IPIP
PROGRAM BRIEF
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Improving Performance in Practice

Improving Performance in Practice: Rx for Primary Care

In the burgeoning movement to lift the quality of health care in America, small primary-care practices face an especially daunting challenge. Compared to big hospitals and integrated group practices, they typically have fewer resources at their disposal to implement the latest and best quality-improvement techniques and protocols.

Most practices are in that boat. In fact, three-quarters of all U.S. physicians work in office-based practices rather than big institutions—and nearly 60 percent work in offices with fewer than 10 doctors.[1] These small practices have their hands full delivering nearly three-quarters of the country's ambulatory care.[2] If they are going to improve their performance, too, they will need help in the form of extra arms, legs and know-how. That is where an innovative program called Improving Performance in Practice comes in.

IPIP, as the program is known, provides small practices with tools, support, coaching and a collaborative learning environment in which they can assess their performance and engage systematically in improvement activities using their own practice data and comparisons to others in their cohort groups as benchmarks.

Organized by primary-care certifying boards and physician-specialty societies, and funded by the Robert Wood Johnson Foundation, IPIP is a state-based program with national leadership. In addition to professional organizations and societies, it brings together government, payers and health systems to create a system and culture of improvement that can accelerate the pace at which medical evidence is incorporated into everyday practice to improve patients' health. That is important because researchers have found that it can take an astonishingly long time—17 years, on average—for effective new treatments to be integrated into routine patient care.[3]

The IPIP program initially focused on asthma and diabetes because they are common conditions; most primary-care practices have patients with one or the other. Diabetes and asthma also are conditions for which the quality of care generally can be improved. In fact, researchers have found that children with asthma typically receive less than half the care that is recommended for them,[4] as do adults with diabetes.[5] But in some states the program now is expanding to incorporate measures for other chronic diseases—such as heart failure, hypertension and coronary artery disease—along with measures of disease prevention, such as immunizations and cancer screening.

This brief describes how IPIP is structured, provides examples of its results to date and draws several practical conclusions for the broader quality-improvement enterprise.

Requirements for Practices Participating in IPIP

- Must be a primary care practice: family medicine, pediatrics or internal medicine
- Located in an IPIP state, currently: Colorado, Michigan, Minnesota, North Carolina, Pennsylvania, Washington or Wisconsin
- Choose diabetes or asthma as a focus of improvement
- Identify a physician leader in the practice
- Have a patient registry to manage the population, or be able to extract process and outcome data from an existing electronic medical record
- Provide data every month on IPIP measures
- Assign roles to each member of the practice team
- Use a planned-care template to manage care
- Use protocols to ensure adherence to evidence-based guidelines
- Provide patients with self-management education and support
- Engage in small tests of change to improve care

How the Program Works

Prospective IPIP enrollees undergo a practice assessment to determine whether they are ready for quality-improvement work, then sign a contract enumerating the benefits and expectations for participants. A key requirement for primary-care practices is that they must commit to using a registry to manage their patient populations if they don't already, or be able to extract process and outcome data from existing electronic medical records. (*See box on the left.*)

Once in the program, practices choose asthma or diabetes as a focus for improvement and begin providing data every month on a set of quality measures covering care processes and outcomes. For diabetes, there are six core measures, including the percentage of patients with A1C blood-sugar tests measuring above an important threshold level; the percentages with blood pressure and cholesterol below important threshold levels; the percentage who have received a dilated eye exam; the percentage tested or treated for kidney disease; and the percentage counseled to stop using tobacco.

For asthma, there are three core measures: the percentage of patients who have had their control of the condition assessed; the percentage with persistent symptoms who are receiving anti-inflammatory medication; and the percentage who have been vaccinated for influenza.

IPIP uses all this data to compile a monthly "Practice Explorer" report for participating practices to see trends in their own performance and compare themselves to others in the program—statewide, network-wide or by practice cohort group.

Such measurement and reporting are essential for any quality-improvement effort. As one Colorado doctor told IPIP staff: "Until I saw my data, I thought I was providing excellent care. Now I see we have a lot of work to do."

To lift the quality of care, IPIP gives participating practices a four-step process-improvement kit based on the Chronic Care Model, which aims to improve patients' health outcomes by coaxing them to take an active role in managing their own health in partnership with well-prepared health care teams.

