# Working Together:
## Collaborative Boosts Quality in the Santa Cruz Safety Net

California HealthCare Foundation



### Introduction

This report describes Santa Cruz County's experience with a Breakthrough Series (BTS) learning collaborative among safety-net clinics that operate within the same community. The main purpose of the collaborative is to advance a coordinated safety-net system of high-functioning patient-centered medical homes (PCMH). The report includes data on improvements in clinic performance regarding access, and quality and efficiency of care.

Health care reform brings to the forefront the need for a strong primary care network to support value-based care, in which good health outcomes are efficiently achieved.[1] Transformation of safety-net clinics into well-functioning medical homes will become increasingly important as increased rates of insurance coverage result in greater demand for their services while reimbursement more closely aligns with accountability for patient centeredness, cost efficiency, and health outcomes.

Recognizing that strong safety-net clinics are integral to a high-performing system, the Health Improvement Partnership of Santa Cruz County (HIP), a coalition of public and private providers, in 2011 began hosting a learning collaborative (funded by Blue Shield of California Foundation) focused on building PCMHs in the local safety net. Learning collaboratives have repeatedly demonstrated effectiveness in achieving improvements in health care delivery. However, such collaboratives usually involve organizations that are separated geographically. The present project in Santa Cruz, however, is an example of a collaborative in a single geographic area, among clinics that to a certain extent compete with one another, using a BTS learning approach to drive changes in a local system of care.[2]

Key factors in the Santa Cruz collaborative's success toward improving the local safety-net system of care include:

- An established cross-sector health care coalition – HIP – serving as collaborative host
- Participation in the Institute for HealthCare Improvement (IHI) Triple Aim Learning Initiative[3]
- Alignment of goals with the Medi-Cal Health Plan Incentive Program
- Use of the formal BTS structure for achieving change and the Safety Net Medical Home Initiative Change Concepts for Practice Transformation[4]
- Hands-on clinic support for the use of data to drive change

This paper provides an overview of HIP — the learning collaborative host — and its unique role within the Santa Cruz County health care community. It also provides insight on HIP's participation in an IHI Triple Aim (TA) Learning Initiative, in which HIP's public and private health care leadership committed to working together to improve the local system of care in each of the TA domains. These common TA goals, plus a community-wide perspective, set the stage for collaboration among safety-net clinics. The paper goes on to share the local Safety Net Clinic

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## Glossary

**Alliance.** The Central California Alliance for Health is a nonprofit health plan serving Santa Cruz, Monterey, and Merced Counties.

**ACSC.** Ambulatory Care Sensitive Conditions is an age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission; it was developed by the Canadian Institute of Health Information.

**BTS.** A Breakthrough Series Collaborative brings together a large number of quality improvement teams for short-term (six to 15 months) structured learning on a specific topic.

**CBI.** Care Based Incentives is a program designed to compensate Alliance primary care providers for improved access, and quality and efficiency of care.

**HIP.** The Health Improvement Partnership of Santa Cruz County is a nonprofit coalition of public and private health care organizations dedicated to building a stronger system of care.

**HIPC.** The Health Improvement Partnership Council is a monthly meeting at which local health care leaders discuss common ground issues.

**PCMH.** The patient centered medical home is a "whole person" approach to primary care delivery that facilitates partnerships between patients and their care team. Hallmarks of PCMHs include quality, safety, enhanced access, and well-coordinated care.

**SNCC.** A subgroup of HIP, the Safety Net Clinic Coalition consists of eight safety-net organizations.

**SNMHI.** Funded by The Commonwealth Fund, the Safety Net Medical Home Initiative is a five-year national demonstration project that supports medical home transformation in 65 primary care safety-net practices to improve quality, efficiency, and patient experience.

**Triple Aim.** The Institute for Healthcare Improvement (IHI) Triple Aim is an approach to optimize health care by designing systems that simultaneously pursue three goals: improving the patient experience of care, improving population health, and reducing per capita costs.

Coalition's experience using a BTS learning collaborative approach among otherwise competing local organizations, focused on advancing PCMHs within the safety net. Also, the paper summarizes key factors supporting an effective learning collaborative in which local clinics work both individually and collaboratively to advance a coordinated, high-functioning system of safety-net care.

## Health Improvement Partnership: Host for the Collaborative

Incorporated in 2004, HIP is a consortium of 24 public and private health care organizations including hospitals, a medical society, the local Medi-Cal managed care plan, county clinics, private physicians, local philanthropies, community health centers, hospice, and the county health services agency. HIP's mission is to unite public and private health care providers and key community stakeholders to advance high-quality, high-value, and patient-centered care throughout Santa Cruz County, with a special focus on low-income residents. HIP is member-run, with one board of directors member from each organization. Working closely with HIP's executive committee, a small staff organizes and conducts HIP's management and operation of the programs, research, meetings, training events, and other day-to-day work.

HIP serves the community with regular face-to-face meetings that have become trusted forums for candid discussions of the community's health. HIP's meeting programs include:

- **HIP Council (HIPC).** The majority of HIP member organizations attend the monthly HIPC meetings at which local health leaders discuss common health care issues and interact with state and national legislators regarding health policy.
- **Safety Net Clinic Coalition (SNCC).** A subgroup of HIP, SNCC is a coalition of eight local safety-net organizations. SNCC meets quarterly to discuss operational and policy issues.

- **SNCC Medical Directors.** SNCC medical directors meet quarterly, with an emphasis on patient care and quality improvement. Since 2010, SNCC medical directors have shared clinic performance data generated by the local Medi-Cal health plan — Central California Alliance for Health — as a way to spread local best practices and to identify opportunities for collaborative quality improvement.

HIP's portfolio of projects reflects its mission to support a local system of integrated, coordinated care for everyone: the uninsured, the newly insured, and the already insured. Key HIP initiatives include:

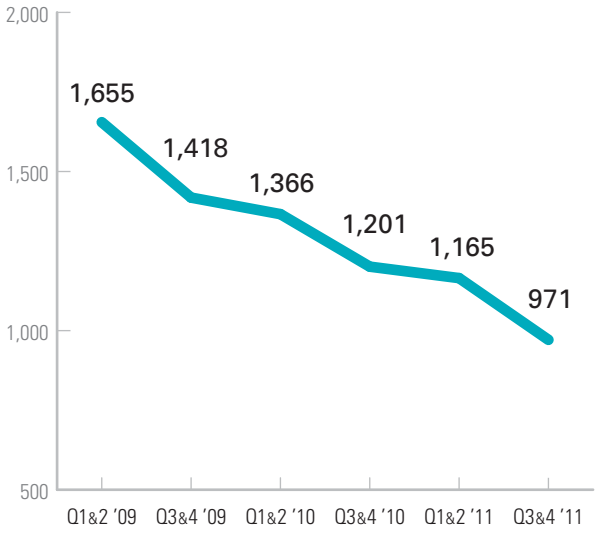
1. **Healthy Kids Santa Cruz.** Healthy Kids of Santa Cruz County is a coalition of two dozen community agencies dedicated to achieving health insurance coverage for all Santa Cruz County children.[5] Healthy Kids helps maintain an extensive network of Certified Application Assistors (CAA) who provide targeted outreach services to help parents find health care coverage for their children and assist them with enrollment. Since 2004, Healthy Kids has enrolled more than 21,000 previously uninsured local children into Healthy Kids, Medi-Cal, or Healthy Families programs.

