



As Good as it Gets?:

Managing Risks of Cardiovascular Disease in California's Top Performing Physician Organizations



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Overview

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1. Interview process and content
 2. Methods
 3. Structural capabilities of top performers
 4. Facilitators and barriers to implementing new systems
 5. Overview of strategies with limited adoption among groups
 6. Reflection- Moving the needle?

Interviews of RCI's Top Performers

- Includes **medical directors** and **quality improvement leaders** from physician organizations scoring better than the **90th percentile of national performance** on LDL and HbA1c control measures among commercially-insured health plan enrollees as part of the 2011 RCI.

Organization	#Primary Care Physicians	# Specialists	Central Location	Year Founded
Sutter Gould Medical Foundation	90	170	Modesto, CA	1948
Arch Health Partners*	25	14	Poway, CA	2010
The Permanente Medical Group*	1570	2449	Oakland, CA	1948
UCLA Medical Group	200	1000	Los Angeles, CA	1985
Palo Alto Medical Foundation	116	160	Burlingame, CA	1930
St. Joseph Heritage Medical Group	60	10	Orange, CA	1964
St. Jude Heritage Medical Group	65	60	Fullerton, CA	1929
Sharp Rees-Stealy Medical Group	105	300	San Diego, CA	1923
Mercy Medical Group/CHW Medical Foundation	50	65	Sacramento, CA	1920
Scripps Clinic Medical Group	134	300	La Jolla, CA	1924
John Muir Physician Network	266	371	Walnut Creek, CA	1965



Interview Study Objectives

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1. To clarify the **common systems, interventions, and care processes** adopted by the physician organizations to achieve high performance on cardiovascular disease management quality indicators.
 2. Interviews assessed **implementation facilitators and barriers** to changing organizational and financial processes, policies, and strategies



Major Strategies Assessed

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1. Individual physician performance reporting and feedback
 2. Medication management protocols
 3. Co-management of hypertension and/or hyperlipidemia
 4. primary care team huddles (structured team communication)
 5. coordination improvement activities with physician specialists (cardiology and endocrinology)
 6. group visits and classes focused on diet, physician activities, hypertension management, and diabetes care, and
 7. scheduled return telephone visits for high risk patients



Interview Methods and Analysis

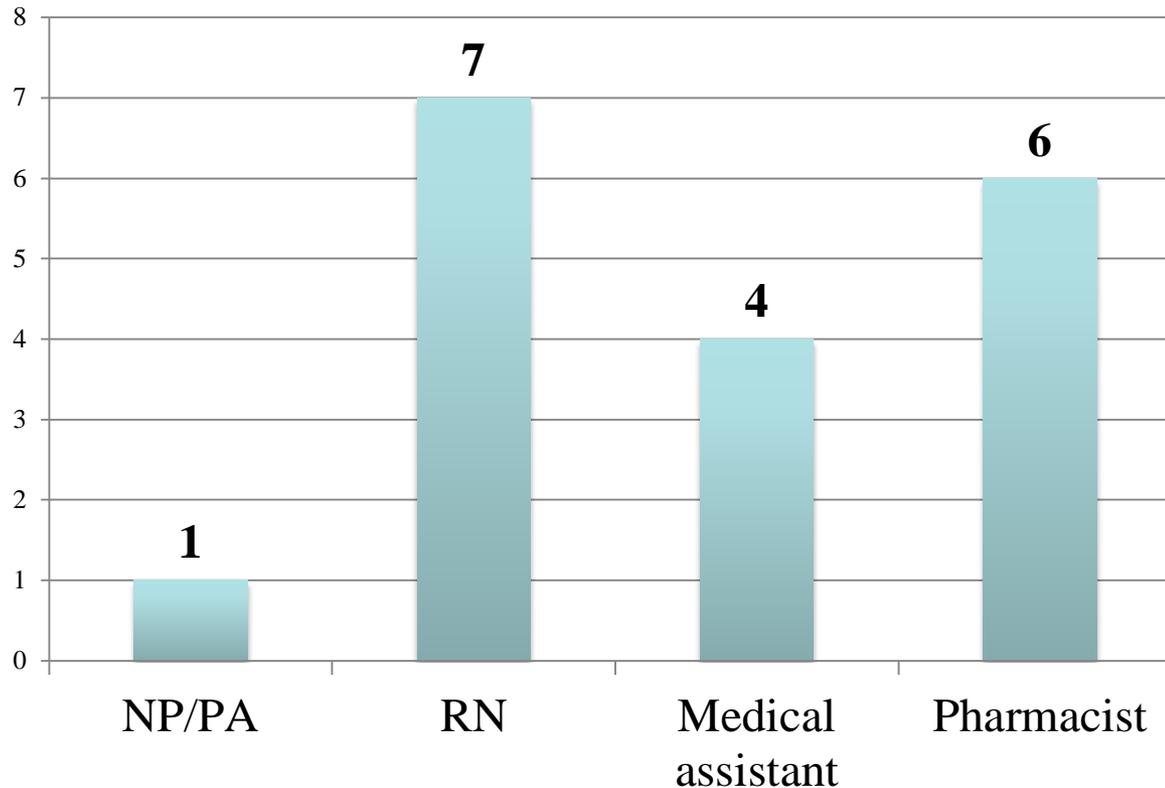
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- 45-60 minute key informant interviews of medical directors and QI leaders from January 2012-May 2012.
 - Record, transcribe, clean transcripts
 - Develop code book based on our interview guide and thorough review of transcripts
 - Use ATLAS.ti to code interviews
 - Employed “member checks” to ensure consistency of coding between researchers

