Original Research

Collaboration in Pennsylvania: Rapidly Spreading Improved Chronic Care for Patients to Practices

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Introduction: *Pennsylvania's Improving Performance in Practice (IPIP) program is administered by the Pennsylvania (PA) chapters of the American Academy of Family Physicians, American College of Physicians, and American Academy of Pediatrics. The project has provided coaching, monthly measurement, and patient registry support for 155 primary-care practices that participate in the 3-year Pennsylvania Chronic Care Initiative led by the PA Governor's Office of Health Care Reform.*

Methods: *Practices participating in this case study are attending regional Breakthrough Series collaboratives and submitting monthly narrative and clinical outcomes reports. The approaches to education include in-person learning sessions with multidisciplinary practice teams, on-site practice coaching, conference calls, and regular feedback of performance data. More than half will receive financial incentives from more than a dozen participating insurers after becoming nationally recognized Patient Centered Medical Homes by the National Committee for Quality Assurance (NCQA).*

Results: *In the first 6 months, practices showed improvement in diabetes process measures and a high level of engagement in the improvement process.*

Discussion: *Early data reporting, practice preparation for the first learning session, monthly narrative reports from practices, and clear and concrete change packages all seem integral to the improvement process. The future of the PA Chronic Care Initiative will include spreading to more practices and moving beyond the initial work in diabetes and asthma to other aspects of primary care, including prevention.*

Key Words: *primary care, chronic care, practice coaching, learning collaborative, system of care, quality improvement, Patient Centered Medical Home, education, continuing*

Introduction

The problems of primary care are well documented: low pay relative to other medical specialties,[1] real and projected workforce shortages as medical students turn away from primary care,[2] outdated practice models that hinder reliable delivery of nationally recommended care,[3] and payment systems that reward fragmented acute care rather than prevention and comprehensive chronic care management.[4]

With this in mind, the Pennsylvania Primary Care Coalition—consisting of the Pennsylvania Academy of Family Physicians, the Pennsylvania Chapter of the American College of Physicians, and the Pennsylvania Chapter of the American Academy of Pediatrics—jointly applied to join

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the Improving Performance in Practice (IPIP) program convened by the American Board of Medical Specialties and funded by the Robert Wood Johnson Foundation. With the support of most of the insurers in Pennsylvania, key state government agencies, and several prominent regional business groups, Pennsylvania's IPIP application was submitted and approved in the summer of 2007.

The IPIP program was designed to bring together stakeholders within a state and to build statewide infrastructure for primary-care improvement. The model includes health professional education on improvement methods and clinical content, performance measurement and reporting, and enduring collaborative improvement networks for sharing data and ideas.

At the same time, Pennsylvania Governor Edward G. Rendell formed the Pennsylvania Chronic Care Management, Reimbursement and Cost Reduction Commission (commonly called the Chronic Care Commission) to develop a strategic plan to address lagging chronic care quality indicators compared with other states and rising health care costs. This commission—including representatives from health plans, physicians, hospitals, nurses, federally qualified health centers, consumers, educators, academic medical centers, labor unions, and state government—presented a strategic plan to Governor Rendell and legislative leaders in February 2008, laying out the case for improving chronic care in Pennsylvania and detailing the specific goals of the initiative.

The strategic plan noted that about half of Pennsylvanians have at least 1 chronic disease and those patients with chronic disease account for 80% of all health care costs, 80% of hospitalizations, 76% of physician visits, and 91% of filled prescriptions in Pennsylvania.[5] Using data from the Pennsylvania Health Care Cost Containment Council, the plan projected more than $4 billion in unnecessary hospital charges for avoidable hospital admissions by chronic care patients in 2007, up from $3.7 billion in 2006 and $3.4 billion in 2005.[6] National benchmarking showed Pennsylvania ranked in the bottom third of states for avoidable chronic disease–related hospitalizations. According to a 2005 study by the Agency for Healthcare Research and Quality (AHRQ), Pennsylvania had 4 times the rate of hospitalizations for diabetes as the best-performing states and 3 times the rate of hospitalizations for pediatric asthma as the best-performing states.[7] These statistics, coupled with the rising incidence of both diabetes and asthma in Pennsylvania,[8] led to an initial focus on adult diabetes and pediatric asthma in the PA Chronic Care Initiative. In early 2008, PA IPIP joined the MacColl Institute and Bailit Health Purchasing as consultants to the Governor's Office of Health Care Reform to help implement the PA Chronic Care Initiative.

