Introduction

This toolkit can be used to implement changes to improve performance on measures of chronic care management and preventive screenings for commercial, Medicare Advantage, and other patient populations. It will provide foundational resources, an overview of the framework to initiate improvement initiatives, and present three approaches to drive clinical quality improvement for chronic disease and preventive care.

Three Proven Approaches to Drive Clinical Quality Improvement

1. Changes by the medical group or IPA to support patient care,
2. Changes by the clinical office practice, and
3. Methods to engage patients as part of the care team.

Specific changes to try and resources are listed for each approach starting on page 6. The intended audience is provider organizations (POs) who have a registry in place and want to maximize its use to improve clinical care. This Toolkit also presents resources for fundamental changes to prepare primary care practices for transformation to patient-centered care.

The changes presented in this toolkit are from multiple sources including:

- Learning from a fifteen-month Chronic Care Collaborative led by the California Quality Collaborative (CQC) with five participating POs located in Southern California. The collaborative focused on building capacity and implementing proven strategies to improve care for patients with diabetes. Participating organizations achieved a 20% relative improvement in one or more diabetes process or outcome measures during the collaborative.

- Learning from a six-month Meteor collaborative led by CQC with fifteen California POs. The Meteor program assisted POs in prioritizing MedicareAdvantage Stars measures and implementing changes to improve performance within a six-month timeframe. Many participants were able to achieve significant improvement in targeted Stars measures within the short collaborative timeframe.

- Expertise from organizations that have successfully implemented changes and sustained improvements in care for patients with chronic conditions.

- Evidence-based practices.

We hope this toolkit is useful for your organization and would appreciate learning how we can improve its usefulness. Please submit suggestions, comments, or questions to info@calquality.org or by calling 415/281-8660.

If you have a paper version, please visit our website at www.calquality.org to download an electronic version which will allow you to access the links to the resources in the toolkit.
Getting Started

As you begin your improvement work, consider the following questions to prepare for your initiative.

- Assess leadership engagement – is the initiative aligned with the organization’s mission, vision, and strategic goals?
- Can your organization define the business case for your work? Are goals improved clinical care and/or financial?
- Does your organization have a robust disease-based or population-based registry?
- Does your organization have knowledgeable analytic staff dedicated to measurement and reporting?
- Can you identify the patient population and gaps in service for the measures you are targeting?
- Do you have data, such as lab results, to stratify the patient population and prioritize outreach?
- Can you stratify data by practice and/or physician to identify negative variation (opportunity for improvement) and positive variation (better/best practice) to focus interventions and select pilots?
- Do you understand which competing priorities might affect your initiative?
- Have you identified physician or other champions to pilot changes and act as spread agents?

Foundational resources

- IHI Open School Whiteboard Videos provides basic training with four brief videos about the Model for Improvement, PDSA cycles, and driver diagrams.
- IHI Open School Courses is a resource for health professionals interested in learning more about quality improvement, patient safety, leadership, patient and family-centered care, and managing health care operations. Courses are free for students, medical residents and university faculty.
- IHI Science of Improvement Resources includes instruction on initiating improvements, tools, resources, white papers, case studies and more.
- Group Health Research Institute’s Improving Chronic Illness Care provides resources to support the Chronic Care Model, practice redesign, patient self-management support, and more.
- Dartmouth Institute Clinical Microsystem Academy provides a variety of resources to facilitate microsystem redesign.
The following sections describe in more detail the steps and framework to develop and implement your improvement initiative.

Get Ready! Define the Business Case

1. **Build will and infrastructure.** Communicate performance, benchmarks, and the business case for change to all stakeholders. The business case includes how the proposed initiative aligns with organizational strategic goals and plans. Intrinsic motivation can be built by identifying how an improvement initiative aligns with the identity that the organization wants to promote itself (look to the organization’s mission/vision statement). Developing a business case

2. **Assess organizational and senior leadership engagement.** This is evidenced by commitment of financial and other resources for the improvement initiative and alignment of the initiative with organizational strategic goals.

