CASE STUDY FOR QUALITY IMPROVEMENT

Adding Value to Our Gains, Managing Growth, Expanding Our Reach

MERCY CLINICS, INC., DES MOINES, IA

Organization Profile

Established in 1983, Mercy Clinics, Inc., operates 44 clinics throughout the greater Des Moines area offering primary care (77%) (family practice, internal medicine and pediatrics); specialty care and services surgery in several areas, including general surgery, trauma surgery, surgical oncology, and gynecologic oncology; specialty clinics, such as Mercy Center for Weight Reduction, Katzmann Breast Clinic, and multiple specialty care and treatment areas); and urgent and quick care. In FY 2009, the combined clinics staffs saw 844,076 patient visits.

Mercy Clinics, Inc., (MCI) is currently engaged in creating a Medical Home based on the Institute of Medicine's (IOM) Six Dimensions of Quality[a] and Wagner's Care Model (self-management, decision support, delivery system design, clinical information system, organization of health care, and community).

Project Summary

MCI Practice Redesign Goals, established in 2004, included a plan to shift to "whole person orientation" to provide or arrange for all of each patient's care needs. Systems were developed to ensure patients receive proper care and registries created to track patients. Health Coaches are used for clinics to keep in touch with patients between visits and to help them meet their DM goals.

Goals and Objectives

Goals included integration of team-based care, self-management support, and improved access. Finally, the team understood the need to define processes to ensure safety.

Mercy Clinics are making changes in the way care is given to patients with chronic diseases, such as diabetes, high blood pressure, heart disease, and asthma. They are using a computer in a secure site to keep track of when patients are due for visits and if they are meeting their goals, such as keeping their blood pressure controlled. Many of their clinics have hired Health Coaches to contact patients when they are overdue for a visit or to help them make a plan to meet goals.

Mercy Expert Care's private computer system not only tracks how patients are doing but also tracks how well Mercy Clinics physicians perform compared to other physicians. Mercy Clinics has shown that the blood sugar control of their patients is much better (above the 90th percentile) than national averages.

Team Composition

David Swieskowski, MD, MBA, Chief Executive Officer and former VP Quality

Ben Gaumer, DO, VP Quality and IT

Kelly Taylor, RN, MSN, Director of Quality

Del Konopka, RN, MS, Education Coordinator

Project Details

Mercy Clinics joined the Institute for Healthcare Improvement (IHI) impact program in 2002. At that time, they shifted from ad hoc projects to a comprehensive plan to redesign care, which they based on Wagner's Care Model and the 6 IOM aims. The plan was initiated in pilot clinics and spread successes throughout the system, using the PDSA approach. PDSA (Plan, Do, Study, Act) is increasingly being used as a tool to deliver immediate and noticeable improvement in patient care. Use of this tool requires a change in the way the team, department, and organization think about improvement and voluntary physician participation.

Measurement

Measurement is vital to improvement. It is important to monitor and measure all patient variables, including blood sugar, blood pressure, and wait times. Process improvement always leads to improved quality and lower cost, and data help to engage others to assist them in QI efforts. All measurements need to be accurate and done at regular intervals.

Registry

There are established statistical needs for a registry: Evidence-based care is given only 55% of time (*New Engl J Med.* 2003;348(26):2635-2645); blood sugar is controlled in only 37% of patients with diabetes (*JAMA*. 2004;291(3):335-342); and blood pressure is controlled in only 35% of patients with hypertension (*Ann Intern Med.* 2006;145(3):165-175).

MCI based the creation of its registry, **"Care Measures,"** on 3 goals:

1. Enable population-based care delivery
2. Population-based care to lead to more individual patients reaching outcome goals, such as blood sugar or blood pressure control
3. Improvement in outcome goals to lead to better health for the population of patients served

Disease Registry vs EHR

Making a process electronic doesn't improve a flawed process. MCI does not currently have an EHR.

Disease Registry	EHR
• Is inexpensive • Is easy to implement • Increases productivity • Enables chronic care • Improves quality • Is low risk • Leads to new chronic care processes	• Is costly • Is hard to implement • Decreases productivity • Mimics flawed care process • May slow QI for years • Is high risk • May lead us to do the wrong thing more efficiently • Is often a poor registry

Disease Registry

"The single most important step to improve chronic care"

Use a disease registry to create patient summary reports, create actionable lists to engage patients, and create performance reports to engage the physicians and staff.

Identifying Patients With Diabetes

If the **billing system is used**, patients who haven't been in the clinic in the search time frame (usually 1 year) will be missed. If **Lab systems are used** to identify patients with HgA1C done, not all patients with an HgA1C will have diabetes and the search will miss patients without an HgA1C. The list needs to be refined over time with either approach (mark the charts of patients in the registry and add patients when an unmarked chart is found; remove patients identified in error).

