

Transforming Healthcare Delivery Through Patient-Centered Care

2011 ACCLAIM AWARD HONOREE HEALTHTEXAS PROVIDER NETWORK



HealthTexas Provider Network team accepting an honoree AMGA Acclaim Award (left to right): Cliff Fullerton, M.D., M.Sc., Vice President, Chronic Disease, Baylor Health Care System, Chief Quality Officer; Sarah Gahm, M.H.A., Chief Administrative Officer; and F. David Winter, M.D., M.Sc., M.A.C.P., Chairman and Chief Clinical Officer

Editor's Note: In September 2011, HealthTexas Provider Network was named an honoree for the American Medical Group Foundation's 2011 Acclaim Award for its initiative "Transforming Healthcare Delivery Through Patient-Centered Care."

healthTexas Provider Network (HTPN) is a physician-led, patient-centered, multispecialty medical group practice established in 1994, with more than 500 physicians practicing at 156 care sites across 5,700 square miles of the Dallas/Fort

Worth area. It is the third largest subsidiary of Baylor Health Care System, a not-for-profit, faith-based, 3,423-bed hospital system with 25 owned/operated/ventured/affiliated hospitals. In FY10 it reported more than 1.4 million encounters with patients, including nearly 95,000 new patients. HTPN has 57 primary care centers, and 69 specialty care centers. Specialty care centers include: 9 psychiatric medicine centers, 3 pulmonology critical care centers, and 23 specialty satellite clinics (this number includes

12 liver disease outreach centers, 1 kidney outreach center, and 1 chronic heart failure outreach center).

IOM Aims Integration

HealthTexas Provider Network has a mission to achieve excellence in the delivery of accessible, cost-effective, quality health care and demonstrated customer satisfaction that delivers value to patients, payers, and the community. Delivering quality care is a continuous journey and the Institute of Medicine's (IOM's) six Aims for Improvement have become a roadmap to achieving this mission.

HTPN has aligned its mission with the IOM Aims by trademarking their own acronym: STEEEP.

HTPN has aligned its mission with the IOM Aims by trademarking their own acronym: STEEEP®, which stands for *safe, timely, effective, efficient, equitable, and patient-centered care* (see Table 1). STEEEP posters can be found at all of their individual care sites and at headquarters as a reminder of how the organization wants employees to approach the way they deliver care to their patients. STEEEP is woven into the corporate culture: it is introduced in new employee orientation, taught in process improvement classes, and presented at their Leadership Development Institute.

The Best Care Committee over-

sees the clinical implementation of STEEEP objectives across the organization. The Best Care Committee is chaired by a physician leader and has a membership comprising patients, executives, and physicians from various care sites within the network. This group strives to improve the quality of patient care by monitoring the development and implementation of quality improvement projects developed at every level of the organization and reporting results to leadership. The goals of the Best Care Committee are:

- To provide physicians with reliable data that enable them to identify best practice and opportunities for improvement
- To implement evidence-based, system-wide standards of care
- To enhance and extend physician relationships
- To advance clinical care through education, research, and new collaborative clinical ventures
- To garner patient input and feedback regarding quality projects

The network is committed to ensuring that physicians and other providers have the tools needed to deliver health care that is STEEEP. For example, HTPN developed an improvement process called ABC (Accelerating Best Care) that is based on the Rapid Cycle Improvement methodology. It is designed to rapidly spread quality improvement initiatives throughout the organization. ABC allows participants to study the cultural changes and tools needed to develop clinical quality improvement initiatives. Using ABC methodology, each participant chooses an area within his or her influence to systematically improve. A team is then assembled to brainstorm where improvements can be made. Then, the team puts their plan in place and measures the impact over a short period. This is known as the “Plan, Do, Check, Act” cycle of change that mirrors the

Rapid Cycle method. The data are then analyzed to determine if the improvement is statistically significant. If so, then the task is to embed the change in the standard process, and repeat the cycle. In addition, HTPN employees and physicians are required to develop ABC projects throughout the year and participate in Baylor’s Quality Improvement Award program. This program recognizes and rewards teams for successfully setting and sustaining process improvements using ABC.