3. **Assemble a team that includes a physician champion and a project lead with oversight** responsibility; having a designated project lead is a key component to keep things on track. Include data analytics or other IT resources to produce reports for practices and measures for key performance indicators. Schedule regular team meetings to follow-up on tasks and review change cycle and performance progress. Establish team rewards and recognition – don’t forget to celebrate success.

4. **Compare baseline measures to benchmarks and create an aim statement** with clear, measurable, time-specific improvement goals. Define the problem, goal(s), measure definition, measurement strategy, changes proposed, and collaborative team members (including physician champions as faculty). Craft changes from the domains of the (Chronic) Care Model and/or the Institute of Medicine aims (patient-centered, timely, efficient, effective, safe, and equitable). Create a plan to measure performance on a real-time basis to gauge if improvement efforts are working. **Sample aim statement and charter form**

5. **Develop key messages and a communication strategy for the project.** Develop the benefits or business case (What’s-in-it-for-me or WIIFM) for stakeholders at all levels. Establish a communication plan to keep leadership, practices, the project team, and other stakeholders informed about progress. **Sample communication plan (Appendix H in the linked document)**

Get Set! Use data to identify opportunities for improvement

1. **Develop, adapt, and use clinical information systems for reporting and patient tracking.** Use robust data repositories and/or registries to produce performance reports for clinical measures. Identify clinical areas, preventive or chronic disease, with opportunities for improvement. Include all patients in the repository/registry, regardless of payer source.

2. **Define the scope** — will the initiative include the entire population or segments of the population such as adult diabetics, commercial, MedicareAdvantage, Medicaid, or ACO members?

3. **Identify the patient population** and stratify to prioritize outreach.
Go! Select Intervention Strategies to Test and Adapt

1. **Identify changes with most potential for improving performance quickly and with the most potential for diffusion.** Characteristics of changes that spread more quickly include:
   - Relative advantage of change
   - Compatibility with existing values and practices
   - Simplicity and ease of use
   - Trialability
   - Observable results (Robinson, 2009)

2. **Identify other resources needed to implement the initiative.** Examples include data/analytical staff, clinical or other staff to complete outreach activities to patients, performance improvement specialists or other staff to complete outreach activities to practices and physicians, and financial resources for incentive or bonus programs.

3. **Set up a work plan** with clearly defined roles, responsibilities, and goals for each team member. Be cognizant of other competing priorities. For example, if your network is in the process of implementing an EHR, check the rollout schedule and set your introduction meeting prior to or well after the EHR is rolled out to that site. [Project plan example and template](#)

4. **Identify patient outreach activities** and the most effective approach – centralized at the PO level or practice-based. When physician buy-in is high and outreach has been shown to be effective at the PO level, centralized outreach efforts to patients on behalf of physicians.

5. **Begin conducting outreach** to practice sites to build relationships and communicate baseline performance and goals. Early promotion of the initiative should contain the key message(s) rather than communicating the initiative as a “project”.

6. **For practice-level interventions, identify changes with most potential for improving performance quickly and with the most potential for diffusion** – think the next five patients or doing something different for the rest of the day. Select proven changes for testing at pilot site(s) and tweak interventions to meet local needs. The practice team should check-in at the end of each test cycle to review what worked and what changes will be made for the next cycle. Frequent huddles during the test cycles can replace formal meetings. Establish clear, meaningful goals for practices that are quickly achievable (Heath, 2010) and prioritize changes systematically. [Sample diagnostic worksheet to identify pilot practices](#)

7. **Build on existing systems and identify any barriers that need to be addressed.** For example, if case managers are currently doing outreach to patients for chronic care, have these staff remind patients about preventive services due and assist scheduling appointments. Ensure that changes leading to improvement during the initiative become part of the everyday work.

8. **Communicate progress** – to senior leadership, internal staff, and the network. Give feedback and progress reports to teams implementing changes. Keep all stakeholders informed throughout the initiative of progress, especially celebrating and publicly recognizing early successes and improvements. Use existing forums to communicate successes and lessons learned by pilot site(s).
Develop a Spread Strategy and Plan

1. **Develop champions** at selected pilot sites. Encourage communication through social networks to encourage adoption of changes by additional practices.

