Evaluation of the *Optimizing Primary Care Collaborative*

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EXECUTIVE SUMMARY

By focusing on patient flow, primary care and other health care settings can increase efficiency and capacity with the potential to generate more revenue through visits and improve patient satisfaction. Achieving optimal patient flow is dependent upon a number of practice-specific factors, including the goals and priorities of the practice, the practice style of its physicians, and characteristics of the patient population, among others. While system redesign efforts can be implemented using a number of strategies, meaningful change is unlikely to occur without a thorough understanding of patient care processes within a practice and identification of practice-specific strategies that can reduce process variation in patient flow.

The CPCA’s Primary Care Optimization initiative, supported by the Bureau of Primary Health Care and facilitated by Mark Murray and Associates, was launched in April 2007. Structured as a one-year learning collaborative and based on the Care Model, the Model for Improvement, and the Learning Model, it was designed to reduce delays in access to care in primary and specialty care settings, reduce delays at appointments, improve clinical care with a special focus on cancer prevention, and improve provider and staff satisfaction. A subsequent Optimizing Primary Care Collaborative (OPCC) for Federally Qualified Health Centers was launched in April 2008 with goals similar to the 2007-08 Collaborative.

White Mountain Research Associates, LLC was asked by CHCF staff to evaluate the OPCC initiative, with a primary emphasis on the impact of the learning Collaborative on a number of access to care process and outcome measures and long-term sustainability of improvement strategies. The overall purpose of the OPCC evaluation was to document key lessons learned in improving access to care among a group of community clinics participating in a collaborative learning community, including program successes, challenges faced, and evidence of sustainability and spread.

Although success was variable across sites, virtually all teams were able to document positive changes in at least one of their advanced access measures overall or for at least one of their provider teams; 88% of teams reported positive changes in at least 2 advanced access and patient satisfaction measures, and 63% reported positive changes in 3 or more these measures. The greatest improvements were documented for access to care measures and cycle time. These findings are noteworthy given the organizational instability and economic uncertainty faced by a number of these community clinics. Interviews with team leaders and feedback through a web-based survey suggest that the overall OPCC goals and practice redesign approaches were aligned with the goals and expectations of the participating clinics. Most teams reported either expanding the use of these redesign strategies as part of OPCC or newly
adopting these redesign strategies. This is also a notable finding since it indicates that virtually all of the teams were introduced to entirely new approaches to improve clinical care at the systems level and/or used redesign approaches that they had previously adopted but in a more strategic way.

The results of the interviews and surveys also suggest that the learning community framework is an appropriate vehicle for introducing practice teams to the *Model for Improvement* and the *Learning Model*. The added value of adopting the strategies used by peers and troubleshooting issues in a true learning community environment was a consistent theme echoed by the participating teams. In addition, the program, its staff, and consultants provide a unique set of skills and strategies to help clinics transform the way care is provided.

Our findings suggest that the OPCC framework is promising and has strong potential for serving as a model for a larger scale rollout of this initiative to other community clinics throughout California, and as a catalyst for a cultural shift in the way health care has been traditionally provided in community health centers.
BACKGROUND AND EVALUATION METHODS

“The healthcare system is currently designed to produce exactly the levels of delays and access we now experience. Results, costs, waiting times, access to services—all are properties of the system of work itself. Performance is not simply—it is not even mainly—a matter of effort; it is a matter of design.”

By focusing on patient flow, primary care and other health care settings can increase efficiency and capacity with the potential to generate more revenue through visits and improve patient satisfaction. Achieving optimal patient flow is dependent upon a number of practice-specific factors, including the goals and priorities of the practice, the practice style of its physicians, and characteristics of the patient population, among others. A number of organizations have either funded or implemented collaborative quality improvement strategies to reduce the process variation that impacts patient flow, including the California HealthCare Foundation, the Robert Wood Johnson Foundation, and the Institute for Healthcare Improvement. For the most part, strategies to reduce variation in patient flow focus on systems-level changes that can be sustained by the health care delivery system and ultimately spread to other settings. Collaborative quality improvement strategies have been implemented across many different types of health care delivery settings in the United States and abroad, using “whole systems” approaches to optimizing patient flow.

While system re-design efforts can be implemented using a number of strategies, meaningful change is unlikely to occur without a thorough understanding of patient care processes within a practice and identification of practice-specific strategies that can reduce process variation in patient flow. Such strategies, for example, might include a number of different systems-level changes to shape demand, match supply and demand, and increase capacity, including:

- Reducing the number of appointment types;
- Reducing the backlog;
- Extending clinically appropriate return visit intervals;
- Predicting and anticipating patient needs;
- Managing the “bottlenecks”;

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Maximizing activity at the visit to reduce future demand;
- Supplementing face-to-face visits with alternative methods of care (e.g., telephone advice and triage, email, group visits);
- Optimizing the care team by expanding the role of nurses and non-clinician staff and reducing non-care tasks for physicians;
- Balancing capacity and demand on a daily, weekly, and long-term basis; and,
- Synchronizing patients, information, and resources within the office to "do today's work today."5,6

A critical first step in implementing access process improvement strategies around patient flow is measurement—including flow mapping and cycle time measurement. Additional measurement strategies also might include tracking physicians' reasons for interrupting patient encounters, talking with patients and staff about their perceptions of patient flow, and continuous monitoring efforts to track implementation strategies to be sure they do not have negative unintended consequences.2 While improvement methods and measurement strategies can vary, a commonly used framework for accelerating improvement is the “Model for Improvement”, which helps health care delivery systems define change processes by using Plan-Do-Study-Act cycles to test changes and determine if the change made results in an improvement.7

In addition, a specific access and efficiency change package has already been developed and shown to improve program outcomes.

In July 2006, The Lewin Group completed an evaluation of the California HealthCare Foundation's Ambulatory Care Redesign Collaborative, which was designed to “…rethink and redesign clinic processes to achieve dramatic improvements in performance. In particular, efforts focus[ed] on improving patient cycle time, provider productivity, and provider and patient satisfaction levels at nine clinic sites affiliated with five public hospital and healthcare systems in California.”8 The overall evaluation indicated a 45% improvement in cycle time across all clinics, a 36% increase in provider productivity, and improved patient and staff satisfaction, with fairly large variation in these outcome measures across sites. Interviews with teams participating in the redesign collaborative indicated a number of factors related to sustaining and spreading these achievements, including committed senior leadership, continued performance measurement, staff cross-training and empowerment, and the use of staff incentive and support programs.9

7 http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/.
8 http://www.chcf.org/topics/view.cfm?itemID=123738
for Healthcare Improvement, a similar set of factors was found to be related to program success, including senior leader oversight and involvement, physician involvement and commitment of the day-to-day project manager, implementing a high percentage of change concepts, ability to modify supply to balance demand, and commitment to data collection and analysis.  

Building upon these redesign efforts, the California HealthCare Foundation provided $1.9 million in support to the California Primary Care Association (CPCA) for an implementation grant, *Accelerating Quality Improvement through Collaboration*, designed to “…accelerate the spread of quality improvement methods and processes, and to use electronic data for standardization by California’s community health centers and clinics to improve diabetes (and ultimately other chronic disease) care for low-income patients.” The CPCA’s *Primary Care Optimization* initiative, supported by the Bureau of Primary Health Care and facilitated by Mark Murray and Associates, was launched in April 2007. Structured as a one-year learning collaborative and based on the Care Model, the Model for Improvement, and the Learning Model, it was designed to reduce delays in access to care in primary and specialty care settings, reduce delays at appointments, improve clinical care with a special focus on cancer prevention, and improve provider and staff satisfaction. A total of 21 of 27 teams completed the collaborative and represented states participating in the Pacific West Cluster Health Disparities Collaborative.

A subsequent *Optimizing Primary Care Collaborative* (OPCC) for Federally Qualified Health Centers was launched in April 2008 with goals similar to the 2007-08 Collaborative. Each team was charged with creating three primary aims around the three categories of primary care optimization: access, office efficiency, and clinical care. Sixteen community health clinics were accepted as “Phase 1” teams (15 California teams and 1 Arizona team) and eight were accepted as “Phase 2” teams (6 California teams and 2 Arizona teams). Phase I activities included a pre-work period (completed in four separate teleconferences in April and May 2008), five learning sessions (face-to-face and virtual), five 1-hour monthly team teleconferences, team reports, and storyboard sessions at each learning session. Phase II activities included quarterly team calls and reports with coaching and technical assistance from Mark Murray and Associates faculty. In addition to documenting the success of the teams in improving various measure of access, office efficiency, and clinical care, CHCF staff and project staff also were interested in documenting efforts around program sustainability and spread of redesign processes from both Collaboratives.

White Mountain Research Associates, LLC was asked by CHCF staff to evaluate the OPCC initiative, with a primary emphasis on the impact of the learning Collaborative on a number of

access to care process and outcome measures and long-term sustainability of improvement strategies. The overall purpose of the OPCC evaluation was to document key lessons learned in improving access to care among a group of community clinics participating in a collaborative learning community, including program successes, challenges faced, and evidence of sustainability and spread. A mixed methods approach (i.e., quantitative and qualitative methods) was used to evaluate the success of the learning community, including the impact of the training curricula and change package, support through teleconferences, and coaching and technical assistance on operational processes, and success in improving access, office efficiency, and clinical care outcomes. A combination of surveys and interviews with community clinic staff also was used to document the initiative’s longer-term impact on systems-level sustainability and spread of change strategies, tools, and resources to other clinic sites/locations. The following logic model was used to help guide the evaluation strategy:
Advanced Access Measures and Reporting

At the beginning of the Collaborative, each team was provided with an Excel workbook developed by Mark Murray and Associates to help teams track a set of advanced access and clinical measures over the course of the OPC Collaborative. Completed workbooks were then posted periodically on the HRSA extranet.

Teams were expected to collect and report on a set of advanced access, office efficiency and clinical measures, as a way to help them document the impact of their practice redesign/rapid cycle improvement strategies and make midcourse corrections as necessary. These measures spanned across access, office efficiency, and clinical care and included the following (see Appendix for definitions of these measures):

- activity
- continuity
- cycle time
- delay
- demand
- no shows
- panel size
- supply
- clinical measures (i.e., cancer prevention) as determined by each team

Summary data for each of the clinics were synthesized from the Excel workbooks documented by each team.

Interviews with OPCC Team Leaders

In a previous midcourse report (Midcourse Findings from Interviews with OPCC Team Leaders, January 2009), findings from interviews with OPCC team leaders of clinics from both the 2007-08 and 2008-09 Collaboratives were presented. The interviews focused on specific ways that the change strategies introduced in OPCC impacted operational processes and efficiencies, plans for sustainability, facilitators of and barriers to sustainability, and feedback on the collaborative methods utilized by the project staff. A subsequent round of interviews was conducted in July 2009 with teams from the 2008-09 Collaborative to document the type and extent of spread initiated by the teams 3-6 months after the program ended.
Patient Satisfaction Measures

Phase 1 teams also were asked to collect information on a set of standardized patient satisfaction measures in September 2008, based on a sample of patients randomly selected at baseline, and then again at the end of the Collaborative in February 2009. Patients were asked to respond to the following three questions at the end of their visit (“Tell Us About Your Visit Today” survey), reflecting access and office efficiency as perceived by the patient:

- How would you rate the length of time you waited to get this appointment?
- How would you rate the length of time you waited during today’s visit?
- How would rate a recent experience getting through to this office by phone?

Team-specific and overall results of the pre/post changes are reported in the Appendix.

Follow-up Web Survey on Practice Redesign

Team leaders and other core team members from participating clinics in Phase 1 and 2 of the 2008-09 Collaborative were asked to respond to a brief web-based survey between August 17 and November 23, 2009 to assess their experiences with the OPCC Learning Community and provide impressions of the program’s overall impact on patient access to care, office flow, and efficiency. The survey focused primarily on the extent to which the various strategies for redesigning access, office efficiency, and clinical care that were taught through the Collaborative were being utilized by each of the sites. The survey also documented the perceived benefits gained through participation in the Collaborative and potential barriers encountered in implementing the various redesign strategies.

