

**San Diego Right Care-GO Leadership Forum**  
**Taking Action Together to Prevent Heart Attacks and Strokes**

**Summary Meeting Notes**

June 4, 2010

University of California San Diego  
Skaggs School of Pharmacy & Pharmaceutical Sciences

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On Friday, June 4, 2010, the Right Care Initiative (RCI) and its NIH GO Grant academic partners from the University of California and RAND convened a day-long summit of medical leadership in the San Diego area. All of the major San Diego medical groups and most of the health plans sent leadership to the Summit. This San Diego Summit launched a community effort among medical leaders and other stakeholders to attain outstanding levels of achievement in the prevention of heart attacks and strokes, building on the unique strengths of the San Diego community. Some of these strengths include:

- The majority of the population is cared for by a small number of private medical systems that have all expressed interest in working on achieving RCI goals. Navy and Veterans Affairs Medical Systems also provide care to a significant share of the San Diego population and may also be potential partners. Thus, concerted action to improve care by a relatively small number of health care systems can have a substantial and rapid impact on the overall health of the community through an intentional focus on the prevention of strokes and heart attacks.
- Other provider groups and systems within San Diego, such as those involved in the CAPG, have also expressed interest and begun discussions related to initial RCI efforts.
- Health Plans serving San Diego are interested in supporting the effort.
- Many additional stakeholders have offered their assistance. For example, the leadership of the San Diego Heart and Stroke Association and the Medical Society Foundation have pledged their support. Dr. Anthony De Maria, a respected cardiologist at UCSD and Editor of the Journal of the American College of Cardiology, has offered to serve as the project's champion among San Diego cardiologists. In addition, the San Diego Department of Public Health is enthusiastic about collaborating in this effort on a community-wide basis.
- Technical and methodological assistance with local implementation and spread of selected evidenced-based approaches and/or evaluation of promising interventions is available from experts from University of California, RAND, and other entities through an NIH GO grant (from federal stimulus funds) and other potential sources of funding as the project progresses.
- Additional technical support and resources related to enhanced information technologies and data registries are also potentially available in conjunction with San Diego's recent selection as one of fifteen "Beacon Communities" by the federal government. The multimillion dollar grant awarded to San Diego is focused on reducing cerebrovascular and cardiovascular events, as is RCI. It is being led by UCSD investigators, one of whom attended this summit, and explained that though the new Beacon Community HIT grant is still at a very early, formative stage, it is quite synchronous with the Right Care goals.
- Several of the San Diego provider groups are not only leaders locally, but are recognized statewide and even nationally for their novel team-based approaches that have yielded outstanding performance.

## **SUMMARY AND HIGHLIGHTS OF THE DAY'S PROGRAM**

### **Provider Group Presentations**

After introduction of the Right Care – GO team, we heard outstanding presentations from leaders from five of the leading medical groups in San Diego, including SHARP Rees-Stealy, Kaiser Permanente, Scripps Clinic, Sharp Community IPA, and UCSD. Presenters shared their experiences and insights about what is and

is not working in terms of the prevention of heart attacks and strokes among their patients. Selected points from these presentations are listed below:

***SHARP Rees-Stealy (SRS), Jerrold Penso, MD***

- Multiple “touch-points” reaching out proactively to patients highly effective (telephone calls in particular), as is joint goal setting with patients
- Much more intensive number of visits required when a patient’s key blood level controls are out of range (Hypertension, lipids, HbA1c), sometimes as often as every two weeks
- Non-financial incentives more important than financial incentives for changing culture (though do both)
- Monthly data feedback is given that is unblinded, by site, and by physician on BP, LDL control. They found that unblinding the data channels competitive instincts into proactive population management
- Thank-you letters from SHARP leadership to high performers. Top administrators send out 5 hand-written letters per week
- Recognition for high-performers through awards given at public celebrations (one award for branch that went from “worst to first” given in front of 18,000 SHARP employees)
- Recognize and reward early wins
- Care management accountability: 5 RNs managing diabetics with A1c > 9, each responsible for a geographical region
- Essential elements for moving the organization to excellence: 1) making the case to physicians and staff (why things need to change; where are we going; how are we going to get there; what I need from you) 2) performance feedback 3) coaching and training (need hardwired processes and tools)
- National and state collaboratives have provided important best practices that SRS has brought back and implemented
- Principles of *Good to Great*

