Achieving Diabetes and Cardiovascular P4P Targets

Stephan Schwarzwaelder MS, RN, PMP
Program Manager Quality Metrics
Palo Alto Medical Foundation
Snapshot September 2014

- 970,000+ Active Patients
- 1,350+ Physicians
- 45% Primary Care 55% Specialties
- 4,500+ Employees
- 35+ Locations
- 46 Clinical Departments
- 25% HMO/ACO and 75% FFS
Do you sometimes feel Quality Metrics are not a Priority at your Organization?

- Competing priorities: Patient access, Cost reduction, Patient Volume, Organizational Change, Patient Satisfaction, Accreditation …
Do you sometimes feel Quality Metrics are not a Priority at your Organization?

A. Always  
B. Sometimes  
C. Rarely  
D. Never
How often do you feel that you are part of a group that strives to collaboratively achieve joint quality targets? ”
How often do you feel that you are part of a group that strives to collaboratively achieve joint quality targets?

A. Always
B. Sometimes
C. Rarely
D. Never

33%  33%  33%
Quality Metrics Steering Committee
(Outpatient Care)
Quality Leadership
Enterprise

Edward Yu
Medical Director of Quality,
PAMF, FM

Larry deGhetaldi
Chair, SMN Quality Committee,
Division President, Santa Cruz
FM

Local Leadership
Supervisors, Dept, Managers
Associate Medical Directors of Quality Division

Barry Eisenberg
Associate Medical Director of Quality, Medical Services, PAD; IM

Tim Lee
Associate Medical Director of Quality, Medical Services, CAD, Pediatrics

David Pilcher
Associate Medical Director of Quality, Medical Services, SZD - IM

Kuttancheri Rema
Associate Medical Director of Quality, Medical Services, ALD-Fremont, FM

John Smucny
Associate Medical Director of Quality, Medical Services, ALD-Dublin, FM
2014 PAMF Quality Recognitions

- **4 Stars (top rating)** on California’s Office of the Patient Advocate (OPA) website.
- “Quality Performer” award winner in IHA Value Based P4P Program. Only Group to earn this award 11 consecutive years.
- **High Quality rating** in the CMS GPRO Quality Composite Score. Top 1-2% of all participating provider organizations in the nation.
- **Elite status** for the 2014 CAPG (California Association of Physician Groups) Standards of Excellence Survey of Coordinated Care.
- **5-star rating** for its overall care of Medicare Advantage (MA) patients, as publicly reported on the Integrated Healthcare Association’s (IHA) website.
- Top score in 2014 **Consumer Reports Health Rating** of physician groups in Northern California. Ratings are based on patient experience.
Disease Management, Clinical Guidelines, Continuing Education

**Group : Endocrinologic Conditions (8)**
- Diabetes
- Endocrinology Hypothyroidism
- Endocrinology Type II Diabetes
- Endocrinology Workup of Hyperthyroidism
- Obesity Code on Patient Problem List
- Osteoporosis & Vit. D
- Weight Management -Fasting Glucose

**Group : Cardiologic Conditions (5)**
- AAA Screening
- Cardiology Low Risk Palpitations
- Hypertension
- Hypertension - Adult Primary Care
- Lipid Management for Adults

**EMR Disease Management Protocol for Diabetes**

Effective *Wednesday, May 22, 2002* any patient with a diagnosis of *Diabetes* (250.00-250.93) on the EMR problem list, will be automatically enrolled in a disease management protocol within the EMR. This protocol will assign five “Health Maintenance/Disease Management topics” to the patient record:

**Upcoming Grand Rounds**

<table>
<thead>
<tr>
<th>Quality</th>
<th>All items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention</td>
<td></td>
</tr>
<tr>
<td>MEC PIE - Education</td>
<td></td>
</tr>
<tr>
<td>MEC PIE - Reference</td>
<td></td>
</tr>
<tr>
<td>MSRA</td>
<td></td>
</tr>
</tbody>
</table>

- June Grand Rounds Power Point Presentation
- June Grand Rounds Webex Recording
The first step

“Priorities & targets”
Medical Director of Quality
My Mission & Vision

Achieve Better Outcomes

#1 Medical Group in Quality Outcomes in the Nation
Large number of quality metrics

How many metrics do you think PAMF is accountable for in 2015, for outpatient and inpatient care?
How many metrics do you think PAMF is accountable for in 2015, for outpatient and inpatient care?

