The Physicians Foundation

Practice Innovation:

New Models for the 21st Century

October 2, 2013

THE PHYSICIANS FOUNDATION
Empowering Physicians
Improving Healthcare

Mission

To advance the work of practicing physicians and improve the healthcare delivery system in America

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Overview

- Pursues its mission through a variety of activities including:
  - **Grantmaking** – Awarded numerous multi-year grants totaling more than $28 million
  - **Research** – Conducted for universities, hospitals, physicians and medical societies
  - **White papers** – Commissioned to explore most important topics
  - **Policy studies** – Guides our research and helps our physicians working through their state medical societies
- Led by Tim Norbeck, Chief Executive Officer and Bill Mahon, Chief Financial Officer

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Welcome

- Grantee Speakers
  - **Boston Medical Center**
  - **California Medical Association Foundation**
  - **Ideal Medical Practices**
- The powerpoint and a recording of the webinar will be available on the Physicians Foundation website (www.physiciansfoundation.org) after today's session.

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Have Questions?

- Please type any questions in the “Question Box” on the GoToWebinar control panel.
  - Please specify which presenter you would like to answer your question.
- Questions will be answered at the end of all three presentations.
- Any questions not answered during today’s session will be answered over email.

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Today's Presenters

John Wiecha, MD, MPH, BU School of Medicine, john383@bu.edu

- Dr. Wiecha is an Assistant Dean for Academic Affairs at Boston University School of Medicine, where is also serves as the Director of the Office of Medical Education. He received his M.D. from the State University of New York at Stony Brook, and M.P.H from the University of Massachusetts. Dr. Wiecha has published studies on patterns of preventive health care among disadvantaged populations, and on tobacco abuse among minority populations in Massachusetts.

Sandra Robinson, the CMA Foundation, srobinson@thecmafoundation.org

- Sandra Robinson, MBA is the Vice President, Programs at the CMA Foundation. She works with medical organizations including county and specialty medical societies, ethnic physician associations, health plans, public health agencies, consumer groups and community-based organizations throughout California and nationally.

L. Gordon Moore, Ideal Medical Practices, gmoore@idealhealthnetwork.com

- L. Gordon Moore has been a faculty member of the Institute for Healthcare Improvement in the domain of office practice redesign, and is a Clinical Assistant Professor with the University of Washington Departments of Family Medicine. He is the president of Ideal Medical Practices, a non-profit supporting adoption of ideal practices in health care settings across America.

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Solving the Adoption of Innovation Dilemma for Solo and Small- Group Practices

John Wiecha, MD, MPH
Assistant Dean, Academic Affairs
Boston University School of Medicine

BOSTON MEDICAL CENTER
EXCEPTIONAL CARE. WITHOUT EXCEPTION.

BOSTON UNIVERSITY

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Overview of Project

- Goals were to support adoption of innovation in primary care practices via development of online educational modules in the following areas:
  - Diabetes care (delivered in virtual world)
  - Promotion of colorectal cancer screening
  - Prevention of medical errors
  - Preventive cardiology
  - Congestive Heart Failure
  - Depression
  - Advanced directives

Overview of Project

- Instructional design emphasized application of principles, not simply transmission of information.
- Asynchronous
- Included one synchronous event in Second Life
- Project ran from 2006-2009
- 360 enrollees
- Highly rated
- 93% reported plans to make changes in practice

Overview of Project

Representative comments:

- "I was totally involved throughout as I had to think, plan, and work on patient charts and involve myself in teaching patients to fully get all the benefits of this program."
- "I enjoyed it immensely, will use the information in my practice."
- "Everyone should do it."

Examples of Screen Shots

Stage 6: Acting/Adopting the precaution - G...

www.bu.edu/fammed/cmetips/colorectalca/snippets/

Stage 6: Acting/Adopting the precaution

Close
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cess Model (PAPM):

After listening to the audio, click the video icon for Stage 6.
Go to the next page after viewing the video.

STAGE-BASED HEALTH BEHAVIOR MODEL SUGGESTS THAT ADOPTING A NEW HEALTH BEHAVIOR INVOLVES SEVERAL STAGES:

Stage 1: Unaware
Never heard of risk/screening test

Stage 2: Unengaged
Aware of and acknowledges risk for others

Stage 3: Engaged/Undecided
Acknowledges personal risk and are deciding

Stage 4:
Decided not to act

Stage 5:
Decided to act/not yet acting

Stage 6:
Acting/adopting the precaution

Stage 7: Maintenance
Repeated behavior at recommended interval

Interviewing
7 Module 4: MI Skills
8 Module 4-A: Managing Resistance
9 Module 5: Video Critiques
10 Patient Assignment #2
11 Post-Survey
12 Request Your Credits

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Physician Counseling to Enhe × | Physician Counseling to Enhe ×

www.bu.edu/dbin/fammed/tips_colonca/index.php

THEORY into PRACTICE SYSTEM
Solving the *Adoption of Innovation*
Dilemma for Primary Care Practitioners

Physician Counseling to Enhance Adherence to Colorectal Cancer Screening Guidelines

COURSE HOME | FACULTY | CARD STUDY | SCREENING GUIDELINES | OFFICE SYSTEMS TOOLBOX

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Please progress in order:

1. Course Directions and Pre-Survey
2. Course Objectives
3. Module 1: Introduction
4. Patient Assignment #1
5. Module 2: Stages of Adoption
6. Module 3: Motivational Interviewing
7. Module 4: MI Skills
8. Module 4-A: Managing Resistance
9. Module 5: Video Critiques
10. Patient Assignment #2
11. Post-Survey
12. Request Your Credits

PATIENT ASSIGNMENT #1

YOUR First Name:

YOUR Last Name:

Determine the stage of adoption of CRC screening of two patients this week. Describe the patient's stage and why you placed him/her in that stage in the space below.

Patient #1: (1-unaware; 2-unengaged, 3-engaged but undecided, 4-decided not to act, 5-decided to act but not yet acting, 6-acting/adopting, or 7-maintenance)

Patient #2: (1-unaware; 2-unengaged, 3-engaged but undecided, 4-decided not to act, 5-decided to act but not yet acting, 6-acting/adopting, or 7-maintenance)

