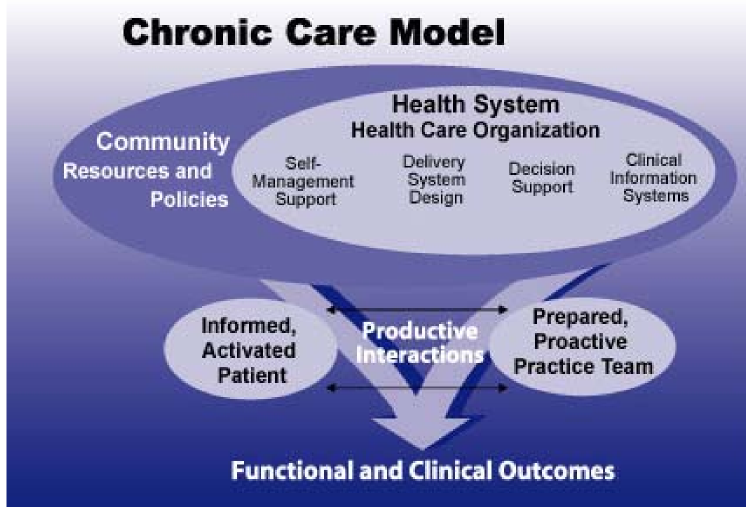
Chronic Care Collaborative

February 2011 – February 2012

CQC California Quality Collaborative *Breakthroughs for Better Healthcare*

Overview

The Chronic Care Collaborative is designed to assist physician groups and independent practice associations to measurably improve care for patients with diabetes and/or a cardiovascular condition within 12 months and thereby build or strengthen their infrastructure for managing other populations of patients. The 2011 collaborative participants chose to focus interventions on patients with diabetes.



Structure

Collaborative participants from five physician groups met for four on-site meetings to implement multiple changes based on the Chronic Care Model. In between the on-site meetings, CQC held webinars on related topics, conducted regular coaching calls, and two on-site visits to each site . The stated goal of the collaborative was that each group makes a meaningful difference in the care of patients with diabetes by strengthening systems for caring for patients living with chronic illness by demonstrating relative improvement of 20% or more on at least one diabetic measure.

Measurement

Each team reported data quarterly on three core measures and selected up to four optional measures for their patients with diabetes. Core measures collected during the collaborative were:

1. HbA1c Testing – Percent of diabetics with one test in the last twelve months
2. HbA1c Control – Percent of diabetics with HbA1c >9.0
3. LDL Testing - Percent of diabetics with one test in the last 12 months

Optional measures included:

1. HbA1c Control – Percent of diabetics with HbA1c <8.0
2. LDL Control in Diabetes – Percent of diabetics with LDL-c <100
3. Nephropathy Monitoring – Percent of diabetics with evidence of, or monitoring for, nephropathy
4. Blood Pressure Control – Percent of diabetics with BP <140/80

Participants

- Bakersfield Family Medical Center (BFMC)
- Desert Oasis Healthcare (DOHC)
- EPIC Management, Beaver Medical Group (EPIC)
- NAMM California/Mercy Physicians Medical Group (NAMM)
- United Family Care (UFC)

Interventions

Highlights of the interventions were:

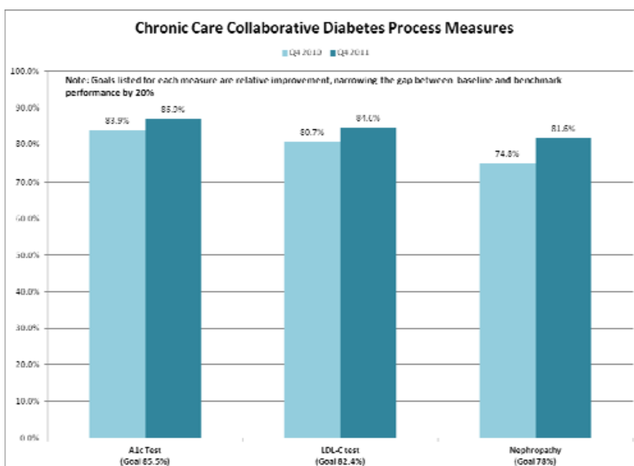
- Groups adapted information systems and refined reports to physician practices to make patient information more usable at the point of care and to give physicians feedback on practice performance.
- Practices made changes to use registries and lists to regularly recall patients with gaps in care or labs outside of recommended ranges.
- Groups provided incentives and public recognition for improved performance and shared best practices across the network.
- Groups provided clinical support through health educators and clinical pharmacists and provided helpful tool to practitioners to educate patients at the point of care.