Other Measures

Teams were encouraged to collect additional information on teamwork measures (i.e., to measure the team’s “state of health”) to guide them in their improvement work. Other sources of information included team storyboards and monthly feedback reports. Finally, program staff rated each team monthly on their progress, using a Likert scale of 1 to 5 (with a score of 1 referring to a “nonstarter” and a score of 5 referring to “leading edge results”).
SUMMARY OF FINDINGS

Team Progress in Meeting Advanced Access Goals

As shown in the Overall Changes in Measures table on page 24, the percentage of teams reporting on specific measures was variable, ranging from 19% for continuity to 94% for access measures, although data were reported from at least half of all teams for five measures and from 80% of teams for four of the tracking measures. In addition, all teams with the exception of one, reported on at least one of the two access measures. The following tables provide a summary of the specific aims developed by each of the teams across access, office efficiency, and clinical care, as well as the findings for the primary measures. Some teams did not consistently turn in their workbooks, so that when available, data were obtained from the other sources noted in the previous section.

As shown in the Team Aims table below, many teams attempted to reach same or next day access for their patients, while a handful of teams set their access goal for anywhere from 2 to 5 days. Some teams concentrated their access aims on achieving an increase in after-hours appointments, reducing missed appointments, or decreasing the response time for calling the clinic. In terms of office efficiency measures, about half of the teams aimed to reduce overall cycle times to an hour or less, while other teams attempted to reduce cycle times to 45 minutes. Clinical care measures were tailored to each team, and therefore, vary greatly across the teams in terms of focus and target populations.
### Optimizing Primary Care Collaborative, 2008-2009

**Team Aims***

<table>
<thead>
<tr>
<th>Team</th>
<th>Access to Care</th>
<th>Office Efficiency</th>
<th>Clinical Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase I Teams</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Team 1</strong></td>
<td>By June 2009, 100% of our patients will be offered an appointment with their primary care provider or a back-up provider in the absence of their PCP, from a baseline of 15 days to same day.</td>
<td>By June 2009, we will achieve a 52% reduction in overall cycle time for appointments, from 117 minutes to 60 minutes</td>
<td>By June 2009, 100% of our female patients 40 years and older will have an annual mammogram.</td>
</tr>
<tr>
<td><strong>Team 2</strong></td>
<td>Within 12 months, we will provide same day access to a 100% of patients that seek care with their primary care provider or a teammate in the absence of the PCP</td>
<td>Within 12 months we will reduce cycle time for appointments by 25%, from 60 minutes to 45 minutes</td>
<td></td>
</tr>
</tbody>
</table>
| **Team 3** | With in 12 months, 100% of our patients will be offered an appointment within 24 hours with their primary care provider or teammate, in the absence of their PCP | • Within 12 months we will reduce the no show rate by 40%, to a 30% overall no show rate.  
• 60 minute cycle time for all scheduled appointments, year round | • 50% of all adults 18 years of age and older will have an assessment and update of needed vaccinations  
• 70% of all diabetics will have at least one follow-up A1c within 6 months of diagnosis |
<table>
<thead>
<tr>
<th>Team</th>
<th>Access to Care</th>
<th>Office Efficiency</th>
<th>Clinical Care</th>
</tr>
</thead>
</table>
| Team 4   | Within 12 months, 100% of our patients will be offered a same day appointment for any reason with their primary care provider, or a teammate in the absence of their PCP | Within 12 months, our office will achieve a substantial reduction in overall cycle time for appointments, from 63 minutes to 45 minutes | • Within 12 months, 90% of female patients 21-64 will have had a pap smear within the last 3 years, either at our clinic or another clinic.  
• Within 12 months, 70% of all women 52-69 will have had a mammogram in the last two years |
<p>| Team 5   | Increase after-hours (after 5:00pm) availability from 16 appointments to 32 appointments; Increase from an average of 45 to 82 after-hours patients per month | Decrease average cycle time to below 45 minutes                   | Increase the percentage of patients over age 51 that have been screened for colon cancer to at least 80% by January 2009 |
| Team 6   | Next available appointment with PCP should be 3 days or less                   | Average time from patient check-in from the receptionist to the completion of the medical visit (cycle time) should be 35 minutes |                                                                                   |
| Team 7   | Within 12 months, 100% of patients will be offered a same day appointment with their own provider (or the provider covering for them) | Within 12 months, achieve a 15% reduction in the overall cycle time for pediatric physicals from 115 minutes to 60 minutes | Within 12 months, 95% of our pediatric patients will be up-to-date on their immunizations |</p>
<table>
<thead>
<tr>
<th>Team</th>
<th>Access to Care</th>
<th>Office Efficiency</th>
<th>Clinical Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Team 8</strong></td>
<td>Every patient requesting an appointment via phone or in person will be seen by a physician within 24-48 hrs</td>
<td>90% of incoming calls answered in person and directed accordingly</td>
<td>Increase access to mammography services and reduce late stage breast cancer diagnosis among women in our county through a comprehensive mobile mammography program</td>
</tr>
<tr>
<td><strong>Team 9</strong></td>
<td>Achieve same day availability for short appointments and next day availability for long appointments by December 31, 2008</td>
<td>Reduce cycle time to 45 minutes by December 31, 2008</td>
<td>Within 12 months we will increase by 50% the number of our low risk patients &gt; 51 years of age who are offered annual colorectal screening</td>
</tr>
<tr>
<td><strong>Team 10</strong></td>
<td>Within 12 months we will offer 100% of our patients an appointment with their PCP or with a teammate in the absence of their PCP in ≤ 5 days</td>
<td>Within 12 months our office will achieve a 25% reduction in overall cycle time for appointments from 60 minutes to 45 minutes</td>
<td></td>
</tr>
</tbody>
</table>
| **Team 11** | - Decrease no show rate to less than 20%  
- Decrease response time for patients calling the clinic to < 24 hours | Decrease cycle time to less than 60 min                                           | • 80% of patients will get a yearly retinal screen  
• 60% of patients will have A1c <7.0  
• 80% of patients will have LDL < 100  
• 80% of patients will be given Pneumovax  
• 80% of patients will have a self-management goal |
### Team Aims*

<table>
<thead>
<tr>
<th>Team</th>
<th>Access to Care</th>
<th>Office Efficiency</th>
<th>Clinical Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Team 12</strong></td>
<td>Within 12 months, 100% of our patients will be offered an appointment within 24 hours for any problem with their primary care provider or a teammate in the absence of their PCP</td>
<td>Within 12 months, our office will achieve a 40% reduction in overall cycle time for appointments, from 75 minutes to 45 minutes</td>
<td>Increase % of women ! age 21 will have had a Pap smear within the prior 3 years from our current rate of 75% to 90% within 1 year</td>
</tr>
</tbody>
</table>

### Phase II Teams

| Team 13 | | |
|---------|----------------|-----------------
| **Team 13** | • By February 2008, 100% of our patients will be offered an appointment today with their primary care provider or a teammate in the absence of their PCP (2007 aim) | • Within 12 months we will have a 24% decrease in cycle time from 53 to 40 minutes (2007 aim) |
| | • Continue same/next day access through the transition to EHR (2008 aim) | • Return to 40 minute cycle time within 2 months of instituting HER (2008 aim) |
| | By June 2008 we will have improved screening for mammography from 35% to 70% of women over 40 having had a mammogram in the past year (2007 aim) | |

| Team 14 | | |
|---------|----------------|-----------------
| **Team 14** | To implement open access for all providers by December 2008 | To improve and increase likelihood to recommend practice and meet the 95% goal by Feb of 2009 |
| | | To enroll all diabetic patients to the registry |

| Team 15 | | |
|---------|----------------|-----------------
| **Team 15** | Within 12 months, 100% of our patients will be offered a same day appointment with their primary care provider or a teammate in the absence of their PCP | Within 12 months, achieve a reduction in overall cycle times from 113 to 50 minutes |
### Team Aims*

<table>
<thead>
<tr>
<th>Team</th>
<th>Access to Care</th>
<th>Office Efficiency</th>
<th>Clinical Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team 16</td>
<td>Within 12 months, 100% of our patients requesting an appointment will be offered an appointment on the same day with their primary care provider or a teammate in the absence of their PCP</td>
<td>Within 12 months, reduce the overall cycle time for appointments by 25%</td>
<td>&gt;70 Percent of women &gt;42 years of age will have had a mammogram in the previous 2 years</td>
</tr>
</tbody>
</table>

*A blank cell indicates that team aims were not available and/or the team did not focus on this aim area.*
<table>
<thead>
<tr>
<th>Team</th>
<th>Access to Care Avg Delay - Short (3rd Next Available Appointment)</th>
<th>Access to Care Avg Delay - Long (3rd Next Available Appointment)</th>
<th>Cycle Time</th>
<th>Supply/Demand</th>
<th>No Show Rate</th>
<th>Continuity</th>
<th>Clinical Measures</th>
<th>Panel Size</th>
<th>Patient Satisfaction Data**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PHASE I TEAMS</strong></td>
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<td></td>
</tr>
<tr>
<td>Team 1</td>
<td>Decrease from 11 to 5 days</td>
<td>Decrease from 17 to 9 days</td>
<td>No change</td>
<td>S&gt;D (increasing)</td>
<td>No change</td>
<td></td>
<td></td>
<td></td>
<td>Mammogram screening increased from 27% to 32%</td>
</tr>
<tr>
<td>Team 2</td>
<td>Decrease for 1 of 4 providers from 23 to 7 days</td>
<td>Decrease for 1 of 4 providers from 23 to 7 days</td>
<td>Decrease from ~60 to ~18 minutes (short appt)</td>
<td>S&gt;D (increasing)</td>
<td>No change</td>
<td></td>
<td></td>
<td></td>
<td>Appropriate panel size identified</td>
</tr>
<tr>
<td>Team 3</td>
<td>• Decrease from 8 to 1 day for site #1</td>
<td>• Decrease from 25 to 4 days for site #1</td>
<td>No Change (short appt) for site #1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Panel determination in process</td>
</tr>
<tr>
<td></td>
<td>• Decrease from 11 to 3 days for site #2</td>
<td>• Decrease from 9 to 4 days for site #2</td>
<td>• Decrease from ~70 min to ~30 min for site #2</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• (% same day appointments increased from ~30% to ~40%)</td>
<td>• (% same day appointments increased from ~30% to ~40%)</td>
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<tr>
<td>Team</td>
<td>Access to Care Avg Delay - Short (3rd Next Available Appointment)</td>
<td>Access to Care Avg Delay - Long (3rd Next Available Appointment)</td>
<td>Cycle Time</td>
<td>Supply/ Demand</td>
<td>No Show Rate</td>
<td>Continuity</td>
<td>Clinical Measures</td>
<td>Panel Size</td>
<td>Patient Satisfaction Data**</td>
</tr>
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</tr>
<tr>
<td>Team 4</td>
<td>Decrease from 25 to 23 days</td>
<td>Decrease from ~75 min to ~68 min (short appt)</td>
<td>S&gt;D</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Panel size calculated</td>
</tr>
<tr>
<td>Team 5</td>
<td>- “always below 72 hours”; “usually &lt;24 hrs” (no data provided)</td>
<td>- Increase from ~75 min to ~90 min for provider #1</td>
<td>S&gt;D</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>98% would recommend clinic</td>
</tr>
</tbody>
</table>
### Changes in Team Measures*

<table>
<thead>
<tr>
<th>Team</th>
<th>Access to Care Avg Delay - Short (3rd Next Available Appointment)</th>
<th>Access to Care Avg Delay - Long (3rd Next Available Appointment)</th>
<th>Cycle Time</th>
<th>Supply/Demand</th>
<th>No Show Rate</th>
<th>Continuity</th>
<th>Clinical Measures</th>
<th>Panel Size</th>
<th>Patient Satisfaction Data**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Team 6</strong></td>
<td>Decreased across 4 providers and overall from 20 to 14</td>
<td>Decreased across 3 providers and overall from 57 to 33 min</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Panel size calculated</td>
</tr>
<tr>
<td><strong>Team 7</strong></td>
<td>Decreased for 3 of 9 providers (no change overall)</td>
<td>Decreased for 1 of 9 providers (no change overall)</td>
<td></td>
<td>D&gt;S</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Calculated individual panel sizes</td>
</tr>
<tr>
<td><strong>Team 8</strong></td>
<td>Decreased for 2 of 3 providers; decreased from 47 to 5 days</td>
<td>Decreased across 4 of 4 providers; overall change from 47 to 3 days</td>
<td></td>
<td>S&gt;D</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Panel size calculated</td>
</tr>
</tbody>
</table>

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*Changes in Team Measures:

- **Team 6**: Decreased across 4 providers and overall from 20 to 14.
- **Team 7**: Decreased for 3 of 9 providers (no change overall).
- **Team 8**: Decreased for 2 of 3 providers; decreased from 47 to 5 days.

