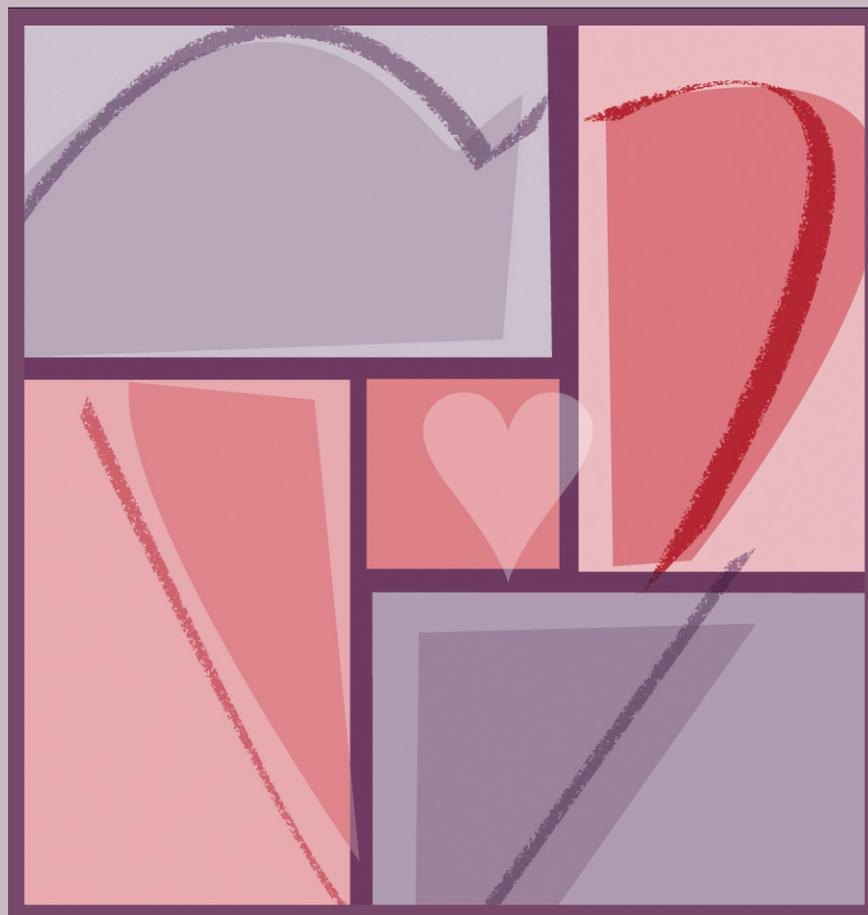


# A Guide to Facilitating



# Health Systems *Change*



Heart Disease  
& Stroke Prevention

Sci i i



**U.S. DEPARTMENT OF HEALTH  
AND HUMAN SERVICES**  
Centers for Disease Control and Prevention

# **A Guide to Facilitating Health Systems Change**



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# **Mission of the Centers For Disease Control and Prevention**

## **Division for Heart Disease and Stroke Prevention**

To provide public health leadership to improve cardiovascular health for all, reduce the burden, and eliminate disparities associated with heart disease and stroke

# Acknowledgments

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# Preface

## Overview

The purpose of this guide is to help states facilitate changes in health care systems to improve prevention and management of heart disease and stroke and their risk factors. The guide was developed with the idea that state health departments can facilitate such changes by involving a diverse group of health care partners to assess the state of heart disease and stroke prevention and management, to identify changes that are needed to improve the quality of care, and to determine how best to make those changes. The goal of this guide is to provide advice to state heart disease and stroke prevention programs in encouraging the adoption of established models to improve the quality of care and outcomes for patients with cardiovascular disease (CVD) or its risk factors. Programs should review the entire guide to determine which sections and resources are most appropriate for them, given the current environment for systems change within their state.

This guide includes samples of tools states have developed to assist with program planning, implementation, and evaluation activities within the health care system. The tools provided at the end of each section can be altered or augmented to meet organizational and partner needs.

## Background

In 1998, Congress provided funding for the Centers for Disease Control and Prevention (CDC) to initiate a national, state-based heart disease and stroke prevention program. As of July 2007, CDC funds heart disease and stroke prevention programs in 33 states and the District of Columbia. Many factors

increase the risk of developing heart disease and stroke; therefore, state-based programs must use strategies that target multiple risk factors in different settings, including health care, work sites, and communities. CDC plays a national leadership role in promoting heart health and reducing the burden of heart disease and stroke. This leadership involves collaborating with many sectors—federal, state, and local governments; voluntary organizations; academic institutions; faith-based organizations; health care organizations; work sites and media—to achieve the vision of a heart-healthy and stroke-free nation.

In 2003, CDC convened key public health partners to develop A Public Health Action Plan to Prevent Heart Disease and Stroke. The Action Plan identifies targeted recommendations and specific steps necessary to reduce the health and economic toll of heart disease and stroke. The Action Plan interventions to improve risk factor detection and control, emergency care, acute case management, and patient management and rehabilitation will require changes in health care systems.

## Role of State Heart Disease and Stroke Prevention Programs

According to the Institute of Medicine's report *Crossing the Quality Chasm* (2001), "The American health care delivery system is in need of fundamental changes." The current system has too many shortcomings, including the gap between evidence-based recommendations and medical practice, limited use of technology, a lack of integration among clinical disciplines, and inadequate coordination among clinicians.

A transition from short-term treatment of acute conditions to prevention and management of chronic diseases through the use of multidisciplinary teams, decision support tools/evidence-based guidelines, and clinical information systems is critical to sustaining systems changes. Increased costs, high use of medical services, and health disparities associated with treating CVD and stroke contribute to the growing realization that health care services must be efficiently delivered for effective management of chronic diseases. Systematic changes are needed to coordinate all aspects of patient care, improve patient self-management, and increase access to care for those at greatest risk. State heart disease and stroke prevention programs will be challenged to establish health care partnerships, commit resources, cultivate leadership within the health care community, and monitor progress once changes are implemented.

### **Definition of Health Systems Change**

A change in organizational or legislative policies or in environmental supports that encourages and channels improvement(s) in systems, community, and individual-level health outcomes.

### **Examples of Health Systems Change**

- National and state-based disparities collaboratives that use the chronic care model
- Standardized emergency medical personnel training
- Electronic medical records or other clinical information system and decision support tools

### **Section Description**

This guide is divided into five major sections, each organized by Section Summary, Lessons Learned, Getting Started, and Resources and Tools.

### **Section One: Building Partnerships**

Identifies potential partners and provides insight into organizing, maintaining, and enhancing partnerships.

### **Section Two: Deciding What You Want to Accomplish**

Provides information on possible data sources that may be used to assess the chronic disease burden and current state of health care systems and to map opportunities for intervention.

### **Section Three: Planning to Make It Happen**

Describes the significance of using data to drive program planning activities; provides a guideline on developing an action plan that outlines priorities, partner responsibilities, objectives, and timelines.

### **Section Four: Implementing Your Action Plan**

Identifies approaches to consider when putting your plan into action, and highlights the successful components of an implementation plan.

### **Section Five: Monitoring the Progress**

Describes methods for monitoring intervention progress and assessing outcomes.

# Section One Building Partnerships

## Section Summary

Changing health care systems requires a collaborative approach. A variety of skills, ideas, and resources are needed to produce meaningful, sustained systems change. In this section, we describe

- Potential partners with the assets and resources to facilitate systems change
- Ideas for initiating and sustaining partnerships
- Lessons learned from states about developing partnerships

## Potential Partners

When states begin working on systems change, the best partners to involve are those who have an obvious interest in the issue, who include systems change as a part of their mission, and who have resources to support the effort. It is important to have representation from diverse and distinct organizations with experience in initiating and sustaining systems change in settings that serve high-risk populations.

To plan, implement, and evaluate health systems strategies and activities, you must first identify and collaborate with stakeholders internal and external to your organization. Partners provide expertise and resources that complement those available within the state. Potential partner organizations and institutions may include employers and employer groups/coalitions, community organizations, professional and voluntary groups, health providers and health delivery systems, and emergency medical services (EMS).

The following list of organizations and agencies should be considered as potential partners. Many of them probably already participate in your state's heart disease and stroke prevention efforts as members of your state coalition or advisory council. This list is by no means complete. Each state is unique and may have other organizations, such as chronic disease programs (e.g., Diabetes Prevention and Control Program), medical schools, employee health benefits departments, and county extension services that can contribute to systems change.

## EMERGENCY MEDICAL SERVICE SYSTEMS

### Overview

EMS represents the intersection of public health, public safety, and health care for prehospital care. General EMS components include

- Emergency medical technicians (EMTs) and paramedics who treat victims at the scene and during transport to hospitals
- Ground and air ambulance response and transport services
- 9-1-1 call centers that dispatch emergency response
- State EMS offices that license providers and serve a regulatory function
- EMS physicians who provide oversight via online and offline medical direction
- EMT schools and training centers.

