

3M™ Value Index Score (VIS) Domains and Measures

Action plans for quality improvement

Create an environment to support change

Primary care providers perceive recent and ongoing changes in care delivery to be stressful and burdensome, with too many demands on their time competing with patient care. Managing the pace of work of primary care can create opportunities for improved outcomes.

Consider:

[Action Plan 3: Address non-medical issues](#)

[Action Plan 6: Improve continuity of care](#)

[Action Plan 7: Engage a clinical pharmacist](#)

[Action Plan 9: Change compensation plans](#)

For any quality improvement efforts, consider:

Quality improvement is most effective with dedicated resources. There are numerous frameworks available that can serve as models to be adapted to the needs of a particular care setting.

Consider:

[Action Plan 1: Create a Quality Improvement Initiative](#)

To improve primary and secondary prevention domain scores (well-child visits, cancer screening):

The basic premise of this domain is to identify and close gaps in care. These components apply to any gap-in-care initiative, whether preventive or addressing the management of chronic conditions.

Consider:

[Action Plan 2: Use data to identify gaps in care and create alerts](#)

[Action Plan 4: Expand access](#)

To improve tertiary prevention domain scores (3M PPAs and 3M PPVs):

Preventable admissions and ED visits can be driven by poorly-managed chronic conditions, difficulty of people with chronic conditions accessing care, non-medical (e.g. social, behavioral health) factors, and complex conditions that patients perceive might not be well-addressed in a primary care practice. In addition, some people use the ED as a “one stop shop” that is perceived to be more efficient, rather than first coming to an office, going elsewhere for imaging or labs, and then waiting for imaging and lab results.

Consider:

[Action Plan 2: Use data to identify gaps in care and create alerts](#)

[Action Plan 3: Address non-clinical issues](#)

[Action Plan 4: Expand access](#)

[Action Plan 8: Increase the capacity of the practice to address very complex needs](#)

To improve panel health status change domain scores (chronic status and severity jumpers):

Reducing or controlling the progression of chronic disease requires both targeted care management and strategies to address non- medical factors.

Consider:

[Action Plan 2: Use data to identify gaps in care and create alerts](#)

[Action Plan 8: Increase the capacity of the practice to address very complex needs](#)

To improve chronic and follow-up care domain scores (3M PPRs, post-discharge follow-up, 3 chronic visits):

The PPR and Post-Discharge Follow up measures can be driven by poorly-managed chronic conditions, difficulty of people with chronic conditions accessing care, non- medical (e.g. social) factors, and complex conditions that patients perceive might not be well-addressed in a primary care practice.

Consider:

[Action Plan 4: Expand access](#)

[Action Plan 8: Increase the capacity of the practice to address very complex needs](#)

To address PPRs and Post-Discharge Follow-Up, also consider:

[Action Plan 3: Address non- medical issues](#)

[Action Plan 5: Manage care transitions](#)

To address 3 Chronic Care Visits, also consider:

[Action Plan 2: Use data to identify gaps in care and create alerts](#)

To improve continuity domain scores (provider visits, Continuity of Care index):

People have better outcomes when they have the chance to develop relationships with their primary care providers over time. This enables better communication and enhances other aspects of care that are associated with better outcomes.

Consider:

[Action Plan 1.2: Outreach coordinator](#)

[Action Plan 6: Build continuity of care](#)

[Action Plan 8: Increase the capacity of the practice to address very complex needs](#)

To improve efficiency domain scores (Generic prescribing, 3M PPS):

There are many services included in the 3M Potentially Preventable Services (PPSs) measure. These services can be addressing through guideline adoption; in addition, there are some high cost/high

volume elements that can be prioritized. Sometimes a PPS is driven by specialists referring to each other or performing many unneeded tests and procedures.

