West County Health Centers
Caring for our Communities

Updated 12/14/17

Quality Watch Checklists

Redwood Community Health Coalition
Promising Practice

PROMISING PRACTICE OVERVIEW

The Quality Management Department of West County Health Centers (WCHC) developed and implemented Quality Watch Checklists and Action Plans to advance data literacy among staff and provide managers with tools to measure staff workload and capacity in achieving agency-wide goals. The Quality Watch process helps to support QI efforts on specific clinical areas of focus. The tool includes information about nine clinical areas including details on internal measure definitions, outline goals, which programs the measure is reportable to, clinical significance, and workflows/systems in place. Care team members complete monthly worksheets which walk them through questions about their progress/performance for each measure and takes them through checklists to assess their progress in following agency-wide workflows. This process takes about 30 minutes to complete and allows each care team member to think through issues and opportunities related to their work and develop monthly action plans for ongoing improvements.

AIM

To ensure that quality measures and performance are reviewed on a monthly basis, staff are engaged in QI activities to reach set goals, and serve as a resource and training tool to improve data literacy among care team staff.

MEASURES

WCHC selected nine priority areas for focus in 2017 and they will select a new set for 2018. The measures align with agency-wide goals and priorities based on current initiatives and areas of opportunity.

Quality Watch for RN (Partial Template)

DIABETES DASHBOARD

	Goal	My Result		Goal	My Result
% of DM patients with an A1C less than or equal to 9%:			% of DM patients with A1C greater Than 9% with a Care Plan Complete in the last 12 months:		
Tab: DM Clinical Outcome / Filter: Rendering Provider			Tab: DM Clinical Outcome / Filter: Rendering Provider		

ISSUES AND OPPORTUNITIES

MONTHLY RN CHECKLIST

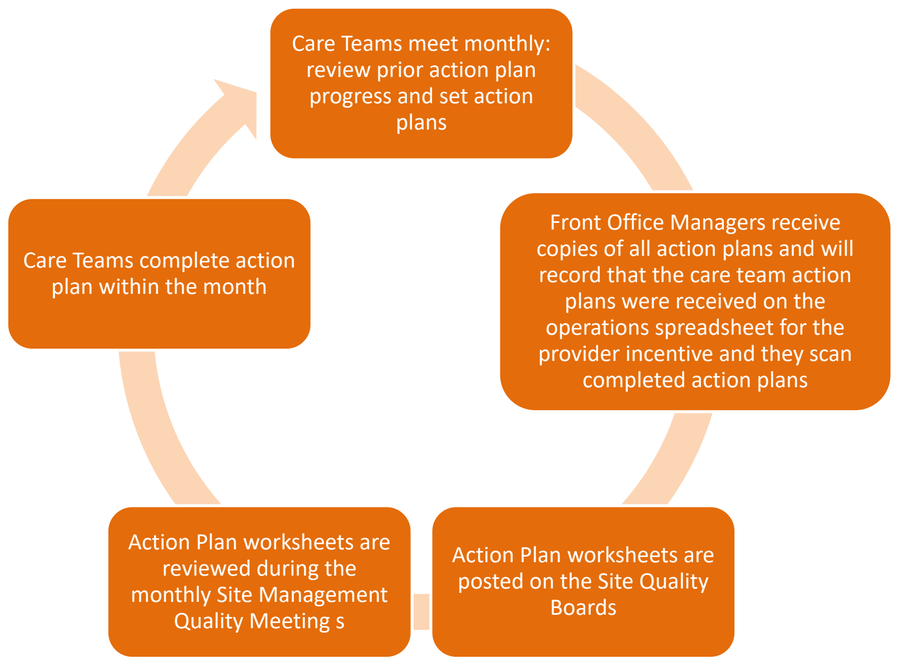
Measure	Result	Measure	Result
Number of open Telephone Encounters assigned to me:		Daily provider jelly management support: (Rx, Dx, Tlx, Lx)	
Date of the oldest Telephone Encounter assigned to me:		Pap and Mammo Tracking complete:	
Number of open Documents assigned to me:		Reconciled tracked labs complete:	
Date of the oldest Document assigned to me:		Performed medication reconciliation: (ER, Hospitalizations, Consult notes)	
Number of open Labs assigned to me:		Coumadin management per protocol complete:	
Date of the oldest Lab assigned to me:		No show/cancellation follow-up complete:	
Do I have any referrals assigned to me?:		Monthly care team meeting: (at minimum)	
		Monthly check-in with CTMA:	
		Chart prep attended huddle: (PAID, goal setting for patients being seen)	
Number of active IOPCM Patients:			
IOPCM items completed:			
Number of transition care patients with a risk score > 20.			
Number of patients with 4 pillars complete for patients with a risk score > 20. (Face-to-face visit + 4 f/u calls)			
Number of transition care patients with a risk score <20			
ED f/u calls complete:			