The Chronic Care Commission established 4 strategic goals for the PA Chronic Care Initiative.

1. Widespread use of a primary-care reimbursement model that rewards use of the Chronic Care Model, team-based care, patient-centered care coordination, delivery of evidence-based care, patient self-management, quality outcomes, timely access to care, use of a patient registry system, and culturally and linguistically competent care.
2. Broad dissemination of the Chronic Care Model through regional chronic care learning collaboratives.
3. Improvement in chronic care patient satisfaction, access to services, health status, function, and quality of life; improvement in primary care provider satisfaction; improvement in health resources utilization; and improvement in clinical process and outcome measures.
4. Reduction in the cost of providing chronic care by reducing avoidable hospitalizations and ER visits, with mechanisms to assure that some of the savings are realized by all entities paying for health care.[9]

Methods

Overview

The PA Chronic Care Initiative is spreading the Chronic Care Model implementation across the state in waves of regional collaboratives. Practices were invited to submit applications to participate in the program. The professional societies sent information about the program to all physician members in the regions, and the Governor's office and payers also made announcements about the opportunity to participate. Of the approximately 300 practices that applied to participate, 155 were selected by the Governor's Office of Health Care Reform to participate and signed multiyear agreements to attend learning sessions, file monthly reports, and implement the Chronic Care Model. Practices were selected to assure diversity of size, ownership, and patient mix in each collaborative. A small number of practices were removed from consideration because of incomplete applications. For the initial collaboratives, all practices are receiving a small stipend to offset costs of attending the in-person sessions. In selected regions, payers have created incentive programs to pay for care consistent with the Chronic Care Model and to help support the practice infrastructure needed to succeed.

Improvement Support for Practices

Teaching Improvement Methods. Primary-care practices participating in the PA Chronic Care Initiative send improvement teams consisting of a provider champion, day-to-day leader, clinical coordinator, and others to Breakthrough Series–style learning collaboratives, as developed by the Institute for Healthcare Improvement and organized and run by the MacColl Institute.[10] The collaboratives consist of 1- or 2-day learning sessions, which are in-person workshops that include didactic information on improvement methods and specific clinical content, along with time to work within a team to plan practice changes and share methods across teams. Between the learning sessions are action periods when practices work on testing and implementing changes in practice. Practice teams work on developing a system of care by implementing the Chronic Care Model.[11] They test changes

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on how they identify patients, deliver care, make decisions, support patients, and collaborate across the health system and within their communities. Practices are taught the Model for Improvement[12] and encouraged to use rapid-cycle, small tests of change, which lead up to broad implementation. Practices test their changes with the provider champion-led care team and patient panel, and then spread successful changes across their practices.

The collaborative model of education was used, recognizing that traditional continuing medical education (CME) does not have a great track record in changing physician behavior. A univariate metaregression analysis of 36 comparisons by Forsetlund et al found that mixed interactive and didactic education meetings were more effective than either didactic or interactive meetings alone.[13]

Quality-Improvement Coaching. Pennsylvania IPIP has provided practice coaching support to participating practices, including monthly written feedback and guidance on changes being tested, implemented, and spread; on-site visits to help teams problem solve and plan additional changes; resource fulfillment of tools, forms, models, and so on; and networking and sharing of best practices. The practice coaching is a supplement to what occurs in the regional learning collaboratives. The coaching is intended to accelerate the implementation that occurs during the periods between the in-person learning sessions by giving customized feedback and modeling problem solving.

Reporting and Sharing Data. Practices collect data from either their electronic medical record system or an electronic patient registry and submit monthly population-based performance reports on IPIP selected process and outcome measures (TABLE 1) as well as a narrative report describing the changes they are testing, implementing, and spreading. Improving Performance in Practice compiles submitted data into monthly reports showing aggregate as well as individual practice performance for each reported measure over time. Practices review these reports with their improvement coach and with other practices on conference calls and during the in-person workshops. For practices that need additional technology to achieve registry functionality, PA IPIP provides training and support for a subsidized patient registry system (RMD Networks of Centennial, CO).

