How will the Health Center evaluate the success of projects listed in section III - Annual Quality Goals?

B. Quality Improvement Plan effectiveness –

1. How will the Health Center assess effectiveness of overall QI Plan?
    - Example: We will review the outcomes of our annual QIC Quality Goals and the effectiveness of this plan at the annual meeting in xx month to review and update the QI plan.

ANNUAL PCQI SUMMARY REPORT

This report must be completed prior to the health center's annual presentation to the Primary Care Quality Improvement Committee (PCQI). This template and a Power Point template will be sent to PCQI Representative at least 2 months prior to scheduled PCQI presentation.

	HEALTH CENTER QUALITY IMPROVEMENT PROGRAM					**2-3 Success or Challenges**
Quality Improvement Committee	# of times met/11 months (minimum req)					
QI INITIATIVES	**Goal**	**Rationale for Project**	**Baseline Data**	**Outcome Data**	**PDSAs Tested**	
Electronic documentation of blood pressure	Achieve 90% threshold OR 50% improvement over baseline	2012 Quality Council Goal				
Electronic documentation of smoking status assessment	Achieve 80% threshold OR 50% improvement over baseline					
Colorectal cancer screening (FOBT in past yr or colonoscopy in past 10 yrs)	If at ≥ 60% at baseline, goal is 5% improvement. If at ≤ 60% at baseline, goal is 60% or 10 % improvement over baseline					
Blood sugar control for diabetics (of active patients with HgA1c tested % with last HgA1c < 8).	If clinic at ≥ 70% at baseline, goal is 5% improvement. If clinic ≤ 70% at baseline, goal is 70% or 10 % improvement over baseline					
Aim X: Can copy and paste from QI Plan						
Aim X: Can copy and paste from QI Plan						

QUALITY ASSURANCE ACTIVITIES	**Results** 2-3 quantitative outcomes of note	**1-2 Changes Implemented** Actions taken in response to activity	**2-3 Success or Challenges to Share**
Healthcare for the Homeless (HCH) Audit			
Family Pact Audit			
CHDP Audit			
Title 3/Care Act Audits			
Other Audits (Provide Agency Name)			
Unusual Occurrences (UOs)	*Report Number of UOs by category and any trends*		
Patient Grievances	*Report Number of Grievances and any trends*		
Morbidity and Mortality Review	*Provide summary by M&M categories*		
PATIENT AND STAFF EXPERIENCE	**Results** 2-3 quantitative outcomes of note	**1-2 Changes Implemented** Actions taken by Health Center in response to activity	**2-3 Success or Challenges to Share**
Patient Experience Survey	Highlight 1 area of high performance and 1 area of low performance		
Staff Satisfaction Survey	Highlight 1 area of high performance and 1 area of low performance		

QI Problem

Primary Care Quality Committee Annual Report,
Fill in *Health Center, SFDPH, Date*

Problem

- *State the problem and issues involved*

AIM and Objectives

- *List your general AIM and/or objectives*

Data: Run Chart Name

- *Place Run Chart or other table, data here which you have collected for this project*

PDSA Cycles or Steps of Change

- *List some pdsa cycles tried to address the problem*
- *Show what effect this had – use data points to highlight this*

Learnings from the QI Project

- *Insights from doing this work*
- *QI principles applied*
- *Accomplishments*

Current Challenges

- *List areas of problem of focus which still need to be addressed*
- *Possible next steps*
- *Questions for the audience which you would like help with –*
  - *Should be practical, specific questions*
  - *Related to issues which other clinics may be working on*

SAMPLE PROJECT

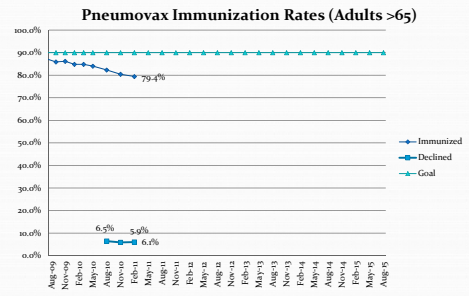
Pneumovax Immunizations

Example Project

Pneumovax Immunization

- Rates are low
- Patients are not receiving recommended IMZ – increased morbidity and mortality
- Patients are unaware of the issues
- Provider alone driven activity
- Support staff do not understand guidelines
- No standardized process for data entry into the LCR

Pneumovax Rate and Goal



Steps of Change

- Create multidisciplinary change team
- Set up weekly standing meeting
- Agree on guidelines
- Train staff on guidelines
- Create process to have RN/MEA give pneumovax based on clinic protocols or guidelines
- Create process to identify patients who are eligible for PNVX
- Track rates
- Analyze why rates are or are not changing

Learnings and Accomplishments

- Guidelines now created
- All staff understand and can articulate guidelines
- Improved staff communication
- Increased trust between nursing and provider team
- Rates going up by 7%

Next Steps/Barriers

- No significant change in rates
- Patients not being offered PNVX consistently
- Patients declining IMZ
- Providers want to order IMZ themselves

Questions:

1. How do you build trust in the team so that providers are willing to let go and MA are willing to take on?
2. How do you approach speaking with patients about IMZ so that they are willing to receive them?

PCQI TOOLS

SFDPH Primary Care QI Committee (PCQI): 2012 CALENDAR*

Each month, health center PCQI representatives give a brief presentation on their center's QI program. Presentations focus on 1-2 improvement projects of note. In addition, PCQI Committee members review primary-care wide quality reports. These reports can be taken back to your health centers to facilitate improvement work for relevant areas of focus.

