CALIFORNIA HEALTHCARE FOUNDATION
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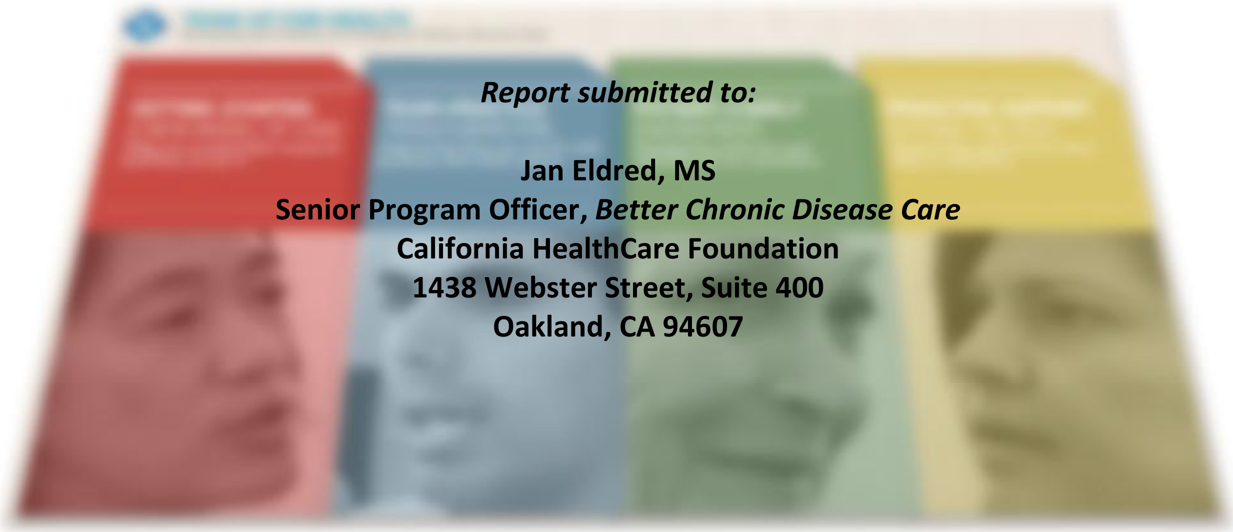
# Evaluation of the California HealthCare Foundation's *Team Up for Health* Initiative



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## Evaluation of the California HealthCare Foundation's *Team Up for Health* Initiative

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# Executive Summary

The purpose of self-management support is to help patients become informed about their chronic conditions and to provide the necessary tools to help patients take an active role in disease management. In 2009, the California HealthCare Foundation (CHCF) launched the *Team up for Health* (TUFH) initiative to improve patients' confidence, behaviors, and clinical outcomes by helping health care delivery systems strengthen their capability to support patients and families in self-care by implementing and spreading proven approaches, and reinforce linkages among people with chronic conditions through community organizations and virtual networks. The initiative included a 6-month planning phase followed by a 2-year implementation phase. Six grantees were selected to participate in the implementation phase.

The Foundation's overall goals for TUFH were to improve and make sustainable changes in system-wide self-management supports among the six participating teams and then foster spread to other clinics at these sites. The Foundation engaged leading experts in quality improvement and practice redesign, provider communication, and patient- and family-centered care to provide one-on-one consultations, training, and technical assistance to the teams.

The two major goals of the TUFH evaluation were to document short- and long-term success in improving patient-level behavior and clinical outcomes, and document the extent to which participation in the TUFH self-management initiative impacted the adoption, sustainability and spread of self-management support services among participating sites.

The majority of sites were able to demonstrate positive trends in patient-provider communication, self-care behavior, and patient- and family-centered care. Although not a primary focus of TUFH, about half of the sites demonstrated positive changes in measures related to community resources for self-management supports. These favorable results are consistent with the TUFH initiative's focus on improving patient-provider communication and patient- and family-centered care. Notable changes in provider satisfaction with self-management support also were demonstrated with statistically significant improvements in the two provider satisfaction indices measured. This suggests positive cultural shifts in the extent to which the various provider teams utilized self-management approaches.

Teams demonstrated favorable results on a number of clinical process and outcome measures, including a1c screening, a1c levels, blood pressure, and LDL. Across all team measures of patient experience and self-care behavior collected in aggregate, positive changes were reported for 82% of these measures. Across all team measures of patient clinical process and outcome measures, positive changes were reported for 63% of measures. Across all team measures of provider satisfaction with self-management support, positive changes were reported for 66% of measures

All sites documented numerous administrative, clinical, and organizational/cultural changes in self-management supports as a result of their participation in this self-management initiative and as documented through logged PDSA cycles and interviews with program leaders at each site. The TUFH initiative stimulated cultural shifts in the participating sites by helping teams understand what self-management support means in working with patients with chronic illnesses, and by providing extensive technical assistance and consultation in how to make these changes more sustainable at each site. Based on our evaluation findings, the program effects appear to be equally strong at the organizational level and the patient level. There are a number of organizational facilitators and barriers that serve to shape the long-term prospects for sustainability and spread of self-management supports at each of the sites, which is not surprising given the variation in success with patient-level behavior and clinical outcomes documented across the teams.

## Background

The purpose of self-management support is to help patients become informed about their chronic conditions and to provide the necessary tools to help patients take an active role in disease management. In a recent review of the literature, Bodenheimer et al. (2005)[1] concluded that self-management support facilitates collaborative decision-making between providers and patients and improves health-related behaviors and clinical outcomes. As a follow-up to a demonstration project in 2004, *Promoting Consumer Partnerships in Chronic Disease Care: Strategies for the Safety Net*, CHCF launched the *Promoting Effective Self-Management Approaches to Improve Chronic Disease Care* initiative, which supported the "…implementation and dissemination of effective strategies to engage patients with diabetes and/or cardiovascular disease to manage their own care in partnership with their health care providers."[2]

As identified by the demonstration sites in this follow-up project, the most essential features of self-management support for patients with chronic diseases included the need for a dedicated chronic disease support team, motivated leadership and support staff, easy-to-use tools and documentation of progress, such as action planning forms, patient follow-up, and skill-building among providers, particularly around motivational interviewing. In terms of the self-management support strategies that were introduced to sites during the course of the project, team leaders reported that virtually all of the strategies were used with at least some providers and patients.

The project evaluation indicated that the CHCF self-management initiative stimulated cultural shifts in the participating sites by helping teams understand what self-management support means in working with patients with chronic illnesses, and by providing extensive technical assistance and consultation in how to make these changes more sustainable at each site. Based on the evaluation findings, the program appeared to have had a greater impact at the organizational level than at the patient level—although, overall, sites were moderately successful in improving roughly half of all tracking measures across all teams. The evaluation concluded that clinical care teams engaging in quality improvement efforts to improve self-management supports at these sites will need to undertake continued, intensive

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[1] Bodenheimer T, MacGregor K, Sharifi C. Helping patients manage their chronic conditions. California HealthCare Foundation. June 2005. ISBN 1-932064-84-2.
[2] California HealthCare Foundation. Request for Proposals. Promoting Effective Self-Management Approaches to Improve Chronic Disease Care. September 21, 2005.

work to sustain and spread these new practices to many more providers and patients to impact population-wide changes in patient behavior change, provider behavior change, and clinical outcomes.

In 2009, CHCF launched *Team Up for Health* (TUFH), a 30-month initiative designed to "…improve patients' confidence, behaviors, and clinical outcomes by helping health care delivery systems: (1) strengthen their capability to support patients and families in self-care by implementing and spreading proven approaches, and (2) reinforce linkages among people with chronic conditions through community organizations and virtual networks." The initiative consisted of a 6-month planning phase followed by a 2-year implementation phase. Six grantees were selected to participate in the implementation phase:

- Asian Health Services, Alameda County
- Golden Valley Health Centers, Merced and Stanislaus Counties
- Northeast Valley Health Corporation, Los Angeles County
- Open Door Community Health Centers, Humboldt County
- San Francisco General Hospital Family Health Center, San Francisco County
- Sharp Rees-Stealy Medical Group, San Diego County[3]

Teams received access to numerous consultants with expertise in care team redesign, provider communication, patient- and family-centered care, community linkages, and social media. Teams also received in-person training and site visits, participated in "reverse" site visits to clinics across the country, which served as models in self-management support, and participated in periodic Webinars and conference calls, and annual meetings.

## Measurement and Evaluation Strategy

A mixed methods approach was used to evaluate the overall success of the TUFH initiative, including the impact of care process redesign, communication and coaching skills, patient and family involvement in care delivery design, development and expansion of virtual support networks and community resources on patient-level (process and clinical outcomes), provider-level and organization-level changes (program sustainability and spread).

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[3] Source: http://www.chcf.org/projects/2011/team-up-for-health

Nine sites (seven original sites and two expansion sites) collected data on patient clinical experience and self-care behavior, clinical process and outcome measures, and provider satisfaction with self-management supports. Data sources for these domains included a patient survey, provider survey, and electronic health records. Teams reported de-identified, aggregate data for these measures using an Excel workbook and have reporting this data quarterly since October 2009. Data were collected over seven quarters from October 2009 through June 2011. Systems level measures of change in clinical care delivery were assessed at baseline in February 2009 and then at 2 years follow-up in April 2011 using the Assessing Chronic Illness Care (ACIC) survey version 3.5.[4] Team project directors, administrators, and TUFH faculty also were interviewed to document system-wide changes in care and overall strengths and weaknesses in the program. Other data sources included the Plan-Do-Study-Act (PDSA) cycle summaries from teams and the 12- and 18-month team summary reports on progress to date. A detailed description of each measure follows:

- *Patient Feedback Survey* – As part of their quality improvement approach, all implementation sites were asked to submit from a sample of patients periodic summary reports on experience, success, and satisfaction with self-management supports (including perceptions of care, behavior change, confidence in self-management, and referrals to and use of online and community resources). A core set of questions was developed with consensus from the demonstration sites. In addition, each site was able to add specific questions to the survey if they were interested in measuring other aspects of patient care. (see Appendix for patient survey and measures).

- *Provider Feedback Survey* – As part of their quality improvement approach, all implementation sites were asked to administer a provider satisfaction survey, a 13-item scale which measured two domains: perceptions of the effectiveness of self-management support strategies on patient care and its impact on the patient-provider relationship. Overall mean changes in these two indices were measured from baseline to 2-year follow-up. (see Appendix for provider survey and measures).

- *Clinical Measures and Documented Self-Management Support Goals* – Similar to the patient behavior measures, all teams were asked to report quarterly on a set of clinical outcome measures. A set of core clinical measures were tracked, including a1c, a1c screening, blood

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[4] http://www.improvingchroniccare.org/index.php?p=ACIC_Survey&s=35

pressure, and lipids (LDL). However, given expected differences in the focus of the projects as well as differences in targeted chronic illnesses for each of the sites, each site also reported on a smaller set of clinical measures that were tailored to the sites' needs. The evaluation team worked with each of the teams to develop these measures. In addition, each site was asked to conduct chart audits on a sample of patients to track the percentage of patients with documented self-management goals.

All sites received an Excel workbook that was used to report and track these summary measures. The workbook also included charts for each measure that automatically generated trends so that teams could receive immediate feedback on their set of measures.

- *Assessment of Chronic Illness Care (ACIC)* – The ACIC v3.5a is designed to help systems and provider practices move toward the "state-of-the-art" in managing chronic illness. The six sub-measures of the ACIC support the components of the Chronic Care Model. The ACIC measures changes in the organization of healthcare delivery systems, community linkages, self-management supports, decision support, delivery system design, clinical information systems, and integration of the Chronic Care Model components. The results can be used to help organizations identify areas for improvement. The ACIC was self-administered by all sites on an annual basis to measure changes in chronic care management at the health system level. Aggregate data was reported back to sites as trend data overall and for each sub-measure, so that each site could address those areas where improvements were warranted through quality improvement processes.
- *Documentation of Team-Specific Re-design Processes –* Teams were asked to periodically self-report documented re-design processes (PDSA cycles). Each of the teams designated an in-house team leader or "champion", responsible for leading the re-design processes within the organization through a Practice Improvement Team (PIT). To document the impact of these PDSA cycles on institutionalizing self-management support strategies, PDSA cycles for each team were "mapped" to the activities of each team encompassing patient-provider communication, patient- and family-centered care, and strengthening community resources.
- *Interviews with Team Leaders, Site Administrators, and TUFH Faculty* – At the completion of the program, each implementation team's project director and a selected site administrator was

interviewed by the evaluation team to assess the extent of integration of the self-management support strategies into routine clinical care delivery and any documentation of spread of self-management supports to other associated clinics or patient populations. The topics addressed included various dimensions of systems-level changes (i.e., changes in administrative and clinical practice, changes in organization cultural, enhanced community supports) and spread of self-management support resources to other clinics. Team leaders also were asked to provide feedback about the various components of the initiative (i.e., training, patient- and family-centered care technical assistance, use of self-management support resources). TUFH project faculty also were interviewed to document their overall impressions of the success of the initiative, as well as strengths and areas of improvement for key intervention and technical assistance strategies used throughout the program. (see Appendix for interview guides).

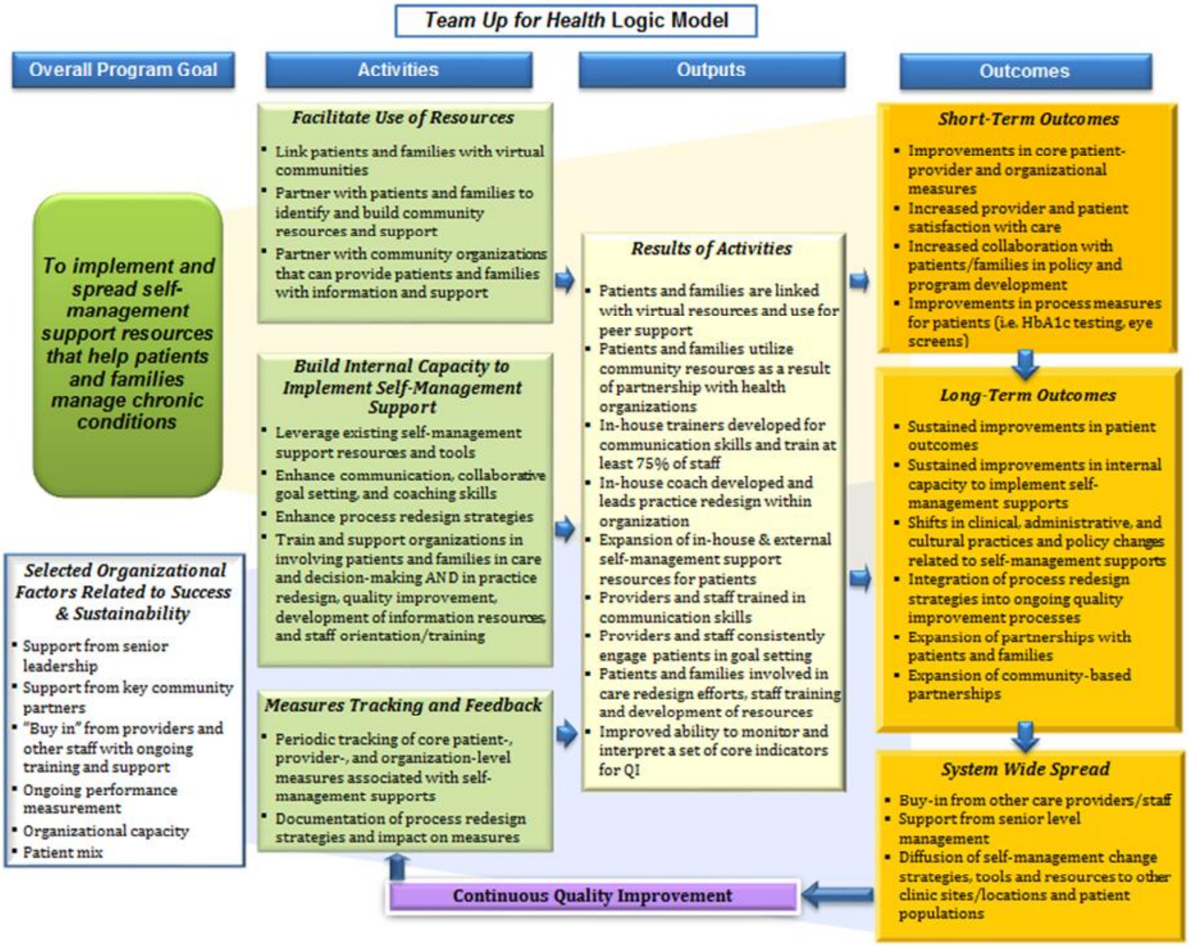
**Summary Table of Measurement Approach**

The following table provides a list of target measures, instruments/data sources, level of analysis (i.e., patient, provider, team, system), timeframe, and whether the measurement approach is quantitative or qualitative:

| Target Measure(s) | Instrument(s)/ Data Sources | Level of Analysis | Timeframe | Overall Evaluation Approach | |
|---|---|---|---|---|---|
| | | | | Quantitative | Qualitative |
| Perceptions of care, behavior change, confidence in self-management, satisfaction, and referrals to and use of online and community resources | ▪ Patient feedback survey | Patient | Quarterly – based on sample of 50-75 patients | ✓<br>(built-in site measure) | |
| Clinical measures, documented self-management support goals | ▪ Chart audit<br>▪ Electronic registry | Patient | Quarterly | ✓<br>(built-in site measure) | |

| **Target Measure(s)** | **Instrument(s)/ Data Sources** | **Level of Analysis** | **Timeframe** | **Overall Evaluation Approach** | |
|---|---|---|---|---|---|
| | | | | **Quantitative** | **Qualitative** |
| Integration of components of Chronic Care Model | ▪ *Assessment of Chronic Illness Care v3.5a* (ACIC) Survey | Provider/ Team/ System | Baseline (during planning phase) and end of program | ✓ | |
| Re-design processes | ▪ Team-specific P-D-S-A cycles | Team/ System | Ongoing | ✓ | ✓ |
| Systems level change, sustainability, and spread | ▪ Interviews with team leaders, site administrators, and faculty | Provider/ Team | Last quarter of initiative | | ✓ |
| General feedback about the initiative | ▪ Interviews with team leaders, site administrators, and faculty | Provider/ Team | Last quarter of initiative | | ✓ |

***Logic Model/Evaluation Framework.*** To help program and evaluation staff frame the overall initiative, the logic model illustrated in the figure below was used. The logic model was refined with feedback from CHCF and program staff. The logic model served as a general guide for the focus of program and evaluation activities.



**Team Up for Health Logic Model**

**Overall Program Goal**

To implement and spread self-management support resources that help patients and families manage chronic conditions

**Selected Organizational Factors Related to Success & Sustainability**

- Support from senior leadership
- Support from key community partners
- "Buy in" from providers and other staff with ongoing training and support
- Ongoing performance measurement
- Organizational capacity
- Patient mix

**Activities**

**Facilitate Use of Resources**

- Link patients and families with virtual communities
- Partner with patients and families to identify and build community resources and support
- Partner with community organizations that can provide patients and families with information and support

**Build Internal Capacity to Implement Self-Management Support**

- Leverage existing self-management support resources and tools
- Enhance communication, collaborative goal setting, and coaching skills
- Enhance process redesign strategies
- Train and support organizations in involving patients and families in care and decision-making AND in practice redesign, quality improvement, development of information resources, and staff orientation/training

**Measures Tracking and Feedback**

- Periodic tracking of core patient-, provider-, and organization-level measures associated with self-management supports
- Documentation of process redesign strategies and impact on measures

**Outputs**

**Results of Activities**

- Patients and families are linked with virtual resources and use for peer support
- Patients and families utilize community resources as a result of partnership with health organizations
- In-house trainers developed for communication skills and train at least 75% of staff
- In-house coach developed and leads practice redesign within organization
- Expansion of in-house & external self-management support resources for patients
- Providers and staff trained in communication skills
- Providers and staff consistently engage patients in goal setting
- Patients and families involved in care redesign efforts, staff training and development of resources
- Improved ability to monitor and interpret a set of core indicators for QI

**Outcomes**

**Short-Term Outcomes**

- Improvements in core patient-provider and organizational measures
- Increased provider and patient satisfaction with care
- Increased collaboration with patients/families in policy and program development
- Improvements in process measures for patients (i.e. HbA1c testing, eye screens)

**Long-Term Outcomes**

- Sustained improvements in patient outcomes
- Sustained improvements in internal capacity to implement self-management supports
- Shifts in clinical, administrative, and cultural practices and policy changes related to self-management supports
- Integration of process redesign strategies into ongoing quality improvement processes
- Expansion of partnerships with patients and families
- Expansion of community-based partnerships

**System Wide Spread**

- Buy-in from other care providers/staff
- Support from senior level management
- Diffusion of self-management change strategies, tools and resources to other clinic sites/locations and patient populations

**Continuous Quality Improvement**

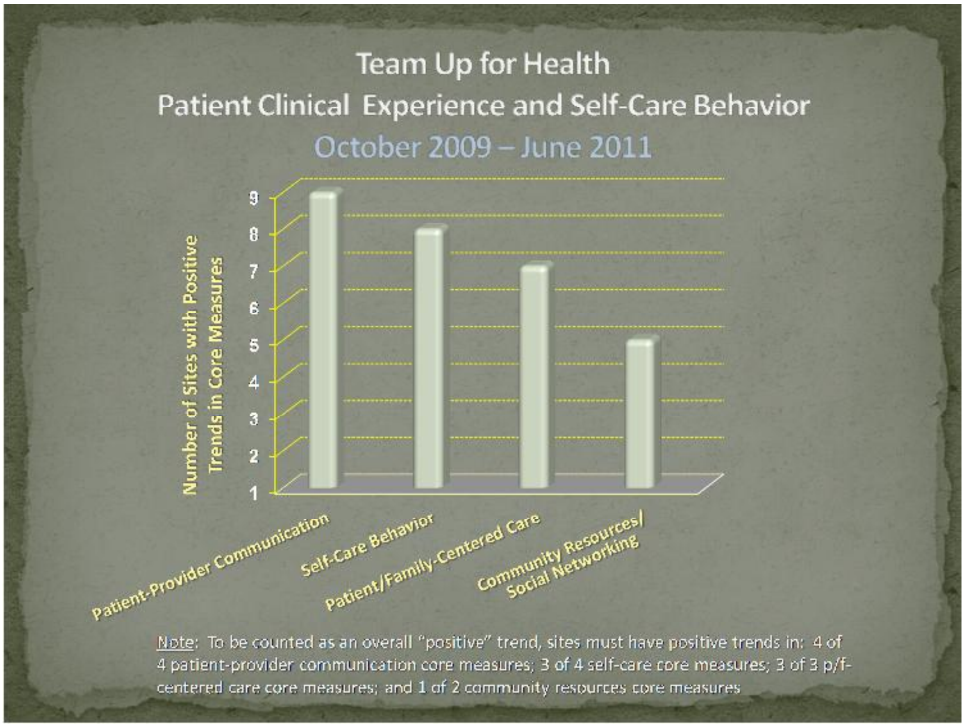
## Evaluation Findings

### *Changes in Patient Clinical Experience and Self-Care Behavior*

Teams demonstrated positive changes in a majority of the patient- and provider-level tracking measures over the course of the initiative. Trends in patient clinical experience and self-care behavior were measured using four domains: (1) patient-provider communication; (2) self-care behavior; (3) patient- and family-centered care; and, (4) community resources/social networking. Because the demonstration sites participating in the TUFH initiative were advanced in their delivery of self-management supports compared to other clinics at the start of the project, and since many of the patient responses from patient surveys were skewed toward reporting positive encounters with their provider team (which is common for patient satisfaction measures), more stringent criteria were used to characterize positive changes in these domains for each team.

