

AF4Q IN

**Aligning Forces  
for Quality**

Improving Health & Health Care  
in Communities Across America

# FOCUS



Robert Wood Johnson Foundation

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*Aligning Forces for Quality (AF4Q) is the Robert Wood Johnson Foundation's (RWJF) signature effort to lift the overall quality of health care in targeted communities, reduce racial and ethnic disparities in health care and provide models for national reform. Alliance teams represent the people who get care, give care, and pay for care.*

The 16 communities and people who engage in the unique work of AF4Q are not only open to new ideas, they are enthusiastically finding and testing them. Learn from their experience in areas such as:

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As the nation's largest philanthropy devoted solely to the public's health, RWJF has a unique capability and responsibility to confront the most pressing health and health care problems threatening American society. Their efforts focus on improving both the health of everyone in America and their health care—how it's delivered, how it's paid for, and how well it does for patients and their families.

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## Aligning Forces for Quality

Improving Health & Health Care  
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Aligning Forces for Quality (AF4Q) is the Robert Wood Johnson Foundation's (RWJF) signature effort to lift the overall quality of health care in targeted communities, reduce racial and ethnic disparities and provide models for national reform.

AF4Q asks the people who get care, give care and pay for care to work together toward common, fundamental objectives to lead to better care. The Foundation has made an unprecedented commitment to improve health care in 16 geographically, demographically, and economically diverse communities that together cover 12.5 percent of the U.S. population.

[www.forces4quality.org](http://www.forces4quality.org)

# Transform Care

We face a tremendous challenge in our country in delivering high-quality, affordable care to everyone. So the Robert Wood Johnson Foundation wondered: Can those who pay for care, provide care, and receive care come together and reach consensus about improving quality in their community?

These questions spurred the Foundation to create Aligning Forces for Quality.

Health care is a national problem, but it is solved locally, and transforming it requires local action.

Nationally, Aligning Forces for Quality (AF4Q) brings together 16 communities—touching 37 million people, 590 hospitals, and 31,000 primary care physicians—to provide a driving force in health care transformation.

Locally, each of those communities is taking on the complicated issue of improving quality of care by aligning their local partners to spark reform.

For instance, one key effort has been around public reporting. By measuring provider performance and providing data that were not available before, physicians and patients



in AF4Q communities are driving toward higher-quality care. The results of that work were visible at one clinic in Minnesota. Staff there saw dismal 1999 data showing that only 5 percent of their patients with diabetes were getting the necessary care, so they took action. After focused outreach and engagement, the 2010 data showed that a full 60 percent of all patients with diabetes were receiving all of the recommended care—an amazing testament to the power of public reporting and the teamwork that AF4Q alliances embody.

Stories like this one abound in the AF4Q communities. Sixteen are featured here, everything from Cleveland's initiative to use electronic health records to standardize the process for pneumonia vaccines to Puget Sound's work to develop measures of value in health care services.

It is our hope that these moments of success—as well as the moments of struggle—will provide a lens for others to use in thinking through their community-level efforts to improve the quality of care.

Sincerely yours,

Robert Graham, MD

Director, National Program Office

Aligning Forces for Quality





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# Bright Spots are Ideas that Take Flight

**E**very day, AF4Q communities are finding new ways of approaching old problems in our health care system.

There is no one road we must take to reach our goal of improving health care quality. How much simpler it would be if one community could blaze a successful trail, and then everyone could follow. We would like nothing more than to offer up the answers to the hard problems we face.

But of course, each community is different—in the illnesses that plague it, in the socioeconomic grid that affects it, and in the people who define it. There can be no formula for improvement, no one template for reform.

This is why we need creative laboratories like the 16 that compose AF4Q.

The bright spots featured in this magazine illustrate the type of ground-level innovation and experimentation going on every day, in ways big and small.

**They don't begin to cover all we have learned, but they begin to light the way.**





# Anything But Routine

Lovelace Westside Hospital Transforms Care at the Bedside

The demands on physicians, nurses, and staff in medical-surgical units can be intense. Juggling complex patient needs, making the rounds, following documentation requirements, and managing staff turnover in a fast-paced environment can leave little time for meaningful patient interaction or evaluating and improving patient satisfaction.

The care team at Lovelace Westside Hospital in Albuquerque, NM, faces the same challenges. But its health professionals are determined to devote the time and attention necessary to improve the quality of care and patients' experiences. The hospital is part of the Lovelace Health System, which includes six hospitals employing nearly 4,000 people throughout New Mexico and a health plan that serves 230,000 members.

Lovelace Westside Hospital also is part of the Transforming Care at

the Bedside (TCAB) initiative, which engages nurses and other frontline staff—with the support of hospital leadership—in the pursuit of patient-centered approaches that deliver high-quality, affordable care. As caregivers who spend the most time with patients and their families, the TCAB team of nurses at Lovelace Westside Hospital considers patients and family members as full partners in delivering care, not just recipients of it.

Initially developed and led by the Robert Wood Johnson Foundation (RWJF) and the Institute for Healthcare Improvement, TCAB is offered at Lovelace Westside through Aligning Forces for Quality, RWJF's signature effort to improve the overall quality of health care in the United States.

Through TCAB, the care team at Lovelace Westside set a goal to increase its score on the federally sponsored HCAHPS patient



## ALBUQUERQUE, NM

satisfaction survey, particularly in the areas of pain management and call button response time. Also known as the CAHPS® Hospital Survey, it gauges patients' perspectives on multiple factors related to their care experience. It also can give health professionals a blueprint for improving the quality of care.

To reach its goal, the Lovelace Westside Hospital team established "purposeful" rounding, or regular check-ins with patients. Research shows that hourly rounding within hospital units decreases call light use and the number of falls. It also improves patient satisfaction, team communication, and efficiency of care, like relocating equipment and supplies or redesigning medication processes.

Rounding is by no means a new concept, but Lovelace Westside Hospital's effort takes it to a new level. Through purposeful rounding, nurses visit patients in their rooms every hour during the day and every two hours at night. Through rounding, nurses are more able to address patients' needs proactively and ask them about their overall experience, including satisfaction with call button

response and educating them about managing their own care once they are discharged.

To ensure the visits are as productive as possible, the TCAB team originally developed a form that included 15 topics for nurses to cover with patients.

However, the team soon realized that with a ratio of six patients for every nurse, a visit during rounds could

"We know hardwiring something is very difficult, but we want this kind of interaction with patients to be the normal course of business."

last just a few minutes. As a result, compliance with the form became a challenge because it was considered too long and cumbersome.

"Frankly, our original form wasn't purposeful," said Rebecca Gallegos, director of inpatient services at Lovelace Westside. "You can't accomplish a lot if you provide too much for someone to do or too many things to check for. When we made it more specific, we saw the improved results."

To streamline the process and improve compliance, the team refined the checklist based on the "3 Ps"—pain, potty, position—to determine accurately and quickly what a particular patient might need.

"We were rounding according to plan, and when there wasn't compliance, we reminded staff constantly," said Gallegos. "Slowly, we saw it take hold. We saw improvements, but we also learned how to make adjustments to serve patients better. For example, at first we conducted rounds hourly—day and night. Patients didn't like nurses going in their rooms so often at night, so we extended visits to once every two hours."

Rounding also can avert crises. For example, a staff member walked into a post-surgical patient's room during rounding and discovered the oxygen was not connected properly. The patient was sleeping, and the problem could have gone unnoticed for too long. The need for oxygen is greater in the first 24 hours after surgery to help address respiratory issues and pain management. Thanks to diligent rounding, the oxygen was reconnected and a potential emergency avoided.

Since Lovelace Westside Hospital launched its purposeful rounding, it has seen improvement in its HCAHPS ratings. All the scores that were a primary focus for improvement through the rounding effort reached the 90th percentile, well above the national average. Program managers attribute improvements, such as the decrease in call button use, to the fact that patients





know someone will be visiting their room frequently.

The hospital also saw an increase in its patient rating for courtesy and respect. “One of the biggest results we saw was a sense of increased respect for nurses,” said Nancye Cole, chief operating officer and chief nursing officer at Lovelace Westside. “The more often nurses were in the room, the more respect we saw from patients and families.” Patients’ and families’ increased perception of nurse courtesy and respect were reflected in the HCAHPS survey results.

As anyone working in the health field can attest, change is hard, but purposeful rounding has been worthwhile.

“We took TCAB to heart. It’s not just a term, it’s a methodology, and it has to be followed in order to work,” said Cole. “We know hardwiring something is very difficult, but we want this kind of interaction with patients to be the normal course of business.”

TCAB’s impact on the culture at Lovelace Westside is evident. Employee satisfaction has more than tripled to 95 percent, and perceptions of organizational engagement with staff have more than doubled, to 97 percent.



The approach now has become a hospital-wide standard for patient interaction, and it is being considered for further expansion within the entire Lovelace Health System. The team at Lovelace Westside Hospital also shares its approach during national TCAB conferences, emphasizing the ‘3 Ps.’ Cole said it may seem obvious, but many nurses overlook the simple questions that can make a big difference.

Cole shares an analogy to drive home the point. “When you’re at a restaurant

and you order your food and a waiter brings it to you, he or she typically asks a set of key questions to make sure you have everything you need to enjoy the meal,” said Cole. “But, if the waiter walks away without asking the key questions, you have to get their attention if you need something. The same goes for nursing care. If you ask pertinent questions to see if there is anything else you can do for patients, including the ‘3 Ps,’ you give them time to reflect on what they need, and you can improve their experience.”

## Lessons Learned

■ When we saw a drop in scores this past May and June, we quickly reviewed cause. We implemented both the new EMR and a new call light system, which turned out to be inaccurately wired. The nurses seemed to rely on the new call light system instead of their purposeful rounding; it didn’t work. Technology is not always the answer! Patients want to have their caregivers respond quickly. If the system isn’t working, don’t give up on the active rounding independent of the call lights.

■ TCAB really can be used across the entire hospital, not just by nurses. We have spread it to the ED and the OR. It is a type of shared governance that empowers the frontline.

■ It is natural for leaders to want to “control and drive” processes on their units, but TCAB is really not designed that way. The true success of TCAB is to be frontline nursing-driven—peers engage peers much easier than directors and managers.

■ It is imperative the chief nursing officer lend his or her support to make an impact on a higher level. We are best cheerleaders not only for our staff, but also for other facilities and our corporate bosses.

# ENGAGING HOSPITAL VOLUNTEERS AND PATIENTS TO IMPROVE CARE

**A**t Mercy Health-Anderson Hospital in a suburb of Cincinnati, OH, a new council composed of hospital volunteers, staff, and leadership is helping to improve the experience of patients and their families. Known as the Patient Family Council, many of the volunteers participating on the council were once patients or are family members of former patients. The group meets once a month to discuss how best to achieve goals like making sure patients receive the information they need during the hospital discharge process and reducing the noise levels in the hospital at night. Members of the council say the discussions have greatly enhanced communication among patient and family volunteers and staff members and led to an increased awareness of patients' needs and perceptions.



“We realized when we were starting the council that our volunteers could be a tremendous resource. A lot of them have family members who are patients, or they’ve been patients here themselves from time to time. They care about the

hospital and have firsthand insight on what goes on here,” said Sarah Varney, RN, a telemetry clinical coordinator at Mercy Health-Anderson Hospital who helps facilitate the Patient Family Council.

Varney works in a medical/surgical unit that was selected to participate in Transforming Care at the Bedside (TCAB) in 2009. A national program initiated by the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement and offered to Mercy Health-Anderson through the Foundation’s Aligning Forces for Quality program, TCAB engages nurses and other frontline staff in hospitals to develop and lead quality improvement initiatives. In her role as a member of Mercy Health-Anderson’s TCAB team, Varney proposed launching a council that could provide feedback on quality and safety improvement efforts.

The council held its first meeting in February of 2011. The largest meetings have included up to 25 people, but five core members attend on a regular basis. In addition to the volunteers and



the nurses from the TCAB team, representatives from departments such as housekeeping and physical therapy have recently been joining in the discussions.

“It’s a very open forum where we can share our feedback and come up with suggestions for better ways of doing things,” said Charlotte Smith, a council member who volunteers at the hospital. “As volunteers we have the luxury of being able to spend more time with patients—we talk with them and help them calm down when they’re upset, and we find out what they want or need. That’s why we can act as the patient advocates on the council.”

Smith was inspired to start volunteering at Mercy Health-Anderson in 2010 because she felt her elderly mother had received excellent care during several emergency room visits that took place before she passed away. Smith also has a personal connection to the hospital because her husband had outpatient hernia surgery, and she has undergone several outpatient tests there.

At the council meetings, the TCAB team asks the volunteers for their input on changes they’re thinking of implementing and for their help brainstorming solutions to problems. Council members also work together to evaluate new equipment—such as visitor chairs, bedside tables, and fall mats—that the hospital is considering purchasing.

The volunteers on the council helped the TCAB team understand that patients sometimes felt rushed during the discharge process and didn’t always receive and understand all the information they needed about their medication or how to pursue follow-up care. As a result, the TCAB team started a trial in which both the nurse and the doctor together are involved in discharging a patient.

“Based on ideas that came from the council, we’ve changed the educational materials we give the patients when they are discharged—for instance, we give them more detailed information about their medication and potential side effects,” Varney said. “We also compiled a list of local primary care providers (PCPs) who are accepting new patients because we’ve learned that a lot of our

patients do not have a PCP.”

Another idea that came out of the council’s discussions was that nurses should try to spend at least five minutes at the patient’s eye level—for example, when they’re taking the patient’s history during the admission process. “Sometimes we’re so busy running in and out of the room that we don’t realize we’re losing the connection with our patients. But we did a trial in which we tried to spend five minutes at their bedside, and it led to a culture change on our unit,” Varney said. “It increased our awareness of the impression we make on patients.”