2. **Baby Gateway.** In 2009, HIP, First 5 of Santa Cruz County, and Santa Cruz County Health and Human Services collaborated to launch the Baby Gateway program.[6] The purpose of the program is to:

   - Provide seamless coverage and access to a medical home for Medi-Cal eligible newborns
   - Help prevent avoidable ED visits for infants
   - Distribute First 5's *Kit for New Parents*

   The cornerstone of Baby Gateway is a CAA visit with new mothers in the hospital. The CAA enrolls eligible newborns into Medi-Cal, assists in selecting a primary care provider, introduces the *What to Do When Your Child Gets Sick* guide, and makes an appointment for the infant's first checkup — all before the baby leaves the hospital.[7] Since Baby Gateway's inception at Watsonville Community Hospital, ED visits per 1,000 births for infants under one year of age have dropped by more than 30%. (See Figure 1.) In 2011, Baby Gateway spread to two other hospitals in the county.

**Figure 1. ED Visits for Infants Per 1,000 Births, Watsonville Hospital, 2009–2011**




Notes: Births and ED visits for infants less than one year old. Annualized ED visits are approximated: (ED visits in six months × 2 ÷ births in the same six months + births in the prior six months) × 1,000.

Sources: Office of Statewide Health Planning and Development (OSHPD), www.oshpd.ca.gov, and the authors.

3. **Health Navigator Program.** Health navigators (HN) help link underserved populations to health and social service systems. In 2010–2011, HIP piloted a hospital-based HN program to assist uninsured, low-income adults with the hospital-to-outpatient transition. During the pilot, the number of patients connected to care after discharge increased from 55% to 78% (based on chart audit of uninsured county clients discharged during a four-month period). Based on these findings, HIP member organizations are now united in support of an HIP HN program to focus on newly insured adults who are at high risk of avoidable hospital use.

## HIP Participation in the Triple Aim Learning Network

In 2009, HIP joined 60 other organizations in the United States, Canada, and Europe to test the IHI's TA framework as a new means for designing specific actions to improve the local health care system. HIP members agreed to appraise the health of the community at large and the effectiveness of the local system of care by measuring key metrics in each TA domain: population health, the experience and quality of health care, and cost containment. Traditionally, health organizations have assessed their performance based on the specific episodes of care they provide and on their own bottom line. However, often what makes sense for an individual organization may be contrary to the interests of the community at large. With establishment of community-wide TA goals, HIP partners, both public and private, committed to work together to strengthen the entire community's health. Though the competitive nature of the business of health care delivery constantly tugs at this commitment, the ability of HIP members to work on common issues and to act in the interests of the entire community continues to grow.

HIP consensus on specific community-wide metrics for each TA domain was reached in July 2011, with the metrics to be tracked and reported annually to HIPC. (See Table 1.) These metrics track the project's community-wide progress toward achieving a high-quality, high-value system of care. In addition to these metrics, HIP now applies the TA framework to its entire portfolio of projects.

In March 2012, the Commonwealth Fund released regional scorecards from its Health System Data Center, which provide performance indicator results for hospital referral regions compared to national benchmarks.[8] These data will serve as an important additional ongoing source for community-wide TA assessment of the local system of care.

**Table 1. HIP's Triple Aim Metrics, 2011**

| | DATA SOURCE/POPULATION | 2010 HIP COMMUNITY-WIDE MEASURES |
|---|---|---|
| Improve Population Health | • OSHPD*/all residents > 17 years<br>• Alliance/Medi-Cal<br>• Hospitals/all residents<br>• CAP† survey | • Ambulatory Care Sensitive Conditions (AHRQ)#<br>• Avoidable ED visits (NYU ED Algorithm)**<br>• Readmissions within 30 days, by diagnosis<br>• Health Adjusted Life Expectancy†† |
| Improve the Experience of Care | • Healthy Kids of Santa Cruz/ all residents < 18 years<br>• CHIS‡<br>• CAP survey/random sample | • Children's coverage rates<br>• Pediatric overweight and obesity rates<br>• Regular source of health care |
| Reduce Cost | • OSHPD/all residents<br>• Dartmouth Atlas§/Medicare Alliance/Medi-Cal | • Total ED visits per 1,000<br>• Total hospital days per 1,000<br>• Total costs per member, per year |

*Office of Statewide Health Planning and Development, www.oshpd.ca.gov.
†Santa Cruz County Community Assessment Project, www.santacruzcountycap.org.
‡California Health Interview Survey, www.chis.ucla.edu.
§Dartmouth Atlas of Health Care, www.dartmouthatlas.org.
#Ambulatory Care Sensitive Conditions (ACSC), Agency for Healthcare Research and Quality, www.qualitymeasures.ahrq.gov.
**NYU ED Algorithm, Center for Health and Public Service Research, www.wagner.nyu.edu/chpsr.
††World Health Organization, Healthy Life Expectancy (HALE), www.who.int.

Source: HIP.

## A Breakthrough Series Collaborative to Advance a System of PCMHs in the Safety Net Clinic Coalition

### The Safety Net Clinic Coalition

HIP's SNCC is composed of eight organizations that provide an array of services to diverse patient populations. The types of sites, programs, and services offered include:

- a community college health center
- a diabetes education program
- a dental clinic
- a hospital-based pediatric clinic
- reproductive services clinics with primary care
- a women's clinic with integrative medicine
- a comprehensive health clinic for migrants, with school-based sites
- county primary care clinics that focus on the homeless
- county mental health and substance abuse services

Collectively, the participating clinics provide 250,000 patient visits a year to low-income residents.

**SNCC Patient Profile**

- 68% Earn less than 100% of the Federal Poverty Level
- 46% Uninsured
- 37% Medi-Cal covered
- 70% Female (adult population)
- 23% Farm workers
- 64% Latino
- 38% Under age 19
- 42% Age 20 to 44
- 4% Age 65 or older

In 2010, SNCC clinic leaders convened to assess new opportunities afforded by local, state, and national health care reforms. Designed to take advantage of these reforms and to help build capacity to serve growing needs, these SNCC leaders developed the 2020 Vision for a Safety Net System of Care, which focuses on primary care and prevention as well as on a "whole person" orientation integrated across all elements of the health care system.[9] Broad evidence shows that communities with strong primary care systems have better quality health care with lower costs. Toward that end, clinic leaders selected five goals to work toward, both individually and together, to prepare the clinics to expand primary care services to thousands of people newly covered by insurance under national health care reform, beginning in 2014:

- Launch a collaborative quality improvement process within SNCC
- Develop PCMHs
- Increase access to urgent care and same-day services
- Expand capacity to provide and coordinate medically, socially, and behaviorally complex care
- Organize collaborative approaches to advance a coordinated system of safety-net PCMHs throughout the community

In December 2010, SNCC was awarded funding from the Blue Shield of California Foundation to help ready clinics to respond to the increasing demand on their services anticipated with health care reform, and in January 2011 a quality improvement collaborative, the SNCC PCMH Initiative, was launched. The initiative leveraged the groundbreaking PCMH transformation experience of the Safety Net Medical Home Initiative, adopting and easily adapting its Change Concepts for Practice Transformation implementation guides.

