

# Docs Need SOCs

## QI Tools for Primary Care



**Final report of the WVPCA Quality Improvement Project**

A joint project of the West Virginia Primary Care Association and the New River Health Association  
Funded by the West Virginia Bureau for Public Health

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**Coordinators Group:** Craig Robinson, MPH, New River Health Association  
Dan Doyle, MD, New River Health Association  
Jennifer Mead, MPH, New River Health Association  
Jennifer Boyd, PA-C, New River Health Association  
Lynn Legg, RN New River Health Association

**Work Group Participants:** Jewell Workman, RN, Community Health Foundation of Man  
Dennis Small, DO, WVSOM  
Mary Simms, LPN, Community Health Systems, Inc.  
Greg Elkins, MD, Lincoln Primary Care Center  
Augusta Kosowicz, PA-C, Roane County Family Health Care  
Mike Kilkenny, MD, Valley Health Systems  
Kenneth Seen, MD, Roane County Family Health Care  
Melody Rickman, RN, Appalachian OH-9  
Lana Stover, RN, Community Health Systems  
Linda Anderson, MPH, Valley Health Systems  
Gary Culver, PA-C, Lincoln Primary Care Center  
Barbara Batista, PA-C, Minnie Hamilton Health Care Center  
Judy Hamrick, LPN, Camden-On-Gauley Medical Center  
Cindy Hurley, RN, Rainelle Medical Center  
J. Michael Herr, DO, New River Health Association  
Pam Frye, RN, Lincoln Primary Care Center  
Rodney Fink, MD, Community Health Systems, Inc.  
Brenda Jarvis, RN, Roane County Family Health Care  
Shannon Sigley, Camdon-On-Gauley Medical Center

**Guest Participants:** Richard Crespo, PhD Marshall University  
Shawn Chillag WVBOH  
Beverly Begovich Carelink

WVPCA Quality Improvement Project, 1997-1998

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As the Coordinators Group, we feel good about the process and this product. But the proof will be in the outcomes.

# Contents

<b>Chapter 1</b>	Quality Improvement: The Four Steps	<b>Page 4</b>
<b>Chapter 2</b>	Death, Taxes, and Performance Measures	<b>Page 12</b>
<b>Chapter 3</b>	Beyond Measurement: Docs Need SOCs	<b>Page 18</b>
<b>Chapter 4</b>	The Right Stuff: Quality Improvement Tools	<b>Page 28</b>
<b>Chapter 5</b>	Redesigning Four Clinical Processes: Adolescent Preventive Screening, Pap Smear, Adult Triage, Diabetes	<b>Page 33</b>

# Chapter 1

## Quality Improvement: The Four Steps

### The Purpose of QA/QI

A health center sets its objectives and performance standards in accord with its particular community's needs, operational needs, financial well being and the requirements of its funding sources and payors. The Quality Improvement policy and procedures are designed and implemented to assure that the organization performs well those tasks that are important to its mission and objectives.

Although QA/QI system is important in holding an organization to its clinical objectives it should serve as an important management tool and help make the entire organization more effective and competitive. The QA/QI policies should help the board and management create and recreate an effective and efficient organization by setting and reinforcing objectives, stimulating training and education, identifying processes needing to be redesigned or re-engineered, and providing information for staff and departmental performance evaluation.

There are five basic areas or levels of a health center's activity where quality counts and where the quality process should be applied. These are presented in the table below:

Health Center Quality Areas	Questions Addressed by QA/QI Process
The Strategic	Do we understand community's health needs? Are we providing the right services and have the right facilities? Do we have appropriate linkages?
The Organizational	Do we have the correct staffing levels, management structure, administrative and financial policies and systems?
Access to Care	Do community members understand our services and can they get to them when needed? Are barriers to needed services low, including referral services?
The Process of Care	Do patients move through the center efficiently and obtain the services they need for both routine and urgent care? Is the patient-related information accurate, collected efficiently and does it get to the right people on time?
Clinical Decision Making	Are clinical judgements regarding the diagnosis and treatment accurate, and are health resources used appropriately? Are clinical protocols and systems of care, including case management, in place and followed?

## Quality Defined

Quality may be defined as doing the right things right and for the right price. That is, first, the quality process must include deciding on what the organization should do (e.g., provide x-ray services); second, determining if the service or activity is conducted in accord with standards (e.g., waiting time is low and x-ray interpretations are accurate); and third, the benefit of the activity must justify the cost and there must be resources to pay for it.

A 1974 policy statement on health care quality of the Institute of Medicine included a statement that quality assurance should lead to... “health care that effectively better the health status and satisfaction of the population, within the resources that society and individuals have chosen to spend for that care.” This definition is powerful because it includes the three points of focus that are key to a health service program’s success: health outcomes, patient satisfaction, and cost.

## The Quality Improvement Process

The quality process involves four steps:

1. Setting objectives (Deciding what we are doing here.)
2. Designing our process and procedures for accomplishing the objectives (Deciding who will do what and what tools are needed to meet the objectives.)
3. Measuring and evaluating our performance (Deciding how well our systems worked.)
4. Responding to what we learned about our performance.

### Comments on the Four Steps:

- All steps require management leadership and staff participation.
- Staff can be organized into departments, teams or workgroups to carry out the process.
- The sequence here is idealized. In fact, the process may start at different points. For example, we may have to start with performance standards imposed by a funding agency and then design the work process to meet the standard.

### 1. Setting Objectives

*“The doers must be planners.”*

Objectives are set at the several levels of organizational activity (from strategic to clinical decision making). Who sets the particular objectives depends on the level. Strategic and budget objectives are usually set by the board; organizational objectives are set by the management; and operational, program and clinical objectives may be set by departments or teams. Another name for objectives is performance expectations. Depending on established management processes and organizational culture various methods of participation in setting objectives by staff and customers can be organized. However, it is important that the staff does understand what is expected from them and how it relates to the overall mission and strategic interests of the health

center. Here are some additional ideas about objectives:

- Objectives should be in alignment with strategic and budget goals.
- Objectives should be set for departments and programs.
- Objectives should also be set for individual program and department leaders. (James Covey calls the individual objectives “Personal Performance Agreements”.)
- For objectives to have meaning specific people must feel responsible for them. Therefore, do be clear about who is responsible (a group or an individual). Include performance against the objectives (or expectations) as part of the regular staff evaluation.
- The BPHC Annual Health Plan format is a convenient tool for recording and organizing the health center’s objectives at all levels, including the personal performance agreements. Be sure to include the department or team that is responsible. (See Chapter 4 for a copy of the form).

## 2. Designing Processes and Procedures

Since we are advised by gurus of quality improvement and work process redesign that most quality or productivity problems can be traced to system problems rather than to individuals, it is important to understand how these work systems come to be and how they can be improved. (The gurus referred to include Edward Demming, whose ideas are explored in the 1986 book by Mary Walton titled *The Demming Management Method*; Peter Senge, who wrote *The Fifth Discipline Fieldbook*, 1994; and Michael Hammer, author of *Reengineering the Corporation*, 1994, and *Beyond Reengineering*, 1996. These books all offer lucid guidance to systems thinking and quality improvement that is highly relevant to primary care center operations.)

The way the work is actually conducted in a health center varies, depending on the particular task and the specific center. Some work can be highly structured and described by rules and written procedures or, alternatively, work processes can be basically made up by the people doing the work or done by the seat-of-the-pants. Much of the work in health centers is a combination of explicit procedures approved by management and of modifications and additions created by the people carrying out the work. The actual work process is frequently the result of informal negotiation among the involved parties.

The work of the staff assigned to billing, collections and bookkeeping tends to be very structured. The work of receptionists and nurses tends to be more of a mix of structure and self-direction. The process of clinical care and clinical decision making is usually left to the clinicians to figure out. If program expectations only relate to the number of patient visits or the amount of clinical charges, and the clinicians have bought into these objectives, such a system can appear to work. However, once you add clinical quality objectives—for example, that all abnormal pap smears receive appropriate follow-up or that 80% of the women over age 50 receive mammography every two years—the seat-of-the-pants system will probably not produce the result you need no matter how much the staff is admonished. Getting results will likely require more structure, such as explicitly describing the flow of work and the delegation of duties, developing forms or materials to assist in the work, training staff and monitoring performance.

Quality and effectiveness requires that health center management apparently head in opposite directions at the same time. On the one hand, meeting patient needs requires taking responsibility and exercising good judgement on the part of staff. The complex nature of the work requires that staff does exercise judgement and creativity all the time and the quality of those judgements are important to the organization's success. In fact, improved performance depends on expanding the areas for judgement on the part of staff and providing the necessary education, motivation and support for making sound judgements. The basis for sound judgement and creativity is identifying with the needs of the customer, understanding the health center's mission and objectives and feeling part of a team.

On the other hand, reducing variations from standards of care requires that we create explicit systems that describe how staff will conduct the work to assure that we meet a standard of care for a particular patient or group of patients. This explicit description of who does what work and what tools they will use is a System of Care. The process of creating the system of care involves obtaining both the input and agreement of key players. Developing systems of care are great opportunities for educating staff about health center objectives and building teams. The development of a SOC can involve identifying or developing tools for the clinicians and staff to facilitate the work. These can include patient assessment and scoring forms, patient education materials, descriptions of referral resources, or computer or manual case management systems. Frequently, systems of care require the re-design of work processes—sometimes radical redesign. The latter is referred to as re-engineering.

What is critical to grasp is that, if the health center sets a performance standard, whether on its own or in response to an outside entity, management must see that work processes are designed to meet the standard.

### **3. Measuring Our Performance**

*“Measurement is essential to recognizable achievement.”*

Measuring performance serves several important functions. It is the way to reinforce the objectives of the health center and keep everybody on track. It stimulates analysis and understanding of the work processes that allow the staff to meet the performance standard. It is how you determine if you have met the expectations of external entities. It is also the way to determine when you have succeeded and when celebration and accolades are in order.

Measurement requires several steps:

- Pick an *Objective* or area of operation that should be evaluated. Pick something important since there are limited resources for the quality process.
- Decide on a *Performance Measure* or *Indicator* that can be measured that is related to the objective or operations. For accounts receivable management the indicator might be number of days of AR over 90 days old by third party. For clinical care issues we refer to a “standard of care”. Standards of care are included in clinical practice guidelines or protocols. An example of a standard of care is that all women over 50 should have a

mammogram every two years.

