



A collaboration between the Department of Family and Community Medicine, University of California, San Francisco, and The Permanente Medical Group

FEATURE ARTICLE

Interview with Dr. Alan Glaseroff

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It is relatively uncommon for significant quality improvement work to take place in small primary care practices because these practices have few resources and little time available for improvement work. It is even less common to observe serious quality improvement taking place in the practices of an entire community. Because the work of Dr. Alan Glaseroff involves a community-wide primary care innovation, we are featuring his work in this e-letter. This interview was conducted by Tom Bodenheimer in August, 2006.

TB: Could you describe the Humboldt-Del Norte Independent Practice Association (HDNIPA)?

AG: The HDIPA is a traditional California IPA, formed mainly to give physicians some clout in negotiating contracts with HMOs. Our IPA includes almost all the physicians in Humboldt County, on the north coast of California. We have 29 practices including 5 community health centers - 240 physicians plus 140 midlevel practitioners and mental health providers. Eighty-four of the physicians are in primary care. The IPA is run by a board including half primary care physicians and half specialists. For about 5,000 HMO patients in the county, health plans pay physicians through the IPA; this represents only 5-10% of the average primary care physician's (PCP's) patient panel. There are also an additional 5,000 patients in self-insured plans administered by us, and we just signed a second HMO contract with Blue Shield for the Public Employees' Retirement System (PERS) employees locally.

TB: What was the innovation that the IPA initiated?

AG: Our goal was to implement components of the Chronic Care Model to improve the care of patients with diabetes in primary care practices. The IPA I work for includes virtually the entire clinician community, so we had an ideal setting to implement the Chronic Care Model. The main innovation was to establish a diabetes registry to be used in improving diabetes care for all patients with diabetes in the county.

TB: Can you describe the innovation in a bit more detail?

AG: The IPA makes available registry software that all its physicians can access through the internet. The information in the registry includes processes of care (whether the patient has had a visit in the past year, a HgbA1c test in the past 6 months, an LDL cholesterol test, microalbumin, foot exams, eye exams, flu shots, pneumovax shots, and behavior change goals). In addition, the registry contains outcomes data: smoking status, BMI, aspirin use, as well as the HgbA1c, LDL, and blood pressure levels over time. When a patient with diabetes comes to the PCP's office, a registry page for that patient is printed out that shows which tests are overdue and how the HgbA1c, LDL and blood pressure are doing and changing over time. The PCP or the medical assistant can quickly order overdue tests, and the trajectory of the outcome measures over time assists with the management of the disease. In addition, the registry page serves as a progress note for the visit. Not only can the PCP and office staff manage each visit more easily, but the PCP can see how he/she is doing in diabetes care for the entire group of patients with diabetes in that PCP's practice, in comparison with other PCPs in the county.

TB: If only 5-10% of most PCPs' patients were IPA patients, how did you get their attention? Isn't the IPA a relatively small player in most of these physicians' consciousness?

AG: That's true, but not that important. We appealed to physicians on 3 levels to adopt the diabetes registry. A few physicians were early adopters. They were willing to take some chances in order to improve quality. A larger

number of physicians wanted to improve quality but their workdays were so busy that they could only do so if the registry made life easier for them (or at the minimum didn't increase work). Finally, when Pay for Performance came to California a few years ago, virtually all physicians saw that the registry could assist them to be paid more Pay for Performance dollars. The 3 arguments – improve quality, make work life easier, and get paid more – were persuasive.

TB: How did you make physicians' work life easier? Often, innovations add more work. Small practices don't have the personnel to enter data into the registry or to create the population-wide reports.

AG: The IPA gave computers and free web access to the practices. The practices fax the progress note, which includes labs, delivered services, and clinical data (blood pressure, weight, pharmacy, aspirin, and foot exams) to the IPA; the IPA enters the data into the registry and creates the reports from the registry. In addition, a nurse practitioner from the IPA traveled from practice to practice to help with the implementation, in particular training medical assistants to do many of the routine tasks associated with diabetes care, thereby saving time for the PCP. I should add that many of the practices have nurse practitioners or physician assistants, so it is all these clinicians who benefit from improved quality and a more streamlined work process.