## Alignment of PCMH Initiative with Community-Wide Triple Aims

The overarching goal of SNCC's PCMH Initiative is to advance a system of medical homes in the safety net by assisting clinics in implementing one or two components of a PCMH within a year. At the outset, metrics reflecting aggregate clinic performance were established in each TA domain, aligning with the priorities of HIP's community-wide TA goals. (See Table 2.) The collaborative drew predominantly on data from the Central California Alliance for Health — Santa Cruz County's local Medi-Cal plan — to assess aggregate clinic performance over time using the Alliance's tri-county (Santa Cruz, Monterey, and Merced) performance as a benchmark.

## Medi-Cal Plan Incentive Payments: Motivation and Data to Drive Change

Since 2006, the Alliance has operated a quality-based incentive (QBI) pay-for-performance program for providers. Over the years, Alliance providers have grown to understand and trust the data produced for this program, and to rely on the added income generated by their QBI performance.

In 2011, the Alliance introduced an expanded version of QBI, its Care Based Incentives (CBI) program, with provider performance measured and high performance awarded in each of the TA domains. The Alliance collects practice data and makes them available to providers in the following areas: access, preventive care, disease detection, management of chronic conditions, prescribing patterns, practice management, and a composite "points earned." In each category, the practice is compared to Alliance peer performance as a benchmark. Reflecting the Alliance's emphasis on improving patient outcomes, 50% of potential earned points (toward incentive payments) is based on performance in two measures: ambulatory care sensitive conditions admissions (30% of available points) and avoidable ED visits (20% of available points). Though CBI incentive earnings are paid once per year, the Alliance updates CBI practice reports quarterly to allow providers to assess their performance on a frequent basis and to make improvements.

Alignment of PCMH goals and Alliance incentive payments serves as a strong motivator for PCMH Initiative participation and strengthened team engagement. For the individual safety-net clinics, incorporation of components of the PCMH is attractive not only to improve clinic efficiency, access, and quality of care but also to result in better CBI performance and thus increased incentive pay from the Alliance. The comprehensive CBI data, in conjunction with their baseline clinic self-assessment, formed an excellent

**Table 2. PCMH Initiative Aggregate Safety-Net Clinic Metrics**

| | DATA SOURCE | MEASURES |
|---|---|---|
| Population Health | • Alliance | • Ambulatory Care Sensitive Conditions (AHRQ)<br>• Avoidable ED visits (NYU Algorithm)<br>• Overall Care-Based Incentives (CBI) access/quality composite score |
| Patient Experience and Quality of Care | • Alliance | • Healthcare Effectiveness Data and Information Set (HEDIS)* preventive and chronic care measures |
| | • Clinic self-assessment | • Clinic scores on self-assessment tool |
| Cost | • Alliance | • ED visits per 1,000 †<br>• Admissions per 1,000 †<br>• CBI earnings per member per month |

*National Committee for Quality Assurance, Healthcare Effectiveness Data and Information Set, www.ncqa.org.
†Patient population, Medi-Cal enrolled only.

Source: 2011 SNCC PCMH Initiative.

foundation for clinics to identify an area of focus for PCMH work. Also, the quarterly CBI reports allow teams to receive regular feedback on the effectiveness of changes implemented and provide regional benchmarks. Overall, CBI serves as a powerful motivator for change and strengthens the case for building PCMHs.

SNCC medical directors have been regularly sharing their clinics' Alliance QBI and CBI performance data since 2010. Though there was initial reluctance among SNCC members to share performance data and best practices due to their competitive positions within the community, the medical directors quickly adapted to the practice and now openly discuss data with peers in order to learn from each other. Quarterly discussion heightens awareness of the potential to earn increased reimbursement though CBI, strengthens understanding of the measures, and helps to make the connection between clinic processes and outcomes.

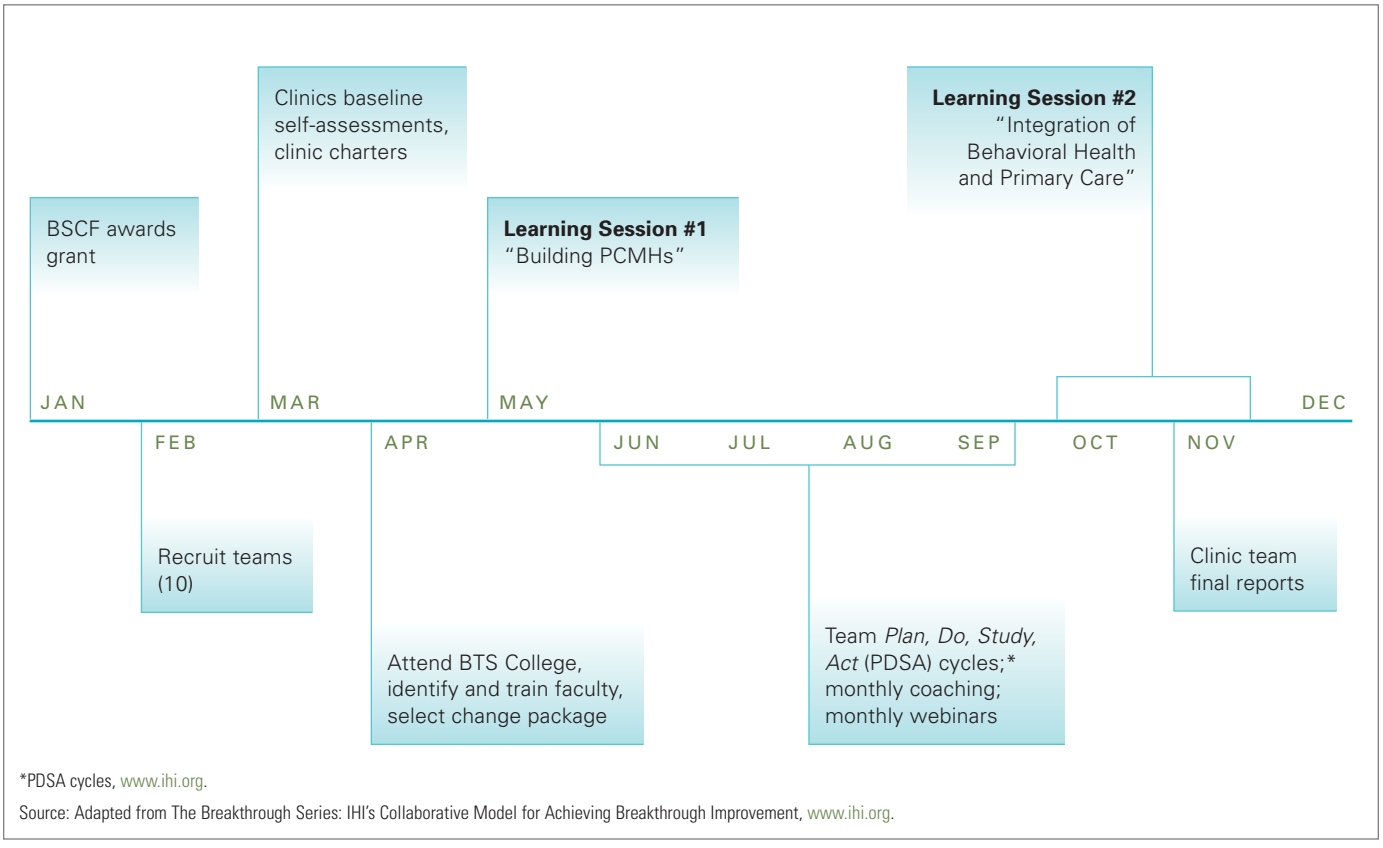
## PCMH Initiative Structure: IHI Breakthrough Series

HIP used the BTS model — which requires a 6- to 15-month learning period — as a framework for the collaborative. Prior to the first "learning session," local faculty (HIP executive director, HIP consulting physician, and the director of quality from a local medical foundation) attended the IHI's BTS College.[10] All agreed that BTS College training, resources, and networking were essential to effectively managing the collaborative.

