Report from the ACHA Benchmarking Committee 2014

Clinical Benchmarking and Beyond
Presenters

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  - I have no financial interests to disclose

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  - Financial disclosure
    - Receives licensing fees from Point and Click Solutions
Goals

- Review evidenced-based guidelines used in the third and final pilot of the Clinical Benchmarking Survey.
- Compare the results of the third pilot of the Clinical Benchmarking Survey with previous surveys and national HEDIS/NCQA data.
- Discuss future key benchmarking initiatives including Clinical Benchmarking Survey Part II, Utilization Survey, and other benchmarking needs.
Benchmarking Committee Members

- Thank you to all the ACHA Benchmarking Committee members who have participated over the past years.
- Special thanks to those who over the past year made significant contributions to the updated and improved Clinical Benchmarking Survey:
  - Cheryl Flynn MD- Medical Director University of Vermont
  - Martha Dannenbaum MD- Director at University of Texas A&M
  - Beverly Kloeppel MD- Director University of New Mexico
  - David McBride MD- Director Boston University
  - Victor Leino- ACHA Staff
Clinical Benchmarking Survey

- **Goals of Clinical Benchmarking Survey**
  - Understand the quality of care provided by member institutions for college students
  - To find areas of potential education and focus for ACHA initiatives to improve quality of care in college health
  - For ACHA and the survey participants to compare quality provided by member organizations against community and national standards.
Pilot #3 Updates

- Make the input of data easier for members
  - Surveys can be completed without having to know all the demographic information by different staff members
  - Created off-line collection tools
- Decrease the time to complete the survey
  - Split the study into two parts with separate releases
- Better assistance when completing the survey
  - Created online PowerPoint video to watch prior to starting.
  - Easier access to answers on measures and filling out the survey.
- Ensure that data collected could be compared when available to national data sets like HEDIS
- Increase member participation to make the data collected more “reliable”
Pilot #3 Overall Participation

- 81 programs by May 9th
- 7450 patients records reviewed
- Anticipate over 100 by completion of entry in summer of 2014

Previous Participation

- Pilot #1 2009-11 schools
- Pilot #2 2011-14 schools

Demographics
Public/Private Non Profit

- Public: 76%
- Private Not for Profit: 24%
Pilot #3- Acute Care Measures
Ottawa Ankle Rules

- **Background**
  - Use of Ottawa Ankle/Foot Rules were first promoted in an original 1993 article that reported a 100% sensitivity of use of the rules to determine the ability to “rule out” fractures.
  - If the criteria of the rules are met, then the patient could avoid the cost and radiation associated with X-rays.
  - In practice, this sensitivity dropped to 96-99% still making a fracture very unlikely.
  - If the criteria were not met, the rules did not apply and thus clinical judgment was required to determine if an X-ray was still needed.
  - It was estimated in a 2004 article that if implemented nationwide the annual cost savings would be $18-$90 million dollars in expenses.
Ottawa Ankle Rules

Explanation of Measures

Compliance with Ottawa Ankle Rules

- All patients with foot or ankle injuries should have documentation of the Ottawa elements
  - Ability to weight bear at the time of injury AND at the time of the evaluation
  - Based on the injured area lack of tenderness at the Ottawa areas.

- Those who had both of these documented and met the criteria above should have not received an X-ray.

- Updated in this survey was that those who had not met the Ottawa criteria should have either
  - Received an X-ray OR
  - Had documentation of still having low risk clinically to be in compliance with clinical follow-up
Results

- 69 schools participated
- Large variability between 12% and 100%
- Average 60% with a confidence interval of +/- 5%
Acute Pharyngitis

Background

- Only 5-15% of all adult pharyngitis are due to GABHS
- From the CDC website: Lab testing is NOT indicated in all patients with pharyngitis, instead all patient should be screened using Centor criteria
  - lack of cough
  - Fever
  - tender cervical adenopathy
  - tonsillar exudates
- Those with none or only one of these finding should NOT be tested or treated for GABHS.
- These recommendations are similar to previous recommendations from the IDSA and ACP.
Acute Pharyngitis

- **Explanation of Measures**
  - 25 patients with pharyngitis and Centor Scores of 0-1
  - Did the patients receive either
    - Testing through Culture or Rapid Antigen Testing
    - Antibiotics

- **HEDIS Measure is for children (2-18).**
  - The measure in this age group is the percentage of all the patients with pharyngitis and receiving an antibiotic who have a positive rapid antigen test.
  - The rates are 68% for Medicaid populations and 80% for HMO private insurance.
Results

