Performance Improvement and Compliance: A Perfect Partnership

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Objectives

• How does it work? A combined program of compliance and performance improvement in a small rural health system.
• Lessons learned from integrated medical care, the use of the patient centered medical home model, LEAN, quality outcomes and compliance audits
• Inform how these tools helped to raise the level of compliance in a small rural health system

We are..... Cherokee Indian Hospital

• Small Inpatient unit-20 beds
• Outpatient Physician Practice- 150,000 ambulatory visits which include:
  – Lab
  – Radiology
  – Pharmacy
  – Physical Therapy
  – Direct care visits
Our Mission
The Mission of the Cherokee Indian Hospital is to be the partner of choice for the community by providing accessible, patient and family centered quality healthcare with responsible management of the tribes’ resources.

Our Core Purpose
To enhance the prosperity of the next seven generations of the EBCI through relationship based quality healthcare.

Our Vision
Our vision is to be significant in the lives of Tribal members, chosen for excellence and exceeding customer expectations, recognized for improving the health of the Eastern Band the Cherokee Indians.
What is the ultimate outcome?

- To provide a safe caring medical home for our patients.
- Compliant with all regulations ie: CMS, Joint Commission, etc.
- Met or surpass all performance measures.
- Continuously improve, communicate and collaborate to achieve our goals

Partner-Compliance

- HIPAA
- Auditing and Monitoring
- Regulatory Environment
- Customer Complaints
- Conflict of Interest
- Peer Review
- Policies and Procedures

Partner-Performance Improvement

- LEAN
- Patient Centered Medical Home
- Integrated Healthcare Team
- Data Reports
- PDSA's-Plan Do Study Act
- Improving Patient Care
- PI Tools
Our Partnership Journey

- A Compliance audit is conducted and the results show provider documentation issues:
  - A cross functional team is developed which includes the Chief of Medical Staff, Medical Records, Compliance, Performance Improvement.
  - Discussion of audit results.
  - Development of performance improvement plan:
    - Audit Data presented to Providers
    - Performance Improvement Champions meet with each provider team to discuss issues.
    - Provider training in Medical Staff meeting and pulsed throughout the year.

The Journey

- Performance Improvement champions determine that a patient safety risk has been identified and notify Compliance.
  - Compliance conducts a risk assessment and investigates the issue.
  - Compliance works with P.I. and the department staff to develop a process flow chart and to analyze all data related to the issue.
  - Compliance issues a determination of investigation along with the PI work to correct the issue.
What is PCMH?

- Patient Centered Medical Home
- Program endorsed by NCQA
- Each patient has a Personal Clinician—providing continuous and comprehensive care, leading a care team while taking responsibility for the ongoing care of patients.
- A Practice providing Whole Person Orientation for All Its Patients—providing for all the patient’s health care needs while taking responsibility for appropriately arranging care with other qualified health professionals...like acute care, chronic care, preventive services, and end of life care
- Patient Care is Coordinated—assuring patients get the indicated care when and where they need and want it, facilitated by information technologies, health information exchange and other means

Patient Centered Medical Home

- Compliance audited current state according to PCMH tools to determine baseline status.
- Compliance scored and developed the radar chart to show areas of deficiency.

Structure of NCQA's PCMH Survey
Scoring

<table>
<thead>
<tr>
<th>Recognition Levels</th>
<th>Required Points</th>
<th>Must-Pass Elements</th>
</tr>
</thead>
</table>
| Level 1            | 35-59 points   | 6 Elements
|                    |                | Must score >50%   |
| Level 2            | 60-84 points   | All 6 are required for recognition |
| Level 3            | 85-100 points  |                    |

Updated Overall Score

<table>
<thead>
<tr>
<th>PCMH 1: Enhance Access &amp; Continuity</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Access During Office Hours (4)</td>
<td>4</td>
</tr>
<tr>
<td>B. After Hours Access (4)</td>
<td>3</td>
</tr>
<tr>
<td>C. Electronic Access (2)</td>
<td>1</td>
</tr>
<tr>
<td>D. Continuity (2)</td>
<td>2</td>
</tr>
<tr>
<td>E. Medical Home Responsibilities (2)</td>
<td>1</td>
</tr>
<tr>
<td>F. Culturally and Linguistically Appropriate Services (2)</td>
<td>2</td>
</tr>
<tr>
<td>G. The Practice Team (6)</td>
<td>4</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>PCMH 2: Identify &amp; Manage Patient Populations</th>
<th>Score</th>
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</thead>
<tbody>
<tr>
<td>A. Patient Information (3)</td>
<td>3</td>
</tr>
<tr>
<td>B. Clinical Data (4)</td>
<td>4</td>
</tr>
<tr>
<td>C. Comprehensive Health Assessment (4)</td>
<td>4</td>
</tr>
<tr>
<td>D. Use of Data for Population Management (3)</td>
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Overall Score