Challenges/Critical Changes

HTPN is a medical group with a diverse collection of primary and specialty care sites located across a vast area of the Dallas/Fort Worth region. Because practices are so spread out, differing cultures tend to emerge. HTPN’s challenge centered on promoting teamwork, engaging physicians, and maintaining communication to ensure that everyone was working toward common goals set by the organization. Some physicians were happy with their care site performance and did not see the need to change anything. The old adage, “If it ain’t broke, don’t fix it,” applied to the mentality of some care sites and fostered a sense of complacency. HTPN leaders tackled this challenge by further strengthening the committee structure and encouraging more physicians to participate. HTPN’s committee structure promotes a teamwork philosophy through physician involvement and participation in the management of the medical group as a whole. With more than 24 physician-led committees and subcommittees, the medical group has a committee that covers almost every aspect of practice management. Over 60% of the physician population serves as either a chair or a member on various committees. Patient input is considered vital to the success of HTPN initiatives. Patients are often recruited to serve on various committees so that their perspectives can be solicited in redesign efforts. As a result of

HTPN’s committee structure, initiatives are developed and physicians and patients are personally invested in their success.

In an effort to improve communication and better engage physicians, HTPN made the decision to divide its service area into regions. Every year HTPN holds Town Hall meetings by region to update physicians and administrative staff on organizational goals, upcoming initiatives, healthcare reform issues, etc. Once a year an annual physician forum is held where the HTPN leadership team and committee chairs present updates on their committee initiatives. Various workshops are held as well to educate physicians on current health topics of interest.

The network measures success through a series of active audits.

Measuring Success

The network measures success through a series of active audits that include patient satisfaction, patient safety, clinical quality, preventative health services, diabetes management, and asthma management. The data from these surveys and audits allow the group to track successes, identify care gaps, and develop initiatives that lead to improvement. All results are made available at individual care sites and posted on the intranet site so physicians, administrators, and support staff can easily view their performance results. The transparency of data allows physicians and care sites to share information and learn from each other. The group found that unblinding data also promotes friendly competition among care sites and has made the implementation of some improvement processes easier. When care sites see data proving that a process is working, they are more likely to implement it themselves. The implementation of an EHR has allowed the group to become more reliant on

TABLE 1

Linking Mission Statement to STEEEP

IOM AIM (STEEEP)	Mission: “Achieve excellence in the delivery of...”	Circle of Care	Initiatives in Place
Safe	Quality	People	<ul style="list-style-type: none"> • Clinical Skill Verification: Standard process for verification of clinical skill levels for non-physician support staff • Train the Trainer: Certified trainers at each care site to assist in clinical skills training • Improved awareness and implementation of patient event reporting • E-prescribing
Timely	Accessible	Service	<ul style="list-style-type: none"> • Urgent Care/After Hours offered by majority of primary care sites • Open access through same-day appointments available at many care sites • Online appointments/physician contact through websites at 80% of care sites • Use of mid-levels • Instant appointments
Effective	Demonstrated customer satisfaction	People/Quality/Service	<ul style="list-style-type: none"> • Adult Preventive Health Services • Disease Management Program • Elder House Calls • Pulmonary Critical Care • Acute and Critical Care • Liver Transplant Biorepository • Organ Transplant Program • Colonoscopy Withdraw Plan • Colonoscopy Perforation Rate • Order Set Utilization • Transitional Care
Efficient	That delivers value to patients	Finance	<ul style="list-style-type: none"> • Electronic Health Record • Clinical Data Warehouse • Automated Audits and Quality Improvement Reporting • Laboratory Services • Standardization of Medical Supplies
Equitable	And the community	Service	<ul style="list-style-type: none"> • Project Access • Volunteers in Medicine • Community Health Service Corps • Surgery on Saturday • Liver Outreach Program • Diabetes Health and Wellness Institute
Patient-Centered	Accessible, cost-effective, quality health care	People/Service/Finance	<ul style="list-style-type: none"> • Patient-Centered Medical Home • Advance Medical Planning for Elder Populations • Scribes • Ambulatory Care Coordination • Patient Satisfaction • AIDET • Secured Patient Messaging • Generic Prescribing • Patient Portal and Kiosk

data and insistent upon the use of data to measure results.

Leadership Role

HealthTexas Provider Network's mission was developed to encompass Baylor Health Care System's four pillars of the Circle of Care:

- **People:** Be the best place to give and receive care
- **Quality:** Deliver safe, timely, effective, efficient, equitable, and patient-centered care supported by education and research
- **Service:** Provide care for our patients and our community
- **Finance:** Be responsible financial stewards

The Circle of Care focuses employees on common goals that benefit HTPN, Baylor Health Care System, and the communities they serve. Four times a year, HTPN leaders attend The Leadership Development Institute provided by Baylor to acquire the tools and skills needed to develop strategic plans supporting the Circle of Care goals.

HealthTexas organizational goals and objectives are aligned with the above Circle of Care pillars and then cascaded throughout the organization. Cascaded goals are refined to describe the exact work a direct report will be doing during the year to support entity goals.

