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Employing Provider Mentoring/Coaching to Improve Preventive Quality Ordering

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Walden University

College of Health Sciences

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Julie Knox-Woodward

has been found to be complete and satisfactory in all respects,
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the review committee have been made.

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2014

Abstract

Employing Provider Mentoring/Coaching to Improve Preventive Quality Ordering

by

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Proposal Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Nursing Practice

Walden University

September 2014

Abstract

Preventive quality ordering is a provider intervention aimed at disease prevention through the ordering of industry-recommended health maintenance tests. This pilot study evaluated the effectiveness of provider mentoring/coaching to improve preventive quality ordering using the 2014 Agency for Healthcare Research and Quality best practice preventive clinical services guidelines. Literature indicates provider inconsistency in preventive and quality ordering as the primary cause of disparate health outcomes. Guided by theories of modeling and role-modeling, as well as the theory of cognitive continuum, this pilot study offered provider mentoring/coaching to encourage timely preventative quality ordering. Routinely monitored historic provider practice patterns in a proprietary database were analyzed; 10 providers with the lowest ordering patterns were identified for participation.

Mentoring/coaching interventions were provided to improve preventive quality measure ordering. This process included a review of the 2014 Adult Healthcare Effectiveness Data and Information Set documentation criteria, a preventive measures clinical checklist, medical record preparation guidance, clinical shadowing, and post-training discussions. Following the pilot, a 5-person subject matter expert panel of key organizational leaders used on-site observations and standardized semi-structured interviews to evaluate the usefulness of mentoring/coaching and the developed documents to improve timely quality ordering. This small-scale pilot study (a) improved providers' awareness of quality ordering through peer mentoring, communication, and training; and (b) provided a platform for future initiatives. A larger follow-up study will allow healthcare leaders/providers to address disparate health outcomes, and patients will likely benefit from optimal delivery of preventive care.

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Dedication

I wish to dedicate this pilot to the healthcare community and those who seek to ensure preventive quality screenings are delivered routinely to patients.

Acknowledgments

I wish to acknowledge the executive management team at Healthcare Partners, and the dedicated faculty at Walden University whose encouragement and commitment made the doctoral journey so rewarding.

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Section 1: Overview of the Evidence-Based Pilot

Introduction

Disparate health outcomes exist for a multitude of reasons, one is a lack of quality measures being implemented in clinical practice (Eddy et al., 2008). Numerous issues compound the etiology [of what?], but inconsistency by the provider in addressing preventive quality measures is prevalent and the primary cause of the disparate outcomes (Friedberg et al., 2009). Addressing provider (e.g., medical doctor, doctor of osteopathic medicine, nurse practitioner, or physician assistant) inconsistency is a relatively new phenomenon in the healthcare setting. According to McEwin and Wills (2011), quality improvement studies are important in defining research, practice, and theory regarding care delivery and improving health outcomes, yet more attention is needed in this area. Through provider education, programs can be developed to overcome disparate quality ordering during routine healthcare visits. This pilot study used (a) provider mentoring/coaching and (b) the integration of quality preventive screenings to remedy this gap in care and improve the delivery of care.

Nursing theories about provider coaching and cognitive behavior permit the consistent use of quality care metrics and practice standards in order to incorporate preventive medicine to improve fragmented care. As providers concentrate on diagnosing and treating multiple comorbid conditions, often overlooked are the wellness, preventive, and quality interventions. Tailoring a mentoring/coaching approach that seeks to adopt and integrate quality measures may correct this gap in care.

To change certain behaviors by providers, the literature indicates that individual clinicians should be able to recognize previous and current practice patterns before implementing mentoring/coaching. Hammond (1981) stated that judgment is a joint function of cognitive processes and task properties. In addition, Hammond mentions two continua of decision-making: cognition and judgment. The cognitive continuum starts from analysis and declines towards intuition, and judgment starts from well-structured and deteriorates to ill-structured. This is important in the clinical setting because the bulk and type of information cues related to judgment tasks are identified components of Hammond's theory. The more well thought out the task, the more prompt the process of analytical decision-making required; conversely, ill-structured decision-making results from intuition-induced situational analysis.

Problem Statement

Looking at a large medical group in the western United States, proprietary reports consistently demonstrated that its providers view chronic disease management, inpatient admission prevention, and acute episodic care as their primary concerns, and fail to address preventive care issues during patient visits (PR, 2013). This is a reactive approach to managing preventive care and providing quality patient care, when it ideally warrants a proactive approach. This pilot study promotes proactive, preventive care through quality improvement training, using forms designed to guide decision-making via mentoring/coaching.

Purpose Statement

The purpose of the pilot study was to improve provider knowledge of preventive care and quality ordering. Implementing provider mentoring/coaching to improve consistency in quality messaging was the intent this developed mentoring pilot. This process of consistent preventive quality ordering leads to improved health outcomes. Additionally, this pilot initiated the foundation for a possible larger project to assess the overall practice outcomes.

Significance/Relevance to Practice

Three factors impede the integration of preventive quality ordering. First, as providers concentrate on diagnosis and treatment of multiple comorbid conditions, they often overlook wellness, prevention, and quality interventions. Second, some organizations incentivize providers according to visit volume rather than quality of visit; and this is compounded by the shortages of providers, resulting in failures to address preventive quality ordering, and inadvertently leading to reactive healthcare delivery. Publications and corporate proprietary reporting consistently demonstrate providers fail to address preventive screening needs during patient visits (Arar et al., 2011; Friedberg et al., 2009; PR, 2013). Third, providers and clinic team members' lack of training on the importance of preventive quality measures hinder appropriate ordering. Through the implementation of mentoring/coaching and use of developed document guides, quality ordering obstacles can be overcome (Buddeberg-Fischer, & Herta, 2006; Burr, Stichler, & Poeltler, 2011; McKinley, 2004; Overeem et al., 2010; O'Toole, Cabral, Blumen, & Blake, 2011).

Objective of the Pilot

Disparate healthcare outcomes are the bane of patients, providers, healthcare organizations, and health insurance companies. Changing patient-provider relationships' presents the best opportunity to eliminate disparate outcomes through preventive quality ordering and timely screenings (Bryant, Moshavi, Lande, Leary, & Doughty, 2011). By mentoring/coaching providers, routinely omitted quality measures during visits can be overcome by translating current evidence into clinical practice. In support of the quality improvement initiatives of O'Toole, Cabral, Blumen, and Blake (2011). The author applied existing knowledge of mentoring/coaching to improve quality ordering. The goal of this pilot study was to introduce developed quality improvement materials via mentoring/coaching to generate a reproducible program in primary care practices that integrate preventive screenings. These findings can lead to reproducing a larger-scaled project in the future.

Evidence-Based Significance

As the problem statement proposes and literature demonstrates, integrating evidence-based preventive care helps reduce the sequelae of chronic conditions, improves outcomes, decreases costs, and reduces care fragmentation (Friedberg et al., 2009). Although providers are aware of the benefit of evidenced-based preventive screening according to industry recommendations, many times these are overlooked. A proactive, rather than a reactive approach to healthcare delivery, based on scientific findings, must be implemented to improve care. One method to accomplish this is through implementation of a provider mentoring/coaching approach that focuses on improved

ordering of preventive quality screenings. As part of this pilot, incorporating resources such as checklists or laminated reference sheets contributes to program establishment. The application of solid nursing theories (e.g., modeling and role-modeling theory and cognitive continuum theory) lends to the creation of a reproducible design.

Implications for Social Change

Through understanding of cognitive behaviors and identification of current practices, provider mentoring/coaching may aid in the reduction of disparate quality ordering. This pilot evaluated the effectiveness of implementing education tools to overcome quality care gaps by promoting preventive screening ordering based on 2014 HEDIS published guidelines (NCQA, 2014). NCQA developed these guidelines to improve the quality of healthcare delivery, and to promote early disease identification to enhance timely intervention of the U.S. population.

As mentioned in the introduction, implementing a provider mentoring/coaching pilot allows for consistency in messaging through a structured mentoring plan, and leads to the process of improved health outcomes. As stated earlier, providers concentrate on diagnosis and treatment of multiple co-morbid conditions—wellness, preventive, and quality interventions are often over-looked. Tailoring a mentoring/coaching pilot that focuses on the adoption of training guidelines that lead to the integration of quality measures will lessen this care gap. This pilot provided education to heighten provider awareness.

