

CASE STUDY FOR QUALITY IMPROVEMENT

Local Independent Practitioner Planned Care Initiative

PHYSICIANS OF SOUTHWEST WASHINGTON

Organization Profile

Physicians of Southwest Washington (PSW) is an Independent Physician Association formed in March 1995 by a group of Olympia, WA, area physicians to provide continuity of health plan access for their patients. PSW contracts with health plans on behalf of its network of physicians and other health providers, the majority of whom operate solo or small group practices throughout the community. The PSW network includes Capital Medical Center, Providence St. Peter Hospital, and many ancillary service providers, such as laboratories, ambulatory surgery centers, physical therapists, and home care service providers. As of July 2008 there were more than 220 physicians who participate in the PSW network (28 Primary Care Sites with a total of 77 physicians and ARNPs; 113 consulting specialists).

PSW contracts with health plans to provide medical and hospital services to members. As part of these health plan agreements, PSW manages medical referrals and processes medical claims on behalf of health plan members in its Olympia office. Health plan members and providers who have any questions or concerns regarding referrals or claims can call or visit the PSW office for assistance.

Project Summary

The Chronic Disease Self-Management Program is a 6-week workshop given once a week in community settings for people with chronic health problems. Central to PSW's Planned Care Initiative was engagement of the Chronic Disease Electronic Management System (CDEMS), an electronic patient registry, that tracks vital information to treat an individual and manage care for all patients. CDEMS is a primary-care-focused registry and tracking and reporting system developed to prompt preventive care practices following national diabetes guidelines of care. Also at the core of PSW's initiative is the Chronic Care Model, which identifies the essential elements of a health care system that encourage high-quality chronic disease care—the community, the health system, self-management support, delivery system design, decision support, and clinical information systems. Evidence-based change concepts under each element, in combination, foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise.

Outcomes and Successes

Essential to the success of the project was ongoing grant support through STEPS and ASISIT Grants and TCPH&SS.

At the practice level successes were as varied as the independent practices themselves:

- Some produced “absolute” change; some little to none.
- Some practices have left the project, seeing no value in the process.
- The changes in patient measures are varied but predictable after becoming familiar with the practice culture.
- The overall project has provided impetus for many future QI projects and established a foundation to build on.

Perhaps most important is that all remaining practices want to continue with the initiative.

Goals and Objectives

The Local Independent Practitioner Planned Care Initiative was formed for independent and small group PCPs, to create a venue for independent practices to implement the Chronic Care Model, to assist many primary care practices in implementing their first electronic application into outpatient care delivery system, and to improve to clinical outcomes for patients with diabetes. Three practices are targeted each year.

Team Composition

Members of the Planned Care Initiative Planning Committee include:

- Mariella Cummings, CEO, Physicians of Southwest Washington
- Joe Wall, Administrator, St. Peter Family Practice Residency
- Jan Norman, RD, CDE Chronic Disease Prevention Unit Director, Washington State Dept of Health
- Rick MacCormack, PhD, Chief Integration Officer, Northwest Physicians Network
- Beverly Roder, RN, CCM, UM/QI Manager, Physicians of Southwest Washington
- Tammie Bigelow, IT Manager, Physicians of Southwest Washington

Diabetes Intervention and Population Baseline

In Washington State, diabetes prevalence has doubled since 1990, with the rising rate driven by an aging population, rising obesity rates, decreasing physical activity, and new diabetes diagnostic criteria.

It is the cause or a contributing factor in nearly 4,000 deaths a year. It is also a factor in more than 67,000 hospitalizations every year, and diabetes-related conditions account for more than \$1 billion annually in hospitalization charges in the state. People who have diabetes need skills to manage their diabetes and to help them stay active and healthy. People with diabetes often have at least one other chronic illness, like heart disease or asthma.

PSW embarked on a care initiative for diabetic patients as a means of offering a local program for independent practices with similar offerings to the Washington State Diabetes Collaborative (WSDC). The project targeted the diabetes population of each practice. Demographics varied based on the type and maturity of the practice (FP/IM). A CDEMS registry was set up in each practice, using practice management systems to identify patients with diabetes. PSW staff (CPCs) performed manual chart abstraction and built a baseline registry for each practice and instructed practice staff in registry utilization and ongoing maintenance. Project team members provided orientation for practice staff with introduction to the chronic care model and the use of PDSAs as a method of change.

