In September 2012, HealthTexas Provider Network (HTPN) was named an honoree for the American Medical Group Foundation’s 2012 Acclaim Award for its initiative “Transforming Healthcare Delivery Through Patient-Centered, Value-Based, Quality Care.” This initiative also garnered HTPN the same honor in 2011 and was featured in this publication last year. This article highlights new projects and outcomes from the initiative.
HealthTexas Provider Network is a high-performing, multispecialty, physician-led, patient-centered medical group practice established in 1994. They employ more than 590 physicians practicing in 191 care site locations. Patient encounters in FY11 reached over 1.5 million, including nearly 95,000 new patients. The network is comprised of 66 primary care centers and 90 specialty care centers. It has 7 hospitalist programs and 28 specialty satellites.

IOM Aims and Six Attributes
The medical group’s mission is 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. To accomplish the mission, HTPN has worked hard to continually set plans, develop strategies, and implement initiatives that address patient’s needs. Delivering quality care is a continuous journey. Along the way, they have found that the Institute of Medicine’s (IOM) six Aims for Improvement have become a guide to achieving the mission. As a result, HTPN has aligned itself with the IOM Aims by trademarking its own acronym, STEEEP® which stands for safe, timely, effective, efficient, equitable, and patient-centered care.²

In 2012, HTPN was honored as a recipient of the Acclaim Award. The organization utilizes STEEEP as the guide for all of its quality improvement initiatives.

HTPN is highly integrated with the hospital system and therefore share the same goals and set joint strategies reflecting both ambulatory and inpatient needs. Together, they leverage resources to improve healthcare delivery through a strategy of clinical transformation demonstrating quality improvements, clinical integration, standardization, efficiency, care coordination, and accountability across all settings. They capture data and set benchmarks for initiatives and measure themselves against both internal and industry standards. They consistently monitor initiatives and proactively look for ways to streamline and improve the patient experience. They have incorporated the six attributes of an ideal healthcare delivery system to become a high-performing medical group.

Transforming Healthcare Delivery Through Patient-Centered, Value-Based, Quality Care
2012 Acclaim Award Honoree HealthTexas Provider Network

HealthTexas Provider Network team accepting the 2012 Honoree Award (from left to right): Michael Massey, M.D., Medical Director, Vice Chairman of Best Care Committee, Champion for Ambulatory Care; Cindy DeCoursin, Chief Operations Officer; David Winter, MD, M.Sc., MACP, President and Chief Clinical Officer, Chairman of the Board; Sarah Gahm, Chief Administrative Officer; Clifford T. Fullerton, M.D., M.Sc., Vice President, Chronic Disease at Baylor Health Care System and Chief Quality Officer at HealthTexas Provider Network; and Thomas G. Ledbetter, M.D., Medical Director, HealthTexas Provider Network Workflow Redesign
Outcomes

The results listed below showcase some of the redesign initiatives and the significant progress HTPN has made to serve patients with Safe, Timely, Effective, Efficient, Equitable, and Patient-Centered care.1

Safe

In addition to clinical skills verification and a train the trainer program, HTPN has expanded these initiatives:

Event Reporting: The Patient Safety Committee’s event reporting initiative requires the reporting of unexpected patient events and near-misses at the care site level. They track these events, categorize them, and develop programs that will assist in the prevention of unexpected patient events in the future. Results: The most recent Medical Office Survey on Patient Safety and Health Care Quality performed by the Agency for Health Care Research and Quality (AHRQ) shows that HTPN is in the 94th percentile of the national average for the following: Implementation – Reporting unexpected patient events. From 2007 through 2011, total yearly event reports from clinics improved from 67 events reported to 357.

Patient Safety Liaisons: At present 119 Patient Safety Liaisons are working in care sites to support 13 Patient Safety initiatives and policies. Results: By end of year 2011, HTPN will have increased their PSL’s supporting Patient Safety initiatives and policies by 38% from 82 PSLs to 113.

e-Prescribing: Advanced e-prescribing has been successfully installed in our EHR allowing HTPN to streamline the prescribing process. Results: In 2011, 34% of prescription refills and 41% of office visit prescription requests are sent electronically.

Timely

In addition to urgent/after-hours care and increased use of non-physician providers, HTPN has expanded these initiatives:

Same-Day Appointments: Many care sites have blocked appointment times with physicians in order to make same-day appointments available, contributing to improvements to Patient Satisfaction scores for Access to Care.