To be counted as having a positive trend in a particular domain, sites had to report positive trends in: 4 of 4 patient-provider communication core measures; 3 of 4 self-care core measures; 3 of 3 patient- and family-centered care core measures; and 1 of 2 community resources core measures. Because less of an emphasis was placed on building community-based self-management support resources, the criterion used to characterize positive trends in this domain was less stringent relative to other domains.

In total, nine of nine sites were able to demonstrate positive trends in patient-provider communication, eight of nine sites demonstrated positive trends in self-care behavior, seven of nine sites demonstrated positive changes in patient- and family-centered care, and five of nine sites demonstrated positive changes in measures related to community resources for self-management supports. These favorable results are consistent with the TUFH initiative's focus on improving patient-provider communication and patient- and family-centered care. Site-by-site findings are presented in the Appendix.

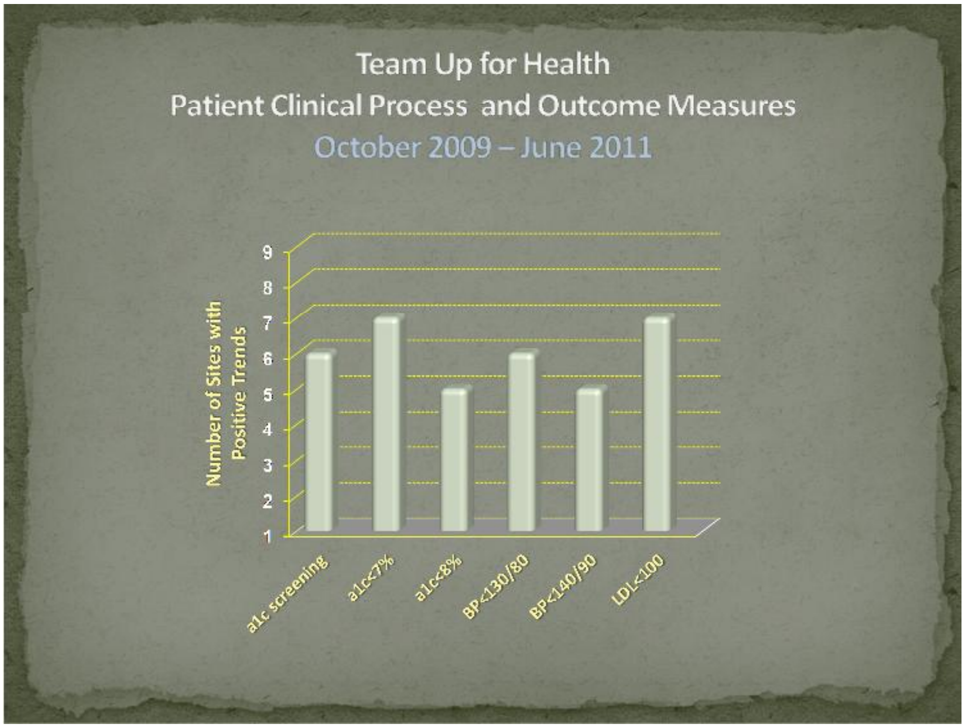


Team Up for Health
Patient Clinical Experience and Self-Care Behavior
October 2009 – June 2011

Note: To be counted as an overall "positive" trend, sites must have positive trends in: 4 of 4 patient-provider communication core measures; 3 of 4 self-care core measures; 3 of 3 p/f-centered care core measures; and 1 of 2 community resources core measures

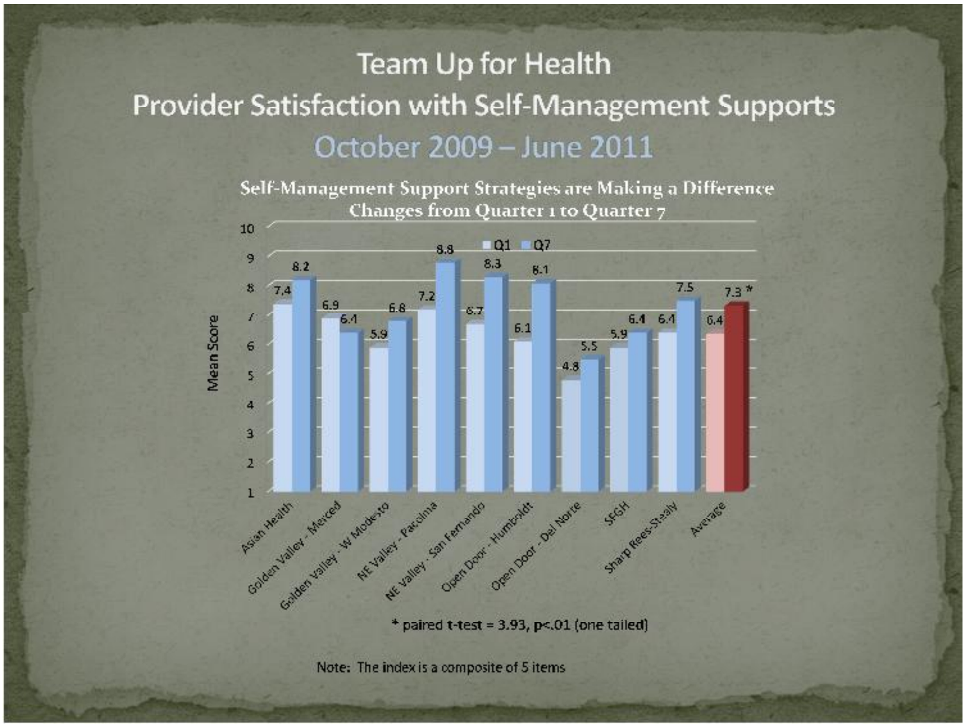
### *Changes in Patient Clinical Processes and Outcome Measures*

Teams collected data on a number of clinical process and outcome measures, including a1c screening, a1c levels, blood pressure, and LDL. Again, teams demonstrated favorable results across a majority of these clinical measures. Six of nine teams demonstrated positive changes in the percentage of patients with appropriate annual a1c screening, seven of nine and five of nine teams demonstrated positive changes in two a1c level measures (percentage of patients with a1c<7% and a1c<8%, respectively), six of nine and five of nine teams demonstrated positive trends in two blood pressure measures (percentage of patients with BP<130/80 and <140/90, respectively), and seven of nine teams demonstrated positive changes in LDL levels (percentage of patients with LDL<100 mg/dL). Site-by-site findings are presented in the Appendix.



### *Changes in Provider Satisfaction with Care*

In addition to patient-level measures, teams collected satisfaction data from providers on the extent to which self-management supports have made a difference during the patient encounter. Provider feedback was solicited once every six months over the course of the initiative. As previously described, provider satisfaction was measured across two domains: (1) the extent to which self-management supports have had positive impacts on patient treatment; and, (2) the impact on the patient-provider relationship. An index was created for each domain. The first domain was created using the average score across five questions; the second domain was created using the average score across eight questions. Changes in the average score for each of the two domains was calculated for all nine reporting sites. A majority of sites demonstrated positive trends in these provider-level satisfaction measures. Eight of nine sites demonstrated positive shifts in providers reporting that self-management supports have made a difference during the patient encounter. Across all sites, the average score increased significantly from 6.4 to 7.3 (paired t-test = 3.93, p<.01 (one tailed)).

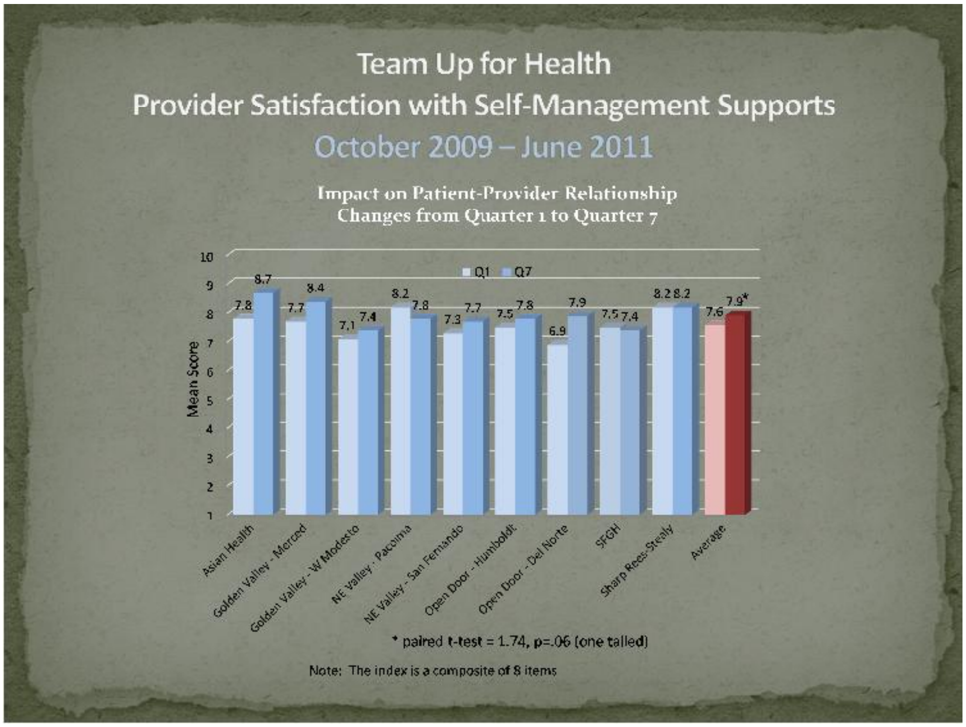

Team Up for Health
Provider Satisfaction with Self-Management Supports
October 2009 – June 2011

Self-Management Support Strategies are Making a Difference
Changes from Quarter 1 to Quarter 7

* paired t-test = 3.93, p<.01 (one tailed)

Note: The index is a composite of 5 items

Consistent with the findings of the first provider satisfaction domain, six of nine sites demonstrated positive trends in providers reporting that self-management supports had a positive impact on the patient-provider relationship. Across all sites reporting this information, the average score increased from 7.6 to 7.9 (paired t-test = 1.74, p=.06 (one-tailed)). Although the changes reported here on average scores appear to be modest, it is important to note that scores are averaged across the teams and have high variation and are also calculated as composite scores from a number of questions, so that even minimal changes from baseline to follow-up represent reasonable gains in these measures.



Team Up for Health
Provider Satisfaction with Self-Management Supports
October 2009 – June 2011

Impact on Patient-Provider Relationship
Changes from Quarter 1 to Quarter 7

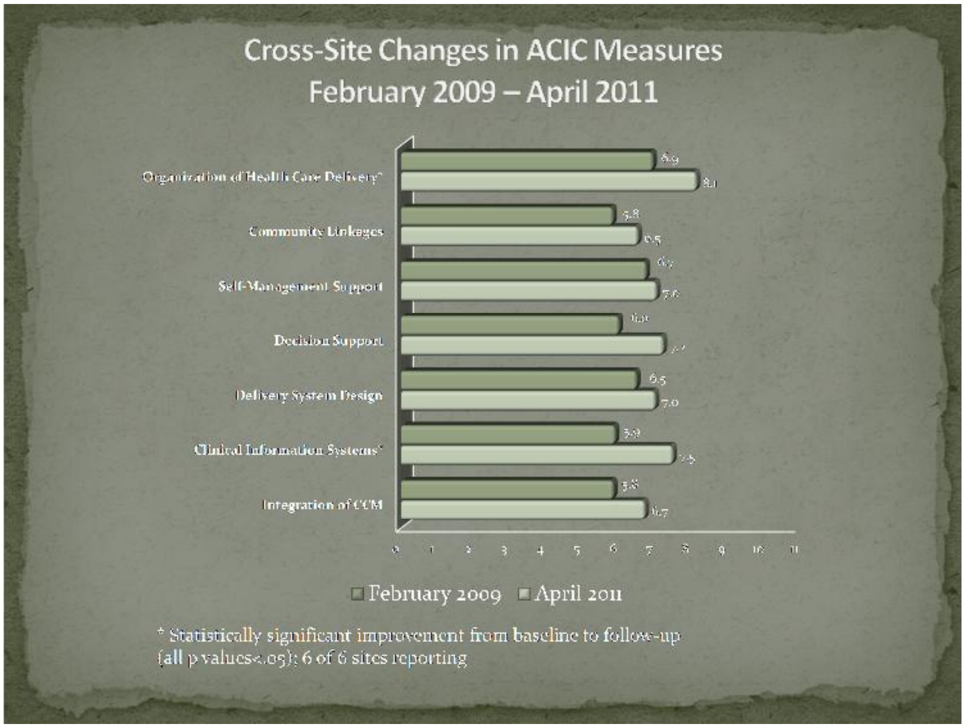
* paired t-test = 1.74, p=.06 (one tailed)

Note: The index is a composite of 8 items

## *Changes in Systems of Care*

As described earlier, teams conducted a number of PDSA cycles over the course of the TUFH initiative to integrate and sustain self-management supports into health care delivery. Teams reported the outcomes of these PDSA cycles periodically in summary reports. To document the impact of these PDSA cycles on institutionalizing self-management support strategies, PDSA cycles for each team were "mapped" to the activities of each team encompassing patient-provider communication, patient- and family-centered care, and strengthening community resources. These activities were then mapped, in turn, to organizational changes reported by teams that resulted from incorporating self-management supports (i.e., reported by teams in their periodic reports). Organizational changes were grouped into administrative, clinical, and cultural shifts in care, reflecting the overall conceptual framework of the TUFH initiative. Consistent with the positive findings from the tracking measures reported above, teams made significant progress in making system-wide changes in care resulting from implementing self-management support strategies. As expected, given the focus of the initiative on improving patient-provider communication and patient- and family-centered care, the majority of PDSA cycles were focused in these two areas across all teams. Teams reported notable progress in implementing and institutionalizing self-management support strategies into care management, reflected across administrative, clinical, and cultural shifts in care. These changes are reported on a team-by-team basis in the Appendix.

All six teams reported on the results of the ACIC survey at baseline and two years later. Across all teams, the average score for all seven domains improved over the 2-year period. The greatest improvements were demonstrated for clinical information systems, organization of healthcare delivery, decision support, and integration of the Chronic Care Model. The least amount of improvement was made for community linkages, but this was not unexpected given that the TUFH initiative did not focus as much on activities in this area relative to other areas. Changes in scores for all teams reporting their follow-up data on the ACIC survey are shown in the Appendix.



As described previously in the report, at the completion of the program, each team leader (and, in some, cases, along with other team members) and an administrator from each clinic were interviewed separately by the evaluation team to assess the extent of integration of self-management support strategies into routine clinical care delivery and any documentation of spread of self-management supports to other associated clinics or patient populations. The topics addressed included various dimensions of systems-level changes (i.e., changes in administrative and clinical practice, changes in organization cultural, enhanced community supports).

The findings from interviews with program directors and site administrators reflect the quantitative findings around institution-wide changes in self-management supports documented through the evaluation. All sites reported one or more strategies to help sustain their work in self-management, and teams from each of the sites also have documented numerous administrative, clinical, and organizational/cultural changes in self-management supports as a result of their participation in the TUFH initiative, which are reported in the Appendix. What follows are verbatim responses from the TUFH project team leaders and administrators, which highlight the various ways that teams have sustained and/or are expanding self-management supports at their respective institutions:

- "Patient and family advisors – culturally this was a change to the organization. The value they brought has been huge."
- "All 3 pieces of TUFH had an impact across our organization, but the patient advisory group seemed to gain a lot of traction. It also has been the most rewarding piece."
- "We did not expect how much of a difference the patient advisors would make. It was a huge effort but we saw value in making patient advisors part of the process. Resources and coaching that came from Bev and Cezanne were wonderful."
- "Being able to change the culture of the clinic is absolutely the hardest thing – we've been able to chip away at these issues (i.e., expanding nursing roles and clerical staff roles to be able to incorporate into daily practice)."
- "Patient advisors are invaluable and are now used in other areas."
- "[Our] strategies will include health coach training and we will broaden training to interpreters and to new staff and will continue to use team-based care and spread this across the clinic and to other sites. We would like to expand the patient/family advisor piece and bring in advisors that are more advanced. We would like to expand skill building to include in hiring descriptions within HR."
- "For providers, the communications training was the most impactful – although this hasn't been spread enough to all of the providers for a culture shift to happen yet – a rude awakening that the communication strategies they used in the past are not effective."
- "For patients, practice redesign component – diabetes cards, involving patients at that level – had a huge impact on their care (a1c's, satisfaction)."
- "Practice improvement teams and practice redesign – we plan to spread in systematic fashion to eventually all the sites."
- "We want to see this spread to all patients, including patient advisory councils at all clinics. It was so well received by patients and providers at the one site, that we will take it and integrate it so it's part of our practice."
- "It's not a question of IF it will happen, but WHEN it will happen. Data and anecdotal provider stories were key to making changes – helpful and impressive. It will have the most impact in the long run on infrastructure to moving ahead with patient- and family-centered care."

- "Cross-training across units has been very helpful. Staff go across units from time to time and the cross-training is important. When we first got i2i, it was harder because we had only one or two MAs who were trained, but with the cross-training of health coaches, staff understood the process a lot better and I've noticed a cultural shift in treatment of patients."
- "We want to focus on patient- and family-centered care and need to develop a roadmap for a larger patient- and family-centered care model. TUFH took us beyond the conceptual and put it into practice."
- "We are looking at the role of the patient differently – not just looking at them as a recipient of the care we think is best for them. Patients have a voice and their voices need to be heard. The patients are at the 'center of the wheel'. There has been a shift here to include the patient's voice."

Project directors and site administrators also were asked to provide feedback on the resources available through TUFH and also provide any suggestions for additional resources they might find useful as they move forward with integrating these comments into patient care. Virtually all project directors found the site visits to be one of the most effective and compelling pieces of the TUFH initiative. Quite a few of the project directors took home very concrete examples of changes they could make in their own organizations. The only criticism they had was that they had wished the site visits occurred earlier in the project. Project directors also were impressed with the communications training as well as the resources available to them to provide a greater focus on patient- and family-centered care. The following are verbatim responses and other program suggestions:

- "Most valuable were the site visits."
- "When this program started, no one knew what to do to get the program started. The site visits helped with those issues – earlier would have been better."
- "Communications training was great. People enjoyed the site visits and came back with all kinds of ideas of how to move forward. Even naysayers were excited about making changes after the site visits."
- "I would like another opportunity for teams to cross-talk and come together in a meeting. Add structure to 'team talk time' to pull out what you want teams to talk about. Each team that has highlighted something should try and force themselves to highlight some other activity."
- Earlier site visits to accelerate change
- Library of resources based on topic (e.g., communications, office flow and SMS, intake, discharge forms, action planning)
- More resources available in different languages (language support)
- Leader training for practice improvement so leaders can manage practice improvement teams

- More information on PCMH certification (i.e., more information on linkage with PCMH, patient- and family-centered care, and meaningful use)
- Better understanding of structural and operational changes to improve patient experience (like improving patient flow, patient cycle time)

A number of cross-cutting themes emerged from our interviews with TUFH faculty. First, virtually all faculty agreed that teams may not have been initially as far along with integrating their self-management support strategies as they thought they were when the teams were selected. Teams were selected for participation in TUFH based on previous progress they had made in incorporating self-management supports into care delivery. However, during program review of the planning phase, faculty concurred that teams may not have been as far along with integrating self-management supports as initially thought (i.e., embedded in care). However, despite this, virtually all faculty agreed that the teams were “quick studies” and were successful in making significant improvements over time and certainly by program end.

