

Eight Strategies & RAND Meeting Highlights RAND Heart and Diabetes Strategy Work Group Right Care Initiative

The purpose of the 2008 RAND meetings was to determine strategies for reaching the national 90th percentile of clinical outcomes performance for Heart and Diabetes HEDIS scores in California, as set out in the Right Care Initiative. The overarching strategy for achieving improved outcomes is through catalyzing the adoption of clinical and management best practices and protocols. Eight specific components of that strategy are laid out in the meeting notes below, including the need to focus first on lipid and blood pressure control.

Dr. Paul Shekelle, practicing physician and director of RAND's Southern California Evidence-Based Practice Center, chaired two meetings before calling for subcommittees to detail out strategies. UCLA Professor Gerald Kominski helped facilitate the majority of meetings, including the subcommittees, which will be reporting back to the Heart and Diabetes Work Group on May 18, 2009 in San Francisco under the chairmanship of Dr. Joe Scherger of Lumetra. Participants included medical directors (Aetna, Blue Cross, Blue Shield, Health Net and LA Care), quality improvement organizations, experts and key stakeholders.

The work group expressed optimism that working together, oaring in the same direction, significant progress can be made by emphasizing patient identification, incentives/reimbursement changes, new models of care, public education, proactive coaching and clinical team training.

The group discussed root causes for lower performance, examined challenges and opportunities and ultimately set forth specific actions for yielding measurable gains. Root causes and key deficiencies discussed included a shortage of clinicians, demographic challenges, regional disparities, resource challenges, and poor IT capabilities. Regional variation was determined to be a root cause for driving overall California performance down. Interest was expressed in hotspots mapping to target resources and interventions appropriately. Challenges noted include financing quality improvement efforts. The group identified interest in working synergistically with existing collaborative efforts to drive improvement, such as the Integrated HealthCare Association's (IHA) Pay for Performance Program, and the California Quality Collaborative (CQC) focused on low performing medical groups in the Inland Empire.

Eight Strategies For Reaching the 90th Percentile in Heart and Diabetes HEDIS Measures

The overarching goal is catalyzing the adoption of clinical and management best practices and protocols. Exploring high level performers in low performing areas could be a rich resource for this information, as will the federal Agency for Healthcare Research and Quality.

A multi-faceted approach is recognized by the work group as essential, with committed stakeholders leading specific components using their expertise and unique resources. The group agreed that there are certain aspects of improving clinical performance that should be prioritized:

- 1) **Of the ten HEDIS measures in heart and diabetes, the greatest emphasis should be first on control of 1) lipids, 2) blood pressure, and 3) glucose levels, because of their importance in preventing mortality and morbidity due to strokes and heart attacks, the greatest killers for both heart disease and diabetes.** This is the perspective of Dr. Shekelle and the heads of the California Department of Public Health's Diabetes and Heart programs, Dr. Dean Schillinger and Dr. Lilly Chaput, as well as the medical director of the Pacific Business Group on Health, Dr. Arnold Milstein; the quality improvement medical director for Sharp Rees- Stealy, Dr. Jerry Penso; and Dr. Ken Kizer. Dr. Fran Kaufman emphasized that all of the HEDIS measures are important, and that glucose control is especially important for preventing retinopathy, renal disease and neuropathy. Dr. Shekelle noted that the commonly-reported finding of a 30% relative risk reduction in mortality among high risk patients with statin use, combined with their availability as generics, as well as less of the outcome being dependent on patient behavior modification, make the use of statins a uniquely important tool for improving clinical outcomes for both heart and diabetes patients.

It was agreed that the win-win opportunity here is that certain strategies can focus on a big push on lipids and blood pressure (i.e. public education campaign), while continuing to emphasize the need for improvement in all 10 heart and diabetes measures. The group consensus was that a combined medical care and public health/ public education approach would yield the best results (see item 6 below).

- 2) **Aligning and improving payments and incentives to support strategy one among all stakeholders (patients, plans, medical groups, employers) is essential.** Dr. Michael Belman noted that California's Pay for Performance Program (P4P) is the second largest in the world, after the United Kingdom, and yet the results have been disappointing. He expressed that pay for performance must be re-tooled to focus on improving the lowest performers instead of showering the best organized and performing with continued bonuses. His analysis is that the \$100 million dollar program of incentives is being wrongly distributed. Dr. Michael-Anne Browne, medical director for Blue Shield, noted that big players are getting bigger and re-thinking of incentives is necessary. The Integrated Health Care Association is continuing to work with health plans and providers to refine P4P to re-orient incentives toward both improvement and relative performance.

