BCCP Breakthroughs in Chronic Care Program

Building an Infrastructure to Support and Accelerate Regional Performance Improvement

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CA Breakthroughs in Chronic Care Program

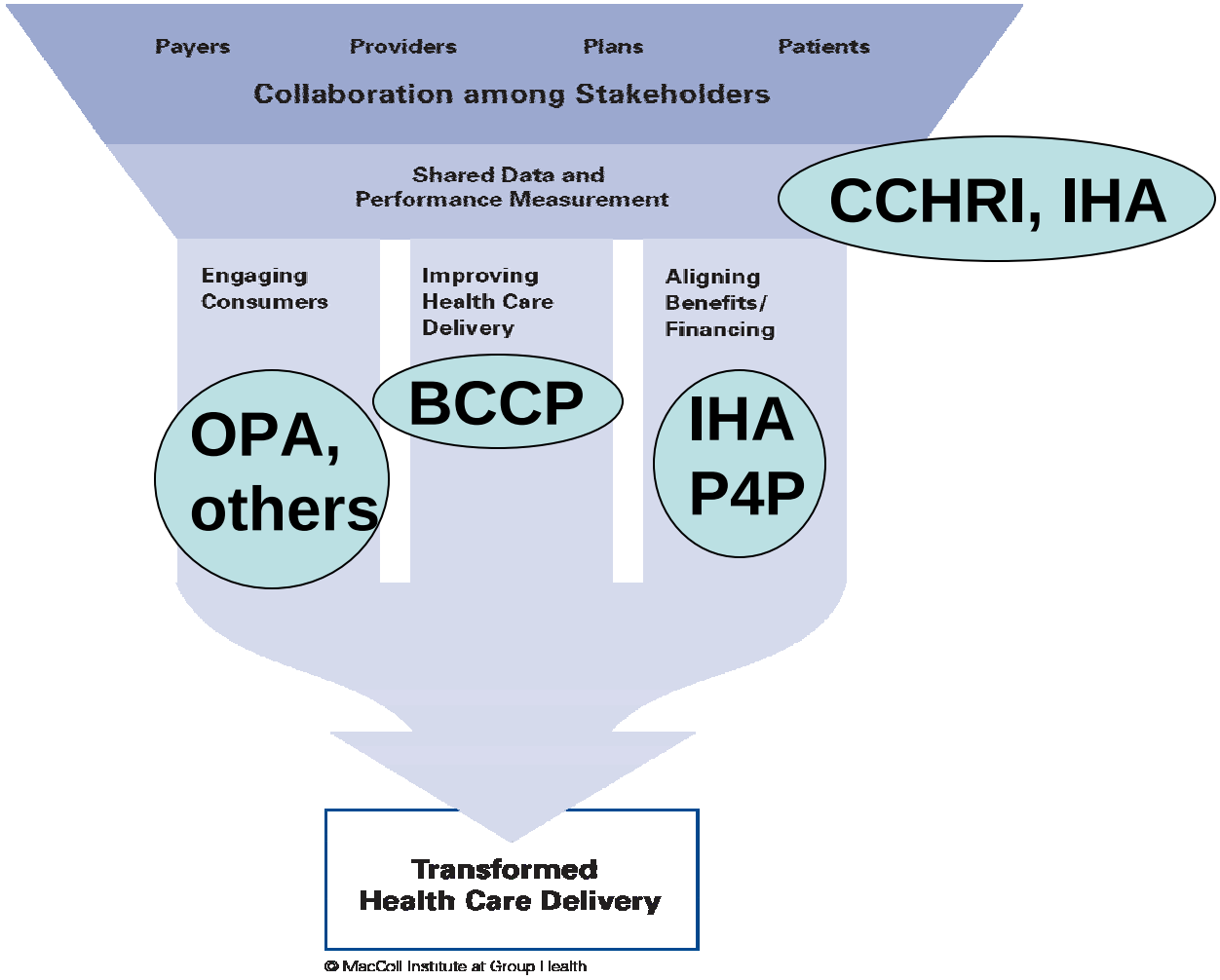
Will $ alone drive change?

