

Lessons in Scaling Transformation:

Impact of California Quality Collaborative's
Practice Transformation Initiative



CALIFORNIA QUALITY COLLABORATIVE
Breakthroughs for Better Health Care

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About CQC

The California Quality Collaborative (CQC) is a multi-stakeholder health care improvement collaborative housed within the Pacific Business Group on Health (PBGH). CQC is dedicated to advancing the quality and efficiency of the health care delivery system. Its purpose is to identify and spread best practices across California's outpatient delivery system. CQC trains more than 2,000 individuals from 250 organizations each year. Through this work, CQC fosters measurable delivery system improvements important to patients, purchasers, providers and health plans.



About the Practice Transformation Initiative

As an entity hosted by the PBGH, CQC led a statewide Practice Transformation Network (PTN), funded by the Centers for Medicare & Medicaid Services (CMS) as part of the four-year Transforming Clinical Practice Initiative (TCPI). CMS designed TCPI to support more than 140,000 clinician practices nationwide to share, adapt and further develop comprehensive quality improvement strategies.

CQC named its PTN the Practice Transformation Initiative (PTI) and implemented this project in collaboration with two key partner organizations, the Integrated Healthcare Association (IHA) and the Center for Care Innovations (CCI). The project concluded in December 2019.



IHA works with stakeholders to advance performance measurement and incentives that are essential to high-value, integrated patient care and to enable public reporting of comparative performance information. As PTI's data partner, IHA facilitated the collection, aggregation and analysis of data on the PTI measure set.



CCI shares practical innovations to help organizations revolutionize health care for underserved communities in California and nationally. CCI served as a critical partner for the duration of PTI, providing improvement advisor support and offering deep experience in how to effectively leverage quality improvement within community clinics and vulnerable populations.

Participants

Alternative payment arrangements in ambulatory care are the predominant payment model in California. This is the result of the managed care wave of the 1990s which proliferated hundreds of intermediary organizations to accept capitated payments on behalf of practices. These groups, such as Independent Physician Associations (IPAs), are a crucial part of the state's health care landscape. In recognition of this fact, CQC designed the PTI to leverage these intermediary organizations. Foundational to its model for technical assistance was a train the trainer approach designed to build capacity within IPAs and other intermediaries. In turn, these organizations would work directly with the practices within their respective networks to foster improvements. This approach addressed a major challenge for large-scale improvement efforts: how to provide efficient and effective hands-on technical assistance to nearly 2,000 physician practices in a state that's more than 160,000 square miles.

A total of 13 provider organizations (POs) from across California completed their work in PTI. Combined, the organizations represented more than three million Californians and all payers (e.g., commercial, Medicare, Medicaid). The five types of organizations that participated included IPAs, Management Services Organizations (MSOs), a consortium of Federally Qualified Health Centers (FQHCs), Medical Foundations and a Health Plan.

Each PO took responsibility for identifying providers within their respective networks to participate in PTI. Approximately 4,500 clinicians enrolled, representing a total of 1,500 practices. Around 90 percent of these practices were small, independent and primary care practices. Eighty-seven percent of enrolled clinicians participated in a capitated payment model and a value-based payment program.

Figure 1



| Cohort | Medical Foundation | IPA/MSO | FQHC/Health Plan |
|---------------|--------------------|---------|------------------|
| Organizations | 3 | 8 | 2 |
| Clinicians | 847 | 3061 | 550 |
| Practices | 98 | 1276 | 90 |
| Practice Size | 8.6 | 2.4 | 6.1 |
| Lives | 1.18M | 0.93M | 0.91M |
| | Payer Mix | | |
| Commercial | 50% | 52% | 11% |
| Medicare | 12% | 27% | 5% |
| Medicaid | 0% | 12% | 58% |
| Other | 38% | 9% | 27% |

Organization Cohort

- Medical Foundations
- FHC Consortium/Health Plan
- IPA/MSO

Network characteristics, including number of clinicians, number of practices, and payer mix, is represented in Figure 1.

PT. Participating Provider Organizations

- Allied Pacific IPA
- AppleCare Medical Group
- Central Valley Collaborative
- EPIC Management
- HealthCare Partners IPA
- MedPOINT Management
- Molina Health Care of California
- Palo Alto Medical Foundation
- Physicians Medical Group of San Jose
- Prospect Medical Group
- Riverside Physician Network
- St. Joseph Heritage Healthcare
- Sutter Pacific Medical Foundation

While 13 POs completed participation, over the project's lifespan, a total of 16 organizations participated. Of this 16, two graduated the program by becoming Next Generation Accountable Care Organizations.¹ One organization left due to provider attrition.



¹More information on the Next Generation Accountable Care Organization model can be found on the CMS Innovation Center website: innovation.cms.gov/initiatives/next-generation-aco-model

Overall Approach

The design of PTI was based on a philosophy of creating capacity within POs to do performance work that could be sustained well beyond the life of project. CQC sought to include a diversity of POs among its cohort, looking at factors such as each PO's provider network, current infrastructure to support quality improvement (QI), data capabilities and reporting infrastructure, and senior leader engagement.

Several considerations drove the final composition of the cohort. CQC recognized the importance of including organizations at all phases of learning and capacity building. Those with more mature infrastructure could serve as models for those earlier in their journeys while focusing on optimizing their work. This reinforced the "all teach, all learn" philosophy.