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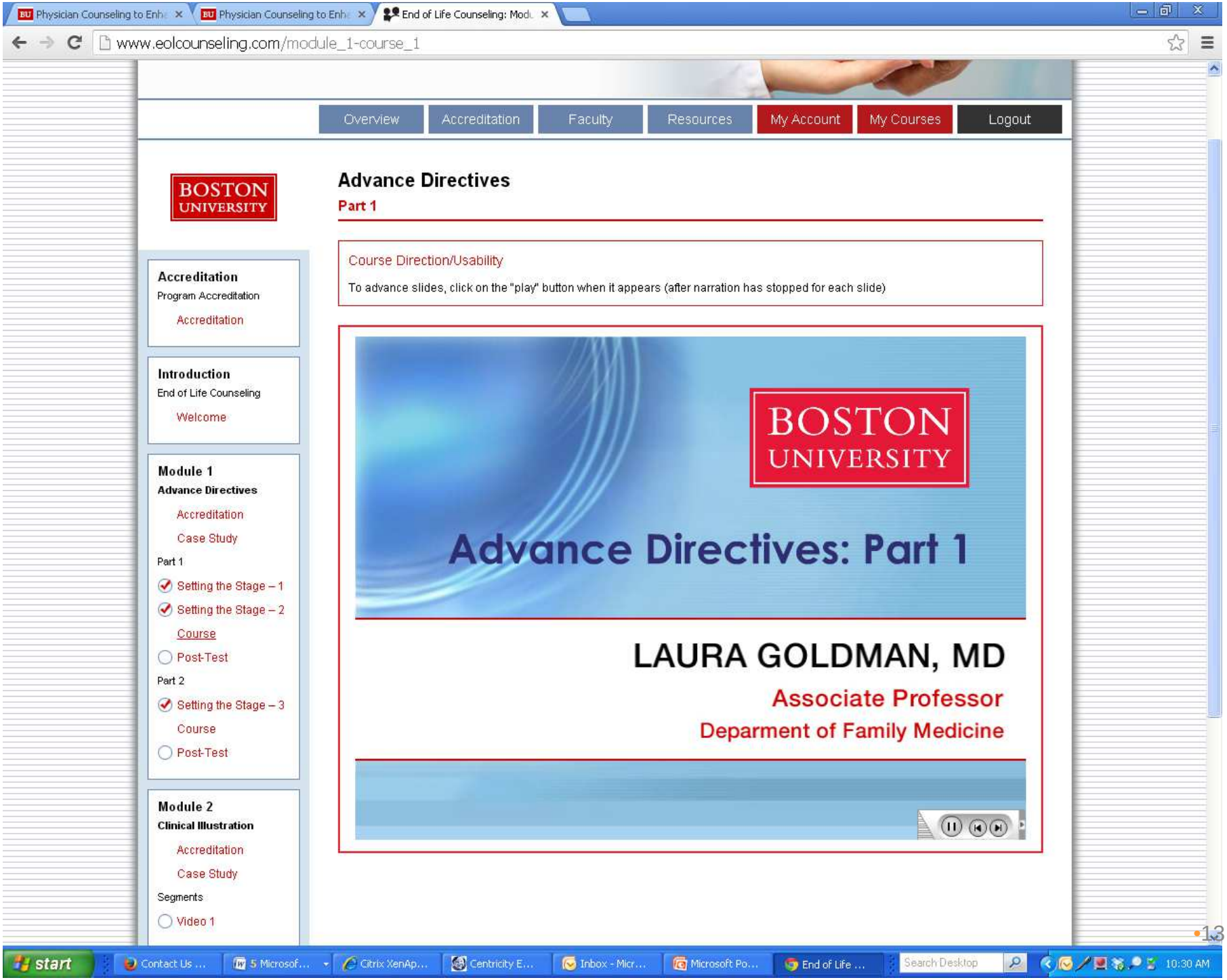
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Advance Directives
Part 1
Course Direction/Usability
To advance slides, click on the "play" button when it appears (after narration has stopped for each slide)
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End of Life Counseling
Welcome
Module 1
Advance Directives
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Part 1
Setting the Stage – 1
Setting the Stage – 2
Course
Post-Test
Part 2
Setting the Stage – 3
Course
Post-Test
Module 2
Clinical Illustration
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LAURA GOLDMAN, MD
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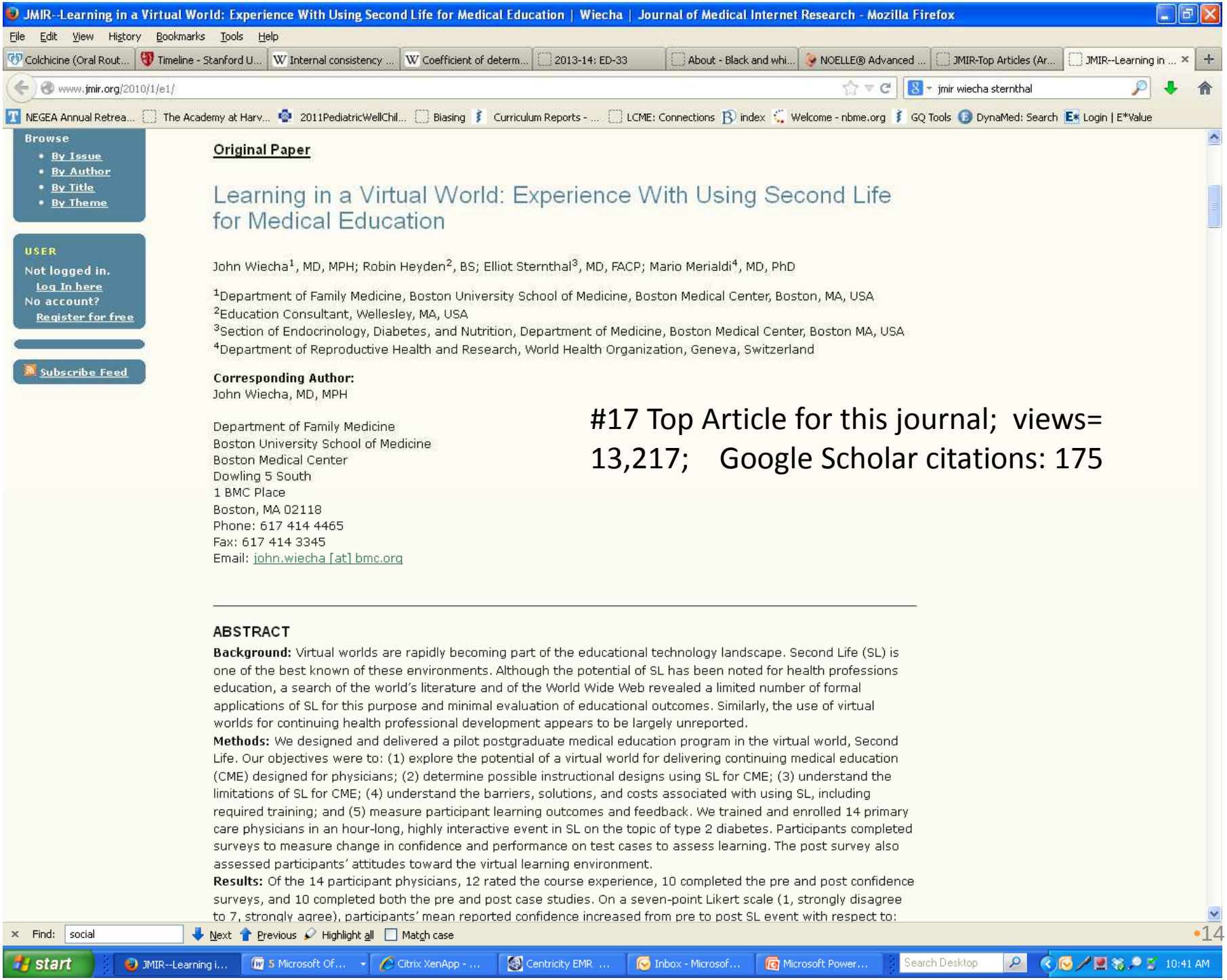
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Original Paper
Learning in a Virtual World: Experience With Using Second Life for Medical Education
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#17 Top Article for this journal; views= 13,217; Google Scholar citations: 175
ABSTRACT
Background: Virtual worlds are rapidly becoming part of the educational technology landscape. Second Life (SL) is one of the best known of these environments. Although the potential of SL has been noted for health professions education, a search of the world's literature and of the World Wide Web revealed a limited number of formal applications of SL for this purpose and minimal evaluation of educational outcomes. Similarly, the use of virtual worlds for continuing health professional development appears to be largely unreported.
Methods: We designed and delivered a pilot postgraduate medical education program in the virtual world, Second Life. Our objectives were to: (1) explore the potential of a virtual world for delivering continuing medical education (CME) designed for physicians; (2) determine possible instructional designs using SL for CME; (3) understand the limitations of SL for CME; (4) understand the barriers, solutions, and costs associated with using SL, including required training; and (5) measure participant learning outcomes and feedback. We trained and enrolled 14 primary care physicians in an hour-long, highly interactive event in SL on the topic of type 2 diabetes. Participants completed surveys to measure change in confidence and performance on test cases to assess learning. The post survey also assessed participants' attitudes toward the virtual learning environment.
Results: Of the 14 participant physicians, 12 rated the course experience, 10 completed the pre and post confidence surveys, and 10 completed both the pre and post case studies. On a seven-point Likert scale (1, strongly disagree to 7, strongly agree), participants' mean reported confidence increased from pre to post SL event with respect to:
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Lessons

