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Hill Physicians, an IPA in Northern California, represents 7 health plans in caring for approximately 400,000 HMO members in a network of 2500 physicians, 778 of whom are PCPs. For several years the IPA has published physician quality profiles and rewarded physicians quarterly for superior outcomes on P4P measures. To expedite advances in clinical improvements Hill had, over the past several years, repeatedly mailed lab slips to patients on behalf of its providers, instituted group appointments and teleclasses and offered disease management programs. Having garnered the “low hanging fruit” in late 2005 we chose to join the PBGH Breakthroughs in Chronic Care Collaborative and to target four offices to test and to operationalize additional office-based changes to improve diabetes outcomes and physician and office staff satisfaction. The BCCP collaborative’s ideas coordinated nicely with our IPA’s pre-existing objectives. These included expanding: group appointments, in-office physician-led classes, use of action planning with telephonic follow-up, placement of one-on-one health educators in MD practices, instituting POS reminder systems and outreach strategies, mandating routine pre-visit labs and paperless lab orders, leveraging online communication between physicians and patients, increasing access to ancillary providers (RDs/CDEs) implementing depression screening, increasing focus on BMI’s and smoking counseling, and implementing a disease (starting with diabetes) registry.

As we plan to exponentially increase implementation of the above strategies, the BCCP collaborative taught us about using health educators as change agents, allowed us to develop physician champions for spread, and gave us the skills to start our own collaborative (scheduled for Dec ‘05 with 15 additional practices). Over the course of the collaborative, the four offices improved A1c screening rates (from 84% to 92%) and LDL screening rates (74.2% to 82.4%) The percent of diabetics with LDLs below 100 increased 30% and blood pressure measures became available for tracking for the first time in our system. The appropriate use of smoking screening and counseling increased and action planning became a standard part of diabetic (and other) visits.

As it is unreasonable to expect physicians to attend a workshop and then implement the ideas presented without additional support, we made Hill’s staff health educators available to assist in prioritizing, implementing, problem-solving and, in some cases, *nagging* to assure start-up and continuation of new practices. These staff members also “cold call” or “detail” non-BCCP offices to excite them about trying care innovations and to solicit them for participation in the next collaborative. Ways they assist the vanguard practices include: providing data, assisting with one-on-ones or group appointments during start-up, supplying materials and insights, and most importantly, listening, being enthusiastic, advocating for the practices, and acknowledging achievements as well as the difficulties of change. Hill used its health educators in this role because they were the staff available to the Director of Integrated Health and improving clinical measures was

among their objectives; but any staff with the right training and temperament could act in this role. Having some IPA staff devoted to acting as change agents is important. That the four vanguard offices were enrolled in the BCCP gave the staff access to these providers in ways that are normally difficult due to office politics and the challenges of physicians' schedules. This also allowed the IPA and the provider offices to learn together and to make mistakes -- getting a second chance when often, with busy physicians, one mis-step and the IPA staff loses its credibility. Involving the office staff who will be impacted by the changes at the physician offices also is crucial. A willing office manager and MA can make or break change efforts. At our next collaborative we will require their involvement at meetings.

Since physicians like to learn from physicians, we selected physicians for our vanguard attempt those whom we thought were early adopters, respected by their peers, natural leaders (but who had been untapped by the IPA for other leadership initiatives as we did not want to burn them out) and providers willing to present to other physicians at our quarterly panel meetings. We will use the same criteria for our next 15 offices... along with, of course, the number of patients in the practice with diabetes and the insights of other internal departments in the IPA, such as Practice Support, Network management and Clinical Support (pharmacy). We believe continuing with early adopters remains important until we are closer to the tipping point, have more outcome data, and can use less intensive approaches to implement new delivery systems. We already are being approached by this cohort rather than having to sell them on changes. This is encouraging given our inability to detail 778 PCPs as intensively as we are doing at this point! For example, 35 practices are now doing group appointments even though only four practices participated in the BCCP.

The collaborative participation has been fun as well as productive and our providers are energized by the changes in their offices. We have raised the bar clinically (i.e., measuring for 2 A1cs annually rather than one.) We believe we are heading in the right direction in making office-based change the focus of our health education department (rather than pamphlets, classes at community locations, and more traditional health education roles) and are influencing other internal departments to consider this as well. Since most of our PCPs are not exclusive to Hill Physicians, we realize that all of their patients, not just Hill's enrollees, are benefiting from our efforts. We are eager to see other medical groups in our area join us in our vision and in our efforts.