- Unclear how to earn the money
- *System* problems are a big barrier to improvement
- Incentives to a single MD often are small
- Physicians not motivated only by $
- Doctors learn best from colleagues, esp. in a non-threatening environment

A Framework for Improving Care Across a Region

Transformed Health Care Delivery

California Landscape



The Preconditions For Change…

1. “Will” = “Why” change

- Business and clinical benefits – Pay for Performance is key

2. “Ideas” = “What” to change

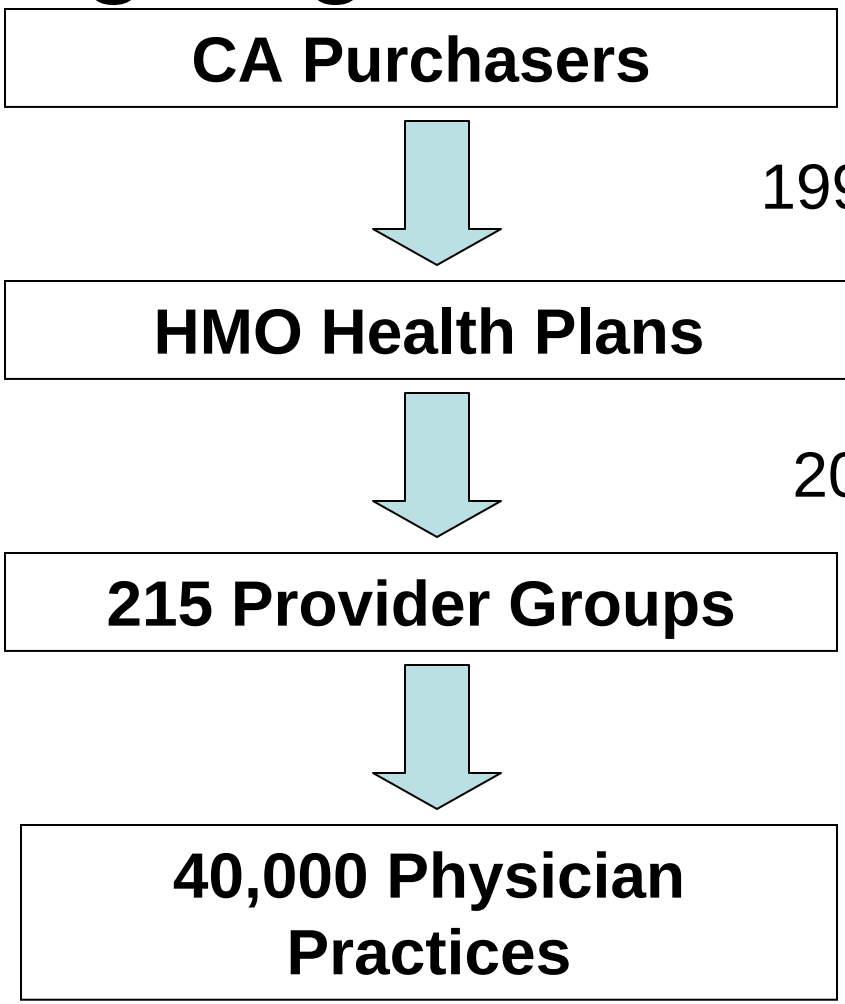
- What are the key process changes that make a difference in performance?

3. “Execution” = “How” to change

- How do organizations/practices (re: adults) change?