ISSUES AND OPPORTUNITIES

ACTIONS TAKEN

In April 2017, WCHC implemented a Quality Watch Checklist for care team roles including care team receptionists, front office managers, care team MAs, MA coordinators, care team nurses and clinic nurse managers. The initial purpose of the quality watch checklist was to improve data literacy and provide staff more training on reported measures, workflows and where to find data. The Care Team Quality Check Worksheet is filled out by each of the responsible roles including the agency's result and the team's result prior to the monthly care team meetings. During the care team meeting, each staff member will formulate a simple action plan using the data collected on the worksheet. The action plan is shared with the front office manager and is reviewed at the site management quality meeting and posted on the site quality board. Since implementing the Quality Watch for Care Teams, WCHC has expanded to RN managers and the Associate Director of Nursing because this process has been helpful in assessing staff workload and capacity as well as facilitating exploitation of data and getting movement on changes. Staff and providers are incentivized to complete action plans and this process has been instrumental in serving as a communication tool and documentation of staff goals for managers. Clinical areas of focus in 2017 are: PHASE ASA Prescribing, Diabetic Care Plans, Tobacco Screening, Cessation Counseling, Colorectal Cancer Screening, Cervical Cancer Screening, and Well Child Exams.

WORKFLOW



RESULTS TO DATE

Results are preliminary since the rollout in April 2017. WCHC's colorectal cancer screening measure for adults ages 50-75 improved from 35% in June 2017 to 37% in October 2017. This 2% improvement was achieved through data clean up that the staff were motivated to take on based on their improved understanding of the measure and clinical significance.

LESSONS LEARNED

WCHC learned that it was helpful to have each of the clinic nurses to have completed the Quality Watch worksheet themselves prior to giving it to their staff so they can answer any questions that will come up. It is recommended that managers sit with staff to walk through the role specific worksheets and clarify any of the process measures, workflows, and expectations. WCHC uses calendar requests through Outlook to remind staff to complete the worksheets and also let them know when they should have received the next month's quality watch document to prepare for their monthly care team meetings.

The Quality Watch Checklists ensure that important quality measures are reviewed on a monthly basis by the support staff, their managers and the department directors.

Overview

Staff and managers are required to review and self-report their relative metrics and complete the issues and opportunities sections on any area of improvement.

The managers will review their sites' data at each of the Department Lead's Monthly Meetings.

Important Dates:

Beginning of the month	*Monthly Quality Watch Checklists* are issued to the qualifying roles to be completed after the dashboard notification email goes out to All Users
The third Friday of each month	*Monthly Staff Quality Watch Checklists* from are due to the Managers
4th Friday of each month	*Monthly Manager Quality Watch Checklists* from the month prior are due to the Department Leads (Operations Director, Assoc. Director of Nursing, Clinical Support Services Manager) and the Quality Watch Spreadsheet is filled out.
2nd Tuesday of each month	Department Leads will review their *Manager Quality Watch Checklists* with the WCHC Quality Team at the monthly WCHC Quality Team Meeting.
1st week of the month	The Assoc. Director of Quality Management will distribute $10 gift cards to each of the site managers to issue to their staff who turned in their checklist on time.

Qualifying Roles

- Care Team Receptionists
- Front Office Manager
- Care Team Medical Assistant.
- Medical Assistant Coordinator
- Care Team Nurse
- Clinic Nurse Manager

Resources

Final Monthly checklists, Reporting Spreadsheet and Protocol are saved on the docshare at:

Quality Improvement/Reports/Quality Watch

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Quality Check Action Plan

Care Team Quality Check and Action Plans

The *Care Team Quality Check* worksheets ensure that West County Health Centers' *Clinical Areas of Focus Measures* are reviewed monthly by each of the care teams. This worksheet will serve as a guide for the team to discuss their performance on each of the *Clinical Areas of Focus* relative to both the goal and the performance of the agency and help the team choose a quality goal to work towards each month.

Overview

The *Care Team Quality Check* worksheet will be filled out by each of the responsible roles including the agency's result and the team's current result before the Monthly Care Team Meeting.

The purpose of the Care Team Meeting is to formulate a simple *Action Plan* using the data collected on the Quality Check worksheet.

This includes:

- reviewing last month's Action Plan to determine if the changes made created an improvement
- reviewing any lessons learned
- selecting one *Clinical Areas of Focus Measure* to focus on each month
- deciding on a *small* goal to help support that measure
- identifying any additional support that may be needed by the team

A copy of the *Action Plan* worksheet is to be given to the Front Office Manager to be reviewed at the Site Management Quality Meeting each month and posted on the Site Quality Board.

The Front Office Manager will record that the C*are Team Action Plan* was received on the Operations Spreadsheet for the Provider Incentive by the 1st of each month and scan completed Action Plans on the docshare at Quality Improvement/Reports/QUALITY WATCH/Completed Action Plans/Site.