- Moving landscape- rapid changes in technology- we responded by moving into VW
- To match LO to technology better
- Led to subsequent successes and projects
- Competition for CME represents challenges
- Recruitment difficult; Note: we got 10x amount via MMS and recertification requirement- “social engineering”!


Second Life CME Pilot
Adding Insulin in Type 2 DM
Elliot Sternthal, MD, FACP
Director of Outpatient Diabetes Program
Boston Medical Center
Boston, MA

Successes

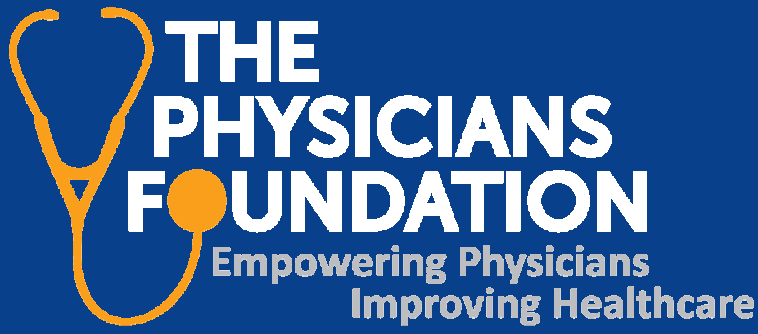
- Obtained Part IV Family Medicine Performance Improvement CME credit certification.
- Motivational interviewing module adapted for virtual world environment, led to several additional projects – including NIH funded study, and follow-on proposals.
- Geriatric end-of-life module adopted directly by the Massachusetts Medical Society (publisher of NEJM) and certified to meet new state requirement for CME in end-of-life care. **Completions to date: 3,276**

Extreme Makeover Project

Sandra Robinson

Vice President of Programs

California Medical Association Foundation



CMA Foundation Best Practices Overview

Best Practices offers a series of steps that solo and small-group practices can take to improve their practice with the goal of freeing the practitioner's time from administrative distractions, to focus on patient care and produce tools and methods for broad transfer to other locations.

1) Redesign and pilot test office workflows (that incorporate technology) to optimize administrative functions and provide foundational support for a subsequent project focused on EHRs;
2) Develop templates, toolkits, self instructional guides and train the trainer materials to enable the diffusion of learning to other practices;
3) Provide concurrent updates of activity via CMA Website, Town Hall meetings and communications.

Best Practices
Project Outcomes/Resources

- The Toolkit - "Best Practices"
  - The First Steps a physician must take when starting a practice.
  - The Elements of a successful practice.
  - Time management and administrative streamlining.
  - Improving practices from the perspective of the patient.
  - Staying financially healthy.
  - Compliance with Federal Health Insurance Portability and Accountability Act (HIPAA), selecting, implementing and using EHR's.
  - Gaps that cause medial practices to violate HIPAA and ways to lower the risk.
  - Developing a defensible fee schedule.
  - Improving quality of patient care and the quality of life for a physician.

Project Successes

- Creation of the toolkit that identified practical steps that small and solo practice physicians could take to improve the efficiency of the operation of their practices, and in doing so improve both the patient's experience and the quality of care being delivered .
- Contracting with the experienced team at CMA's Center for Economic Services, as well as enlisting the help of experts renowned in the areas they've contributed, resulting in the "Best Practices" offering a document with cutting-edge content.
- The web-based version of Best Practices is now available on both the CMA and CMAF websites, and is free to any physician regardless of whether they are a member of their state or local medical society.
- Seminars were conducted throughout the state based on the content of the toolkit.

Lessons Learned

- Due to the tight timelines, the project coordinators did not have as much time as they would have liked to work with small and solo practices in the design of the toolkit.
  - The adjustment to the tight timeline was that the participating physicians and office managers were surveyed and the appropriate adjustments were made.

- We are confident that several of the lessons we learned from completing Best Practices can be of use to future grant recipients.
  - One is that drawing on the strengths of our state medical society's staff was instrumental to both our ability to complete the grant project and to the quality of the materials we developed.
  - Teaming with the outside contributors was also key, as the combination of CMA staff versed in the practical difficulties faced by solo and small-group practices every day, coupled with the expertise of the outside contributors, resulted in a much better product than would have been produced by either type of contributor on their own.

Thank You!