<table>
<thead>
<tr>
<th>PCMH 3: Plan &amp; Manage Care</th>
<th>Score</th>
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<tbody>
<tr>
<td>A. Implement Evidence-Based Guidelines (4)</td>
<td>4</td>
</tr>
<tr>
<td>B. Identify High Risk Patients (3)</td>
<td>3</td>
</tr>
<tr>
<td>C. Care Management (4)</td>
<td>2</td>
</tr>
<tr>
<td>D. Medication Management (5)</td>
<td>2.50</td>
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<tr>
<td>E. Use Electronic Prescribing (3)</td>
<td>3</td>
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</table>

<table>
<thead>
<tr>
<th>PCMH 4: Provide Self-Care Support &amp; Community Resources</th>
<th>Score</th>
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</thead>
<tbody>
<tr>
<td>A. Support Self-Care Process (6)</td>
<td>1.5</td>
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<tr>
<td>B. Provide Referral to Community Resources (3)</td>
<td>3</td>
</tr>
</tbody>
</table>
### Overall Score

<table>
<thead>
<tr>
<th>PCMH 5: Track &amp; Coordinate Care</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>A: Test Tracking and Follow-Up (6)</td>
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</tr>
<tr>
<td>B: Referral Tracking and Follow-Up (6)</td>
<td>6</td>
</tr>
<tr>
<td>C: Coordinate with Facilities and Care Transitions (6)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>PCMH 6: Measure &amp; Improve Performance</th>
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<tbody>
<tr>
<td>A: Measure Performance (4)</td>
<td>4</td>
</tr>
<tr>
<td>B: Measure Patient/Family Experience (4)</td>
<td>4</td>
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<tr>
<td>C: Implement Continuous Quality Improvement (4)</td>
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<tr>
<td>D: Demonstrate Continuous Quality Improvement (4)</td>
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<tr>
<td>E: Report Performance (3)</td>
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</tr>
<tr>
<td>F: Report Data Externally (2)</td>
<td>1.5</td>
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</table>

Total Score: 88.25
Level of Recognition: 3

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### PCMH Standard Percentages

- Enhance Access and Continuity
- Identify and Manage Patient Populations
- Plan and Manage Care
- Provide Self-Care Support and Community Resources
- PCMH-Performance Improvement

- A Charter was developed and team members identified.
- All sections of the PCMH guidelines were given to team leaders and smaller work teams.
- A Gant Chart was populated and completion dates identified.
- Teams met weekly.
Collaboration is the Key:

- Chart audits were conducted again by compliance in order to verify adherence to guidelines.

- Project completed in 9 months.

- CIHA is a recognized PCMH Level 3.

Integrated HealthCare Teams

- RN Case Manger
- Case Management Support
- LPN/CMA
- Medical Provider
Case Management Support

- Patient’s first point of contact with Integrated Care Team
- Emphasis placed on “Customer Service”
- Makes appointments with guidance from RN as needed
- Shares in telephone contact and is the liaison between the patient and team. Pod management (faxing, sending appointment reminders, sending outreach letters)
- Participates in pre-visit planning with pod members
- Manages Open Access scheduling with guidance from the RN to give patients the primary help they need and want at a time they need and want it.
- Documents information as needed in EHR.

Certified Medical Assistant & Licensed Practical Nurse

- Primarily works 1:1 with the PCP
- Participates in pre-visit planning to anticipate patient and PCP needs
- Vital signs, screenings, procedure and room set up.
- Immunizations, depo injections, B12, etc...
- Completes ordered treatments and point of care testing
- Manages daily schedule

RN Case Manager

- Shares in responding to telephone calls
- Utilizes iCare to identify and manage PCP panel
- Develops individualized care plan for high risk patients
- Follows up on referrals to outside providers ensuring PCP has access to pertinent information
- Ensures the plan of care is followed/up to date
- Support team
- Connection with provider/team
- Assesses patient for needs through a holistic approach
- Participates in pre visit planning
- Provides Holistic Case Management
- Manages Nurse Clinic and provides direction to CMS
- Health system navigator
- Chronic disease management
- Results, medication management, and patient education
Primary Care Provider

- Active participant in pre visit planning
- Responsible for initial assessment and diagnosis
- Responsible for in-clinic visit
- Adjusts treatment plan for known diagnosis where goals are not being met
- Helps set focus for team on priority work areas
- Sets plan for follow-up for known diagnosis where treatment is stable.
- Utilizes radiology and lab results in management of care as needed.

Traditional Methods of Managing Work Flow

Parallel Work Flow Redesign
So what?

- Redesigned healthcare model – all staff are trained on the new model.
- Compliance and PI must have knowledge of the new design and be able to adjust auditing, monitoring and performance processes in order to affect positive change.

Performance and Compliance Outcomes

- CIHA has found that with a collaborative approach to compliance and performance improvement we are surpassing IHS goals and are benching marking against national top Decile for quality measures and compliance goals.
Tools

- Record Review Workbook-PCMH
- Performance Improvement Request form.

Questions

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