

CASE STUDY FOR QUALITY IMPROVEMENT

Clinical Integration— A System Approach

DREYER MEDICAL CLINIC

Organization Profile

Established in 1922 by John Dreyer, Dreyer Medical Clinic is part of Advocate Healthcare, one of the top 25 integrated health systems in the US with 9 acute hospitals, 2 children's hospitals, and a total of 200 sites throughout Illinois, making it the largest system in Illinois. Advocate Health Care purchased Dreyer Medical Clinic in 1996. Dreyer includes 150 physicians in 26 specialties and 60 allied health professionals. Together, Dreyer's 11 sites manage 500,000 patient visits a year using Epic EMR since 2002.

In 2007 Dreyer Medical Clinic embraced a new management philosophy based on core concepts and principles intended to reduce variation in processes and improve overall patient care.

Dreyer's APP Clinical Integration Program

Advocate Physician Partners (APP) is a P4P collaborative effort by 3,400 physicians in 2 medical groups, 9 PHOs, and the 9 affiliated hospitals that drives targeted improvements in health care quality and efficiency.

APP's core focus is a comprehensive set of diabetes management metrics.

Project Summary

An "Ambulatory ICU" was introduced for difficult-to-control patients run by a Doctor of Pharmacy with complete authority from the collaborative to prescribe and manage patient medications. Together these changes/interventions helped to streamline processes, make improvements in low-performance areas, and significantly increase the percentage of patients achieving preferred levels on A1C, LDL, and BP testing.

Goals and Objectives

Individual diabetes metrics goals that apply to the group, PCPs, and endocrinologists are set annually by APP based on improvement of the current state. For many participating independent small practices, metrics are based on improvement from the baseline.

Dreyer clearly saw its overall goal for the diabetes program as achieving and exceeding benchmark care levels. The charge to APP staff for achieving this goal was relentless measuring and managing.

Team Composition

The Dreyer Medical Clinic APP diabetes Clinical Integration Program team consists of:

- Medical Directors
- PCPs and an endocrinologist
- Quality Director, Manager, RN, RHIT & Data Analyst
- Disease Management Director, RN CDE, Dietitian and 3 Clinical PharmDs
- EMR Team/MIS

Diabetes Care	Goal	2008
Percent HbA1C test yearly	≥ 81%	97%
Percent with HbA1C result < 7% (last value)	≥ 32%	64%
Percent with HbA1C result > 9% (last value)	≤ 40%	10%
Percent LDL screening yearly	≥ 79%	94%
Percent with LDL result <100 mg/dL (last value)	≥ 46%	61%
Percent with LDL result >130 mg/dL (last value)	≤ 36%	16%
Eye exam yearly	≥ 50%	57%
Nephropathy monitoring yearly	≥ 60%	87%
Smoking cessation counseling yearly	≥ 76%	79%
Blood pressure control <140/90 mmHg (last value)	≥ 46%	81%
Blood pressure control < 130/80 mmHg (last value)	≥ 23%	51%
Foot exam yearly	≥ 50%	63%

Project Details

The Advocate Physician Partners (APP) Clinical Integration Program is a collaborative effort by 3,400 physicians in 2 medical groups, 9 PHOs, and the 9 affiliated hospitals. Its purpose is to drive targeted improvements in health care quality and efficiency in a pay-for-performance program.

Diabetes Intervention & Population Baseline:

The program offers population management for patients with diabetes as identified through billed diagnoses, problem lists, and drug utilization. A diabetes registry was created to manage the identified 4,406 patients, ages 18-75. Demographics within the identified patient population include 21% Hispanic, 12% Medicare, 56% PPO, 24% HMO, and 54% female.

Diabetes Interventions: Upon initiation of the program, active management and tactics to combat clinical inertia were introduced. These include:

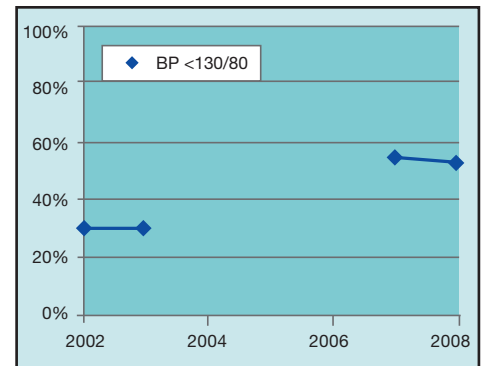
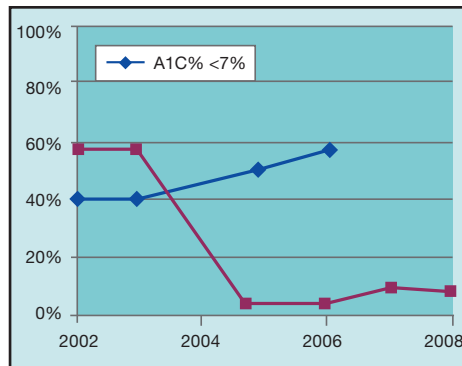
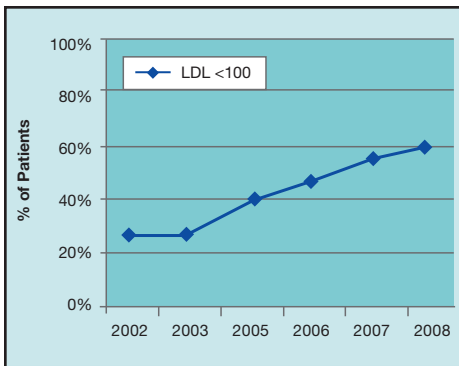
- “Ambulatory ICU” for difficult-to-control patients. In this case the clinic is run by a Doctor of Pharmacy with complete authority from the collaborative to prescribe and manage patient medications
- Coordination with a dietitian and a CDE
- A podiatrist was hired

