

MEG 2012

Quality Improvement: Lessons from Practice

June 20, 2012

Presented by the Pfizer Medical Education Group



Agenda

- Introductions
- Goals for the session
- Presentations
- Q&A

Quality Improvement: Lessons from Practice.

- **Moderators: Bob Kristofco and Laura Bartolomeo Pfizer Medical Education**
- **Presenters:**
- **Cynthia Kear-CCMEP**, Senior Vice President of the **California Academy of Family Physicians**. Prior to joining the CAFP 11 years ago Ms Kear was Founder/President of Ibis Software, an educational software company and worked extensively in education and technology serving as VP & General Manager of a PC-SIG, a software, video and book publisher in Silicon Valley and as VP /Co-General Manager of a \$20 million medical, nursing and science business unit for Pearson Publishing Company. Cynthia is a graduate of the Institute for Healthcare Improvement Breakthrough College on Collaboratives and Virtual Collaboratives,

Presenters

- **Shelly Rodrigues**, CAE, FACME, CAFP Deputy Executive Vice President (DEVP) **California Academy of Family Physicians**, has more than 27 years' experience in medical society management, the past 19 years with the California Academy of Family Physicians.

Shelly is a graduate of the Institute for Healthcare Improvement Breakthrough College on Collaboratives and Virtual Collaboratives, and is a Certified Association Executive (CAE). While her role includes oversight for communications and technology, the vast majority of her time is spent as a member of the CAFP's TEAM CME/CPD, working on educational programming and administration.

Shelly has served on the Commission on Continuing Professional Development of the American Academy of Family Physicians. She is also the current chair for the Alliance for Continuing Education of the Health Professions annual conference committee.

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Presenters

- **Lee Ann Grajales** vice president for quality initiatives for the **Pennsylvania Academy of Family Practice Foundation (PAFP/F)** is responsible for all programs, projects and activities on improving quality in primary care, including practice-based research, the patient-centered medical home and other family medicine initiatives.

Lee Ann a 32-year healthcare administration veteran, works with key stakeholders including insurance companies, local and state governments, businesses and pharmaceuticals, all pivotal partners in sustaining quality initiatives and maintaining practice improvement.

Lee Ann is administrator of a PAFP program registering primary care providers who want to take advantage of the resources and assistance offered through PA REACH East, part of a nonprofit partnership led by Quality Insights of Pennsylvania and created by federal economic stimulus legislation to assist small practices when choosing, implementing and using electronic health records (EHRs).

Presenters

- **Angie Halaja-Henriques** has worked at the **Pennsylvania Academy of Family Physicians** since 1999 – first in communications then public health and now as Quality Initiatives Grants Director. She works with various stakeholders that are key to family medicine, including the Pennsylvania Department of Health, various associations, such as the PA Association of Community Health Centers, and pharmaceutical companies. Current quality initiative priorities include quality improvement collaboratives for primary care, EHR implementation and, of course, the patient-centered medical home.

Presenters

- **William J. Warning II, MD, CMM, FAAFP, CAQ SpMed:**

Dr. Warning is a board certified family physician with a CAQ in Sports Medicine and a Certificate of Medical Management from Carnegie Mellon University.

He is the Program Director of the Crozer-Keystone Family Medicine Residency Program located in Delaware County, outside of Philadelphia. He has been an employed physician at Crozer since 1993 and has Directed the FM Residency Program since 2000.

Dr. Warning is active in the PAFP serving as Chairman of the Assembly of Program Directors and Dept Chairs, as a member of the Board of Directors and as a member of the Resident and Student Affairs Commission.

The Crozer Family Medicine office has a volume of over 20,000 visits per year and a staff of 15 faculty attendings, 27 FM residents and 2 Fellows in Sports Medicine. He led his office to Level 1 NCQA Medical Home Certification in 6 months and to Level 3 Certification within 1 year. The Crozer FM Residency is one of the first FM residencies in the USA to achieve Level 3 NCQA Medical Home Certification and is one of 25 practices selected to participate in Governor Rendell's SEPA Chronic Care Initiative and the CMS Advanced

7 | [It all starts here.](#)
Primary Care initiative.