- Decide on the *Performance Target* or *Criteria* for success. For the AR example, the criteria might be no more than 30 days of a third party's charges are over 90 days old from the time of billing. Or, for the clinical example, 80% of women aged 50-70 will have a mammogram within the two-year audit period.
- Decide on the *Audit Methodology*, which is the method of determining compliance with the criteria. The components of the method include what population or sample will be examined; how the data will be collected, recorded, tabulated and presented; and who does it. It may be that information is being recorded concurrently in a computer database and the required report can be produced automatically or data may have to be collected from medical records and then tabulated.
- Distributing the information to those responsible for acting on it and to relevant management or governing body.

Note that some audits will be done regularly according to a schedule in the QA/QI policy and some will be done in response to a one-time desire for performance information in a certain area.

#### **4. Responding To What We Learned**

*"If the effort does not result in action plans, it is probably wasted."*

It is the QA/QI Committee's job to report to the departments and/or health center teams, as well as to management, on their findings as revealed by the evaluations and audits it conducts and reviews. It is management's task to organize the response to problems or opportunities for improvement reported by the Committee. Management may be involved directly in making the necessary changes or delegate the issue to the department or create an ad hoc staff team to deal with the problem. It is usually appropriate to involve those staffers who are doing the work that is being evaluated in coming up with the solution.

There are a number of possible actions that management or the team may take to respond to a gap between actual performance and the standard. This response may involve one or more of the following actions:

1. Carry out additional analysis to get a better idea of the cause of the problem. Further analysis might involve surveying staff or patients to get ideas of the source of the problem or creating flow charts to help visualize present work process as well as to describe redesigned process.
2. Modify a procedure or policy description.
3. Change job descriptions.
4. Organize a training or education program for the staff involved.
5. Send staff to another center to learn another approach to the problem or talk to experts in the field.
6. Develop tools that will reinforce the standard of care in the actual practice situation such as an assessment form, a patient education packet or a program brochure.
7. Develop a System of Care that clearly describes the work process for meeting a clinical standard.

## **The QA/QI Framework**

To carry out a QA/QI process the health center needs to establish a framework that meets the needs of the organization and the requirements of the BPHC. The framework should be set forth in a policy statement. (See Chapter 4 for a sample Quality Improvement Policy.) Essentially, the framework involves a QA/QI Committee working closely with the departments, programs, and sites of the health center; a planning process also involving departments and programs; and the externally imposed standards.

## **The QA/QI Committee**

- A committee is formed by management with a charge to implement a QA/QI program. The committee should be interdisciplinary and may be made up of department heads or, in the case of small programs, the entire staff. There are some basic rules for the committee. It carries out its work with agendas and minutes. It establishes some method of decision-making and has a chairperson.
- The committee creates, and works from, a Calendar of Audits and Performance Reviews which includes standard audits done routinely every month, quarter, or year, and special audits.
- There is an Audit Form on which the audits are described and results and follow-up are noted.
- The QA/QI Committee reports go to management and the board.
- It is the Committee's job to see that the real work of quality improvement takes place at the department or program level or at the various clinic sites. The people delivering the services should be measuring their performance and analyzing the results and planning and implementing the response to discovered problems.

## **The Planning Process**

*“Strategy development is more about choice than analysis.”*  
*“Strategy implementation is more about commitment than correctness.”*

The health center has a planning process that is carried out by the health center that sets budget and program objectives, including objectives that are to be monitored by the QA/QI Committee. (This process produces the annual plan required by the BPHC.) All departments and staff should have an opportunity for input into the plan and have access to the final plan. Objectives for the annual plan may come from QA audits, from a group process involving teams and departments, and from review of the quality requirements of funding or regulatory agencies.

Use the planning format offered by the BPHC that calls for objectives, work tasks required for the objective, and progress toward meeting the objective. Use a budget format that can allow for input and review by the different departments, or programs and/or satellite health centers. That is create a budget based on cost and revenue centers as well as the categorical budget in the BPHC applications. Budgets should have meaning to the people doing the work and provide a basis for

evaluating the performance of the departments and programs that make up the health center.

The plan can and should be modified as the year proceeds and new objectives are developed and/or old ones become irrelevant. The plan can be the glue that holds together the creative forces of the organization and keeps the staff's focus on what is important to the health center's mission.

### **Externally imposed standards**

Quality standards imposed by funding or licensing agencies, or third party payors, should be integrated with the quality improvement policy and process of the organization. Although the imposed standards may sometimes seem irrelevant to measuring real performance, frequently they can be used to add weight and credibility among the staff to objectives that will serve the organization. The quality standards in the Primary Care Effectiveness Review (PCER) or those of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) provide excellent guidance for what to include in a health center's quality policy as well as in the annual health care plan. See Chapter 2 for a discussion of the quality and performance measures required at most primary care centers.

# Chapter 2

## Death, Taxes and Performance Measures

*“In order to fashion an integrated approach, the BPHC is committed to a single set of performance measures that integrates measurements important for the health care industry with measurements that are essential to document improvements in health status of the underserved.”*

**BPHC Improvement Collaborative RFP, April 1998**

“There are only two things in life you can count on: death and taxes.” So goes the saying. But for primary care centers, there’s another: Performance measures.

Unfortunately, this whole discussion is bedeviled by varying usage of some of the key terms. The purists insist on very specific definitions of the terms “structure”, “process”, and “outcome”. For them, performance measures are the same as process measures. See Chapter 4 “What is HEDIS?” in “Clinician Skills for Managed Care” for a discussion using that approach. But in this discussion we are referring to a broad set of requirements imposed on primary care centers by outside agencies. Some of these are “structural,” requiring the presence of certain staffing, facilities, committees and systems. Some of them are clinical quality indicators.

These external requirements fall into two broad categories:

- Those that are comprehensive, dealing with the overall primary care program such as are found in the PCER, the JCAHO accreditation, and the HEDIS (the Health Plan Employer Data Information Set, applied to managed care companies seeking NCQA accreditation). The PCER and the JCAHO accreditation process are discussed in detail below.
- Those related to categorical health programs such as Family Planning, EPSDT, Black Lung and School-based Health. These measures are often in the form of audit checklists to determine if the various required elements of the service have been completed and recorded on the proper form. A compilation of these is presented in Table 2.1.

A major challenge for primary care centers is how to integrate these external requirements into the internal QI life of the organization. We can and should make these measures work for us. If we treat them simply as bureaucratic busywork to be sent in, filed, and forgotten, we are missing an important opportunity. They are mostly well chosen and right on target with respect to important clinical and administrative issues.

Management teams and QI committees should review the sets of performance measures that apply to them and adjust both the Quality Improvement Policy and the Annual Plan accordingly. The Policy should include the quality improvement structure and processes as well as the specific audits required by the relevant external measures.

The Annual Plan should include objectives related to establishing certain policies, procedures or systems of care to meet the external performance standards. For example, if a performance measure is the provision of certain adult preventive health screening, and the health center is not satisfied that it has a medical record form that collects the needed information easily, the Annual Plan could include an objective for a team or person to develop a screening instrument that will facilitate compliance with the measure, and an objective for the QA/QI Committee to audit this indicator.

## **Comprehensive Measures**

### **JCAHO Accreditation**

Given the direction of the Bureau regarding accreditation and given the potential competitive benefits, health centers may want to consider aligning their quality program with the JCAHO standards even if accreditation is not sought immediately. The quality improvement sections of the JCAHO accreditation process for ambulatory care focus almost exclusively on process and structural standards and are consistent with sound management practices. JCAHO standards do not include specific clinical outcome measures (e.g. percent of patients with cardiovascular risk assessments), such as are included in the PCER, although the health center's QI process will include setting or identifying appropriate specific performance standards. On the other hand, the JCAHO standards are explicit and demanding regarding the administrative systems and processes that must be in place and operational. The JCAHO 1996 Accreditation Manual for Ambulatory Care-Standards Section covers quality improvement in the sections dealing with Organizational Performance and Leadership and call for the following systems and processes related to quality improvement:

- A plan in place for process design, performance assessment and improvement;
- Explicitly described processes of care to assure that standards are met;
- Measurement of processes of care is carried out systematically;
- Conclusions are drawn about the measurement of performance; and
- Systematic improvement of performance and a clear record of improvements.

The standards also require evidence that certain leadership responsibilities are carried out related to quality improvement including:

- An organizational plan is developed and communicated throughout;
- A planning process that includes setting performance improvement priorities;
- An annual budget is prepared and budget performance is monitored;
- There is a process for monitoring variations in patient care;
- A program exists for recruitment and developing and educating staff;
- There is a process for credentialing and authorizing professionals to perform specific procedures and services;
- Make formal arrangements for needed services not provided by the organization; and
- Promote cooperation and communication throughout the organization.

## **Primary Care Effectiveness Review (PCER)**

The clinical section of the PCER is actually much more specific in its requirements for health centers than the JCAHO standards. It also includes administrative requirements but, in addition, requires specific tracking processes and, of course, detailed clinical outcome measures. The PCER reflects the fact that the BPCH has set specific clinical outcomes for the various life cycles for health center users and has specific population-based objectives such as the improvement of immunization and HIV case finding rates. JCAHO, on the other hand, is focused almost entirely on the process of care for the individual patient and the organizational structure within which that care is provided and leaves it to the practice to set any specific clinical objectives.

The PCER quality requirements are more easily understood if they are organized into the three types of quality measures: Organizational, Process and Clinical Outcomes. (Note that this is not how they are organized in the Bureau's protocol.)

### **Organizational Measures:**

- Services, hours, and staffing meet program requirements;
- There is a Health Care Plan, that is comprehensive in that it deals with all lifecycles and with community health needs, and that is monitored by the quality management program of the center.
- There is committee that is charged with implementing the quality management program and functions according to a relatively formal structure and there is a record of its work and decisions;
- The organization has established functioning workgroups or teams that carry out work, that meet regularly to set objectives and evaluate progress, that coordinate with management and each other, and that have both an external and internal customer focus;
- Formal linkages or arrangements with outside resources and referral services; and
- Organizational and policy standards are met for ancillary services including pharmacy, radiology, laboratory, dental and hospital care.