All faculty agreed that teams made the most significant progress with provider communication. Faculty also agreed that the team communication trainers did a wonderful job of not only delivering the communication training but also, in many cases, implementing follow-up strategies and events (such as shadowing, coaching, checking in with staff at staff meetings about their use of skills and impact on patients and family members) to sustain any gains made. This also was documented through the evaluation measures in addition to our interviews with site project directors and administrators. As one faculty said, “The innovative follow-up strategies that the communication trainers developed...were creative, resourceful, tailored to the teams' patient populations, ongoing, inserted into the cultural norms and routines of the sites (e.g., staff meetings), [and] inclusive of all staff (front line staff in addition to clinical staff). So very impressive!”

Faculty also identified a number of challenges impacting the success of the overall initiative. Faculty thought that as a group it could have been more synchronized and tighter in integrating the various components initially, but all agreed that this did come together midcourse through the initiative. A significant rate-limiting factor was engaging clinicians to participate. While faculty agreed that staff were more amenable to changes, getting clinician buy-in was more challenging, since a number of providers were resistant to changing the way they cared for patients. There is also still pushback with team-based care, since many clinicians are not team-oriented, and this represented a huge cultural shift for clinicians to work with teams. However, the improvement teams really empowered staff and got the staff engaged in the process so there was movement despite not having clinicians engaged. All faculty agreed that this would be an important area of focus for future projects, since this truly represented an *entire* team-based process. On a similar note, a related challenge was getting senior leadership engaged. For some teams, there was a lack of commitment and leadership from program start, and it was difficult to get this on their "radar screens". As one of the faculty acknowledged, "unless there is a really strong leader that mandates very clearly that this has to happen, it's DOA." Finally, faculty also acknowledged that it was difficult to recruit and sustain patient advisors. However, teams that persisted were able to gain some traction here.

Despite these challenges, all faculty believed the overall TUFH initiative to be successful in helping teams do a better job in sustaining and spreading self-management supports and embedding this in routine care. When asked what grade they would assign to the overall accomplishments of all of the teams and the project in terms of success in moving the needle with self-management supports, the average grade was a B/B+. As one faculty stated, "We learned a lot. There are some teams going in the right direction." However, all faculty agreed that two years may not have been long enough to make sustainable changes, although sites were able to document system-wide changes in care. As one faculty stated, "Putting the whole spectrum in front of them forced them to consider all of these important areas and they did eventually pull together the pieces." Another faculty added, "2 years is not long enough. The changes we're asking practices to make are very deep and require cultural shifts."

Finally, faculty offered a number of suggestions for future initiatives. These included the following:

- "Need more face-to-face time in order to move the pace along – this is an investment in change!"
- "The staff liaison for PFA needs to be someone high enough in the organization that they are comfortable with their own facilitation skills…but not someone who…doesn't have the self-confidence or the facilitation skills."
- "Emphasis on leadership is important."
- "Maybe [we] should have done site visits within the first 6 months of the project. Could have been good inspiration. But, then, still allow a site visit midcourse in the project."
- "Should have added more measurement feedback with other faculty."
- "Should have had SMS activities more integrated with patient and family-centered care."

- "We needed a more centralized shared learning experience in which we were providing a context within which everyone was trying to do the same thing at the same time and talk about the learning of it…We needed closer relationships with the practice teams plus the addition of physician champions."
- "We should have evaluated capacity upfront."
- "A change package to give the teams structure for making the changes – perhaps this needs to be individualized to the practice – is there an optimal model for how you layout the TA and the change package? The practices need some initial structure to get them started in the right direction, but you need to allow them flexibility to account for each unique practice variability."

## Conclusions

Teams participating in the TUFH initiative have made substantial gains across a series of patient, provider, and organizational level measures. The most notable improvements were made across the three major areas of focus for the initiative, namely patient-provider communication, self-care, and patient- and family-centered care. Notable changes in provider satisfaction with self-management support also were demonstrated with statistically significant improvements in one of the two indices measured. This is most likely attributable to provider "buy in" and greater confidence in using the various tools, resources, and skills used and learned throughout the self-management initiative. This suggests positive cultural shifts in the extent to which the various teams utilize self-management approaches.

Overall, teams have made substantial progress in impacting patient behavior and outcomes and provider satisfaction by incorporating self-management support strategies. Across 125 measures of patient experience and self-care behavior collected in aggregate across all teams (i.e., the number of single data points captured across all teams), positive changes were reported for 102 of these measures (82% of measures). Across 81 measures of patient clinical process and outcome measures, positive changes were reported for 51 of these measures (63% of measures). Finally, across 117 measures of provider satisfaction with self-management support, positive changes were reported for 77 of these measures (66% of measures).

Improvements in these measures also have resulted in institutionalizing self-management support strategies. This is documented by teams' success in achieving positive administrative, clinical, and cultural shifts in care resulting from integrating self-management support strategies into routine care. The TUFH initiative stimulated cultural shifts in the participating sites by helping teams understand what self-management support means in working with patients with chronic illnesses, and by providing extensive technical assistance and consultation in how to make these changes more sustainable at each site.

It is important to note limitations of our evaluation strategy. First, there were no control or comparison sites in which to judge changes in the intervention sites that might have been attributable to the programming strategies. Second, the data from the patient satisfaction surveys were skewed towards positive results. This is commonly observed with patient satisfaction surveys. However, the evaluation incorporated more stringent statistical criteria in documenting positive changes in the various measures to try and reduce this bias. Third, there is no way to attribute the positive changes observed solely to the TUFH interventions. The teams that were selected were more advanced in incorporating self-management support strategies in comparison to other sites. In fact, this was a criterion for selection into the overall initiative, and in particular, the implementation phase. And, finally, there were notable cross-site differences in patient populations served, staff roles, type of health care delivery system, and amount of technical assistance requested and received across each site, making it difficult to generalize these findings to other sites.

Based on our evaluation findings, the program effects appear to be equally strong at the organizational level and the patient level. There are a number of organizational facilitators and barriers that serve to shape the long-term prospects for sustainability and spread of self-management supports at each of the sites, which is not surprising given the variation in success with patient-level behavior and clinical outcomes documented across the teams. This suggests that self-management support is a necessary tool but not sufficient, by itself, to bring about sustained changes at the organizational level and subsequently impact patient behavior change and clinical outcomes. This is supported by the work of Wagner et al. (2001) in the development of the Chronic Care Model.[5] Wagner's team found that more comprehensive interventions were more likely to be successful and that a combination of provider education, computerized tracking and reminder systems, and organized approaches to follow-up achieved the greatest success in improving process indicators (such as foot and eye exams). In addition, systematic efforts to increase patients' knowledge, skills, and confidence to manage their condition is

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[5] Wagner EH, Austin BT, Davis C, Hindmarsh M, Schaefer J, Bonomi A. Improving chronic illness care: Translating evidence into action. Health Affairs 2001; 20(6): 64-78.

critical to success. Clinical care teams engaging in quality improvement efforts to improve self-management supports at these sites will need to undertake continued intensive work to sustain and spread these new strategies to many more providers and patients to impact population-wide changes in patient behavior change, provider behavior change, and clinical outcomes.

## Epilogue

In June 2011, the CHCF Board approved the availability of additional funds to enable current TUFH grantees to spread their current resources, tools, and strategies from their original grant funding to other sites. CHCF released an augmentation funding application to all current TUFH grantees with a required one-to-one matching fund of up to $62,500 for one year, so that grantees could "more fully spread TUFH activities to additional sites and to integrate improvements in self-management support and patient- and family-centered care into ongoing operations", and "serve as models for other health care organizations." As of the writing of this report, five of six teams have received augmentation funding with one site still pending. Teams will be required to submit two additional reports of clinical measures (at six and 12 months), an additional round of provider satisfaction surveys (at 12 months), and a final ACIC survey (at 12 months). Team project directors and administrative leaders also will be asked to participate in wrap-up phone interviews to document sustainability and spread of SMS. Teams will not be required to collect patient survey data during the augmentation funding year.

# APPENDIX

# *"Team Up for Health"* Initiative – Phase 2

## Patient Core and Tailored Measures

## Quality Improvement Survey and Instructions

## *Team Up for Health* Implementation Phase
## Core and Tailored Tracking Measures for Patients

### Tracking Measures by Domain:

### Clinical processes and outcomes

| Measure | Source(s) of Data |
|---|---|
| % patients with a1c < 7% (good control)<br>% patients with a1c < 8% (control)<br>% patients with a1c > 9% (poor control) | - registry or chart audit |
| % patients with 2 a1c's at least 91 days apart in past year | - registry or chart audit |
| % patients with BP < 140/90<br>% patients with BP < 130/80 | - registry or chart audit |
| % patients with LDL < 100 | - registry or chart audit |

### Patient clinical experience

| Measure | Source(s) of Data |
|---|---|
| % patients with a written action plan | - registry or chart audit |
| My health care provider(s) and I worked together to set personal goals to manage my illness. *[Likert Scale (1-7): Definitely NO→Somewhat→ Definitely YES]* | - patient survey |
| My health care provider(s) listened carefully to me at today's visit. *[Likert Scale (1-7): Definitely NO→Somewhat→Definitely YES]* | - patient survey |
| I understand my health care provider's advice and what I need to do to manage my illness. *[Likert Scale (1-7): Definitely NO→Somewhat→Definitely YES]* | - patient survey |
| My health visit helped me gain confidence in managing my health problems. *[Likert Scale (1-7): Definitely NO→Somewhat→Definitely YES]* | - patient survey |

### Self care behavior

| Measure | Source(s) of Data |
|---|---|
| (a) I have a written action plan to help me manage my illness. [yes/no]<br>(b) Over the past 7 days, I was able to follow my action plan to help me manage my illness. *[Likert Scale (1-7): Definitely NO→Somewhat→Definitely YES]* | - patient survey |

| | |
|---|---|
| **Answer this question only if you have diabetes (blood sugar):**<br>Over the past 7 days, I checked my blood sugar when I was supposed to. *[Likert Scale (1-7): Definitely NO→Somewhat→Definitely YES]* | - patient survey |
| **Answer this question only if you take prescribed medicines:**<br>Over the past 7 days, I took all of my prescribed medicines when I was supposed to. *[Likert Scale (1-7): Definitely NO→Somewhat→Definitely YES]* | - patient survey |

## Patient-/family-centered care

| Measure | Source(s) of Data |
|---|---|
| You and your family were able to participate in decisions about your care. *[Likert Scale (1-7): Definitely NO→Somewhat→Definitely YES]* | - patient survey |
| Clinicians/staff respected your choice of whether or not to have family members or friends with you during your care. *[Likert Scale (1-7): Definitely NO→Somewhat→Definitely YES]* | - patient survey |
| Clinicians/staff respected your family's cultural and spiritual needs. *[Likert Scale (1-7): Definitely NO→Somewhat→Definitely YES]* | - patient survey |

## Community resources/social networking

| Measure | Source(s) of Data |
|---|---|
| In the past 3 months, have you used the internet to find information about your illness or to get support from other people with the same or similar illness? *[Yes, No]* | - patient survey |
| In the past 3 months, have you contacted community organizations for information about your illness or participated in a community support group for people with the same or similar illness? *[Yes, No]* | - patient survey |

## Tailored measures

- ***Asian Health Services*** – % patients who have received follow-up phone calls post clinic visit ("In the past 3 months, have you received at least one follow-up phone call from your health care provider(s) regarding your health condition?" Y/N)
- ***Golden Valley HC*** – % patients with comprehensive foot exam in last 12 months; % patients who completed a depression screening in last 12 months
- ***Northeast Valley HC*** – % patients filling prescriptions (Please answer this question only if you were given a prescription at your last visit: "I picked up my medicine(s) from the pharmacy after my last visit with my doctor." YES/NO); "I know the results of my A1c" YES/NO

- ***Open Door CHC*** – none
- ***SF General Hosp FHC*** – % patients with internet access (“Do you have internet access?” YES/NO); % patients with a health coach (“Does the patient have a health coach?” YES/NO)
- ***Sharp Rees-Stealy Medical Group*** -- % patients who know their a1c, ldl, and bp values ("I know the results of my HbA1c, LDL, and blood pressure (if applicable)") *[Likert Scale (1-7): Definitely NO→Somewhat→Definitely YES]*; % patients who know their a1c, ldl, and bp goals ("I know what my HbA1c, LDL, and blood pressure GOALS are (if applicable)") *[Likert Scale (1-7): Definitely NO→Somewhat→ Definitely YES]*; % patients with 1 a1c screening in past year; % patients with $\geq$7 a1c $\leq$9; relative value units (RVUs)/physician/month; visits/month; avg # days until 3rd next available appointment for office visits, new office visits, and complete physical exams; bp<140/90 for ischemic vascular disease population

## Tell Us About Your Visit!

**<You may format this prototype survey any way you like with the exception of changing the wording and response categories of the questions. You also may add questions to the survey if you wish.>**

**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. Please be honest so that we can improve how we can best serve you in the future. Thank you for answering these questions!**

| **For each item below, please circle a number between 1 and 7 that best fits how you feel.** | ☹<br>**Definitely NO** | | | 😐<br>**Somewhat** | | | ☺<br>**Definitely YES** |
|---|---|---|---|---|---|---|---|
| **My health care provider(s) and I worked <u>together</u> to set personal goals to manage my illness.** | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| **My health care provider(s) listened carefully to me at today’s visit.** | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| **I understand my health care provider’s advice and what I need to do to manage my illness.** | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| **My health visit helped me gain confidence in managing my health problems.** | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| **I have a written action plan to help me manage my illness → ☐ Yes ☐ No (go to next question)**<br>↓<br>**Over the past 7 days, I was able to follow my action plan to help me manage my illness.** | **1** | **2** | **3** | **4** | **5** | **6** | **7** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Answer this question only if you take prescribed medicines:** Over the past 7 days, I took all of my prescribed medicines when I was supposed to. | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| **Answer this question only if you have diabetes:** Over the past 7 days, I checked my blood sugar when I was supposed to. | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| **You and your family were able to participate in decisions about your care.** | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| **Clinicians/staff respected your choice of whether or not to have family members or friends with you during your care.** | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| **Clinicians/staff respected your family's cultural and spiritual needs.** | **1** | **2** | **3** | **4** | **5** | **6** | **7** |

| | | |
|---|---|---|
| **In the past 3 months, have you used the internet to find information about your illness or to get support from other people with the same or similar illness?** | **☐ YES** | **☐ NO** |
| **In the past 3 months, have you contacted community organizations for information about your illness or participated in a community support group for people with the same or similar illness?** | **☐ YES** | **☐ NO** |

## Instructions for Administering "Tell Us About Your Visit" Quality Improvement Survey for Patients

For the implementation phase of the *Team Up for Health* initiative, we ask that you distribute this survey to a sample of your patients at the practice site(s) where the initiative is being implemented to track the level of self-management support over the course of this project. During the implementation phase, we ask that you administer this survey to a total of between 60-75 patients each quarter (roughly 20-25 patients each month) – these should be patients of providers who are participating in this initiative. Data collection activities will begin in October so that the first data report will be due in January 2010 (see table below for reporting periods and due dates). In December 2009, we also will be sending you an Excel workbook where you can record the summary data that you collect and e-mail back to us for each of your practice sites. The workbooks will contain self-generating charts so you can track your progress for both the patient- and provider-level measures. Please note that as your team expands the project to other practice sites, we will ask you to collect similar patient and provider data for EACH new site during the implementation phase. Here are some additional points about administering this survey:

- You should feel free to change the formatting and/or add information to this survey, for example, if you need clinic/practice site identifiers or if you want to change the instructions or add your logo.
- If you have to read this survey to patients with limited reading ability, please try to get someone other than the provider who just saw the patient to do this. The patient might be more comfortable and provide more honest answers.
- Your patients should know that their answers will be kept confidential, will not be part of their medical chart, and will in no way affect the care they receive from your clinic. You might even want to provide patients with an envelope in which to seal the survey when they finish.
- Ideally, the survey should be administered to patients right AFTER their visit with their health care provider. We understand that in some settings this is not possible and that patients need to complete the survey while they're waiting to see their provider or at some other time. The important point is to be sure that you choose one method and do it consistently for every patient. So, decide which method will work best for each practice site, and do it that way every time. It's also important to remember to tell the patient whether his/her responses should be based on experiences from this visit or the previous visit—if the survey is administered after the visit, patients' responses should reflect that day's visit, whereas if the survey is administered before the visit, patients' responses should reflect their previous visit to the clinic.
- For projects with multiple practice sites implementing the initiative, please assign a unique name or number to each site so that you and we can track results over time.
- If at some point you would like to add new questions to the patient survey, please contact Seth Emont so that he can work with you in developing your questions and also make the necessary changes to your tracking measures workbook.
- Please see additional notes below.

## Additional Notes for Summarizing *Team Up for Health* Patient Self-Management Support Quality Improvement Data

When you receive your Excel workbook in December 2009, please be sure to include the date, name of your practice site(s), and the contact information of the person completing the summary tracking form in the first tab of the workbook (in case we need to contact that person if we have any questions). The Excel workbook also will contain a notes section on the first tab, so that you may include any specific notes about data collection activities that we should know about. If your organization has more than one practice site implementing the initiative, please complete a separate workbook for each site.

Ideally and if possible, any patient summary measures derived from your registry (e.g., a1c, bp, ldl) should reflect the patient panels of providers participating in this initiative. So, for example, if you are working with half of the providers in a clinic, you should attempt to summarize the registry/clinical measures for only those patient panels potentially seen by the participating providers. Likewise, the patient surveys should be limited to patients in these same provider panels. Otherwise, it will be difficult to demonstrate improvements in these measures if you're also surveying patients of providers who are not participating in this initiative. If your project includes plans for expanding to other practice sites (e.g., other clinics and/or providers/pods within a particular clinic), then your data collection strategy also should change accordingly.

The patient summary data should be entered into the Excel workbook (forthcoming) along with the provider summary data (please refer to separate toolkit for provider data). The tabs in the workbook will be set up to reflect quarterly reporting, so that patient data will be entered every quarter for each site and provider data will be entered every *other* quarter for each site. Due dates for the patient and provider survey summary data are as follows:

| **Patient Survey Data** | **Provider Survey Data** | **Data Collection Period** | **Workbook Due Date** |
|---|---|---|---|
| × | × | Oct-Dec 2009<br>(Baseline) | January 13, 2010<br>(Wednesday) |
| × | | Jan-Mar 2010 | April 16, 2010<br>(Friday) |
| × | × | Apr-Jun 2010 | July 14, 2010<br>(Wednesday) |
| × | | Jul-Sep 2010 | October 13, 2010<br>(Wednesday) |
| × | × | Oct-Dec 2010 | January 14, 2011<br>(Friday) |
| × | | Jan-Mar 2011 | April 13, 2011<br>(Wednesday) |
| × | × | Apr-Jun 2011<br>(Final) | June 17, 2011*<br>(Friday) |

*Note: The final data collection period will be 10 weeks instead of a full 12 weeks. During this wrap-up period, we ask that you submit your final data set by mid-June.

Please e-mail your completed Excel workbook to Seth Emont.  If you have any questions regarding data collection and reporting, please feel free to call Seth Emont at 603-768-5933 or send an e-mail to semont@myfairpoint.net.