## **Function**

Every state has an EMS office, which may be associated with the health department or the public safety arm of the government. Most offices are responsible for regulating and licensing EMTs and responders. All offices have a director and may include additional staff to address systems changes. EMS coordination often involves a patchwork of local provider systems, which may be public, private, volunteer, or, most often, a combination. Public provider locations include fire departments, health departments, emergency management agencies, and other state and local units.

No single federal agency has oversight for EMS. Consequently, no uniform system of public financial support exists for EMS at any level of government. However, the National Highway Traffic Safety Administration provides significant leadership, including responsibility for developing training courses such as the First Responder: National Standard Curriculum. The Health Resources and Services Administration also provides support for EMS issues.

## **Role in Systems Change**

EMS is in a unique position to partner with health care provider organizations, professional organizations, and federal health authorities to provide emergency responses. EMS agencies develop policies and practices that affect prehospital treatment and management.

## **Initiating Contact**

Initial contact should be made with the state EMS director. EMS state directors have different roles in every state, but all have regulatory and licensure responsibilities. They are to be contacted about emergency response issues (e.g., 9-1-1, EMT training, automated external defibrillators). EMS

directors bring experience in working with first responders at the local, county, regional, and state levels in rural and urban settings across a variety of EMS systems. Some state associations also are related to EMTs, EMS, and emergency medical directors who have working relationships with first responders. A list of state EMS contacts is available at <http://www.nasemsd.org/>

## **EMPLOYERS**

### **Overview**

Most people spend the majority of their waking hours in the workplace. Employers who provide health insurance coverage to employees have an interest in controlling insurance costs and maintaining a healthy workforce. The amount of employee out-of-pocket contributions and the types of services purchased and covered vary among employers.

### **Function**

Large employers or employee groups and business coalitions have purchasing power to influence employees' level of care and access to health services.

### **Role in Systems Change**

Employers or employer coalitions (made up of small and mid-sized companies) purchase benefits and determine the amount of coverage employees will receive for their health care. Using their purchasing power, employers and coalitions can negotiate for benefits that cover preventive services, chronic disease management programs, quality improvement initiatives, and rehabilitation services.

### **Initiating Contact**

Employee wellness program managers and health benefits officers should be engaged in discussions related to health systems changes. The Human Resources office is

your gateway into most businesses. The personnel in this office can help you learn more about the dynamics and needs of the organization and its employees. Initial meetings should include Human Resources personnel involved with employee benefits and the wellness program. Later meetings should involve personnel from the Financial Management Office to help make the economic case (cost-benefit analysis) for the proposed initiative.

## **HEART DISEASE AND STROKE VOLUNTARY ORGANIZATIONS**

### **Overview**

Usually, the mission of voluntary organizations such as the American Heart Association, American Stroke Association, Brain Attack Coalition, and National Stroke Association might be described in general as reducing disability and death caused by cardiovascular disease (CVD) through education, research, fund-raising, and advocacy. Most voluntary organizations offer an array of programs, products, and services such as patient education materials and scientific papers and guidelines.

### **Function**

Voluntary agencies work with the public, patients, health care professionals, government officials, and community groups to develop and implement programs and policies to deal with heart disease and stroke. Most have local, state, or regional chapters or affiliates that enable them to implement interventions at the state and local levels.

### **Role in Systems Change**

A unique asset of voluntary agencies is their ability to encourage federal, state, and local legislators to support public policies that advance the fight against heart disease and stroke. They also support first responder services and public policy to promote access

## **ARKANSAS CHRONIC ILLNESS COLLABORATIVE**

The Arkansas Cardiovascular Health (CVH) Program, in collaboration with the Diabetes Prevention and Control Program, University of Arkansas for Medical Sciences, Arkansas Foundation for Medical Care (the state quality improvement organization), Community Health Centers of Arkansas, Inc., and Area Health Education Centers, sponsor the Arkansas Chronic Illness Collaborative, which involves federally qualified community health centers, area health education centers, and private clinics in a 13-month program to increase their capacity to provide evidence-based care to patients with CVD or diabetes.

The CVH Program works with partners to develop content for learning sessions (using the National Health Disparities guidelines); recruit community health centers, area health education centers, and private clinics to participate; conduct trainings; and monitor progress.

to quality medical care, including preventive care, diagnostic procedures, risk modification programs, and heart and stroke rehabilitative programs. Some voluntary agencies develop and promote guideline recommendations to improve the quality of care in hospitals and other health care settings. Many voluntary organizations have access to medical professionals who serve as advisors or board members and can assist with local training sessions and presentations to decision makers.

### **Initiating Contact**

Most voluntary agencies can be found on the Internet with any of the large search engines or in local phone directories. Most agencies offer a menu of services and provide a variety of contacts, depending on the services or resources needed.

## HEALTH CARE PROVIDERS

### Overview

Health care providers are the clinicians, hospitals, and health care networks that deliver and manage patient care. This category includes physicians, nurses, physician extenders, clinics, ambulatory care centers, rehabilitation centers, and other sites where medical care is provided. The clinicians and facilities are certified and accredited to provide care.

### Function

Health care providers deliver and manage medical care based on patient health status, medical training, and recommendations outlined in clinical practice guidelines.

### Role in Systems Change

Clinicians adopt and implement best or promising practices and guidelines to provide the most appropriate care to patients. Clinicians are in the best position to ensure that patients possess self-management tools to control their condition adequately. Hospitals and hospital systems, particularly emergency departments and rehabilitation centers, can develop and implement quality improvement initiatives and policies to ensure that patients receive appropriate treatment.

### Initiating Contact

Within provider practices and clinics, the best person to contact initially is the office manager, who oversees the day-to-day operations and has direct access to physicians in many cases. Hospitals and health care systems are more difficult to navigate because of their complex structure and multiple departments. The appropriate contact depends on the type of initiative that is being planned. For example, a quality improvement activity to improve the identification and triage of stroke patients must

involve the emergency department. Before approaching clinicians in individual departments, it is appropriate to initiate a discussion with the chief medical director or chief executive officer. Additionally, it may help to involve the chief financial officer and make the economic case for initiating the proposed project or activity. It is important to identify a physician champion who will communicate with other physicians to ensure buy-in and adoption.

## HEALTH PLANS

### Overview

Health plans and managed care organizations finance and deliver benefits and coverage for health care services. Variations in plans are based on factors such as reimbursement design, payment system, cost, and quality control. Preferred provider organizations, health maintenance organizations, and point of service products are typically offered.

### Function

Health plans provide insurance products and benefits that may be purchased by employers, government agencies, and individuals seeking access to health services and providers. Plans contract with individual providers or provider groups and hospital systems to provide health care services to their members. In return, health plans reimburse providers and hospital systems for the services they provide.

### Role in Systems Change

Health plans and managed care organizations play a significant role in initiating and facilitating systems changes, including 1) developing and implementing disease management programs to ensure accurate identification and management of high-risk and chronic disease patients, 2) adopting and disseminating clinical practice guidelines,

3) developing policies to promote and enhance evidence-based practice, and 4) covering preventive and rehabilitation services

### **Initiating Contact**

The America's Health Insurance Plans Web site, [www.ahip.org](http://www.ahip.org), provides a list of companies that cover health benefits. Search engines can also be used to locate a specific company. The following individuals may be important contacts when initiating conversations with a health plan: medical director, quality management/improvement officer, disease management program manager, and accreditation officer

## **HEALTH PROFESSIONAL AND HOSPITAL ASSOCIATIONS**

### **Overview**

Health professional and hospital associations are membership organizations that represent the interests of hospitals, physicians, nurses, pharmacists, and students who pursue careers in these professions. These organizations include the American Medical Association ([www.ama-assn.org](http://www.ama-assn.org)), American Nursing Association ([www.ana.org](http://www.ana.org)), American Pharmacists Association ([www.aphanet.org](http://www.aphanet.org)), American College of Cardiology ([www.acc.org](http://www.acc.org)), and state medical societies, among many others. When planning to develop and direct activities to priority populations, consider contacting organizations such as the Association of Black Cardiologists ([www.abcardio.org](http://www.abcardio.org)) and the National Association of Hispanic Nurses ([www.lanahn.com](http://www.lanahn.com))

### **Function**

Health professional organizations promote standards in medical education and practice, advocate for practice management and patient health issues, and provide continuing medical education training to enhance the

quality of health care. These organizations also develop educational resources and information for patients to complement the care they receive

### **Role in Systems Change**

Health professional organizations engage in a number of activities that have the potential to effect changes across health systems. These activities include providing education and training to enhance adherence to evidence-based clinical care practices and recommendations and advocating for health policies

### **Initiating Contact**

Many of these organizations have state chapters. The executive committee may be the ideal body to initiate contact with and discuss proposed activities. If it proves to be a challenge to get on the executive committee's agenda, consider scheduling meetings with individual officers, such as the president or vice president. For a list of state medical societies, visit the American Medical Association Web site, <http://www.ama-assn.org/ama/pub/category/7630.html>. Most state hospital associations can be found by using search engines on the Internet

## **PRIMARY CARE ASSOCIATION**

### **Overview**

Most states have a primary care association (PCA), a not-for-profit organization with the goal of strengthening community-based primary care systems. PCAs do not provide care but often serve as a membership association for those who do. PCAs often focus on issues such as maximizing access to health care, with emphasis on the medically underserved. Members of the PCA often include primary health care clinics, federally funded health centers, migrant health centers, health care consultants, and others interested in health care

### **Function**

The PCA identifies areas of unmet need, assists in developing systems of care, advocates for primary care resources, and promotes awareness of community health centers and the services they provide. PCAs are often the bridge between community needs and decision makers at the federal, state, local, and corporate levels. Associations often focus on health care policy as advocates for a stronger primary health care system and ensured access to care; they often serve as a vehicle through which health centers and providers of health care for the medically underserved relate to each other.

