BEST PRACTICES

Managing Patients with Multiple Chronic Conditions

PRIMED PHYSICIANS CASE STUDY

Organization Profile

Based in greater Dayton, Ohio, PriMed Physicians is a community-based, physician-owned/led, independent medical group. Although the group has a close affiliation and working relationship with a nonprofit hospital system, its physicians have preferred to remain an independent organization to date.

PriMed is a primary care–based group with the majority of its 56 physicians in internal medicine, family practice, and pediatrics. The group also has a 7-person cardiology division that includes general and interventional cardiology; other disciplines include electrophysiology, endocrinology, and neurology.

Currently, PriMed has approximately 120,000 active patients.

Project Summary

In 2004, PriMed created a standing committee to organize and oversee a 10-year process to make substantial improvements in medical quality and cost-effectiveness. An early decision was to set a high goal for chronic disease success—that 90% of patients would reach the evidence-based standards. PriMed typically uses multiple evidence-based standards for the more complicated diseases.

Thus, for example, PriMed measures success in hypertension by whether the patient meets the Joint National Committee (JNC)-7 blood pressure (BP) goals, but uses the Minnesota "D5" goals for diabetes. The D5 standard includes BP, low-density lipoprotein (LDL), A1C, nonsmoking status, and aspirin or antithrombotic therapy. The D5 standard is an "all or none" standard in that failure in only 1 dimension marks the patient as "not at goal," even if the patient is successful in the other 4 dimensions.

PriMed uses the term WRAP, which stands for Wellness, Risk Assessments, and Preventive care. The organization set a goal to have 90% of patients meet the evidence-based WRAP standard.

PriMed aimed to implement care processes defined by using a combination of Lean and Six Sigma quality methods. The priority order for clinical work was as follows: hypertension, lipids, diabetes, osteoporosis screening and disease management, asthma, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, and the entire evidence-based standard for WRAP.

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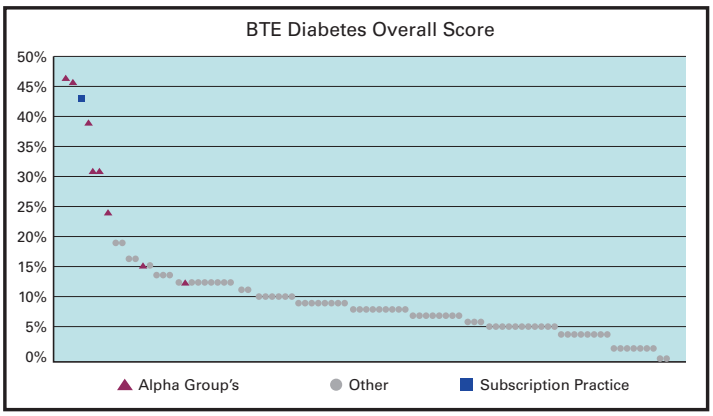
Program Goals and Measures of Success

The overall goal for PriMed was to be a national leader in chronic disease and WRAP outcomes.

The project began with a chronic disease process to address hypertension. A task force designed a "Hypertension Process" to be used every time a patient diagnosed with hypertension appeared for care. PriMed results are amongst national leaders—more than 90% of patients with hypertension are at the JNC-7 goal for BP. After hypertension, PriMed began work on diabetes and pediatric asthma, followed by osteoporosis and lipids.

With respect to diabetes, PriMed is currently compared to more than 350 doctors in its region who are measured and audited by the D5 standard process originally developed and currently used in Minnesota. As stated above, D5 captures and counts patients as successfully treated only if all 5 of the following criteria are met: BP ≤129/79; LDL <100; A1C <7; nonsmoker; and on aspirin or antithrombotic therapy. The group's results exceed the regional average by over 300%.

BTE indicates Bridges to Excellence.



It is extremely difficult to compare results with respect to asthma because the clinical benchmarks are harder to measure. PriMed is using the frequency and severity of exacerbations, especially those that require urgent care, emergency room care, or hospital admission. Unfortunately, there are no regional or national benchmarks to use.

Population Identification

As each chronic disease is addressed by the group through the creation and adoption of a formal process, the target population is all patients who have that diagnosis. To the extent that patients with a diagnosis require specific treatment modifications based upon comorbidities (eg, patients with hypertension who have either diabetes or renal disease), the population is identified based upon the diagnosis and any comorbid factors that affect treatment or goals.

Population Registries

Until 2010 or 2011, all chronic disease processes were implemented using a paper-based system as all clinical records were on paper. Thus, for the vast portion of the chronic disease improvement program, the development and use of a registry was paper based. Each office was charged with the responsibility to identify every patient who had a specific chronic disease. It was the obligation of the office to include the necessary forms and tools on the chart for the physician and others to fill out as the patients presented for care. Failure to have the formal process documentation on the official tools and included in the chart was recorded as a process failure. Different offices developed different methods to track patients and their chronic diseases but, in general, few failed to meet the documentation standard.