Health care information technology was introduced to the practices with the implementation of the registry software and the interfaces with lab vendors, enabling them to download lab values into the software. This was the first electronic application for most offices, creating significant changes in work flow. Some practices already utilized parts of the model; others had no systems for Chronic Disease Management.

Each practice designated a staff person, usually the office manager, to be the contact point for the registry implementation. Implementing changes in the care delivery system required a variety of activities over a significant period of time, including ongoing practice-level consultations; sharing of clinical registry data among participating teams; supporting emerging team leaders in each practice; comparing local aggregate results to WSC data; sharing success stories (and failures); and ongoing didactic education related to chronic care model, system change, and advances in clinical care related to diabetes.

Improvement Interventions

Registries were established utilizing CDEMS in each practice. CDEMS is a Microsoft Access database application developed by the Washington State Diabetes Prevention and Control Program in 2002 to assist medical providers and management in tracking the care of patients with chronic health conditions. CDEMS is pre-coded to track diabetes, asthma, and adult preventive health but is customizable to change those tracking measures or define measures for monitoring other chronic conditions. Printed progress notes, patient lists, and summary reports generated from the registry database can alter the way services are delivered and measure quality improvement efforts.

Practice staff was trained in registry maintenance and use. Custom queries and special reports all make the application more complex, but also meet the specific workflow and reporting needs of each individual practice.

Practice teams were educated on the implementation of the Chronic Care Model, pictured here, which summarizes the basic elements for improving care in health systems at the community, organization, practice, and patient levels.

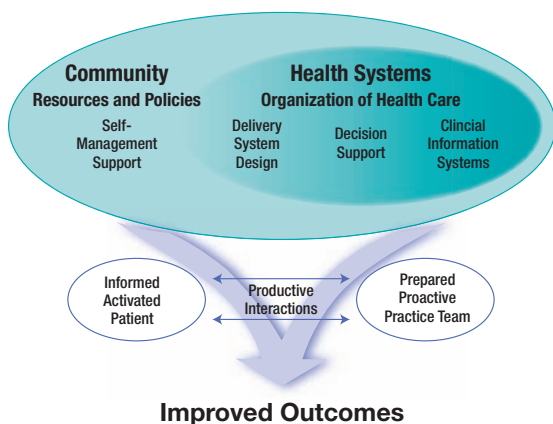
Practices utilized and tracked the objectives of the WSDC (<http://www.doh.wa.gov/cfh/diabetes/default.htm>) and planned a system of ongoing education and exchange.

Measures used were adapted from the Washington State Collaborative (WSC) Patient-Centered Medical Home:

- Percentage of patients with most recent A1C <7.0%
- Percentage of patients with most recent blood pressure <130/80 mmHg
- Percentage of patients with most recent LDL <100 mg/dL or non-HDL <130 mg/dL
- Percentage of patients with documentation of a self-management goal
- Percentage of patients offered tobacco-cessation counseling

Practices were allowed to add additional goals.

The Chronic Care Model



Challenges or Obstacles

While the WSDC did impact the physicians, introducing the Planned Care Initiative into independent practices was at first met with a degree of negativity. It was necessary to overcome the impression the initiative meant more work to bring teams on board. It was also necessary to introduce hard data to show them that contrary to what they thought, they weren't already doing a great job with their diabetic patients. Further, it was difficult to involve practice teams without the full buy-in of the docs. Substantial effort was needed to help teams learn ways to empower and ask patients to encourage self-management. However, because independent doctors don't easily delegate, it took a determined effort to convince them to delegate clinical activities to their teams. It was important for all involved to recognize that change doesn't happen overnight; they needed to expect change to come in small increments.

Future Steps

The PSW board is embarking on a strategic plan to develop a means to continue Quality Initiatives. This includes the recent development of the PSW Foundation for Quality Improvement as a means to seek grant funding for projects and building a structure of "Clinical Champions" to support QI projects.

To meet practice requests for a registry that allows them to query data and feed it back out to the doctors, PSW is researching alternative integrated registry options.

Also, the group plans to provide additional information assistance to member practitioners by providing them with information on national trends and their impact on independent practices.

Lessons Learned

- **If you have worked with 1 small practice, you have worked with 1 small practice—no two are alike.**
- **Small changes have huge impacts on independent practices.**
- **Having a "Clinical Champion" makes all things easier.**
- **Patience, patience, patience!**