Physician Engagement in Quality Improvement

: Measure Up/Pressure Down™ - AMGA Webinar

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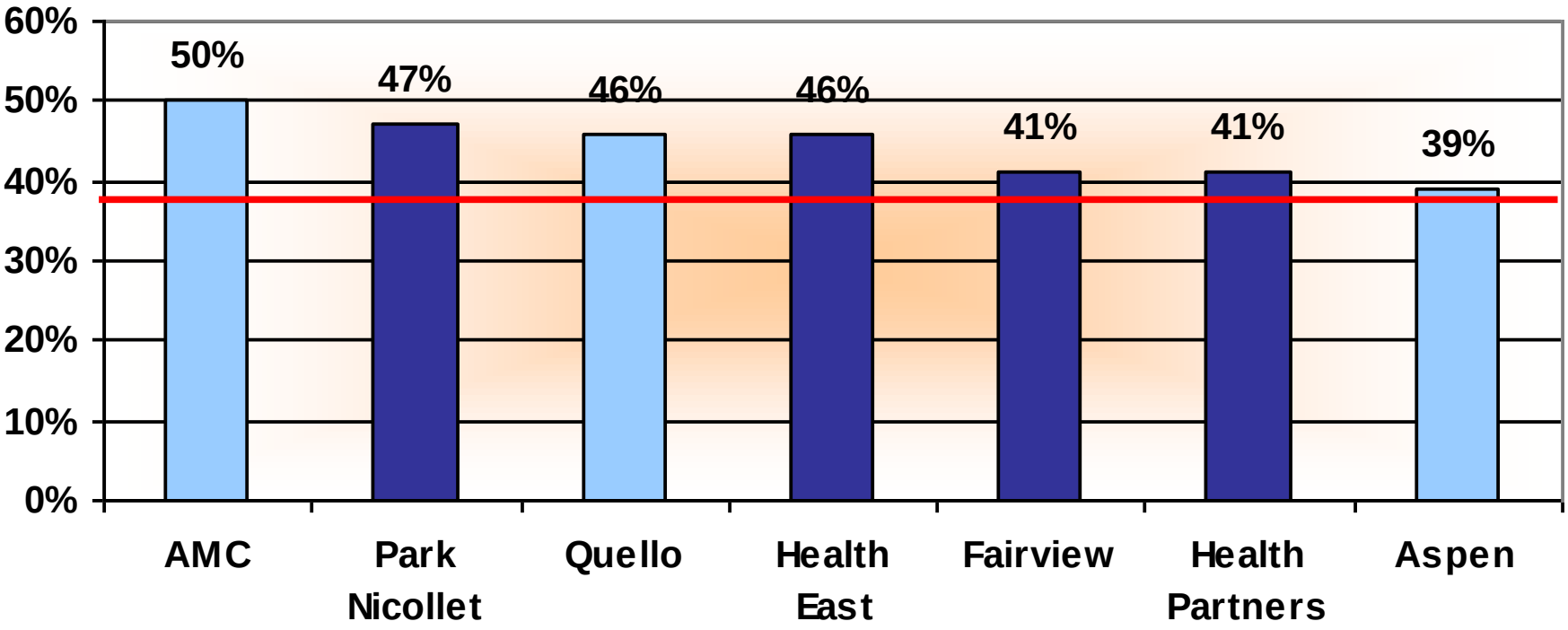
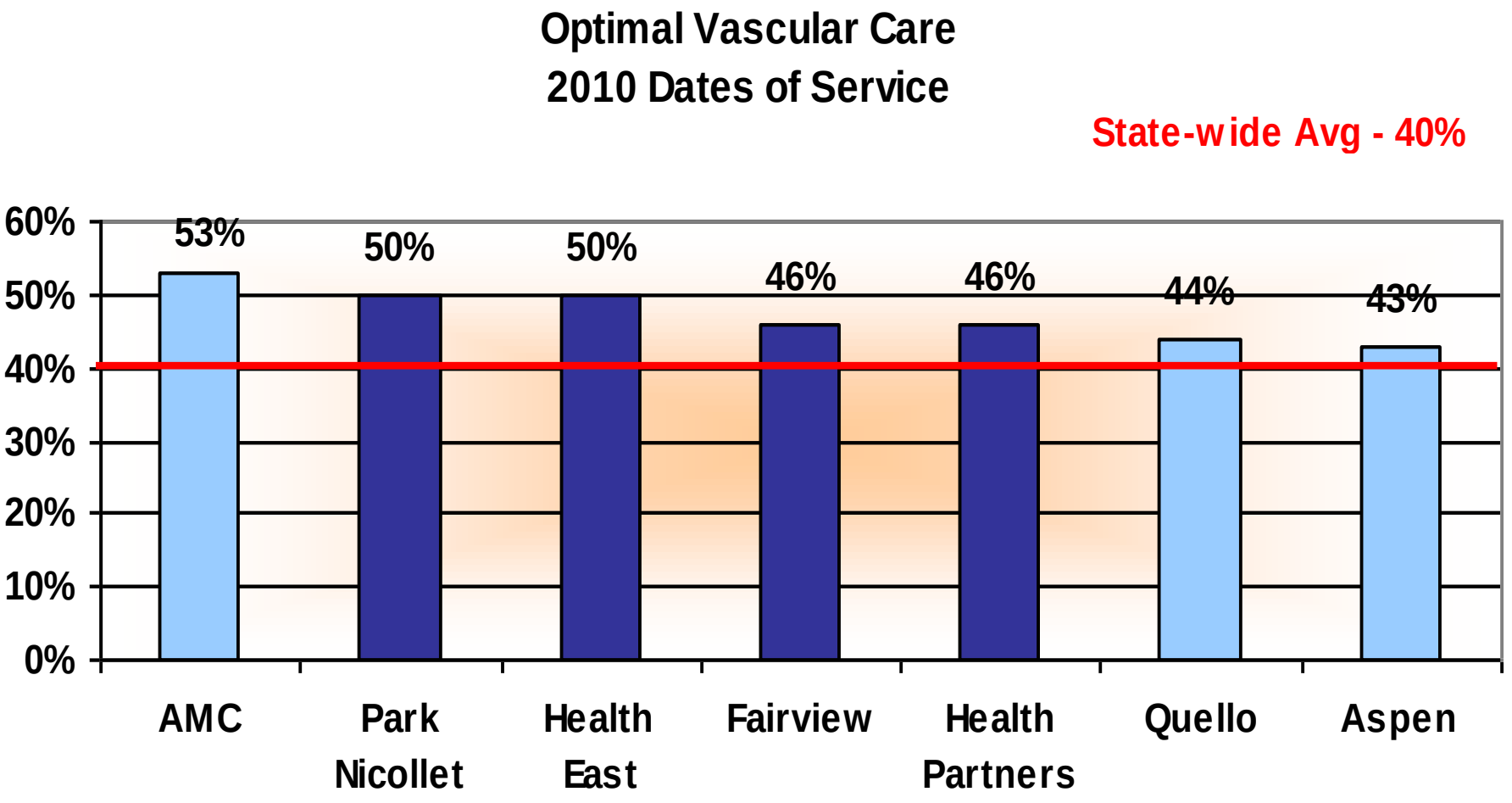
Lessons Learned from 2 Health Systems