**Panel Size** and **Patient Satisfaction Data** have been calculated for the respective teams.

---

**No Show Rate**

- **Team 6**: Decreased across 3 providers and overall from 57 to 33 min.
- **Team 7**: Decreased for 1 of 9 providers (no change overall).
- **Team 8**: Decreased across 4 of 4 providers; overall change from 47 to 3 days.

---

**Continuity**

- **Team 6**: Decreased across 2 of 4 providers.
- **Team 7**: Decreased from ~38% to ~22%.
- **Team 8**: No show % ranges from 19-23% across 3 providers; no change data provided.

---

**Supply/Demand**

- **Team 6**: Decreased across 3 providers and overall from 57 to 33 min.
- **Team 7**: Decreased from ~38% to ~22%.
- **Team 8**: No show % ranges from 19-23% across 3 providers; no change data provided.
## Changes in Team Measures*

<table>
<thead>
<tr>
<th>Team</th>
<th>Access to Care Avg Delay - Short (3\textsuperscript{rd} Next Available Appointment)</th>
<th>Access to Care Avg Delay - Long (3\textsuperscript{rd} Next Available Appointment)</th>
<th>Cycle Time</th>
<th>Supply/Demand</th>
<th>No Show Rate</th>
<th>Continuity</th>
<th>Clinical Measures</th>
<th>Panel Size</th>
<th>Patient Satisfaction Data**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Team 9</strong></td>
<td>Delay trends &lt;1 day across all 3 providers</td>
<td>Decreased across 3 of 3 providers; overall change from ~17 to ~7 days</td>
<td>No change</td>
<td>D&gt;S</td>
<td></td>
<td></td>
<td>Range from 87-92% across 3 providers</td>
<td>Calculated individual panel sizes</td>
<td>• 98% would recommend clinic to family/friend</td>
</tr>
<tr>
<td><strong>Team 10</strong></td>
<td>“Sporadic” decreases among 4 of 4 providers, but not sustained</td>
<td>“Sporadic” decreases among 4 of 4 providers, but not sustained</td>
<td>S&gt;D (demand increasing)</td>
<td>No change</td>
<td></td>
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</tr>
</tbody>
</table>

* Changes in Team Measures

**Patient Satisfaction Data**

- 98% would recommend clinic to family/friend
- 95% were satisfied with access to services, care they received, and phone access
### Changes in Team Measures*

<table>
<thead>
<tr>
<th>Team</th>
<th>Access to Care Avg Delay - Short (3rd Next Available Appointment)</th>
<th>Access to Care Avg Delay - Long (3rd Next Available Appointment)</th>
<th>Cycle Time</th>
<th>Supply/Demand</th>
<th>No Show Rate</th>
<th>Continuity</th>
<th>Clinical Measures</th>
<th>Panel Size</th>
<th>Patient Satisfaction Data**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Team 11</strong></td>
<td>No change, but reached goal (&lt;60 min)</td>
<td>S&gt;D</td>
<td>Overall decrease from ~30% to ~20%</td>
<td>Range from 42-75% across 8 providers</td>
<td>80% of patients receiving annual eye exams (at goal)</td>
<td>No change in A1C, pneumovax, or LDL</td>
<td>Slight increase in patients with SMS goals</td>
<td>Calculated individual panel sizes</td>
<td></td>
</tr>
<tr>
<td><strong>Team 12</strong></td>
<td>Decrease from ~32 to ~10 days</td>
<td>Decrease from ~70 to ~30 days</td>
<td>Increase from 49 to 77 minutes (short appt)</td>
<td>D&gt;S; S&gt;A; all trends increasing</td>
<td>Decrease from 48% to 28%</td>
<td>Calculated individual and ideal panel sizes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team</td>
<td>Access to Care Avg Delay - Short (3rd Next Available Appointment)</td>
<td>Access to Care Avg Delay - Long (3rd Next Available Appointment)</td>
<td>Cycle Time</td>
<td>Supply/Demand</td>
<td>No Show Rate</td>
<td>Continuity</td>
<td>Clinical Measures</td>
<td>Panel Size</td>
<td>Patient Satisfaction Data**</td>
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<tr>
<td>Team 13</td>
<td>Decrease from 14 to &lt;2 days</td>
<td>Decrease from 52 to 49 minutes</td>
<td></td>
<td>S&gt;D; Activity&gt; supply</td>
<td>Decrease for 11 of 13 providers; overall decrease from ~18% to 15%</td>
<td></td>
<td></td>
<td>Calculated individual and ideal panel sizes</td>
<td>Increases across all patient sat measures (i.e., providers and other staff, access, likelihood of referrals, identifies PCP)</td>
</tr>
<tr>
<td>Team 14</td>
<td>Decrease from 29 to 7 days</td>
<td></td>
<td></td>
<td></td>
<td>Decrease from 18% to 11%</td>
<td></td>
<td></td>
<td>Calculated individual and ideal panel sizes</td>
<td></td>
</tr>
<tr>
<td>Team 15</td>
<td>• Avg decrease from 22 to 9 days in peds clinic</td>
<td>• Avg decrease from 34 to 2 days in one clinic</td>
<td>No changes across 2 clinics</td>
<td></td>
<td></td>
<td>No changes across 2 clinics</td>
<td>At 100% for peds clinic and 90% for one clinic</td>
<td>Calculated individual panel sizes</td>
<td></td>
</tr>
</tbody>
</table>
### Changes in Team Measures*

<table>
<thead>
<tr>
<th>Team 16</th>
<th>Access to Care Avg Delay - Short (3rd Next Available Appointment)</th>
<th>Access to Care Avg Delay - Long (3rd Next Available Appointment)</th>
<th>Cycle Time</th>
<th>Supply/Demand</th>
<th>No Show Rate</th>
<th>Continuity</th>
<th>Clinical Measures</th>
<th>Panel Size</th>
<th>Patient Satisfaction Data**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team 16</td>
<td>Avg increase over time from 1 to 27 days</td>
<td></td>
<td>S&gt;D</td>
<td>No change</td>
<td></td>
<td></td>
<td></td>
<td>Calculated individual and ideal panel sizes</td>
<td></td>
</tr>
</tbody>
</table>

* A blank cell indicates that team measures were not available and/or the team did not focus on this area.

**Patient satisfaction measures developed by site (standard patient satisfaction measures across participating sites are presented elsewhere in this report)
Because each team varies greatly in its organizational structure, staff and management support, available resources, patient population, other organizational and team-specific factors, we are cautious about drawing conclusions at the aggregate level. Consistency in data collection and reporting also varied across teams and across measures within teams, despite the offer of a $1,000 cash bonus for meeting specific requirements that included data collection and reporting. However, with these limitations noted, virtually all teams were able to document positive changes in at least one of their advanced access measures overall or for at least one of their provider teams. In fact, of 16 teams reporting data across Phase I and Phase II, 14 teams (88%) reported positive changes in at least 2 advanced access and patient satisfaction measures, and 10 teams (63%) reported positive changes in 3 or more these measures. The greatest improvements were documented for access to care measures and cycle time. Seventy-five percent of teams documented positive changes in either short or long 3rd next available appointments. In addition, over half of reporting teams documented reductions in cycle time. Finally, 81% of teams were able to calculate panel sizes, some of which, subsequently, were able to calculate ideal panel sizes.

The performance of each measure is summarized as follows:

<table>
<thead>
<tr>
<th>Overall Changes in Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Teams Reporting on Measure</td>
</tr>
<tr>
<td>Phase I: 92% Phase II: 100% Overall: 94%</td>
</tr>
<tr>
<td>% Teams Reporting Positive Changes in Measure of All Teams Reporting Data</td>
</tr>
</tbody>
</table>

* process measure on team documentation of panel sizes
**Access** – Three-fourths of all teams reporting access tracking data were able to substantially reduce the days to third next available appointment for either short or long appointment types, and across multiple provider panels.

**Cycle Time** – Of 11 teams reporting on average cycle time, six demonstrated overall decreases and/or decreases across at least one of their clinics. Additionally, six teams reported cycle times that were 60 minutes or less.

**Supply/Demand** – Of 13 teams reporting on supply vs. demand, 77% documented greater supply than demand, and 5 of these teams reported increasing demand over time.

**No Show Rate** – Of 14 teams reporting no show percentages, 50% reported positive changes.

**Continuity** – Although a continuity measure was reported by only 3 teams, 2 of these teams reported at 90% or greater.

**Clinical Measures** – Of 4 teams reporting on clinical measures, all reported improvements in at least one of their measures.

**Panel Size** – 13 of 16 teams (81%) were able to calculate individual panel sizes.

The relatively high success with access and office efficiency measures is also consistent with the monthly team rating reports provided by OPCC program staff. Monthly team ratings\(^\text{11}\) increased consistently from an average rating of 2 in July 2008 (baseline) to an average rating of 3.4 in March 2009 at the final learning session:

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[Image: Average Team Assessment Scores by OPCC Program Staff]

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\(^\text{11}\) Ratings were made by program staff using the following scale: 1.0 - Non-starter; no report; 1.5 - Beginning activities; 2.0 - Activity and aim; no changes; 2.5 - Began testing; no measurable progress; 3.0 - Testing; initial measurable progress; 3.5 - Testing multiple changes; measurable progress over greater than two data points; 4.0 - Reached goals for Collaborative Process; 4.5 - Surpassed goals; spread to wider area; 5.0 - Results are leading edge nationally in Advanced Access
Standardized Patient Satisfaction Measures

Phase 1 teams from the 2008-09 Collaborative were asked to collect and report on a small set of baseline and end-of-program patient satisfaction levels measures in addition to their sitespecific measures. Patients were asked to respond to three questions at the end of their visit, reflecting their perceptions of access and office efficiency. At baseline (September 2008) patient satisfaction varied greatly across the teams reporting on this data for each of these measures. In general, however, while it was expected that a fairly large percentage of patients would rate each of these experiences highly as is typically the case with patient satisfaction measures, there was still considerable room for improvement across the measures, as shown in the following aggregate chart.