A. Over 50
B. Over 150
C. Over 250
D. Over 350
Quality Target – Sutter Dashboard (Outpatient Care)

28 = Total Sutter Dashboard measures
19 = PAMF target for # measure above 90% rank
68% = PAMF target for % measure above 90% rank
Part of the Quality Dashboard in 2014

Right Care initiative Measures:

1. 75% of hypertensive patients with **blood pressure controlled**: <140/90 mm Hg
2. 70% of patients with cardiovascular conditions with **lipids properly managed** (proxy: controlled to LDL-C < 100 mg/dL)
3. 69% of diabetic patients with **blood sugar controlled**: HbA1c < 8
4. 56% of diabetic patients with **lipids controlled**: LDL-C < 100 mg/dL
5. 55% of diabetic patients with **blood pressure controlled**: <140/80 mm Hg
The second step

“Visibility of Care Gaps”
“It’s not enough to do your best; you must know what to do, and then do your best.”

— W. Edwards Deming
Making gaps visible
Do your care teams know during the year how they are performing on BP, A1c and LDL metrics AND which patients are measure non-compliant?
Do your care teams know during the year how they are performing on BP, A1c and LDL metrics AND which patients are measure non-compliant?

A. Real-time (24hrs)
B. Monthly updates
C. Periodical updates, less than monthly
D. Not really
Visibility of our current performance by measure, gap to P90 and EOY trend

- Example: 12 Medicare measures from the Sutter Quality Dashboard
- Scores for each Division

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**Medicare Measures**

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>AL</th>
<th>CA</th>
<th>PA</th>
<th>SZ</th>
<th>PAMF Total</th>
<th>2013 Percentiles</th>
<th>PAMF Patients away, P90 focus areas in Yellow</th>
<th>EOY Trend</th>
<th>Focus Area</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>50th</td>
<td>75th</td>
<td>90th</td>
<td></td>
</tr>
<tr>
<td>ABA Body Mass Index</td>
<td>99.52%</td>
<td>98.90%</td>
<td>98.19%</td>
<td>99.07%</td>
<td>99.06%</td>
<td>79.90%</td>
<td>97.17%</td>
<td>95.62%</td>
<td>-11</td>
</tr>
<tr>
<td>ART Disease-Modifying Anti-Rheumatic Drug Therapy</td>
<td>100.00%</td>
<td>79.41%</td>
<td>78.00%</td>
<td>100.00%</td>
<td>81.15%</td>
<td>80.31%</td>
<td>77.61%</td>
<td>93.56%</td>
<td>9</td>
</tr>
<tr>
<td>BCS Breast Cancer Screening Ages 42 - 69</td>
<td>92.93%</td>
<td>88.80%</td>
<td>92.91%</td>
<td>93.84%</td>
<td>93.86%</td>
<td>83.05%</td>
<td>85.43%</td>
<td>91.49%</td>
<td>-5</td>
</tr>
<tr>
<td>CDMM Eye Exam Done</td>
<td>95.23%</td>
<td>87.46%</td>
<td>93.13%</td>
<td>98.40%</td>
<td>80.70%</td>
<td>83.13%</td>
<td>73.53%</td>
<td>84.00%</td>
<td>-33</td>
</tr>
<tr>
<td>CDC Diabetes: HbA1c Poor Control &gt; 9%</td>
<td>10.39%</td>
<td>8.15%</td>
<td>11.25%</td>
<td>7.70%</td>
<td>7.72%</td>
<td>17.95%</td>
<td>17.35%</td>
<td>7.16%</td>
<td>8</td>
</tr>
<tr>
<td>CDC Diabetes: LDL-C Screening</td>
<td>86.61%</td>
<td>84.92%</td>
<td>92.15%</td>
<td>90.00%</td>
<td>85.16%</td>
<td>91.89%</td>
<td>95.66%</td>
<td>97.31%</td>
<td>-10</td>
</tr>
<tr>
<td>CDC Diabetes: LDL-C Control &gt; 100</td>
<td>81.94%</td>
<td>68.67%</td>
<td>77.52%</td>
<td>85.15%</td>
<td>73.86%</td>
<td>59.82%</td>
<td>69.55%</td>
<td>79.89%</td>
<td>-35</td>
</tr>
<tr>
<td>CDC Diabetes: Nephropathy Monitoring</td>
<td>86.61%</td>
<td>97.61%</td>
<td>100.00%</td>
<td>98.41%</td>
<td>95.45%</td>
<td>97.44%</td>
<td>95.12%</td>
<td>-1</td>
<td>-3</td>
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<tr>
<td>CDC Cardiovascular: LDL-C Screening</td>
<td>100.00%</td>
<td>88.87%</td>
<td>92.84%</td>
<td>90.00%</td>
<td>88.81%</td>
<td>93.02%</td>
<td>92.67%</td>
<td>93.10%</td>
<td>-1</td>
</tr>
<tr>
<td>CSM Colon Cancer Screening</td>
<td>86.85%</td>
<td>57.97%</td>
<td>81.69%</td>
<td>91.46%</td>
<td>89.47%</td>
<td>69.15%</td>
<td>72.24%</td>
<td>88.41%</td>
<td>30</td>
</tr>
<tr>
<td>CSM Bladder Cancer Screening In Older Adults</td>
<td>80.89%</td>
<td>65.64%</td>
<td>79.47%</td>
<td>88.82%</td>
<td>72.38%</td>
<td>69.42%</td>
<td>72.24%</td>
<td>79.93%</td>
<td>62</td>
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<tr>
<td>CMW Osteoporosis Management In Women Who Had a Fracture</td>
<td>12.50%</td>
<td>20.68%</td>
<td>20.00%</td>
<td>20.00%</td>
<td>23.76%</td>
<td>30.55%</td>
<td>73.87%</td>
<td>86.89%</td>
<td>64</td>
</tr>
</tbody>
</table>