Medical group characteristics

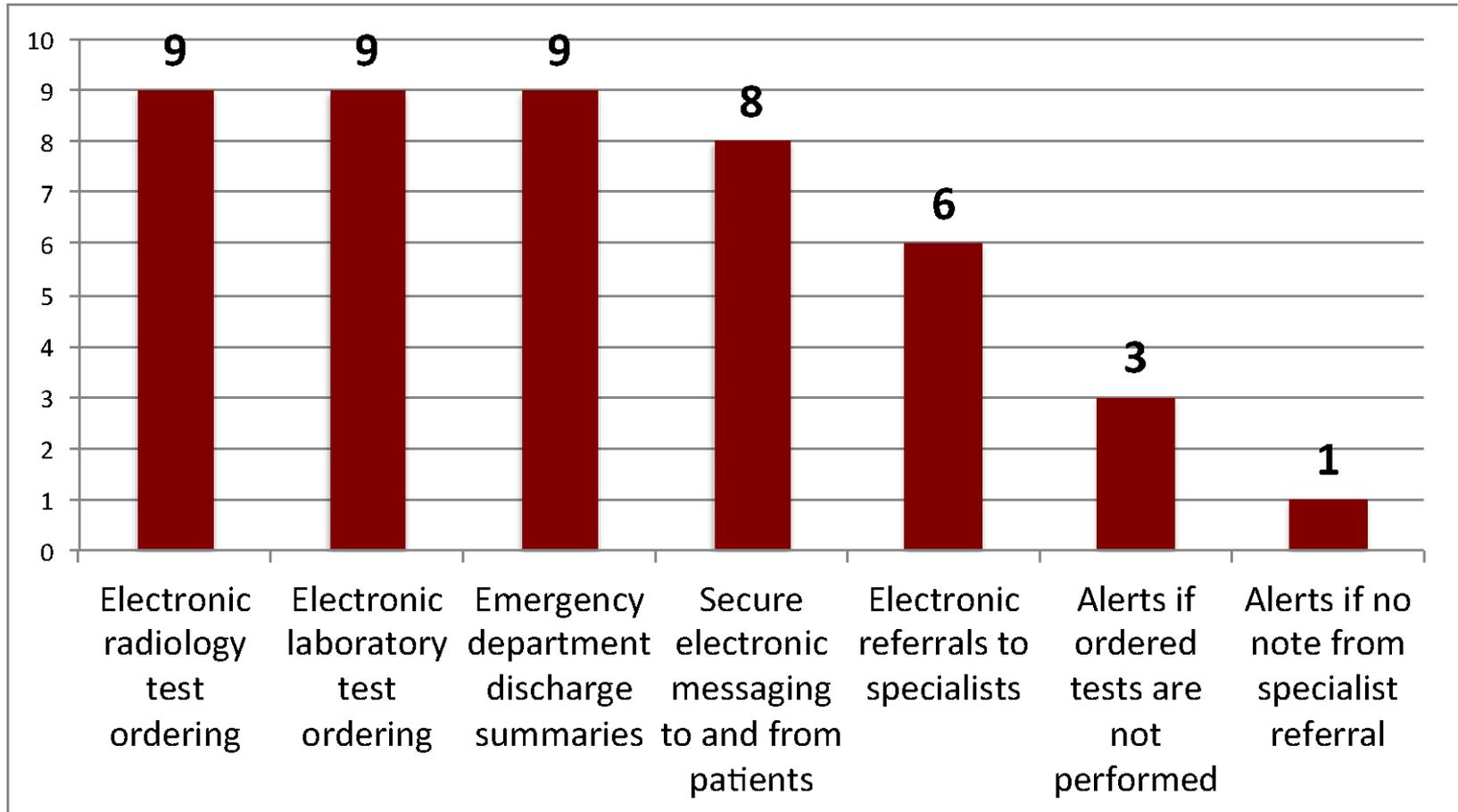
Medical group Median
(IQR)