Taken from IHI

Aligning Incentives for Quality



1993: Performance Guarantees

2003: Pay for Performance

Physician Incentives

One IPA's Physician Incentive Program

- Primary care physicians rewarded for care to 400,000 patients
- Measures are: clinical quality, patient satisfaction, utilization, participation.
- 15% of total PCP compensation:

Quarterly distribution amount:	$3 Million
Average check per practice:	$9,800
% of practices receiving PMF:	84%

- Substantially exceeds physician group P4P bonus

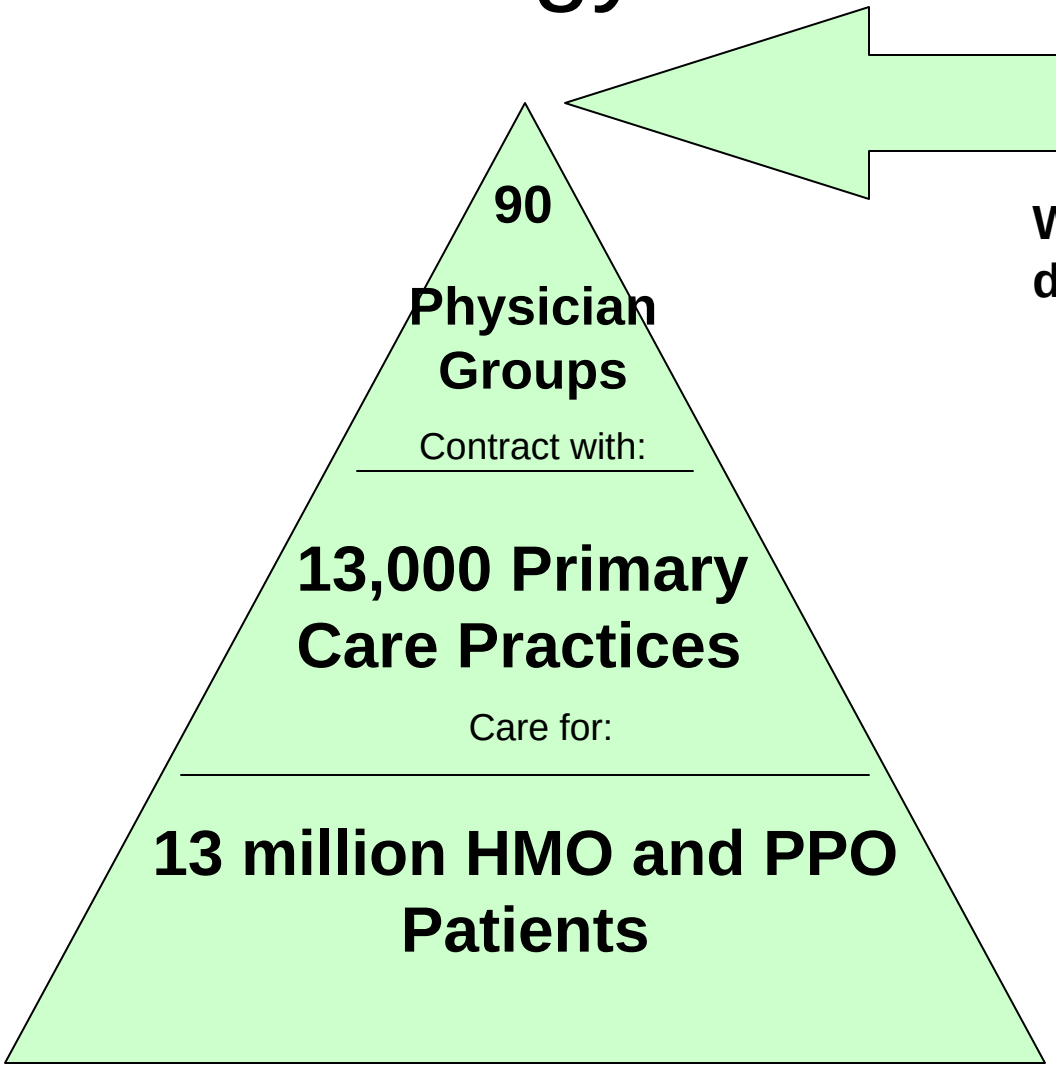
Breakthroughs in Chronic Care

- Offers education and training programs to provider organizations
  - Various convenings: IHI model collaboratives, regional facilitation of ideas; curriculum at CAPG annual meeting
- Target audience is medical groups
  - Secondary audience is physician practice
- Steering Committee sets priorities
  - Comprised of medical groups, plans, purchasers, academics and public health representatives