QUALITY WATCH

KEEPING OUR GOALS IN SIGHT

NURSE MANAGER

Name:

Month:

PHASE DASHBOARD

	My Result	Site Results	High	Low
PHASE eligible patients assigned to my site, seen in the last 12 months: Tab: PHASE patients / Filter: Site				
PHASE eligible patients not enrolled in PHASE: Tab: Population Management / Filter: Site, Enrolled in PHASE = 'no'				
PHASE eligible patients who are not a goal and due for Case Management: Tab: Population Management / Filter: Site, Case Management 'due', At Goal = 'No'				
PHASE eligible patients on ASA with an exclusion to ASA: Tab: Population Management / Click on the '*QA: ASA Exclusion on ASA Therapy*' To get to the drill sheet				
Active PHASE eligible patients last seen over 12 months ago: Tab: Office Visit Recall List / Filter: Site, Last Office Visit = 'NULL' and 'greater than 12 months'				
% of PHASE eligible patients who are not at goal with Case Management complete: Tab: Case Management Complete / Filter: Site, At Goal = 'No'				
% of PHASE eligible patients without an exclusion to ASA with ASA in their current medication list: Tab: Percent of ASA / Filter: Site				

DIABETES DASHBOARD

% of DM patients with A1C less than or equal to 9%: Tab: DM Clinical Outcome / Filter: Site				
% of DM patients with A1C greater than 9% with a Care Plan complete in the last 12 months: Tab: DM Clinical Outcome / Filter: Site				

MONTHLY RN CHECKLIST

Measure	Result
Number of open Telephone Encounters assigned to me:	
Date of the oldest Telephone Encounter assigned to me:	
Number of open Documents assigned to me:	
Date of the oldest Document assigned to me:	
Number of open Labs assigned to me:	
Date of the oldest Lab assigned to me:	
Do I have any referrals assigned to me?:	
Number of active IOPCM Patients:	
IOPCM Items completed:	
Number of transition care patients with a risk score > 20.	
Number of patients with 4 pillars complete for patients with a risk score > 20. (Face-to-face visit + 4 f/u calls)	

Measure	Result
Number of transition care patients with a risk score <20	
ED f/u calls complete:	
Daily provider jelly management support: (Es, Ds, TEs, Ls)	
Pap and Mammo Tracking complete:	
Reconciled tracked labs complete:	
Performed medication reconciliation: (ER, Hospitalizations, Consult notes)	
Coumadin management per protocol complete:	
No show/cancellation follow-up complete:	
Monthly care team meeting: (at minimum)	
Monthly check-in with CTMA:	
Chart prep attended huddles: (PARS, goal setting for patients being seen)	

PLAN OF ACTION

QUALITY WATCH NURSE

KEEPING OUR GOALS IN SIGHT

Name:

Team:

Month:

PHASE DASHBOARD

	My Result
Number of PHASE eligible patients assigned to my team, seen in the last 12 months:	
Tab: PHASE patients / Filter: Rendering Provider	
Number of PHASE eligible patients Not enrolled in PHASE:	
Tab: Population Management / Filter: Rendering Provider, Enrolled in PHASE = 'no'	
Number of PHASE eligible patients who are not at goal and are due for Case Management:	
Tab: Population Management / Filter: Rendering Provider Case Management = 'due', At Goal = 'No'	
Number of PHASE eligible patients On ASA with an exclusion to ASA:	
Tab: Population Management / Filter: Click on the yellow *QA: ASA Exclusion, on ASA Therapy'* for the drill sheet	

	Goal	My Result
% of PHASE eligible patients who are not at goal, with Case Management complete:		
Tab: Case Management Complete / Filter: Rendering Provider, At Goal = 'No'		
% of PHASE eligible patients without an exclusion to ASA with ASA in their current medication list:		
Tab: Percent on ASA / Filter: Rendering Provider		
Number of active PHASE eligible patients last seen over 12 months ago:		
Tab: Office Visit Recall List / Filter: Rendering Provider, Last Office Visit = 'NULL' and 'greater than 12 months'		

ISSUES AND OPPORTUNITIES

DIABETES DASHBOARD

	Goal	My Result
% of DM patients with an A1C less than or equal to 9%:		
Tab: DM Clinical Outcome / Filter: Rendering Provider		

	Goal	My Result
% of DM patients with A1C greater Than 9% with a Care Plan Complete in the last 12 months:		
Tab: DM Clinical Outcome / Filter: Rendering Provider		

ISSUES AND OPPORTUNITIES

MONTHLY RN CHECKLIST

Measure	Result
Number of open Telephone Encounters assigned to me:	
Date of the oldest Telephone Encounter assigned to me:	
Number of open Documents assigned to me:	
Date of the oldest Document assigned to me:	
Number of open Labs assigned to me:	
Date of the oldest Lab assigned to me:	
Do I have any referrals assigned to me?:	
Number of active IOPCM Patients: IOPCM Items completed:	
Number of transition care patients with a risk score > 20.	
Number of patients with 4 pillars complete for patients with a risk score > 20. (Face-to-face visit + 4 f/u calls)	
Number of transition care patients with a risk score <20	
ED f/u calls complete:	