- **Allina Medical Clinic (Allina Health)**
  - 700 providers (600 MDs), 46 clinics
  - Twin Cities area: Urban, suburban, rural
  - EPIC EMR
- **Columbia St. Mary's Health System**
  - SE Wisconsin
  - 340 providers, 30 clinics
  - A ministry of Ascension Health
  - Cerner EMR
  - Insurance Coverage
    - 21% Medicaid, Medicare/medicaid
    - 30% Medicare
    - 47% Commercial fee-for-service
    - 2% Charity Care (< 250% poverty level)

Quality


Optimal Diabetes Care
2010 Dates of Service
State-wide Avg - 37%
60%
50%
40%
30%
20%
10%
0%
50%
47%
46%
46%
41%
41%
39%
AMC
Park Nicollet
Quello
Health East
Fairview
Health Partners
Aspen
MN Community Measurement Preliminary Results

Quality


Optimal Vascular Care
2010 Dates of Service
State-wide Avg - 40%
60%
50%
40%
30%
20%
10%
0%
53%
50%
50%
46%
46%
44%
43%
AMC
Park Nicollet
Health East
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Health Partners
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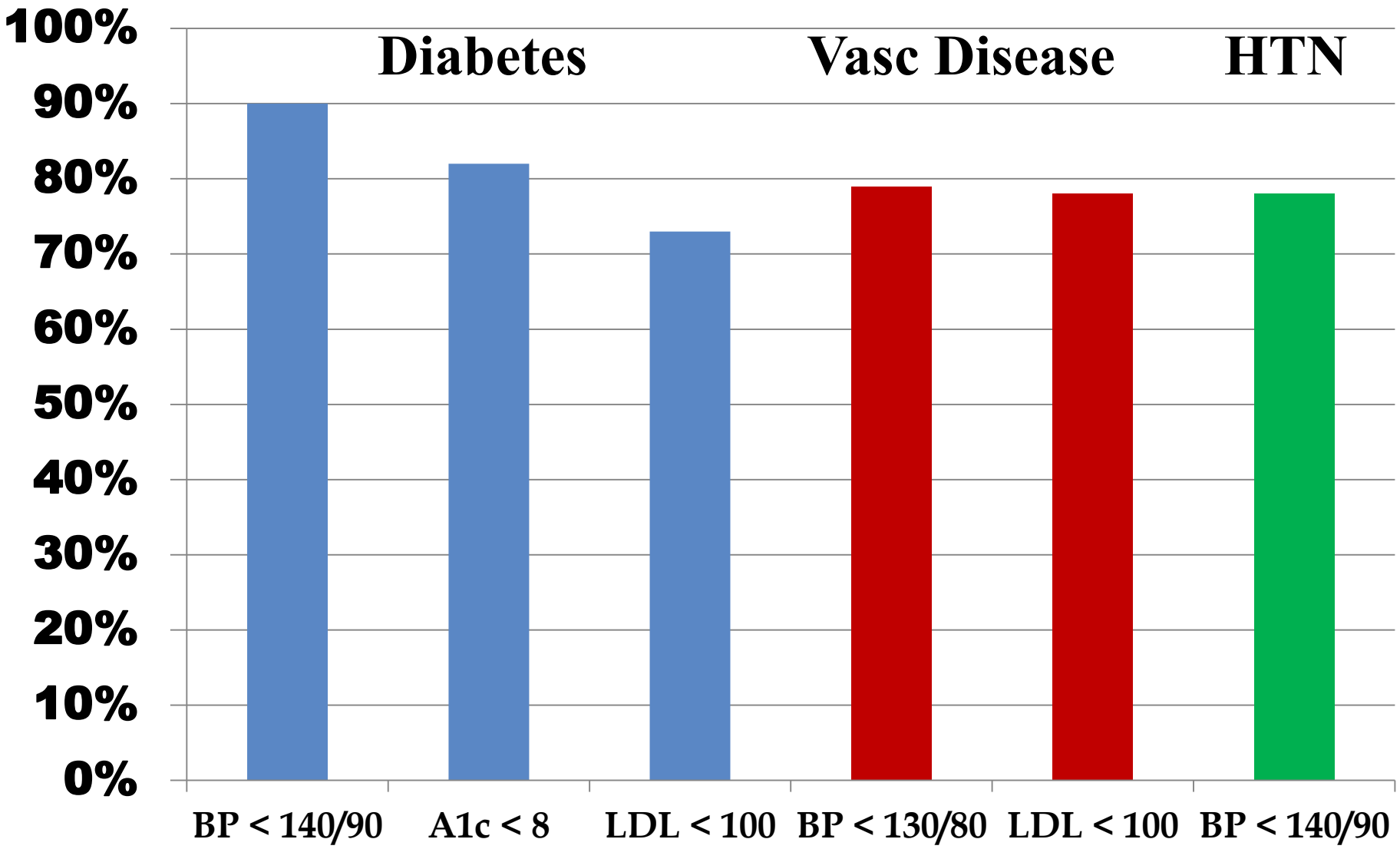
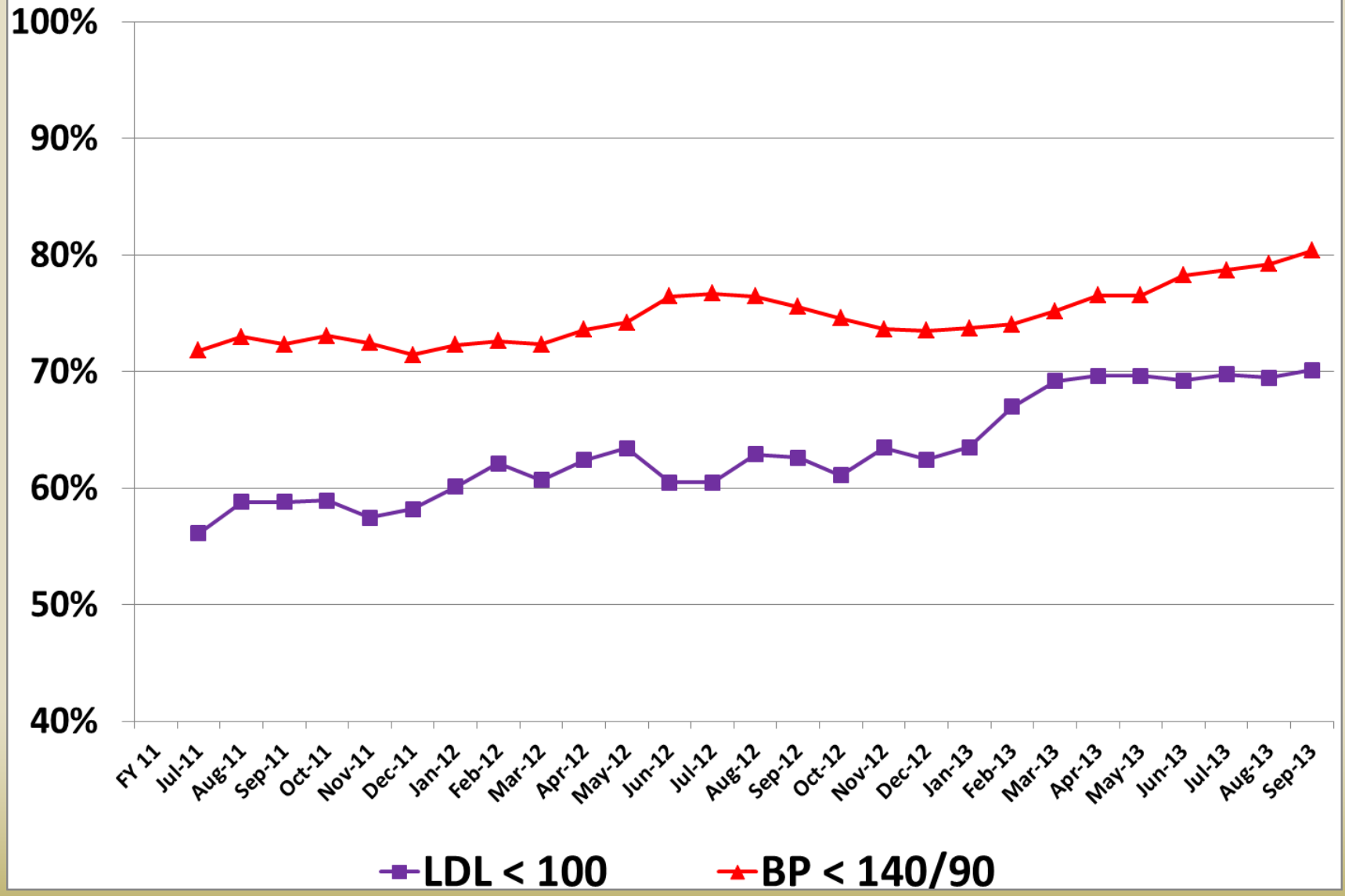
Control of Individual Risk Factors