![OPCC Phase I Patient Satisfaction Chart]

Overall, a majority of patients rated highly the length of time to get an appointment (48% reported “great”), followed by getting through to the office by phone (46% reported “great”), and finally, length of time waiting during their visit (39% reported “great”). Aggregate follow-up data from the teams reporting on these measures suggest that patient satisfaction remained unchanged and overall was fairly consistent with baseline measures. However, site-specific changes from baseline to follow-up varied greatly among the sites. And, in fact, patient reports of cycle time showed the greatest and most consistent improvements of all three patient satisfaction measures. This is a noteworthy finding since it is consistent with the teams’ overall success in improving cycle times through their participation in the Collaborative, and suggests an association between practice redesign and its subsequent and direct impact on patient satisfaction with care.
Findings from Interviews with OPCC Team Leaders

Interviews were conducted with OPCC team leaders of clinics from both the 2007-08 and 2008-09 Collaboratives. Fourteen team leaders and Collaborative participants from twelve teams were interviewed by telephone by a member of the evaluation team in the first round of interviews conducted between October 9 and December 5, 2008 for a response rate of 80% (12 of 15 teams responded). A second round of follow-up interviews was conducted July 6-27, 2009 with Phase I team leaders participating in the 2008-09 Collaborative for the 11 teams that completed the Collaborative (response rate = 100%). Specifically, interviews were conducted with:

- 1 team from the 2007-08 Collaborative that completed the learning sessions but did not continue to Phase II of the 2008-09 Collaborative;
- 6 teams from the 2007-08 Collaborative that completed the learning sessions and continued to Phase II of the 2008-09 Collaborative;
- 5 teams from both Collaboratives that did not complete all of the learning sessions (2 teams from the 2007-08 Collaborative and 3 teams from the 2008-09 Collaborative); and,
- 11 teams from the 2008-09 Collaborative that completed all of the learning sessions.

The evaluation team received feedback from California HealthCare Foundation staff and project staff from Mark Murray and Associates and the California Primary Care Association during the development of the interview guide to be sure topics of interest were captured for documenting the project’s success (see Appendix for copy of the interview guide). The evaluation team collected information on specific ways that the change strategies have impacted operational processes and efficiencies, plans for sustainability, facilitators of and barriers to sustainability, and feedback on the collaborative methods utilized by the project staff. Each interview followed a standard protocol developed in advance, which included questions about the developments at each site to implement the OPCC change strategies. Assurance of confidentiality preceded each interview. The interviews lasted anywhere from 30 minutes to an hour. Detailed notes taken during the interviews were analyzed qualitatively and summarized for this report.

**OPCC Impact on Clinical, Administrative, and Cultural Change**

Teams utilized a number of very practical strategies introduced in OPCC through Mark Murray and Associates and designed to impact system level changes. These practice redesign
strategies, as reported by the teams, follow Dr. Murray’s guiding principle of “See your own patients. Don’t make them wait.” and, among others, these included:

- Regular staff meetings
- Give providers feedback on their cycle times
- Dedicate provider support team
- Online appointment access
- Implement a phone triage process so that every patient can come to the clinic for a same-day appointment without going through a nurse (this strategy also reportedly reduced liability because it reduced medical judgments via phone; it also freed up time for receptionists)
- Continue use of the Excel workbook (or portions of the workbook) to track changes
- Use the “four cut” method to determine the individual provider panel
- Remove rules around scheduling and type of appointment; no longer dividing people up by appointment (i.e., simplified scheduling process)
- Provide frequent training to change culture of staff and get buy-in to the importance of panels and continuity
- Working knowledge of how to balance daily supply and demand by utilizing a system with more flexibility (i.e., didn’t put limits on appointments day-to-day; some days see more patients, some days fewer patients)
- Introduce backlog reduction strategies
- Utilize team-based approach to care and “team huddles”
- Implement open access scheduling

To get a better sense of the ways in which the Collaborative influenced changes at the systems level, team leaders were asked to provide examples of how implementation of these change strategies impacted clinical, administrative, and/or cultural and organizational shifts in care access and office efficiency at their sites. All teams reported at least one of the following examples of how the OPC Collaborative impacted care at the systems level:

- Increase in patient satisfaction
- Providers are more likely to address multiple concerns at the same visit
- Routine use of data monitoring
- New patient check-in procedure resulted in freeing up time for receptionist
- Providers are more attuned to continuity after implementing a panel management approach
- Cross-department “buy in” and adoption of practice redesign tools
Senior management team is very data driven and wants to institutionalize the collection and reporting of demand/supply and no-show data

Providers were initially resistant to a true open access model but now are engaged, committed, and fully supportive of a new delivery model

Cross-department cultural shift in “doing today’s work today”

Greater overall staff satisfaction and motivation to keep patients to their scheduled appointments and reduce no shows

“…there’s always more people to serve that need care, so if you can take care of the ones that you have better, more efficiently…it gives you more room in your practice for new patients and for expanding your service area, for getting new types of clients, for having more patients that have insurance….”

Feedback on the Overall Impact of the Collaborative

Team leaders were initially asked about their primary reasons for participating in this Collaborative. As expected, all team leaders indicated a desire to improve patient flow in their clinics. Some team leaders could readily identify specific areas for improvement, while others knew they needed to improve patient flow, but did not know where to start or what steps to take to begin this process. One site indicated that the goals of the Collaborative aligned with the clinic’s goals, and staff and patients were frustrated by long wait times resulting in dissatisfaction among patients. Similarly, a second clinic’s medical director heard about the OPC Collaborative and was looking for tools to move to an open access or advance access system because of long wait times experienced by their patients for appointments. Another team could not pinpoint specific areas of need but knew they needed to improve patient access given their growth and the fact that their providers and MAs were always busy. Still another team indicated that the Collaborative would help specifically with improving provider productivity.

“Physician productivity was low and we wanted new tools to make our clinic more efficient and to make ‘productivity’ a good word.”

A few teams joined the Collaborative because they were preparing for rapid growth within their clinic or expansion to other sites. Two teams joined the Collaborative because of a directive from an administrator, despite the fact that the team leaders may have been reluctant to participant in the Collaborative because of clinic/staff readiness and buy-in. A number of teams also were curious about the problems experienced by other teams and possible solutions, underscoring the importance of using the collaborative model as a true learning community. Our experience with other collaboratives is consistent with the feedback from the OPCC clinics,
suggesting the added value of adopting the strategies used by peers and troubleshooting issues in a true learning community environment.

“\textit{The hardest thing in the beginning is that you first have to take time out to figure out the problem and that takes away from provider time. Also, there is a drop in demand that is worrisome initially. You’re doing more complex work that you can bill at a higher rate than you’re doing now, but it’s a hard mindset. Also, people were afraid of the ‘what if.’}”

Team leaders also were asked whether they could recall their original aims and, if so, whether they were still using those aims. Virtually all teams from the 2007-08 \textit{Collaborative} had a general sense of what their original aims were, although only two teams could state specific goals around access, office efficiency and clinic measures. All team leaders reported that they continued to follow their original aims and one team expanded its goals around clinical care.

When asked, specifically, about whether or not teams have met their goals, of the seven teams that completed the 2007-08 \textit{Collaborative} and were interviewed, two teams reported making measureable improvements in one or more of their goals and one team reporting lapsing on their goals (this was attributed to the provider with the largest panel leaving the clinic). For teams participating in the 2008-09 \textit{Collaborative}, all but one of the eleven team leaders that were interviewed reported improvement in at least one of their goal areas although all teams could recall their specific goals. In fact, virtually all teams reported some level of success with a focus on establishing provider panels, which to a great extent served as a gateway for other office improvements. This is consistent with the results of the tracking measures presented above, which show that 83\% of Phase I teams, 75\% of Phase II teams, and 81\% of teams overall reported positive changes through the establishment of provider panels. In addition, it underscores the importance of defining panels as a primary practice re-design strategy, since panel size ultimately impacts patient satisfaction, helps define workload, predicts patient demand, reveals differences in provider productivity, and improves clinical outcomes and reduced costs.\footnote{Murray M, Davies M, Boushon B. Panel size: How many patients can one doctor manage? Family Practice Management, American Academy of Family Physicians. April 2007 (pp 44-51).}

As an example of specific areas of focus for redesign, one team reported improved efficiency at point of entry for patients (achieved by implementing the following redesign strategies: standardize all exams rooms with forms; review all providers’ templates to see how they could help the front desk look for appointments and design a simpler template, since everyone had different appointment codes; develop a protocol for each provider for the front desk around setting appointments). Another team reported their biggest improvement around access to care with an average delay for 3rd next available appointment reduced from 13-14 days at the start
of the Collaborative to 1-2 days by the end of the Collaborative. They also decreased their cycle time from an average of 55 minutes (goal = 40 minutes) to 37 minutes. The clinical aims were a bit harder to reach and the team experienced a more difficult time with the measurement tools to get the information they needed (i.e., does not yet have EMRs to automate the measure and still has to pull this information manually). However, this team reported continued improvements in their mammography rates (improvement from 35% to 45%), although they are still aiming for greater improvements. The clinic has now put a greater emphasis on prevention.

A few teams reported struggling with more basic issues that needed to be overcome before they could even implement strategies to reach their goals, including basic data collection and monitoring—some because of lack of access to electronic measurement strategies and others because of a lack of a basic data collection protocol. For example, one team reported that they were not yet really working on their goals, but are using just a couple of tools first since they are having problems getting their practice management system and EMR working together. A few teams faced challenges with staff buy-in as a first step to success. Still another team reported that they had many steps to take before they could “even begin thinking about their aims.” However, since their original participation in last year’s Collaborative, they report on a positive note to be “on the verge of making changes.”

“…one good thing about us participating in OPC for the prior year was that we could really look at supply and demand in an intelligent way and see the impacts of having more demand than supply on how we function. Realizing that was important to get that more in balance. So we weren’t able to meet the aims but at least we knew what we had to do.”

As a follow-up question to whether teams were able to meet their goals, team leaders were asked about specific change strategies that were implemented at their site, which strategies were the most and least successful, and whether or not they continued to utilize them. The following change strategies were reported by teams to be successful and continue to be used:

- Utilizing cross-disciplinary ½-hour meetings to generate ideas about what works and what doesn’t
- PCP assignment
- Pairing MAs with providers (teamlet approach – some teams referred to this as an MA—provider “marriage”)
- Changed phone triage process so that every patient could come to the clinic for a same-day appointment without going through a nurse (this strategy also reportedly reduced liability because it reduced medical judgments via phone; it also freed up time for receptionists)
- Continued use of the Excel workbook (or portions of the workbook) to track changes
Using the “four cut” method to determine the individual provider panel

Removed rules around scheduling and type of appointment; no longer dividing people up by appointment

Working knowledge of how to balance daily supply and demand by utilizing a system with more flexibility (i.e., didn’t put limits on appointments day-to-day; some days see more patients, some days fewer patients)

Introduced backlog reduction strategies

Utilizing team-based approach to care

Implemented open access

Scheduled providers close to full-time

Doing more training for schedulers

Carved out same-day appointments for all providers

Trained MAs to do most of the patient education and also shifted work from MAs to assistants to free up the physicians office visit time; this did not translate into shorter wait times but did impact work flow

A realization of how the measures were interconnected! (an important point that was mentioned by only a few teams)

“You feel like you’re not meeting your aims, like you’re not progressing and it doesn’t feel good—need some ‘pre-aim’ aims, like those process goals that you feel like you can meet and show some accomplishments. We’ve made a lot of accomplishments, but they’re not related to the aims.”

Teams also were asked about any unintended consequences—either positive or negative—that resulted after putting redesign processes into place. A number of teams commented on the impact of the program at the system/staff level. One team noticed that their receptionist’s time on the phone with patients was dramatically reduced. In addition, the same team reported that their MAs were more satisfied since they were paired exclusively with one provider. In fact, a number of teams commented on the positive impact that pairing MAs with providers had on their clinic and improved satisfaction among providers and MAs. Another team began to realize the importance of a chronic disease management system to track information as a result of working on this project and have regained their focus on getting this up and running. A couple of teams anticipated resistance from providers but actually found that provider and staff satisfaction improved, staff turnover had decreased, and over time providers really were not resistant to the changes being made. One team reported less nonproductive, non-appointment work as a result of the increased continuity of care (for example, responding to calls from upset patients). Still another team reported how significant vacation time was in the equation. Only one team reported a negative consequence of establishing provider panels: they reported difficulties in
establishing a stable team around one provider and are currently trying different strategies to create a more functional team.

