QUALITY IMPROVEMENT IN DIABETES CARE

"Best practices" in diabetes quality of care among physician organizations

Jerry Penso, MD, Sharp Rees-Stealy Medical Group

Integrated Healthcare Association (IHA) "Best Practices" Study (2009)

California Association of Physician Groups (CAPG) 2010 Healthcare Conference: Diabetes "Best Practices" Workshop

Abstract

Objective:
To identify the practices in a physician organization that contribute to effective management of a diabetes population.

Conclusions:
Sharp Rees-Stealy Medical Group's "DM-9" program demonstrates improved diabetes quality scores among physician organizations. Key practices include:

1. Making the case;
2. Performance feedback;
3. Coaching and training;
4. Incentives and recognition.

Adhering to these core practices can change the culture of physician organizations. In addition to SRS's four core practices, SRS stresses the importance of a fifth: strong local physician leadership.

Introduction

Although there is a substantial body of performance analytics relating to diabetes quality of care, there is limited inquiry into the specific practices that physician organizations implement in order to achieve that quality.[1] To address this deficiency, this paper seeks to identify the practices in a physician organization that contribute to effective management of a diabetes population. Such practices can lead to better physician organization performance related to diabetes care in California.[1]

Sharp DM-9 Program Overview

Dr. Jerry Penso, Associate Medical Director, Quality Programs, at Sharp Rees-Stealy Medical Group (San Diego, Calif.), recently provided an assessment of "DM-9," an effective "real-life" diabetes program, at the 2010 CAPG Healthcare Conference. His presentation, summarized below, provides examples of successful educational concepts, strategies and tactics by physician organizations in California that report positive results in quality measurements for diabetes care.

Sharp Rees-Stealy Medical Group, with more than 400 primary care doctors and specialists, has been recognized by the Integrated Healthcare Association as a top performing medical organization in the state's P4P program for 2006–2009.[2] NCQA/IHA recently produced a report on "best practices" in diabetes care among physician organizations, and shared the findings of this report at the CAPG Conference.[1]

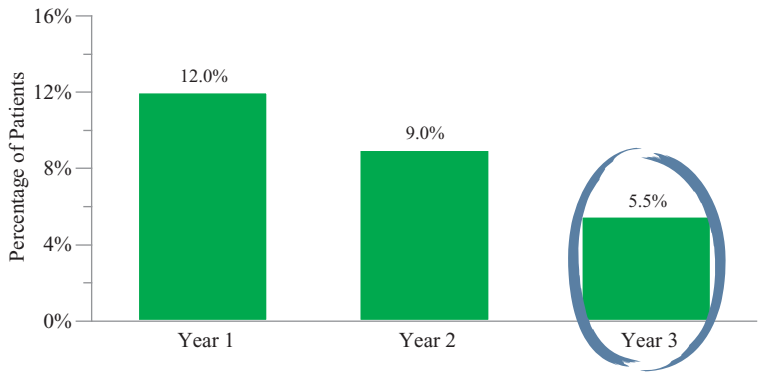
[1] *Diabetes Care in California: 2008 P4P Program Results and Findings of Best Practices Study, November 2009.*

[2] *The California Pay for Performance Program, The Second Chapter Measurement Years 2006–2009.*

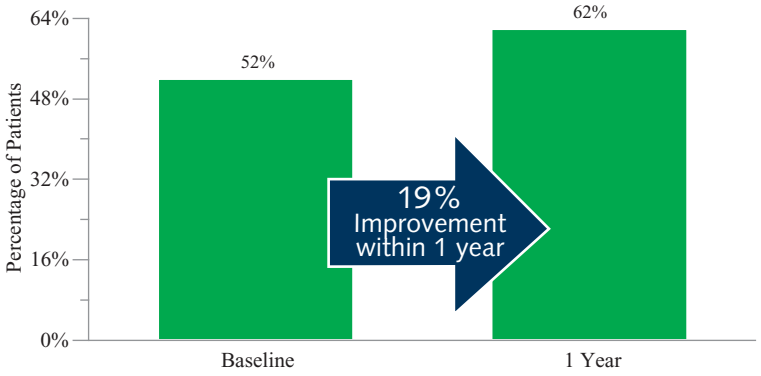
Sharp DM-9 Program: Results and Discussion

Sharp calls their program "DM-9," after that portion of their HMO/PPO patient population whose HBA1c control levels were >9.0%. The achievements of the DM-9 program were concentrated in clinical measures, but they could just as easily have translated to the patient experience:

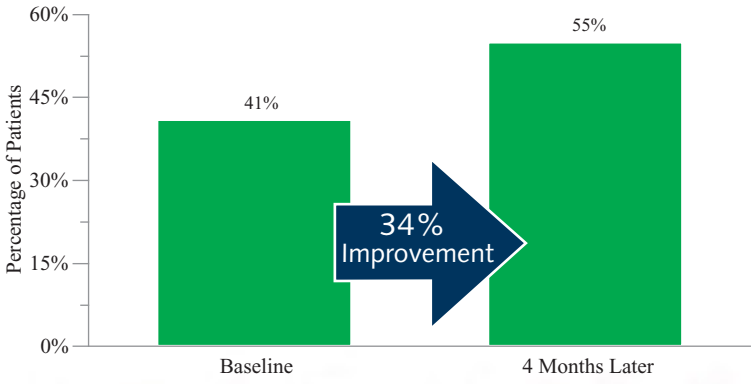
PERCENT OF PATIENTS IN POOR CONTROL[3]



<100mg/dL LDL PATIENT PERCENT[3]



<130/<80 mmHg PATIENT PERCENT[3]



❖ HBA1c Level Patient Share

In the first year of the project, the Sharp registry included 15,500 patients with diabetes, 12% of whom had HBA1c levels >9.0%. By year two, the percentage had dropped to 9%; by the third year, the percentage fell to 5.5%. The most recent share was 5.3%.

❖ LDL Control

Sharp likewise sought to address LDL control for HMO/PPO patients with diabetes or ischemic vascular disease. **The percentage of patients who achieved target LDL control grew by 19% in one year.**

- Sharp credits the improvement to the teamwork of quality department and nursing operations personnel, along with physicians, all of whom understood their role and knew from monthly feedback if it was working.

❖ Blood Pressure

Sharp's newest project, blood pressure, shows positive results:

- The project started at one site at a baseline of 41% of patients with systolic blood pressure <130 mmHg or diastolic blood pressure <80 mmHg.
- Within four months of the project's initiation, the percentage bumped up to 55%.
- The goal is 60% of patients; this has yet to be achieved. The program is expanding to the other Sharp Rees-Stealy sites.

[3] *Standards of Medical Care in Diabetes—2010. Diabetes Care. January 2010. vol. 33 Supplement 1 S11-S61.*

DM-9 Philosophy, Strategy and Tactics for Diabetes Quality Improvement

Physician Leadership: In addition to SRS's four core practices of effective diabetes care, the DM-9 program stresses the importance of a fifth: strong local physician leadership. Sharp Rees-Stealy has a designated physician leader at every one of its 18 San Diego County sites.

Making the Case: The first, most important step that leads to better results in changing our culture and outcomes is "making the case":

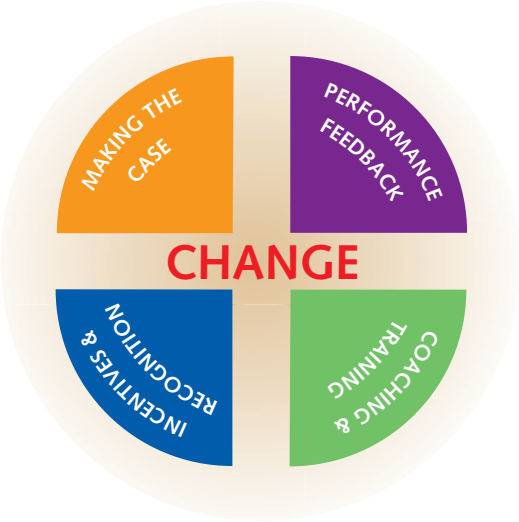
- Approach the physician organization in a way that resonates with physicians, administrative leaders and staff—otherwise, it won't work.
- Develop a 30-second elevator speech: "We are focusing on BP at Sharp, getting 60% of our patients at <130 mmHg or <80 mmHg. Right now, we are at 40% of patients. The reason we are doing this is because even a small decrease in BP can dramatically reduce the risk of heart disease, stroke and even death." Keep a positive attitude and an open mind among the staff. Provide very specific guidance.

Performance Feedback: Sharp keeps groups informed about exactly how they are doing, by site and by individual physician: What percent of patients is in the >9.0% "red zone," what percent is in the 7.1–9.0% "yellow zone," and what percent is in the ≤7.0% "green zone." Name names, and hand them out to everybody: physicians, nurses, even administrative staff. Everyone gets the report once a month.