TABLE 1. Pennsylvania Improving Performance in Practice Measures

Diabetes Measures
Most recent HbA1C > 9
Most recent HbA1C < 7
HbA1C test in past 12 mo
Most recent blood pressure < 130/80
Most recent blood pressure < 140/90
Most recent LDL cholesterol < 100
Most recent LDL cholesterol < 130
LDL cholesterol test in past 12 mo
Annual kidney assessment
Annual eye exam
Annual foot exam
Documented self-management goal
Aspirin use
Statin prescription
ACE/ARB prescription
Annual influenza immunization
Pneumococcal immunization
Query about tobacco use
Smoking cessation counseling
Annual eye exam referral
Asthma Measures
Annual symptom assessment
Persistent asthmatics on controller medication
Annual influenza immunization
Bundle (all or none) of 3 measures above
Asthma action plan
Query about tobacco use/exposure
Smoking cessation counseling

Regional Strategy

The PA Chronic Care Initiative began with the southeast (SE No. 1) region in May 2008, followed by south central (SC), southwest (SW), northwest (NW), northeast (NE), north central (NC), and back to southeast (SE No. 2) (see FIGURE 1). All types of primary care practices (pediatrics, family medicine, and internal medicine) were encouraged to participate. Enrollment was by region to minimize participants' travel time and costs to and from the in-person meetings. Most collaboratives have 20–30 participating practices.

Incentives for Practices

More than a dozen health plans are supporting practices in 4 of the 7 regions (SE No. 1, SC, SW, NE). Although the methods and amounts of payments differ across the regions (TABLE 2), the 104 payer-supported practices are required to participate in their regional learning collaborative and become National Committee for Quality Assurance (NCQA)–recognized Patient Centered Medical Homes to receive the incentive. The Governor's Office of Health Care Reform facilitated a strategy for payments to practices based on the number of full-time-equivalent physicians in the practice, as a proxy for total panel size. By acting as an uninterested intermediary, the Governor's Office negotiated this agree-

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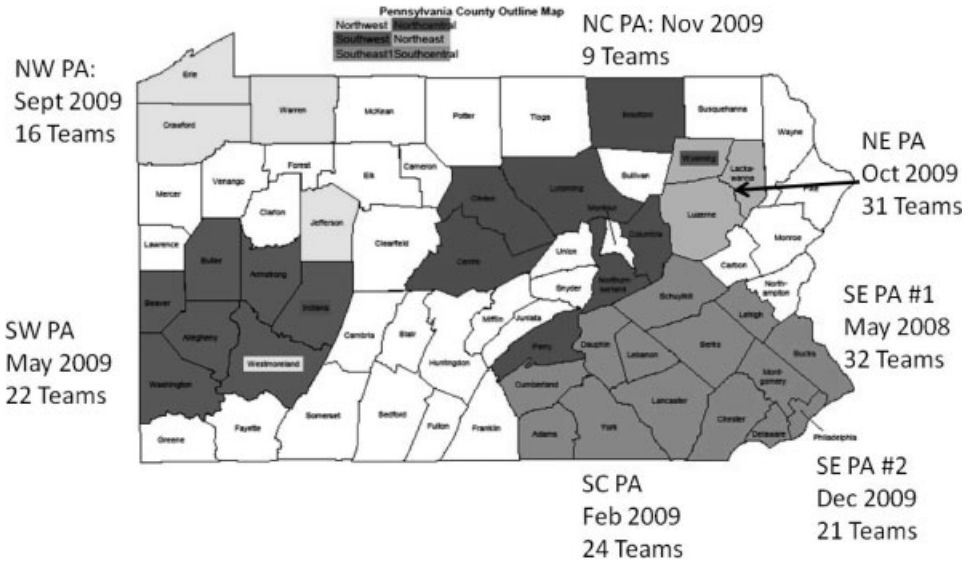

FIGURE 1. Map of Pennsylvania Chronic Care Initiative regional rollouts.

