CASE STUDY

CQC'S PRACTICE TRANSFORMATION INITIATIVE

Palo Alto Medical Foundation Offers Lessons For Large Medical Foundations In Deploying Practice Transformation Efforts

CQC
CALIFORNIA QUALITY COLLABORATIVE
Breakthroughs for Better Health Care

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About CQC

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

- CQC generates scalable and measurable improvement in the care delivery system important to patients, purchasers, providers, and health plans. Its purpose is to identify and spread best practices across the outpatient delivery system in California.
- CQC trains more than 2,000 individuals from 250 organizations each year.
- CQC is governed by a multi-stakeholder committee and is administered by the Pacific Business Group on Health (PBGH).

Partner Organizations

The Integrated Healthcare Association (IHA) convenes diverse stakeholders, including physician organizations, hospitals and health systems, health plans, purchasers and consumers committed to high-value integrated care that improves quality and affordability for patients across California and the nation.

The Center for Care Innovations (CCI) is strengthening the health and health care of underserved communities. We cultivate innovation within organizations impacting care and services for low-income populations.

Program Model

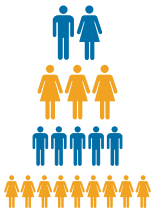
From 2016 through 2019, **the Practice Transformation Initiative (PTI)** engaged 4,400 clinicians contracted with 13 provider organizations to improve performance across a set of clinical and utilization measures in California. The program was run through California Quality Collaborative (CQC), which is hosted by Pacific Business Group on Health (PBGH) and was implemented in partnership with Center for Care Innovations (CCI) and the Integrated Healthcare Association (IHA).

PTI deployed a train-the-trainer model by providing robust technical assistance – including training and seed funding of practice facilitators, in-person quarterly convenings, monthly virtual learning sessions, individualized coaching, and data systems support – to the 13 provider organizations to effectively engage in transformation work with their practices. Care redesign at practice sites followed UCSF's 10 Building Blocks of High-Performing Primary Care[1] adapted for the small practice. Provider Organizations also evolved their centralized services and systems to meet the needs of small practices.

Improvement was tracked at the clinician, practice and provider organization levels for measures common across Value-Based Payment programs for Medicare, Commercial, and Medi-Cal payers. Data on PTI's 13-measure set was submitted quarterly on a rolling 12-month basis and shared back to the Provider Organizations through an online portal where participants compared performance within their organizations and to their PTI peers. Also, a bi-annual self-evaluatio. via the practice assessment tool was utilized and reflected progress and opportunities on transformation.

PBGH received funding for PTI through the Centers for Medicare & Medicaid Services' Transforming Clinical Practice Initiative which included 29 other programs nationally and ended September 2019. The PTI's network of clinicians was unique nationally, as 90% of participating practices primary care made up of 1 or 2 providers, representing a significant portion of the care provided by small independent practices in our state.

PBGH
PACIFIC BUSINESS GROUP ON HEALTH



90%
PRIMARY CARE
4,400
TOTAL CLINICIANS

[1]MBodenheimer 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.

PTI's Train-the-Trainer Model

To achieve improvement at a large scale among 1,900 practices and 4,400 clinicians across a state as large as California requires efficient dissemination of change ideas and best practices adaptable to diverse practice settings, geographies, populations, organization types, payment models, and delivery systems. The PTI's technical assistance approach was to focus technical support on teams at the 13 provider organizations – that represented widely different structures from employed groups to FQHCs to Independent Physician Associations – who could adapt change ideas and best practices for the clinicians and patient populations within their own networks, thereby cascading the learning from one level to the next. The train-the-trainer model accelerated learning through peer sharing that engaged an improvement collaborative of diverse provider organizations. By working with organizations across the State, there was also an opportunity to come together to collaboratively identify and problem-solve for common challenges facing all practices within California.