## BTS Timeline

The 2011 PCMH Initiative BTS framework consisted of spring and fall learning sessions for clinic teams, with an intervening "action period" during which teams worked intensively on quality improvement projects. (See Figure 2.)

**Figure 2. 2011 Breakthrough Series Timeline, Santa Cruz PCMH Initiative**




*PDSA cycles, www.ihi.org.

Source: Adapted from The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement, www.ihi.org.

**Formation of teams.** HIP met individually with each SNCC organization to acquaint clinic leaders with the PCMH Learning Collaborative and with the potential demands on clinic staff time and resources that participation could require. Ten SNCC teams were formed, representing six private safety-net clinics plus four County of Santa Cruz Health Services Agency clinics.

Teams consisted of three to six members per organization from all aspects of care delivery (e.g., reception, nursing, providers, medical records, administration). This structure fosters a clinic-wide culture of quality improvement. To help offset the cost of staff time to participate in SNCC workshops and other quality improvement efforts, HIP provided each team a stipend of $3,000.

### SNCC PCMH Teams

- Cabrillo Student Health Center
- Diabetes Health Center
- Dominican Pediatric Clinic
- Planned Parenthood Westside
- Salud Para la Gente
- Santa Cruz Womens Health Center
- Santa Cruz County:
  - Emeline Clinic
  - Watsonville Health Center
  - Homeless Persons Health Project
  - Mental Health and Substance Abuse

**Baseline clinic self-assessment.** Each SNCC clinic team completed a baseline TransforMED Medical Home IQ self-assessment to identify its clinic's strengths and weaknesses in becoming a PCMH.[11] HIP staff met with each team to review its self-assessment results and to provide coaching in order to ready teams to participate. Based on these results, each team chose a specific aim for its collaborative work throughout the PCMH Initiative.

**Learning sessions.** The spring learning session focused on what a PCMH is and how to achieve change using the Model for Improvement.[12] Team members received a "change package" containing the Safety Net Medical Home Initiative (SNMHI) Implementation Guides for each PCMH change concept. Early in their PCMH work, teams identified a key barrier to advancing patient-centered care: a lack of integration among local behavioral health, substance abuse, and primary care services. In response, the fall learning session focused on integration among these services. Between learning sessions, teams worked on self-identified projects in one or more PCMH components.

### Learning Sessions Expert Faculty

**Spring Session**
David Labby, MD, CareOregon
Rebecca Ramsey, BSN, MPH, CareOregon
Xavier Sevilla, MD, Whole Child Pediatrics, FL

**Fall Session**
Wendy Bradley, LPC, Southcentral Fdn., AK
Chris Campbell, PAC, Southcentral Fdn., AK
Brenda Goldstein, MPH, Lifelong Medical, CA

**Team coaching.** Teams came to the initiative with varied experience and resources in quality improvement (QI). Three teams had dedicated QI staff capable of running reports, displaying data, and analyzing results, but most other teams had limited resources for data collection and analysis. To help fill this gap, local PCMH faculty provided monthly individual team coaching on-site. Coaches helped teams learn to use the Model for Improvement, including defining their project aim and measures, and employing a PDSA cycle to achieve change. Coaches also linked teams to PCMH resources and provided encouragement when teams experienced difficulties.

**Webinars.** Monthly PCMH webinars provided an opportunity for teams to share successes, ask questions, and learn more about data use.

**Extending CME to the broader community.** With the support of the Alliance, HIP was able to arrange for Breakthrough Series national experts to provide community-wide Continuing Medical Education (CME) events on PCMH. These events were open to all Alliance providers in the three counties it serves (Monterey, Merced, and Santa Cruz) and to PCMH Initiative teams, as well as to Community Health Partnership providers.[13]

**Community CME Expert PCMH Faculty**

**Spring CME Speakers**
David Labby, MD, CareOregon
Rebecca Ramsey, BSN, MPH, CareOregon
Xavier Sevilla, MD, Whole Child Pediatrics, FL

**Fall CME Speakers**
Jurgen Unutzer, MD, MPH, Aims Center, WA
Jim Winkle, MPH, SBIRT Oregon Initiative

Over the course of the PCMH Initiative, HIP provided 23.5 hours of CME through dinner presentations and learning sessions (13.5 hours of CME for team members at learning sessions, with an additional 10 CME open to the community).

## PCMH Initiative Outcomes

### Team Project Outcomes

All 10 teams completed the 2011 PCMH Initiative BTS project and made substantial progress on implementing one or more PCMH components (empanelment, team-based care, patient-centered care, enhanced access, care coordination, engaged and effective leadership, QI, and organized, evidence-based care) within the action period. The status of team projects at end of the first year is summarized in Table 3.

In December 2011, HIP was awarded a second Blue Shield of California Foundation grant to continue this PCMH work during 2012. All 10 teams from 2011 are continuing their work in the 2012 PCMH Initiative, and four new teams have joined the group.

**Table 3. Santa Cruz County HIP PCMH Project, Team Outcomes, 2011**

| TEAM | PCMH COMPONENT(S) | PROJECT AIM | TEAM OUTCOMES AFTER SIX-MONTH CYCLES |
|---|---|---|---|
| 1 | Team-Based Care | Decrease visit cycle time (check-in to check-out) for prescheduled clients to 40 minutes or less within six months | • Decreased average visit cycle time from 65 to 54 minutes |
| 2 | Patient-Centered Care; Care Coordination | Identify patients with substance misuse by implementing Screening, Brief Intervention, and Referral to Treatment (SBIRT) for all patients 18+ years old, within six months | • Developed screening workflow<br>• Trained all staff<br>• Developed Spanish language screens<br>• Developed referral directory<br>• Implemented SBIRT screening with two providers (spread to all providers at 10 months) |
| 3 | Evidenced-Based Care | Leverage EHR data to help reduce hospitalizations due to pneumonia (their most common preventable admission diagnosis) for patients with chronic disease by increasing the percentage of patients with documented pneumococcal vaccination | • Increased rate of documented vaccination in high-risk patients from 45% to 85% |

