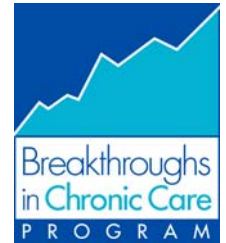


# Breakthroughs in Chronic Care Program's Diabetes & Cardiovascular Care Collaborative

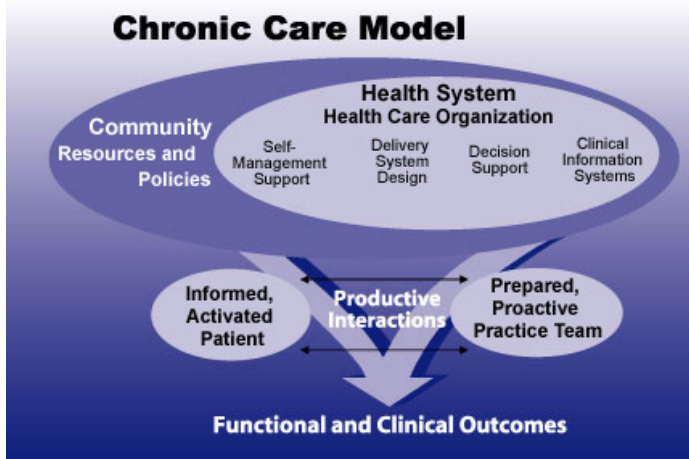
October 2004 – November 2005



## Overview

The *Breakthroughs in Chronic Care Program* (BCCP) is a cooperative effort of California's purchasers, health plans, physician groups and public health advocates to *achieve the highest attainable performance in the clinical care and service for all Californians with chronic conditions.*

The **Diabetes and Cardiovascular Care Collaborative** was BCCP's first initiative aimed at re-designing care at the practice site with California physician groups.



## Diabetes & Cardiovascular Care Collaborative Structure

Between October 2004 and November 2005, collaborative participants from 13 physician groups and 13 pilot practice sites met for 4 on-site meetings to implement dozens of changes based on the Chronic Care Model.

- All groups adapted information systems to make patient information more usable at the point of care.
- All practices made changes to support patient self-management, such as group visits, scheduling planned care visits, screening for

depression, office staff follow-up on patient action plans or medication adherence. Participants kept connected through monthly teleconferences, an email listserv and monthly reporting of data on web-based extranet.

Teams reported data monthly on 5 core measures and up to 5 optional measures for their patients with diabetes and/or cardiovascular disease. Core measures collected during the collaborative were:

1. HbA1c Testing - Percent of diabetes patients with two tests in last 12 months
2. HbA1c Control - Percent of diabetes patients with HbA1c <7.0
3. LDL Testing - Percent of diabetes patients with one test in last 12 months
- 4a. LDL Control in CAD - Percent of CAD patients with LDL-c <100 or
- 4b. LDL Control in Diabetes - Percent of diabetes patients with LDL-c <130
5. Blood Pressure Control - Percent of population with most recent documented BP ≤130/80

For more information on data collected and results obtained, please visit [www.breakthroughcare.org](http://www.breakthroughcare.org)

