



Davies Ambulatory Award – Community Health Organization

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- Menu Case Study: Clinical Value

Executive Summary

HealthNet's mission is to improve lives with compassionate health care and support services, regardless of ability to pay. The organization was established in 1968 to provide much needed services to central Indiana's inner-city neighborhoods. Through a network of health, dental, school-based and homeless sites, HealthNet provides care to more than 59,286 patients annually. In 2009, we began our journey to adopt electronic medical records (EMR) to improve patient care, clinical documentation and billing practices after choosing eClinicalWorks as our vendor. Using a phased approach to EMR "Go Lives", it took almost 2 years to fully implement the EMR at all locations. Upon completion of the Go Live project at medical sites in 2011, HealthNet focused on using the new electronic technology to develop templates and reports and redesign workflows to improve performance on a selected set of clinical quality measures, which had previously been stagnant and far below national averages. After project implementation, improvements on the selected measure sets were dramatic, ranging from 4% improvement on measures that were already being done well, to 181% improvement on the lowest performing measures at baseline.

Background Knowledge

HealthNet, Inc. is a Federally Qualified Health Center (FQHC) and since 1968, the organization has improved the health status of Indianapolis' inner-city neighborhoods by delivering quality health services. Through 150 licensed providers, HealthNet annually provides affordable health care to more than 59,286 individuals, 65% of whom are Medicaid recipients. In addition, 77% of patients served are under the age of 35 (54% ages 0-17 years, 23% ages 18-34 years). HealthNet has a network of 8 primary care health centers, 1 OB/GYN care center, 1 pediatric and adolescent care center, 1 maternal fetal medicine center, 6 dental clinics, 97 school-based clinics, a homeless program with 8 shelter clinics, and additional support services. HealthNet's mission is *to improve lives with compassionate health care and support services, regardless of ability to pay*. The organization has also been accredited by Joint Commission as an Ambulatory Practice since 1980, and is the only FQHC in Indiana with this distinction. HealthNet achieved Patient Centered Medical Home (PCMH) designation from the Joint Commission in October 2012 and has successfully attested 98% of its eligible providers for Medicaid Meaningful Use.

Some of HealthNet's goals of EMR implementation were to improve clinical care and performance on standardized measure sets, as well as reduce costs by creating a coordinated and integrated care model that would link all our health centers and practitioners in one EMR. While HealthNet utilized only paper charts, staff spent the majority of their time focused on auditing paper charts to obtain data. This was extremely time consuming and by the time data was collected, little time was left to allow for performance improvement initiatives to be planned and implemented.

Opportunity for Improvement

The Healthcare Effectiveness Data and Information Set (HEDIS) is a list of measures used by more than 90% of U.S. health plans to measure performance on key clinical quality indicators. Not only are these measures important indicators of performance internally, but they also serve as an excellent external benchmarking tool. HealthNet's performance on multiple HEDIS measures were stagnant and below average prior to EMR implementation in 2009. We did not have a standardized process for identifying patients in need of well child care and the information provided by the health plans was not usually actionable at the individual health center and practitioner level. In many cases the health plans provided the data after the HEDIS measurement deadlines had passed, and the data provided was often 18 months old. In addition we also needed to demonstrate improvements on several Uniform Data Set (UDS) measures, which is a required standardized report all FQHC's and Federal 330 Public Health Fund recipients must submit annually to the Bureau of Primary Health Care (BPHC). Performance on these measures is used to compare FQHCs across the nation, as well as demonstrate to national leaders the value of investment into this form of health care delivery.

Design and Implementation

The first step of the implementation was to form a multi-disciplinary implementation team which reviewed the specific HEDIS and UDS measurement criteria and determined which measures to initially focus on. Team members initially included the Chief Medical Officer, Associate Medical Director, EMR Program Manager, Quality Manager, EMR Analysts, and Quality Coordinator. The review of measurement criteria and final measurement selection involved an in-depth review of the numerator and denominator for each measure, current documentation and measurement options, and review of new options available within the EMR. After much discussion and several team meetings, the measures of focus from each measure set were chosen based on the potential population health impact and available documentation and measurement options within the EMR. Measures chosen included:

UDS: Adult tobacco assessment and counseling, adult weight screening and follow up and weight assessment and counseling for children and adolescents.