Goals for Today's Session

This webinar is intended to provide insights into quality improvement initiatives from two diverse perspectives. It will:

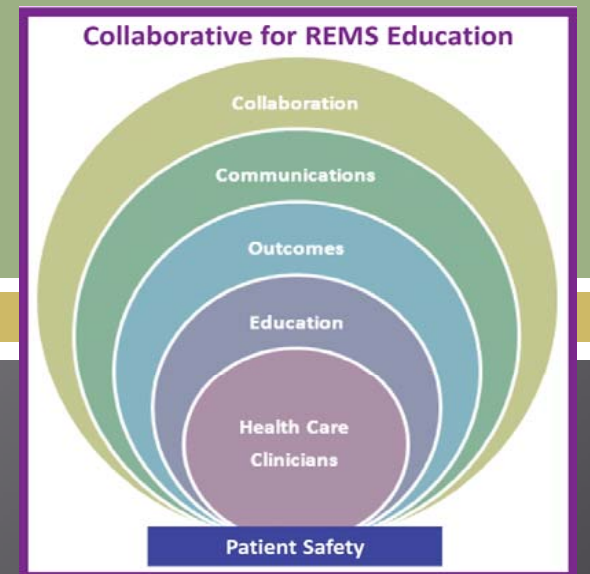
- Describe a collaboration that has resulted in important strides in educational planning to address a public health emergency
- Review how collaboratives are changing primary care practice in Pennsylvania
- Demonstrate the role education can play in the improvement of care

The Path to Improvement: Learning from California's AB847

Collaborative for REMS Education (CO*RE)

Cynthia Kear, MDiv, CCMEP

Shelly Rodrigues, CAE, FACEHP



Pfizer Webinar Series | June 20, 2012

**While it is true that pain is a universal human experience, it is never true that one can feel another's pain. The effort to protect the public from inadvertent harm through use of strong analgesic medications must never supersede the importance of providing comfort to those who suffer. The core tenets of the CO*RE initiative are simply these:
to protect those who suffer, as well as those who do not.**

Katherine Galluzzi, DO, family physician, geriatrician and pain specialist



Representing CAFP and CO*RE

Cynthia Kear



Shelly Rodrigues



Cynthia and Shelly declare no financial relationships with any corporate entity supporting the work done on this project.

The CO*RE Needs Assessment and Educational Design project was supported in part by unrestricted educational grants from Pfizer, Inc. and Purdue Pharma, LLD.



CO*RE Members

CO*RE Partners

American Academy of Hospice and Palliative Medicine (AAHPM)

American Academy of Nurse Practitioners (AANP)

American Academy of Physician Assistants (AAPA)

American Osteopathic Association (AOA)

American Pain Society (APS)

American Society of Addiction Medicine (ASAM)

California Academy of Family Physicians (CAFP)

Nurse Practitioner Healthcare Foundation (NPHF)

CO*RE Associates

American Pharmacists Association (APhA)

Interstate Postgraduate Medical Association (IPMA)

Healthcare Performance Consulting (HPC)



Our Mission and Goal

- ✎ **CO*RE's** immediate mission is to ensure that LA/ER opioids are prescribed, when indicated, in an appropriate manner that enhances patient well-being and does not contribute to individual or public harm.
- ✎ The overarching goal of **CO*RE**, a collaboration that includes primary care, addiction medicine, pain specialty and pharmacy perspectives, is to design, develop, deliver and evaluate a multi-faceted, multi-phase, multi-year competency-based educational initiative to the targeted 1,200,000+ (*) prescribers of Long-Acting/Extended-Release (LA/ER) Opioids.

() Moving target per recent FDA-IWG discussions*



The driving question: How Can We Avoid?

- ⌘ We were driven by a desire to avoid the results of:
- ⌘ Accutane: Physicians simply decided to opt out
- ⌘ AB 487: The medical board was left holding the bag



AB 487: Pain Management and the Appropriate Care and Treatment of the Terminally Ill

A look at what got us
to this point!

- ⌘ AB 487, signed into law on October 4, 2001, requires most California-licensed physicians to take, as a one-time requirement, 12 units of continuing medical education (CME) on “pain management” and “the appropriate care and treatment of the terminally ill.”
- ⌘ The bill, which has become Business and Professions Code section 2190.5, exempts pathologists and radiologists.



AB487 Details

- ✎ The Medical Board will accept courses or programs that address one or both topics. The courses or programs must qualify for Category 1 credit and be presented by an organization accredited to provide CME by the Accreditation Council for Continuing Medical Education (ACCME), the American Medical Association (AMA), the California Medical Association (CMA), or the American Academy of Family Physicians (AAFP). In addition to accrediting CME providers, AMA, CMA, and AAFP may also present CME programs which will be accepted.



- ☞ The 12 units may be divided in any way that is relevant to the physician's specialty and practice setting. Acceptable courses may address either topic individually or both topics together. For example, one physician might take three hours of "pain management education" and nine hours of "the appropriate care and treatment of the terminally ill;" a second physician might opt to take six hours of "pain management" and six hours of "the appropriate care and treatment of the terminally ill;" a third physician might opt to take one 12-hour course that includes both topics."
- ☞ The Medical Board will accept any combination of the two topics totaling 12 hours.