### **Process Measures:**

- A credentialing process that meets FTCA requirements;
- A patient complaint procedure is in place;
- Patient Tracking and Recall systems for over 20 different clinical situations;
- Preventive health schedules and strategies for the five life cycles and oral health, immunizations, violence and abuse, TB, HIV and other STD screening and treatment;
- Clinical protocols are in place for certain chronic and acute diseases;
- Medical Record format and use meets detailed standards; and
- A professional orientation and continuing education program is ongoing that covers specified topics and access to needed clinical information by center providers is assured.

## Outcome Measures:

- Waiting time;
- Clinical Outcome Measures are evaluated for the five lifecycles -- perinatal, pediatric, adolescent, adult, and geriatric; and
- Reports on the performance of the tracking systems.

## Categorical Measures

The quality measures for categorical health service programs are usually embodied in checklists used either by outside or in-house auditors who review a portion of the charts of patients who have received the categorical health service. Family planning, EPSDT, Breast and Cervical Cancer Screening are examples of programs using such audit checklists. The health centers face a challenge in meeting the service requirements of all these preventive health programs while integrating them into a seamless system of comprehensive primary care services. Each program has special requirements in the following categories: patient assessment including medical history, testing and physical exams; health education and/or anticipatory guidance; follow-up on identified problems; and record keeping. The challenge presented by these requirements can be met by creating a simple system of care. Although the System of Care model is discussed more fully in Chapter 3, for categorical programs the process of establishing a system that meets the standards efficiently and with high patient satisfaction involves the following five steps:

- Management creates a Team (e.g., the Family Planning Redesign Team) that includes staff involved with providing the services from providers to front desk people and gives the team a “charge” (objective), a deadline, and provides time and resources for the team work;
- The Team reviews the program performance standards and evaluates the present health center process for providing the service, using flow charts, etc., and identifies problems and opportunities for improvement;
- The Team designs a process to meet the standards and satisfy patients (should address delegation of tasks, staff training needed, forms and other tools needed);
- The new process is given a trial run, evaluated by objective and subjective means, and modified as needed;
- Redesigned process put into service and the Team meets periodically to assess performance.

Table 2.1 presented here lists the various sets of performance measures related to categorical programs. Specific requirements and formats for these reports can and should be obtained from the specific funding agencies.

Table 2.1

### Quality Improvement/Assurance Requirements for Primary Care Centers

Program	Agency	Reports	Forms/Tools Used	Frequency	Who Audits
330 CHC	DHHS/BPHC	Clinical Outcome Measures	COM Forms	Annual	Internal
330/CHC	DHHS/BPHC	PCER	Checklist	3 years	External
330/School Health	DHHS/BPHC	None	NA	NA	NA
Rural Health Clinic	DHHS/BPHC	Program Review and Plan	Checklist	Annual	External
Primary Care Grants	WVBPH	Performance Measures	Checklist	Annual	Internal
Family Planning Program	WVBPH	Chart Audit	Audit Checklist	Annual	External
Cancer Control Program	WVBPH	Chart Audit	Audit Checklist	Annual	External
EPSDT	WVBPH	Chart Audit	Audit Checklist	Annual	External
Black Lung Clinics	WVBPH	<i>Annual Report</i>	<i>Report Form</i>	Annual	Internal
Medicaid Managed Care	WV-DHHR	MCO's submit report on indicators	Medicaid HEDIS Form	Annual	Internal
Other Managed Care	NCQA	HEDIS	HEDIS Forms	Annual	Internal
JCAHO-Accreditation	JCAHO	Audit Report	Manual for Ambulatory Care	3-year intervals	External

### A Glimpse of the Future

As indicated by the quote at the start of this chapter, the leadership of the federal Bureau of Primary Health Care (BPHC) is grappling with how to develop and deploy a single set of performance measures and how to teach the best available quality improvement practices and tools to help health centers survive. Toward these ends they are investing in at least two major quality strategies:

1. The merger of the Bureau's PCER with a national accreditation process (JCAHO) as a way to provide health centers with additional standing or credibility with managed care companies and consumers; and
2. Providing assistance to clusters or networks of health centers in developing systems of care (reengineering) to enable them to meet important clinical objectives and improve their competitive position.

"Breakthrough Collaboratives" are one form of this re-engineering approach. The purpose of the "Breakthrough Collaboratives" is for groups of health centers to work together to radically

change the process by which certain care is provided to achieve dramatic improvements in patient satisfaction and clinical performance. Breakthrough Collaboratives have been launched to address diabetic care and to redesign the patient visit for the purpose of dramatically reducing waiting time. Others are envisioned for infant mortality, adult and pediatric immunizations, cardiovascular disease, HIV, and cancer prevention.

The Breakthrough Collaboratives are organized by the Quality Center of the BPHC with technical assistance from the Institute for Healthcare Improvement of Boston. Implicit in this initiative is that the Bureau has concluded that significant improvements in health center services require substantial effort in designing and implementing new processes of care (involving more delegation, systematic approaches to assessment and patient education, and appropriate use of new technologies.) Furthermore, such efforts require central support and technical assistance and the sharing of experience and insights among several centers. We would say they are identifying and redesigning key processes and fitting them together to form systems of care (SOCs). Chapter 3 presents this SOC approach in detail.

# Chapter 3

## Beyond Measurement: DOCS Need SOCS

### The What and The Why

A system of care (SOC) is a detailed and systematic plan by which health services are delivered for an important health care condition in a particular setting. The SOC describes how health services are organized, provided, and monitored; it specifies roles, processes, tools, and record keeping. Unlike a Practice Guideline, which arrives broadly applicable standards and procedures for a health condition, a SOC is about how we will actually get the job done HERE. In our setting. With our people. With our unique strengths and limitations. Our concept of a SOC is that it starts where Practice Guidelines leave off. In fact, we consider SOCs to be "the missing link" from Practice Guidelines to actual practice.

Docs need SOCS. That is, our health care teams need systematic and detailed plans, plans that are actually followed, for important clinical problems in order to achieve dramatic improvements in process and outcome.

There is a philosophy that the way to achieve quality health care processes is to hire well-trained and conscientious physicians and get out of their way. Abundant health services research demonstrates the flaw in this approach. Good people can fail in bad systems. We believe even the best docs need SOCs.

To achieve effective and efficient systems of care REDESIGN is needed. In fact, the SOC planning process can and should be thought of as a redesign tool. Health care teams must identify important health care problems, identify the key processes of care for these problems, redesign these processes where necessary, then weave them into an overall efficient and effective system of care. The awareness of the need for redesign is becoming pervasive in American industry as it strives to remain competitive in the global economy. We are all discovering that the public sector of primary care is not immune from these global economic effects.

The Bureau of Primary Health Care (BPHC) of the Public Health Service has embarked on a major redesign QI initiative in collaboration with leading groups in the HMO industry such as the NCQA and the Institute for Health Improvement. This initiative is taking many forms including the funding, of "Breakthrough Collaboratives" (network redesign projects) for the patient visit and for diabetes care. More are planned. A BPHC Quality Center has been formed. This effort also includes major revision of the

"Clinical Outcome Measures" to be more aligned with HEDIS indicators and more tied to redesign and the achievement of "dramatic improvement". The BPHC along with its private sector partners is sending us a very

clear message: Measurement is not enough. Redesign and reengineering to achieve dramatic improvements in quality are required to remain competitive in the current era.

## **The Soc Planner**

So how do you actually do it? Essential ingredients are determination, teamwork, cooperation, imagination, and just the right amount of technical assistance (outside ideas). Trial and error. Blood, sweat, and tears. It's a process that takes so much effort, that you want to pick your targets and pick your path very wisely. The "SOC Planner", Figure 3.1, is a tool to help guide your teams through the SOC design process.

## SOC Planner

**Table 3.1**

The eleven steps of a SOC are listed in the table below. The format of the table allows its use in SOC development, SOC description and self-evaluation.

	<b>Present?</b>	
	<b>0-2</b>	
<b>1. Well-defined health problem</b>		
<b>2. Standards of Care that are evidence-based</b>		
<b>3. Staff Agreement on Objectives and Interventions Analysis of Costs and Preparation of Budget by Management</b>		
<b>4. Decision whether to Proceed</b>		
5. Interdisciplinary Team with clear staff roles		
6. Well-defined patient education modules and patient involvement		
<b>7. Presence of necessary tools to accomplish care</b> Case finding and tracking Patient assessment tools Treatment guidelines Medical Records: Uniform notation and flow sheets Referral resources and process		
<b>8. Care provided according to standards</b>		
9. System of care coordination in place with tracking		
<b>10. Periodic measurement and reports</b>		
11. Regular staff education and program revision based on evaluation from step 10		

(0=not at all; 1=partly; 2=fully)

Items in bold are required for a Basic SOC.

Items not in bold are added over time to achieve an Advanced SOC.

This SOC Planner can be used in several ways. First, it's a list. The 11 steps defined here are ones that we have found important in planning and redesigning systems of care. We consider 7 of these steps (the ones in BOLD print) to be essential requirements of a Basic SOC. We consider the other four (5, 6, 9, 11) to be highly desirable but able to be added later.

Second, it's a planning tool, a brainstorming tool for the planning process. Column 3 of the table (the wide blank area) can be used to scribble thoughts and ideas as you work individually and together to plan your systems. When you reach consensus about important parts of your system, type up a draft on this form and distribute it at a team meeting to stimulate further discussion.

Third, it's a format for compact description of your completed SOC. At the end of this section are examples of actual SOCs developed by work groups for Diabetes, Tuberculosis, Chronic Pain, and Indigent Drug Programs. Note that each of these SOCs has attachments that describe numerous tools and processes that are parts of the larger system. These are not included here. We have also included a process diagram developed by a workgroup seeking to redesign and improve the process of breast cancer screening. Tools to describe, diagram, and analyze processes are found in the "Memory Jogger" Q1 book which is being distributed with this manual to WVPCA clinical leaders (Medical Directors, DON, Administrator). Remember that the SOC Planner is a broad overview of a system of care. Within that system, there may be a few or many distinct processes, all of which should be identified, some of which may need major redesign.