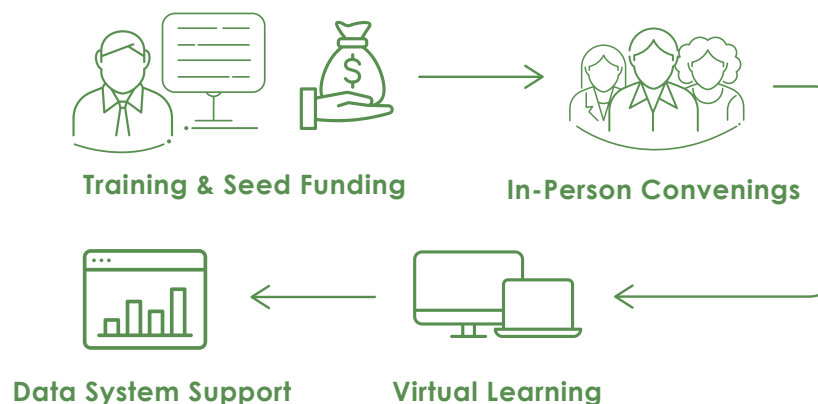
As a result of the predominance of small and solo primary care practices, CQC also sought significant representation from IPAs with a large proportion of such practices in their network. Inclusion of IPAs with limited infrastructure and capacity offered the opportunity to fill a gap in knowledge about how practice transformation happens in these settings and which change elements are most impactful. Evidence shows that small practices encounter significant and unique challenges. For example, when compared to larger practices or integrated systems, small practices use fewer care management processes and are less likely to use rapid-cycle quality improvement.² Research has demonstrated that small practice physicians within IPAs were less likely to describe performance reports from the organization as useful, as the data was perceived to be focused on lowering the cost of care rather than improving

quality.³ The physician-centric mindset also hindered the team in taking on broader responsibilities of care and quality improvement.⁴ IPAs affiliated with small practices face their own challenges. They may be relatively new to QI and transformation work and, as a result, require more intensive hands-on assistance.

In order to meet each PO's individual needs, PTI offered robust technical assistance (e.g., training and seed funding of practice facilitators, in-person quarterly convenings, monthly virtual learning sessions, individualized coaching, and data systems support). Improvement was tracked at clinician, practice, and PO levels for measures common across value-based payment programs for commercial, Medicare, and Medi-Cal.

To achieve broad-scale improvement in a large state also required efficient learning and dissemination of change ideas and best practices that could be adapted to diverse practice settings: differing geographies, populations, organization types, payment models, and delivery systems.

Technical Assistance Offered By PTI



²Rittenhouse DR, Casalino LP, Shortell SM, et al. "Small And Medium-Size Physician Practices Use Few Patient-Centered Medical Home Processes." *Health Affairs*. 2011;30(8):1575-1584. doi:10.1377/hlthaff.2010.1210.

³Rittenhouse DR, Grumbach K, O'Neil EH, Dower C, Bindman A. "Physician Organization And Care Management In California: From Cottage To Kaiser." *Health Affairs*. 2004;23(6):51-62. doi:10.1377/hlthaff.23.6.51.

⁴Nutting PA, Crabtree BF, Mcdaniel RR. "Small Primary Care Practices Face Four Hurdles—including A Physician-Centric Mind-Set—in Becoming Medical Homes." *Health Affairs*. 2012;31(11):2417-2422. doi:10.1377/hlthaff.2011.0974.

Technical Assistance Overview

PTI offered a range of supports designed to facilitate improvement among participating POs. At the heart of this work was a focus on building practice facilitation programs within each PO. With funding from PTI, POs hired new or re-purposed existing staff as practice facilitators, also known as practice coaches, who were then trained by PTI staff.

PTI convened teams from each PO for in-person and virtual learning events. The foundation of these events was an evidence-based framework of adult learning principles and methodology, known as Dialogue Education.⁵ Dialogue Education seeks to maximize engagement through learner-centered design, active decision-making and achievement-based objectives.

These activities were part of a broad array of technical assistance vehicles to meet the varied needs of POs. Improvement advisors and subject matter experts also offered individualized support to organizational leaders and practice facilitators.

Technical assistance offerings were organized into the following categories and content areas:

- **Trainings:** 10 Building Blocks of High-Performing Primary Care,⁶ improvement coaching, the Model for Improvement⁷, motivational interviewing, patient and family engagement, storytelling, adaptive leadership
- **Resources:** Organizational-level dashboards and data, tools and templates, virtual resource library
- **Consultation:** Improvement Advisor support, access to subject matter experts, a master coach development program (also known as the Aspiring Coaches of Excellence Collaborative, or “ACE Program”)
- **Peer Sharing:** Case-based learning, quarterly convenings that highlight best practice sharing

The PTI team trained participants in the Model for Improvement, practice facilitation skills, the 10 Building Blocks of High Performing Primary Care,⁷ change management frameworks and tools, communication, and many other technical skills. In turn, practice facilitators coached their own PO's practices and PO staff in other departments on the many facets of practice transformation. In total, PTI trained more than 300 individuals.

CQC also intentionally modeled improvement culture-building within events through co-design with participants, the transparent and non-judgmental sharing of performance data, and gathering and incorporating participant feedback through various techniques and iterative tests of change. Initially, PTI relied heavily on the expertise of external faculty; however, over time as the network became a safe place for sharing and learning, faculty and facilitators rose from POs. These peer faculty led their colleagues through collaborative activities and sharing expertise and experiences of practice transformation.

Measurement Strategy

PTI designed a robust measurement strategy, including the collection, analysis, and reporting of a variety of performance data. Each PO was required to report data on a measure set for each enrolled clinician. The set included a total of 13 measures. Eight measures were clinical, focusing on chronic diseases, and four measures addressed the utilization of health care services, including screening and use of both inpatient hospital and emergency department care. One measure addressed patient satisfaction.

⁵Vella, J. (2002, June). *Learning to Listen, Learning to Teach: The Power of Dialogue in Educating Adults*. Montpelier, Vermont: Global Learning Partners.

⁶Bodenheimer T, Ghorob A, Willard-Grace R, Grumbach K. "The 10 Building Blocks of High-Performing Primary Care." *Ann Fam Med*. 2014;12(2):166-171.

⁷Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd edition)*. San Francisco: Jossey-Bass Publishers; 2009.

⁸Ibid.

Each PO was required to report on a minimum of seven measures, including a minimum of two utilization measures. Network-wide, each organization reported an average of 11.38 measures, an increase from 7.89 measures at baseline (2015).

Results of the measures were reported quarterly on a rolling 12-month basis. Each quarterly submission included results across three performance periods. Data were reported at the clinician level (NPI Level 1) and identified the number of patients eligible for the measures numerator and denominator. In addition to identifying the clinician, results also flagged their associated practice and payer/product mix.

