Health Center Field Example

Perry Pong, MD, Chief Medical Director
Sumana Rao, RN, MBA, Clinical Director

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CHARLES B. WANG COMMUNITY HEALTH CENTER

Charles B. Wang Community Health Center
王嘉廉社區醫療中心

The Chinatown Health Clinic opened its doors in 1971, run entirely by volunteer doctors, nurses, social workers, community health workers, and students.

The clinic was renamed Charles B. Wang Community Health Center in 1999. It has continuously expanded and grown to provide bilingual and bicultural health care services to underserved communities.

Total Patients Served: 55,510

UDS Measure	National	Charles B. Wang
Colorectal	42%	68%
Cervical	53%	81%
HTN	60%	70%
BMI	61%	93%
Depression	67%	85%
Diabetes	32%	11%

QI/QA Program

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Culture

- **Leadership commitment to QUALITY**
  - Investment of resources & effort
    - Clinical Informatics staff build and generate reports
    - Staff with specific responsibilities for QI/QA support/reporting

Policies and Procedures

- **Structure**
  - QI/QA Policy
  - Annual QI/QA Work plan

Structured QI Processes: Reporting & Review

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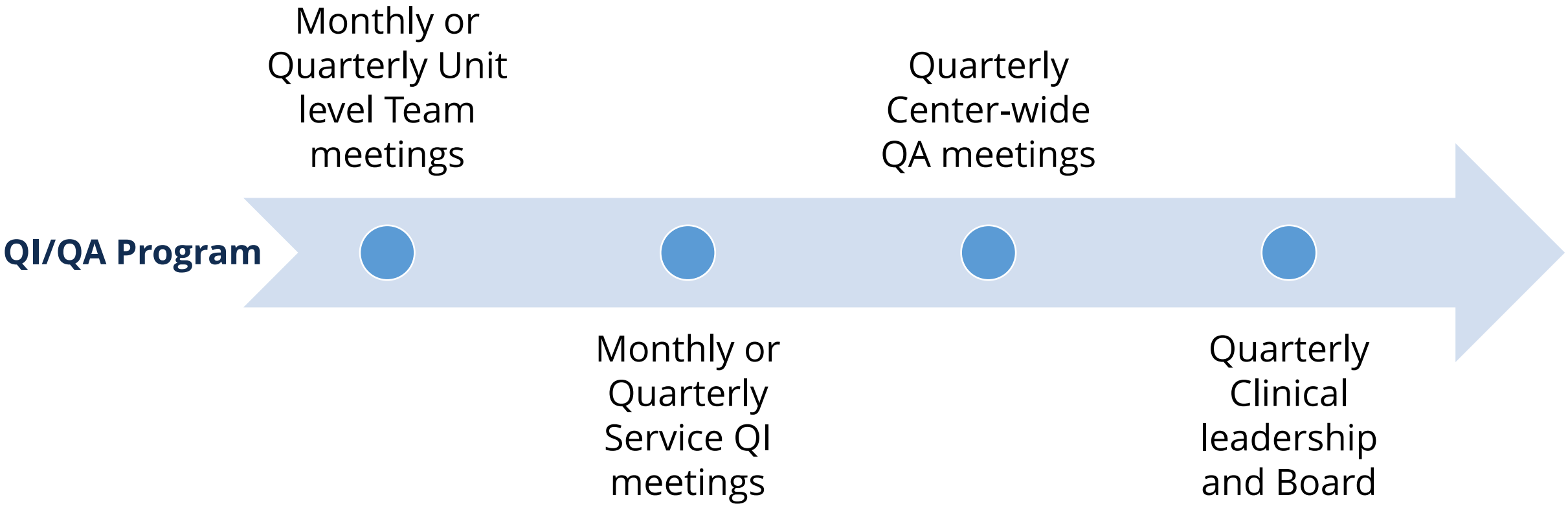

Center-wide QA Committee: Quarterly UDS Data Review

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Ideally, all staff know the basic definitions and what the health center is trying to achieve