Currently, several practices are using the registry progress note electronically in the exam room, which saves on data entry costs at our end, and appears to be working well for the clinicians with computers in the exam room.

TB: How many physicians in the IPA actually adopted the registry and used it to improve the care of their patients with diabetes?

AG: Almost all the physicians are now using the registry. We estimate that more than half of people with diabetes in the county are cared for using the registry. As a result, we have seen a striking improvement in diabetes care in Humboldt County. Our community wide registry contains 4227 patients with diabetes. This includes the entire safety net, and constitutes the majority of patients with diabetes in Humboldt County, based on identifiable patients within the billing systems of our 29 practices. Undoubtedly there are many as-of-yet undiagnosed patients with diabetes, and others we have been unable to find within the billing data.

TB: What results have you seen?

AG: Community numbers are as follows: average HgbA1c 7.1; average BP 130/75; average LDL 103.7. Safety net numbers are very similar: average HgbA1c 7.2; average BP 130/75; average LDL 103.9. We also received NCQA Physician Recognition for the entire PCP community in 2005, the first community-wide recognition granted in the US. During our initial year, we surveyed the study population of 803 patients before and after with Short Form 12's (SF12's), a survey used to provide a glimpse into mental and physical functioning and overall health-related-quality of life, and saw improvement in all domains. The "before" levels for all domains were below national average for diabetes, whereas the "after" levels were all above national averages for diabetes except in the chronic pain domain (although we saw improvement in that domain as well).

In California's Pay for Performance (P4P) system, our IPA had the 4th best record in the Blue Cross HMO Network – the only small IPA to achieve such results. While P4P is a useful program, I find the community-wide outcomes data much more compelling. P4P only applies to <5% of Humboldt's population, while our IPA's clinicians care for everybody living here (130,000 at last census).

TB: What's the next step?

AG: We are not stopping with a diabetes registry. Along with the private physicians, our IPA includes 5 community health centers; we are training health center personnel to assist patients in becoming more active partners in the management of their diabetes; this includes encouraging healthy behavior changes through goal setting and action plans. We have also trained primary care practices in the recognition and management of depression, a condition which often accompanies diabetes and other chronic illnesses. We are also expanding the registry to include hypertension, hyperlipidemia, depression, and preventive services.

TB: Many organizations pilot new ideas with a small number of clinicians and a couple of hundred patients, and then try to spread the changes to all the clinicians and patients in the organization. Often they find that spreading the innovation is really hard to do. Somehow you have succeeded in getting most of the PCPs in the county to adopt the diabetes registry. Did you start with a couple of practices and gradually spread the innovation?

AG: We didn't use that model for spreading change. We used the "big bang" approach, creating a burning platform and a sense of urgency. We had a community meeting to which many clinicians, office staff, mental health providers, and diabetes educators came. We publicized our ideas, explained how it might work in their practice, and got started in as many practices as possible. We did a month-long pilot in three practices to assure that the IT pieces fit together, and then launched the system across the entire county within 3 months. We built the registry by sending chart abstracters with laptops to gather the initial data. We worked out the kinks in many practices at the same time, getting regular feedback from our "Office Champion" network, made up of a designated person in each practice. These champions ranged from physicians to medical assistants. In addition to the champion network lead nurse practitioner who listened to the successes and challenges of each practice, we formed a clinical leaders group that met frequently to oversee the project, and design the interventions. We also had an internal weekly project meeting, attended by IT, senior leadership, case management, diabetes educators, outside clinical leaders, the champion network lead nurse practitioner, and medical management. It was critically important to be responsive to the problems brought to our attention, as clinicians' tolerance of a poor process is very low, and their input was invaluable. We live by the concept: "Invite the implementers into the planning process!" Different practices adopted the registry faster or slower, but our true pilot was the entire county. Maybe you could say that our entire county is a pilot for other communities to learn from.

