

Facing Health Reform: Public Hospital Systems Gear Up for Change

Final Evaluation Report of the
Seamless Care Center Initiative

Prepared for the California HealthCare Foundation

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Learning
Partnerships

Introduction

This evaluation assesses the cumulative impact of the Seamless Care Center Initiative, a two-year, ambitious investment of the California HealthCare Foundation to build public hospital systems' capacity for performance improvement. The Seamless Care Center Initiative (SCCI) aimed to achieve two specific improvements in four public hospital systems¹. The first improvement the SCCI aimed for is to increase clinic efficiency through improving outpatient scheduling. The second is to improve the quality of care for patients with chronic disease – diabetes in this pilot – by using registries and team-based, proactive care that emphasizes patient self-care.

Through these innovations, the Initiative also aimed to build capacity in two important skills common to both the interventions and critical for other reform initiatives: effective teamwork and data driven management. The two primary evaluation questions that flow from these goals to assess achievements of the SCCI are: Were public hospital systems able to make the improvements they were aiming for? Were the meta-skills supporting these and other improvement efforts attained and maintained? Answers to these questions are provided in the pages that follow.

Backdrop: Mandates for change

The California HealthCare Foundation has funded improvement initiatives in public hospital systems since the 1990s against a backdrop of increasing pressure to decrease costs and provide more effective and efficient care. In the public sector these changes were expected to occur at institutions simultaneously mandated to serve the relentlessly spiraling numbers of people lacking adequate health insurance.

The public policy context during the 2010-2012 implementation of the Seamless Care Center Initiative ramped up pressures for change even further. The Affordable Care Act of 2010 signaled major reform on the health care horizon that was jump-started for public hospital systems in California by the Section 1115 Medicaid Waiver. Beginning on

¹ We will refer to public hospital systems as PHS, an acronym that refers to public hospitals and their clinics. SCCI was implemented in clinics that were located both within public hospitals and in remote locations.

November 1, 2010, the 1115 Waiver started to reimburse public hospital systems, including the four implementing SCCI, according to their ability to meet pre-established milestones transforming care in their systemsⁱ.

The Supreme Court June 2012 decision upholding the Affordable Care Act focuses these winds of change into a consistent headwind with a pivotal question for California's public hospital systems: will these 19 public hospital systems survive in the era of health reform?

Each year California public hospital systems, the venerable providers of health care to those who have few alternatives, serve 2.5 million Californians living outside the health security zone. Over two-thirds of the patients seen in public hospital systems are uninsured or receive Medi-Cal benefitsⁱⁱ. Others hold health insurance inadequate to their needs.

Health reform, as welcome as it is by providers to low-income populations, holds two risks for public hospital systems. One is that they will be inundated by the estimated 4 million newly insuredⁱⁱⁱ of California's approximately 6.5 million uninsured^{iv} that are projected to purchase health insurance from the exchange portal slated to open on October 1, 2013. The other risk is that the newly insured, who will be able to choose their providers, will choose not to go to public hospital systems.

For both scenarios, public hospital systems need to rapidly increase their capacity to provide high quality care to patients. Inability to attract patients – or to serve the greatly increased numbers of people who will have health insurance – could result in significant hardship and even closure of public hospital systems^v.

Simply put, the capacity for change has become a life and death issue for public hospital systems. This evaluation sheds light on capacity for change as well as factors that facilitate or serve as barriers to it in the four public hospital systems where the Seamless Care Center Initiative was implemented. The findings from these four public hospital systems also hold important information and implications for other public health systems.

Initiative Design and Delivery

The Seamless Care Center Initiative consists of two programs: Increasing Access and Efficiency, and Clinical Quality Improvement. Both programs include a primary intervention and a secondary intervention supporting skill attainment important to the success of the primary intervention. The Safety Net Institute² implemented Clinical Quality Improvement's primary intervention and managed delivery of the three other interventions by contracted consultants. The four interventions are synopsized below with additional information about them included in Appendix 1. The Access and Efficiency programs converge with Quality by both teaching two skills basic to improvement: working in teams and using data to manage change.

Participants

Participating public hospital systems included Public Hospital System A in the San Francisco Bay Area; Public Hospital System B in Southern California as well as a rehabilitation center (referred to as Clinic B); two county community health agency clinics (referred to below as the Public Hospital System C) in the Inland Empire³; and Public Hospital System D, also in the San Francisco Bay Area. SCCI focused on primary care in the outpatient clinics of these four systems competitively selected by the Safety Net Institute based on the strength of their proposals, the commitment of their leadership, and their capacity to participate in all aspects of SCCI. A total of 309 unduplicated individuals participated in the Seamless Care Center Initiative and most individuals participated in more than one intervention.

Clinical Quality Improvement Interventions

Primary Intervention: Clinical Quality Improvement improves clinics' capacity to provide high quality chronic care by teaching four related components of the Chronic Care Model (See Appendix 1 for more detail on the Chronic Care model): using registries for population management; providing care through coordinated, multi-disciplinary teams; proactive outreach to patients requiring testing or care; and teaching self-care to patients. The SCCI used diabetes, an epidemic in California, as the focus of this pilot program.

Secondary Intervention: Choices and Changes improves providers' communication skills with patients with chronic conditions in order to increase providers' capacity to impart self-care skills and motivation. SCCI participants were trained to become trainers of Choices and Changes in a two-and-a-half-day workshop with the expectation that they

² The California Health Care Safety Net Institute (Safety Net Institute or SNI) is the improvement arm of the California Association of public hospitals and Health Systems.

³ Public Hospital System C participated through part of one year but chose not to continue due to competing public hospital system priorities.

would provide four-hour trainings to additional health care professionals in their health systems.

Access and Efficiency Interventions

Primary Intervention: Patient Centered Scheduling (PCS) is designed to increase access to health services for patients by decreasing the number of days that they have to wait for appointments. This is achieved by scrubbing schedules to assure that appointments are necessary and appropriate; confirming appointments; and opening up appointments for patients requiring urgent care visits. Success for PCS results from reducing the number of days until the third next available appointment (TNAA) and reducing the number of patients that do not make their scheduled appointments (no shows).

Secondary Intervention: The High Impact Management Program (HIMP) teaches teamwork and leadership across a cross-section of health system leaders through a series of teaching and coaching exercises delivered remotely by Coleman Associates.

Among the 309 individuals that participated in the Seamless Care Center Initiative, many played multiple roles. For the primary interventions, 191 participated in the Access and Efficiency program's Patient Centered Scheduling intervention and 161 participated in the Clinical Quality Improvement program's Chronic Care Model. For the secondary interventions, 80 participated in the Access and Efficiency program's High Impact Management Program; and 31 in the Clinical Quality Improvement program's Choices and Changes. One hundred ninety-seven individuals participated in one intervention, 77 in two, 34 in three, and one in all four.

Evaluation Methods

This evaluation is a multi-method, multi-measure assessment using both quantitative and qualitative data. Sites collected and reported data to SNI for both Patient Centered Scheduling and Clinical Quality Improvement and these data, listed below, were also made available to the Learning Partnerships evaluation team. In addition, Learning Partnerships conducted surveys and interviews to sample participants' and system leaders' experiences and assessments of what they were able to accomplish under SCCI and factors they perceived to influence their success.