2. Using data to identify opportunities for improvement, **select spread site(s) based on a number of strategies**. Including innovators and early adopters is fine, but the changes they implement may not foster adoption by the majority. Others may view them as more capable of adopting changes and always being on the cutting edge. If other practices view the pilot practice as different, they will have the perception that changes made there may not be replicable. Selecting a "middle of the road" practice with a respected physician champion will prove advantageous in the long-run for diffusion of changes to other practices. Target high-volume practices first to quickly impact performance, especially those that have buy-in and commitment to the initiative and data shows opportunities for improvement. The outreach and communication strategy should be based on the readiness of the practice to implement changes. A strategy for practices that are "gung ho" would be to give them the tools and check-in by e-mail or phone on progress. More high-touch communication strategies should be employed for other practices that need more technical assistance. In-person communication is more effective with this population by initiating one-on-one meetings with the physician(s) and/or office manager or attending staff meetings.

A Framework for Spread

LEADERSHIP
- Topic is a key strategic initiative
- Goals and incentives aligned
- Executive sponsor assigned
- Day-to-day managers identified

SET-UP
- Target population
- Adopter audiences
- Successful sites
- Key partners
- Initial spread plan

SOCIAL SYSTEM
- Key messengers
- Communities
- Technical support
- Transition issues

Source: (Nolan, Schall, Erb, & Nolan, 2005)(p. 340)
## Proven Approaches and Specific Changes to Try

The following tables summarize specific changes to drive improvement at three levels: centralized group/IPA, practice-based, and patient engagement. Examples and links to resources are included for each change which you can test and adapt to conduct outreach and close performance gaps for your improvement initiative.

### CENTRALIZED GROUP/IPA INTERVENTIONS

<table>
<thead>
<tr>
<th>CHANGES TO TRY:</th>
<th>RESOURCES:</th>
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<tbody>
<tr>
<td><strong>Establish and/or strengthen relationship(s) with physicians and practice site staff and communicate the goals and messages for the initiative.</strong></td>
<td>Sharp Rees-Stealy presentation on Diabetes Perfect Care implementation (pages 1-14)</td>
</tr>
<tr>
<td>▶ Schedule and conduct on-site meetings with the physician, office manager, and any other staff that may be involved</td>
<td>Dr. Howard Beckman’s presentation on engaging physicians</td>
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<tr>
<td>▶ Bring information about “what’s in it for me (WIIFM)” for the practice to make the case for change</td>
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<tr>
<td>▶ Employ proven communication strategies, using non-judgmental communication techniques, to successfully engage physicians and office staff</td>
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<tr>
<td>▶ Provide education about incentives (financial or other) associated with change implementation or performance improvement</td>
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<td>▶ Provide training in QI concepts for practices if needed to build capacity for change</td>
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<tr>
<td>▶ Use existing forums, such as physician and office manager meetings, to communicate details of the initiative.</td>
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<tr>
<td><strong>Provide regular performance data across the network, for individual practices, and for individual physicians.</strong></td>
<td>Sharp Rees-Stealy Presentation – Performance reports (pages 11-13)</td>
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<tr>
<td>▶ Regularly and frequently measure clinical performance indicators</td>
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<tr>
<td>▶ Ensure that data is as complete and accurate as possible when using for performance measurement — no data is perfect</td>
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<tr>
<td>▶ Performance reports should compare performance to peers and/or benchmarks</td>
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<td>▶ Look for variation in performance to identify better/best practices and opportunities for improvement.</td>
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<tr>
<td>▶ Use an unblinded format for the most impact or transition from blinded to unblinded data over time</td>
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<tr>
<td><strong>Conduct outreach efforts on behalf of PCP practices if effective for your initiative. Promote and get physician buy-in first!</strong></td>
<td>CQC Meteor program member and physician outreach tips and tools</td>
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<tr>
<td>▶ Letters/postcards to patients</td>
<td>Heritage Provider Network and Monarch HealthCare® presentation on centralized outreach strategies</td>
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<tr>
<td>▶ Phone calls (education, reminders) to patients</td>
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<tr>
<td>▶ Personal phone calls</td>
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<tr>
<td>▶ Automated Voice Response system calls</td>
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<tr>
<td>▶ Create scripts for staff and provide training as needed</td>
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<tr>
<td>▶ Mail health education materials to patients</td>
<td></td>
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<tr>
<td>▶ Sponsor community health fairs or wellness clinics</td>
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<tr>
<td>▶ Inform practice physicians and staff about all communications to patients. Provide a list of patients contacted and a sample of the message conveyed to patients.</td>
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<tr>
<td>▶ Communicate to patients that outreach is on behalf of the physician or at the physician’s request</td>
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## Centralized Group/IPA Interventions