ABSTRACTS

Improving Office Practice: Working Smarter, Not Harder

Family Practice Management, November-December 2006.

Sinsky CA

Article available at: www.aafp.org/fpm

Christine A. Sinsky, MD, a general internist, who practices in a large multispecialty group in Dubuque, Iowa, offers simple but very effective strategies for transforming the office practice in the latest edition of *Family Practice Management*. In "Improving Office Practice: Working Smarter, Not Harder," she provides an excellent definition of the overarching goal of practice redesign: to create a well-organized office system that fosters sound medical decision making, minimizes error and creates an atmosphere that patients, staff and physicians can enjoy." She lays out 12 strategies for achieving that practice redesign, and makes available her office's pre-appointment questionnaire and post-appointment order sheet forms as well as sample dictation templates. Two things stand out: 1) because of better chart preparation (nursing staff organizes all of the pertinent information for the encounter), Dr Sinsky spends less time hunting for information and notices that errors related to missing or overlooked information are fewer; 2) the office utilizes RNs extensively and found that "...primary care physicians with 1.75 nurses were 35 percent more productive than those with 1.25 nurses." According to Dr. Sinsky, increased staffing costs were more than balanced by the improved productivity.

Shaping the Future of Academic Health Centers: The Potential Contributions of Departments of Family Medicine

Annals of Family Medicine, September-October 2006. Supplement.

Newton WP, DuBard CA

Supplement available at: <http://www.annfammed.org/>

In September, the *Annals of Family Medicine* published a supplement entitled, *Shaping the Future of Academic Health Centers: The Role of Family Medicine Faculty and Departments*. Warren Newton and C. Annette Dubard, in the lead article, delineate the challenge facing academic health centers (AHC's) to adapt and meet the changing needs of patients and societies. It encourages a re-vitalization of the relationship between AHC's and communities they serve and emphasize innovation in clinical care, teaching, and research. The supplement, through multiple case studies and commentaries describes ways in which departments of family medicine can play leadership roles in the evolution of AHC's to meet these needs. The lead article provides background for the case studies and

commentaries that follow, and the supplement then goes on to provides a roadmap for the role that family medicine leadership can take including: 1) dramatic organizational improvement in primary care and ambulatory networks, 2) development of new partnerships with community-based organizations, 3) care of indigent populations, 4) development of new curricula in community and international settings, 5) response to workforce needs, policy and practice, and 6) developing translational research that emphasizes the health of populations and effectiveness of care. A brief summary of one selected article follows.

Successful Turnaround of a University-Owned, Community-Based, Multidisciplinary Practice Network

Annals of Family Medicine, September-October 2006. Supplement.

Magill MK, et al.

Supplement available at: <http://www.annfammed.org/>

In this interesting article, Michael Magill, Chair of the Department of Family and Preventive Medicine at the University of Utah, and his fellow authors describe the 7 year, multi-level transformation of a financially failing, university-owned, multi-specialty, community-based practice into a profitable entity. The article describes the three-phase transformation in detail. Following significant restructuring of the organization, governance, leadership, financing (into fee-for-service environment) and consolidation of practices over 2 years, significant practice innovation and performance improvement took place in the second phase. This practice redesign included: 1) revision of physician compensation and benefits to incentivize productivity, 2) renewed focus on patient-centered care through re-engineering of the ambulatory visit and facility design improvements, 3) implementation of advanced access scheduling, 4) implementation of an electronic medical record through all clinics, 5) establishment of a quality improvement program, and 6) development of new services and practice sites. In phase three, the leadership turned their attention to the integration of this re-designed health system into the academic mission of teaching and research. Although this transformation may not be generalizable to many settings, it demonstrates how an academic health center, with a committed leadership, can successfully and comprehensively transform a community based practice into a financially viable entity that both provides improved care to the community it serves and expands its academic missions of education and research. Please also refer to accompanying commentary by Richard Krugman entitled, The Utah Primary Care Experience in the same supplement.