- California Medical Association Foundation
- Phone: 916.779.6620
- http://www.thecmafoundation.org

Lessons from the Ideal Medical Practices project

L. Gordon Moore MD

www.IMPCenter.org

A non-profit group supporting those working toward delivering ideal care

ideal medical practices

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Comprehensive Primary Care

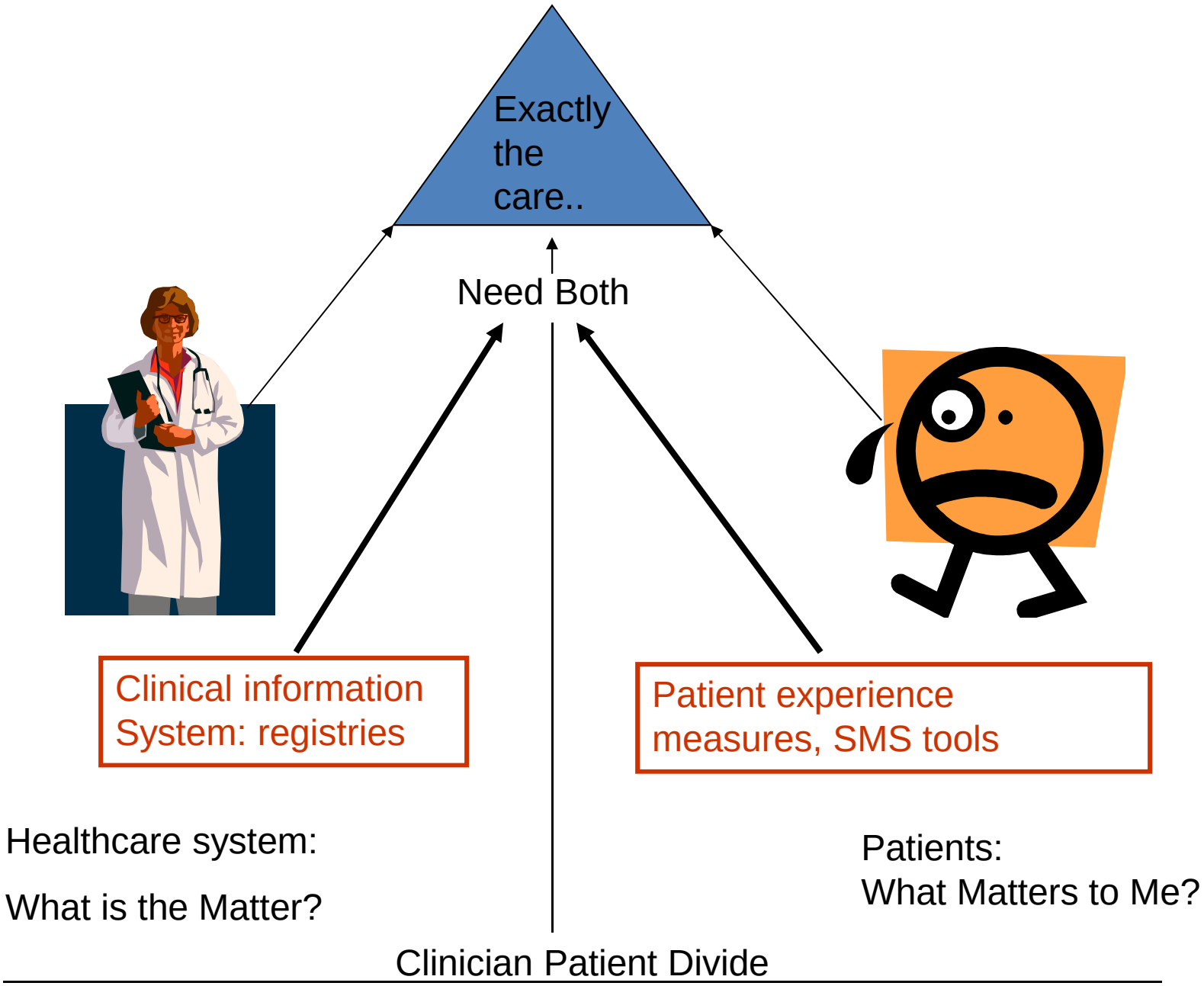
- First point of contact
- Relationship over time
- Comprehensive scope of services
- Coordination of care

- World Health Organization 1978 Alma Ata Conference

Ideal Medical Practices Project*

- 2006-2009
- Volunteer practices
- Mostly solo/small and independent
- Low cost IT/EMR

*Funded by the Physicians Foundation


Exactly the care..
Need Both
Clinical information System: registries
Patient experience measures, SMS tools
Healthcare system:
What is the Matter?
Patients:
What Matters to Me?
Clinician Patient Divide

Patient's Agenda and Experience

- Patient's agenda is a major driver of their behavior and outcomes
- Patient's experience is a major driver of their behavior and outcomes
  - Poor relationship predicts lack of follow up with preventive recommendations and chronic disease management
  - Poor continuity predicts hospitalization
  - Poor experience of access or wasted time in the office predict "no show"

ideal medical practices

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Schematic of the Planned (Chronic) Care Model

Adapted from Wasson et al, Jt. Comm J Qual Safe 29:5, 227 – 237, May 2003

CM = Clinical Microsystems

Necessary ingredients

- Room to breathe
- A method for improvement
- Ideas that work
- Ongoing feedback on performance
- Supportive technology

ideal medical practices

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HowsYourHealth Action and Planning Form

Print this action form and take it to your doctor to improve the medical care you receive. This form is intended for your doctor or nurse.

Your (Patient) Name:_____

Date: **2011-03-16** Age: **18-34** Gender: **Female**

Patient Purpose for Visit	Patient Symptoms
New Concern increase loose stools **Concern Since** last month or so **Implications** The cramps cause poor work activities.	**Stomach or Bowel:** abdominal pain **Nervous system:** headache **Bones or Muscles:** muscle weakness; joint pain

PATIENT ASSETS

FUNCTION	HABITS	KNOWLEDGE	PREVENTION
Daily Activities - Little difficulty Feelings - Slight problem Social Activities - No limitations	Generally good health habits Does not smoke Does not drink excessively	Birth control Sexual diseases Mammography/Cholesterol	Had pap test Does breast self-exam Education about birth control Education about sexual diseases Education about mammography/cholesterol

Feedforward to Clinician

PATIENT NEEDS

FUNCTION (*italics = clinician unaware*): None

SYMPTOMS/BOTHERS: Headaches; Eating/Weight/Exercise problems; Medications maybe making ill

CONCERNS OR FAMILY HISTORY: Violence/abuse; Health care system; Substance abuse; Exercise/nutrition needs; Preventing injuries/accidents; Preventing cancer/heart disease; Ear/eye/mouth care; Heart trouble/arteries; Diabetes; High fat

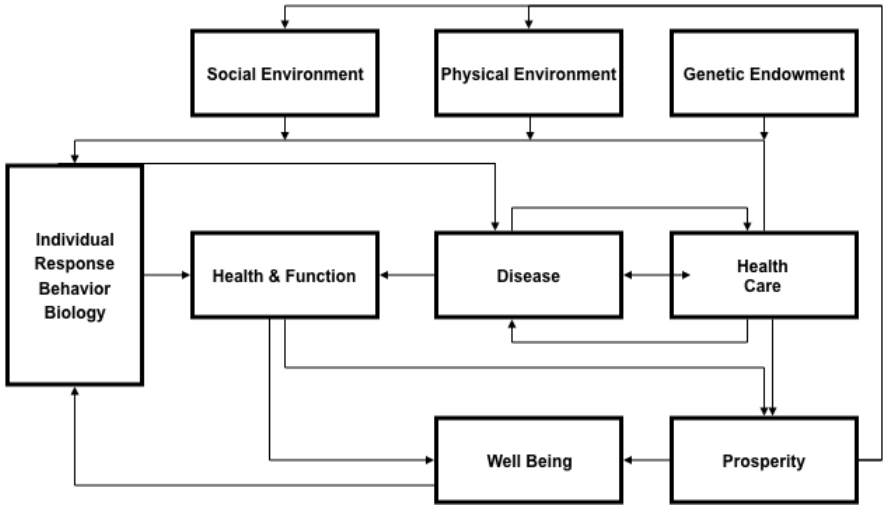
HABITS: None

Real Time Summary in Setting Serving Low Income

	All Records	Income Problems
Patient-Centered Processes	1047	650
Single Measure for Patient Centered Medical Care	17.71	11.92
Medical Home	44.74	36.31
Interaction Style	29.91	30.95
Very Good Communication for Chronic Disease	44.01	40.26
	All Records	Income Problems
Desirable Consequence	44	50
Aware of Functional Limits	36.80	35.93
Patient Confidence	29.03	19.23
Practice Benchmark	59.54	51.45
Wellness Activities	53.98	46.97
No Hospital or ED use for chronic disease	76.44	71.52
Meds not making ill	64.35	59.62