BCCP: History and Rationale

- Grew out of narrower CA Diabetes initiative
- Supported from the start by like-minded senior people in key organizations
- Increased interest with rise of P4P
- Developed partnership with CAPG (non-profit trade association of the provider groups)
- Looked to ICSI as a model
- Initially funded by pharma, now wider array of financing streams

CA Strategy for Changing Practice



What groups can do that most doctors can't:

- **Coordinate care across settings and offices**
- **Hire staff to implement change**
- **Hold colleagues accountable**
- **Gain access to innovations in care**
- **Invest capital for IT systems (EMR/registries)**
- **Offer financial incentives**

Program Offerings

- Education and training programs to provider organizations
- Change Packages
- Various convenings
  - IHI model collaboratives
  - Regional facilitation of ideas
  - Curriculum at CAPG annual meeting
- Target audience is medical groups
  - Secondary audience is physician practice

Where Do The Ideas Come From?

At the practice and the group

- Taken from literature and example elsewhere
- Concrete high leverage changes
- Proven within California delivery systems

Improvement Knowledge

Change Packages for the 6 IOM Aims, plus…

2007

- Clinical (Effectiveness)
  - Including chronic care and clinical IT
- Patient Experience (Patient-centered, Timely)

2008

- Efficiency
- New Delivery Models to extend primary care

2009

- Culturally Competent (Equitable)
- Safe

What Do We Mean By "Change Package?"

Patient Experience Example:

Key Changes	Practice	Group
MD-Pt Communication	• Shared visit agenda setting • Warm Greeting • Empathy	• Regular practice level pt. experience surveys • Practice site Customer service training program
Coordination of Care	• Inform pts. of all tests • Create/review medication list • Review consults before entering room	As above, plus: • Offer tools to track medications

Organizational Factors Supporting Quality Care

- Strategic values and leadership that support long term investment in managing chronic diseases
- Well aligned goals between physicians and corporate managers
- Investment in information technology systems and other infrastructure to support chronic care
- Use of performance measures and financial incentives to shape clinical behavior
- Active programs of Quality Improvement based on explicit models

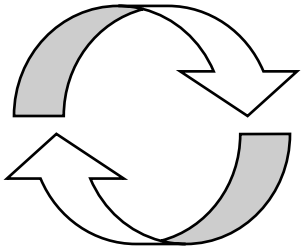
*King's Fund Study

Key Changes on Both Sides of the Equation

Strategic

The *"Hows"*

1. **Leadership and culture**
2. **Improvement infrastructure**
   - **Staff to support practice change**
   - **Improvement skills/methods**
3. **Change management**
   - **Network spread**