TABLE 2. Regional Financial Incentives in Pennsylvania (PA) Chronic Care Initiative

PA Region and Start Date	No. of Practices and Payers	Available Incentives
SE No. 1, May 2008	32 practices, 6 payers	• Year 1 infrastructure ○ Some lost revenue from attending Learning Sessions ○ Registry/EMR reporting preparation ○ NCQA survey/application fees • Various-sized incentive payments based on practice size for achieving recognition levels in the NCQA's Physician Practice Connections–Patient Centered Medical Home (PPC-PCMH) Physician Recognition Program[14] starting as soon as NCQA scoring complete (practices required to achieve at least NCQA PPC-PCMH Level 1 by Month 12)
SC, February 2009	24 practices,[a] 6 payers	• Year 1 infrastructure (described above) • Care management payment starting as soon as Month 13 for practices that are either hiring or contracting for care management services • NCQA PPC-PCMH Level 1-Plus[b] payment at Month 18 (practices required to achieve at least Level 1-Plus by Month 18) • NCQA PPC-PCMH Level 3 payment at Month 24 for practices that have achieved Level 3
SW, May 2009	22 practices, 4 payers	Same as SC (above)
NE, October 2009	31 practices, 2 payers	• Practice support payments for 3 yr • Care management payment starting as soon as Month 4 for practices that are either hiring or contracting for care management services • Value reimbursement every 6 mo starting at Month 13 for savings that exceed previous payments received, prorated, based on performance on selected improvement criteria starting at Month 12 (practices required to demonstrate improvement on selected criteria by Month 18)
NW, September 2009	16 practices, no payers	$12 000 state grant
NC, November 2009	9 practices	$12 000 state grant
SE No. 2, December 2009	21 practices	$12 000 state grant

[a]Five practices agreed to participate without the payer incentives.

[b]Level 1-Plus = NCQA PPC-PCMH Level 1, with additional requirement for scoring as follows on selected elements: Element 3C at 75% or higher; Element 3D at 100%; Element 4B at 50% or higher.

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ment without violating principles of unfair trade on the part of the payers and clinical practices. Each participating insurer pays its pro rata share of the total available to each practice based on the percentage of revenue that practice receives from that insurer. For example, if Aetna constitutes 20% of the revenues in Practice X, Aetna would pay 20% of the payment defined by the Governor's Office. Because participating insurers pay only on behalf of their membership, not on behalf of fee-for-service Medicare or nonparticipating insurers, no practice receives the full available amount. Some practices have 80% or more patients covered by participating health plans; others have less than half. Payments generally are made to practices on a quarterly basis.

Practices are expected to use these revenues to provide enhanced care management, chronic disease management, and other services associated with being a Patient Centered Medical Home (eg, enhanced access to care, referral and test tracking, e-prescribing, etc). Some of the regional incentive programs have been more prescriptive than others about how practices use these revenues. Statewide, the health plans have committed approximately $30 million over 3 years to the Chronic Care Initiative. This represents less than 0.1% of their collective expenditures on physician claims.

About a third of the total practices—those in NW, NC, and SE No. 2 and including 5 in south central PA who are participating without payer support—have received a 1-time $12,000 grant from the Governor's Office of Health Care Reform to cover the cost of participating in the learning collaborative (eg, foregone revenue from not seeing patients while attending full-day learning sessions). Through the IPIP program, physicians participating in the PA Chronic Care Initiative for 1 year also are able to earn credit toward Part IV of their maintenance of board certification. Starting in 2010, continuing education credits from the American Academy of Family Physicians and Pennsylvania Nurses Association will be available for both participating physicians and nurses.

Staffing

Six staff members in the Governor's Office of Health Care Reform, 5 faculty and consultants, 3 practice coaches, 1 director of quality improvement, and the state director of the PA IPIP program have supported the Chronic Care Initiative to date, including 7 regional learning collaboratives involving 155 practices in 18 months, complicated financial incentive arrangements negotiated via 4 regional steering committees, and a statewide grant program for 3 regional collaboratives.

Results

By the end of 2009, a total of 155 practices were participating across Pennsylvania. Together the practices care for more than 1 million Pennsylvanians, almost 10% of Pennsylvania's population. The practices include all sizes, all geographies, and all primary-care specialties (general internal medicine, family medicine, and pediatrics). Some are federally qualified health centers, some are residency training programs, and some are nurse-managed clinics. More than half had an electronic medical record at the start of the initiative.