An Interactive Computer Kiosk Module for the Treatment of Recurrent Uncomplicated Cystitis in Women

Journal of General Internal Medicine, November, 2006.

Aagaard EM, et al.

Objective: To validate and implement a computer module for the management of uncomplicated urinary tract infections (UTI).

Participants: Women age 18 to 64 years, with a previous UTI, voiding symptoms, and absence of complicating features (co morbidities, vaginal discharge, back pain, emesis, and fever/chills).

Measurements: The computer module was validated against clinician diagnosis and urine culture. Following validation, the module was implemented in the urgent care clinic as a management option for women with suspected UTI; computer-directed therapy (CDT)-eligible women received antibiotic treatment without a clinician examination. Patient satisfaction with the module and return visits for UTI-related complaints were assessed.

Results: In the validation study, 18 of 68 women (26%) were CDT-eligible. Clinicians diagnosed 17/18 CDT-eligible women with uncomplicated UTI. Sixty-seven percent of CDT-eligible women had a positive urine culture. Since implementation, 162 women have accessed the module, and 35% have received CDT. Ninety-eight percent (95% confidence interval: 95% to 100%) found the program easy to use and 95% (89% to 100%) would recommend it to friends/family. Two (4%) CDT-treated women had a return visit to our institution for a UTI-related illness within 2 weeks.

Conclusions: A computer module accurately identifies women with culture-confirmed, uncomplicated UTIs. Patients are highly satisfied with the module.

Changes in Career Decisions of Internal Medicine Residents During Training

Annals of Internal Medicine, November 21, 2006.

West CP, et al.

Background: Little is known about the timing and stability of internal medicine resident career decisions during the course of residency training.

Objective: To assess changes in reported career plans among internal medicine trainees during their training.

Design: Observational cohort using data collected as part of the annual Internal Medicine In-Training Examination (IM-ITE) survey.

Setting: 411 internal medicine residency programs in North America participating in the annual IM-ITE.

Participants: 2638 internal medicine residents who took the IM-ITE and responded to career plan questions on the test survey in all 3 years of training (2002–2004).

Measurements: Self-reported career plans for individual residents during their postgraduate year 1 (PGY-1), postgraduate year 2 (PGY-2), and postgraduate year 3 (PGY-3) of training.

Results: 2281 of 2638 residents (86.5%) identified a specific career plan in internal medicine during PGY-3. Of these 2281 residents, 1417 (62.1%) changed career plans at least once during the study period. Career plans reported by PGY-1 and PGY-2 residents matched subsequent PGY-3 plans for 55.1% and 68.4%, respectively. Six hundred eighty-six (26.0%) PGY-1, 278 (10.5%) PGY-2, and 205 (7.8%) PGY-3 residents remained undecided about their career plans at the time of the IM-ITE. Only 25.0% of graduating residents reported plans for a general internal medicine career.

Limitations: The study cohort represents a convenience sample and is restricted to the subset of residents sitting for the IM-ITE and responding to career plan questions in all 3 years of postgraduate training. Career plans were assessed by self-report, and it is possible that residents who responded in all years of training differed from those who did not.

Conclusions: In a subset of internal medicine residents in the class of 2004, career decisions changed late into residency training and enthusiasm for careers in general internal medicine remained low.

IN THE NEWS

UK fares well in survey of primary care, but US doesn't

British Medical Journal, November 11, 2006.

