From the President & CEO...

On the right track – leveraging opportunities and capabilities

Regular readers of this column know that for at least two years we have been voicing concerns about the competitive threat posed to voluntary, private-sector regional health improvement collaboratives – like WCHQ – by federal data mandates and initiatives flowing from the economic stimulus (American Reinvestment and Recovery Act) and health reform (Affordable Care Act) legislation. As others joined in this advocacy, the Centers for Medicare and Medicaid Services (CMS) responded positively by allowing organizations to seek designation as a Qualified Clinical Data Registry (QCDR; formerly referred to as the “deeming” initiative) for submission of performance data under its various programs.

We immediately recognized this as a major opportunity for WCHQ, for it will strengthen the connection between our work and provider efforts at the local level and complement our strategy to be positioned as both a measurement and improvement organization.

Making it real – connecting the work

This “connection” became clear during a particularly satisfying “aha moment” experienced when a provider member at our January 14 Assembly meeting began to see the potential benefits of his organization submitting data to WCHQ as a QCDR. Given the multitude of initiatives and current data demands, the member initially voiced some doubt that his organization would be able to make the 17 common measures approved by the Statewide Value Committee’s (SVC) Wisconsin Measures Alignment Project (WIMAP) a priority. However, it all came together for him when he heard more detail about the role of a QCDR and WCHQ’s ability to specify the performance measures it can collect and report for credit under CMS regulatory programs.

Seeking clarification, the member asked, “What you’re saying is, you could include WCHQ measures and SVC measures in the approved registry and by submitting data for those measures to WCHQ, we get credit for participation in CMS programs?” When the answer was affirmative, he simply exclaimed, “Wow, that’s big!”

We couldn’t agree more. In fact, as our strategic plan continues to advance, there are many signals suggesting that we are on the right track in enhancing the value we seek to bring to our members by connecting our work to their efforts to improve performance.

QCDR approval

I’m pleased to announce – after only a surprising one-day turnaround – our self-nomination as a QCDR for CMS was approved on January 29. We now have until March 31 to confirm a list of up to 20 measures that we will be reporting to CMS as an approved registry sponsor. It is our goal to include as
We are in the process of touching base with key thought leaders and partner organizations to make certain we select measures that optimize our role as a connector between the SVC and provider groups throughout the state. We are enthused about our new role as an approved QCDR and the many benefits it will afford the health care organizations in Wisconsin. Look for more information from us on the confirmed measures and process details in the coming weeks.

**“Transformational” grant opportunity**
There is no question that robust performance measurement and improvement capabilities and infrastructure already exist in Wisconsin through organizations such as the Wisconsin Hospital Association and MetaStar, as well as WCHQ. However, the missing piece continues to be a payment reform model that will tie measurement and improvement activities together with real financial incentives for provider organizations to improve the “triple aim” of health, affordability, and the patient experience.

To that end, the SVC’s Leadership Council has given its support to moving forward with the development of a proposal in response to the Center for Medicare and Medicaid Innovation’s (CMMI) anticipated announcement of a new round of funding under its State Innovations Model (SIM) grant program. The program includes either large-scale demonstration projects or pre-planning and design grants.

Given the commitment to WIMAP’s 17 common measures and the capabilities and infrastructure already in place, the SVC leaders believe Wisconsin is well-positioned to launch a demonstration project that would accelerate momentum toward achieving a high-value, high-reliability health care system. A successful grant application would bring an infusion of funding to support significant, additional investment in infrastructure and subject matter expertise that could truly be transformational in its scope and impact.

**Quality Improvement Organization (QIO) program invitation**
Another opportunity to leverage WCHQ’s role as both a measurement and improvement organization may reside in the 11th Scope of Work (SOW) recently issued by CMS for the QIO program. The SOW is a recurring competitive bidding process, which this year places a strong emphasis on partnerships, data collection/submission under the Physician Quality Reporting System (PQRS), and ambulatory quality improvement. Wisconsin’s incumbent QIO, MetaStar, invited us to outline our capabilities and accomplishments in diabetes and cardiovascular measurement and improvement, as well as our past experience and future role in PQRS data submission via our new QCDR. We provided MetaStar with the information they were seeking and now await the outcome of the competitive review as to any possible next steps.