The PTI measures were also intentionally aligned with existing measures in other federal, state and commercial value-based payment programs (see Figure 2). This had the benefit of reducing burden on participants and also facilitated the use of an existing reporting infrastructure (i.e., IHA's Align.Measure.Perform program⁹) and work with a set of measures familiar to the POs and their clinicians. Many measures were also aligned with internal incentive structures so that improvement in these measures offered benefit outside of PTI.

Data underwent multiple rounds of validation which confirmed submission formatting and content (e.g., cross-referencing level 1 and level 2 NPIs to the NPEES registry), internal consistency checks (e.g., the diabetic population was constant across the suite of diabetes measures) and performance comparison checks (e.g., to flagged large performance swings compared to benchmarks or prior submissions).

| PTI Measure Set | | NQF ID | QPP | Medicare Stars | Medicaid Core Set |
|-------------------|---|--------|-----|----------------|-------------------|
| Clinical Outcomes | Controlling Blood Pressure for People with Hypertension | 0018 | ✓ | ✓ | |
| | Asthma Medication Ratio (0-64) | 1800 | | | ✓ |
| | Diabetes: Two HbA1c Tests | 0057 | | | ✓ |
| | Diabetes: HbA1c Poor Control > 9.0% | 0059 | ✓ | ✓ | |
| | Diabetes: HbA1c Control < 8.0% | 0575 | | | ✓ |
| | Diabetes: Eye Exam | 0055 | ✓ | ✓ | ✓ |
| | Diabetes: Nephropathy | 0062 | ✓ | ✓ | |
| | Controlling Blood Pressure for People with Diabetes | 0061 | | | |
| Utilization | Cervical Cancer Screening | 0032 | ✓ | | ✓ |
| | Cervical Cancer Overscreening | | | | |
| | Overuse: Low Back Pain Screening | 0052 | ✓ | | |
| | Emergency Department Visits | | | | |
| | Inpatient Bed Days | | | | |
| | Patient Feedback Quarterly | | | ✓ | |

Figure 2

Variation in performance across different organization cohorts was also substantially reduced. The PAT is a survey that CMS required be administered every six months for all PTI-enrolled practices. There were two versions of the PAT, one focused on primary care (27 items) the other on specialist practices (22 items).¹⁰ The PAT evaluates the implementation status of levers of change within a physician practice, focusing on areas such as: patient and family engagement, use of performance data, panel management, etc. Each lever was scored on a range from 0 to 3.¹¹

| PAT Scoring | |
|-------------|-----------------------------------|
| 0 | Lever not implemented |
| 1 | Getting started |
| 2 | Implementing, partially operating |
| 3 | Fully implemented |

Practice Assessment Tools

Click below for resources:

Primary Care PAT+
Specialist PAT+

⁹IHA's Align. Measure. Perform. (AMP) programs use a fair and transparent approach to measurement and benchmarking to create a reliable assessment of performance for medical groups, IPAs, and ACOs across health plans. The AMP programs are recognized nationally for partnering with organizations across California and the nation to drive meaningful changes that reduce costs and improve healthcare quality and outcomes.

¹⁰Each element within the PAT is referred to as a milestone by CMS.

¹¹The Primary Care PAT can be downloaded [here](#) and The Specialist PAT can be downloaded [here](#).

Results and Findings

PTI conducted multiple analyses of performance data and also explored the qualitative experience of participants. Results from each of these activities are shared below.

Data Analysis and Outcomes

Figure 3 highlights network level performance changes over PTI's four years. Performance changes impacted all major payers (commercial, Medicare, Medicaid) but predominately reflect the managed care population. The arrows depict absolute levels of improvement (green) or deterioration (red) on 10 of the 12 measures (see next page for remaining 2 measures). It's important to note that among HbA1c Poor Control >9%, rates were inverted so that higher rates are better.

Among PTI participants, there was positive improvement across the diabetes suite of measures including both outcomes (e.g., HbA1c control) and processes of care (e.g., HbA1c, nephropathy screening). Early evidence suggests that a number of the measures (e.g. HbA1c Good Control <8%) improved at a faster rate compared to the State as a whole. Of note, there was a deterioration of performance related to asthma and unnecessary testing. Several factors may have contributed to this deterioration. First, these two performance domains were not the primary focus areas of PTi's technical assistance program after discovering through baseline data analysis that improvement opportunity was quite small. Additionally, these measures were among the least reported across the network.