Third-Available Tracking: Each physician achieves and maintains an appointment capacity to schedule patients according to the patient’s or family’s requests by pre-scheduled, non-urgent appointments utilizing a “3rd next available appointment” methodology. Results: HTPN has just begun measuring provider access through the 3rd available appointment standards based on NCQA criteria.

24/7 Appointment Scheduler: Patients can schedule appointments around the clock. Results: This also contributes to improvements to Patient Satisfaction scores for Access to Care.

Interactive Websites: All care sites have interactive websites available for patients to schedule appointments online and contact a physician, contributing to our improvements in Patient Satisfaction scores for Access to Care.

Physician Directory iPhone App: Available for free download at the iTunes store, apps allow users to search a list of physicians by specialty, location, or name. Call and direction features are included that will automatically dial the physician’s office and map to their location. Results: Moving from a printed directory to an iPhone App has saved the medical group approximately $10,000 per year in printing costs.

Advanced Practitioners Included in Care Team: The group has restructured physician compensation to provide additional rewards for advanced practitioner (Physician Assistant and Nurse Practitioner) oversight, as well as to alleviate a degree of risk associated with physician start-ups. Results: The number of advanced practitioners has increased, resulting in an increase in patient visits.

Effective

In addition to adult preventive health services, HTPN has expanded these initiatives:

Specialty-Specific Care Quality Metrics: The board of directors has approved specialty metrics in Cardiovascular Disease, Endocrinology, ENT/OTO, General Surgery, Gerontology, Hepatology, Neurosurgery, Pediatrics, Pulmonary, Rheumatology, and Thoracic Surgery. Results: HTPN is in the process of mining its clinical data warehouse to gather baseline performance results.

Disease Management Program: Results of the Disease Management efforts have yielded an increase in the percentage of clinical preventative diabetic services screened for male and female patients to the age of 75. A review of data during the period of June 2007 through March 2012 indicates the following improvements:

■ LDL<100 outcomes increased from 54.2% to 56.7%; significantly above the national HEDIS average of 37.3%
■ ASA outcomes increased from 35.3% to 92.0%;
A1c has increased from 52.6% to 56.8%; significantly above the national HEDIS average of 28.2%

Blood pressure outcomes increased from 36.6% to 52.7%; no HEDIS measure available for this category

Tobacco Use screening increased from 83.4% to 87.1%; significantly above the national HEDIS average of 71.7%

Bundled care scores increased from 4.9% to 18.0%

Percent Opportunity Achieved (POA) increased from 52.7% to 68.2%

HTPN actively participates in the NCQA Diabetes and Heart/Stroke Recognition Programs. The medical group significantly outperforms the Medical Quality Improvement Consortium (MQIC), a GE Healthcare data consortium, for both of these programs (see Figures 1 and 2).

Colonoscopy Withdrawal Time: Gastroenterologists are accountable for colonoscopy completion, complications, and perforation rates as well as colonoscopy withdrawal time. The current database measures the withdrawal time from the cecum on all patients. Results: All GI physicians in the endoscopy center have maintained a cecum withdrawal rate between 6 – 9 minutes for 99.8% of the colonoscopies performed between the periods of 2008 through 2011.

Colonoscopy Perforation Rate: The current database measures the perforation rate on all patients. Results: Quality measures for the endoscopy center for the periods 2008 through 2011 show that it consistently maintains a less than 1% perforation rate.

Care Standard Penetration:

Intensivist Model (Pulmonary Critical Care): Board-certified pulmonary critical care (PCC) physicians utilize an Intensivist model, developed in collaboration with the hospital system. PCCs work with surgeons to co-manage patients admitted to the ICU. This has enabled the system to lead the way in World Health Organization (WHO) quality measures for critical care. Results: Through the use of specific critical care bundles, ventilator-associated infections and central line infections have remained at zero. Patients experiencing Deep Vein Thrombosis have decreased significantly. The hospital system’s mortality rates as measured by the Hospital Standardized Mortality Ratio (HSMR) have decreased steadily from more than .90 HSMR in 2005 to .69 HSMR in 2011.