How it Worked ...

- ☞ Physicians with an active license before January 1, 2002, had until December 31, 2006, to obtain the 12 hours.
- ☞ Physicians licensed on or after January 1, 2002, must complete the mandated hours by their second license renewal date or within four years whichever comes first.
- ☞ The 12 required hours shall count toward the 25 hours of approved continuing education each physician is required to complete during each renewal year.

California has two medical boards: MD and DO. Both have been charged with requiring pain CME.



Sounds Good, but ...

☞ AB487, and the resulting rules/regulations

- Had no consistent content based on needs assessment, practice gaps, evidence-based guidelines, or documented research
- Had no consistent educational design or format
- Had no consistent evaluation or outcomes measurement

☞ And as a result

- Cannot show any change in clinician behavior, practice improvement, and benefit to patient health status



Enter CO*RE

- ∞ Building a Collaboration to address a public health crisis
- ∞ Ensuring stakeholders voices are included, consulted and heard



The REMS Discussion Begins

- ∞ In September 2009, CAFP leaders first met with a representative of the Industry Work Group (IWG) who sought to engage the voice of family physicians in the REMS process, especially California-based physicians because of their experience with AB487.
- ∞ The CAFP Board of Directors approved a request for a survey about pain management, REMS, the FDA and DEA in November 2009. In January 2010, the survey was sent to members of CAFP and eight other AFP state chapters.
- ∞ At the same time the APS was completing work on its evidence based *Clinical Guideline for the Use of Chronic Opioid Therapy in Chronic Non-Cancer Pain*.
- ∞ Simultaneously, CAFP reached out to APS to inquire about possible collaboration. Other organizations were recommended by APS based on their roles in pain care and a demonstrated willingness to enter into a collaborative.



First CO*RE Summit

- ☞ On June 10, 2010, representatives from 12 organizations attended the first CO*RE summit in Chicago. The group developed the CO*RE competencies for safe and effective pain management and opioids prescription. The competencies were adopted by all of the organizations.
- ☞ During the following summer, CAFP and APS led the organizations through a series of exercises to develop the *Scope of Proposal* document, which outlined work to be done to meet and exceed the soon-to-be-released REMS. The document delineated the partnership's infrastructure, roles, responsibilities, and educational activities with budgets. It was submitted to the IWG and FDA on October 18, 2010.



Second CO*RE Summit

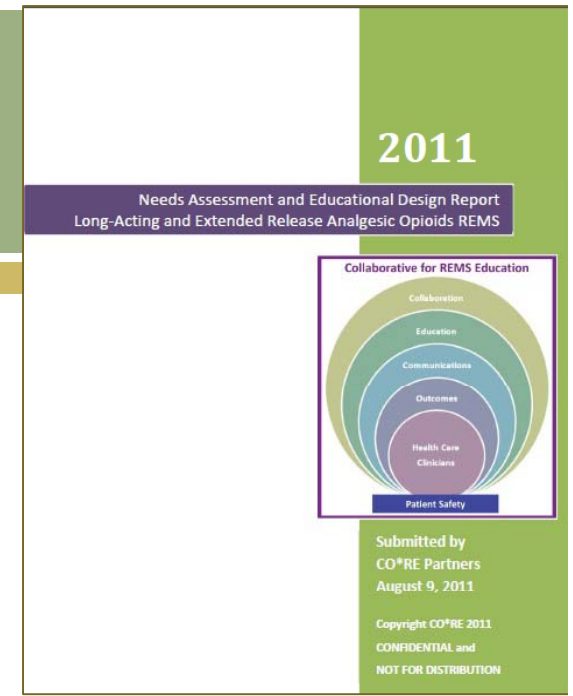
- ⌘ During the first quarter of 2011, the infrastructure documents necessary to formalize the CO*RE relationship were developed, including a Participation Agreement and Addenda. All eight founding partners have signed the agreement.
- ⌘ In March 2011, on behalf of CO*RE, CAFP submitted grant proposals to Pfizer, Purdue, Endo, and Janssen to support a needs assessment and educational design summit. CO*RE received approval from Pfizer and Purdue in May 2011 and completed the needs assessment and hosted the design summit on July 19, 2011.