**Committing to quality improvement**
We have also begun to organize our staff and capabilities around the layered quality improvement model that is included in our strategic priorities (News & Views, Summer 2013). Under the leadership of Theresa Mees, WCHQ’s director of quality, we have established an internal work group – dubbed the “quality roundtable” – that will be the hub for our quality improvement work.

The roundtable will guide our layered quality improvement approach, the purpose of which is to:

- **Focus** – seek improvement in three key areas: diabetes, cardiovascular and cancer screening
- **Engage** – involve all of our members to make an impact across the state through dynamic learning opportunities such as site visits and provider only learning events
- **Accelerate** – set a high bar to improve quality faster than the rate of cost increase.

We firmly believe we have the right focus on the right opportunities to strengthen our position as a measurement and improvement organization and connect our work in a meaningful way to our provider groups and their performance improvement activities. As we move forward in this exciting era, we look...
to you for your continued support and participation.
The Analyst’s Perspective

Using data for member-led improvement efforts

In previous columns I have reported that the WCHQ board of directors has initiated a new strategic direction for the Collaborative to help facilitate performance improvement among the WCHQ membership. As a result, the WCHQ staff has spent the past few months working in earnest to bring the Collaborative’s new performance improvement focus to light.

We are in the process of forming a Quality Improvement Planning Committee which will serve as the voice of membership to help guide the improvement work of the Collaborative and its members. In the coming months WCHQ staff will help form member-led improvement teams that will focus on three different improvement areas – diabetes care, hypertension management, and preventive cancer screening. It is the vision of WCHQ staff that these improvement teams will use in-person improvement events, site-visits, and webinars to facilitate connections between members in order to share improvement strategies and disseminate best practices.

One component of the new performance improvement focus will be the use of data – drawn from within the WCHQ membership itself – to help target opportunities and identify high performing organizations, clinics, and providers. The data the improvement teams will use will be dependent on their area of focus. For example, they may simply use performance results on www.wchq.org, or they may involve more detailed analyses that will require drawing additional data from organizations on the improvement teams.

Identifying high performing providers has recently been made much easier through the adoption of site-level reporting by WCHQ member organizations. Site-level reporting was rolled out over the course of 2013 and applies to all of the ambulatory measures that WCHQ collects. All clinics that have over 100 eligible patients and greater than two providers currently publicly report data.

As an illustration of how site level data might be used to identify high performing clinics, the graph below displays the average organizational performance for WCHQ’s Diabetes: A1c Good Control (A1c <8.0%) measure. The bars around the average performance illustrate the range of clinic performance for each organization, with the top of the bar indicating the top performing clinic and the bottom bar indicating the lowest performing clinic for each organization.

Diabetes: A1c Good Control - Range of Clinic Performance
You will note the overall range of clinic performance stretches from 59% to 85%. This gap in performance is where the opportunity lies for improvement, and it will be the goal of the improvement team to figure out how to close the gap. Data like this will help the improvement teams identify clinics or organizations who have developed processes to achieve high performance. These high performers can then share what they have learned and done to achieve high performance with the other members of the improvement team.

Of additional interest, all organizations have a range of clinic-level performance, indicating that there are opportunities to identify high performers both within and outside of individual member organizations. There will be many components involved in improving quality across the WCHQ membership, and the effective use of data will be one of them.
Patient experience – Aurora Health Care leads by example

Beginning in 2013, WCHQ members began publicly reporting patient experience data. Patient experience, as measured by Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) surveys, asks patients about the care they received during their most recent visit to their provider in an outpatient setting. Presently 12 members publicly report their data. Recently, staff from one such member, Aurora Health Care, shared their experience in measuring and improving the patient experience.