Definition of Terms

The following terminology includes associated definitions that is not defined within the document:

1. *Health Outcomes*: Health outcomes are the results from medical interventions administered toward a patient's condition or disease state (Kelly, 2011).
2. *Healthcare Effectiveness Data and Information Set (HEDIS) Guidelines*: These are evidenced-based quality guidelines utilized by major health plans to influence optimal care delivery, and were developed by the National Committee for Quality Assurance (Eddy et al., 2008).
3. *Medicare Advantage*: This is a program for Medicare-eligible patients who sign over their fee-for-service benefits to a managed care health plan (Borichevsky, 2007).
4. *Mentoring/Coaching*: A medical provider who is well-versed (e.g., pattern of consistent quality ordering >90th percentile) on a subject, provides teaching/training/education to a fellow provider to improve their performance (Buddeberg-Fischer, & Herta, 2006).
5. *Ordering*: A provider prescribed instruction requesting a medical intervention be completed (e.g., testing, medications, therapy, etc.) (Friedberg, et al., 2009).
6. *Pioneer Accountable Care Organization*: A healthcare innovation model that coordinated care for aligned patients, to provide better health, better care, and reduce financial expenditures (triple aim) (Kelly, 2011).

7. *Proprietary System*: An electronic system or database that is owned or developed by a specific organization (Kelly, 2011).
8. *Quality Preventive Ordering*: A provider prescribed instruction requesting a medical intervention be completed (e.g., testing, medications, therapy, etc.) based quality guidelines developed by the National Committee for Quality Assurance (NCQA, 2014).
9. *Special Needs Program*: Similar to Medicare Advantage, this option focuses on specific chronic diseases, and may provide additional covered options or services, for example, lung diseases (asthma, emphysema, chronic obstructive pulmonary disease), diabetes (type I, type II), heart failure (chronic) (Borichevsky, 2007).
10. *Triple Aim*: A term presented by former CMS director, Donald Berwick, indicating the pursuit of three aims by healthcare organizations that ultimately lead to improving the U. S. healthcare delivery system; *better health, better care, and lower costs* (Berwick, Nolan, & Whittington, 2008).

Assumptions and Limitations

Assumptions

Ordering of preventive quality measures may be increased by providing structured mentoring/coaching. Healthcare industry experts, such as the U.S. Preventive Services Task Force (2013), HEDIS, and NCQA, conclude that individuals who receive preventive screenings, based on evidenced-based recommendations, are likely to have improved healthcare outcomes. Literature indicates that impacting healthcare delivery through implementation of evidence-based preventive quality measures provide the best

opportunity to improve care delivery (Eddy et. al, 2008). It is assumed that by increasing preventive quality ordering, it will lead to a healthier population, by allowing early interventions of identified conditions.

Limitations

This study was subject to two limitations: (a) Maintaining the attention of the provider during education sessions or when providing materials on clinical improvement was difficult. To minimize this issue, mentoring/coaching was done when the provider had a lighter clinical schedule. This helped enhance the learning process. (b) Some medical doctors (MD) and doctors of osteopathic medicine (DO) had difficulty receiving mentoring/coaching from a nurse practitioner. With solid support from organizational leadership, this challenge was lessened.

Summary

The practice of evidence-based medicine and advancements in medical exploration has evolved over the last century, as a result, people live much longer today than in the early 1900s. While an individual's increased lifespan is good, not all people enjoy an optimal quality of life. Many elderly have chronic conditions that overwhelm daily activities often increasing healthcare access requirements and raising insurance premiums. Both patients and providers must focus on preventive healthcare interventions that recognize or prevent disease. This pilot was designed to enhance provider ability to arrest chronic conditions facing patients by increasing quality ordering to screen for early signs of co-morbid conditions, and institute early interventions.

Section 2: Review of Literature and Theoretical and Conceptual Framework

Introduction

A review of literature is outlined in the following section. The existing literature supports provider mentoring/coaching and use of educational tools as a method to improve clinical practice. This approach was applied.

Provider Mentoring and Coaching

A literature review has shown that mentoring and coaching programs have proven beneficial in improving clinical practice and positively influencing metrics and strengthening health care delivery. In a study by Arar et al., (2011), complex adaptive systems (CAS) were used to recognize how individuals adapt to their clinical environment and learn. This study examined providers' awareness of opportunities and challenges associated with practice change implementation. The study gathered semi-structured interview results from a random sample of 56 providers, in 16 small community-based primary care practices. Content analysis identified two main practice improvement areas: (a) the care process, and (b) patient involvement in disease management. For example, process changes included improved follow-up through patient tracking, care process standardization (e.g., preventive care ordering), and overall clinical documentation. In addition, increasing patient involvement in their care by including (a) health education and (b) self-care management improve health outcomes.

Taylor, Houlston, and Wilkinson (2012) published a study on pairing high performing providers with substandard performing providers in a longitudinal peer-mentoring program. It targeted underperforming providers who suffered from high stress,

burnout, or physical/mental illness. Mentees were encouraged to discuss personal challenges in a nonjudgmental setting and work with their mentors to reflect on experiences and then develop a plan for moving forward. The program successfully managed a delicate balance between confidentiality and patient safety. In this sample study, participants' post-program surveys highlighted the value of a mentoring program and its impact on their careers.

Influencing Clinical Practice

To change specific provider behaviors, the literature indicated that individual providers must recognize previous and current practice patterns prior to implementing mentoring/coaching. As mentioned earlier, Hammond (1981) stated that judgment is a joint function of cognitive processes and task properties. Hammond also mentioned two continua of decision-making: cognition and judgment. The cognitive continuum declines from analysis to intuition, and judgment deteriorates from well-structured to ill-structured. This is important to the clinical setting because the bulk and type of information cues related to judgment tasks are identified components of Hammond's theory. The more well thought out the task, the more prompt the process of analytical decision-making required; conversely, ill-structured decision-making results from intuition-induced situational analysis.

Additional review of literature indicates that mentoring/coaching programs and use of training materials have proven beneficial in improving clinical practice and positively influencing quality measures metrics and strengthening healthcare delivery (Buddeberg-Fischer, & Herta, 2006; Burr, Stichler, & Poeltler, 2011; Hicks &

McCracken, 2009; McKinley, 2004; Overeem et al., 2010; O'Toole, Cabral, Blumen, & Blake, 2011). Also, it has shown that mentoring/coaching programs and individual recognition of cognitive behaviors among providers has proven beneficial in refining clinical practice and positively influencing metrics that strengthen healthcare delivery (O'Toole, Cabral, Blumen, & Blake, 2011). These studies identified the need to expand mentoring programs among established providers to address preventive care issues during patient visits, as these lead to increased screenings and improved quality completion rates. Use of Erickson, Tomlin, and Swain's (2009) description of the essence of nurturance (e.g., understanding proven evidence-based practice metrics as it applies to the patient) provides the foundation and guides development of the educational materials.

The literature also highlights the fact that provider/peer mentoring can increase job satisfaction while advancing healthcare delivery and improving patient satisfaction. Bryant, Moshavi, Lande, Leary, and Doughty (2011) indicated that peer-mentoring is potentially more effective than commonly employed training methods to improve provider abilities, manage patient relationships, enhance interpersonal skills, and strengthen communication. The objective is to transfer knowledge to providers from the developed educational resources via the method of mentoring/coaching. This instills a sharing of best practices across a healthcare organization.

Theoretical Framework

Cognitive Continuum Theory

The cognitive continuum theory (CCT) was introduced in K. R. Hammond's 1996 book. It has application to disparate outcome improvement processes through practice enhancement and understanding clinical decision-making processes (Cader, Campbell, & Watson, 2005). This middle-range theory aids healthcare providers in bridging knowledge gaps. In an effort to improve quality and hold providers accountable for the decision-making, this descriptive theory illuminates one's situational judgment (Harbison, 2001). Hammond's theory recognizes that task properties and cognitive processes are a joint function. Fawcett and Garity (2009) introduced their bi-component framework of evaluation and analysis of Hammond's theory, because it is useful in practice and provides a foundational step in developing a model for addressing disparate healthcare outcomes.

First introduced in 1981, Hammond explained that with a more organized task, a more specific decision-making analysis is necessary. The opposite occurs when the task is disorganized; hence the importance of preciseness. Three components are widely accepted regarding the theory (Hammond, 1981):

1. Analysis (conscious and slow data processing),
2. Intuition (unconscious and rapid data processing), and
3. Quasi-rationality (both intuition and analysis).

Teaching provider decision-making follows the traditional dichotomous approach. CCT proposes a compromise between intuition and analysis. Unless providers understand that

decision-making accuracy depends on the tasks currently performed, one will not apply the appropriate skills required of intuition or analysis or a combination of both. Including CCT in provider education increases the provider knowledgebase, and the level of analysis in their decision-making process becomes explicit (Cader, Campbell, & Watson, 2005). The author believes that cognitive continuum theory design is a necessary first step for improving provider application of quality metrics and positively impacting medical practice standards that averts disparate health care outcomes.