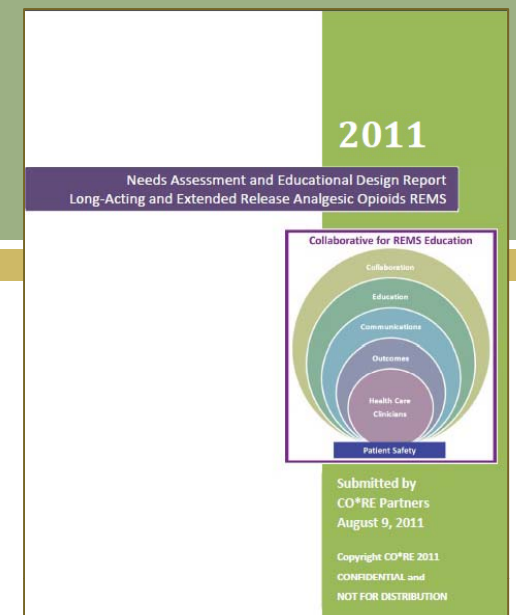
CO*RE Report

∞ The four-armed needs assessment project provided CO*RE partners with baseline knowledge about clinicians' perceived and actual practice gaps, concerns about treating persons living with pain, barriers to optimal care, and attitudes toward REMS and voluntary or mandatory education. This baseline knowledge was instrumental in understanding the implications of this project going forward.

CO*RE partners learned that clinicians — specialists and primary care providers alike — acknowledge need and educational gaps across the continuum of care for persons living with pain. These needs include the initial assessment of the patient, development of a treatment plan, assessment of risk for abuse, and ongoing reassessment of the patient.



➤ Additionally, clinicians perceive many barriers to best practices. Both primary care providers and specialists expressed concern about accidental overdose and patients' concerns that they may become dependent or addicted. Primary care providers also listed among the top barriers the limited access to pain specialists for consultation or referral.



Third CO*RE Summit

- ✎ In March, 2012 the partners and clinical experts met in Chicago to discuss and develop an efficacious educational design and system approach for the seven-part FDA module.



What's Next?

- ✎ Finalize infrastructure
- ✎ Continued process planning
 - Launch website: <http://www.core-rems.org/>
- ✎ Awareness campaign with Medscape
 - <http://www.medscape.org/viewarticle/763585>
- ✎ Out reach
 - Associations – local, state, national and specialty
 - Government
 - Payors
- ✎ Wait and see...



In Summary

- ☞ Since the fall of 2009, the CO*RE partners have progressed from a group of eight discrete organizations to a unified collaborative partnership committed to advancing best education in pain management and safe use of long-acting opioid medications.
- ☞ The group has undertaken countless hours of research, discussion, expert advice, stakeholder input, and analysis to determine the most salient lessons for the development, implementation, and evaluation of long-acting opioid REMS programming and curriculum.
- ☞ While CO*RE fully understands the request to educate 1,200,000+ prescribing clinicians on this complex topic on a voluntary basis will be challenging, CO*RE, representing key prescribers across multiple disciplines, remains committed to participating in a manner that will make a difference for our members, all prescribers and the patients they serve.



Post Script – This Collaboration

- ☞ Transdisciplinary approach is vital
- ☞ Hesitancy due to inexperience and competition
- ☞ Clarity is essential
- ☞ Managing expectations is key
- ☞ Letting organizations participate to their highest comfort level is required
- ☞ EAPs
 - Don Moore, PhD
 - Marcia Jackson, PhD
 - Nancy Bennett, PhD



Thanks and Questions

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PENNSYLVANIA ACADEMY OF
FAMILY PHYSICIANS FOUNDATION

Pennsylvania IPIP

Improving Performance In Practice

June 20, 2012

Pfizer Medical Education Group

QI: Lessons from Practice

Pennsylvania IPIP www.paafp.com/IPIP



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What is the PAFP?

www.pafp.com

The PA Academy of Family Physicians (501C6) is the professional association for family physicians in Pennsylvania.

- Established in 1948
- ~4,800 members; MDs and DOs, residents and medical students; 77% market share in PA
- Largest sole specialty physician organization in PA
- Unified with the American Academy of Family Physicians
 - PAFP is the 3rd largest state chapter
- No. 1 reason for membership is advocacy; No. 2 is CME

What is the PAFP Foundation?

www.pafp.com

The PAFP Foundation (501C3) was created in 1985.