Measure	Result
Daily provider jelly management support: (Es, Ds, TEs, Ls)	
Pap and Mammo Tracking complete:	
Reconciled tracked labs complete:	
Performed medication reconciliation: (ER, Hospitalizations, Consult notes)	
Coumadin management per protocol complete:	
No show/cancellation follow-up complete:	
Monthly care team meeting: (at minimum)	
Monthly check-in with CTMA:	
Chart prep attended huddles: (PARS, goal setting for patients being seen)	

ISSUES AND OPPORTUNITIES

Support for the 2017 Clinical Areas of Focus

PHASE on ASA | PHASE Dash/On ASA Tab | Goal: 75%

Percent of PHASE eligible patients, seen in the last 12 months who have either a contraindication, an exclusion to ASA or have ASA in their current medication list.

Reportable to: Annual HRSA UDS; Redwood Health Coalition Population Health PHASE Grant

Clinical significance: 40% reduction in heart attack and stroke in high risk population.

Systems in place: RN Tracking; FWC HTN Resources; HeartMath; Ceres Nutrition; Yoga; Qi Gong; FWC Beyond Stress Group; recall on PHASE not seen >12 months, allergy or contraindication to ASA workflow

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Diabetic Care Plans | Diabetes Dash/Clinical Outcomes Tab | Goal: 90%

Diabetic patients, seen in the last 12 months, with last A1C test in the last 12 months with a result of >9 or above with a Care Plan in the last 12 months.

Reportable to: Annual HRSA UDS; Hearts of Sonoma County, Redwood Health Coalition Performance Improvement Program (PIP); Partnership Health Plan Quality Improvement Program (QIP)

Clinical significance: Diabetes is the number one cause of blindness, amputation and dialysis.

Systems in place: RN Care Plans on >9; Non-interfaced Labs Charting Workflow; CTMA DM Standing Lab Order; FWC Diabetes Group (OAHC Spanish Speaking DM Group); Ceres Nutrition; Mindful Eating Group; Herbal Consult; Farmacy; HeartMath; Beyond Stress Group; Recall on DM not seen >12 month, New Patient Chart Abstraction

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Tobacco Screening | CTMA Dash/Tobacco Screen 12 months tab | Goal: 75%

Percentage of patients aged 13 and older, seen in the last 12 months, who have been screened for tobacco use in the last 12 months.

Reportable to: Annual HRSA UDS; Redwood Health Coalition Population Health PHASE Grant

Clinical significance: Cigarette smoking harms nearly every organ of the body, is the number one risk factor for lung cancer and is the number on cause of preventable disease and death worldwide.

Systems in place: chart prep for missing status

Cessation Counseling | CTMA Dash/Cessation 12 months tab | Goal: 75%

Percentage of 'current' smokers, seen in the last 12 months who have documentation of cessation counseling in the last 12 months

Reportable to: Annual HRSA UDS; Redwood Health Coalition Population Health PHASE Grant

Clinical significance: Cigarette smoking harms nearly every organ of the body, is the number one risk factor for lung cancer and is the number on cause of preventable disease and death worldwide.

Systems in place: chart prep for missing status; 1-800-No-Butts handouts; FWC Freedom from Smoking Class via procedure or referral; FWC Acupuncture; Beyond Stress Group

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Annual Depression Screenings on all patients 18 and over | CTMA Dash/Depression 12 months tab | Goal: 50%

Patients seen in the last 12 months, with PHQ2 or PHQ9 complete in the last 12 months.

Reportable to: Annual HRSA UDS, Redwood Health Coalition Population Health PHASE Grant

Clinical significance: Depression is the leading cause of disability and untreated contributes to poor health outcomes with chronic illness.

Systems in place: CTMA DM and HIV Standing Lab Order; SDOH Screening Questionnaire

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Colorectal Cancer Screening | WCHC Clinical Priorities Dash/Colorectal Tab | Goal: 50%

Patients aged 50-75 years, seen in the last 12 months with FIT/FOBT test in the last 12 months OR Colonoscopy in the last 10 years OR Sigmoidoscopy in the last 5 years.

Reportable to: Annual HRSA UDS, Redwood Health Coalition Performance Improvement Program (PIP); Partnership Health Plan Quality Improvement Program (QIP), WCHC Provider Incentive

Clinical significance: Colon cancer is the second leading cause of cancer deaths in the U.S.

Systems in place: eCW alert system; Chart Abstraction Workflow; history of colorectal cancer or colectomy charting workflow; Flu/FIT recall workflow; chart abstraction, non-interfaced lab workflow,

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Cervical Cancer Screening | WCHC Clinical Priorities Dash/Cervical Ca Tab | Goal: 75%

Female patients aged 24-64 with a pap in the last 3 years, if aged 30 and above a pap and HPV in the last 5 years.