**Table 3. Santa Cruz County HIP PCMH Project, Team Outcomes, 2011,** *continued*

| TEAM | PCMH COMPONENT(S) | PROJECT AIM | TEAM OUTCOMES AFTER SIX-MONTH CYCLES |
|---|---|---|---|
| 4 | Enhanced Access | Improve patient access to appointments by establishing enhanced access scheduling for all providers by June 2012 | • Demand/supply monitored for five months; scheduling changes implemented, including simplified appointment types and times |
| 5 | Care Coordination; Access | Increase access to diabetes self-management education by implementing Shared Medical Appointments (SMA)* in primary care offices; provide SMA visits to 40 individuals by June 2012 | • Developed protocol and memorandum of understanding<br>• Recruited private MD as test site<br>• Conducted first SMA and scheduled monthly SMA sessions through June 2012 |
| 6 | Team-Based Care; Engaged Leadership | Establish care teams for primary care patients; engage leadership in supporting development of PCMH and QI | • Care teams for two providers established; regional leadership engaged in PCMH work and agreed to creation of clinic QI position |
| 7 | Patient-Centered Care | Test the feasibility of implementing depression screening during primary care visits at a student health center and determine potential need for resources to meet uncovered needs | • Early results show 32% of students presenting for primary care had PHQ-2† depression screens requiring PHQ-9s,‡ with 33% of these scoring moderate to severe symptoms. These results help define the potential resources needed when screening is fully implemented for all primary care visits. |
| 8 | Enhanced Access | Improve the patient experience by implementing enhanced access and decreasing the need for walk-ins within six months | • Enhanced access scheduling implemented clinic-wide; 90% of requests are seen the same day; staff triage time decreased; 100% of staff report that enhanced access is an improvement; 92% of patients report it is easier to get appointments; 83% of patients report it is easier to get through to clinic by phone. |
| 9 | Enhanced Access; Evidence-Based Care | Patients will obtain needed appointments with their PCP promptly, by June 2012<br>Use EMR alerts to optimize preventive and chronic care for all patient visits by June 2012 | • Tested advanced access template for one provider resulting in time to "next third" 20-minute appointment decrease from under 22 days to 14 days or less; time to "next third" 40-minute appointment decreased from under 22 days to 11 days or less.<br>• EMR alerts implemented and all providers trained in use; testing in process for MAs to facilitate addressing alerts. |
| 10 | Empanelment; Team-Based Care | Improve patient satisfaction and care outcomes by empanelment to a provider and care team | • Empanelment and care-based teams established for two providers. Care teams include provider, MA, and front office staff. MAs and providers trained in panel management.<br>• Panel Summary Report implemented, including percentage of encounters in which patients were seen by PCP. |

*"A Shared Medical Appointment (group visit) is when multiple patients are seen as a group for follow-up or routine care. These visits are voluntary for patients and provide a secure but interactive setting in which patients have improved access to their physicians, get the benefit of counseling with additional members of a health care team (for example, a behaviorist, nutritionist, or health educator), and can share experiences and advice with one another." American Academy of Family Physicians, www.aafp.org.

†K. Kroenke, R. S. Spitzer, and J. B. Williams, "The Patient Health Questionnaire-2: Validity of a Two-Item Depression Screener," *Med Care* 41 (2003): 1284–92.

‡K. Kroenke, R. S. Spitzer, and J. B. Williams, "The PHQ-9: Validity of a Brief Depression Severity Measure," *J Gen Intern Med* 16 (September 2001): 606–13.

Source: Team presentations, PCMH Initiative Learning Session #2, November 2011.

### 2011 Team Evaluation Survey

A year-end survey elicited participants' assessments of their PCMH Initiative experience and suggestions for improvements. Out of 34 team members, 13 (34%) responded. (See Table 4.)

**Table 4. Santa Cruz County HIP PCMH Project, 2011 Team Evaluation Survey Results**

| YEAR-END SURVEY (SCALE: 1=NOT USEFUL; 5=EXTREMELY USEFUL) | RESULT (AVERAGE) |
|---|---|
| How useful was learning session #1? | 4.0 |
| How useful was learning session #2? | 4.0 |
| How useful were monthly webinars? | 3.4 |
| How useful was team coaching? | 4.6 |
| Was the BTS format structure valuable to achieve change within your organization? | 13/13 = Yes |
| Would you like to participate in another BTS QI Collaborative? | 13/13 = Yes |

Source: HIP Team Participant Survey.

**PCMH initiative format.** Respondents were unanimous in their positive response to BTS as a format for achieving change within their organizations.

> *"Enhanced access, scrubbing charts, creating care teams — these are things we have always wanted to do, but just didn't get around to until we had support and structure to do it."*
>
> — CLINIC DIRECTOR

**Learning sessions.** Learning sessions were highly valued, with teams greatly appreciating the connection with experts who have broad experience building PCMHs. Small group breakout sessions with local and national experts provided a chance to delve more deeply into particular areas of focus and gave participants an opportunity to ask experts, "How did you do it?" Teams also appreciated the opportunity to come together and network with one another away from the pressure of daily work.

After the first learning session, teams indicated that they wanted more time during the session to debrief as a team and to think about how to apply what they just learned to their specific project. As a result, the collaborative incorporated more "team time" in the second learning session. Some participants also wished the learning sessions were longer.

> *"I can't think of any way it could have been better, more useful, or more tangible. That's what I loved about the process — we made actual changes, little by little, and the coaching made it possible to stay on track and move forward. Otherwise, a project like this would have taken a backseat to everyday concerns and crises in a busy clinic setting like ours."*
>
> — PARTICIPATING PROVIDER

**Monthly webinars.** The five webinars during the action period were rated by participants somewhat lower than the learning sessions and the coaching. Didactic webinars that focused on measurement and data collection strategies were rated high, while those that focused on team progress reporting were rated low. Teams expressed a preference for content webinars that had a strong visual component (e.g., those using PowerPoint) but for fewer webinars overall.

**Team coaching.** On-site team coaching was very highly rated. Coaches guided teams through their PDSA cycles and helped spur them on when results were discouraging. Many teams reported that the scheduled monthly meetings with their coach helped to keep them focused on their project.

> *Just a stunning process! I am totally jazzed about participating again 2012. There are so many other changes that we could be implementing, and this process gives impetus and the seal of approval to do so."*
>
> — PARTICIPATING PROVIDER

**Participation in another BTS.** Respondents were unanimous in reporting enthusiasm about participating in another BTS QI collaborative with SNCC partners.

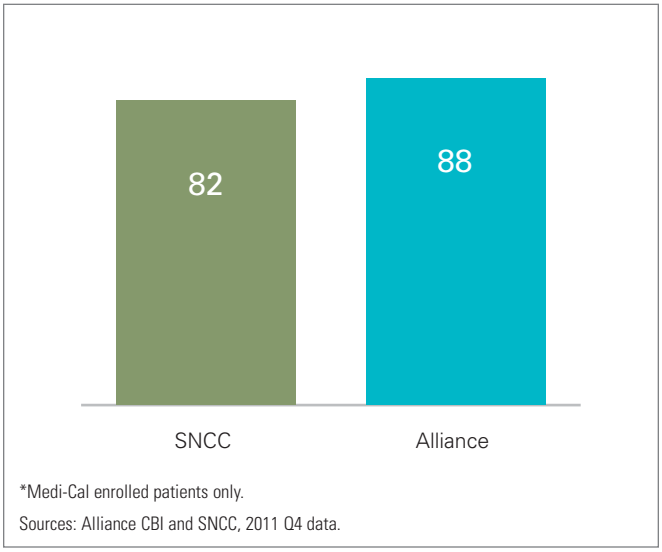
## Collaborative Level Outcomes: Aggregate Clinic CBI Performance

The following four graphs compare aggregate SNCC clinic performance on the Alliance 2011 CBI compared, as a benchmark, to the median performance by Alliance providers. (See Figures 3, 4, 5, and 6.) These comparisons are limited by the fact that 2011 was the first year of Alliance CBI data; therefore, measuring performance over time is not yet possible. Further, since the PCMH Initiative continued throughout 2011, the impact of clinic projects may not yet be fully reflected in CBI results.