Smith and the other volunteers shared their observations with the council that patients sometimes didn’t realize care providers had come by during hourly rounding. “Because they were groggy and not feeling well, they didn’t notice certain things that were happening, and they would say, ‘Nobody has been here to see me all day,’” Smith explained. Now the volunteers leave a note card that says someone stopped by and will be back in an hour if the patient is away from their bed or asleep when they stop by. The card also includes a phone number for the patient to call if they need help in the meantime. “We’ve received positive feedback from patients and family members about the card. We want to make sure they know we care and we’re there for them” Smith said.

Staff members have taught the volunteers on the council about TCAB processes, including small tests of change and “snorkel” (or brainstorming) sessions. They also share Mercy Health-Anderson Hospital’s patient satisfaction scores at council meetings.

Patient satisfaction scores as measured by the Hospital Consumer



Assessment of Healthcare Providers and Systems (HCAHPS) Survey increased during the year after the Patient Family Council started meeting. For example, from January 2011 to December 2011, the score for “communication with nurses” went from 69 percent to 88 percent, and “would definitely recommend the hospital” went from 64 percent to 81 percent.

Terri Martin, RN, BSN, MBA, clinical director at Mercy Health-Anderson Hospital, believes the work of the TCAB team and the council helped boost the scores. “The small tests of change to improve our processes that were driven by the frontline staff have been improving the patient experience,” she said. Martin noted that in the future the council hopes to recruit some patients who don’t volunteer at the hospital to serve as additional members and share their points of view.

“Partnering with the volunteers to start the council couldn’t have worked out better,” Martin said. “They were thrilled to have a voice on the council, and they are invested in the hospital and want to see it succeed.”

The TCAB team has presented its Patient Family Council successes to the leadership team at the hospital, the Greater Cincinnati Health Council, the Catholic Health Partners 7th Annual Patient Experience Forum, and on conference calls for TCAB teams in Minnesota and Wisconsin.



## Lessons Learned

■ When you’re trying to start a patient and family council, you need to make it a high priority. Because the hospital staff members who will be participating are so busy and have so many competing priorities, the council may not get off the ground unless you’re really committed to the effort at the beginning.

■ There are many benefits to recruiting hospital volunteers to serve on a council. For example, they’ve already had training in complying with the Health Insurance Portability and Accountability Act, they are familiar with how things work at the hospital, and they feel invested in the hospital. They have a unique perspective because they work so closely with the patients, and some have been patients themselves. And since they choose to spend time volunteering at the hospital, they have a positive attitude that helps to keep the council productive.

■ Keep the discussions at council meetings at a level the volunteer and patient members can understand. Don’t get too carried away with using medical terminology, for example, or get too detailed in your discussions of HCAHPS Survey scores.

■ Create an environment in which the discussion can be very open and people can say what’s on their minds. It’s important for the volunteers to feel they can give honest feedback to the staff, and building trust is a key factor to get to this point.

■ Over time, the volunteer members of the Patient Family Council can take on a bigger role in guiding the discussions at the meetings, and they will value this opportunity.





**P**neumonia can be a life-threatening infection for anyone, particularly for individuals with diabetes. People with diabetes are three times more likely to die from influenza and pneumonia, yet only one in three have been vaccinated to protect against an important bacterial pneumonia, according to the Centers for Disease Control.

Providing pneumonia vaccines to patients with diabetes is among the nationally endorsed quality standards for diabetes that *Better Health Greater Cleveland* measures and publicly reports twice a year. It's also the measure that blazed the trail for *Better Health's* development of Replicable Best Practices.

*Better Health* is a nonprofit health care improvement organization that was established in 2007 under the Robert Wood Johnson Foundation's

# Sharing

# Best Practices

to Protect Patients from Pneumonia



## CLEVELAND

national Aligning Forces for Quality initiative. Data provide the foundation for *Better Health's* multiple initiatives to improve the quality and value of health care. Twice a year, *Better Health* measures and publicly reports on the care delivered by nearly 500 primary care providers in 46 practices for patients with diabetes, heart failure, and high blood pressure. Administering a pneumonia vaccine for diabetes patients has been one of the measures since *Better Health's* first public report in 2008.

### TREND SPOTTING

Before each public report, or Community Health Checkup, *Better Health* aggregates the data its clinical partners submit from their electronic health records (EHRs) and analyzes them to identify trends and patterns to share with the community. Did the region improve in the number of patients whose high blood pressure is under control? Are we making progress in reducing the disparities in care and outcomes we see among different groups of patients?

*Better Health* also looks at the achievement of each physician

practice—the percentage of their patients who meet or exceed the particular quality benchmark—and their improvement on the metrics from the previous report. The director of *Better Health's* Data Management Center was reviewing the diabetes data for its second report in January 2009 when he spotted a notable pattern: The nine top-achieving practices for pneumonia vaccination rates among 35 practices were part of the same health care organization, The MetroHealth System. Its rates had climbed from less than 30 percent to more than 85 percent.

Randall D. Cebul, MD, director and president of *Better Health*, asked MetroHealth, “What did you do, and how did you do it?”

### USING EHRs TO STANDARDIZE PROCESS FOR VACCINATIONS

Kathleen Lehman, RN, now senior clinical efficiency analyst in strategic planning at MetroHealth, offered a clear answer to those questions. She had noticed pneumonia vaccination rates were extremely low and did not meet standards of the Centers for Disease Control. She led a team that used technology—MetroHealth's electronic





health record, or EHR—to boost vaccination rates.

“We created a report every Friday of any patients who were scheduled to come in the following week, so we could pre-identify who was coming in Monday and know for that week who needed the vaccine,” she said.

When patients on the list checked in at the front desk, staff handed them a brochure about the pneumonia vaccine and told them they fit the criteria of someone who should receive the vaccine. Physicians had written “standing orders” authorizing nurses to offer the vaccines and administer them, and then nurses documented patient consent and administration of the vaccine in the EHR. The new process sounds simple, but Lehman said a number of detailed steps were involved that required teamwork and follow-through.

The results were dramatic. In 2005, MetroHealth had identified 6,000 high-risk patients who needed the vaccine. “Prior to the intervention, we had only vaccinated 27 percent of this group,”

Lehman said. “After the new protocols, we vaccinated 70 percent of the high-risk group in the first year and 90 percent of this group in 2009.”

When Lehman explained the process to Dr. Cebul, his next question was whether *Better Health* could share MetroHealth’s protocol with other practices so they could replicate it to improve *their* vaccination rates. Lehman and MetroHealth agreed.

“This was everyone’s success. It was administration’s job in identifying who was at risk. The medical assistants had to answer questions. The nurses and providers were great in reinforcing the importance of this. That whole team approach was very helpful in getting everyone engaged, and it led to better patient care.”

To begin to disseminate the “Replicable Best Practice,” MetroHealth’s accomplishment was recognized at the community-wide meeting at which *Better Health* shared highlights from the new report. When the bar graph was projected showing nine top-achieving practices in orange, Dr. Cebul asked Lehman, once again, to answer the question, “How did you do that?” The results and protocol also were shared

in other *Better Health* meetings and Community Health Checkups.

Subsequent reports show the impact of MetroHealth’s successful quality improvement initiative soon was multiplied across northeast Ohio. Vaccination rates of practices in other health systems have climbed from 70 percent to 82 percent in just three years.

MetroHealth has sustained its high rates, which also is a significant accomplishment. Lehman says that ongoing coaching, encouragement, reminders, and dialogue across staff at all levels are required to keep the momentum going and ensure the intervention

becomes embedded in a practice. “Our patients might not be thinking about health maintenance, but it’s everyone’s job here to make sure as many people are being immunized against pneumonia as possible,” Lehman said.

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#### LOOKING FORWARD

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Lehman and her colleagues presented their successes in driving



## CLEVELAND

up pneumonia vaccination rates at a recent American Academy of Ambulatory Nurses national conference. While EHRs were a key, Lehman said the job got done because of team work. “The responsibility didn’t rest on one person’s shoulders,” she said. “This was everyone’s success. It was administration’s job in identifying who was at risk the medical assistants had to answer questions the nurses and providers were great in reinforcing the importance of this. That whole team approach was very helpful in getting everyone engaged, and it led to better patient care.”

*Better Health* has identified other instances of best practices that were uncovered in mining the data. Like the cluster of higher vaccination rates, these Replicable Best Practices were verified and disseminated through a variety of channels. Increases in achievement across the region followed.

In one, Kaiser Permanente of Ohio had the top eight physician practice achievers in an early report on *Better Health’s* process measure for managing kidney health in diabetes patients. The achievement was traced to a mnemonic and to EHR-powered outreach to patients who needed treatment or were due for testing. Three years later,



after Kaiser shared its best practice, two other large health systems with EHRs had increased their rates from 87 percent to 92 percent, while Kaiser had boosted its high rate from 92 percent to 94 percent.

Another possible Replicable Best Practice was flagged when a pattern of high achievers emerged among practices that actively used their EHR’s “health maintenance” section to ensure their diabetes patients had

received their annual eye exam, which is important for monitoring vision loss, a common complication of diabetes. The regional rates for diabetes patients who had received their annual eye exam subsequently rose to 64 percent from 57 percent three years earlier.

## Lessons Learned

■ *Better Health* has adopted the deliberate search for “positive outliers” as one of its best practices in every six-month data cycle. Further probing of the practices is a critical part of the process. Did the primary care practice or practices know about the change? Was it purposeful? Are there demographic or insurance coverage changes among their patients that could account for it? Can they describe what they did? Could the process be replicated by other practices?

■ A common vision and sharing of experiences across sometimes competing health care organizations are key to unlocking the power of partnership. Continued progress relies on continued sharing of data and partners’ commitment to improve on common standards.



# PROVIDING DIABETES SELF-MANAGEMENT EDUCATION

## in the Workplace

The Greater Detroit Area Health Council (GDAHC), which leads the AF4Q initiative in Detroit, wanted to make it more convenient for people in southeast Michigan with diabetes to learn how to manage their care better. Inspired by an earlier effort funded by the Agency for Healthcare Research and Quality (AHRQ) to identify interventions with the most impact, in 2008 GDAHC started developing a pilot program to provide diabetes self-management education (DSME) sessions to local employees where they work.

“Most DSME programs in our region are offered in hospital settings, but our goal was to make the classes much more accessible—we thought it would help if participants could take a free class during their lunch break and didn’t have to leave their worksite,” said Lisa Mason, vice president of cost quality for GDAHC.

Initially, GDAHC reached out to Detroit-area employers and unions directly and asked them to consider offering an onsite DSME program. They used a diabetes cost calculator AHRQ developed to demonstrate to the employers and unions that they could potentially save money in the long term on employee medical costs and improve productivity by implementing a DSME program. Although the employers agreed with the projected savings in medical costs, they were not willing to make the up-front investment required to cover the cost of the DSME sessions because they were concerned about the effects of the economic recession on their businesses.



GDAHC and its partner, Medical Network One, decided to approach Blue Cross Blue Shield of Michigan (BCBSM), a nonprofit corporation that is the state’s largest provider of health insurance. BCBSM agreed to cover the cost of a DSME pilot program and help identify employer and union groups who would be willing to offer the DSME at their worksites and union halls. Ultimately, the DSME pilot program included five employer sites and two union halls. Medical Network One provided the American Diabetes Association-certified education sessions. At each site, an average of 20 participants were recruited to participate in eight one-hour DSME sessions with professional staff, including registered nurses and dietitians, certified diabetes educators, and behavioral health and exercise specialists. The first class started in the fall of 2009. In most cases, the class sessions took place during lunch, but at the unions, they were offered in the evening and Saturday morning.

“We grappled with whether the classes should just be for people with diabetes, but the employers we worked

## DETROIT

with didn't want them to feel singled out, and we decided to make the classes available to anyone who was interested," said Mason. She noted that about half of the people who signed up for the pilot had been diagnosed with diabetes, and half were either at risk for diabetes or caring for a family member with diabetes.

Classes were free for participants and covered topics such as how to better manage or even prevent diabetes with diet and exercise, how to monitor blood sugar levels, and how to prevent complications from diabetes.

Shanda Reardon signed up for the DSME sessions that were offered starting in 2010 through OakFit, a wellness program for Oakland County employees. An office leader in Oakland County Circuit Court's Family Division, she lives in Waterford, MI, with her husband and two children. Although she does not have diabetes, she wanted to attend the lunchtime classes to learn how to eat healthier and prevent diabetes because of her

family history. Her father has diabetes, and her aunt and grandfather died from diabetes-related complications.

Reardon said the classes helped her lose weight and change her family's eating habits. "I learned about portion control, healthier snacking, and how to read food labels," she said. "I'm much more cautious and aware of what we're eating now. We avoid snacking after 7 p.m., and when we do snack, we reach for fruit or granola bars rather than chips." Reardon also has shared some of the information and handouts from the class with her father.

She said she appreciated that the teachers made her feel comfortable about asking questions at any time. "They were very forthcoming and encouraging," she said. "It made me realize that you should never be afraid to ask your health care provider any questions you have."

Before the educational sessions began at each site, Medical Network One collected baseline data on the

participants' weight, blood pressure, body mass index, cholesterol, and blood sugar levels. The participants also completed a survey about their health behavior—containing questions about medication adherence, exercise, nutrition, and blood glucose monitoring—and a questionnaire developed by Tufts University about their productivity levels at work. They were asked to return for follow-up evaluations so these data could be collected again at three, six, and 12 months after the initial educational sessions ended. At the three- and six-month follow-up evaluations, participants also filled out a program satisfaction survey.

Mason noted it was challenging to get participants to return for the six- and 12-month follow-up evaluations. GDAHC eventually began offering \$50 gift cards for participating in these sessions. This improved attendance, but low attendance continued to be a problem that hampered data collection efforts.

The last of the 12-month follow-up evaluations was completed in the summer of 2012, and the University of Michigan is helping to analyze the data.