### Changes to Try:

1. **Provide gap reports to practices listing patients who have not had needed services or whose lab values do not meet goal.**
   - Validate the data and check reliability – identify shortcomings of the data/data sources and be up front about these when distributing reports.
   - Seek input from practitioners and other users on the content, layout, frequency, and usefulness of the reports.
   - Incorporate practitioner/staff feedback into revised versions of reports.
   - Provide sample letters and patient materials for distribution.

2. **Provide centralized services on behalf of your provider network.**
   - Conduct annual health assessments in a centralized facility.
   - Organize a senior wellness center to provide comprehensive care to older patients.
   - Maximize efficiency by reviewing hierarchical condition codes (HCC) appropriate for each patient with diagnoses listed in the medical record this year and identifying gaps in needed chronic and preventive services.
   - Provide services (lab, dexascan, mammograms) at the central location.

3. **Educate practices on better/best coding and documentation practices to improve data accuracy and completeness.**
   - Use CPT Category II codes to record blood pressure readings (and/or other measures not readily available from other data sources) in administrative claim/encounter data.
   - Revise superbill forms to include CPT II codes which staff can circle and enter values.
   - Have HCC coding reviewers enter CPT II codes during medical record review.
   - Drill down to the patient level on reports to identify potential miscoding issues.
   - Educate practice and coding/billing staff on procedure and diagnosis codes important for measurement purposes to improve efficiency and effectiveness of data collection.

4. **After engaging practices in the initiative, provide incentives to motivate change at the practice level.**
   - Initiate financial incentives based on performance in select indicators: those with opportunities for improvement and with clear changes that work.
   - Initiate public recognition of high performers and encourage champions to share better/best practices, challenges, effective strategies, and lessons learned.
   - Provide incentives to practice staff to complete outreach activities or otherwise contribute to the improvement initiative.