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Predicted EOY Gap

Medicare diabetes and cardiovascular patients

Focus Area
Dashboards for each Department and monthly updated Patient Lists

<table>
<thead>
<tr>
<th>Type</th>
<th>PMF Measures Description</th>
<th>Status</th>
<th>Score</th>
<th>Patients Away EOT</th>
<th>P90</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic</td>
<td>Comm CDC: Diabetic: HbA1c Control &lt; 9%</td>
<td>18</td>
<td>35 51.43%</td>
<td>13</td>
<td>69.54%</td>
</tr>
<tr>
<td>Chronic</td>
<td>Comm CDC: Diabetes: HbA1c Screening</td>
<td>25</td>
<td>35 71.43%</td>
<td>15</td>
<td>95.10%</td>
</tr>
<tr>
<td>Chronic</td>
<td>Comm CDC: Diabetes: Nephropathy Monitoring</td>
<td>19</td>
<td>35 51.43%</td>
<td>24</td>
<td>94.12%</td>
</tr>
<tr>
<td>Chronic</td>
<td>Comm WW: AMR compliant total: 3-54 years</td>
<td>1</td>
<td>3 100.00%</td>
<td>3</td>
<td>100.00%</td>
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<tr>
<td>Chronic</td>
<td>Medicare CDC: Diabetes: Nephropathy Monitoring</td>
<td>7</td>
<td>9 77.78%</td>
<td>25</td>
<td>92.86%</td>
</tr>
<tr>
<td>Chronic</td>
<td>Comm CDC: Diabetes: BP Control &lt; 140/90 mm Hg</td>
<td>18</td>
<td>35 51.43%</td>
<td>28</td>
<td>96.00%</td>
</tr>
<tr>
<td>Chronic</td>
<td>Medicare CDC: Breast Cancer Screening: Ages 52-74</td>
<td>7</td>
<td>12 50.00%</td>
<td>21</td>
<td>36.36%</td>
</tr>
<tr>
<td>Chronic</td>
<td>Medicare CDC: POC RAS Antigens</td>
<td>0</td>
<td>3 0.00%</td>
<td>6</td>
<td>0.00%</td>
</tr>
<tr>
<td>Chronic</td>
<td>Medicare CDC: High-risk Medication</td>
<td>2</td>
<td>88 52.38%</td>
<td>245</td>
<td>95.00%</td>
</tr>
<tr>
<td>Chronic</td>
<td>Medicare CDC: Prostate Cancer: Ages 52-74</td>
<td>1</td>
<td>11 100.00%</td>
<td>30</td>
<td>35</td>
</tr>
<tr>
<td>Chronic</td>
<td>Medicare CDC: Adult BMI Assessment</td>
<td>161</td>
<td>155 65.16%</td>
<td>254</td>
<td>604</td>
</tr>
<tr>
<td>Chronic</td>
<td>Medicare CDC: POC Statin Medications</td>
<td>0</td>
<td>4 0.00%</td>
<td>6</td>
<td>0.00%</td>
</tr>
<tr>
<td>Chronic</td>
<td>Medicare CDC: Breast Cancer Screening: Appropriate Age 40+ Years</td>
<td>150</td>
<td>180 83.33%</td>
<td>375</td>
<td>446</td>
</tr>
<tr>
<td>Chronic</td>
<td>Medicare CDC: Cervical Cancer Screening: Appropriate Age - 24 Ages</td>
<td>60</td>
<td>61 99.17%</td>
<td>13</td>
<td>100.00%</td>
</tr>
<tr>
<td>Chronic</td>
<td>Medicare CDC: Colon Cancer Screening: Ages 52-74</td>
<td>24</td>
<td>27 92.59%</td>
<td>71</td>
<td>83.60%</td>
</tr>
</tbody>
</table>

