Improving Patient Care (IPC) Measures and Data Collection

Nese Myles
IT Specialist, Data Management
IPC Program, Rockville, MD

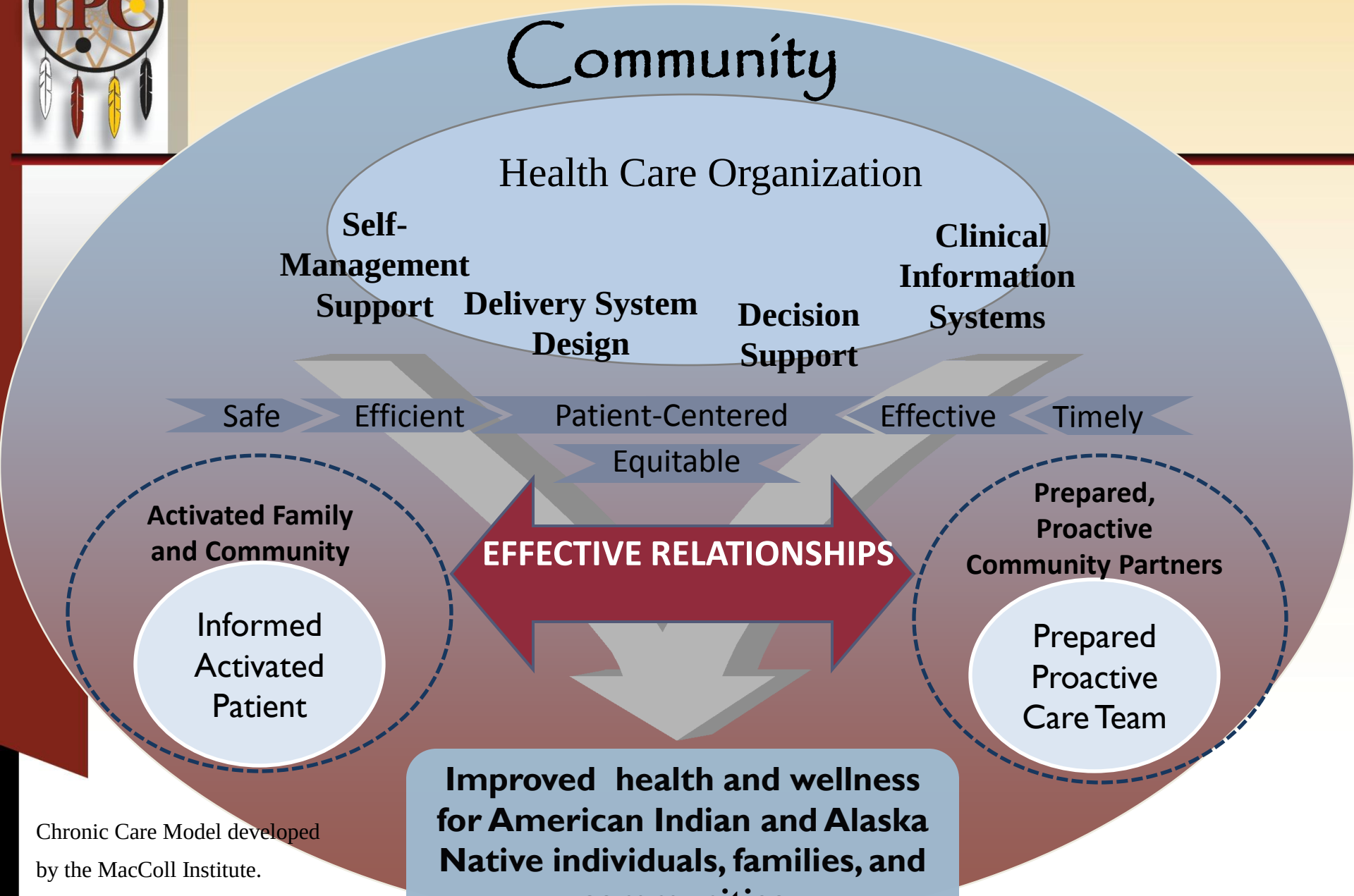
Objective

- Summarize IPC measures
- Review CRSv13.0 logic changes w/ IPC Measures
- Report process and collection on IPC measure data

IPC National Program

- IPC Collaborative year Sept 2012-Dec 2013 – 15 months
- 95 Teams (32 IPC4 and 63 QILN Teams)
- Federal, Tribal and Urban Representation
- IPC National Website: www.ihs.gov/ipc

Care Model for the Indian Health System



Chronic Care Model developed by the MacColl Institute.