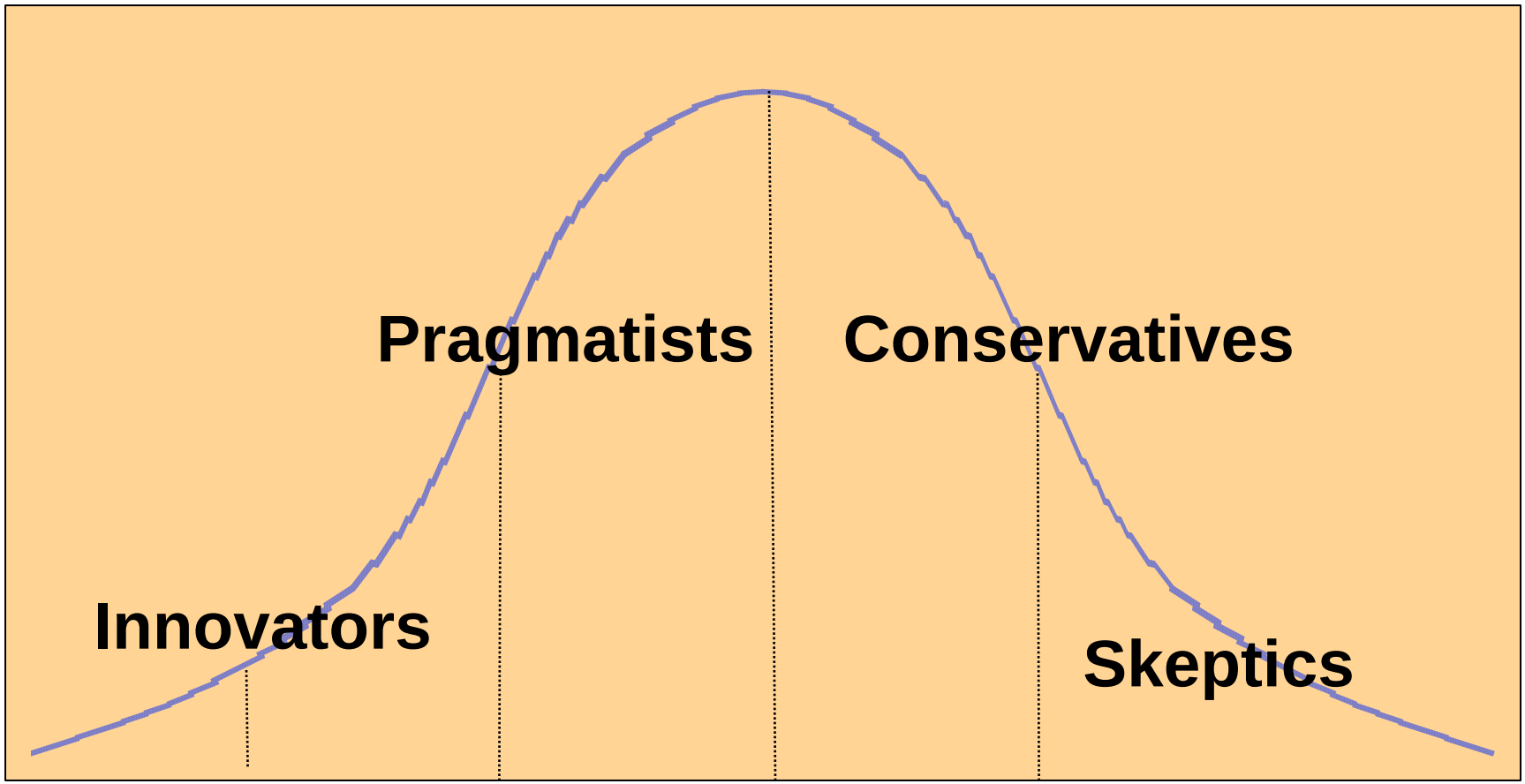


Tactical

The "Whats"

1. **Patient Experience**
2. **Clinical outcomes**
3. **Efficiency etc.**

How Do We Raise All Boats?