# *"Team Up for Health"* Initiative – Phase 2

## Provider Satisfaction with Patient Self-Management Support

## Quality Improvement Survey and Instructions

## *"Team Up for Health"* Program
## Provider Satisfaction with Patient Self-Management Support

**<You may format this survey any way you like with the exception of changing the wording and response categories of the questions. You also may add questions to the survey if you wish.>**

**We are interested in how satisfied you are helping patients develop strategies to self-manage their chronic illnesses (i.e., self-management support). Your survey responses will be kept anonymous.**

| Circle a number between 1 and 10 for each statement below or circle 'NS' if you're not sure | Extremely Dissatisfied | | | | | | | | | Extremely Satisfied | Not Sure |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | NS |
| How satisfied are *you* with how well you and your staff are helping your patients self-manage their chronic illness? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | NS |
| How satisfied do you think your *patients* are with how you are helping them manage their chronic illness? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | NS |
| How satisfied are you with how well you and your staff are *involving patients in their own care*? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | NS |
| How satisfied are you that the self-management tools and resources you are using are making a difference in your patients' clinical outcomes? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | NS |
| How satisfied are you with your clinic's ability to connect patients to community-based resources to help them manage their chronic illnesses? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | NS |

**Please indicate the extent to which you agree or disagree with each of the following statements about how self-management supports have impacted your relationships with your patients and your ability to communicate and care for your patients. If you are not sure, circle 'NS'.**

| Circle a number between 1 and 10 for each statement below or circle 'NS' if you're not sure of the impact at this time | Strongly Disagree | | | | | | | | | Strongly Agree | Not Sure |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | NS |
| Self-management supports help my patients become better prepared to discuss their treatment with me. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | NS |
| Using self-management support strategies has led to better communication with my patients. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | NS |
| Using self-management supports makes it easier for me to care for my patients. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | NS |
| Self-management support strategies I learn about are sometimes inconsistent with the advice I give my patients. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | NS |
| Using self-management support strategies has increased my confidence in assisting patients to manage their health condition. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | NS |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Using self-management support strategies has increased my ability to activate my patients' involvement in their own care.** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **NS** |
| **Staff and clinicians view patients and families as essential members of the health care team.** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **NS** |
| **Providers encourage and support patients and their families to set goals and create action plans for self-management of chronic conditions.** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **NS** |

## Instructions for Administering the *Team Up for Health* "Provider Satisfaction with Patient Self-Management Support" Quality Improvement Survey

As part of the California HealthCare Foundation's *Team Up for Health* program, we ask that you distribute this survey **every 6 months** to providers (e.g., physicians, nurses, MAs, health educators, etc.), at your practice site(s) who are involved in the initiative (e.g., participating in trainings or practice changes to improve self-management support, or provided with resources generated through this initiative). Here are some additional notes about administering this survey:

- There are no requirements around how many team members complete this survey – it is up to you, but respondents should represent the providers involved in this initiative. The key is consistency, so that when you re-administer this survey at 6-month intervals, you want to be sure to survey the same group of providers involved in the initiative, if possible.
- Be sure to include yourself in the survey if you are a provider involved in the initiative.
- If you would like to add questions to this survey, please feel free to do so. You might be interested in learning other things that are unique to your setting.
- For teams with multiple clinics/practice sites participating in the initiative, please administer this survey to the participating providers at **each** of your clinics/sites. As you spread the initiative from your initial practice site(s) to additional sites, be sure to survey providers wherever the initiative is being implemented at that time.
- Please make every effort to ensure anonymity of survey responses.
- The summary data should be entered into the Excel workbook (forthcoming). If you have more than one practice site, separate Excel workbooks should be used. The workbooks will be used to record the summary data for both providers and patients. The tabs in the workbook will be set up to reflect quarterly reporting, so that patient data will be entered every quarter for each practice site and provider data will be entered every *other* quarter for each practice site. Due dates for the patient and provider survey summary data are as follows:

| Patient Survey Data | Provider Survey Data | Data Collection Period | Workbook Due Date |
|---|---|---|---|
| × | × | Oct-Dec 2009<br>(Baseline) | January 13, 2010<br>(Wednesday) |
| × | | Jan-Mar 2010 | April 16, 2010<br>(Friday) |

| | | | |
|---|---|---|---|
| ✕ | ✕ | Apr-Jun 2010 | July 14, 2010<br>(Wednesday) |
| ✕ | | Jul-Sep 2010 | October 13, 2010<br>(Wednesday) |
| ✕ | ✕ | Oct-Dec 2010 | January 14, 2011<br>(Friday) |
| ✕ | | Jan-Mar 2011 | April 13, 2011<br>(Wednesday) |
| ✕ | ✕ | Apr-Jun 2011 (Final) | June 17, 2011*<br>(Friday) |

*Note: The final data collection period will be 10 weeks instead of a full 12 weeks. During this wrap-up period, we ask that you submit your final data set by mid-June.

## California HealthCare Foundation
## *Team Up for Health*
## Faculty Interview Guide

Background:

I'm interested in your thoughts about the extent to which the TUFH project met its goals as well as your opinion on other features of the program. Your individual responses to 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. Do you have any questions for me before we begin?

| |
|---|
| In thinking about the overall progress that the teams have made in improving self-management support and patient-centeredness, how would you sum up the teams' biggest achievements overall (across teams)? Are there specific areas where, overall, teams seem to have made more improvements than other areas? |
| What would you consider to be the grantee teams' greatest challenges with the project to date? |
| What do you anticipate to be the teams' greatest challenges moving forward? |
| Looking back over the project, what do you think was your biggest surprise? |
| In thinking back when the teams were selected for the TUFH project, do you think they were further along in certain areas of care (e.g., SMS, provider-patient communication, p/f-centered care, rapid-cycle quality improvement) than you had originally anticipated or not as far along as you would have liked to see (i.e., when they first started the project)?<br>Follow-up Q:<br>Do you think it's reasonable that we asked teams to make changes in these areas of care at the same time? Also, do you think it was reasonable to expect major changes in all of these areas in just two years? |
| Are there other ways we could have structured the technical assistance components of this project that you think would have been more successful? Are there other resources or types of technical assistance we should have made available to grantees? |
| Which of the teams, if any, do you think could serve as models for other sites for each of the three primary areas of focus for the TUFH project (i.e., practice improvement/QI, communication skills, p/f-centered care)? Are there any teams that you feel did well in all of these areas? |
| If we could start from the beginning, what should we have done differently or added to the project? |
| If you could assign one overall grade to the overall accomplishments of all of the teams and the project in terms of success in moving the needle with self-management supports, what grade would you give (from A to F (+/-))? |

## California HealthCare Foundation
## *Team Up for Health*
## Project Director Interview Guide

Background:

We are very interested in your organization's experiences with the TUFH project. This interview focuses on ways in which self-management support services have been introduced and used in your organization, and how your organization has become more patient-centered. As the project director, your insights are particularly important and will help us improve these strategies in the future. Your individual responses to 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. Do you have any questions for me before we begin?

What activity or process related to TUFH do you think has had the greatest impact on your organization, and why?

Have there been any unanticipated outcomes or surprises (either positive or negative) as a result of your organization's participation in this project?

If you could start the TUFH project over again, what one thing do you wish you had in place at the outset that could have helped you make better progress? Is there anything else that you would do differently?

The TUFH project focused primarily on three areas: communication skills, quality improvement through a practice improvement team, and partnering with patients and families.

In looking broadly across these three areas, which was the easiest to incorporate into your clinics and why? Which was the most challenging to incorporate into your clinics and why? In looking ahead to the next year or two, where do you think you'll focus your efforts? [probe: equally across all areas; try to make inroads in more challenging areas; try to sustain the success we've had in one or two areas]

Follow-up Q:

Although the TUFH project didn't focus as much on leveraging community and web-based resources, based on your experience with this, how easy or difficult has it been to incorporate into routine care for patients? [Probe for examples]

Do you feel that there have been changes in the underlying organizational *culture* of your organization (or pilot site) as a result of implementing the TUFH work? If so, what examples can you provide (e.g., more opportunities for skill development, integration of SMS strategies with other programs, greater awareness among staff, applying QI efforts to other programs)? [Note: will build on this from teams' specific responses to the 18-mo summary report, but will initially leave open-ended]

Follow-up Q:

To what extent do you feel that the changes you have made with the TUFH project align with your organization's larger goals and vision?

| |
|---|
| Have you discussed the future of your TUFH work (or components of it) with decision makers/management in your organization, your partner organizations, other funders, or policy makers at any level? What have their reactions been? What might decision makers in your organization need to see in order to continue support for this initiative (e.g., clinical outcomes, return on investment)? |
| Do you have any plans for expanding (or continued expansion of) your site's use of self-management support strategies and partnering with patients and families in QI after current funding ends? Are you already engaged in these expansion efforts? (For example, including expanding to implement new components, new populations of patients, more providers or training for them, other clinic sites, different levels of staff, expanded scope with new patients, etc.). If not, why not?<br><br>What specific products or resources have you developed, if any, as part of the TUFH project and are currently rolling out or planning on rolling out across multiple sites?<br><br>Would you be willing to share some or all of these with other clinics outside of the TUFH initiative? |
| Quite a few types of resources, technical assistance, and expertise were made available to the TUFH teams, including training, annual meetings, webinars, conference calls, one-on-one technical assistance with faculty members (both phone-based and onsite), and site visits to other organizations. Do you think this was a good balance of technical assistance to meet your sites' needs or do you feel it was burdensome? Did any of these resources prove to be more valuable to your site than others? If so, which ones?<br><br>Do you think the technical assistance that was offered was able to strike a nice balance between the use of outside experts vs. sharing among grantees or would you have preferred more of one than the other?<br><br>In thinking about the types of resources and expertise that your team had access to as part of the TUFH initiative, what other kinds of resources and/or expertise, if any, would you recommend for any future initiatives in this area? |
| Finally, we would be interested in speaking with another leader at your organization who may have not been directly involved in the *Team Up for Health* project to get their perspective on the extent to which the *Team Up for Health* project has led to institutional capacity building at your organization around self-management support and patient-centered care. Ideally, we would like to interview an individual who is in senior management – preferably on the administration side of things, although we could also interview a clinical leader if this is not possible.<br><br>Could you recommend someone else that I could speak with for a half-hour interview? If you need time to think about who that might be, that's fine, and you can always send me an e-mail with their contact information. |

## California HealthCare Foundation
## *Team Up for Health*
## Site Administrator (or Clinical Leader) Interview Guide

Background:

We are very interested in your perspective on your organization's experiences with the *Team Up for Health* project. This interview focuses on the extent to which the *Team Up for Health* project has led to institutional capacity building at your organization around self-management support and patient-centered care. As an (administrator/clinical leader/) at [name of organization], your insights are particularly important and will help the California HealthCare Foundation improve its programming efforts in the future. Your individual responses to 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. Do you have any questions for me before we begin?

How would you describe the extent of your involvement in the *Team Up for Health* project? [PROBE: Minimal or no involvement; provided some input; familiarity with aspects of project; decision maker]

(Depending on their involvement in the project) What activity or process related to TUFH do you think has had the greatest impact on your organization, and why?

Have you been involved in discussions with your organization's *Team Up for Health* project team about this initiative? Have you been involved in discussions with team members about the future of the project? What kinds of evidence would you want to see in order to continue support for this initiative (e.g., clinical outcomes, return on investment)?

(Based on what you know about the *Team Up for Health* project), do you feel that there have been changes in the underlying organizational *culture* of your site (i.e., administrative, clinical, operational changes)? If so, what examples can you provide (e.g., more opportunities for skill development, routine use of SMS strategies, greater awareness among staff, integration of SMS strategies into QI efforts)? [Note: will build on this from teams' specific responses to the 18-mo summary report]

Follow-up Q:

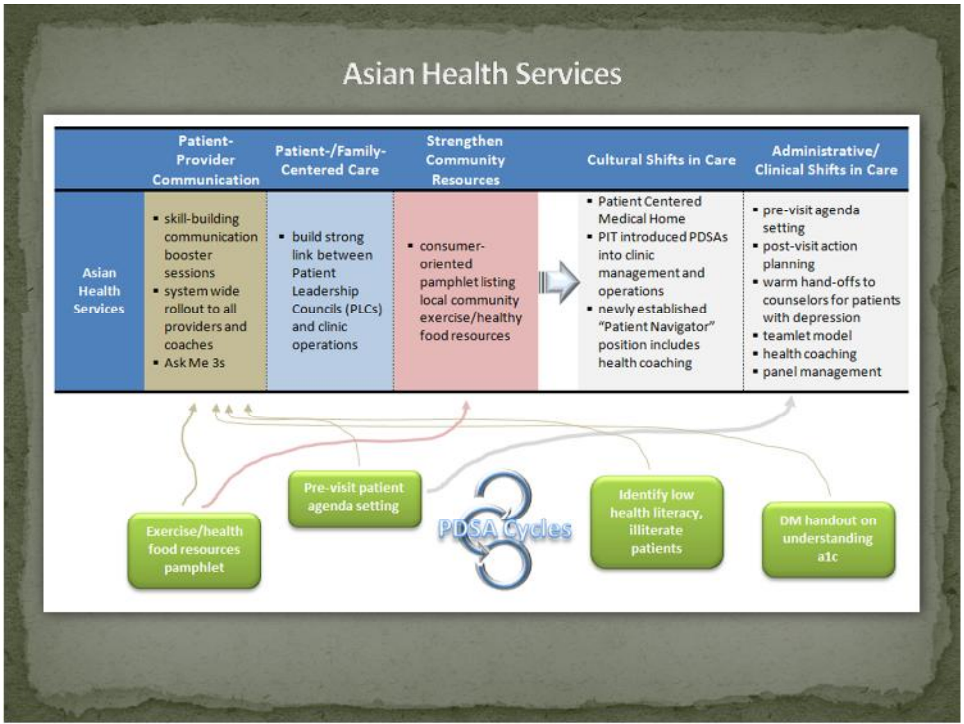
To what extent do you feel that the changes you have made with the TUFH project align with your organization's larger goals and vision?

Have you seen evidence of your site's focus on self-management support and patient-centered care spreading to other areas outside of the *Team Up for Health* project? Do you have any plans for expanding (or continued expansion of) your site's use of self-management support strategies and partnering with patients and families in QI after current funding ends? Are you already engaged in these expansion efforts? (For example, including expanding to implement new components, new populations of patients, more providers or training for them, other clinic sites, different levels of staff, expanded scope with new patients, etc.). If not, why not?

One of the central goals of the *Team Up for Health* project was to provide your organization with resources and technical assistance in engaging patients and their families in the care they receive. As you know, patient-centeredness has been a major focus of QI efforts over the past few years and is also a major focus of the patient-centered medical home model. Have you witnessed any changes in the extent to which p/f-centered care has been strengthened at your organization as a result of the *Team Up for Health* program?

In thinking about self-management supports and their potential value to both providers and patients, what other kinds of resources and/or expertise, if any, do you think would be helpful to your organization to enhance quality of care and patient-centeredness?

## What TUFH Teams are Doing to Promote System Wide Change Using Self-Management Supports



### Asian Health Services

| | Patient-Provider Communication | Patient-/Family-Centered Care | Strengthen Community Resources | Cultural Shifts in Care | Administrative/ Clinical Shifts in Care |
|---|---|---|---|---|---|
| Asian Health Services | ▪ skill-building communication booster sessions<br>▪ system wide rollout to all providers and coaches<br>▪ Ask Me 3s | ▪ build strong link between Patient Leadership Councils (PLCs) and clinic operations | ▪ consumer-oriented pamphlet listing local community exercise/healthy food resources | ▪ Patient Centered Medical Home<br>▪ PIT introduced PDSAs into clinic management and operations<br>▪ newly established "Patient Navigator" position includes health coaching | ▪ pre-visit agenda setting<br>▪ post-visit action planning<br>▪ warm hand-offs to counselors for patients with depression<br>▪ teamlet model<br>▪ health coaching<br>▪ panel management |

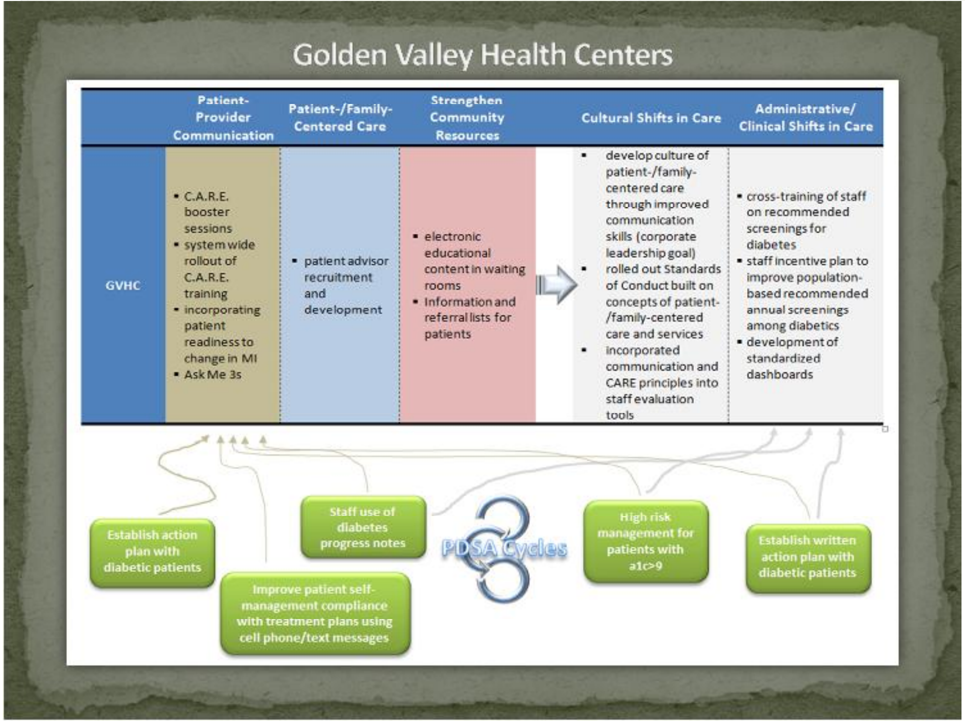
Exercise/health food resources pamphlet

Pre-visit patient agenda setting

PDSA Cycles

Identify low health literacy, illiterate patients

DM handout on understanding a1c



### Golden Valley Health Centers

| | Patient-Provider Communication | Patient-/Family-Centered Care | Strengthen Community Resources | Cultural Shifts in Care | Administrative/ Clinical Shifts in Care |
|---|---|---|---|---|---|
| GVHC | ▪ C.A.R.E. booster sessions<br>▪ system wide rollout of C.A.R.E. training<br>▪ incorporating patient readiness to change in MI<br>▪ Ask Me 3s | ▪ patient advisor recruitment and development | ▪ electronic educational content in waiting rooms<br>▪ Information and referral lists for patients | ▪ develop culture of patient-/family-centered care through improved communication skills (corporate leadership goal)<br>▪ rolled out Standards of Conduct built on concepts of patient-/family-centered care and services<br>▪ incorporated communication and CARE principles into staff evaluation tools | ▪ cross-training of staff on recommended screenings for diabetes<br>▪ staff incentive plan to improve population-based recommended annual screenings among diabetics<br>▪ development of standardized dashboards |

Establish action plan with diabetic patients

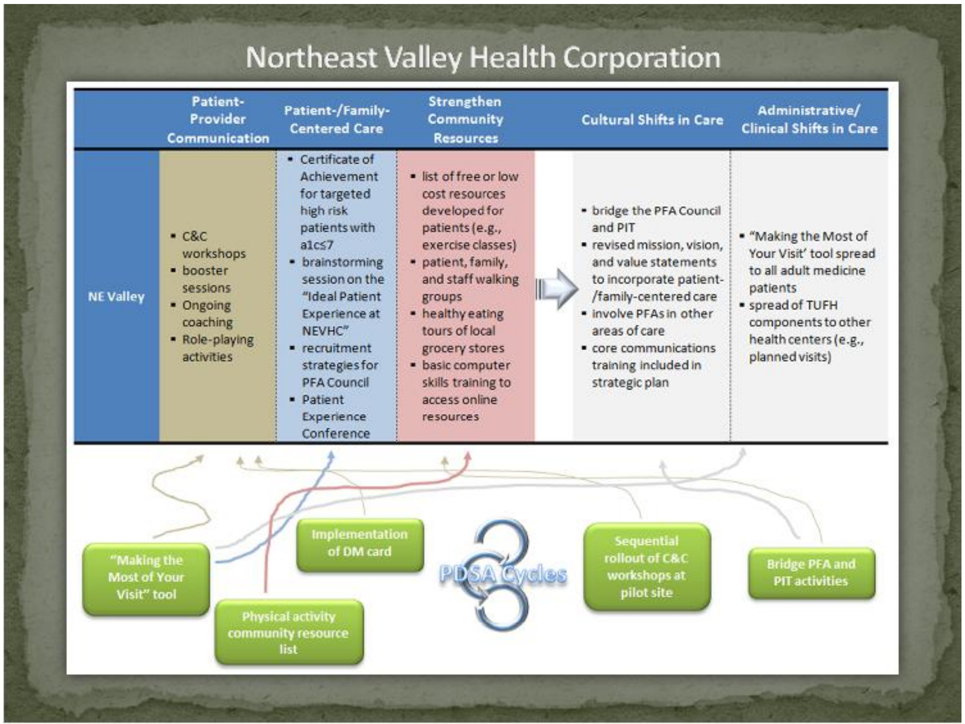
Staff use of diabetes progress notes

Improve patient self-management compliance with treatment plans using cell phone/text messages

PDSA Cycles

High risk management for patients with a1c>9

Establish written action plan with diabetic patients



## Northeast Valley Health Corporation

| | Patient-Provider Communication | Patient-/Family-Centered Care | Strengthen Community Resources | Cultural Shifts in Care | Administrative/ Clinical Shifts in Care |
|---|---|---|---|---|---|
| NE Valley | ▪ C&C workshops<br>▪ booster sessions<br>▪ Ongoing coaching<br>▪ Role-playing activities | ▪ Certificate of Achievement for targeted high risk patients with a1c≤7<br>▪ brainstorming session on the "Ideal Patient Experience at NEVHC"<br>▪ recruitment strategies for PFA Council<br>▪ Patient Experience Conference | ▪ list of free or low cost resources developed for patients (e.g., exercise classes)<br>▪ patient, family, and staff walking groups<br>▪ healthy eating tours of local grocery stores<br>▪ basic computer skills training to access online resources | ▪ bridge the PFA Council and PIT<br>▪ revised mission, vision, and value statements to incorporate patient-/family-centered care<br>▪ involve PFAs in other areas of care<br>▪ core communications training included in strategic plan | ▪ "Making the Most of Your Visit' tool spread to all adult medicine patients<br>▪ spread of TUFH components to other health centers (e.g., planned visits) |