Improving Patient Care (IPC) Measures

IPC Measures

- Track improvements and dissemination activities in IPC Collaborative
- Identify the relationship and value between the measures and change packages
- Assess progress and improvement work
- Promote the use of data for improvement
- Identify how access, roles, the clinical information system affect measures
- Indicators that are in need of improvement

IPC Core Measures

Measurement Domain	Areas of Focus/Coverage	Core Measure(s)	Goal
Clinical Prevention Screening	Keeping Current on Preventive Screenings	**Health Risk Screening Bundle:** BMI, Tobacco Screening, DV/IPV Screening, Depression Screening, Alcohol Screening, Blood Pressure.	80%
	Keeping Current on Cancer Screening	**Cancer Screening Bundle:** Colorectal Cancer Screening, Cervical Cancer Screening, Breast Cancer Screening.	70%
Management and Prevention of Chronic Conditions	Control of Blood Pressure, Lipids, and A1c	**Outcome Bundle:** A1c in Control (DM), Control of Blood Pressure (DM/IHD or HTN), Control of Lipids (DM and/or IHD)	70%
	Diabetes Care	**Diabetes Comprehensive Care Bundle:** Documented A1c, Documented BP, Documented LDL, Nephropathy Assess, Retinal Screen, Foot Exam	70%
	Chronic Illness and Cancer Prevention	Tobacco Cessation & Counseling	70%
	Chronic Illness and Behavior Change Support	Identification of the Obese / Weight Management Follow-Up (18-64)	70%
		Anti-Depressant Medication Management (18+)	70%
Costs	None	See Advanced Measures	N/A
Patient Experience	Experience and Efficiency	Average Office Visit Cycle Time	45 minutes
		Patient Experience: Single question (#7)*	90% (4 or 5)
	Building Relationships for Care	Percent of Patients Empanelled to a Primary Care Provider	90%
		Number of patients in the Microsystem	1000+
		Continuity of Care to a Care Team	80%
		Continuity of Care to a Primary Care Provider	80%
	Access	Third Next Available Appointment to a Medical Provider	0 days
		Number of ER and Urgent Care Visits	50% decrease
	Patient Activation	Percent of Patients with Self-Management Goal Set	70%

Health Risk

Comprehensive Bundle: Goal 80%

Alcohol Misuse Screening	**BMI Assessed**	**Depression Screening**	**Domestic/IPV Screening**	**Tobacco Screening**	**Blood Pressure Screening**

Health Risk Screening Measures (6)

- BMI (body mass index)
- Tobacco Screening
- DV/IPV – Domestic/Intimate Partner Violence
- Depression Screening
- Alcohol Misuse Screening
- Blood Pressure Screening

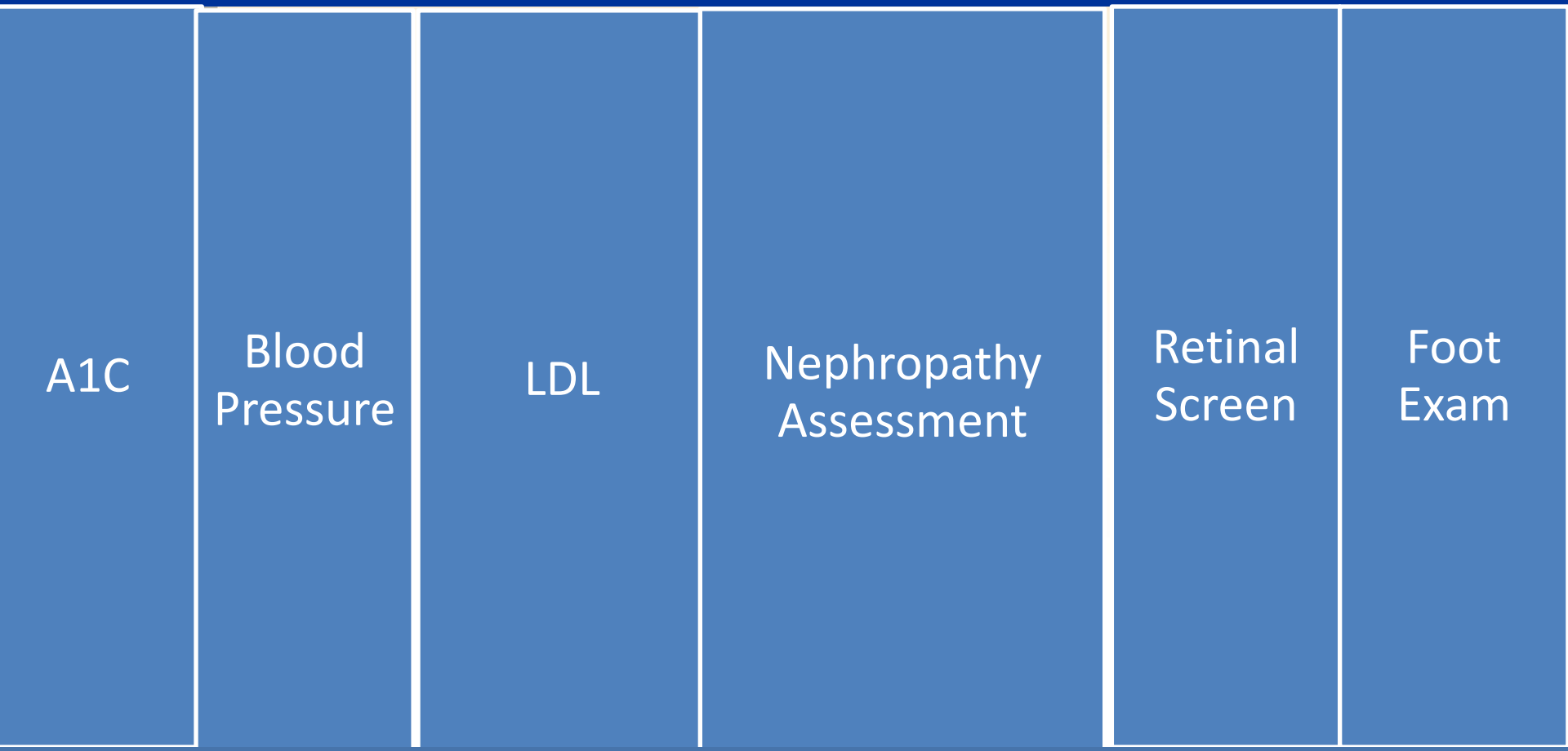
Cancer Screening Comprehensive Bundle: Goal 70%