Quantitative

Access and Efficiency: Patient Centered Scheduling (PCS)

As previously mentioned, the metrics of success for PCS are:

- Third Next Available Appointments (TNAA): A measure of the number of days that it takes for clinics to see patients needing appointments
- No shows: The ratio of the number of patients who do not come to the clinic for previously scheduled appointments to all patient visits

Clinical Quality Improvement: Chronic Care Model

The Safety Net Institute tracked eight key metrics for improving clinical quality. Of these, Learning Partnerships selected one process measure and three outcome measures to follow:

Process Measure

- Percentage of eligible diabetic patients with one HbA1c^{vi} test recorded in the registry in the past 12 months (SNI measure 7)

Outcome Measures

- Percentage of eligible diabetic patients whose most recent LDL-C^{vii} is <100 mg/dl (SNI Measure 5)
- Percentage of eligible diabetic patients whose most recent blood pressure is <130/80 (SNI Measure 6)
- Percentage of eligible diabetic patients whose most recent HbA1c test is > 9% (poor control) (SNI Measure 8)

Additional explanation about these metrics and their clinical significance is included in Appendix 1.

Qualitative

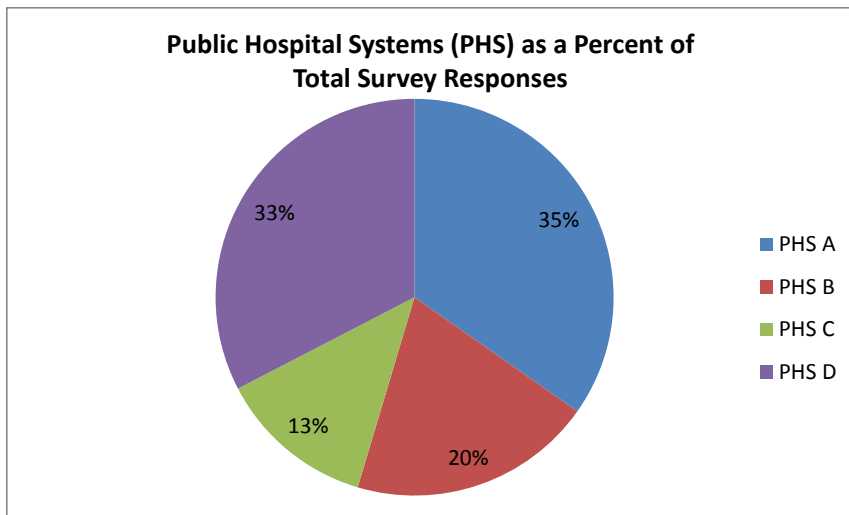
Learning Partnerships conducted interviews and a survey to add participants' voices to the qualitative data.

Survey

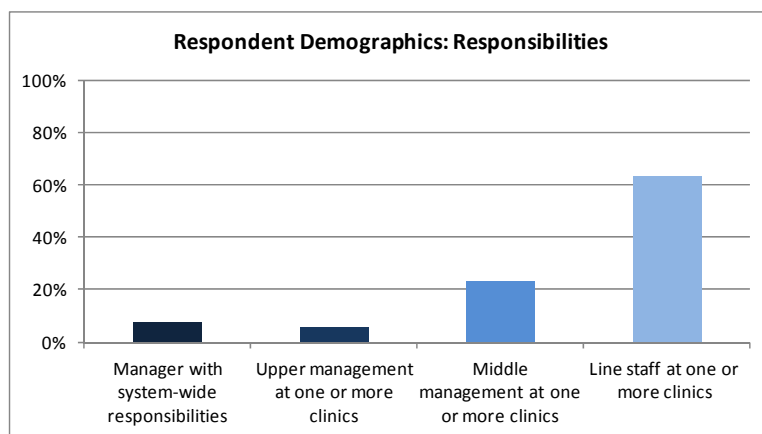
Survey invitations were sent to the 245 out of 309 SCCI participants for whom a reliable email address could be obtained, requesting that they submit responses between April 24 and June 22, 2012. A copy of the survey template is included in Appendix 2. Sites were sent four reminders about the survey, including an email reminder from the Safety Net Institute emphasizing the importance of their responses.

Fifty eight percent (141 participants) responded to the survey. Participation in the survey by public hospital system is described in the chart to the right.

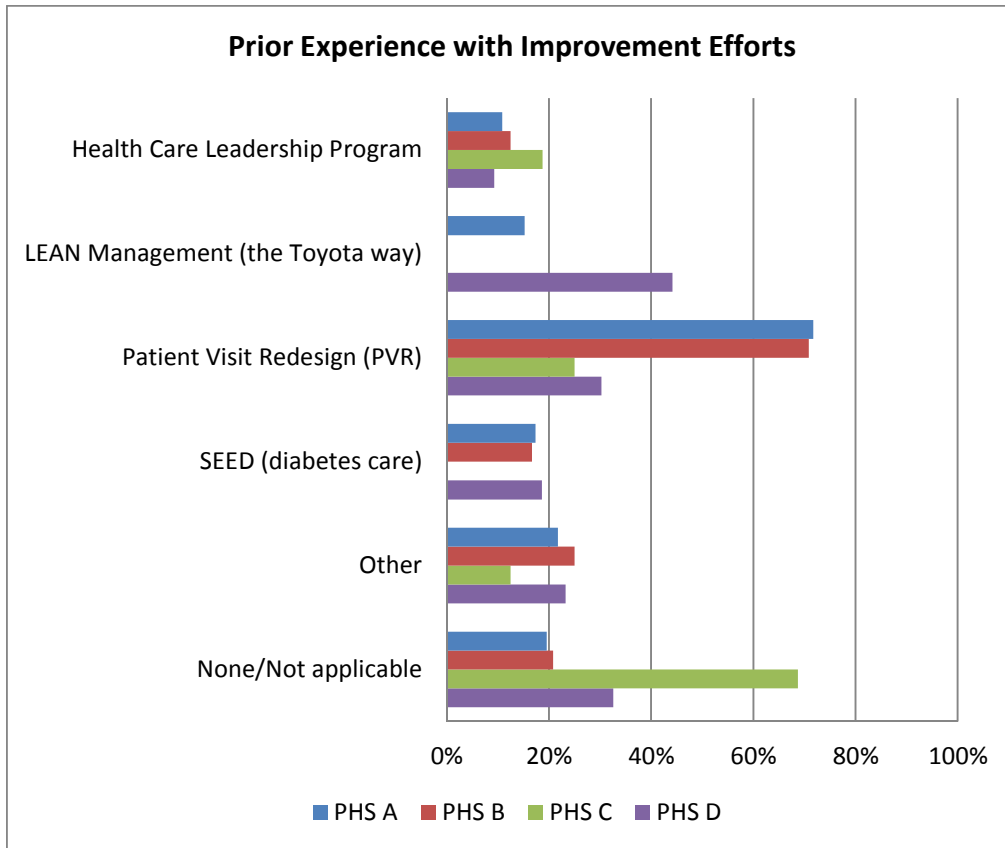
Response Rates by public hospital system	Number Responded	Percent Responded
Public Hospital System A	49	57%
Public Hospital System B	28	44%
Public Hospital System C	18	60%
Public Hospital System D	46	68%



Because health systems vary in size, even a low response rate from a large health system may result in more responses than a small health system with a high response rate. The chart on the left displays the four health systems according to the percentage of the total that their survey responses represent.



Respondents included many different positions and levels of responsibility. As the chart on the left indicates, most reported they are line staff. In terms of professional training, 21% are physicians, 29% nursing staff, 42% in administration, and 8% social workers, community health workers or health educators.



SCCI was designed to build upon skills and capacities developed through other improvement initiatives sponsored in public hospital systems by CHCF and the Safety Net Institute. A large percentage of respondents were seasoned in change by participating in past improvement initiatives. Notably, over 60% of Public Hospital System A and Public Hospital System B respondents had participated in Patient Visit Redesign, the precursor to PCS. Far fewer Public Hospital System C participants were improvement veterans, with approximately 70% reporting no prior improvement experience.