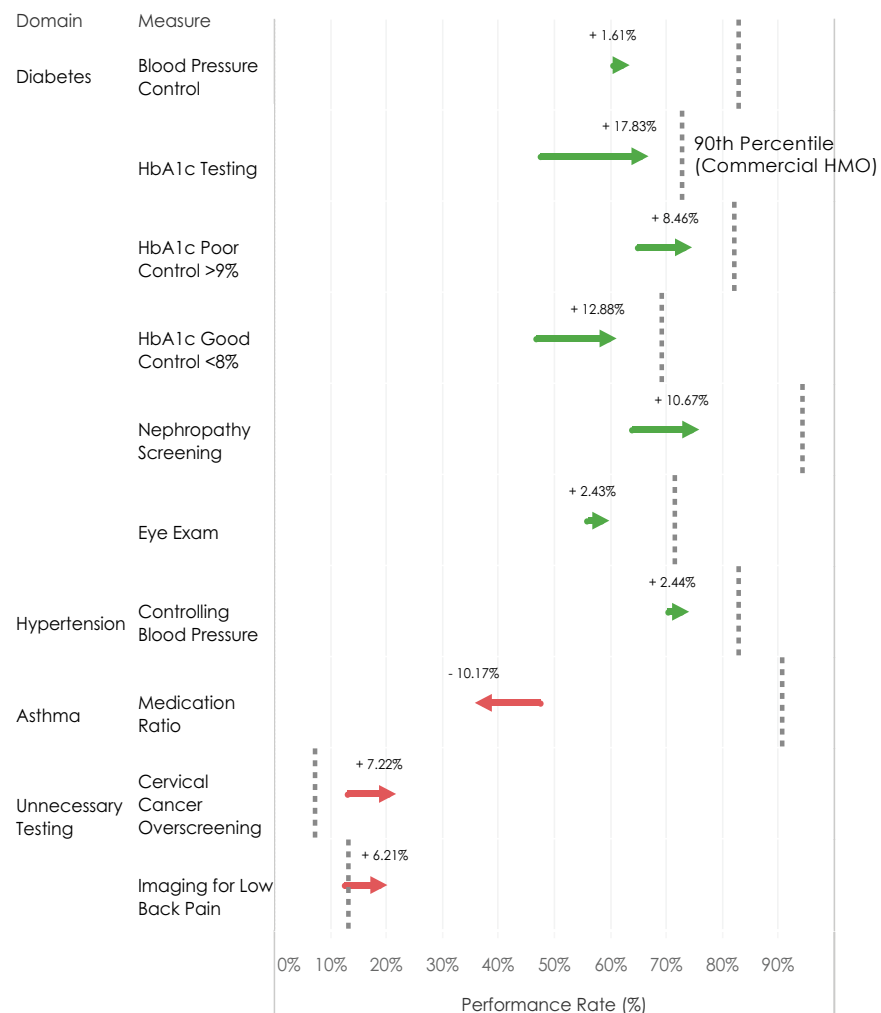


Figure 3

Hospital Utilization (2015 - 2019)

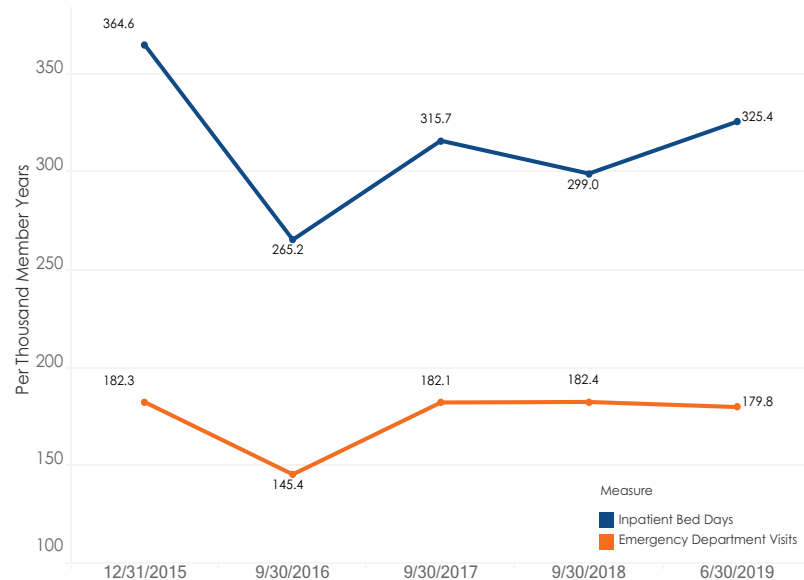


Figure 4

Figure 4 shows network performance related to the two hospital-based utilization measures (inpatient bed days and emergency department visits). Performance on these two measures enabled CQC to calculate health system-related cost savings through avoided hospital bed days and emergency department visits. As reflected in Figure 4, inpatient bed days experienced a reduction from 364.6 per thousand member years (PTMY) at baseline to 325.4 PTMY at the conclusion of the program (from December 31, 2015 to June 30, 2019). Additionally, over the 4 years, emergency department utilization also saw a reduction from 182.3 PTMY to 179.8 PTMY.

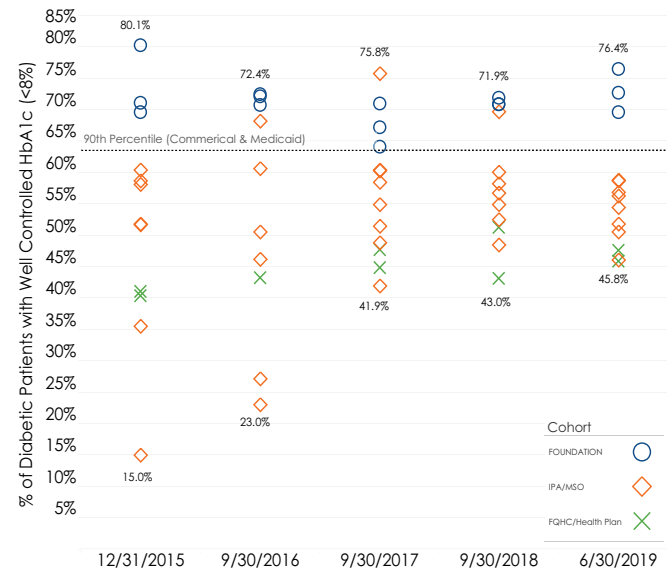


Figure 5

In addition to improved clinical outcomes, PTI reduced the amount of performance variation across different cohorts of organizations. The organization cohorts were based on PO structure (e.g., Medical Foundations vs. IPAs) and analyses also reflected the population served (e.g., commercial vs. Medicaid lives - see also Figure 1). For example, when looking at the diabetes measure of HbA1c Good Control <8%, the Foundation cohort (blue circles) maintained a high-level of performance during the program (above 90th percentile). Most notably, the IPA/MSO (orange diamonds) and FQHC/Health Plan (green cross) that started the program with lower levels of performance, closed the gap with the Foundation cohort. See Figure 5.

The IPA/MSO (orange diamonds) and FQHC/Health Plan (green cross) that started the program with lower levels of performance, closed the gap with the Foundation cohort.

In addition to analyzing performance on the clinical measure set, analyses were also conducted on the results from the Practice Assessment Tool. The top areas of improvement varied by organization type. Medical Foundations saw the most improvement in financial transparency, while the IPA/MSO cohort experienced improvements in continuity of care. Meanwhile, the FQHC/Health Plan cohort experienced the most improvement in hospital follow-up. See Figure 6.

PTI developed a linear regression model to determine what PAT change levers, if any, were related to performance across the measure set. The model assessed the current implementation status of each lever in conjunction with measure performance rates. This work enabled a distillation of program focus areas on four primary levers that were associated with high performing practices, i.e. higher levels of quality and lower utilization. These levers included: reviewing regular and transparent performance reports as a care team, consistently managing care and documenting care plans for high-risk patients, expanding the roles of care team members, and actively building QI capability within the practice. By narrowing technical assistance efforts to focus on a subset of changes a practice may be more likely to see results quickly and build motivation and momentum for continued performance improvement work. Understanding these drivers also enabled PTI to develop a more targeted way to support POs, including narrowing the focus of technical assistance priorities in the last two years of the program.