Care Gap to P90

- Quality Dashboard only Patient List
- Anti-Coag Clinic Patient List
- Birthday Letter Order List.rpt
- Birthday Letter Outreach Template
- CA Anti-Coag Clinic Patient List
- Childhood and Adolescent Immunization Report.rpt
- Health Maintenance Topics Patient List
- HPSM Immunization
- P+P HPV Outreach
- P+P Metric Definition.rpt
- Patients Without Assigned PAMF PCPs.rpt
- Provider Attention Report
- Provider Attention Report Instructions
Visibility: Do you know what to do?

Why is this important?
High blood pressure is the most important risk factor for stroke.
7.6 million early deaths and 92 million disabled years are attributed to hypertension.
Diabetes can cause damage to, and narrowing of, large blood vessels, which can lead to heart disease, strokes, and/or amputation of a toe, foot, or leg.
It can also damage to small blood vessels, such as those in the kidneys or eyes, which can lead to blindness or kidney failure.

Quality Metrics: August 2014
CONTROL MEASURES
Who:
Patients with Diabetes and/or Hypertension
What:
For hypertension only patients:
These are new measures for 2014:
• Age 18-59, BP < 140/90 mm Hg
• Age 60-85, BP < 150/90 mm Hg
For diabetic patients (Ages 18-75):
• BP < 140/90 mm Hg
• A1C < 7% (Ages 18-65)
• A1C > 9%
There is also a new optimal Diabetes care:
Outcome Combination measure defined as:
• BP < 140/90 mm Hg AND
• A1C < 8%

What can I do?
• Follow clinical guidelines for both conditions
• Clinical Pharmacist available to provide telephonic medication management
At Present and Palo Alto, Champion Health Coaches available for patient action planning
Hypertension patient list will be available on launchpad site under the patient outreach folder

TIP SHEET
Documenting External Lab Results

Palo Alto Medical Foundation
Sutter Health
We Plus You
Visibility at Gemba walks
“Communication at the center of ongoing quality work”

• Gemba = Japanese term for "the real place" (where the work is done)
• Leadership discusses roadblocks with you and your team at your site
• Engagement through time-trended charts, e.g. SPC-Charts
The third step

“General Outreach Strategy and Tactics”
General Outreach Strategy and Tactics

General Strategy
1. Start early
2. Every patient counts!
3. Everyone (inc surgeons and specialists) can help: Remind everyone to close care gaps in Health Maintenance

Tactics
1. Visibility - monthly performance updates
2. Priorities for every month (e.g. Quality metrics calendar)
3. Provide monthly one pagers on measures, job aids and scripts
4. Visit care teams at their site (especially new staff)
Tactics: Multimodal Outreach Processes

Multiple Reminder Modalities

Epic Health Maintenance Reminders
Which Quality Outreach Reminder Approach is NOT used at PAMF?

A. Automated Phone Calls  
B. Personal Calls from Primary care Provider  
C. Personal call from Medical Director  
D. Notifications via health apps on smartphones, smartwatches and tablets
Which Quality Outreach Reminder Approach is NOT used at PAMF?