A web-based performance management system is used to effectively track and measure employee performance. Individual performance at all levels of the organization is rated in two categories: behaviors and goals/responsibilities. Value-based behaviors are: integrity, service, quality, innovation, and stewardship. All goals have a link to the entity leadership goal and are SMART (specific, measurable, attainable, relevant, and time-bound).

Activities that Support Goal Achievement

On a quarterly basis, 90-day action plans for meeting goals and objectives are drafted. As metrics of

achievement become available, plans and report card outcomes are updated. Department outcomes are posted by Pillars of Care on communication boards at corporate headquarters and throughout care sites, as well as posted on the intranet. This creates a transparent environment that promotes an atmosphere of sharing information and learning from each other. Any individual or department struggling to meet goals and objectives is encouraged to contact one of HTPN's improvement coaches, on staff with their human resources department, for assistance. Rounding (based on the Studer Group model) is performed on a monthly basis at all levels of the organization and care sites to ensure that employees, physicians, administrators, and staff are all aligned with organizational goals and have the tools they need to achieve them.

Accountability for Achieving Goals

The medical group sets salaries and rewards employees based on a pay-for-performance philosophy. Salary increases are dependent upon how well employees meet their goals for the year. Twenty-five percent of senior leaders' salaries are tied to the achievement of entity-wide goals.

In addition, after years of tracking clinical quality and service excellence metrics, the board of directors approved a resolution that ties quality and service excellence components to physician compensation. Since July 1, 2009, 10% (5% for quality measures and 5% for patient satisfaction measures) of certain physician salaries are at risk if quality and patient satisfaction measurement goals are not met. However, if the physician rises above the threshold in the next audit, the deductions are stopped and any withheld funds are repaid. Physicians have one year to meet or exceed the thresholds before funds are permanently lost. Physicians in the bottom 10% are strongly encouraged to take advantage of coaching and individual attention to help improve quality

scores. The goal for these physicians is to meet the quality threshold, improve overall patient quality scores, and ultimately keep all of their compensation.

Step-by-Step Implementation Plan

To accomplish the mission of quality improvement, the organization, along with Baylor Health Care System, adopted a strategy called Clinical Transformation. Clinical Transformation is an enterprise-wide commitment to continually improve the quality of patient care by transforming key processes. The dimensions of Clinical Transformation include improvement in all STEEEP metrics and in all processes of care by reducing unnecessary variation, costs, waste, and error. At the same time, transformation encompasses building a patient-centered medical home that allows for significant improvements in: patient outcomes, access, satisfaction, value, and coordinated care across the continuum.

Step 1: Adult Preventive Health Services (APHS)

HTPN's first call to action for Clinical Transformation was improving preventive health measures. Medical records for patients of all primary care physicians were audited for 11 different adult preventive services prescribed to patients that include: smoking cessation, lowering cholesterol, colorectal and breast cancer screenings, and more. Through the use of a flow sheet attached to a patient's medical record (either in the EHR or on a paper chart), physicians, nurses, and office staff are prompted to check on the need for preventative health services at each patient visit. Physicians are audited every three months and are scored on how well they do in ensuring that their patients actually receive preventative health services they have recommended. Results of these audits are transparent and accessible throughout the network.

Step 2: Chronic Disease Management

The development of the Chronic Disease Management program, in conjunction with the implementation of the EHR system, followed the APHS initiative and used the same principles of data measurement, continuous improvement, and reporting to effectively manage patients with chronic diseases. The program's goal is to assist patients with an existing and/or chronic illness with managing their condition, maximizing the impact of the physician's treatment plan, and improving quality of life. HTPN has improved chronic disease management by implementing the following interventions:

- Physician champions or academic detailers were hired to collaborate with physicians on new improvement reports and patient management tools within the EHR.
- Physicians use tools embedded in the EHR, such as the Diabetes Dashboard, to measure how well a patient's diabetes is being managed. The Diabetes Dashboard lists the following metrics and prompts physicians during treatment: hemoglobin A1c, LDL, blood pressure, ASA use, tobacco use, and bundled care scores. Percent Opportunity Achieved (POA) is tabulated to reflect the degree to which patients reach treatment goals.
- A "Barriers to Goals" template was created in the EHR to prompt physicians to find the root cause of noncompliance with recommended diabetes treatment plans.
- Decision support reports were developed to track all diabetic patients and coordinate their care.
- An ambulatory care coordination department was created. Care coordinators proactively contact patients regarding outstanding needed services, schedule appointments, perform visit follow-up

calls, and track inpatient events to ensure timely follow-up care.

