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Implementation for Best Practice Tools to Improve Healthcare Effectiveness Data and Information Set (HEDIS) Scores Across a Large Diverse Outpatient Network

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Abstract
The project is a retrospective study analyzing HEDIS quality measure scores documentation before and after group educational interventions over a period of one year. The study was conducted in a large network of outpatient family medicine clinics. Each clinic worked to develop a team-based approach to address the selected measures as a partnership between providers, medical assistants and supporting staff. The Department of Billing Collections collected the data for the study. The project leader analyzed the reports and communicated the results to the providers. Focused education on how to improve HEDIS scores was performed. Peer comparisons lead to competitive pressure among providers and resulted in significant improvement in scores for many of the HEDIS measures. At the end of the project, the change in score was calculated for each physician. Wilcoxon Signed rank test was used to see if there was a significant change. There was a significant increase in HEDIS score for seven of the nine measures from January to December.

1. Introduction

Healthcare Effectiveness Data and Information Set (HEDIS) is a registered trademark of the national committee for quality assurance (NCQA). HEDIS is a set of measures that is used to report the performance of health plans. HEDIS measures relate to many significant public health issues, such as cancer, heart disease, smoking, asthma and diabetes. [1]

In the interest of improving HEDIS scores and patient quality outcomes, the University of Florida, Jacksonville campus developed a team educational program. Introduction of this educational program included twenty-four primary care outpatient clinics spread throughout Florida and Georgia. This program included the entire care team consisting of medical directors, physicians, non-physician providers, customer service representatives, medical assistance, office managers and administrators. The

educational process stressed the importance of the HEDIS scores from both a quality perspective and a financial perspective since this impacts reimbursement. The program also stressed the need for the initiative to be a team based approached and not a single individual or group`s responsibility. All providers received a monthly report on their HEDIS scores allowing participants to see their own scores in comparison to their peers. After a period of one year, a retrospective study was conducted to see if a coordinated effort to improve awareness and education of HEDIS quality measure scores could demonstrate improvement in these scores.

2. Body Text

Transition from a fee for service reimbursement system to one based on value is one of the greatest financial challenges in the American healthcare system. Value based payments are mostly structured according to a shared savings model. Shared savings incentivizes providers to reduce spending for a defined patient population by offering them a percentage of any net savings they realize. More of today's value based incentives and penalties rely on quality measures. [2].

Health plans collect the data and measures for a required set of preventive and chronic disease services and submit the indicators to the Agency of Health Care Administration (AHCA). For each indicator plans are assigned a 1-5 star rating. [3] A 1 star quality rating means the individual is worse than 90% of all health plans scores in a line of business. While a 5 star rating is at or above 50% of all health plan scores in a line of business. [3]. Public and private payers are increasingly shifting the risk of providing health care from payers to physicians and other health care providers by tying reimbursement to value. [4]. The Medicare Access and CHIP Reauthorization Act 2015 (MACRA) reaffirmed this shift from volume to value and created new incentives for physicians to transition to value-based, alternative payment models. [4].

Physicians, health plans, and health systems are increasingly evaluated and rewarded based on HEDIS and HEDIS like performance measures. [5].

HEDIS measures generally reflect cost-effective practices and are relevant for the assessment of care quality and provide useful data for quality improvement. [6], [7].

Primary care is a critical and foundational component of this system-wide transformation.

Its value to patients and payers alike is well documented in terms of its positive effects on cost, access, and quality in the United States and numerous other health systems. [8].

One component of the upcoming changes in Medicare reimbursement payment is the requirement for public reporting on the patient's perception of their care. Patients will be able to view the quality scores of physicians or physician groups to help them choose a provider. These changes further substantiate the need for not only providing excellent care, but ensuring that the care that is provided is reflective in the provider`s scores.

3. Methods

The University of Florida College of Medicine Jacksonville Department of Community Health and Family Medicine conducted a study in a large network of outpatient family medicine clinics. This network consists of over twenty-four outpatient clinics spread throughout five counties and two states, Florida and Georgia. The clinics range from large multidisciplinary clinics in underserved urban environments with a large Medicaid population to smaller clinics in more suburban settings whose patients predominantly are commercially insured.

HEDIS measures are multiple and extensive and only a selected number of measures were used for this study. The nine HEDIS measures in this study included: HgbA1c reporting, lipid management, control of blood pressure, nephropathy screening for diabetics, medication reconciliation, depression screening, fall risk assessment, advanced care planning, functional status assessment, pain assessment and health risk factors including urine incontinence, smoking status and tobacco cessation.