January 2012	**February 2012**	**March 2012**	**April 2012**	**May 2012**	**June 2012**
MHHC Quality Council Goals	FHC Quarterly UO report (Oct-Dec 2011)	CMHC Chronic Conditions (PHASE & DM)	OPHC Cancer Screening: Breast, Cervical, Colorectal	SAFHC CV Risk Factors: BP, Smoking Status, Lipids Screening Adult immunizations: Pneumovax, Tetanus Quarterly UO report (Jan-Mar 2012)	PHHC SPY
July 2012	**August 2012**	**September 2012**	**October 2012**	**November 2012**	**December 2012**
CPHC Abnormal results follow up	GMC Quarterly UO report (Apr-Jun 2012)	SEHC Chronic Conditions (PHASE & DM) Quality Council Goals	TWHC HUH Cancer Screening: Breast, Cervical, Colorectal	CHPY Pediatrics / Adolescents Quarterly UO report (Jul –Sep 2012)	Curry

**Health centers scheduled to present may change*

Performance Improvement Calendar 2012
Community Health Network
PRIVILEGED AND CONFIDENTIAL (Protected by Evidence Code 1157)

This calendar supports management teams in planning agendas so consistent and timely review of patient population, administrative, operational, and key aspects of high quality care delivery are addressed by center leadership.

Aspect of Care/Indicator	**Recommended Frequency of Review**	**Data Source**	**Data Reporter Team Member responsible for bringing data to meeting**
Patient Experience	Yearly	Annual CG CAHPS Survey	
Staff Experience	2 x/ year	Internal	
Abnormal Results System Review (Mammo, Pap, FOBT)	**X** (monthly)	Lab	
Mortality Review – Annual Summary	Annually	Internal	
Diabetes Care Clinical Quality Outcomes	Minimum expectation: **Semiannually**	Registry Reports/Internal	
Cancer Screening: Breast, Cervical, Colon	Minimum expectation: **Semiannually**	Registry Reports/Internal	
Lipids Screening	Minimum Expectation: **Semiannually**	Registry Reports/Internal	
Immunizations	Minimum Expectation: **Semiannually**	CAIRS (Pediatrics) Registry Reports/Internal	
UO Review	Quarterly	UO Electronic System	
Allergy Documentation Review	Semiannually	Internal	
Prenatal Outcomes Summary (if appropriate)	Per health center	Internal	
Access and Productivity	Quarterly	Registry Reports	
External Audits	Per health center	Internal	

Audits:

HCH = Healthcare for the Homeless **HIV** = HIVQual/ CARE **Title X** = Title X Family Planning
MediCal Managed Care audit (ABC= Anthem Blue Cross **or** SFHP=San Francisco Health Plan)

HEALTH CENTER NAME
QI COMMITTEE Meeting Template
PRIVILEGED AND CONFIDENTIAL
(Protected by Evidence Code 1157)

DATE:
PRESENT:
ABSENT:

Time	Topic	Discussion	Next Actions	Owner/s
	Review agenda	2-3 main points	Follow up required/by when	Team member responsible for reporting
	Quality of Care Results • Chronic Care Outcomes • Quality Council Goals • Health Care Maintenance • Operations/access			
	Specific QI Initiatives			
	CareLinks SF Implementation			
	Mortality Review			
	Unusual Occurrences			
	Patient Complaints			
	Audits or Peer Review Sessions • Upcoming audit • Results of audit • Peer Review Planned • Debrief on Peer Review Session			

NEXT MEETING:

Quality Improvement Committee Meeting Evaluation Questions

A good practice is to regularly assess the efficiency and productivity of meetings. Below are a set of questions that can adapted to fit your needs. It is recommended that survey respondents be permitted to remain anonymous. Survey Monkey can be used to track results continuously, or easy-paper pencil versions can be administered after meetings and tallied as part of your debrief session with 1-2 team members who can give feedback to the Committee leader.

Meeting Evaluation Question Set

1. Meeting times are announced well before the meeting and everyone arrives on time.
2. An agenda with timelines is provided and followed.
3. Our meetings are about the right duration to accomplish the goals.
4. Our team leader keeps us focused on one topic at a time.
5. Interruptions are minimized and off-task discussions are avoided.
6. All members participate.
7. Members present assigned topics or reports in a brief, organized manner.
8. We solicit from the most knowledgeable informants.
9. We communicate openly and with sensitivity.
10. We openly “brainstorm” solutions and agree upon decisions.
11. Before the next meeting, members complete tasks.
12. Before the next meeting, members are prepared for discussion, problem-solving, and decision-making

Response Choices

1. Agree
2. Neutral
3. Disagree

Guide to Data Collection Planning

When new Quality Improvement Initiatives are introduced, we often overlook the need to have team members agree to a do-able data collection plan. The guide below can be used to facilitate conversations about how improvement data will be collected, who will collect it and how often it should be collected during your pilot phase.

Team members present:
Date:

IMPROVEMENT AIM

Measure:

Patient Population: (e.g., patients with A1c over 9, or visits to primary care):

METHODOLOGY

Frequency of data collection:

Sources of data (What data already exist, even if not perfect?):

PLAN

Who will collect data?

Starting when?

Additional tools or training needed to collect data:

How will data be used?