Modeling and Role-Modeling Theory

Once a provider can address needed changes in how cognitive processes affect healthcare delivery, a mentoring/coaching model can teach behaviors that are more effective. Through the application of Erickson's 1983 modeling and role-modeling Theory (MRM) mentoring/coaching can provide a foundation for addressing the lack of consistent quality measures that lead to disparate healthcare outcomes. Within the nursing community, MRM is widely accepted as a grand nursing theory. Historically, research, clinical practice, and education have used this grand theory. An evaluation of the theory's versatility in all three areas concludes that it is an important framework for study of provider mentoring. Erickson, Tomlin, and Swain, (2005) stated there are five aims of the interventions specific to the MRM:

1. Building trust,
2. Promoting a positive orientation,
3. Promoting client control,
4. Affirming client strengths, and

5. Setting mutual goals.

Price and Price (2009) described methods of role modeling using clinical practice students. Utilizing MRM as the strategic foundation, the student-mentor situation was adapted to the provider mentoring/coaching situation. MRM emphasizes criticality of clinical shadowing as an important learning opportunity for providers, as it is for students. They also stated that role modeling is applicable beyond the clinical practice/teaching scenario, and reproducible in clinical practices. Ideally, this individual approach is applicable in provider mentoring/coaching situations where training materials are distributed to improve a provider's clinical knowledge and skills. By developing a project grounded in MRM theory, mentoring strategies enable mentors and providers to address specific disparate health outcomes and increase provider quality ordering.

Conceptual Framework

Both aforementioned theories lend to the development of a mentoring/coaching training pilot. These theories and their components apply to clinical practice improvement through provider cognitive understanding and knowledge deficit awareness. Research indicates evidence exists that CCT is an important component in the clinical decision-making process; additionally, CCT offers an understanding of decision-making to all members of a multidisciplinary team facing challenges in diverse clinical practice. Today modern medicine and associated health services demand that every clinical professional is accountable for his or her decision-making processes. Development of clinical job-aids provides a quick and concise method to augment the providers' awareness of industry recommendations. Studies indicate that this theory provides the

needed understanding to enhance decision-making processes; by identifying areas of practice weakness, remedial intervention would occur, thus reducing non-evidence-based practice (Cader, Campbell, & Watson, 2005; Hammond, 1981; Harbison, 2001; O'Toole, Cabral, Blumen, & Blake, 2011).

The malleability of the modeling and role-modeling theory makes it an ideal theoretical framework for study on provider mentoring/coaching. Integrating a role-modeling theory within a practice improvement project proves beneficial in enhancing care delivery. In design of a mentoring/coaching plan, one should consider four ways to succeed (Overeem et al., 2010):

1. Find mentors who can provide constructive feedback if required to their colleagues.
2. Avoid matching mentors and mentees that have familiarity with each other.
3. Find opportunities for mentors to participate in group best-practice sharing sessions to discuss lessons-learned.
4. Consider compensating mentors for their time.

Use of traditional skill enhancement and professional development in the clinical setting is insufficient and limited research exists on coaching/mentor training in the healthcare industry. Bryant, Moshavi, Lande, Leary, and Doughty (2011) suggested that mentoring is integral to provider training throughout nursing or medical school, and can therefore be mirrored in this similar pilot.

Summary

Through the review of literature, results show that mentoring/coaching techniques and use of training devices have proven beneficial in improving clinical practice, positively influencing metrics, and strengthening healthcare delivery. Research indicates that theories such as modeling and role-modeling can provide a foundation for addressing the lack of consistent quality measure ordering by providers. In the following section the approach will be described in greater detail.

Section 3: Approach

Approach

For this quality improvement intervention pilot, the application of solid nursing theories (modeling and role-modeling theory and cognitive continuum theory) created the foundation for a reproducible approach to strengthen healthcare delivery (Cader, Campbell, & Watson, 2005; Erickson, Tomlin, & Swain, 2009). CCT has application to improve preventive screening ordering through practice enhancement and understanding clinical decision-making processes (Cader, Campbell, & Watson, 2005). This middle-range theory aids healthcare providers to bridge knowledge gaps. In an effort to improve quality and to hold providers accountable for their decision-making, this descriptive theory illuminates individual situational judgment (Harbison, 2001). Using Erickson's MRM, mentoring/coaching provides a foundation for addressing a lack of consistent quality ordering that leads to disparate healthcare delivery. Within the nursing community, MRM is widely accepted as a grand nursing theory. Historically, research, clinical practice, and education fields have used this grand theory. Price and Price (2009) described methods of role modeling to clinical practice students, using MRM as the strategic foundation; the student/mentor situation was adapted to the provider mentoring/coaching situation. The malleability of the modeling and role-modeling theory made it an ideal theoretical framework for training on quality improvement, through use of provider mentoring/coaching and developed educational materials.

These nursing theories were the basis for this initiative to improve practice standards and increase preventive quality ordering. This pilot was a tailored

mentoring/coaching initiative that focused on the adoption and integration of quality measure guides to correct current preventive care gaps.

Pilot Design

Using educational materials to help understand practice patterns, provider mentoring/coaching influenced preventive quality ordering. This pilot translated current evidence into clinical practice to improve quality ordering. Providers and support staff were trained to integrate quality ordering using a checklist-based system.

The author-developed checklist-based system consisted of two major tools. First, the 2014 Adult HEDIS Measures Description and Documentation Criteria outlined the specific quality measure and age range, along with the screening to be performed and documentation requirement. Second, the 2014 Adult HEDIS and Preventive Measures Clinical Checklist guided the provider and clinical team on preventive measures to assess at set intervals (e.g., every visit, every 6 months, every year, and every 2–10 years). These documents were created according to the published 2014 HEDIS recommendations, and other internal organizational recommended preventive screenings. The documents are outlined in the appendix.

The pilot team consisted of three interdisciplinary representatives. The medical director (DNP preceptor) provided extensive knowledge regarding medical practice and screening procedures. The second member, the quality nurse, brought expert knowledge about HEDIS quality measures, preventive screenings, documentation requirements, data collection, and reporting analysis. The final member was the DNP student (nurse practitioner) who brought a clinical background, previous practicum and quality

improvement experience, and well-researched subject knowledge. Using this diverse group along with an observational validation team of subject matter experts assessed training effectiveness through interactive feedback. Lamb et al. (2011) stated to assess new quality information dissemination, use of a multidisciplinary team is best. Utilizing the same evaluators decreases variability when assessing behaviors and clinical performance, after introduction of new information. The multidisciplinary team provided validation through use of expert observation and assessment.

Providers identified by the organization (e.g., medical director, quality nurse) with historical practice patterns less than the 50th percentile in preventive quality ordering were given training. This educational training occurred at one clinical site. The mentoring/coaching group of providers received instruction (e.g., review of quality pilot overview document, review of 2014 adult HEDIS measures description and documentation criteria, review of 2014 adult HEDIS and preventive measures clinical checklist, guidance on medical record preparation, clinical shadowing, and post-training discussion to providers/clinical support staff) to increase knowledge on preventive quality measure ordering. As stated previously, the pilot mentoring team consisted of one nurse practitioner (DNP student), the DNP preceptor (medical director) and the quality nurse. Each provider received approximately 12 hours of one-on-one coaching/mentoring, and clinical support teams received approximately 12 hours of primarily group training.

The pilot concluded after 16 days of skills training in the clinical setting. Post-pilot, the organizational medical director, quality nurse, and DNP student discussed the educational training pilot, specifically, focusing on feedback, observations, and

perceptions of the pilot's usefulness. Based on that discussion, the medical director and quality nurse may choose to expand the pilot into a larger project in the future, or may review routinely collected provider performance data in the future. The DNP student did not participate in data collection.

Improving patient quality ordering of preventive measures is critical to increasing better health and care, reducing healthcare related costs, and ensuring patient satisfaction. At the foundation of this effort is the emphasis on evidence-based practice and sound employment of the DNP Essentials across the practice paradigm (Kelly, 2011). Before beginning any care improvement project or practicum, it is essential for a doctoral nursing student to understand the eight DNP Essentials required for all program graduates. Those eight competencies include (ACCN, 2006):

1. Organizational and Systems Leadership for Quality Improvement and Systems Thinking
2. Information Systems/Technology and Patient Care Technology
3. Scientific Underpinnings for Practice
4. Health Care Policy for Advocacy in Health Care
5. Clinical Prevention and Population Health for Improving the Nation's Health
6. Inter-professional Collaboration for Improving Patient and Population Health Outcomes
7. Clinical Scholarship and Analytical Methods for Evidence-Based Practice
8. Advanced Nursing Practice

This pilot aligned with three DNP Essentials: (a) Inter-professional Collaboration for Improving Patient and Population Health Outcomes, (b) Clinical Prevention and Population Health for Improving the Nation's Health; and (c) Advanced Nursing Practice. At the project site, providers primarily see Medicare and Medicare Advantage patients. This component of preventive medicine is foundational to arresting chronic conditions that cause greater health problems for older clients.