Reportable to: Annual HRSA UDS, Redwood Health Coalition Performance Improvement Program (PIP); Partnership Health Plan Quality Improvement Program (QIP), WCHC Provider Incentive

Clinical significance:

Systems in place: Well Woman Exam Recall; hysterectomy documentation workflow; chart abstraction workflow; non-interfaced labs workflow

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Well Child Exams | WCHC Clinical Priorities Dash/WCE Tab or Master Recall/WCE Tab | Goal: 75%

Patients aged 3-6 years old, seen in the last 12 months, with a Well Child Exam in the last 12 months.

Reportable to: WCHC Provider Incentive

Clinical significance: Early developmental screenings are important to identify very young children with developmental delays, disabilities and learning problems. Vaccination helps to protect against serious diseases.

Systems in place: Well Child Recall; Children aged 0-5 years (0-71 months) not seen in >18 months recall; Inactive protocol; Immunization Recall workflow; CAIR/eCW Reconciliation; WAY COOL FWC Referral.

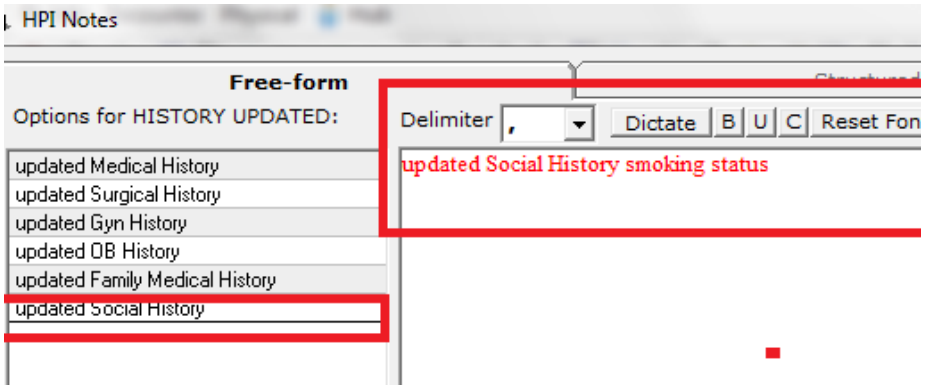
West County Health Centers, Inc.
Clinical Protocol

Clinical Protocol:	Documenting Smoking Status	Category: Clinical
Staff Role:	CTMA	Page: 1 of 3

Protocol Summary:

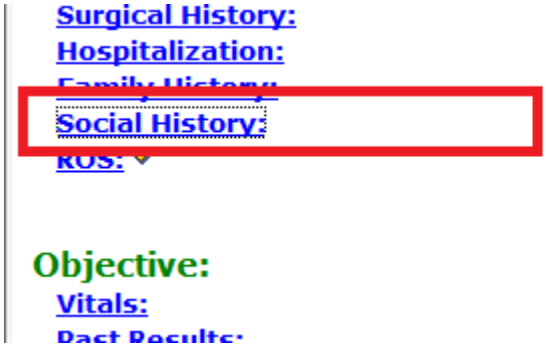
- The CTMA is responsible for obtaining the smoking status on all patients age13 years and older.
- The CTMA will verify the patient's smoking status at every visit.
- The CTMA will inform the provider if they have made any changes to the smoking status by indicating in the HPI section of the Progress Note.
- The CTMA will provide current smokers-The smoking cessation material yearly.

- To notify the provider of a change in the patients smoking status, the CTMA should chart the change in the HPI section of the patients progress note.

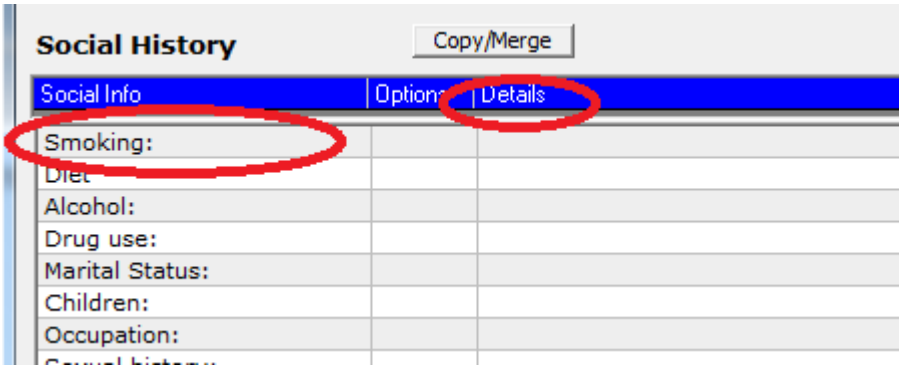


- To chart the smoking status:

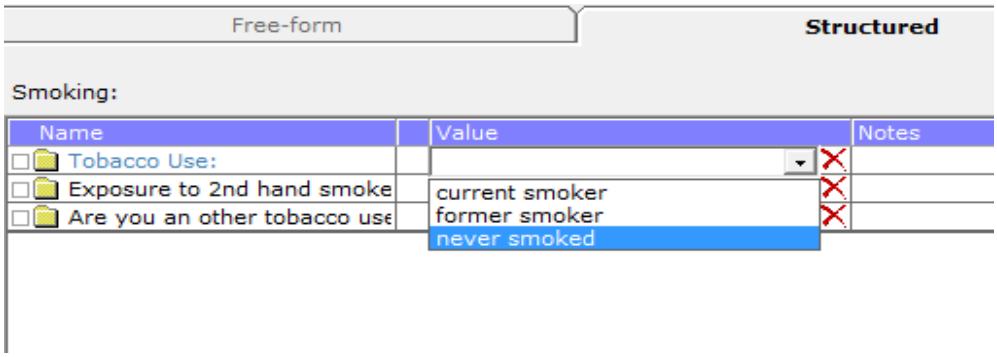
1) In the progress note click on the Social History tab



2) The Social History box will open. Click on the “Details” box next to smoking.

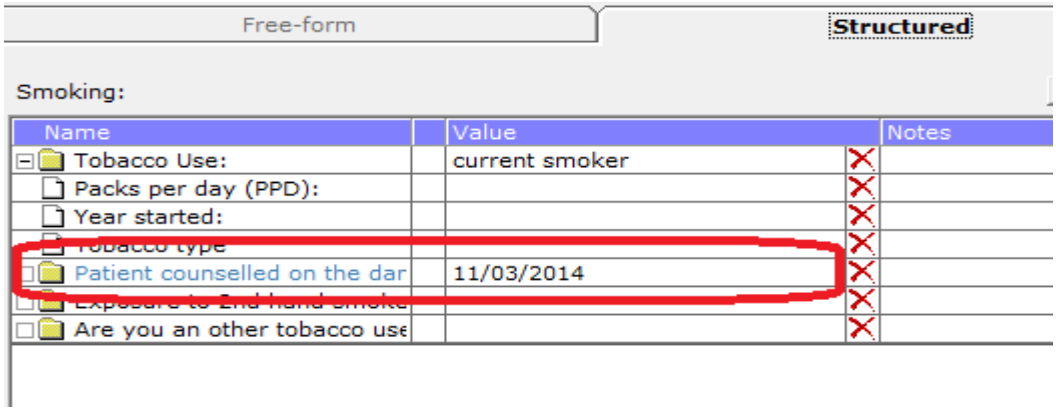


3) The Social History notes tab will appear. Using the structured data fields select current smoker, former smoker or never smoked.

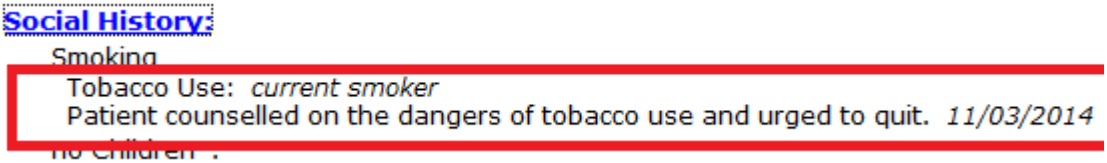


4) If the patient is a current smoker the CTMA will provide patients with the 1-800-NO-BUTTS handout. The CTMA will notify the provider.

5) The CTMA will chart the date the patient was counseled to quit smoking



6) This will populate into the progress note.



7) During chart prep for every office visit, the CTMA should click on the social history tab to make sure that the patient has been counseled within the last year if they are a current smoker.

8) The smoking status should be updated and counseling provided for current smokers annually.

Effective Date: 10/20/2014	**Revision Date: N/A**
Supervisor Approval: JAH *Initial*	**Medical Director Approval: JLC** *Initial*

Volume 13 December 2017

West County Health Centers, Inc.