- CME Programs
 - 3 Annual Live CME Conferences
 - Fall Regional Member Lecture Series
 - Maintenance of Certification Part V Programs
 - Lots of online CME
- Public Health Grants
 - Connect public health to family medicine
 - Current projects:
 - Immunization, Child Sexual Abuse, Traumatic Brain Injury
- Quality Improvement Initiatives
 - REACH East contractor, use or implement EHR for meaningful use
 - PA IPIP

Status Quo

- Pandemic of chronic disease¹
- United States: worse outcomes, highest cost per capita²
- Demoralized health care professionals³

1. http://www.who.int/topics/chronic_diseases/en/

2. <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Jun/Mirror-Mirror-Update.aspx?page=all>

3. Steiger Bill. "Physician Morale Study." 2006. American College of Physician Executives (ACPE). www.acpe.org/morale

What We Offer

- Evidence-based adult education + systems change models
- Healthier patients
- Happier health care workforce¹
- Positive clinical and process outcomes
- Opportunity for long-term QI community
- Experienced faculty and productive, competent staff
- Healthy organization (PAFP) at the core
- Strategic alignment with all primary care orgs
- Opportunity for national model

1. PA IPIP RPC site assessment, 2010, improvement in “practice climate” and “general morale” in particular

Pennsylvania IPIP

All Pennsylvania Academy of Family Physicians Foundation (PAFP/F) quality improvement and practice transformation initiatives are operated through the PA IPIP (Improving Performance in Practice) Program.

Pennsylvania IPIP

- Sponsored by the PA Primary Care Coalition
 - PA Academy of Family Physicians
 - PA Chapter, American Academy of Pediatrics
 - PA Chapter, American College of Physicians
- Strong partnership with PA Association of Community Health Centers
- Operated by the PAFP Foundation

What is PA IPIP?

Improving Performance In Practice (IPIP)*

- Started as a national initiative
- PA IPIP programs qualify as a performance improvement activity for Maintenance of Certification with the Family Medicine, Internal Medicine and Pediatric Boards
 - Primary care physicians can count IPIP participation toward board re-certification

** Pronounced ip-ip, like “hip-hip hurray”*

PA IPIP Mission Statement

- Accelerate quality improvement among primary care practices;
- Support primary care physicians and their care teams to provide consistently high quality care that improves patient health;
- Motivate collaboration at state, regional and practice levels;
- Improve physician and team satisfaction;
- And improve the financial sustainability of primary care physician practices.

PA IPIP Core Services

Support
&
Facilitation

Education:
Clinical,
Process, QI

Data
Collection &
Sharing

Collaborative Network

Current Projects

- **Data management for statewide Chronic Care Initiative, operated by Pennsylvania Dept. Of Health**
 - Contractor since the beginning in 2007
 - Originally provided coaching and data services
 - Practices have “graduated” out of coaching
 - Now: data collection, analysis and reporting
 - PA IPIP services supported with DOH grants (CCI, CVD, diabetes)
 - Work closely CCI staff
 - 161,000+ patients

Current Projects

- **Colorectal Cancer Screening Collaborative**
 - Funded by DOH
 - Improve CRCS rates using systems-based changes
 - Full range of services: data, education, support from staff/physician faculty
 - Open to any primary care practice!
 - More than 85,000 patients
- **Residency Program (RPC) & Community Health Center Collaboratives (CHCC)...**

Residency Program (RPC) & Community Health Center Collaboratives (CHCC)

GOAL:

- Transform participating practices so that they both teach and practice quality improvement and patient-centeredness.

Why these practices?

- Medicare and Medicaid were the primary payers for 71.4 % of diabetes hospitalizations for Pennsylvanians in 2009.

[Diabetes Hospitalization Report, 2009 Data. Pennsylvania Health Care Cost Containment Council. November 2011](#)

- Makes sense to focus on safety net providers

RPC & CHCC Objectives

- Improve care for those patients served by participating practices, whose patient populations include the most vulnerable members of our communities.
- Spread system change by teaching residents how to practice the principles of the Patient-Centered Medical Home.

Patient Population

Collaborative	HealthIndication	DM Pts 18-75 Count	IVD > 18 Count	Total Pt Count
RPC	Diabetes	9,336		
RPC	IVD		2,705	
CHCC	Diabetes	7,064		
CHCC	IVD		460	
	Total	16,400	3,165	19,565

Current as of 6/18/2012

Learners

- 28 teams in RPC
 - all family medicine residency programs
- 17 teams in CHCC
 - 16 CHCs, 1 residency program
- Typically about 200 people attend learning sessions
- Does not include the physicians, providers and staff impacted by change back at the practice

Multiplier Effect



Team Members

3-PERSON TEAMS:

- Physician (required)
- Resident (required) or Administrator
- Non-physician staff (office manager, CRNP, nurse)

Team Requirements

- Attend live sessions (3x/year)
 - Many teams bring more than 3 people
- Participate in monthly calls
- Report monthly data
- Work with a physician mentor
 - Use feedback form
- Apply for NCQA PCMH Recognition