Teams also were asked whether they had developed plans for sustaining any of the gains they made through implementing their practice redesign strategies. In addition, they were asked to describe any factors that contributed to improvements or major operational barriers to sustainability. In general, most sites struggled with developing sustainability plans mostly because of organizational barriers. These barriers included competing program priorities, lack of commitment from management, staff turnover or being short-staffed, limited infrastructure, difficulty in creating stable and/or cross-disciplinary teams, lack of an automated data collection system, lack of staff buy-in, and resistance to a change in role definition.

For Phase I teams from the 2008-09 Collaborative, project leaders reported that it was somewhat early in the process for them to think about sustainability. A couple of teams were grappling with issues around senior management turnover, and were working specifically on re-educating management about the benefits of practice re-design, while most teams were drawing up plans around sustainability. Only one of the six sites interviewed from the 2007-08 Collaborative had developed a solid plan for sustainability. That team implemented a number of strategies to sustain the changes they made while simultaneously anticipating the organizational barriers they would face in the practice redesign process. Notably, the team leader from that team reported that, for them, OPCC was never considered a “fringe” project, but mainstreamed into the way they deliver care. “Best practices” included the following: (1) from the beginning, their plans included embedding these strategies into their daily operations and expanding them beyond the OPCC project; (2) obtaining solid institutional support, including support from the medical director and COO; and (3) continued vigilance around measurement (and specifically with panel size) with an eye toward framing this as a quality improvement exercise.

In addition to asking teams whether they had developed sustainability plans, teams also were asked about whether they had spread their practice redesign strategies deeper within the improvement team, to the practice team from the improvement team, or from the practice/improvement team to an entirely new entity. As with the sustainability plans, all teams were interested in spreading their lessons learned across their health care delivery system, although few were in a position for full scale spread to other sites. It is likely that this may be due, in part, to the relatively short follow-up period between the time that 2007-08 Collaborative teams completed the final learning session and the time that the interviews were completed (i.e., about 8 months) and the even shorter follow-up for Phase I 2008-09 teams (i.e., about 4 months). The notion of spread for some of these teams may be a distant goal since these sites are still focusing on their practice redesign strategies and/or are still working toward more basic goals like establishing electronic registries or engaging support from senior staff. However, a few of the teams have reported giving presentations to other clinics about their practice re-design efforts with an eye on spread to these sites. Virtually all of these teams report “testing
the waters” with these clinics to first strategically obtain provider and senior management buy-in. A couple of teams have reported success in spreading their redesign strategies to other sites, while other teams are in the process of drafting plans for spread to some of their larger clinics. These teams are also strategically integrating some of their redesign strategies (such as provider paneling and improving cycle time) into their overall quality improvement processes as a vehicle for spread to other clinics.

One team reported offering their practice redesign strategies and consultation to other clinics. At this point, they are working with these clinics on some of the general principles of practice redesign such as panel assignment. This team also offered a program overview to their management team with the hope of gaining their support for wide-spread use of these strategies by other clinics. Another team reported spreading their practice redesign strategies to other departments. This team anticipates using the same tools with these new departments, although they acknowledge that they may face new challenges because some of these strategies may not be applicable to all departments or the departments may have unique cultures that may not be as amenable to change. Only one team reported failure with an attempt to spread to another clinic—this team started with the largest clinic in the system and thought that if they could successfully implement there, they could implement the process in any of their clinics with success. However, they could not “make a dent in backlog” with this site.

As a final question on the impact of the Collaborative on care access and office efficiency, teams were asked what they would do differently if they could do this over again. The following are selected responses from teams:

- “Took a long time to adopt the teamlet approach and would have liked to do this sooner”
- “Unless there is buy-in from leadership, it isn’t worth investing in this”
- “Need to make sure the infrastructure is there first”
- “Involve more MAs on the team to get their investment”
- “Needed the basics first”
- “Would streamline data collection”
- “Practice management system is antiquated, and would like if some of the processes were automated”
- “Would have gone to an easier/smaller site first to get a ‘win’”
- “Try to get panel size right off the bat”
- “Would have involved a few more people – key support staff (receptionist, MA) – other than just the management staff to immerse clinic in OPC culture”
“I’m a believer of ‘you sometimes have to do a process to get to the point where you want to get to’. It’s really taught us about our data collection systems. We’ve been able to streamline that and automate reports to do…what we need to do. Part of it is truly the process improvement that really gets you there. I wouldn’t change anything. As we do this, we’re learning to capture data and different team methods. A lot of different things come from this that we’re exploring. So this has opened up our ability to explore further.”

Feedback from Team Leaders on OPC Collaborative Methods

The OPC Collaborative used a variety of methods to facilitate sites’ practice redesign processes, including virtual Learning Sessions, coaching for individual sites, phone calls, and other methods. Teams from both Collaboratives were asked to provide feedback on how helpful they thought each of these learning strategies was. Overall responses from both Collaboratives were very similar. For each learning method below, we provide its overall rating as reported by teams (by giving one, two, or three “thumbs up”) along with site-by-site summarized comments about each learning strategy. Although not a primary focus of this evaluation, we hope that plans for future collaboratives might consider these suggestions.

Value in continued data tracking/monitoring and associated measurement tools (Excel workbook)

Overall Rating: ❌

- Critical to use but also hard to use; never used the whole workbook
- Very helpful; a lot of work to keep on track; they used all of the workbook sections except “supply and demand” (they couldn’t do this piece because they had to involve a different department)
- Very positive about use of this, although there were some measures that they still didn’t monitor
- Using a section of the workbook on “reducing delays”; thought it was “kind of helpful” but wanted to understand more how the formulas were set up. The books started getting big when they added a lot of data to it. They weren’t really sure how to use some portions of the workbook and separate workbooks for different departments
- Very helpful – used it consistently, though they had trouble tracking demand, since this measure wasn’t automated
- Very helpful – gave a structure for collecting data; they are using manual data collection and they’re working to automate the data collection; they’re also continuing to use this
- Just used sections of it
Redesign strategies that you learned about

Overall Rating: ⭐️⭐️⭐️

- Having options that worked for their clinics was helpful
- Very useful
- Didn’t get a chance to operationalize this
- Adopted these “subconsciously” and didn’t really use P-D-S-A cycles, per se, and just implemented them. A lot of the strategies validated some of the strategies they already were using.
- Used “huddles” and thought it was effective and still use it; chart prep; team approach; room standardization; assess supply/demand by day of week (balancing supply and demand); developing a scheduling committee; changed how people wait in line; made environmental changes (e.g., amount of space, number of rooms, number of MAs); hired RNs to relieve burden of providers; involved more staff

“We’re on the verge of seeing some really great things.”

Monthly phone calls

Overall Rating: ⭐️⭐️

- Didn’t find calls helpful
- After the second or third phone call they became very repetitive
- Important, but didn’t help with bigger issue around management support
- Teams were good about this and particularly liked this when they heard from other teams about what they tried as opposed to “high concept” themes. They got about 80-90% participation (it was offered with a “free lunch”).
- Very helpful; typically had the whole team (6-8 staff) participate
- Not helpful when listening to other sites’ issues; need to listen for an hour to get a few tiny nuggets
- Liked the smaller groups, but got bored with the larger groups

Coaching/Technical assistance

Overall Rating: ⭐️⭐️

- Somewhat helpful - nice option to have; answers to clinic questions weren’t quite what they hoped
- Coaching was good but didn’t need to seek their assistance
Evaluation of the Optimizing Primary Care Collaborative

- Used on a limited basis
- Very easy to send an e-mail and Mark was good with detailed responses – very responsive. Sometimes the responses were very long, especially along with the articles
- Liked having a resource that was available when they needed it
- Could really use more intensive individual coaching

**WebEx conferences**

Overall Rating: ⭐⭐

**Value**
- In-person meeting was very helpful, but web-ex was repetitive (virtually all teams underscored the value of the in-person meetings and the chance to network with other teams)
- Fairly helpful, but limited because they’re didactic
- Should have some follow-up sessions; some of the session topics were repetitious; they wish they’d spent more time with the teams
- After a couple of sessions some of the information was repetitive, and they tended to lose people
- The most useful was the extended time to work as a team
- Presentations could have been shorter, but having a chunk of time as a team to re-focus and plan was most helpful

**Length of Sessions**
- Too long and too hard to focus on computer screen
- Maybe have less meetings and, if you have to do WebEx, make it shorter
- Might have been a little long
- The presentation parts could have been shorter

**Attendance**
- A nice critical mass at the beginning but team size dwindled
- Hard to keep people at the meetings
- On average they got about 80-90% participation
- It was good because they could host them locally and they could invite other people. On the other hand, it was easy to run off and do other things—people lost interest
- Had to make sure schedules were blocked
Spans funny times across the clinic and it’s hard to schedule patients

These were good but they just got notices and confirmations just a few weeks before – they would have liked more lead time with scheduling – at least quarterly

Tried to bring in team members whenever the topic applied

Down-time didn’t affect them as much since they are a large clinic and there was always coverage

**Storyboards**

Overall Rating: 

- It was good because it forced them to encapsulate their lessons learned; helpful for themselves but listening to other teams was not as helpful
- Very helpful
- Think these are great and fun
- The presentation was a good tool to share with their supervisor and CEO
- They were not of great value
- OK, but a lot of work; liked the storyboards and useful as learning tool – they could then seek out other clinics where they had questions
- Thought this was just busy work

**Background papers**

Overall Rating:

- Thought these were good and took advantage of them – would have liked this in a virtual office environment
- Too many papers and they were repetitive
- Read a lot of the papers
- The ones that Mark published were good but others were hard to “fish out” and were redundant
- Would have preferred to get them all at once broken down by section (an organized library) – maybe a CD with folders (for example, on patient management) – triggered by questions that came up

**Monthly status reports**

Overall Rating:

- These were challenging but useful – they reviewed these as a team
Evaluation of the Optimizing Primary Care Collaborative

- Thought these were helpful
- Helpful to re-focus every month to figure out what was working and what wasn’t
- Very lengthy process and not sure they’re very personalized – don’t feel like they know us
- Thought these were helpful; thought some comments were “direct” (but in a positive way)

**Monthly feedback reports from project staff**

Overall Rating: 🌟🌟🌟🌟🌟

- They became more helpful as the project progressed
- Responses were detailed towards us, but some were “canned responses” (copy and paste). It was still good information, but the report started getting long and they “tuned out” with reading them
- Extremely long; questions seem to be redundant – not getting feedback on time (feedback is “cut and paste” from article); might be worthwhile to get a coach to help with this feedback – not getting feedback in timely manner

**Clinic walkthrough**

Overall Rating: 🌟🌟🌟🌟🌟

- It was useful
- Found this helpful
- Hard to step outside of their roles, but didn’t really do it successfully. The difficulty in doing this was partly due to them.
- Would have been more helpful if more people on the team walked through this.
- Useful to get more people involved in the process and also a good way to identify and understand some of the issues they needed to resolve

“I just want to emphasize that the frankness is real important. It was really helpful for him [Mark] to just say these things and have our CFO hear it and have our CEO hear it. He’s able to say ‘you need to fix this.’ It’s nice for another person to say that! I would keep emphasizing that.”
Feedback from Program “Dropouts”

In addition to documenting the extent to which teams were able to successfully implement and sustain practice redesign strategies, the evaluation team interviewed team leaders from clinics that, for one reason or another, were unable to complete the OPC Phase I Collaborative (from either the 2007-08 or 2008-09 collaborative). Documenting reasons for dropping out of the Collaborative can be helpful for preventing this in the future and for screening, targeting and recruiting clinics that are likely to complete the program. Team leaders were asked why they chose to join the learning community, why they dropped out, and what they would do differently if they had another opportunity to fully participate in the Collaborative.

