Laying the Foundation

Chapter FastFACTS

1. **Fundamentally changing your workflow can put your practice on the leading edge of QI strategy.**

2. **Frequent communication and access to resources help foster a culture of change.**

3. **Measuring how closely you are following the Chronic Care Model can help create an initial assessment of your practice.**

4. **Starting with general aim statements, then focusing on the ones that are most critical to your practice will yield the best results.**

5. **Using a deliberate strategy to analyze everyone's work and to determine how to reduce waste and eliminate duplication will improve your work processes.**

By the time Edward R. Sobel, DO, walks into the exam room, he has already reviewed his patient's lab tests and X-ray results in her EHR. Before his arrival, the nurse had reminded the patient to get a mammogram, had administered a flu vaccine, and had already scheduled her next visit. Consequently, Dr. Sobel is able to jump immediately into a discussion with the patient about her condition, conduct a thorough physical exam, and answer any questions she might have, all in a standard 15- to 20-minute session that doesn't feel rushed on either side.

Office visits weren't nearly this efficient or effective before

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Wilmington, Del.-based Family Practice Associates—where Dr. Sobel is one of five primary care physicians—invested in an EHR and reorganized the office workflow. Five years later, Dr. Sobel can't imagine working any other way. "I am not spending my time gathering information that someone else can gather," says Dr. Sobel, who is also medical director for Quality Insights

"**Originally, with QI,** a lot of the work primary care saw was very condition specific, like how do you improve diabetes or prenatal care. Now we're moving to a systems approach that says we need to fix the way we do medicine and how offices are run. It's a transformative process."

David Meyers, MD
Director, Center for Primary Care, Prevention, and Clinical Partnerships
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of Delaware, the state's Medicare Quality Improvement Organization (QIO). "Instead, I can spend my time, which is a higher-level time, interviewing the patient and making some clinical decisions. I more effectively use my time with the patient being a doctor versus being a data gatherer."

By fundamentally changing its workflow, Family Practice Associates is on the leading edge of the QI movement in primary care. Besides implementing an EHR, the practice uses registries to track populations of patients with chronic diseases such as diabetes or heart disease; participates in a Medicare demonstration project focused on preventative screenings; and connects with the state's regional health information exchange to receive lab results electronically in real time.

Technology is integral to the practice's success; but none of it would be as effective had workflow not been reorganized to redistribute more responsibility for patient care to non-physician staff, among other things. That's because engaging in QI is a fundamentally different approach to medicine that goes far

beyond setting specific goals or targeting certain diseases. "Originally, with QI, a lot of the work primary care saw was very condition specific, like how do you improve diabetes or prenatal care," Dr. Meyers observes. "Now we're moving to a systems approach that says we need to fix the way we do medicine and how offices are run. It's a transformative process."

Taking Stock

Before you engage in QI projects, use the same strategy that you would use before implementing an EHR: First analyze your practice's operations and workflow to see where you can achieve efficiencies and best integrate new tools and technology. You might consider participating in ACP's QI programs, which offer free Web-based training on implementing QI tools and techniques. There are two distinct programs—ACPNet, an AHRQ practice-based research network, which educates office-based physicians on evidence-based practices for specific clinical conditions; and Closing the Gap, which helps office teams develop strategies for implementing systems change. More information on both programs is available online (*http://www.acponline.org/running_practice/quality_improvement/*).

A workplace analysis is the first step for consultants at TMF Health Quality Institute, Medicare's QIO for Texas, which helps primary care practices implement and optimize use of EHRs. TMF ran Medicare's Doctors Office Quality-Information Technology (DOQ-IT) program in Texas from 2005 to 2008 and is now working with the state's federally funded regional extension centers to help 150 practices learn how to use EHRs to improve quality. "We visit a practice to do a readiness assessment, then evaluate the culture and how the staff will be affected by change," says Robert Ligon, director of health information technology (HIT) services for TMF. "We look at the current state of

the workflow on critical processes and map those out, then decide where they need to make changes."