Step 3: Information Technology

A critical component of HTPN's Clinical Transformation and quality improvement initiatives was the adoption of the Centricity EHR system. HTPN used Edward Wagner's Chronic Care Model as its guide when designing the EHR system functionality and therefore included features such as self-management support tools, delivery system design, decision support, clinical data warehouse, and patient portal.

The EHR system seamlessly integrates with Baylor Health Care System's informatics system to provide a single repository for all patient data. The EHR also supports the ABC rapid-cycle process improvement program and has been instrumental in enabling the medical group's practices to achieve level 3 (the highest level) Physician Practice Connections®-Patient-Centered Medical Home™ (PPC-PCMH) recognition from the National Committee of Quality Assurance (NCQA).

In addition, the EHR system positions the medical group well for achieving:

- Physician Quality Reporting System (PQRS) measures
- Meaningful Use
- Future accountable care initiatives

Clinical Data Warehouse

HealthTexas Provider Network used their in-house talents to build a data warehouse that contains essential clinical information for every patient that is available at any point of care in the network and hospital system. The clinical data warehouse has improved efficiency in many ways, most notably in auditing efforts. Using data mined from the warehouse, reports are created that tabulate results for each of our physicians in regards to how well they are completing all measures related to APHS and Disease Management. Summary reports are distributed to

practices and physicians within days of the end of the audit period and offer the capability to drill down to patient level detail. In addition to the automated audit reports that score and rank our care sites and physicians, HTPN has also created improvement reports that update physicians on their progress in meeting their goals regarding APHS, Disease Management, and Asthma Management measures.

Step 4: Patient-Centered Medical Home

The network's APHS, disease management, and EHR successes created the foundation for the PCMH initiative based on consistent, coordinated care with a focus on prevention and risk reduction. The medical group has been diligent in reengineering care sites to become PCMHs and has put infrastructure in place to support PCMH redesign.

The infrastructure includes a dedicated PCMH department that is responsible for guiding care sites in becoming PCMH-ready. The PCMH department has developed training sessions, standardized guidelines, and tracking tools that enable care sites to sustain PCMH principles, close care gaps, and meet payer specifications. Each of the care sites has implemented the following PCMH guidelines as "hardwired" standards of care:

- Patient-physician match
- E-mail services (secure patient messages)
- Coordinating visits (ambulatory care coordination department)
- Website services (contacting a physician, making an appointment)
- Pre-visit planning
- Test and referral tracking via EHR
- Appointment triage
- Language preference
- Appointment capacity (same-day appointments, 24/7 appointment