### **Role in Systems Change**

The PCA can allow access to a number of providers, particularly those who serve high-risk populations. Because many are already involved in strengthening health care systems, they share an interest in facilitating change and often bring experience in working with providers.

### **Initiating Contact**

Initial contact may be made with the executive director. A list of state and regional PCA contacts can be found on the National Association of Community Health Centers Web site, [www.nachc.com](http://www.nachc.com).

## **QUALITY IMPROVEMENT ORGANIZATIONS**

### **Overview**

Quality improvement organizations (QIOs) are not-for-profit entities funded by the Centers for Medicare and Medicaid Services (CMS) to address and develop initiatives focused on health care quality, access, and cost. QIOs represent states, territories, and the District of Columbia.

### **Function**

QIOs have knowledge and experience in developing, implementing, and evaluating programs directed at improving the outcomes of cardiovascular and other chronic diseases within health systems. QIO heart-disease-specific national projects include acute myocardial infarction and heart failure projects. These organizations have also been involved in providing support for the Health Disparities Collaborative and state-based collaboratives that focus on cardiovascular and other chronic diseases.

### **Role in Systems Change**

QIOs work with health care systems stakeholders such as consumers, physicians, hospitals, and local and national organizations to enhance care delivery systems and implement quality improvement strategies to ensure that the right patients receive appropriate care at the right time, particularly among priority populations. Additionally, QIOs have access to medical and cost data that may be useful when developing and evaluating quality improvement initiatives. QIOs work from a scope of work established by CMS, which may influence their focus on certain projects.

### **Initiating Contact**

An appropriate initial contact is the quality improvement director. A list of QIOs, their Web sites, and telephone numbers is included in the resources section.

## **LESSONS LEARNED**

- Expect the level and type of participation to vary with each partner at each step of the planning and implementation process. Not all partners need to be involved in every aspect of planning and implementation.

- Learn how partners want to be involved and their expectations. Ask all partners what they can bring to the effort—that is, what skill, perspectives, and resources they have to contribute.
- Learn all partners' limitations—that is, what they can and cannot do, what data they are willing to share, and under what circumstances.
- Seek the involvement and support of health care leaders in your state even if it is limited. A simple endorsement from those in leadership positions is often enough to encourage and enhance others to participate.
- Testimonials from those who have benefited from systems change can be a valuable incentive for others to support change.
- Periodically assess partnership members to determine their satisfaction with how the partnership is functioning.
- Recognize when approaching new partners that the heart disease and stroke program staff will need to explain the role and purpose of the state health department in clinical intervention.
- When approaching partners, understand why they may be motivated to work with the state heart disease and stroke prevention program: improved patient care, management of health care costs, financial resources or data analysis provided by the state, achieving a competitive edge over another hospital, or recognition for their cardiac/stroke program.
- Garner the support of one or more program champions who will help to stimulate interest in initiating or expanding projects within and across health care settings.

### WASHINGTON STATE COLLABORATIVE

The goal of the Washington State Collaborative (WSC) is to implement and support systems changes and strategies within primary care practices and to improve the quality of care provided to patients with chronic diseases. In 2004, with CDC funding for a state Heart Disease and Stroke Prevention Program (HDSPP), the WSC expanded to address CVD. The HDSPP works with partners on a number of activities, including generating funds to support the WSC.

The cost to participate is \$4,000 per clinic team, which covers the cost of the learning sessions and outcomes congress. Clinic teams can apply for a scholarship of up to \$10,000, which can be used to cover costs related to registration, travel, chart abstraction, and staff replacement during the learning sessions.

The cost covered by the Department of Health (DOH) includes scholarships and staff time. Four DOH staff (one from the HDSPP) spend some percentage of their time on this project (10%–15% each). Time includes weekly planning meetings with Qualis Health, the state QIO, developing materials and connecting with clinic teams and WSC faculty. Scholarships from multiple DOH programs total around \$250,000. HDSPP provides about \$160,000.

The cost covered by Qualis Health includes overseeing nearly all the logistics. It contracts with the hotel, brings in special speakers for the learning sessions, and manages the registration of about 250 attendees per learning session. Qualis dedicates two full-time equivalents for this project—a project coordinator who oversees the clinic teams from the point of enrollment and manages the logistics, and an improvement advisor who ensures that proper measurement strategies are used and connects with the clinic teams about their data. Qualis receives monthly senior leader reports (reviewed by both DOH and Qualis) and analyzes the data. It also produces all materials related to the WSC—this will be the first year all syllabi and presentation handouts are electronic.

## GETTING STARTED

- Sponsoring a kick-off event is one way to generate interest and get the ball rolling. Some states have convened a conference where national or state experts present models for health care systems change, highlighting potential benefits. If you do not have time or resources for a conference, you may elect to have an expert present at a meeting of potential partners followed by meetings to determine how to apply what was learned.
- Convene potential partners to assess the group's skills and capacities for addressing health care systems change. Determine what skills, perspectives, and resources are needed. Have the group identify people or organizations that can be recruited to become part of the health care setting.
- Develop and adopt formal rules for managing the partnership, including how decisions will be made, how leadership will be determined, how differences will be resolved, and a communication plan.
- Partnerships are more likely to be sustained if they have a clear mission with realistic expectations, provide regular communication, share responsibility for decision making, have rules for management, have good leadership, and acknowledge the successes of those involved.

## RESOURCES AND TOOLS

Disclaimer: Some of the links provided below include nongovernmental Web sites. In this document we provide you with samples of the *Emergency Medical Services: Agenda For The Future*.

The agenda outlines the future of EMS as a community-based health management system that is fully integrated with the overall health care system. The document also serves as a strategic plan and needs assessment to guide enhancement of the EMS system. The document is available at <http://www.nhtsa.dot.gov/people/injury/ems/agenda/emsman.html>

### *Developing Effective Coalitions: An Eight Step Guide*

This guide outlines and explains steps to identify and engage coalition members, ensure and assess the quality of partner contribution and involvement, and evaluate the impact of the coalition. The guide is available at [http://www.preventioninstitute.org/tool\\_8step.html](http://www.preventioninstitute.org/tool_8step.html)

### *Partnership Satisfaction Surveys*

Ohio State University developed this collection of process evaluation tools to diagnose project team problems, to improve team effectiveness, and to discover areas for team training and development. These process evaluation tools are available at <http://www.ag.ohio-state.edu/~ptd/Evaluation.htm>

### *Rural and Frontier Emergency Medical Services: Agenda for the Future*

This document provides an outline and describes the strategies that need to be funded and implemented to ensure that EMS functions properly and adequately in rural communities. The document also provides a tool that community leaders and stakeholders can use to determine what to do with existing resources and how to plan for the future of EMS in the community. The document is available at <http://www.nrharural.org/groups/sub/EMS.html>

*Successful Business Strategies to Prevent Heart Disease and Stroke Toolkit*

This toolkit provides an ideal resource for state programs to collaborate with other chronic disease partners throughout the state in developing comprehensive CVH work site programs. The toolkit is available at <http://www.cdc.gov/DHDSP/library/toolkit/index.htm>

*The Partnership Self-Assessment Tool*

This Web-based tool is designed to help assess the effectiveness of partnerships and evaluate how well the collaborative process is working and what it needs to do to realize the full potential of collaborations. This tool is available at <http://www.cacsh.org/>

*The Tension of Turf: Making It Work for the Coalition*

Building on earlier work of the Prevention Institute, which described the coalition start-up process in *Developing Effective Coalitions: An Eight Step Guide*, this document was developed in response to something commonly experienced within coalitions—turf struggle. This publication explores turf issues that commonly arise among coalition members and offers recommendations for limiting the negative aspects of turf struggles. This document is available at [http://www.preventioninstitute.org/tool\\_turf.html](http://www.preventioninstitute.org/tool_turf.html)

## **PRIMARY CARE ASSOCIATIONS**

For an up-to-date list of primary care organizations or to locate a PCA in your state, visit the Bureau of Primary Health Care Web site at <http://bphc.hrsa.gov/osnp/PCADirectory.htm>

## **QUALITY IMPROVEMENT ORGANIZATIONS**

For an updated list of QIOs or to locate a QIO in your state, visit the American Health Quality Association Web site at [www.ahqa.org](http://www.ahqa.org)

# Sample Of A Memorandum Of Agreement Between Arkansas State Heart Disease And Stroke Prevention Program And A Community Health Center Concerning Participation In The State-Based Health Disparities Collaborative

## Memorandum of Agreement Stephens Community Clinic and Arkansas Department of Health's Cardiovascular Health Program

The Stephens Community Clinic, a rural health clinic located in Stephens, Arkansas, is owned and operated by the Ouachita County Medical Center. The clinic has as its stated mission to “establish and maintain an innovative, financially stable organization capable of recruiting and retaining sufficient qualified physicians and mid-level practitioners to staff and operate a comprehensive primary health care system for the residents in the service area of the Ouachita County Medical Center.” To improve cardiovascular health in Arkansas, one strategy being used by the Cardiovascular Health (CVH) Program is partnering with other organizations to improve provision of medical care. To do so, the CVH program is helping to implement environmental and policy changes that will impact cardiovascular health in Arkansas. The CVH Program is funded through a cooperative agreement grant from the Centers for Disease Control and Prevention's Heart Disease and Stroke Branch. The CVH Program is offering mini-grants to encourage clinics to implement and spread the chronic disease collaborative model in Arkansas. Incorporation of the chronic care model can help to improve processes that will lead to improved medical care.