Results show that the participants' at-work productivity increased by 20 percent at six months and more than 11 percent after 12 months, as measured by their reduced burden of illness in that setting. At some sites, participants also showed significant improvement in clinical measures—for example, weight, BMI, and systolic and diastolic blood pressure decreased significantly for employees at General Dynamics Land Systems at their six-month follow up evaluation. GDAHC is collecting data from the employers and health plans to see if there was an impact on medical and pharmaceutical claims costs for the participants and their family members.







During the pilot, Blue Cross Blue Shield of Michigan changed its reimbursement policy to cover DSME in locations other than outpatient facilities and physician offices. GDAHC and its partners are working to encourage

other southeast Michigan health plans to do the same. “We’re trying to remove the barriers so that we can make this important education more widely available in the community,” said Mason.

## Lessons Learned

Health care plans view the employers as customers and often know which ones are more forward thinking and progressive about things like health and wellness education. Ask the health care plans which employers in the community would be most receptive to offering a diabetes self-management education program. At the same time, work with the plans to see if they can cover the cost of the program both for people with diabetes and for those at risk for the disease.

Employers vary widely in their readiness to take on a health education activity. Some already have health and wellness promotion programs, and others are not as accustomed to thinking about investing in employees in this way. But you can show them the value—for example, by demonstrating the potential long-term savings in medical costs—and tailor the program to meet their needs.

More health care organizations need to be encouraged to deliver DSME in workplaces and other community settings and not just hospital settings. GDAHC found that Medical Network One was the only health care organization in its region that had the clinical expertise and experience to offer DSME in community settings. Convincing health plans to cover the cost of the program can provide an incentive for vendors to become involved. To find potential organizations to provide the training, ask the American Association of Diabetes Educators and the American Diabetes Association for recommendations.

Partnership and collaboration are the keys to success. Our pilot depended on an innovative health care organization willing to take the DSME sessions into the community, a health plan willing to try something new, and employers and unions who viewed their members’ health as a priority.





# Helping Consumers

Make Better Health Care Choices





**P**ublishing information about how patients experience the care they receive at their doctor's office is one way to increase physician accountability and drive public awareness about health care quality. That was what Massachusetts Health Quality Partners (MHQP) had in mind when it participated in a pilot project with the Robert Wood Johnson Foundation and Consumers Union, publisher of *Consumer Reports*. The result? In June 2012, *Consumer Reports* published its first patient experience ratings for nearly 500 primary care physician practices in Massachusetts, expanding the reach of this information as a way to encourage dialogue among patients, physicians, and advocates about what quality healthcare should look like.

The ratings, made available on newsstands and to all Massachusetts *Consumer Reports* subscribers, were based on MHQP's statewide patient experience survey results. The survey included questions about the aspects of care that matter most to patients—for example, whether their doctors listen to their needs and concerns, whether patients understand how to take care of their problems after leaving the doctor's office, whether it is easy or hard to get appointments or have questions answered over the phone, how hard or easy it is to get lab or other test results, and how well their doctor coordinates their care with specialists. These ratings also are published on MHQP's website and can be found at [mhqp.org](http://mhqp.org).

Why is reporting on patient experience important for both patients and physicians? Executive Director of Massachusetts Health Quality Partners Barbra Rabson explained, "Research shows patients who have a better experience of care with their providers are more likely to follow their treatment plans and have better outcomes. The results of our survey can help improve and strengthen the patient-physician relationship. That relationship is the cornerstone of a changing health care system."

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#### A NEW PARTNERSHIP

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To help patients and physicians connect in new ways, MHQP and *Consumer Reports* teamed up to combine MHQP's skills in survey data



collection and analysis with *Consumer Reports*' reputation as a trusted source of information for consumers and its ability to present information about performance to a general audience.

Launched in 1995, MHQP formed as a coalition of physicians, hospitals, health plans, professional societies, patient advocates, and government agencies, working together to drive improvement in health care by publicly reporting valid and comparable performance data. To advance this goal, in 2005 MHQP began reporting patient experience survey results on physician performance to provider organizations and the public. When the opportunity to partner with *Consumer Reports* presented itself, MHQP knew it could greatly increase the dissemination of its patient experience results to health care consumers in an unprecedented way.

"*Consumer Reports* has been a trusted name for over 75 years," said Rabson.

"Working together helped us to amplify the voices of patients even more than we already had and helped us get this information to patients that we hadn't reached before."

### HOW DID IT WORK?

As noted, MHQP collected the survey data, analyzed responses, and reported results according to its performance levels. *Consumer Reports* provided editorial context for results and created the format for published results.

MHQP sent the Patient Experience Survey out to more than 200,000 commercially insured primary care patients in the spring of 2011.

Overall, 47,500 adults and 16,500 parents of children responded to the survey. Compared to other similar surveys, this response rate was very good.

The survey asked patients and parents about their experiences with the entire clinic staff, from physicians and nurses to front office staff such as receptionists. Questions

ranged from, "Did you and your doctor talk about a healthy diet?" (77 percent responded "yes") to, "When your doctor ordered a blood test, x-ray, or other test for you, how often did

someone from his or her office follow up to give you those test results?" (28 percent did not always receive their test results). Parents also were asked questions, such as whether their child's pediatrician "seemed up to date or informed about the care the child received from specialists" (66 percent of respondents said "yes").

"Working together helped us to amplify the voices of patients even more than we already had and helped us get this information to patients that we hadn't reached before."

**ConsumerReportsHealth**  
Special Report for Massachusetts residents  
**How Does Your Doctor Compare?**  
Exclusive: Patients rate 487 adult, family & pediatric practices  
How to get the best care  
Quiz: Does your physician measure up?  
GUIDE TO PRIMARY CARE PHYSICIANS IN MASSACHUSETTS PAGE 10  
MHQP MASSACHUSETTS HEALTH QUALITY PARTNERS

Primary care physicians who performed well on the survey "usually take action to operate their practice in a way that focuses on the needs of their patients," Rabson said. This includes providing test results within a specific time frame, implementing steps for better care coordination, such as using electronic medical records to identify who is due for check-ups, and taking time to address patient's questions at the time of the visit.

Media coverage about the collaboration between MHQP and *Consumer Reports* was very positive. The MHQP/*Consumer Reports* partnership was covered in more than 119 news articles, with more than 27 original stories that appeared online or in print, as well as in 58 radio and two television segments.



Media coverage also led to a spike in website visits, with a total of almost 4 million web impressions since the ratings were released in June. MHQP also experienced a significant bump in social media traffic, including more than 2,100 new visitors to the website and a 200 percent increase in traffic on Twitter during the days surrounding the public release.

### THE PHYSICIAN PERSPECTIVE

Media coverage shows that consumers were interested in the published ratings, but what did physicians think about this project? Michael Cantor, MD, JD, chief medical officer of the New England Quality Care Alliance and a member of the MHQP Physician Council, says obtaining physician buy-in on this project involved overcoming some hurdles.

“Some physicians, myself included, thought this was a really good idea because we live in a world where you can go online and find what looks like objective information about doctors,” said Dr. Cantor, who is a trained geriatrician as well as an attorney. “Others didn’t like being lumped with this *Consumer Reports* approach. They would say things like ‘I’m not a toaster’ or ‘I’m not a dishwasher.’ Their point, understandably, was that the physician-patient relationship is filled with nuance, and it’s hard to boil that down or rate on a scale. Doctors cope with difficult situations all the time and were concerned whether these evaluations would be fair and would take into account that delivering care is complicated.”

Doctors wanted multiple qualifiers around the information, yet consumers need straightforward information that is easy to understand. This conflict presented a tremendous challenge to present the results in a way that was both clear for consumers and fair to physicians.

Ultimately what brought many doctors around to supporting the project, Dr. Cantor explained, was the recognition that physicians have an obligation to their patients, and that includes providing accurate and current information about care. “People need to make choices based on transparency,” said Dr. Cantor. “The MHQP survey and *Consumer Reports* ratings help inform those choices.”

### AIMING FOR THE ‘TRIPLE AIM’

The MHQP collaboration with *Consumer Reports* furthers the discussion about the importance of publicly reporting on physician performance. Under current federal health care reform, doctors and hospitals are being asked to focus on the “triple aim” of lowering healthcare costs, enhancing the quality of care, and improving outcomes. “These ratings with *Consumer Reports* are one piece of the healthcare quality puzzle,” said Dr. Cantor. “We are in a transition to provide high-value care that is more focused

on quality. Massachusetts has been practicing accountable care before the term was on the national radar. We are being accountable to each other and accountable to the public.”

### LOOKING AHEAD

“Both MHQP and *Consumer Reports* have learned a tremendous amount from each other about sharing performance information with the public during our collaboration,” said Ms. Rabson. MHQP will continue to work to engage the public around health care quality performance information. “Whether we decide to continue the partnership with *Consumer Reports* is unknown at the moment, but we will continue to build on the work we have done with them,” she said.

## Lessons Learned

Strong collaborative relationships are critical in bringing stakeholders to the table and keeping them there. MHQP has long been engaged with its stakeholders around public reporting. Because of the strong relationships and trust built over time, MHQP was able to convene the Massachusetts physician community, health care consumers, and *Consumer Reports* to develop reporting that would achieve everyone’s goals. Physician and consumer stakeholders met with *Consumer Reports* on numerous occasions to devise a framing that would be acceptable and balanced to physicians while making the information clear to consumers. MHQP advises other communities that building and strengthening collaborative relationships is necessary before embarking on a high-stakes reporting project like the *Consumer Reports* project.

To launch this project successfully, MHQP found it was necessary to learn how to achieve balance among the independent perspective of a partner like *Consumer Reports*, the collaborative process at the core of AF4Q communities, and a regional health care collaborative like MHQP. Both *Consumer Reports* and MHQP had to take the time to learn about the other organization’s perspective and come to a compromise that integrated processes in a balanced way.



# STEP BY STEP: CREATING A PATHWAY TO BETTER HEALTH

**H**alf of the 135,000 residents in Humboldt County, CA, live outside its small towns. Like many rural areas, Humboldt has significant health challenges, including limited access to certain types of care, hundreds of miles separating some residents from their doctors, and higher rates of those with chronic health conditions or no health insurance.

Fortunately, Humboldt County also is home to one of the most promising health care initiatives helping people with chronic conditions manage their own care more effectively.

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## CLEARING THE PATH TO BETTER HEALTH

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To improve overall health and reduce costs in an overextended system of care, there is an increasing focus on chronic disease self-management programs (CDSMP) like Humboldt's "Our Pathways to Health." The effort is supported by the Robert Wood Johnson Foundation's Aligning Forces for Quality (AF4Q) initiative.

Through AF4Q and with the support of local patient advocates, a series of free, six-week-long Our Pathways to Health (Pathways) workshops was launched in 2008. Coordinated by Aligning Forces Humboldt, it is a locally branded version of a nationally recognized CDSMP

developed by Kate Lorig, RN, DrPH, of the Stanford Patient Education Research Center. Dr. Lorig is a leader in developing patient-driven health solutions that provide skills to manage chronic conditions like diabetes, arthritis, pain, depression, obesity, and heart problems.

During each Pathways workshop session, individuals or their caregivers learn how to overcome barriers to better health. The self-management toolbox provides guidance on goal setting and step-by-step action plans. To facilitate efforts to get well and stay well, Pathways guides them on incorporating health-related activities into their daily routine, like organizing medications, communicating with medical providers, understanding emotions, managing pain, and increasing physical activity. Other Pathways course materials include a book, *Living a Healthy Life with Chronic Conditions*, and *A Time for Healing* relaxation CD.

"Pathways participants may not have the same condition, but they face the same challenges," said Michelle Comeau, Aligning Forces Humboldt's operations coordinator for Our Pathways to Health. "They're dealing with a wide range of emotions, as well as isolation. They may struggle with how to communicate what they're going through or the symptoms they're experiencing. They also struggle with how to manage a complex medical system and partner with their doctors more effectively."



The workshops, which are offered in English and Spanish, became highly regarded in the community. By 2011, there were more than 30 trained Pathways leaders and more than 25 workshops a year. In July 2010 their CDSM program had the highest participation rate, per capita, in the state of California, according to the Partners in Care Foundation.

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## GROWING IMPACT, GROWING CHALLENGES

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Yet, as the program grew, so did some management challenges. First, Comeau said, it became apparent Pathways needed a more efficient, sustainable management structure. Second, Pathways needed a more streamlined and broader referral network to fill a growing number of Pathways workshops.

“While Our Pathways to Health is lifted directly from the Stanford model, how we work with volunteers and recruit people is different,” Comeau said. “The biggest challenge was knowing that we needed to change to a more efficient structure, but also maintain our deep commitment protecting the consumer voice and our valuable trained leaders.”

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## RESTRUCTURING

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Originally, Pathways was managed by peer-to-peer consensus. However, as the program grew, it became evident that implementing a new management strategy was necessary for keeping up with workshop demand. Comeau said that one of the most important

lessons was the realization that successful restructuring of the program had to come from outside Pathway’s leadership team.

Enter the University of Maryland. Pathways worked with representatives from the university who provided outside technical assistance throughout the restructuring while maintaining Stanford’s curriculum and a core focus on consumer engagement. The assistance included a day-long workshop using the Myers-Briggs approach to recognize the skills and communications styles of volunteer leaders and staff.

“We learned about how people process new information and approach tasks,” Comeau said. “We came to better understand how people perceive the roles and responsibilities within an organization. That informed how we structured Pathways to make it more successful.”

The clarity of roles was considered a refreshing change and laid the groundwork for continued progress. Day-to-day operations became more efficient, and a clear chain of command enabled staff and volunteers to work together more effectively. A new, separate advisory group began to meet monthly to focus on the leader and consumer perspective.

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## EXPANDING THE REFERRAL NETWORK

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The program’s expansion also necessitated the development of new recruitment strategies. Word-of-mouth recommendations, free radio and television PSAs, and newspaper articles drove initial workshop attendance but did not have a sustained impact. Additionally, while many medical offices were aware of Pathways, they were not providing patient referrals to the program.