FIGURE 1

Clinical Transformation Timeline

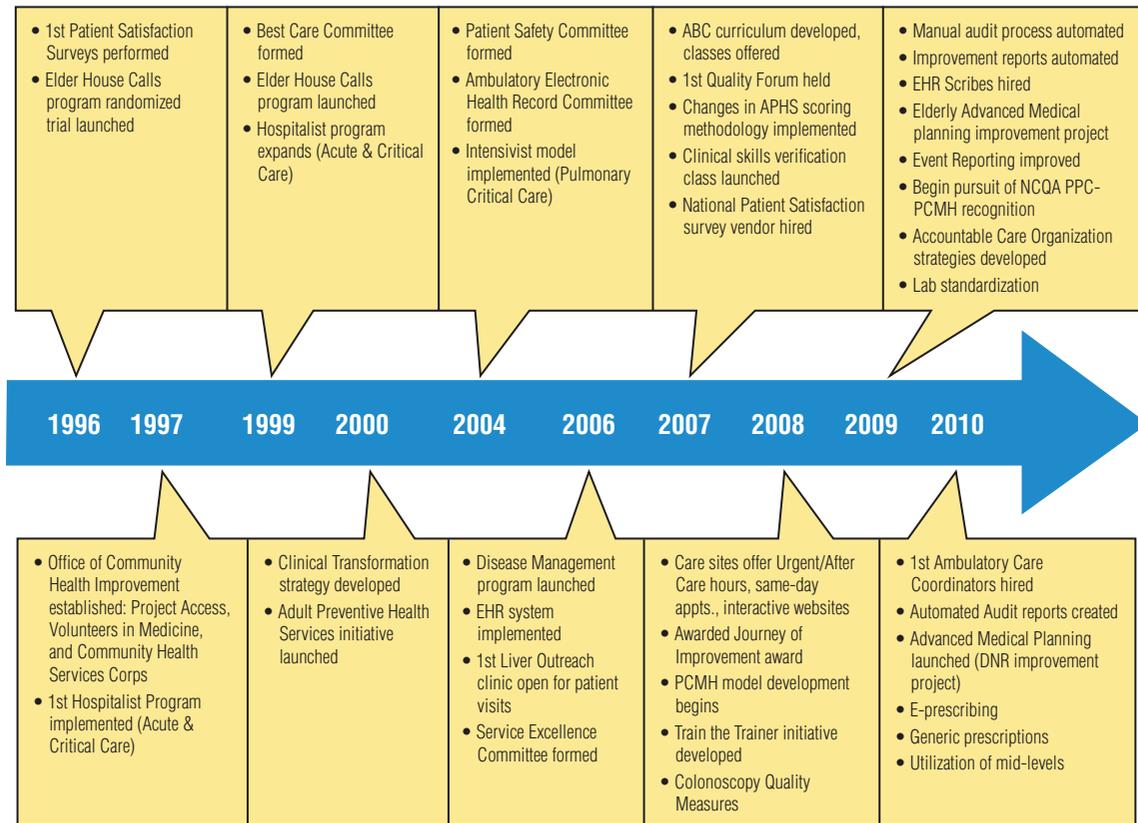


FIGURE 2

Convenience of Office Hours

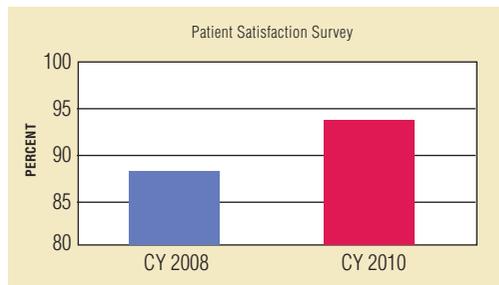
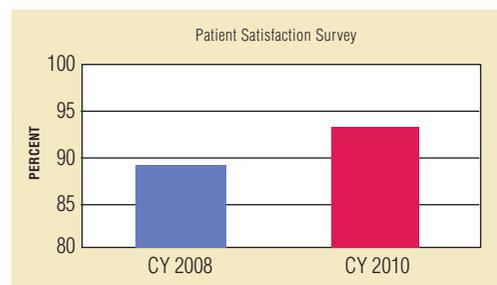


FIGURE 3

Standard Access to Care



schedule capabilities)

- Health resources for patients without insurance
- Vision-hearing assistance
- Telephone advice for clinical issues
- After-hours calls

Quality Improvement Implementation over Time

HealthTexas Provider Network's Clinical Transformation has been a result of organizational and process changes that have taken place over

time. Consult the timeline in Figure 1 to review the evolution of HTPN's efforts to achieve an ideal healthcare delivery system.

Key Players in the Redesign

The board of directors, physician-led committees, and patients are the key players in HTPN's redesign and implementation. The president of HealthTexas Provider Network reports to a 19-person, all-physician executive board, which oversees physician-chaired committees that

deal with many different aspects of practice management. One of the earliest committees was the Best Care Committee, established by the Board of Directors in 1999 after the Institute of Medicine published *Crossing the Quality Chasm*. The Best Care Committee Chair commissioned a detailed review of the report by all Best Care Committee members. A workshop environment was created where committee members used *Crossing the Quality Chasm* as their guide to study and identify

FIGURE 4
Average Patients per Physician (FP & IM Only)

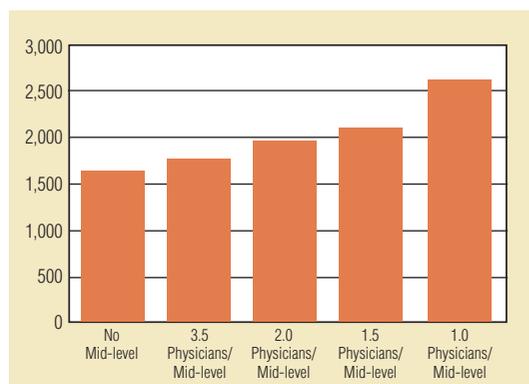


FIGURE 5
Uncompensated Costs Associated with Hospital Utilization

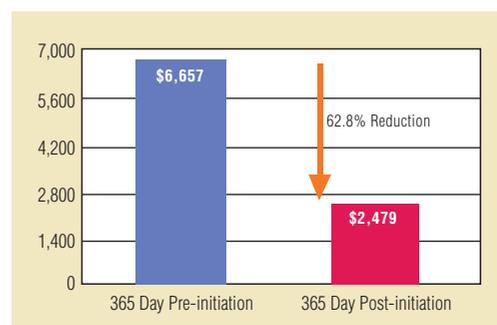


FIGURE 6
Cost of Purchases by Category (1)