The Arkansas Chronic Illness Collaborative for People with Diabetes and/or Cardiovascular Disease is the combined effort of the CVH Program and the Diabetes Prevention and Control Program at the Arkansas Department of Health. Other partners include the Community Health Centers of Arkansas, the Arkansas Foundation for Medical Care, and the Arkansas Health Education Centers.

The chronic care model is about process change, i.e., finding ways to improve health care. One of the key elements is having data available for appropriate medical care and for identifying whether successful change is occurring. In the chronic disease collaborative, the data used to determine whether successful change is occurring is referred to as a registry. To become involved in the Arkansas or national chronic disease collaborative, a registry of appropriate patients has to be developed to cover specified patient care information. Because most clinics' staff is already busy providing patient care, there is little time for the initial chart review and data entry to form the registry baseline. Once data are abstracted from the patients' charts and entered, the maintenance of the data will become part of the clinic routine and will not require large blocks of time commitment. The registry will provide medical providers with the information needed for quality medical care. The registry will also provide data for the Cardiovascular Health Program as it collaborates with partners to update

the current state plan for improving cardiovascular health. Therefore, the Arkansas Cardiovascular Health Program is providing one-time grants to help develop the patient registry.

Clinics or groups of clinics that are eligible for receiving these funds include 1) clinics or systems that are new to the Arkansas Chronic Illness Collaborative and so have not yet completed abstraction of patient charts for formation of the patient registry or 2) clinics that have participated in the collaborative and are ready and willing to incorporate either the diabetes and/or cardiovascular registry at the clinic, but have not yet abstracted baseline data for either registry.

In Arkansas, cardiovascular disease and diabetes are the two chronic disease states currently addressed by the collaborative in several health care clinics. The Chronic Disease Collaborative core measures include developing a registry containing a minimum of 100 patients, documentation of self-management goals for patients with diabetes and/or cardiovascular disease, and attempting to reach goals specific to diabetes or cardiovascular disease. For example, CVD core measures include assuring blood pressure that is <140/90 and that CVD patients have blood pressures documented at least 2 times per year. For diabetes, measures include assuring that patients have 2 HbA1C's in the last year, and the average HbA1C for registry patients is at an acceptable level.

The Stephens Community Clinic agrees to provide the following elements to fulfill its part of this agreement:

- 1) Develop a new chronic disease patient (diabetes and/or cardiovascular patient) registry that fulfills the requirement for participation in the chronic disease collaborative being initiated. This entails identifying a population of focus, which should be a natural population such as all patients within a given clinic, all patients of a physician group or provider, or all patients from several small clinics. The clinic can decide to focus on diabetes, cardiovascular disease, or both, depending upon the collaborative the clinic has selected. From the natural population, the patients for the registry will be selected. The registry must include all patients from the natural population, who within a specified time period (e.g., 6 months to 1 year), have the specified diagnosis, such as all patients with cardiovascular disease (or diabetes) from a clinic (or several small clinics) or all patients with CVD from a participating physician/provider group. At least 100 patients with the selected disease must be identified for the population base or registry. To determine the patients who should be included in the registry, all charts will be reviewed for the given time period and all patients with relevant ICD9 codes will be entered into the registry (Diabetes: ICD9=250; Major Cardiovascular Disease: ICD9=390–434 and 436–448). Each patient with the relevant ICD classification will have data abstracted for all fields in the data sheet relevant to the disease of interest (see attachment), either CVD or diabetes for the specified time period.
- 2) Once the data are entered, a summary of the baseline data will be provided to the CVH program.
- 3) The clinics also agree to provide follow-up data at least every 6 months on all fields from the registry form to the AR CVH program.

- 4) One component in the chronic care model is providing relevant education for physical activity and nutrition to help patients make healthy choices. As staff become available to the clinic, they will be provided the opportunity for education on counseling on physical activity and nutrition relevant to chronic disease prevention. Dates and sites of training will be determined in collaboration with the clinics. Clinics receiving the collaborative data entry funds will agree to allow their education specialists or other staff to receive training relevant to physical activity and nutrition as feasible.
- 5) The grantee agrees to provide oversight of the progress within the clinic/group of clinics to assure appropriate progress and completion of data abstraction for the registry. This will include review of ICD codes for all patients from the natural population from which the registry is selected to assure appropriate patient selection. This will also include random re-evaluation of at least 5% of charts from patients chosen for the registry to assure accurate abstraction of data.

**CVH Program Responsibilities:**

- 1) Provide \$3,000 to the clinic for participation as specified above. The AR CVH Program will disburse moneys upon completion of the data entry and receipt of invoice.
- 2) Provide educational opportunities relevant to nutrition, physical activity, and chronic disease for the clinic staff working in the chronic disease collaborative as requested.
- 3) As feasible, provide up to one monitoring visit to assure appropriate progress.

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Lynn May, APN  
 Director of Stephens  
 Community Clinic

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Date

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Linda Faulkner  
 CVH Program Team Leader

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Date

# Template Of A Memorandum Of Understanding Used By The North Carolina Heart Disease And Stroke Prevention Program With Its Grantees

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MEMORANDUM OF UNDERSTANDING  
BETWEEN

1 \_\_\_\_\_ AND \_\_\_\_\_

This MEMORANDUM OF UNDERSTANDING is hereby made and entered into by  
\_\_\_\_\_ and \_\_\_\_\_

A PURPOSE:

The purpose of this MOU is to ensure proper use of \_\_\_\_\_  
\_ Program funds distributed by \_\_\_\_\_

B STATEMENT OF MUTUAL BENEFIT AND INTERESTS:

\_\_\_\_\_ Program funds distributed by \_\_\_\_\_  
must be used according to guidelines set by \_\_\_\_\_

C (GRANTOR):

1  
2

D GRANTEE:

**MODIFICATION** Modifications within the scope of the instrument shall be made by mutual consent of the parties, by the issuance of a written modification, signed and dated by all parties, prior to any changes being performed

**PARTICIPATION IN SIMILAR ACTIVITIES** This instrument in no way restricts the grantee from participating in similar activities with other public or private agencies, organizations, and individuals

**TERMINATION** Any of the parties, in writing, may terminate the instrument in whole, or in part, at any time before the date of expiration

PRINCIPAL CONTACTS The principal contacts for this instrument are:

NON-FUND OBLIGATING DOCUMENT This instrument is neither a fiscal nor a funds obligation document

COMMENCEMENT/EXPIRATION DATE This instrument is executed as of the date of last signature and is effective through \_\_\_\_\_ at which time it will expire unless extended

IN WITNESS WHEREOF, the parties hereto have executed this agreement as of the last written date below


	DATE		DATE
		Grantee (administrator)	

	Grantee (administrator)

This instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act	
	DATE
Finance Officer	

# Sample Memorandum Of Understanding Developed For The North Carolina Chronic Disease Management Collaborative Partnership

## Memorandum of Understanding

### ROLES AND RESPONSIBILITIES STRUCTURE

The North Carolina Chronic Disease Management Collaborative partnership (hereafter referred to as the CDMC) comprises the following organizations:

- North Carolina Community Health Center Association
- North Carolina Division of Public Health, Chronic Disease & Injury Section (CDIS), specifically, the Diabetes Prevention and Control Program (DPCP), the Heart Disease and Stroke Prevention (HDSP) Branch, and the Cancer Prevention and Control Program (CPCP)
- Medical Review of North Carolina

The CDMC will operate under the auspices of a lead team comprising one or more representatives from each of the three partners and including members from each of the branches/programs in the CDIS. Annually, the lead team will select advisory board members. The advisory board comprises lead team members and other stakeholders who are knowledgeable and experienced in use of the collaborative models. The board will advise the lead team as a new collaborative and tracks are developed.