CMS Core Measures (Acute and Critical Care): Hospitalists are instrumental in the implementation of initiatives and processes to increase percentages of patients receiving quality acute and critical care interventions using CMS Core Measures. Results: Improvements for Core Measures met during the periods FY08 through FY11 for hospitalists:

- Acute MI all or none bundle – 93.8% to 98.1% met
- Heart Failure all or none bundle – 91.8% to 95.4% met
- Pneumonia all or none bundle – 87.8% to 92.1% met
- Combined Quality Index—a compilation of all the measures above plus surgical infection rates, etc.—remained steady at 94% met; significantly above the national average of 88.6%

Order Sets (CHF and PNE): Implementing an evidence-based, standardized order set has significantly improved outcomes for Congestive Heart Failure (CHF) and Pneumonia (PNE) patients, in addition to a reduction in mortality and readmission rates. Results: Physician order set use rates for PNE and CHF are 97.9% and 93.9%, respectively, contributing to the system’s reductions in 30-day readmission and mortality for both CHF and PNE patients (Figures 3 and 4).

Transitional Care – CHF: This program has significantly improved continuum of care for CHF patients in the hospital system by decreasing 30-day readmission rates and mortality. The group employs Advanced Practice Nurses (APNs) who perform transitional care interventions with elder patients, 65 years or older, who are hospitalized for heart failure. Results: CHF readmission rates are currently at an average of 9%, significantly below the national average of 23%.

Elder House Calls: This program serves the senior population with comprehensive geriatric assessment, regular visits for chronic medical problems/disease management, same-day visits for acute medical problems during regular business hours, 24-hour access via telephone and EHR, and coordination of home care. Results: HTPN’s readmission rate for this sub-segment of the entire house calls population is between 12%
and 14%, significantly lower than the national average of 35% and results in 80% of patients dying at their residence or in hospice rather than the emergency room or hospital.

Liver Transplant Biorepository: A resource bank of serum, cells, and tissue from previous transplant recipients and donors has led to collaborations with leading investigators around the country to pursue answers for transplant questions.

Results: HTPN recently began investigating the effect of Donor Specific Antibodies (DSA) in patients who chronically reject post Orthotopic Liver Transplant (OLT).

Organ Transplant Program: All hospital system transplant surgeons are employed with the medical group and have trained more than 36 transplant surgeons who now perform transplants worldwide.

Results: Three-year liver transplant patient survival rates are currently at 82.3%, exceeding the national average of 50% for patients undergoing transplantation.

<table>
<thead>
<tr>
<th>TABLE 1: HTPN Diabetes Recognition Program</th>
<th>Consortium</th>
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<tbody>
<tr>
<td>Total Points (Goal 75 or More)</td>
<td>85</td>
</tr>
<tr>
<td>Diabetes Patients</td>
<td>22,733</td>
</tr>
<tr>
<td>HbA1c Control &gt; 9.0% (Goal 15% or Less)</td>
<td>13.10%</td>
</tr>
<tr>
<td>HbA1c Control &lt; 7.0% (Goal 40% or More)</td>
<td>47.24% ✓</td>
</tr>
<tr>
<td>Blood Pressure &gt; 140/90 mm Hg (Goal 35% or Less)</td>
<td>22.15% ✓</td>
</tr>
<tr>
<td>Blood Pressure &lt; 130/80 mm Hg (Goal 25% or More)</td>
<td>49.55% ✓</td>
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<tr>
<td>Eye Examination (Goal 60% or More)</td>
<td>27.26% ✓</td>
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<tr>
<td>Smk Stat, Treatment (Goal 80% or More)</td>
<td>97.84% ✓</td>
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<tr>
<td>LDL ≥ 130 mg/dl (Goal 37% or Less)</td>
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<tr>
<td>LDL &lt; 100 mg/dl (Goal 36% or More)</td>
<td>59.55% ✓</td>
</tr>
<tr>
<td>Nephropathy Assessment (Goal 80% or More)</td>
<td>93.23% ✓</td>
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<tr>
<td>Foot Exam (Goal 80% or More)</td>
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<thead>
<tr>
<th>TABLE 2: HTPN Heart Recognition Program</th>
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<tr>
<td>Adult Heart Stroke Patients</td>
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<tr>
<td>Overall Percentage for BP Control (Goal 75 Percent)</td>
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<tr>
<td>Blood Pressure Control (Score 10 Points)</td>
<td>10 ✓</td>
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<td>Percentage with BP LT 140/90 Credit 1.00</td>
<td>77.69% ✓</td>
</tr>
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<td>Percentage with BP LT 145/90 or BP LT 140/90 Credit 0.75</td>
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<td>Percentage with BP GE 145/90 Credit .50</td>
<td>11.55%</td>
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<tr>
<td>Percentage with BP GE 145/90 Credit 0.0</td>
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<td>Percentage with Complete Lipid Profile (Goal 80 Percent)</td>
<td>84.92% ✓</td>
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<tr>
<td>Complete Lipid Profile (Score 10 Points)</td>
<td>10 ✓</td>
</tr>
<tr>
<td>Overall Percentage for Lipid Control (Goal 50 Percent)</td>
<td>73.93% ✓</td>
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<tr>
<td>LDL Control (Score 10 Points)</td>
<td>10 ✓</td>
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<tr>
<td>Percentage with LDL LT 100 Credit 1.00</td>
<td>67.61% ✓</td>
</tr>
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<td>Percentage with LDL LT 110 Credit 0.75</td>
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<td>Percentage with LDL LT 120 Credit 0.50</td>
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<td>Percentage with LDL LT 130 Credit 0.25</td>
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<td>Percentage with LDL GE 130 Credit 0.00</td>
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<td>Percentage on Aspirin or Antithrombotic Medication (Goal 80 Percent)</td>
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<td>Aspirin or Antithrombotic Use (Score 10 Points)</td>
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<tr>
<td>Percentage with Smoking Status and Cessation Intervention (Goal 80 Percent)</td>
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<td>Smoking Status and Cessation Intervention (Score 10 Points)</td>
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<tr>
<td>Total Score (Goal 40)</td>
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rate of 79.62%. Three-year kidney transplant patient survival rate is 94.7%, above the national rate of 91.7%. Heart survival is also above average for both one- and three-year survival rates.