Clinical support staff also received information on the pilot. The clinic support staff reviewed patient records and noted any screenings that had not been completed prior to taking the patient to the exam room. The clinical team flagged the medical record to alert providers of existing quality care gaps. The chart review assisted providers in prioritizing ordering of specific quality measures based on HEDIS recommendations, according to age and gender. Following the patient visit, the orders were logged into the patient's electronic health record for subsequent visit availability.

Population

Healthcare providers chosen by the organization, who practice primary care, and are employed by a large multispecialty healthcare organization in the Western United States, were chosen to partake in the training. The providers primarily treat a patient population consisting of Medicare-eligible patients, generally over the age of 65 years. These individuals are enrolled in a global risk population management (e.g., Medicare Advantage, Special Needs Program, and Pioneer Accountable Care Organization).

Data Collection

The use of routinely collected data was utilized by the organization (e.g., medical director, quality nurse) to identify one clinic to receive training. Provider mentoring/coaching to improve quality measures in clinical practice was based on the organization and industry accepted benchmarks through recognized agencies (e.g., HEDIS [2014], Agency for Healthcare Research and Quality [AHRQ, 2013]). Evaluation of practice patterns, regarding quality ordering post-pilot may be an option for the organization to pursue in the future. Through observation and interactive feedback, the educational training was evaluated during the pilot to aid in refinements that can be applied toward a possible large-scale project in the future. Ekundayo et al. (2013) stated evaluating readiness for evidence transfer, originates from the introduction of similar or smaller initiatives prior to the commencement of a larger project. This small-scale pilot provided quality improvement awareness to providers through peer mentoring, communication, training, and provided a platform for future initiatives.

Data Analysis

During the DNP practicum, the initial initiative included the development of a checklist to improve quality ordering at one clinical site, which resulted in a 16% improvement. During the subsequent semester, the quality ordering checklist was launched organization-wide to 50 primary care clinics, resulting in an improvement of 13%. Utilizing the previous feedback from the two similar initiatives, a positive outcome was anticipated in this pilot. At a later date, the organization may decide to examine referral ordering patterns to determine intervention changes. Rekleiti et al., (2012) stated

that healthcare professionals must be trained on patient quality and safety to impact improved care outcomes. The author's promote education dissemination at the project onset, and delay the monitoring of actions until later, when the initiative effectiveness can more reliably be determined.

Pilot Evaluation Plan

The following graph depicts the key areas of the programs activities, to include the problem, purpose, process improvement stages, and evaluation feedback mechanism (Figure 1).

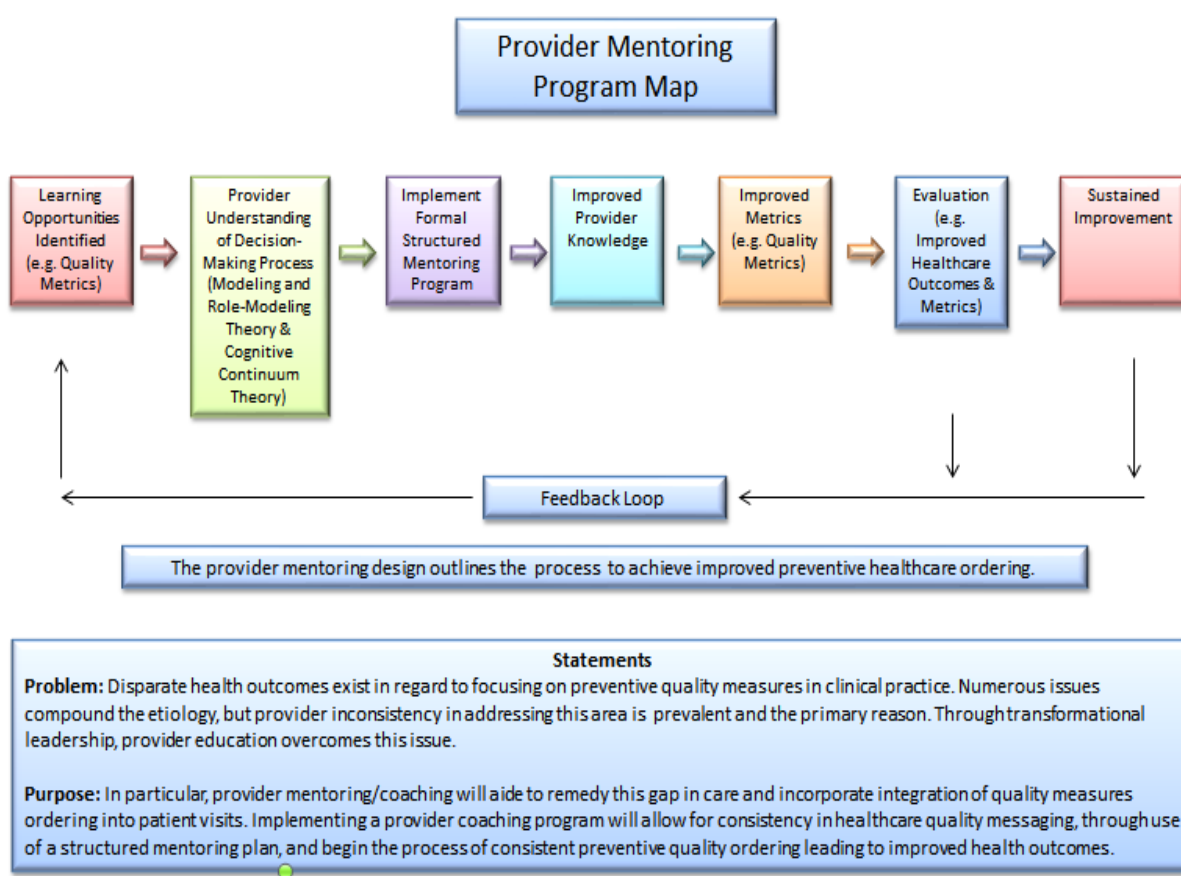


Figure 1. Provider Mentoring Program Map

To incorporate long-term outcome evaluation, the organization may consider review of future metrics. Afsar-Manesh and Martin (2012) found that quality improvement initiatives require immediate follow-up and open discussion between the executing project team. After gaining immediate feedback and applying necessary refinements, long-term data analysis can then be performed. A possible timeframe for re-evaluation would be at six-months and one-year, based on preliminary discussions with the organization. The organization states in-depth data analysis occurs routinely at these intervals, therefore, facilitating post-intervention assessment.

Summary

Through understanding of cognitive behaviors and identification of current practices, provider mentoring/coaching aids in the reduction of disparate quality ordering. According to NCQA (2014), increased preventive screenings would reduce the loss of 2 million lives annually and avert \$3.7 billion in healthcare costs if the healthcare industry commits to implementing targeted preventive medical screening. As the nation's healthcare system evolves into an accountable-care environment, expansion of preventive-care evidence-based practices is essential to provide high-quality, low-cost care, with consistent outcomes.

This demand places a high emphasis on the ability of providers to perform at the highest levels and to maximize best practices to produce superior patient satisfaction and health outcomes. Through the establishment of mentoring programs, provider performance in the clinical environment is likely to improve. Hicks and McCracken

(2010) summarized the role of mentoring as sharing knowledge and professional experience with others to advance their understanding.

As a preventive healthcare strategy, this pilot translated current evidence into clinical practice. Quality improvement occurred by implementing mentoring/coaching to increase provider behaviors that promote integration of quality ordering, through use of educational materials. By using a mentor, providers and their support staff were trained to integrate quality ordering through the employment of a checklist-based system. Through observation and interactive feedback, the educational training was evaluated during the pilot to aid in refinements that can be applied toward a possible large-scale project in the future. In the next section, the pilot's findings, discussion, and future implications are discussed.

Section 4: Findings, Discussion, and Implications

Quality Improvement Summary

This quality improvement initiative developed clinical training documents to overcome disparate quality ordering during routine healthcare visits. A checklist was integrated into the training to improve preventive screenings to remedy care gaps and improve care delivery. Couvillon (2005) stated that (a) adequate planning and preparation are fundamental to successfully implementing an evidenced-based project (EBP) and that (b) working within the clinical setting significantly improves the use and adoption of the EBP.

The pilot was 16 days long; emphasis was on the mentoring/coaching component during the months of May and June, 2014 (see Figure 2).