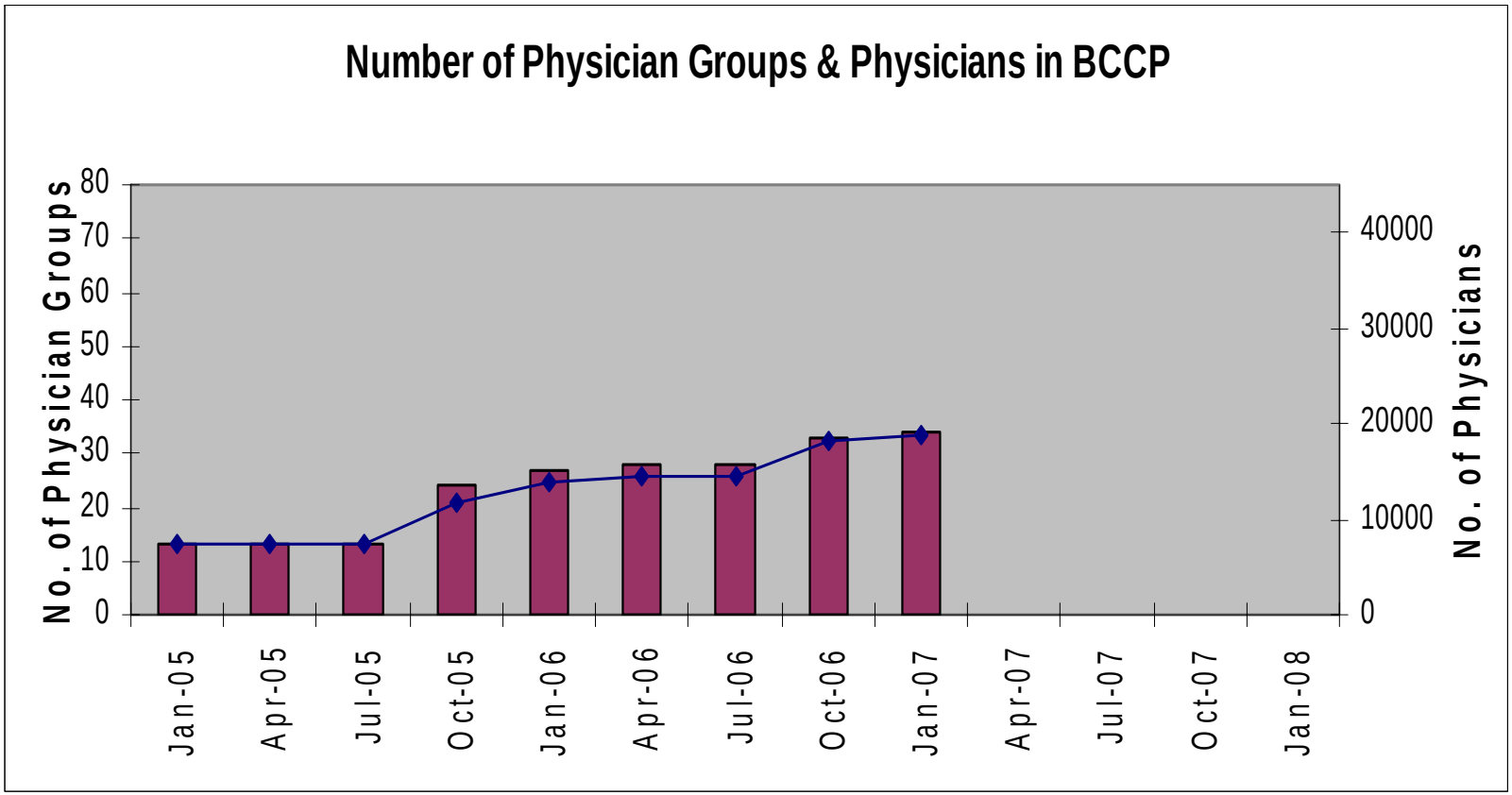
Execution

- Training
  - OPS – Strategic and tactical change for leadership teams
  - Improvement skills
  - EHR Implementation
- Pragmatist/Conservative Groups
  - Go local
  - Get Tactical
- Innovator/Pragmatist Groups
  - Focus on strategic change/spread within group
  - Build Learning network
  - Use as coaches for others

Programs To Date

- DM/CAD Collaborative
- Optimizing Performance Series
  - Performance Improvement for executive teams
- Optimizing EHR Implementation
- Patient Experience Collaborative

Engagement: Target largest 80 Physician Groups contracting with 45,000 physicians



Lesson Learned

- Financial incentives link well with quality improvement training; strong synergy
- Organizational capacity for change often most important predictor of improvement
- Engagement beyond the early adopters is hard work
- Collaboratives are good for some things, but not others

Lesson Learned

- Trust among leaders of competing or contracting organizations very important
- Localized and personal outreach more effective than wide distribution lists
- Groups and practices are at very different stages, and need a spectrum of assistance offerings