Breast Cancer Screening: women ages 52-64 with mammogram in past 2 years	Cervical Cancer Screening: women ages 25-64 with documented PAP smear in past 4 years	Colorectal Cancer Screening: Patients ages 50-75 years with colorectal cancer screening

Outcome Bundle: Goal 70%

A1C in Control: Diabetic Patients with an A1C<8.0 within the past year	**Blood Pressure in Control:** DM/IHD patients with BP<140/90 or HTN pts with BP <140/90	**LDL in Control:** DM/IHD patients with last LDL<100 in the past year

Diabetes Comprehensive Measures: Goal 70%



Additional IPC Core Measures

Measurement Domain	Areas of Focus/Coverage	Core Measure(s)	Goal
Conditions	Chronic Illness and Cancer Prevention	Tobacco Cessation & Counseling	70%
	Chronic Illness and Behavior Change Support	Identification of the Obese / Weight Management Follow-Up (18-64)	70%
		Anti-Depressant Medication Management (18+)	70%
Costs	None	See Advanced Measures	N/A
Patient Experience	Experience and Efficiency	Average Office Visit Cycle Time	45 minutes
		Patient Experience: Single question (#7)*	90% (4 or 5)
	Building Relationships for Care	Percent of Patients Empanelled to a Primary Care Provider	90%
		Number of patients in the Microsystem	1000+
		Continuity of Care to a Care Team	80%
		Continuity of Care to a Primary Care Provider	80%
	Access	Third Next Available Appointment to a Medical Provider	0 days
		Number of ER and Urgent Care Visits	50% decrease
	Patient Activation	Percent of Patients with Self-Management Goal Set	70%

IPC Core Pediatric Measures

Measurement Domain	Areas of Focus/Coverage	Core Measure(s)	Goal
Clinical Prevention	Women's Health	HIV Screening for Pregnant Women	80%
	Let's Move! in Indian Country: Physical Fitness and Prevention of Childhood Obesity Baby Friendly Initiative: Breast Feeding Assessed	Breastfeed Assessment Breastfeed Screen at 2 months.: exclusive/mostly breastfed Breastfeed Screen at 6 months: exclusive/mostly breastfed Breastfeed Screening at 2 months Breastfeed Screening at 6 months	80%
	Physical Activity Level, and Behavior Change Support	Physical Activity Screening (5+)	70%
		Weight Assessment & Counseling (2-16) *	80%
	Keeping children current on childhood immunizations	Pediatric Immunizations: Percentage of 19-35 month olds with 4:3:1:3:3:1:4	90%
	Early Childhood Caries: Dental prevention of early child caries	Fluoride Application for Pediatric Patient Population	50%
	Evidence Based Treatment	Appropriate Testing for Pharyngitis (2-18)	80%

IPC Advanced Measures

Measurement Domain	Areas of Focus/Coverage	Core Measure(s)	Goal
Management of Chronic Conditions	Cardio Vascular Disease (CVD) Care	**CVD Bundle**: Tobacco Use, BP Assessed, BMI Assessed, LDL Assessed, Lifestyle Counseling	70%
	Million Hearts Campaign	IVD: Use of Aspirin or other Antithrombotic	80%
		Hypertension (HTN): Controlling High Blood Pressure	80%
		Cholesterol – Fasting Low Density Lipoprotein (LDL) Test Performed AND Risk-Stratified Fasting LDL: IVD Lipid Panel Assessment and LDL Control	80%

CRSv13 Impact on IPC Measures

- 64 IPC Measures
- 13 IPC Measure Changes based on FY 2013 CRS Measure logic changes
- These IPC measures will reflect new logic