These early aggregate SNCC clinic CBI results reveal that these clinics performed better than the Alliance provider median in the following measures:

- Avoidable ED visits (lower score is better)

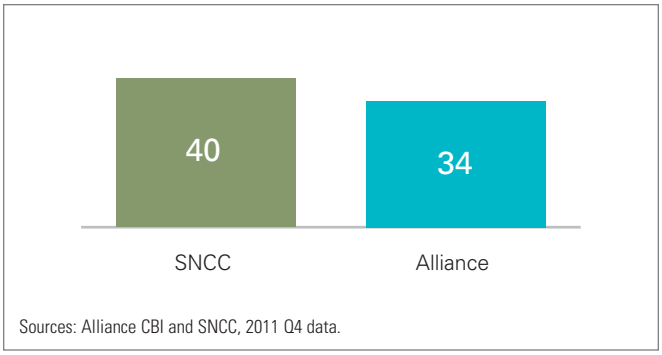
**Figure 3. Avoidable ED Visits per 1,000* per Year, SNCC vs. Alliance Peer Medians, 2011**




*Medi-Cal enrolled patients only.

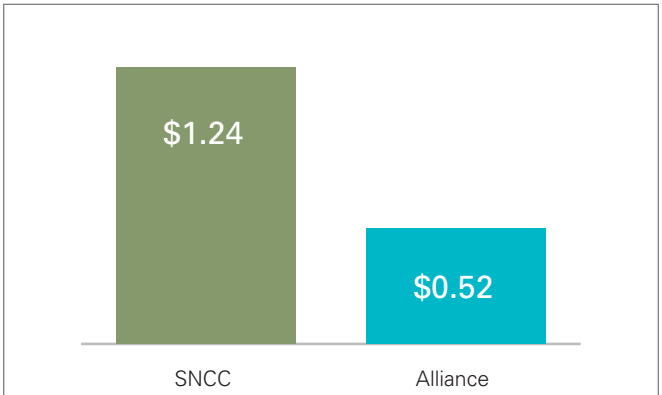
Sources: Alliance CBI and SNCC, 2011 Q4 data.

**Figure 4. Access and Quality Measures Composite Score, SNCC vs. Alliance Peer Medians, 2011**




Sources: Alliance CBI and SNCC, 2011 Q4 data.

**Figure 5. CBI Earned per Member per Month, SNCC vs. Alliance Peer Medians, 2011**

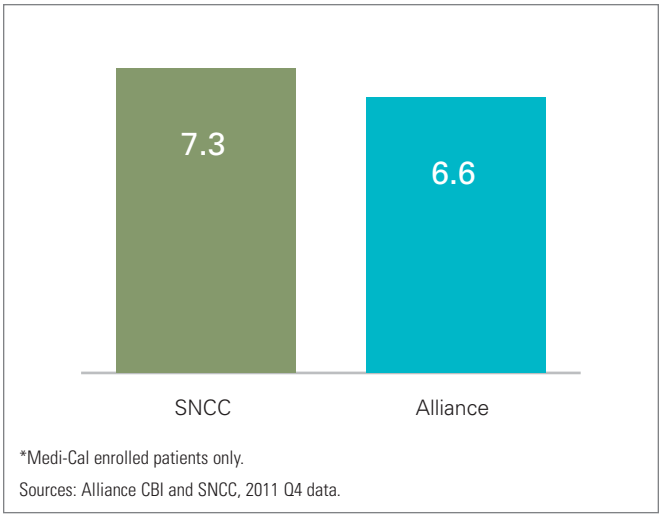



Sources: Alliance CBI and SNCC, 2011 Q4 data.

- Access and Quality Measures Composite Score (higher score is better)
- CBI earned per member per month (higher score is better)

Early aggregate SNCC clinic CBI results show that SNCC clinics did not perform as well in preventing Ambulatory Care Sensitive Conditions admissions (lower score is better). (See Figure 6.)

**Figure 6. Ambulatory Care Sensitive Conditions Admissions per 1,000* per Year, SNCC vs. Alliance Peer Medians, 2011**



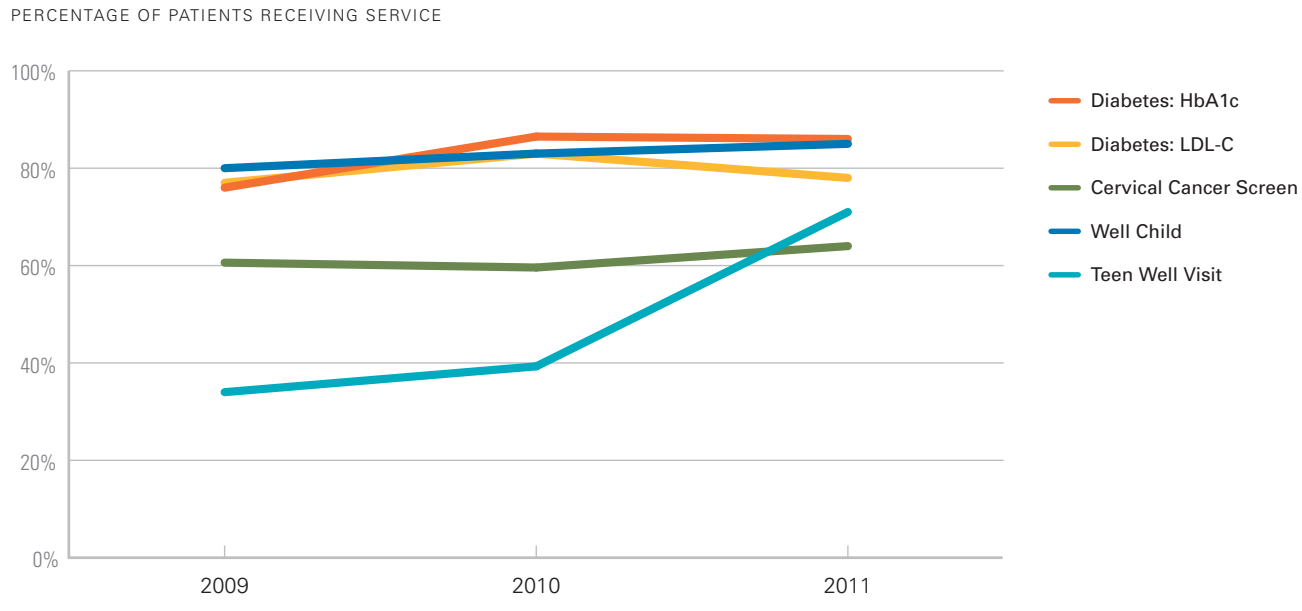

*Medi-Cal enrolled patients only.

Sources: Alliance CBI and SNCC, 2011 Q4 data.