## HUMBOLDT COUNTY, CA

To enhance the referral network, Pathways targeted medical offices to reach potential participants. The program launched a pilot with Eureka Internal Medicine, asking it to incorporate referral recruitment into its routine for one day. That secured 23 referrals and 11 people who signed up for the workshop—a promising result. Recognizing the time commitment required for sustaining the referrals, Pathways and Eureka Internal Medicine devised a more streamlined, targeted, and manageable approach.

Dr. Lorig from Stanford provided an additional nudge and encouraged more community participation. At a local meeting of health care providers and staff, she challenged attendees to join the program and strive for at least two patient referrals per month—a manageable goal.

Dr. Lorig emphasized the Stanford model's success, as well as the power of the personal touch in recruiting participants. She explained that providing a more detailed explanation to patients about the program's benefits and getting permission for a follow up was far more effective than just providing a brochure and a simple recommendation that patients register for the program.

After some initial reluctance, the program became integrated into medical practices. In December 2011 alone, Pathways logged 60 new referrals through electronic and fax referrals—a 300 percent increase. Now, approximately 30 local medical providers are referring 20 to 30 candidates each a month.

"We used to get very few referrals from medical offices—maybe one or two every few months," said Comeau. "In 2010-2011, 28

percent of referrals we received were from medical providers. Now it's 40 percent."

Studies show CDSMPs can reduce health care costs through fewer and shorter hospitalizations and fewer emergency room and outpatient visits. Those who participate in self-management programs also are more likely to see significant improvements in managing their health conditions.

Our Pathways to Health continues its relentless quest for the health and well-being of residents in Humboldt County. Through 94 workshops since 2008, the program recently surpassed a milestone of serving 1,000 participants. Of those participants, 720 have graduated from the program, meaning

they have attended at least four workshops. Pathways also partners with other community organizations and offers "closed" workshops to groups with specific needs. The program began tailoring its services for veterans, senior groups and homes, and the visually impaired.

Virtually all participants attribute the Pathways workshops to their increased ability to manage their own care. By enhancing its management structure and more effectively targeting its recruitment and partnership efforts, Pathways is well positioned to serve more residents in Humboldt and improve the overall health of the community.

"I came into this six-week program a death-fearing, self-pitying, chronically ill person," says Eunice Noack of Eureka. "Now I am mainly chronically well."

"I came into this six-week program a death-fearing, self-pitying, chronically ill person," says Eunice Noack of Eureka. "Now I am mainly chronically well."





# Giving Kansas City Providers a New Tool for Quality Improvement

In the past, physicians in the Kansas City area didn't have an easy way to validate the accuracy of the data from their electronic medical record (EMR) systems. The Kansas City Quality Improvement Consortium (KCQIC), which leads the greater Kansas City area's AF4Q initiative, believed if the physicians in their community could verify their EMR data, they could identify gaps in care and improve patient outcomes.

"When health care providers have good, accurate data, they're able to move forward with quality improvements with a

greater assurance that they're focusing on the right things," said Catherine Davis, APN, PhD, executive director of KCQIC.

KCQIC teamed up with Health Metrics Systems, Inc., the developer of a software platform called Solutions for Quality Improvement (SQI). It works by extracting and merging data from

a medical practice's EMR, billing, laboratory, pharmacy, or practice management system, as well as other relevant databases. Physicians can use SQI to view their data and produce reports in a wide variety of ways. For example, they can create lists of patients grouped according to a chronic disease, such as diabetes or

asthma, and filter those for particular variables, such as diabetics who also are hypertensive. "SQI is like a patient registry on steroids," Davis said.

With funding from AF4Q, KCQIC began

offering the SQI software platform to local physicians in the spring of 2011. Since then, more than 200 primary care providers in the greater Kansas City area have signed on to use SQI. As part of the project, Health Metrics Systems has been working to customize the software platform to suit the needs of particular medical practices.

"When health care providers have good, accurate data, they're able to move forward with quality improvements with a greater assurance that they're focusing on the right things."



## KANSAS CITY

After the software platform is installed at a participating clinic and key staff members have received training on how to use it, Health Metrics Systems conducts a series of reviews to validate the accuracy of the clinic's EMR data. During phone calls or webinars with the clinic staff, they go over the harvested data and discuss potential inaccuracies. The clinic staff can then make corrections.

"It's an easy way for doctors to find the mistakes they would not normally find if they only have an EMR system," Davis noted. "And when we're validating the data, we come across some very interesting things."

Clinics had records, for instance, of a 17,000-pound patient with a BMI of 2,000, a patient who was 5.2 inches tall, and a newborn who weighed 24 pounds. One physician had not documented the foot exams he conducted for his diabetic patients, even though it was required that he do so because it's a standard quality measure. It turned out he had been typing notes about the foot exams into the EMR system rather than recording them using a drop-down menu, and that's why they weren't showing up correctly.

In addition, the staff of a primary care practice with 22 physicians discovered their EMR system wasn't sending all their immunization records to the Missouri Immunization Registry as required by the Missouri

Department of Health and to demonstrate meaningful use. Health Metrics Systems worked with the practice to upload the more than 30,000 missing immunization records into the Missouri Department of Health's registry.

Not only can physicians detect mistakes and missing data using SQI, they also can use it as a tool to improve patient care and reduce avoidable hospitalizations. The SQI software can, for example, send them a reminder that a patient needs a mammogram or colonoscopy at a particular time and can notify the appropriate staff member to follow up with patients who

don't complete lab work or refill their medication. Physicians can print out a trend line on a patient to see if his or her blood pressure or A1C levels are increasing over time. They also can track whether a patient's condition is being treated according to clinical guidelines, such as the ATP III guidelines for treating high cholesterol in adults.

"We're thrilled to have the SQI software—it will allow us as an organization to monitor our progress, set goals, identify needs, and move toward improving quality."

"We think that working with SQI can lead to better performance scores and improved care," Davis said. She pointed to a recent analysis conducted by her team at KCQIC. They compared benchmark data from their 2011 public report of Kansas City area physicians (drawn from the Healthcare Effectiveness Data and Information Set and based on claims health plans received from primary care practices) to data from practices in the Kansas City area that are using the SQI platform and have verified their EMR data. A sampling of providers that have SQI showed the percentage of their patients who had an A1C level of 8 percent or less was on average ten percent higher than that of other providers.

In addition, the data from the providers with SQI showed that





69 to 78 percent of their patients with diabetes had an LDL cholesterol level of 100 mg/dL or less. By contrast, an average of 55 percent of patients at the other primary care practices had an LDL cholesterol level of 100 mg/dL or less.

Kansas City Internal Medicine (KCIM), a multi-specialty practice with five clinics, is one of the local medical groups exploring how to use SQI as a tool for quality improvement.

“We’re thrilled to have the SQI software—it will allow us as an organization to monitor our progress, set goals, identify needs, and move toward improving quality,” said Marianne Hudgins, MD, a physician at KCIM.

KCIM’s quality committee recently decided to use SQI to create lists of its patients with diabetes who were not meeting treatment goals, Hudgins said. The physicians will go over these lists to make sure the correct diagnostic codes are being used and identify patients who are no longer pursuing treatment. Next, the team will contact these patients and encourage them to actively pursue diabetes education and treatment. “We want to reach out to this patient population and let them know that we would like to take further steps in their care,” said Hudgins. In the future, Hudgins wants to use the SQI software to help monitor the care of patients with high blood pressure, congestive heart failure, chronic obstructive pulmonary disease, and asthma.

KCQIC is providing the SQI software platform to medical practices for free for two years. After that, practices will need to pay a small fee for access. Davis said it’s been gratifying to see how excited the local providers are to start using their newly verified data. She also feels KCQIC strengthened its relationships with the providers in the community by working together on this project.

“They’re telling us that they see so much potential for how they can use the data,” she said. “And they’re enjoying sharing the data with the other doctors in their practices and showing them the potential, too.”



## Lessons Learned

Choose the right vendor to develop your software platform. KCQIC teamed with Health Metrics Systems because they understood how to work with physicians and how to improve health care quality. They were very patient and open to feedback about their software platform and more than willing to customize it for different types of medical practices—for example, for pediatricians and OB-GYNs.

The staff at medical practices may be reluctant at first to admit there are problems with the data from their EMR. A good process for validating the data from the EMR should be established up front.

Once a data validation process is initiated, clinic staff will be empowered to recognize data inaccuracies and their impact on quality of care. KCQIC found staff members were eager to receive training and correct inaccurate data after they learned more about the problem.

Working with the SQI software platform helped motivate some physicians to focus more on quality improvement. Physicians said they are excited to brainstorm about all the potential uses of the validated data.

# Driving

Aligning Forces is driving health care transformation in communities across America.

**T**ransparency in health care quality is a core principle of Aligning Forces. AF4Q communities have improved the quality of information about physicians' performance and are ensuring the public has access to that information—so consumers can make informed choices about their care, so doctors and hospitals can identify areas for improvement, track progress, and see how they compare to others, and so consumers and purchasers can determine the value they are getting.



These reports comparing health care at the regional level are often referred to as “community check-ups” and provide a common foundation for everyone in the community to work together toward improved care for all residents.

AF4Q communities are proving that publicly reporting information about health care quality is possible. 37.7 million people in all 16 AF4Q communities now have access to information on the quality of care provided by local providers through publicly available reports. Visit their websites to read more—links to all 16 sites are available at [www.forces4quality.org](http://www.forces4quality.org).

Find links to these public reports and more @ [www.forces4quality.org](http://www.forces4quality.org)



# Change



albuquerque, nm



cincinnati, oh



cleveland, oh



detroit, mi



greater boston



humboldt county, ca



kansas city, mo



maine



memphis, tn



minnesota



oregon



puget sound, wa



south centra pa



west michigan



western new york



wisconsin

# Applying a Team

## Approach

to Patient Discharge



At St. Mary's Medical Center, a 233-bed acute care facility in Lewiston, ME, “patient-centered” is more than just a buzz word—it’s a standard of practice that’s carried out by every staff member on every shift. St. Mary’s approach to patient-centered care is clearly evident in its adoption of Transforming Care at the Bedside (TCAB), a process improvement methodology the hospital is using for discharge planning. Developed and led by the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement, TCAB seeks to engage patients further and elevate the effectiveness of providers.

Working with the Robert Wood Johnson Foundation’s Aligning Forces for Quality initiative, administrative leadership, physicians, and most importantly, nurses—who are in the day-to-day trenches of patient care—St. Mary’s adopted TCAB in 2009 because of the model’s potential to improve the patient experience as

well as coordination of follow-up care, boost post-discharge compliance, and reduce patient falls and hospital-acquired conditions, such as pressure ulcers. TCAB requires a multidisciplinary team of providers that include the charge nurse, the patient’s nurse, a physician, a case manager, a social worker, a physical therapist or occupational therapist, and pastoral care.

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### COORDINATING CARE AT THE BEDSIDE

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With each patient, using TCAB during discharge, the primary nurse gives a one-minute-long presentation at the bedside followed by input from the care team, including the patient. All of this takes place at the patient’s bedside right before release from the hospital, and the patient can ask questions or offer suggestions to the entire care team. This is a shift from traditional discharge planning, which typically occurs behind closed doors, away from the patient,



and allows limited opportunities for shared learning among the care team.

“TCAB directly supports one of the strategic priorities of Maine Quality Counts, which is to offer quality improvement assistance to providers,” explained Lisa M. Letourneau, MD, MPH, executive director for Maine Quality Counts, a regional collaborative working with area providers and hospitals to improve health care quality. Dr. Letourneau noted the TCAB model has been useful to a number of small hospitals in Maine working to pilot the TCAB initiative to improve care. “Many quality improvement initiatives can sometimes feel like a chore for hospital staff, whereas TCAB turns that on its head and brings in frontline nurses who historically weren’t always included in these types of quality improvement initiatives. Frontline nurses know from their gut what to do and what patients need. Engaging nurses in this way creates energy and makes good use of their skills.”

Melissa Brisson, RN, a clinical resource nurse in the cardiac-pulmonary unit at St. Mary’s Medical Center, agreed. “Our unit was among the first at St. Mary’s to introduce TCAB,” she said, “and the nurses have been very excited about it. Our unit is very fast paced—we see just about every specialty, from telemetry to oncology. It’s a good unit to test the effectiveness of TCAB because we have many challenges here, like high patient turnover and high staff turnover. There’s a lot of movement.”

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#### TCAB: AN RX FOR PATIENTS AND PROVIDERS

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TCAB appears to be good for both patients and providers. A small survey among no more than 20 patients at St. Mary’s reveals that patients’ responses to the new multidisciplinary bedside discharge model are overwhelmingly positive. When asked questions about having a role in their care, feeling their concerns were heard, and feeling the information presented

was understood, the majority of patients responded “yes.” Patients also were asked if they ever felt intimidated with the number of staff visiting their bedside at once, since TCAB can involve several providers from multiple different specialties coming together at once. The majority of patients responded “no,” it was not intimidating.

TCAB also offers providers many benefits, including cultivating trust among staff, teams, and specialties, and improving dialogue between staff and upper management. Shift reports are carried out at bedside, ensuring full continuity of care, which further develops a sense of teamwork among providers.

“Before TCAB, decisions were made at the top and brought down,” said Brisson. “The action is happening at the bottom, and upper management is increasingly recognizing that. Now nurses have a voice in how care should be delivered.”



Care at St. Mary's also has become more collaborative as a result of TCAB, added Brisson. "Everyone had their separate job. The case manager or social worker arranging for the patient's home health care would do her bit, the nurse would do her education piece, and the physician ordered any follow-up tests or prescriptions. It was much more siloed. Now we all come together at the patient's bedside, and we're learning from each other."