The Quality Quadrant

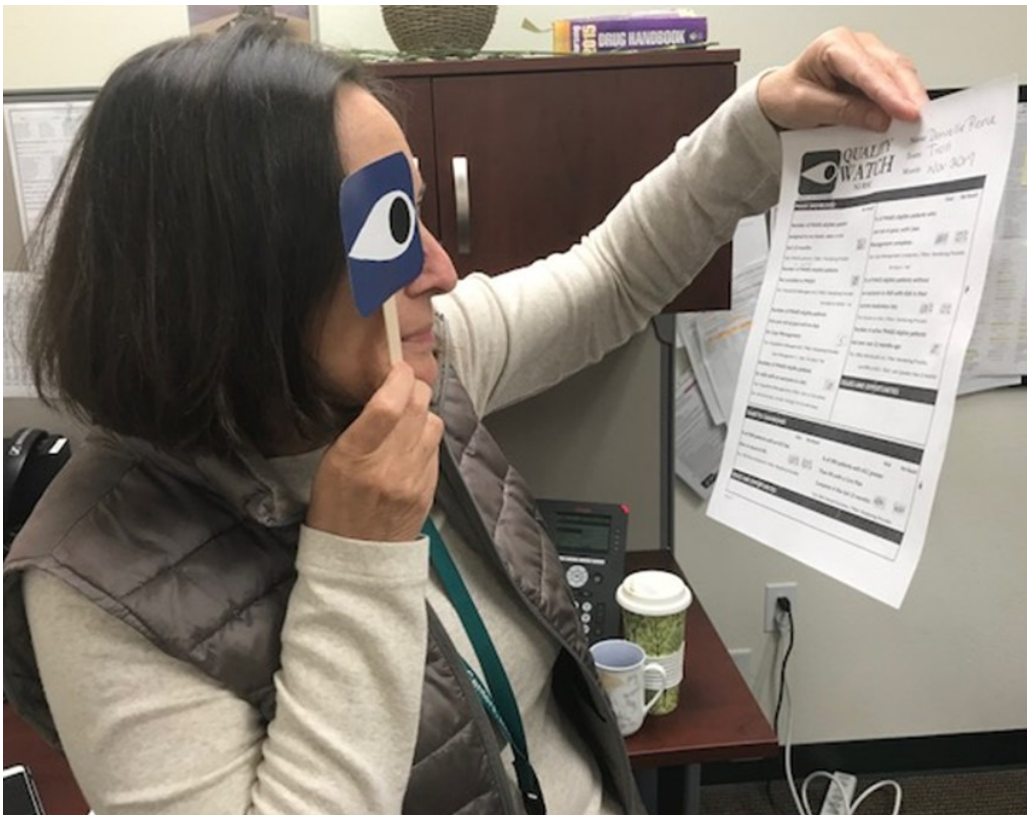
West County Health Center's Quality Management Monthly Report

SPECIAL EDITION

QUALITY WATCH

KEEPING OUR GOALS IN SIGHT

In this issue:



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Check out these Care Team's Action Plans!


DeEtte


Charlie


Ivan


Jennifer

Team DeVille November Quality Goal: FIT Testing

November Colorectal Cancer Screening Results: 23%

Why is this measure important to our team? A great focus that the team is passionate about.

Action Plan: Charlie will Chart Prep; DeEtte will pitch to the patient; Ivan will follow up and Jen will take care of everything else.


Emily


Kenia


Mary


TBD

Team Ramsey November Quality Goal: Well Child Exams

November Well Child Exam Results: 77%

Why is this measure important to our team? Because we have a very small number of patients that are due.

Action Plan: Front Office to recall using the WCE Due list.


Jason


Yazmin


Diana


Donna

Team Cunningham November Quality Goal: Smoking Cessation

November Tobacco Cessation Results: 64%

Why is this measure important to our team? Important for our team to create a consistent workflow.

Action Plan: Diana to review Tobacco Status at Chart Prep.


Steve


Marlee


Adriana


Joe

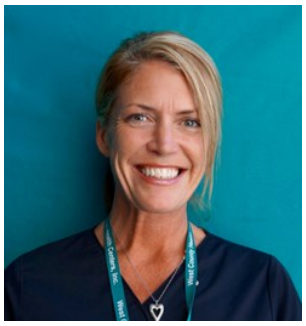
Team Bromer November Quality Goal: Colorectal Cancer Screening

November Colorectal Cancer Screening Results: 36%

Why is this measure important our team? We want to prevent Colorectal Cancer

Action Plan: Mail out the FIT kit one week prior to patient's Office Visit with reminder letter of importance for screening.


Brooke


Eve


Jymmey


Becky

Team Vezino November Quality Goal: Depression Screening

November Depression Screening Results: 14%

Why is this measure important to our team? Depression is common in general and increased not because of increased stress in our community. We want to increase the behavioral health connection.

Action Plan: Eve will screen each adult. Team to check-in end of day on success.

Team Griego November Quality Goal: Tobacco Screening and Cessation Counseling

November Tobacco Screening Results: 60%

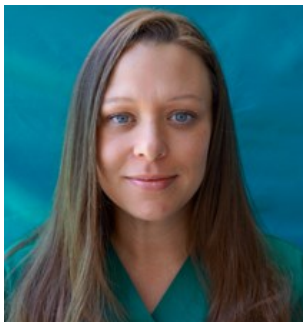
November Cessation Counseling Results: 28%

Why is this measure important to our team? Smoking is bad for you. Everytime it is mentioned it makes a difference.

Action Plan: Jessica to add date after status to remind MA/Provider when the year is up.


Kathleen


Blanca


Danielle


TBD

Team Whisman November Quality Goal: PHASE on ASA

November PHASE on ASA Results: 42%

Why is this measure important to our team? Many of our patients are entering into this population. It is important to prevent the risk.