The IPIP kit includes:

1. A guide to setting up electronic or paper patient registries so providers have a way of systematically monitoring the treatment and health status of every patient in their practice.
2. Templates such as flow sheets and visit planners for managing patients' care for the health condition that the practice has chosen as a focus.
3. Protocols for providing all the recommended care corresponding to each of the diabetes or asthma quality measures.
4. Self-management support tools such as worksheets and questionnaires for patients.

All of these tools are made available to participating practices along with the monthly "Practice Explorer" reports on a password-protected Web site, *http://ipip.qiteamspace.com*, which also features a message board and other ways for practices to share information.

The program provides quality-improvement coaches, typically registered nurses, to guide practices through the process of implementing and making good use of all the resources. Each state participating in IPIP has several coaches who are assigned to specific regions. They go into practices to help them use patient registries, electronic medical records, templates to plan care visits and protocols detailing who in the office should do what in what order to prepare for and manage patient visits. The coaches also help locate support services such as diabetes educators for patients' self-management efforts.

The concept of "team care" underpins this entire approach. Coaches help practices improve their division of labor and work flow by relentlessly asking the question: "Is this physician work or non-physician work?" If a doctor isn't needed for a particular task, then someone else in the office should take care of it so doctors can focus on the things that only doctors can do. For example, at Spruce Street Internal Medicine in Boulder, Colo., when a patient with diabetes comes in for an appointment, a file clerk pulls the patient's chart and prints a flow chart with protocols for the visit. A medical assistant removes the patient's shoes as a reminder for the doctor to do a foot exam—and if the patient is due for an annual sensory exam to test for nerve damage, the medical assistant performs and documents it.

These work-flow improvements have had a beneficial side effect. Not only do practices get more done, but the increased efficiency also improves job satisfaction. "I was considering leaving the profession," Dr. Tracy Hofeditz of Lakewood, Colo., told IPIP staff. "But now I have rediscovered the joy of practicing medicine."
Leadership by doctors is critical to making IPIP work. Participating practices each must designate a physician to serve as the day-to-day point person in implementing the program's tools and systems.

Meanwhile, at the state level, the program identifies "physician champions" who are respected medical leaders to lend their expertise to the collaborative-learning enterprise. They often come from academic medical centers and are prominent in primary-care societies and state-based quality initiatives. They have been instrumental in spreading the work of improvement across their respective states.

Almost (Medical) Home

The IPIP program supports the principles of the patient-centered medical home, an approach to providing comprehensive primary care that facilitates partnerships between individual patients, families and personal physicians.[6] It replaces episodic care based on illnesses and patient complaints with coordinated care and a focus on long-term health.[7] To put it another way, the point of both IPIP and the medical-home model is to help doctors be better doctors and patients be better patients.

IPIP does this in several ways:

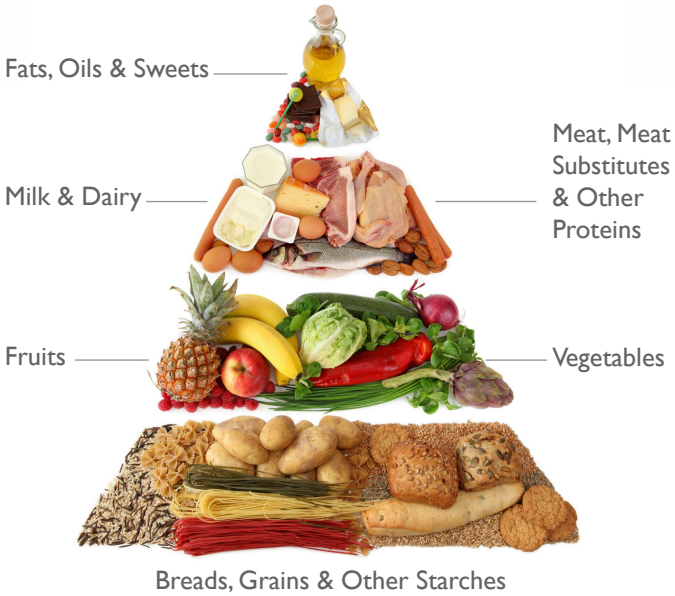
- It encourages transparent sharing of performance data through the implementation of electronic registries.
- It provides training and practice-level support to apply quality-improvement methods that redesign care delivery.
- Its organized, state-based networks of practices work together to improve care for geographically defined populations of patients.

IPIP and the "Diabetic Superstar"

Thanks to IPIP, Holland Medical Associates in Philadelphia and Bucks County, Pennsylvania—recently certified by the National Committee for Quality Assurance as a patient-centered medical home—now has a patient whom the practice team has dubbed a "diabetic superstar."