A formal evaluation of the PA Chronic Care Initiative is slated to begin in mid-2010 and should provide insight about the levels of improvement achieved, cost savings attained, and improvements in patient or provider satisfaction. Here we present limited quantitative results and our qualitative observations from creating this program.

Practice-Level Change

In Pennsylvania, we have seen remarkable progress in how primary-care practices engage in the improvement process. We have maintained a consistently high number of practices submitting monthly narrative and performance reports (80% or higher in most months). The practices have been encouraged to begin monthly reporting as soon as possible after the first learning session, with the expectation that the sooner practices start reporting data, the sooner they could start improving. Many practices were surprised at what they learned when they first looked at their data. Most realized they had more room for improvement than they thought and became eager to improve their performance. In Pennsylvania, 90% of practices have started reporting within 3 months of their first learning session.

We have seen steady and persistent trends in improvement in performance measures, as illustrated in the data from the first 3 regional collaboratives (FIGURE 2). In all 3 (SE, SC, SW), the rate of improvement was greater for process measures, such as attention to nephropathy, prescribing statins, and establishing self-management goals, than it was for outcomes such as A1C, blood pressure, and cholesterol levels. Early results from the later collaboratives appear to be following similar improvement trajectories.

Many practices have shared that their patient care today is substantially different from their patient care before their involvement in the PA Chronic Care Initiative. They cite greater teamwork, better communication in their practice, and a new partnership with patients among their most valuable outcomes.[15] One practice said the program gave them permission to try new things. One shared they were able to retain patients who were planning to leave the practice, and another shared that 1 patient became so empowered she started a support group for diabetes in her apartment complex. Others said their providers now have data in hand at visits to make decisions about patient care. Several said that using flow sheets and other visit planning tools has improved their efficiency.

Patients also seem to appreciate the new models of care being developed. They like the phone calls from their doctor's office to see how they are doing in between office visits and many more are agreeing to set self-management goals (see FIGURE 2). Some have engaged in group education

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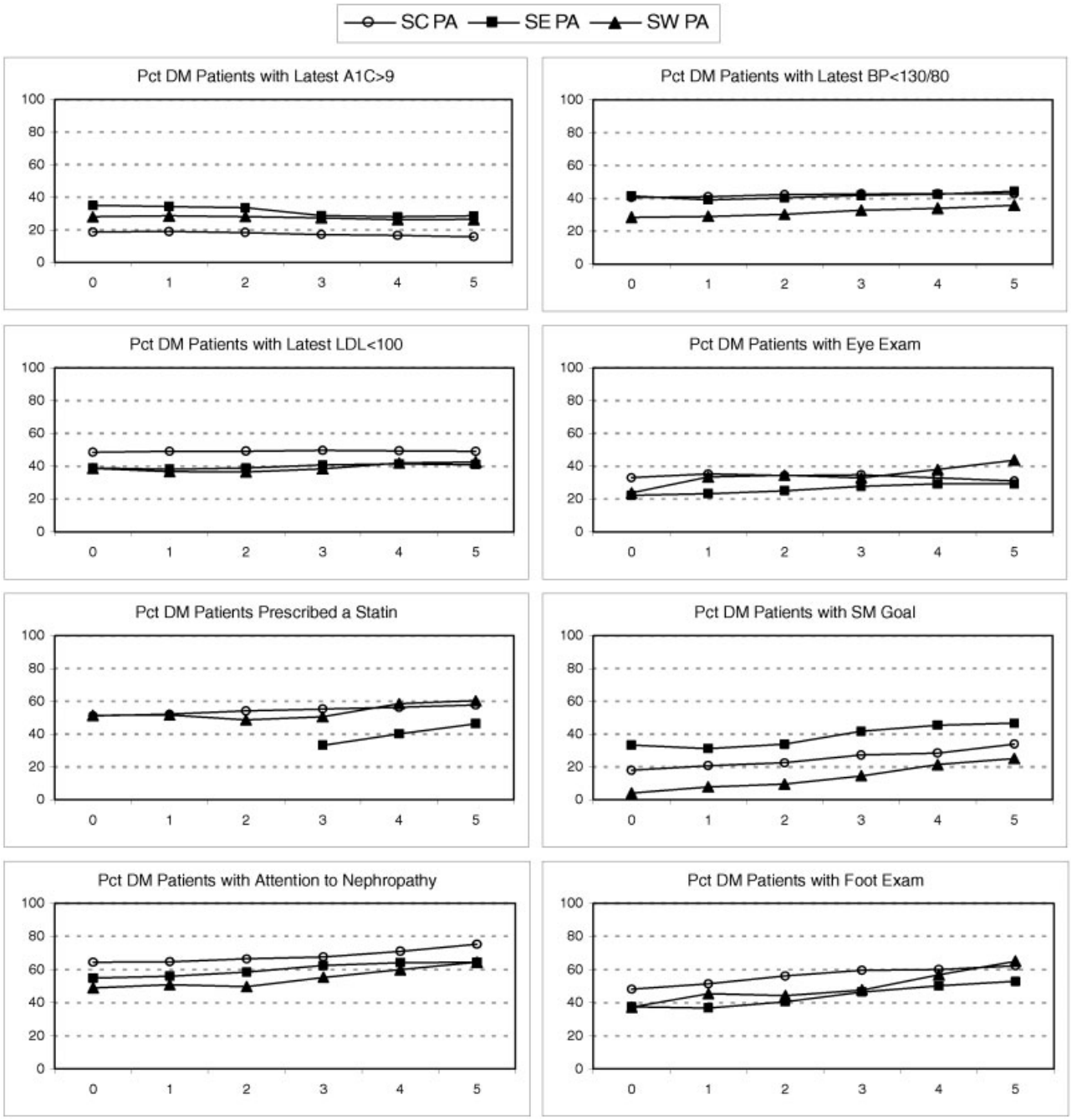