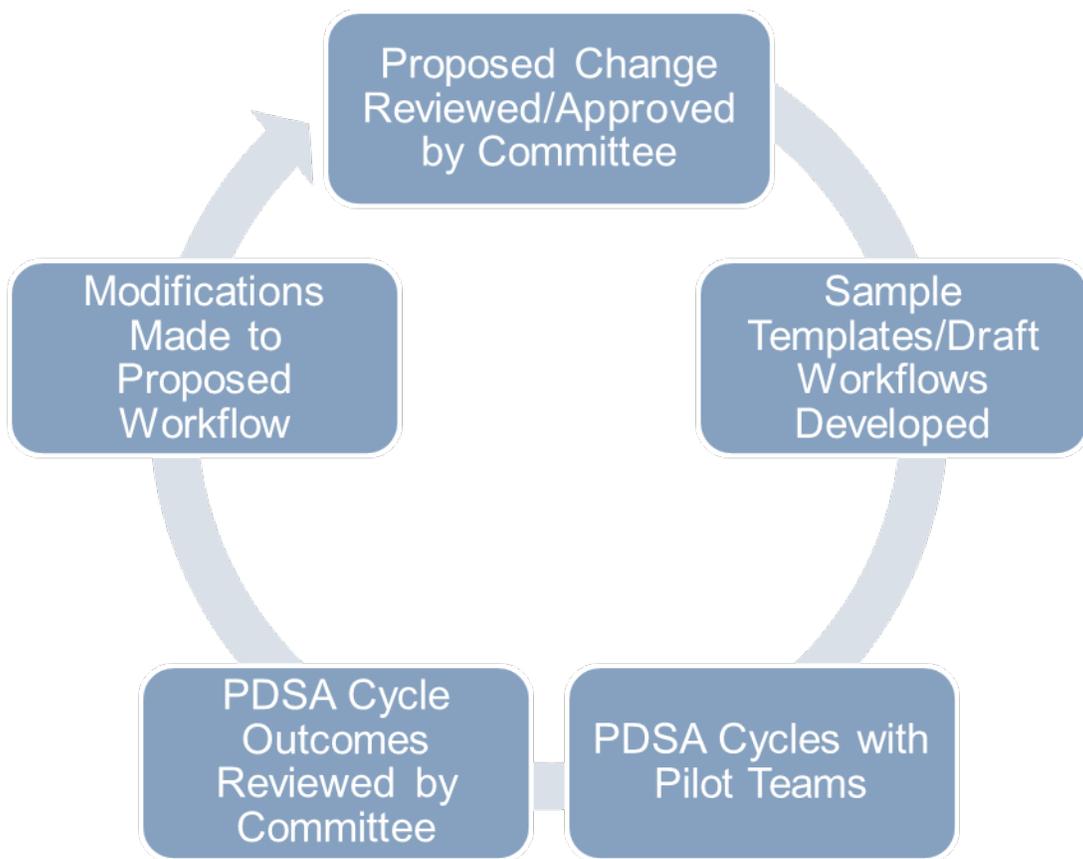
HEDIS: Well child checks for 0-15 month olds, 3-6 year olds and 12-21 year olds.

After the measures were selected, the team conducted an initial data/performance review and gap analysis. The team also examined which internal and external reports were already available for regular data monitoring for each of the measures. Unfortunately, there was a significant deficit in the number of available and actionable reports to be reviewed regularly to help improve performance. Thus, the Quality Manager and Quality Coordinator planned to use the training they received on an EMR reporting module to develop additional reports. This proved to be difficult and time consuming while competing with other responsibilities required of these individuals. We realized a data analyst needed to be hired whose sole function would be to develop reports for the organization, beginning with those identified by the implementation team.

The Quality Manager, in conjunction with the Chief Medical Officer, Chief Financial Officer, and IT Director proposed to Senior Leadership that a data analyst was necessary using a cost/benefit analysis, which was unanimously approved. The data analyst was hired from within the organization, and quickly got started on developing the needed reports.

While the reports were being developed, the implementation team focused on developing and revising templates within the EMR to assist providers and support staff with required measurement documentation to standardize the data capture for the project. Creating consistent data capture insured optimal data output on the measure set. Providers and clinical support staff were involved in the development of all templates to ensure they would be as useful as possible to the end users. Templates included both structured data fields and billing codes to remind staff of the documentation requirements but also automatically add billing codes when appropriate to save providers time from having to add them during visits. The change management process utilized is depicted in **Figure 1** below:

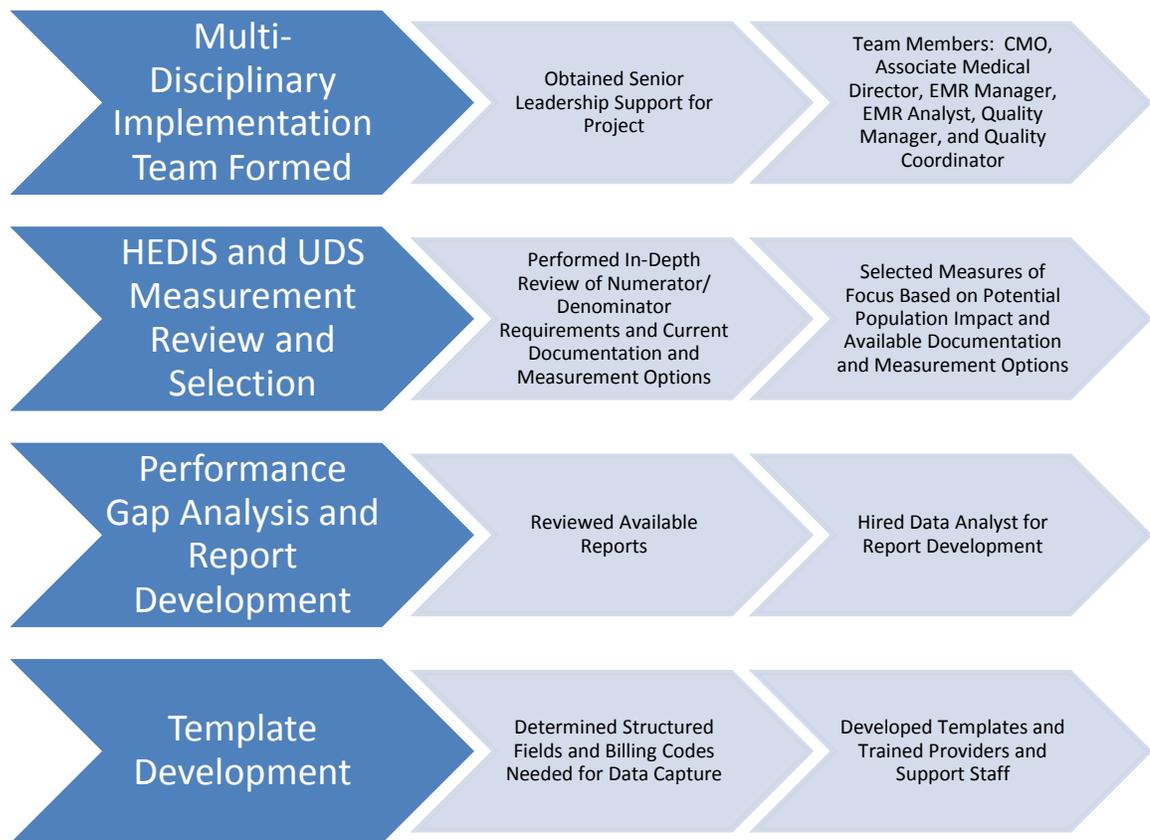
Figure 1: Change Management Process



Once the templates had been developed, training of providers and staff was conducted by the EMR and Quality Teams to ensure they were aware of the template changes and their purpose. **Figure 2** below depicts the overall design and implementation plan.

During the training, complaints were voiced about this being “one more thing” they needed to do, and “how will we have time to do all of this in a 15 minute visit?” Having the Chief Medical Officer and Associate Medical Director involved was helpful to address these specific concerns. It was further explained to end users that the templates were designed to save the provider’s time, and training focused on ensuring the right task was accomplished by the right level of associate. This helped create provider buy in because providers understood the intent was not to add more tasks to their plates, but rather ensure that their teams were functioning at optimal

Figure 2: Design and Implementation Plan



In addition to the core team, other providers, nursing, and front line staff were consulted before, during and after program implementation through various existing meetings and email. This allowed for them to still provide input into the process, but minimized the impact on patient flow, access to care, provider productivity, and practice operations.

How Health IT Was Utilized

HealthNet utilized the customization available within the EMR to develop templates for documenting required data in structured fields and used pre-programmed assessment codes which were needed to capture the data from claims. Templates were developed for: adult tobacco assessment and counseling, adult weight screening and follow up and weight assessment and counseling for children and adolescents, as well as all three well child measures. **Figure 3** below shows an example of the tobacco template, and **Figure 4** shows an example of the well child check template.

Figure 3: Tobacco Use Template

Progress Notes | Scribe | Orders

Quick Search

Subjective:

Chief Complaint(s):

- estab care

HPI: ▾

IDENTIFIERS

Name and DOB Verified? _____. Interpreter Name: _____. Accompanied by (name/relationship to pt): _____.

Nurse/MA putting patient in room: _____.

Tobacco Use

Smoking Status - _____. Are you Ready to Quit? _____. Advice to quit given on: - _____. Would you like to talk to someone about quitting? _____.

Current Medication:

Medical History:

- No Medical History.

Allergies/Intolerance:

- N.K.D.A.

Gyn History:

OB History:

Surgical History:

- Denies Past Surgical History

Hospitalization:

- No Hospitalization History.

Family History:

Father: diagnosed with Hypertension

Mother: diagnosed with Diabetes

Social History:

ROS: ▾

Figure 4: Well Child Check Template

Reason for Appointment

1. Etab care

History of Present Illness

IDENTIFIERS:

Name and DOB Verified? _____. Interpreter Name: _____. Accompanied by (name/relationship to pt): _____. Nurse/MA putting patient in room: _____.

Tobacco Use:

Smoking Status - _____. Are you Ready to Quit? _____. Advice to quit given on: - _____. Would you like to talk to someone about quitting? _____.