As part of analyzing your practice, establish some underlying principles that will guide your planning process and help you develop specific goals, he says. A good place to start is the Institute of Medicine's six "aims for improvement." Although the report, "Crossing the Quality Chasm: A New Health System for the 21st Century," is a decade old, he says the points are still relevant. According to the report, an ideal system is one where care meets the following criteria:

- **Safe:** Avoids injuries to patients from care that is intended to help them
- **Effective:** Matches care to science; avoids overuse of ineffective care and underuse of effective care
- **Patient-centered:** Honors the individual and respects choice
- **Timely:** Reduces waiting for patients and caregivers
- **Efficient:** Reduces waste
- **Equitable:** Closes racial and ethnic gaps in health status

See "How to Set Aims: Five Tips from IHI" for more pointers.

You can silence naysayers and engage skeptics by fostering a culture of change. Do this by communicating with your team frequently and ensuring that everyone has access to necessary resources and training so that they understand the scope of what you're trying to accomplish. Note that you will be constantly testing and refining ideas—that you are in the process for the long term. Emphasize that you're not just trying to meet quality measurements, but moving toward a whole new way of working.

"There is a tendency for people to say, 'Okay, just tell me what to do.' They will change, but they want it spelled out," Dr. Meyers says. "That may be okay at first, but in general it's learning the process that's important. It's getting the mindset so that you're always looking at how you're doing and why something's not working so you can figure out what you want to change."

One way to make an initial assessment of your practice is to measure how closely you are following the Chronic Care Model (CCM). This model, first developed in 1998 (and updated in 2003 to reflect advances in the field) by Ed Wagner, MD, and colleagues at Group Health Cooperative in Seattle, is a central tenet of the PCMH and has been shown to improve patient out-

How to Set Aims: Five Tips from IHI

State the aim clearly. Teams make better progress when they are very specific about their aims. Make sure that the aim statement describes the system to be improved and the patient population. In addition, ensure that the aim gives guidance on the approaches to improvement.

Include numerical goals that require fundamental change to the system. Teams are more successful when they have unambiguous, focused aims. Setting numerical goals clarifies the aim, helps create motivation for change, directs measurement, and focuses initial changes. Including numerical goals also helps team members begin to think about what their measures of improvement will be, what initial changes they might make, and what level of support they will need.

Set stretch goals. A "stretch" goal, such as reducing patient waiting time for an office visit to less than 15 minutes within six months, is one to reach for within a certain time. Effective leaders make it clear that the goal cannot be met by tweaking the existing system. Once this is clear, people begin to look for ways to overcome barriers and achieve the stretch goals.

Avoid aim drift. Once the aim has been set, the team needs to be careful not to back away from it deliberately or drift away from it unconsciously. To avoid drifting away from the aim, repeat the aim continually. Start each team meeting with an explicit statement of aim, and review progress quantitatively over time.

Be prepared to refocus the aim. Every team needs to recognize when to refocus its aim. If the team's overall aim is at a system level (for example, "Reduce adverse drug events in critical care by 30% within 12 months"), team members may find that focusing temporarily on a smaller part of the system (for example, "Reduce adverse drug events for critical care patients on the cardiac service by 30% within 12 months") will help them achieve the desired system-level goal.

Source: IHI, http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/ tipsforsettingaims.htm.

comes. For example, health systems participating in Improving Chronic Illness Care (ICIC), a national program funded by the Robert Wood Johnson Foundation, were able to significantly decrease risk of cardiovascular disease among diabetes patients and reduce hospital stays for chronic heart failure patients by

implementing the CCM, according to a RAND Corp. evaluation of ICIC from 1999 to 2003 (*http://www.rwjf.org/pr/product.jsp?id=15009*). Similarly, a 2007 study of 30 small primary care practices, published in the *Annals of Family Medicine*, concluded that incorporating elements of the CCM is associated with better outcomes for diabetes care. The study reported that use of the CCM was associated with lower HbA1C values and lower high-density lipoprotein cholesterol. The authors noted that the results were not influenced by use of EHRs, suggesting that the benefit of EHRs is dependent on how they are used. Practices had to have a good process in place, such as flagging overdue screenings, in order to benefit from the technology.