For the most part, clinics that dropped out of the Collaborative chose to participate in the program for the same reasons reported by clinics that completed the Collaborative, including long wait times, “blocked up” schedules, high “no show” rates, staff and patient dissatisfaction with wait times, and a desire to achieve same or next day visits. Some clinics reported general reasons for participating, including an overall benefit to the clinic (“It sounded like it would benefit the clinic and our patients”) or alignment with an organization-wide strategic plan for change.

Clinic leaders also were asked about their primary reason for not continuing in the Collaborative. All reasons cited for discontinuing in the Collaborative were directly related to readiness of the clinic to participate and/or organizational factors; none were associated with the perceived value of the Collaborative (i.e., all teams placed a high value on the potential benefits of participating in the Collaborative). Given the very different reasons provided by team leaders for dropping out of the Collaborative, we simply present these site-by-site reasons as follows:

- Already were participating in a similar collaborative and decided to drop out of OPCC
- Dropped out prior to the Collaborative because of concerns that their practice management system was too “primitive” to accomplish the supply analysis
- The site was in a severe financial crisis, and the changes they were going to make going forward would perpetuate the crisis by putting a dent in the revenues they would see (i.e., by reducing patient encounters). The clinic has since filed for bankruptcy and was sold to another organization. Reducing the backlog would have resulted in overtime of staff and other staffing issues, as well. The team understood that the process was resource intensive up front and the payoffs would come over time, but in the short-term they were operating in “crisis mode.”
- For financial reasons, this clinic laid off 20% of its employees. In addition, several providers resigned and overall morale in the clinic was very low. The remaining 80% of staff could not spare the time for the Collaborative and the clinic subsequently had to withdraw from it.
This team found collecting the necessary data to be completely overwhelming. The practice management system the team was using was not flexible enough to gather the data so the team had to do it manually. Attempting to go through over 8,000 patients and assign them to a primary care provider to try and meet the "see your own, don't make them wait" goal was impossible, as reported by the team leader.

On a positive note, despite dropping out of the Collaborative, one team noted that it had adopted several of the strategies suggested by the OPC Collaborative with the hope of eventually participating in a future OPC Collaborative.

“…Nonetheless we have adopted several of the interventions suggested by OPCC: we began tracking the time to the third next appointment for every provider and for classes of appointment, waiting time, and no-show rate. We also assigned all our patients to ‘pods’ where providers cover for each other, and we have a system to get our ‘walk in’ patients to see their own provider (holding walk in slots for most providers most days to meet this need). We hope to do the entire OPCC after we implement our EHR, and have decided to begin with assigning all chronically ill and elderly patients to a primary care provider, as a step in the right direction for both OPCC and EHR implementation.”

Finally, team leaders were asked what they would do differently if they had another chance to participate in the Collaborative. One team leader commented that she had the full support of the CEO and CMO, but wish she had reviewed the finances of the organization “…before pursuing such a resource-intensive approach.” However, she is more than ready to participate in this Collaborative in the future, resources permitting. Other team leaders made similar comments, noting that the timing to participate was wrong given financial instability and/or lack of resources needed to fully participate in the Collaborative. A team leader noted, “Our situation has not changed much. This was a great opportunity for our clinic. Thank you for this opportunity. We really appreciate it and DO have the tools we learned.” Still another team leader noted, “Nice to have the faculty support and the support of other teams. I am still pretty jazzed about this and will continue to work on this.”

Summary Findings from the Follow-up Web Survey

Team leaders and other core team members from each of the teams from Phase I and II were asked to complete a web-based survey as a complement to the interviews. The survey focused on use and adoption of practice redesign strategies, benefits and barriers to continued use of these strategies, and overall impact on target outcomes. All teams from Phase I participated in the survey and all but one team from Phase II participated in the survey. The following results
are based on the responses from 28 respondents. Forty-four percent of respondents were involved in direct patient care and 56% were in other roles that did not include direct patient care (e.g., administrator, manager, data support, IT, quality improvement).

Adoption of Various Practice Re-Design Strategies

Legend
- Used Strategy Before OPCC
- Expanded Use During OPCC
- Started Using During OPCC
- Not Yet Using
Teams were asked to indicate whether they had previously used a number of re-design strategies that were introduced during the project or whether they newly adopted these approaches to changing office efficiency and access. The charts above show that, in general, most teams reported either expanding the use of these strategies as part of OPCC or newly adopting these re-design strategies. **This is a notable finding since it indicates that virtually all of the teams were introduced to entirely new approaches to improving clinical care at the systems level and/or used redesign approaches that they had previously adopted but in a more strategic way.** Teams also combined their use of re-design strategies with other critical change strategies to leverage the overall effectiveness of these strategies.

Teams also were asked about the overall “ease” in implementing the various re-design approaches. Most teams reported that it was moderately difficult to implement the redesign strategies and for providers/staff to understand how to use these strategies at their sites. This was most likely due to the fact that OPCC teams reported that providers/staff at their sites believed that implementation of practice redesign strategies took more time than they were able to free up and some did not believe the redesign strategies were worth the time to implement. Nevertheless, the OPCC teams persevered with the realization that implementation of these strategies would result in a payoff at the end of the project. In fact, a majority of teams reported...
moderate to strong benefits through reduced cycle time and delays, improved continuity and quality, and improved patient satisfaction. A relatively smaller percentage—but still a majority of teams—reported benefits gained through improved clinical outcomes, a reduction in unnecessary visits, and improved provider and staff satisfaction. A notable one quarter of team leaders reported moderate to strong financial improvements, although it may be too early for most teams to report on this.
A majority of respondents (68%) reported that continued use of practice redesign strategies would result in strongly more benefits to their sites, and, in fact, there were no teams that believed that the practice redesign strategies they learned about during the OPCC would be costly or disadvantageous to their sites. This is consistent with the findings from the interviews with team leaders.

As mentioned previously, team leaders were impressed with and saw value in continued data tracking/monitoring and the associated Excel measurement tool developed by Mark Murray’s team. The following chart reinforces this finding and shows that the majority of respondents (68%) believed that it is “extremely likely” that their teams would continue to track measures to monitor improvements in access and office efficiency; only 4% of respondents were not sure whether their site would continue with measures monitoring.
As described above, about one-fourth of team leaders reported moderate to strong financial improvements as a result of participating in the OPCC. When asked whether their teams had done any specific analyses related to the business case to improve access and office efficiency, 58% reported working on the business case during their participation in the OPCC, 12% reported they had just begun to work on this, and about a third of leaders reported that they had not yet worked on this or had no plans to pursue this.
Finally, teams were asked about other types of technical assistance that they would have liked to receive. It should be noted that all teams were quite positive about the technical assistance they received during and in between the learning sessions, and with the program overall. The following short list reflects additional types of technical assistance as reported by the team leaders:

- More one-on-one, tailored technical assistance
- Stress senior leader involvement and understanding of concepts
- Assistance in promoting OPCC strategies to staff/providers (i.e., buy-in)

**Endorsements from Team Leaders**

“I feel that now ____ has taken on OPC, we have become a better place to work and also a better place for patients to receive treatment. Who knows where we would be without OPC?”

“Excellent Collaborative. I would highly recommend it to any clinic.”

“I am a strong advocate of OPCC. It provided us guidance for patient flow redesign and helped us consolidate our workflow before our implementation of EMR. Many, many thanks to the OPCC team of Dr. Murray, Barbara, and also CPCA (Vanesscia Bates, Marjorie Katz and others) for making our participation possible.”

“I found OPCC to be a great tool to work with, and it has improved our quality and satisfaction with our patients.”
RECOMMENDATIONS AND OVERALL CONCLUSIONS

Recommendations

The following set of process recommendations should be helpful to CPCA and CHCF program staff for planning a larger-scale rollout of this initiative. These recommendations were generated from a synthesis of the assessment findings along with feedback from the team leaders:

- As described in this report and in a previous midcourse report, virtually all teams found the Excel tracking workbook to be quite helpful and were able to document positive changes in at least one of their advanced access measures. Project faculty might consider spending more time up front reviewing the workbook so teams can take full advantage of this valuable tool and gain a better understanding of how it works. Use of the workbook also may subsequently impact the extent to which teams consistently use and report their data after the Collaborative is over.

- Related to the first recommendation, we previously documented teams’ needs for some initial information before taking the next step into practice redesign. What is required of the team/clinic before proceeding to this step? Teams suggest devoting a whole session on what is needed initially. This could include a brief ramp up phase devoted to laying the foundation for practice redesign, which may be equally useful for setting up strategies around implementation of practice redesign as well as data tracking. Specific strategies that teams reported include an initial understanding of what needs to be in place before the measurement process begins (i.e., ideally a registry, for example) for any of the core measures the teams would track, who would measure what and how long this process might take, and a more intensive, upfront walk through of the Excel workbook. The project staff did an excellent job in reiterating and reinforcing these issues throughout subsequent learning sessions and even initially through the use of the pre-work packet. But, an even more intensive, upfront pre-work period devoted to start-up issues might help, as suggested by the teams.

- As a part of the OPCC pre-work activities, project staff might consider including a “data contact” as an essential member of the improvement team. The primary responsibilities of the data contact might include serving as the coordinator for collecting, summarizing, and reporting the advanced access measures. The data contact might have previous experience working with electronic health registries and/or other clinical data sources and have a firm understanding of the utility of using
data for quality improvement. This role may be similar to the role of the “technical expert” described in the pre-work packet, but emphasizing the importance of the data contact role could underscore the importance of data monitoring for quality improvement, and increase the chances for sustainability once the Collaborative has ended.

- CPCA program staff considered the utility of offering teams incentives for meeting certain program and evaluation requirements. The CPCA offered each of the Phase I and Phase II participating teams a $1,000 bonus at the end of the Collaborative for meeting these requirements, which included participation of key staff in learning sessions and monthly phone calls, timely submission of monthly or quarterly status reports and tracking workbooks, and participation in interviews and surveys for the evaluation. Program staff might consider revisiting this incentive program to perhaps include tiered incentives at the start of a collaborative based on the accomplishment of sets of tasks over the course of the learning sessions.

- Use a screening process up front to group clinics into collaborative “classes” according to their level of experience and readiness to make system level changes. At a minimum, such a screening process should include an assessment of commitment by staff and senior management to fully support and participate in a collaborative and ready access to (electronic) data needed for tracking.

- Offer periodic, one-on-one phone calls/coaching with teams to be sure that teams can trouble-shoot current issues in “real time” with faculty, particularly between learning sessions, when external prompts are needed to keep teams motivated to move through the practice redesign strategies. Teams that utilized technical assistance found this to be very helpful. It might be worth considering making technical assistance more proactive (e.g., periodic check-ins with teams), since some teams may be reluctant to ask for assistance.

- As a part of a collaborative, integrate an ongoing process for engaging senior leadership in planning and implementation.

- Provide periodic onsite technical assistance – a number of teams suggested that coaches visit their clinics to assess the needs of and provide tailored assistance to their particular site.

- Organize background papers by topic and possibly make them available on a CD at the beginning of a collaborative (background papers also could be organized in this way on the extranet).
Feedback from team leaders about the WebEx conferences was mixed. Although most people prefer in-person meetings, they are clearly neither as cost-effective nor as convenient to attend as virtual meetings. However, the combination of in-person and virtual meetings appears to work optimally, with the two in-person sessions serving as “book ends” to the virtual meetings. Meeting participants recommended the following changes to the learning sessions. We present these suggestions with the caveat that it may be difficult logistically to implement them, given time and budget constraints:

- Should include follow-up (“booster”) sessions
- Reduce the repetition in topics across learning sessions
- Include more “team time”
- Reduce the length of the learning sessions (or break the learning sessions into smaller sessions)
- Provide more lead time with scheduling

In general, learning tools found to be the most helpful were those that were interactive, particularly the in-person learning sessions, opportunities for “team time,” and one-on-one coaching. Based on team leaders’ responses, future collaboratives might consider expanding the use of these interactive learning strategies.