The study analyzed HEDIS measure documentation before and after group educational interventions. The interventions included educating the Medical Directors and Administrators of the participating clinics about the importance of this initiative and proper documentation of these measures in our electronic health record system (Epic). The Medical Directors were also given monthly updates of each clinician`s score to review and share with their providers. The educational program team gave the non-Medical Director providers their individual HEDIS scores and comparison values of their peers. The project leader also provided the individuals with tools and recommendations to improve their performance. The project leader recognized the high performing clinics at the medical director meetings for their performance during the year in front of their peers. At these meetings there was also time given for discussion of best practices and ways to address any challenges identified collectively.

Each clinic worked to develop a team-based approach to address these measures as a partnership between providers and medical staff. There was initially pushback at the beginning of the project from the providers because of a perception of adding another task which could take away time from patient care. Some providers felt overwhelmed and unprepared to add another task to their daily routine of patient care. Unfamiliarity or uneasiness of using electronic health record was also an obstacle for some providers to complete the data collection in HEDIS. Some felt it challenging to document all measures in the electronic health record and maintain the human compassion towards the patient.

A recent study of primary care physicians across the country showed that only 41 percent felt they know which

quality measures apply to their patients under value-based models, 65 percent said they do not have all the health care information they need about their patients, 36 percent said they were satisfied with access to patient data within their existing workflow, and 68 percent felt they do not have the tools to succeed in a value based system. [9]. Primary care physicians cite a lack of time allowed with their patients as the primary reason of increasing rates of discontent and burnout. [10].

The educational process stressed that HEDIS improvement needed to be a team effort for this project to be successful. It emphasized that not all of the additional work needed to completed by the providers, and could be delegated by other medical staff.

Bodenheimer and Smith estimated that 24% of clinician`s time can be saved by sharing the care among a primary care team. [11]. The medical assistants were trained by each clinic on how to both properly assess these measures and accurately document the HEDIS measures in discernable data. They were also encouraged to identify any abnormal or missing measures, and given "standing orders" so that care gaps could be completed more efficiently. The standing orders included performing blood draws to include Hemoglobin A1C and lipids not performed within six months on diabetics, performing urine for microalbumin if not done within one year on diabetic patients. The team`s orders also included reviewing and documenting the PHQ -9 depression scale. If questions arose, the medical assistant communicated with their provider on how to address these issues.

The process developed was labor intensive for the medical assistants and providers. The data collection was required to be completed at each visit. Further automation of the collection of discreet data will significantly improve the process of HEDIS and quality measures. The electronic health records improvement in its ability to auto-populate, compute and track this data will help make HEDIS improvement less work intensive. In the near future, it will further assist providers and teams in identifying which patients are due for health screenings and are at risk for poorly controlled disease states.

The Department of Billing Collections collected the data for the study. The project leader then analyzed the reports and communicated the results to the physicians. Initially physicians with low scores were contacted individually on their low HEDIS measures. Support and education was offered to any provider or clinic that were low performers on how to improve and collect data more efficiently. Subsequently all physicians measures were shared and this peer comparison lead to competitive pressures among providers and helped improve the scores among the low performers. This process was done on a monthly basis for a period of one year.

At the end of the project the change in score (December minus January) was calculated for each physician. Wilcoxon Signed rank test was used to see if there was a significant change from January to December for each score.

4. Results

There was a significant improvement in the HEDIS score for seven of the nine measures from January to December 2016. They include Hemoglobin A1C (p=0.0027), LDL (<0001), microalbuminuria (p<. 0001), advance care directives (p=0.0063), medication list review/reconciliation (p=0.0019), falls assessment (p=0.0004), tobacco cessation counseling (p=0.0009). Systolic and diastolic blood pressure measures did improve but did not reach statistical significance. The reason for this lack of change was believed to be due to the initial scores being high at the beginning of the study.

5. Discussion

The team-based approach included Medical Directors, Practice Administrators, Medical Assistants, Customer Service Representatives and support staff. Education was given to all providers and staff on how to properly and consistently document these measures in uniform ways in discernable data. Recognition of high performers and providing individual HEDIS scores compared to the provider's peers increased awareness of the providers' strengths and weaknesses. Using a team-based approach with standing orders allowed medical assistants to help close care gaps in the HEDIS scores without waiting for orders from the provider.

6. Conclusion

Using group educational interventions and team based approach significantly improved HEDIS quality measures. Interventions at other institutions may need to be tailored to the problems encountered with achieving HEDIS quality scores. Utilizing educational interventions, Team–based approach, optimizing data collection with their electronic health record, protocols for standing orders and peer score comparisons help to achieve the goal of improved HEDIS scores, and most importantly improve quality of care to our patients.

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