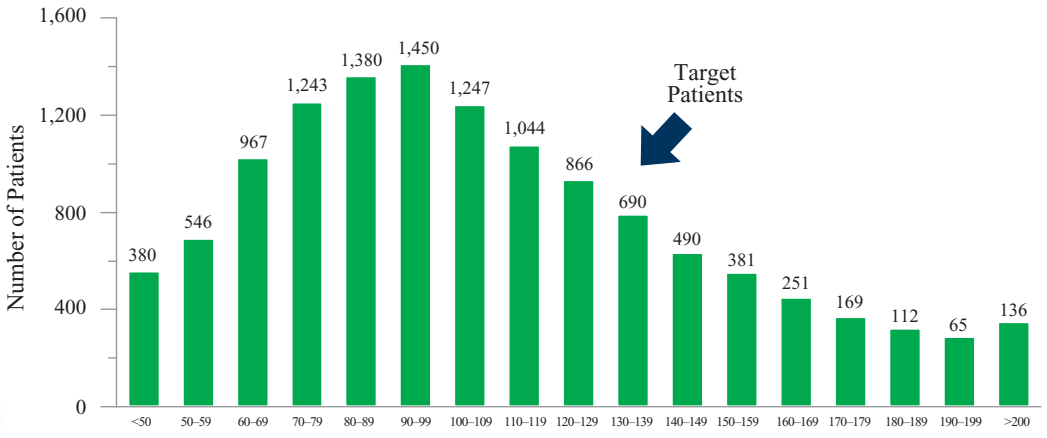
- This fosters friendly peer-pressure. But it is also a way of making transparent everything that is going on and where it is going, thus creating a "new norm."
- Sharp used Health Information Technology (HIT) to make the problem of high patient HBA1c levels apparent. All 15,500 patients with diabetes who had an LDL test in the past year were featured in a histogram, for example, that initially formed a bell-shaped curve.
- They used the histogram to focus their argument on the group of patients who were doing better, which shifted the curve to the left.

Pictured: L-R, Michael W. Murphy, President and CEO, Sharp HealthCare; Jorge Pelayo-Garcia, MD, a Physician Site Leader for Diabetes Management; Donald C. Balfour III, MD, President and Medical Director, Sharp Rees-Stealy Medical Group. Dr. Pelayo-Garcia received the Pillar award for Quality in front of 18,000 Sharp HealthCare employees.

DM-9 PHILOSOPHY, STRATEGY AND TACTICS FOR DIABETES EDUCATION



LDL CONTROL LEVELS, BY NUMBER OF PATIENTS

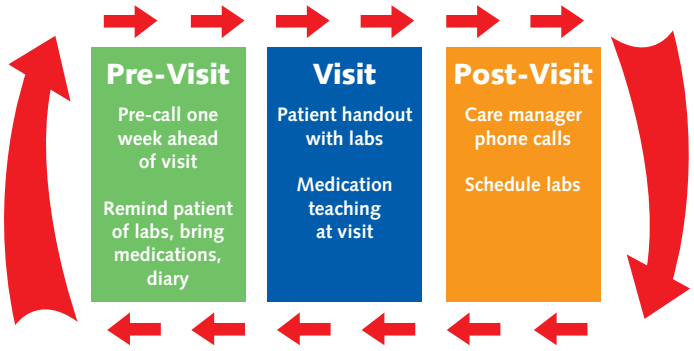


DM-9 Philosophy, Strategy and Tactics for Diabetes Quality Improvement *(continued)*

Coaching and Training: Have the right processes in place. DM-9 focused on plan visits: before, during and after the visit. Why? Patients typically spend, say, two hours during a physician office visit a year, but 9,000 hours on their own outside the visit. So Sharp changed the health care system to focus on before and after the visits. If you don't contact patients during these periods, the chances of behavior change are reduced. Think about it: it's hard to get to >9.0%. Patients are not watching their diet; they are not exercising. What are we going to do to influence their behavior?

- ***Pre-Visit:*** Sharp found that many >9.0% patients had not had appointments in one to four months. Get them an appointment! It is an easy fix. A third of these patients did not even have appointments on the books. Sharp provided a list of >9.0% patients who had not recently had appointments to the receptionists, then gave them a script. The receptionists then phoned these patients a week ahead to alert them of their upcoming visit, then asked if they had their labs. They encouraged the patients to bring a list of their medications to their appointment. This practice dramatically reduced no-shows. Sharp called this a "touch point": remind patients of what is really important.