Consider:

[Action Plan 1.4: Develop standards of care](#)

[Action Plan 6.2: Create care teams](#)

[Action Plan 7: Engage a clinical pharmacist](#)

Action Plans Details

1. Create a Quality Improvement (QI) Initiative

1.1. Create a team that meets regularly to review results, problem solve, and continually improve.

Roles represented on the team include at least:

- *Outreach Coordinator*. If this person is reaching out to patients with a gap to make appointments, then the role can be staffed by a non- medical individual. If a patient or caregiver brings up medical issues, the Outreach person would follow an established process to involve the appropriate clinician.
- *Analyst*. This role requires someone who can regularly run reports, and who understands the strengths and weaknesses of the data, including delays in health plan data and lack of standardization in EMR data and how these factors impact the results.
- *Clinical oversight advisor*. A doctor or nurse with some experience in quality improvement should work closely with the analyst to review the criteria used to define numerators and denominators. This person should also at least participate in (if not lead) data standardization meetings (see below).
- *Quality Improvement Director*. Someone with training in process improvement can support these efforts in practice. Consider six sigma training, quality improvement or quality advisor training.

1.2. Review data reports regularly. Identify variation by attributed provider, practice, or group, and work with entities with high rates of gaps.

- Review data with clinicians who have high rates of potentially preventable events or with high rates of gaps in care to gain understanding of what might be driving outcomes and develop strategies to address them.

1.3. The designated Outreach Coordinator receives reports on a regular basis (see Health IT), identifies patients with gaps in care, and develops systems to proactively address those gaps.

For example:

- Identify infants with missing well-child visits and contact the infant's caregiver to recommend an appointment.
- Identify patients without a recent PCP visit and contact the patient to recommend a visit.

1.4. Adopt a standard approach to prevention and the management of chronic conditions. For example:

- The Chronic Care Model: www.improvingchroniccare.org

1.5. Develop standards of care and create a regular meeting for clinical staff to review guidelines.

For example:

- Adopt guidelines around management of low back pain, head imaging, spine imaging, use of physical therapy, chiropractic.
- Adopt a standard approach to screening guidelines (e.g. USPSTF, ACS, other)
- Address generic/brand prescribing standards
- Embed guidelines in the work flow to make it easier for clinicians to access them
- Create a service agreement with specialists.
See <http://www.ihl.org/resources/Pages/Tools/ServiceAgreementYellowCard.aspx>

1.6. Adopt a model for improvement. For example:

- The IHI Model for Improvement: www.IHI.org

2. Use data to identify gaps in care and create alerts.

- 2.1. Standardize data capture
- 2.2. EMR data tends to be unstructured, with different clinicians record things inconsistently. For example, if a key data element is captured in a note as, “She had a normal screening mammogram last month” the data may be invisible to reporting engines, which makes reports inaccurate.
- 2.3. Create a data standardization clinical meeting. Clinical groups working on improving outcomes often benefit from creating a regular venue for discussing how data are captured in their electronic systems so that they can better represent what is truly happening with their patients.
- 2.4. Work with the EMR/IT department to identify how gaps are recorded and identified. Use existing reports or build new ones to identify patients with gaps. For example,
 - The EMR produces a report of all infants eligible for well-child checks and flags those who have not had them according to the appropriate schedule.
- 2.5. Run Gaps in care reports on a regular basis and give to an outreach person.
- 2.6. Test and implement a process for alerts to appear in patient charts and be available to be addressed by a member of the care team.
 - Develop the process by which any person with appropriate access to the patient’s record can see the care gap alert and recommend an appropriate response. For example, a mother stops by the practice to pick up a form for her child. The registrar sees that the child is overdue for a well-child check and recommends making an appointment.
- 2.7. Standing orders for screening test referrals. For example:
 - A standing order to provide a flu shot for all eligible patients who meet specified criteria
 - A standing order for mammography referrals for all eligible patients based on a recommended screening interval, as discussed with the patient
 - Standing orders for colonoscopy referral or other CRC screening.