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## LOOKING AHEAD

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New payment models being supported by the current federal health care law emphasize value over volume and may give models like TCAB a platform on which to thrive. For example, a care delivery model known as an accountable care organization (ACO) relies heavily on greater coordinated care among providers to reduce hospital readmissions, which then ultimately controls costs. TCAB could have a role in this environment by controlling costs through reducing the need for repeat hospitalizations because discharge planning is now more thorough and comprehensive. Patients and their families leave the hospital with a clearer understanding of what they need to do to take better care of themselves at home and are better equipped to manage their conditions in the outpatient setting, which then hopefully reduces or eliminates the need for return hospital visits.

Implementing TCAB at St. Mary's has had its ups and downs, and ensuring TCAB remains sustainable will require support. "Sometimes we need to rejuvenate TCAB, especially when new staff come on or there are changes in management," said Brisson. "People also get busy, or they're used to doing things a certain way, and so we have to constantly remind and support people about the new processes in place. I'm really a champion for TCAB because I see that it works and that the patients and staff really benefit both in the short and long term." Brisson added that St. Mary's Medical Center is interested in adopting the TCAB model in other units, including other medical-surgical units and possibly emergency medicine.

"We want to try out some ideas with ER," said Brisson, "such as looking at the bedside report with the ER nurse at beginning of admission, and ER nurses giving admission reports over the phone."

TCAB could change that and bring it to the patient bedside. The primary nurse who would be receiving the patient would also be there. It could really help everyone."

Added Dr. Letourneau, "With the upcoming changes in health care reform and new payment models such as ACOs, hospitals and provider groups will increasingly be in charge of their destiny. Our hope is that hospitals will see the value of TCAB and use it as a model for improving both the quality and costs of care."

## Lessons Learned

Overall, maintaining data entry was a challenge. For example, turnover in nursing staff requires reminders about updating data logs and maintaining current records about inpatient stays, unit admissions, falls, falls with harm, and pressure ulcers, and then breaking down these categories by the patient's race, ethnicity, and language.

The team conducted periodic progress reports about what was working and not working. For example, a vitality survey asked staff questions such as, "My ideas really seem to count on this unit" or "Essential patient care equipment is in good working condition on this unit." However, teams did not keep up with the progress reports, making it difficult to gauge progress.

TCAB activities required pre- and post-measurement to evaluate how the intervention was working. For example, did implementing hourly rounding reduce call bells, which can impact a nurse's time if call bells are being repeatedly signaled? Counting call bells is time consuming and will need to be encouraged and supported so that data are accurate.



# Bringing Farm-Fresh Foods

to an Urban Community Fighting Obesity

**T**he term “food desert” has been mentioned widely. Many have questioned whether living in a food desert contributes to obesity because of the preponderance of fast foods and convenience stores and the dearth of healthy options, including grocery stores selling fresh fruits and vegetables.

To tackle the food desert problem in one South Memphis neighborhood, Aligning Forces for Quality grantee Healthy Memphis Common Table supported the efforts of the South Memphis community partners to fill a void in a nutritional wasteland by bringing in a farmers market, an approach being tested by many urban communities across the United States. The short-term goal focused on increasing a community’s access to healthier food choices. The long-term hope is that by having greater ease to purchase affordable fresh fruits and vegetables, individuals can reduce their risks for obesity and related health conditions.

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## A PUBLIC HEALTH EPIDEMIC

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Obesity is one of the top public health threats in the United States and a high priority for the Robert Wood Johnson Foundation, which initiated Aligning Forces. According to the Centers for Disease Control and Prevention (CDC), 35.7 percent, or about 78 million Americans, are

clinically obese—meaning their body mass index, a calculation based on height and weight, is 30 or higher. Tennessee has the 15th-highest obesity rate in the nation at 29.2 percent. Moreover, obesity is strongly associated with low-income status and increases the risk for other debilitating chronic conditions, including diabetes, hypertension, stroke, heart disease, and even certain types of cancer. Combating obesity on many fronts can result in many benefits, including improving a population’s overall health, reducing the risks for several types of chronic illnesses, and reducing health care expenses. The medical care costs for obesity are about \$147 billion in 2008 dollars, according to the CDC.

How can farmers markets help fight obesity? The thinking is that providing farm-fresh fruits and vegetables to low-income communities often overrun by convenience stores stocked with processed, packaged foods will give these residents access to healthier options. Healthy Memphis Common Table, a regional healthcare improvement collaborative serving the greater Memphis area, and the University of Memphis were members of the committee organized to assist The Works, a community development corporation founded by St. Andrews AME church that supports residents in South Memphis in establishing the farmers market. Memphis is an area in dire need of intervention: In 2010 the

## MEMPHIS

Food Research and Action Center, a national nonprofit in Washington, DC, that studies undernutrition, ranked Memphis the “hunger capital of the United States” and first in food hardship had difficulty obtaining healthy foods between 2008 and 2009.

“Health isn’t at the top of the agenda for low-income areas,” said Renee’ S. Frazier, chief executive officer of Healthy Memphis Common Table. “These folks have other pressing needs. The foods at convenience

stores are cheap but loaded with sugar, salt, and fat. Finding affordable,

fresh produce in South Memphis requires multiple bus stops, lugging groceries several blocks. Supporting those who could bring in a farmers market aligns with the Robert Wood Johnson Foundation’s goals of promoting equity and empowerment. A farmers market provides people in struggling communities the opportunity to make healthier choices.”

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### HOW FARM FRESH CAN MAKE A DIFFERENCE

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The new South Memphis Farmers Market is on Mississippi Boulevard and South Parkway in South Memphis and opened in July 2010. It’s open from April to the end of October, every Thursday from noon to 6 p.m., and attracts about 350 shoppers during that period, said Curtis Thomas, deputy executive director for The Works, Inc. During the change in seasons, the number of farmers selling goods ranges from six to 10. The farmers accept USDA and Tennessee-provided food vouchers and food stamps. In fact, in 2009 the Healthy Memphis Common Table received a grant from the Assisi Foundation for a program called Lift Every Voice, which helped provide

support for a double coupon program, allowing food supplemental program beneficiaries to double the amount of fruits and vegetables purchased at the market. A beneficiary could receive \$10 of fresh produce for only \$5.

“South Memphis is your classic distressed inner city community that’s seen several decades of disinvestment,” explained Thomas, who has worked in the area for 11 years. “That’s evident in the lack of grocery stores. Our community has a Kroger

grocery store about 2.5 miles away and another Kroger 3.2 miles away in the other direction. Two-

and-a-half miles might not sound like a lot, but if you are coping with chronic conditions or are elderly and carrying groceries, getting on and off buses, it’s a burden. The farmer’s market brings some optimism about investing in the future.”

“What was great about this project is that it was entirely community-led,” said Frazier. “Residents had a say on where the market should be, who participates, all of that. It’s by the community, for the community, and the response has

“What was great about this project is that it was entirely community-led.”





been very positive, which gives us hope that the market will be sustainable and lead to similar long-term venues that will further support South Memphis in providing access to healthy, fresh foods.” The South Memphis Revitalization Plan, a resident-driven community revitalization facilitated by the University of Memphis Graduate Program in City and Regional Planning and the Department of Anthropology, identified the community’s desire and vision for a farmers market.

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#### LOOKING AHEAD

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How access to the market will affect obesity and type 2 diabetes rates remains to be seen and will be a subject of future study. Nationally, public health officials are encouraging the development of farmers markets in urban areas to counter obesity rates, but whether access to these markets has directly resulted in greater fruit and vegetable consumption, and, as a result, weight loss or lower rates of obesity in a population, remains unknown. For example, a July 2011 study published in the *American Journal of Preventive Medicine* found that availability to farmers markets selling produce within one mile was associated with a lower risk of being overweight or obese among young girls. But much more research is needed to understand better how farmers markets are making a difference and where they are having the greatest impact. Thomas says they want to survey South Memphis residents about their fruit and vegetable intake from the market and partner with the University of Memphis to evaluate the health impact as well as identify populations the farmers market isn’t reaching.

There are also plans to do a year-round market in 2013, which would nearly double the market’s calendar. In the meantime, Frazier said there also is interest in bringing a grocery store into the community now being served by the farmers market. “Aligning Forces For

Quality is about building community-level trust and engaging folks,” she said, “and funding from the Robert Wood Johnson Foundation allowed us to plant various community seeds of trust by having hands-on staff involvement in the planning of the

farmers market. Now we can build on that trust, build on these relationships, and scale up.”



## LESSONS LEARNED

Despite the popularity of the farmers market, it took a lot of paperwork and effort to see the project through, with some surprises along the way. Both Frazier and Thomas remarked on developing a more savvy understanding of city, county, and state regulations when it comes to agricultural commerce. Memphis is unique in that “the local community is right across the Mississippi River and state line,” said Frazier. “Arkansas is part of the South Memphis local community, so any border state would need to pay attention to any ordinances. Sometimes the ordinances seem very outdated, and that was a challenge for us in bringing the farmers to South Memphis.”

Moreover, food vouchers don’t carry the same value state to state. “A South Memphis resident can use a Tennessee-issued Senior Farmers Market Nutrition Voucher with a Tennessee farmer but can’t use that food voucher with a farmer from Arkansas or Mississippi, which is confusing for shoppers when you’re a state border community like ours,” said Thomas.

Frazier said they have their work cut out for them in terms of navigating city, county, and state regulations. “We need to be sure,” she said, “that the local ordinances meet the evolving needs of the community. There’s so much potential, but we have to be sure we dot our *i*’s and cross our *t*’s.”



# Partnering with Patients

To Make Decisions About Colorectal Cancer Screening





Colorectal cancer is the second leading cause of cancer-related deaths in the United States and the leading cause of cancer deaths among nonsmokers, according to the Centers for Disease Control and Prevention. But in Minnesota, MN Community Measurement has found that only 64 percent of people are getting appropriate colorectal cancer screenings.

To help health care providers talk with patients about the benefits and risks of all their colorectal cancer screening options, the Institute for Clinical Systems Improvement (ICSI) developed an innovative pilot project. It set out to train the staff of two primary care clinics to use shared decision-making techniques in discussions with patients about colorectal cancer screening options.

“Our philosophical approach is that clinicians should engage with the patient as a partner in making shared decisions about care, and that should be woven into everyday practice,” said Jan Schuerman, MBA, team director for ICSI, which is a partner in the Minnesota AF4Q Alliance.

With funding from Aligning Forces for Quality (AF4Q), ICSI developed curriculum materials and began the training sessions in July 2011. The two primary care practices that participated are part of a physician-owned family practice group in Saint Paul, MN, called Entira Family Clinics.

“We chose to join the pilot because these two clinics—our White Bear Lake/Banning Avenue location and our White Bear Lake/Bellaire Avenue location—are becoming certified by the Minnesota Department of Health as health care homes,” explained Kathleen Conboy, director of clinical practice and quality for Entira Family Clinics. “Shared decision making has to be introduced as part of the certification process, and we realized this is a great opportunity to get educated about it.”

At each clinic, the staffers who received the training were part of the “health care home

team.” This team consists of three providers, a care manager, a clinic manager, and a certified medical assistant. Through three individualized, face-to-face training sessions and one webinar, they learned how to work collaboratively with patients to make informed decisions about colorectal cancer screening. In a shared decision-making conversation, the provider describes the benefits and risks of all the relevant screening options, and the patient expresses his or her preferences and values. Ultimately, they arrive at a decision together.

The clinics use evidence-based guidelines developed by ICSI to help determine appropriate treatment methodology for patients at average and increased risk for developing colorectal cancer. These guidelines also include resources such as a description of the set of skills needed to engage the patient in a “collaborative conversation.”

ICSI’s Patient Advisory Council reviewed all of the materials that were incorporated in the training sessions in advance to ensure they were easy for patients to understand. Some patients on the council also volunteered to participate in a webinar and share their experiences with colorectal cancer screening and patient- and family-centered care in Minnesota.

“The patients talked about the logistics of making an appointment for a screening, filling out the required forms in person or via email, which information they received prior to



“Involving the patients in the training was instrumental to the success of the project.”

the appointment and at other stages of the process—they showed the clinicians how things look through the patients’ eyes,” said Schuerman.

“Involving the patients in the training was instrumental to the success of the project,” she added. “The training sessions that included patients were the ones that most engaged the physicians.”

After the training sessions, the health care home team members at both clinics began implementing shared decision making with appropriate patients. David C. Thorson, MD, a physician at Entira Family Clinics’ White Bear Lake/Banning Avenue location who participated in the pilot, said the staff wound up spending more time discussing the full range of screening options. Rather than focusing mainly on the pros and cons of colonoscopies, staff devoted more attention to talking about options like a fecal occult blood test (FOBT) and flexible sigmoidoscopy.

“The providers had a pretty good handle on who should be screened, but the thing we didn’t necessarily do as well in the past was to talk with the patients who said no to a colonoscopy and find out what the barrier was for them,” Thorson said.

He noted providers often view colonoscopy as the gold standard for colorectal cancer screening, but for lower-risk patients, a number of other methods are adequate and should be discussed. One option is for patients to be screened initially using a less-invasive test like an FOBT. If that comes back positive, they can get a colonoscopy. By talking more about the different screening options, the team at the Banning Avenue clinic increased the number of patients who chose to get screened for colorectal cancer. In many cases, those patients chose an FOBT rather than a colonoscopy.

Before the pilot began in 2011, 67 percent of eligible patients at the Banning Avenue clinic were screened for colorectal cancer using one of three methods. In 2012, after shared decision making was implemented, 71 percent of eligible patients were screened. At the Bellaire Avenue clinic, the screening rate rose from 66 percent in 2011 to 74 percent in 2012.