***WCC: Child:**

CONCERNS: _____, INTERVAL HISTORY: _____, **DIET:** _____, OUTPUT: _____, SLEEP: _____, GROSS

MOTOR: _____, FINE-MOTOR ADAPTIVE: _____, PERSONAL-

SOCIAL: _____, LANGUAGE: _____, DAYCARE: _____, SCHOOL: _____, SOCIAL: _____, TV/COMPUTER

TIME: _____, **EXERCISE:** _____, SAFETY: _____, DENTIST: _____.

Examination

Pediatric Exam II:

GENERAL: awake, alert, NAD.

HEAD: normal.

EYES: PERRL, EOMI, +RR bilaterally, normal cover/uncover test.

EARS: TM's clear bilaterally.

NOSE: nares clear.

O/P: clear.

NECK: supple, no LAD, no masses.

CV: NL S1, S2, RRR no murmur, femoral pulses 2+ and equal bilaterally.

LUNGS: bilaterally CTA.

CHEST: normal.

ABDOMEN: soft, NT, ND, no HSM, no masses.

GU: _____.

BACK: spine straight.

EXTREMITIES: NL with FROM.

NEURO: intact and nonfocal.

SKIN: normal with no rashes.

Assessments

1. Routine child health exam - Z00.129 (Primary)
2. Dietary counseling - Z71.3
3. Exercise counseling - Z71.89

Custom reports were built to provide staff with lists of patients who were in need of such services prior to measurement deadlines. In addition, compliance reports were generated monthly to allow leadership and the EMR and Quality Teams to gauge the level of improvement for each measure. See **Figure 5** on the next page for an example of the report used to identify patients in need of well child check (WCC) visits.

Figure 5: Report of 0-15 Month Olds Needing a Well Child Check (WCC)

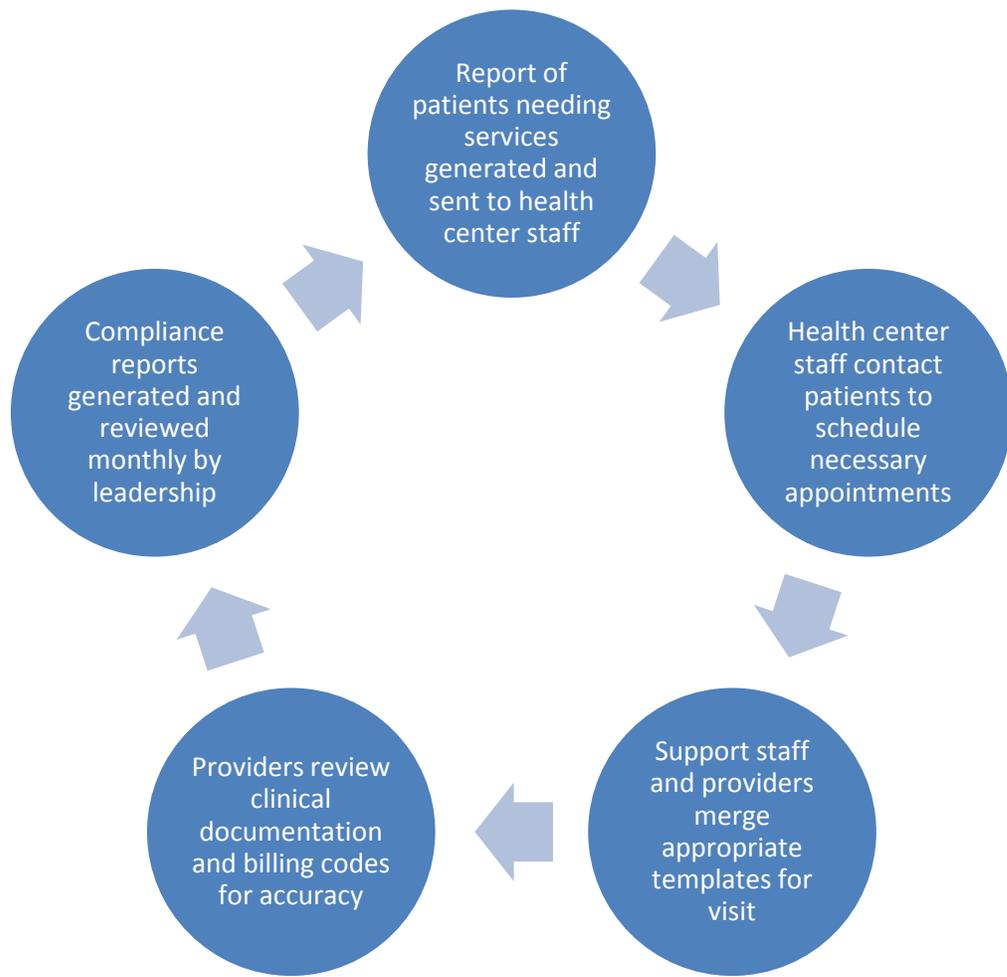
Non-Compliant 0 - 15 Month Olds for WCC							
Facility Name	Account Number	Patient Name	Date of Birth	Age (Months)	Patient Phone Number	Primary Insurance Name	Total WCC Visits
Barrington Health Center	#####	Patient Name A	May 20, 2013	15	###-###-####	Medicaid Anthem Methodist Pkg A	0
Barrington Health Center	#####	Patient Name B	Mar 23, 2014	5	###-###-####	Medicaid IU Health Pkg A	0
Barrington Health Center	#####	Patient Name C	May 28, 2013	15	###-###-####	Medicaid IU Health Pkg A	1
Barrington Health Center	#####	Patient Name D	Jun 21, 2013	14	###-###-####	Medicaid IU Health Pkg A	1
Barrington Health Center	#####	Patient Name E	Jun 19, 2014	2	###-###-####	Medicaid PQHC Pkg A	1
Barrington Health Center	#####	Patient Name F	Jun 21, 2014	3			1
Barrington Health Center	#####	Patient Name G	May 2, 2013	15	###-###-####		2
Barrington Health Center	#####	Patient Name H	Jan 17, 2013	14	###-###-####	Medicaid Anthem Methodist Pkg A	2
Barrington Health Center	#####	Patient Name I	Jul 6, 2013	13	###-###-####		2
Barrington Health Center	#####	Patient Name J	Mar 8, 2014	5		Medicaid IU Health Pkg A	2
Barrington Health Center	#####	Patient Name K	Mar 13, 2014	5	###-###-####	Medicaid MHS Pkg A	2
Barrington Health Center	#####	Patient Name L	Mar 20, 2014	5		Medicaid Anthem Methodist Pkg A	2
Barrington Health Center	#####	Patient Name M	Mar 22, 2014	5	###-###-####	Medicaid Anthem Methodist Pkg A	2
Barrington Health Center	#####	Patient Name N	May 7, 2013	15	###-###-####	Medicaid MHS Pkg A	3
Barrington Health Center	#####	Patient Name O	May 9, 2013	15	###-###-####	Medicaid IU Health Pkg A	3
Barrington Health Center	#####	Patient Name P	Jan 24, 2014	7	###-###-####	Medicaid Anthem Methodist Pkg A	3
Barrington Health Center	#####	Patient Name Q	Jan 21, 2014	7	###-###-####	Medicaid PQHC Pkg A	3
Barrington Health Center	#####	Patient Name R	May 23, 2013	15		Medicaid Anthem Methodist Pkg A	4
Barrington Health Center	#####	Patient Name S	Jun 7, 2013	14	###-###-####	Medicaid IU Health Pkg A	4
Barrington Health Center	#####	Patient Name T	Jun 17, 2013	14	###-###-####	Medicaid Anthem Methodist Pkg A	4
Barrington Health Center	#####	Patient Name U	Oct 15, 2013	10	###-###-####	Medicaid PQHC Pkg A	4
Barrington Health Center	#####	Patient Name V	Oct 30, 2013	10	###-###-####	Medicaid IU Health Pkg A	4
Barrington Health Center	#####	Patient Name W	May 2, 2013	15	###-###-####	Medicaid Anthem Methodist Pkg A	5
Barrington Health Center	#####	Patient Name X	Jul 28, 2013	13	###-###-####	Medicaid IU Health Pkg A	5
Barrington Health Center	#####	Patient Name Y	Jul 27, 2013	13	###-###-####	Medicaid Anthem Methodist Pkg A	5