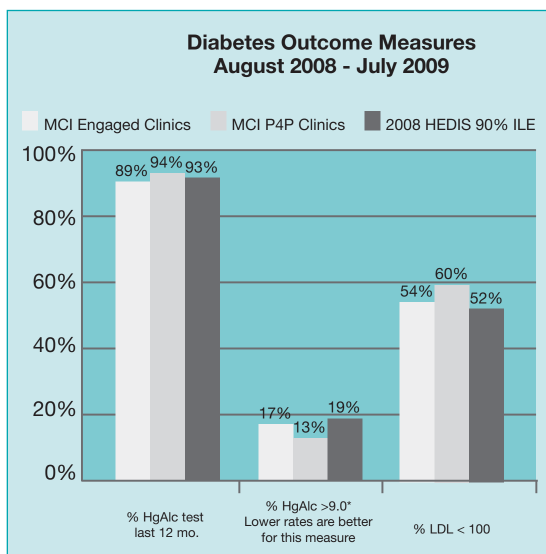
Population Health Coach

MCI has 23 (soon to be 24) full-time Health Coaches. Initially, a health coach could be an RN, CMA, LPN, or receptionist, and the responsibilities were more data oriented. New Health Coaches must now be RNs and are more clinically oriented.

Performance Indicator	MCI All Patients Jan 08 - Dec 08 (All 17 Clinics)	MCI All Patients Jan 08 - Dec 08 (12 Clinics Reporting Data)	MCI P4P Patients Jan 08 - Dec 08 (12 Clinics Reporting Data)	MCI P4P Patients Jan 08 - Dec 08 (12 Clinics Reporting Data)
Diabetes				
Number of Patients	*9,090*	*7,946*	*1,320*	
HgA1C Exam	79.2%	86.8%	95.1%	92.9%
Low-density Lipoprotein Exam *LDL not done counts as ≥130*	69.8%	76.6%	90.9%	88%
Microalbumin Exam	59.8%	65.8%	81.2%	87.3%
Retinal Exam	34.3%	37.8%	67.4%	71.2%
Blood Pressure <140/80 *BP not done counts as ≥140/90*	49.4%	53.8%	71.1%	n/a
Low-density Lipoprotein <130 *LDL not done counts as ≥ 130*	60.7%	66.6%	81.1%	n/a
Hemoglobin A1C ≤8 *Denominator is only patients with a HgA1C done*	66.1%	72.4%	79.2%	n/a
Hypertension				
Number of Patients	*15,415*	*13,144*	*3,085*	
Blood Pressure <140/90	57.2%	64.8%	82.2%	64.4%

The Health Coach performs 5 essential core functions:

1. Oversee the disease registry database
2. Conduct pre-visit chart review
3. Support patients & families on self-management
4. Coordinate care across the care continuum
5. Be involved in QI activities



Essential Core Function #1 – Oversee the registry

Coaches make sure data are entered into the registry timely and accurately, review performance reports, and contact patients overdue for visits or not meeting goals (care opportunities list). This outreach to patients has proved successful, with 90% of patients responding positively. In the past only 70% of patients with diabetes visited the clinic within 1 year—now 95% do so yearly.

Essential Core Function #2 – Pre-visit chart review and visit plan

Health Coaches review the charts of patients with diabetes before they are seen. They review for chronic disease standards of care, preventive health care efforts, and immunizations. They arrange to have labs and referrals completed before the patient is seen by the physician (based on standing orders) and start the diabetes office visit form. This is both effective and efficient, freeing up the doctor's time.

MCI Global Steps to Achieve Goals

The redesign team sought a Board commitment to make quality a strategic priority, with dedicated resources for the Quality Department, including 1 FTE physician and 2 FTE MSNs. Other internal groups focused on quality include a system-wide Quality Committee; the Council of Medical Directors; a Physician P4P Champions committee; a Patient Advisory Workgroup on Quality; and engagement with outside organizations, such as IHI, AMGA, IFMC (State QIO), Wellmark, BCBS, and Des Moines University.

Clinical Quality: Responsibility of Management at the Clinic Administration and Individual Clinic Levels

This is a necessity to make sure processes are in place, create and perform measures to evaluate the effectiveness of the processes, prioritize the processes to work on, and make resources available to proactively improve processes.

Advantages of Clinic-Based Disease Management

The physician's office has a level of knowledge about the patient, access to the patient, and the trust of the patient that no one else has. In addition, because of the currently existing infrastructure, the clinic is able to deliver DM services at a lower cost than anyone else.

Future Steps

MCI intends to expand care coordination efforts. Progress has been made internally coordinating the office care team. Effort will now be focused on improving all other transitions along the care continuum, including exploring ways to collaborate with the institution's diabetes education experts housed in the Endocrinology office.

Lessons Learned

There is a positive business case for chronic care improvement, even in a 100% fee-for-service environment. Aligning the incentives does contribute to the resulting improvements noted overall in the diabetes outcomes. Unfortunately, it has also led to disparity between the entire system population and the Pay-for-Performance (P4P) population.

Regardless of how great the ideas and the plans are, implementation is difficult as it calls for a fundamental culture shift to population-based care that must battle the inertia of the status quo and is proactive rather than relying on the tyranny of the urgent. Plus, measuring performance is often threatening and anything new generates a misperception that it is a new cost without offsetting revenue.

[a] Six Dimensions of Quality: 1. Safe: Do no harm; compliance with National Patient Safety Goals; safety for all patients, in all processes, all the time; 2. Effective: Produces the desired result; evidence-based; emphasis on preventing disease, early detection; 3. Patient-Centered: Seamless between levels of care; care provided with respect and compassion; 4. Timely: Without undue delay; 5. Efficient: Done without waste (resources, time, people); resourced appropriately; done competently; 6. Equitable: Equity at the population level (across subgroups, locations) and at the individual level.

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