DIABETES CONTROL — PLANNED VISITS



- ***During the Visit:*** They provided handouts to patients to let them know what their HBA1c levels were. Many of the patients did not understand what an HBA1c was or what it meant. They also trained the on-site nurses to start patients on medication at the time of their visit, so patients did not have to wait for a diabetes education appointment. It was a big barrier.
- ***Post-Visit:*** When Sharp started the DM-9 program it had one diabetes care manager; now there are five. These care managers follow up on every >9.0% patient after the visit. The managers are more like diabetes psychologists: they work with patients, overcome barriers, support them and remind them.

So the patient is being contacted before, during and after the visit. Then, to drive the point home, Sharp developed 3 Rules of Success for DM-9. They told their physicians that using these practices will dramatically reduce the number of >9.0% patients.

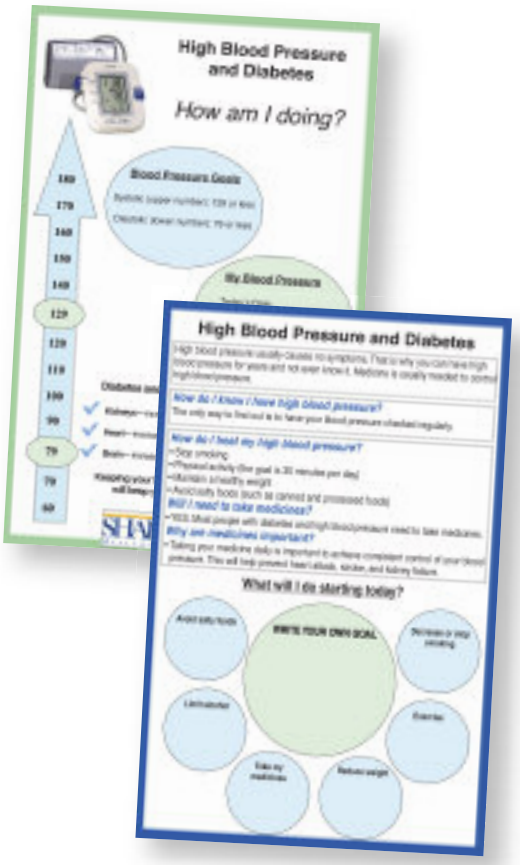
1. ***Appointment every four weeks.*** If patients are coming in every four weeks, and professionals are calling them before and after their visit, they are being touched 5–6 times per month. After 3–4 months in succession, control can improve. Patients get the message that the physician is not giving up on them. See patients every four weeks until the problem is improved.
   – Sharp provided double-sided handouts, in which they tried to make the message simple. Many patients do not know what their goal is. Sharp wanted them to know, because if patients do not know the goal or the number, they are not going to get there. They wanted patient engagement. This was a psychological goal, but they wanted to make it as apparent as possible and have patients engage by entering their own score. This practice creates a virtual cycle—nice feedback. The handouts, printed in color, were more expensive, but effective.

2. ***Laboratory every four weeks.*** Measure HBA1c levels every month for patients who are >9.0%. This is a controversial part of the program. But Sharp learned that this practice provides feedback to patients. Results improved within a month, as the practice encourages patients and changes the dynamic.

3. ***Titration of medication every four weeks.*** But they found that it wasn't that patients weren't prescribed the right medications—they just were not taking them.
   – LDL is a simpler issue. Many patients are taking their medications. Sharp provided physicians of high LDL (>100mg/dL) patients who had an upcoming appointment on the books a simple reminder to take an LDL test.

Incentives and Recognition: Sharp considers nonfinancial incentives—like simple recognition—preferable to financial incentives. Sharp talks about fostering an atmosphere of gratitude. Everyone likes being recognized. Hint: physician and administrative leaders send five handwritten thank-you notes a week, in which staff members are recognized for specific accomplishments. Sharp believes that it is the nonfinancial incentives that change cultures.

"It wasn't that patients weren't prescribed the right meds—they just were not taking them."



3 Rules of Success for DM-9

1. ***Appointment every 4 weeks***
2. ***Laboratory every 4 weeks***
3. ***Titration of medication every 4 weeks if needed***

Results of NCQA's study on high-performing physician organizations in California

Jennifer Benjamin, National Committee for Quality Assurance (NCQA)

IHA P4P Program Overview

The Integrated Healthcare Association (IHA) is a statewide leadership group that promotes quality improvement, accountability and affordability of health care in California. IHA is now in the seventh year of the Pay for Performance (P4P) program, the largest non-governmental physician incentive program in the U.S. It includes eight health plans and over 200 medical groups representing 35,000 physicians providing care for 11.5 million HMO members.