"Making the Most of Your Visit" tool

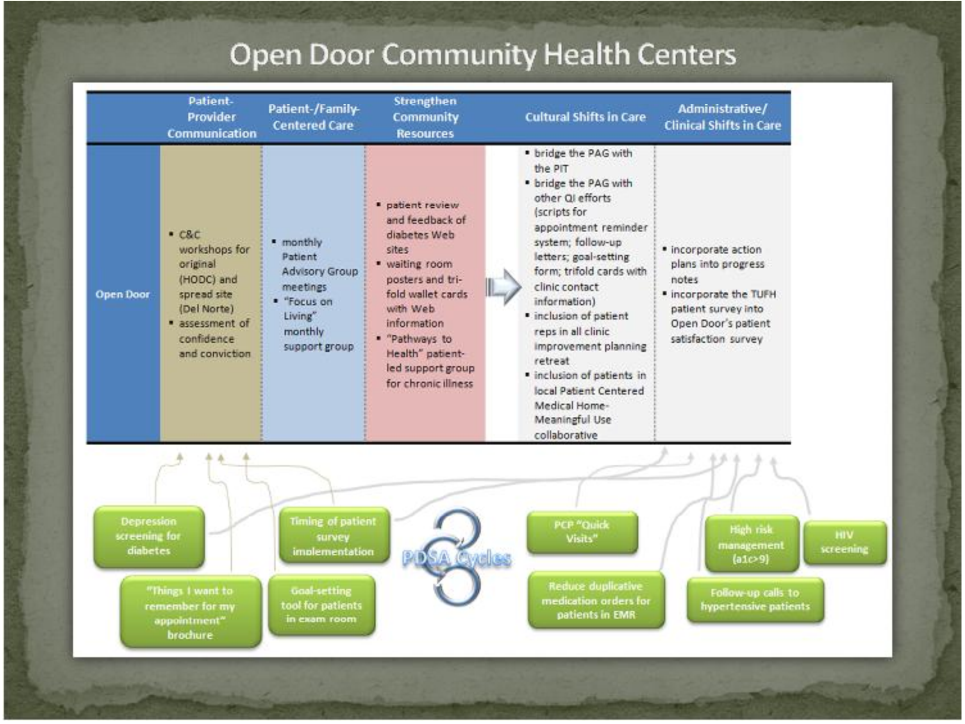
Physical activity community resource list

Implementation of DM card

PDSA Cycles

Sequential rollout of C&C workshops at pilot site

Bridge PFA and PIT activities



## Open Door Community Health Centers

| | Patient-Provider Communication | Patient-/Family-Centered Care | Strengthen Community Resources | Cultural Shifts in Care | Administrative/ Clinical Shifts in Care |
|---|---|---|---|---|---|
| Open Door | ▪ C&C workshops for original (HODC) and spread site (Del Norte)<br>▪ assessment of confidence and conviction | ▪ monthly Patient Advisory Group meetings<br>▪ "Focus on Living" monthly support group | ▪ patient review and feedback of diabetes Web sites<br>▪ waiting room posters and tri-fold wallet cards with Web information<br>▪ "Pathways to Health" patient-led support group for chronic illness | ▪ bridge the PAG with the PIT<br>▪ bridge the PAG with other QI efforts (scripts for appointment reminder system; follow-up letters; goal-setting form; trifold cards with clinic contact information)<br>▪ inclusion of patient reps in all clinic improvement planning retreat<br>▪ inclusion of patients in local Patient Centered Medical Home-Meaningful Use collaborative | ▪ incorporate action plans into progress notes<br>▪ incorporate the TUFH patient survey into Open Door's patient satisfaction survey |

Depression screening for diabetes

"Things I want to remember for my appointment" brochure

Timing of patient survey implementation

Goal-setting tool for patients in exam room

PDSA Cycles

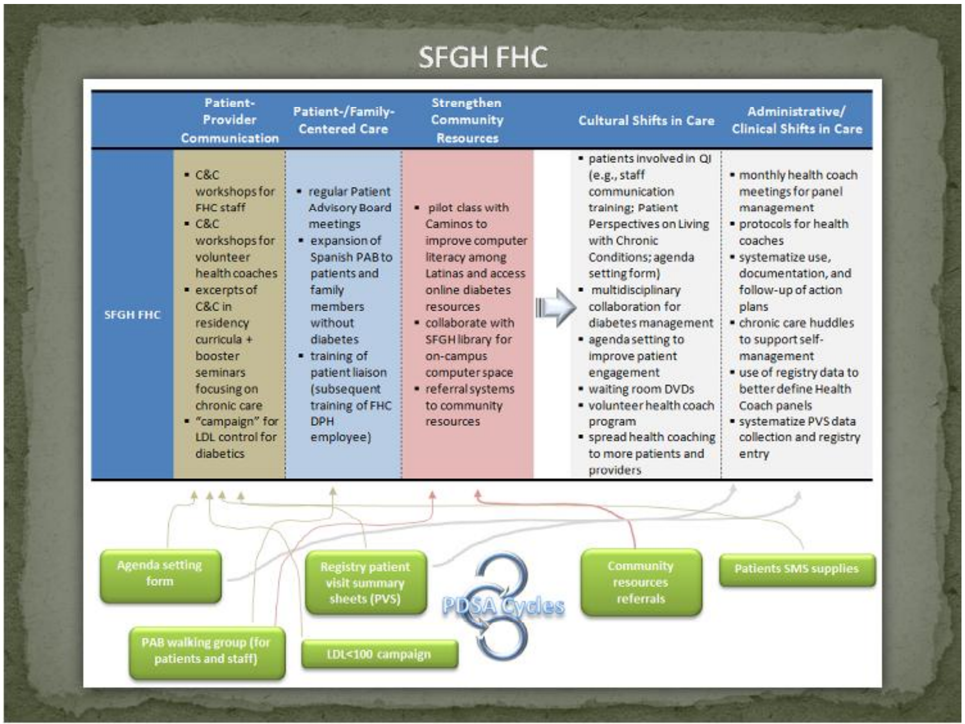
PCP "Quick Visits"

Reduce duplicative medication orders for patients in EMR

High risk management (a1c>9)

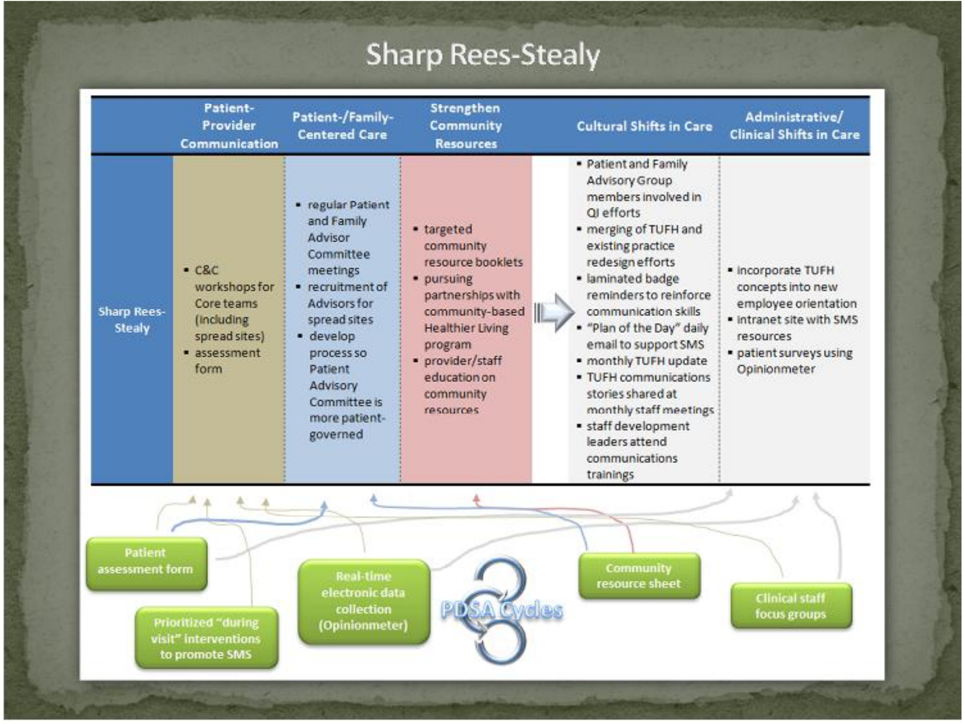
HIV screening

Follow-up calls to hypertensive patients



## SFGH FHC

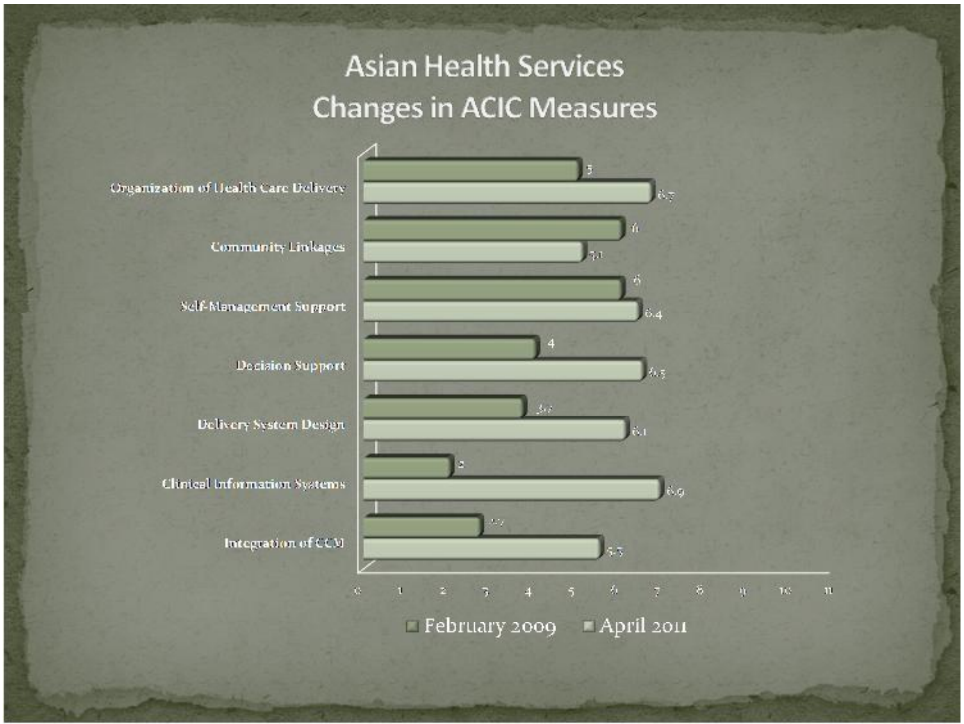
| | Patient-Provider Communication | Patient-/Family-Centered Care | Strengthen Community Resources | Cultural Shifts in Care | Administrative/ Clinical Shifts in Care |
|---|---|---|---|---|---|
| SFGH FHC | ▪ C&C workshops for FHC staff<br>▪ C&C workshops for volunteer health coaches<br>▪ excerpts of C&C in residency curricula + booster seminars focusing on chronic care<br>▪ "campaign" for LDL control for diabetics | ▪ regular Patient Advisory Board meetings<br>▪ expansion of Spanish PAB to patients and family members without diabetes<br>▪ training of patient liaison (subsequent training of FHC DPH employee) | ▪ pilot class with Caminos to improve computer literacy among Latinas and access online diabetes resources<br>▪ collaborate with SFGH library for on-campus computer space<br>▪ referral systems to community resources | ▪ patients involved in QI (e.g., staff communication training; Patient Perspectives on Living with Chronic Conditions; agenda setting form)<br>▪ multidisciplinary collaboration for diabetes management<br>▪ agenda setting to improve patient engagement<br>▪ waiting room DVDs<br>▪ volunteer health coach program<br>▪ spread health coaching to more patients and providers | ▪ monthly health coach meetings for panel management<br>▪ protocols for health coaches<br>▪ systematize use, documentation, and follow-up of action plans<br>▪ chronic care huddles to support self-management<br>▪ use of registry data to better define Health Coach panels<br>▪ systematize PVS data collection and registry entry |

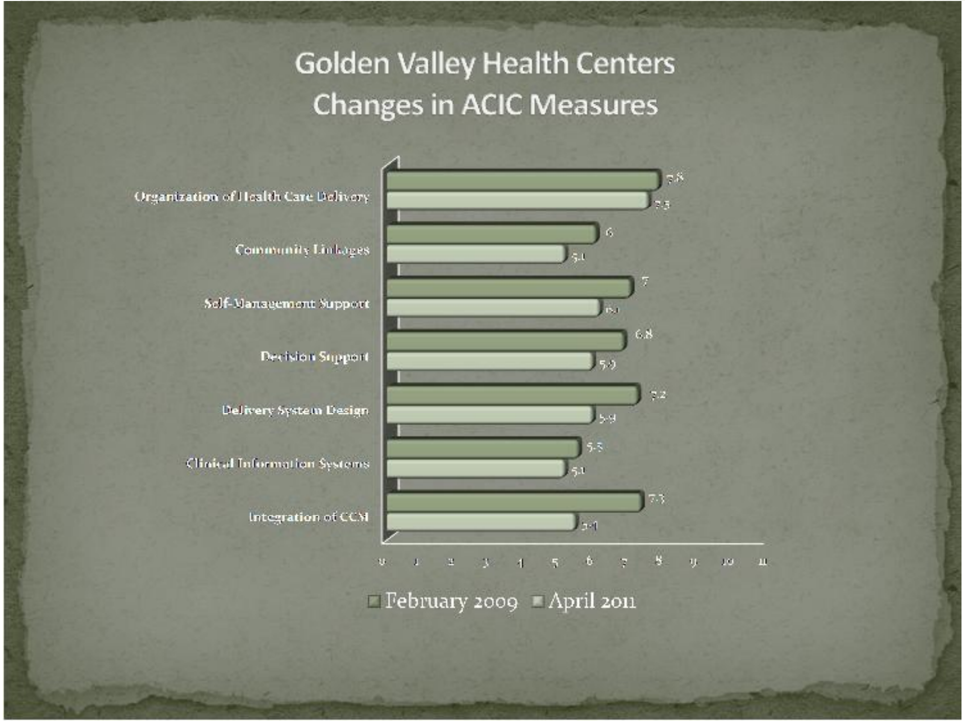


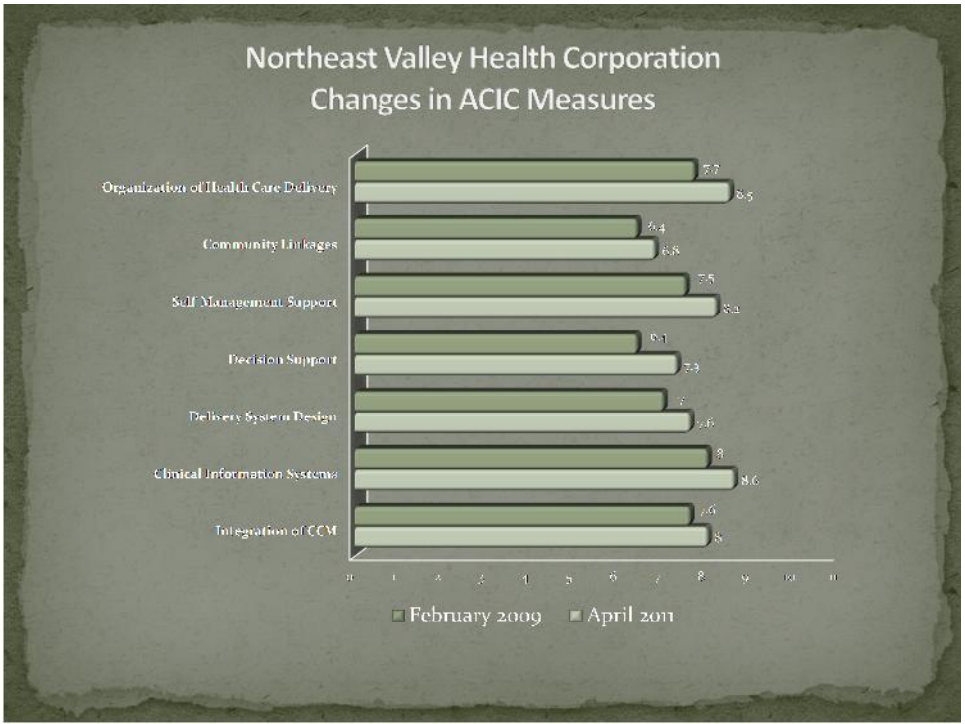
## Sharp Rees-Stealy

| | Patient-Provider Communication | Patient-/Family-Centered Care | Strengthen Community Resources | Cultural Shifts in Care | Administrative/ Clinical Shifts in Care |
|---|---|---|---|---|---|
| Sharp Rees-Stealy | ▪ C&C workshops for Core teams (including spread sites)<br>▪ assessment form | ▪ regular Patient and Family Advisor Committee meetings<br>▪ recruitment of Advisors for spread sites<br>▪ develop process so Patient Advisory Committee is more patient-governed | ▪ targeted community resource booklets<br>▪ pursuing partnerships with community-based Healthier Living program<br>▪ provider/staff education on community resources | ▪ Patient and Family Advisory Group members involved in QI efforts<br>▪ merging of TUFH and existing practice redesign efforts<br>▪ laminated badge reminders to reinforce communication skills<br>▪ "Plan of the Day" daily email to support SMS<br>▪ monthly TUFH update<br>▪ TUFH communications stories shared at monthly staff meetings<br>▪ staff development leaders attend communications trainings | ▪ incorporate TUFH concepts into new employee orientation<br>▪ intranet site with SMS resources<br>▪ patient surveys using Opinionmeter |

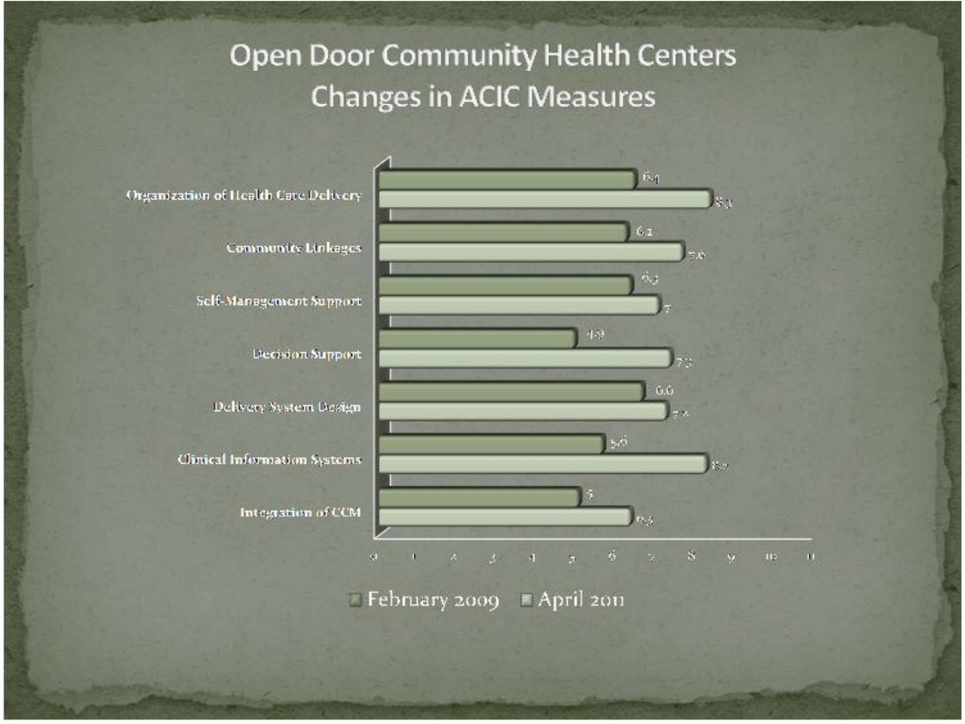
**Changes in ACIC Measures by Team**



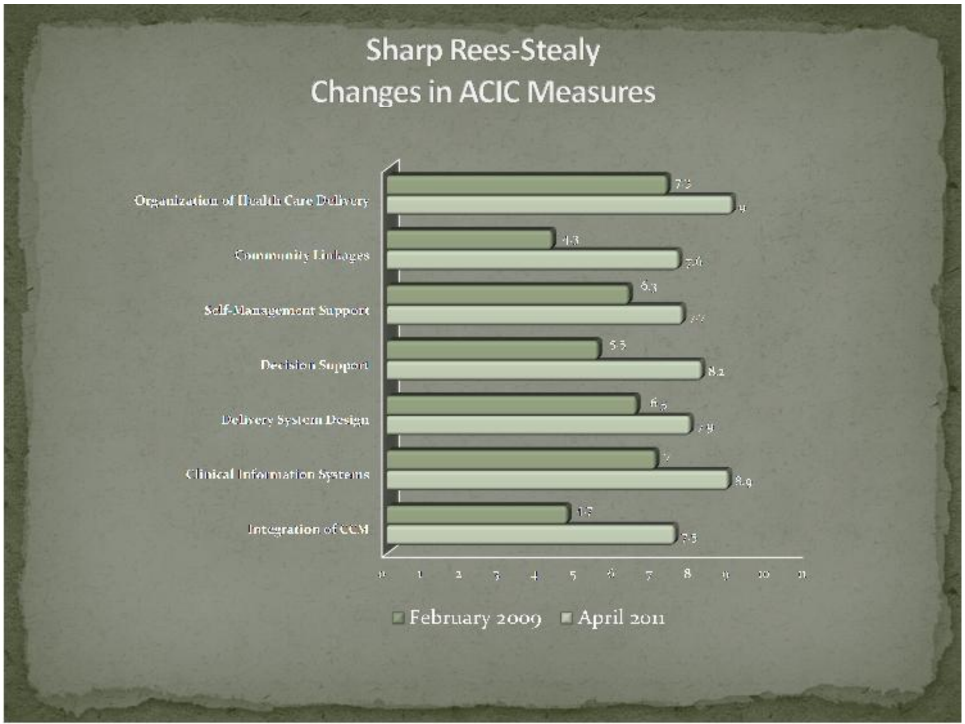




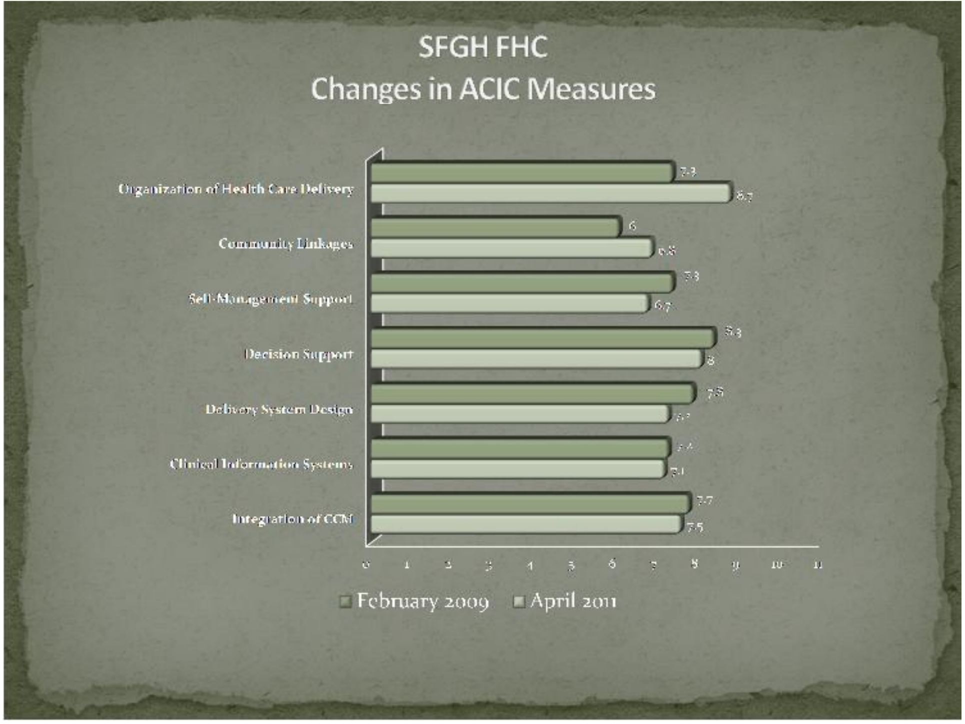
Northeast Valley Health Corporation
Changes in ACIC Measures