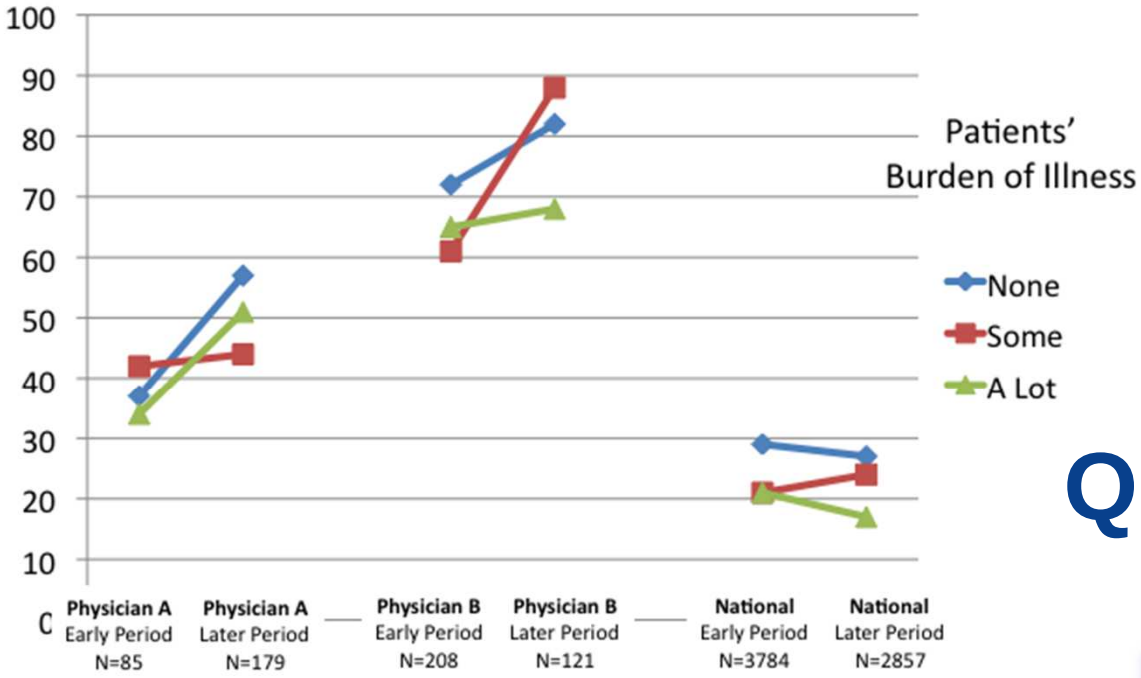
Feedforward to Clinician

"Determinants" of Population Health



	Low financial status ($N = 19\,930$)	Adequate financial status) ($N = 68\,590$)
Examples of Evans and Stoddart's determinants of well-being		
Genetics (family history of diabetes)	12	6
Physical environment (concerned about violence or abuse)	8	2
Social environment (poor social support)	24	8
Prosperity (not enough money for essentials)	100	0
Function and disease (above median burden of illness)	69	50
Personal response (smoker)	26	11
Personal response (confident for self-care)	29	53

Wasson JH and Moore LG.. J.Amb.Care.Mgmt. 2009. 32: 299-302.



Summary Information Enables Quality Tracking

Hypertension	2006 (*n* = 60)	2007 (*n* = 58)
Patient knows what to do if missed dose	68%	75%
Patient knows effect of weight/salt on hypertension	76%	82%
Patient is informed about side effects of medications	59%	79%
Systolic blood pressure < 150	92%	94%

Wasson et al. JCJQI 2008;34: 445-451

IdealMedicalPractices.org http://www.idealmedicalpractices.org/practice/toolchest

ideal medical practices

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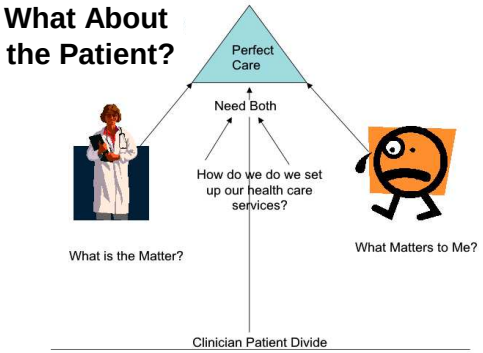
home practice toolchest

Toolchest

Curriculum	TOOL TITLE	BRIEF DESCRIPTION	LINK
Patient at the Center	The "Pyramid" and ways to improve care	How the IMP approach fits and works	Pyramid
	CARE Vital Signs and Visit Planning	Paper method to identify what matters and plan visit	CareVital/Visit Planning
	HowsYourHealth	Foundational for improving and measuring IMP	Using HowsYourHealth
	Resource Planning	A behaviorally sophisticated, effective and efficient alternative to N of 1" medical care"	Resource Planning
	Problem-Solving Module	Phone Support; and "Campaign for Confidence",Needed to support patient confidence for self-management	Confidence Toolkit
	Group Visits	Another way to support patient self management	Group Visits
	Podcast: Patient at the Center	A discussion of how some practices use HowsYourHealth to place patients at the center	PatientPod Sharing Audio -- Sharing Slides
Access and Efficiency	Know Your Processes	Handy tool from clinicalmicrosystem work; reduce the waste that is undermining your care	Processes
	10 Points of Advanced Access; Advanced Access FAQs	These documents provide a very helpful checklist for what you need to do to start and establish advanced access.	Advanced Access
	Podcast: Access and Efficiency	A discussion of basic principle and approaches that make access and efficiency sustainable	AccessEfficPod Access Audio; Access Slides -- Efficency Low Flow Audio; Low Flow Slides -- High Flow Audio; High Flow Slides
Defragmentation	Specialty Referral/Consult Form and Follow-up	Under advanced testing by advanced IMPs	Specialty -- Editable Specialty
Other Approaches	Medication Care	Helpful for patients and useful for practice to describe basic office procedures/expections.	Med Card
	Newsletters	Describe progress of IMPs and useful to tell patients about your practice's participation	News Sample
	Podcast: Technology	Before you invest, see how others spend pennies to save thousands.	Tech Demo
	Getting Paid	How IMPs might get paid for performance.	PaidPod Audio One -- Audio Two