Number of primary care physicians (PCPs) in medical group	97.5 (60,134)
% PCPs accepting new patients	82.4% (62.5%,89.5%)
% Specialists in medical group	58.1% (48%,71%)
Payor mix	
% Medicaid	5% (<1%,9%)
% Medicare	25% (16%,26%)
% Commercial health plans	60% (40%,72%)
% Revenues from capitation arrangements	40% (30%,45%)

Diverse non-physician support specially trained in cardiovascular disease prevention. All but 2 had one clinical/staff role specially trained.



High on electronic data use, except for specialty interface and alerts for ordered tests not performed



<u>Strategies</u>	<u>Level of Adoption</u>
Point of care use of disease registries	HIGH. Most medical groups use registries to identify high risk patients.
Group visits	LOW. With exception of health education classes, expansion of group visits has been restricted by complex logistics and limited reimbursement.
Planned return telephone visits	LOW. Although two medical groups use telephone visits in health education interventions, no medical groups reported the return use of planned return phone visits.
Team huddles	LOW. Many noted the clinical benefit of team huddles, but efforts are hindered by scheduling issues.
Pharmacists on the care team	LOW. While pharmacists are used for medication protocols and management, hiring cost restrict complete integration onto primary care teams for most.
Team-based care	MEDIUM. Multiple medical groups have attempted to maximize staff's role in clinical care but financial constraints minimize group's ability to expand team members.

