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PATIENTS DESERVE BETTER
Interview with Tim Young, MD, President, OMNI Medical Group, President, St. Johns Physicians & President, Physician Support Services, Inc.
Tulsa, Oklahoma
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Tim Young MD
...short story... medical leader & EBM champion, making a difference within his system of care through leadership, engaging other leaders to create culture change, use of small groups and through creating system changes

footprints: internist | interest in applying evidence to the practice of medicine | **what makes it all worthwhile?** better patient care

Delfini: What one or two issues would you like to address for this interview and why?

Tim: My theme for this interview is "Patients Deserve Better." Patient's contacts with the health care system are often unsatisfactory, both from an access perspective and from the perspective of getting adequate information to make a rational decision. I've had several family members who've had these unsatisfactory kinds of encounters, and I hear about them.

One family member with cancer was told by the oncologist that, "There is some chemotherapy we usually do for this, and we can do it if you want. It may help and, of course, you'll have side effects." So, I was asked if this family member should have chemotherapy or not. I looked it up, and it turns out that there were two recently published RCTs that showed that this chemo didn't provide a significant benefit for the cancer in question, but did have significant side effects. So, if all this information had been presented, the rational choice would have been "no." I've heard these stories often enough that I believe that patients aren't getting enough information from the system to allow them to make an informed choice that's right for them.

At OMNI Medical Group, we developed the slogan "Patients Deserve Better." We are putting this into action in our medical home initiative. Our initial focus is patient access. In Tulsa, if patients call a physician for a routine appointment, it is not unusual to be told that the wait time is weeks to months. At OMNI, we want all the access barriers to go down so that patients are seen on the same day or the problem is taken care of on the day they call. Several of our physicians' offices have successfully implemented this and, although it may seem counterintuitive, same day access really is possible.

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Next on the "Patients Deserve Better" list is the huge problem of high quality information. Here our initial focus was cancer screening information, but E-visits and effective patient-care teams are important parts of the solution, and we are working on them also. We decided as a medical group to use the United States Preventive Services Task Force (USPSTF) guidelines and have them available as decision support on our electronic health record (EHR). We are currently looking at various information sources for various conditions. We keep exploring new ways to provide decision support. Some groups listen to and discuss the EBM podcasts from the University of British Columbia [Delfini Note: the podcasts are available at http://therapeuticseducation.org/useful-tools/].

We are developing processes to provide patients with useful information. At present, some offices print out the patient-specific information for each patient from our EHR or linked resources, (e.g., for a 55 year old

male, the staff would print out the USPSTF recommendations for prostate cancer screening and colon cancer screening). We also update this information. In the case of prostate cancer screening, we have added the two recent prostate cancer screening clinical trials to our EHR. Our plan is to continue to add useful health information such as information regarding various medical conditions. Currently this type of work is done by staff. I am exploring ways to have alerts, reminders, etc. appear on work station screens just-in-time to improve care.

Our docs are very interested in shared decision-making (SDM) tools and would use them if we put them up on the EHR —we just need the tools. I am currently trying to make the first iteration of tools easy to access by reducing the number of clicks to get to them, but better long-term solutions are needed.

Examples of currently available tools exist. For example, the Ottowa Health Research Institute has made shared decision making (SDM) decision aids on several topics available to the public. [Delfini Note: You can see these decision aids at the following URL—http://decisionaid.ohri.ca/decaids.html]. In the near future we will continue to look for off-the-shelf SDM tools, but eventually we will utilize a local resource person to develop or synthesize the content.

Culturally speaking, our group now knows there is a way to "do" EBM even though we, like others, continue to explore how to obtain and make available reliable and useful information. And Delfini's laying of the groundwork in EBM with training has made this much easier—and that does make things go a little faster at times.

Let me give you an example that happened recently. A physician in our group was approached by a stent manufacturer and invited to participate in a study of stenting versus intensive medical therapy for renal artery stenosis. A local hospital research committee approved the study, but one physician on the committee asked if there was any existing evidence on this. I did a search and when participation in this study was reviewed at our institutional review board (IRB), I presented the results of previous RCTs reporting no benefits of stenting in renal artery stenosis. Our IRB did not approve participation in this study. Without the EBM groundwork, the IRB might very well have approved participation.

Delfini: Let's go back to when your group first started with evidence-based clinical improvement work. Can you briefly review how you got started and how things have evolved?