### COLLECTIVELY, THE CDMC AGREES TO—

#### 1) Training

- Plan and provide training in the form of three, 2-day learning sessions and one, 2-day outcomes congress at a designated location within the state and serve as faculty
- Identify scholarship funds to support staff to attend the three learning sessions and the congress
- Provide ongoing support and postcollaborative and periodic training to support spread and sustainability

#### 2) Technical Assistance

- Provide training and resource materials, educational materials, and handouts necessary to implement the collaborative models
- Provide technical support for implementation of the models including conference calls, listserv communication, and up to two site visits
- Provide technical support and training on use of the selected electronic monitoring system, which includes up to two site visits for training, problem solving, and follow-up with the information support coordinator, and telephone and e-mail communication as needed

- Ensure access to staff knowledgeable in use of the models, databases, state and local chronic disease-related statistics, current chronic disease care and research, and local, state, and national resources

### 3) Handling of Data and Evaluation

- Receive monthly reports from teams without patient identifiers, compile reports, track data and outcomes, and report to participating teams as well as the funding agency
- Maintain and safeguard the confidentiality of data or information that is written, photographed, or electronically recorded, generated, and/or acquired
- Develop and implement the evaluation plan for the CDMC
- Ensure the protection of human subjects through annual application and review by an existing Institutional Review Board (IRB)
- Follow established procedures and policies as well as all IRB requirements for use and manipulation of collaborative data

### 4) Collaboration

- Hold monthly lead team meetings with representatives from the three participating organizations, including each CDIS branch or program representative
- Share in decision making through consensus
- Develop, review, and approve publications using an approved protocol
- Collaborate with the Bureau of Primary Health Care and the South Carolina Primary Health Care Association, the lead for the southeastern U.S. region, to sustain and spread the initiative

- Coordinate advisory board efforts including planning agendas, disseminating the information, and developing meeting minutes

### 5) Compliance

- Partners agree to comply with any restrictions on the use of grant funds and/or any special terms and conditions set forth by the various funding agencies. Partners will notify one another of any such conditions as soon as the information becomes available

### 6) Ownership

- Partnering organizations will share in ownership of all materials, publications, and data that are produced
- Aggregate data will be accessible to all partners at all times
- Publication, dissemination, and other use of collaborative materials and data shall be at the discretion of the lead team and will follow the procedures outlined in the North Carolina CDMC Review Policy for Abstracts and Manuscripts

## SPECIFIC ROLES/RESPONSIBILITIES FOR EACH OF THE THREE PARTNERING ORGANIZATIONS

### The North Carolina Community Health Center Association (N.C. CHCA) will

Dedicate 0.9 full-time equivalent (FTE) for a collaborative director. The FTE resides in and is an employee of the N.C. CHCA and under the direction of N.C. CHCA's executive director. The director will be responsible for the following:

### 1) Administration and Logistics

- Manage enrollment and prework activities for participating teams
- Arrange toll-free conference call lines.
- Develop and edit correspondence and meeting materials
- Coordinate listserv development and capacity
- Coordinate advisory board and lead team meetings, develop agendas, disseminate them, and compile minutes with the coordinator

### 2) Technical Assistance and Training

- Serve as faculty during learning sessions and coach participating teams during action periods
- Create and facilitate all monthly conference call agendas/minutes for participating teams
- Manage action period activities including mail, e-mail and listserv, fax, conference calls, and reporting process
- Make site visits to participating teams when necessary for additional coaching

### 3) Evaluation/Measurement

- Collect all monthly reports and send to the improvement advisor

### 4) Information Technology

The N C CHCA will provide and/or contract for information technology (IT) services including

- Travel to each of the designated clinics and provide individual training per site. Training will include assessment of current staff capability, capacity, and access to a computer and the proper software; introduction to the collaborative models; downloading and implementing the electronic registry; instruction in data entry

and assistance to teams to begin entering data for their population of focus; information on producing queries and reports; and general problem solving

- Provide technical assistance and problem solving to participating teams through phone calls and e-mail including further instruction in data entry and assistance to teams to continue to enter data for their population of focus, information on producing queries and reports, and general problem solving
- Serve as IT faculty and provide IT assistance for all learning sessions and conference calls
- Participate on lead team and advisory board

## **THE NORTH CAROLINA DIVISION OF PUBLIC HEALTH, CDIS INCLUDES THE DPCP, THE HDSP BRANCH, AND THE CPCP**

### **The North Carolina DPCP will**

Dedicate 0.5 FTE, for a collaborative coordinator and diabetes lead. The FTE resides in and is an employee of the DPCP and under the direction of DPCP's branch head. The coordinator will be responsible for the following:

#### **1) Coordination**

- Coordinate advisory board and lead team meetings, develop and disseminate agendas, and compile minutes with the director
- Manage learning session logistics, including coordination of conference rooms, hotel accommodations for teams, audiovisual equipment needs, agendas, copies of materials and handouts, and meals

- Work with other lead coordinators to arrange speakers/faculty for each learning session
- Facilitate linkages with local public health organizations

## 2) Technical Assistance and Training

- Serve as faculty during learning sessions and participating team conference calls and coach participating teams during action periods
- Continuously update diabetes materials, resources, and tools and disseminate them
- Make site visits to participating teams when necessary for additional coaching
- Target clinical staff for scholarships to attend the East Carolina University Brody School of Medicine Diabetes fellowship, a week-long, intensive, mostly didactic training in current diabetes care and education offered three times per year in Greenville, North Carolina

## 3) Planning and Development

Develop new CDMC materials for future diabetes-related tracks including the charter, measures, and change package

## 4) Recruitment

Recruit new primary care practice teams through statewide presentations or training, travel, and other communication modes; develop new recruitment materials

The North Carolina DPCP and CPCP (Cancer Prevention and Control Program) will contract for services for the improvement advisor and lead physician. The role of this person (must be MD) will include

### 1) Evaluation

- Serve as the lead evaluator for the CDMC

- Develop and/or adapt CDMC evaluation tools
- Receive monthly aggregate data reports from the director, input and analyze data, and compile reports
- Provide data reports to the lead team, participating teams, and funding agencies
- Provide a summary evaluation report at the completion of the CDMC year (LS 1-3 and congress)
- Coordinate IRB protocol development and submission
- Determine CDMC measures for each track; coordinate CDMC measures to be consistent with Bureau of Primary Health Care measures and/or requirements of Agency funding sources

## 2) Physician Lead

- Serve as the medical liaison to the CDMC providers by providing linkages to the medical community, current literature, and training when needed
- Serve as the lead physician on the planning team for continuing medical education provided during the learning sessions
- Serve as faculty during learning sessions and conference calls, and coach teams during action periods

## 3) Sustainability and Spread

The CDIS will also provide the time of the chronic disease prevention and control manager to ensure sustainability, growth, and spread of the CDMC. This will include

- Recruit new state partners.
- Share models and lessons learned across the state and nationally
- Pursue funding opportunities for expansion of the CDMC

- Serve as faculty during learning sessions and conference calls

#### 4) Other

- Provide scholarships to participating teams to cover the CDMC registration fee
- Provide partial funding for the CDMC through a contractual agreement

#### The North Carolina HDSP Branch will

Dedicate 0.20 FTE, for the cardiovascular lead. The FTE resides in and is an employee of the HDSP and under the direction of HDSP's branch head. The cardiovascular lead will be responsible for the following:

##### 1) Coordination

- Coordinate CDMC initiative with the six regional HDSP lead coordinators to establish community resource linkages
- Encourage HDSP lead coordinators to provide scholarships or other financial support to participating cardiovascular teams to cover the CDMC registration fee or other related CDMC fees

##### 2) Technical Assistance and Training

- Serve as faculty during learning sessions, participate in team conference calls, and coach participating teams during action periods
- Continuously update CVD materials, resources, and tools and disseminate them
- Work with other lead coordinators to arrange speakers/faculty for each learning session

##### 3) Recruitment

Recruit new primary care practice teams through statewide presentations or training, travel, and other communication modes; develop new recruitment materials

#### 4) Other

Provide partial funding for the CDMC through a contractual agreement

The North Carolina CPCP will Dedicate 0.5 FTE, for a cancer lead. The FTE resides in and is an employee of the CPCB and under the direction of CPCP's program manager. The coordinator will be responsible for the following:

##### 1) Coordination

- Facilitate linkages with local public health programs or organizations
- Work with other lead coordinators to arrange speakers/faculty for each learning session

##### 2) Technical Assistance and Training

- Serve as faculty during learning sessions, participate in team conference calls, and coach participating teams during action periods
- Continuously update cancer materials, resources, and tools and disseminate them
- Make site visits to participating teams when necessary for additional coaching

##### 3) Planning and Development

Develop new CDMC materials for cancer screening track including the charter, measures, and change package

##### 4) Recruitment

Recruit new primary care practice teams through statewide presentations or training, travel, and other communication modes; develop new recruitment materials

The DPCP and the CPCB will contract for services for the improvement advisor and lead physician. This work has been previously described

#### 5) Other

Provide partial funding for the CDMC through a contractual agreement

**Medical Review of North Carolina (MRNC) will—**

Dedicate \_\_\_\_\_, for the continuing education lead. The FTE resides in and is an employee of MRNC and under the direction of MRNC's \_\_\_\_\_. The continuing education lead will be responsible for the following:

**1) Continuing Education Process**

- Coordinate and complete the continuing education application and process for all CDMC learning sessions and the outcomes congress
- Provide linkages to health care providers across North Carolina to promote the CDMC
- Provide scholarships to participating teams to cover the CDMC registration fee

**2) Technical Assistance and Training**

- Serve as faculty during learning sessions and conference calls
- Provide resources, materials, and tools developed by MRNC
- Work with lead coordinators to arrange speakers/faculty for each learning session

**3) Evaluation**

- Participate in lead team discussions on data analysis and report/manuscript development
- Contribute expertise in ACCESS data management through analysis of combined registries

**4) Recruitment**

Recruit primary care practice teams through established linkages with physicians and physician practices

## Section Two

# Deciding What You Want To Accomplish: Collecting And Analyzing Data

### SECTION SUMMARY

Now that you have a partnership, or are in the process of building one, it is time to do an assessment and begin the planning process. This section describes a formal assessment process focusing on three issues:

- Evaluating the status of health care systems and efforts to improve performance
- Identifying partner roles and responsibilities
- Deciding as a group what you would like to accomplish

### DATA SOURCES

Data will be significant when assessing the state of health care in your state. At the state level, you may have access to disease burden, disparities, mortality, and health care use and cost data. However, data may be available through your partners that will help to further define what you want to accomplish. If data are not available, you may have to develop tools, such as surveys, to collect the information you need. Some data sources are listed below. States should use data from the Behavioral Risk Factor Surveillance System and Vital Statistics in addition to those listed below to define the burden of disease within the state and the quality of care that is being provided.

