

Case Study #2

Medical Group Organization, Bellin Health System
Green Bay, Wisconsin

- 1. What was the impetus for deciding to initiate improvement at your site?*

In the late 1990s we acquired 20 sites throughout a broad region of Wisconsin. This was a completely disparate group of clinics that were experiencing significant financial losses. The physicians were frustrated. They thought they had joined a system and what they had expected was not occurring. It was a chaotic group that was losing money. A decision was made as an organization to bail out of the primary care network or to make it work.
- 2. Has leadership been important to your efforts? If so, please describe the role of leadership in improvement.*

There was no team structure or leadership before. There was little physician involvement. It was an administratively run medical group. We did a two-day planning retreat with 16 physicians and administrators and took a cold, hard look at our current situation and where we wanted to be. Then we decided on our priorities and organized four excellence teams to focus on operational, clinical, service, and business improvement efforts.

In addition, the Bellin Medical Group Governing Committee (BMG) has the following functions:

- Provide oversight for the development and implementation of vision and strategy
- Monitor key operational performance measures and identify priorities for improvement
- Define future direction for the Medical Group including structure, services, and position in the market

3. *In your opinion, what activities have been especially important to sustaining improvement?*

Having a team structure and specific processes to lead the improvement work has been important. Each of the four excellence teams has specific aims/purposes as well as defined roles and responsibilities. For example, if the clinical excellence group agrees on a protocol, they bounce it to the executive governance committee and ask for its approval. If the executive committee adopts the protocol, then the sites are asked to implement the changes. All the providers are on an internal listserv that helps generate feedback. This has helped a lot. We used this process to standardize the use of a follow-up strep culture with patients who have a negative rapid strep test in the office. Several physicians researched infectious disease guidelines before we came up with the guideline.

When we decide on an improvement, we spread it numerous ways. This may include a letter in the mail, letter on the listserv, internal publications, or managers may share information and ask for feedback from staff.

Pushback from folks has not been a major problem. It's a given here that physicians participate in improvement work. Everyone is expected to work to improve the group. There is a list of provider expectations and some relate to participation. It took 6-8 months to get agreement on the expectations of physicians who want to work in the group. The fact that we're quality driven and innovative helped us to recruit.

Most sites have a physician leader and an administrative leader. This seems to work well. The physician leader and administrative leader report to the Health System Executive Vice President/CFO.

We've found that there are 10 steps to ensure sustainable improvement:

1. Describe who you are today
2. Describe the environmental forces impacting your business
3. Define where and what you want to be in the future
4. Determine how you are performing today
5. Identify what you will focus your time, energy, and resources on
6. Determine how you will organize yourself
7. Utilize a standard process for improvement

8. Remain on track
9. Review progress and adjust if necessary
10. Maintain momentum over time

In addition, setting goals has also helped us to have a specific focus and identify progress.

Our goals are:

- a. To be the top performer in Clinical Quality
- b. To develop relationships with patients that create loyalty and trust
- c. To be the Lead Innovator in Clinic Redesign
- d. To grow Primary Care 10% per year
- e. To be profitable as a medical group
- f. To be recognized as a great place to work

We've also found that it's important to limit the number of improvement initiatives going on to provide focus and increase our chances for success.

4. *How important have core values been to your improvement work?*

We're convinced that great performance can only be achieved through sustained system-level redesign.

5. *How are core values communicated to staff?*

The executive committee reinforces core values. We make money available for quality results and try to make data transparent. We believe in the power of measurement and create financial report cards regularly—providing unblinded data down to the individual physician level. VIP awards are given to clinics with significant improvement.

6. *Do you have an ongoing team that leads improvement in your organization? If so, please describe who is on it, how often they meet, and the structure for initiating improvements.*

As noted earlier, we have four excellence teams that lead improvement in a variety of areas. They report to the governing committee. Our Clinical Excellence team has sanctioned an IHI IMPACT network team who recently took a look at the CHF (congestive heart failure) population across the continuum of care. We're trying to look at care through the eyes of the patient, trying to improve all the handoffs between hospital, home health, and community resource folks. We found that there is a great deal of variation in patient education handouts that was confusing to patients. We decided that we needed the right team at the table to resolve these issues. For us, this includes several primary care and specialty care physicians, a hospitalist, nurses, patients, nurse practitioners, pharmacists, clinical nurse specialists, as well as home health and case management staff. The power of having the right people at the table to talk about a registry for CHF patients has made a big difference. One of our goals is for staff from any department to be able to view and make entries into the common

CHF registry. We are researching a Quality of Life survey to allow us to demonstrate effectiveness of our improvements.