Fourth, the SOC planner can be used as a self-evaluation tool. Column 2 is titled, "Present? 0-2". The purpose of this is to allow evaluation of where your group is in the development of each SOC element and thus where more work is needed. A good group process is to ask each member of a workgroup or team to complete this self-evaluation then to share and discuss responses. This is what the four WVPCA QI workgroups did as their first step in SOC development. Their reports are presented in Chapter 5. Likewise, you can see how the NRHA workgroups evaluated progress for each element in two of the examples provided here.

### **Pick the Problems Carefully**

Which clinical conditions should you design SOCs for? It depends on the population you serve, identified subgroups within that population, and the special needs of those subgroups. Certain payors and funding agencies require you to meet performance measures for conditions such as Diabetes, Prenatal Care, Asthma, Cancer Screening, Pediatric Immunization. These are excellent potential topics. But your clinical teams or management may perceive the need in your center for other SOC initiatives. This part of SOC development fits very well with the Community-Oriented Primary Care (COPC) approach used by many health centers for community diagnosis and program planning.

One way to think about picking problems for SOC design is shown in Table 3.2, SOC Sorter.

Table 3.2

### SOC Sorter

	<b>Acute/Curative</b>	<b>Preventive</b>	<b>Promotive</b>	<b>Rehabilitative</b>
<b>Perinatal</b>		Prenatal Care	Right from the Start	
<b>Peds</b>	Asthma Pediatric Triage	Immunizations		
<b>Adolescent</b>	Mental Health Services	Guidelines for Adolescent Preventive Services (GAPS) Behavioral Risk Intervention Screening		
<b>Adult</b>	Adult Triage	Breast Cancer Screening Cervical Cancer Screening Diabetes Care		Chronic Pain, including use of Controlled Substances
<b>Geriatric</b>		Geriatric Functional Assessment (GFA)		

The column Headings for this table come from the World Health Organization definition of Primary Care. The Row Headings come from the U.S. Public Health Service "Life Cycle" concept.

Usually SOC's are developed only for health problems that are serious, prevalent and require high intensity or effort.

In this table, possible SOC topics are classified by life cycle and by dimension of primary care. Such an approach is useful because it can help your team identify important clinical issues that span the full spectrum of primary care. You can't design and consistently apply SOC's for everything. But it makes sense to select clinical problems that address the needs of different life-cycle groups and meet the challenges of different dimensions of primary care.

The actual topics included in this table are important. They come from topics given high priority by the WVPCA clinical leaders who were polled during this project and by ongoing, NRHA clinical QI efforts. But they are just one of many possible sets. Just as interesting would be use of this SOC Sorter to classify the HEDIS Clinical Quality Indicators or the BPHC Clinical Outcome Measures.

## SOC Planner: Diabetes

Present?

0-2

<b>1. Well-defined health problem</b>		High prevalence of DM in NRHA Service area and WV. Demonstrated shortcomings in process of care and intermediate outcomes for NRHA diabetic patients. Limited resources (Insurance, Dieticians, Ophthalmology).
<b>2. Standards of Care that are evidence-based</b>		None presently available. Most widely accepted are American Diabetes Association Standards of Care. (A1) Carelink Standards also used. (A2)
<b>3. Staff Agreement on Objectives and Interventions Analysis of Costs and Preparation of Budget by Management</b>		Done in 1983, 1987, 1991 but required on ongoing basis, at least every two years. NRHA participates in the R & B RHEP Diabetes Self-Care Clinic Project (DSCC) which developed consensus guidelines among four practices. (A3) Also WVPCA QI Project and WV Comprehensive Diabetes program.
<b>4. Decision whether to Proceed</b>		
5. Interdisciplinary Team with clear staff roles		UC is patient, provider, nurse. DSCC care includes pt, support person, provider, nurse educator.
6. Well-defined patient education modules and patient involvement		Multiple materials available and in use at NRHA including DSCC educational materials. But a well-defined set of educational materials is lacking. The scope of DM education is very broad. A diabetes support group met for several years in 1985-1991.
<b>7. Presence of necessary tools to accomplish care</b> 7a. Mechanism for case-finding		UC: Standard Facility and Process Tools are all available except Dietician/Nutrition. DSCC: adds additional tools, including Visit Sheet Protocol, computer tracking, Self-Care Report, and Care Plan Self Care Record. See DSCC Manual (A4). Also sulfonylurea failure criteria and management.
<b>8. Care provided according to standards</b>		Care is ongoing both as UC and 2-3 DSCC sessions/month.
9. System of care coordination in place with tracking		No. But this is needed and feasible. Ideally, care coordinator should be a CDE who supports groups of rural clinics with functions of education, coordination, tracking, and education.
<b>10. Periodic measurement and reports</b>		UC: Periodic student audits 1983, 1987, 1994, 1995. Large Marshall-Benedum study 1997 N=1158 (NRHA 259) DSCC: Computer database provides ability for detailed performance reports. Limited use so far.
11. Regular staff education and program revision based on evaluation from step 10		UC: SOC Process 1997 DSCC: Major revision, improvement Approximately 1x/year CPG CME on focused DM topic, e.g., sulfonylurea failure. In light of performance on 1997 Marshall Audit, more CME needed.

(0=not at all; 1=partly; 2=fully)

Items in bold are required for a Basic SOC.

Items not in bold are added over time to achieve an Advanced SOC.

**Definitions:** Diabetes FBS x 2 ≥ 140  
DSCC = Diabetes Self Care Clinic  
UC = Usual care (never seen in DSCC)  
CDE = Certified Diabetes Educator

Original: 6/7/97  
Revised 8/10/98

## SOC Planner: Indigent Drug Programs (IDP)

Present?  
0-2

1. Well-defined health problem	2	Approximately 35% of NRHA patients (1,000 Medicare + 3,386 uninsured) have no coverage for medications and thus are often unable to pay for needed medications. Indigent Drug Programs (IDP) exist but create heavy paperwork and phone burden for providers and nurses.
2. Standards of Care that are evidence-based	2	Abundant evidence demonstrates that patients suffering from many acute and chronic diseases enjoy increased survival and quality of life with appropriate drug therapy. Examples include Diabetes, HPN, CHF, Pneumonia, Asthma, Peptic Ulcer disease, and Depression. Therefore, the standard is that patients should receive all medications of proven benefit for their respective acute and chronic conditions.
3. Staff Agreement on Objectives and Interventions Analysis of Costs and Preparation of Budget by Management	1	See HEAT minutes from 7/30/97 for consensus principles concerning IDP. Also see NRHA pharmacy special fund formulary list. Within the HEAT team, there were different opinions on the most effective intervention to meet the practice need for advocacy functions related to IDP.  <b>Option A:</b> Supported by the majority and currently in effect is that nurses should play a major role in carrying out these advocacy functions.  <b>Option B:</b> (See attached proposal by E. Stollings, PA-C) is that a full-time IDP manager/care coordinator should be appointed.
4. Decision whether to Proceed	1	A <i>de facto</i> decision to proceed has been in effect since at least 1993. Option B would require additional decision.
5. Interdisciplinary Team with clear staff roles	2	The ID team in this case includes the patient, nurse, provider, and pharmacy. Any team member may identify the need for IDP. Nurses work with providers and patients to complete all necessary paperwork. The NRHA pharmacy fills IDP prescriptions, provides IDP information to staff, and manages the special fund. Bonnie Tilley, RN, plays a leading role in IDP management at North Fayette. The nurses distribute and log free samples as they are distributed.
6. Well-defined patient education modules and patient involvement	1	Patients are taking an increasing role in completing necessary paperwork: "self-advocacy" and "the patient as a producer."
7. Presence of necessary tools to accomplish care 7a. Mechanism for case-finding	1 1	*Central file of forms and information at or near nurse station. NRHA Special Fund. Free Samples Closet. (There is no systematic effort at case findings at this time. As noted under Item 5, all team members are involved in this.)
8. Care provided according to standards	1	No defined measures so far. Patients in need of IDP are identified by any and all members of the team. Special Fund is used only for Formulary Drugs.
9. System of care coordination in place with tracking	0	Option A: No care coordinator but "yes" to "in-house expert." This is Diana Neal at NR Scarbro and Bonnie Tilley at NR Lookout.

<b>10. Periodic measurement and reports</b>	1	There are no specific measures so far. Ideas for system monitoring include volume reports from specific IDPs such as Pfizer. NRHA pharmacy does special fund report to management team monthly. NRHA pharmacy reviews special fund formulary yearly. Stay tuned for feedback from patients, nurses, providers, and pharmacy.
11. Regular staff education and program revision based on evaluation from step 10	1	IDP SOC should receive annual review as part of the pharmacy report to the QI committee. New River pathway for IDP SOC can be used for staff education.

(0=not at all; 1=partly; 2=fully)

Original: 7/30/97 revised by HEAT Team 2/18/98

Items in bold are required for a Basic SOC.

Items not in bold are added over time to achieve an Advanced SOC.

**Attachments:**

1. HEAT Consensus Statement
2. Special Formulary List
3. Eric Stollings, Care Coordinator proposal
4. New River Pathway for Indigent Drug Program

## SOC Planner: Chronic Pain

Present?  
0-2

<b>1. Well-defined health problem</b>	2	From CP-IDT (Chronic Pain-Interdisciplinary Team) Problem Statement and Objectives. High prevalence of opiate dependence. Need for NRHA (New River Health Association) guidelines and SOC for chronic pain. (A1)
<b>2. Standards of Care that are evidence-based</b>	1.25	None available for chronic non-malignant pain. CP-IDT has collected, reviewed, and adapted guidelines from WV Board of Medicine and national organizations. See also NRHA Chronic Pain Guidelines. (A2)
<b>3. Staff Agreement on Objectives and Interventions Analysis of Costs and Preparation of Budget by Management</b>	1.75	Meetings held with NRHA staff in 1994 and 1997 to discuss (DUCS) criteria and Draft Guidelines.
<b>4. Decision whether to Proceed</b>		
5. Interdisciplinary Team with clear staff roles	1.75	CP-IDT meets monthly. Much student participation. Better differentiation of roles and more active consultation between meetings are goals.
6. Well-defined patient education modules and patient involvement	1	Multiple tools have been created and are in use. Opiate withdrawal (A3), Benzodiazepine withdrawal (A4), and Intervention Contract (A5). Chronic Pain Support Group 2/96.
<b>7. Presence of necessary tools to accomplish care</b> 7a. Mechanism for case-finding	1.25	DUCS Audits, IDT and Meetings, Chronic Pain Library and Resource List (A6). Intervention process and contract. Case register and records. Full case finding is difficult.
<b>8. Care provided according to standards</b>	1.5	Care is ongoing and is continuously monitored by the NRHA interprovider audit and monthly CP-IDT case reviews.
9. System of care coordination in place with tracking	0	Limited care coordination provided by CP-IDT via monthly case presentations, care plans, and tracking. Care coordination of entire population at risk is not feasible.
<b>10. Periodic measurement and reports</b>	.75	CP-IDT monthly case conferences and follow-ups, occasional studies: 1994 Rohrer and Oyco (A8). NRHA interprovider audit.
11. Regular staff education and program revision based on evaluation from step 10	1.25	Problem Statement and Objectives revised 9/95, 10/96, 2/97, 4/97. Provider curriculum under continuous development (A9) and partly presented to staff 12/11/96.