PTI offered several supports to the provider organization teams. PTI convened participating organizations on a recurring schedule: quarterly in-person convenings, and monthly virtual convenings. Two-day in-person convenings included knowledge-sharing, skill-building, performance stories, and collaborative problem-solving on common challenges. Monthly virtual learning events were tailored to different roles within organizations to build capacity through case-study sharing and learning; role cohorts included leadership, practice coaches, and data analysts. Also, each provider organization was assigned an Improvement Advisor from the PTI team who coached the leadership team and practice facilitators on strategies specific to their organization through frequent video calls and periodic onsite, elbow to elbow support.

At the foundation of all learning events is an evidence-based framework of adult learning principles and methodology, known as Dialogue Education, to maximize engagement through learner-centered design, active decision-making and achievement-based objectives. The PTI modeled learning events and content design for organizations to carry out their own local events, as well as provided direct training to participants in designing meetings using this methodology. In addition, PTI 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. Over the course of the project, the arc of learning shifted from externally-focused to network-driven. Initially, the 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 the provider organization participants leading their peers through collaborative activities and sharing expertise and experiences of practice transformation. Participants exhibited a deep engagement with learning that was noteworthy and more than has been witnessed in other collaboratives.

A Scalable Practice Coaching Model

California's heavily delegated model means hundreds of intermediary organizations, such as Independent Physician Associations (IPAs), that contract with and support the thousands of very small, independent practices that provide care to a substantial number of Californians. Originally formed to contract with health plans on behalf of clinician practices, many of these organizations were new to quality improvement and transformation work. The PTI helped these organizations build infrastructure and capacity to support QI and practice transformation beyond the life of the program.

Through PTI, provider organizations hired practice facilitators (or repurpose existing staff) who the PTI team trained in the model for improvement, practice facilitation skills, the 10 Building Blocks of High Performing Primary Care, change management frameworks and tools, communication, and many other technical skills. Those practice facilitators then coached their own provider organization's practices on the many facets of practice transformation. The PTI trained more than 80 practice facilitators across the 13 provider organizations.

The PTI's Participating Provider Organizations:

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

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

CASE STUDY PURPOSE

This case study describes the **Palo Alto Medical Foundation (PAMF)** approach in PTI. PAMF is an example of a large multispecialty system with strong centralized structures and services and includes large, well-resourced practices already performing very well on most clinical care measures. Despite performance already at or above the 90th percentile on many measures, PAMF improved performance further while addressing their largest issue: clinician burnout. Key lessons from their experience in PTI could apply to other large, integrated systems involved in similar practice transformation efforts.

Another case study offer profiles of an Independent Physician Associations (IPAs) that participated in the PTI and the contrasting approach they took in their own practice transformation work. That can be found on our PTI Online Resource Library **here.**

PROVIDER ORGANIZATION DESCRIPTION

PAMF is a large multispecialty ambulatory network with care sites located throughout the San Francisco Bay Area, including across Alameda, San Mateo, Santa Clara and Santa Cruz counties. It is comprised of about 1,000 clinicians caring for about 1 million patients annually. PAMF is part of Sutter Health, a large integrated delivery system operating across Northern California.

PAMF came into PTI as one of the highest performing provider organizations in the state of California, demonstrating performance at or above 90th percentile benchmarks on many of the measures in the PTI measure set. PAMF decided to include all its primary care clinicians and care sites across its system in PTI, which involved about 325 primary care providers at 27 care sites. The organization is well-resourced, highly organized, and deploys many systems and services centrally. Also, PAMF underwent a Lean transformation several years prior so had well-developed visual management systems across all care sites, standard work for many care processes and highly trained teams at all levels to deploy improvement work.

