Project SPEED

A Case Study in Demonstrating Impact in Coaching Strategies for Performance Improvement in Small and Solo Practices

December 2019

Project SPEED, A Case Study in Demonstrating Impact in Coaching Strategies for Performance Improvement in Small and Solo Practices was prepared for the California Quality Collaborative by Elevation Health Partners of San Diego, California, innovate@elevationhealthpartners.com.

The Pacific Business Group on Health PBGH's Member organizations -- private employers and public agencies -- are the most powerful voice for consumers and patients in the U.S. Ultimately, the profound concern of purchasers about the high cost and poor quality of healthcare puts them on the same side as the American public when it comes to driving improvement throughout the healthcare system.

The California Quality Collaborative (CQC) is a healthcare improvement organization dedicated to advancing the quality and efficiency of the health care delivery system in California.

The Practice Transformation Initiative (PTI) is a four-year initiative to engage 4,800 clinicians statewide contracted with provider organizations to improve measures of cost, quality and patient experience. CQC is one of 41 organizations nationally included in the Centers for Medicare & Medicaid Services' Transforming Clinical Practice Initiative (TCPi), which began in 2015. CQC partners with the Center for Care Innovations (CCI) and the Integrated Healthcare Association (IHA) to execute the program.

Elevation Health Partners is a Woman Owned Small Business California-based consulting firm that specializes in the development and execution of strategies to advance meaningful, measurable improvements in all areas of the health care delivery system. Elevation Health Partners is included in three TCPi's serving California providers.

Pacific Business Group on Health/ California Quality Collaborative

275 Battery St

San Francisco, CA 94111

Tel: (415) 281-8660

Email:

Website: pbgh.org | calquality.org

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Project SPEED Summary

In California, health plans contract with medical groups and independent practice associations (IPAs) on a capitated basis and delegate responsibilities to these provider organizations, referred hereafter as POs. Many of the small and solo practices (1-2 providers) in southern California have as many as 2-7 contracted relationships and consequently lower patient volume per provider organization. Lower patient volume can dilute the relationship and services between the IPA and practice.

This case study aimed to understand if intensive short-term, narrowly targeted coaching interventions by independent expert quality improvement practice coaches were likely to be more effective in achieving PTI aims than those staffed by POs for these "low volume" small and solo practices with multiple PO affiliations.

The Challenge

Deliver an intensive two-four month coaching intervention focused on improving diabetes care through enhanced capabilities around data use and capture insights and lessons learned on how to effectively engage with small and solo practices to achieve demonstrated results.

The Goal

The PTI engaged Elevation Health Partners, a leading consulting firm with local expertise in small practice quality improvement coaching to enroll up to 100 small and solo practices and achieve practice level transformation in data use and reporting and demonstrated improvement on select diabetes clinical quality measures. Project SPEED practice level goals are detailed below in Figure 1.

Figure 1, Project SPEED Goals Per Practice

Project SPEED is an initiative of the Pacific Business Group on Health (PBGH) and California Quality Collaborative statewide Practice Transformation Network, known as the Practice Transformation Initiative (PTI). The PTI is funded by the Centers for Medicare & Medicaid Services (CMS) as part of the four-year Transforming Clinical Practice Initiative (TCPi) designed to support more than 140,000 clinician practices nationwide to share, adapt and further develop comprehensive quality improvement strategies.

The Execution

From January to July 2019, Elevation Health Partners enrolled 50 small practices and conducted short, intensive practice coaching engagements averaging two to four months per practice and achieved and exceeded all program and practice level goals, capturing important insights in the opportunities and challenges small practices face in generating and using practice-wide panel and performance reports to drive improvement among three diabetes measures and two organizational milestones (***Figure 2***).

Figure 2, Practice Assessment Tool (PAT) Milestones

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 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.

POs were responsible to communicate the project to small practices, provide a warm hand off to assigned practice coaches in initial engagement, administer an incentive program, and respond in engagement escalation.