The report is emailed monthly to clinic managers. The patients have had the majority of their WCC at that clinic. Patients who are in the system who haven't had a WCC go to ALL clinic managers

Months Old	# of WCC since birth
= 1	< 1
1 < Months Old <= 4	< 2
4 < Months Old <= 6	< 3
6 < Months Old <= 9	< 4
9 < Months Old <= 12	< 5
12 < Months Old <= 15	< 6

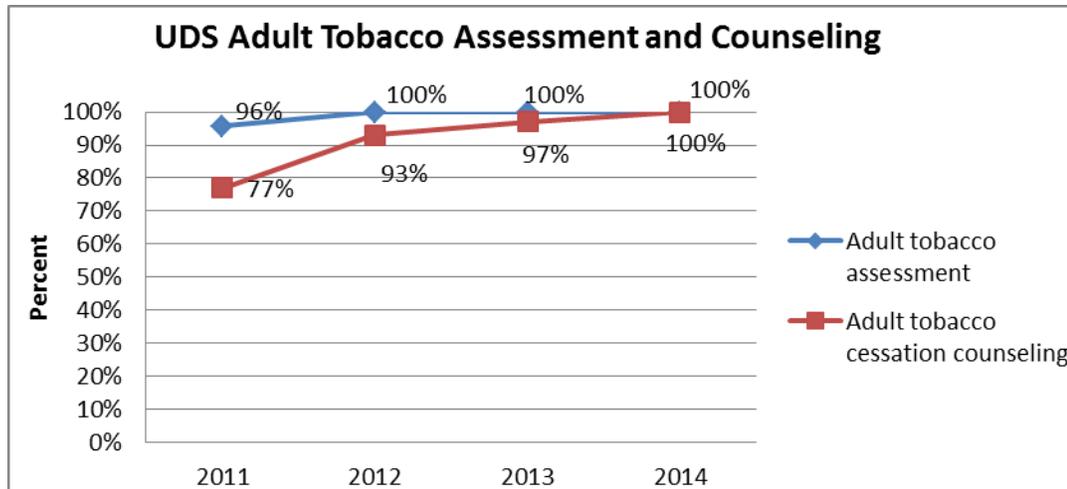
Managers at each clinic designated staff to work this report monthly. In some cases medical assistants are reaching out to patients to scheduled needed appointments, and in other cases the job is assigned to front office staff. If a patient/guardian can't be reached and a message has to be left for the patient to return the call, the staff will enter a "note" in eCW to alert the phone staff of why this patient/guardian is returning a call from the health center. This report is utilized regularly to fill Saturday clinic slots at all health centers, and this process is repeated monthly as new patients needing services are identified. In addition, providers have started adding Well Child Check codes to the patients' problem lists to show when this code has been used in the past. **Figure 6** shows the workflow diagram for the Health IT process utilized.