## Collaborative Results

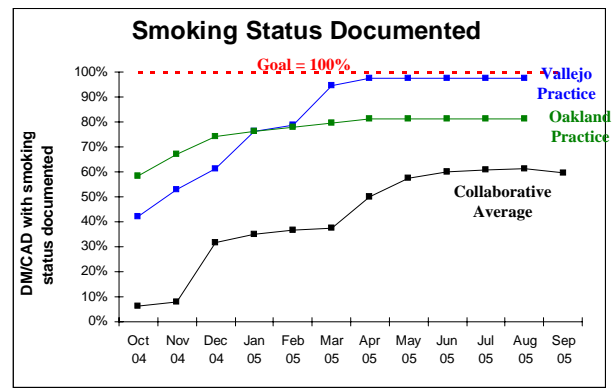
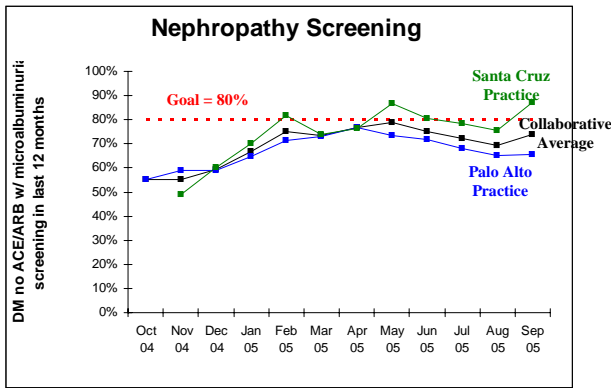
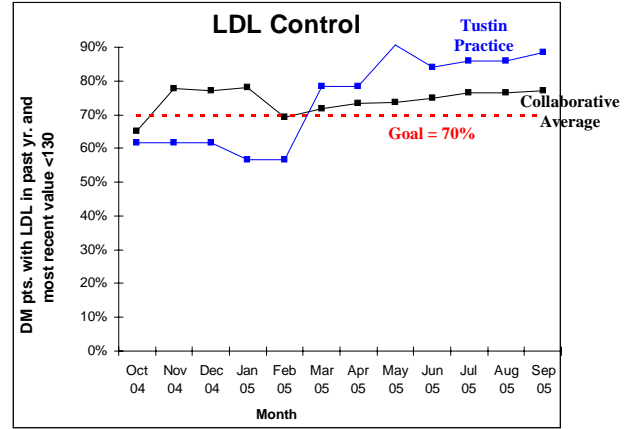
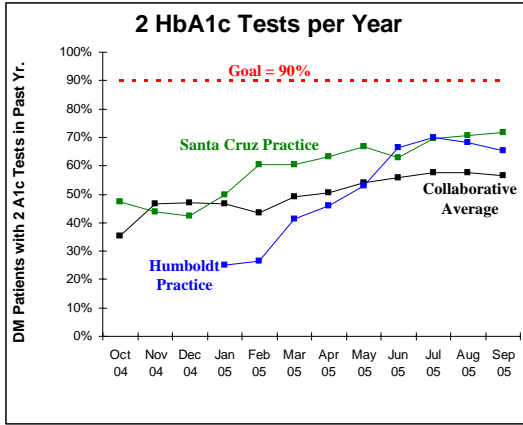
Outcomes of the collaborative will continue to emerge over time as teams implement changes for all patients. During the 12-months of the collaborative, participating physician offices made significant improvements in several areas including:

- 100% improved in at least one measure
- 92% exceeded national benchmarks for at least one measure, 77% exceeded at least two.

*"BCCP changed the way we work with our physicians."*

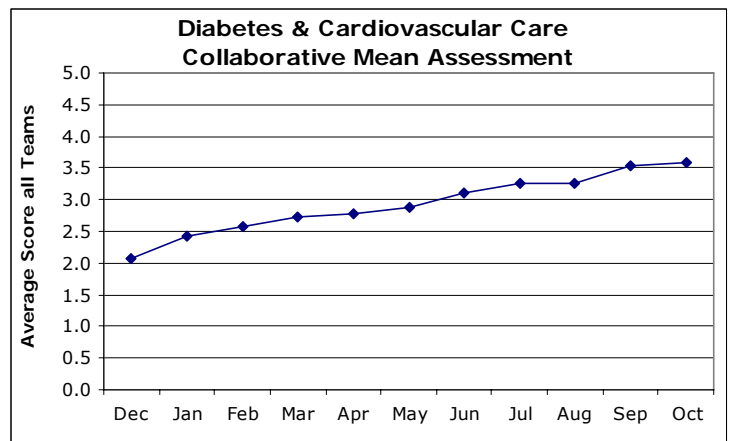
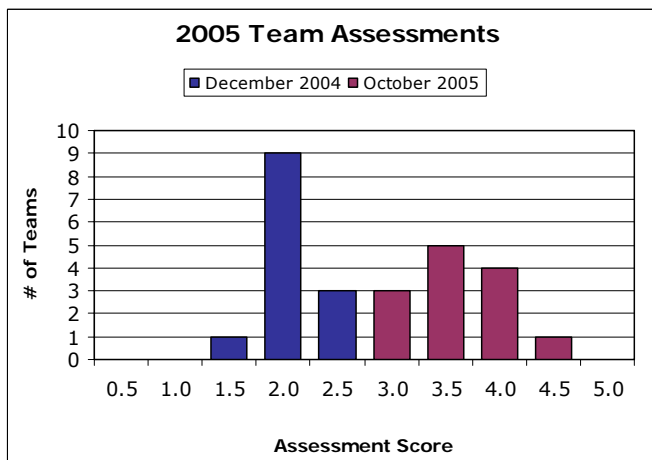
- IPA Quality Improvement Director