Allina Medical Clinic 2010



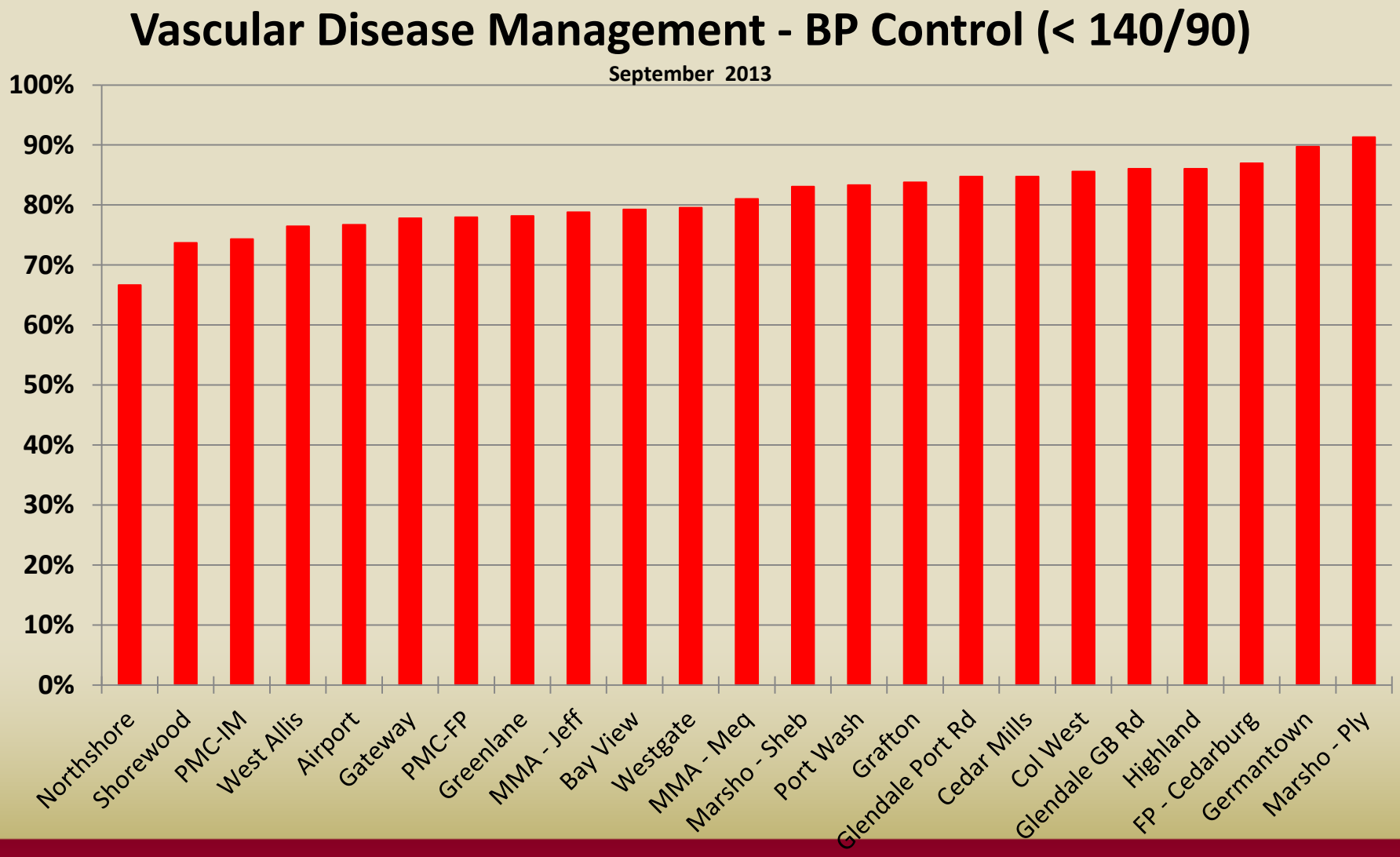
Vascular Disease Management - % of Patients in Control



What has worked?

- Policies , Policies, Workflows
- Leadership

Provide Clinic Results Transparently



Provide Physician Results Transparently

Diabetes and Vascular Quality Measures

Airport Clinic

Source Data from Quarterly Physician Diabetes Report

Population Definition: Patients ages 18-75 with a diagnosis of Diabetes for at least 1 clinic visit within 10/1/12 - 9/30/13.