### Resources:

- Sharp Rees-Stealy presentation with sample gap reports (pages 5-10)
- CQC Meteor sample physician outreach tools
- CAPG Senior Outreach Brochure
- High Desert Primary Care Medical Group, Choice Medical Group, and Torrance Hospital IPA’s Senior Health Center
- CPT Category II Codes – CQC webinar presentation
- CQC CPT Category II codes tip sheet
- CQC Office Staff Incentives webinar
- Tip sheet from Monarch Healthcare on designing office staff incentives
- Nancy Greenstreet, MD at Physicians Medical Group of Santa Cruz on PMGSCC’s physician incentive program
<table>
<thead>
<tr>
<th>PRACTICE-BASED INTERVENTIONS</th>
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<tr>
<td><strong>CHANGES TO TRY:</strong></td>
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<tr>
<td><strong>Develop standing orders/protocols and automated support (this can be done at a PO or practice level)</strong></td>
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<tr>
<td>▶ Convene primary care and specialists to develop standing orders/protocols — this will help with buy-in when implementing</td>
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<tr>
<td>▶ Employ automated lab order entry</td>
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<tr>
<td>▶ With the physician’s permission, send lab slips to patients with the results directed to the patient’s physician</td>
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<tr>
<td><strong>Optimize use of decision support tools</strong></td>
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<tr>
<td>▶ Build EHR templates with embedded evidence-based care</td>
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<tr>
<td>▶ Use EHR templates to initiate prompts at the point-of-service</td>
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<tr>
<td><strong>Set up a systematic process to work gap reports of patients needing services or recall appointments.</strong></td>
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<tr>
<td>▶ Set clear expectations for who is responsible and action steps</td>
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<tr>
<td>▶ Break the initiative down into doable steps (example: contact 5 patients a week for the next 10 weeks)</td>
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<tr>
<td>▶ Set aside protected time for staff doing outreach</td>
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<tr>
<td>▶ Set up incentives for staff to achieve practice goals</td>
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<tr>
<td><strong>Implement team-based care</strong></td>
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<tr>
<td>▶ Leverage physician time by delegating tasks to mid-levels, MAs, and others. Ensures that all care team members are supporting the patient from the same knowledge base. Roles of staff are clearly defined and licensed staff operate at the highest level defined by the license</td>
</tr>
<tr>
<td>▶ Consider including pharmacists/pharmacy technicians, behavioral health practitioners, social service workers, Certified Diabetes Educators, nutritionists and other appropriate specialties on comprehensive care teams</td>
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<tr>
<td><strong>Implement planned visits</strong></td>
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<tr>
<td>▶ Provides a prepared-proactive care team, a key concept in the Chronic Care Model</td>
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<tr>
<td><strong>Implement group medical appointments to develop capacity and efficiency and to engage patients.</strong></td>
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## Engaging Patients

**Changes to Try:**

1. Adopt techniques, such as motivational interviewing/health coaching, to prepare the care team to effectively interact with patients and empower them as part of the care team.
   - Have the care team complete Kaiser’s web-based Brief Negotiation/Motivational Interviewing training as an introduction. The training is no-charge to non-Kaiser individuals and awards CME hours.
   - Study how others have incorporated self-management techniques into care delivery. Have the practice team select techniques to implement.
   - Measure patient engagement/activation. A higher patient activation level has been linked to improved ability of the patient to self-manage and improved health outcomes. Using a structured method to determine where the patient is on the continuum will assist the care team in providing the right services to each patient.

**Resources:**

- CQC Patient Engagement webinar by Team Up for Health groups
- CQC Self-Management Change Package – includes training resources
- CHCF Team Up for Health Program Resources
- Patient Activation Measurement tools
- Kaiser Permanente online Brief Negotiation/Motivational Interviewing Training

## Planning for Spread and Sustaining Changes

**Changes to Try:**

1. Include sustainability planning throughout implementation
   - Changes that are effective should be incorporated into everyday work.
   - Continue to measure initiative indicators.
   - Communicate results to all stakeholders – celebrate success!
   - Conduct training to address slippage.

2. Build champions and encourage communication through social media.
   - Primary characteristics of physician champions:
     - Wide peer and social network and knowledge of how his/her colleagues interact with each other.
     - Perceived as credible and is respected by peers.
     - Highly knowledgeable and stays connected to his/her area of expertise through a variety of sources.
     - Willing to share knowledge with others.
     - Willing to support and advocate for process changes.
     - Willing to implement new guidelines and serve as a resource for others.
     - Easy to interact with, welcomes contact by others, makes time to attend to their issues and shows an interest in their views.
     - Is flexible and controlled in the face of stress, leading others by example.
     - Is not afraid to speak his/her mind or of trying to influence others, but does so in a way that respects the personal boundaries of others.

**Resources:**

- Sustaining improved outcomes toolkit
- Spread strategies presentation by Tammy Fisher, MPH
- Assessing physician champion’s potential for success (Appendix F)

## References


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CQC thanks the following groups and individuals that contributed learnings, sample tools and other materials for this toolkit:

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- DeeAnn Schmucker, MSW, LCSW
- Sharp Rees-Stealy Medical Group
- Torrance Hospital IPA
- United Family Care