Open Door Community Health Centers
Changes in ACIC Measures



Sharp Rees-Stealy
Changes in ACIC Measures



SFGH FHC
Changes in ACIC Measures

## Changes in Patient Measures by Team

### I. Patient Clinical Processes and Outcomes Measures

| | Asian Health | Golden Valley - Merced | Golden Valley - W Modesto | NE Valley - Pacoima | NE Valley - San Fernando | Open Door - Humboldt | Open Door - Del Norte | SFGH | Sharp Rees-Stealy |
|---|---|---|---|---|---|---|---|---|---|
| A1c < 7% | + | + | + | + | nc | + | + | + | nc |
| A1c < 8% | + | + | + | + | nc | + | nc | nc | nc |
| A1c > 9% | nc | + | + | + | nc | + | nc | - | nc |
| A1c ≥ 7 and ≤ 9 | | | | | | | | | + |
| 2 A1c's at Least 91 Days Apart | + | + | nc | + | + | nc | + | + | |
| 1 A1c screening in past year | | | | | | | | | nc |
| BP < 130/80 mmHg | + | + | + | - | nc | + | - | + | + |
| BP < 140/90 mmHg | + | + | + | - | nc | nc | - | + | + |
| Patients with HYPERTENSION BP < 140/90 mmHg | | | | | | | | | |
| Patients with IVD BP < 140/90 mmHg | | | | | | | | | - |
| LDL < 100 mg/dl | + | + | + | nc | + | nc | + | + | + |
| Documented Written Action Plan | - | | | + | + | + | | + | + |
| Completed Depression Screen | | - | + | | | | | | |
| Comprehensive Foot Exam | | + | + | | | | | | |
| Health Coach | | | | | | | | + | |
| Relative Value Units per Physician per Month | | | | | | | | | + |
| Visits per Physician per Month | | | | | | | | | nc |
| Third next available appointment (avg # days) for: OFFICE VISIT | | | | | | | | | - |
| Third next available appointment (avg # days) for: NEW OFFICE VISIT | | | | | | | | | - |
| Third next available appointment (avg # days) for: COMPLETE PHYSICAL EXAM | | | | | | | | | - |

+ = positive change
– = negative change
nc = no change

## II. Patient Experience and Self-Care Behavior

| | Asian Health | Golden Valley - Merced | Golden Valley - W Modesto | NE Valley - Pacoima | NE Valley - San Fernando | Open Door - Humboldt | Open Door - Del Norte | SFGH | Sharp-Rees Stealy |
|---|---|---|---|---|---|---|---|---|---|
| **Patient-Provider Communication (pos changes in 4 of 4 measures)** | | | | | | | | | |
| **My health care provider(s) and I worked together to set personal goals to manage my illness.** | + | + | + | + | + | + | + | + | + |
| **My health care provider(s) listened carefully to me at today's visit.** | + | + | + | + | + | + | + | + | + |
| **I understand my health care provider's advice and what I need to do to manage my illness.** | + | + | + | + | + | + | + | + | + |
| **My health visit helped me gain confidence in managing my health problems.** | + | + | + | + | + | + | + | + | + |
| **Self-Care Behavior (pos changes in 3 of 4 core measures)** | | | | | | | | | |
| **I have a written action plan to help me manage my illness** | + | - | nc | nc | + | + | - | + | + |
| **Over the past 7 days, I was able to follow my action plan to help me manage my illness.** | + | + | + | + | + | + | nc | - | + |
| **Over the past 7 days, I took all of my prescribed medicines when I was supposed to.** | + | + | + | + | + | + | + | + | + |
| **Over the past 7 days, I checked my blood sugar when I was supposed to.** | nc | + | + | + | + | + | + | + | + |
| **I picked up my medicine(s) from the pharmacy after my last visit with my doctor.** | | | | + | + | | | | |
| **I know the results of my A1c.** | | | | - | + | | | | |
| **I know the results of my HbA1c, LDL, and blood pressure.** | | | | | | | | | + |
| **I know what my HbA1c, LDL, and blood pressure goals are.** | | | | | | | | | + |
| **Patient- and Family-Centered Care (pos changes in 3 of 3 core measures)** | | | | | | | | | |
| **You and your family were able to participate in decisions about your care.** | + | + | + | + | + | + | + | nc | + |
| **Clinicians/staff respected your choice of whether or not to have family members or friends with you during your care.** | + | + | + | + | + | + | nc | + | + |
| **Clinicians/staff respected your family's cultural and spiritual needs.** | + | + | + | + | + | + | nc | + | + |
| **Community Resources / Social Networking (changes in 1 of 2 measures)** | | | | | | | | | |
| **Do you have access to the internet?** | | | | | | | | nc | |
| **In the past 3 months, have you used the internet to find information about your illness or to get support from other people with the same or similar illness?** | + | + | + | + | - | nc | nc | nc | + |
| **In the past 3 months, have you contacted community organizations for information about your illness or participated in a community support group for people with the same or similar illness?** | nc | nc | + | + | - | - | nc | nc | + |
| **Patient Follow-Up** | | | | | | | | | |
| **In the past 3 months, have you received at least one follow-up phone call from your health care provider(s) regarding your health condition?** | - | | | | | | | | |

| |
|---|
| + = positive change |
| – = negative change |
| nc = no change |

# Addendum to *Team Up for Health* Evaluation Report

(Evaluation Report submitted by White Mountain Research Associates, LLC, in October 2011)

Addendum prepared by: Kate Meyers, MPP, Project Manager, *Team Up for Health*

Data analysis and table/graph preparation performed by: Seth Emont, PhD, MS, White Mountain Research Associates

Qualitative interviews performed by: Kate Meyers

## Background

The California HealthCare Foundation's *Team Up for Health* (TUFH) initiative began in 2009 to strengthen self-management support and patient- and family-centered care. As described in the full Evaluation Report, the initiative originally consisted of a 6-month planning phase and a 2-year implementation phase, and was scheduled to conclude in August 2011. However, in June 2011 the CHCF Board approved the availability of additional funds to enable TUFH grantees to spread their current resources, tools, and strategies from their original grant funding to other sites. CHCF released an augmentation funding application to all current TUFH grantees with a required one-to-one matching fund of up to $62,500 for one year, so that grantees could "more fully spread TUFH activities to additional sites and to integrate improvements in self-management support and patient- and family-centered care into ongoing operations," and "serve as models for other health care organizations."

All teams received augmentation funding for one additional year, ending August 2012. While teams received additional funds during this time, the technical assistance provided by external faculty during the implementation phase was not continued under the grant for the final year. Some teams did use these grant funds to send additional staff to an Institute for Healthcare Communication "Choices and Changes" communication skills faculty course, the same course provided during the implementation phase. CHCF staff and the initiative's contracted Project Manager continued to provide assistance and coaching to the teams as needed, including individual calls for updates and problem-solving, and group conference calls on topics of common interest.

This report serves as an addendum to the original Evaluation Report submitted by White Mountain Research Associates in October 2011, summarizing the results of quantitative and qualitative evaluation activities that took place during the final augmentation funding year.

## Measurement Activities

During the augmentation funding year, teams were required to submit two additional reports of clinical measures (at six and 12 months), an additional round of provider satisfaction surveys (at 12 months), and a final Assessment of Chronic Illness Care (ACIC) survey (at 12 months). These measures and surveys were the same as those used during the implementation phase. Teams were encouraged to collect these data for quality improvement purposes at all sites where they were implementing *Team Up for Health*, but for the purposes of the formal project evaluation, they were required to submit data only or those sites where they had submitted data during the implementation phase of the initiative.

Team Project Directors and administrative leaders also participated in structured phone interviews at the end of the final year to document sustainability and spread of self-management support and patient- and family-centered care. The interview tools used to guide these discussions are included in the Appendix of this addendum report.

Teams were not required to collect patient survey data during the augmentation funding year.

## Evaluation Findings – Final Year of Initiative (August 16, 2011 – August 15, 2012)

### *Changes in Patient Clinical Experience and Self-Care Behavior*

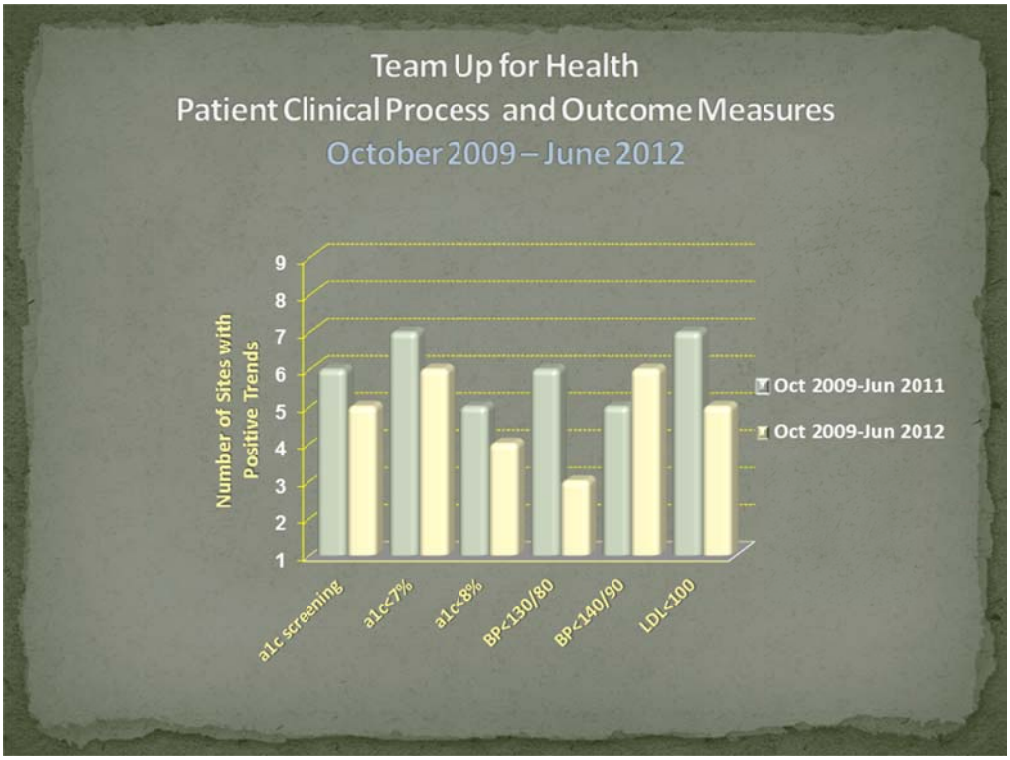
Teams were not required to administer patient surveys during the augmentation funding year, so no additional data are available on patient clinical experience and self-care behavior beyond what was reported in the original Evaluation Report.

### *Changes in Patient Clinical Processes and Outcome Measures*

As was the case during the Implementation Phase of the initiative, during the final year teams collected data on a number of clinical process and outcome measures, including a1c screening, a1c levels, blood pressure, and LDL. Results showed some “slippage” compared to those reported in the original Evaluation Report, as indicated on the graph below. Final data showed that five of nine sites demonstrated positive changes in the percentage of patients with appropriate annual a1c screening, six of nine and four of nine sites demonstrated positive changes in two a1c level measures (percentage of patients with a1c<7% and a1c<8%, respectively), three of nine and six of nine teams demonstrated positive trends in two blood pressure measures (percentage of patients with BP<130/80 and <140/90, respectively), and five of nine teams demonstrated positive changes in LDL levels (percentage of patients with LDL<100 mg/dL). Six of nine sites showed positive trends in percentage of patients with documented written action plans. Site-by-site findings are presented in the Appendix.

It is important to note that one organization (with two sites reporting data) with fewer positive trends in June 2012 than in June 2011 noted their results on some clinical measures may have been influenced by recent changes in income verification requirements for some patients, that led to charges for visits that had previously been free, resulting in a decrease in visits and possible negative impact on clinical outcomes.

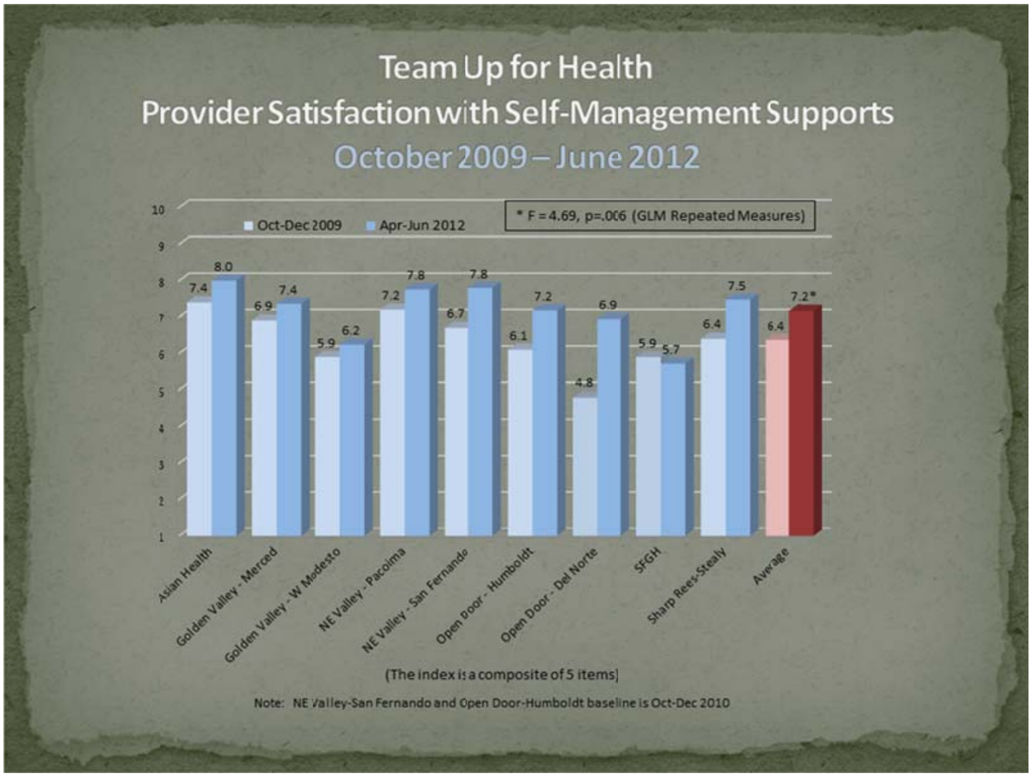
That same organization had also undergone a drug formulary switch from a once-daily insulin product to another that needs to be injected more than once a day, leading to possible medication adherence challenges for patients with diabetes.


Team Up for Health
Patient Clinical Process and Outcome Measures
October 2009 – June 2012

### *Changes in Provider Satisfaction with Care*

During the augmentation funding phase, teams submitted one additional set of provider surveys toward the end of the final year. As described in the Evaluation Report, provider satisfaction was measured across two domains: (1) the extent to which self-management supports have had positive impacts on patient treatment; and, (2) the impact on the patient-provider relationship. An index was created for each domain, using the average score across five questions for the first domain, and the average score across eight questions for the second domain. Data were reported by nine sites (three of the six organizations reported data for two clinical sites).

Regarding the extent to which self-management support had positive impacts on patient care, over the course of the initiative, eight of nine sites demonstrated positive shifts in providers reporting that self-management supports have made a difference during the patient encounter. Across all sites, the overall average score increased significantly from 6.4 to 7.2 (F=4.69, p=.006 [GLM Repeated Measures]).

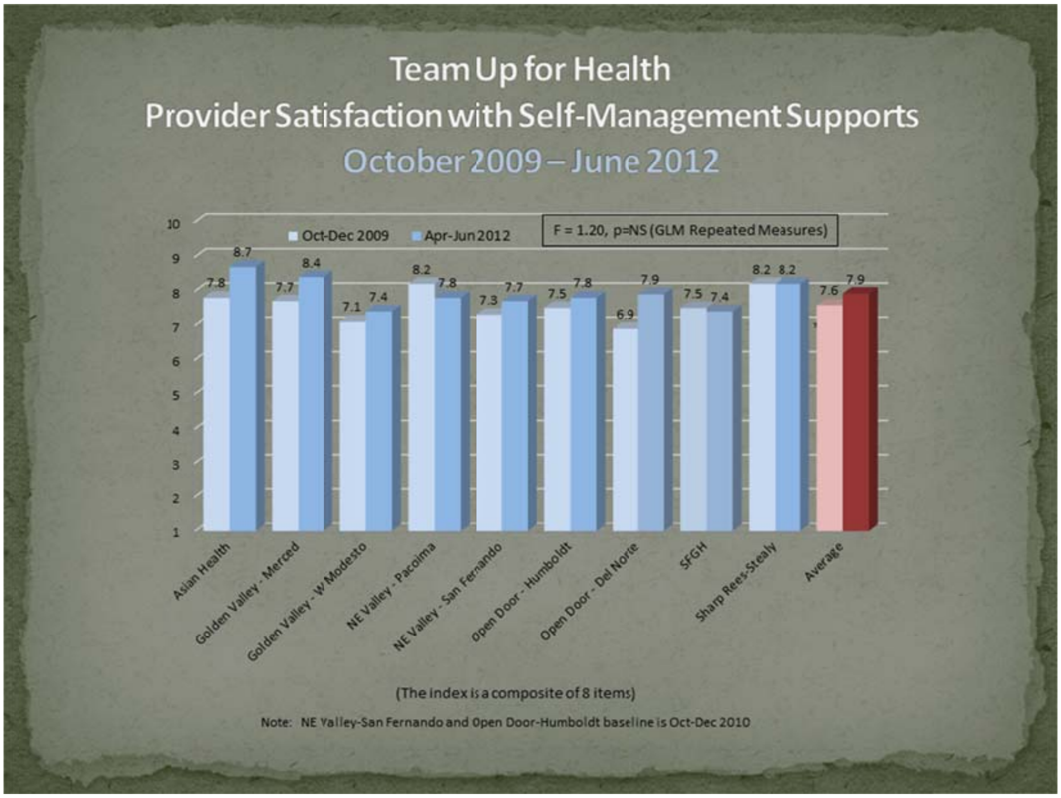


Team Up for Health
Provider Satisfaction with Self-Management Supports
October 2009 – June 2012

(The index is a composite of 5 items)

Note: NE Valley-San Fernando and Open Door-Humboldt baseline is Oct-Dec 2010

Regarding the impact of self-management supports on the patient-provider relationship, six of nine sites reported improvements from first reporting period to last, and across sites the average score increased from 7.6 to 7.9, although this change was not statistically significant.