	# of Pts	% A1C < 8	% A1C > 9	% A1C > 9 with CDE visit in last 12 mos	% w/o A1C in last 12 mos.	% LDL < 100	% w/o LDL in last 12 mos.	% BP < 140/90	Microalb %
Best in State/Midwest	---	**86%**	**8%**	---	---	**65%**	---	**90%**	**83%**
2014 Goals	---	**79%**	---	---	---	**66%**	---	**82%**	---
Provider	562	78%	10%	42%	2%	68%	5%	85%	88%
Dr. Andrew XXXX	102	77%	10%	40%	2%	69%	7%	90%	83%
Dr. Kristina XXXX	148	82%	8%	50%	2%	67%	5%	83%	83%
Dr. Noelle XXXX	6	33%	17%	100%	33%	33%	33%	83%	50%
Dr. Mark XXXX	47	85%	9%	75%	2%	55%	4%	85%	81%
Dr. Mark XXXX	259	77%	12%	34%	1%	71%	3%	83%	94%

Provide Physician Results Transparently

PCP Site	PCP	# of Pts	% BP < 140/90
AIRPORT MEDICAL CLINIC		48	93.8%
HIGHLAND FAMILY HEALTH CENTER		29	93.1%
SHOREWOOD FAMILY PHYSICIANS		70	92.9%
GRAFTON MEDICAL CLINIC		33	90.9%
COLUMBIA WEST MEDICAL CLINIC		109	89.9%
MARSHO FAMILY MEDICAL GROUP - A		126	88.1%
GATEWAY MEDICAL		67	88.1%
FAMILY PRACTICE ASSOC OF CEDARBURG		25	88.0%
NORTHSHORE MEDICAL		53	62.3%
SHOREWOOD FAMILY PHYSICIANS		100	61.0%
PROSPECT MEDICAL COMMONS IM		206	60.7%
MARSHO FAMILY MEDICAL GROUP - B		132	57.6%
MADISON MEDICAL - MEQUON ENDO		24	54.2%
PROSPECT MEDICAL COMMONS IM		166	50.0%

Provide patient level data that can be verified

Roster for Dr. XXXX

PCP	PCP Site	MRN	Name	DOB	Last Visit	Tel #	A1C Date	A1C	LDL Date	LDL	BP Date	SBP	DBP	NOTES
Dr. XXXX	PMC	111	AAA	04-13-67	07-22-13	414-731-6000	05-22-13	11.5	05-22-13	115	05-22-13	**118**	**74**	
Dr. XXXX	PMC	112	BBB	11-21-55	12-17-12	414-731-5000	11-12-12	11.3			12-17-12	**122**	**70**	
Dr. XXXX	PMC	113	CCC	12-14-56	03-15-13	414-731-4000	03-15-13	9.4	03-15-13	74	03-15-13	**147**	**80**	
Dr. XXXX	PMC	114	DDD	04-11-87	07-22-13	414-731-4000	09-23-13	8.8	09-23-13	124	09-23-13	**98**	**68**	
Dr. XXXX	PMC	115	EEE	03-05-60	06-17-13	414-731-4000	05-25-13	8.6			06-12-13	**130**	**80**	
Dr. XXXX	PMC	116	FFF	03-06-24	09-10-13	414-731-4000	09-10-13	8.1	03-15-13	60	09-10-13	**122**	**62**	
Dr. XXXX	PMC	117	GGG	12-26-67	08-19-13	414-731-4000	07-20-13	8	07-20-13	118	07-31-13	**132**	**86**	

Convince Physicians to Increase Tempo

Use data:

- There is simply too much to do in only 4 visits per year. *Yarnal, et. Al. Am J Public Health. 2003 Apr;93(4):635-41*
- Control of LDL results in a 10-15% reduction in MI/stroke/death within the first year! *Baigent, et. al. Lancet 2005 Oct 8;366(9493):1267-78*
- More appts correlates with better glycemic control *O'Connor et. Al. J Fam Pract 1999 Apr;48(4):305*

Use experience of successful individuals and groups

Increase Tempo

- Schedule f/u in 2-6 wks if not controlled
- Problem-solve barriers to access
  - **Use MA BP checks**
  - **Use RN visits**
  - **Use f/u chronic care visits with partnered advanced practice providers**