	2019 UDS Report	2020 UDS Report	2021 Q1-Q4 UDS Report	CBWCHC 2019 Goal & HRSA 2022 (3 Year) Goal	NYS 2020 Health Center Average
Prenatal Care - *% receiving prenatal care in the 1st trimester*	95.16%	94.45% (1140/1207)	**96.9% 864/892**	90.00%	79.13%
Low Birth Weight - *% of births under 2500g*	6.22%	5.70% (38/667)	**5.7% 29/512**	5.00%	8.46%
Cervical Cancer Screening - % women 21-64 with appropriate screening* *2016 obsolete definition*	82.25%	78.78% (14244/18080)	**81.2% 15941/19635**	82.50%	56.64%
Breast Cancer Screening (new measure, revised 2020)	N/A	67.53% (4462/6607)	**67.9% 5015/7386**	*75.00%*	52.22%
Weight Assessment and Counseling for Children and Adolescents 3-17	94.40%	91.24% (11895/13037)	**91.4% 12542/13715**	95.00%	66.78%
Adult Weight Screening / Follow Up	93.76%	92.80% (27376/29499)	**93.5% 31859/34079**	88.00%	63.18%
Tobacco Use Assessed and Counseled	96.39%	94.71% (28796/30404)	**85.7% 29761/34711**	97.50%	84.37%
Colon Cancer Screening	67.35%	67.52% (8078/11963)	**68.0% 8930/13126**	70.00%	46.40%
Immunizations - *% of 2 yo received 25 required immunizations (*revised 2016)*	81.44%	84.30% (714/847)	**83.3% 660/792**	82.00%	43.35%
Statin Therapy (*new measure, revised 2019)	69.12%	71.54% (3366/4705)	**84.1% 3375/4012**	*72.00%*	67.30%
Ischemic Vascular Disease – *on aspirin or other antithrombotic drug use*	89.55%	88.70% (722/814)	**87.6% 742/847**	95.00%	79.19%
Hypertension Control – *% under 140/90*	80.72%	66.25% (4338/6548)	**70.3% 5297/7540**	80.00%	60.46%
Diabetes Control - *% poorly controlled (Hba1c missing or >9)*	10.31%	13.32% (401/3011)	**11.0% 353/3209**	8.00%	32.10%
Dental - % of children 6-9 at mod or high risk had sealant on 1st permanent molar during yr (*revised 2016)	84.78%	72.22% (52/72)	64.71% 102/129	80.00%	43.70%
MH – Depression Screening and follow up care	84.77%	72.50% (26401/36413)	**85.1% 33633/39524**	92.50%	64.81%
HIV - New Dx and Linkage to Care	50.00%	100% (1/1)	100% 1/1	100%	87.74%
HIV Screening (new measure, revised 2020)	N/A	52.81% (17321/32801)	**56.4% 20091/35604**	*60.00%*	48.14%
Depression Remission at 12 Months (new measure, revised 2020)	N/A	9.09% (26/286)	10.76% 27/251	*15.00%*	23.43%

Track Performance: QI Example - Diabetes Measure

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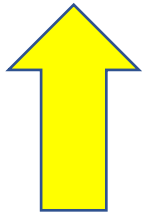
UDS Measure	2017	2018	2019	2020	2021
Diabetes: Hemoglobin A1c Poor Control	9.16 %	11.40 %	10.31 %	13.32 %	11.00 %

Diabetes: Hemoglobin A1c Poor Control (source: HRSA/UDS)



Use Data to Drive Improvement

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QI Example – Diabetes Measure

	2020				2019				GOAL
	Denominator	Numerator	%		Denominator	Numerator	%		8%
	2638	260	9.86%		3132	323	10.3%		
Site - Dept	Denominator	Numerator	%						
Canal - IM	1416	126	8.9%						
Flushing - IM	1003	80	8.0%						
F45 - IM	186	28	15.1%						
Canal - WH	18	18	100.0%						
Flushing - WH	8	4	50.0%						
Flushing Urology	3	3	100.0%						
CBWCHC	2	1	50.0%						
Canal - CARDIO	1	0	0.0%						
Flushing - PED	1	0	0.0%						

Look at the data and ask questions:

- What do we see?
- Why are some patients not meeting target?