Testing of a Standard IMP Curriculum for Two Years with Ongoing Evaluation

Experience By Respondents	Rank order of Curriculum Tools	Rank order of Curriculum Information
High (70+ percent have used/recalled)	Problem Solving (8.5)	Advanced Access (8.4)
	HowsYourHealth (8.0)	NThe PyamidÓ (75)
	Staff survey (7.0)	
	Overhead Survey (7.0)	
	C.A.R.E. Vital Signs (6.5)	
Not High (Fewer than 70% used/recalled)	Know Your Processes (7.6)	Defragmentation (8.6)
	Specialty Referral Process (7.4)	Resource Planning (7.0)
	Phone Coach for Confidence (5.4)	Managing Standard Problems (6.7)

Key Attributes of Effective Primary Care

I receive exactly the care I want and need exactly when and how I want and need it	Strongly agree	Disagree

Do you have:	% agree	%agree
Continuity	95%	60%
Access	85%	10%
Efficiency	80%	20%
Information	80%	20%
Confident Self-Care	75%	15%

Moore LG, Wasson JH, JACM Vol 29, No 3, pp. 195-198

Professional Care and Information WITH Patient Confidence is Collaborative Care

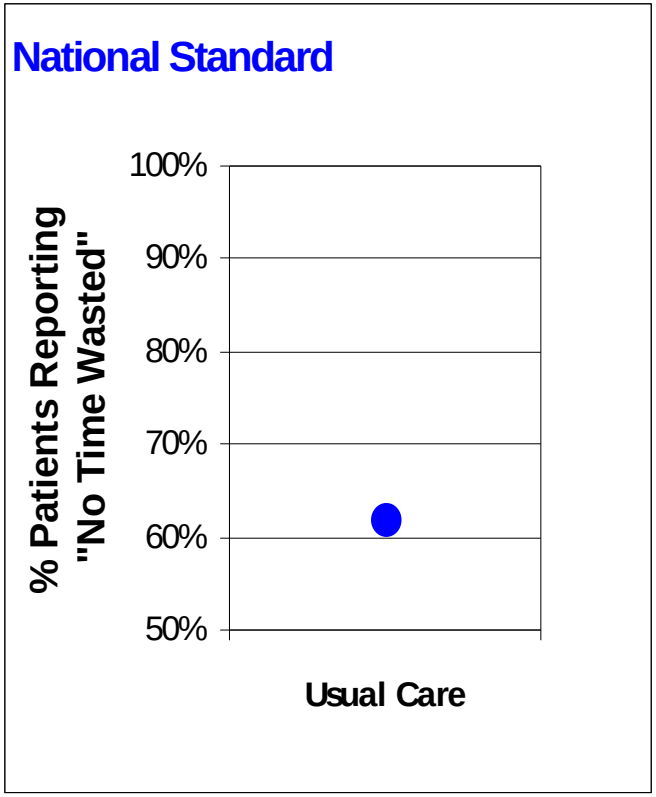
Study of 25,000 Americans 19-69

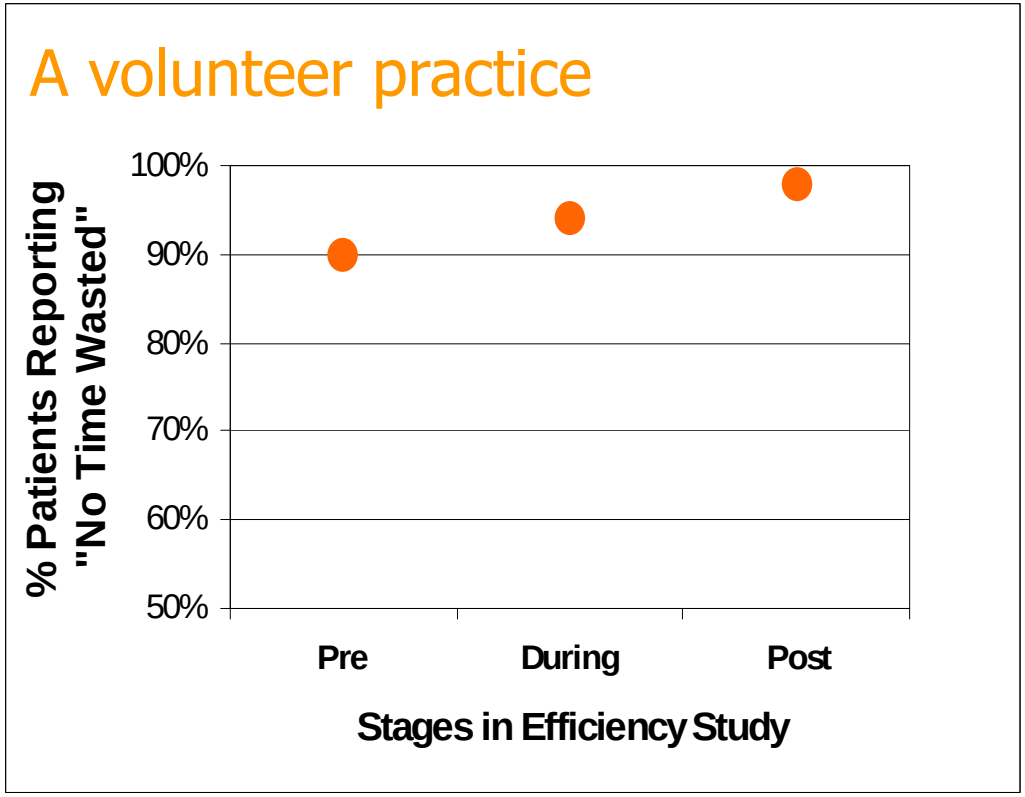
Past treatment has made:	Good collaborative care	Poor collaborative care
pain much better	34.7%	9.6%
emotional problems much better	34.8%	12.5%
Pts with HTN, CAD, DM report their systolic BP<140	74.8%	64.6%
Reports of problems from their medications	8.6%	20.1%
Spent at least one day at home because of illness in past 3 months	26.9%	31.6%
Physical or emotional problems limiting capactity to work in past 2 weeks	18.0%	33.4%
Hospitalized in past year with common chronic diseases	12.3%	14.2%

Wasson, Johnson, et al. JACM Vol. 29, No. 3, pp. 199–206

When you visit your doctor's office, how often is it well organized, efficient, and does not waste your time?

PATIENT EFFICIENCY DATA





DATA FROM HOWSYOURHEALTH SURVEY

Ideal Medical Practices: A Test-Bed for a Future Medical Home

The Joint Commission Journal on Quality and Patient Safety

Clinical Microsystems Series

Clinical Microsystems, Part 2. Learning from Micro Practices About Providing Patients the Care They Want and Need

John H. Wasson, M.D.; Scott G. Anders, M.D.; L. Gordon Moore, M.D.; Lynn Ho, M.D.; Eugene C. Nelson, D.Sc., M.P.H.; Marjorie M. Godfrey, M.S., R.N.; Paul B. Batalden, M.D.