IPC Measures Affected from CRS v13.0 Logic Changes

Area of Focus /National Initiative	IPC Measure	New Logic	Old Logic
Control of Blood Pressure, Lipids	Outcome Bundle - A1c Control	A1c < 8	A1c < 7
Control of Blood Pressure, Lipids and A1c	Outcome Bundle - Control of BP (**DM**/IHD, HTN)	<140/90	<130/80
Early Childhood Caries: Dental Prevention	Fluoride Application for Pediatric Patient Population	Fluoride application in children 1-15	Fluoride application in children 2-15
Keeping children current on childhood immunizations	Pediatric Immunizations	4313*314 3* HiB	4:3:1:3:3:1:4
Keeping current on Cancer Screenings	Cancer Screening Bundle: Cervical Cancer Screening	25-64, Pap screenings w/i previous 4 years	21-64, Pap screenings w/i previous 3 years
Keeping current on Cancer Screenings	Cancer Screening Bundle: Colorectal Cancer Screening	HEDIS Logic, 50-75 yr.	51-80 yr., included DCBE
Chronic Illness and Cancer Prevention	Tobacco Cessation and Counseling	Numb: Current tobacco users or users in cessation or ex-smokers, Den: Current tobacco users or tobacco users in cessation	Numb: Current tobacco users or users in cessation, Den: Current tobacco users
Cardio Vascular Disease (CVD) Care	Cardio Vascular Disease (CVD) Care Bundle	LDL Assessment during the year, CVD Patients	LDL Assessment in last 5 years, IHD Patients
Chronic Illness and Behavior Change Support	Anti-Depressant Medication Management Optimal Practitioner Contacts	Anti-Depressant Medication Management Acute and Continuous Phase	All 3 Anti-Depressant Medication Mgmt. Measures

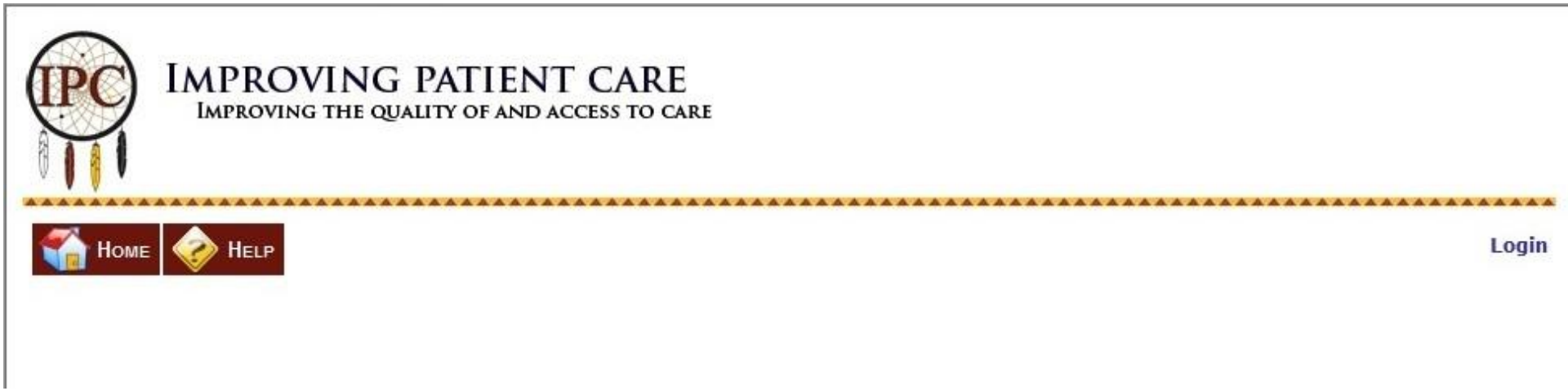
IPC Data Collection

Data Collection

- IPC Data Portal
- IPC4-QILN Data Template
- Reporting w/ iCare on IPC measures
- Reporting out on manual IPC measures
- Upload templates to the Data Portal