Action Plan: Blanca to ask all PHASE patients when rooming if they are taking ASA.


Rain


Maritza


Linda


Sasha

Team Moore November Quality Goal: Well Child Exams

November Well Child Exam Results: 77%

Why is this measure important to our team? We are so close to the goal.

Action Plan: Maritza to run the recall list and recall the patients.


Molly


Cruz


Daniel


Rachel

Team Kirkconnell November Quality Goal: Colorectal Cancer Screening

November Colorectal Cancer Screening Results: 40%

Why is this measure important to our team? This is important preventive medicine and our team is still below the goal.

Action Plan: We will focus on capturing data on patients already screened. Molly to review patients who have been screened but alerts still show as due. Will create a TE to fix documentation. Cruz and Daniel to work on getting patients docs in.


Trina


Kim


Maritza


Jeanette

Team Bowen November Quality Goal: Cervical Cancer Screening

November Cervical Cancer Screening Results: 81%

Why is this measure important to us? Paps are an important health exam

Action Plan: Maritza to print the recall list. Trina to review to be sure the rendering provider is assigned correctly and will note who sees a GYN Specialist.


Tori


Melissa


Daniel


Jade

Team Davis November Quality Goal: Depression Screenings

November Depression Screening Results: 4%

Why is this measure important to us? We know this is an important topic to discuss with every single person and also a workflow we can definitely improve on.

Action Plan: Melissa to ask every single patient that is over 18 the PHQ-2 questions.


Wendy


Jasmine


Julie

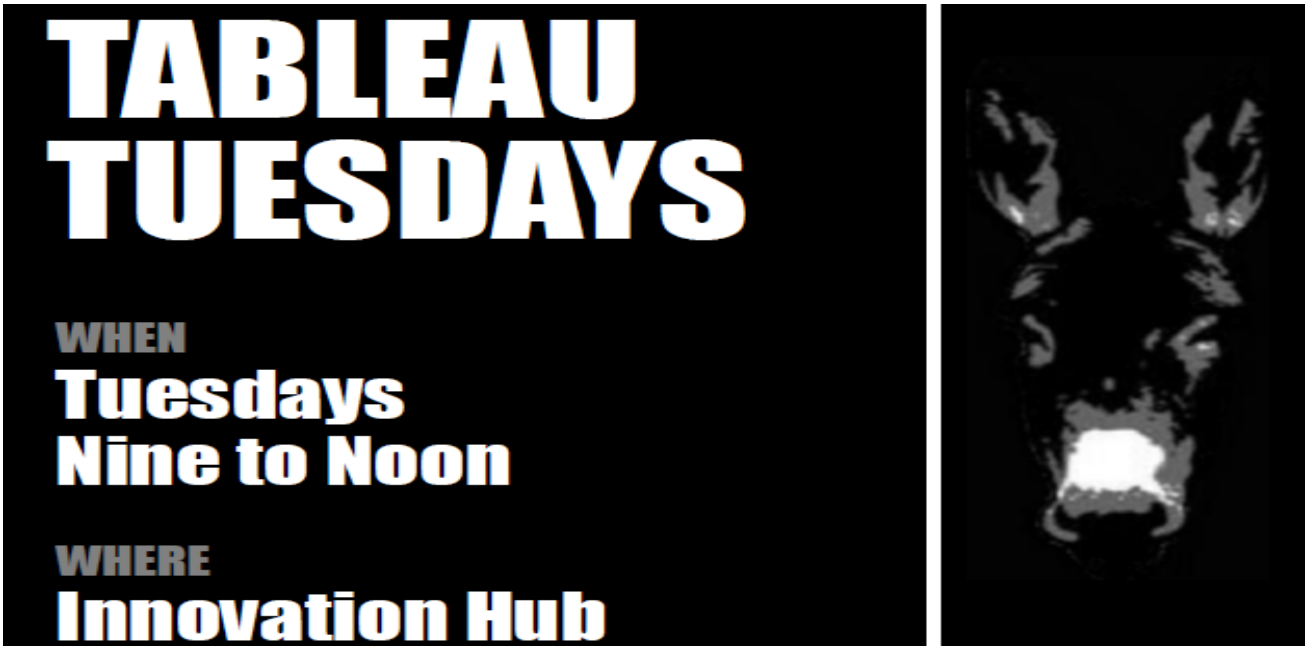

Daniel

Team Wiley November Quality Goal: Depression Screening

November Depression Screening Results: 9%

Why is this measure important to our team? We feel it is an important issue that we can focus and improve on.

Action Plan: Jasmine and Julie to make sure they review and understand the Depression Screening Charting Workflow.



Data Donkeys

Donkey Egg Scavenger Hunt

Tableau Server

What is your favorite part about Tableau Server?

Yazmin Vazquez

"My favorite part is how quickly everything loads and how easy it is to use. It's a one stop shop"

Kendrick Alexander

"It's faster!"