Annual QA/QI Evaluation/Summary Report 2021

The purpose of the Quality Management Program is for SCHDC to continuously monitor, analyze, and improve our performance. The QM Committee collects data to facilitate ongoing feedback for regular evaluation and improvement. Priories are set for evaluation of patient care and services.

The QM program focuses on the following:

- Meeting all requirements of the QA/QI Plan required by HRSA
- Setting guidelines for the quality structure within the organization
- Addressing quality assurance requirements from government agencies
- Reporting on quality data as required by contracts
- Describing key initiatives
- Addressing findings identified through audits and assessments

Quality goals become priority for quality improvement activities in the organization. Goals include:

- To measure, monitor, and improve performance in key aspects of clinical and health services delivery for our patients, providers, and employees for the coming year
- To provide a foundation for complying with regulatory and accrediting agencies such as HRSA and NCQA
- To redesign guidelines, protocols and procedural operations with the objective of producing a medical home health care delivery system that improves clinical and functional outcomes for patients served at this facility

Measurement and monitoring of performance allows the QM team to understand if efficient and effective processes are implemented to service patients. Measurement and monitoring allows the QM team to determine if RVHDC is improving the health of patients.

Measures are based on the following categories:

- High risk
- High volume
- Problem-prone
- Related to patient outcomes
- Related to patient, caregiver, customer and/or staff satisfaction
- Related to compliance with regulatory/contractual requirements
- Related to financial resources and utilization of services

River Valley Health and Dental Center QM Program 2021					
QI Initiatives	**Goal**	**Rationale**	**2020 Data**	**Interventions/PDSAs/Contributing Factors**	**Outcomes 2021 Data**
Uncontrolled Diabetes	30%	RVHDC population of patients diagnosed with diabetes continues to grow. Metric is a focus for HRSA quality improvement	33.14%	-Outreach to patients overdue for testing -Chart scrubbing to include A1C -Standing order for A1C if no test in last year -Referral to care management team for patients with A1C >10 -Implementation of diabetes management program w CRNP -Enhanced health education processes and materials	30% patients diagnosed with diabetes have A1C >9 or no test **Goal met!**
Nephropathy Screening	85%	HEDIS metric as part of providing comprehensive diabetes care. Metric identifies percentage of patients with diabetes who had nephropathy screening test.	76%	-Expanded rooming to include standing order for microalbumin -POC microalbumin test -Added as metric during scrubbing process -Outreach to population of patients overdue for screening	79% **Restricting factors:** • Missed appointments • Missed opportunities • Staffing challenges • SDOH barriers
Controlled Hypertension	72%	UDS/HEDIS metric RVHDC population continues to grow. If HTN is controlled, there will be less cardiovascular damage later in life	67.05%	-Staff education -Outreach to patients with poorly controlled BP overdue for follow up appointments -Referral to health education/care team staff for self-management support -Purchase and dissemination of self-monitoring BP machines -Make Control the Goal resources from Quality Insights	69% patients diagnosed with hypertension whose blood pressure was adequately controlled during the measurement year **Restricting factors:** • Telehealth appointments • Missed appointments • Lack of documentation for repeat vitals

				-Training for repeat vitals and appropriate documentation	• Medication adherence concerns
Breast Cancer Screening	65%	UDS/HEDIS metric. Early intervention is possible if appropriate screening is completed	57.91%	-Implementation of expanded rooming processes to include standing order -Providing transportation to scheduled mammogram appointment -Outreach to patients overdue for screening -Enhanced education and awareness throughout the center	60% patients 50-74 years of age appropriately screened for breast cancer **Restricting factors:** • SDOH barriers • Lack of appointment availability • Lack of patient priority • Missed appointments
Cervical Cancer Screen	74%	UDS/HEDIS metric. Early detection and treatment can occur if screenings are completed as recommended	71.41%	-Chart scrubbing to identify patients overdue for screening -Outreach to patients overdue for screening -Referral to in-house Reproductive Health services -Addition of primary care providers -Enhanced education and awareness	60% women ages 23-64 appropriately screened for cervical cancer **Restricting factors**: • Reduction in face-to-face visits for preventive screenings d/t COVID • Missed appointments • SDOH barriers • Lack of patient priority • eCW limitations for standing orders
Referrals to BH for positive PHQ2	75%	Internal metric to increase BHC referrals and provide warm handoffs; to ensure use of services		-Staff education -Teams communication to access Behavioral Health team for warm hand off -Additional behavioral health staff added to team -Expanded rooming training for clinical support staff to initiate warm hand off	55% **Restricting factors:** • Staffing challenges • Patient refusal

Dental Sealants	50%	UDS metric. Children at moderate to high risk of caries will be lest likely to experience dental decay if they have sealants on first permanent molars	38%	-Addition of dental navigator to medical space to increase dental care provided during primary care visits -Mobile dental program implementation -Restarting of dental school program	47% **Restricting factors:** • SDOH barriers • Lack of patient priority • Missed appointments • Staffing challenges
Dental Treatment Plan Completion	44%	Percentage of patients with phase 1 treatment completion within 1 year of the creation of the treatment plan		-Staff training -Implementation of dental dashboard -Improved reporting	57% **Goal met!** v
ED Utilization	10% decrease	Patients complaints in the emergency department may be cared for by their RVHDC primary care provider or walk in provider. By increasing access to non-emergent care RVHDC patients can lower ED utilization	Avg 325 visits/month	-Follow up with patients following ED visit -Education provided to patients accessing the emergency department during office hours for non-emergent complaints -Additional providers -Care management referrals for high utilizers (3+ visits in 30 days) -Monthly meeting with emergency department -Enhanced education and awareness -Improved express care services -Education provided during ER follow up visits	Average 297 visits per month **Goal met!**
Immunizations for Adolescents	80%	Percentage of patients 13 years of age who had one dose meningococcal,	62.5%	-Staff education -Partner with Pfizer to provide outreach reminders to patients overdue for vaccines	86% **Goal met!**