Dr. Don Rebhun, chair of the Integrated Health Care Association and medical director for Health Care Partners, noted that incentives are important at every level of health care. He suggested that gas cards in exchange for getting certain tests, or achieving certain control levels, are potentially powerful patient incentives. He mentioned additional examples such as forgiving co-payments and incenting employers, for example through the potential of gain-sharing. Reimbursement strategies that reward clinicians for providing specific essential care, like foot exams for diabetics, were recommended by Karen Vicari, executive director, Alliance for Better Medicine. Dr. Jack Lewin, president of the American College of Cardiology, volunteered to lead the incentives and payments refinement effort. Karen Vicari and Drs. Belman, Rebhun are also interested in working on this.

- 3) **Proactive outreach and coaching of patients is critical.** It was noted that the two California health plans with the best HbA1C glucose control scores for 2007 and 2008, Kaiser North and Health Net, both use nurses, physician assistants and educators to proactively reach out to coach patients. Kaiser uses diabetes clinical team members, and Health Net uses Health Dialog external disease management to augment the work of the patient's clinical team.

Dr. Dean Schillinger presented information that UCSF has developed an inexpensive automated telephone outreach program that helps to triage which patients need direct contact by a clinician for coaching and medication adjustment (used by the San Francisco Health Plan). This multi-lingual automated telephone self-management support system has patients respond to a set of automated questions. When certain concerns are raised or values exceeded, nurse coaches then reach out to patients personally. Other examples of proactive outreach and coaching need to be researched, such as the Asheville clinical pharmacist intervention project. Catalyzing the adoption of the most efficient and effective strategies in patient outreach and coaching is an essential a priority of this project.

- 4) **A broad team approach to patient care for chronically ill patients is proven to be effective, and efforts that are underway to spread this model require additional support.** This expanded team concept includes front office medical personnel, pharmacists, nutrition counselors, nurses, doctors, disease educators, including paid peer counselors, "promotoras," etc., even extending out into community centers.

A) Grow capacity of existing team training efforts - CQC is focused on team training of medical groups, while the California Medical Association Foundation is reaching out to solo and small group practices. Dr. Belman emphasized that one of the lowest performing areas is Los Angeles, noting that outreach to the low performing medical groups there by CQC has been unsuccessful. He stressed the importance of improving performance in Los Angeles in order to impact the largest number of lives. Riverside and the Inland Empire are also areas of agreed high need. It was noted that underperforming groups may have difficulty joining CQC because of personnel and financial constraints. Dr. Belman and Dr. Wells Shoemaker suggested that DMHC encourage low performing groups to participate, and to

encourage those health plans that are not contributing to CQC to do so. DMHC is willing to help with this. Despite regional variation, no region consistently performs at the national 90th percentile, so all regions can benefit from clinical quality improvement efforts.

B) Amplify community centers as resources for patient education and support – Broadening the concept of a team approach further into the community was recommended by Dr. Wells Shoemaker and supported by the work group. He recommended that community centers are well positioned to provide culturally appropriate self-care education, etc. and that they could be jointly supported by health plans. He facilitated a presentation by June Simmons about the patient self management model developed by Stanford's Kate Loreg and David Sobel of Kaiser at the Stanford Patient Education Center. This program has been shown to pay for itself through modest reductions in hospitalizations and length of stay. (See <http://patienteducation.stanford.edu/programs/cdsmp.html>).

A related idea was brought to the group by Dean Schillinger, Chief, California Diabetes Program: RAND's Dr. Nicole Lurie and Allen Fremont have been conducting small area analysis of hot-spots based on national health plan data that we may be able to build on to focus community center efforts. Through this data, precise targeting can direct scarce resources by identification of high risk geographic areas for focused public health, outreach, education and clinical interventions.

5) **Practice redesign, including preset protocols and flow charts, should be broadly deployed to improve outcomes and ensure up-to-date scientific research is incorporated into care management.**

Dr. Fran Kaufman stressed the importance of moving patients onto insulin more quickly when specific criteria are reached as an important example of needed spread of best practices. She emphasized the power of simple and inexpensive tools such as pre-set protocols and inexpensive flow charts that help with mapping a patient's disease progression/co-morbidities, as well as decision trees to help identify appropriate timing for additional therapies. Check lists, color coding and card catalogs are also simple, inexpensive tools that can enhance the ability of nurses and medical assistants to assist with care management and make visits more efficient. Dr. Jerry Penso also suggested that simple matrices and protocols are very important to improving clinical outcomes and practice efficiency. Dr. Penso provided an example of one matrix that saves clinicians time in prescribing appropriate medications, attached.

Dr. Joe Scherger of Lumetra offered to lead a subgroup to explore practice redesign to include the importance of continuous relationships, stressing that there are proven models that can work that are increasingly important in the context of shortages and challenging economic and demographic issues. He recommended de-emphasizing care that is episodic and reactive in the traditional model of physician visit orientation, calling on the group to assist in evolving practice to be continuous and supported by information systems and web based tools. Notable examples of this approach include the Redwood Consortium of Care and Kaiser Richmond (going from worst to first through practice redesign that included telephone outreach and additional physician assistants). Other ideas include sending mobile clinical teams into areas of shortage in appropriately equipped large vehicles, etc.