A history measuring the patient experience

According to Kathy Leonhardt, MD, vice president of patient experience and patient safety, “Aurora has had a long history of embracing patient experience measurement, before it was even referred to as patient experience. Since the mid-to-late 1990s, with the development of the concept of service standards, we have sought to measure whether we were meeting our patients’ needs. By 2011, realizing we needed an organizational structure to formalize and support the work around enhancing patient experience, we developed the office of patient experience. Since then we have worked hard to standardize our strategies, tactics and metrics while also embracing the external requirements that have been mandated around patient experience measurement and reporting.”

When WCHQ’s board of directors made the decision to ask members to publicly report their patient experience data, Aurora Health Care eagerly committed to do so. “Aurora has always supported transparency and public reporting. We thought it was important to share our data and our learnings to help drive improvements in patient experience throughout the state,” explained Dr. Leonhardt.

Improving performance through provider coaching

In late 2012, with a commitment to patient experience measurement and publicly reporting results in place, Aurora began to plan its approaches to improve its performance. Embracing a strategy that supporting providers to improve their communication with patients would yield a better experience for both patients and clinicians, Aurora initiated a Clinician Coaching pilot program. Prior to initiating the coaching aspect of the pilot, Aurora required that all clinicians (MDs, APNPs and PAs) in its medical group attend a four-hour Clinician Patient Communication workshop within a three-year timeframe. The curriculum for the workshop was based on work done by the Institute for Healthcare Communications (IHC).

“We understood that providing a workshop alone was not going to change behavior at the practice site,” said Sue Weiss, manager, clinical practice and education. “We felt we needed to leverage the investment we were making in providing the workshop by developing a coaching program. There is considerable evidence that providing coaching is a key to changing behavior,” Weiss added.

Aurora identified several physicians and administrative staff to serve as coaches. Each coach participated in a two-and-a-half day training workshop prior to serving as a coach. For the pilot, seven primary care physicians and one PA agreed to be coached. “It is important to stress that we only selected clinicians for coaching that wanted to be coached. It was not a remedial program,” said Nancy Corkle, director, coaching.

“We began the coaching process by reviewing the CG-CAHPS scores with the clinicians we were
coaching. We then helped them to identify the specific communication goals they wanted to accomplish to enhance their patients’ experience,” explained Corkle.

Over the course of four months – once each month – the coaches observed the clinicians interacting with their patients for a three- to four-hour block of time. After each observation, the coaches facilitated feedback discussions to review how their performance compared to the communication goals they had set for themselves.

“We began by asking the clinicians to provide a self-assessment of what they believed they did well, based on their communication goals. We then asked for their thoughts on what they might do next time to improve their communication skills even more. After this self-assessment, we offered descriptive feedback, and encouraged brainstorming on specific tactics to continue to improve communication. At the end of each observation, we asked the clinicians to identify which of these tactics they intended to practice over the next month until we got together again,” added Corkle. Clinicians who completed the coaching program received 20 CME credits.

**Preliminary results**

While results of the pilot phase are still preliminary, they are encouraging. Based on CG-CAHPS scores of those clinicians who have gone through the coaching regimen, statistically significant improvement was seen on scores related to listening skills and the ability to give easy-to-understand information. Although not statistically significant, improvement was also observed on two other measures – one related to respecting what the patient had to say and another concerning explaining in a way that was easy to understand.

**Phase two and beyond**

Phase two commences this month with more clinicians going through the coaching, including expanding the program to include specialists. Simultaneously, executive leadership has asked the project team to put together a proposal for a more significant expansion of the coaching program with dedicated resources.

“This coaching program is really part of a broader effort to improve communication throughout the organization,” explained Dr. Leonhardt. “When you look at adverse events and bad outcomes, the majority have communications as the root cause. Effective communications is one of the greatest challenges we have in healthcare because it is such a complex field. Anything we can do to enhance communication will serve our patients and our clinicians well,” added Dr. Leonhardt.

If you have questions or want to learn more about Aurora’s work in patient experience, please feel free to contact Dr. Kathy Leonhardt at Kathy.Leonhardt@aurora.org; Nancy Corkle at Nancy.Corkle@aurora.org; or Sue Weiss at Sue.Weiss@aurora.org.