Figure 6: Clinical Quality Measure Improvement Project Workflow



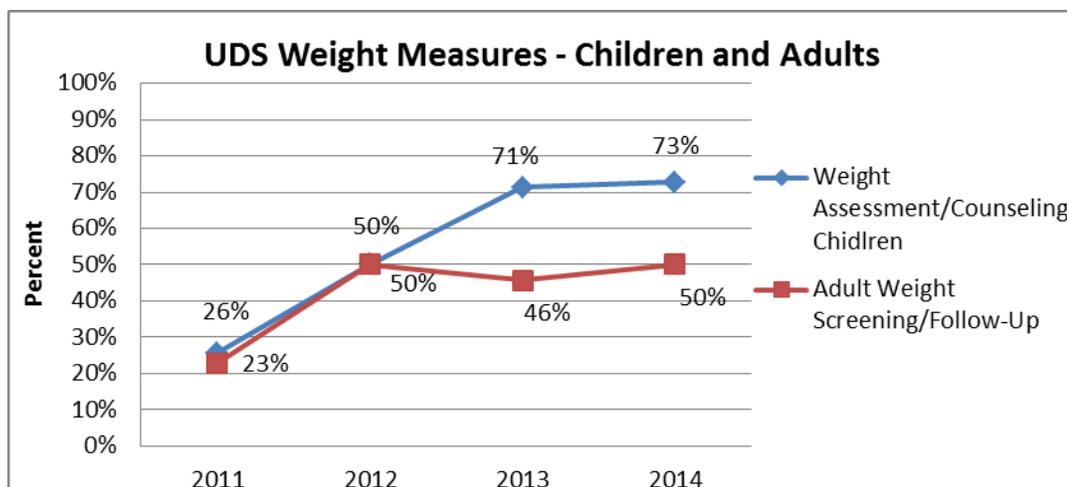
Value Derived

Since 2011, which was pre-implementation of the workflows and process improvements described in this case study, HealthNet has improved significantly in the measures chosen for intervention as the graphs below demonstrate.



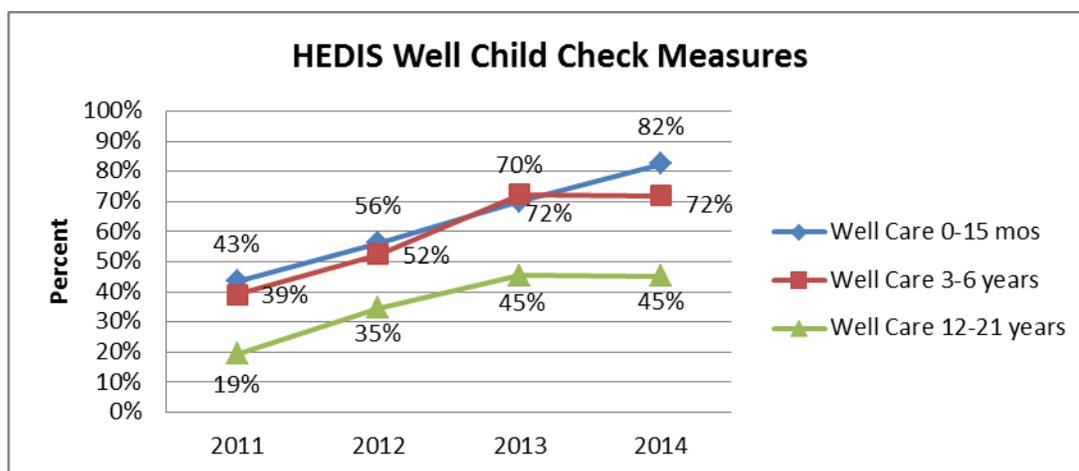
% Improvement from 2011-2014:

Tobacco Assessment: 4%
 Tobacco Cessation Counseling: 30%
 Now both 100% compliance!