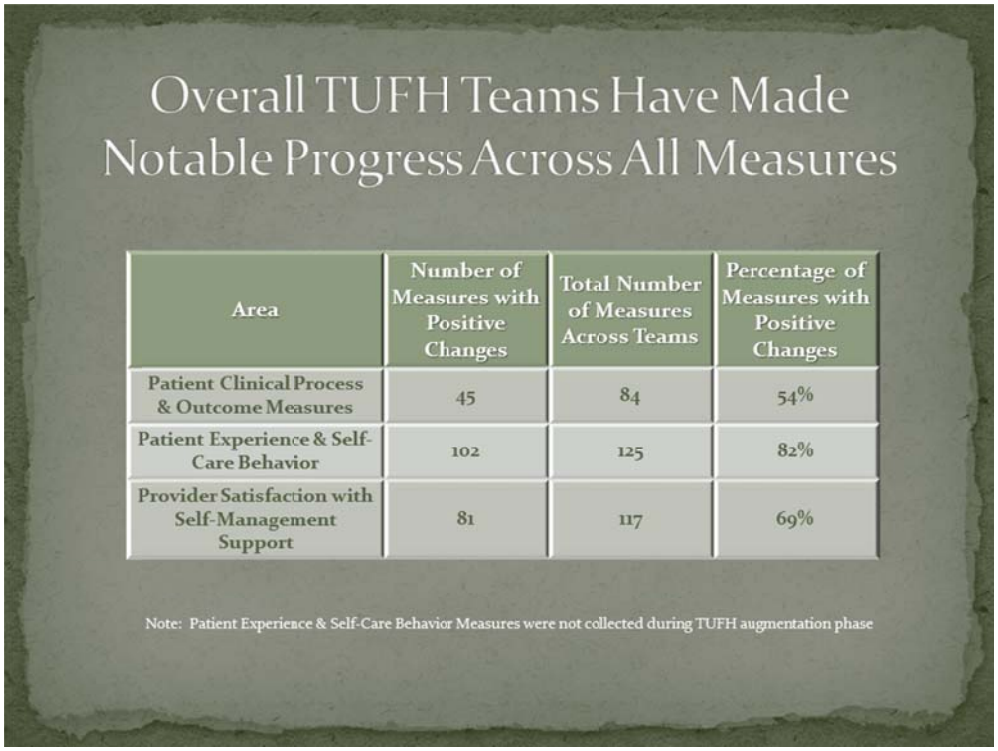
Team Up for Health
Provider Satisfaction with Self-Management Supports
October 2009 – June 2012

(The index is a composite of 8 items)

Note: NE Valley-San Fernando and Open Door-Humboldt baseline is Oct-Dec 2010

As noted in the Evaluation Report regarding the provider satisfaction measures, “Although the changes reported here on average scores appear to be modest, it is important to note that scores are averaged across the teams and have high variation and are also calculated as composite scores from a number of questions, so that even minimal changes from baseline to follow-up represent reasonable gains in these measures.”

Overall, over the course of the entire initiative, teams made positive progress on the majority of patient and provider measures, as indicated in the table below.



Overall TUFH Teams Have Made Notable Progress Across All Measures

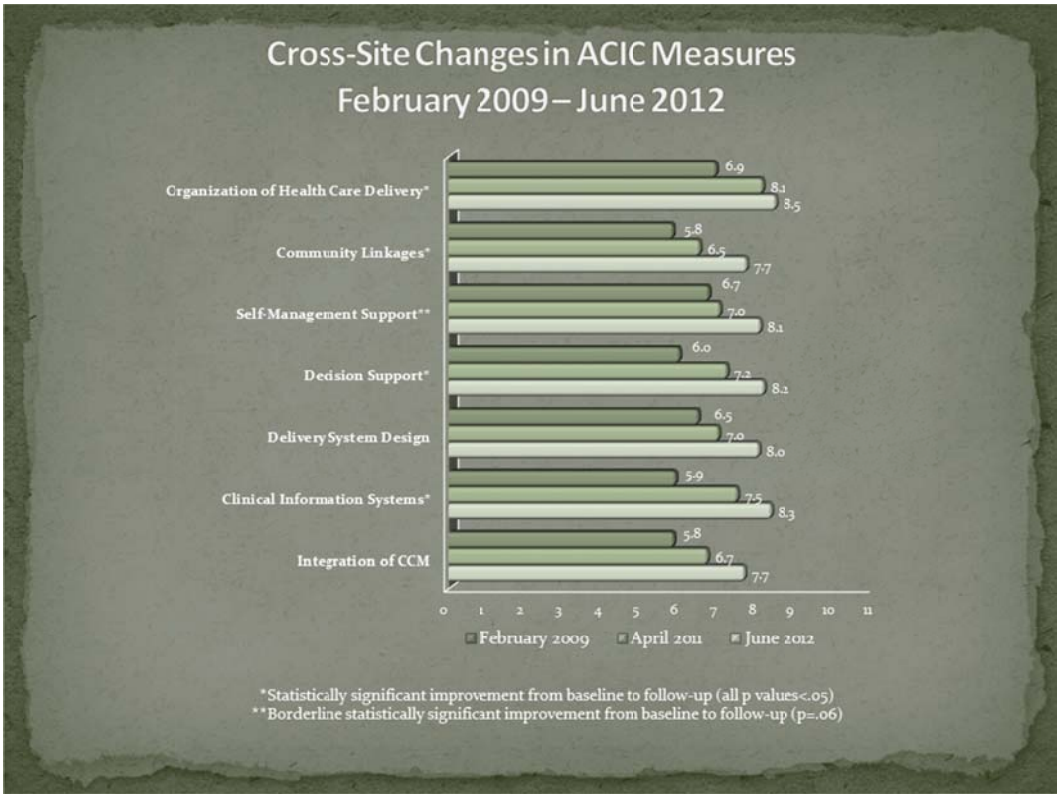
| Area | Number of Measures with Positive Changes | Total Number of Measures Across Teams | Percentage of Measures with Positive Changes |
|---|---|---|---|
| Patient Clinical Process & Outcome Measures | 45 | 84 | 54% |
| Patient Experience & Self-Care Behavior | 102 | 125 | 82% |
| Provider Satisfaction with Self-Management Support | 81 | 117 | 69% |

Note: Patient Experience & Self-Care Behavior Measures were not collected during TUFH augmentation phase

### *Changes in Systems of Care*

As described in the Evaluation Report, the Assessment of Chronic Illness Care (ACIC) measures changes in the organization of healthcare delivery systems, community linkages, self-management supports, decision support, delivery system design, clinical information systems, and integration of the Chronic Care Model components. The ACIC was self-administered at all 6 organizations at three points during the initiative: baseline in February 2009, and follow-up in April 2011 and June 2012.

Across all teams, there were statistically significant improvements in 4 of 7 ACIC domains and 1 borderline statistically significant improvement over the 3-year period. Compared to the results in April 2011, by the final results in June 2012 an additional 2 domains improved. Even those measures that did not show statistically significant improvement did improve over the course of the initiative, as shown in the chart below. The greatest improvements were demonstrated for clinical information systems and decision support, followed by integration of the Chronic Care Model and community linkages – the latter showing its strongest improvement in the final year of the initiative. Changes in scores for all teams reporting their follow-up data on the ACIC survey are shown in the Appendix.



Cross-Site Changes in ACIC Measures
February 2009 – June 2012

*Statistically significant improvement from baseline to follow-up (all p values<.05)
**Borderline statistically significant improvement from baseline to follow-up (p=.06)

Similar to the process used toward the end of the Implementation Phase, in July and August 2012 individual structured interviews were conducted with the TUFH Project Director at each organization, as well as an administrative leader from each organization. These interviews aimed to assess various dimensions of systems-level changes (i.e., changes in administrative and clinical practice, changes in organizational culture) as well as challenges and successes in sustaining and spreading these activities and plans for ongoing efforts in these areas. The interview guides used at the end of the augmentation phase differed from those used at the end of the implementation phase, with a greater emphasis on sustainability and spread. These guides are included in the Appendix. Verbatim responses from interviewees are included below as quotes.

All sites indicated interest in and commitment to continuing efforts to improve self-management support for patients with chronic conditions and to make care at their organizations more patient- and family-centered. Several interviewees expressed the strongly positive impact the initiative has had on their organization's approach and culture:

- *Team Up for Health* "was probably one of the best things we've done in the 35 years I've been here."
- "*Team Up for Health* has changed us. It really has."
- "As we moved through the pillars of *Team Up for Health*, we've moved along a journey of organizational transformation."
- "The organizational change that has occurred is really significant."

- This "will just be a part of how we do business now" and "will be integrated into who we are."
- "No one has said, 'when funding goes away, what will we do?' – they say, 'well, this is how we need to do things now.'"
- The initiative has helped us "change from seeing patients as 'individual encounters' to seeing patients as 'progressing along a continuum of better health.'"
- We have "become more proactive than reactive" and we're "looking at patient as a whole rather than they problem they present with."
- "To sit where I was two years ago, I never would have thought we'd be where we are today."
- "*Team Up for Health* is a name for what nurses and doctors should have been doing – it's now our responsibility to continue it."

There were, not surprisingly, differences between organizations regarding which *Team Up for Health* activities had the greatest impact, and why. Some interviewees focused on the influence of partnering with patients and families as advisors:

- Organizational leaders had been talking about the need to integrate the patient voice, but *Team Up for Health* "urged us to just do it!" Now, "it will be part of who we are."
- In the beginning, providers and staff felt, "no way do we want a patient here – we don't want them to see our dirty laundry. But they're experiencing our dirty laundry!"
- "Patient advisory groups have been a hoot beyond words!"
- Deliberately chose to include a few patients on Patient Advisory Group who were not most eloquent, had mental health issues, "they have thrived on the Patient Advisory Group – attend every meeting, volunteer for projects, offer different perspectives."
- "Anything we're doing [that impacts patients] goes before the Patient Advisory Board."
- Patients have been willing "to commit time to working as partners" because they see the clinic "changing the way they're doing things."
- With previous efforts at engaging patients as advisors, "I realized we were flying in the dark. We didn't know how to recruit, train, or elicit feedback." Now very different. "Very satisfying to have gone through this process."
- "When we started the project, there was a lot of skepticism [about patient advisors] – are they going to demand things that are unreasonable?" Now, when having meeting related to *Team Up for Health* activities without a patient there, people ask, "where are the patients?"

Some felt their development and implementation of Practice Improvement Teams (PITs) were most impactful:

- While the organization has had a focus on quality improvement, "it was helpful to have a more concrete framework and set of tools" to get and keep the QI efforts going.
- Involving diverse team members on the PIT "elevated people's sense of morale and importance no matter what position they hold."
- "Investing in our staff [through the PIT] has made a huge difference in the care we

provide to our patients." Now meeting regularly, thinking more broadly, and engaging all team members, "all at the table together;" involving the people who are directly dealing with patients, "giving them a space and tools to improve care."

- PIT has provided a chance for front-line staff to get involved – "they feel empowered."
- With PIT, have seen "how our employees embraced the process. They feel empowered; they are becoming a part of the change process, and they are doing it themselves."
- PIT is "where the rubber meets the road" in terms of change and improvement.
- "This is an approach for many different areas….a way to make change."
- "Staff input is absolutely essential to make change and sustain change."
- The structure of the PIT and the use of PDSAs "has set a mindset in the clinic"; "PITs are a big deal."
- "Everyone gets a say and they have equal weight."
- After a career of running provider meetings and administrative meetings, "to see a functioning improvement team made up of the ones implementing clinic procedures…I love it!"

Some felt communication skills training (using the "Choices and Changes" curriculum) had the greatest impact:

- Organization had already begun to focus on communication skills, but *Team Up for Health* provided "tools and a structure that has helped us institutionalize this work."
- The communications training was "presented in a way that our physicians and nurses had not thought about communication." It taught them how to "listen and engage patients in conversation."
- Have gotten feedback from physicians who have gone through the training that have said, "I will change the way I practice."
- Communication training has "helped move us to more of a team culture."
- Communication training provided a grounding that all other aspects of *Team Up for Health* could build on.

Overall, interviewees felt that *Team Up for Health* meshed well with other organizational priorities, and that there was a positive synergy between some of these efforts:

- Several people cited the strong alignment with their current efforts to become Patient-Centered Medical Homes (PCMH): "*Team Up for Health* has prepped us for PCMH;" The initiative has helped us "work on what will help truly transform our organization, not just what will get us PCMH certification."
- "*Team Up for Health*" came at the perfect time – right before there was an organizational focus on patient engagement. We're looked at as leaders. That's really satisfying."
- "We don't do things that don't align with our goals; we took this on because it aligned with what we wanted to do."
- TUFH "primarily strengthened work that needed to be done anyway."

One interviewee felt that TUFH was generally very well aligned with many of the organization's priorities, but that the clinic's ongoing emphasis on physician productivity (seeing a certain number of patients per day) can conflict with TUFH's emphasis on communication and building stronger relationships between providers, patients, and families. Others cited the strain of competing priorities and other large-scale organizational changes, such as EMR implementation.

Interviewees also described successes and challenges related to sustaining and spreading TUFH activities, and plans for ongoing efforts. Teams experiences with and plans for spread vary – different teams have found different TUFH activities to be easier or more difficult to sustain and spread, and their varied experiences with these activities naturally inform their plans for ongoing efforts in these areas. For example, three teams found communications training to be one of the easiest of TUFH's activities to spread (though some found sustaining this skill-building more difficult), while two others found communications training to be the hardest aspect to sustain and spread. Four teams found Practice Improvement Teams (PITs) to be among the easiest to sustain and spread, while two others found PITs to be the most difficult to implement and integrate successfully.

Their views on the broader issue of spread include the following:

- "Spread is still a field of unanswered questions" and is an area where CHCF could support clinics in learning about best approaches.
- It would have helped to have deeper conversations with other teams and with experts about how to spread, sharing "good, bad, and ugly about spreading and maintaining" new approaches.
- Determining cost-effectiveness of self-management support activities and resources may be helpful in securing ongoing organizational support and funding.
- It would be helpful to have a "more uniform approach to roll-out" rather than implementing different aspects of TUFH at different sites.
- Anchoring TUFH concepts in broader frame of Patient-Centered Medical Home may help with spread, as PCMH provides more concrete desired end-points to drive toward.
- Self-management support needs to be integrated into EMR systems in order to become standard of care (e.g., documenting goals, templates to support care processes, etc.)
- Barriers to sustaining and spreading are time and resources – not motivation or information.
- Turnover of staff in leadership roles for TUFH (e.g., Liaison to Patient/Family Advisors, QI Coach, Communications Trainer) has been a challenge for some – because they did not receive the initial training and support for these roles, more structured ongoing support would have been useful.
- Similarly, more training in the TUFH concepts at spread sites would have been useful.

Four organizations described plans to continue their version of Health Coaches or a similar role for certain people with chronic conditions; four expressed commitment to continue PITs (while the other two left the door open to continuing those teams for specific purposes); four specified that they would continue communications training using “Choices and Changes” and, in two of those cases, the Institute for Healthcare Communication’s “CARE” curriculum; five teams indicated a commitment to continuing to engage patients as advisors/partners (and the sixth team indicated some interest in trying to make this work). Additional interest areas included developing stronger care teams and continuing to develop connections to community-based resources.

## ***Conclusions***

During the augmentation funding year of *Team Up for Health***,** grantees continued to demonstrate improvements along many patient-, provider-, and system-level measures. But the results also demonstrate the challenges of maintaining gains over time: some sites saw fewer positive trends in patient-level clinical measures in this final year compared to the data reported in the original Evaluation Report. Gains in provider satisfaction remained over the final year, and positive system-level changes increased in the final year. Qualitatively, reactions from TUFH Project Directors and other administrative leaders at the end of the augmentation year shared much consistency in the overall impact of the initiative on organizational culture and commitment to this work, with variations in the specific activities that worked best and would be continued in different organizations.

Through *Team Up for Health*, participating organizations worked to improve self-management support and patient- and family-centered care by focusing on:
- improving communication skills of providers and staff to build relationships with patients and engage them in their own care;
- tapping into the ideas of front-line staff about what changes in the practice would better support patients with chronic conditions;
- connecting patients to and forging partnerships with community-based resources;
- engaging patients and families as partners in improving the practice.

Any one of these focus areas requires significant attention to keep it moving forward; developing and strengthening these capacities simultaneously in TUFH seemed to help raise the “profile” of self-management and patient- and family-centered care to a point where some of these organizations see their new approaches moving from innovation to the way they need to do business.

These organizations’ efforts in *Team Up for Health* have positioned them well for the broader national movement toward Patient-Centered Medical Homes (PCMH), which emphasizes (among other things) patient-centeredness, patient experience, patient engagement in their care and self-management support, quality improvement, and coordinated care teams. Continued focus on the types of activities and capacities developed during the TUFH initiative is necessary for these organizations, and others, to continue to make progress on their journey toward truly patient-centered care.

# Appendix

# Interview Tools

## California HealthCare Foundation
## *Team Up for Health*
## 2012 Project Director Interview Guide

Background:

We would like to build on the information gathered through interviews conducted by Seth Emont last summer, to get a sense of your organization's overall experiences with the TUFH initiative. This interview focuses on ways in which self-management support services have been implemented and spread in your organization, and how your organization has become more patient- and family-centered. As the project director, your insights are particularly important and will help us understand which aspects of the initiative have been most impactful and where you continue to see opportunities for improvement. Your individual responses to 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. Do you have any questions for me before we begin?

As you think back on your experiences of the past three and a half years, what activities related to TUFH do you think has had the greatest impact on your organization, and why?

Have there been any unanticipated outcomes or surprises (either positive or negative) as a result of your organization's participation in this project?

In your work over the past year to sustain changes made in your pilot site(s) and spread elements of TUFH to additional sites, what one thing do you think could have helped you make better progress? Is there anything else that you would do differently to support sustaining and spreading these activities?

The TUFH initiative focused primarily on three areas: communication skills, quality improvement through a practice improvement team, and partnering with patients and families to improve the practice.

In looking broadly across these three areas, which has been the easiest to sustain and spread and why? Which has been the most challenging to sustain and spread and why? In looking ahead to the next year or two, where do you think you'll focus your efforts? [probe: equally across all areas; try to make inroads in more challenging areas; try to sustain the success we've had in one or two areas]

Follow-up Q:

Although the TUFH initiative didn't focus as much on leveraging community and web-based resources, based on your experience with this, to what degree do you want to continue or expand work in this area? [Probe for examples]

Do you feel that there have been changes in the underlying organizational *culture* of your organization (or pilot site) as a result of implementing the TUFH work (i.e., administrative, clinical, operational changes)? If so, please provide a specific example (e.g., more opportunities for skill development, integration of SMS strategies with other programs, greater awareness among staff, applying QI efforts to other programs)?