***Kaiser Permanente (San Diego), Rae Boganey, MD***

- Complete Care Program emphasizes integrated, continuous, team-based care
- Instituting unblinded performance feedback for physicians and sites
- Coordination with specialists and all patient touchpoints so that they reinforce messages about chronic care management/prevention (e.g. BP control)
- Include the pharmacist on the care team
- Important to recognize and incentivize non-physician staff for team care with right level of training and skills
- Critical to set clear goals and hold providers accountable, which is how they have achieved 80% of hypertension patients at target
- Patient engagement must be prioritized to overcome cultural and language barriers that differ significantly by culture
- Media engagement and accuracy important for improving patient compliance

***Scripps Clinic, Dan Dworsky, MD***

- Currently focused on building cultural and leadership foundation to drive advanced processes moving forward
- Pride is the motivator of physician behavior at Scripps, with perception that among the best anywhere
- No financial incentives at this point, but believes that there should be; however, moving in very deliberate manner to make sure that program structured optimally, because if there are too many or the wrong financial incentives you dilute and skew their value
- Wants incentives to be at the site/team level, not the individual physician level, to reward teams for managing their population

- Engaging cardiologists; having them measure hypertension and record in the Allscripts system during visits
- Need to change physician schedule and incentives away from high volume of 15-20 minute visits to get to next level of quality. May experiment with model in which physicians see only diabetics on Tuesday morning, then include an endocrinologist into the room; and diabetes educator meets with patients the same morning at same location. Patient would come in for ~3 hours for comprehensive assessment, treatment, and training.

### ***Sharp Community, Gregg Garner, MD***

- Quality Incentive Service Recognition (QISR) payment: twice-yearly physician payment based on quality metrics and patient satisfaction which can be up to 20% of annual income
- Board recently decided to make receipt of QISR payment contingent upon good patient satisfaction score
- Plan to institute unblinded PCP performance comparisons soon, but haven't done yet perhaps due to IPA model
- Rolling out HIE with IBM / Active Health to bring meaningful data to point of care
- Pharmacist important on care team

### ***UCSD, Anupam Goel, MD***

- Designed physician evaluation program to focus on factors that physicians are most clearly accountable for, so motivating them should be easier
  - Physicians evaluated based on both process and outcome measures for visits, not patients, because physicians own the visit
  - Likewise, higher priority given to processes such as test ordering, then risk factor control and outcomes, because physicians own the ordering moment
- Roll-up / summary metrics (for "CVD all" or "Diabetes all") more important clinically than specific measures, so these becoming more important for evaluation
- Have to pick measures for evaluation that have overwhelming preponderance of evidence for physician buy-in
- Eliciting patient preferences when setting treatment goals key, and important to get patient satisfaction up
- Working on streamlining alerts by developing weighting protocols so only the most critical elevated for initial physician view

### **Some Promising Interventions**

A number of evidenced-based and/or promising interventions that had been previously identified by participants in the Right Care Initiative and that might be of interest and applicable to San Diego providers were briefly presented. Interventions described included:

- ***ALL Protocol.*** Jim Dudl, MD, of Kaiser's Care Management Institute shared the generic medication protocol they have developed with the help of David Eddy's Archimedes modeling. This simple protocol which stands for Aspirin, Lipid lowering agent (Simvastatin), and Lisinopril- **Prevent Heart Attacks and Strokes Everyday**, has been credited with a significant decline in the number of heart attacks and strokes since the year 2000, and was described in a New England Journal of Medicine article June 2010.
- ***Community Pharmacist on Care Team.*** Daniel Cusator, MD, Chief Medical Officer of Greater Newport Physicians, and Rebecca Cupp, VP of the Pharmacy Council and Ralph's, presented data from the Asheville Study and their own companies on the power of adding a clinical pharmacist to the care team to reduce clinical events, hospitalizations, emergency room visits, and costs.
- ***Chronic Care Self-Management.*** June Simmons, CEO of the Partners in Care Foundation, presented the Stanford Patient Self Management model that was jointly developed by Kaiser Permanente and has been

documented to be powerful in activating the patient in taking charge of their care. This model has been instituted in multiple countries.

- ***Novel Education and Outreach Programs.*** Athena Phillis-Tsimakis, MD, Scripps Whittier Institute Corporate Vice President, provided the group with published studies on the effectiveness of Project Dulce for improving patient outcomes through carefully crafted education programs and the addition of promotoras and proactive nurses to the care team. She has recently expanded Project Dulce to include a program dedicated to hypertension control, which is particularly relevant to this project on preventing strokes and heart attacks.