**Efficient**

**Automated Audit Reports:** Online summary reports for Adult Preventive Health Services (APHS) and Disease Management measures for care sites and physicians have drill-through to patient detail. **Results:** The elimination of manual audits saves approximately $721,000/year and allows HTPN to broaden its APHS audit from a limited random sampling to now include all patient charts.

**Laboratory Services:** HTPN recently internalized all “laboratory services” for the medical group, significantly improving “test result” turnaround time. **Results:** Bringing laboratory services in-house saves approximately $500,000/year per lab. In addition, boosted lab employee morale has resulted in a significant improvement in lab quality.

**Reducing Care Site Start-Up Costs:** HTPN has pioneered a more-integrated approach to its new physician start-up process that includes: Physician Orientation, a two-day New Physician On-Boarding series, and a physician mentoring program. These programs have contributed to a decrease in care site start-up costs. **Results:** These programs offer new physicians the training and mentoring they need to build a practice in a more efficient and timely manner.

**Physician Job Sharing:** As a means to reduce costs and retain an aging physician workforce, HTPN now offers physicians the opportunity to job share. **Results:** A slight adjustment is made to reflect that there are some additional costs in having two physicians behave like one (i.e., extra benefits, malpractice, etc.), but overall, this strategy has been successful in not only retaining older physicians, but more efficiently leveraging the fixed costs of the medical practice environment.

**Equitable**

In addition to Surgery on Sunday, HTPN has expanded these initiatives:

**Volunteers in Medicine:** Since 1998, the Volunteers-in-Medicine (VIM) program has provided the medical group’s physicians and staff with opportunities to take part in the reduction of health disparities throughout our community and beyond. **Results:** More than 42% of our physicians and staff participated in giving back to the community through various community programs. Since FY01, the value of services donated by Volunteers-in-Medicine has topped more than $43 million. In FY11, they provided more than $11 million in community benefit. Based on the work done by VIM and Project Access, HTPN was awarded a $1.68 million, five-year grant which has enabled our medical group to improve access and quality of care delivered to low-income, minority, uninsured, and underserved people with diabetes.

**Outreach Programs:** Outreach clinics are located throughout the state and include: 13 Liver, 1 Kidney, and 1 Heart Failure (with an additional 2 liver clinics, 2 heart failure clinics and 1 kidney clinic planned). **Results:** The liver outreach patient volume has grown from 9 patients to almost 1,200 patients per year since 2006. Kidney patient volume is 47 patients, heart patients are at 7 with 2 of those patients receiving a heart transplant within the hospital system.

**Diabetes Health and Wellness Institute:** The hospital system invested $15 million to open a diabetes institute that serves patients in a low-income rural area. **Results:** In 2011, there were 1,409 patient visits to the institute; 463 of those visits were new patients.