AIM STATEMENT

Despite PAMF's many strengths described above, the organization was undergoing a crisis of burnout on the part of clinicians and care teams and was looking for support with pockets of newly emerging experiments to transform care, as well as ongoing quality improvement efforts across the system. Reflecting this reality, PAMF formed a project team for PTI in early 2016 that included executive champions, primary care clinician leaders and a project manager, and formulated the following aim statement for their participation in PTI:

> *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.*

IMPLEMENTATION

Understanding that the burnout problem was most acute in PAMF's primary care practices, the leadership chose to embed ownership of the work in primary care operations, with close coordination and involvement of the quality leaders in the organization. Also mirroring its centralized structure, PAMF hired a skilled project manager with experience in healthcare and whose previous role was within the Sutter system. This person was housed in the primary care operations and tasked with identifying quality initiatives currently underway across all 27 primary care sites. The project manager also spent time observing and shadowing the San Carlos Internal Medicine Department which was at that time piloting the Care Model Transformation (see box on page 11) for eventual spread across the system.

The role was also responsible for deploying and collecting the Practice Assessment Tool, the 27-item survey that CMS required be administered every six months for all practices participating in the program. While initially deployed as a tool to simply measure baseline and then progress on specific change interventions, PAMF leveraged the survey and data collected through it to uncover variation, jumpstart learning and focus leaders on areas of strength and weakness. The project manager spent time in each site with the practice manager to orient them to the tool and then held group sessions so that assessment completion could also be a learning and peer sharing opportunity across primary care sites at PAMF. After the baseline assessment was completed in November 2016, the project manager convened some of the clinician champions to discern which of the 27 items were performed by centralized PAMF departments and functions, and then decide how to score those items across the sites. As a result of that process, the team identified 10 items that were truly practice-level processes at PAMF and that should be scored individually by each site. The table on the next page shows the 10 items and their respective domains in the assessment.

PAMF's assessment items, or milestones, scored independently by each practice

Assesment Milestone	
Domain	**Results related to Aims**
1	Practice has met its targets and has sustained improvements in practice-identified metrics for at least one year.
2	Practice has reduced unnecessary tests, as defined by the practice.
3	Practice has reduced unnecessary hospitalizations.
Domain	**Patient and Family Engagement**
4	Practice can demonstrate that it encourages patients and families to collaborate in goal setting, decision making, and self-management.
5	Practice and/or provider organization has a formal approach to obtaining patient and family feedback and incorporating this into the QI system, as well as the strategic and operational decisions made by the practice.
Domain	**Team-Based Relationships**
6	Practice sets clear expectations for each team member's functions and responsibilities to optimize efficiency, outcomes, and accountability.
7	Practice has a process in place to measure, or analyze existing data, and promote continuity between a patient and his/her care team so that patients and care teams recognize each other as partners in care.
Domain	**Coordinated Care Delivery**
13	Practice and/or provider organization follows up via phone, visit, or electronic means with patients within a designated time interval (24 hours/ 48 hours/ 72 hours/ 7 days) after an emergency room visit or hospital discharge.
14	Practice clearly defines care coordination roles and responsibilities and these have been fully implemented within the practice.
Domain	**Quality Improvement Strategy**
20	Practice builds QI capability in the practice and empowers staff to innovate and improve.

PAMF's dedicated project manager also cascaded information and resources from the PTI convenings and trainings across the primary care sites. For example, she put the train-the-trainer model into action by replicating a powerful training activity, called *Share the Care* (developed by **UCSF's Center for Excellence in Primary Care**), to demonstrate a fundamental concept of Team Based Care. Using the materials from the Team Based Care training through PTI and in collaboration with the PTI Improvement Advisor assigned to PAMF, the activity was revised to more accurately represent roles and care tasks most common across the PAMF primary care sites. The project manager leveraged a pre-existing meeting of all the Primary Care Directors and including the Executive Sponsor to deliver the training. Directors were provided the materials to further cascade the activity across all the primary care sites as a way to lay the groundwork for eventual spread across the system of PAMF's Care Model Transformation.

Additional infrastructure at PAMF that supported the improvement work included a Sponsors meeting at a regular cadence where the project team, including the executive sponsor and all clinician champions, would meet to discuss project status and review data. This group used standard work for each meeting developed through its Lean transformation to create structured dialogue that moved the group to action. The Sponsors group was crucial for maintaining leadership engagement in the work and support for the experiments and QI initiatives happening at each care site.