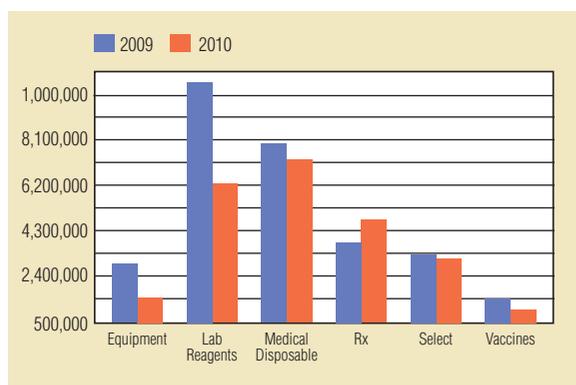
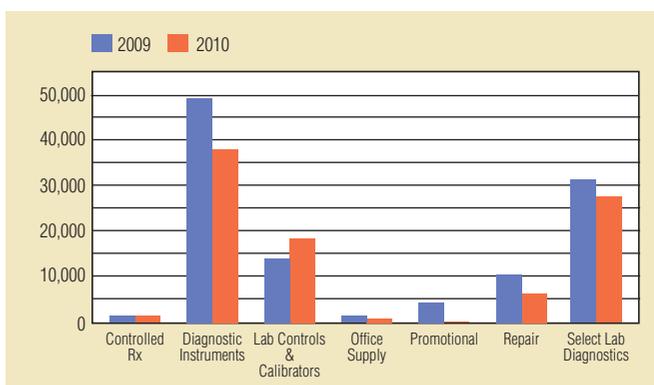


FIGURE 7
Cost of Purchases by Category (2)



improvement opportunities within HealthTexas Provider Network. After the completion of this review, a Clinical Transformation strategy was developed to foster greater accountability for quality and facilitation of improvements throughout the organization.

Biggest Challenges and Why

The biggest challenge for HTPN has been managing change. The Clinical Transformation strategy has required some physicians to make changes to the way they practice medicine. At times, physicians have had to rethink their customs and practices, sometimes changing techniques and habits that have been followed for years and even decades.

These changes have taken a great deal of emotional capital and have sometimes been met with resistance.

For example, some of these changes initially decreased the available time physicians had to spend with their patients. The changes were distracting at first and required extensive communication and interaction with other members of the healthcare team.

Throughout the transformation, the network continues to work through some of these challenges with good, clear, candid, open communication with their physicians.

Results

HealthTexas Provider Network uses financial, quality, patient satisfaction, and productivity metrics to measure how well it is meeting goals. Data are mined from the EHR's clinical data warehouse as well as the organization's financial records. The group's entire patient population has been positively impacted by healthcare redesign

efforts as seen by results in the areas of safe, timely, effective, efficient, equitable, and patient-centered care outlined below.

Safe

Clinical skills verification: A standard process for verification of minimal clinical skill levels of medical assistants (MAs), licensed vocation nurses (LVNs), and registered nurses (RNs) who are hired as physician care partners. **Results:** 432 out of 623, or 70%, of MAs/LVNs/RNs have attended clinical skills verification class. Based on a 5-point scale, 99% of attendees rate the class either a 4 or 5. Also, 98% of attendees stated their knowledge level was improved by the class.

Train the trainer: Provides sustainability for clinical skills verification class by placing a trained clinical employee in each of the care

FIGURE 8
Likelihood of Recommending the Practice

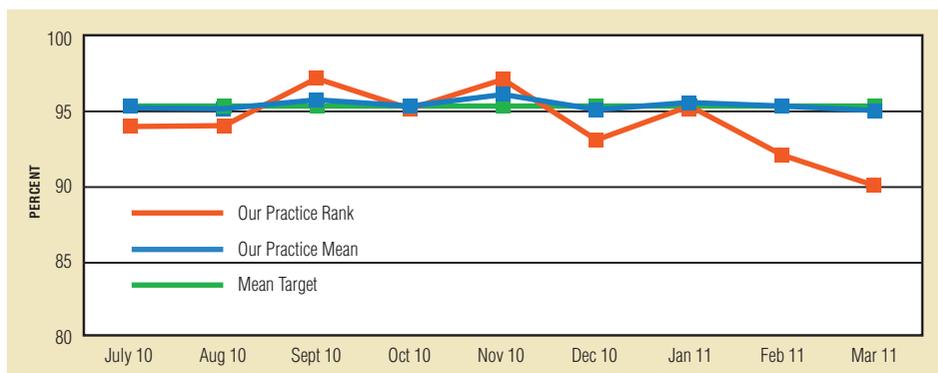
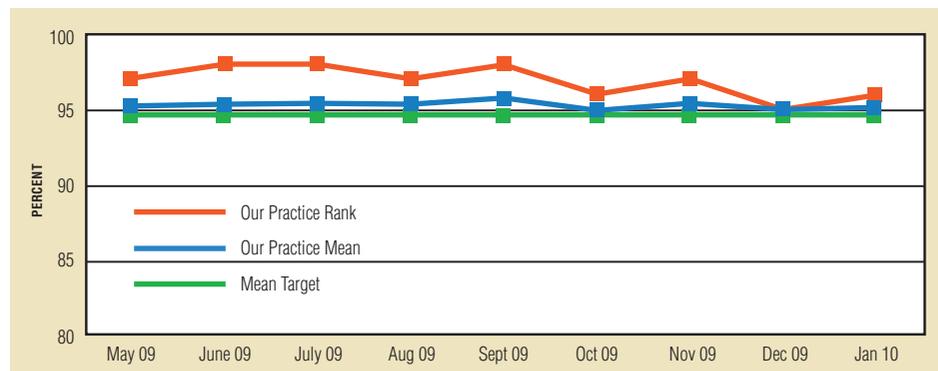