**Patient-Centered**

In addition to Patient Satisfaction and Patient-Centered Medical Home initiatives, HTPN has expanded these initiatives:
EHR Scribes: Many primary care physicians have hired scribes to update patient records in the EHR during the actual patient visit. This allows physicians to spend more time in direct conversation with the patient. **Results:** Patient flow is improved and patient revenue has increased; on average, physicians have realized an increase in patient revenue of $35.15 per patient encounter.

Advanced Medical Planning: HTPN implemented an Advanced Directive initiative within its Elder House Calls program that works to ensure that elderly patients have an Advanced Directive on file. **Results:** Documented discussion of advanced directives has increased from 79% to 99%. The Do Not Resuscitate orders on file for elder patients also have increased from 54% to 71%.

Ambulatory Care Coordination: Ambulatory Care Coordinators (ACC) are placed in 49 care sites, supporting 245 providers. **Results:** Each ACC averages 65 patient contacts per day and has experienced many positive outcomes as a result of patient follow-up.

Secured Patient Messaging: More than 40% of patients receive secure messages—generally lab or other test results—from their physicians, courtesy of the EHR system. **Results:** Increased convenience for patients as wait times for lab and/or test results are diminished.

Generic Prescribing: HTPN has entered into an agreement with one of its payers that incentivize the organization and encourage physicians to prescribe generic medications when appropriate. **Results:** Physicians have increased their generic prescribing rate where appropriate from 62% to 72.7% for patients insured with the payer. As a result, patients have saved approximately $900,000 on prescriptions and the organization has earned $755,000 out of the $800,000 incentive.

Patient Portal: Patients have online access to their health and billing information through the use of a personalized log-in. **Results:** The patient portal has significantly enhanced services by streamlining efficiency through automated appointment requests and prescription refills, reducing call volume, allowing for more efficient response by staff, reducing costs, improving patient satisfaction, and enhancing revenue cycle management with self-service bill pay options.

Lessons Learned
The greatest lesson HTPN has learned along its quality improvement journey is that, while transforming health care is not easy, results of efforts can better the lives of patients. Some of the lessons they have learned on their journey toward an ideal healthcare delivery system are:

- **Put your patients first.** Their philosophy to do right by their patients and do it well has always been the guide when developing initiatives.

  - Encourage and empower employees at all levels. Help them to 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. Steps to improvement do not always have to be monumental to make a difference.

  - Teamwork and communication are crucial. HTPN's committee structure allows for leaders, physicians, patients, administrators, and staff to all come together as a team, 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. Cascading goals from top to bottom allows employees to set goals for themselves that they know will support the accomplishment of entity goals. It has worked to improve employee motivation within the organization.

  - Rounding is important. It has fostered communication among leaders, physicians, administrators, staff, and patients. It ensures that they are all listening to each other and sends the message that the organization cares.

  - 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 continues to astound with the boundless opportunities it offers 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.

- **Partner with health plans.** Works to improve care coordination for targeted patient populations across all care settings. This is an approach to accomplishing the same population health goals as accountable care organizations (ACOs). These partnerships are an excellent example of how health plans and physicians can work together to achieve a healthy, productive work force and create an ideal healthcare system.

**Advice for Implementing Change**

HTPN’s advice to others who are thinking of implementing a dynamic organizational environment is to anticipate the future of healthcare trends—nationally, state-wide, 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. The implementation of programs and initiatives did not happen overnight, but HTPN began efforts, first, by 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.

Patients are what drive their dedication and commitment to quality. Through the development and implementation of the STEEEP initiatives, HTPN knows they have improved the care delivered to patients and have given them the means to better manage their overall health and quality of life. The hope is that you give your patients a reason to trust in you by making it a part of your mission to provide care that is safe, timely, efficient, effective, equitable, and patient-centered. This can be accomplished by creating a participatory management structure that cultivates communication, empowering employees to develop improvement initiatives, involving your patients in redesign efforts, and implementing initiatives that benefit your patients and the communities you serve.

Lastly, we must listen and learn from our 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.

**References**

2. Ibid.
3. Ibid. Other initiatives are featured in the earlier article.

Adapted from the 2012 Acclaim Award Application from HealthTexas Provider Network submitted by Jean Sullivan, marketing manager. Data reflects as reported at the time of applying and do not include updated outcome data.