Clinic staff filled out surveys at the beginning, middle, and end of the pilot, and patients completed surveys at the beginning and end. These surveys were conducted for quality improvement purposes, and the sample sizes weren't large enough to be statistically significant. The patient surveys at both clinics reflected that there had been more discussions about different types of screening, and patients felt they could make an informed decision. The White Bear Lake clinic staff reported that shared decision making is more involved than they had expected, and it can be difficult to conduct a shared decision-making conversation within the confines of a 15-minute appointment. Schuerman said she observed during the pilot that one of the biggest challenges of implementing shared decision making is that there are already so many competing demands on physicians' time.

In the future, Thorson said his team at the Banning Avenue clinic plans to continue using shared decision-making techniques, but it won't always be the physicians who conduct the conversation.

"Some of the shared decision-making tools require 15 to 30 minutes of active, facilitated conversation, and the physician does not have the time to do that—the visit will run too late. We're exploring having another member of the team, such as the care manager, facilitate the conversation right after an appointment with the physician or at another time," said Thorson.

He pointed out that the current payment model makes it difficult to allocate resources and staff for this, but Entira Family Clinics is nonetheless interested in moving toward more of a team-based approach to providing shared decision making. The pilot also laid the foundation for them to start using shared decision making in discussions of mammography and back surgery options.

In the meantime, ICSI also will be applying what it learned from the pilot to other projects, such as a low-back-pain initiative. In addition, it's sharing its experiences with the advisory committee of a large colorectal cancer community health project called Colorectal Cancer Screening With Improved Shared Decision Making (CRCS-WISDM). "We'll be drawing on the knowledge that we gained about shared decision making in lots of our future efforts," Schuerman said.



## Lessons Learned

Since health care providers in Minnesota publicly report rates of colorectal cancer screening as a quality measure, some may be reluctant to engage in shared decision making with patients for fear the patients may elect not to have any screening at all. Lower screening rates could have a negative impact on the provider's "score," quality rating, and in some instances, income. If new measures are developed in the future so providers are publicly reporting on shared decision making as well, that could help mitigate these problems.

A significant barrier to providing shared decision making is that the active conversation with the patient can take 15 to 30 minutes, and physicians often cannot devote this much time to it. Clinics should explore the possibility of having other staff members besides the physician—such as a care manager or certified medical assistant—receive training and facilitate the shared decision-making conversations with patients. This conversation could take place after the appointment with the physician or at another time.

It's essential to incorporate the voices of patients in shared decision-making training materials. In the webinars ICSI developed, patients talk about patient- and family-centered care and share their experiences with colorectal cancer screening. ICSI found clinic staff really appreciated hearing the patient's perspectives, and training materials that include patient voices are much better received than those that do not.





**“If we knew then what we know now...”**

“It’s the mantra of frustrated health professionals the world over who crave real-time, actionable data that leads to meaningful improvement in the delivery of patient care.

Determined to provide meaningful information and advance the quality and affordability of health care in its state, the Oregon Health Care Quality Corporation (Quality Corp) supported the implementation of the Oregon Health Leadership Council’s (OHLC) High-Value Patient-Centered Care Model (HVPCCM) demonstration. As part of a two-year demonstration, the organizations produced quarterly utilization reports for 3,600 patients served by eight health plans and 14 medical groups.

The interactive, user-friendly reports include information on emergency department (ED) use, hospitalizations, use of imaging services, pharmacy fill rates by therapeutic class, generic fill rates, visits over time to primary care, and visits over time to specialists. The reports are available through an online portal and released within four to six weeks of obtaining claims data.

## Seeing All the Data Supports High-Value, Patient-Centered Care



OHLC's overall model is designed to provide coordinated, high-quality care to patients with chronic and complex conditions and achieve shared savings for medical groups and payers. The model of care was based on the successful demonstration project launched by the Boeing Corporation. The evaluation of cost savings will occur at the end of the demonstration.

"We wanted to provide more timely and actionable information about the care enrolled patients are receiving," said Denise Honzel, executive director of the OHLC. To accomplish this, the OHLC turned to Quality Corp to provide this information. "By providing claims-based reports on utilization of services, we provide value-added information about care that is happening outside clinic walls," said Mylia Christensen, executive director, Quality Corp.

Building on an existing partnership and a shared commitment to improving the quality of care and reducing costs, the Robert Wood Johnson Foundation's (RWJF) Aligning Forces for Quality initiative

provided support for the project. In fact, as a result of past work with RWJF and participating health plans, much of the necessary data for the utilization report project was already in place. Through this project, participating health plans and medical groups received their patient data more frequently.

"This is the first time that the medical groups are getting aggregate claims data for unique populations," said Honzel. "They are seeing all the data from all of the players in one place."

"By providing claims-based reports on utilization of services, we provide value-added information about care that is happening outside clinic walls."

Each of the utilization topic areas contains multiple reports. For example, emergency departments use reports that include:

- Visit rates by quarter compared to benchmarks over time
- Avoidable visits
- Visits broken down by each day of the week
- Visits by weekend versus weekday
- Visits by patient

The reports are examined primarily by nurse case managers, who are required to develop individualized care plans for identified patients. Medical groups also can track their enrolled patients' progress in avoiding ED

use over time. It's usually difficult for medical groups to get timely information about their patients' ED visits and hospitalizations. Even when a large health system has records of all ED visits to their hospitals in the patients' EMRs, they don't have records of visits to other hospitals.

Through the utilization reports, medical groups can see their patients' activity regardless of their health plan. For example, one provider looked at the ED visits across the quarter and realized that a majority of hospital visits by people in their health system were not at affiliated hospitals. Data from the utilization reports were updated in the EMRs, providing a more complete picture of the care their patients were receiving.

"It turns out there is so much leakage of data when patients are going all over the place," said Dr. Pranav Kothari, founder of Renaissance Health, a developer



of innovative health care models that OHLC hired to support this work.

“These utilization reports help identify when people receive care that we might not know about otherwise. It helps defragment care in a way that is useful for the patient.”

Dr. Kothari pointed to one example of conducting a similar review of data in one community. It uncovered a disproportionate number of ambulatory/ED visits during certain times of day, particularly during the hours of 3 p.m. to 5 p.m.

“We found out that simultaneously the primary care practices were under pressure to contain costs,” Dr. Kothari said. “Situations that might result in overtime spending would often result in the patient being sent to an ED, even though they might be able to be seen in an outpatient setting if extended access was an option.”

The reports brought a new recognition of how frontline staff at primary care facilities respond in such situations. The utilization reports helped drive an effort to formally extend hours and rethink the implications of ED referrals to avoid overtime spending.

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## LESSONS LEARNED

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Medical groups, nurses, and staff are eager to know how they are doing with their patients, but ability varies greatly in evaluating and acting on data provided in utilization reports. Producing utilization reports from claims that are easily understood and actionable by clinical staff can be challenging. By soliciting feedback from users, organizers can institute modifications based on the first reports. Additionally, Quality Corp worked diligently to ensure the data are presented in a user-friendly way and provided training to maximize the use of the reports.

“The real fundamental value of reports is finding out about utilization opportunities you didn’t know about before,” said Dr. Kothari. “It’s not necessarily revealing a gap in care, but a missed opportunity to know something or to take action, like who had a hospitalization I didn’t know about? Who is not filling all of their prescriptions? A month could be missed. It’s important because you can talk to the patient about it or do something to improve.”

The added responsibility of tracking

enrolled patients on a monthly basis has been tough for medical groups, project managers say. But there is now a unified understanding of its necessity and value for timely, accurate reports and per-member-per-month payments.

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## PROMISING SIGNS

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When initiatives such as the HVPCCM have an evaluation component at the end of the project, too much time passes without feedback to the clinic staff and payers about care delivered. The OHLC/Quality Corp utilization reports provide timely snapshots of how patient care and services used are changing over time, both at the patient level and across settings of care.

While more detailed evaluation of the entire two-year demonstration project is under way, early indicators point to a positive impact on quality and efficiency. The organizations involved expect to see a reduction in ED visits and hospitalizations, and project managers say there is a strong foundation on which to achieve a broader impact.

In fact, the Pacific Business Group on Health in California is looking at the project as a way to better serve their intensive high-risk patients. And, there is a coalition of large employers in Washington State—including the state and two county governments—that are exploring ways to replicate the effort.

“Getting the health delivery system to change is a huge mountain to climb,” said Steve Hill, director of the Washington State Department of Retirement Systems. “I think there is great potential, and the state is one of the big players. This makes intuitive sense, and it has huge potential, particularly if we direct incentives toward systems integration and care coordination.”





# AF4Q's National Health Care Collaborative

Supported by the **Robert Wood Johnson Foundation**, AF4Q's forward thinking health solutions produced real results felt by real people in **16 communities** throughout the United States.

Over the 18-month initiative, more than 100 hospitals improved the **quality and safety of patient care** in measurable ways.

Participating hospitals **avoided hundreds of readmissions** within 30 days of discharge.

Two million limited English proficient patients were **screened for their preferred written or spoken language** when receiving healthcare, and 4,500 patients had qualified interpreters at initial assessment and discharge.

More than half of participating AF4Q teams **reduced the time patients spent in their Emergency Departments** by an average of 30 minutes.

These results are just the beginning. For more information on HQN and AF4Q, visit **[www.forces4quality.org](http://www.forces4quality.org)**.



**Aligning Forces  
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*Transforming Health Care in Communities Across America*





# IS MORE ALWAYS BETTER?

Puget Sound probes one of the most important questions in health care





For more than 20 years, the Dartmouth Atlas Project ([www.dartmouthatlas.org](http://www.dartmouthatlas.org)) has focused on regional variations in the quality of health care services delivered across the United States. This research has emphasized that too often supply drives demand. Patients receive surgeries, tests, and procedures they may not need and that sometimes cause harm, which drives costs up and quality down. While the results are eye opening, few who provide and pay for health care appear to have acted on this information for younger, commercial populations. Questioning treatment choices or the use of specific services is tricky.

The purchasers, payers and providers who are part of the Puget Sound Health Alliance, an Aligning Forces for Quality (AF4Q) community, embraced the challenge, recognizing that variation can be symptomatic of inconsistent, wasteful, and potentially inappropriate care.

After several years of issuing “Community Checkup” reports that compared provisions of generally recommended “effective care” across the Puget Sound region, the Alliance set its sights on developing measures of value in health care services. The Alliance highlighted two important steps on the path to assessing value: (1) gauging the appropriateness of treatment choices and (2) comparing the composition of services providers deliver for similar treatments. The Alliance conducted the following two separate analyses.

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#### APPROPRIATENESS

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First, the Alliance examined geographic variation in treatment choice for “preference-sensitive” conditions—conditions with a variety of treatment options, each with different risk-benefit tradeoffs, from which patient and doctor choose. The Alliance examined how frequently the more aggressive surgical options (see sidebar) occurred in the population, asking the question: “Does where patients live influence what treatments they receive?” Significant variation in the rates of back surgery, cardiac procedures, and hysterectomies emerged



for distinct residential areas. The results potentially could improve the appropriateness of treatment selection and target deployment of shared decision-making aids.

The Alliance and other AF4Q communities are encouraging providers and patients to engage in shared decision making to choose treatments that align with patient values and treatment goals. Research shows that when patients are fully informed of all options available for their conditions, they tend to choose less aggressive options. These options tend to be less expensive, involve fewer clinical risks, and may be associated with faster recovery.

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### SERVICE INTENSITY

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The second analysis measured service intensity as reflected by differences in the composition of similar treatments (e.g., the number of tests, the length of hospitalization, the types of physician services, etc.). It captured how the quantity and type of services for a particular treatment vary among delivery systems. The Alliance chose to focus on the most common hospitalizations but included the activities of all health professionals who were active during the patient's hospital stay—a perspective suggestive of accountable care organizations.

As writer Atul Gawande, MD, surgeon at Brigham and Women's Hospital in Boston, associate professor, Harvard School of Public Health, and associate director, Center for Surgery

and Public Health, pointed out, performance reporting and changes in payment are radically altering the relationship between hospitals and doctors. "They offered us space and facilities, but what we tenants did behind closed doors was our business. Now it's their business, too," wrote Dr. Gawande in the August 16 *New Yorker* article "Big Med."

Service intensity is an important lens through which to view health care variation—research suggests local practice culture and medical discretion may account for this variation among providers. Estimates place as much as 30 percent of all health care spending in the potentially unnecessary category.

The Alliance drew results from its large multi-payer claims database supplied by health plans, self-insured employers, and union trusts. The database contains all hospital encounters, office visits, procedures, tests, and other services for which insurance pays. While there are no transaction prices in the database, the service intensity data provide a directional signal about potential drivers for the cost of care.

Project consultant James Andrianos of Calculated Risk, Inc., used an analogy to distinguish between price and service intensity: "Think about an entrée at a restaurant instead of a hospitalization. The menu price would be analogous to the fee-for-service transaction price paid by the health plan. Service intensity, on the other hand, is more akin to the calories in the entrée. If one restaurant offers this entrée with significantly more or less caloric content than we typically see, we may wish to look at the ingredients they are using to understand what is driving the difference. Therefore, service intensity is not about who is most or least expensive. It is concerned with variation in the 'recipe' of care."

The Alliance's service intensity results have practical





Surgeries associated with conditions having multiple treatment options:

*Angioplasty*  
*Heart bypass*  
*Heart catheterization*  
*Heart valve replacement*  
*Surgery to clear neck artery*  
*Leg artery restoration*  
*Abdominal artery repair*  
*Hysterectomy*  
*Back surgery*  
*Hip and knee replacement*  
*Leg amputation*  
*Gall bladder removal*  
*Mastectomy*  
*Colon removal*  
*Lung removal*  
*Kidney removal*  
*Prostate removal*

implications for the region: All things being equal, delivery systems with more consistent, lower-intensity service patterns will appeal both to employers and to hospitals and medical groups. Employers could use the results to identify treatments and delivery systems where potentially unnecessary “discretionary services” are less likely to occur. Providers could use the data to identify sources of variation that could threaten their ability to succeed with payment reforms, such as bundled payment.