## Individual SNCC Clinic Performance: HEDIS Preventive and Chronic Care Measures

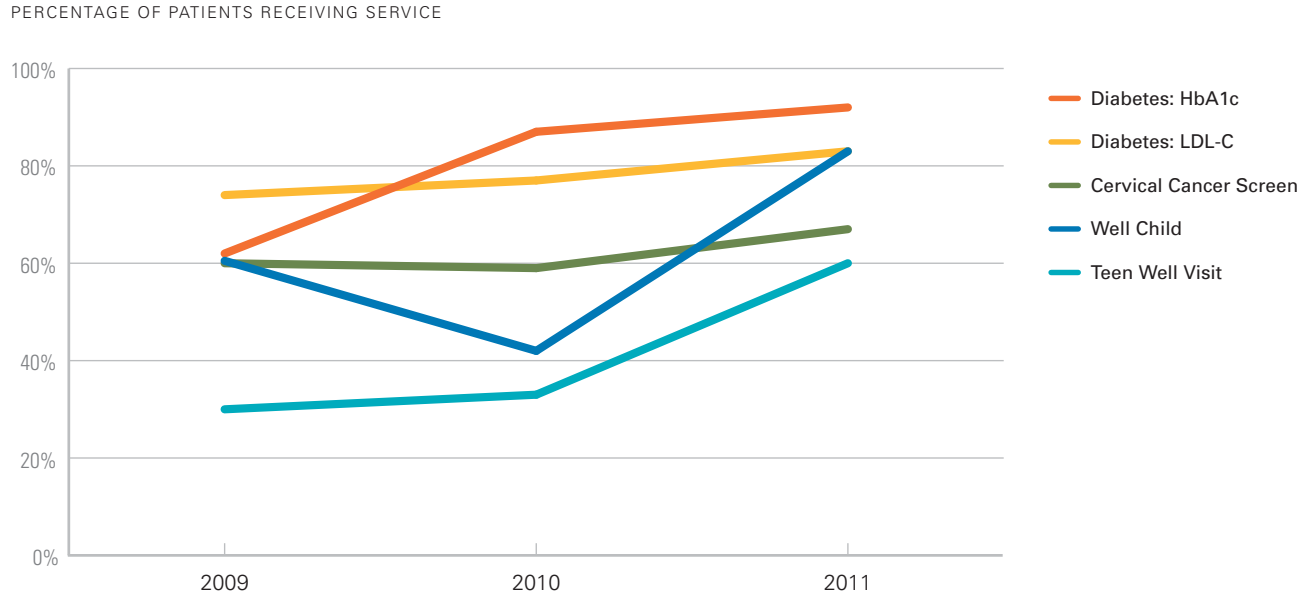
The following four graphs show SNCC individual clinic performance on the HEDIS preventive and chronic care measures reported by Alliance QBI (2009 and 2010) and Alliance CBI (2011). (See Figures 7, 8, 9, and 10.) Sharing of clinic performance data among SNCC medical directors began in 2010, based on Alliance 2009 QBI HEDIS results, and continues to the present day (now including all CBI measures). SNCC clinics improved in the majority of 2011 CBI HEDIS measures compared to 2010. Since the PCMH Initiative spanned all of 2011, the impact of clinic projects may not yet be fully reflected in 2011 results. (The Alliance reported 2011 CBI at the organization level, so data for SNCC clinics in the same organization were grouped. Beginning in 2012, the Alliance will report separate results for each clinic.)

**Figure 7. HEDIS Performance Trends for SNCC Organization A (3 Clinics), 2009–2011**



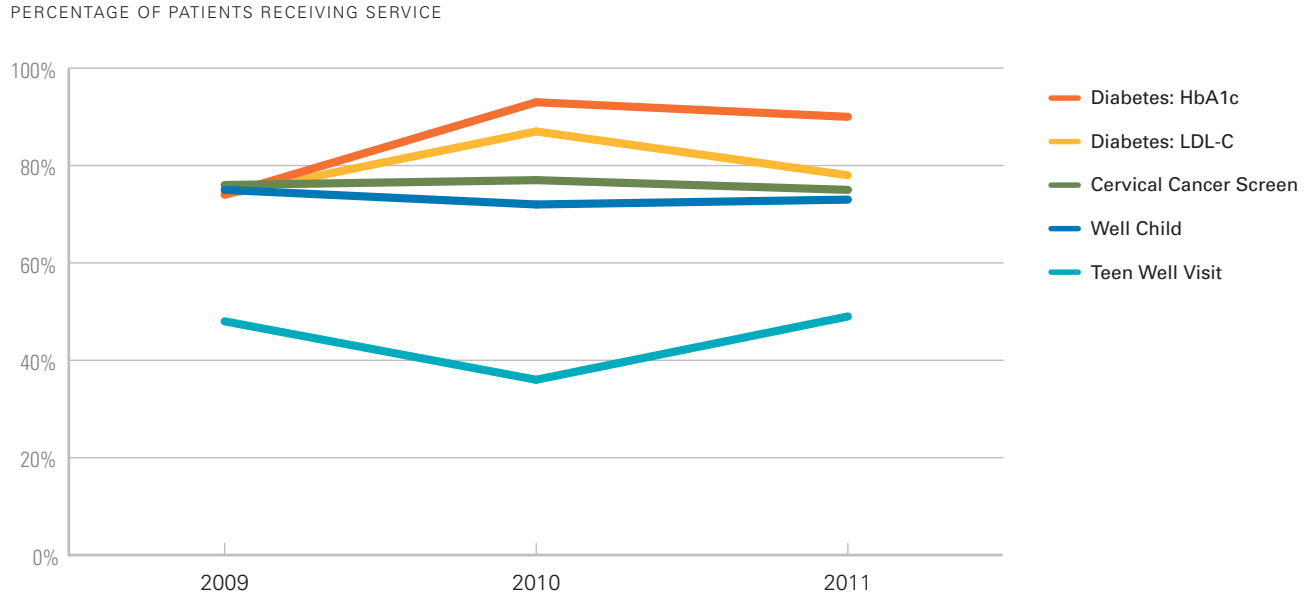

Sources: Alliance QBI, 2009–2010 and CBI, 2011.

**Figure 8. HEDIS Performance Trends for SNCC Organization B (2 Clinics), 2009–2011**



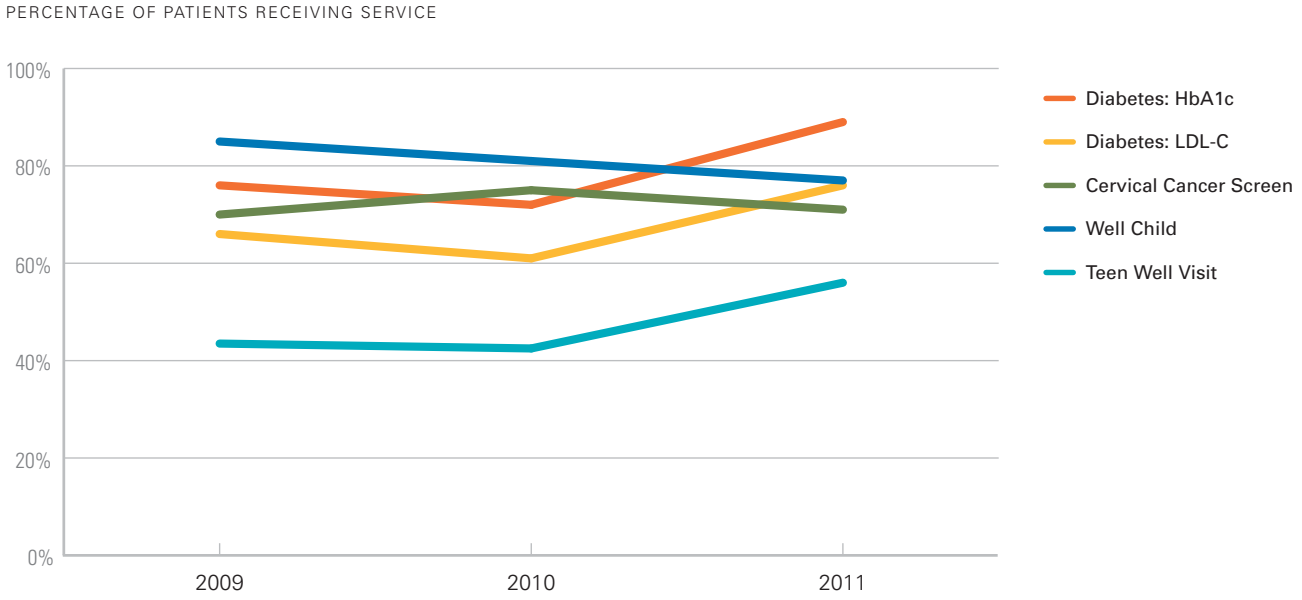

Sources: Alliance QBI, 2009–2010 and CBI, 2011.