For the purposes of measuring group performance, every patient who presented for care, and had at any time been assigned 1 or more of the chronic disease diagnoses, was included in the measurements on a randomized basis.

PriMed stopped its focus on introducing more chronic disease processes while it implemented its Allscripts electronic health record (EHR) system. The rollout of the EHR was just completed, and the group is now shifting from manual, paper-based data extractions to extractions from the EHR database.

The Intervention

From the start of this 10-year program to improve clinical outcomes, PriMed has recognized the need to completely redesign primary care services. This is a very complicated and involved planning process and requires significant changes in how the group is paid by insurance carriers and the Centers for Medicare and Medicaid Services.

As anticipated, PriMed realized that spending the additional required time and resources on very difficult, high-risk, highly complicated patients is a cost to medical groups in a straight, fee-for-service payment model. However, there are benefits of this type of care and those benefits accrue to the insurance entity in reduced system costs per patient.

Also, PriMed discovered that providers simply did not have enough time to deliver all of the evidence-based required care for all of the diseases and WRAP unless they drastically reduced patient populations, which seemed unwise in the face of a declining primary care supply.

Thus, process redesign is centered on rethinking the care delivery team, adding other non-physician providers, obtaining new ways to track population information, and finding new ways to deliver care. All of these changes cost money and, thus, are linked to changing to new payment models for the group based upon improvements in the total cost of care for a defined population and achieving certain quality metrics.

Information technology

PriMed made the decision to delay implementing an EHR until the products were further refined and the group had more experience in medical quality. The group felt it would be a better customer for an EHR once the actual challenges of significantly improving quality in the day-to-day clinical practice were understood. In 2010 and 2011, PriMed implemented its EHR system and has completed its conversion from paper to electronic records.

PriMed has been involved for over a year in developing new forms of data gathering and analysis of its population in the effort to identify high-risk and high-cost patients, improve case and care management, and make other improvements in the cost and quality of care.

PriMed is presently rolling out additional care processes in accordance with the National Committee for Quality Assurance (NCQA) certification requirements for the Level 3 Patient-Centered Medical Home using the new 2011 standards.

PriMed also designed, implemented, and measured "meaningful use" of the EHR.

Workflow and process changes

PriMed's approach to patients who are unsuccessful in achieving the evidence-based standard is premised on the notion that (1) there are significant medical challenges that have not yet been addressed, and/or (2) there are personal, social, and emotional challenges that impede the patient's ability to succeed in care and therapy.

PriMed's present focus for improvement is to maintain contact with patients who have high-risk or high-cost diseases even if they fail to pursue care. The group has developed models for identifying these patients and is testing methods for reaching out to those who discontinue care for personal, financial, or other reasons.

Leadership Involvement and Support

Starting in 2002, formal and informal physician leaders began to participate in 2-day offsite leadership and group development sessions approximately every 4 months. In the interim, the board spent uncounted hours doing this same work.

In 2005, the group linked attendance at the monthly physician meeting to physician compensation. In these large group meetings and in section meetings, the physicians, leadership, and management discuss and plan future changes to care.

Moving from purely volume-based success criteria to value-based success criteria is a major challenge for medical groups and PriMed was no exception. The shift in paradigms from volume to value required the development of a new culture in the organization.

In the past, physicians tended to see their performance as a function of individual skill. Physicians were neither trained in, nor familiar with, processes, metrics, and other quality methods. As PriMed began moving more and more to a process approach, some complained that the process orientation impeded individual autonomy.

During the period of process deployment, it became clear that the vast majority of physicians were pleased with the changes in PriMed. They saw themselves achieving better outcomes and results showed fewer complications. The group decided, for example, not to recruit an additional interventional cardiologist because interventional volumes were being reduced. However, there were some physicians who decided to leave PriMed.

The amount of time given to group discussions related to the changing health care marketplace, pay for performance vs pay for volume, quality theory and methods, clinical issues, change management, EHR preparation, data analysis, and other topics has been and is considerable. PriMed is a physician-owned partnership, and the degree of change that it has achieved had to be supported by the majority of its members.

Lessons Learned

Several lessons are prominent:

1. Process is very important when conducting performance improvement.
2. No matter how much time you spend discussing and communicating change in health care, it is not enough. Spend all the time that you possibly can.
3. Improving quality costs money. Find new revenue sources quickly.
4. Past a certain point in quality improvement, you cannot stay with traditional fee-for-service payments. Groups need some sort of payment based upon cost and/or quality improvements.
5. Employers and insurers are interested in quality improvements, but they really need cost improvements.
6. Having Patient-Centered Medical Home status is a tool, not a goal. It is possible to be a patient-centered medical home and really “move the needle” in quality and cost improvement.

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