Do the analysis and share the findings

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QI Example – Diabetes Measure

Clinical Informatics and Clinical Units collaborate on generating reports

Reasons for no A1c: All Sites

Reason	Number	%
GYN visit(s) only	64	43.2%
Televisit(s) only	51	34.5%
Not ordered	37	25.0%
Ordered, not done	27	18.2%
Switched to outside PCP	17	11.5%
Deceased	5	3.4%
Out of country	4	2.7%
Pulmonology visit(s) only	4	2.7%
Out of state	3	2.0%
Urgent care visit(s) only	3	2.0%
Refused/deferred labs	3	2.0%
F/U with endo	1	0.7%
Outside PCP	1	0.7%
DM diagnosis removed (resvolved)	1	0.7%
In Rehab	1	0.7%
APE visit only	1	0.7%
ER F/U only	1	0.7%
IPE late Dec	1	0.7%
# Unique patients	148	

CBW	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
# Active patients in DM Registry	2943	2947	2962	2997	3010	3065	3111	3122
% 2 A1C tests in past 12 months (>=91 days apart)	66.26%	66.27%	71.40%	77.44%	80.83%	83.23%	83.90%	83.79%
Average A1C	6.86%	6.81%	6.89%	6.97%	7.02%	7.05%	7.05%	7.04%
% A1C < 7.0%	53.89%	52.77%	52.53%	52.99%	53.19%	52.76%	53.81%	54.64%
% A1C >= 7.0 and <= 9.0%	36.73%	37.19%	37.85%	37.94%	38.67%	39.22%	38.51%	38.28%
% A1C > 9.0%	5.84%	5.70%	5.98%	6.37%	6.08%	6.43%	6.24%	5.93%
% A1C < 8.0%	82.09%	81.40%	80.62%	81.41%	81.99%	82.41%	83.16%	83.89%
No A1C in the past 12 months	3.53%	4.34%	3.65%	2.70%	2.06%	1.60%	1.45%	1.15%
Average BP	129/77	129/77	129/77	129/77	129/76	128/76	127/76	127/75
% BP < 130/80	40.98%	40.38%	40.55%	42.21%	43.09%	46.56%	48.54%	49.39%
% BP < 140/90	81.82%	82.15%	81.26%	81.35%	82.62%	83.59%	83.86%	84.24%
Average LDL	84.12	83.71	83.73	84.18	84.56	85	85.82	85.85
% LDL < 100 in past 12 months	64.80%	64.40%	65.80%	67.50%	68.31%	68.32%	67.18%	66.98%
Average BMI	26.8	26.8	26.77	26.76	26.76	26.72	26.64	26.62
% BMI < 23 in the past 12 months	18.42%	18.12%	18.47%	18.15%	17.91%	18.30%	18.90%	19.60%
% Microalbuminuria screening in past 12 months	85.73%	85.41%	87.61%	89.92%	91.03%	91.71%	90.97%	90.29%
% Influenza Vaccination in past 12 months	76.32%	76.42%	76.57%	76.64%	76.45%	76.08%	75.15%	74.50%
% Pneumococcal Vaccination ever	92.12%	92.03%	91.53%	90.86%	90.50%	90.21%	90.00%	90.39%
% Depression screening in past 12 months	73.84%	73.63%	74.41%	80.05%	84.35%	86.59%	88.97%	89.91%
% Dilated eye exam in past 12 months	33.61%	32.34%	33.79%	37.14%	40.03%	41.96%	42.75%	42.99%
% Foot exam in past 12 months	58.48%	58.50%	61.58%	65.50%	69.47%	72.37%	73.83%	73.70%
% Dental exam in past 12 months	1.09%	1.29%	1.89%	2.10%	2.09%	2.25%	2.28%	2.21%
% Smoking Assessment in past 12 months	74.89%	74.75%	75.42%	78.18%	80.47%	81.60%	82.45%	81.71%
% Current smokers	8.77%	8.82%	8.88%	9.04%	8.80%	8.97%	9.23%	9.35%
% Smokers received cessation counseling in past 12 months	74.42%	73.46%	73.76%	75.65%	78.87%	79.27%	81.53%	80.48%
% CDE referral ever	34.39%	34.24%	33.93%	33.63%	33.39%	32.79%	32.40%	32.64%
% CDE visit ever	25.38%	25.35%	25.22%	24.96%	24.72%	24.31%	24.04%	24.18%
% Nutrition referral ever	51.10%	50.83%	51.05%	50.88%	50.70%	50.38%	50.02%	50.00%
% Nutrition visit ever	21.27%	21.48%	21.64%	21.65%	21.69%	21.27%	21.22%	21.11%