Another study of 25 small practices, published in the May/June 2010 *Journal of the American Board of Family Medicine*, found an association between implementing CCM elements and providing appropriate diabetes care and counseling for overweight patients. While it is ideal to incorporate the model as a whole, the authors note that adopting one or more features made a difference in quality; the key was a staff that embraced change and learning. "A practice's openness to innovation can impact how effective a model is for improving care," the authors say. "Existing literature identifies characteristics of practice organization that may inform these processes, such as the nature of relationships among practice members, the practice members' ability to work as a team, and how a practice manages knowledge." A practice's "organizational systems to innovate and deliver high-quality care" should be a primary consideration in getting started, the authors add. For more about teamwork, see "ACOs Call for Teamwork."

The Specifics of Setting Goals

It's easy to agree on the general goal of providing better evidence-based care; but achieving it is still relatively rare among primary care practices, according to the National Committee for Quality Assurance's (NCQA) 2010 State of Healthcare Quality report. For example, despite evidence that counseling patients about weight control and smoking cessation is effective in preventing diseases such as heart disease, the report notes, only 42% of patients had their BMI measured during an outpatient

visit in 2009. And while most physicians advised patients to quit smoking, only about half went on to discuss treatments or programs that might help them, the NCQA reports. The report highlights the importance of setting specific goals—such as

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James Lee, MD
Associate Medical Director for Coordinated Care
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measuring every patient's BMI during office visits—to ensure that evidence-based practices are applied consistently.

Clinical Microsystems, a project of Dartmouth-Hitchcock Medical Center and Dartmouth College that provides tools for assessing, diagnosing, and treating your practice (see "Assessing Your 'Clinical Microsystem'"), recommends starting with a global aim statement that will provide focus and will help you stay on track as you implement quality initiatives. Together with your staff, try filling in the blanks on the following template suggested in the project's "Greenbook" workbook:

"We aim to improve (name the process) in (clinical location). The process begins with (name where) and ends with (name ending point). By working on the process, we expect (list benefits). It is important to work on this now because (list imperatives)."

Specific aim statements should address the following points, according to Nicole Van Borkulo, practice improvement specialist for Qualis Health, a Seattle-based Medicare QIO with offices in Washington, California, Idaho, Nebraska, and Alaska:

■ What is expected to happen;
■ The system to be improved or the population of patients;
■ Specific numerical goals;
■ Time frame; and
■ Guidance for activities, such as strategies, or limitations.

How to Get Started: Examples

It may be difficult to know where to start; but a good rule of thumb is to focus on one general theme at a time, such as workflow or patient access, then zero in on elements that would make the most difference to your practice. "It could be things like communication, phone messaging, prescription refills, or referral management," says Kevin Warren, senior vice president of operations for TMF Health Quality Institute (formerly the Texas Medical Foundation), the Austin, Tex.-based QIO for Texas. "You can talk through these items with your team and decide which one will give you the greatest win, which is the most complex, which are you hearing complaints about."

Improving your work processes "requires a deliberate strategy to look at everyone's work and figure out how to reduce waste and eliminate duplication," says James Lee, MD, associate medical director for coordinated care at physician-owned Everett Clinic, a multispecialty group practice with 16 clinics in and surrounding Everett, Wash. The clinics have streamlined processes and emphasized teamwork to free up physicians to spend more time on direct patient care during a regular office visit. In the traditional office model, the physician would have a chart in the office with checkboxes for preventive items such as mammograms and other needed tests specific to the patient's condition, he says. "But there would be no accountability for who was the right person to fill in those boxes, so it fell into the realm of the physician," Dr. Lee says. Instead, the office does extensive pre-visit planning to maximize efficiency when the patient visits the office. The key is making various staff members responsible and accountable for specific steps in the process.

ACOs Call for Teamwork

The NCQA is developing standards for Accountable Care Organizations (ACOs)—physician practices that improve patients' health and experience while reducing per-capita costs. Under the Patient Protection and Affordable Care Act, ACOs would share in Medicare cost savings. While ACOs are still in a preliminary state, NCQA's draft criteria for primary care ACOs emphasize team-based care that includes the following elements:

Roles: The organization defines the roles of clinical and non-clinical staff in job descriptions and emphasizes team-based care in evaluations. NCQA reviews the practice's job descriptions, outlining the roles and functions of team members.