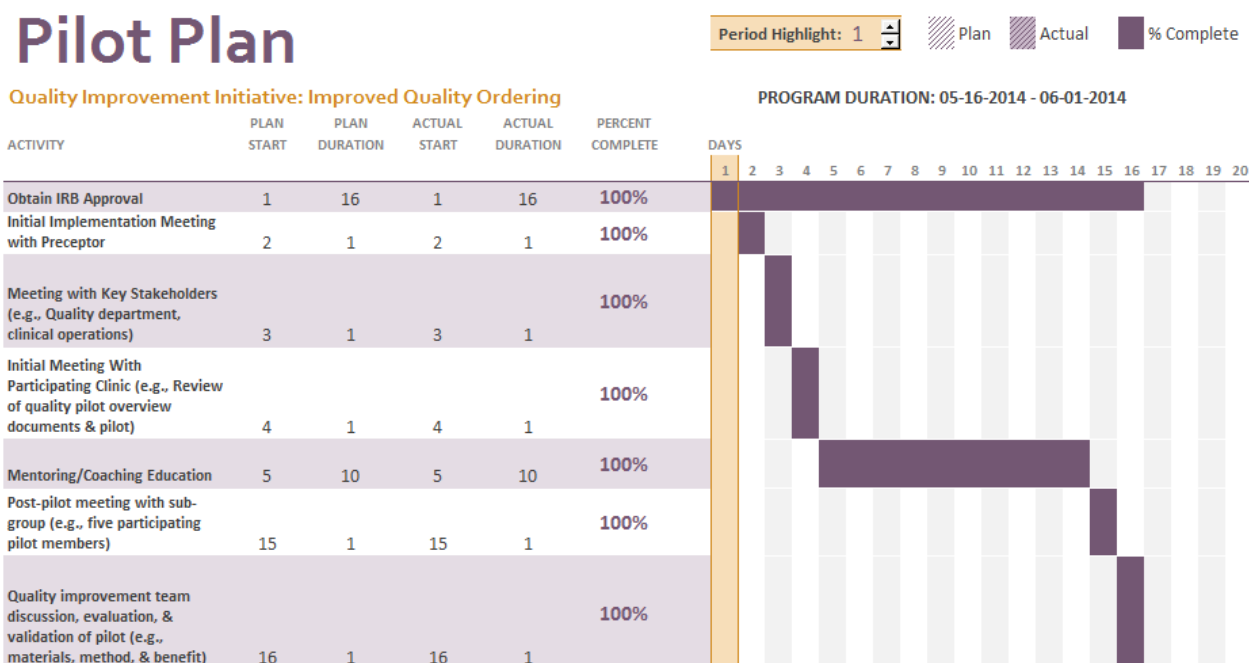


Figure 2. Gantt chart and timeline for pilot study

Stakeholder consultation directly influences the overall outcome of a change initiative, (Mahadkar, Mills, & Price, 2012). To engage stakeholders, meetings were held with key department representatives (e.g., Director of Quality, HEDIS Manager, Vice President of Clinical Operations/Medical Director, and Director of Performance Improvement) about implementing the quality improvement initiative and evaluating the educational documents. To facilitate this engagement, both the quality and clinical operation teams (e.g., Medical Director, Quality Nurse, Vice President of Clinical Operations, Director of Operations, and Lead Provider) were actively involved. The purpose of the initial planning meeting was to discuss clinics performing below the established organizational benchmark for quality ordering, and which clinic should be targeted for training. Using an organizational proprietary system, the providers' historical practice patterns were reviewed by the medical director and the quality nurse, and one clinic was chosen to take part in the educational training. Examining the De Mast and Trip (2007) publication on exploratory data analysis (EDA), the steps to a prescriptive framework in quality improvement projects was explained. Based on this information, the methods to review data pre-project were more clearly defined, increasing the understanding of what the organizational team (e.g., medical director, quality nurse) examined. The three EDA steps are: (a) display of the data, (b) identify the salient features, and (c) interpret the salient features. Using this method to evaluate the quality ordering patterns of the provider, the organizational team identified four clinics as possible locations for implementing the quality improvement initiative. The clinic chosen had the lowest reported measures, and therefore that clinic was designated as the pilot

site. The clinic caters to a primary care population, and has full-time providers (10) consisting of five medical doctors (MD), two doctor of osteopathic medicine (DO), two nurse practitioners (NP), and one physician assistant (PA). The clinic operates on 12-hour shifts and is open 7-days per week. The average daily census per provider is between 15 and 20 patients. Post-pilot review of the clinical checklist/forms was done through observation and interactive feedback; the educational training was evaluated to aid in refinements that can be applied toward a possible large-scale project in the future. Through use of a subject matter expert (SME) panel, these professionals provided opinions about the usefulness of the initiative and the documents.

An initial meeting with the chosen pilot clinic occurred, including the practice manager, providers, and clinical staff. The discussion focused on the quality improvement pilot and an overview of the documents. The pilot consisted of training on capturing HEDIS measures and preventive screenings to eliminate potential knowledge gaps; to determine if dedicated training at the clinical level assisted in improving quality ordering. During this pilot, the 2014 HEDIS measures were utilized (NCQA, 2014), as well as organizational recognized preventive screenings.

During the 16-day pilot, training and instruction on the available resources were provided. The pilot was developed with support of the quality department. The following resources were reviewed:

1. Quality Pilot Overview Document
2. 2014 Adult HEDIS Measures Description & Documentation Criteria
3. 2014 Adult HEDIS & Preventive Measures Clinical Checklist

4. Guidance on medical record preparation (training for clinical support team)
5. Clinical shadowing for providers
6. Additional resources:
 - a) Quality support telephone line
 - b) High-risk medication list for the elderly website: www.ncqa.org
7. Post training discussion (reaffirm understanding of quality ordering)

It was decided that rotating intervals (approximately 2 hours each) would be spent with each provider, and the front and back office teams throughout the day. The time focused on discussing the importance of quality, the specific quality metrics, ordering, and methods to capture quality ordering during routine office visits (e.g., pre-visit chart preparation). By including the clinical team, additional screenings were identified and brought to the attention of the providers. The providers used the 2014 Adult HEDIS & Preventive Measures Clinical Checklist to guide the appropriate testing necessary for each patient. Once a screening was deemed necessary, the provider placed an order in the referral ordering system. The referral ordering system is a proprietary system that synchronizes with the quality department's database to capture quality-ordering patterns at the provider and clinic level.

Using the SME panel to elicit constructive feedback regarding the pilot, developed documents, and mentoring method provided validation regarding the usefulness of the methods. Through use of these proven interventions, the SME panel of

professionals concluded that the method, developed forms, and practice improvement was beneficial to care delivery.

Literature Discussion

The literature showed that mentoring and coaching programs have proven beneficial in improving clinical practice and positively influencing metrics and strengthening healthcare delivery to overcome healthcare gaps. In the pilot, provider awareness and adaption to the practice change initiative was realized. This is consistent with the Arar et al. (2011) study, which stated through complex adaptive systems (CAS) providers acclimate to the transformed clinical environments and learn.

Consistent with the Taylor, Houlston, and Wilkinson (2012) published study on pairing high performing providers with substandard performing providers, both this pilot and the study were parallel in the findings. Mentees were receptive to training and improving care delivery.

Information cues related to mentoring/coaching were assimilated by the providers and behavioral change led to quality improvement. This practice pattern change is consistent with Hammond's theory of cognitive continuum (1981). To accomplish provider behavioral change, previous and current practice patterns were examined. This interchange lent to enhanced decision-making and improved clinical judgment.

Additional review of literature indicates that mentoring/coaching and clinical guides have proven beneficial in improving clinical practice and positively influencing metrics and strengthening healthcare delivery (Buddeberg-Fischer, & Herta, 2006; Burr, Stichler, & Poeltler, 2011; Hicks, & McCracken, 2009; McKinley, 2004; Overeem, et al.,

2010; O'Toole, Cabral, Blumen, & Blake, 2011). The pilot demonstrated positive results concerning practice delivery, utilizing the checklist-based guideline to bridge healthcare gaps. This is also consistent with Erickson, Tomlin, and Swain's (2009) statement that describes how the provider's understanding of evidence-based practice metrics clearly influences healthcare delivery change.

Additionally, providers reported augmented patient satisfaction because of the diligence to order necessary testing. Bryant, Moshavi, Lande, Leary, and Doughty (2011) indicated that peer-mentoring is directly correlated to enriched patient relationships. Also highlighted is how provider/peer mentoring can increase job satisfaction while advancing healthcare delivery and improving patient satisfaction. The objective is to transfer knowledge to providers from the developed educational resources via the method of mentoring/coaching. This instills a sharing of best practices across a healthcare organization.