Hospital CFOs have been quick to express interest in what the comparisons say about their production activities, particularly within multi-hospital systems. For their part, employers recognize service intensity variation as a key component in beginning to identify higher-performing delivery systems.

These two analyses are an important step forward for the Alliance community. They join the process quality measures that also are emphasized in the Alliance’s Community Checkup report. As the Community Checkup expands to encompass patient experience, cost, and outcomes, it will begin assembling a more complete picture of health care value in the region. With each step, the Alliance moves closer to its overarching goal of physicians, other providers, and hospitals in the region achieving the top 10 percent in performance nationally in delivery of quality, evidence-based care, and reduction of unwarranted variation, resulting in a significant reduction in medical cost trend.



'Lean' Teams Build

# Patient-Centered Medical Homes



**T**hanks to health care reform, the idea of patient-centered medical homes (PCMHs) is a topic du jour in policy circles. But 22 physician practices are making the concept a reality as part of the South Central Pennsylvania Alliance's (SCPA) Patient-Centered Medical Home Collaborative. SCPA is a community in Aligning Forces for Quality (AF4Q), the Robert Wood Johnson's signature effort to lift the overall quality of health care in targeted communities, reduce racial and ethnic disparities, and provide models for national reform.

Now in its third year, the collaborative has steadily grown more sophisticated. It aims to improve care quality, transform practices into patient-centered medical homes, and give patients a seat at the table.

The program starts with an intensive year-long practice improvement effort. In the initial phase,

coaches teach the practices of the Toyota Lean method. This step helps practices "see waste in what they're doing in their processes every day," said Karen Jones, MD, the Alliance's physician champion. "If they can eliminate some of the waste in their practices, then they can have time and energy to work on quality improvement and becoming a patient-centered medical home."

The entire staff, not just care providers, are trained in the Lean method and are part of developing solutions, said Rush Gross, the collaborative's coordinator. They realize Lean is not a way to cut jobs but rather to fix frustrating work practices, remove barriers to care, and reduce redundancies.

Each practice creates a quality leadership team that includes a physician champion, coach, practice manager, clinical coordinator, and quality improvement apprentice, who gets extra training and hands-on experience in



quality improvement. In the first year, the teams meet once a week, have five dinner meetings, and participate in regular phone meetings.

The practices work toward becoming a “functional” PCMH, Jones said. “The reason we call it a functional patient-centered medical home is because being recognized by an external agency doesn’t mean that you really are a medical home,” she said. The collaborative focuses on the importance of demonstrated practice leadership and the commitment to reducing unnecessary waste in health care spending. Those two items don’t appear to be included in external agency PCMH recognition or certification, Jones added.

Health care has been very provider-interest driven, said Christine Amy, project director of the South Central Pennsylvania Alliance. “What works best for the hospital? What works best for the practice? The doctor wants to work from 8 to 4, so that’s our hours. Well, patients work during that time,” she said. “Does a primary care doctor feel responsible if someone is admitted to the hospital? If a patient is obese, is the

practice really invested in that person being able to actually lose weight?” Both Lean and the PCMH model switch the focus to the consumer/patient, Amy said.

The collaborative took its PCMH definition, developed by the Alliance’s Payment Reform Involving Corporate Engagement Work Group, melded it with National Committee for Quality Assurance (NCQA) criteria, and developed steps to transform the practices. The practices are working toward qualifying for NCQA patient-centered medical home recognition under its 2011 standards by June 2013. The 2011 NCQA standards are more stringent than the 2008 criteria.

Quality improvement also is part of the program. The collaborative, initially focused on diabetes, now has a broader reach. It tracks and shares with the practices their results on diabetes performance measures, ED visits, and potentially avoidable hospitalizations.

“The end outcome is a patient-centered medical home, and Lean is a tool,” explained Jones. “Then diabetes, ED visits, and preventable hospitalizations

are a way to focus people and to rally them around meaningful data so that they can say, ‘That patient had that amputation, and these patients have an A1C greater than nine, so how is it that we make our medical home better to prevent those things?’”

Initially the collaborative’s leadership team thought one year of intensive learning would be enough for the practices, Amy said. But in the second year, the performance results from the practices that participated in the first year started to drop. As a result, the collaborative created the Enduring Learning Forum so practices can sustain their quality improvements and take on new challenges.

Practices in the forum agree to continue to measure quality, their quality leadership teams continue to meet regularly, and the practices gather as a larger group three times a year. Nine practices are in the 2011 intensive learning phase, and 13 are in the enduring learning forum. The practices in the intensive phase participate in enduring learning meetings so they can learn from the more-experienced practices.





Another major change came to the program in its second year. That's when the collaborative created the Patient Partner Program. Each practice invites two patients to join its quality leadership team. The patients take part in leadership team meetings at least once a month. The collaborative got the idea at an AF4Q national meeting from two Alliances that had started involving patients in their PCMH efforts, Jones said.

"The patients keep us honest because we can think we're developing the best processes in the world but develop it around ourselves inadvertently, and our patients say, 'Why do you do it that way? What about this?'" Jones said.

The patients have brought practical ideas forward. One diabetic patient partner inspired his practice to replace the old, large, painful glucometer that had to be retrieved by a nurse at every visit with the newer, less-painful device he used for self-monitoring. The new glucometers are now in each of the practice's exam rooms, and the change has spread to other practices.

Michael Chilcoat, patient partner at Partners in Family Health since July 2010, created a walking group for himself and other patients that is managed through the practice's patient portal.

The physicians respect and value his opinion, he said. Being a patient partner has taught him to be more engaged in his own health. "One of the things that I push now is that the patient is totally responsible for his own recovery or to get himself straightened out," Chilcoat said. "The doctor can tell you to take these meds, to exercise and to watch your diet, but it's up to you to do it."

The practice is now part of the Enduring Learning Forum. Chilcoat introduces himself to patient partners at practices in the intensive learning phase. "The big thing the first meeting or two is to make them feel comfortable," he said. At the joint meetings, he tells the new patient partners: "Just tell yourself before you go in that the doctors put their pants on the same way you do."

The dinner meeting discussions educated Chilcoat about the challenges practices face. "When they explain all the things they're trying to do to cut health care costs, it will open your eyes to the fact that they're as concerned about it as the patients are," he said.

One of the latest additions to the collaborative is the team maturity assessment tool. "It came from an industrial background, and we coaxed it into an examination of the culture of the practice," Gross said. The tool helps practices assess their cultures through a rating system that looks at leadership, collaboration, continuous process improvement, and learning.

So far, the tool has been used twice to measure leadership team culture. "By January we're expecting to roll it out to an assessment of the entire practice," Gross said.



### Lessons Learned

- Start with a committed leadership team that can shepherd the PCMH collaborative forward because it is labor intensive. PCMH collaboratives also need to have a project coordinator dedicated solely to the project, as does the Patient Partner Program.
- Use performance data to drive change. The collaborative establishes performance goals for process and outcomes measures and shares the results monthly so practices can compare their performance to others and learn from each other.
- Involving patients in PCMH leadership teams helps practices become truly patient centered. They identify inefficiencies that providers might overlook, bring a unique perspective to the team, and come up with fresh ideas for change.



# BECAUSE EVERY PATIENT COUNTS

**B**y participating in the national AF4Q program to reduce 30-day readmission rates for heart failure (HF), Carson City Hospital in Michigan was able to use the lessons it learned to focus the staff on performance on other core measures.

At the time, the floor nurses were familiar with core measures but didn't fully understand what they were all about and how important documentation is to the hospital meeting its performance targets. To educate and re-energize the staff, the hospital created the "Because Every Patient Counts" project.

The initiative, which began in the summer of 2010, focuses on achieving a perfect care score for every patient. That means the patient got all the care he or she should have received for the diagnosis.

The campaign was named Because Every Patient Counts not only because the 77-bed acute care hospital embraces that philosophy, but also because even one miss on an indicator can hurt the facility's overall score on a measure due to

small patient volumes, said Joan Sweet, vice president and chief quality and risk officer.

The initiative emphasizes one Centers for Medicare & Medicaid Services (CMS) core measure each week. The measures are color

"The nurses have to be involved in designing the process because they're the ones who are actually doing it. It's easy for me to say, 'That's how I'd do it,' but I don't actually work on the floor."

coded by diagnosis and described in a one-page sheet posted in nursing units and in a weekly newsletter. In addition, managers and supervisors review the material with staff.

The measure sheets include the diagnosis, performance measure name, the measure's description, the rationale behind it, the type of measure, and the elements—including documentation—needed to pass the measure.

"They're a quick reference so nurses can look at them to see what they need to do," Sweet said. Performance is reported back to the units by nurse managers to share with frontline staff.

## WEST MICHIGAN

The project, which began with heart failure measures, went beyond the one-page measure sheets. The staff went back to the drawing board and developed a standardized HF care plan, patient education, and discharge instructions.

Frontline nurses were part of these efforts. “The nurses have to be involved in designing the process because they’re the ones who are actually doing it,” Sweet said. “It’s easy for me to say, ‘That’s how I’d do it,’ but I don’t actually work on the floor.”

Nurses want to be involved in quality efforts, and a lot of time it’s just a matter of enabling them to get off the floor briefly to attend quality meetings, Sweet said.

After heart failure measures, the Because Every Patient Counts campaign moved on to measures for the surgical care improvement project, pneumonia, and acute myocardial infarction. “That was the goal: to learn from heart failure,” Sweet said. “What can you take from that and then apply to other diagnoses or groups of patients?”

Just as with heart failure, a measure of the week was selected for special attention, including the one-page sheets posted in the nursing units, to help the staff achieve the goal of 100 percent compliance with the surgical care improvement, pneumonia, and acute myocardial infarction measures.

A big part of the quality campaign is education, and not just for nurses. At every leadership meeting, a quality item is included on the agenda, Sweet said. The hospital’s performance on core measures is rolled into the pay-for-performance incentive system for hospital leaders. “If we do well on our core measures, then everybody benefits,” Sweet said.

The pay-for-performance incentives are expected to be rolled out to staff members in 2013. Nurse incentives will be tied to their units’ performance on the core measures. “Every unit will sink or swim on its own merit,” Sweet said. “Everybody passes, or everybody fails. It’s not just one individual.”

The campaign also includes physician education. Information about core-measure-of-the-week sheets was boiled down into a short document for doctors that laid out the various measures and what is required to pass them.

The hospital’s efforts quickly showed results. The compliance rate for measures of ideal care rose from 83 percent in the third quarter of 2010 to 94 percent in the third quarter of 2011.

For heart failure, the hospital has reached 100 percent compliance for nearly two years in giving patients discharge instructions, Sweet said. It’s gone more than half a year without a single miss on any heart failure measure, she added.

CMS data showed that the hospital’s 30-day readmission rate for heart failure was 24.2 percent around the





time the project began. It is now down to 22.5 percent, Sweet said. Nationally, the median 30-day readmission rate for heart failure is 24.8 percent (the range is from 17 percent to 33 percent), according to CMS.

Another measure of the campaign's success is that the hospital is expecting to get incentive pay under the new Medicare Value-Based Purchasing Program, which was created by the Affordable Care Act of 2010, Sweet said. Conversely, thousands of hospitals soon will be subject to Medicare payment penalties under value-based purchasing.

Carson City Hospital's project reflects the measures used in the Medicare Value-Based Purchasing Program for acute myocardial infarction, heart failure, pneumonia, and surgical care. Other factors in the Medicare initiative are health care-associated infections and patient satisfaction scores.

The hospital has no plans of letting up on its campaign, Sweet said, and continues to select additional measures for the measure-of-the-week sheets and staff education. For example, it is targeting respiratory conditions—not just pneumonia, but also asthma and chronic obstructive pulmonary disease.

The Because Every Patient Counts project is helping to drive a lasting culture of quality at the hospital, said Duane C. Miller, senior vice president for finance. "Everybody is a lot more sensitized to making sure that certain things happen because of the downside risks on patients and on us as a facility."



## LESSONS LEARNED

- Don't assume your quality message is being heard. At Carson City Hospital, the nurses were familiar with the core measures but didn't understand what it takes to be compliant with them.
- Involve frontline nurses in the performance improvement effort, including the design of processes, because they're at the bedside providing the care.
- Keep things simple. The hospital creates one-page "core measure of the week" sheets that are posted in the nursing units as quick reference on performance measures, what they entail, and what documentation is needed.



# SHAMELESSLY STEALING GREAT IDEAS

Sometimes perfect compliance on a quality measure is only as far away as a store-bought shower caddy and a bit of MacGyver ingenuity. That's how an Erie County Medical Center unit lifted nurse compliance with its IV-tube labeling measure out of the 20 percent to 30 percent range to 100 percent.

This creative solution was just one outcome of the hospital's Transforming

Care at the Bedside (TCAB) project. Erie County Medical Center embarked on the initiative after it was selected in 2009 to participate in Aligning Forces for Quality's (AF4Q) TCAB collaborative.

TCAB's primary focus is to engage nurses and other frontline staff to develop and lead quality improvement efforts on medical-surgical units, where an estimated 35 percent to 40 percent of unexpected hospital deaths occur annually. Five units at the Erie County

Medical Center are using the model, which was developed by the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement.

Staff members were trained in the "plan, do, study, act" method and then

encouraged to "snorkel," or brainstorm to come up with ideas for change that could improve patient care

Not only did the unit's compliance jump to 100 percent and stay there, but the hospital saved \$5,000 in seven months on IV tubing and solution.

or their work environment, explained Karen Ziemianski, RN, acting director of nursing. The medical-surgical unit that Patty Kiblin manages settled on IV-tube labeling as one target because it had been striving to improve compliance but was falling short.

The nurses decided that poor access to the labels was the main barrier. Nurses had to walk to a medication room to get the labels, which indicate when IV tubing must be changed. Changing tubing at appropriate intervals helps





prevent bloodstream infections, and nurses realized they needed to have the labels in patient rooms. The medication carts were too small to carry the necessary seven rolls of labels, color-coded to represent each day of the week.