(0=not at all; 1=partly; 2=fully)

Original: 6/7/97

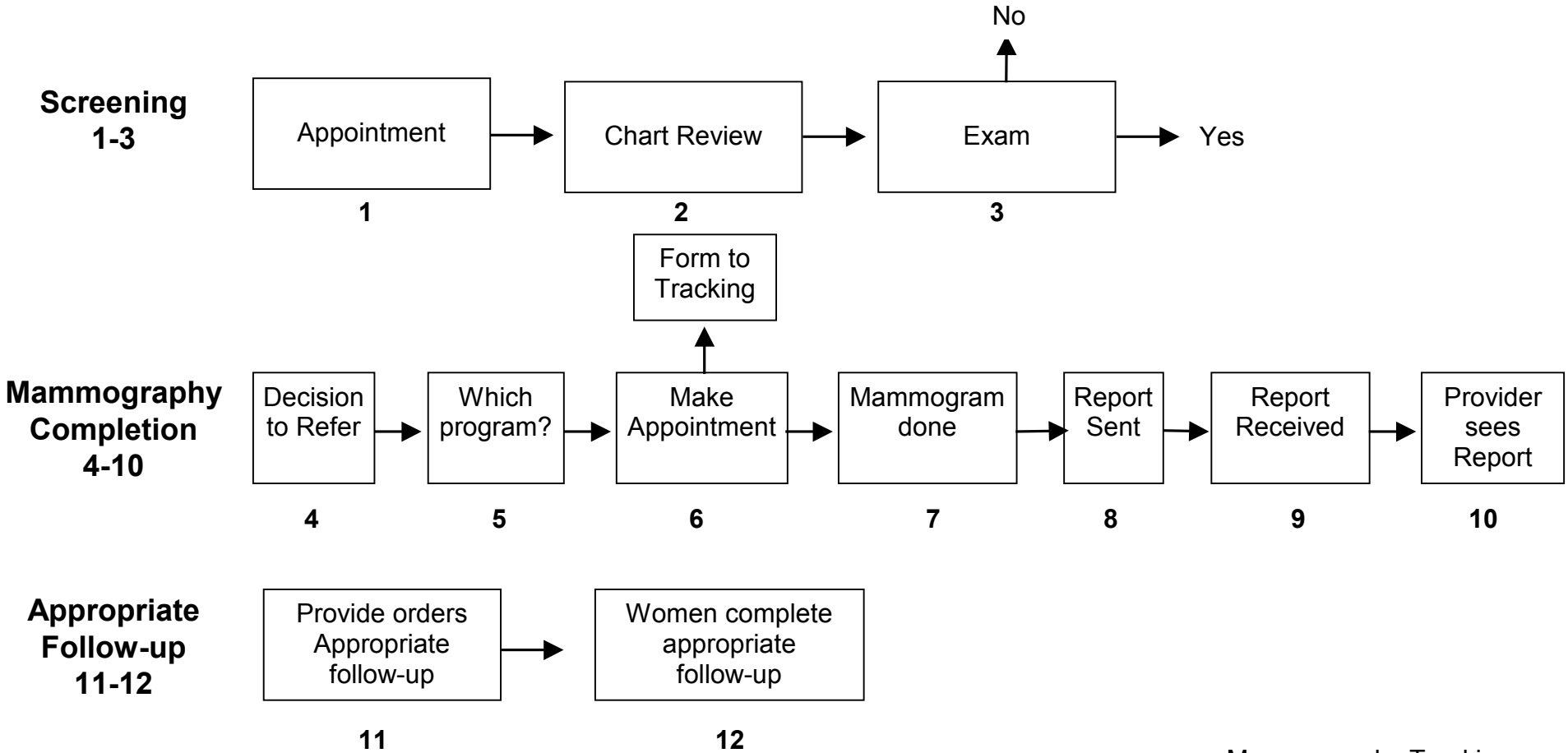
Items in bold are required for a Basic SOC.

Items not in bold are added over time to achieve an Advanced SOC.

Rankings in Column 2 ("Present 0-2") are based on independent rankings of NRHA CP-IDT members. 3/96 (N=4)

Letters (A1-A9) in parentheses refer to separate documents and instruments that would be attached to this cover sheet for full SOC documentation.

# Flow Chart for Breast Cancer Screening and Appropriate Follow-up



Mammography Tracking  
Workgroup: 11/1/95

# Chapter 4

## The Right Stuff: Quality Improvement Tools

### Introduction

You need the right tools for the job. “The job,” in this case, is the whole QI process we have been describing. Like any complex and technical job, having the right tools and knowing how to use them will be a determining factor in success.

The concept of “QI Tools” is extremely broad in scope. Some, you might take for granted. Examples are process tools to facilitate work group meetings and task completion, communication tools (office mail, e-mail, Intranet) to bind work groups together, and presentation graphics to convey complex ideas about data and redesigned processes. Nothing can be taken for granted.

Other QI tools include planning models, budget formats evaluation schemes, scheduling systems, model QI policies, checklists, forms for specific tasks, report formats for external requirements, specialized software.

Finding the right tools can be a chore. Sometimes you have to invent your own, custom-made for the particular QI task at hand. But often there are good tools and instruments already out there, in the public domain, which you can obtain and adapt to your particular need. It’s much more cost-effective to borrow the best and modify it than to spend valuable staff time reinventing the wheel. Patient satisfaction surveys and employee satisfaction surveys are good examples.

In the remainder of this chapter we offer a set of such QI tools. This set is neither systematic nor comprehensive. Rather, it’s a careful selection of some things we have actually seen work well or we know to be essential. We hope this will be a first step in a continuing process of “tool-sharing” among primary care centers by which we share our best finds and creations. With the WVPCA, we hope to develop a Web site with a systematic classification of tools to facilitate this sharing process.

### Quality Improvement Tools

#### 1. Model Quality Improvement Policy

Provides a model for health centers to use in formulating their quality improvement policy. The model incorporates the BPHC and JCAHO requirements and addresses the QI Committee, recurring and special audits, credentialing, patient complaints, and mid-level practitioner supervision.

## **2. QA Audit Planning Form**

A form for use in planning and presenting a quality performance audit.

## **3. QA Audit Example**

A completed Audit Planning Form examining performance with respect to follow-up on abnormal mammograms.

## **4. The BPHC Annual Plan Format**

The BPHC format for the annual health care plan. can also be used for organizing and presenting departmental and personal performance objectives. This example addresses the problem of immunization rates.

## **5. Provider Performance Audit Form**

A description of the procedure for conducting regular provider performance audits, including selection of records, feedback to providers, and reporting.

## **6. Provider Performance Audit Procedure**

A description of the procedure for conducting regular provider performance audits, including selection of records, feedback to providers, and reporting.

## **7. Evaluation Guide for Health Center Leaders and Supervisors**

A sample format for evaluating department heads, program directors, and other management in a health center. The guide reflects the need for quality improvement-related competencies in health center leadership.

## **8. The BPHC Clinical Outcome Measures**

The list of Clinical Outcome Measures for each of the five lifecycles (perinatal, pediatric, adolescent, adult and geriatric). Audits are to be conducted and reported annually.

## **9. The HEDIS 3.0 Reporting and Testing Set Measures (<http://www.ncqa.org>)**

Presents the measures to be reported on by managed care plans seeking NCQA accreditation or who are otherwise required to report on HEDIS measures. Presents those measures that are now being used to evaluate health plans and those that are being tested for possible inclusion. The HEDIS may apply to health centers in so far as they contract with managed care companies that are required to report on these measures.

## **10. The Quality Assurance Calendar**

A sample grid for planning and tracking all of a health center's performance audits.

## **11. and**

## **12. Patient Satisfaction Surveys**

Samples of patient satisfaction surveys. Note that the second survey is offered by the Partners in Health Network, which will scan completed survey forms into a computer database and provide quarterly reports for health centers for a fee of \$250 per year.

## **13. Staff Opinion Survey**

A sample survey for discovering strengths and weaknesses of a health center related to staff perceptions of their work environment. Meets JCAHO requirements.

## **14. Health History and Risk Assessment Data Collection Forms.**

Sample medical record forms to facilitate collecting clinical and psycho-social information on patients in each of the five life cycles. The forms collect information for several purposes: to identify preventive health needs of the particular patient; and to identify health problems or risks that may require more intensive case management (particularly important if the health center has some financial risk for the total cost of care.) the forms also are designed to facilitate compliance with the BPHC Clinical Outcome Measures and the JCAHO requirements for routine preventive health screening.

## **15. Principles of Graphical Excellence**

From Tufte, Edward R. *The Visual Display of Quantitative Information*. p. 51, Cheshire, CT: Graphics Press, 1983.

## **16. Integrated Service Agreement**

The sample Integrated Service Agreement provides health centers, or health center networks, with a format for establishing formal relationships with some referral service providers to improve the integration of health services and assure access to needed specialist service.

## **17. Preventive Health Schedules and Data Collection Forms**

Three medical record forms for guiding compliance with Preventive Health Schedules for Children, Adolescents and Adults, and Patients over Age 65. Provides a grid that facilitates preventive health data collection and retrieval services. The actual content of the agreement depends on the service and the specific objectives of the health center. This format would meet PCER and JCAHO requirements for evidence of integration with services needed by patients, but not provided by the health center.

