

The Kentucky Ambulatory Network and Quality Improvement in Practice

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A day in the life

John Doe, MD arrived at his office at 8:30 AM after finishing rounds on his three patients in the hospital; ahead of schedule for once, since his first patient was scheduled for 9:00 AM. He spent a few minutes next to his waste basket sorting through his pile of mail. He threw away his latest Confidential Clinical Report Card from an insurer (payer) after scanning it to confirm that most of the things it “informed” or “reminded” him about regarding clinical guidelines and his patients were either completely in error or not pertinent, considering his patients’ real issues not captured by the billing claims data. He did not notice the new statement in this Clinical Report Card about the payer’s new “performance rewards program”.

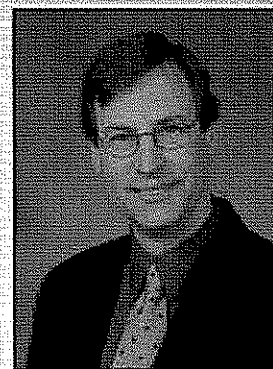
Dr. Doe logged onto his electronic medical record system. He rapidly closed the six new ‘primary care alert’ messages about new findings in the medical literature that had been posted to his opening page from his medication prescribing program. That day, Dr. Doe saw 30 patients in the office while his two partners had similar and typical days. He managed two or more problems for all but seven of the patients; for each of five patients he managed at least four problems, and he provided preventive services to one-fourth of the patients that day. During the lunch hour Dr. Doe handled messages from eight patients, vetted some rejected Medicare reimbursement claims with his office manager, and looked over the new requirements for Maintenance of Certification from the American Board of Family Medicine (ABFM) that he

had been ignoring for too long. After checking in on his hospitalized patients, Dr. Doe got home around 6:30 PM.

The ‘quality movement’ in primary care

It seems safe to presume that most family physicians want to provide high-quality healthcare. But most also feel the burden of competing demands and missed opportunities for delivering the best possible medical and preventive services to their patients. Indeed, following all current guidelines for prevention and chronic disease management may be impossible under prevailing practice models.^{1,2} Physicians like Dr. Doe find it extremely difficult to find the time or the resources to systematically improve quality and demonstrate it to those who might scrutinize their practices. Hard work and hectic days are inherent to comprehensive primary care practice in the U.S.; so why is there now a ‘quality movement’?

Quality improvement (QI) programs in healthcare are not new, but a widespread quality movement has been catalyzed by the Institute of Medicine (IOM) 2001 Quality Chasm Report, as well as the earlier IOM report on medical errors and patient safety.^{3,4} These highly publicized reports, along with omnipresent concerns over cost, access and satisfaction with health care, have pushed quality to center stage as employers, public payers, private payers, and individual patients try to get the most for their money. Professional credentialing bodies have added their muscle to the demands for measurable quality.^{5,6} While hospitals felt the impacts of this latest quality movement first, attention is rapidly turning to the ambulatory care settings where most people get most of their medical care, most of the time.⁷



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These demands for demonstrated quality in ambulatory care are being translated into prescribed measures of quality using indicators that physicians are being either encouraged or required to embrace. At present, encouragement comes mainly in the form of Pay for Performance (P4P) programs being rolled out by Medicare and by private insurers (payers).⁸⁻¹⁰ The degree to which reimbursement levels become tied to quality measures in the future will determine whether these encouragements become de facto requirements. Physicians are already faced with requirements from their specialty boards to measure and improve quality, and some payers require quality indicator reporting for all physicians on their preferred provider lists.^{5,9}

Many physicians and professional organizations, including the American Academy of Family Physicians, embrace QI as a good thing.¹¹⁻¹³ However, the paucity of methods for improving quality and measuring it in meaningful ways in ambulatory practices has caused a new sort of quality chasm between QI theory and QI practice. Like Dr. Doe, many primary care physicians do not have adequate resources or preparation to engage in QI programs; nor are they ready to produce reports of quality indicators to satisfy payers or medical specialty boards. Methods to accomplish these things that are reasonable and effective in large integrated medical groups often translate poorly into small private practice environments. Physicians in small practices who expected electronic medical records

(EMRs) to make QI and quality indicator reporting easy for them have been largely disappointed. Primary care EMRs are rare (if they exist) that efficiently link updated evidence and guidelines to individual or aggregated patient care data, provide point of care decision support, facilitate self-audit, provide accurate alerts or reminders and facilitate patients' involvement in their own care.

What the Kentucky Ambulatory Network is doing

Most primary care physicians practice in small private groups,¹⁴ and most small medical groups lack strategies and methods to keep them from being left behind as the quality movement rolls on.¹⁵ The Kentucky Ambulatory Network (KAN) has embraced developing QI strategies and methods for small practices as central to its mission to enhance the ability of office-based clinicians to deliver high-quality primary care to their patients through collaborative and translational research. KAN is a practice-based research network with over 200 community-based clinician members plus over 75 members from the University of Kentucky and the University of Louisville. The Kentucky Academy of Family Physicians (KAFF) supports the QI-related work of KAN through the KAFF foundation.

In 2005, KAN began concentrating on QI strategies in practice by conducting a faxed survey of a random sample of Kentucky primary care physicians to gauge their interest in tailored change facilitation for systems-oriented quality improvement, in anticipation of P4P incentives and maintenance of board certification requirements. Tailored practice change facilitation (TPCF) would consist of centralized services tailored to specific objectives and capacities of each practice and would be adjusted according to each practice's achievements and/or setbacks. Best practices for achieving QI goals would be shared among participating practices.