Care Model Transformation

One of PAMF's experiments to transform care and solve burn-out was in its early stages when PAMF joined PTI in 2016. It was called Care Model Transformation and reflected the tenets of Team Based Care developed by Bodenheimer, et. al. in the 10 Building Blocks of High-Performing Primary Care. PAMF first selected a pilot clinic with a strong physician champion, with whom they worked to recruit patient co-designers, and together developed the Care Model Transformation prototype. The new model redistributed care responsibilities across an integrated team, alleviating the load from the MA and MD. The initial MD/MA dyad was expanded to a pod, which included a full-time NP or PA, a shared LVN, and a shared social worker. A Cell Lead (MA) was also added to the clinic to manage the operations and provide some administrative support to alleviate the MA and MD. The clinic ran many experiments on new care processes across the expanded team until coming to a functional, stable model. Insights from the team that implemented the team-based care pilot include:

- Engaging closely with the practice manager and site director, who offered important insights into the practice's staff and culture, was critical. They knew what would be feasible to implement and what would not work
- Including patient advisors in the design session was a major contributing factor, as they had ideas about the model that the project team would not have considered
- MAs felt that their time was being better used, which engaged them more in their work
- Creating a culture of transformation was crucial as the team was actively running PDSA processes, and learning and adjusting based on their findings. Specifically, daily huddles with the right people; constant communication really made a difference in understanding what was working and what needed to be adjusted
- Having a strong physician champion helped as he served as the voice of his provider colleagues as well as the voice of the project team. He was also an important driver for buy-in throughout the practice, and served as the point person for needs or concerns as changes were being implemented

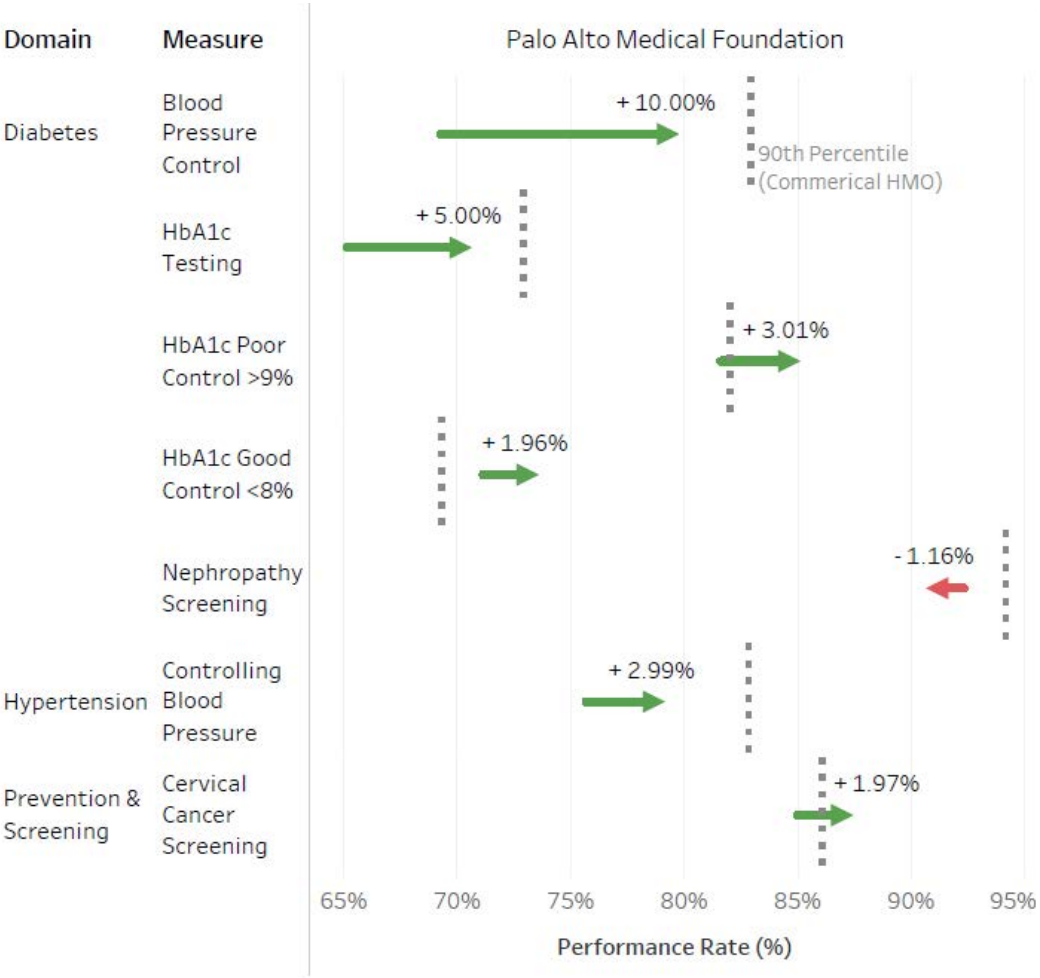
Data was collected throughout the Care Model Transformation development cycle and showed improved patient experience, reduced provider burnout, and increased staff satisfaction. Importantly, the pilot clinic experienced virtually no staff turnover for a multiple year period once the model was fully implemented. PAMF is in the process of spreading the model across the system to all primary care sites.