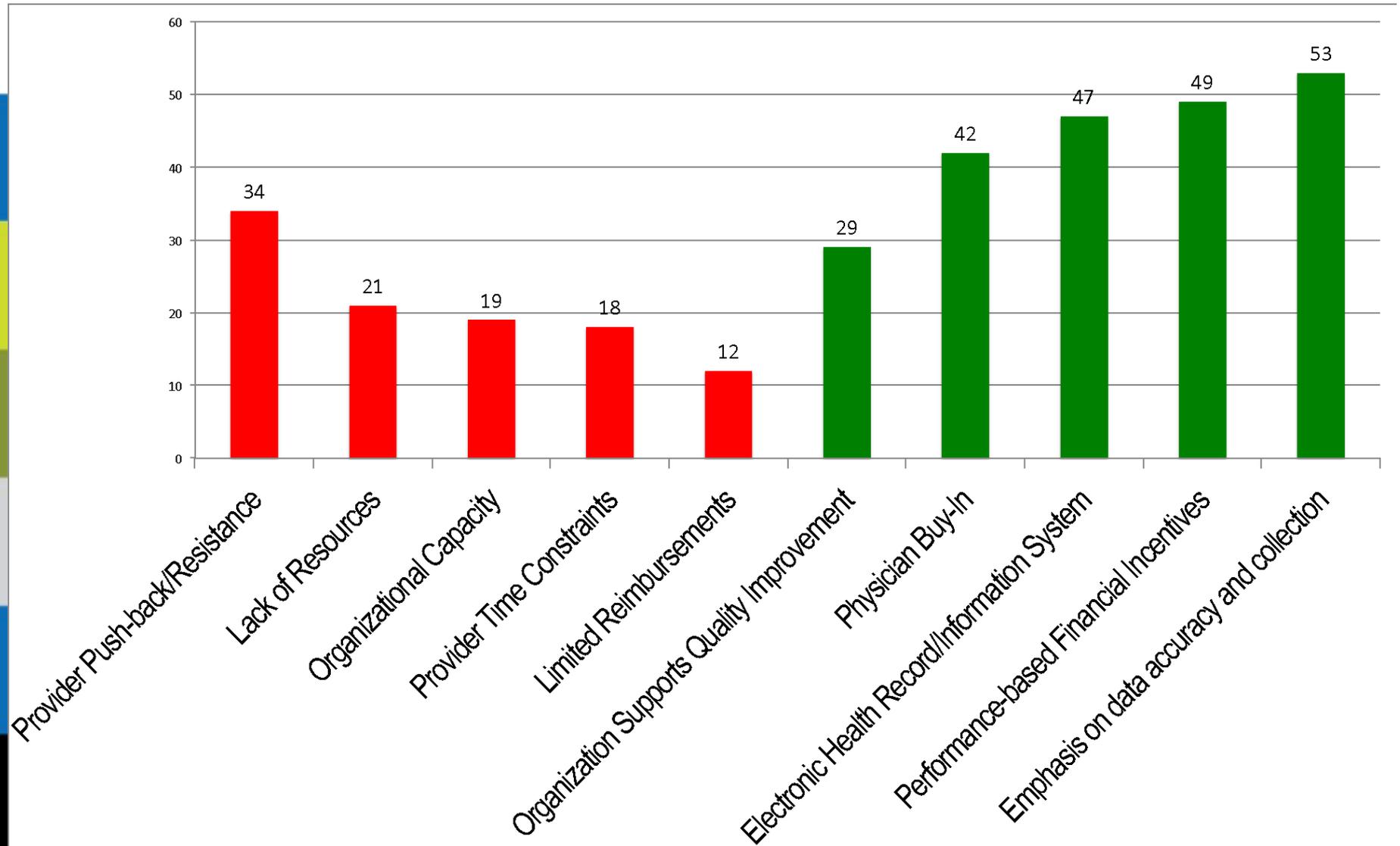
Key:

HIGH → ≥9 medical groups

MEDIUM → 5-8 medical groups

LOW → ≤4 medical groups

Facilitators and Barriers to Care Management Systems Implementation



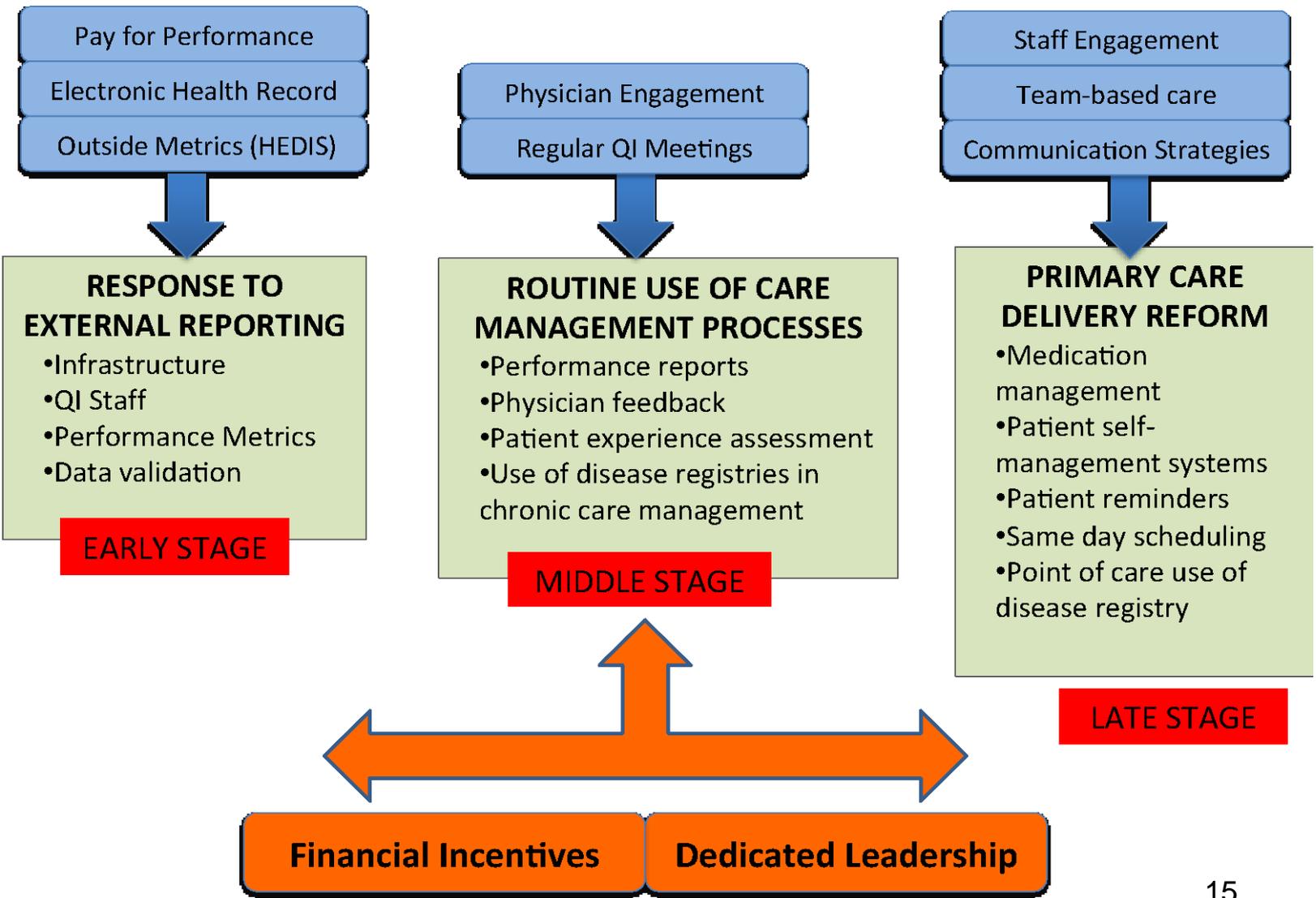


“A particular challenge that we see in implementing quality improvement strategies **very broadly speaking is [the issue of] money and capital.** Those products and strategies can be very expensive. At times we don’t have the capital to work with...another increasing barrier is the capacity of departments to take on so many projects”

“So if you ask why certain strategies are not implemented, it is because there’s no reimbursement for it. **Anytime you ask ‘why’ the answer is usually money...**”



“The biggest barrier is finding that **staff time to test different strategies**. Some of these strategies can be very labor intensive and some providers will not commit to 15-30 minutes because that will take away time from treating patients.”





Summary of Top Performing Groups' Experiences

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1. High emphasis on individual physician performance feedback and improving data integrity
 2. Physician resistance is a common experience as changes were implemented.
 3. Structural capabilities are high, except for electronic specialty interface and electronic clinician-patient communication.
 4. Financial/capital constraints are perceived as major barriers to the implementation of self-management support systems
 5. Primary care team approaches do not appear to be consistently implemented across top performing sites.

Moving the Needle?- What will it take?