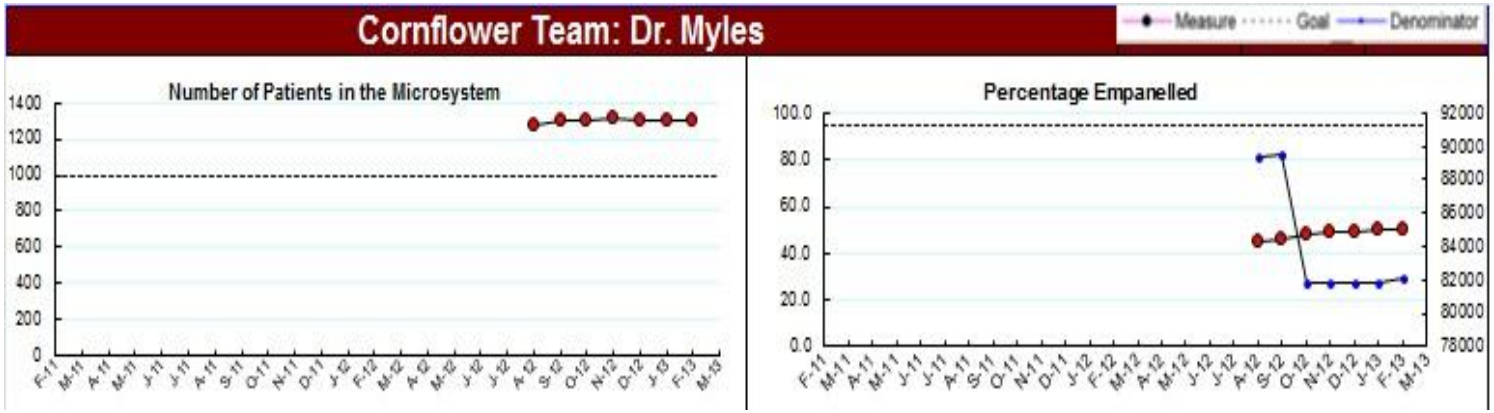
IPC Data Portal

- Centralizes reporting to one location so
- Teams can upload measure data and narrative reports
- Teams can view report status, data results with run charts, and small multiple graphs



IPC4-QILN Data Template

Cornflower Team: Dr. Myles											
	Total Patients in Microsystem		Empanelled Primary Care Provider			Diabetes Comprehensive Care - Bundle			Health Risk Screening Bundle		
Month	Number of Patients	Total	Patients with a visit within last 3 years empanelled to PCP	Pts with a visit to any clinic in the last 3 years	Percent of Patients Empanelled to a Primary Care Provider	Patients with complete Diabetes Comprehensive Care ≤ 1 year	Active Diabetic Patients	Percent of Patients with all Diabetes Comprehensive Care components	Patients with all 6 indicators met	Denominators from the 6 indicators	Percent of Patients Screened in All Applicable measures
Aug-12	1282	1282	40202	89437	45.0	311	328	94.8	693	1239	55.9
Sep-12	1301	1301	40777	89506	45.6	307	333	92.2	693	1222	56.7
Oct-12	1306	1306	39393	81861	48.1	303	333	91.0	683	1226	55.7
Nov-12	1310	1310	39939	81846	48.8	302	333	90.7	690	1231	56.1
Dec-12	1296	1296	40437	81869	49.4	301	334	90.1	689	1221	56.4
Jan-13	1303	1303	40791	81872	49.8	300	333	90.1	670	1221	54.9
Feb-13	1303	1303	41202	82169	50.1	315	328	96.0	658	1218	54.0
Mar-13		#N/A			#N/A			#N/A			#N/A