% Improvement from 2011-2014:

Children: 181%
 Adults: 117%



% Improvement from 2011-2014:

0-15 Mos: 90%
 3-6 Years: 83%
 12-21 Years: 134%

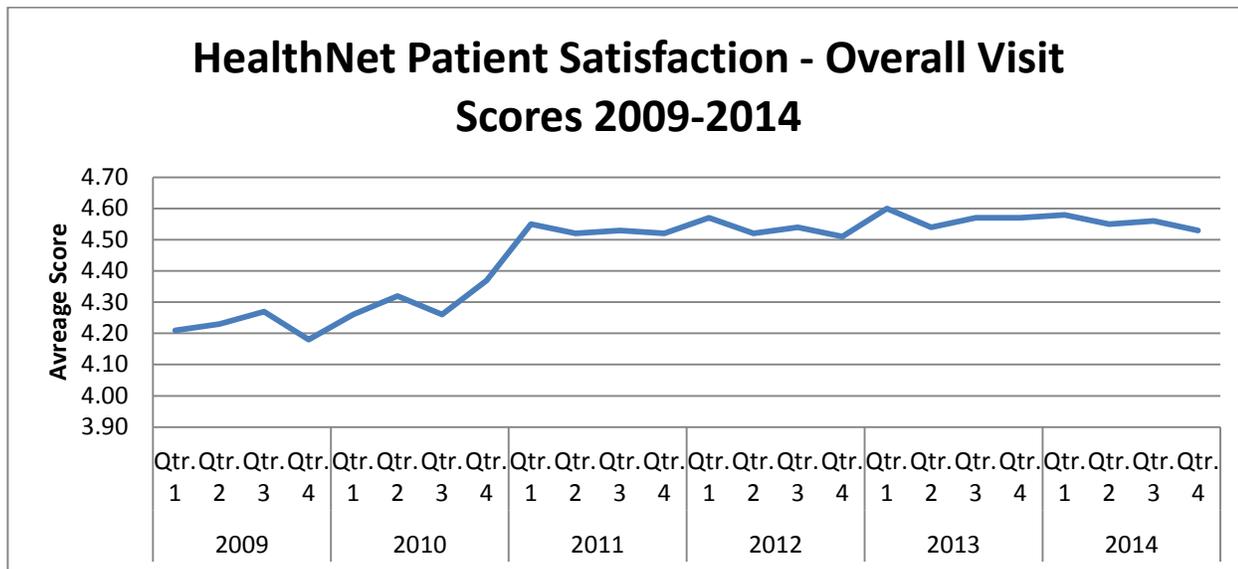
Based on improvements made to UDS measure performance as compared to other FQHCs in the nation, HealthNet was awarded a grant for \$83,801 at the end of 2014 to focus on additional quality and performance improvement initiatives. Appendix A lists some Federal UDS Quality Measures that FQHCs like HealthNet have to report annually, and which our EMR makes more streamlined and comprehensive than when we were on paper records.

Not only did increasing performance on well child checks increase access to care for HealthNet's patient population, it also had a tremendous impact on the organization's financial performance. In addition to payments received for services rendered, we earned \$1,527,940 in pay for performance dollars for improving HEDIS measure performance from 2011 to 2014. As health plans are a couple of years behind in paying out these bonuses, HealthNet stands to earn more in the next 2 years for improved performance reported in 2013 and 2014. We anticipate earning at least another \$100,000 for performance on these measures in 2013 and 2014.

The project continues to move forward at each health center, and measures have been incorporated into HealthNet's annual Performance Improvement Plan as well as the provider and staff incentive plan. Data on each measure is obtained quarterly to ensure the intervention is being sustained across the entire organization. In addition, HealthNet leadership in 2015 asked each health center to conduct at least one Saturday clinic to offer increased access to care and improve performance on clinical quality measures. Therefore, this intervention is being used across the system both during regularly scheduled clinic hours and during expanded hours to increase the number of patients who receive needed services.

Prior to EMR implementation, patient satisfaction with their overall visit was around 4.2 on a 5.0 scale. Even though those results exceeded our goal of 4.0, we believed implementing EMR would improve the overall experience for our patients. The graph below in **Figure 7** demonstrates HealthNet performance from 2009-2014 on the overall visit score from patient satisfaction surveys. The question patients are asked to rate is "Overall today's visit was excellent". Response options with corresponding scores are: Strongly Disagree – 1; Disagree – 2; Neutral – 3; Agree – 4; and Strongly Agree – 5. HealthNet experienced a dramatic increase in overall patient satisfaction after implementing EMR.

Figure 7: 2009-2014 Overall Visit Patient Satisfaction Scores



In addition to the value derived in the measures discussed in detail in this case study, HealthNet has applied this same workflow to several other measures required for UDS reporting. Performance on those measures compared to HealthNet goals can be found in Appendix A.