FIGURE 9
Standard Care Provider



sites. **Results:** Currently 70 trainers are established in 49 facilities.

Timely

Urgent /after-hours care: Many primary care sites offer urgent care and/or after-hours care, giving patients improved access while providing them a medical home. Patients can be seen by their primary care physician instead of receiving care at the emergency room or retail clinic. **Results:** Patient satisfaction scores in the category of Convenience of Hours have increased 4.8 points from a mean score of 88 in 2008 to 92.8 in 2010. Scores in Access to Care increased 2.3 points from a mean score of 93.5 in 2008 to 95.8 in 2010 (see Figures 2 and 3).

Increased use of non-physician providers: Physician's integrating non-physician providers (mid-levels)

as part of their care team to serve patients with acute care needs has significantly increased access and improved continuity of care for patients. **Results:** Data show that the integration of non-physician providers (mid-levels) has increased patient panel size at family and internal medicine practices (see Figure 4). At care sites where there is a one-to-one ratio of non-physician providers (mid-levels) to physicians, panel size has increased by an average of 1,000 patients, or 60%, per physician. At sites where there is 1 non-physician provider (mid-level) for every 2 physicians, panel size has grown by an average of 330 patients, or 20%. Mid-levels provide greater flexibility to meet changes in demand.

Effective

Adult preventive health services: HTPN has seen significant

gains in the following improvement measures as a result of the APHS initiative. Among adult patients 18 and older 92% are currently screened for preventive care services—up from 57% in 2000. In addition, the APHS initiative has enabled the group to achieve screening results well above the national average for Healthcare Effectiveness Data Information System (HEDIS) measures as shown in Table 2.

HealthTexas Provider Network hired a consultant to research the effect their Adult Preventative Health Services program had on their patients. Their consultants' studies concluded that HTPN's APHS initiative has prevented:

- 400 cases of cancer, including 150 cancer deaths
- 1,600 cases of coronary heart disease, including 325 sudden cardiac deaths

TABLE 2

Preventive Services and HEDIS Scores

Preventive Service	HealthTexas	AVG. HEDIS
Screening for colorectal cancer	71.0%	54.9%
Screening for osteoporosis	82.0%	68.0%
Flu vaccination rate	60.5%	51.3%
Screening for breast cancer	75.0%	71.3%
Screening for cervical cancer	80.5%	77.3%

- 4,000 cases of influenza and pneumonia, including 110 hospital admissions
- 300 fractures due to osteoporosis

These same studies, projected 10 years into the future, show the impact of the efforts as preventing:

- 48 deaths from breast cancer
- 125 deaths from cervical cancer
- 224 deaths from colon cancer
- 222 deaths related to hypertension
- 489 deaths related to hyperlipidemia
- 190 deaths from tobacco use
- 110 hospital admissions due to pneumonia
- 130 hospital admissions related to influenza
- 1,030 hospital admissions related to osteoporosis

Efficient

Charitable care sites: In FY10, HTPN expanded from two charitable care sites to six to improve access to care for the underserved population and reduce unnecessary utilization of local hospitals and emergency departments. As a result, the hospital system's uncompensated costs per patient have decreased by 62.8% (see Figure 5).

Standardization and consolidation of medical supplies: In 2011, HTPN began standardizing medical and office supplies across all 57

primary care sites (see Figures 6 and 7). A standardized order sheet can be easily accessed via the intranet site.