CQC translated the results of performance into a higher-level analysis of the improvements across PTI's four years (see also Figure 7). This analysis – which translated practice-level improvement into the aggregate impact on patients – also reflected the way PTI reported its progress to CMS. Notably, 40,000 patients in California had improved HbA1c, a measure that is central to improved outcomes for patients with diabetes. Across PTI, avoidable inpatient bed days were reduced by 47,000 and 17,000 emergency department visits were avoided.

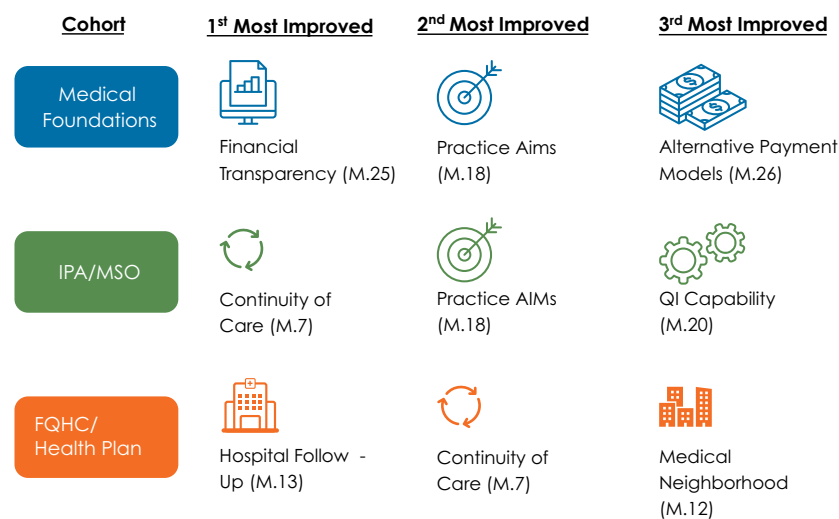


Figure 6

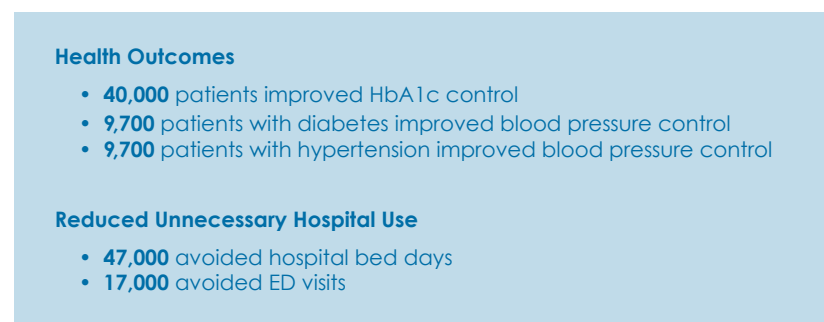


Figure 7



PTI also analyzed strategies used by small practices and their contracted POs. These analyses are useful because the scarcity of money, time, expertise, and staff make even the most impactful process changes challenging to undertake on their own. Understanding the most impactful changes may be useful to others pursuing this work.

Higher-performing practices carried out processes by leveraging resources provided by POs. Similarly, IPAs learned to create deeper connections with their network. For each key element, small practices partnered with POs to take advantage of economies of scale they would not otherwise have and distributed the workload for effectiveness.

Examples PTI identified include:

- **Standardized quality reports:** POs standardized and produced quality performance reports so practices could access them and review together.
- **Centralized care management:** POs provided centralized care management services with RNs and communicated bi-directionally with care teams, including sharing the care plan and documenting in the EHR. Care management services also increased the practice's effectiveness by allowing the care team members to focus on real-time work with patients and enabled care team members to take on additional care responsibilities.
- **Practice facilitators:** Practice Facilitators were hired by POs, trained by PTI, and deployed to PTI-enrolled practices. These facilitators provided one-on-one technical assistance to build QI capabilities within a practice.

Small practices partnered with POs to take advantage of economies of scale they would not otherwise have and distributed the workload for effectiveness.

Performance Stories

As part of the qualitative exploration of the experience of participation in PTI, CQC developed a series of five-minute videos highlighting performance stories of three participating POs: Allied Pacific IPA, HealthCare Partners, and Riverside Physician Network (RPN). The videos can be accessed [here](#).

Allied Pacific IPA

Allied Pacific is an IPA in southern California's San Gabriel Valley. This performance story highlights a partnership between Allied Pacific and Herald Christian Health Center, a Federally Qualified Health Center with sites in Rosemead, San Gabriel, City of Industry, and San Diego.

In 2017, Allied Pacific identified Herald Christian as a high-membership practice with low performance within Allied Pacific's network. Identification of these types of practices was one strategy Allied Pacific used in order to yield greater impact both in terms of their participation in PTI and also to improve effectiveness within their own network.

Allied Pacific worked with Herald Christian to analyze the drivers of this low performance. A system glitch that led to data loss was identified. To address the glitch, the pair collaborated to improve the clinic's data management and reporting capabilities. In turn, this would enable the care team to increase its focus on improving quality outcomes. The collaboration went so well that they decided to continue meeting on a regular basis. Allied Pacific helped Herald Christian implement workflow changes, fortify their call center, bolster patient outreach, and provide patient self-management tools and resources. The Allied Pacific team also focused on improving coding and implementing workflow changes which led to markedly improved clinical outcomes for patients with chronic disease. Herald Christian received awards in 2019 from the U.S. Health Resources and Services Administration for performance in quality, health disparities reduction, and improved access.

The Allied Pacific video can be viewed [here](#).



HealthCare Partners

Dr. Emil Padre is a primary care provider with a small practice serving 1,500 patients in Carson, California. Carson is located in the South Bay region of Los Angeles (LA). Dr. Padre collaborated with staff practice facilitators at HealthCare Partners, its IPA, to ensure that patients could easily access diabetes management classes and resources. HealthCare Partners also worked with Dr. Padre and his team to create better ways to work with patients with diabetes.