Hurdles

PO Support for Initial Engagement

The short timeline of the project challenged POs in meeting the project obligations. Challenges observed included delays in decision making, inconsistent communication among leadership and provider relations teams, lack of data engagement, and competing priorities. For the recruiting and engagement efforts, the POs were unable to provide the name of the practice point of contact and EHR system in use necessary for successful targeting, recruiting and initial practice engagement. Practice coaches were left to cold call practices. Most practices sought validation from their specific PO representative to validate the project effort before committing to participation. The minimum enrollment target of 50 practices was achieved at the cost of maximum enrollment.

Practice Level Understanding of EHR

Practices lacked understanding of how to effectively use their EHR system for population health management efforts and reporting and did not follow best practices for EHR adoption and use. EHR vendors were largely unresponsive within the short project timeline and small practices had difficulty effectively communicating and resolving data issues. Despite progress in EHR purchases that may have resulted from the Federal EHR Incentive Program, small and solo practices have not fully adopted the EHR with many not coding at the point of care. While 92% of Practices have an EHR, only 62% are charting at the point of care. No practices were able to generate accurate data for the diabetes clinical quality measures.

PO Portal Data Inaccuracies

Within the first few weeks of the project, the coaching team identified inaccurate data reporting in one of the PO portals for the entire comprehensive diabetes care measure set. Despite escalation through the project, the PO did not confirm data inaccuracies or commit to investigation or resolution.

The Team

Three Elevation Health Partners quality improvement practices coaches supported a total of 50 enrolled practices. Two PO organizations provided an organization point of contact and assigned practice provider relations staff to work with Elevation Health practice coaches. The overall project was supported by the Senior Manager for Practice Transformation at the California Quality Collaborative.

Metrics

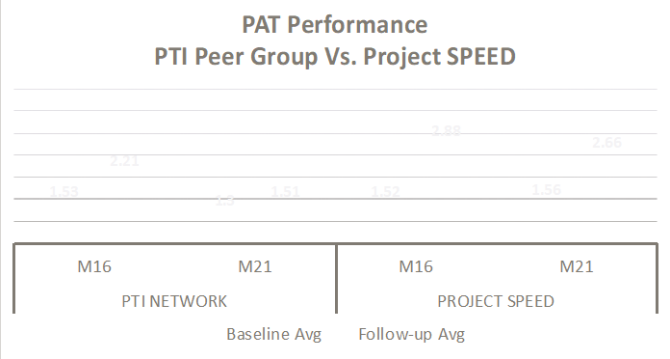
The coaching intervention aimed to improve performance on three diabetes clinical quality measures and advance maturity in Milestones 16 and 21 of the PTI initiative.

Practice Assessment Tool (PAT)

Project SPEED practices began with less capacity in these areas when compared with their peers within the network, but with the Elevation Health Partners coaching intervention, Project SPEED practices significantly outperformed the larger PTI cohort, see ***Figure 3, PAT Performance*** below. Baseline and follow up assessments were completed rating practices on a scale of 1-3 for

the two operational milestones with the goal of achieving a score of 2 for Milestone 16 for at least 75% of practices. Milestone 21, was also tracked.

Figure 3, PAT Performance



PDSA Interventions for Clinical Quality Measure Improvement

A core objective of Project SPEED was to practice a quality improvement intervention for CQM improvement. Coaches taught root cause analysis through fish bone diagraming and the Plan Do Study Act (PDSA) strategy.

All 50 practices completed a fish bone diagram and documented their intervention on a PDSA A3 template. A total of 70 interventions were implemented (***Figure 4, Figure 5***).

