Advancing the Use of the Electronic Health Record (EHR) to Support Quality Improvement

Agency for Healthcare Research and Quality (AHRQ)
Model for Primary Care Transformation

Practice Facilitation (PF)Program

Implementing Evidence-Based Practice

- Origins of Practice Facilitation (PF) can be traced back to the Oxford Prevention of Heart Attack and Stroke Project in England in 1982.
- Meta analysis of studies of PF concluded that primary care practices are three times more likely to adopt evidence –based guidelines compared with no intervention control groups.

Purpose of a PF Program:

- Align efforts and motivate action across primary care specialties and at all levels of the health care system.
- Assist practices in redesigning care.
- Improve outcomes.
- Support learning collaboratives to enable providers, staff and clinic leaders to share best practices.

Elements of a PF Program

- QI Coach
- EHR implementation expert
- Workflow forms development
- Data management and TA specialists
- HIT personnel
- Collaborative Learning/ Cross Pollination

Quality Improvement Activities

- Assess current QI Plan and activities
- Assist with developing a plan
- Establish measurement strategies/review data
- Conduct workflow analysis
- Coaching on change concepts
- Identifying resources and tools
- Accelerate learning and implementation of evidence-based practice

Learning Objectives

(at the end of this session participants will)

1. Better understand how to use clinical and patient data to identify and drive quality improvement efforts.
2. Be able to use work flow mapping to identify process gaps.
3. Apply the PDSA cycle to active improvement efforts.

What are the drivers of your Quality Improvement focus?

Internal

- UDS
- Needs of your patient population
- Board of Directors focus areas
- What's available

External

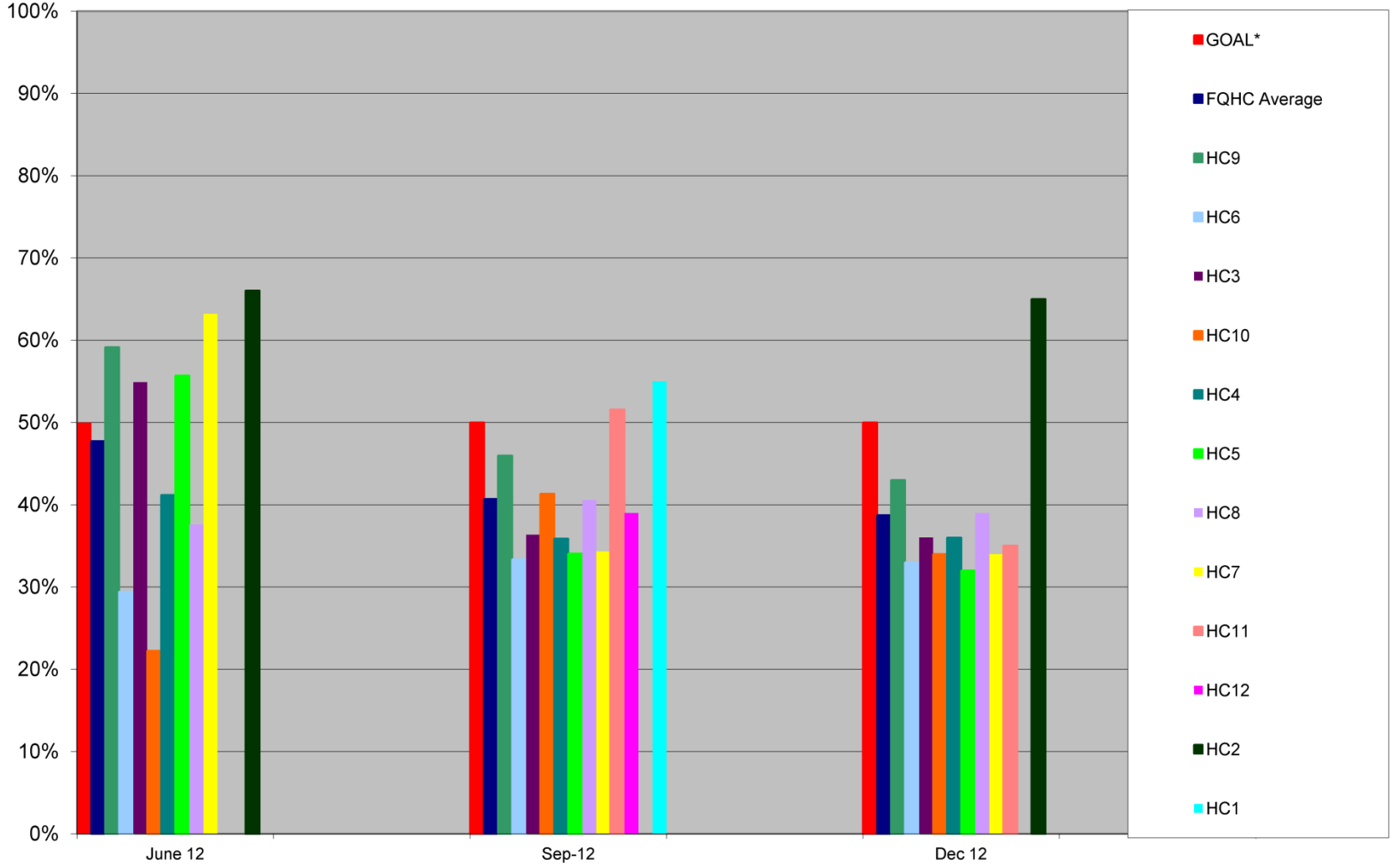
- Grant funding
- Payers
- Federal initiatives: MU PCMH
- Pay for Performance

Dashboard Reports

- What are you measuring and why?
- Do you use de-identified data?
- What do you use for benchmarks?
- What does the evidence say?
- Who decides?
- Are they useful to providers?

BMI
Goal: 50%

Pts age 18 - 64 with BMI outside "normal" w/in past year and follow up is documented



HCCN QI Measure:

To reduce the proportion of persons with diabetes with an A1c value greater than 9%. The **Healthy People** *20/20* target is 16.1%.

What's your number?

Baseline is: Feb, 2012 UDS measure.

Next measure is: June 30, 2013 and 12 months prior.

Workflow Mapping