One such change was improving the ability of patients to access HealthCare Partners' Health Enhancement Program. The program offers a diabetes management class for patients. The class did not have high attendance; the requirement for physician referral to the program was determined to be a factor contributing to limited participation. HealthCare Partners decided that instead of requiring a provider referral, they would instead reach out to patients considered high-risk. These patients were identified based on data submitted by the practice. To improve chronic disease management, HealthCare Partners also offered phone consultations between patients and a dietician and connected patients to a diabetic specialist.

While the collaboration between the health care organizations is important, what undergirds the effort is a commitment to collaboration on the holistic, team-based care approach to meet patient needs.

The HealthCare Partners video can be viewed [here](#).



Riverside Physician Network

Riverside Physician Network (RPN) is an IPA in the Inland Empire in Riverside, California. As part of its PTI participation, RPN worked with 40 small practices in California's Inland Empire to help them meet various administrative requirements that were central to sustaining their businesses.

With quality patient care at the forefront, RPN supported their network's small practices by providing education and tools and facilitating internal process improvement. The goal was to better equip these practices to provide standard preventive care to their patients and also manage the varied requirements laid out by health plans with which they contract. This work was achieved, in part, by using a team of quality management nurses that work hand-in-hand with practices.

In the past, small practices in the Inland Empire were typically autonomous. It is this fact that serves as a testament to the value of RPN's centralized administrative support. The results of this support include improvements in operations as well as improved clinical performance, such as higher rates of preventative screenings.

The RPN video can be viewed [here](#).



Case Studies

PTI completed a two case studies, profiling the **Palo Alto Medical Foundation (PAMF)** and **Allied Pacific IPA**. The purpose of the case studies was to:

- Provide a more in-depth and qualitative understanding of PTI's Foundation and IPA cohorts, including highlighting different approaches and strategies to undertake the work given the stark differences between these two types of organizations
- Summarize practice facilitation activities and how PTI supported them
- Highlight individual PO achievements, how their different approaches impacted performance, and lessons that could be applied more broadly



Palo Alto Medical Foundation



Allied Pacific IPA



Palo Alto Medical Foundation (PAMF)

PAMF is a large multispecialty ambulatory network with sites throughout the San Francisco Bay Area. The network includes approximately 1,000 clinicians caring for about one million patients annually. PAMF is part of Sutter Health, an integrated delivery system operating across Northern California.

PAMF joined PTI as one of the highest performing POs in California, demonstrating performance at or above 90th percentile benchmarks on many PTI measures. PAMF included all its primary care clinicians and care sites in PTI – a total of 325 providers at 27 sites. The organization is well-resourced, highly organized, and centrally deploys many services and supports.

With already strong infrastructure and performance, PAMF took a different approach to its work in PTI. PAMF focused on its crisis of clinician and care team burnout. Leaders were looking for support to amplify pockets of emerging experiments to transform care and ongoing quality improvement efforts across the system. PAMF formed a project team that included executive champions, primary care leaders and a project manager.

Highlights from PAMF's PTI work include:

1. Mapping quality initiatives across all 27 primary care departments.
2. Dedicating a portion of a project manager's time to work with each practice manager to orient them to the PAT. The project manager also held group sessions so the process could be a learning and peer sharing opportunity across primary care sites.

3. **Methodically designing and testing a new care model in a pilot site (the pilot was underway prior to PTI).** The care model reflected the tenets of the 10 Building Blocks of High-Performing Primary Care and focused on redistributing care responsibilities across an integrated team. Based on findings from the pilot site – improved patient experience, reduced provider burnout, increased staff satisfaction, and reduced staff turnover – PAMF designed a process to spread the model across all its primary care practices.
4. **Exploring other ways to distribute work across a broader care team.** For example, PAMF's Watsonville Family Medicine practice tested the use of a Multidisciplinary In-Basket Support Team (MIST). MIST addresses the challenge of incoming patient requests arriving via EHR. It leverages a virtual care team, working via jointly agreed upon protocols, to route or resolve patient messages and requests before they get to the provider. The virtual team coordinates with the onsite team and only routes messages to physicians that require physician-level care. The Watsonville pilot yielded a 25% reduction in physician in-basket work and is being spread to PAMF's other primary care sites.

PAMF Aim Statement for PTI (created in May 2016)

The current structure of adult primary care delivery and workload are unsustainable. We will transform the structure of primary care delivery at PAMF from a physician – support staff dyad to a team based, sustainable approach to provide optimal patient care and reinvigorate the joy of practicing medicine, with a 20% relative improvement in all measures and achieving 90th percentile in all measures by the end of 2019.

PAMF learned several lessons relevant to other large medical foundations undertaking similar efforts:

- **Establish a Framework:** By mirroring its own centralized structure in its approach to practice transformation, PAMF created an organizing framework, infrastructure and role to connect and track all quality improvement efforts across its primary care sites.
- **Use Senior Leader Champions:** Across the lifespan of PTI, PAMF had engagement from an executive sponsor and multiple primary care clinician leaders. This consistent engagement was crucial to success. Leaders had lines of sight to improvement work happening within their own departments and across the system and were able to connect initiatives that would have otherwise been siloed.
- **Identify Variation and Use it as a Tool to Promote Best Practice Sharing:** PAMF used the PAT to collect data and identify variation in care processes across primary care sites. They also convened practice managers to discuss the tool and the variation. This process fostered best practice sharing, unearthing resources and voicing shared challenges that could be escalated to leadership.

Access the complete PAMF Case Study [here](#).



Allied Pacific IPA

Allied Pacific IPA enrolled physicians representing 257 practices within Los Angeles, Orange and San Bernardino counties. In total, these practices cared for 250,000 patients. Allied Pacific is one IPA within Network Medical Management (NMM), an MSO providing comprehensive administrative support to IPAs and medical groups.

Allied Pacific came into PTI as one of the lowest performing POs with respect to its clinical outcomes. Despite this, Allied Pacific quickly emerged as a committed and motivated participant, intent on achieving robust goals for performance improvement. Ultimately, Allied was the most improved organization among all participating POs across the PTI measure set.