To what extent has the work of TUFH aligned with or diverged from other organizational priorities and goals over the course of the past three years? (Probe for specifics)

| |
|---|
| Have you discussed the future of your TUFH work (or components of it) with decision makers/management in your organization, your partner organizations, other funders, or policy makers at any level? What have their reactions been? |
| Do you have any plans for expanding (or continued expansion of) your site's use of self-management support strategies and partnering with patients and families in QI after current funding ends? Are you already engaged in these expansion efforts? (For example, including expanding to implement new components, new populations of patients, more providers or training for them, other clinic sites, different levels of staff, expanded scope with new patients, etc.). If not, why not? |

# California HealthCare Foundation
# *Team Up for Health*
# 2012 Site Administrator (or Clinical Leader) Interview Guide

Background:
As we wrap up the final year of the *Team Up for Health* initiative, we are having conversations with the Project Directors and administrative leaders from each of our participating organizations. Thank you for your willingness to share your perspective on your organization's experiences with the *Team Up for Health* project. This interview focuses on the extent to which the *Team Up for Health* project has led to institutional capacity building at your organization around self-management support and patient- and family-centered care. As an [administrator/clinical leader] at [name of organization], your insights are particularly important and will help the California HealthCare Foundation improve its programming efforts in the future. Your individual responses to 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. Do you have any questions for me before we begin?

| |
|---|
| How would you describe the extent of your involvement in the *Team Up for Health* project? [PROBE: Minimal or no involvement; provided some input; familiarity with aspects of project; decision maker] |
| (Depending on their involvement in the project) What activity or process related to TUFH do you think has had the greatest impact on your organization, and why? |
| Have you been involved in discussions with your organization's *Team Up for Health* project team about the future of the kinds of activities the initiative has focused on? What experiences or outcomes related to TUFH have influenced your thinking about continuing support for these activities? |
| (Based on what you know about the *Team Up for Health* project), do you feel that there have been changes in the underlying organizational *culture* of your site (i.e., administrative, clinical, operational changes)? If so, please provide a specific example (e.g., more opportunities for skill development, routine use of SMS strategies, greater awareness among staff, integration of SMS strategies into QI). |
| To what extent has the work of TUFH aligned with or diverged from other organizational priorities and goals over the course of the past three years? |
| Have you seen evidence of your site's focus on self-management support and patient-centered care spreading to other areas outside of the *Team Up for Health* project? Do you have any plans for expanding (or continued expansion of) your site's use of self-management support strategies and partnering with patients and families in QI after current funding ends? Are you already engaged in these expansion efforts? (For example, including expanding to implement new components, new populations of patients, more providers or training for them, other clinic sites, different levels of staff, expanded scope with new patients, etc.). If not, why not? |
| One of the central goals of the *Team Up for Health* project was to provide your organization with resources and technical assistance in engaging patients and their families in the care they receive. As you know, patient-centeredness has been a major focus of QI efforts over the past few years and is also a major focus of the patient-centered medical home model. Have you witnessed any changes in the extent to which p/f-centered care has been strengthened at your organization as a result of the *Team Up for Health* program? |
| In your organization's work on TUFH, what one thing do you think could have helped you make better progress? Is there anything else that your organization could do differently to support sustaining and spreading these activities? |

## Trends in Patient Clinical Processes and Outcomes Measures

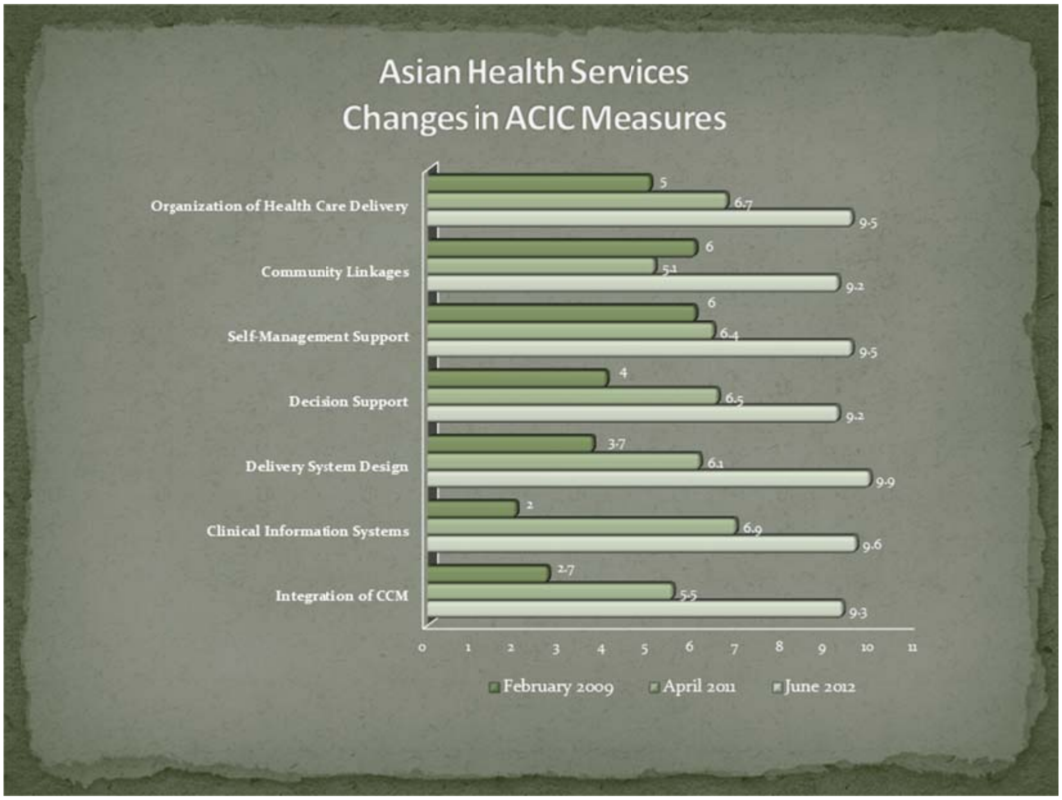
| | Asian Health | Golden Valley Merced | Golden Valley W Modesto | NE Valley Pacoima | NE Valley San Fernando | Open Door Humboldt | Open Door Del Norte | SFGH | Sharp Rees-Stealy | Percentage of Clinics with Positive Change in Core Measures from Oct 2009 - Jun 2012 |
|---|---|---|---|---|---|---|---|---|---|---|
| A1c < 7% | ▨ + | ▨ + | ▨ + | + | - | ▨ + | nc | + | - | 67% |
| A1c < 8% | nc | ▨ + | ▨ + | ▨ + | - | nc | nc | + | nc | 44% |
| A1c > 9% | nc | ▨ + | ▨ + | ▨ + | - | nc | ▨ + | + | nc | 56% |
| A1c ≥ 7 and ≤ 9 | | | | | | | | | nc | |
| 2 A1c's at Least 91 Days Apart | ▨ + | ▨ + | ▨ + | ▨ + | + | nc | - | nc | | 63% |
| 1 A1c screening in past year | | | | | | | | | nc | |
| BP < 130/80 mmHg | ▨ + | ▨ + | ▨ + | - | nc | nc | nc | nc | nc | 33% |
| BP < 140/90 mmHg | ▨ + | ▨ + | ▨ + | - | nc | ▨ + | ▨ + | nc | | 63% |
| Patients with HYPERTENSION BP < 140/90 mmHg | | | | | | | | | ▨ + | |
| Patients with IVD BP < 140/90 mmHg | | | | | | | | | nc | |
| LDL < 100 mg/dl | ▨ + | ▨ + | ▨ + | nc | nc | nc | - | ▨ + | ▨ + | 56% |
| Documented Written Action Plan | - | + | + | ▨ + | ▨ + | ▨ + | nc | ▨ + | nc | 67% |
| Completed Depression Screen | | nc | ▨ + | | | | | | | |
| Comprehensive Foot Exam | | ▨ + | ▨ + | | | | | | | |
| Health Coach | | | | | | | | ▨ + | | |
| Relative Value Units per Physician per Month | | | | | | | | | + | |
| Visits per Physician per Month | | | | | | | | | - | |
| Third next available appointment (avg # days) for: OFFICE VISIT | | | | | | | | | - | |
| Third next available appointment (avg # days) for: NEW OFFICE VISIT | | | | | | | | | - | |
| Third next available appointment (avg # days) for: COMPLETE PHYSICAL EXAM | | | | | | | | | - | |

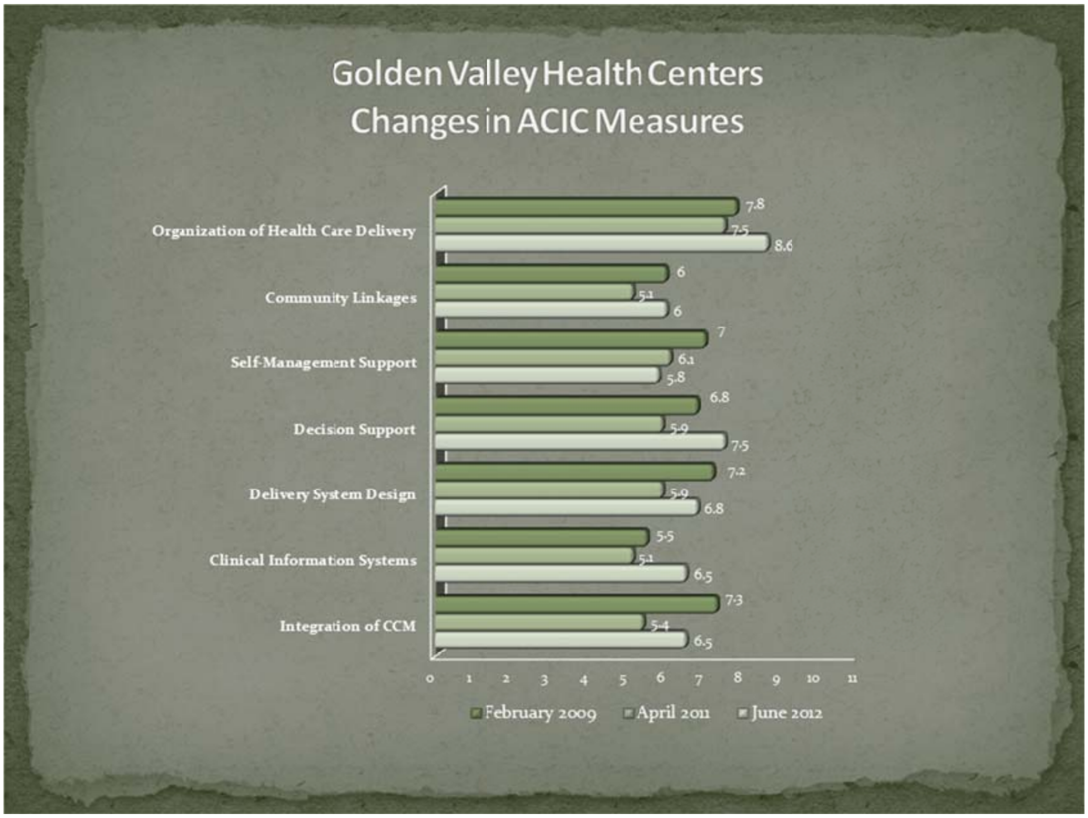
+ positive trend in measure (i.e., toward desired outcome)
- negative trend in measure (i.e., away from desired outcome)
nc no change in measure (i.e., no change from baseline)

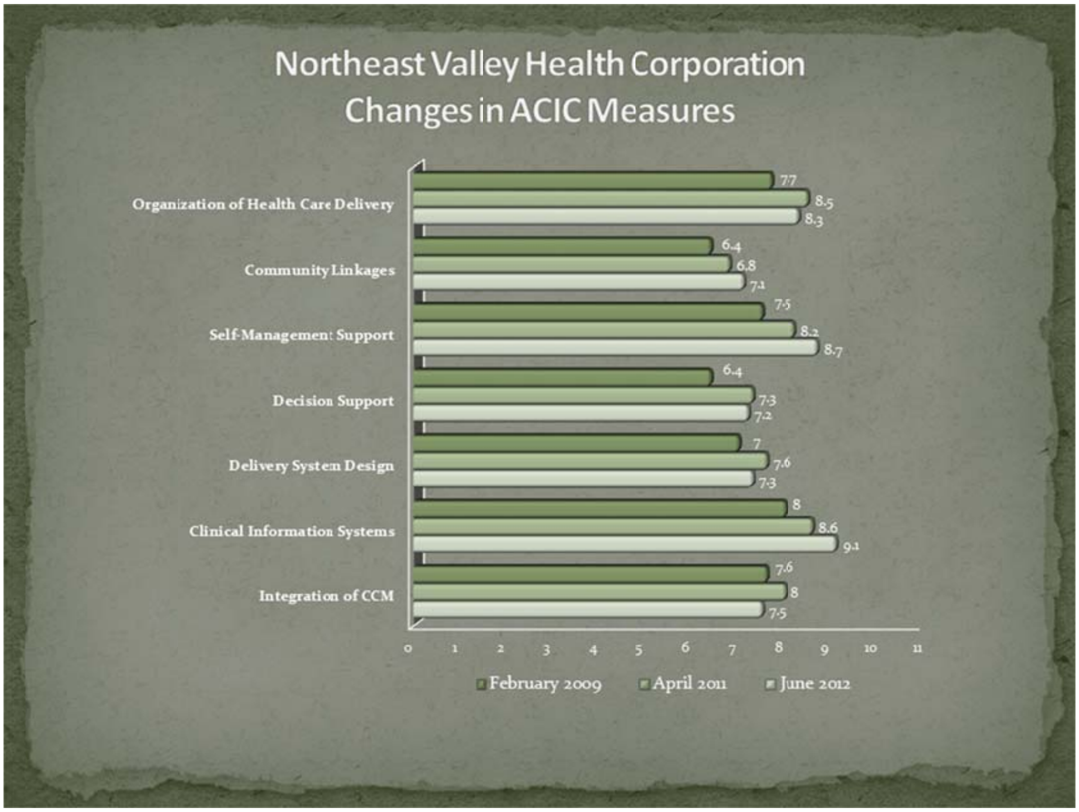
▨ chi square for linear trend is statistically significant

Notes: 1. Outlier removed from **Golden Valley** - W Modesto a1c and BP trend analyses due to reported unstable data from practice management/EHR conversion;
2. At **NorthEast Valley - Pacoima**, policy changes occuring after July 2011 with a transition to HWLA resulted in a change in program eligibility requirements, a decrease in patient visits, and transition to a new formulary, all which were reported to have had an impact on care delivery. Although all a1c measures trended positive, exclusion of the final two data points (after the policy change) for a1c level < 7% would have resulted in a statistically significant positive trend;
3. At **NorthEast Valley - San Fernando**, policy changes occuring after July 2011 with a transition to HWLA resulted in a change in program eligibility requirements, a decrease in patient visits, and transition to a new formulary, all which were reported to have had an impact on care delivery. Although a1c level measures remained unchanged prior to the policy change, inclusion of the final two data points (after the policy change) resulted in a statistically significant decrease in measures of a1c levels; also, there was a statistically significant positive trend in a1c screenings prior to the policy change, and inclusion of the data after the policy change resulted in a loss of statistical significance, although the trend is still positive.

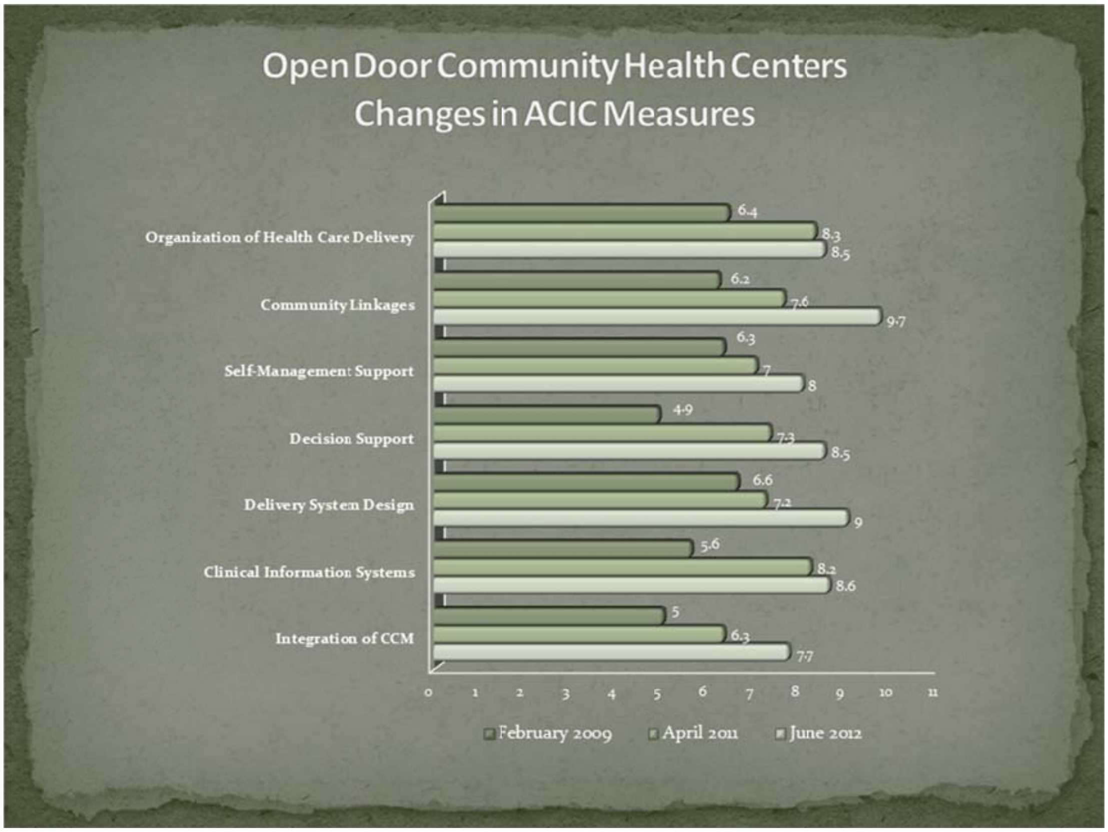
# Changes in Assessment of Chronic Illness Care (ACIC) Measures by Team



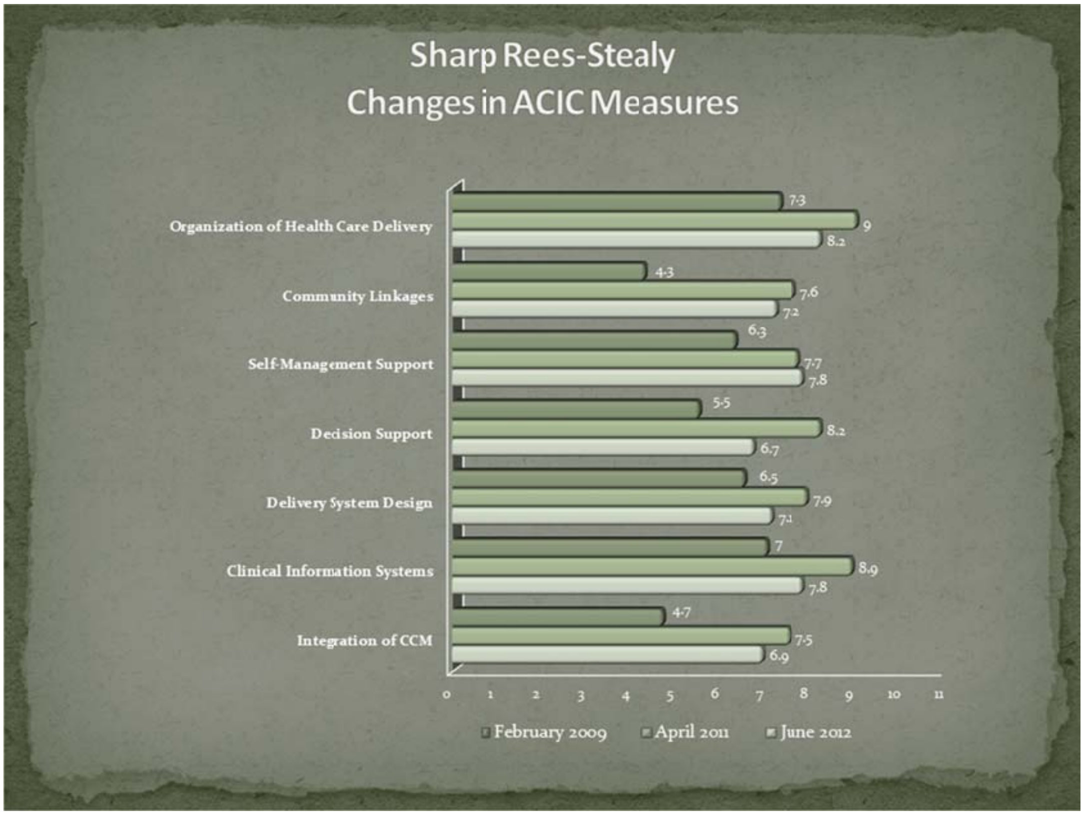




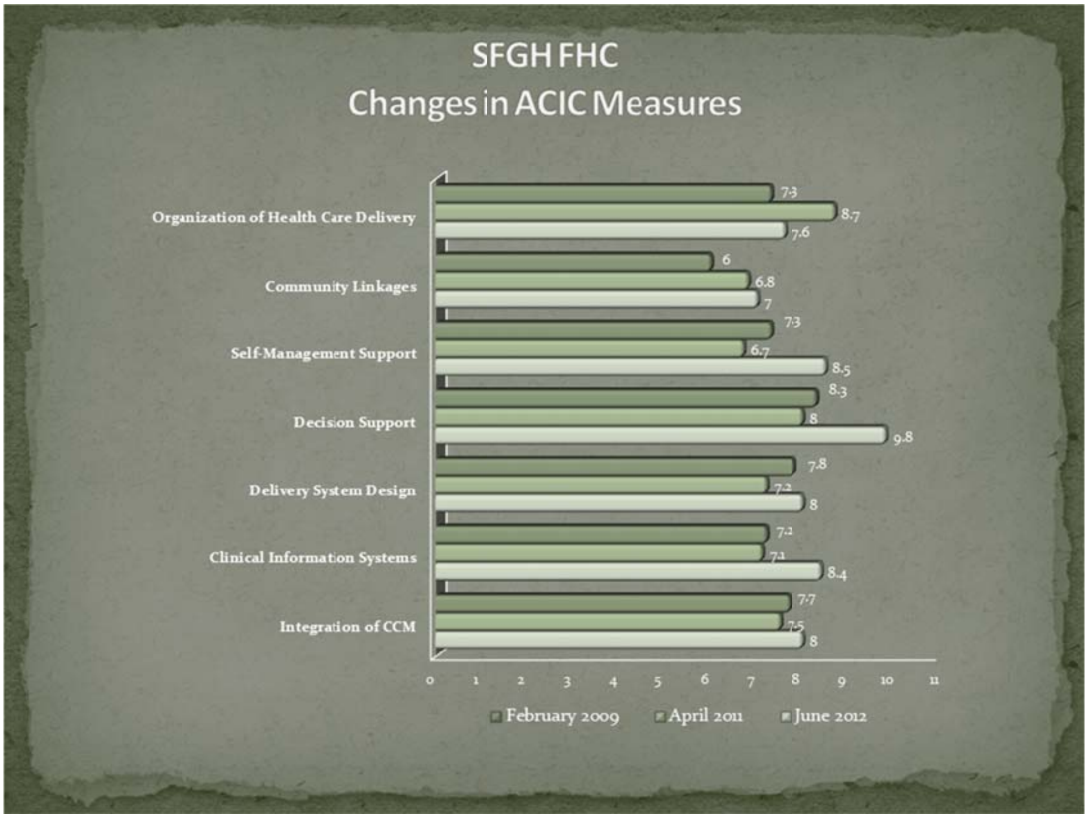
Northeast Valley Health Corporation
Changes in ACIC Measures



Open Door Community Health Centers
Changes in ACIC Measures



Sharp Rees-Stealy
Changes in ACIC Measures



SFGH FHC
Changes in ACIC Measures