In January 2009, the patient was doing very poorly. While entering his lab information into its registry, the practice team saw that the patient's A1C level was a very high 13.0, his weight was climbing, and his triglycerides were coming down but still high at 175. The practice had just instituted a case-management model in the office as part of its participation in IPIP. So the patient was offered a nutrition class taught by the certified nurse practitioner and RN in charge of case management for the practice.

The patient enjoyed the experience—and was happy that someone had taken the time to explain what foods do to his body. He realized that his problems stemmed not from what he was eating but from his portions. So he developed a "living the pyramid" spreadsheet to track and moderate his diet. His lab results show the results of his hard work. After three months, his A1C was down to a healthier 8.8 and his triglycerides were down to 125.



To be recognized as a medical home, practices must use patient registries, health information technology, information exchanges and other means to assure that patients get recommended care when and where they need and want it. Thus, practices that clear all the hurdles to participate in the IPIP program are a good part of the way to medical-home status.

Success Stories

IPIP began as a pilot program in Fall 2006 in Colorado and North Carolina and now operates in five other states, too: Pennsylvania, Michigan, Minnesota, Washington and Wisconsin. By the end of 2009—after just three years of operation—more than 350 practices had signed up, with 1,400 doctors and more than 350,000 asthma and diabetes patients.

In Pennsylvania, IPIP is part of the Governor's Chronic Care Initiative, which is closely aligned with insurer-sponsored incentive programs that encourage doctors to qualify for recognition as a medical home with the National Committee for Quality Assurance. A chance for that recognition—and the chance to qualify for larger reimbursements—helped ensure doctors would be interested in the IPIP program.

Patients, meanwhile, got more effective care and their health improved. To take just one measure of quality as an example, in the 16-month period between June 2008 and October 2009, Pennsylvania IPIP practices saw a 15-percentage-point increase in the share of diabetes patients with blood pressure of 140/90 or less. And that success may be understated because it includes data from practices that started the program somewhere in the middle of that period.

Results can be more dramatic at the individual practice level. Consider the experience of Spruce Street Internal Medicine: In the 12-month period to April 2009, it saw the share of its patients with A1C blood-sugar levels higher than 9 (the goal for people with diabetes is 7 or less) drop from 80 percent to less than 30 percent in a population of 160.

Or consider a practice in North Carolina, Albemarle Nephrology, which posted a nearly 60-percentage-point increase in the share of its diabetes patients given foot exams between July 2008 and October 2009.

As in Pennsylvania, the IPIP program in North Carolina has been designated as a key component of the Governor's Quality Initiative. This official integration into the state's plan to restructure its health care payment and delivery systems assures continued financing for the program. Indeed, IPIP has broadly diversified its sources of support in North Carolina to include backing from insurers, the North Carolina Area Health Education Centers, the state Department of Community Health and the state's Medicaid program. And in addition to those financial supporters, the program also receives significant in-kind contributions of medical leadership and professional support staff, notably including Warren Newton, M.D., chair of the Family Medicine Department at the University of North Carolina, Chapel Hill.

Lessons Learned

IPIP staff has learned from other improvement initiatives that a relentless focus on results is necessary to achieve and maintain sustainable improvement in outcomes for patients. For chronic care, this can be slow and tedious work, so it is important to monitor changes within the practice to keep the momentum going. On the other hand, practices that incorporate the changes will benefit from greater efficiency, cost-savings and larger reimbursements, not to mention improved health for patients.

Another important lesson is the importance of emphasizing the benefits to the practice of participating in the program—especially stressing that it helps in complying with ABMS Maintenance of Certification®, professional recognition for quality and pay-for-performance programs.

IPIP staff also has been able to draw a number of nuts-and-bolts conclusions about how to undertake quality improvement. For example, it has found that standardized practice-level coaching is a reliable way to produce results. And it has found that not all patient registries are created equal; some do not offer robust functionality, which is essential in collecting data for quality improvement and managing patient populations.

It is clear that the IPIP program is already affecting change in primary-care practices in the seven states in which it operates—and its leadership team believes the program has the power to replicate that success to help transform the delivery of health care across the entire country.

Where to Go for More Information

IPIP is sponsored in part by the Robert Wood Johnson Foundation and convened by the American Board of Medical Specialties. For more information about IPIP, visit *www.ipipprogram.org*. For more on the Robert Wood Johnson Foundation's health care quality work, visit *www.rwjf.org/qualityequality*. And for more on ABMS, visit *www.abms.org*.

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