Usual medical care in the United States is frequently not a satisfying experience for either patients or primary care physicians. For example, only a minority of patients agree that they receive "exactly the care they want and need exactly when and how the patients want and need it," whereas many primary care physicians are leaving primary care or not entering primary care at all.[1,2] Whether primary care can be saved and its quality improved is a subject of national concern. In this context, an increasing number of physicians are using microsystem principles to radically redesign their practices.[1,3] The transformation is motivated both by physicians' self-interest and altruistic interest for the sake of their patients.

Two problems confront health systems when they try to improve the quality of office practice. First, there is the problem of the weak link in the chain. From the patient's perspective, the value of care in a health system can be no better than the services generated by the small clinical units—or microsystems—of which it is composed.[4] When some of its microsystems are weak links, essential services of the health system will back up, break down, or result in inefficient and costly workarounds.

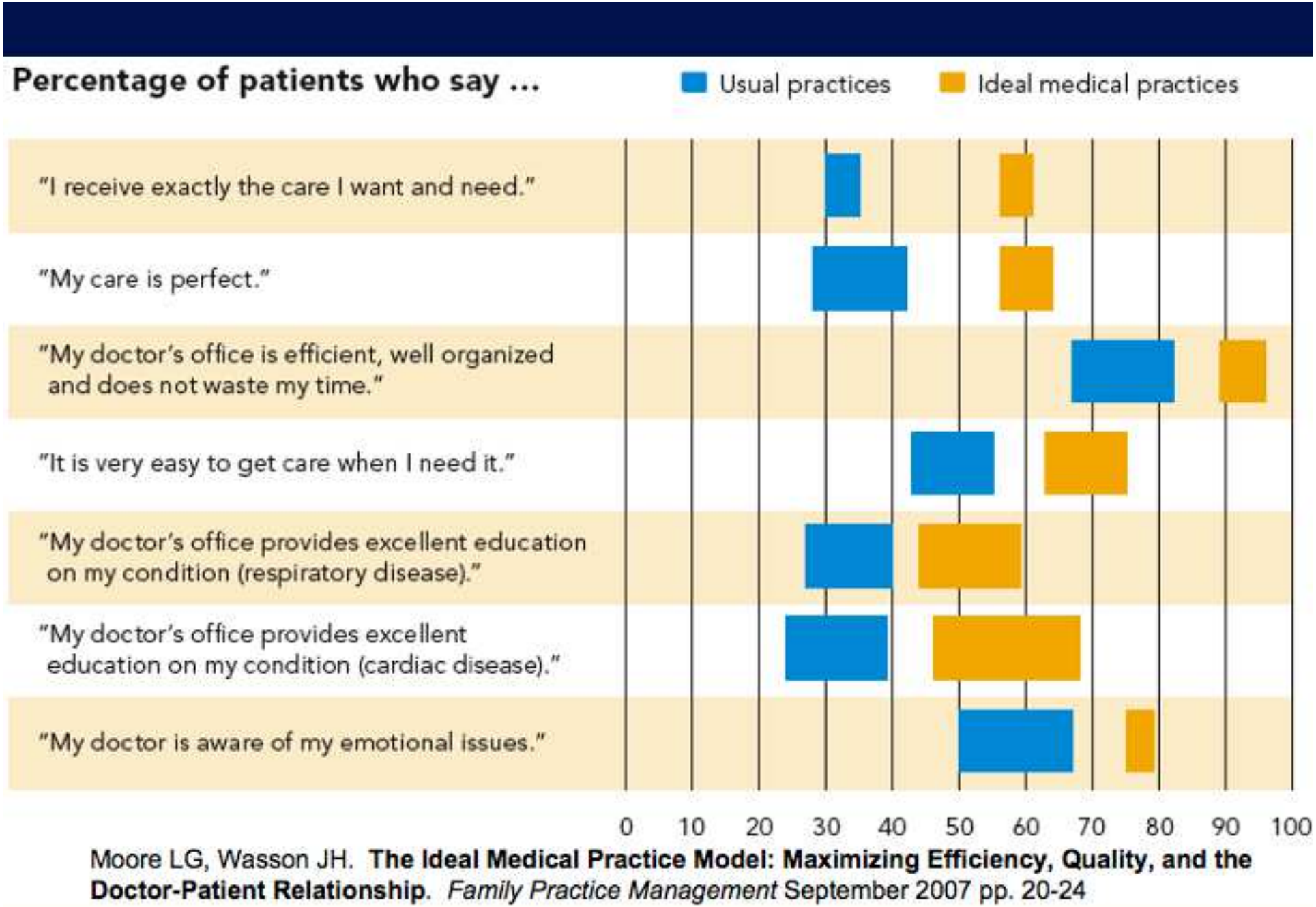
The second problem is the need to get many processes and handoffs right. For example, there seem to be at least nine attributes of successful microsystems within an exemplary health system.[4,5] Imagine that your health system can reliably

Article-at-a-Glance

Background: Usual medical care in the United States is frequently not a satisfying experience for either patients or primary care physicians. Whether primary care can be saved and its quality improved is a subject of national concern. An increasing number of physicians are using microsystem principles to radically redesign their practices. Small, independent practices—micro practices—are often able to incorporate into a few people the frontline attributes of successful microsystems such as clear leadership, patient focus, process improvement, performance patterns, and information technology.