## 18. Clinic Referral Form

A sample three-part form for making and tracking specialist referrals or referrals for diagnostic tests or treatment procedures. This form was modified from the original model developed by the WVU Office of Health Services Research. It is relevant to referral management for managed care purposes and to BPHC and JCAHO tracking and case management requirements.

## Other References and Tools

1. *The Memory Jogger II: A Pocket Guide of Tools for Continuous Improvement and Effective Planning*. Brassard and Ritter. Methuen, MA: Goal/QPC, 1994. Telephone: 1-800-643-4316. Web site: <http://www.goalqpc.com>.
2. *How To Make Meetings Work*. Doyle and Straus. New York: Jove Publications, 1982.
3. *Clinician Skills for Managed Care*. Doyle. Morgantown: WVU Offices of Rural Health, 1997. Telephone: (304) 293-6999.
4. *The Team Handbook, Second Edition*. Sholtes. Madison, WI: Oriell Inc., 1996. Telephone: 1-800-669-8326.  
Excellent comprehensive step-by-step guide to the development and operation of teams engaged in quality improvement and process redesign.
1. *Reengineering The Corporation and Beyond Reengineering: How The Process-Centered Organization Is Changing Our Work And Our Lives*. Hammer. New York: HarperBusiness, 1993 and 1996.  
The principles and practice of reengineering key processes really do have great relevance to creating effective and competitive health centers. These books provide inspiration and direction.
2. *The Complete Idiot's Guide to Project Management*. Baker. New York: Alpha Books, 1998.  
Making improvement in health care services usually comes down to projects, both small and large, carried out by teams. In fact, much of health center management can be understood as project development and management. Despite the insulting title, this book provides lots of helpful guidance on how to plan and implement projects that meet your objectives within the budget.

## Computer Software for Quality Improvement

The NRHA has developed the following database programs to assist in meeting various quality objectives. These are available to health centers who want to build tracking processes around electronic tools. Contact Craig Robinson at the NRHA (304) 469-3348.

- **Abnormal PAP Smear Tracking and Recall.** Database: Microsoft Access.
- **Diabetic Self-Care Clinic Tracking and Recall.** Database: Microsoft Access.
- **Immunization Tracking and Recall.** Database: Microsoft Access.
- **Database for Collecting and Analyzing Staff Survey Data.** Database: Epi Info.
- **Database for Collecting and Analyzing Provider Performance Audits.** Epi Info.

Also note that the **Centers for Disease Control** offer free software tools that are helpful for quality management, including Epi Info, an easy-to-use database/statistical program that can be used to develop surveys, audits, and report results. See the CDC Web site at <http://www.cdc.gov/publications.htm>.

**Ambulatory Innovations** (<http://www.ambulatory-innovations.com>) of Indianapolis, Indiana (a subsidiary of Methodist Hospital of Indiana, Inc.), has developed a number of electronic and print aids to quality assurance and quality improvement. Telephone: 1-800-367-9180. This effort is led by Dale Benson, MD, the executive director of the Community Health Network (a CHC) of Methodist Hospital. They offer ambulatory clinical protocols and telephone triage protocols in print and in word processor formats. They also have created databases for collecting and reporting provider and patient satisfaction audit data.

# Chapter 5

## Redesigning Four Clinical Processes: Adolescent Preventive Screening, Pap Smear, Adult Triage, Diabetes

### Introduction

An important part of the WVPCA QI project was to provide health center clinical leaders with hands on experience in QI methods and to develop actual Systems Of Care for four severe health problems.

As this project began in June 1997, NRHA formed a five-person coordinating group from its own clinical QI leaders. At the same time, a letter and survey were sent to the Medical Directors and DON's of all 31 WVPCA member organizations. This letter explained the project and asked for suggestions of clinical topics for SOC development. By the end of August, 17 organizations had responded and voted. These votes were tallied, and four SOC work groups were formed. Each group was assigned a convener from the coordinators' group. The groups and their conveners were:

Adolescent Preventive Services (Jennifer Mead)  
Breast and Cervical Cancer (Jennifer Boyd, PA-C)  
Adult Triage (Lynn Legg, RN)  
Diabetes (Dan Doyle, MD).

Out of respect for busy clinic schedules and time constraints, the groups worked mainly by correspondence, individual calls, and conference calls. With guidance from the convener, each group followed a similar work process.

1. An analysis of present System Of Care (or non-system) in member centers,
2. A review of available practice guidelines for the condition, and
3. Development of common system of care.

All groups completed the first two steps. There was varying progress on the third, most difficult of the steps. But each group was asked to report and summarize the progress they had made toward a sample SOC for its topic.

The membership, progress, and recommendations of each group is reported in this section.

# Adolescent Preventive Screening

## I. Problem Statement

Adolescent morbidity and mortality are largely related to health behaviors. Health behaviors learned in childhood and adolescence impact health in adulthood. Adolescents generally do not seek out preventive care services due to cost, lack of transport, lack of awareness, and disinterest. Early identification of health risk behaviors allows for the possibility of intervention by means of education, appropriate referrals, or programs that address frequent or serious needs. The adolescent preventive screening SOC will develop recommendations regarding screening tools and systems that are feasible to implement in primary care centers.

## II. Group Membership

Jennifer Mead, MPH, New River Health Association, Convener

Gary Culver, PA-C, Administrator, Lincoln Primary Care

Linda Anderson, MPH, Director of Women's & Children's Services, Valley Health Systems

Melanie Hall, RN, Nurse Director, Valley Health Systems

Jewel Workman, Community Health Foundation of Man

Jennifer Boyd, PA-C, New River Health Association

Lynn Legg, RN, Director of Nursing, New River Health Association

Melody Rickman, RN, Mercer County Health Dept./ Southern WV Clinics

## III. Process/Chronology

Adolescent preventive screening SOC questionnaires were sent out in late November to individuals who had expressed interest in participating. Phone calls were made to participants who did not return their forms. A summary of participant responses to the questionnaire, as well as sample screening tools, were distributed to group members in late December.

Group members identified the following barriers and possible solutions to providing systematic preventive screening to adolescents:

1. Adolescents don't come for preventive care
  - Take advantage of sports physicals, EPSDT exams, family planning visits, and acute visits to do a full screening
  - Case management - use clerical, nurse, CWEP, Americorps, or Vista person to work with Medicaid outreach worker to ID kids due their EPSDT exam, make reminder phone calls or send out reminder cards, talk with schools and give them information about being available for referrals
  - Develop school-based health centers Offer well-child exams in schools during the school day

2. Brevity of office visits & complexity of issues to be discussed
  - Use questionnaires that adolescents can complete in waiting room to save time, and help uncover critical issues Explore mental health/social work referral options in community
  - Find/use good health education materials
  - Develop protocols for each potential health problem/risk area
  - Provide training on interviewing/counseling skills
3. Lack of reimbursement for preventive services
  - Use of GAPS or preventive health education can be billed as a "partial visit" under EPSDT
  - Encourage/train nurses to do more GAPS-type review/anticipatory guidance
  - Find out which health plans will reimburse for an annual exam
4. No system/plan
  - Include adolescent health/behavior risks on medical history/problem list in chart
  - Develop protocol for "any adolescent visit" -- health centers have protocols for certain types of visits (i.e. family planning, EPSDT), but need something that would work for any visit by an adolescent
  - Consider periodic chart audits on selected adolescent preventive issues

The conference call scheduled for January 6 had low attendance. Further development of the adolescent preventive screening SOC occurred in January and February based on individual conversations and work with the Coordinators Group.

#### **IV. Recommendations/Future Priorities**

Recommendations:

1. Systematic universal adolescent preventive screening should be an important clinical priority in every primary care practice.
2. Practices should adopt a nationally endorsed screening tool. We think the AMA's GAPS (Guidelines for Adolescent Preventive Screening) is best because it allows adolescents to respond on their own to written questions, it is easily reviewable by providers, and it covers most health issues. Completion should be initiated by nurse or provider at any visit. Provide adolescent with the form, a pencil, a clipboard, and privacy, and indicate that any questions they cannot read or do not understand can be left blank. Reassure adolescent to extent possible that responses are confidential.
3. Screening should occur at least once between ages 12 and 19. Preferably screening will occur once between ages 12-15 and again between ages 16-19.
4. Develop site-specific "suggested interventions and resources" for problem areas identified by screening. The provider should discuss and counsel adolescent about identified problem areas.

5. When circumstances prevent completion of screening (adolescent reluctance or parent resistance), then providers should screen verbally one-on-one with adolescent.

### **Issues Still to Be Addressed:**

1. Each site needs to consider arrangements to ensure adolescent confidentiality:
  - Space away from parent/provider to complete form, if written form is used
  - Time to speak with provider privately, and then together with parent
  - Information on what can be kept confidential and what information the provider is legally required to share with parents or authorities (this can be done verbally, in writing on any forms that are used, and on signs in the exam area)
2. If sites use written screening, tools (i.e. GAPS), each site needs to decide what to do with screening form: include the form in the chart; include a summary in the chart; offer the adolescent the option of including it in the chart or destroying it (to encourage confidence in the confidentiality of the screening process).
3. Each site needs to develop a list of referral resources and information to use to address risks identified in the screening process. This information will depend on local resources & preferences.

### **V. Bibliography/References**

WV Healthy People 2000.

Kathleen Perkins, MD, and others, "You Won't Know Unless You Ask: The Biopsychosocial Interview for Adolescents," *Clinical Pediatrics*, Feb. 1997 p 79- 86.

Guidelines for Adolescent Preventive Services (GAPS), developed by the American Medical Association.

Short Screening Questionnaire for Teenagers, developed at the Children's Hospital of Los Angeles.

"Things That Worry Me" questionnaire, from the Children's Hospital of Columbus, Ohio.

"Safe Times Questionnaire/Risk Appraisal" revised version with scoring, scales developed by Howard Schubiner, MD.

### **VI. Relation to West Virginia HP 2000 goals**

Objectives relating to reducing use by adolescents of tobacco products, alcohol, and other drugs; increasing the percent of 10-18-year-olds who have received information on human sexuality; increasing percent of children receiving appropriate identification and follow-up for physical or sexual abuse; reducing youth suicide; and reducing motor vehicle crash deaths in youth.