Interviews

Interviews for this cumulative evaluation were conducted with two system-wide leaders at each of the four sites. Interviewees were promised confidentiality and therefore names of respondents are not included in the pages that follow. Some quotations from clinic leaders interviewed for a prior interim report have been added to this report, which further diffuses the ability to tie individuals to specific quotations. For the final report and the interim report, a total of 29 unduplicated individual were interviewed. The protocol for interviews with system-wide leaders is included in Appendix 3.

Results: Clinical Quality Improvement Interventions

Highlights

One hundred sixty one individuals participated in implementing the Chronic Care Model and thirty-one in the first generation Choices and Changes communications training. Sites were able to make progress toward fully implementing the Chronic Care Model by working in teams, proactively calling clients needing care, and teaching self-care. Although registry deficiencies were a barrier to being able to fully manage panels through registries, sites were able to make progress toward more efficient data management while they awaited more robust electronic systems. Sites showed an aggregate 25% improvement in a key measure indicating that care standards for testing were occurring. Insufficient time and data capacity resulted in three outcome measures showing little or no improvement. 481 individuals in the four health systems have now been trained in communicating with patients to promote self-care through Choices and Changes. Clinical quality trainings were highly valued by participants, and the changes are seen as very aligned with changes clinics need to make for healthcare reform. Relatively few participants (20) were part of the precursor diabetes care initiative (SEED). There has been some drop-off (in the 10% to 20% range) in utilizing Chronic Care Model skills since the trainings ended.

The Chronic Care Model: Quantitative Data

Electronic registries are central to collecting and using quantitative data relevant to the Chronic Care Model. The ability to store information about patients, their treatment protocols, medications, test results, and visits that can be accessed at multiple sites (such as the physician's office and the pharmacy) and that can provide information (such as when a test is due) are critical for managing panels of patients.

The assumption of SNI and sites going into the Seamless Care Center Initiative was that sites already had functional registries and that their work with SCCI would expand, fine-tune, and upgrade their capacity to manage chronic care. Sites and program managers became aware early in the implementation process that registry capacities, for the most part, were not as robust as desirable, and struggling with the registries themselves became a major focus of work and improvement for most sites. Highlights related to registry capacity at each site include:

Public Hospital System A was the most advanced in their technology capacities, and SCCI provided an opportunity to sharpen their skills using data to manage care. A registry manager hired to work with clinics during SCCI implementation significantly boosted registry use and the ability of clinics and providers to obtain timely and accurate data to manage care. Public Hospital System A registry data reported to SNI include all diabetic patients in their system, not just those in participating clinics.

Public Hospital System B was limited in their registry capacity by an EHR system that was not able to manage a registry. Some clinics kept their own Excel spreadsheets to manage data. These data issues that were ongoing during SCCI implementation were slated to be addressed through implementation of i2i Tracks in the summer of 2012.

Public Hospital System C started SCCI with a registry that included many patients that should not have been included and conversely, did not contain information for many whose care they were managing. An important Public Hospital System C activity was therefore to comb their registry data to remove inactive patients and add current patients. The Public Hospital System C made major strides during the initiative to make their registry more reflective of current patients and to provide their practitioners with timely provider-level data. They currently await installation of a more robust Electronic Health Records (EHR) system that can provide a better registry function.

Public Hospital System D had a registry that was partially functional in that it was possible to input data into the registry. The frustration for clinics was that the system was not able to sort and produce data at a provider or clinic level in a timely enough way for most providers to use it for day-to-day patient management.

With this varied registry capacity, providing solid data to SNI was a challenge for sites, and the data they did provide did not always accurately reflect active panels. Bearing these caveats in mind, below we report the metrics followed by Learning Partnerships.

Learning Partnerships followed one process measure and three outcome measures of the eight measures reported to SNI. Charts for the process measure – percent of diabetic patients with HbA1c tests in the past year – are reported on the following page, first in an aggregate chart and below that, broken out by the four different clinics. Clinic run charts include markers indicating the time period when interventions were administered (labeled LS for Learning Sessions).

Percentage of eligible diabetic patients with one HbA1c^{viii} test recorded in registry in the past 12 months (SNI measure 7): As the chart on the following page indicates, there was a 25% increase in the percentage of patients receiving recommended testing in the two year period of data collection, bringing the aggregated four sites to 81%, just nine percentage points shy of the SCCI 90% goal. Public Hospital System B and Public Hospital System C charts show steep increases in close time proximity to the Learning Sessions (labeled LS in the charts). Public Hospital System A also shows a steep increase that had crested by the time the Learning Sessions were delivered.

Percentage of eligible diabetic patients whose most recent LDL-C^{ix} is <100 mg/dl (SNI Measure 5): In the aggregate, sites increased from 52% to 54% of patients with LDL under 100, 22% short of the 80% goal. System level charts indicate that this increase was driven primarily by Public Hospital System A and Public Hospital System B, which both show a discernible bump up during and after the intervention periods.

Percentage of eligible diabetic patients whose most recent blood pressure is <130/80 (SNI Measure 6): The aggregate increase in patients with blood pressure in the desired range was 2% (from 45% to 47%), short of the 80% goal by 37 percentage points. Increases were due to improvements in Public Hospital System A (4%), Public Hospital System B (17%), and Public Hospital System C (8%).

Percentage of eligible diabetic patients whose most recent HbA1c test is > 9% (poor control) (SNI Measure 8): The aggregate numbers show a 2% increase in the number of patients with poor HbA1c control – a move in the wrong direction. Although there were decreases at Public Hospital System B and Public Hospital System C, these changes in a positive direction were offset by increases at other sites.