**OPCC’s Impact on Practice Redesign and Outcomes**

The *Optimizing Primary Care Collaborative* is one of only a handful of available comprehensive programs which fill a critical niche in helping health care delivery systems provide patient-centered, timely, and efficient care through system redesign. As indicated through the positive findings of this evaluation and previous efforts from project staff, the consultants (Mark Murray and Barbara Boushon of Mark Murray and Associates) and CPCA staff offer a unique set of skills to help community health clinics transform and leverage the way care is delivered to their clients. As described through CPCA’s original proposal, the desired impact of the *Optimizing Primary Care Collaborative* was to reduce backlog so “…clinics can offer patients same day appointments, have the ability to complete today’s work today so providers are not staying late to complete their work, have standardized appointment lengths, have appropriate panel sizes so providers can effectively manage their patients, improve patient and provider satisfaction, and most importantly, improve their patients health.” Although success was variable across sites (and even across clinics within sites), virtually all teams were able to document positive changes in at least one of their advanced access measures overall or for at least one of their provider
teams. These findings are noteworthy, particularly given the organizational instability and economic uncertainty faced by a number of these community clinics.

In fact, 88% of teams reported positive changes in at least 2 advanced access and patient satisfaction measures, and 63% reported positive changes in 3 or more these measures. The greatest improvements were documented for access to care measures and cycle time; seventy-five percent of teams documented positive changes in either short or long 3rd next available appointment and over half of reporting teams documented reductions in cycle time. Site-specific changes in patient satisfaction from baseline to follow-up varied greatly among the sites. However, patient reports of cycle time showed the greatest and most consistent improvements of all three patient satisfaction measures. This is an important finding since overall patient satisfaction with wait times correlates with teams’ overall success in improving cycle times through implementation of practice redesign strategies to improve cycle times.

Interviews with team leaders and feedback through the web-based survey suggest that the overall OPCC goals and practice redesign approaches were aligned with the goals and expectations of the participating clinics. Most teams reported either expanding the use of these redesign strategies as part of OPCC or newly adopting these redesign strategies. This is a notable finding since it indicates that virtually all of the teams were introduced to entirely new approaches to improve clinical care at the systems level and/or used redesign approaches that they had previously adopted but in a more strategic way. Teams also combined their use of redesign strategies with other critical change strategies to leverage the overall effectiveness of these strategies.

An important practice redesign strategy introduced to clinics was the notion of establishing provider panels. While this strategy was initially difficult for a number of teams to implement, virtually all teams reported some level of success with this, which to a great extent served as a catalyst for other practice redesign improvements. For example, although not formally tracked through the Collaborative, a notable one quarter of respondents to the web survey self-reported moderate to strong financial improvements. This finding also was consistent with previous work in this area showing that panel size serves as a conduit in impacting patient satisfaction, helps define workload, predicts patient demand, reveals differences in provider productivity, and improves clinical outcomes and reduced costs.13

While it may have been somewhat premature for some teams to think about spread given their competing priorities and organizational (such as staff and management turnover and consolidation) and economic instability, a few teams were successful in spreading the tools and redesign strategies to other practice teams and/or clinics. Not surprisingly, successful teams “mainstreamed” OPCC into care delivery and quality improvement (i.e., embedding these strategies into their daily operations and expanding them beyond the OPCC project), obtaining
solid upper management support, and continued to pursue their measurement activities to make real time changes in their practice redesign strategies.

The results of the interviews and surveys also suggest that the learning community framework is an appropriate vehicle for introducing practice teams to the Model for Improvement and the Learning Model. The added value of adopting the strategies used by peers and troubleshooting issues in a true learning community environment was a consistent theme echoed by the participating teams. Not surprisingly, teams varied in their opinions about the most effective of the program strategies offered. But, teams consistently rated highly the value of measures tracking, the expertise and knowledge base of the consultants, and the significance of the interactive and in-person learning sessions. Ideally and budget allowing, teams would have liked to have more one-on-one tailored and on-site technical assistance, a comprehensive strategy for including senior leaders in the process, and more assistance with “buy in” from other providers and staff.

Taken as a whole, these findings suggest that the OPCC framework promises strong potential for a larger scale rollout of this initiative to other community clinics. The program, its staff, and consultants provide a unique set of skills and strategies to help clinics transform the way care is provided. A large scale effort, with appropriate funding levels and organizational support from the CPCA, could serve as a catalyst for a cultural shift in the way health care has been traditionally provided in community health centers and clinics throughout California.
ACTIVITY -- The measure of how many available appointment slots were used (retrospective). This is a measure of provider productivity. This measure is sometimes called "supply used".

CONTINUITY -- Continuity is the 'count of visits by 'my' panel patients to me' divided by the 'total visits by my panel patients to the clinic'. Continuity is measured retrospectively using patient visit information over the previous month. Continuity cannot be calculated until patient panels have been defined.

CYCLE TIME -- The total time patients spend in your office from check-in to check out, including the amount of time patients spend at each of the steps within the office.

DELAY -- Delay is the wait time for an appointment and refers to the wait time between today and the day that "open space" appears on the schedule. Teams reported on delay for short and long appointments.

DEMAND -- The number appointments booked today (calls, fax, email, walk-in, squeeze-in, follow-up) irrespective of the day of the appointment.

NO SHOWS -- Patients who fail to keep their scheduled appointment without notifying the clinic of their inability to keep that appointment before the scheduled time.

PANEL SIZE -- Panel size is the number of unique individuals who have seen a provider in the practice and which the provider coordinates the majority of care within the last 18 months.

SUPPLY -- The number of appointment slots each provider can offer each day (prospective).
Tell Us About Your Visit Today!

We would like to know about your visit with your doctor, nurse, or other clinic staff. Your answers to these questions will be kept confidential and will not affect the care you receive at our clinic. Thank you for answering these questions!

Did you see the clinician or team member that you wanted to see today?

- [ ] Yes
- [ ] No
- [ ] Did not matter who I saw today

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<th>For each statement below, put an “X” in the box you think fits best with how you feel.</th>
<th>Great</th>
<th>Good</th>
<th>Okay</th>
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<th>Poor</th>
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<tr>
<td>How would you rate the length of time you waited during today’s visit?</td>
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<tr>
<td>How would rate a recent experience getting through to this office by phone?</td>
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Results of Baseline vs. Follow-up Patient Satisfaction Survey by Participating Teams

OPCC Phase I Patient Satisfaction
Team 1

OPCC Phase I Patient Satisfaction
Team 2
**OPCC Phase I Patient Satisfaction**

**Team 3**

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<th>Service</th>
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<th>Feb-09</th>
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<td>Length of Time to Get Appointment</td>
<td></td>
<td></td>
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<tr>
<td>Length of Time Waiting During Today's Visit</td>
<td></td>
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<tr>
<td>Getting Through to This Office by Phone</td>
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**Team 4**

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<td>Length of Time to Get Appointment</td>
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<tr>
<td>Length of Time Waiting During Today's Visit</td>
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<td></td>
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<tr>
<td>Getting Through to This Office by Phone</td>
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OPCC Phase I Patient Satisfaction
Team 13

<table>
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<th>% Respondents</th>
<th>Sep-08</th>
<th>Feb-09</th>
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<tbody>
<tr>
<td>Length of Time to Get Appointment</td>
<td>Great</td>
<td>Good</td>
</tr>
<tr>
<td>Length of Time Waiting During Today's Visit</td>
<td>Great</td>
<td>Good</td>
</tr>
<tr>
<td>Getting Through to This Office by Phone</td>
<td>Great</td>
<td>Good</td>
</tr>
</tbody>
</table>

Evaluation of the Optimizing Primary Care Collaborative
Note: Will interview key contacts TBD from selected teams in the following categories:
- teams that completed last year’s Phase I and did not continue to the current Phase II
- teams that completed last year’s Phase I and continued to the current Phase II
- teams that dropped out (1 from 2007-08 Phase I and 4 from 2008-09 Phase I)

**Background**
The Optimizing Primary Care project staff and California HealthCare Foundation staff are very interested in your site’s experience with the 1-year Learning Community in which you and your team participated in the past year to help you introduce practice redesign strategies as a way to improve access, office flow, and efficiency. As the project leader, your insights are particularly important and will help us improve these collaborative strategies in the future. Your individual responses in this interview will remain confidential and will not be disclosed to anyone outside of the evaluation team. All responses will be presented in aggregate format only to the coordinating office at the California Primary Care Association and other project staff, as appropriate.

Do you have any questions for me before we begin?

<table>
<thead>
<tr>
<th>Interviewee Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
</tr>
<tr>
<td>Organization:</td>
</tr>
<tr>
<td>□ Dropped Site (2007-2008)</td>
</tr>
<tr>
<td>□ Dropped Site (2008-2009)</td>
</tr>
</tbody>
</table>

**For “Phase I only sites” and “Phase I continuing sites”**

**A. Feedback on Overall Impact of OPC Collaborative**

1. Thinking back to the beginning of this program, why did your organization decide to join this learning community? What did you hope to accomplish from it? Was it part of an ongoing process of change?
1. {Probe: Can you recall what your original aims were and, if so, have these changed? Are you still using these aims? Are your goals still pertinent and in alignment with the goals of leadership and overall mission?}

2. When you think about your site’s overall program goals of improving access to care, increasing office efficiency, and improving clinical measures, how successful has your site been to date? Have you maintained, lapsed, or improved on your goals since the project ended?

{Probe on goals specific to Access, Office Efficiency, and Clinical Care/Cancer Prevention, whether they still have a measurement strategy in place, and whether the data are being used to make improvements}

3. What specific change strategies did you implement at your site? In thinking about the various strategies that you implemented to improve your practice, which ones do you think were the most successful in bringing about changes? Which were the least successful? Are you continuing to use these change strategies? Have you tried new strategies since the collaborative ended?

4. Were there any unintended consequences of putting these redesign processes into place – either positive or negative?

5. Are you developing plans for sustaining the gains you’ve made through your process redesign strategies? For those aims in which you were successful in maintaining or making new improvements, what factors do you think contributed to that success? Conversely, what do you think are the major operational barriers to sustainability and what specific challenges at the operational level do you think need to be addressed?

{Probe on availability of resources, continuity in working with same team (turnover), commitment of leadership, staff buy-in}

6. When the project ended, did you consider spreading your redesign strategies? When we think about “spread,” this could mean spread deeper within the improvement team, or spread to the practice team from the improvement team, or from the practice/improvement team to an entirely new entity. Have you started this process yet, and, if so, what have you achieved to date and what are your ongoing plans?
{Probe on what exactly is being spread—for example, redesign strategies, simple tools, etc. – as well as spread to other populations of focus, the number of providers involved, and number of sites involved. Also, have they used the redesign methodology to address other issues in their clinics?}

7. Can you provide examples of how your participation in the collaborative has influenced clinical, administrative, or cultural/organizational shifts in care access and office efficiency at your site?

8. [If applicable], what kinds of resources are planned to ensure and/or further enhance sustainability and spread? Do you have support from senior leaders and staff?

9. If you could do this over again, what do you think you would do differently?

B. Feedback on OPC Collaborative Methods

10. The OPC Collaborative used a variety of methods to facilitate your sites’ change processes, including the virtual Learning Sessions, coaching for individual sites, phone calls, and other methods. I’d like you to think about each of the following methods or strategies, and tell me how much your team participated in it, and whether it was helpful or not so helpful for your site.