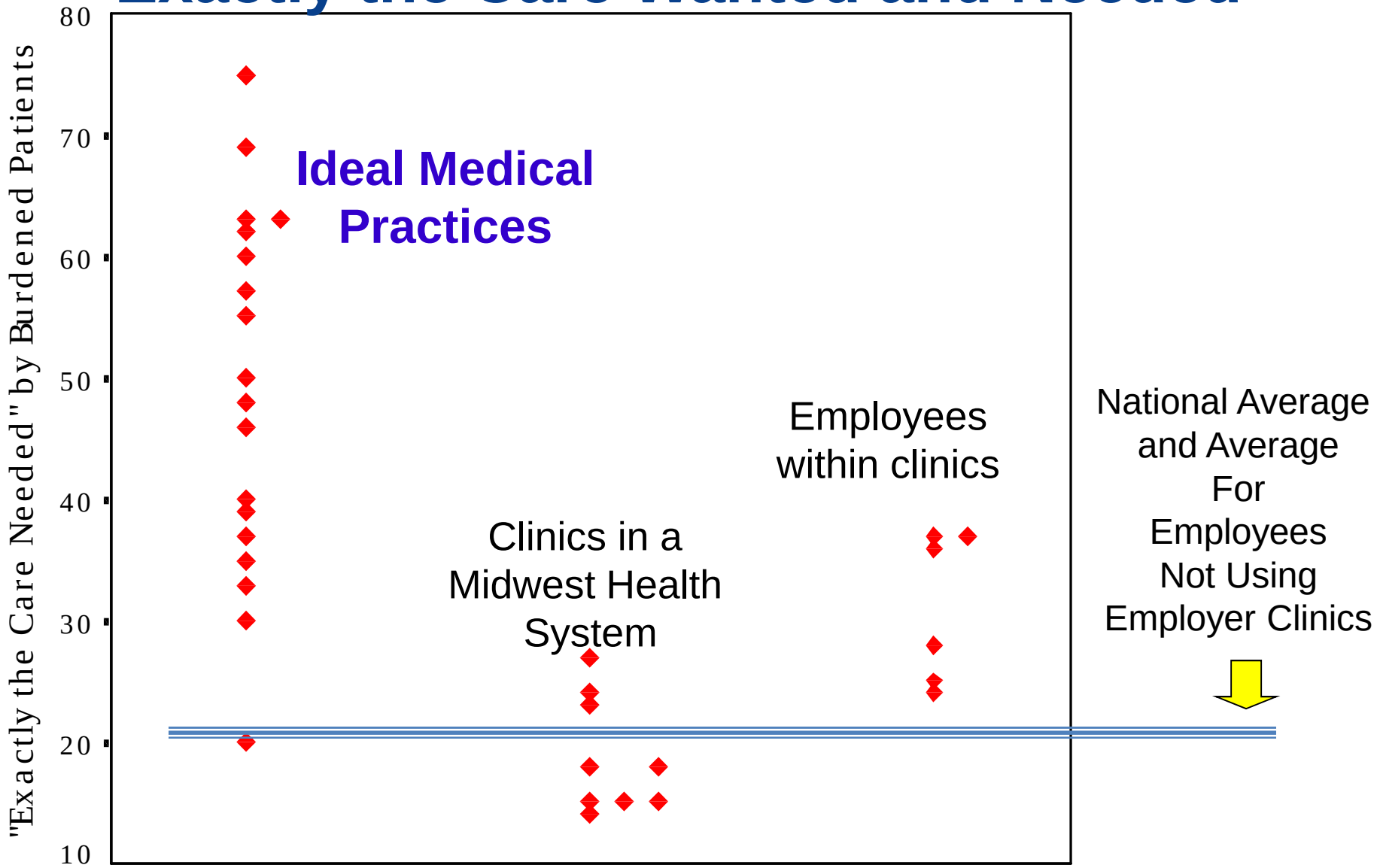
Patient Focus, Process Improvement, and Performance Patterns: An exemplary microsystem will (1) have as its primary purpose a focus on the patient—a commitment to meet all patient needs; (2) make fundamental to its work the study, measurement, and improvement of care—a commitment to process improvement; and (3) routinely measure its patterns of performance, "feed back" the data, and make changes based on the data.

Lessons from Micro Practices: The literature and experience with micro practices suggest that they (1) constitute an important group in which to demonstrate the value of microsystem thinking; (2) can become very effective clinical microsystems; (3) can reduce their overhead costs to half

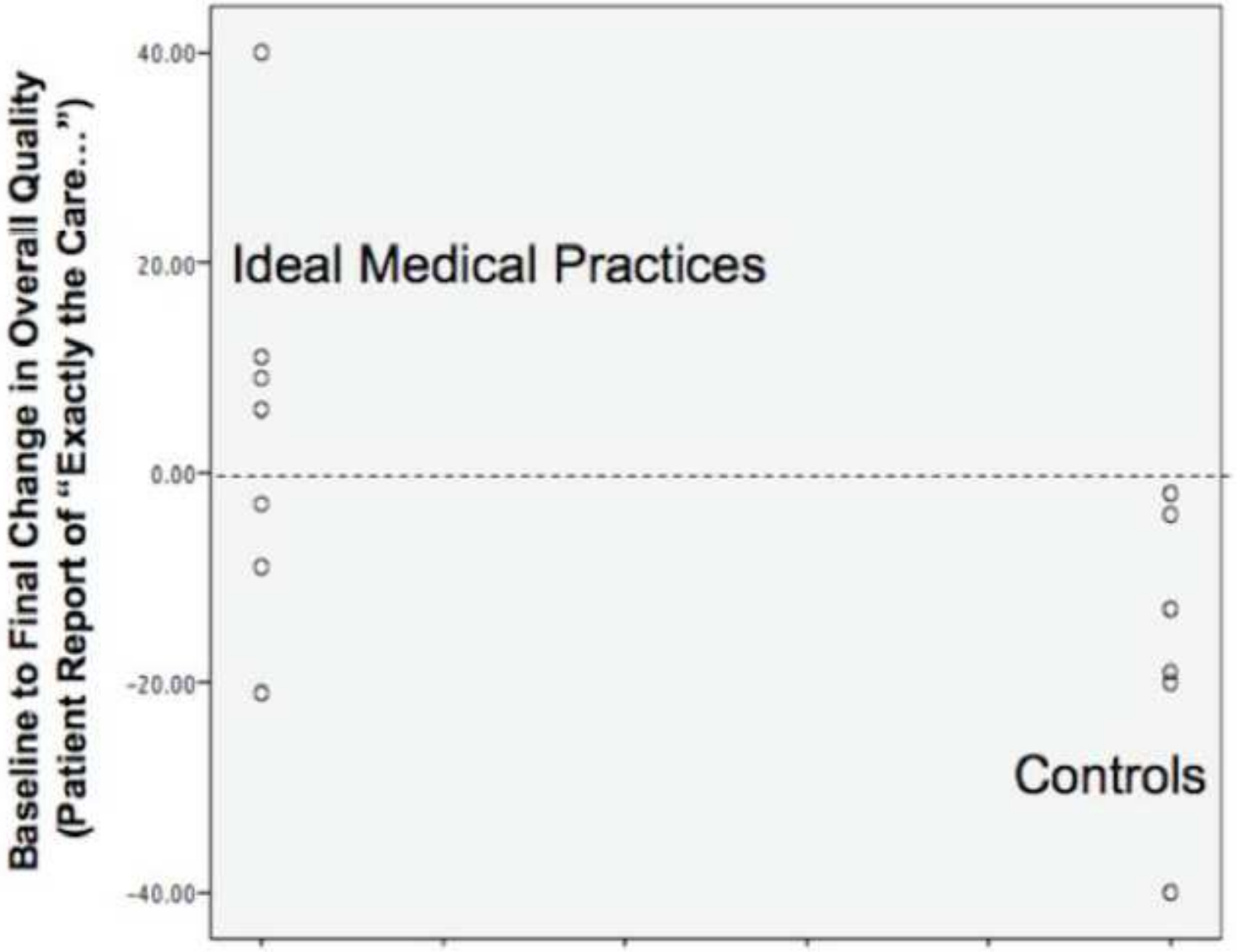


Moore LG, Wasson JH. **The Ideal Medical Practice Model: Maximizing Efficiency, Quality, and the Doctor-Patient Relationship**. *Family Practice Management* September 2007 pp. 20-24

Performance On a Measure of "Exactly the Care Wanted and Needed"



18 Month Change In Care Quality for Volunteer Practices Who Used (IMP) Or Did Not Use (Controls) HowsYourHealth



Resources

- Gmoore@idealhealthnetwork.com
- www.IHI.org
- www.IMPCenter.org

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