Results: This vast undertaking has saved approximately \$550,000 in one year. In addition, because the medical group is able to take advantage of volume discounts, it is able to order higher-quality point of care (POC) tests such as strep, pregnancy, and flu at a lower cost. As a result, overall testing accuracy (based on manufacturer's claims) has improved by 98%. All care sites are now using POC kits with some of the highest sensitivity and specificity on the market, ensuring patients get the most accurate results and treatment.

Equitable

Surgery on Saturday: This program is patterned after the successful Surgery on Sunday™ program (founded by noted Lexington, Kentucky surgeon, Dr. Andrew Moore) bringing surgery services to the uninsured. HealthTexas collaborates with an ambulatory surgical center to host surgical events on designated weekends. HealthTexas Provider Network's surgeons volunteer their services while the ambulatory surgical center collaborator donates use of a facility and support staff. Ambulatory surgical services offered include: colonoscopy, laparoscopic hernia repair, gall bladder removal, and endoscopy.

Results: The first event yielded 9 patients seen: 4 general surgery

cases (gall bladder, hernia repair, and mass removal) and 5 diagnostic colonoscopies. In attendance were 3 general surgeons, 2 colorectal surgeons, and 3 anesthesiologists. Support staff included 14 nurses and techs. There is a plan to host these events quarterly with patients referred by physicians staffing local charitable clinics.

Liver Outreach program: There are currently 12 Liver Outreach centers located throughout Texas bringing specialized liver care to those who may not be able to travel long distances. HTPN hepatologists travel to a Liver Outreach center once a month to see patients with chronic viral hepatitis, cirrhosis, liver masses, and other general liver conditions. This gives patients with liver-related illness in rural areas access to hepatology care and a wider range of treatment options. **Results:** Patient volume has grown by 96.5%, from 9 patients to 869, since the inception of this program in 2006.

Patient-centered

Patient satisfaction: A Press Ganey survey is mailed to 15 HTPN patients per provider per month based on a random sample of recent service dates. **Results:** In the Press Ganey database, HTPN is consistently ranked in the 90th percentile for "likelihood of recommending practice" among the nation's 646 practice groups, which include 8,897 individual practice sites (see Figure 8). In addition, HTPN physicians are consistently ranked in the 95th percentile among the nation's 86,975 physicians for the "Standard Care Provider" (see Figure 9).

Patient-Centered Medical

Home: Four primary care sites have been recognized as level 3 NCQA PPC-PCMHs. Fourteen additional primary care sites are in the process of completing their applications. The organization is on track to have 69 primary and specialty care sites recognized as level 3 PPC-PCMHs by the end of June 2012.

Lessons Learned

- Put your patients first.
- Encourage and empower employees at all levels. Help them identify and implement techniques to improve healthcare quality. Give them the training and the tools they need to be successful. Reward them.
- Make collective, incremental changes. Small changes throughout an organization can add up to real results in improving care.
- Teamwork and communication are crucial. The HTPN committee structure brings leaders, physicians, patients, administrators, and staff together as a team to work collaboratively on initiatives and develop a true sense of partnership and trust. The committee structure is also instrumental in the dissemination of information throughout the care site network.
- Cascade organizational goals and objectives from top to bottom. This allows employees to set personal goals that will support the accomplishment of entity goals. It has also improved employee motivation in that they feel personally invested in goal achievement.
- Rounding is important. It has fostered communication among leaders, physicians, administrators, staff, and patients.
- Measure results. Track progress and performance through evidence-based research/tools. Make results transparent throughout the organization, share information, and learn from each other.
- Engage technology. Information technology offers opportunities to improve communication, patient experience, and process automation.
- Maximize and manage supply. To improve access to healthcare services, predict and manage patient demand and integrate non-physician providers in the care team to cover acute care needs of the patient. This approach can increase efficiency and streamline the

flow of patients. It also provides patients coordinated care within their medical home where they can be seen by their physician.

Advice for Implementing Change

Anticipate future healthcare trends nationally, statewide, and locally and stay abreast of healthcare reform. Change will always be a part of the healthcare industry and we must embrace it, welcome it, adopt it, and support it through innovation and new discoveries. HealthTexas Provider Network began its efforts by first recognizing the needs of patients, and second, by developing solutions, creating strategies for

implementation, and then encouraging patients and all levels of the organization to get involved.

Lastly, you must listen and learn from your competition and the industry as a whole. We must remain inspired and applaud the efforts of others as we work together to improve the delivery of health care across this nation and ultimately cross the quality care chasm.

Adapted from the 2011 Acclaim Award Application of HealthTexas Provider Network submitted by Jean Sullivan, marketing manager.

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