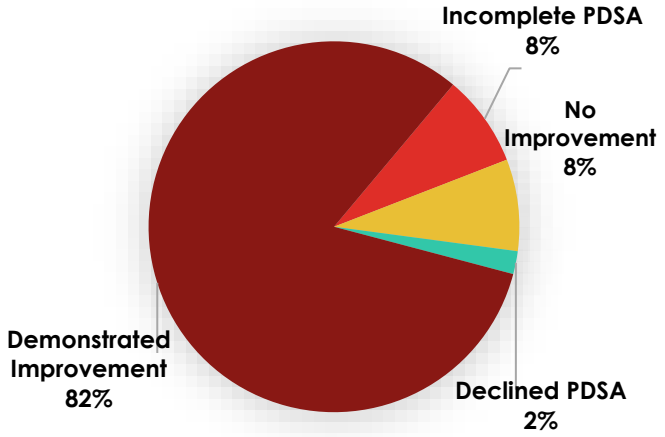
Figure 4: Number and Percent Interventions Demonstrating Improvement

CQM Outreach	49	70%
EHR Vendor and Data Engagement	1	1%
Portal Access only	8	11%
Portal Access and Reporting only	2	3%
Training	1	1%
Workflow Improvement	9	13%
Total	70	100%

Forty one (41) of 50 practices or 82%, demonstrated improvement on their planned intervention. All practices unable to complete the PDSA encountered a loss of data during the intervention period.

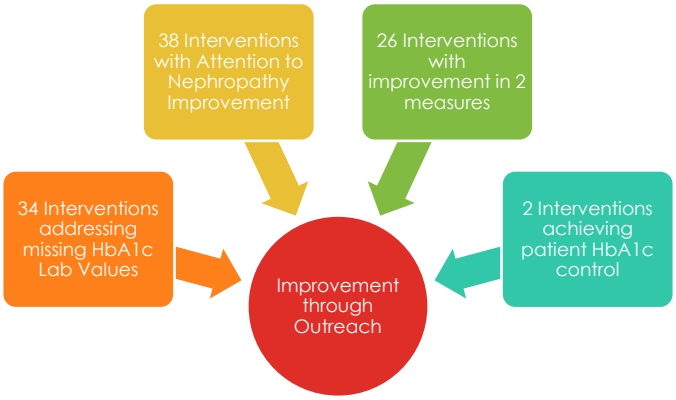
The majority of practices were able to leverage the PO portal to identify patients due for services and complete one or more basic CQM outreach interventions. All practices with a CQM intervention received extensive data reporting training and assistance from their coach to access and run reports necessary to design their CQM interventions. The interventions that addressed data and reporting challenges (11) and workflow improvement (9) helped to lay the foundation for future improvement efforts.

Figure 5: Key Interventions Outcomes



CQM Improvement Through Outreach

Interventions with passive outreach (form letter mailing) saw no improvement while tailored interventions that included personalized messaging and phone calls resulted increased visits and screenings.



Pharmacy Interventions

Two practices elected to test medication adherence interventions to improve HbA1c poor control that proved successful in bringing A1c under 9 in under three months. Practice coach Dr. Savitri Modi, PharmD, was able to demonstrate significant improvements in A1c

rates for 4 of 10 patients with improvement ranging from .3 - 3.3. The six patients in the cohort did not return to the clinic to get follow-up lab results.

CQM Performance Comparison to PTI Peer Group

The practice level data was known to be invalid for performance reporting. Combined with the short term engagement and lag time associated with PO level data collected, it was not possible to assess CQM performance of Project SPEED compared to the PTI Network Peer Group.

While 92% of Practices have an EHR, only 62% are charting at the point of care. No practices were able to generate accurate data for the diabetes clinical quality measures from the EHR.

Where to Start

1. Engage with POs and establish a PO planning period to assess and build PO capacity to support project initiatives and address data strategies.
2. Establish criteria for practice enrollment (EHR use, current performance on quality measures, geography, IT resources). Establish approaches to engage with practices to fully test project assumptions in the planning phase.
3. Develop practice responsibilities but allow these to develop over time as the practice demonstrates readiness.
4. Engage with local leading experts in practice engagement and improvement capabilities to build PO capacity or work directly with practices.
5. Conduct a baseline and follow-up assessment to measure project success.
6. Analyze data and evaluation project success and lessons learned.