Nurses began visiting retail stores to find a product that would meet their needs. Kiblin took to carrying seven label rolls with her wherever she went. That's how she happened upon the shower caddy. "I opened up the seven rolls, shoved them in there, and thought, 'Oh my gosh, it works,'" she said. The unit charge nurse's father adapted it by adding a spindle with caps on the ends so nurses could hang the rolls in the caddy and easily replace them when they ran out. The unit bought enough labels and caddies for each patient room.

"It's amazing what a change it made just to have the accessibility for the nurses," Kiblin said. Not only did the unit's compliance jump to 100 percent and stay there, but the hospital saved \$5,000 in seven months on IV tubing and solution. Before the project, if a nurse found tubing that wasn't labeled, she had to discard it and the IV solution, which led to waste.

The shower caddy idea spread, not just to other Erie County Medical Center units but also to other hospitals participating in TCAB. The program promotes the concept of "shamelessly stealing" successful ideas from others.

Erie County Medical Center's new family-activated rapid response initiative is an example of how shameless stealing works. Staff learned about the concept at a national TCAB meeting, which featured a heart-wrenching video by the mother of Lewis Blackman. The 15-year-old died in 2000 from internal bleeding after elective surgery, even though his mother repeatedly brought concerns about his deteriorating condition to the hospital staff.

"Based on that, we decided at our hospital that our families really need to become part of our team," Kiblin said. The staff engaged patient families in the effort by asking them to review and give input on informational materials that explain to families they have the right to call a rapid response if they believe their loved one's condition is worsening and the staff isn't listening to their concerns. Several units have implemented the rapid-response program, and it is being rolled out to the entire hospital.

When the medical center first started its TCAB

journey, nurses were doubtful it would have that kind of success. "They thought, 'Nobody is going to listen to us,' or 'We're not going to be able to do anything about it,'" Kiblin said. "But as they saw that people were listening and changes were happening—and they're changes that make their job easier or help patient care—they really had buy-in." Now Kiblin's nurses routinely walk up to her in the hall to propose ideas. Ziemianski said staff members slip notes under her door about products that might improve patient safety or grants they want the hospital to seek.

"You want the staff in the beginning to say, 'That was super easy. We could have done that years ago.'"

To win nurses over, it helps to start small, Kiblin said. She hung a poster board on a wall in her unit where nurses could write down their ideas. They worked on the easiest ones with the highest impact first. "You want the staff in the beginning to say, 'That was super easy. We could have done that years ago.'"

One simple project that had a big impact was getting a discharge board for the unit. The nurses and discharge planners weren't communicating well. "All of the sudden, an ambulance would show up for Mr. Smith, and he wouldn't be





ready,” Kiblin said. The board posts patients’ room numbers, the time they’re leaving, where they’re being discharged to, and how they’re getting there. The discharge planner loves it because she was tired of trying to track down nurses to discharge a patient. The board’s success spurred other units to shamelessly steal the idea, Kiblin said.

Other projects have been large, multipronged efforts. For example, the hospital revamped its heart failure treatment program using TCAB principles, Ziemianski said. “I brought the frontline staff in, and we looked at what we were doing. Was it patient-centric? Was it really adding value to the patients? What we found out was that it really wasn’t.”

Admitting when a practice isn’t working is an essential part of TCAB, Ziemianski said. “You can never acknowledge different challenges that are holding you back if you always say that you’re 100 percent correct.”

The heart failure effort resulted in the change of myriad processes and implementation of new ideas. The hospital used the American Heart Association’s “Get with the Guidelines” program and received the Gold Quality Achievement Award. The heart failure program includes quality improvement measures, discharge protocols, standing orders, and measurement tools. The staff reworked all the patient education materials. They collaborated with the informatics staff to change the electronic medical record so nurses conducting patient education could see what the patient had already learned about and what his or her struggles still were.

Nurses introduced a calendar that tracks heart failure patients’ weight and how they feel that day using red, yellow, and green as indicators. The patients take the calendar home and then bring it to their outpatient hospital or primary care physician visits, Ziemianski said. The staff also initiated a post-discharge callback program through which they check on such items as whether patients are taking their medications and if they’re being weighed.

TCAB’s bottom-up approach makes all the difference, Ziemianski said. “It really changes the complexion of your organization when you really listen to your front line staff who are doing the work,” she said.

The hospital’s senior leadership has fully supported TCAB, Ziemianski said, and has provided funds when they’re needed. “To be honest, the nurses are very frugal,” she added. “Many of their ideas don’t cost a lot of money at all and really increase patient safety or

really try to change that experience for the patient.”

The program’s biggest challenge has been time constraints, especially when the TCAB units have high caseloads, Ziemianski said. Nurses need time to test their ideas to see if they should be adapted, adopted, or abandoned, she said.

But Ziemianski added: “You have to continue to break down your challenges and work around them.

You have to keep saying to yourself that this is the best opportunity that the front line staff has right now to get their voice heard in an organization.”

“It really changes the complexion of your organization when you really listen to your front line staff who are doing the work.”



### Lessons Learned

Listen to your frontline staff. Nurses are very creative and patient centered. They should be at the forefront of the quality improvement process because their position at the bedside enables them to see where change is needed.

Create opportunities for staff to “shamelessly steal” successful ideas from other units within the hospital and from other hospitals so that positive changes spread.

Empower patients and their families. One of the program’s pillars is to improve patients’ and family members’ experience of care. Don’t be afraid to ask for their input when creating education materials or embarking on projects such as family-activated rapid response.



# Small Tests of Change Grow to Big Results in Reduction of ED Overuse

Heightened awareness of growing problems in the medically underserved population—such as fragmented and duplicative care, poor access to care, and a lack of care coordination—helped spark Milwaukee County's five health care systems to join forces to address these pressing issues.

The health systems created the Milwaukee Health Care Partnership in 2007, and the organization has since grown to include the area's four federally qualified health centers, the Medical College of Wisconsin, and state and local government health agencies. The Wisconsin Collaborative for Healthcare Quality, the Aligning Forces for Quality (AF4Q) Alliance in that state, is a collaborating partner.

"There was a leap of faith that by working together we could improve care for underserved populations and achieve better outcomes and better health care at a lower cost," said Joy R. Tapper, the partnership's executive director.

A major catalyst for the partnership's creation was overuse of hospital emergency departments (EDs) for primary care and ambulatory sensitive conditions among the uninsured and Medicaid populations. In 2011, 47 percent of ED visits in Milwaukee County were classified as non-emergencies. Medicaid and uninsured patients accounted for 67 percent of those visits.





One of the partnership's first projects was the ED Care Coordination Initiative. It has three goals: decrease avoidable ED visit and related hospitalizations, reduce avoidable and duplicative tests and procedures, and connect high-risk ED users with medical homes. The project targets people without health insurance or on Medicaid who lack a medical home and are pregnant, are frequent ED users, or have at least one of five chronic conditions: asthma, chronic obstructive pulmonary disease, diabetes, hypertension, or HIV/AIDS. The partnership settled on these categories because these patient groups could benefit most from gaining a medical home, Tapper said.

The initiative features an ED-to-medical-home transition care management process through which case managers at the county's eight adult EDs identify patients in the target population, provide printed and face-to-face patient education, schedule primary care appointments, and make referrals to one of the health centers, which then serves as the patient's medical home.

Getting the various stakeholders on the same page to create a common program was no easy task, said both Tapper and Betty Ragalie, the initiative's project manager. Some of the health systems already were exploring different strategies to address avoidable ED visits. So the partnership created an ED care coordination steering committee that includes ED medical directors and care managers, Medicaid managed care personnel, and representatives from the safety net clinics. Together, they diagnosed the situation, learned about each other's efforts, and looked at best practices in the community and nationally to develop their unified approach.

The initiative benefited greatly by the concurrent development of the Wisconsin Health Information Exchange, for

which the five health systems provided some funding. AF4Q, through its funding from the Robert Wood Johnson Foundation, also provided some health information technology grant money to the Wisconsin Department of Health Services on behalf of the partnership's ED Care Coordination Initiative.

The information exchange gives ED providers and case managers information on patients' ED, ambulatory, and inpatient utilization history across the Milwaukee delivery system. The health information exchange (HIE) gives physicians and other providers the information that can guide clinical decisions and care coordination. For example, the record could show a patient just had an MRI—knowledge that could prevent a physician from repeating the scan. Also, if a patient sought treatment at one ED in the morning and then visited another ED later in the day for the same reason, providers would see that in the electronic record. For care coordination purposes, the system allows providers and case managers to identify a patient's primary care provider and share information regarding the ED visit and recommended plan of care.

It also helps guide case managers' decision making by showing, for example, whether a patient is in the target population or has a pattern of ED use. The HIE also flags frequent ED users—patients who have visited an ED four or more times in a year—so that case managers can provide coaching regarding the importance of continuity of care and the benefits of a medical home.

The HIE now is being expanded into the health centers. "Already the first clinic is finding it gives them information about which of their patient groups is going to the ED most frequently and learned that it's asthma, behavioral health, and pain," Ragalie said. "That information is



really allowing them to look at their patient management strategies.”

Another technology that is instrumental in the initiative is a web-based, electronic scheduling tool called MyHealthDIRECT. It allows the community health centers to post open appointment slots so ED case managers can schedule a medical home appointment while the patient is still in the emergency department. Appointments in MyHealthDIRECT automatically are populated in the HIE. The five health systems entered a community contract with MyHealthDIRECT.

The product allows case managers to select a medical home for the patient using such criteria as the health center's proximity to the patient, physician specialty, such as internal medicine or OB/GYN, and patient preferences, such as the provider's language or gender. The case managers print out an appointment confirmation sheet that gives the patient all of the necessary information. Patients also receive a fact sheet on the community health center and are offered other support to ensure they keep the appointment.

After an appointment is made, a health center intake coordinator reaches out to the patient, provides information about the center, encourages the patient to keep the appointment, and follows up if he or she doesn't show.

In 2011, the initiative resulted in Milwaukee EDs scheduling 7,600 appointments with safety net clinics for

“There was a leap of faith that by working together we could improve care for underserved populations and achieve better outcomes and better health care at a lower cost.”

Medicaid and uninsured patients. Forty-two percent of patients kept their initial appointments, and about 45 percent returned for a second appointment within six months.

The partnership now is testing a way to use information technology to compare patients' ED and inpatient utilization before their referral to a medical home with their utilization after the referral, Ragalie said.

The ED initiative has faced several challenges over the years. One has been “trying to adopt common processes and maintain constancy of

purpose and consistency of application across multiple providers and organizations that are very dynamic and where there is considerable turnover of personnel and multiple competing priorities,” Tapper said. Having a strong commitment from the organizations' CEOs and chief medical officers has helped to address the issue and reinforce the importance of these collaborative efforts. Additionally, the initiative's steering committee, with representation of all the stakeholders, is instrumental in keeping everyone on the same page. It's also vital to have a project manager to keep track of all the initiative's moving pieces and measure progress, Tapper added.

Although it's important to have standard implementation of core processes and patient referral criteria, it's okay to have some variation among the EDs and health clinics. For example, the initiative's approach was to identify ED case managers' roles and responsibilities but then to respect the health systems' role in determining exactly how to staff them.

Another major challenge has been “the multiple variables and confounding factors that result in people using the ED for primary care purposes,” Tapper said. One of the biggest factors is insufficient primary care capacity for uninsured and Medicaid patients. So in 2008, the partnership commissioned a primary care access study. It showed that 10 Milwaukee ZIP codes with the highest rate of poverty generated 60 percent of avoidable ED visits. Tellingly, those 10 ZIP codes also have the lowest concentration of primary care providers in the community.

The study spurred the partnership to invest in building primary care capacity. The health systems have contributed \$1.7 million a year to subsidize medical homes in the health centers, and each system sponsors other safety net clinics' capacity, Tapper said. The partnership also is trying to expand the number of community health centers.



To make primary care available when patients in the target population need it, all of the health centers expanded their after-hours and weekend appointments. The partnership learned valuable lessons for its ED Care Coordination Initiative through its participation in the Institute for Healthcare Improvement's Reducing Avoidable Emergency Department Visits Prototyping Project. One lesson was to start small with pilot projects and then build from there, Ragalie said. The initiative wasn't implemented all at once and continues to progress in stages.

Another tactic the Milwaukee initiative learned from the IHI project is to involve patients in developing and improving processes, Ragalie said. For example, in a recent effort to evaluate the primary care appointment confirmation sheet, the ED case managers and health center intake coordinators interviewed a small number of patients about whether the information was clear, if the patients would change anything, and whether it helped them keep their appointments.

The ED Care Coordination Initiative continues to act as a catalyst for new partnership projects. For example, in working to improve primary care



access to decrease ED overuse, the partnership has recognized that specialty access for the uninsured also is a significant issue. So now it's in the early stages of creating a model for specialty access for the uninsured, Ragalie said. "Connecting

ED patients with medical homes is one issue, and it's connected intimately with all of the other coverage, access, and care coordination initiatives of the partnership."

## Lessons Learned

■ Focus on a well-defined population. The ED Care Coordination Initiative targets people who would benefit most from gaining a medical home: patients without health insurance or on Medicaid who are pregnant, are frequent ED users, or have at least one of five chronic conditions.

■ Conduct small tests of change and get patient feedback. The entire ED Care Coordination Initiative wasn't launched overnight. At each step of the way, pilot projects were conducted to test change, and patient input often was sought.

■ Strong support from participating organizations' leaders is essential to get multiple providers to adopt common processes and maintain constancy of purpose and consistency of application. Also, a project manager is necessary to keep tabs on all the moving pieces.

■ Multiple factors contribute to medically underserved patients' use of EDs for primary care. No one solution is going to address all of them, so project organizers must be willing to adapt.



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