70 schools participated

Large variability between 0% - 92%

Average 34% with a confidence interval of +/- 6%
Acute Bronchitis

**Background**

- Despite strong evidence to avoid antibiotics for acute bronchitis in otherwise healthy adults that is almost always due to viral causes, almost 60% of adult patients are treated with antibiotics.
- Treating acute bronchitis with antibiotics has not been found to be effective treatment.
- Acute bronchitis accounts for more than 10 million visits annually in the US.
- The cost of developing antibiotic resistance in bacteria has been estimated at $55 billion dollars when including both health related costs and lost productivity.
Acute Bronchitis

Explanation of Measures

- 25 patients with bronchitis AND
  - No evidence of underlying pulmonary, cardiac, renal, immunological disorder AND
  - Have symptoms less than 3 weeks AND
  - Do not have abnormal exam findings consistent with pneumonia

- Of the 25 above, did the patients receive antibiotics.

HEDIS Measure for adults (18-64).

- The percentage of adults NOT prescribed an antibiotic for acute bronchitis.
- The average rates are 21.2% for the PPO population to 24.6% for the HMO population with 24.2% for the Medicaid population with a 90th percentile at 39.6% for HMO plans
Acute Bronchitis

- Results
  - 66 schools participated
  - Large variability between 4%-100%
  - Average 56% with a confidence interval of +/- 7%
Acute Care Results Summary

2009: 80%
2011: 60%
2014: 60%

HEDIS Data Report 90th percentile

OTTAWA
PHARYNGITIS
BRONCHITIS
Chronic Care
Asthma Care

Background

- 2007 NCHA data estimates suggest that 12.1% of our college population has asthma. National figures put it between 4-15%.

- The National Asthma Education and Prevention Program (NAEPP) last updated in 2007 had guidelines on management of asthma to decrease long term risk for exacerbations and lung impairment. These included:
  - Follow-up care visits no less than every 6 months to monitor symptoms, assess asthma control and medication usage, and review a written action plan that should include teaching of home monitoring either through symptoms or Peak Flow monitoring.
  - For those with persistent asthma, treatment should include an asthma controller medication, preferably a steroid inhaler if tolerated.
Asthma Care

- **Explanation of Measures**
  - For all 25 patients are there 2 visits in the last year that the patient has had:
    - Their asthma symptoms reviewed and asthma control assessed
    - A review of a written action plan that should includes teaching of home monitoring either through symptoms or peak flow monitoring.
  - For 10 patients of the 25 who have persistent asthma
    - Did the patient either receive an asthma controller medication (preferably a steroid) OR
    - Have evidence of either refusal or intolerance to controller medications.
Asthma Care

- **HEDIS Measures**
  - **Prescribing**: The percentage of 5-64 year olds with persistent asthma during the last year who were prescribed a controller medication.
  - **Compliance**: The percentage of 5-64 year olds who used their controller medication for at least 75% of the year.

- **2012 HEDIS Data**
  - For 19-50 year olds the prescribing rate ranged from 73.9% for Medicaid patients to 88.2% for commercial HMO patients.
  - For 19-50 year olds the compliance rate ranged from 34.3% for Medicaid patients to 42.1% for commercial PPO patients.
Asthma Care Results

- 84% in 2009
- 85% in 2011
- 92% in 2014

- 53% in 2009
- 62% in 2011
- 31% in 2014

2012 HEDIS Data Range for Prescribing
Safety and Preventive Care
Documentation of Allergies

- **Background**
  - This was chosen as a safety measure in caring for patients to avoid potentially dangerous medication reactions.
  - Standard for AAAHC accreditation
  - Documentation of allergies not only on the first initial visit but on every subsequent visit the patient’s allergies are reviewed and updated.
Documentation of Allergies

- **Results**
  - 59 schools participated
  - Majority were at 100% with a few outliers (low of 32%)
  - Average 96% with a confidence interval of +/- 3%
Screening for Offering of Flu Vaccination

Background

- In Feb 2013, the CDC’s ACIP recommended flu vaccination for all patients >6 months of age without a contraindication.
- In the 2013 NCHA data set only 43.1% of surveyed students reported receiving a flu vaccination.
- Cold/flu/sore throat was the #4 reason for negative impact on academic performance behind anxiety, stress, and sleep problems.