6) **Clinician and public health/education campaigns are an essential component of an overall outcomes improvement campaign.**

Dr. Jerry Penso, medical director for Sharp Rees Steely Medical Centers emphasized that a public airways campaign is a critical component to success, noting his experience working on the appropriate use of antibiotics project. In response to the potential of celebrities, such as Joan Lunden, assisting with such a campaign, Dr. Penso noted that after Ms. Lunden of Good Morning America fame appeared in an advertising campaign for Claritin, prescriptions rose dramatically, indicating the power of her messaging. Ms. Lunden's brother recently died of diabetes and indicated interest in a public service campaign, building on her father's work as a Sacramento physician.

Sang Mi Oh, Director of the American Heart Association's State Health Alliance/Stroke Program, offered to lead a public airways, clinician and public education campaign work group, in partnership with Kristy Lee of Johnson and Johnson (former news anchor and UCLA master's student), as well as the heart and diabetes programs of the California Department of Public Health. The Johnson and Johnson Diabetes Center may also be an important asset in this effort.

- 7) **HIT- Clinicians need accurate and timely information about patients as individuals, as well as from a macro-analysis panel perspective.** There is consensus among the group that information technology is a very important tool for meeting the goals of reaching the 90th percentile of national performance. While many in the group emphasize the need for a patient registry so that physicians can look at their entire panel of patients, Dr. Alex Li of LA Care suggested that an important alternative is that the plans work together to provide the needed data. Dr. Harvey of Aetna concurred. Dr. Don Rebhun suggested that an incremental work-around is to ensure that clinicians are provided laboratory results. Dr. Jack Lewin of the American College of Cardiology mentioned that there is a great deal of activity at the state and federal levels, and that his group will be providing new software to community physicians that will assist with adherence to guidelines. Dr. Paul Shekelle noted that to do population based quality improvement one must have a registry or some mechanism to track patients. Doctors Fran Kaufman and Don Rebhun both stressed that real-time electronic infrastructure capacity is the long-term goal, however, important progress can be made even with low-tech solutions, such as card files and handwritten flow sheets, and that some high tech takes time away from patient care. Federal assistance may make this
- 8) **Over the longer term, support a broader payer/purchaser/clinician quality collaborative modeled after Minnesota's Institute for Clinical Systems Improvement (ICSI includes all 6 major health plans and 57 medical groups).** Dr. Wells Shoemaker introduced this idea to enhance California's quality improvement capacity. He stated that in contrast to Minnesota, where all plans and groups participate in ICSI, Health Net, Blue Cross and Blue Shield actively work on quality improvement with CQC, The Integrated Health Care Association, Pay for Performance, etc. and asked that the Department encourage the other health plans to participate in supporting CQC. One approach to building a California ICSI is to build it on the foundation of the California Quality Collaborative (CQC). Diane Stewart of CQC noted that two states have universal participation (Minnesota on a voluntary basis (costing 80 cents per resident) and Vermont on a mandatory basis (60 cents per resident)). Dr. Joe Scherger noted that Minnesota's ICSI grew out of a culture of excellence, and that ICSI was not the instigator of the culture of continuous quality improvement. He further stated that we should consider adopting some of the Minnesota ICSI materials and strategies as they are publicly available. Phyllis Torda of NCQA also noted that New England has a similar culture of intentional collaboration around excellence that has resulted in outstanding performance results. It is recognized that building that culture and capacity is a long term goal.

Meeting participants also indicated that beyond activities of health plans and medical groups to improve clinical quality -- the direct focus of this project -- there may be additional opportunities to collaborate, for instance:

- **Employers and health coverage purchasers are important partners in healthy outcomes.** Employers can provide employees with incentives and opportunities for making healthy lifestyle choices, for instance through benefits design and by ensuring availability of healthy food choices at the work site. They can also provide opportunities for exercise, and ensure a physical environment that supports physical activity, such as easy use of stairs. Recent innovations in building design and workstations that incorporate gentle exercise are promising developments to reduce the trend toward obesity and prevent illnesses driven by sedentary lifestyles. Employers with on-site clinics and staff nurses are an additional venue for patient education and support.
- **Interest was expressed in alignment with Medi-Cal's Quality Improvement Program.** DMHC has explored potential synergies with the Medi-Cal program, but at this time, Medi-Cal's quality improvement program has a different focus.

The work group recognizes that each of the strategies above are valuable and that a multi-faceted approach is necessary. With different stakeholders taking leadership roles in specific components, this collaborative effort can better leverage the significant talents of the community more effectively.

Action Items

Task 1: Identify low performance in particular geographic areas.

Task 2: Engage groups, plans, community, purchasers and professional societies in this effort.

Task 3: Explore community center options for improving patient disease self-management.

Task 4: Identify efficient and effective patient outreach, coaching and disease management.

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