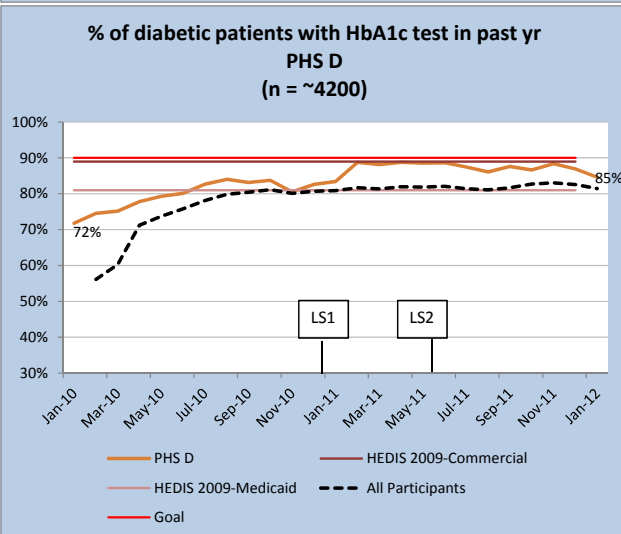
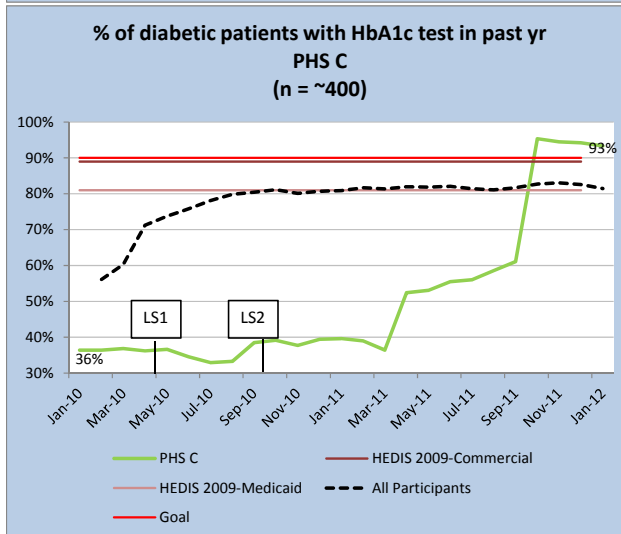
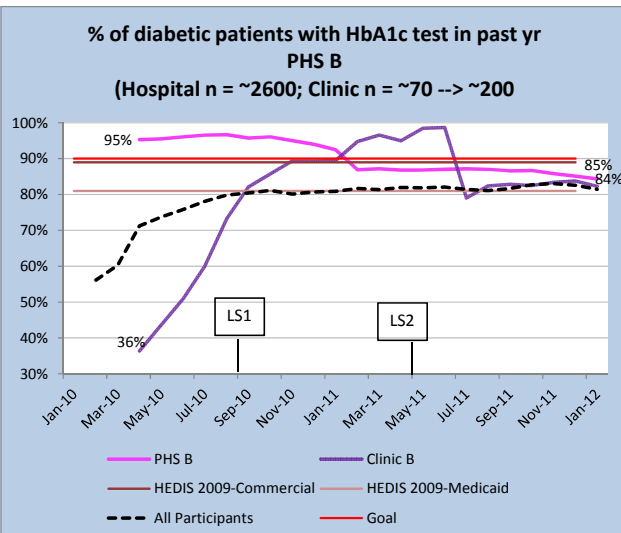
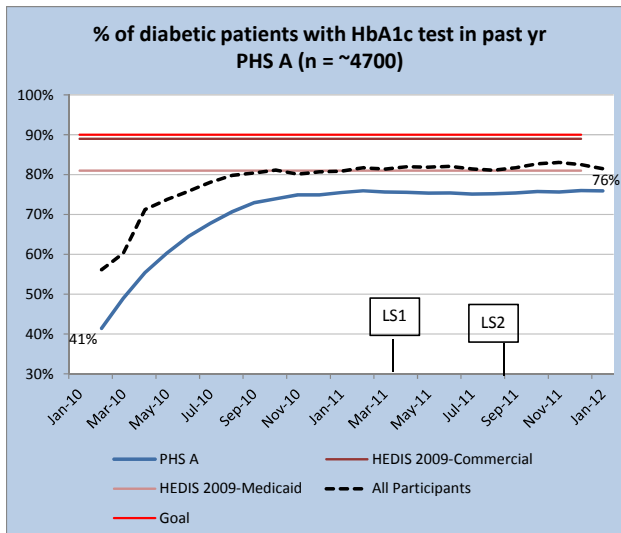
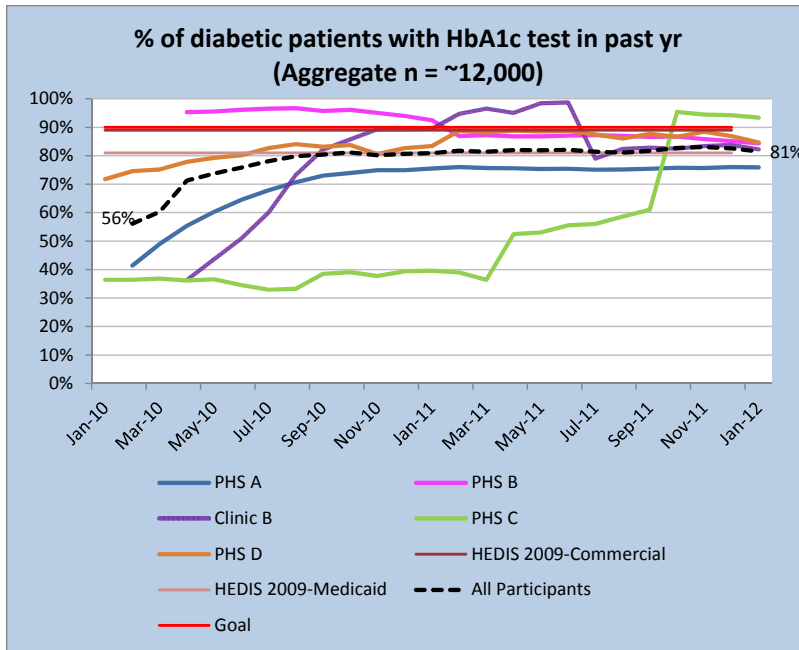
Reflections on the Quantitative Results: It is extremely positive that the process measure (the percentage of patients with HbA1c tests recorded in the past year) shows a 25% increase and gets close to the goal line established for SCCI. In a sequence of events tied to improvement, processes can be expected to be the first to change.

Outcomes change only after processes for changing them have had time to mature, so it is not surprising that the outcome measures do not show significant change within the time period captured by the run charts. Especially for sites where the intervention was administered in the second year of the initiative (Public Hospital System A and Public Hospital System D) the expectation that outcome measures would change within the two years of the initiative may have been setting the bar too high. It is also possible that a cohort analysis would be more likely to reflect positive change than the open panel, cross-sectional analysis that sites used.

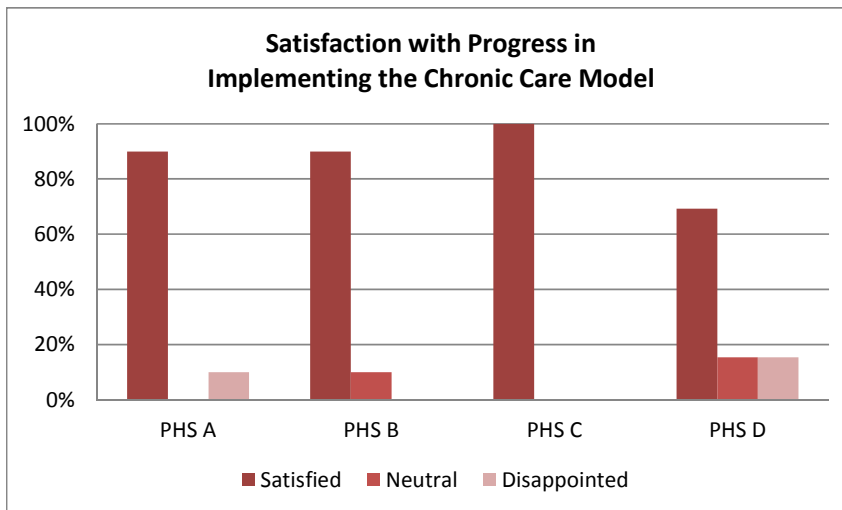
The fact that quantitative data for the most part were not yet able to detect changes occurring at sites makes it especially important to “look under the hood” of the aggregate data to understand changes that were occurring. SNI staff administering the program pointed to several relevant trends:

- Data reporting, utilization and management improved throughout the SCCI implementation period for most sites.
- Sites with fewer patients, Public Hospital System B and Public Hospital System C, were, not surprisingly, more successful than larger systems in getting a handle on registry data.
- As was pointed out in the SNI final report to the California HealthCare Foundation,^x aggregate trend lines reported for health systems sometimes mask important changes occurring at individual clinics. Her report highlights individual clinics where progress is visible at the clinic level but not strong enough in most cases to influence overall health system trend lines.

Qualitative data collected in Learning Partnerships’ surveys and interviews also enable a deeper look under the hood of the quantitative data.



The Chronic Care Model: Qualitative Data



Participants in SCCI were asked to report on their satisfaction with the progress their clinics made implementing the Chronic Care Model (CCM). Overall, the satisfaction level was high. 84% of the 41 participants in the CCM trainings who responded to the survey reported they

were very satisfied (33%) or somewhat satisfied (51%) with their clinic's progress. Comments from interviewees and survey respondents in each of the health systems shed light on these ratings.

Public Hospital System A

"It was a really good step in helping us develop a foundation for standardizing diabetes care. Each clinic had different approaches, so this brought a systems approach to our care and the recognition that we could do a better job. There were a lot of relationships built among people who didn't work together before. I think what we are doing is laying a foundation and the data won't be as robust as the changes we are starting to make for the changes we want. We are laying the foundation. Eventually the numbers will catch up."