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2021 Annual QI Project – Diabetes Measure

Site A Internal Medicine

Targeted **new** patients & **newly diagnosed** patients who have uncontrolled diabetes with HbA1C > 9%, who are most likely to be **amenable to interventions** of treatment and lifestyle modifications.

Site B Internal Medicine

Targeted patients with **poor diabetes control** (<9%) who have been poor controlled **for 1 year or more.**

Not everything is a project – sometimes we just try something! We introduced point of care A1c machines – and encouraged teams to use for patients who did not have A1c documented.

QI Tools: Sample QI Project Progress Report Form

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QI Example:
Diabetes Measure

Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)				
	Q1	Q2	Q3	**Project Progress** Assess actions and describe improvement or other results
Measure Data	7.19% 80 active patients in target population	41/1018=4.03% 82 active patients in target population	36/1137=3.17% 81 active patients in target population	
Action steps to achieve goals 1. Use EMR reports to identify patients with uncontrolled diabetes. 2. Analyze if any race/ethnic disparity in targeted uncontrolled patients. 3. Use collaborative care model to identify and case manage patients. 4. Recall patients with no scheduled appointments in the next 4-6 weeks to follow up with clinician, and/or care manager/CDE. 5. Monitor medication compliance closely .	❖ 31 on insulin = 39% ❖ 14 refused insulin ❖ 34 with diabetic complication ❖ 73 non-compliant patients ❖ 43 patient with obese Breakdown of target population is above. Rate/number of patients meeting criteria is higher than initial baseline due to more patients returning for onsite visits. Will use patient centered, Individualized care approach: Understanding patient's social behavior changes and	Net increase of patients= 2 35 /82 on insulin = 43% 18/82 refused insulin – 22% 37/82 with diabetic complications = 43% 78/82 non-compliant patients = 95% 46/82 = overweight or obese = 56% Overall improved the number and % of patients on insulin, which is a positive outcome. Continuing Care management strategies employed:	34 /81 on insulin = 42% 17/81 refused insulin – 21% 37/81 with diabetic complications = 46% 74/81 non-compliant patients = 91% 45/81 = overweight or obese = 56% **Continuing Care management strategies employed:** Intervention regarding home/social service needs: • Problem solve adherence issues • Locating and referral to community resources	

Regular Schedule of QI Activities & Expectations

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Quarterly **progress meetings**

Clinical director may attend to advise or help with documentation

Project **progress reports** are due quarterly to QI/QA Clinical director and CMO

Results summarized quarterly and provided for review by our Board and MDAC*

*MDAC – the Medical and Dental Advisory Committee – a standing subcommittee of the governing board.

Key Takeaways

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Invest in the program:
Communicate the importance of QI/QA, designate resources, ensure participation at all levels.

Have a process and follow it:
Establish reporting and set deliverable goals – provide support to get it done!

Report to the board and key management:
QI/QA work is reported to the MDAC/Board. This includes UDS Measures, patient experience data, QI/QA project summaries, risk management data, and peer review results. Dashboards are great if you can do them.

Make space to share the lessons learned:
Every clinical service presents at the QA Committee at least once a year to share PDSAs, findings, and most importantly– lessons learned!