2012 HEDIS data

- Adults age 50-64 in commercial HMO plans was at 65% (90th percentile) to 45% (10th percentile)
- For children the influenza vaccination rate was 76% (90th percentile) to 49% (10th percentile)
Screening for Offering of Flu Vaccination

- ACHA Survey Measure
  - For patients seen at the health center between Oct-Feb when influenza vaccination was available
  - Of the 25 patients seen did they either:
    - Receive the vaccination from the health center
    - Receive the vaccination from another provider
    - Documented refusal of vaccination after being offered the vaccine
    - Documented an allergy to influenza vaccination
Documentation of Influenza Vaccination

Results

- 58 schools participated
- Wide variability between 100% to 0% for influenza vaccination
- Average 36% with a confidence interval of +/- 8%
Screening for Depression

- **Background**
  - Leading impediment of learning and thus of student success, wellness and retention.
  - A 2008 study suggested that over 50% of students with symptoms of depression have not received any treatment in the past year.
  - USPSTF recommends screening adults for depression when there are supports in place for diagnosis/effective treatment/follow-up.
  - Cheung et al showed that screening is an effective approach for detecting depression among college students.
Screening for Depression

Explanation of Measures

For 25 charts of students without a known history of depression who have had at least one visit with a clinician over the past academic year

- Is there documentation of screening for depression using a standardized screening instrument (PHQ-2/9, Beck, CES-D) OR
- Is there documentation of the refusal to be screened for depression

- AND if the screen is positive is there documentation of any follow-up assessment within 4 weeks with a definitive evaluation.
Screening for Depression

Results

- 36 schools participated
- Wide variability between 100% to 0% for screening for depression
- Average 53% with a confidence interval of +/-12% and SD of 35%
Screening for Tobacco Usage

- **Background**
  - Leading cause of preventable death in the US
  - 2011 NCHA data reported that 15% of college students used cigarettes at least one day in the last 30 days and another 9% using another form of tobacco.
  - ACHA supports Health Campus 2020 with the goal to reduce cigarette use to below 14% and smokeless tobacco below 3% by 2020.
  - USPSTF recommends that clinicians screen all adults for tobacco use and advise all who are smoking to quit.
Screening for Tobacco Usage

- **HEDIS data**
  - The HEDIS measure is for adults over 18 who do smoke and receive cessation advice during the measurement year.
  - 2012 data for commercial HMO’s for receiving cessation advice ranged from 87% (90th percentile) to 68% (10th percentile).

- **ACHA Survey Measures**
  - Were patients screened for smoking AND
  - If screened and positive were they advised to quit AND
  - If a smoker and ready to quit were they given support to quit
Tobacco Screening Programs

**Results**

- 45 schools participated
- Wide variability between 100% to 0% for tobacco screening. All or none.
- Overall average- 50% with a confidence interval of +/- 12% and SD of 42%
- In the 11% of smokers, only 50% received advice to quit and of those ready to quit, only 53% got help
Allergy Documentation
Influenza
Tobacco Screening
Depression Screening
Clinical Benchmarking Part II

- Description/Explanation of Upcoming Survey
  - Women’s Healthcare
    - Chlamydia
    - PAP Testing
  - Depression Treatment
    - Initial Assessment
    - Use of standardized instrument
    - Assessment of response to treatment
Clinical Benchmarking

HEDIS Measures

A. Low back pain- Patients with a primary diagnosis of low back pain who do not get imaging studies in the first 28 days after diagnosis

B. BMI Measurement- How many patients received a BMI measurement during the past two years.

C. Hypertension- the percentage of patients with diagnosis who are controlled under 140/90.

D. ADD- (pediatric measure) Follow up care in the initiation phase and continuation phase.
Other Benchmarking Surveys

- **Existing**
  - Utilizations
  - Facilities
  - Staffing and Salary
  - Patient Satisfaction

- **Potential/Future**
  - Use of Electronic Health Records
  - Insurance/Impact of Affordable Care Act
  - Financing Models/Billing Practices
  - Campus Climate
Why Benchmark?

- It is a way of using data to compare key performance measures with those of similar organizations and/or against nationally-recognized best practices, targets, or goals.

- Ultimately, however, the goal of benchmarking is to use the data derived from benchmarking to initiate and sustain performance improvement over time.

- Benchmarking is a critical component of meeting accreditation standards.
Open Forum-

- Clinical Benchmarking
  - What are the top 5 that should be included in future clinical benchmarking surveys?
  - What are the continued barriers to participation?
- Are there other surveys/topics that should be addressed?
- Call for participation/members
  - Email Carlo Ciotoli cc47@nyu.edu