Collaborative Outcome Measure	California Average	Collaborative Average	Collaborative Best Rate
HbA1c control < 7.0	42%	61%	83%
LDL Control in CAD < 100	40%	61%	94%
Blood Pressure control for patients with diabetes or heart disease < 130/80	unknown	52%	94%



## More Results

The Diabetes & Cardiovascular Care Collaborative used a Collaborative Assessment Scale developed at the Institute for Healthcare Improvement (IHI) to review progress made by the teams. Each month, the collaborative director and improvement advisor assessed the progress of collaborative teams by scoring them on a scale of 1 to 5. A score of 1 signifies that a plan for change has been agreed upon and a score of 5 indicates that all goals have been met and the best-known care is being provided.



## Spreading the Collaborative Work

During the collaborative, participants became presenters and teachers. Participating physicians became champions within their groups for spreading change, and participating groups became champions among their colleagues for spearheading practice improvement. Some examples include:

- Members from 5 teams (including physicians, medical assistants, nurse practitioners, and physician group improvement directors) presented at the statewide California Healthcare Foundation conference on chronic care in November 2005.
- One IPA launched an internal collaborative in December 2005 to spread changes to other primary care physicians in its four regions.
- At another IPA, the pilot physician's 6 physician partners were also outperforming the rest of the IPA on all diabetes and CAD process and outcome measures by the end of the project year.

*"As other MDs hear about our changes and see the benefit for patients, they are becoming more motivated to try changes themselves."*

- Medical Group Medical Assistant

## What They're Saying

All the results from the collaborative are not quantifiable. In fact, many include personal stories of physicians who, for the first time in years, enjoy their work and of patients who have taken an active role in their care. Below are some examples of what we've heard.

- "Our pilot physician was ready to quit practice last fall, now she's a rejuvenated physician and a rejuvenated person." Physician Group Medical Director
- "Being a diabetic myself, the collaborative has helped me understand that I am not alone in this battle against diabetes and that there are great minds and ideas at work to try and control this epidemic." Medical Assistant
- "I got a lot of ideas from everyone about how to help my patients. It was really, really hard to change my practice, but it was really, really fun." Physician from Pilot Practice

## Collaborative Participants

Bright Medical Associates\*  
Brown & Toland Medical Group  
Diabetes Society of Santa Clara Valley\*  
Greater Newport Physicians\*  
Hill Physicians Medical Group  
Humboldt Del Norte IPA  
John Muir/Mt. Diablo Health Network\*

Memorial Healthcare IPA  
Palo Alto Medical Foundation  
Physicians Medical Group of Santa Cruz County  
Santa Cruz Medical Foundation  
Sharp Community Medical Group\*  
St. Joseph Heritage Medical Group  
St. Joseph Hospital Affiliated Physicians

\* These groups participated as collaborative observers. Observers did not have a pilot physician site testing changes and submitting data to the project.

## Next time

The Diabetes & Cardiovascular Care Collaborative is the first initiative of the Breakthroughs in Chronic Care Program. A review of the collaborative process by the staff and participants brought about suggestions for change including,

- Increased focus on planning for and supporting spread of changes to other practices
- Simplification of core and optional measures
- Alternate formats for collaborative meetings, such as web-ex.

For more information on the Breakthroughs in Chronic Care Program or the Diabetes & Cardiovascular Care Collaborative, please visit [www.breakthroughcare.org](http://www.breakthroughcare.org).



**BCCP would like to acknowledge the following organizations for supporting the program.**

**BCCP Major Program Sponsors**

**AstraZeneca  
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Sanofi Aventis**

**BCCP Program Contributors**

**Blue Cross of California  
Blue Shield of California  
California Diabetes Program  
California HealthCare Foundation  
GlaxoSmithKline  
Health Net  
Pacific Business Group on Health  
Pfizer**

**BCCP Program Collaborators**

**California Association of Physician Groups  
California Cooperative Healthcare Reporting Initiative**

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