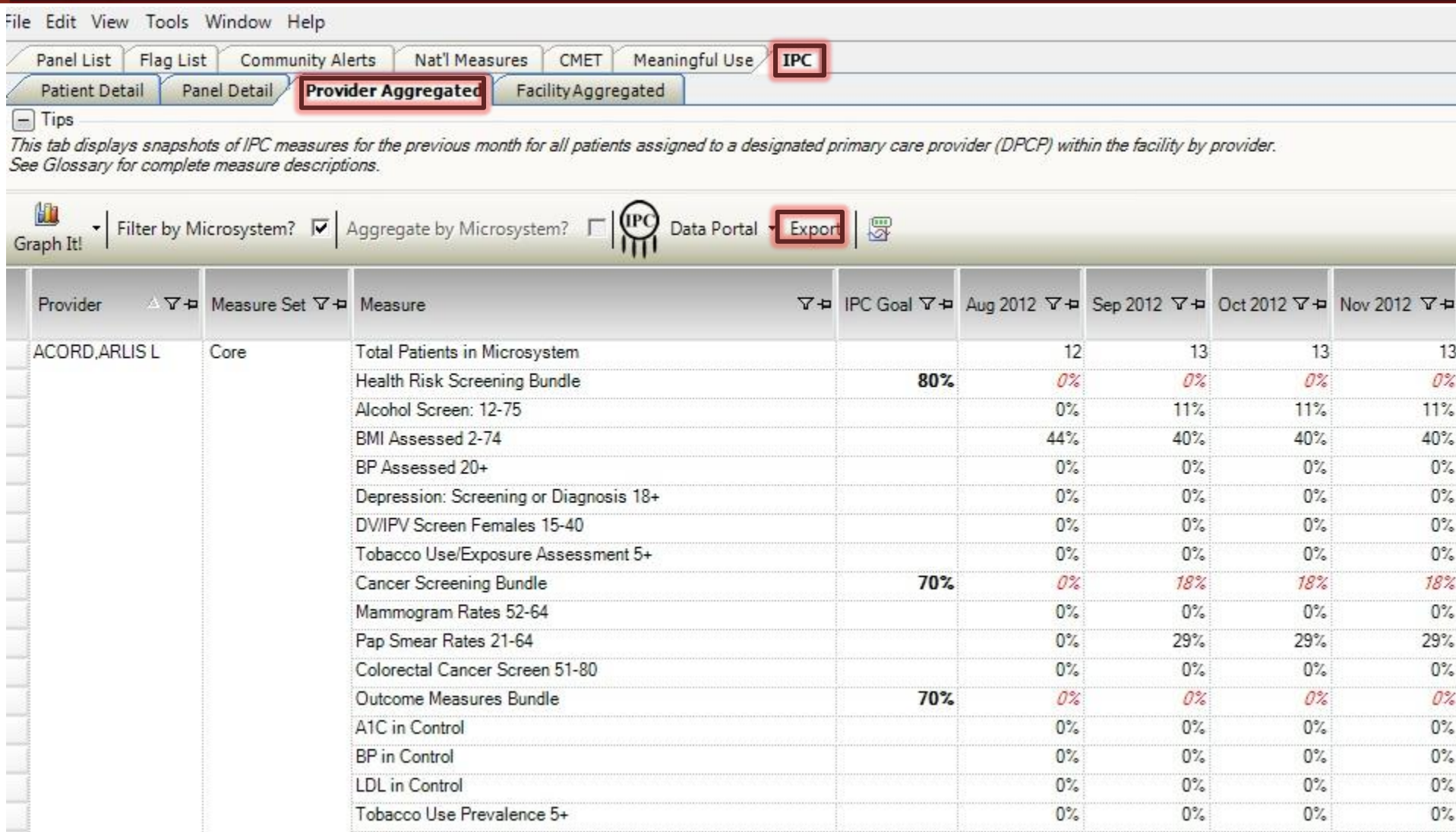
IPC Measure Reporting w/ iCare

- iCare streamlines reporting process for IPC sites by collecting measure data
- Ability to drill down on measures
- Monthly data collection on IPC measures
- Export measure automatically into IPC data templates
- Patient panels are designated as IPC panels

iCare v2.6 Patch 1 Release

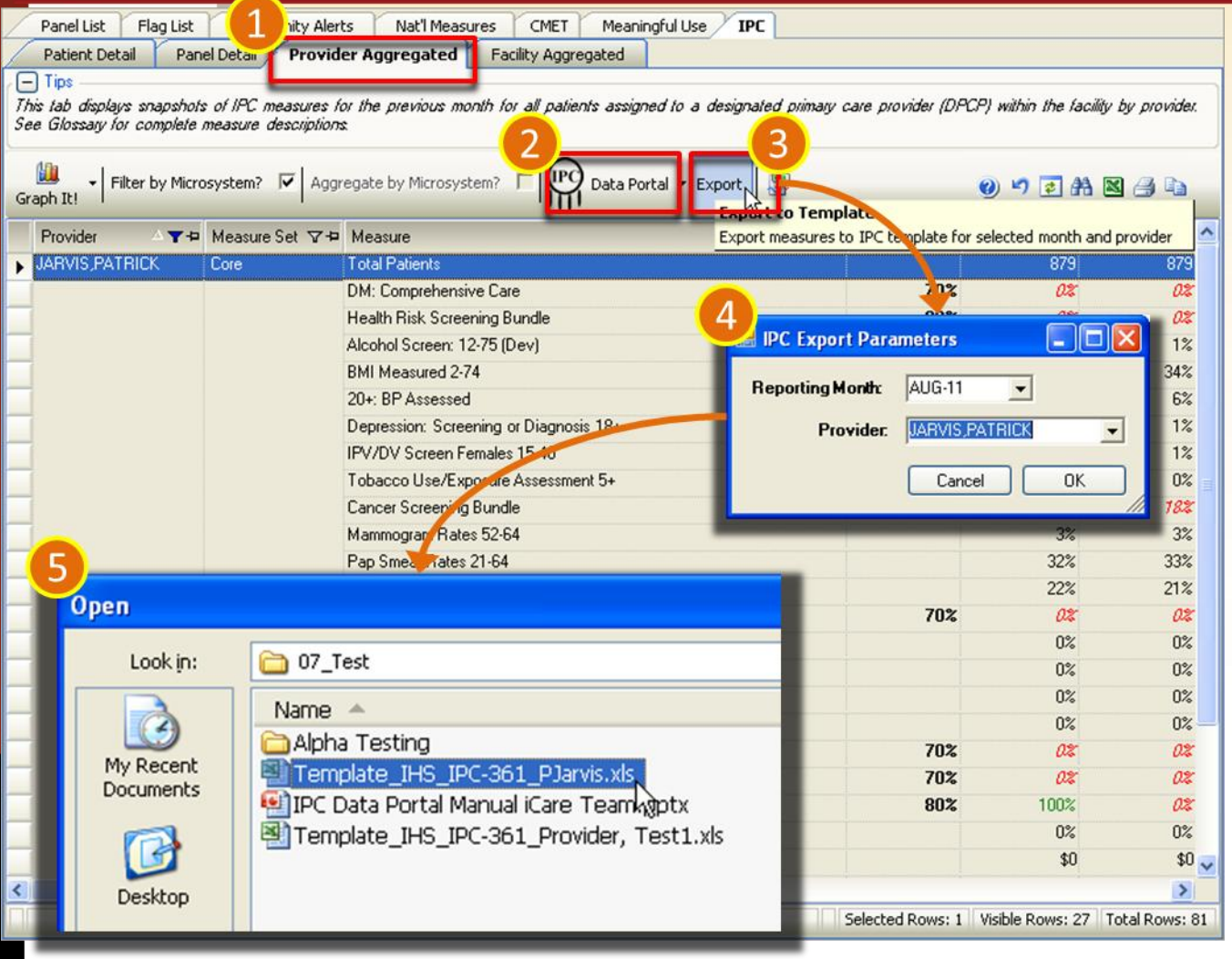
- IPC Teams to install iCare v2.6 Patch 1 Release for November 2012 data
- Teams to have CRS v13.0 installed
- Change over from CRS 2012 to CRS 2013
- CRS 2013 triggers update in iCare
- Patch 1 release automatically maps and populates updated CRS and IPC4 Measures