#### Electronic Medical Records/Clinical Information Systems

Health delivery systems, such as hospitals and clinics, may use electronic medical records or clinical information systems to collect demographic, health status/history,

and other information needed to adequately treat patients. Data collected in these systems can be used to assess the level of care that is being provided and to monitor performance across the population, by disease or condition, by provider, or by degree of congruency with evidence-based recommendations and treatment protocols.

#### MONTANA: ASSESSING THE AVAILABILITY OF STROKE DIAGNOSTIC, TREATMENT AND EDUCATIONAL SERVICES

A stroke work group composed of hospitals from across the state and staff from the Cardiovascular Health Program developed a survey to assess stroke services. The work group provided input on the type and form of questions to be asked and helped to analyze the results. The stroke work group created a Web site to communicate stroke survey activities and findings.

Measures evaluated included availability of

- Prehospital and educational services.
- Patient care services and administrative protocols.
- Stroke diagnostic capabilities.
- Stroke care personnel.
- Stroke interventional procedures.

Summary of results

- Approximately 50% reported no emergency medical services prehospital stroke identification program.
- 54% reported a written emergency department stroke protocol.
- 26% had an acute stroke care map or pathway.
- More than 75% had no community awareness program.

## Hospital Admissions

Hospitals, hospital associations, and other organizations establish or maintain databases that contain hospital admissions and discharge information such as reason(s) for admission, cost expenditures associated with treatment, length of stay, source(s) of payment, patient demographics and other characteristics, and discharge status. Analysis of the information in these data sources can be valuable when trying to assess the quality and level of care that is being provided, determining financial and disease burden, and pinpointing the “where” in the system that may need to be “fixed.”

With respect to hospital admissions data, the Agency for Healthcare Research and Quality administers the Healthcare Cost and Utilization Project (HCUP), which sponsors data collection efforts with state data organizations, hospital associations, private data organizations, and the federal government. HCUP collects hospital care data from all payers and encounter levels. The following databases are available through HCUP:

- **The Nationwide Inpatient Sample (NIS)** contains data from approximately 7 million hospital stays. The database captures hospital inpatient admissions for people covered by Medicare, Medicaid, and private insurance, as well as for those who are uninsured, from 995 hospitals in 35 states, which represent approximately 90% of all hospital admissions in the United States.
- **State Inpatient Databases** contain hospital inpatient discharge data, clinical and nonclinical, for people covered by Medicare, Medicaid, and private insurance, as well as for those who are uninsured. These data are collected by data organizations in 36 participating states.
- **The State Ambulatory Surgery Database (SASD)** stores ambulatory surgery (surgeries performed on the same day patients are admitted and released) encounter data, which are reported by data organizations in 20 participating states. The information in this database is similar to that in the NIS; however, SASD contains state-level data.
- **State Emergency Department Databases** capture discharge information for all emergency department visits that do not result in an admission, including a core set of clinical and nonclinical information for all patients regardless of their insurance coverage.

Many of the databases are available for purchase through the HCUP central distributor. For more information on HCUP, visit [www.hcup-us.ahrq.gov](http://www.hcup-us.ahrq.gov). To contact the central distributor, e-mail [HCUPDistributor@ahrq.gov](mailto:HCUPDistributor@ahrq.gov), call 866-556-4287, or fax 866-792-5315.

## MEDICAL, PHARMACY, LABORATORY, AND HEALTH PLAN EMPLOYER DATA AND INFORMATION SET (HEDIS)

Health plans collect patient encounter data from health settings such as medical practices, clinics, and hospitals. The data include diagnosis, treatment, cost of care provided, and provider type. In addition to medical claims data, some health plans collect pharmacy and laboratory data on medication prescription patterns and use, compliance, and health status. Plans use medical, pharmacy, and laboratory claims data to evaluate the quality and effectiveness of care. This information is used in the HEDIS to analyze specific outcomes measures. Evaluation of the data helps to identify gaps and opportunities for intervention. Specific HEDIS measures help to assess the quality of care.

provided to members with cardiovascular disease. These measures, which fall within the effectiveness-of-care domain, include

- Control of high blood pressure.
- Beta blocker treatment after a heart attack
- Cholesterol management for patients with cardiovascular conditions:

Cholesterol screening

Cholesterol control

### **NATIONAL EMERGENCY MEDICAL SERVICES INFORMATION SYSTEM (NEMSIS)**

NEMSIS is a developing nationwide emergency medical services (EMS) database under the auspices of the National Association of State EMS Directors and Trauma/EMS Systems program

The goal of designing such a system is to include variables that will capture the entire EMS event from activation of EMS through release of the patient from EMS care. The system encompasses multiple data sources and components such as dispatch data, incident data, patient data (demographics, medical history, assessment, medical device data, treatment/medications, procedures, disposition), injury/trauma data, cardiac arrest data, financial data, EMS system demographic data, EMS personnel demographic data, quality management indicators, outcome indicators, and domestic terrorism data.

This database can be used to

- Develop nationwide EMS training curricula
- Evaluate patients and EMS system outcomes
- Facilitate research efforts.

- Determine national fee schedules and reimbursement rates
- Address resources for disaster and domestic preparedness

More information on participating states, components of NEMSIS, organizational participation, and funding can be found at [www.nemsis.org](http://www.nemsis.org)

For additional information on EMS data collection systems, refer to the National Emergency Medical Services for Children Data Analysis Resource Center at [www.nedarc.org](http://www.nedarc.org)

### **LESSONS LEARNED**

The following are suggestions and considerations when beginning the planning process:

- Before planning begins, do a baseline assessment of your state's health systems. An assessment is most successful when done as a group activity that everyone contributes to as opposed to something one or two people do on behalf of the others.
- Plan with data. Use the best information and most relevant data available.
- Realize that your group may not have all the data you want or need. Make the best decisions possible with the data you have and move forward, or develop a mechanism to collect additional data.
- Going through the process of assessment is an important activity that can greatly increase partner interest and commitment to the effort.
- Some partners may not be willing to share all their data. Consider their reservations and explore options to address their concerns. In the end, accept what they are willing to give and proceed with planning activities.

- Providing health care is a very competitive business and many of your partners may be in competition with each other. This does not mean they cannot be partners, but it may limit what they are willing to do or which ones you are able to work with.
- Partners may decide to share additional data as you make progress and as they learn how the data will be used and protected.
- Once the assessment is complete, look for the needs, gaps, and priorities that emerge.
- Designate someone or a small group to organize the data for easy understanding and presentation in sequence that will identify the needs and gaps to support planning.
- Compare the findings about the health care systems with evidence-based practices and models of care.
- At the end of the assessment you should have a general sense of your partners' commitment and what you would like to accomplish. Once you reach this point, it's time to move on to more formal planning.

For more information visit <http://www.hcup-us.ahrq.gov/partners.jsp>

## GETTING STARTED

To get started complete the following:

- Begin with the end in mind. Your goal is to use or incorporate systems approaches that may include multidisciplinary teams, decision support tools, and clinical information systems to improve management of heart disease and stroke. The assessment phase should include the analysis of data that will help you identify where health care systems are in terms of making this transition.
- Have each partner identify relevant data it has access to and specify under what conditions it is willing to share data with the group. Potential sources for data include, but are not limited to, the State Heart Disease and Stroke burden document, Behavioral Risk Factor Surveillance System, health plans' claims data, hospital diagnosis and discharge data, and quality improvement organization data.
- Be prepared with solutions for protecting sensitive data. Partners may be more willing to share data if confidentiality is guaranteed.