"We had done a lot with SNI on diabetes care as part of SEED and before that. So (SCCI) was a chance to spread a lot of the work we had been doing and implement concepts around panel management and improvement generally. One of the things that was the most useful was engaging a broad cross section of our staff to help them understand the concepts."

Public Hospital System B

Our system didn't reflect the right numbers – that data dump wasn't working. One clinic was the most successful, but it never really worked for us. Most everything fell through. We did better in some clinical areas than the data showed. We were better at doing patient education, group visits, phone follow-ups and health education visits. That was a forte for us rather than the registry stuff."

Public Hospital System B was preparing for medical homes (an initiative to provide comprehensive care to patients through interdisciplinary teams) and reported, *"This gave us a glimpse of how it will be with empanelling and tracking all numbers. It was a launching point for how the big picture will look."*

Public Hospital System C

“One of the things we got was the ‘cold water splash in the face’ of how poorly we were actually doing. Each clinician has their own gestalt about how they are doing, but it’s not actually till you have the data that you can say, ‘we suck.’ It changes it from a guessing game to a challenge and an opportunity for improvement. We want to expand our use of registries to other projects as well. We want to be able to have the doctors be able to see their own data as well and track things useful to their particular issue, like prenatal care.”

“Our improvement in our process measures went through the roof. We couldn’t see changes in outcomes, but that happens with time.”

Public Hospital System D

“We suffered in the quality year because the registry was and remains a limiting factor and we couldn’t do what we want. Given that, there were good clinic work flows and programmatic changes with what we did. We were not quite ready enough for registries – but they were set up well and the investment of our time was valuable.”

“One or two individuals can get data out of the system but it should be a barrier-free approach to getting it. We are right on the cusp of having good data systems. We will get to it.”

Stick and Spread

The following chart presents information about the degree to which survey respondents reported implementing elements of the Chronic Care Model “a lot” during and after the intervention⁴. Although 64% of survey respondents reported that it is “very important” to both their clinic leadership and the system-wide leadership that they continue to make progress implementing the Chronic Care Model, there is some fall-off

Chronic Care Management Skills Used			
"A Lot" During and After Intervention			
	<u>During</u>	<u>After</u>	<u>Δ</u>
Increase the number of patients in registries	33%	33%	=
Use registries to identify patients requiring tests	49%	39%	-10%
Increase Outreach to patients requiring a test or visit	44%	31%	-13%
Work as a team to meet the needs of diabetic patients	51%	40%	-10%
Use data to guide care	51%	31%	-20%

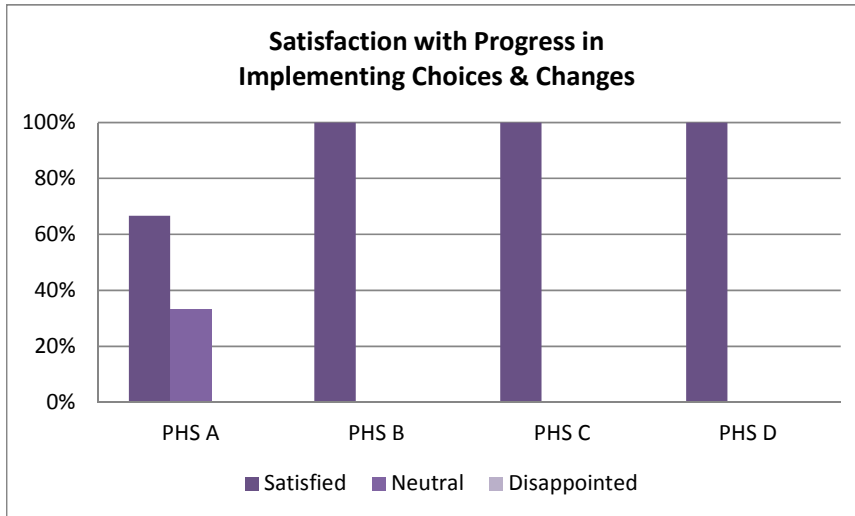
utilizing these skills. The fact that sites were continuing to increase the number of patients in registries “a lot” at the same rate as during the intervention indicates that the most basic element of the CCM has been maintained. Given the inadequacy of registries

⁴ This chart is the highest standard for using these skills. If it were changed to “a lot or “somewhat” the skill utilization rates would move up into the 60% and 70% ranges.

and that several sites were simply waiting to implement new electronic systems, it is perhaps not surprising that using data to guide care was the skill that dropped off the most.

Spreading the CCM model across sites or systems was not an explicit goal for SCCI, but providers in some clinics and sites reported that when other providers saw what their peers were able to accomplish, they also started to work on combing their panel data and taking other steps to implement the CCM.

Choices and Changes



Choices and Changes (C&C) complements the Chronic Care Model by drilling down on communication skills that promote patients' motivation and skill sets to manage their own health conditions. Thirty-one individuals participated in C&C and 24 of these

became certified trainers. Twelve of these also participated in Chronic Care Model training. Choices and Change was the most highly rated of the four interventions in terms of the effectiveness that participants ascribed to it. The trainings were reported to be enjoyable and the skills could be put immediately to work. Unlike all the other interventions, putting Choices and Changes into action required no teamwork, measurement, or systems changes. Providers could reap immediate rewards from their new skills.

While feedback was generally very positive, respondents also had some constructive feedback. A participant from Public Hospital System A said that their experience was *“essential, high impact, time-consuming.”* Another said that Choices and Changes was *“Innovative, provides valuable fundamentals in communication, but difficult to spread/simplify.”*

System-wide managers' responses to this module include, *“I personally liked Choices and Changes. It was very motivating and insightful. We learned how to give feedback to each other. It was a very safe setting. It motivated me to make some changes in my own life.”*-Public Hospital System C

“I really enjoyed C&C and hope to do more of that.”-Public Hospital System A

“It was a very good program. One of the trainers ended up leaving, but they are continuing that training. We carried out what we learned about customer service, how we communicate with the patients.” -Public Hospital System C

The survey indicates that the certified C&C trainers have done an excellent job of spreading the training. All but one of the certified trainers (23 individuals) report that they have trained others. Data collected by SNI indicates that the trained faculty has

presented the workshop to an additional 450 public hospital system staff (SNI final report).

Results: Access and Efficiency Interventions

Highlights

One hundred ninety-one individuals participated in Patient Centered Scheduling and 80 in High Impact Management Program. Many (67 survey respondents) had also participated in the earlier Patient Visit Redesign intervention that was a precursor to Patient Centered Scheduling. Objective measures show impressive improvements in the two key efficiency indicators, and there is compelling evidence that PCS is being sustained and spread. The value associated with the High Impact Management Program varied considerably by health system and prior experiences with leadership training, with those health systems and individuals with little prior exposure to leadership roles and training benefiting the most.

Patient Centered Scheduling: Quantitative Data

The following chart shows sites' achievements reducing the numbers of no shows and days required to wait for third next available appointments at baseline, at the end of the final learning session, and in January 2012, which was as much as sixteen months and as little as ten days after the final learning sessions.