Several summit participants observed that these interventions, used in tandem, or according to what works best in a particular medical setting, would very likely bring patients into safer control for the prevention of unnecessary cardio- and cerebrovascular events.

### **Issues and Themes from Discussion Period**

A proactive approach is essential. In the words of one of our presenters, the more patients “feel the love” from providers through proactive outreach and care, the more likely they are to engage in self-management of chronic conditions and healthy behavior.

#### ***The reactive visit-based “come-and-get-it” model of healthcare delivery yields poor outcomes for hypertension, cerebro and cardiovascular disease and diabetes at the population level***

- 15-20 minute office visits every 3-4 months woefully inadequate
- Disconnect between what happens inside and outside clinic walls
- Vast majority of a patient’s time is not spent interacting with medical professionals, so the patients must be activated to ensure that unnecessary progression of disease does not occur
- Lack of satisfaction among providers and patients in their “dance of denial”
- Self-directed compacts between clinicians and patients to reach goals is empowering

#### ***Many physicians being asked to do more with less***

- Shift from managing individuals one at a time to managing a population of patients; this requires resources and the redesign of care processes, can’t simply require physicians to run faster on the visit treadmill
- Increased care / administrative demands with less money, less time, less staff resources require moving to a team based model that maximizes the skills of each (e.g. promotoras, pharmacists, nurses, peer coaches, etc.)
- More IT-enabled care-management tools like registries, online communication portals and email, but not reimbursed for using them
- Need payment reform in alignment with care redesign that incents quality, for instance a hybrid capitated-FFS model

#### ***The PPO and higher deductible products are gaining market strength in California relative to strict managed care, as the HMO cost differential is declining as the non-HMO products become actuarially less valuable***

- This poses challenges to redesigning office practice and reimbursement away from the visit-based model for most providers
- Healthcare reform will impact the delivery and reimbursement of care through Accountable Care Organizations and the medical home model, but it’s not clear how or how much yet
- Regardless, there are growing advantages to an integrated group model that is more structured than a traditional IPA, even in an FFS environment

#### ***Integrated systems in San Diego are experimenting with IT-enabled, team-based, “high-touch” approaches to monitor, treat, and activate their population of patients with positive results***

- Monitor patients through registries, EHRs, and other IT tools
- Care management and coordination: dedicate sufficient human resources to reaching, treating, and supporting patients
  - Increased visits; pre-visit outreach and post-visit follow-up
  - Disease prevention and management training/coaching; peer education combined with nurse management
  - Culturally-congruent outreach and support through promotoras, etc
  - Coordinate with specialists and all patient touchpoints so that they reinforce messages about chronic care management/prevention (e.g. BP control)
- Physicians must relinquish certain responsibilities to other team members

### *New models of physician evaluation, motivation, and pay*

- We're moving from a model of autonomous physicians to physicians being rigorously and continuously evaluated
- Physicians rated based on both process and outcome measures, often against peers (rather than against an absolute standard) and increasingly unblinded; problem rating relative to peers is that there are always some lower performers, even if everyone is at a high level; one system evaluates physicians based on visits, not patients, because physicians indisputably "own" the visit
- Financial / non-financial incentives for changing organizational culture and physician behavior
  - Non financial motivators I: pride, competition, cultural expectation of excellence, desire to serve patients well
  - Non-financial motivators II: personal thank-you letters from leadership, awards and recognition for great results
  - Financial incentives: pay-for-performance type bonus payments accounting for up to 20% of physician annual pay (but generally in mid/low single digits)
- Unit of evaluation and reward ranges from individual physician to care team, building, etc
- By rewarding a team or clinic site as a whole, also important for morale
- Evaluation guidelines have to be evidence-based, but skepticism remains given multiple sources for them; roll-up / summary measures (for "CVD all" or "Diabetes all") some view as more important clinically than specific measures

### **Next Steps:**

- Follow-up emails from the Right Care-NIH-GO team to participants as well as e-mails from summit participants with comments, ideas and suggestions.
- Individual or small group phone or in-person meetings with selective Summit participants to clarify various options and preferences for moving forward.
- The next regional Right Care- NIH GO meeting will be held in San Diego on **July 7, from 1:30 to 4:30, immediately following the regional CAPG meeting. Note: The meeting is currently scheduled to be held at Sharp Healthcare, 8695 Spectrum Center Blvd. in San Diego. However, depending on size of group interested in attending, the venue may need to change. Please RSVP to [lizhelms@chroniccareca.org](mailto:lizhelms@chroniccareca.org). Agenda to be sent out in late June.**