3. Address non-medical issues

- 3.1 Develop a process for unmasking and addressing non-medical factors. For example:
 - To address the two measures Post-Discharge Follow-Up and 3M PPRs, screen hospitalized patients for their level of understanding of their care plan, their confidence in ability to manage once at home, their level of family and social support.
 - See How’s Your Health: <https://www.howsyourhealth.org/>
- 3.2 Develop a self-management support intervention.
 - For example, see <http://www.chcf.org/publications/2009/09/selfmanagement-support-training-materials>
- 3.3 Motivational interviewing.
 - For example, see <https://www.centerforebp.case.edu/practices/mi>
- 3.4 Stages-of-change interventions.
 - For example, see <http://www.aafp.org/afp/2000/0301/p1409.html>
- 3.5 Group visits
 - For example, see <http://www.aafp.org/fpm/2003/0500/p66.html>

3.6 Peer counseling

- For example, see <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20B/PDF%20BuildingPeerSupportPrograms.pdf>

3.7 Develop relationships with behavioral health practitioners

- For example, see <http://www.ihl.org/resources/Pages/Publications/IntegratingBehavioralHealthPrimaryCare.aspx>
- Hire a social worker

3.8 Identify community resources that address non-medical factors that impact outcomes and develop a process for connecting the need with the resource.

- For example, see <https://pcmh.ahrq.gov/page/coordinating-care-adults-complex-care-needs-patient-centered-medical-home-challenges-and>

4. Expand access

4.1. Develop expanded hours.

- This can make it easier for patients and caregivers whose work schedules or other obligations interfere with access during usual business hours.

4.2. Conduct group visits for infant well-child visits.

4.3. Develop a specific time for well-child visits. For example, a well-child visit clinic on the second Thursday of the month from 4-9 pm.

4.4. Implement open access scheduling, For example,

see <http://www.ihl.org/resources/Pages/ImprovementStories/OpenAccessatPrimaryCarePartners.aspx>

4.5. Partner with laboratory, imaging, and pharmacy providers to reduce waits and delays, or bring some of these services in-house.

4.6. Partner with nearby screening providers to provide earlier and easier access. For example:

- IHI's Yellow Card model <http://www.ihl.org/resources/Pages/Tools/ServiceAgreementYellowCard.aspx>
- An imaging center for mammography
- A GI group for colorectal cancer screening

5. Manage care transitions

5.1. Develop a relationship between the facility and primary care practices around transitions of care. For example:

- Project Red <http://www.ahrq.gov/professionals/systems/hospital/red/toolkit/index.html>
- Project BOOST http://www.hospitalmedicine.org/Web/Quality_Innovation/Mentored_Implementation/Project_BOOST/About_BOOST.aspx

5.2 Create a segmentation model that flags how soon people need to be seen in follow-up.

6. Improve continuity of care

People have better outcomes when they have the chance to develop a relationship over time. This enables better communication among other factors that lend themselves to better outcomes.

- 6.1. Schedule appointments based on continuity without creating any waits or delays.
- 6.2. Create care teams that share a common patient population yet are small enough that a patient is likely to be personally known by team members. For example:
 - The Bodenheimer Teamlet model: <https://cepc.ucsf.edu/teamlets>
- 6.3. Have part-time clinicians pair up so that one of them is available for the bulk of business hours.

7. Engage a clinical pharmacist

- 7.1 Add a clinical pharmacist to the practice team to identify appropriate generic substitutions and to manage patients with specific health profiles (e.g. polypharmacy). Have regular meetings with a clinical pharmacist to get additional expertise on chronic disease management and increasing staff knowledge of pharmacologic options.

8. Increase the capacity of the practice to address very complex needs

- 8.1 The capacity of the practice to manage patients with complex needs is increased as a culmination of the other Action Plans: Use data to identify gaps in care and create alerts, address non-medical issues, expand access, manage care transitions, improve continuity of care, and engage a clinical pharmacist. **Change compensation plans**
- 9.1 Create compensation plans that signal and support the change from volume to value of delivered care