Faculty

- Chairperson, Co-Chairperson Plus 6 Faculty
 - All primary care physicians, all faculty at residency programs
- Develop and deliver the education
- Work directly with learners
 - Each are assigned to a group of teams
- Review and interpret data
 - Complete feedback forms for assigned teams

Curriculum

- What we teach
- How we teach it

Change Package

1. Chronic Care Model

- Clinical Information Systems (ex: EHR systems or patient registries)
- Decision Support (ex: algorithms)
- Patient Self-Management (ex: action plans)
- Delivery System Design (ex: team-based care)

Change Package

2. Patient-Centered Medical Home

- Population management
- Expanded team care
- Patient-centeredness
- Performance measurement
- Care coordination
- Evidenced-based care
- Plus NCQA recognition

Implementation

3. Model for Improvement

- PDSA (Plan-Do-Study-Act) cycles

4. Breakthrough Series

- 12 month cycles
- 3 live learning sessions (1-day events)
- Monthly phone conferences

Measurement

- In God we trust, everybody else needs data.
- If you don't measure it, it never happened.

Measured Outcomes

Moore's Outcomes-Based CME Evaluation Model¹:

Level 1	Participation
Level 2	Satisfaction
Level 3A	Learning: Declarative Knowledge (Knows)
Level 3B	Learning: Procedural Knowledge (Knows How)
Level 4	Learning: Competence (Shows How)
Level 5	Performance (Does)
Level 6	Patient Health ←
Level 7	Community Health

1. Moore D E. Achieving desired results and improved outcomes: Integrating planning and assessment throughout learning activities. J Contin Educ Health Prof. 2009 Winter;29(1):1-15.

Tools to Measure Outcomes

- Standard evaluations + Pre/post-tests
 - Measure baseline knowledge
 - Predispose learners to primary messages
 - Inform faculty of gaps in knowledge
- Practice assessment
 - 14 areas, 75 indicators
- NCQA PCMH recognition program
- Patient-level data collection
 - Clinical and process quality measures

Data Collection

- Robust data systems
 - Expert staff
 - Stable, scalable platforms
 - Add measures, teams, whole collaboratives
- Education stresses data integrity
- Reporting is user friendly for learners
- Slice/dice data
- Statistically significant

Measures & Outcomes



William Warning, MD

Faculty Chair,

Residency Program & Community Health
Center Collaboratives

Program Director,

Crozer-Keystone Family Medicine
Residency Program

Springfield, PA (near Philadelphia)

DM Measures

- Good HbA1C Control (<7)
- Intermediate HbA1C Control (<8)
- Poor HbA1C Control (>9)
- HbA1C Documented
- Intermediate LDL Control (<130)
- Good LDL Control (<100)
- Good BP Control (<130/80)
- Intermediate BP Control (<140/90)
- LDL Documented
- Eye Referral
- Retinopathy Screened
- Foot Examination
- Aspirin Prescribed
- Statin Prescribed
- Nephropathy Attention
- ACE/ARB Prescribed
- Self-Management Goals
- Tobacco Use Documented
- Smoking Cessation Counseling
- Diabetics who use Tobacco
- Pneumococcal Vaccination
- Influenza Vaccination

IVD Measures

- Count IVD
- Blood Pressure (<140/90)
- Lipid Testing
 - includes total cholesterol, TG, HDL-C, LDL-C
- LDL Result (< 100 mg/dL)
- Lipid Therapy
- Aspirin or Antithrombotic
- Smoking Status Smoking Counseling

NEW: Depression Measure

Measure	Numerator	Denominator	Status	Additional Information
Screened for Depression	# Patients 18-75 screened annually for depression with a standardized tool	Total DM patients 18-75	Required	Example of tool: PHQ-2 or PHQ-9

NEW: Obesity Measure

Measure	Numerator	Denominator	Status	Additional Information
Adult Weight Screening and Follow Up	Patients with BMI calculated in the past six months and a follow-up plan documented if the BMI is outside of parameters (too low or too high).	Total DM patients 18-75	Optional	Parameters: age 65 and older BMI ≥ 30 or < 22 ; age 18-64 BMI ≥ 25 or < 18.5

Results

- NCQA recognition statistics
- Satisfaction survey with the collaborative concept, faculty and staff
- Self-assessment survey of practices as PCMHs
- Process and clinical outcomes data

NCQA Recognition

Recognition statistics for the 22 teams in the RPC as of June 2012:

NCQA Recognition (100%)

- ★ **Level 3: 18 teams (82%)**
- ★ **Level 2: 1 team (4%)**
- ★ **Level 1: 3 teams (14%)**



CHCC practices are expected to achieve recognition in 2012.