## SOC Planner: Adolescent Preventive Screening

SOC steps	What is currently being done at your site?	How good is this current system? (0=not at all; 5=verysuccessful)
1. Defined health problem (see problem statement above)		
2. Standards of Care	<p><b>WV Medicaid Program:</b> Requires annual physical and behavioral risk screening</p> <p><b>AMA recommendation:</b> "From ages 11 to 21, all adolescents should have an annual preventive services visit. These visits should address both the biomedical and psychosocial aspects of health, and should focus on preventive services. Adolescents should have a complete physical examination during three of these preventive services visits. One should be performed during early adolescence (age 11-14), one during middle adolescence (15-17), and one during late adolescence (age 18-21), unless more frequent examinations are warranted by clinical signs or symptoms."</p> <p><b>American Academy of Pediatrics:</b> Annual preventive health care visits.</p> <p><b>Bureau of Primary Health Care Clinical Outcome Measures.</b></p> <p><b>Bright Futures:</b> Annual health supervision visits for adolescents (11-21) judged not to be at undue risk. An augmented schedule is recommended for adolescents with additional problems.</p>	
3 and 4. These steps are critical to the success of developing an adolescent preventive screening SOC. Currently, all practices will do one or more of the following:	<p>A. Nothing. <span style="float: right;"><b>(Unacceptable)</b></span></p> <p>B. Personal lists of screening questions asked verbally by nurses and providers <span style="float: right;"><b>(Better)</b></span></p> <p>C. Use of standard list of screening questions asked verbally <span style="float: right;"><b>(Even better)</b></span></p> <p>D. Written questions (GAPS or other) with discussion by provider <span style="float: right;"><b>(Best)</b></span></p>	
5. Interdisciplinary Team.	While this will depend on the staff availability, training, and interest at each site, a recommendation is made for nurses to provide adolescents with a written screening tool to complete prior to seeing the provider, who would review the responses.	

6. Patient education modules.	Sites already have selected materials and resources; however, part of the SOC process at each site will involve defining the education/referral resources available for each aspect of the health screening.	
<b>7. Necessary tools and case finding.</b>	There is a variety of screening tools available. The recommendation for use of the AMA GAPS (Guidelines for Adolescent Preventive Screening) partial screening (two pages) to be used for adolescents; however, primary care centers can also use alternative screening tools that they feel to be effective and comprehensive.	
<b>8. Care provided according to standards.</b>	Screenings are done by designated persons (nurses and/or providers) at times of visits.  A major issue to be addressed is whether this happens only at “preventive care visits,” i.e., scheduled well-child physicals or at every opportunity including sports physicals and illness visits.	
9. System of care coordination in place with tracking.	Implement Tracking and Care Coordination if possible. Highly dependent on the practice’s resources and priorities.	
<b>10. Periodic measurement and reports.</b>	Use samples or electronic medical records to conduct periodic performance reports on percent of adolescents actually receiving screening. This is already done on a limited scale by all FQHC and 33o sites as part of the Annual Clinical Outcome Measures. But are the audits done validly and consistently from one year to the next so that meaningful in-house comparisons are possible? And shouldn’t sample sizes (or total population with EMR) be larger to obtain accurate picture of performance?	
11. Regular staff education and program revision based on evaluation from step 10.	Nurses and providers will need training in the specific screening tool selected. Relevant team will need to meet periodically to maintain high motivation and review progress toward goal. Also, team will need training in local resource manuals for teens with identified risks who need referrals.	

# Breast and Cervical Cancer

## I. Problem Statement

In 1995 in West Virginia, only 67% of women age 50 and older report having had a mammogram within the past two years. In addition, in 1995 in West Virginia, only 72% of women age 18 and older report having had a PAP test within the past two years. Early detection of breast and cervical cancer significantly saves lives of women. Given the proven effectiveness of screening with careful follow up, we intend to develop a System of Care that will assure full detection, treatment, and education of women at risk for these cancers in primary care centers.

## II. Group Membership

Jennifer Boyd, PA-C, New River Health Association  
Judy Hamrick, LPN, Camden on Gauley Medical Center  
Melody Rickman, RN, Mercer County Health Department  
Barbara Batista, Minnie Hamilton Health Center

## III. Process and Chronology

### 11/97 - 12/97

Members were mailed a "SOC Questionnaire". Members completed this either in writing or during an initial telephone conversation with Jennifer Boyd. See attached summary of SOC Questionnaire, which outlines status of Breast and Cervical Cancer Screening at each site currently.

### 12/22/97

Conference Call -- See minutes. Group members agreed on standards of care:

- Annual mammography and CBE for women ages 50-74, with education re: BSE.
- PAP Smears beginning at the age of sexual activity or age 18, annually for high risk, otherwise, every 3 years after 3 normal PAP's.
- BCCSP algorithm for management of abnormal PAP's (independent of age or financial status of patient) (see enclosed BCCSP algorithm)

### 1/98

Group members reviewed standards of care with clinical staff at their respective sites. Standards agreed upon by clinical staff at Mercer County Health Department, New River Health Association, Minnie Hamilton Health Center, and Camden on Gauley.

## IV. Recommendations

Next steps in development of SOC:

1. Determine performance TARGETS (e.g. Healthy People 2000 targets)

2. Develop (or share) TOOLS for performance MEASUREMENT (audit tools) based on performance targets.
3. Develop (or share) tracking systems.

## SOC Planner: Breast and Cervical Cancer Screening

Present?  
0-2

1. <b>Well-defined health problem</b>		In 1995 in West Virginia, only 67% of women age 50 and older report having had a mammogram within the past two years. In addition, in 1995 in West Virginia, only 72% of women age 18 and older report having had a PAP test within the past two years. Early detection of breast and cervical cancer significantly saves lives of women. Given the proven effectiveness of screening with careful follow up, we intend to develop a System of Care that will assure full detection, treatment, and education of women at risk for these cancers in primary care centers.
2. <b>Standards of Care that are evidence based</b>		Annual mammography and CBE for women ages 50-74, with education re: BSE. PAP Smears beginning at the age of sexual activity or age 18, annually for high risk, otherwise, every 3 years after 3 normal PAP's. BCCSP algorithm for management of abnormal PAP's (independent of age or financial status of patient) (see enclosed BCCSP algorithm).
3. <b>Staff Agreement on Objectives and Interventions Analysis of Costs and Preparation of Budget by Management</b>		All sites currently agree on objectives of SOC Further intervention/analysis is site specific
4. <b>Decision whether to Proceed</b>		All sites participating in SOC team
5. Interdisciplinary Team with clear staff roles		[Site specific]
6. Well-defined patient education modules and patient involvement		Future SOC team work to include assessing patient information
7. <b>Presence of necessary tools to accomplish care mechanism for case finding</b>		Tracking systems needed [ideal = computerized] Audit tools for performance measurements needed
8. <b>Care provided according to standards</b>		In place
9. System of care coordination in place with tracking		Site specific
10. <b>Periodic measurement and reports</b>		Performance targets need to be decided Performance measures need to be defined
11. Regular staff education and program revision based on evaluation from step 10		Regular CME/CEU for nursing and provider staff BCCSP inservices

(0=not at all; 1=partly; 2=fully)

Items in bold are required for a Basic SOC.

Items not in bold are added over time to achieve an Advanced SOC.

# **Adult Triage**

## **I. Problem Statement**

The word "triage" refers to the process by which patients requesting medical care are directed to appropriate care providers according to the acuity and severity of their problems. A well-organized system of patient triage is an important part of quality improvement efforts related to providing patient access for all primary care centers. But many Primary Care Centers find it difficult to reach agreement on a triage system for their practice. Such a system must include defined categories of severity levels and must be guided by the standards required by external payors. The Adult Triage System of Care will be a compilation of tools, techniques and methods for an effective triage system.

## **II. Group Members**

Lynn Legg, RN, NRHA, Convener

Cindy Hurley, RN, Rainelle Medical Center  
Lana Stover, RN, Community Health Systems  
J. Michael Herr, DO, NRHA

## **III. Process and Chronology**

This QI effort was begun by collecting data from the participants regarding how triage was done in their facilities. This information was compiled in a SOC Planner format and sent to all participants in their SOC binders. In addition, a literature search was done to determine what models of triage systems already existed in other Community Health Centers. This data search revealed that most of the literature is reflective of triage in emergency rooms. Telephone triage systems are also available, but mostly are for purposes of providing advice to patients. Little relevant literature was found that addressed the issue of face-to-face patient triage in community health centers or similar primary care settings.

The Nursing staff of New River Health was polled for input into "drawing a picture" (process diagram) of how triage is done at New River and a flowchart was drafted. Categories used for purposes of this flowchart were Emergent, Non-urgent and Urgent. A Resource list of manuals was also developed for distribution to all participants along with the flow chart example.

Two face-to-face meetings were held with Cindy Hurley R.N. from Rainelle Medical Center to discuss how triage could/should be a RMC. Nurse initiated protocols and the New River Health Walk-in policy were shared with Cindy and all the other participants along with a chapter called Access Mobilization from a book by Dan Doyle, MD on preparing for Managed Care.

## **IV. Resource List**

The Clinical Protocols

Community Health Network Practitioners  
Healthnet Community Health Centers and Methodist Hospital of Indiana, Inc.

Triage  
Problem Oriented Sorting of Patients  
Robert J. Brady Company written by Donald M. Vickery, M.D.

Telephone Triage and Management  
A Nursing Process Approach  
Written by Reba McGrear/Jo Simms

Telephone Medicine  
Training and Triage  
A Handbook for Primary Care Health Professionals  
Written by Harvey P. Katz, M.D.

Pediatric Telephone Advice  
Guidelines for the Health Care Provider on Telephone Triage and Office Management of  
Common Childhood Symptoms  
Written by Barton D. Schmitt, M.D.

## **V. Progress in SOC development**

Some basic information was gained in assisting centers in developing their triage system. An outline guiding how to begin using the tools included in the packet was sent to all participants and emphasized the need to make this a group activity that is specific to each center. Some basic QI information was also included to assist with getting started. The meetings with Cindy Hurley provided some specific information for RMC on how to get the Medical Staff and other parties involved from the beginning. Also, it was found that several of the systems already in place could be considered a part of triage. So, the task may not be creating a system as much as pulling together already existing processes (REDESIGN) into a triage method.