Behind the Scenes: The rollout began 2.5 years ago. A clinical outcomes measure was established for medical groups in the system, with diabetes management being the most heavily weighted measure. Aspects of this measure were integrated into institutional scorecards. Additionally, a disease management auto referral process was set up for use by PCPs of all patients with A1C >9.

Workflow: Clinical Integration was added to visit pre-work; rooming standard work (CMEs); and refills via protocols (screening labs were checked; if patient was not at goal, auto refills were not given).

HIT Interventions: Measurements were recorded via the registry and numerous real-time EMR alerts were used: Best Practice Alerts; Health Maintenance Alerts. Regular physician progress reports were generated. Set-up was done for “smart sets” (electronic lists of common diagnoses, lab tests, and imaging for each of the most common types of problems seen to complete the ordering process quickly and efficiently by simply checking things off a list) and “dot” phrases that allow the user to enter a phrase 1 time or choose from a large library of pre-entered phrases and save with a keyword (eg, whenever a dot is typed followed by the keyword, such as .sleep the computer replaces with the pre-determined phrase for use within the program).

Staff Involved: Staff initially worked “behind the scenes” with the team working the process.



Physician Change Methods

Two change influencers helped to gain physician buy-in to changes:

Moral – Raison d'être (reason for existing—justification as a means to an end in effective management measurement and feedback)

Social – Culture and peer pressure with transparent results. Physicians cautiously agreed to turn over diabetes management to the pharmacists. Many were skeptical until they saw the results.

Financial components also were built into the system.

Measures/Data Sources

- Used Intermountain Healthcare (Utah) DM practice guidelines.
- APP uses HEDIS, IOM, NAS, NQF, Leapfrog, HHS, and TJC for setting measures.
- Data are largely collected from the database, with chart review (minimal) as a supplement.

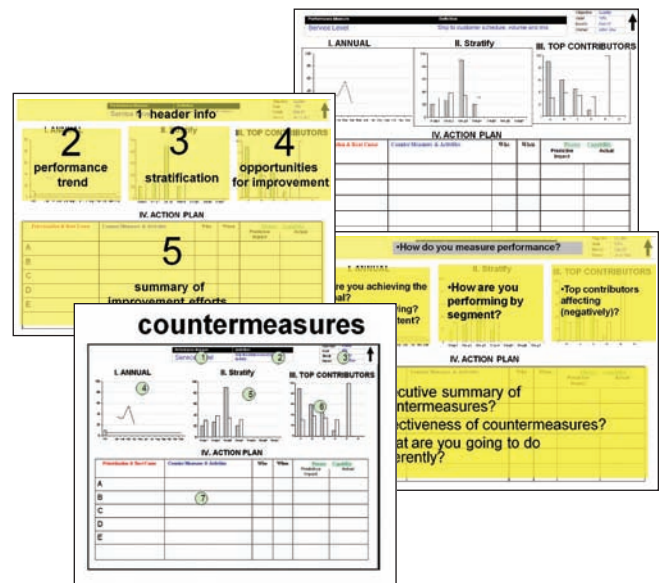
Outcomes

From the onset of the program in 2002 through 2008, patient improvements were made in 3 standard tests. Patients with A1C <7% (glycated hemoglobin) increased from 40% to more than 60%; LDL cholesterol at <100 mg/dL increased from 30% to 60%; and the number of patients with a BP (blood pressure) <130/80 mmHg increased from less than 30% to 55%.

Challenges or Obstacles: Four-Box Templates

Clinicians finding that patients aren't following recommendations regarding their care typically assume patients are "noncompliant." Noncompliance suggests that the system/clinician has done everything possible to help and that the patient is the cause of the failure. While this may be true occasionally, the actual impediment to compliance is often system/clinician people skills and workflows. Dreyer uses the four-box approach to measure performance in underperforming areas such as this to develop action plans based on stratification and contributor analysis. The action plans have expected goals and if the goals are not realized, another round of action plans is developed and implemented until the desired performance levels are realized.

Other challenges include convincing physicians to accept non-physicians as active managers and justifying disease management for noncapitated patients.



Lessons Learned

The Dreyer team has learned that by changing the process to avoid clinical inertia and to "touch" the patient more frequently, they can provide much better care for people with diabetes.