# Sample Of A Data Collection Sheet Used By The Maine Cardiovascular Health Program To Collect Organizational Information On Health Care Facilities

Practice Profile Sheet: \_\_\_\_\_

Name of practice: \_\_\_\_\_

Project contact: \_\_\_\_\_

Please characterize your practice: \_\_\_\_\_

**Patient Profile:** \_\_\_\_\_

Total number of patients: \_\_\_\_\_ Average number seen annually: \_\_\_\_\_

**Payor Mix** (please estimate percentages): \_\_\_\_% Medicare \_\_\_\_% Medicaid \_\_\_\_%

Managed Care \_\_\_\_% Private Insurance \_\_\_\_% Sliding scale/reduced fee \_\_\_\_%

Other: \_\_\_\_%

**Basic Demographics:** \_\_\_\_\_

Age range: \_\_\_\_ Mean age: \_\_\_\_ Gender: \_\_\_\_ Male \_\_\_\_% Female \_\_\_\_%

**Practice Sites:**

Number of sites: Locations: \_\_\_\_\_

**Financial Structure:**

Private \_\_\_\_ Hospital-based \_\_\_\_ PHO \_\_\_\_ Managed Care \_\_\_\_

Other: \_\_\_\_\_

**Electronic Medical Records (EMR) & Disease Registry:**

Does your practice have an EMR? \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_

Describe: \_\_\_\_\_

Does your practice have a disease registry? \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_

Describe: \_\_\_\_\_

**Please describe your practice's decision-making structure:**

Board of Directors \_\_\_\_\_

Committees \_\_\_\_\_

Management Team \_\_\_\_\_

Does your practice have an existing quality control team?  Yes  No

Does your practice have a medical director? \_\_\_\_\_

Name: \_\_\_\_\_

Does your practice have a clinical director? \_\_\_\_\_

Name: \_\_\_\_\_

**Provider Profile:**

Staff Type	#	Nonclinical Practice Responsibilities (if appropriate)
Physician		Quality Improvement _____ Administrative _____ Staff Supervision _____ Other _____
Physician Assistant Nurse Practitioner		Quality Improvement _____ Administrative _____ Staff Supervision _____ Other _____
Registered Nurse		Quality Improvement _____ Administrative _____ Staff Supervision _____ Other _____
Medical Assistant		Quality Improvement _____ Administrative _____ Staff Supervision _____ Other _____
Case Manager/Coordinator		Quality Improvement _____ Administrative _____ Staff Supervision _____ Other _____
Health Educator		Quality Improvement _____ Administrative _____ Staff Supervision _____ Other _____
Social Worker		Quality Improvement _____ Administrative _____ Staff Supervision _____ Other _____
Other		Quality Improvement _____ Administrative _____ Staff Supervision _____ Other _____

**Administrative Staff Profile:**

Provider Type	#	List any Quality Improvement Responsibility
Practice/Clinic Manager		
Office Manager		
Reception		
Billing		
Information System		
Medical Records		
Other		

# Stroke Diagnostic, Treatment, And Educational Services Assessment Tool Used By The Montana Cardiovascular Health Program

**INSTRUCTIONS:** Please answer **each** of the following questions

1 Are the following prehospital and educational services available in your institution or within your community?

- a Emergency medical services (EMS) in-the-field stroke victim assessment tool (e.g., Los Angeles prehospital screen, Cincinnati stroke scale)  Yes  No
- b Mechanism for EMS to prenotify hospital of potential stroke victim  Yes  No
- c Community stroke awareness program  Yes  No

**2. Are the following services or programs available in your institution?**

- a Emergency department  Yes  No
- b Written emergency department stroke protocol  Yes  No
- c Written tissue plasminogen activator (rtPA) protocol for thrombolytic therapy of acute ischemic stroke (including patients who may be transferred after Rx)  Yes  No
- d Established relationship with another hospital to transfer patients for acute stroke care  Yes  No

**IF YES . . .**

1 To which institution(s) do you most frequently transfer stroke patients? \_\_\_\_\_  
\_\_\_\_\_

**3. Does your institution have stroke diagnostic capabilities available?**

- Yes — **IF YES**, please complete **a through k** of this question below
- No — **IF NO**, skip to Question 4

- a Cranial computed tomography (CAT Scan/CT of the head)  Yes  No  
**IF YES**, is it available 24/7?  Yes  No
- b CT angiography  Yes  No
- c Magnetic resonance imaging (MRI)  Yes  No
- d Magnetic resonance angiography (MRA)  Yes  No
- e Diffusion-weighted MRI  Yes  No
- f Perfusion MRI  Yes  No

- g Carotid ultrasound/duplex  Yes  No
- h Transcranial Doppler  Yes  No
- i Conventional (catheter) cerebral angiography  Yes  No
- j Transthoracic echocardiography  Yes  No
- k Transesophageal echocardiography  Yes  No

**4. Are the following services or programs available in your institution?**

- a Intensive care unit  Yes  No
- b Acute stroke team  Yes  No
- IF YES**, is it available 24/7?  Yes  No
- c Acute stroke care map or pathway  Yes  No
- d Stroke unit  Yes  No
- e Neurologist  Yes  No
- IF YES . . .**
  - How many? \_\_\_\_\_
  - Available 24/7 in **PERSON**?  Yes  No
  - Available 24/7 by **PHONE**?  Yes  No
- f Neurosurgeon  Yes  No
- IF YES . . .** How many? \_\_\_\_\_
- g Intervention capability  Yes  No
- IF YES . . .** is it available 24/7?  Yes  No
  - Intra-arterial thrombolysis . . .  Yes  No
  - Carotid stenting . . . . .  Yes  No
  - Intracerebral angioplasty . . .  Yes  No

**5. Are the following stroke rehabilitation and other services or programs available in your institution or within your community?**

- a Rehabilitation services  Yes  No
- IF YES . . .**
  - Is this a dedicated rehabilitation unit?  Yes  No
  - Is this unit outpatient?  Yes  No
  - Is this unit inpatient?  Yes  No
  - Services to follow chronic anticoagulation?  Yes  No
- IF YES . . .**
  - Is this a dedicated clinic specific to anticoagulation?  Yes  No

# Washington State Collaborative Clinic Systems and Infrastructure Assessment Tool

Team Name: \_\_\_\_\_ Date: \_\_\_\_\_

## **Assessment of Chronic Illness Care Survey — Organizational Team Meeting 1**

For each component of the Chronic Care Model, please circle the number that best represents the level of care that currently exists for your pilot population. A higher number means that the “areas to consider” are more fully implemented (i.e., a score of 11 on Community Resources indicates that your clinic has accomplished all the “areas to consider,” a score of 1 indicates that your clinic has not accomplished any of the “areas to consider”). **Please submit one copy of this form to the registration desk by 5:00 p.m. on Tuesday, January 11.**

### **Community Resources and Policies**

Linkages between the health care organization and community resources play important roles in the management of chronic illness and the prevention of disease.

Areas to consider include the following:

- Linking patients to outside resources
- Partnership with community organizations
- Working with regional health plans

1 2 3 4 5 6 7 8 9 10 11

### **Health Care Organization**

Chronic illness management programs are more effective if the overall system in which care is provided is oriented and led in a way that allows for a focus on chronic illness care.

Areas to consider include the following:

- Organizational goals for chronic care
- Overall organizational leadership in chronic illness care
- Improvement strategies for chronic illness care
- Senior leaders are actively involved
- Benefits and incentives support chronic illness care, where appropriate

1 2 3 4 5 6 7 8 9 10 11

### **Self-Management Support**

Effective self-management support can help patients and families cope with the challenges of living with chronic illness and reduce complications and symptoms.

Areas to consider include the following:

- Emphasis on the patient’s central role
- Assessment and documentation of self-management needs and activities
- Effective behavior change interventions and peer support
- Assurance of care planning and problem solving with patients and caregivers

1 2 3 4 5 6 7 8 9 10 11

### **Delivery System Design**

Evidence suggests that effective chronic illness management involves more than simply adding interventions to a current system focused on acute care. It may necessitate changes to the organization of practice that impact provision of care.

Areas to consider include the following:

- Practice team functioning and leadership
- Planned visits for chronic illness care
- Continuity of care across providers and settings
- Practice-initiated follow-up

1 2 3 4 5 6 7 8 9 10 11

### **Decision Support**

Effective disease management and prevention programs assure that providers have access to relevant, up-to-date, evidence-based information.

Areas to consider include the following:

- Evidence-based guidelines embedded in practice
- Involvement of specialists in improving primary care
- Effective methods of provider education
- Informing patients about guidelines

1 2 3 4 5 6 7 8 9 10 11

### **Clinical Information Systems**

Timely, useful information about individual patients and populations of patients with chronic conditions is a critical feature of effective disease management and prevention programs, especially those that employ population-based approaches.

Areas to consider include the following:

- Registry (list of patients with specific conditions)
- Provider prompts (reminders of services due)
- Feedback of results to providers
- Information about relevant subgroups of patients needing services
- Patient treatment plans

1 2 3 4 5 6 7 8 9 10 11

### **Integration of Model Components**

Effective health care organizations use all components of the Chronic Care Model, integrating them where possible. An example of integration is linking patients' self-management goals to the registry.