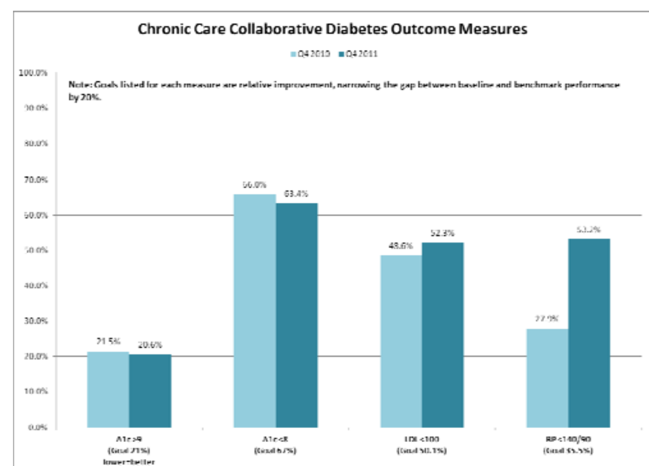
Each group selected and customized interventions based on the needs of the organization, available resources, and unique characteristics of the network practices.

Results

Outcomes of the collaborative will continue to emerge over time as teams spread changes to all practices. The groups set goals for selected measures to demonstrate 20 -30% improvement of the gap between 2010 performance and the IHA P4P 90th percentile for commercial plans for at least one measure by December 2011. Over the one-year collaborative, the results showed that participating physician offices made significant improvements including:

- Two groups exceeded 20% relative improvement goals for two measures.
- Two groups exceeded 20% relative improvement goals for four measures.
- One group exceeded 20% relative improvement goal for five of six measures.
- One group, United Family Care, mandated use of CPT Category II codes to record blood pressure and demonstrated over 90% compliant visit records during the follow-up audit.
- Aggregated results showed improvement in all measures except the A1c <8.0 measure.





Lessons Learned

- Active participation in this collaborative provided motivation to pilot test, measure, and spread changes according to the participants.
- A functioning registry is fundamental to improvement as it enables participants to measure performance regularly, assess the effectiveness of interventions, and to identify patients needing services.
- A key to success is to have a good communication plan to disseminate results at all levels of the organization and for the key team members to meet regularly both at the group and practice level.
- Competing priorities such as implementation of an electronic health record prevented spread from occurring as quickly as the organization would like. The plans recognized this reality and included active management of competing priorities into their work plan
- Some solo/small practices may not always be disadvantaged. They can implement changes quickly and delegate tasks to other practice staff.
- Development of a strong lead with excellent project management skills is critical to success both at the group and practice level.
- Use of evidenced based quality improvement models such as the Model for Change and PDSA cycles advocated by the Institute for Healthcare Improvement led to improved outcomes
- Data accuracy is critically important to provider outreach efforts
- Setting realistic goals based on the availability of organizational resources was critical to success.
- Persistence and follow through seemed to be more critical to success than great ideas.
- Well designed, thoughtfully implemented small financial incentives and non-financial incentives were very helpful in changing behavior.
- Engaging senior leadership was important to realize organizational change.

Spread

During the collaborative, participants became presenters and teachers and acquired communication skills they found valuable in presenting data to practices. Participating physicians who became champions within their groups spread changes and shared better and best practices to achieve high performance. Groups were able to pilot test and spread changes to all or most of each network by the end of 2012. They will continue to measure and monitor performance and have learned skills that can be applied to other improvement initiatives.

California Quality Collaborative would like to acknowledge the following organizations for supporting the program:

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