Tim: Sure. In 1995, our group realized that the same requests kept coming to our utilization review committee from the same docs. It became clear through this that we had to know "what to do." At the same time we discovered the Lovelace disease management materials and the guidelines that you were developing at Group Health Cooperative in Seattle. That's when we started getting into EBM. We sent folks to your education programs, and culturally we accepted the premise that good evidence is required to ensure effective treatment. For us, EBM is truly a big piece of "the answer." Additionally, we have used a lot of group process activities to implement EBM in our group.

For us, it took a while, laying the ground work, and understanding process improvement. Someone in the organization needs to know how to do it and just start doing it — I think it's just that simple. Everyone here knows that if they bring up a new device or procedure, I'm going to ask them for the evidence supporting its use.

> *"I'd like to create a culture where, when physicians want something, they have to figure out how to justify it generally via cost and patient benefit and to measure it…."*

Delfini: Can you give us an example of the group process activities?

Tim: Early on we required our physicians to meet in small groups to discuss their specialty referrals — they had to justify their reasons for referral to the group. Each group has a leader and these small group leaders met at first weekly and now every other week with me and OMNI'S medical director, Rob Gray. We used these groups to develop screening criteria for various conditions, agree upon the elements we put up into our registries and develop performance measures. For example the group agreed to use antiplatelet Rx, LDL measurement and beta blockers for our performance

measures in coronary artery disease and beta blockers, ACE inhibitors and ejection fraction for heart failure. We decided on LDL, blood pressure measurement and hemoglobin A1c for diabetes. We started with 9 "Did-you-do-it" measures. As expected our physicians and staff developed systems and quickly improved their performance, often to 100% of targets. We are now moving to outcome measures and will start with LDL<100 for patients with coronary artery disease.

Beyond evidence-based QI activities, the small groups are great forums for new ideas and discussions — for example, criteria for refills and work flow issues — and one of the groups is specifically charged with doing new stuff.

One team decided they would like to have an RN on the team. They were very open to initiating same-day access and redesigning their work flow in exchange for getting the RN position. Basically, teams can recommend changes they want to make, but they have to figure out how it can be paid for or how it will improve care enough to benefit patients. In this instance, they discussed and changed their work flow to eliminate 2 medical assistant positions to combine the salary to hire an RN.

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And, at St. John in Tulsa, we are now also employing specialists who are interested in teamwork and systematically improving quality. There is a 4-5 year phase when you first start to hire physicians that's tough. I would like to have a fixed number of specialists, having them really busy doing what they need to do as specialists — which they like — and pass on more work to primary care. We're trying to get them to think systematically and get them on the EMR. Some are really taking to it. Some are reluctant and don't want to do it, so we are trying to get through that first stage. So our real theme is "Patients deserve better, and we are trying to make *your* life better too."

Delfini: Thanks, Tim. Could you briefly summarize what you believe to be the elements for success in establishing an evidence-based culture?

Tim: It's hard to get people to think about stuff differently. I think you need to carefully lay the groundwork for EBM, have a good understanding of how to achieve process improvements and people to start doing the work. Much can be accomplished with simple tools such as Plan, Do, Study, Act (PDSA) cycles and balance sheets.*

Don't let the perfect be the enemy of the good. If something doesn't work, throw it away; if it works, try to generalize it.

And with change, you have to have it be good for the physician — not more work — it has to be better or work neutral. And then it's important to get testimonies from docs directly: "This made my life better and my patients' lives better." There is a huge difference in this coming from the doc and not the "suit."

* [**Delfini Note**: A balance sheet is a simple tool that is used to ensure that the effects of various clinical practice changes being contemplated have been formally considered before completing or implementing them. They frequently take the form of tables displaying information about current and projected outcomes such as number of visits, referrals, lab tests, costs, etc. The balance sheet has been described by David Eddy as a tool to 1) estimate the health and economic outcomes from clinical research and clinical experience, 2) assist decision-makers to develop an accurate understanding of the important consequences of adopting the different options, 3) condense important information into a space that can be grasped visually and mentally at one time, and (4) assist in planning organizational change (eg, organize thinking, structure the analysis of evidence, and focus debates). Ref. Eddy DM. Comparing benefits and harms: the

balance sheet. JAMA 1990;263:2493, 2498, 2501 passim.

Q: Do you have a favorite story for us?

A: Here is a very brief story I like. I spent some time convincing an internist that open access would be beneficial all around. She was extremely reluctant, but said she would give it a try. Later she thanked me for facilitating a really important improvement for her patients and practice.

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