An Innovation to Share the Care: Multidisciplinary In-basket Support Team (MIST)

Along with the Care Model Transformation, PAMF was running other pilots to alleviate the burden on the MD/MA dyad and distribute work across a broader team. An intervention tested first in 2018 in PAMF's Watsonville Family Medicine practice is called Multidisciplinary In-basket Support Team, or MIST. MIST is a concept born from clinical grassroots and leadership brainstorming to find a solution to the in-basket problem and meet patients' needs. PAMF's primary care clinicians have been experiencing what PCPs across the country voice as the most difficult part of their jobs: the continually increasing amount of electronic care time, much of which does not need a physician. PAMF clinicians were seeing more than 100 patient items arriving to their EHR in-baskets daily, requiring hours of night and weekend work and contributing to high levels of burnout. The innovation behind MIST is it offers a way for much of the in-basket volume to be resolved offsite, rather than by the practice's onsite team of physicians and MAs. Also, MIST creates a virtual team with varied clinical licenses, such as advanced care providers and pharmacists, so all members of the MIST team and the onsite practice team are working to the top of their clinical scopes. The remote MIST team uses protocols developed and vetted by the care teams to route or resolve messages coming to the physician's inbasket. MIST only routes messages to the physicians that require their clinical level of care to resolve, thus opening up physician time to patient care. MIST also allows for consistent, timely, virtual patient care and improved outcomes. For example, the pharmacist checks the A1C level before refilling diabetes medicines and if not well-controlled, the pharmacist calls the patient to see if there are medication barriers and adjusts the medicine and sets up a follow up appointment with the patient's PCP to check if working. MIST has shown a 25% reduction in the volume of physician in-basket work for the Watsonville Family Medicine Practice and is being spread to other primary care sites in the system.