The IHA P4P program includes a comprehensive set of measures, including measures of diabetes care. Diabetes care clinical measures have gradually been added to the measure set since the program's inception in 2003. In 2008, IHA added the Coordinated Diabetes Care domain, "to promote process redesign to systemize and strengthen diabetes care in California."

Data from 2008 show that there are variations in diabetes care clinical measure rates across California regions and individual physician organizations.

- At the regional level, there is a 30 percentage-point differential in glycemic control rates (specifically, HBA1c range levels of <8.0%) between the lowest (in the Inland Empire and Los Angeles) and highest performing (in Sacramento and the Bay Area) regions in the state.
- At the group level, there is an 80 percentage-point differential between the lowest and highest performing groups in the state.

At that time, sanofi-aventis approached IHA to propose partnering with them to identify best practices in California in terms of how the diabetes population is being treated. More specifically, the partnership sought to determine which practices used by physician organizations contribute to better glycemic control in a commercially insured population. IHA subcontracted with NCQA to perform the analysis.

At the CAPG Conference, Jennifer Benjamin, Assistant Vice President, Strategic Initiatives, NCQA presented an overview of this publication "Assessment of 'Best Practices' in Diabetes Quality of Care among Physician Organizations." The purpose of this study was to determine:

- best practices of the high-performing groups,
- what they are doing that is different, and
- if there are any comparisons that could be made between and among them.

"...the purpose of the IHA P4P program is to determine the best practices of the high-performing groups, what they are doing that is different, and if there are any comparisons that could be made between and among them."

The study selected 15 groups each in the top- and bottom-performing quartiles to interview, ensuring that they had adequate geographic distribution and the state was well represented.

Of those 30 selected, 17 responded and participated in the interviews: Twelve high-performing and five lower-performing physician organizations.

Executive Summary: High-Performing Physician Organizations

The key is to convince medical and quality directors that diabetes program goals are top-down and part of the system. Which diabetes treatment system is in place and who is following it really makes a difference.

❖ Characteristics of high-performing physician organizations:

- Adopted more resource-intensive strategies
- Coordinated care by following "medical home" or "care team" models
- Emphasized patient self-management by offering classes and Web portals
- Developed interactive electronic platforms or EMR
- Focused on what works and further improvement

❖ Characteristics of lower-performing physician organizations:

- Struggled with limited resources, lots of challenges. (Within the first five minutes of the call interviewers would know from the group attitude if they were a low- or high-performing group. Yet high-performing groups were optimistic and had a can-do attitude: "What can we do with what we have?")
- Struggled with basic standards of care: regular screenings, reminders and follow-ups
- Had only partial or no electronic platform, registry, EMR
- Lacked support staff for care management, e.g., educators, case managers
- Were challenged by composition of patient population, e.g., SES, race, and low resources for quality improvement

Implications

❖ Patient engagement is key to managing chronic diseases.

❖ A team-based approach to caring for patients includes not only care coordination but also organizational support for good glycemic control—it is organization-wide, including specialists and hospitals.

"Best Practices" Associated with Good Performance

❖ Care management

- Well-coordinated "Care Team": PCPs, endocrinologists, diabetes educators, case managers
- Regular reminders and follow-up system
- Exchange of information between the PCP and the specialist; electronic tracking of referrals
- Systematic use of case managers and educators
- Diabetes clinics, group visits

❖ Patient resources

- Classes and education: value in diabetes patients working together
  – Lifestyle, cooking, diet, knowing numbers
- Patient self-management tools, e.g., Web portals, "health buddy"
- Tracking of class attendance
- Home visits by dietitians
- Translation services, bilingual staff

❖ Feedback mechanisms and rewards

- Routine reporting mechanism to doctors: weekly, monthly, quarterly—a lot of direct management of "outliers," if you will, to make sure they got the care they needed
- Unblinded and blinded reports; unblinded reports drive competition, so we have seen more of them in recent years
- Monetary rewards through P4P:
  – Clinical quality, performance improvement, patient experiences, use of information technology

❖ Health Information Technology (HIT)

- Key here is integration; cannot exist in a vacuum
- EMR or interactive electronic platforms
- Registries sometimes used in conjunction with EMR
- Supports care management
- Problematic to get older physicians to use electronic systems

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