FIGURE 2. Average practice performance for the first 6 months in each of the first 3 regional collaboratives in Pennsylvania (SE, SC, SW). The time periods are as follows: SE PA, June 2008 through November 2008; SC PA, March 2009 through August 2009; SW PA, June 2009 through November 2009. Early improvements were seen in process measures, such as patients with attention to nephropathy, statin prescriptions, foot exams, and self-management goals. Outcome measures for hemoglobin A1C, blood pressure, and LDL (cholesterol) improved more slowly. Note that the statin measure was added in September 2008.

classes or exercise programs organized by their physician's office.[15]

Team engagement in Pennsylvania has been strong, likely due to the alignment of the Governor's Office of Health Care Reform, the health plans, and the provider community through the primary-care societies and PA IPIP. There is a sense among the teams that they are being watched by the nation and that their work and success may help determine the future of primary care. The enthusiasm for this work is palpable across the entire improvement team as they experience a positive change in how they provide care.

Even so, some practices have achieved greater levels of improvement than others. Several practices began implementing electronic medical records just as they were begin-

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ning to participate in the PA Chronic Care Initiative. These practices were challenged to report on the measures as they transitioned from paper to electronic records and generally had more limited time for performance improvement work during their electronic medical records implementation. Other practices were challenged by staff and physician absences and turnover. For example, 3 of the practices had lead clinicians become ill during the process. The effect of these events on ability to make progress reminds us of the fragility of small practices.

Program-Level Change

Just as at the practice level, there is continuous improvement in the program infrastructure at the state/program level. The rapid regional spread schedule of the PA Chronic Care Initiative has provided rapid-cycle opportunities to evaluate how participating practices are being taught and supported. As a CME program, The PA Chronic Care Initiative is focused on achieving change in practice and improved outcomes for patients. In this regard, we continually assess the educational mission of the program. We review qualitative feedback from each learning opportunity combined with the quantitative information reflected in the practice reports.

One example of state-level improvement of the regional collaboratives was additional time and effort devoted to prework before the practices started attending learning sessions. After the first regional collaborative, we began giving practices a month to 6 weeks to review an introduction to the Chronic Care Model, form their improvement team, identify their patients, collect baseline outcomes data, and prepare a poster presentation about their practice for the first learning session. Having this groundwork done prior to the first learning session allows much better use of the in-person time together at the collaborative and enables practices to get right to work on improvement.

Cumulative monthly practice narrative reports provide the story that goes along with the data. Although time-consuming to complete, monthly narrative reports help teams track and record their improvement work. The practice coaches and quality improvement director compare the narrative to the data to provide monthly feedback and strategic guidance to each team. The narrative report template has been revised several times to make it clearer and easier to complete. See FIGURE 3 for an example of the current Year 1 narrative report template.