IPC Tab in iCare v2.6 Patch 1



Provider	Measure Set	Measure	IPC Goal	Aug 2012	Sep 2012	Oct 2012	Nov 2012
ACORD,ARLIS L	Core	Total Patients in Microsystem		12	13	13	13
		Health Risk Screening Bundle	**80%**	*0%*	*0%*	*0%*	*0%*
		Alcohol Screen: 12-75		0%	11%	11%	11%
		BMI Assessed 2-74		44%	40%	40%	40%
		BP Assessed 20+		0%	0%	0%	0%
		Depression: Screening or Diagnosis 18+		0%	0%	0%	0%
		DV/IPV Screen Females 15-40		0%	0%	0%	0%
		Tobacco Use/Exposure Assessment 5+		0%	0%	0%	0%
		Cancer Screening Bundle	**70%**	*0%*	*18%*	*18%*	*18%*
		Mammogram Rates 52-64		0%	0%	0%	0%
		Pap Smear Rates 21-64		0%	29%	29%	29%
		Colorectal Cancer Screen 51-80		0%	0%	0%	0%
		Outcome Measures Bundle	**70%**	*0%*	*0%*	*0%*	*0%*
		A1C in Control		0%	0%	0%	0%
		BP in Control		0%	0%	0%	0%
		LDL in Control		0%	0%	0%	0%
		Tobacco Use Prevalence 5+		0%	0%	0%	0%

Provider Aggregated IPC Template Population - Export



1. Select the IPC: Provider Aggregated tab

2. Download your Data Template

3. Click Export

4. Select the Reporting Month and Provider(s)

5. Select and open your template

Measure Data Exported into Data Template

	Focus Population		Building Relationships for Care			Diabetes Care				
	Total Patients in Microsystem		Empaneled Primary Care Provider			Diabetes Comprehensive Care - Bundle			Health F	
Month	Number of Patients	Total	Patients with a visit within last 3 years empaneled to PCP	Patients with a visit to any clinic in the last 3 years	% of Patients Empaneled to a Primary Care Provider	Patients with complete Diabetes Comprehensive Care ≤ 1 year	Active Diabetic Patients	% of Patients with ALL Diabetes Comprehensive Care Measures	Patients with all 6 indicators met	D on th in
Aug-12	351	**351**	4154	5931	**70.0**	27	70	**38.6**	262	
Sep-12	364	**364**	4152	5929	**70.0**	28	74	**37.8**	272	
Oct-12	368	**368**	4133	5924	**69.8**	27	76	**35.5**	278	
Nov-12	372	**372**	4121	5934	**69.4**	29	75	**38.7**	285	
Dec-12		**#N/A**			**#N/A**			**#N/A**		
Jan-13		**#N/A**			**#N/A**			**#N/A**		
Feb-13		**#N/A**			**#N/A**			**#N/A**		