Implications

Policy

To encourage preventive screenings, health insurance plans are incorporating coverage for these high-value services. This expanded coverage is a result of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. This policy allows preventive services to be provided regardless of the annual deductible being met. Prior to this, these services were not routinely covered or were covered only after the deductible had been met, instituting a barrier to preventive care. This financial burden led to decreased utilization of preventive screenings and resulted in late identification of

medical conditions (Meeker et al., 2011). By implementing this policy change, increased use of preventive services has trended upwards. Cost associated with decreased screenings is estimated to burden the nation's fiscal healthcare budget. According to NCQA (2014), increasing preventive screening reduces the loss of 2 million lives annually and averts \$3.7 billion in healthcare costs. If the healthcare profession commits to implementing preventive care, industry improvements would result in better patient outcomes and reduced financial costs.

Policy development must center on achieving optimal patient care and foster continuous quality improvement. The development of the Affordable Care Act (ACA), signed into law in 2010 has implemented programs such as Accountable Care Organizations (ACO) to improve healthcare delivery to populations. Specifically, these organizations desire to reduce costs, align care, deliver prevention and wellness, and most importantly increase quality of care (Bennett, 2012). It is through these healthcare policy changes that strong outpatient systems can be established which are proactive in care management, instead of a reactive structure reluctant to promote preventive services.

From an organizational standpoint, policy implementation and institutionalization of quality measure ordering according to evidence-based practice can improve patient care standards. Such policies allow the overcoming of barriers, since providers realize that the policies promote the utilization of clinical decision-making. Organizational policies must establish benchmarks necessary to evaluate quality measure ordering and patient satisfaction, thus leading to superior patient outcomes.

Practice

As the problem statement and literature demonstrates, integrating evidence-based preventive care helps reduce the sequelae related to chronic conditions, improves outcomes, decreases financial expenditures, and reduces care fragmentation. Although providers are aware of the benefits of evidence-based practice and preventive screenings, many times the guidelines are overlooked. A proactive, rather than a reactive approach to healthcare delivery based on scientific findings must be implemented to improve care, as was identified in this quality improvement pilot. Replication of the provider mentoring/coaching pilot, which focused on improved ordering of preventive quality screenings through a checklist-based approach is a method to employ practice improvement.

Through publication, presentation, and other knowledge transfer opportunities the benefits of provider mentoring/coaching and clinical guides can be conveyed within the healthcare industry. As more education floods the profession, practice improvement and preventive services will become the mainstay.

In addition to increasing professional knowledge, future efforts can be directed toward patient mentoring/coaching to promote self-advocacy of prevention and wellness. Wright and Palmer (2012) studied behavioral change to promote healthy lifestyles and found that marketing approaches significantly make a difference in changing behavior. The authors mention that optimal marketing can lead to health promotion, smoking cessation, helmet safety, preventing drinking and driving, optimal caloric intake, and

other lifestyle improvements. Incorporating Wright and Palmers findings on marketing would be another avenue to engage patients and educate them in the wellness pursuit.

Outcome

This pilot demonstrated that care delivery changes are possible through implementation of training materials using mentoring/coaching. Although provider post-pilot performance metrics were not evaluated in this small-scale pilot, observations indicated that an interval metric evaluation at six months and one year may be beneficial in determining if a follow-on larger scale study is advisable.

To validate further the benefits of the checklist-based clinical guide, beyond the participant and quality improvement team responses, the information was presented to the SME panel to validate the accuracy, usefulness, and appropriateness of the training resources. Corroborated in literature, Rauta, Salanterä, Nivalainen, and Junttila (2013) used a validation panel as a method to validate the worthwhileness of content and process created for perioperative nursing delivery. The perioperative team found the use of the panel helpful in determining if the initiative was relevant to clinical practice. Similar to the quality improvement pilot, the SME panel was a practical resource for gaining consensus from multiple experts.

Five panelists weighed in through an open discussion forum, to determine if there was a consensus among the panel, whether the pilot, developed documents, and mentoring/coaching method were advisable and meaningful to clinical practice. The panel consisted of the Director of Quality, HEDIS Manager, Vice President of Clinical Operations/Medical Director, Director of Performance Improvement, and Lead Physician

(participated in pilot). These individuals formed a tiger-team with diverse knowledge and skills related to clinical delivery, quality, preventive care, process improvement, and document content. These individuals were asked to provide feedback on the developed quality improvement materials and the use of mentoring/coaching to convey increased clinical awareness. The SME panel of professionals concluded that the method, developed forms, and practice improvement was beneficial to care delivery.

This feedback was provided to the quality implementation team (DNP student, medical director, quality nurse) to determine the benefit of the materials and the learning delivery method. Based on the quality implementation team and SME response, both the clinical documents and mentoring technique was deemed successful. Both groups decided that future data analysis is of value to the organization, as well as a large-scale follow-on study.

As discussed earlier, during the DNP practicum, the initial initiative included the development of a checklist to improve quality ordering in one clinical site, which resulted in a 16% improvement. During the subsequent semester, the quality ordering checklist was launched organization-wide to 50 primary care clinics, resulting in an improvement of 13%. Using the previous feedback from the two similar initiatives, a positive outcome was anticipated in this pilot. Later the organization may decide to examine referral ordering patterns to determine intervention changes. These previous practicums proved helpful in the continuous improvement approach that guided this pilot.

Social Change

The concept of implementing change was introduced during the pilot and the team learned how their dedication improves the lives of the population and directly influences social change. Feedback from the clinical team was positive, as comments regarding meaningful change were repeatedly referenced. Dodwad (2013) states that social change occurs using quality improvement projects, and leads to improved population health. Additionally, some examples of positive social change occur through eliminating costly treatments, avoiding unnecessary costs, and improving care delivery and patient safety.

Through understanding of cognitive behaviors and identification of current practices, provider mentoring/coaching lent to improve disparate quality ordering. The pilot evaluated the effectiveness of mentoring/coaching and improved preventive screening ordering based on 2014 (HEDIS) published guidelines (NCQA, 2014). The (NCQA) developed these guidelines to improve the quality of healthcare delivery, and to promote early disease identification to enhance timely interventions aiding the U.S. population.

Project Strengths and Limitations

Strengths

This quality improvement pilot successfully implemented strategies to translate evidence tied to preventive quality ordering. The pilot was consistent with previous studies of a similar nature (Buddeberg-Fischer, & Herta, 2006; Burr, Stichler, & Poeltler, 2011; McKinley, 2004; Overeem et al., 2010; O'Toole, Cabral, Blumen, & Blake, 2011). The improvement that occurred provided confirmation to the referenced literature. Ament, et al., (2012) states the sustainability of healthcare innovations on a long-term basis are attributed to engagement of key stakeholders working as change agents. These change agents are successful when the implemented change results in increased efficiency, cost-effectiveness, or other meaningful improvement. This initiative aimed to create meaningful improvement concerning quality care delivery.

Additionally, application of solid theories (e.g., modeling and role-modeling theory and cognitive continuum theory) provided a solid foundation to guide future quality improvement initiatives or longitudinal studies. Organizational cooperation and engagement by leadership, providers, and the clinical team strengthened the success of the pilot.

Limitations

Due to the small scope of this pilot, long-term outcomes were not evaluated in the measured population. Information collected was observational and via feedback utilizing the quality improvement team and the SMEs for a response. Long-term data may be evaluated by the organization, outside of this pilot, in the future.

Another issue that became evident during the pilot, was the problem of providers who are absent from the clinic (e.g., paid-time-off) during the pilot. Fortunately, the clinic that was chosen had ten providers; therefore, the absence of one provider during one week of the pilot did not affect the overall training. Utilizing a smaller clinic for the pilot would have impacted the training initiative. Moore, Carter, Nietert, and Stewart (2011) published their recommendations for planning pilot studies in clinical and translational inquiry and stated that population samples should be of adequate size to account for potential participant loss. In future projects, this will need to be considered when choosing an implementation site, as the results could falsely demonstrate improvement or non-improvement.

Analysis of Self

As Scholar

During this practicum experience, much was learned that can be applied toward future evidence-based projects. Through the result of these experiences, overcoming barriers to change, organizational acceptance, and implementation challenges were mitigated and can be applied toward future endeavors. Reflecting back on practicum initiatives during NURS 8410, NURS 8400, and NURS 8500 the author's leadership skills, planning competency, and abilities to communicate vision have grown. These tactics to improve organizational acceptance, processes, methods, structures, culture, leadership practices, and internal/external stakeholder relationships are consistent with current literature (Stroubouki, 2013). As the nation's healthcare system evolves into an accountable-care environment, expansion of preventive care evidence-based practices is

essential to provide high quality, low-cost care with consistent outcomes, which the author is proud to contribute in future endeavors.

Quality improvement initiatives will shape healthcare delivery change—now and in the future. This pilot realized significant success that can be replicated for use in future studies and through efforts such as publication in industry journals.