7. *Have there been specific processes or ways of using resources that you have focused on, such as leadership development, access, teams, or chronic care?*
Our challenge is to improve the work while doing the work. We're using the IHI-endorsed Chronic Care Model and looked at whether we're doing enough in the right places to impact care for patients with chronic disease.

We worked hard on achieving Advanced Access in early 2000 and since have worked on care team redesign and other efficiency and flow processes. We have 40-60% of most primary care providers' appointment schedules open at the beginning of each day. Our appointment lengths and templates have been simplified. Patients can call in to make an appointment 24 hours a day, 7 days a week.

8. *Does your site vary the ways that patients can access care, such as group visits, nurse clinics, phone care, and e-mail with patients? If yes, please describe.*
Some sites use e-mail to communicate with patients. Some physicians send lab reports via e-mail; we also do group visits at some sites.

9. *How do you track and post results or outcomes? (These include operational, clinical, satisfaction, and financial.) How do you select which metrics to use? Have you found it important to limit the number of metrics used? What metrics do you use?*

We use electronic and hard-copy data walls to post and track results over time for a number of items from immunizations and mammograms to chronic disease prevention and treatment. The Business Excellence Team Leader provides a monthly productivity report and shares staffing information, including percentage of overtime. Managers are encouraged to discuss the reports at staff meetings, which are done monthly at most sites.

We've had numerous improvement breakthroughs to date at our various sites:

Financial: Reduced days in AR from 120 to 64, 77% of our clinics improved their operating margins between 5% and 50%. Supply costs at one site dropped from 8% to 5.1% of net operating revenue. Visit volume growth of 10-13% per year. Claims accuracy of 98%. Improved coding accuracy from 56% to 76%.

Operational: Open access for physical exams 100% of the time in 3 clinics and 75% of the time in 6 clinics; PDSA as an improvement technology has been implemented at 100% of our clinics; care team redesign work has been accomplished at 86% of clinics.

Clinical: Piloted asthma care quality initiative at one clinic, developed a smoking cessation program, joined the Institute for Healthcare Improvement's IMPACT

network, implemented electronic disease management registry in 100% of clinics, and achieved benchmark status on effectiveness of care results.

Satisfaction: Patient satisfaction has improved for five straight quarters.

10. *Does your site do any structured population management such as tracking patients with chronic disease?*

The Touchpoint health plan, which we co-own with Thedacare, was named the #1 health plan in the nation for two years in a row. It has helped to teach us a lot about population management. This includes aligning the financial incentives for providers and tying part of our financial reimbursement to quality measures. In 2000, we had \$187,000 returned; in 2001, this increased to \$175,000; and in 2002, we got \$465,000 back (an amazing 28% increase from 2001 figures). Results that were tracked included HEDIS measures for Hb A1c, cholesterol, immunizations, hypertension control, asthma and depression measures, as well as pediatric and adolescent immunizations.

No health plan in the nation distinguished itself more consistently in terms of performance on the HEDIS measures included in NCQA's accreditation program than Touchpoint.

11. *Do you regularly measure patient satisfaction? If so, how often is it measured?*

How are satisfaction results shared with staff? Have you tracked patient response to specific improvement efforts such as cycle time or access?

We use Press Ganey to survey approximately 200 patients per quarter per clinic at random. Satisfaction results are shared with staff at meetings and by posting the data at each clinic. They are also available on our internal systemwide website.

12. *If you were starting your improvement work now, what would you do differently?*

What would you do the same way?

We would have the 10-step road map in front of us. Our sequence has been very much like the 10 steps. We would invest more upfront time in teaching skills such as effective, assertive communication and quality improvement methodology.

13. *What advice would you give to others embarking on sustainable improvement?*

We found that there is a road map and sequence as noted earlier, but use your own road map. Involve as many physicians as possible and send them to IHI conferences. Put lots of resources into training and education.

14. *Please describe your organization:*

Primary care group

15. *Are you part of an integrated delivery network?*

Yes

16. *Approximately how many patients are cared for at your site/organization?*
N/A
17. *On average, approximately how many patient visits occur at your site weekly, monthly or yearly?*
270,000 in the last year
18. *How many FTE physicians and mid-levels (nurse practitioners and/or physician assistants) are employed at your site?*
50 physicians, 20 mid-levels. We have 72 providers working here part-time and full time at 18 sites.
19. *If you're using formal care teams, what is the makeup of your team(s) (e.g., 1 FTE MD, 1 mid-level, 2 MAs, 1 clerk, etc.)?*
These vary among sites.
20. *Do you use an electronic medical record?*
Will be implementing Meditech within the next year
21. *What is your average cycle time for a patient visit?*
Varies between 11-17 minutes for an acute visit (face-to-face provider time to patient time) and 30 minutes for a long visit
22. *How are physicians compensated?*
Production. Would like to move to production and performance.