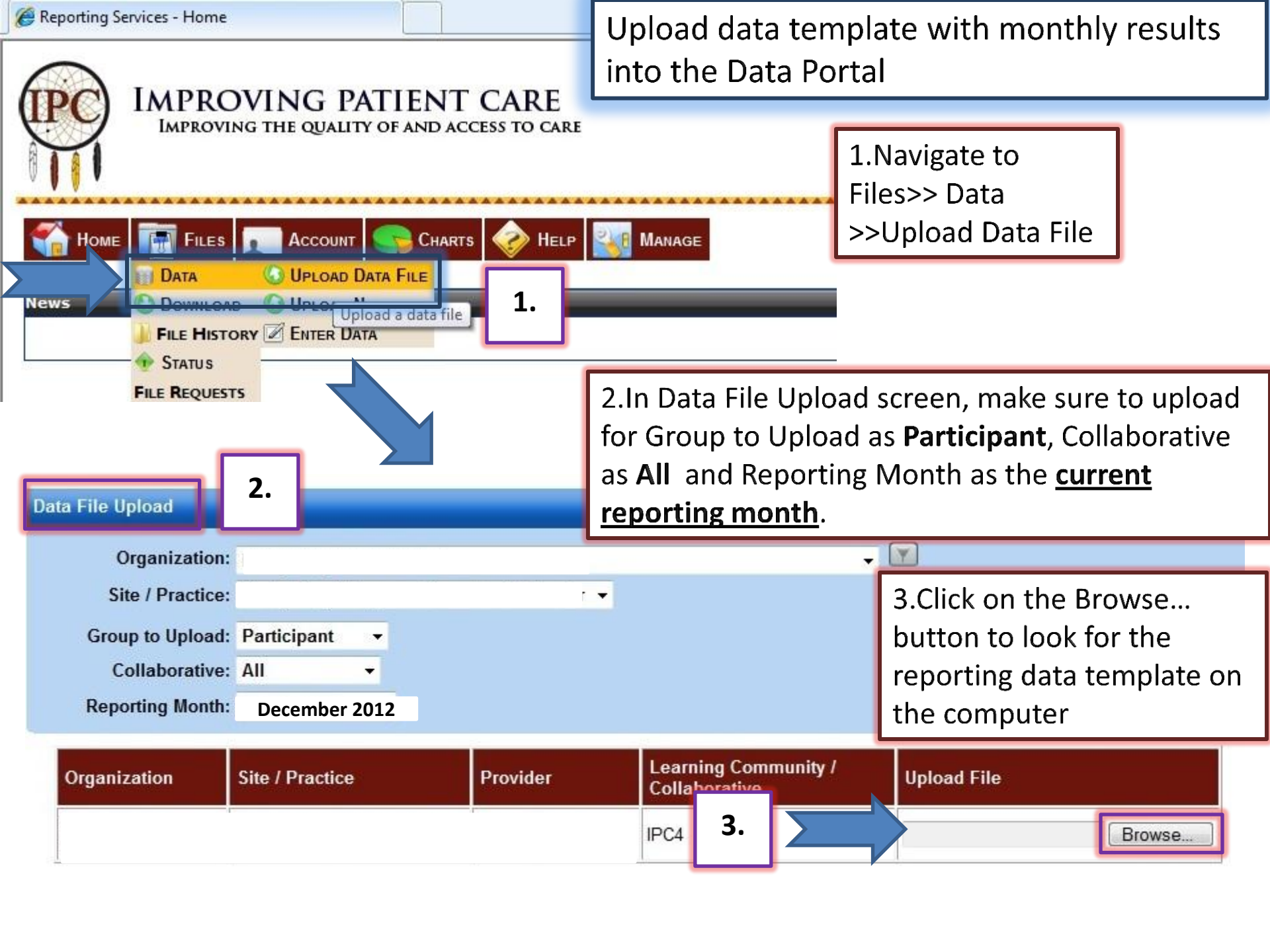
Data Reporting: Manual Measures

- Average Cycle Time
- Patient Satisfaction Survey
- 3rd Next Avail Appointment
- Continuity of Care to Care Team

Manual Measures

	Experience and Efficiency: Patient Survey			Average Cycle Time			Third Next	Building Relationships for Care: Continuity of Care		
	Patients who answer a 4 or a 5 to the question #7			Toes in Toes Out			Third Next Available Appointment	Continuity to the Care Team		
Month	Number of Patients who responded with a 4 or a 5 on #7	Total Number of Surveys	% Patients with a 4 or a 5 on survey question on #7	Total Minutes	Total Visits	Average Cycle Time in minutes per visit	Third Next Available Appointment - Monthly (Calculated From Weekly_Data Tab)	Visits to Designated Care Team	Total Number of Visits	% of Visits to Designated Care Team
Aug-12	1	1	100.0	0	0	#N/A	53.5	71	83	85.5
Sep-12	0	0	#N/A	0	0	#N/A	46.8	56	63	88.9
Oct-12	6	6	100.0	0	0	#N/A	45.6	103	119	86.6
Nov-12	6	6	100.0	0	0	#N/A	49.8	68	88	77.3
Dec-12			#N/A			#N/A	#N/A			#N/A
Jan-13			#N/A			#N/A	#N/A			#N/A
Feb-13			#N/A			#N/A	#N/A			#N/A
Mar-13			#N/A			#N/A	#N/A			#N/A
Apr-13			#N/A			#N/A	#N/A			#N/A
May-13			#N/A			#N/A	#N/A			#N/A
Jun-13			#N/A			#N/A	#N/A			#N/A
Jul-13			#N/A			#N/A	#N/A			#N/A
Aug-13			#N/A			#N/A	#N/A			#N/A
Sep-13			#N/A			#N/A	#N/A			#N/A

Upload data template with monthly results into the Data Portal



1.Navigate to Files>> Data >>Upload Data File

2.In Data File Upload screen, make sure to upload for Group to Upload as **Participant**, Collaborative as **All** and Reporting Month as the **current reporting month**.

3.Click on the Browse… button to look for the reporting data template on the computer

Resources and Support

- Measurement Guide
- Team Sharing of Lessons Learned
- IPC Knowledge Portal
- IPC Team and iCare Listservs
- Adobe Connect Recordings
- Additional tools, sample forms, etc.
- Support from National Team and Area Level

Final Thoughts

- IPC Measures and National Initiatives
- Using iCare to collect data
- Aggregate results with data template and and Data Portal
- Questions?