A. Automated Phone Calls
B. Personal Calls from Primary care Provider
C. Personal call from Medical Director
D. Notifications via health apps on smartphones, smartwatches and tablets
Quality Outreach Reminders

1. Automated Phone Calls
2. Personal Calls from Medical Staff
3. Personal Calls from Primary care Provider
4. Personal call from Medical Director
5. ‘Inreach’ – at any primary and specialty care appointment
6. Patient Portal E-mails
7. Snail Mail

Closing care gaps: Personal Calls from Providers have been most effective for us to encourage (almost all) patients

Effectiveness

<table>
<thead>
<tr>
<th>Method</th>
<th>Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Automated Phone Calls</td>
<td>50%</td>
</tr>
<tr>
<td>Personal Calls from Medical Staff</td>
<td>Highly effective, Last gaps</td>
</tr>
<tr>
<td>Personal Calls from Primary care Provider</td>
<td>10%, growing importance</td>
</tr>
<tr>
<td>Personal call from Medical Director</td>
<td>10%, 75% of our patients have an account</td>
</tr>
<tr>
<td>“Inreach” – at any primary and specialty care appointment</td>
<td>10%</td>
</tr>
<tr>
<td>Patient Portal E-mails</td>
<td>10%</td>
</tr>
<tr>
<td>Snail Mail</td>
<td>10%</td>
</tr>
</tbody>
</table>
The fourth step
Engagement & Motivation
Oppenheimer on Reality

“But Frank, we live in the real world.”

“No, we don’t. We live in the world we made up.”
Long Patient Lists
Providing excellent patient care: Sharing patient stories

I saw a patient from a different Division for an office visit.

His complaint was unrelated to his diabetes and hypertension.

I noticed that he was overdue for appropriate labs and stressed the importance of doing them the same day.

He had moderate renal insufficiency.

The patient was thankful that this was identified and could possibly be reversed with optimal control of his diabetes and hypertension.
Care team engagement through patient stories
‘A health coach patient story’

• The patient’s initial A1c was 10.3. After working with a health coach, the A1c got down to 6.9 in a span of 9 months.
• I got diagnosed approximately two years ago. My doctor started me off with exercise and diet. After 9 months we went with 2 pills, Metformin and Glipizide, and after 6 months she increased the doses. At that point she offered me a health coach, Grace.
• I started seeing Grace and she suggested dieting, walking and cutting out the junk food. So, I gradually cut out all the junk food. She also suggested to stop eating out – just once in a while. As the weeks went by we started increasing my walking and exercise habits.
• Grace and my doctor suggested a nutritionist. So, I signed up for that class. They taught me how my portions of food should be and that was an eye opener. I started eating a lot of vegetables and cutting out a lot of carbs. In the beginning it was super hard and I was always hungry! After a couple of months, your body gets used to it. I started increasing my walking to 3 miles a day. In the beginning it was tough, but you get used to it. Now it is easy. Sometimes I walk 2 times a day. I really owe a lot to Grace for her help. She kept me motivated. Actually my doctor and my nutritionist helped out a lot. You can say it was a team effort.
Motivation through Recognition & Celebrations

This certificate is awarded to

In recognition of your contributions to the
P4P Performance Improvement, Alameda Division,
Palo Alto Medical Foundation.

October 23, 2014

Edward M. Yu, MD
Sorensen, MD John
Ingo Tusee

NewsleRer	ar8cle
Changing our mindset: Motivation through continuous improvement

“Improvement isn’t an interruption to the work. Improvement is the work.” -- Thedacare RN
Patient Engagement
Assembling a team around a patient to be a proactive partner

- Health Coach
- PCP
- Flow Manager
- Community Health Resource Center
- Engaged Patient
- RN Education
- Clinical Pharmacist
- Care team outreach
Best Practice Ideas to Consider

- **Visibility** of targets, current performance and gaps
- **Actionable** information: Patient lists, What needs to be done? How can we do it?
- Build a **broad support team** for patient outreach. Include specialties
- **Multi-method** approach
- Continuous engagement and improvement, patient-focused, **at the Gemba**
- **Celebrate** success and **recognize** individual & team contributions
- Patient engagement through different contacts – system as a **proactive partner**
Questions?

Please feel free to contact me:

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schwars2@pamf.org