Patient Centered Scheduling Data						
	No-Show ⁵			TNAA ⁶		
	Baseline	LS4 ⁷	Jan 2012	Baseline	LS4	Jan 2012
Public Hospital System A	35%	20%	24% <i>12 months post-LS4</i>	54 days	45 days	50 days <i>12 months post-LS4</i>
Public Hospital System B	19%	6%	5% <i>0 months post-LS4</i>	28 days	8 days	10 days <i>0 months post-LS4</i>
Public Hospital System C	19%	8%	15% <i>4 months post-LS4</i>	7 days	1 day	1 day <i>4 months post-LS4</i>
Public Hospital System D	16%	10%	11% <i>16 months post-LS4</i>	14 days	8 days	6 days <i>16 months post-LS4</i>

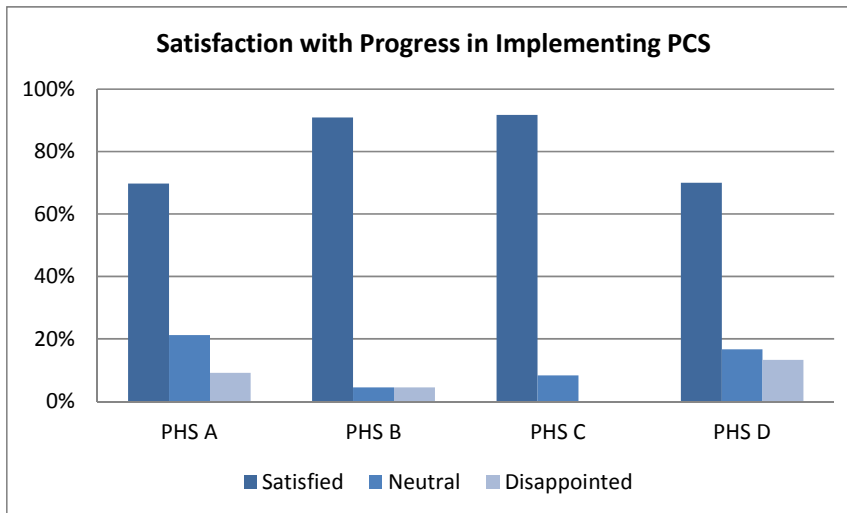
⁵ No shows: The ratio of the number of patients who do not come to the clinic for previously scheduled appointments to all patient visits.

⁶ Third Next Available Appointments (TNAA): A measure of the number of days that it takes for clinics to see patients needing appointments.

⁷ LS4: Learning Session 4

Overall, there are some impressive achievements including reducing TNAsAs by as much as 20 days (Public Hospital System B) and no shows by 14% (both Public Hospital System B and Public Hospital System C). Some of the smaller losses are equally impressive when they started with a baseline that was relatively low already. Public Hospital System D, for example, which had extensive prior experience with efficiency work, started with low no show rates and TNAsAs and was able to bring them down even further.

Patient Centered Scheduling: Qualitative Data



Sites' satisfaction with the impact of PCS is quite aligned with quantitative achievements. The Public Hospital System B and Public Hospital System C were very satisfied with their achievements, with Public Hospital System A and Public Hospital System D a little less so.

Public Hospital System A

“This was challenging because we haven’t limited panels for any of our providers. As a result some of our providers have enormous panels, so scrubbing our schedules didn’t make a great difference. We made changes (35%-25% for NS) – but our goal was 10%. We had a sense of failure as well as accomplishment. I think because we have these enormous panels we can’t reduce dramatically. Our consultant coach doesn’t agree. We would call people a day before, two days before, they would say they are coming and still didn’t come. They also complained that they were getting called too many times by us. Our challenge is our bigger, more impacted clinics.”

Public Hospital System B

“When we were rolling out, they (senior leadership) came to every roll-out session. The willingness to change on the part of staff – we tried to get the key people on board so they could get everybody else on board ... and it wasn’t as bad as they thought it would be. We met resistance every darn day. They would ask, ‘Why exactly are we doing this again?’ ‘Why are we doing this?’ They could go off. You can’t go to your boss and tell him that we’ve got all this resistance. I really believe we have given exceptional care to our patients but measuring TNAA, capacity, and NS – we are being held more accountable to what we have done in a day.”

Public Hospital System C

“The highlights were the successes we had at one health center where we got down to 1% to 3% no shows consistently. It emphasized a need we had never seen before which is that it is hard for mothers of young children to live by an appointment type of life. Even if we scheduled them for the same day, they often didn’t make it – ‘my kid was throwing up at that time.’ We changed the pediatrics schedule to all walk-in so they could come in. We saw the productivity of the pediatric team go through the roof. The team commitment and letting them bond was very important.”

Public Hospital System D

“To maintain our gains is great, but there is a big next step – reduce another 3% – we haven’t been able to do that yet, but it’s great that we have kept our progress. What will it take to make that much difference in the future? NS rates are hovering around 10%. It’s a challenge to see what we can do differently to keep our numbers moving down.”

“The areas that are the greatest challenge are those areas where it has been historically most difficult. Those challenges still are there. The clinics are different populations – maybe SES reasons or ability to call to cancel or even to see that there is a need to call or cancel.”

Stick and Spread

There is compelling evidence that PCS is being sustained and spread.

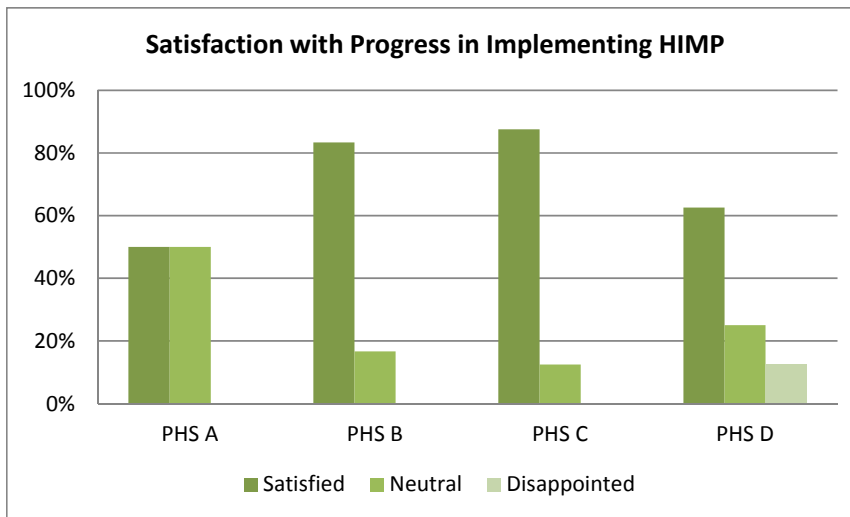
Clinics that Report Regularly Collecting Efficiency Data	
Efficiency Metric	Percent Clinics
Wait times for Third Next Available Appointments	74%
Number of No Shows	84%
Length of Cycle Times	78%
Provider Productivity	81%

The chart on the left points out that three-quarters or more of participating clinics report that they are continuing to collect efficiency data on a regular basis after the intervention concluded.

Data is only as important as how it is used. Over half of all survey respondents report that their data are reviewed by clinic management (82% report this), system-wide management (71%), and front-line improvement teams (58%). Data are most frequently used by front line improvement teams (45%), followed by clinic management (40%) and system-wide management (32%).

Sites are also active in spreading efficiency interventions. Twenty-seven of the participants reported in the survey that they had helped spread PCS to other sites and most reported spreading to two or more sites.

High Impact Management Program



The High Impact Management Program (HIMP) complements PCS by teaching leadership and teamwork skills. Of the four interventions this received the widest discrepancy in ratings, from participants who thought it was wonderful to those

who reported it a waste of time. Eighty people participated in HIMP and one-quarter of these also participated in PCS.

The value associated with HIMP varied considerably by health system, positions within the health systems, and whether participants had previous exposure to leadership. Participants in the second year of HIMP (Public Hospital System B and Public Hospital System C) found it more effective than first year participants. The most frequently voiced criticism of HIMP was that it was taught remotely. It is possible that some of the challenges associated with leading groups remotely had been worked out by the second year. Coleman Associates, who had little prior experience teaching HIMP remotely, reported that they always learn from their processes but did not consciously make changes in the second year.

Some of the voices that were most positive about HIMP came from people who did not have prior leadership training experience. For some, it was new to be recognized as a leader. Participants from Public Hospital System C, who were noticeably low in prior improvement initiatives, were most enthusiastic about the training.