As Practitioner

As new theories and care delivery methodologies emerge (e.g., evidence-based practice), awareness of emerging nursing knowledge is crucial. Nursing knowledge is a bi-product of the evolution of nursing theory and research. Today, many practitioners understand the vital role nursing knowledge plays in theory as it guides critical thinking in healthcare practice. The body of nursing knowledge has many definitions. Knowledge is described as the constructs and concepts of relationships between the nursing intervention and the patient response to prevention and health delivery. In nursing practice, the body of knowledge must be cyclic in regard to generating and testing nursing perspectives in order to provide relevant substantiated information for the guidance of future practice (Fawcett, 2003).

Nurse leaders need remain vigilant concerning future practice trends, organizational goals, and industry innovation to lead practice transformation. Today, many healthcare organizations experience practice failures; nurses must understand how to manage resources efficiently to overcome these barriers. With movement toward national healthcare reform, cost-effective utilization, and quality healthcare delivery, improved practice is at the foundation.

As Project Developer

Over the past ten years, the healthcare industry continues to emphasize that the translation of peer-reviewed evidence is foundational to strengthening clinical delivery. Evidence-based practice is the meticulous, unambiguous, and cautious use of current best evidence/knowledge regarding care-related decisions affecting individual patients (Cohen et. al, 2008). Disparate health outcomes exist because of a lack of implementing quality measures in clinical practice (Eddy et al., 2008). To overcome practice impediments, methods to identify and plan remediation are necessary to initiate change management methodologies.

Planning and implementing system change to execute quality improvement initiatives requires transformation of tasks, processes, methods, structures, culture, leadership practices, and internal/external stakeholder relationships (Stroubouki, 2013). To transform, four key change management steps are necessary to create evidence-based processes (Fineout-Overholt, Williamson, Gallagher-Ford, Melnyk, & Stillwell, 2011) in an organization that can successfully employ continuous quality improvement. These steps derive from the Shewhart cycle or more commonly known as the PDCA cycle (Kelly, 2011) that can be applied to new care delivery approaches. The four steps that comprise the PDCA cycle are:

1. Plan: Plan for change by identifying the opportunity
2. Do: Implement a small-scale project to make the change
3. Check/Study: Determine the results of the change with data
4. Act: If successful, expand integration while continuing to monitor

This method proves helpful in the continuous improvement approach and guides organizational change using critical thinking and solving processes. These steps were beneficial in the mentoring/coaching quality-ordering pilot and during the development of clinical documents.

Future Professional Development

Advocating for new processes, innovations, and increasing quality improvements in healthcare are important components of effective healthcare leadership. Ensuring that healthcare professionals stay abreast of new approaches, evidence-based practices, and methods to advocate health policy is obligatory. Poorly informed decision-making is the lead contributor to failure to deliver optimal healthcare, leading to increased costs, patient dissatisfaction, and disparate health outcomes. Visionary leadership; knowledge and awareness of the latest breakthroughs in practice, research, and technology; evidence-based practice roles in strengthening healthcare; and, policy's role in evidence-based practice ensure healthcare leaders can meet the demand of a global marketplace. These support quality improvement as the result of effective medical leadership linked with innovation (Stanley 2012).

Leadership training opportunities that allow professionals to develop and hone the necessary skills to become future leaders is requisite within the industry. Sonnino (2013) states that opportunities for leadership training of healthcare professionals result in the creation of visionary leaders. These visionaries contribute to the profession by designing healthcare delivery innovation and integration of evidence-based practice.

Summary and Conclusions

This quality improvement initiative developed clinical training documents to overcome disparate quality ordering during routine healthcare visits, using a mentoring/coaching method. In particular, provider mentoring/coaching was integrated to improve quality preventive screenings that aid to remedy care gaps and improve care delivery. Through use of mentoring/coaching interventions, replication on a grander scale could mitigate potential limits associated with a small-scale pilot, thus achieving greater outcomes. The concept of implementing change was introduced during the pilot and the participants learned how quality improvement dedication improves the lives of the population and directly influences social change.

This quality improvement pilot successfully implemented strategies to translate evidence tied to preventive quality ordering. As stated previously, literature shows that mentoring and coaching programs and use of training tools prove beneficial in improving clinical practice and strengthening healthcare delivery to overcome care gaps. In the pilot, provider awareness and adaption to the practice change initiative was realized. This pilot resulted in success that can be replicated in a large-scale study and through efforts such as publication in industry journals. This initiative identified the need to expand mentoring programs to established providers to address preventive care deficiencies during patient visits. As the nation's healthcare system evolves into an accountable care environment, expansion of preventive care evidence-based practices is essential to provide high quality, low-cost care with consistent outcomes.

Section 5: Project Summary and Evaluation

Project Summary

This pilot was designed to determine if using a checklist-based quality improvement resource, along with mentoring/coaching could increase provider practices/behaviors that promote integration of quality ordering as a preventive healthcare strategy. The pilot comprised mentoring/coaching interventions (e.g., review of quality pilot overview document, review of 2014 adult HEDIS measures description and documentation criteria, review of 2014 adult HEDIS and preventive measures clinical checklist, guidance on medical record preparation, clinical shadowing, and post-training discussion to providers/clinical support staff) to improve preventive quality measure ordering. It was anticipated that initiation of clinical tools utilizing mentoring/coaching would train providers to integrate quality ordering during routine office visits. Both providers and the clinical team members participated to ensure patient preventive screening became a component of every patient visit. Baseline provider practice patterns were examined through an organizational proprietary tracking system that monitors referrals and ordering. Providers were chosen from one clinic based on historical practice patterns that rated less than the 50th percentile in preventive quality ordering. The pilot timeline encompassed 16-days, with emphasis on the mentoring/coaching component during the months of May/June 2014. Through use of a subject matter expert (SME) panel, these professionals provided opinion about the usefulness of the initiative and the developed documents.

Project Evaluation Report

Through use of education materials to aid in the understanding of practice patterns, provider mentoring/coaching influenced preventive quality ordering. This pilot translated current evidence into clinical practice to improve quality ordering. Providers and support staff were trained to integrate quality ordering through the employment of a checklist-based system. The clinic chosen had the lowest reported measures. The clinic caters to a primary care population, and has ten full-time providers. Each provider received approximately 12 hours of one-on-one mentoring/coaching, and clinical support teams received approximately 12 hours of primarily group training. It was decided that rotating intervals (approximately 2-hours each) would be spent with each provider, and the front and back office teams throughout the training. The time focused on discussing the importance of quality, the specific quality metrics, ordering, and methods to capture quality ordering during routine office visits (e.g., pre-visit chart preparation). By including the clinical team, additional screenings were identified and brought to the attention of the providers. The providers used the 2014 Adult HEDIS and Preventive Measures Clinical Checklist to guide the appropriate testing necessary for each patient. Using a subject matter expert (SME) panel to elicit constructive feedback regarding the pilot, developed documents, and mentoring method provided validation regarding the usefulness of the methods and its benefit to care delivery. Based on the quality implementation team and SME response, both the clinical documents and mentoring technique was deemed successful. Both groups decided that future data analysis is of value to the organization, as well as a large-scale follow-on study. The outcome of this

initiative will be reviewed at a nursing community continuing education unit (CEU) presentation during 2014.

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Quality Pilot Overview

Introduction:

In an effort to increase quality and preventive screenings, a pilot will be implemented at your clinic. The pilot consists of training on capturing HEDIS measures and preventive screenings to eliminate potential knowledge gaps. This is being done to determine if dedicated training at the clinical level assists in improving quality ordering. By ordering preventive screenings, early disease identification to enhance timely interventions for discovered conditions can be applied.

HEDIS stands for Healthcare Effectiveness Data and Information Set and it is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) to measure quality healthcare delivery effectiveness. Each year NCQA releases an annually revised list of quality measures that promote optimal healthcare delivery. During this pilot the 2014 HEDIS measures will be utilized.

This overview will orient you to the available resources and how to utilize them during the next weeks. This pilot has been developed in conjunction with the quality department who is also available for any questions or necessary support.

Resources/Discussion:

1. Review Quality Pilot Overview Document
2. Review the 2014 Adult HEDIS Measures Description & Documentation Criteria
3. Review the 2014 Adult HEDIS & Preventive Measures Clinical Checklist
4. Guidance on medical record preparation (Training for clinical support team)
5. Clinical shadowing for providers
6. Additional resources:
 - Quality support telephone line: 702 332-4868
 - High risk medication list for the elderly website:
www.ncqa.org/tabid/1091/Default.aspx
7. Post-training discussion (Reaffirm understanding of quality ordering)

Appendix A: Quality Pilot Overview Document (Page 2)

Questions & Answers:**Why is the pilot being done?**

It is being done to increase clinical awareness regarding quality and preventive screenings and to increase appropriate ordering.