Allied Pacific formed a project team comprised of an executive champion, a primary care clinician leader, a project manager, and a HEDIS/Quality Care Improvement Team manager. The project team started with building infrastructure, including the foundational work of establishing relationships with low-performing, high-volume practices. The IPA emphasized building and spreading the adoption of centralized systems before jumping into intensive direct practice coaching.

Highlights from Allied Pacific's work included:

1. Focused IPA support on high-priority measures, rather than addressing all measures. While practices had access to all data, coaches opted to use one-on-one time to focus on a subset of measures important to both the IPA and the practice.
2. Re-envisioned support for practices via a new coaching program, such as:
 - a. Creating coaching roles among existing HEDIS staff. Allied Pacific also rebranded the HEDIS department as the Quality Care Team to reinforce its commitment to quality.

- b. Focusing coaching support on engaging low-performing and high-volume practices instead of using resources for practices that were already highly engaged.
 - c. Using a tiered practice engagement plan with specific coaching activities for each level of engagement. This ensured that limited coaching resources were deployed to practices where they could have the greatest impact (e.g., practices with a high volume of the PO's members). These practices had an opportunity to improve low performance and had demonstrated a readiness to work with coaches.
3. Invested in centralized data infrastructure and validation, including:
 - a. Identifying gaps in data flow (e.g., from individual practices to the IPA and then to health plan) and analyzing barriers to closing these gaps.
 - b. Developing an online provider portal that enabled sharing performance data and care gap reports, performance incentive opportunities, data collection for quality measures (e.g., exam results, colonoscopies, diabetes eye exams, discharge summaries), care team reminders, and identification of high-risk patients.
4. Expanded access to care for patients of small practices, focusing on:
 - a. Opening IPA-managed urgent care centers in geographies with a high concentration of small providers.
 - b. Providing after-hours coverage and care through a rotation of community clinicians.

Several factors contributed to Allied Pacific's success. Centralizing improvement within the IPA's HEDIS staff and rebranding that team reinforced the focus on high-quality care and improved outcomes. In addition, prioritizing lower performing practices with a high volume of the PO's members meant that gains within these practices had a larger impact on Allied Pacific's overall performance. Further, providing resources to meet the needs of high-risk patients – access to urgent care, care management and wellness services, care gap reports – offered additional support to practices to better able them to meet patient's needs. Finally, as leadership observed measurable improvements and milestone achievements, their engagement and support for this work increased.

Access the complete Allied Pacific Case Study [here](#).



Allied Pacific Aim Statement for PTI (created in June 2016)

To improve the care for over 250,000 lives in a diverse population faced with cultural challenges, Allied Pacific IPA will transform its care delivery to achieve better care and health to our members by improving the processes of care delivery throughout our PCP network on better access, integration of chronic disease management, and improved member satisfaction.

- Allied Pacific IPA will improve the following clinical outcomes by 10%:
 - Controlling Blood Pressure for Patients with Hypertension
 - Comprehensive Diabetes Care Measure Set
 - Emergency Room Department Visits

Learnings from PTI's Practice Facilitation Program

Given the central role that practice facilitation played in PTI, CQC developed tools that reflected its experience building practice facilitation programs across California. To directly support practices with transformation efforts, PTI invested in developing practice facilitators, also referred to as practice coaches, within each PO. PTI supported coaches and POs as they created new or strengthened existing practice facilitation programs through a range of activities. Support for practice facilitation was interwoven into the cloth of PTI. This included offering support through traditional technical assistance provided during in-person and virtual trainings. PTI focused on transformation concepts, evidence-based change interventions, practical tools, skill building, and educational resources. The team also established pathways to leverage the network and its experiential expertise through frequent and regular access to experienced improvement advisors and subject matter experts, peer networking opportunities for cross-pollination and best practice sharing, and elbow-to-elbow mentoring by Master Coaches to develop local expertise.

CQC designed a roadmap for organizations interested in building or refining their existing practice facilitation capacity. Described in more detail below, *Improvement Coaching: What Matters Most for Practice Transformation* highlights themes and concrete tasks that organizations wishing to build new or strengthen existing programs can use. CQC also analyzed the results of a short-term effort that worked to improve performance on diabetes measures among a cohort of small practices. This was accomplished by providing hands-on coaching from a local technical assistance organization that focused on data capabilities and data-driven decision making. This effort was referred to as Small Practice Engagement to Enhance Data or Project SPEED.

Improvement Coaching: What Matters Most for Practice Transformation

Improvement Coaching: What Matters Most for Practice Transformation is a roadmap to developing and deploying practice facilitators. It describes the elements that were central to the effectiveness of PTI's practice facilitation work, combined with specific examples and first-hand experiences from improvement coaches. It is designed to inform stakeholders – such as health care delivery systems and public agencies – of the key design features that contributed to the success. It also affirms and highlights the value of the practice facilitator, also referred to as an improvement coach or practice coach.

In analyzing PTI's practice facilitation activities, three themes were associated with success: building improvement infrastructure, engaging practices through collaboration, and investing in coaching mastery.



Theme 1

Build an improvement infrastructure to serve as the underpinnings for work moving forward. Infrastructure elements include:

- Constructing a firm foundation, such as a framework to manage improvement work (e.g., staffing model, reporting relationships, etc.), selecting an improvement model and tools, and establishing goals and measures to monitor performance.
- Defining the role of the improvement coach within the organization and establishing the core competencies that will equip a coach to be successful in improvement work. This work should also define what support new or existing staff taking on this role may require.
- Designing an impactful coaching model, which includes assessing the readiness of and need for coaching support among target practices and translating this into a coaching capacity assessment. A coaching model should include a menu of engagement activities coupled with a tiered engagement strategy to match practice needs, readiness and capabilities with right activities. The coaching model should also reflect practice-to-coach ratios and should include a practice engagement strategy.
- Making practice transformation a priority within an organization, as demonstrated by senior leadership support and a leadership-endorsed plan, clearly defined, advocates and champions, and organization-wide communication about the coaching program.

Theme 2

Engage practices, leveraging various communication and collaboration techniques:

- Developing the mindset of a servant leader, which is characterized by communication that fosters trust and facilitates collaboration, empathetic listening, and identifying the priorities of and barriers to improvement that the clinic and its staff have identified.

