

2020 and 2021 PHC QIP High Performers: How'd they do that?

Webinar series summary

The Partnership HealthPlan of California (PHC) Improvement Academy presented six (6) best practice webinars, *PCP QIP High Performers* in 2020 and 2021 in which primary care organizations with some of the highest scores in the Quality Improvement Program (QIP) discussed how their practices were able to achieve a high level of performance.

Reflections on the process to achieve consistently high performance from the provider practices interview revealed some common themes, including:

- High QIP performance did not happen overnight; it requires shifting the culture of the organization to one that is focused on continuous quality improvement.
- Investment in staffing and dedicated staff time for patient outreach, quality improvement, and care team coordination is essential.
- Population health management processes¹, standardized workflows², and actionable data are key components to high performance.

Across the six webinars, some patterns emerged as to the structural, cultural, and programmatic factors these clinics attributed to their success. The checklist that follows is based on those patterns as a quick reference guide to the high performers featured in the webinar. Note that a blank check mark does not indicate that the featured clinic does not have that factor in place at their practice, only that it was not discussed. This resource is meant as a summary to the webinar recordings to identify common themes and success factors discussed. This resource is not an exhaustive descriptor of each organization's QIP efforts or their Quality Improvement department and structure. On page three you will find more detailed webinar highlights from each success factor.

PHC Technical Assistance

Do you have questions on how to use eReports or the Partnership Quality Dashboard (PQD) to identify care gaps and focus patient outreach? Partnership HealthPlan offers customized technical assistance to providers that is designed to support performance improvement on the Quality Incentive Program (QIP). For more information or to request assistance, email: gip@partnershiphp.org

¹ For example: Pre-visit planning, care team huddles for chronic care management, eReports and QIP measure patient lists.

² For example: Organization wide standardized pre-visits planning checklist, job aides, etc.

Checklist
of Key
Factors
for
Success
Discussed
During
PHC QIP
High
Performer
Webinars

Factor for Success Discussed During QIP HP Webinars	2020 Webinars			2021 Webinars		
	#1	#2	#3	#1	#2	#3
Clinician Leadership: Clinicians see quality improvement as part of their role and have dedicated time for improvement work.	✓			✓	✓	✓
Patient Preference: Understanding what patients want from their care, particularly during the COVID-19 pandemic, helps practices to meet patients where they are at and meet their care needs.	✓	✓		✓	✓	
Pre-Visit Planning: Medical assistants engage in standard work before a patient comes into the clinic to identify any care gaps or needs that is informed by the EHR (e.g. Care Guidelines, alerts, etc.).	✓	✓	✓	✓	✓	✓
Dedicating Time: Setting aside protected time for care team planning, panel management, and training.		✓	✓	✓	✓	✓
Utilizing Dedicated Staff for Outreach: Dedicated staff (population health specialist, QI medical assistant, health coach, etc.) create patient lists with care gaps (from eReports, PQD, EHR) and conduct patient outreach to schedule them for care.		✓	✓	✓		✓
Patient Empanelment: For larger practices, patient empanelment (often an ongoing process) supports management of care gaps.			✓			✓
Transparency and Data Sharing: Progress on QIP measures is shared with all staff in different ways such as through team level dashboards, newsletters, contests, and staff meetings. Use data to highlight missed opportunities and learn from them to improve the process.	✓	✓	✓		✓	✓
Celebrating Success: Brining some fun to quality work throughout the year with acknowledgement in newsletters, contests, or staff breakfast events.		✓	✓	✓		✓

PCP Practices Interviewed During PHC QIP High Performer Webinars

2020 Webinar #1: Dr. Martha Cueto-Salas and Swenson Medical Practice Small Practice (< 10,000 assigned PHC members)

Interviews with two small provider practices explore how the practices met patient needs during the COVID-19 pandemic and achieved high performance on the QIP 2020.

Dr. Martha Cueto-Salas

This small practice relied on telehealth during the pandemic to address patient needs. Standard notes are used for documenting preventive screenings. The team reviews eReports monthly and uses pre-visit planning in identifying care gaps for patients.

Swenson Medical Practice

Due to the lack of broadband in Siskiyou County, telehealth use was limited during the pandemic. The practice uses eReports and PQD daily in pre-visit planning and identifying care gaps for patients. Clinical data is uploaded to eReports regularly.

2020 Webinar #2: Winters Healthcare and Alexander Valley Healthcare Medium Practice (10k-20k assigned PHC members)

This webinar offers interviews with two medium sized health centers that emphasize the importance of delivering patient centered care and embedding quality at all levels of the organization.

Winters Healthcare

Strategies discussed include pre-visit planning, use of measure specific outreach lists, health coaches, daily huddles, learning from missed opportunities, fostering a culture of quality, and always delivering care from a “people serving people” point of view.

Alexander Valley Healthcare

This health center fosters a culture of quality, utilizing formal measure-specific improvement plans, leveraging data analytics, quality and excellence as a mission statement. They budget for QI and track ROI on efforts. Successes are celebrated, and change ideas are gathered from those doing the work.

Webinar #3: CommuniCare Health Centers and Marin Community Clinic Medium Practice (10k-20k assigned PHC members)

Within these larger practices, teams work together to address care gaps and set quality goals. Teams describe how patient empanelment is foundational to assessing care gaps and offer tips to engage staff.

CommuniCare Health Centers

Shared how the Quality Improvement Committee worked to set and achieve goals with a monthly clinical focus. Targets were set based on high performers in the region. Patient empanelment and preventive care coordinators help address care gaps as well a regular outreach by working care gap lists. Actionable data is shared to support teams and fun challenges help inspire healthy competition.

Marin community Clinic

Shared how pre-visit planning, standing orders, and Care Guidelines in the EHR system support achievement of quality goals. This clinic communicates with staff about quality and highlights missed opportunities to drive a holistic approach to addressing patient needs.

2021 Webinar #1: Sonoma Valley Community Health Small Practice (< 10,000 assigned PHC members)

This small practice shares how rotating staff on the Quality Improvement committee ensures that all perspectives are incorporated. Routine training for staff on quality measures allows every member of the team to talk with patients throughout their experience on the importance of addressing care gaps.

2021 Webinar #2: North Bay Medical Group Medium Practice (10k-20k assigned PHC members)

In this interview, the years-long transformation to a culture of quality is described, beginning with a focus from leadership. Providers within this practice have shifted to a population health approach through the use of a team based care model, actionable data, cross-team collaboration, and standardization of workflow.

2021 Webinar #3: Santa Rosa Community Health Large Practice (> 20,000 assigned PHC members)

This large community health center discusses how the care team is structured to support care coordination. Teams are provided with data tools to drive improvement and focus on QIP measures in the Fall supports high performance. Lean processes, including Leader Standard Work, support monitoring and recognizing quality improvement.

View recordings of QIP High Performers webinars: <http://www.partnershiphp.org/Providers/Quality/Pages/PIATopicWebinarsToolkits.aspx>

Acknowledgement: This summary was prepared by Melanie Ridley and Gabe Deckert, Health Alliance of Northern California