

Independent physicians collaborate to improve quality

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Introduction

Waukesha Elmbrook Health Care, S. C. (WEHC) represents over 490 independent primary and specialty care physicians in southeast Wisconsin and has been dedicated to providing quality care for over 23 years. A significant portion of WEHC's network is comprised of small practices with 1-2 physicians. These smaller practices typically do not have the time or resources to focus on quality improvement and have a limited number of patients for specific quality monitoring. These small practices also have a limited number of patients from any single health plan, which doesn't allow for statistically valid quality monitoring. WEHC facilitates collaboration by providing support, resources, and pooled data to generate statistically sound measurements of the improvement process.

Chronic Disease Management and Patient Health Registries

While many national and regional entities have spent a great deal of

time identifying and harmonizing the standards for quality health care measurement, there is even more work to be done to achieve behavioral change in health care professionals and patients. Recognizing that this change begins at the physician-patient level, and because of the major impact that chronic diseases have on health care costs, WEHC began gathering the necessary baseline data to identify gaps in the diagnosis and management of diabetes, asthma, hypertension, and cholesterol management.

Practices that have an electronic medical record (EMR) are providing data electronically to WEHC; however, many practices cited concerns about cost and disruption to their busy practice as barriers to adopting a full EMR. As WEHC's quality initiatives grow, it was no longer practical to pay nursing auditors to go to each office to conduct manual chart audits. Therefore, WEHC offered physicians a web-based patient health registry, called DocSite®, as a low-cost and easily adopted electronic health record.

Patient health registries provide point of care connectivity with provider offices for communication and tracking of clinical information, improve early high-risk patient identification, and lower the administrative costs for quality improvement and popula-

tion health management. WEHC has centralized access to all patient and physician data and uses this information to identify process improvement opportunities in a manner that is consistent with applicable privacy laws.

The implementation and use of the DocSite's PatientPlanner® Registry was streamlined to include 5 steps.

1. An initial meeting is held with the physicians and clinic manager to describe the process for implementation of the patient registry.
2. From the clinic's billing system, patients are identified for inclusion in the initial registry set-up.
3. Patient information is entered into the registry by WEHC staff, and on average, 150 patients are loaded into the registry per day.
4. After the initial data is entered in the registry, a summary sheet is printed out and placed in the patient's chart. The clinic staff receives training on the DocSite registry and is then responsible for the ongoing patient data updates and adding new patients to the registry.
5. A summary report is generated and shared with the physician, including the physician specific information and comparisons with the NCQA

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standards. During this follow up meeting, the clinic staff is taught how to generate its own reports, which are specific to their clinic or to each physician within a clinic.

Through hard-earned experience, WEHC has learned that pilot-testing process improvements on a small scale helps facilitate honest and open benchmarking among physicians who know and respect each other, which leads to broader adoption of a process improvement. Because the quality initiatives involve data obtained at the point of care, the improvement cycles avoid the many challenges that initiatives based on claims data encounter. This approach is relevant for every specialty in WEHC, including those that may not yet have evidence-based standards for care.

Specialty Care Physician Involvement

Most current clinical measures are directed only at primary care physicians. WEHC recognized the void in quality measures for specialists, and implemented a plan to incorporate specialist self-directed workgroups. Specialist workgroups are initiated by inviting all WEHC physicians within a given specialty to an opening meeting. The agenda of the first meeting includes a process improvement overview, research on the national quality metrics/standards specific to the specialty, and sharing the current quality metrics being captured by each group. Subsequent meetings are conducted, as needed, to finalize WEHC specialty measures and implement any new measurement collection processes. Following baseline data collection and gap analysis, process improvement cycles are implemented for specific areas of improvement.

Specialist work groups have been evolving over the past year and include pathology, radiology, dermatology, podiatry, ophthalmology, allergy and asthma, pediatrics, orthopedic, and gastroenterology specialties, with several other specialty groups being added in 2007. Specialties that interrelate to the chronic disease projects are given priority (e.g., cardiology, endocrinology, ophthalmology, and podiatry integrate with the diabetes initiative). The specialists have been very supportive of this approach and are active participants in the workgroup meetings. Examples of specialist quality initiatives include:

- Pathology—The pathologists have identified 3 clinical indicators to track per physician: report turn-around-time, amended report rate, and rate of discrepancy on frozen sections.
- Radiology—The radiology groups focus their measures in the areas of mammography, interventional radiology, and double-read accuracy.
- Dermatology—The dermatology metrics for patients with a primary cutaneous melanoma lesion include clinical excision margins that are appropriate for the tumor thickness, completed routine follow-up exams with lymph node palpations at specific intervals, and patient education on self-examination.

The WEHC Physician Performance Profile

In addition to the programs described above, every physician in WEHC is provided with a Physician Performance Profile (“the Profile”) of his or her compliance with WEHC clinical integration measures on an annual basis. The Profile contains measures that physicians are

expected to achieve in key categories such as WEHC Patient Satisfaction Survey, Specialist Peer Survey, Information Technology Compliance, Generic Pharmacy Use, Clinical Measures, and other WEHC participation requirements.

Each category has a specific measure and scoring methodology (e.g., physicians achieve points for electronic claims submission). Most categories are the same for all physicians; however, clinical measures will vary by specialty (e.g., the measures for primary care focus on colon cancer and diabetes whereas the measures for pediatrics focus on immunizations and asthma protocols). Physicians who achieve optimal scoring are eligible for organizational and peer recognition.

Development of AMICUS Health Care Consumer Advocacy, Inc.

WEHC has also formed a non-profit foundation, AMICUS Health Care Consumer Advocacy, Inc. (AMICUS). The genesis of AMICUS was based, in part, on the following quote from the Institute of Medicine’s 2004 report *Health Literacy: A Prescription to End Confusion*: “Health consumers face a number of challenges as they seek health information, including the complexity of the health systems, the rising burden of chronic disease, the need to engage as partners in their care and the proliferation of consumer information available from numerous and diverse sources.” AMICUS is dedicated to the following principles:

- Educate health care consumers to improve the degree to which they obtain, process, and understand basic health care data, information, coverage, products, and services.

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- Through education, enable health care consumers to better participate in the health care decision-making process.
 - Identify and implement options designed to establish and improve various types of communication between health care consumers and health care professionals.

WEHC and AMICUS continuously seek grant funding to support their health advocacy staff who, in 2007, will begin to provide direct support to encourage patient compliance (e.g., contacting patients directly to discuss preventive care and address barriers to achieving that care). From a 2006 pilot test of the health advocacy program, WEHC learned

that patients appreciate the direct contact as an extension of their physician visit, and that compliance rates were significantly improved with such contact. The goal is to help patients become more involved in the self-management of their chronic illnesses.

Conclusion

Taken together, WEHC's quality improvement and clinical integration programs are designed to positively impact every aspect of WEHC's existence as a professional organization. Physicians in WEHC are motivated to adopt best practices for many reasons, including the obvious benefit of improved patient care. Another factor is the ability to participate

as a member of WEHC and cultivate stronger business and professional relationships with other WEHC physicians. The increased interdependency between primary and specialty care physicians provides for strong, efficient, and patient-friendly referral patterns. In addition, the necessity of joint contracting is valued by all physicians and provides a strong impetus for compliance with clinical integration programs. Ultimately, physicians support WEHC's quality improvement and clinical integration programs because they promote improved outcomes, improved efficiencies, and the practice of collaborative medicine by strong, independent health care professionals.

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