



From 'DOH' to Wow! One CHC network's experience with Clinical Quality Improvement (and everything else in its' wake)

Craig Law

CEO

Delaware Health Net, Inc.

and

STATpay, Inc. (www.statpay.com)

Multi level support necessary

- Every level of the organization must be committed to improvement
 - Leadership and Executive Levels (50,000 feet)
 - Operational and Managerial Levels (treetops)
(Supervisory)
 - Front line Staff (deep in the woods)
(front desk, nurse, provider)
- Without total commitment, any level of organizations lack of buy-in will cause organizational inertia

Changes must be beyond simple goal setting

- **Success is seen by measuring quality differently and tying quality to the:**
 - **Patient experience**
 - **Staff experience**
 - **Clinician experience**
- **Quality change must be pervasive, measured and shared**

We have reached a critical “inflection” point

- We can no longer “manage”, we lead
- The internet is maturing and creating a near free technology infrastructure
- Healthcare has merged into the “more for less” economy (10% less per year)
- Science and technology both at inflection points of digitization

Organizational changes to support better care

- Improve use of best practices (clinical and business)
- Better use of information technology for access to information and support of clinical decision making
- Better care coordination for chronically ill
- Ruthless sharing of performance and outcomes
- Redesign of the medical record as a tool

“System” approach to patient care

- Knowledge based care
 - **We have unreliable use of best science and best practices that should put knowledge at point of use but does not**
- Patient Centered care
 - **lack of focus on individuality, ethnicity, social endowments and individuals information needs**
 - **put the patient in control of their own care**
- **Cooperation (not expertise) as the premier professional value**

Five Simple Rules

1) Deliver information to patients every way possible

- mail, face to face, phone, email, fax

2) Evidence based delivery

- should not vary based on clinician
- Condition focused practice protocols

3) Safety as a system and NOT a goal

- Greater attention to systems that prevent errors and waste

Five Simple Rules

4) Cooperation throughout the patient visit continuum as a priority

- All involved should actively collaborate and communicate to ensure exchange of information

5) Identification of WASTE throughout the patient visit continuum as the prime goal

- Thou shall not waste time (patient, staff or provider)
- Knock "cost reduction" out of vocabulary



What did we want to “Fix”?

Clinicians wanted:

*=key

- Track patient meds and allergies
- Improve patients ability to help themselves
- Provide relevant services and improve preventive services
- Improve condition management
- Improve patient education materials*
- Provide timely, actionable clinical data*
- Create a database that tracks/monitors each patient and evaluates outcomes
- Improve clinical automation to provide value*

Objectively evaluate the “As Is”

- Tremendous time/resource commitment to track clinical data manually
- multi-point opportunity for failure in workflow
- 56% Chronic disease patients get recommended care
- 24% Diabetes patients get 3 HbA1c in 2yrs.
- 66% CHF patients get ACE Inhibitors
- Not all facilities had expertise to improve

Barriers in Selection Process

- Lack of time to implement
- Lack of resources (\$) for costly system
- Minimal IT infrastructure
- Clinicians wanted to select/create guidelines themselves
- One chance to gain clinicians confidence
- Limited appetite for radical change

Training and System Set up

- Contract signed in June
- System set up within 72 hours
- Demographic uploads took 8 weeks
- System training in July
- August - Basic cancer screening (4), then Pediatric measures (25)
- September - Rest of Lifecycle measures (~100)
- October - Rollout of Chronic Condition measures (75)
- Now - 1 year worth of data (want min. 3)

Minimal Information to enter

- **Name**
- **Gender**
- **Date of Birth**
- **PMS Account Number (optional)**
- **Race/Ethnicity**
- **Chronic Condition(s)**
- **Provider**

Training & Implementation

- Login/password concepts
- Demographic data entry
- Clinical data entry (pick lists)
- Several months later
(allergies/meds/comments)
- Last to implement (reporting)

Waste - The final frontier

- Three areas of waste
 - Patient waste
 - Staff waste
 - Provider waste
- Theory of Constraints
- How do we change the way we operate to reduce our costs 10% a year

Theory of Constraints Eli Goldratt

- Determine the constraint and its ill effect
- Determine how to release the constraint
- Subordinate everything to the above decision
- Verify the constraint is released
- Determine where the constraint has shifted
- Determine how to release the *new* constraint
- Repeat the above steps

PDSA's

- Rollout guidelines progressively
- Lots of Data entry at beginning
- Printing out a form for each patient takes time
- Someone needs to cull record for historical data
- Time from data collection to data entry crucial
- GIGO review needed
- Strongly resist the urge to generate reports

Moments of Truth

- “It’s changed everything”
- “When can I start (fill in blank)?”
- “Does it (fill in blank)?”
- “I am practicing better medicine”
- “I need to add a measure that...”
- “It’s like a mini-medical record”

The End

**Craig Law
President**

STATpay, Inc.

6400 Baltimore National Pike, Suite 346

Baltimore, MD 21228

410-788-9715

www.STATpay.com