Dr. Edward G. Zurad, MD, Corporation is featured as a high performer in cardiovascular care, identified by NCQA. This project is in support of Million Hearts® and funded by the CDC’s Division for Heart Disease and Stroke Prevention. High performer provider practices were identified based on performance in NCQA’s HSRP. Practices selected also had NCQA’s PCMH Recognition. We interviewed practice leadership to learn what they do to achieve good results.

The table shows HSRP 2011 results for the clinicians participating in the HSRP program.

Overview

Dr. Edward G. Zurad is a family practitioner who operates a solo private practice in Tunkhannock, a rural community in northeastern Pennsylvania.

Strategies

Practice Activities and Helping Patients Maintain Health

This high-performing practice engages patients through in-office education and practice initiatives to promote cardiovascular care and maintenance. Dr. Zurad and his nurse also counsel patients and their families and caretakers.

Patient Registry and Electronic Health Record System

Dr. Zurad participates in the Pennsylvania Academy of Family Physicians-funded
registry, which includes 1 million patients in Pennsylvania. The patient registry also incorporates the evidence-based guidelines of the American Diabetes Association, the American Heart Association and the National Heart, Lung and Blood Institute for risk factor management.

Dr. Zurad’s patient registry tracks diabetes, cardiovascular disease and COPD. The registry includes information, entered daily, on lab results, blood pressure, medications, behavioral modifications and ER visits/hospitalizations. This allows staff to track chronic-care patients in real time. Patients are “flagged” in the registry when their blood pressure and other cardiovascular indicators need to be reevaluated, and the nurse manager contacts each patient for a follow-up test.

Dr. Zurad’s office does not use an EHR.

Patient Education, Risk Factor Management and Physician Feedback

Dr. Zurad is a member of the steering committee for the Governor’s Chronic Disease Initiative, which developed a cardiovascular and diabetes-focused PCMH program in Pennsylvania. Participating in this initiative enabled Dr. Zurad’s practice to become one of the high-performing cardiovascular practices. The practice performs population analysis and population-based medicine for its small patient population, and gathers data to see how it compares with benchmarks developed by the steering committee.

All patients are educated in their disease and its treatment. Office staff use pre-visit calls to patients to remind them to get their labs done, so results are available before their visit.

For example, diabetic patients bring their glucometer and blood pressure readings to the office for pre-visit data entry into their medical record.

Dr. Zurad and his nurse educate patients about test results, managing risk factors and exercise and cholesterol, and their importance to maintaining or improving health. With help from the nurse care manager, patients develop their own goals and lifestyle changes. Data are assessed at every office visit and recorded in the medical record.

### Standards*  

<table>
<thead>
<tr>
<th>Standard</th>
<th>Edward Zurad</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Patients With BP at Goal</td>
<td>92</td>
</tr>
<tr>
<td>Percentage of Patients With Complete Lipid Profile</td>
<td>100</td>
</tr>
<tr>
<td>Percentage of Patients With LDL at Goal</td>
<td>79</td>
</tr>
<tr>
<td>Percentage of Patients of Using Aspirin or Another Antithrombotic</td>
<td>100</td>
</tr>
<tr>
<td>Percentage of Patients With Documented Smoking Status and for Those Who Are Current Smokers, Cessation Advice or Treatment Given</td>
<td>100</td>
</tr>
</tbody>
</table>

*Each physician submitted data on a random sample of 25 or more patients. Assigned points depended on whether the maximum percentage of patients in the sample achieved the desired threshold, as specified in the various indicators used in the program.
Dr. Zurad and his staff are committed to patient outreach and education. The practice has participated in multiple external sponsored events on diabetes, hypertension and cardiovascular disease. Dr. Zurad is medical director for Procter and Gamble and has organized events at the local manufacturing plant.

Physician Incentive Programs and Strategies to Improve Care

Dr. Zurad submits CMS Chronic Disease Initiative demonstration data.

Dr. Zurad receives a quarterly stipend for disease management, care management and care coordination through the CMS Innovation project. This incentive program has reduced the number of ER visits and the number of patients on dialysis, cardiac catheterizations and inpatient stays.

Lessons Learned

Dr. Zurad believes that his patient registry has helped track patient trends for individual patients and for the patient population as
a whole. He also believes that it is essential to have dedicated staff who believe in the PCMH mission, in order to improve performance on cardiovascular care measures.

**Success Factors**

Dr. Zurad identifies the following as key success factors for strong performance on quality indicators related to cardiovascular disease:

- Counseling patients one-on-one on risk factors.
- Using a patient registry to track patient care and population level trends over time.
- Interacting daily with a patient care manager nurse to discuss patient feedback and how to improve patient management.
- Using pre-visit patient reminder calls.
- Developing patients’ relationship and confidence in nursing staff.

**Hypertension control:** Dr. Zurad’s practice asks patients to report their blood pressure readings to their care manager by phone several times a week. On a weekly basis, the practice contacts patients whose blood pressure is not controlled, in order to review their home blood pressure readings. Based on the results, the practice will change medications to develop an appropriate customized pharmacologic plan for each patient. These “frequent touches” also provide a degree of risk management that prevents medication duplication, adverse drug effects or mistakes. The cyclical nature of these visits also provides an opportunity for a sign-and-symptom overview that lets the practice maximize adherence.