How long will the pilot last?

This quality improvement education training pilot will last approximately two weeks.

What will be provided during the pilot?

Training will consist of mentoring/coaching and utilizing developed preventive quality guidelines to influence appropriate quality ordering.

Is there any special documentation that is required?

Providers must document the specific information outlined on the 2014 Adult HEDIS Measures Description & Documentation Criteria form in the patient's medical record, and order the outlined screening exam(s).

Is the pilot being done in all clinics?

No, the pilot is only being conducted at one clinical site. Depending on the results, the organization may decide to replicate the training at other clinical sites in the future.

Will the patient need to know about the pilot?

Only the provider is partaking in the educational training. The patient is not a participant, and therefore does not need to know.

Where can additional copies of these documents be found?

Documents regarding this pilot are located on the company Intranet. That site is located at: <http://mynevada.com/Clinic/SitePages/Home.aspx>

Where should one call for additional information?

Any questions during the pilot phase can be addressed by calling the quality team at: 702-332-4868.

Appendix B: 2014 Adult HEDIS Measures Description/Documentation Criteria (Page 1)

2014 Adult Healthcare Effectiveness Data and Information Set (HEDIS) Measures Description & Documentation Criteria	
Quality Measure	Screening/Documentation Criteria
Blood Pressure Control Age 18–85 years	Documentation of diagnosis with hypertension (HTN) and that BP was adequately controlled (<140/90) during the measurement year
BMI Assessment Age 18–74 years	Documentation in the medical record must indicate the weight and BMI value dated during the measurement year
Breast Cancer Screening Age 50-74 years	Documentation of a mammogram performed during the past 24 months
Cardiovascular LDL Screening Age 18 – 75 years (Dx: Acute myocardial infarction (AMI), coronary artery bypass graft (CABG), percutaneous coronary interventions (PCI), ischemic vascular disease (IVD))	Documentation of an LDL performed during the measurement year, including the date the test was performed and the result LDL <100
Cardiovascular Beta-blocker Use Age 18 and older (Post AMI)	Documentation of persistent beta-blocker treatment for at least 6 months post-discharge after AMI
Cervical Cancer Screening Women age 24–64 years	Documentation of patients screened for cervical cancer using one of the following criteria: <ul style="list-style-type: none"> • Women age 21–64 who had cervical cytology performed every 3 years (Look back period to 21 years of age) • Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years
Chlamydia Screening Women age 16–24 years	Documentation of at least one chlamydia test during the measurement year.
Chronic Obstructive Pulmonary Disease (COPD) Spirometry Age 40 and older	Documentation of Spirometry screening and evidence of management during the measurement year
Colorectal Cancer Screening Age 50-75 years	One or more screenings for colorectal cancer. Appropriate screenings are defined by one of the following: <ul style="list-style-type: none"> • Fecal occult blood test (FOBT) during the measurement year • Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year • Colonoscopy during the measurement year or the nine years prior to the measurement year
Diabetic Eye Exam Age 18–75 years with Diabetes	Optometrist/ophthalmologist exam every two years for patients without retinopathy and every year with diabetic retinopathy
Diabetic HbA1c Testing Age 18–75 years with Diabetes	At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result <9.0%
Diabetic LDL Screening Age 18–75 years with Diabetes	Documentation of an LDL performed during the measurement year, including the date the test was performed and the result LDL <100
Diabetic Nephropathy Screening Age 18–75 years with Diabetes	Documentation of a nephropathy screening or evidence of nephropathy management during the measurement year

Appendix B: 2014 Adult HEDIS Measures Description/Documentation Criteria (Page 2)

Quality Measure	Screening/Documentation Criteria
Diabetic Renal Screening Age 18–75 years with Diabetes	Documentation of a renal screening for microalbumin or evidence of on ACE/ARB use during the measurement year
Glaucoma Screening Age 65 years or older	Documentation of annual glaucoma screening
Medication Management Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy for Rheumatoid Arthritis (Adults 18 years and older)	Documentation of at least one prescription for a DMARD for patients diagnosed with rheumatoid arthritis during the measurement year
Medication Management High Risk Medication in the Elderly (including antihistamines, skeletal muscle relaxants, estrogens, and others) Age 65 years or older	Review medication history for high risk medications and consider alternative therapy choices. The full list of high risk medications in this age group can be accessed at www.ncqa.org/tabid/1091/Default.aspx
Medication Management ACE or ARB Use in Hypertensive Diabetics Age 18 or older	Documentation in patients with diabetes and hypertension of a prescription for an ACE or ARB
Medication Management Oral Diabetic Medication Adherence Age 18 or older	Documentation that patients with diabetes are adhering to use of oral diabetic medications during the measurement year
Medication Management Antihypertensive Diabetic Medication Adherence Age 18 or older	Documentation that patients with diabetes are adhering to use of antihypertensive (ACE or ARB) medications during the measurement year
Medication Management Cholesterol Medication Adherence in Diabetics Age 18 or older	Documentation that patients with diabetes are adhering to use of cholesterol lowering (Statins) medications during the measurement year
Osteoporosis Screening Women age 67 or older	Documentation of bone mineral density (BMD) screening in the previous year or prescription for a drug used to treat/prevent osteoporosis. BMD is required within 6-months of a fracture.

Appendix C: 2014 Adult HEDIS and Preventive Measures Clinical Checklist

2014 Adult HEDIS & Preventive Measures Clinical Checklist												
Patient Name:			Date of Birth:					Medical Record Number:				
EVERY VISIT	Date of Visit	Date of Visit	Date of Visit	Date of Visit	Date of Visit	Date of Visit	Date of Visit	Date of Visit	Date of Visit	Date of Visit	Date of Visit	Date of Visit
	Initials	Initials	Initials	Initials	Initials	Initials	Initials	Initials	Initials	Initials	Initials	Initials
Medication Review												
HTN- BP / Med check - (goal <140/90)												
***Recheck & Record if out of range												
CVD / CHF / MI												
ACE Inhibitor/ARB												
Beta Blocker												
ASA												
Statin												
DIABETES												
B/P Check- (goal < 140/90)												
***Recheck & Record if out of range												
Foot Exam-												
Neuropathy Screening (Monofilament)												

EVERY 6 MONTHS or as needed	Date & Initials	Date & Initials
Well Being Assessment / Frailty Marker (PHQ2, Pain Screening, Fall Risk, Bladder Control Screening, Physical Activity Screening, Memory Impairment Screening)		
CHF		
Lipid Panel - (goal LDL <100 mg/dL)		
2D ECHO, EF or Chest X-ray (Newly diagnosed or New Exacerbation)		
DIABETES		
HbA1c Testing - (goal <9.0%)		
Lipid Panel - (goal LDL <100 mg/dL)		
Nephropathy Screening (Micro albuminuria q 1 yr. Visit to Nephrologists q 1 yr. (if necessary))		
Retinal Eye Exam (Annually by Eye Care Professional)		
COPD		
Spirometry Testing/Evaluation (Newly diagnosed or New Exacerbation)		

EVERY 2 – 10 YEARS	Date & Initials
Fasting Blood Sugar- (Non Diabetic) ≥ 18 yrs. with BMI >25 or 40-65 yrs. q 3 yrs.	
Glaucoma Screening - ≥ 65 q 2yrs. (if no previous DX of glaucoma)	
Colorectal Cancer Screening 50-75 yrs. -Flexible Sigmoidoscopy (every 3 years) or -Colonoscopy (every 10 years)	
Mammogram- 50-74 yrs. q 2 yrs. (HEDIS) Pap- 21-65 yrs. q 3 yrs., or Pap Test & HPV Co-testing - 30-65 yrs. q 3 yrs. Dexscan (HEDIS) -Osteoporosis Screening - ALL ≥ 65 yrs. once repeat as indicated -Post fracture (within 6 months) ≥ 67 yrs.	
PAD Screening - LE s/s on exertion, Non-healing leg ulcer, >50 yrs. (Hx of DM or smoking), all patients ≥ 65 yrs.	
Pneumovax - ≥ 65 yrs. once, <65 yrs. repeat in 5 yrs from initial vaccination	

YEARLY	Date & Initials	Date & Initials
Body Mass Index (BMI) - 18-75 yrs. old		
Flu Shot- q 1 yr.		
Colorectal Cancer Screening- FOBT, iFOBT or guaiac		
Chlamydia Screen- 18-25 yrs. sexually active		

Name:	Date & Initials	Date & Initials

Appendix D: Institutional Review Board Confirmation Number

The Confirmation of Ethical Standards (CES) has an IRB record number of 05-16-14-0402832 for this project.