Meetings and communication: Team meetings may include daily huddles or review of daily schedule with follow-up tasks. A daily huddle is a team meeting to ensure efficient patient visits by discussing patients on the day's schedule. A communication process may include e-mail exchanges or messages in the medical record about the patient. NCQA reviews the practice's communication process and an example of a meeting summary, agenda, or memo to staff.

Standing orders: Standing orders may be clinician pre-approved or executed as permitted by state law without prior approval of the clinician. Examples include standing test protocols, standing prescription orders, medication refills, vaccinations, and routine preventive services. NCQA reviews the practice's standing orders.

Care coordination: Care coordination may include obtaining test and referral results and communicating with community organizations, facilities, and specialists. NCQA reviews a description of training related to coordinating care and a schedule of trainings held.

Source: NCQA draft criteria for Accountable Care Organizations,
www.ncqa.org/publiccomment.aspx.

Meeting Financial Goals with Target Date Funds

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When a patient calls, for example, the receptionist reviews the EHR for missing tests and orders diabetes lab tests if needed. When the patient arrives, the medical assistant makes sure any other missing screenings, vaccines, or lab tests are ordered and makes appointments for follow-up tests. The assistant then prints out a summary for the patient to take home.

By getting the rest of the team involved in visit planning and assigning staff members ownership for specific steps in the process, Dr. Lee says he has been able to spend more time doing what he enjoys most: caring for patients. "I can focus on the work that's really relevant, which is sharing data with patients and having more detailed discussions with them about their goals and what they can do to improve their health," he says. "It frees up time and lessens the complexity of the process that the physician has to deal with every day."

Billings Clinic in Billings, Mont., recognized flaws in its work process for following up on lab reports and test results when the office was switching from paper to an EHR several years ago, says Douglas F. Carr, MD, an internist and the clinic's medical director of education and system initiatives. In the process of customizing its EHR, the practice realized that they had a "hit-or-miss way of doing things in the paper world," he says. There was no system for confirming that results were conveyed to the patient or that the physician had reviewed the information before it went into the file.

With the new processes implemented as part of adopting an EHR, lab and imaging results now go directly to individual physicians' EHR inboxes, where they are verified using Veriphy critical test result management technology offered by the speech and imaging technology company, Nuance, Dr. Carr explains. The technology allows physicians to send or receive test results securely via phone or computer and to automatically comply with HIPAA rules. When results are sent, Veriphy issues alerts to the receiving physician until the message is retrieved, then sends verification of receipt to the reporting clinician. The group is now working on making follow-up with patients more secure and reliable than e-mail or telephone by making the patient Web portal (where patients must sign in with a personal password) the preferred mode of communication for test results, Dr. Carr says.

Assessing Your 'Clinical Microsystem'

Clinical microsystems are the "building blocks that form practices," according to the developers of Clinical Microsystems, a project of Dartmouth-Hitchcock Medical Center and Dartmouth College that provides tools for assessing, diagnosing, and treating your practice. The Website's "Greenbook" worksheets recommend assessing your practice's need for change according to the "Five P's": purpose, patients, professionals, processes, and patterns. The workbook offers step-by-step instructions and tools for developing a detailed profile of your practice that will include the following:

Purpose: Define why your practice exists.

Patients: Create a picture of your patient population that includes data such as age distribution, top diagnoses/conditions, top referrals, and satisfaction scores.

Professionals: Create a picture of your practice that includes details on the responsibilities of each staff member, your business hours, duration of appointment types, number of exam rooms, etc. Consider whether the right person is assigned to the right task and whether all roles are being optimized.

Processes: Document the steps of each process and how long they take, and identify any points of delay or handoffs. Track the time of a visit, from check-in until patients leave the office.

Patterns: Identify the patterns in your microsystem on such metrics as access, morale, safety, etc. Ask the following:

- Does every member of the practice meet regularly as a team?
- How frequently?
- What is the most significant pattern of variation?
- Does your team discuss safety and reliability issues regularly?
- What have you successfully changed?
- What are you most proud of?
- What is your financial picture?

Source: "Assessing, diagnosing, and treating your outpatient primary care practice," www.clinicalmicrosystem.org. Click on materials/ workbooks to download the free guide.