The survey asked physicians to indicate general interest in such an endeavor as well as specific clinical areas of interest. Among 86 respondents, 69 indicated interest in collaborative QI work using TPCF. The most common areas of interest were diabetes (68 respondents), cardiovascular disease (66 respondents), and substance abuse or smoking (43 respondents).

EQUIP-4-PCPs

In response to this survey, KAN developed a program in collaboration with the KAFF to pilot-test the TPCF concept for QI in small private practices. The program was dubbed Enabling Quality Improvement in Practice for Primary Care Physicians (EQUIP-4-PCPs). EQUIP-4-PCPs is designed to adapt proven methods for QI in healthcare to the problems faced by small practices. It relies on a sustainable model in which centralized (but limited) resources external to the practice are deployed to help each practice set QI goals and achieve them in gradual, step-wise fashion; keeping objectives as realistic as possible. The basic components of the prototype EQUIP-4-PCPs service are:

- 1) **People:** KAN personnel trained to serve as Change Facilitators visit each practice at least twice, then interact via telephone and the internet with practice personnel. A Physician Champion at each practice leads the QI effort, and a staff member at each practice manages the project (QI Coordinator).
- 2) **Preparation:** A brief web-based QI training program is provided for each practice's QI Coordinator. The KAN Change Facilitator visits the practice, orients the Physician Champion and the QI Coordinator to the EQUIP program and helps them set targets for QI (such as improving the proportions of diabetic patients that get foot exams or a urine microalbumin test). A focused self-audit of medical records against

selected benchmarks for the QI target(s) is facilitated by the Change Facilitator, who also guides the practice through a self assessment of their readiness for change. The self-audit helps Physician Champions and their QI Coordinators determine their QI goals and set tailored, realistic goals for their practices. The KAN change facilitator performs a larger audit of medical records to provide the practice with more baseline data related to their QI target.

- 3) **Support and follow-up:** The Change Facilitator stays in touch with the practice via telephone and email to coach and offer advice to the QI Coordinator at each practice. A library of selected tools and guidelines for preventive services and chronic disease management, chosen for practical use in primary care, is provided in a manual and on a website. The website also has other information and web-links dedicated to helping Kentucky PCPs pursue their QI goals. In the future the website will include a secure area for the exchange of ideas among PCPs to facilitate a best-practices approach to QI. After a set period of time, a repeat audit of medical records is performed by the Change Facilitator and compared with the baseline audit.
- 4) **Immediate rewards:** Participants in the EQUIP-4-PCPs pilot project will receive up to 10 hours of free CME credit. They can use the data that they gather during their self audits to fulfill an ABFM maintenance of certification requirement.

The EQUIP-4-PCPs pilot focused on the management of type 2 diabetes, because of its popularity as an area for QI in the initial survey. Nine small Kentucky primary care practices are participating in this pilot phase, which will be completed by the summer of 2007. These PCPs and their staffs are being encouraged to share ideas and successful strategies for QI in practice and obtaining maximum quality-based reimbursement. They are also

providing feedback on the most (and least) useful components of the program and will be asked for suggestions for its improvement.

PEAs

KAN recently explored an alternative model of external facilitation of QI based on having a trained graduate student spend one to two days per week at a practice to help the practice identify and pursue QI goals. These facilitators were provided at no charge to participating practices. This service adapted the Practice Enhancement Assistant (PEA) concept developed by J. Mold, MD and others for small primary care practices in Oklahoma.¹⁶ PEAs are trained to facilitate planning, implementation and evaluation of QI and research projects. In Oklahoma, PEAs are paid employees of the research network, with funding from organizations interested in improving the cost-effectiveness of primary care. In our model, PEAs were graduate students in public health who spent 6 months working as PEAs for no salary, as a practicum experience. Our senior Research RN also served as a PEA in this project in order to maximize her validity as a trainer for the student PEAs

In 2005, KAN first piloted this PEA concept in four KAN member practices. The PEAs were trained and supported by University of Kentucky (UK) faculty and the KAN Research RN. By design, they all pursued the goal of improving breast cancer screening at each practice. Each PEA was assigned to one practice, visiting once or twice per week on a predictable schedule. Each PEA spent her time at her assigned practice in different ways, according to the practice's needs, but all pursued the goal of assisting the practice with their QI objectives related to breast cancer screening. The PEAs met regularly together with faculty and KAN staff at UK. Typical PEA activities included meeting with the physicians and their support staff about practice patterns and barriers to breast cancer screening,

observing work-flow patterns, analyzing information management, and helping design systems-based improvements such as reminders or mammography referral forms. Each PEA also performed standardized medical record audits to provide the practice with data on their rates of appropriate breast cancer screening. Although the pilot PEA project focused on breast cancer screening, it could be easily adapted to multiple areas of clinical interests. The results of this pilot project were mixed. Its main strength was also its main weakness: graduate students represent an excellent resource that could be sustainable, but their preparation to serve as PEAs is expensive and medical practices probably need more than five or six months of PEA service to bring about lasting positive changes.

KAN's current goals

KAN aims to create a sustainable infrastructure that will help PCPs improve measurable quality in their practices, and promote quality improvement (QI) research. The results of the pilot work are being used to improve KAN's models for facilitation of QI in practice. KAN's leaders envision the network earning support from various sources that are interested in improving quality and/or advancing knowledge about QI through research. Grant applications to the NIH from KAN for QI research and the translation of research into practice are under review, and explorations for other sources of funding, including a fee-based service are ongoing.

If you are interested in learning more about KAN and/or the EQUIP-4-PCPs program, please contact any of the authors of this paper at (859) 323-4889, or send an email message to Mary Barron at mabarr2@email.uky.edu.

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