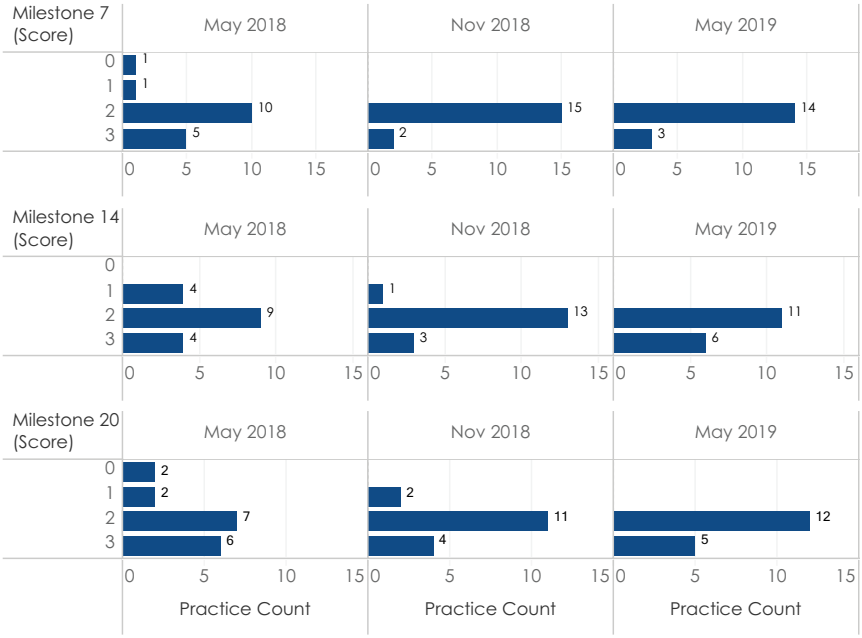
While PAMF was already performing close to benchmark on many of the clinical outcome measures in PTI, the primary care sites involved in the program managed to still improve their performance over the course of the 4-year program. The graphic below shows change (absolute, not relative) from baseline to final measurement on the diabetes measure suite and the cervical cancer screening measure.

PAMF Improvement in Patient Outcomes & Processes of Care (2015-2019)



As shown above, PAMF now performs above the highest benchmark on 3 measures and improved 10 absolute percentage points on an important outcome measure for patients with diabetes (blood pressure control). While it's not possible to directly attribute all of this improvement to PAMF's participation in PTI, there is a strong case to be made for PAMF's approach to its transformation work driving system-wide improvement. Also, the same levels of improvement on these measures were not seen in the other medical foundation participants in PTI.

Also, PAMF's approach to surfacing and then addressing variation across primary care practices using data from the Practice Assessment showed some compelling results. Over the course of the latter two years of the program (2018-2019), a number of the assessment items showed an improvement in consistency of scoring across the practices. The table below shows examples of how for three of the practice-level care processes the range of scores became much smaller, meaning the practices were implementing these processes in a more consistent way over the 2-year period.



Finally, PAMF received national recognition through the CMS Transforming Clinical Practice Initiative, first through a patient and family engagement award for its efforts to include patients in the design of the Care Model Transformation, and then through a national conference for its exceptional performance on quality measures. The spotlight on these innovative pieces of work within PAMF would certainly not have occurred without the organization's participation in PTI and had the benefit of increasing the visibility of the efforts within the PAMF and Sutter Health enterprises.

Milestones

Milestone 7: Practice has a process in place to measure, or analyze existing data, and promote continuity between a patient and his/her care team so that patients and care teams recognize each other as partners in care

Milestone 14: Practice clearly defines care coordination roles and responsibilities and these have been fully implemented within the practice.

Milestone 20: Practice builds QI capability in the practice and empowers staff to innovate and improve.

APPLICABILITY FOR OTHERS

Reflecting on PAMF's progress during its four years in PTI, key highlights of the organization's approach to the work are important to note and could be lessons for other large medical foundations undertaking similar efforts:

- By mirroring its own centralized structure in its approach to PTI, PAMF created an organizing framework, infrastructure and role to connect and track all quality improvement efforts across its primary care sites
- Engagement of a consistent executive sponsor along with multiple clinician leaders from primary care practices from beginning to end of the program was crucial. The leaders had lines of sight to improvement work happening within their own practices as well as across the system and were able to help connect initiatives that would have otherwise been siloed
- PAMF leveraged the Practice Assessment Tool as a way to surface – expectedly or unexpectedly – where variation might be happening in care processes across their 27 primary care sites. They also wisely used it to bring together practice managers who, while walking through the survey question by question, ended up discussing and sharing best practices, unearthing resources and voicing shared challenges to escalate to leadership

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