RPC Learner Survey March 2012

- 93%: glad their practice is participating
- 91%: Collaborative is valuable
- 92%: Collaborative is a key resource to support practice transformation
- 74%: Collaborative is improving care at their practice
- 76%: helped to educate residents about practice transformation, medical home skills and quality improvement

Practice Self-Assessment

- Self-reported experience with transformation
- PCMH indicators are on the rise (*even with challenging processes such as care coordination being tracked*)

- ↑ Access & Scheduling
- ↑ Care Coordination
- ↑ Curriculum Redesign
- ↑ Practice Climate
- ↑↑ MH/BH Integration
- ↑ Leadership
- ↑↑↑ Population Management
- ↑ Registry & Measure Usage
- ↑ Staff/Resident Engagement
- ↑ Team-Based Care
- ↑ ↓ ↑ QI Team Function

RPC Diabetes Outcomes

July 2010 - May 2012

Type	Measure	Start%	End%	Improve%	mGoal	CompToGoal
Process	Self-Management Goals	13.05	46.87	↑	33.82	90 ❌ -43.13
Process	Eye Referral	7.85	39.86	↑	32.01	90 ❌ -50.14
Process	Pneumococcal Vaccination	35.98	64.11	↑	28.13	90 ❌ -25.89
Process	Influenza Vaccination	36.99	62.46	↑	25.47	90 ❌ -27.54
Process	Smoking Cessation Counseling	50.97	74.29	↑	23.32	90 ❌ -15.71
Process	Retinopathy Screened	14.3	37.46	↑	23.16	80 ❌ -42.54
Process	Foot Examination	47.25	63.12	↑	15.87	90 ❌ -26.88
Process	Nephropathy Attention	58.2	69.8	↑	11.6	90 ❌ -20.2
Process	Tobacco Use Documented	78.33	89.85	↑	11.52	90 ❌ -0.15
Process	Statin Prescribed	62.35	70.46	↑	8.11	90 ❌ -19.54
Process	Aspirin Prescribed	54.63	62.6	↑	7.97	90 ❌ -27.4
Outcome	Intermediate LDL Control	50.09	56.53	↑	6.44	90 ❌ -33.47
Process	ACE/ARB Prescribed	71.62	75.74	↑	4.12	90 ⚠️ -14.26
Outcome	Good BP Control	40.52	44.14	↑	3.62	70 ❌ -25.86
Outcome	Good LDL Control	36.31	39.87	↑	3.56	70 ❌ -30.13
Outcome	Intermediate BP Control	63.74	66.79	↑	3.05	90 ❌ -23.21
Special	Diabetics who use Tobacco	26.47	24.24	↑	2.23	
Special	Poor HbA1C Control	37.23	35.75	↑	1.48	5 ❌ -30.75
Outcome	Good HbA1C Control	37.18	38.17	→	0.99	75 ❌ -36.83
Process	HbA1C Documented	78.71	76.8	↓	-1.91	90 ⚠️ -13.2
Process	LDL Documented	69.55	66.6	↓	-2.95	90 ❌ -23.4

CHCC Diabetes Outcomes

July 2011-May 2012

Type	Measure	Start%	End%	Improve%	mGoal	CompToGoal
Process	Tobacco Use Documented	67.6	90.28	↑	22.68	90 ❌ 0.28
Process	Eye Referral	23.72	42.02	↑	18.3	90 ❌ -47.98
Process	Influenza Vaccination	41.18	56.77	↑	15.59	90 ❌ -33.23
Process	Aspirin Prescribed	51.01	62.72	↑	11.71	90 ❌ -27.28
Process	Smoking Cessation Counseling	66.05	76.09	↑	10.04	90 ❌ -13.91
Process	Self-Management Goals	28.53	37.94	↑	9.41	90 ❌ -52.06
Process	Retinopathy Screened	16.66	24.78	↑	8.12	80 ❌ -55.22
Outcome	Intermediate LDL Control	53.68	61.77	↑	8.09	90 ❌ -28.23
Process	Nephropathy Attention	69.33	76.99	↑	7.66	90 ❌ -13.01
Process	LDL Documented	67.75	74.76	↑	7.01	90 ⚠️ -15.24
Process	Pneumococcal Vaccination	47.97	54.62	↑	6.65	90 ❌ -35.38
Process	Statin Prescribed	61.59	68.08	↑	6.49	90 ❌ -21.92
Process	HbA1C Documented	72.42	77.57	↑	5.15	90 ⚠️ -12.43
Outcome	Good LDL Control	40.3	44.89	↑	4.59	70 ❌ -25.11
Outcome	Intermediate BP Control	68.23	70.88	↑	2.65	90 ❌ -19.12
Outcome	Good HbA1C Control	34.7	37.3	↑	2.6	75 ❌ -37.7
Process	ACE/ARB Prescribed	75.07	76.39	↑	1.32	90 ⚠️ -13.61
Process	Foot Examination	60.8	61.07	→	0.27	90 ❌ -28.93
Special	Poor HbA1C Control	24.36	25.93	↓	-1.57	5 ❌ -20.93
Outcome	Good BP Control	48.1	45.92	↓	-2.18	70 ❌ -24.08
Special	Diabetics who use Tobacco	22.92	27.84	↓	-4.92	