**Figure 9. HEDIS Performance Trends for SNCC Organization C (1 Clinic), 2009–2011**




Sources: Alliance QBI, 2009–2010 and CBI, 2011.

**Figure 10. HEDIS Performance Trends for SNCC Organization D (2 Clinics), 2009–2011**




Sources: Alliance QBI, 2009–2010 and CBI, 2011.

## Obstacles to Quality Improvement Encountered by Clinics

SNCC member clinics face ongoing short-term challenges that hinder them from devoting resources to long-term QI. In particular, all SNCC members have staffing limitations that make it difficult to release staff for offsite meetings. Recognizing the importance of recruiting teams that have the resources to succeed, HIP staff made clear during individual recruiting meetings with clinic leadership what clinic resources would be required for breakthrough improvement. As a result of this vetting process, 10 teams were identified that could fully engage in the project.

Despite the recruitment process that sought to enlist only those clinics capable of QI efforts, there were multiple obstacles to progress on the clinics' change projects. All teams cited lack of time and staff to dedicate to QI as an impediment to progress. Also, most teams had limited expertise in using structured processes for improvement, including small testing of change, collecting data, displaying data in run charts, discussing data in clinic meetings, and using data to drive changes aimed at improving efficiencies and patient outcomes.

Building effective quality improvement processes and establishing a clinic-wide culture of continual improvement takes time and is fueled by many small successes along the way. Assigning local coaches to each team to teach the improvement model and provide best practice examples helped to ameliorate these challenges. For 2012, HIP has hired a program assistant skilled in data collection, display, and analysis to assist teams that do not have dedicated QI staff.

HIP's own core staff capacity was challenged by its efforts to engage and sustain clinic teams and to lead a well-resourced BTS. For 2011, the HIP board of directors allocated core funding to support the work of HIP core staff on this initiative. HIP's ability to continue to lead BTS systems change during 2012 has required an expansion of HIP staff and other resources, for which

HIP has been awarded a second Blue Shield of California Foundation grant. A key difference for 2012 is the recruitment of additional coaches experienced in PCMH transformation to support teams.

## Conclusion

A year-end evaluation of the PCMH Initiative demonstrated that a learning collaborative approach to QI can be highly effective in driving changes in the local system of care. Five key factors supported the Initiative's success:

### 1. An Established Local Health Care Coalition

HIP has a seven-year track record of working across organizational boundaries to improve the local system of care. As collaborative host:

- HIP provided vision, structure, local faculty, initiative management, and funding (through a Blue Shield of California Foundation grant and support from the Alliance).
- HIPC meetings provided the platform for readily engaging local health leadership in understanding the importance of strengthening medical homes in the safety net and keeping leadership informed of the PCMH Initiative's progress.
- The QI focus of HIP's ongoing SNCC medical directors meetings simplified team recruitment and enhanced shared learning.
- The cross-sector (public and private) nature of HIP's membership enabled both sectors to benefit.

### 2. Participation in the Triple Aim Learning Network

HIP member organizations committed to working together to improve the local system of care in each domain of the TA learning network: improving the health of the population, improving the experience and quality of health care, and containing costs. This commitment superseded organizational boundaries and encouraged collaboration. Recognizing that strong safety-net clinics are integral to a high-performing system, both public and private HIP member organizations actively supported the PCMH Initiative, setting the stage for collaboration among safety-net clinics.

### 3. Alignment with Medi-Cal Health Plan Incentive Payments

Alignment of PCMH Initiative goals with the local Medi-Cal health plan CBI program strongly supported the QI project. CBI provided practices with both the motivation and aggregate data needed for improvement. Comparison of results among clinics fostered best practice sharing and built collegial relationships in an otherwise competitive environment.

### 4. Formalized Structure Based on IHI's Breakthrough Series and SNMHI Change Concepts

Adoption of the IHI BTS structure provided an excellent roadmap for collaborative QI that was readily adaptable to local conditions. The SNMHI Change Concept framework and implementation guides were also readily adaptable to the PCMH Initiative and served as invaluable learning resources for clinic teams.

### 5. Support for Clinics to Develop a Culture of Quality Improvement

Busy safety-net practices had limited resources to devote to developing strategies for meaningful QI change. Participation in the PCMH collaborative provided a foundation for building a culture within the clinics of continuous QI, including:

- Training in IHI's Model for Improvement involving all levels of staff
- Experience with stepwise Plan, Do, Study, Act change cycles
- Familiarity with using data to drive change

- Hands-on coaching and technical support for data collection, display, and analysis

The 2011 PCMH Initiative provided the opportunity and structure for collaborative quality improvement among SNCC clinics, focused on incorporating components of the PCMH into their daily work. The 2011 PCMH Initiative set the stage for continuing intensive PCMH work in 2012, again using the Breakthrough Series structure. These efforts increase the capacity of SNCC clinics to work both individually and collaboratively toward building a coordinated safety-net system of high-functioning PCMHs. As such, these efforts embody the fiscal and clinical policies associated with national health care reform legislation; they improve quality while reducing costs, thereby helping to build the capacity of the clinics to serve the increased number of patients expected to begin arriving in 2014.


## Author

Barbara Palla, MD, is a pediatrician and consulting physician to the Health Improvement Partnership of Santa Cruz County. Dr. Palla provides consultative leadership for projects involving access to health care and medical systems integration on California's Central Coast.

The Health Improvement Partnership of Santa Cruz County is a nonprofit coalition of public and private health care organizations dedicated to increasing access to care and building a stronger health care delivery system in Santa Cruz County.



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## About the Foundation

The California HealthCare Foundation works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit us online at www.chcf.org.

## Endnotes


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3. The IHI Triple Aim Initiative, www.ihi.org.
4. Safety Net Medical Home Initiative, *PCMH and Qualis Health Change Concepts for Practice Transformation,* www.qhmedicalhome.org.
5. Healthy Kids is made possible by First 5 Santa Cruz County, the Santa Cruz County Health Services Agency, Sutter Maternity and Surgery Center, the Palo Alto Medical Foundation, the Central California Alliance for Health, the Community Foundation of Santa Cruz County, the United Way of Santa Cruz County, the Pajaro Valley Community Health Trust, Dominican Hospital, and donations from local individuals and businesses.
6. First 5 Santa Cruz County was established by the Santa Cruz County Board of Supervisors on December 8, 1998, to ensure that family-friendly services and education are available so that each child reaches the fifth year of life healthy, ready and able to learn, and emotionally well-developed.
7. Gloria G. Mayer and Ann Kuklierus, *What to Do When Your Child Gets Sick* (La Habra, CA: Institute for Healthcare Advancement, 2010).
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11. TransforMed Medical Home IQ, www.transformed.com.
12. G. L. Langley et al., *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance,* 2nd ed. (San Francisco: Jossey-Bass, 2009).
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