The faculty have added more specific guidance on changes that should be tested before the second learning session. This specificity, or prescriptiveness, has seemed to help practices leave the first learning session with more focused and well-developed plans for change. For example, more practices starting in Fall 2009 immediately developed an electronic- and/or paper-based system to identify their diabetes patients readily so they could provide planned care any time they saw the patients. Such an identification system allows practices to identify and close any gaps in care in patients that might otherwise be lost to follow-up. It also helps speed up the improvement work as gaps in care are filled more quickly.

Discussion

The PA Chronic Care Initiative has made remarkable progress toward transforming primary care in the state. One hundred fifty-five practices are engaged, are reporting performance data monthly, and are actively participating in improvement collaboratives. The organization of the initiative itself continues to evolve and improve to disseminate best care for our patients more rapidly. Early performance data indicate substantial improvement in care processes. We anticipate additional growth and improvement of the program and of the care received by the patients in PA.

Following a model of continuing education, the program is helping practices implement reliable systems for practicing evidence-based medicine. Although we use lecture format and didactic strategies, they are coupled with ongoing data collection and reporting along with active collaborative sharing. Additionally, the content of learning is more about the systems and processes of care than it is about traditional clinical topics in diabetes and asthma. This style of learning de-emphasizes traditional models of separate education for physicians, nurses, and other staff and brings members of the care team together. This also lays the groundwork for ongoing learning about systems-based care within the practice and translates to improved care for the patient.

As more and more practices pass the 1-year mark in their work in Pennsylvania, we are discussing additional changes in care beyond diabetes and asthma so that other chronic illnesses and preventive services get subsumed into the improved processes. Spreading the system of care necessitates the practice to understand fully its processes of care. We still believe that initial work in 1 disease population affords the practice the opportunity to learn new processes and put in place new systems, but primary-care addresses numerous acute and chronic illnesses and preventive services that can benefit from new approaches.

Another key question at the state program level is what level of practice support is needed for ongoing improvement beyond the first year. In the first year, coaches provide monthly feedback on team progress, and call or visit multiple times. We expected that practices would need less support over time, but we are finding that after 1 year, ongoing support seems helpful. The process of change in clinical practice takes time, and stable, reliable systems are often not in place within 1 year. Moreover, as new content becomes available, some level of practice support is needed to help with implementation. We hope that the role of the practice coach can become more of a connector and facilitator of social connections and spread of ideas and that expertise at the practice level will help to sustain implementation.

Not all practices improve at the same rate, and we are discussing the best way to allocate limited practice coaching

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PA Chronic Care Initiative Collaborative
Cumulative Monthly Practice Report

Practice Name: **Date:**
Person Completing Report:

Team Members: (Please list the members of your team and update as needed with changes. This list should include both the core and expanded team members.)

Team Member Name	Role on team/Title	Email Address	Phone/Extension

Aim:
POF Description: **TPOP:**

Key Measures:

Required Measures	Your Goal	Current Status
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
Any Additional Measures Selected		
1.		
2.		
3.		

Describe your practice as follows.

Total # Physicians/Providers	
Total # Non-Provider Clinical Staff	
Total # Office Staff	

Total # Patients in Practice	
If EMR, what vendor/version?	
What registry system using?	

NCQA Status:	**Tool Purchased:**	**Application Submitted (Date):**

(*continued*)

FIGURE 3. Year 1 Narrative Report Template (3 pages). This is a cumulative monthly report. Teams add to it every month to note the changes they are testing, implementing, and spreading.

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Description of Changes Tested (PDSAs)