- Investing the time needed to build relationships.
- Walking care teams through the improvement process, including creating time and space for field work and demonstrating the application of tools and templates.

Theme 3:

Invest in coach mastery through the use of practical tools, skill building, development and/or use of educational resources, and providing expert advice. Coach mastery can be broken down into four categories:

- Providing access to technical assistance, including skills trainings, curated resources, a community of practice, peer support, one-to-one coaching, and personalized support.
- Learning and applying improvement methodology, which typically consists of aim statements, measures, data-driven improvement, theories for change and change ideas, and conducting Plan-Do-Study-Act cycles.
- Building skills for practice improvement through regular touchpoints (e.g., in-person and remote work), use of expert faculty, interactive facilitation, and small- and large-group learning). Providing elbow-to-elbow support can also enable participants to observe and dialogue with experienced practitioners, refine hands-on skills in a training setting, and use hands-on experience as the foundation for learning.
- Developing the practice coach through peer learning. These peer networking activities should include both internal and external opportunities. Internal networking can be used to perfect operational workflows or introduce new tools, while external networking can provide unique viewpoints and fresh perspectives.

The roadmap *Improvement Coaching: What Matters Most for Practice Transformation* can be accessed [here](#).



Project SPEED

The genesis for Project SPEED was the challenge PTI encountered in working with solo and small providers with contracts across multiple IPAs. While some practices with multiple IPA contracts had strong relationships, others had little volume within any single IPA. As a result, the IPA understandably prioritized its practice facilitation and other resources to practices with larger patient volumes. This meant that a subset of PTI practices were receiving limited support from the overall PTI model. To fill this gap, PTI designed a different coaching model, one that relied on third-party practice facilitators rather than those staffed within POs.

The design of Project SPEED also took into account other learnings of PTI. For example, interim analyses demonstrated that short-term and narrowly targeted coaching activities were more likely to be effective. As a result, Project SPEED was designed to provide practices a two-month coaching intervention focused on improving diabetes care through enhanced capabilities around and use of data.

The target measures for improvement included a mix of diabetes clinical quality measures from the PTI measure set and PAT milestones that related to the ability of practices to use care gap and performance reports to drive improvement.

Project Speed included the following activities:

- Recruitment of individual practices
- Completion of baseline PAT and a workplan diabetes assessment by each participating practice
- Coaching to support practices to better utilize their EHR and linkages to PO data portals to (1) design and produce panel reports related to diabetes care; (2) conduct small tests of change based on these reports; and, (3) complete a minimum of two data submissions on the diabetes clinical quality measures
- Completion of the follow-up PAT to evaluate improvement.

Recruitment was a significant focus of this effort. Criteria included: engaged practices with low performance on diabetes related measures; practices without existing capability in producing and using care gap and performance reports; and those lacking strong relationships with their contracted IPAs and that had not adopted centralized resources. Multiple outreach attempts were accomplished, using both in-person and telephone outreach.

Once practices were identified, coaches worked on practice level-changes. Coaches started by working with staff to establish the ability to create accurate diabetes care-related reports within the EHR across a practice's entire patient population. Coaches then worked to train staff to regularly produce reports. The final step focused on translating the results of those reports into practice-level changes that would result in improved patient care. For example, once patients who did not have HbA1c on file were identified, practice staff could develop a process to outreach to patients in order for them to get the test.

A total of 50 practices completed the project.

Results included:

- **PAT Milestone 16:** Nearly half of enrolled practices (24 count or 48%) scored a 0 or 1 at initial assessment. **At reassessment, all practices scored a 2 or 3.**
- **PAT Milestone 21:** More than half of practices (28 count or 56%) scored a 0 or 1 at initial assessment. **At reassessment, 17 practices (34%) scored a 2 and 32 practices (64%) scored a 3.**



The results of this work emphasized the importance of relationships to improvement work. It required a significant investment of upfront time for an organization, and its coach, to establish a trusting relationship with a practice before improvement work begins. In addition, CQC also found that a third-party coaching entity could be well-positioned for time-limited, intensive coaching within a narrow scope. As a result, improvement work doesn't have to rely on the usual employed and contracted relationships. Organizations can supplement their resources by contracting out, and this can give the organization the capacity to focus on its own high-value providers with whom they have pre-existing relationships.

The full Project SPEED report can be accessed [here](#).



Project SPEED

Measure Set and priority Assessment Milestones

Diabetes: Two HbA1c Tests

Diabetes: HbA1c Poor Control > 9.0%

Diabetes: HbA1c Control < 8.0%

Diabetes: Nephropathy

PAT Milestone 16: Organized, evidence-based care: Practice uses population reports or registries to identify care gaps and acts to reduce them

PAT Milestone 21: Transparent measurement and monitoring: Practice regularly produces and/or receives PO reports and shares reports on performance at both the organization and provider/care team level, including progress over time and how performance compares to goals. Practice has a system in place to assure follow up action where appropriate.

Conclusions

The PTI fundamentally changed the approach to providing technical assistance and support at a broad scale in California. The project established key components that are necessary to drive change and also demonstrated that this type of work, though intensive, is more than worth the up-front investment of resources. PTI yielded a total cost savings of \$186 million, equivalent to \$42,000 saved per PTI-enrolled clinician. The majority of savings related to avoided inpatient bed days and emergency department visits. See Figure 8.

Return on Investment



\$186 Million
in Total Cost Savings



\$10.11
returned to the health care
system for each grant
dollar awarded



\$42,000
saved per enrolled clinician

Figure 8

Resources

The PTI team has created a resource library that compiles tools, templates and materials that were shared and developed throughout the 4-year program:

calquality.org/resources/pti-resource-library

The library includes:

- Resources organized across PTI's six focus areas: engaged leadership, accessing and using data, practice assessment, practice facilitation, patient and family engagement and team-based care.
- Tools, content and resources that drive practice transformation at both the organization and practice levels.
- Additional external resources that were leveraged during PTI.
- Summaries of PTI successes and lessons learned.



To access all tools, resources and content developed over the life of PTI, visit our online resource library at:

calquality.org/resources/pti-resource-library

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PTI participants and staff during the final convening