Key Takeaways

Data Validity. Even in the face of significant data validity challenges, practices may be able to use PO portals and EHR reports to identify patients in need of services and follow up. For large scale impact, POs need improved strategies and resources to address small practice population health data and reporting needs.

PO Data Portals and Gaps in Care. Practices were more invested in the PO portal over their EHR for clinical quality reporting, believing it would more directly impact positive beliefs of practice performance and appropriate reimbursement for services rendered. PO data portals offer greater opportunity and efficiency to support practice population health strategies but improvements in data validity and overall portal strategy are needed. Practices are motivated and interested to engage when PO data sources are incorrect or not fully reflective of services rendered. POs are advised to avoid solutions that require duplicate entry or undermine the EHR as the primary source of data for services rendered and billed.

EHRs: Despite progress in EHR purchases that may have resulted from the Federal EHR Incentive Program, small and solo practices have not fully adopted the EHR, are not coding at the point of care, and need professional assistance to fully transfer from paper records. These practices are on record with the PO as having an EHR. Missing this deeper understanding, POs are offering support, training and services – such as coding training, in vain. Emphasis should be given to elevating EHR use to best practice for point of care data capture. The variety of EHR systems in use among small practices complicates solutions to improve EHR use.

PO Relationship. Coaches observed communications with practices and PO provider representatives. Often, communication appeared un-directional. POs may be hearing without listening. More attention is needed to leverage the important feedback and insights from small practices to improve overall network performance.

Clinical Quality Measures. Practices lacked knowledge of clinical quality measure numerator and denominator definitions. In one PO portal, the denominator among all of the measures within the HEDIS defined Comprehensive Diabetes Care Measure Set were consistently incorrect. The practices did not have the training or knowledge to identify this discrepancy. When shared, several PO provider representatives defended the definitions furthering misinformation.

Trainings and Population Health Management: The summary of trainings identified to support small and solo practices included best practice EHR use, population health quality improvement tools and techniques, EHR population health decision support, EHR chronic disease management tools, deeper understanding of clinical quality measure mechanics, generating population health reports, use of IPA portals, claim and billing submission, and best practices to effectively outreach to patients for gaps in care or test results. Improvements in these areas can directly impact screening and related measures and are necessary *before* practices can embark on clinical care strategies to improve HbA1c poor control.

Practice Coaching Model: Elevation Health Partners has developed a master practice coaching model to ensure successful practice engagement and project outcomes using active listening, adult learning, transtheoretical, and change management models, among other evidence based approaches. Fidelity to key elements of these practice coaching best practices are necessary to achieve breakthrough results. Practice coaches were able to establish consistent communication and engagement with each practice and gain deeper insights not typically secured by the POs.

Language Matters: Practices feel vulnerable with EHR reporting shared outside of the immediate practice staff. Mishandling of this discussion by the practice coach or "data seeker" can bring the entire engagement to a halt. Examples of tailored talking points include, "*Next week, we will look at those patients with the high A1c values and brainstorm how we might be able to bring them in to the office. Let's include any staff members you feel may have some good ideas to help us.*" rather than, "*We need to run a diabetic panel report.*"

Pharmacy Intervention. The pilot pharmacy intervention reduced HbA1c levels notably in just 2-3 months. This pilot was extremely small but suggests further investigation is warranted to develop strategies of bringing the pharmacist into the small practice care team. Recommended strategies include: optimizing medication therapy, training practice staff on evidenced based medication education, and providing direct patient medication assessment and education in consult with the primary care provider.

Sustainability of Results: Small and solo practices maintain very high daily patient volume and are limited in resources and staffing. Practices are fully engaged when the practice coach is onsite but struggle to follow through on even the smallest test of change (for example, outreach to just three patients) during the action periods in between practice visits. Little to no work happened between onsite visits. Further investigation is needed on the barriers and solutions (for example, staffing, training, incentives, penalties, methods, etc.) for small and solo practices to sustain population health and chronic disease management efforts independently.