Develop Rooming Standards

- Check if patient is due for labs. Alert MD or order directly.
- Check BP according to stds
- alert MD if above target (“Orange Cards”)

Give patients written assessment and follow-up instructions

THE FACTS:

- 50% of patients leave the office visit not understanding what they were told by the physician. [Roter and Hall. Ann Rev Public Health 1989; 10:163]
- 50% of Patients, when asked to state how they were supposed to take a prescribed medication, did not understand how the physician had prescribed the medication. [Schillinger et all. Medication miscommunication, in Advances in Patient Safety (AHRQ, 2005)]

THE PLAN:

Provide patients with their results vs goals and follow-up instructions.

- Printed After Visit Summary (EPIC, Cerner)
- **Schedule f/u appts BEFORE pt leaves**
- Document “next steps” if BP still elevated in clinic note A/P

Adopt a Refill Policy

Do not refill medications if there has not been appropriate follow-up

- Limit Rx to a total supply of 6 Months
- For refill requests, limit to 1 month supply and schedule an appointment
- If no appt occurs and there is another refill request, limit to 1 week supply and schedule an appt

Teach MAs to “work” the roster

- Clean up data (died, transferred care, no DM/vascular disease)
- Call patients (or send letter) to schedule visits if > 3 mos and A1c/BP/LDL ⇧
- Check with PCP for patients with visit > 1 month if pt uncontrolled
- Order and schedule labs in advance of visit
- Manager collects rosters with notes from every MA at the end of each month

Provide patient level data that can be verified

Roster for Dr. XXXX

PCP	PCP Site	MRN	Name	DOB	Last Visit	Tel #	A1C Date	A1C	LDL Date	LDL	BP Date	SBP	DBP	NOTES
Dr. XXXX	PMC	111	AAA	04-13-67	07-22-13	414-731-6000	05-22-13	11.5	05-22-13	115	05-22-13	**118**	**74**	
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Create brief, practical, and pragmatic CME programs

- Strictly limit background to key evidence
- Focus on step-by-step management, especially “resistant HTN”
- Focus on cost to patient
- Focus on key leverage areas: tempo, adherence, resistant hypertension
- Ensure attendance (bring to each clinic, “mandatory attendance”, built into schedule for new PCPs on guarantee)

Part II. Leadership is Everything

First establish "what are we fighting for?"

- In clinical trials, antihypertensive therapy has reduced stroke incidence 35–40 %; MI 20–25 %; and HF > 50 %.
- In patients with stage 1 hypertension (SBP 140–159 mmHg and/or DBP 90–99 mmHg) and additional cardiovascular risk factors, achieving a sustained 12 mmHg reduction in SBP over 10 years will prevent 1 death for every 11 patients treated.

Adapted from JNC-7

Execute a specific communication plan that includes the staff

- Craft simple, consistent, evidence-based messages that are meaningful and transmissible.
- Ask MDs to present to staff the “why” and what we are asking them to do
- Check that the message got through

Every physician and staff member should be able to articulate the “why”.

Align Leadership

- Paired leadership
  - Administrative and clinical leaders have the same operational and clinical goals
- “Guiding coalition”
  - From different sites or within site opinion leaders
- Engage the power of nursing/MA staff

Establish the "moral high ground"

- Focus on the "why"
- Don't talk about "the numbers", talk about patients
- Use results of chart reviews to persuade MDs that that while there really are some who won't comply, etc., there ARE some who need more aggressive care

Prove that systems can support practice and improve care

“Evidence-based Practice”:

Pilot new workflows/policies or visit sites that already use them or check literature

“ Consistency breeds reliability”

Tenaciously check that workflows and policies are reliably followed every time

Establish culture through action

“A policy not observed is much worse than no policy at all.”

“Culture is everything you promote and everything you tolerate”

Teach Leaders to Lead

- Communicating the evidence and importance
- Leader rounding on staff
- Influencing skills
- Coaching skills for 1:1 meetings with physicians
- Dealing with Resistance

"All change eventually requires one clinician to talk to another about changing behavior."

Establish Culture Through Action

"Culture is everything you promote and everything you tolerate."

"A policy not observed is much worse than no policy at all."