Tanne JH

The United Kingdom is a leader in: 1) use of electronic patient records and reminder systems, 2) provision of care outside normal business hours and outside the emergency room, 3) use of a team approach to care for patients with multiple chronic illnesses, and 4) use of financial incentives to doctors to improve their quality of care (pay for performance). In a news report in the *British Medical Journal*, Janice Hopkins Tanne discusses the results of an international survey of 7000 primary care doctors conducted by the Commonwealth Fund. Although the US has higher per capita spending compared to the 6 other developed countries represented, the survey showed US primary care physician practices are more limited than the leading countries in information capacity, provide less patient access outside of "normal" work hours and are among the least likely to use teams or to receive financial rewards for quality.

The US lagged behind the other countries in use of electronic medical records to alert doctors to drug interactions and need for check ups or a test with 40% of US doctors reporting no available reminder system, manual or otherwise. US doctors were also less able to generate lists of patients with chronic diseases; whereas general practitioners in other countries said this was easy to do. Additionally, as compared to other countries, more US doctors said their patients often had difficulty paying for medical care or for prescriptions drugs, even among people with health insurance.

Patients Report Unnecessary ED Visits

California Healthline. October 30, 2006

Article available at: <http://www.californiahealthline.org/>

In a news report published in the California Healthline on 10/30/06 describing a study released by the California Healthcare Foundation (CHCF), about half of patients seeking care at an emergency department reported difficulty in getting a same-day doctor's appointment. Commissioned by CHCF, Harris Interactive surveyed Emergency Department (ED) patients and physicians separately by phone and mail respectively over a 2 month period. Over 1400 patients and over 500 primary care and ED physicians participated. Forty-six percent of ED patients felt that a primary care provider could have provided the treatment sought in the ED. The majority of primary care physicians (76%) reported advising their patients to consider clinic visits before emergency visits, but only 35% of patients reported receiving this advice. Forty-five percent of ED patients reported having at least one chronic health condition. These people with chronic conditions reported limited access to medical care at nights and on weekends. MediCal beneficiaries were twice as likely to seek care at an ED as privately insured patients and were more likely to report that ED's provide better care than a physician's office. These patients reported difficulty in finding a physician that accepts MediCal.

The patient survey data indicates that ED utilization can be attributed to: limited access to medical care (including MediCal patients), lack of alternatives to ED's (i.e. at night and on weekends), patient unfamiliarity with how to handle sudden medical problems, and positive attitudes about the ED. Maribeth Shannon, director of CHCF's hospitals and nursing homes program, said that ED utilization could be reduced by improving access to same-day appointments and after-hours care and more effectively discussing urgent care options with patients.

More doctors tell patients, 'we'll see you today'

Physicians who offer open access report happier patients and healthier revenues

ACP Observer. November 2006.

Lola Butcher

Article available at: <http://www.acponline.org/journals/news/nov06/access.htm>

An article in the November ACP Observer by Lola Butcher highlights open access (or advanced access) scheduling. The article describes the model, barriers and benefits to implementation, and how to go about transitioning to an open access scheduling system.

Eleven satellite campuses enter orbit of Canadian medical education

Canadian Medical Association Journal. August 29, 2006

Wayne Kondro, in this article, describes the Canadian experiment with the distributive learning model. The experiment will result in the training of roughly 250 students annually by 2009 in "satellite learning centres" associated with 7 of the nation's 17 medical schools. The satellites, through extensive use of information technology, will deliver off-site basic science and clinical instruction with an emphasis on local needs. The motivation for creating satellites is based on the fact that a physician trained in a more rural or remote environment is more likely to practice in a smaller community on completion of training. Dr. Joanna Bates, the University of British Columbia (UBC) Associate Dean of Admissions and a key architect in UBC's distributive learning model, reports that the students at UBC have embraced the changes. To date, students at satellites are scoring as well on core UBC exams as those studying on-site in Vancouver. However, it is too early to accurately assess the effects of the satellite e-learning; and the Canadian Experiment has not proven that it can attract doctors to remote, underserved areas.

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Contact Us

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