Lessons Learned

- 1. Data analyst and actionable reports** – HealthNet discovered early in the planning process that a data analyst was crucial to the success of the project. After having existing staff attempt to develop reports while focusing on their existing duties, we decided we needed to hire a data analyst whose primary focus was on creating actionable reports for the organization. Initially this was difficult to sell to our leadership, as adding positions can be at any organization. In order to get the position approved, we developed a proposal outlining the expected return on investment from adding a data analyst. After reviewing the proposal, HealthNet’s senior leadership unanimously approved the position. As highlighted below in the Financial Consideration section, this position more than paid for itself with the creation of the first report. This enabled HealthNet to regularly monitor data and provide timely feedback to stakeholders.
- 2. Provider and staff frustrations** – Providers and staff are constantly frustrated with the tasks that continue to be added to their plates while trying to provide direct patient care. Leaders of the project heard over and over that providers could not take on one more thing or do “one more click” without having some of the tasks they were required to perform removed from their list of things to do during a visit. In order to address these frustrations, HealthNet made changes in several areas:

 - Limited the number of quality measures chosen as high priority/focus areas, and chose measures that were required by more than one source to provide more “bang for the buck.” We permitted these other measures to be put on the back burner.

- Included measures chosen as focus areas in the provider and staff incentive plan so they could earn extra money for meeting goals.
- Leadership, Quality and EMR Departments worked closely with front line staff to design templates and workflows that would require the least amount of clicks and assign the right task to the right staff person.

- 3. Maintain balance between clinic time and involvement in the process** – As discussed earlier, HealthNet created ad hoc multidisciplinary teams of providers, nurses, and other front line staff to involve them in the feedback process. Rather than involve them in the core team and ask them to attend meetings during scheduled patient care hours, members of the core team attended existing meetings at the health centers to ask for input on the process and obtain their feedback. This allowed them to still be involved in the process, but minimized the impact on patient care and operations.
- 4. Rewards for performance and partnership with health plans** – In addition to rewarding providers and staff through the incentive plan, HealthNet partnered with health plans to promote contests among all locations for the highest overall percentages of compliance, most improved performance from baseline and most engaged staff. It's amazing how much a small lunch time pizza party can do to reward staff and encourage improved performance! Partnering with the health plans for this meant the cost of the food was covered by the health plans and each location received recognition from both inside and outside of HealthNet, in addition to bragging rights!
- 5. Engage leadership** – HealthNet engaged Senior Leadership from the start, including both the Chief Medical Officer and Associate Medical Director. Nevertheless, program leaders learned quickly that they also needed to involve the lead provider and clinic manager at each location to ensure buy-in from all providers and staff. This created a forum for open communication at the individual health center level to address barriers and troubleshoot any issues that arose.

Financial Considerations

HealthNet did not require any capital funds for this initiative. The design and development of templates and reports were completed internally by HealthNet's EMR team and Data Analyst. The total cost associated with these items is estimated at less than \$3,000. About \$20,000 of the Data Analyst's salary and benefits can be contributed to this project. Training of staff and providers on template changes and reports was provided via e-mail and face-to-face interaction with the EMR staff. Prior to this project, the EMR team had already implemented a schedule in which analysts would rotate to each location weekly to provide regular on-site support. Training for this project was rolled in to that onsite support, and as a result there were no additional costs associated with this training.

As previously mentioned, HealthNet earned \$1,527,940 in pay for performance incentive dollars from health plans in 2011 to 2014 for performance on quality measures described in this project. In addition, in the fall of 2014 HealthNet was awarded a grant for \$83,801 from HRSA for improvements made in UDS performance.

Although not fully studied as part of this project, we believe it is helpful to also share the initial return on investment we earned from hiring a data analyst. The first report created by the data analyst identified completed appointments without a claim created. From August 2012 to February 2014, this report identified 1212 claims that had not been submitted. Although the amount of each claim varies, we estimate an additional \$210,000 was billed due to these claims being identified and submitted. This report continues to be run daily, and is sent to the cashiers at each health center so claims can be created. HealthNet experienced a 95% decrease in the number of claims that were not submitted.

Appendix A

2014 Federal FQHC Clinical Quality Measures

Uniform Data System (UDS) Preventive Health Screening and Services Measures	HealthNet Percent	Target Goal
Weight assessment and counseling for children/adolescents	73%	40%
Adult weight screening and f/u	50%	15%
Adult tobacco assessment	100%	80%
Adult tobacco cessation counseling	100%	50%
Colorectal cancer screening	30%	15%
Childhood immunizations by 3rd birthday (measurement criteria changed in 2013)	83%	80%

Uniform Data System (UDS) Chronic Disease Measures	HealthNet Percent	Target Goal
Asthma pharmacologic therapy	89%	90%
CAD and lipid lowering therapy	83%	80%
IVD and aspirin or other thrombotic therapy	80%	60%
Blood pressure control for hypertensive patients	55%	55%
Diabetic control (A1c <9%)	69%	80%