## **VI. Recommendations**

It was recommended in the outline that centers review the triage information, decide what triage system will work best for their facility and develop a plan based on this information. There is great room for imagination and flexibility. The bottom line is that whatever system is used it must assure timely and appropriate access to care for the community and meet the external standards required by the payers, discussion and agreement.

# Diabetes

## I. Problem Statement

“There is a very high prevalence of diabetes in West Virginia. Many diabetics are poorly controlled with the consequences of excess premature mortality and morbidity such as blindness, amputation, and renal failure. Primary Care practices need a well-organized, systematic approach to diabetes to maintain >75% of patients with A1C < 8.0% and to achieve early detection and treatment of diabetic complications.

## II. Work Group Members

**Convener:** Dan Doyle, MD, New River Health Association

Jewel Workman, RN, Community Health Foundation of Man  
Dennis Small, DO, WVSOM, Robert C. Byrd Clinic  
Mary Simms, LPN, Community Health Systems, Inc.  
Greg Elkins, MD, Lincoln Primary Care Center  
Augusta Koswicz, PA-C, Roane County Family Health Care  
Mike Kilkenny, MD, Valley Health Systems  
Kenneth Seen, MD, Roane County Family Health Care

## Guest Participants

Richard Crespo, Ph.D., Marshall University  
Shawn Chillag, West Virginia Bureau of Health, Diabetes Control Program  
Beverly Begovich, Carelink HMO

## III. Process and Chronology

Based on the responses received from 17 of 31 of the WV PCC's a SOC work group for Diabetes was established in September 1997. The diabetes SOC questionnaire was mailed to group users on 10/97. The responses from seven centers were tabulated and returned to group members along with a *Docs Need SOC's* binder in December. This binder also contained the 1998 ADA Standards of Care, a summary of the 1997 Marshall Diabetes Care Study, the “Minimum Technical Standards for Diabetes” from the National Health System of Spain, and an article reporting a successful approach to systematic Diabetes Care (Koperski, M., *British Journal of Gen Prac*, 1992, 42, 508-511).

The diabetes work group held two conference calls. The first, on Jan. 13, 1998, was attended by 10 persons from six centers.. The second, on Feb. 10, 1998, was attended by 12 persons from seven centers. At both meetings, discussion focused on the current situation, existing clinical guidelines, what is realistic for WV rural primary care, and what our priorities should be.

By the end of the second meeting, the group had reached near-consensus on a broad set of

standards for diabetes care. A summary of the group's conclusions, "Diabetes Care Standards and Priorities," is included here.

While this group has not continued to meet since February 1998, there is optimism that its efforts can continue within the framework of the WV Diabetes Control Program, which recently received a Comprehensive Diabetes Grant from the Centers for Disease Control. Of the seven centers participating in this WVPCA Diabetes Work Group, at least two are targeted as intervention sites within the first year of this program. Hopefully, this number will be increased in the second and third years.

#### **IV. Progress in SOC Development**

The main work of the group, after local needs assessment, focused on steps 2 and 3 of the SOC Model, namely selection of standards and agreement on objectives. Step 2 (Standards of Care) was a particular challenge given the respectability of the ADA guidelines despite the fact that many PCP's view them as unattainable in the short term for many patients who are uninsured and/or living in rural areas. The group studied and discussed the ADA guidelines carefully, coming to near-consensus on a set of recommendations that selectively embraced nearly all of the key elements of the guidelines. The group also took the important next step of prioritizing the areas of basic and continuing patient education, regular lab monitoring, eye care, foot care, and immunizations (Pneumococcal, Influenza, Tetanus).

#### **V. Recommendations and Future Priorities**

1. All primary care centers represented in the work group should join the WV Diabetes Comprehensive Project and fully implement its package of Patient Education and Primary Care measures.
2. In or out of the Diabetes Comp Project, all WV PCC's should develop a systematic approach to diabetes because of the high prevalence of diabetes and its complications in our state.
3. PCP's should seek to do as much diabetic care on site as possible, including annual eye exams (Snellen and Fundiscopic), oral exams, and foot exams complementing, not substituting, with ophthalmology, dental, and podiatry referrals.
4. Front-line primary care clinicians, especially those to underserved populations, should strongly question standards of care that tell us what to do without providing resources or infrastructure to do it, and should advocate for realistic standards linked to programs for meeting them.

## WVPCA QI Project Diabetes Work Group

### Final Recommendations for Minimum Standards of Care for Diabetes

Several WV Primary Care Centers are working together to improve care and outcomes for diabetic patients. One step is to get agreement on minimum standards of care for diabetes and to set realistic targets for all patients many of whom have limited resources and education.

Participants in The Diabetes Work Group are Dan Doyle, MD (New River), Greg Elkins, MD and Pam Frye, RN, CDE (Lincoln), Rod Fink, DO (Chas - Beckley), Mike Kilkenny, MD (Valley Health Systems), Ken Seen, MD and Augusta

Kosowicz, PA-C, Brenda Jarvis, RN (Roane), Dennis Small, DO (WVSOM - Clinic), Jewel Workman, RN (Man), Shannon Sigley (Camden On Gauley), Richard Crespo (Marshall University Medical School), Shawn Chillag (WV Diabetes Control Program), Beverly Begovich AND Karen Mullins (Carelink HMO) and Barbara Batiska, PA (Mini Hamilton).

Measure	ADA Guidelines	WVPCA Work Group Recommends
Ht	1/ever	same
Wt	1/year	2/year
Type of Diabetes Recorded	1/ever	same
Date of Diagnosis Recorded	1/ever	same
Basic Diabetes Education including Diet and Exercise Prescription	1/ever	1/ever
Annual update of basic education and Self Management Goals including Tobacco Avoidance	1/year	1/year
Episodes of Hyperglycemia and Hypoglycemia recorded	1/ever	every visit; at least 2/year
BP Check	2/year	every visit; at least 2/year
Check Medication List Specify type of treatment	2/year	every visit; at least 2/year
Flu vax	1/year	every Fall
Pneumovax	1/ever	same
A1C	4/year on insulin 1/year not insulin	every 6 months
Baseline EKG	1/ever	same
Partial UA/Dipstick only	1/year	same
Micro Albuminuria screen	1/year	no consensus
Serum Creatinine	1/year	same
Cholesterol & TG	1/ever (If normal)	1/year
Foot Exam (pulses, skin, nails, sensory)	2/year	same no consensus on exact contents
Eye Exam	Regular 2/year Comprehensive Specialist	PCP fundiscopic 1/year AND specialist referral

	exam 1/year	
Oral Exam	Dentist 1/year	1/year AND dental referral
Cardiovascular Risk Assessment		1/year
Aspirin Prophylaxis	As indicated	As indicated
ACE Inhibitors	As indicated	As indicated

Greatest priorities in improving Primary Care of Diabetes should be:

1. Initial and Annual Education about Diabetes Basics plus review of care plan and treatment goals. All sites agreed: "Most of our patients don't know basic information about diabetes."
2. Meeting or surpassing minimum standards for lab monitoring: A1C 2/year. Annual Creatinine, Cholesterol, TG, Glucose, and Dipstick Urine.
3. Meeting or surpassing minimum standards for eye care. Annual Snellen Wall Chart visual acuity test and fundiscopic.
4. Meet or surpassing minimum standards of foot care. Foot exam (pulses, skin, nails, sensory) 2/year.
5. Achieve adult immunization goals. Pneumovax 1/ever; Fluvax annual in Fall; adult Tetanus (primary series plus booster).



## SOC Planner for Diabetes

Present?

0-2

1. Well-defined health problem		There is a very high prevalence in West Virginia. Many diabetics are poorly controlled with the consequences of excess premature mortality and morbidity such as blindness, amputation and renal failure. Primary care practices need a well organized, systematic approach to diabetes to maintain > 75% of patients at A1C < 8.0% and to achieve early detection and treatment of diabetic complications.
2. Standards of Care that are evidence based		Clinical Guidelines adopted by the WV Diabetic Comprehensive Project which will be based on WVPCA Recs, ADA, State Programs in Oregon, ND, TX.
3. Staff Agreement on Objectives and Interventions  Analysis of Costs and Preparation of Budget by Management		Clinical Director must obtain support for all or selected elements of guidelines from all clinical leaders and all providers.  Address how and by whom patient education will be done. Budget time and cost of this.
4. Interdisciplinary Team with clear staff roles		Practice needs a person who is responsible for coordinating, evaluating and troubleshooting diabetic care. The Interdisciplinary Team at the clinic-wide level is the DM coordinator, the Director of Nursing, and the Clinical director. At the micro patient visit level, the team is the patient, the nurse, the provider supported by the diabetes coordinator. Depending on the size of the clinic or the network, the diabetes coordinator may be a part-time position.
5. Decision to proceed		
6. Presence of necessary tools to accomplish care		Medical Records System A diabetic flow sheet Practice Guidelines distributed and available to all providers and nurses. Educational and key materials (to be provided by Goal I of WV Diabetic Comprehensive Project) A Snellen Eye Chart A regularly updated List of Diabetics
6a. Mechanism for case finding.		CEO and Clinical director commit and deliver on promise MIS produces a diabetic list of least annually and this is used for recall and clinical audit.
7. Care provided according to standards		Teams (pt, nurse, provider) perform care with knowledge of the accountability for meeting agreed upon guidelines and objectives.
8. System of care coordination in place with tracking		Limited coordination as described for Step 4 in place at system level. Few practices have sufficient staff or resources for true universal diabetes care coordination. Selective care coordination and case management are a practical approach.

<b>9. Periodic measurement and reports</b>		Clinical Performance Measures are linked to target set by practice in steps 2 and 3. Examples: 1. List of diabetics, names and record number is on hand and less than a year old N=X. 2. 90% of diabetics have had A1C in past 6 or 12 months. 3. 90% of diabetics have had visual acuity check in past year. 4. 4. 90% of diabetics have had any formal education or diabetic review in past year.
10. Regular staff education and program revision based on evaluation from step 10		Clinical director and coordinator are responsible that audits be performed and be reported and discussed with staff. New objectives, new initiatives, , agreed on at least annually.

(0=not at all; 1=partly; 2=fully)

Items in bold are required for a Basic SOC.

Items not in bold are added over time to achieve an Advanced SOC.