A Public Hospital System C system wide leader described her experience with HIMP, *“I thought it was overall excellent. We had some of the senior leadership who thought, ‘We know all about management. Why do we have to do this?’ It took a while to teach everybody that we were all going to play, but then it worked. The ones for whom it worked the best were those who came in with open minds and those who were new leaders. The nurse navigators ate it up.”*

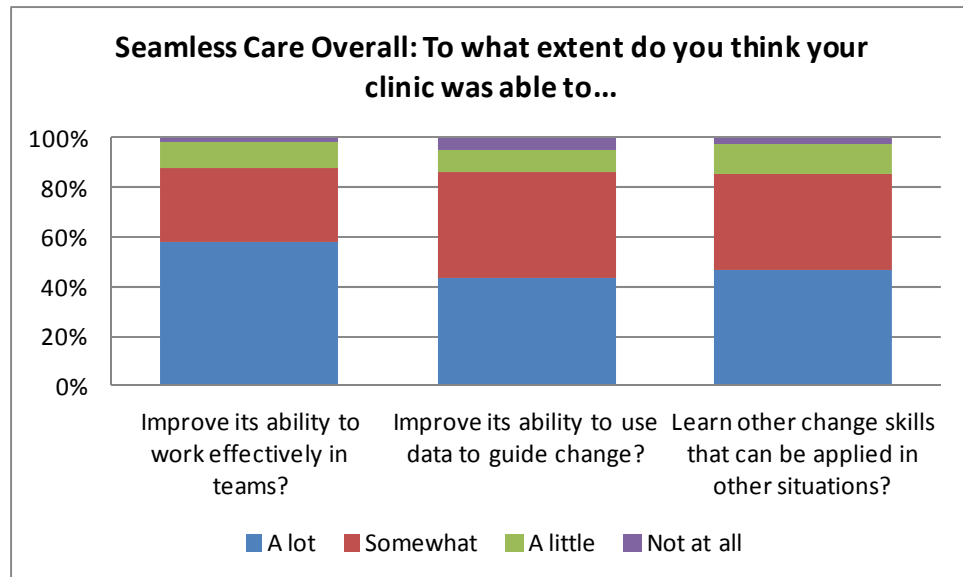
A Public Hospital System D system wide leader also explained, *“We did notice that for people like clerical supervisors – one step above line supervisor – these were books and ideas that they had not been exposed to, but for anyone above the front line supervisory*

role, they had had a lot more and more in depth grounding than HIMP. They found the curriculum was dumbed down.”

Change Skills: Teamwork, Data Driven Management

Both the quality and efficiency programs placed a focus on two important skills – teamwork and data driven management – as hinges to the doors of change. In this section we examine the extent to which participants report they were able to improve these skills as well as facilitators and barriers to improvement. The accompanying chart indicates that over 50% of

survey respondents reported that they were able to improve their ability to work in teams a lot, and slightly under half (42%) that they improved their capacity to use data to guide change a lot.



Teamwork

Patient Centered Scheduling and the Chronic Care Model require participants to work closely and interactively on teams that cross boundaries of rank, responsibility and training. When teams worked well, they were a highlight for participants who enjoyed getting to know and work with people usually separated by rank, training and function, and to share responsibility for outcomes. When things worked well, effective teamwork was perceived as key to positive outcomes. Conversely, when outcomes were not achieved, participants identified lack of teamwork as an important limiting factor.

A nurse system leader explained, “When you work in teams, you can’t put blame on everyone, because everyone has a piece of the team; the doctors can’t blame the nurses and the nurses can’t blame the clerks ... everyone has to work all together. I love the whole idea of working in a team.” And a physician chimed in, “One of the things that was the most useful was engaging a broad cross section of our staff to help them understand the concepts. Our challenges in the system aren’t what happens in the examining room – it’s important to build a skill set that goes beyond providers.”

Effective teams take careful construction, maintenance and support. Factors emphasized as helping to promote effective teamwork include: support from management including executive and system-wide management; being given the freedom by system-wide management to make changes; meeting to assess and continue to make adjustments; and the flexibility to make changes quickly and in real time. Protected time, regular meetings and communications among staff members were repeatedly emphasized.

Conversely, staff resistance to change was a barrier to implementation mentioned by all four health systems. Comments included, *“We had difficulty getting ‘buy-in’ from the members of our staff who were not actively participating in the PCS process/meetings. People were pretty unwilling to take on the extra work or make the changes we were suggesting.”* *“We met resistance every darn day. Staff would ask, ‘Why exactly are we doing this again?’ ”*

Many emphasized the critical role that physician leadership and champions play, yet pointed out that some physicians were interested in the benefits of teams for their own patients but did not see beyond to push for improvements that would affect the entire clinic or system. Management resistance to change was also highlighted in some comments such as: *“Upper management did not fully embrace the whole idea.”* And another, *“At the time, there was no management on our PCS working team. This was very frustrating and hindered out ability to get things done.”* In turn, system-wide leaders sometimes suggested that they needed more support from consultants to manage resistance. *“We needed more guidance about the specific difficulties in our clinic and I felt very little support from the consultants to address these problems.”*

SCCI participants identified still more resistance stemming from functions outside the teams. One interviewee explained that change also needed to come from other departments, *“Get some of the old schoolers to be accountable and do their part. I don’t think the issue is with physicians. They have been unsupported for so long, or beaten down for so long ... I think it’s more an operations thing. It’s like all the auxiliary, finance and pharmacy ... it doesn’t change. It’s not patient centered.”*

In summary, the point made in open-ended questions and interviews is that for teams to function well they need to be led, driven and supported by people with sufficient authority and training in teamwork that they can help manage and overcome the inevitable resistance that comes from many directions. One system-wide leader articulated how SCCI initiatives have paved the way for a next phase of developing teams, *“There are so many things that need to happen next. One of the things that we see that needs to happen next is defining and broadening and changing work roles in clinics. All of these collaboratives have been working on this in different ways, training clinicians to let go of some of the proprietary information that they feel is only physician owned in the examining room – it’s important to build a skill set that goes beyond providers.”*

Driving Change with Data

The capacity to drive change with data for continuing improvement is a critical skill for health reform, and both PCS and the Chronic Care Model included an important focus on it. We have already seen that most PCS participant survey respondents report that their sites continue to collect and use PCS data. The drop-off for Chronic Care Model data usage was higher where frustrations with registry capacity dominated the discussion.

Comments from system wide managers include:

“Working with SNI helps us work with data, keep the eye on the ball of managing with data. They [the SNI training team] were extremely good and we’re still not that far along.” -Public Hospital System D

“I think the capacity to know how many new patients we can see in a day, and to judge our staffing and how much we need is a big step forward. We always say we need more staffing, but now we can tell whether it is true or not. The numbers piece has a lot to do with this.” -Public Hospital System B

And a constructive comment about the initiative, *“There were too many measures to worry about. We should have picked one measure, such as A1c. The menu was well defined but it was too big.”* -Public Hospital System C

Because Public Hospital System A had a more functional registry than other sites, they had a perspective on next steps with management by data that other sites had not reached yet and emphasized developing a culture of data sharing, *“Participating in collaboratives improves teamwork. Giving people data – both PCS and quality involved data – yes, and i2i is part of our changes. We haven’t shared data with people as much, but we are increasingly, on a group basis, so it is becoming more of our culture.”*

In summary, substantial progress in using data to manage care has been made, especially in the efficiency interventions that do not require sophisticated health information technology tools to accomplish. Prior experience and practice were also important factors contributing to this progress.

Other Factors Influencing Change

In addition to the primary skills describe above, interviewees and survey respondents mentioned a number of other change elements that are hinges on the doors to change. These include:

Readiness: Some sites were more prepared than others to engage in improvement initiatives. A clinic simultaneously undergoing a construction project, for example, had difficulty focusing on the SCCI changes.