		Tdap, and complete HPV series by their 13th birthday. Receipt of recommended vaccines is the best defense against vaccine preventable diseases.		-Adding vaccinations as part of scrubbing process -Enhanced education and awareness	
Medication Reconciliation	90%	Identifies accurate lists of medications patients is taking. Meaningful use metric and PCMH standard	73%	-Provider education -Workflow changes -Staff training -Creation of templates for coding -Expanded rooming process implementation	88% **Restricting factors:** • Staffing challenges • New staff • Telehealth visits • Missed opportunities
Hospital follow up	80%	HEDIS/PCMH standard. Ideally 75% of patients will be seen following hospital discharge within 7 days.	60%	-Additional primary care providers -Tracking of hospital admissions/discharges -Outreaching patients not scheduled following discharge -Coordinating care with hospital case managers to assist with transition of care from inpatient to outpatient facility -Care management referrals for patients with frequent hospital admissions/discharges -Implementation of TOC process utilizing staff RNs	68% **Restricting factors**: • Missed appointments • Lack of patient priority • SDOH barriers • Staffing issues
No Shows	23%	Missed appointments influence patient outcomes and the	30.7%	-Changes made to Missed Appointment policies -Close follow up to patients who miss appointments	17% **Goal met!**

		health center's overall ability to care for the community.		-Follow up within minutes from missed appointment to try to turn visit into telehealth visit -Planning of Missed Appointment class	
Visits with PCP	85%	PCMH standard to ensure continuity of care this metric monitors the percentage of patients seen by their PCP for the visit rather than an alternative provider.	75%	-Panel management -Re-assignment of patients from providers -New providers -Staff training and re-education on importance of appointments being scheduled with PCP -Blocks for specific appointment types	75% **Restricting factors:** • Staffing challenges • Lack of availability
SDOH screening	300 patients screened	HEDIS/PCMH standard to identify social barriers effecting patient health outcomes. Utilizing a standardized screening allows staff to connect patients to appropriate resources.		-Implementation of PRAPARE screening tool -Expanded rooming processes -Implementation of screening for all care management patients -Addition of community navigator	646 patients screened **Goal met!**

Patient Experience	Goal	2020 Data	Interventions	Outcomes 2021 Data
Medical I know how to get medical advice when the office is closed	85%	76.4%	-Text/email campaign reminding about after-hours access -Facebook page for promotion -Reinforced during visits/calls -Enhanced education and awareness	86% **Goal met!**
Dental Access – Wait time on the phone is satisfactory	96%	92.6%	-Staff education -Monitoring call volume -Customer service training	84% **Restricting factors:** -Staffing issues -Increased call volume
General Increase % of patients surveyed annually	5% increase in responses collected	831 responses	-Shortened survey -Staff education -Awareness on monitors/flyers -Text following appointments to complete surveys -Survey on tablets at check out -Monthly raffle for survey respondents	455 responses **Restricting factors:** -Lack of survey implementation first 6 months of the year d/t COVID -Lack of response on text follow up -Patient refusal

Ongoing areas of improvement:
-staff education/training
-documentation/implementation of standardized processes and procedures
-staffing challenges
-changes/challenges r/t COVID
-telehealth

Narrative Summary and Annual Evaluation
In 2021, RVHDC recognized improvement in many areas of quality while managing major challenges including the ongoing global pandemic. Quality measures were monitored throughout the year and through interventions/PDSA cycles many measures recognized improvement by the end of 2022. QA workgroup focused on metrics above and met goals in 7 of the metrics. Improvement projects implemented included staff education, expanded rooming processes, and enhanced point of care testing. Regular patient outreach for overdue services continues to close care gaps and improve metric rates. These interventions led to improvement in many metrics as noted above and meeting of quality goals. However, accurate data capture continues to be a challenge for our population.

COVID continues to influence population health outcomes. In 2021, patients were combatting social barriers that affected appointment compliance and overall health. Patients experienced barriers related to work, childcare, medication, financial insecurity, homelessness, and sickness. The care management team including two nurse care managers and a community health worker was implanted fall 2021 to assist with addressing these barriers and connecting patients to resources to meet their personal health goals while improving overall health outcomes. We look forward to seeing the care management program continue to grow and lead to more positive health outcomes for our population.

Specific initiatives have been decided for 2022 focus. Due to changing quality incentive programs metrics chosen for focus are related to the Uniform Data Set (UDS) but also HEDIS metrics included in incentive programs. Metrics such as medication reconciliation post-discharge and statin therapy in persons with diabetes are new areas focus for 20222 that are included in payer incentive programs. The QA team will continue improving use of the EHR to implement standard, efficient workflows that provide high quality care with accurate data capture. Improvement in team structure will continue in 2022.