Component	Date	Description of PDSAs
Community		Identify effective programs and encourage patients to participate. Form partnerships with community organizations to support or develop evidence-based programs.
Self Management		Emphasize the patient's central role in managing his illness. Assess patient self-management knowledge, behaviors, confidence, and barriers. Provide effective behavior change interventions and ongoing support with peers or professionals. Assure collaborative care-planning and problem-solving by the team. Provide self-management support at all visits.
Delivery System Design		Define roles and delegate tasks among team members. Integrate planned care into all visits. Build effective case management functionality into practice. Assure continuity by the primary care team. Get patients in for regular follow-up care (planned visits, group visits, disease clinics).
Organization of Healthcare		Include measurable goals for chronic illness in the business plan. Senior leaders visibly support improvement in chronic illness care. Use effective improvement strategies aimed at comprehensive system change. Ensure care coordination agreements are in place.
Decision Support		Implement risk stratification strategies to identify high risk patients. Implement the use of standing orders and protocols by team members. Embed evidence-based guidelines, which describe stepped-care, into daily clinical practice. Integrate specialist expertise into primary care. Use proven physician and staff education modalities to support behavior change. Inform patients about guidelines pertinent to their care.
Clinical Information Systems		Provide reminders and feedback for physicians and patients. Identify relevant patient populations and subgroups and provide proactive care. Ensure collection of performance data for quality improvement. Share data with providers and patients. Facilitate individual patient care planning through the registry.

Describe data changes (improvement, lack of improvement, decline in measures)

(*continued*)

FIGURE 3. *Continued*

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List of Changes Implemented

*List, by component of the Chronic Care Model, changes tested that have been **adopted permanently. These changes are now part of the practice/clinic routine**. A one-sentence description is all that is needed.*

Component	Date	Changes **Implemented** (Adopted permanently by the POF)
Community (CO)		
Self Management (SM)		
Delivery System Design (DSD)		
Organization of Healthcare (OH)		
Decision Support (DS)		
Clinical Information Systems (CIS)		

Component	Date	Changes **Spread** to Other Staff, Providers, or Patients
CO		
SM		
DSD		
OH		
DS		
CIS		

What have you learned and what have been your challenges?

What do you plan to work on next month?

FIGURE 3. *Continued*

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Lessons for Practice

- Prework is an important part of a learning collaborative that should not be skipped.
- Narrative reports help practice coaches provide feedback and strategic guidance, as teams track and record their quality improvement work.
- To help practices focus and plan tests of change, prescribe what practices should do between the first and second learning sessions.
- The sooner practices begin to report data, the sooner they can begin to improve.
- Regular team meetings and consistent monthly reporting may be predictors of improvement.

and support resources. One approach is to stratify the practices based on the levels of clinical improvement they have achieved and then to allocate the level of coaching support based on the level of stratification. This consideration has led to a discussion of where to invest the most time: with the high-performing teams to learn what they are doing for "best practices" replication, with the lower-performing teams to help them achieve greater improvement, or with the midperforming teams that are not far from becoming high-performing teams. These decisions create a constant tension in how to allocate limited resources and are important topics for learning across all the state IPIP programs.

We are also experimenting with another approach to practice support by facilitating practice-to-practice learning via "communities of practice."[16] We may, for example, facilitate a community for residency programs, solo practices, or federally qualified health centers. An initial effort to facilitate a pediatric practice community has been very successful. Since the summer of 2009, the pediatric practices from across different regions have had monthly conference calls specific to asthma issues and have had an asthma listserv separate from the regional collaborative listservs. The pediatric practices have appreciated having time and a communications vehicle to discuss asthma separate from diabetes, which has tended to overshadow asthma in the regional collaboratives by virtue of so few practices working on asthma.

Exploring options for practice support is especially important given the limited number of people working on the PA Chronic Care Initiative. As the program grows, without commensurate growth in programmatic budget, we will need to reduce the amount of personal coaching and other support that we provide to practices. It is possible that the momentum achieved, natural social networks, and efficiencies in how to teach the content will obviate some of the current coaching. However, we will continue to follow improvement trajectory closely and revisit the intensity of coaching if improvement pace slows down.

A remaining question—and the 1 asked most frequently—is what comes next? Given the 3-year financial investments by insurers in 4 of the 7 regional collaboratives in Pennsylvania, the PA Chronic Care Initiative represents a new way of thinking about how to purchase primary care. Although the optimum level of investment is not known, it seems clear that some level of investment in primary-care practices is beneficial in achieving higher levels of commitment, achievement, and performance improvement. It also seems clear that the insurers are eager to assure that their investment is well spent. Insurers in Pennsylvania have helped pay for practice coaching in the PA Chronic Care Initiative and may wish to continue that support to protect their investment in primary-care practice transformation. The results of the statewide evaluation will be central to discussions for expansion and spread of the PA Chronic Care Initiative and a revised primary-care payment system that centers on population management.

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