- Value in continued data tracking/monitoring and associated measurement tools (Excel workbook)
- Redesign strategies that you learned about
- Monthly phone calls
- Coaching/Technical assistance
- WebEx conferences -
  - Did all the members of your team tend to stay for the whole session?
  - What is your team’s opinion about the length of these sessions?
  - Were they helpful to your team?
- Storyboards
- Background papers
- Monthly status reports
- Monthly feedback reports from project staff
- Clinic Walkthrough
11. Overall, which of these methods were most helpful and which were least helpful to your site in making these changes?

12. Could the project team have provided other kinds of technical assistance to help your site?

13. Is there anything else that you’d like to tell me about your experiences with the Optimizing Primary Care Collaborative, that we have not already discussed?

Thank you very much for taking your time to talk with me about the Optimizing Primary Care Collaborative!

***************************

For “dropped sites” from either Collaborative

1. Thinking back to the beginning of this program, why did your organization decide to join this learning community? {What did you hope to accomplish from it? Was it part of an ongoing process of change?}

2. What was the primary reason why your site decided not to continue in the Collaborative? Were there any other reasons you can think of?

{Probe for staffing issues, time, resources, lack of staff or administrative support}

3. Could the project team have provided other kinds of technical assistance to help your site?

4. If you could do this over again, what do you think you would do differently? Do you think that your team would be ready to participate in a collaborative like this in the near future?

Thank you very much for taking your time to talk with me about the Optimizing Primary Care Collaborative!
Optimizing Primary Care Collaborative 2008-09
Interview Guide
3-6 Month Post Program Follow-up

Background
The Optimizing Primary Care project staff and California HealthCare Foundation staff are very interested in your site’s experience with the Learning Community in which you and your team participated between June 2008 and March 2009 to help you introduce practice re-design strategies as a way to improve access, office flow, and efficiency. As the project leader, your insights are particularly important and will help us improve these collaborative strategies in the future. Your individual responses in this interview will remain confidential and will not be disclosed to anyone outside of the evaluation team. All responses will be presented in aggregate format only to the coordinating office at the California Primary Care Association and other project staff, as appropriate.

Do you have any questions for me before we begin?

Interviewee Name:

Date:

Organization:

A. Feedback on Overall Impact of OPC Collaborative

1. Thinking back to the beginning of this program, why did your organization decide to join this learning community? What did you hope to accomplish from it? Was it part of an ongoing process of change?

   {Probe: Can you recall what your original aims were and, if so, have these changed? Are you still using these aims? Are your goals still pertinent and in alignment with the goals of leadership and overall mission?}

2. When you think about your site’s overall program goals of improving access to care, increasing office efficiency, and improving clinical measures, how successful has your site been to date? Have you maintained, lapsed, or improved on your goals since the project ended 4 months ago?
3. What specific change strategies did you implement at your site? In thinking about the various strategies that you implemented to improve your practice, which ones do you think were the most successful in bringing about changes? Which were the least successful? Are you continuing to use these change strategies? Have you tried new strategies since the collaborative ended?

4. Were there any unintended consequences of putting these re-design processes into place – either positive or negative?

5. Since the project ended in March 2009, have you thought about a plan for spreading your redesign strategies? When we think about “spread,” this could mean spread deeper within the improvement team, or spread to the practice team from the improvement team, or from the practice/improvement team to an entirely new entity. Have you started this process yet, and, if so, what have you achieved to date and what are your ongoing plans?

{Probe on what exactly is being spread—for example, redesign strategies, simple tools, etc. – as well as spread to other populations of focus, the number of providers involved, and number of sites involved. Also, have they used the redesign methodology to address other issues in their clinics?}

6. Can you provide examples of how your participation in the collaborative has influenced clinical, administrative, or cultural/organizational shifts in care access and office efficiency at your site?

7. [If applicable], what kinds of resources are planned to ensure and/or further enhance sustainability and spread? Do you have support from senior leaders and staff?

8. If you could do this over again, what do you think you would do differently?
B. Feedback on OPC Collaborative Methods

9. The OPC Collaborative used a variety of methods to facilitate your sites' change processes, including the virtual Learning Sessions, coaching for individual sites, phone calls, and other methods. I'd like you to think about each of the following methods or strategies, and tell me how much your team participated in it, and whether it was helpful or not so helpful for your site.

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  - Did all the members of your team tend to stay for the whole session?
  - What is your team’s opinion about the length of these sessions?
  - Were they helpful to your team?
- Storyboards
- Background papers
- Monthly status reports
- Monthly feedback reports from project staff
- Clinic Walkthrough

10. Overall, which of these methods were most helpful and which were least helpful to your site in making these changes?

11. Could the project team have provided other kinds of technical assistance to help your site?

Thank you very much for taking your time to talk with me about the Optimizing Primary Care Collaborative!
OPCC Post-Program Survey on Practice Redesign

Thank you in advance for completing this 10-minute survey about your experiences with the California Primary Care Association's (CPCA) Optimizing Primary Care Collaborative (OPCC). This survey is being conducted by an independent evaluation team funded by the California HealthCare Foundation (CHCF). You are receiving this survey because you are part of a core team of providers and staff who participated in the OPCC from June 2008-March 2009.

The purpose of this survey is to assess your experiences with the OPCC Learning Community and your impressions of the program's overall impact on patient access to care, office flow, and efficiency. The majority of questions are "check-the-box" type questions allowing you to quickly complete the survey. Your individual responses to this survey will be anonymous and will not be disclosed to anyone outside of the OPCC evaluation team. Only aggregate responses will be presented to OPCC, CPCA, and CHCF staff.

Thanks again for your help with this important survey! Please click the "SUBMIT" button below to start the survey.

With which health center are you associated?(Check one response under either the Phase 1 or Phase 2 Teams)

Phase 1 Teams:
Imperial Beach Health Center

Indian Health Center of Santa Clara Valley

La Clinica de La Raza (Pittsburg site)

San Mateo Medical Center

United Health Centers of San Joaquin Valley

Other, please specify

Phase 2 Teams:

La Clinica de la Raza (Clinica Alta Vista)

Petaluma Health Center

Golden Valley Health Centers

North East Medical Services

UCI Family Health Centers

South County Community Health Center

Other, please specify

What is your primary role at your health center?

(Select one of the following)

- Primary care provider (e.g., physician, nurse, medical assistant)
- Other role that includes direct patient care (e.g., dietician, social worker, health educator, or other allied health professional)
- Coach, community health worker, peer support
- Other role that does NOT include direct patient care (e.g., administrator, manager, data support, IT, quality improvement, etc.)
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Used this strategy before OPCC</th>
<th>Expanded use during OPCC</th>
<th>Started using during OPCC</th>
<th>Not yet using this strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishing specific aims for practice redesign</td>
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<tr>
<td>Using the “Model for Improvement”</td>
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<tr>
<td>Using P-D-S-A cycles to make improvements</td>
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<td>!</td>
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<tr>
<td>Measuring supply, demand, and activity/supply used</td>
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<tr>
<td>Measuring the delay (third next available appointment)</td>
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<tr>
<td>Measuring future open capacity</td>
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<tr>
<td>Measuring panel size</td>
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<tr>
<td>Measuring cycle time</td>
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<tr>
<td>Measuring continuity</td>
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<tr>
<td>Measuring no shows/fail to keep</td>
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<tr>
<td>Flow mapping</td>
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<tr>
<td>Measuring health outcomes</td>
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<tr>
<td>Measuring financial outcomes</td>
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<tr>
<td>Measuring provider satisfaction</td>
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<tr>
<td>Measuring staff satisfaction</td>
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<td>!</td>
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<tr>
<td>Measuring patient satisfaction</td>
<td>!</td>
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<tr>
<td>Developing a backlog reduction plan</td>
<td>!</td>
<td>!</td>
<td>!</td>
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</tr>
<tr>
<td>Managing patient follow-ups (e.g., with group visits, phone calls)</td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
</tr>
<tr>
<td>Reduce appointment types and times</td>
<td>!</td>
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</tr>
<tr>
<td>Developing a contingency plan to manage variation in supply/demand that pools referrals</td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
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</tr>
<tr>
<td>Developing a contingency plan to manage variation in supply/demand that adjusts daily supply to match demand</td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
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</tbody>
</table>
Developing a contingency plan to manage variation in supply/demand that plans for time away from office/return to office

Address seasonal variation in demand

Reduce demand for visits by extending return visit intervals

Reduce demand for visits by combing future schedules

Reduce demand for visits by promoting continuity

Reduce demand by reducing no-show appointments

Reduce demand by exploring alternate care delivery models (e.g., self-management, e-mail)

Maximize visit efficiency (i.e., do more than one task with one visit a day and “save” a future visit)

Manage variation in supply by managing short- and long-term loss (e.g., time off policies, post-vacation scheduling)

| Consider those redesign strategies that you indicated were new to your site (i.e., strategies for which you checked box #3 in the question above), please rate them collectively on the following dimensions. If you did not indicate any strategy in the question above as being new to your site, simply check “N/A” below for each question. |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Very Easy       | 2               | Moderate        | 4               | Very Difficult  | N/A             |
| How easy or difficult was it to "try out" those strategies within your site, to see if they could be carried out? | ! | ! | ! | ! | ! |
| How easy or difficult was it for providers and other staff to understand how to use those strategies within your site? | ! | ! | ! | ! | ! |

Evaluation of OPCC – Dec 2009
### How easy or difficult was it to observe whether providers and other staff are using those strategies in their interactions with patients?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial improvement (e.g., work RVU/physician, net revenue)</td>
<td>![ ]</td>
<td>![ ]</td>
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</tbody>
</table>

### Which of the following potential benefits has your site gained from participating in the Optimizing Primary Care Collaborative? Select a response from 1 through 5 for each item. If you don’t know, check the “Don’t Know” box.

(You must check one box for each line.)

<table>
<thead>
<tr>
<th></th>
<th>Did not have this benefit</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial improvement (e.g., work RVU/physician, net revenue)</td>
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</table>

### How much of a disadvantage do you think each of the following factors is to your site's continued use of practice redesign strategies? Select a response from 1 through 5. If you don’t know, select the “Don’t Know” box.

(You must check one box on each line)

<table>
<thead>
<tr>
<th></th>
<th>Not a disadvantage</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice redesign strategies require more staff time that is hard to free up</td>
<td>![ ]</td>
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</tr>
</tbody>
</table>
We have not yet documented any positive changes in measures!

Some providers or other staff members do not believe these practice redesign strategies are worth the time and effort!

It’s too difficult to make the needed changes in how our site operates!

Senior staff members do not believe these practice redesign strategies are worth the time and effort!

It’s risky for staff in our site to try new practice strategies that may not be approved by senior management!

---

**All in all, do you think there are more benefits or disadvantages for your site in continuing to use the practice redesign strategies that you learned about through the Optimizing Primary Care Collaborative?**

Using the scale below, select a number between 1 and 10 that best represents how you feel.

<table>
<thead>
<tr>
<th>Strongly more costs/disadvantages</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>About</th>
<th>even</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>Strongly more benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>!</td>
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</tr>
</tbody>
</table>
How likely is it that your site will continue to track any of the measures to monitor improvement and maintain gains in access and office efficiency?

Extremely unlikely  2  Somewhat likely  4  Extremely likely  Don't Know

Has your site done any specific analyses related to the business case, to support the cost-effectiveness of implementing practice redesign strategies to improve access and office efficiency at your site? (select one answer below)

- Yes, we worked on this during our participation in OPCC but are no longer pursuing this issue.
- Yes, we worked on this during our participation in OPCC and are continuing to pursue this issue.
- Yes, we have just started to work on a business case.
- No, we have not worked on a business case for practice redesign but are thinking about pursuing this.
- No, we have not worked on a business case for practice redesign and have no plans to pursue this.

Could the project team have provided other kinds of technical assistance to help your site?

Do you have any other comments about your work with the Optimizing Primary Care Collaborative that you would like to share with us?

Thanks again. Your feedback is greatly appreciated!

Please click on the "SUBMIT" button below to record your responses and exit the survey.