RPC IVD Outcomes

July 2011-May 2012

Type	Measure	Start%	End%	Improve%	mGoal	CompToGoal
Process	IVD Tobacco Use Documented	67.63	94.42	↑ 26.79	90	✓ 4.42
Process	IVD Statin Prescribed	67.29	70.61	↑ 3.32	90	✗ -19.39
Process	IVD Aspirin Use Documented	73.46	75.3	↑ 1.84	90	⚠ -14.7
Outcome	IVD Good LDL Control	38.46	37.09	↓ -1.37	70	✗ -32.91
Process	IVD LDL Documented	70.34	66.75	↓ -3.59	90	✗ -23.25
Outcome	IVD Intermediate BP Control	69.61	64.1	↓ -5.51	90	✗ -25.9

CHCC IVD Outcomes

- Stay tuned!
- IVD data collection begins this summer

Team-Level Feedback

Allows for:

- teams to be self reflective
- specific faculty suggestions

Faculty Feedback & General Comments (see below):

Keep up the great work. Consider trying 1-2 focused PDSA's, perhaps for item#17, maybe 10?

Process Measures	Goal %	Current Month %	Previous Month %	Difference between months	Difference Goal to Team %	Comments
Appt with > 1 A1C annually	90%	74.79%	76.63%	-2%	-15%	See my Nov PITT comments - this is such a critical number to move, you may want to essentially make this a high priority, as - to an extent - it's a marker for patient engagement, etc.
Clinical Measures	Goal %	Current Month %	Previous Month %	Difference between months	Difference Goal to Team %	Comments
Appt with A1C >6	5%	19.44%	19.78%	0%	-14%	Hmm... As item#17 continues to improve, what is holding this back? Physician Inertia?

Process Measures	Goal %	Current Month %	Previous Month %	Difference between months	Difference Goal to Team %	Comments
Appt with > 1 A1C annually	90%	74.11%	74.36%	0%	-16%	Hmm - a little stagnant with this parameter; how to move this forward? Basically, 1 in 4 patients haven't had this checked in a year; have you made efforts to reach out to them? That's the "low-hanging" fruit.
Clinical Measures	Goal %	Current Month %	Previous Month %	Difference between months	Difference Goal to Team %	Comments
Appt with A1C >6	5%	19.58%	19.44%	0%	-15%	Address item 17 above and this will improve.

Process Measures	Goal %	Current Month %	Previous Month %	Difference between months	Difference Goal to Team %	Comments
Appt with > 1 A1C annually	90%	74.79%	74.11%	1%	-15%	Good, glad you are addressing this.
Clinical Measures	Goal %	Current Month %	Previous Month %	Difference between months	Difference Goal to Team %	Comments
Appt with A1C >6	5%	18.54%	19.58%	-1%	-14%	wonderful; again, as mentioned in previous months, if #17 above improves, so will this

Evaluation & Final Thoughts

Lee Ann Grajales

State Director, PA IPIP

Vice President of Quality Initiatives,
PA Academy of Family Physicians Foundation

Evaluation

- Penn State University
 - Contracted by the PAFP Foundation for an independent study to analysis the effectiveness of our intervention both in the practices and among residents
- CDC Evaluation
 - Awarded through a competitive evaluation program (nominated by the PA DOH)
 - 1 of 2 awardees nationwide
 - 30-month intense evaluation
 - Document and confirm what the CDC already believes – that our intervention is effective

Summary

- The PAFP Foundation's Residency Program & Community Health Center Collaborative is a successful, long-term intervention to build a primary care community around transformation that leads to better patient care, happier physicians and providers and true patient-centered medical homes.

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Thank You!



PENNSYLVANIA ACADEMY OF FAMILY PHYSICIANS FOUNDATION



Residency Program Collaborative



Community Health Center Collaborative



Questions



Mark Your Calendars!

Next Webinar: September 19, 2012

**Topic: 2012 Update- MEG Request for
Proposal Strategies**