Staffing changes: Always an issue that challenges change momentum, staff turn-over affected some sites more than others.

Quality of the consultants and initiatives: Many respondents mentioned with appreciation the quality of the consultants working with them, as well as the importance and structure of the interventions they experienced.

The pilot nature of the change: A provider pointed out, *“You have to remember that only one provider (FTE) per clinic participated, so it was really a pilot. Their role was to help us pilot this and figure out what would work and what wouldn’t. It was not to spread.”*

Competing organizational priorities: One system-wide administrator expressed frustration that she would like to ‘strike while the iron is hot,’ spreading what she learned in SCCI, but had to temper the enthusiasm of the staff for taking the SCCI initiatives further by prioritizing other changes that were occurring in her health system.

The Road Ahead

“We have been rolling a huge boulder uphill, and once we get to the top – and we’re getting close – it will roll on its own.” -Physician participant

The Seamless Care Center Initiative was seen by its participants as strongly aligned with the changes that their health systems need to make for health care reform – two-thirds of participants responding to the survey reported this. To consider the implications of SCCI for health reform brings us back to the two questions this evaluation set out to answer: Were public hospital systems able to make the improvements they were aiming for? Were the meta-skills supporting these and other improvement efforts attained and maintained?

The short answer is yes, public hospital systems were able to make improvements and build meta-skills supporting these and other improvement efforts – and there are nuances in the degree to which capacity was built and the degree to which it has been maintained. The preceding pages document that a great deal was accomplished, and yet the Seamless Care Center Initiative was an ambitious initiative and not all indicators crossed the goal lines that had been defined at the outset. There are important considerations in both the successes and failures that merit calling out:

1. Improvement by quantitative measures was most visible for access and efficiency, and they were impressive. Significantly, over 67 survey respondents or over one-third of PCS participants had also been trained in its precursor, PVR, with the result that PCS reinforced skills in team-based time management that participants had previously learned. The important lesson here is that learning and improvement do take place; continued attention to skill development and change pay off even in the complex and constantly changing environments of public hospital systems.
2. For implementing the Chronic Care Model, significant change was evident in the one measure where change could first be expected to appear, and sites reported making important changes in the processes required for interdisciplinary, proactive team management of chronic disease patients. This occurred even in the context of ongoing frustration over data management system inadequacy in three of four sites. Significantly, far fewer CCM participants had a foundation in the precursor SEED innovation, so the skills and capacities of CCM did not have the same reach as in the efficiency measure.
3. Resistance to change cannot be underestimated and was a factor articulated at all four sites, including requests for more assistance managing it. Even though resistance to change was highlighted, providing patients with better care was an important motivator for participants in these improvement initiatives that echoed throughout interviews and open-ended survey responses. This is a strong point of positive leverage for change that can be used to overcome resistance.
4. These were pilot projects, and there is some decrement in the impact of interventions that can be anticipated because of their pilot nature. For example, one clinic that had been

very successful in improving access through PCS found that their improvements were eroded by the patients that started pouring into their clinic from a sister clinic that had not made these changes. This exemplifies that some pilots have built-in factors that likely make them less successful than if the same changes were occurring system-wide.

5. A significant contribution of SCCI and the build-up of change initiatives that CHCF and SNI have partnered in for over a decade is that they have helped health systems visualize the changes that are coming, create an image of what they are aiming to achieve, and develop a sense of the journey and where they are on it. Two respondents referred to being able to see a “promised land” as a result of these interventions.

Although an image of journey and goals for the journey of change were achieved for some, another image articulated by participants in SCCI was that they were making changes in health systems buffeted by the winds of change coming in many directions and in many ways. Given the current policy context for public hospital systems, this high level of change occurring simultaneously is likely going to intensify before it subsides. One system level manager reported that she was simultaneously managing twenty-four different change initiatives, which was simply too much. She went home one weekend to decide which she would jettison and came back on Monday morning knowing that there were none that she could.

For front line workers in the health systems, a challenge is knowing how to distinguish signal from noise – which are the new ways of doing things that are there to last and which will pass. A number of survey respondents and interviewees referred to innovation fatigue, that they have experienced such a parade of consultants with different approaches to change coming through their clinics that they have come to experience innovation as a flavor of the week that doesn’t galvanize their full attention. For some, the complexity of the SCCI with its four different but related interventions and many different metrics helped to create a vision and sense of journey related to change. For others, the many different moving parts may have contributed to the “noise” of change.

Factors that sites talked about as working for them to manage change boil down to three essential related ingredients: structure, alignment, and accountability. Structure involves locating the focus of responsibility for change; clarity about processes for implementing change; and sequencing, spacing, and communicating about change so that it is experienced as more than a breeze coming through the clinics. Alignment has to do with assuring that the vision of and commitment to change is shared all the way up from the front-line to clinic managers to system wide managers and leaders. Accountability assures communication at the different levels of authority for the changes – that they are occurring and that their indicators of progress are being watched. For example, public hospital systems are putting dashboards in place, and some SCCI metrics would make good metrics for those dashboards. A next phase in the journey for public hospital systems is to assure that change innovations occur with structure, alignment and accountability to channel the many currents of change into a tailwind that will secure their positions in the era of health reform.

ⁱ California Association of public hospitals and Health Systems, Policy Brief, “The Delivery System Reform Incentive Program: Transforming Care Across public hospital systems,” June 2011. <http://www.caph.org/content/upload/AssetMgmt/PDFs/Incentive%20Program%20Policy%20Brief%20June%202011.pdf>. Last referenced July 1, 2012.

ⁱⁱ “Fast Facts California’s Essential public hospital and Health Systems,” website of the California Association of public hospital and Health Systems, <http://www.caph.org/content/FastFacts.htm>, last accessed July 1, 2012.

ⁱⁱⁱ Figure based not on eligibility but on the number estimated that will sign up for health care. <http://www.therepublic.com/view/story/SCOTUS-HEALTHCARE-CALIF-8352980/SCOTUS-HEALTHCARE-CALIF-8352980>. Last referenced on July 1, 2012.

^{iv} 2008 figures. Brown, E. Richard, Shana Lavaderra, Erin Peckham and Jenny Chia, UCLA Health Policy Research Brief, December 2008, “Nearly 6.4 Million Californians Lacked Health Insurance in 2007,” http://tcenews.calendow.org/pr/tce/document/CAs_Lack_Insurance_PB_121508.pdf, Last referenced July 1, 2012.

^v California Association of public hospital and Health Systems, Policy Brief, “The New Section 1115 Medicaid Waiver,” November 2010, last referenced on the CAPH website, October, 2011

^{vi} HbA1c is a form of hemoglobin which is measured primarily to identify the average plasma glucose concentration over prolonged periods of time. Normal levels of glucose produce a normal amount of glycated hemoglobin. As the average amount of plasma glucose increases, the fraction of glycated hemoglobin (HbA1C) increases in a predictable way thus serves as a marker for average blood glucose levels over the previous months prior to the measurement. In diabetes mellitus, higher amounts of glycated hemoglobin, indicating poorer control of blood glucose levels, have been associated with cardiovascular disease, nephropathy, and retinopathy. Lower levels of HbA1C are better. (Wikipedia, September 2011)

^{vii} Low-density lipoprotein (LDL) enables transport of lipids like cholesterol and triglycerides within the water-based bloodstream. Blood tests typically report LDL-C, the amount of cholesterol contained in LDL. In a clinical context, mathematically calculated estimates of LDL-C are used to estimate how much low density lipoproteins are driving the progression of atherosclerosis. Lower levels of LDL are better. (Wikipedia, September 2011)

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^x Gonzalez, Denise, MD, Final Progress Report, Transforming Care in California’s Public Clinics (Seamless Care Center Initiative), April 2012