Areas to consider include the following:

- Informing patients about guidelines
- Information systems
- Community programs
- Organizational planning for disease management and prevention
- Routine follow-up for appointments, patient assessments, and goal planning
- Guidelines for chronic illness care

1 2 3 4 5 6 7 8 9 10 11

## Section Three

# Planning To Make It Happen: Setting Priorities

### SECTION SUMMARY

With your data assessment completed, you should have a sense of the quality of health care in your state, what issues you need to address, and what you would like to accomplish. Your partnership is ready to establish a plan for getting there. If you have partners, health systems, or medical professionals who are on board and willing to contribute to planning and implementation, you need to bring them together to help them move forward.

If your state is on a fast track to initiating systems change, review this guide and use the parts most relevant to your effort. If your state is new to health systems change, you may want to spend more time developing a detailed plan with your partners, which may help them to establish commitment and ownership.

This section addresses

- Prioritizing next steps and developing the action plan
- Considering resources necessary to implement the plan

### Things to Consider in the Planning Process

Your assessment should identify areas where your state is doing well and areas where improvement is needed. Information collected during the assessment will raise questions to be answered during the planning process. For example, should your priority be to enhance health care systems that are doing well or to improve systems that need more help?

### VIRGINIA: DEVELOPMENT OF BLOOD PRESSURE MEASUREMENT STANDARDIZATION TOOLKITS

The Virginia Department of Health (VDH) provided the initial funding and a staff liaison to develop a toolkit that can be used to train health care professionals on appropriate blood pressure measurement techniques. In addition to the financial and human resources commitments, the VDH assisted in developing the script, producing 3,000 videos and 2,000 DVDs, and printing support materials. Local health department staff were also recruited as volunteer participants in taping this training video.

The decisions about what to start working on are judgment calls that your partnership must make. There is no formula to make these decisions, but you can develop some criteria for deciding as a group where you would like to start. Below are some sample criteria that can be used as your group decides what to do next:

- What is the current situation.
- Frequency of the problem.
- Scope of the problem.
- Severity of the problem.
- Cost/difficulty of ignoring the problem.
- Availability of resources.
- Political will for addressing the problem.
- Which priority focus areas are we going to address?
- Increase the number of people with high blood pressure (BP) who have it under control.

- Increase the number of people with total blood cholesterol less than 200 mg/dL
- Increase the number of people who know the signs and symptoms of heart attack and stroke, the risk factors for heart disease and stroke, and the importance of calling 9-1-1
- Improve emergency response.
- Improve quality of care.
- Eliminate disparities.
- Which entities within the health care setting are we going to work with?
- Hospitals.
- Community health centers and/or primary care practices (private)
- Area health education centers/health education training centers
- Emergency medical services.
- Are our partners interested and do they believe we can accomplish this?
- Do we have or can we get the resources we need?
- Do we agree on the actions to take?
- Are any organized efforts under way related to this activity?
- Are there ways to track progress?

### **A Few Words About Resources**

You can usually count on someone raising the issue of resources very early in the planning process. The resources you have available will determine how much you can get done, but deferring decisions about resources until the group has set priorities can help you be more creative about what you can do and how you can obtain the resources

Most people think of resources as money. Often, though, human (e.g., volunteers, donated staff) and other organizational resources (e.g., computers, space) are just as valuable as financial resources. The commitment of time, experience, passion, and expertise is a key to success. At the same time, it is important to acknowledge that financial resources are needed and to determine where the money will come from. Use the data assessment and planning process to go after the resources you need.

### **LESSONS LEARNED**

When developing the program complete the following:

- Base the planning process on what you learned in the assessment
- The planning process should result in decisions about what activities, needs, and gaps are most important and realistic to address
- Once priorities are established, match the skills and resources you need to address them with those in your partnership. If your partners do not have all the skills or resources necessary, try to recruit additional partners who do
- Bring as much data as you can to the planning process so everyone has access to the information necessary to make good decisions
- Clearly articulate what you expect of your partners. Members of the partnership should express their needs and expectations from the partnership

## GETTING STARTED

When starting the process complete the following:

- Planning may take several meetings. At a minimum, the planning process should include determining major objectives and activities, deciding what needs to be done first, identifying needed resources, and assigning responsibilities and timelines
- As part of the planning process, you should determine the scope of what you are going to do Questions to consider: Should you initiate interventions with a few health care providers as a pilot or work with a large number of providers? Should you implement comprehensive systems change or should you do it incrementally? What component of the system are you going to influence (training, clinical information systems, adoption of clinical practice guidelines)?
- Agree on measures you will use to determine progress Your assessment may provide a baseline for measuring progress
- Once you have established the plan, future meetings should focus on reports from those responsible for portions of the plan, resolving barriers encountered when trying to carry out the plan, checking progress against timelines, and celebrating successes



# Resources And Tools

## An Abbreviated Version Of The Arkansas Collaborative On Improving Care For People With Chronic Conditions Charter

### **COLLABORATIVE CHARTER**

Arkansas Chronic Illness Collaborative on Improving Care for People with Diabetes and Cardiovascular Disease

#### **Problem Statement**

In 1995, nearly 100 million people in the United States had some type of chronic illness. Almost half of those people experience difficulties in their daily life due to illness. It is estimated that \$470 billion was spent in 1990 caring for people with chronic conditions. Numerous surveys and audits have documented the difficulties practitioners have in complying with established guidelines for the care of patients with chronic disease. Although we know the essential elements of good care for people with chronic conditions, there is still a gap between what we know and what we do. Providers are doing their best, but often the systems in which they work make it difficult to provide guideline-recommended care. Providers may feel unprepared and too rushed to meet the educational, clinical, and psychological needs of patients and their caregivers. Patients may experience care that is uncoordinated, impersonal, and unsupportive, which may leave them feeling incapable of meeting the day-to-day needs of living with a chronic condition.

#### **Mission**

The Arkansas Department of Health (ADH) Diabetes Control Program, the Community Health Centers of Arkansas, the Arkansas Foundation for Medical Care, and the Arkansas Cardiovascular Health Program

are teaming up to implement a model of care for Arkansans statewide diagnosed with diabetes mellitus (DM) or cardiovascular disease (CVD). The principles to improve care for these chronic conditions will serve as a template for managing various chronic illnesses.

As a collaborative, we will strive to meet our goals within a 13-month time frame. We will attain these goals by—

- Sharing ideas/knowledge.
- Learning and applying new methodologies for organizational change.
- Implementing the Chronic Care Model systemwide in an effort to align our medical practice with evidence-based clinical guidelines.

The collaborative participants will learn and implement an organizational approach to caring for people with DM and/or CVD in the primary care setting. The system is population based and creates practical, supportive evidence-based interactions between an informed, activated patient and a prepared, proactive practice team.

#### **Collaborative Goals**

The long-range goal of this collaborative is to maximize the length and quality of life for patients with DM and CVD, satisfy patient and caregiver needs, and maintain or decrease the cost of care. This will be achieved by implementing a systemwide model of care that focuses on improving interactions between patients and providers.

The collaborative sponsors will strive to help each participating organization achieve the collaborative goals and its own specific aims. Examples of cardiovascular track goals for participating organizations that are consistent with the mission include the following:

**Patients with 2 blood pressure readings**

The number of CVD patients in the registry who >90% last year have had two BPs in the last 12 months, divided by the total number of CVD patients in the registry

**Hypertensive patients**

The number of patients with a diagnosis of >50% with BP<140/90 mmHg hypertension with BP<140/90 at their last visit, divided by the number of patients in the registry with hypertension

**Patients with fasting**

The number of CVD patients in the registry with >80% lipid profile documented a documented fasting lipid profile within the last 5 years divided by the total number of CVD patients in the registry

**Low density lipoprotein**

The number of CVD patients in the registry with >60% (LDL) cholesterol coronary artery disease (CAD) or DM whose fasting <100mg/dL LDL value is less than 100 mg/dL divided by the number of CVD patients in the registry with CAD or DM with a fasting LDL

**Documentation of self-management**

The number of CVD patients in the registry with >70% management goal setting documented self-management goals in the last 12 months divided by the total number of CVD patients in the registry

**Aspirin or other**

The number of patients in the registry >90% antithrombotic agent use with CAD who are taking aspirin or other antithrombotic agent divided by the number of patients in the registry with CAD

## Methods

Each health system is expected to identify a specific population of patients (e.g., elderly, diabetic, or cardiovascular) that can be monitored for the duration of the collaborative. A patient database (simple or sophisticated) must be available during the collaborative to document and track results of interventions. Participating health systems must be open to changing actions and systems to improve clinical management and office efficiency. The Arkansas Chronic Illness Collaborative will help participating organizations to capitalize on the learning and improvement from the focused project by simultaneously coaching senior leaders in participating organizations to develop a system for spreading the practice redesign to other locations/offices/clinics.

## Collaborative Expectations

The Arkansas Diabetes Control Program, The Arkansas Cardiovascular Health Program, Arkansas Foundation for Medical Care (AFMC), Community Health Centers of Arkansas, Collaborative Directors, the Committee, and Clinical Faculty will commit to the following:

## Clinical Faculty

- Is a noted authority in collaborative topic
- Creates a shared vision and provides intellectual leadership and science
- Teaches at learning sessions.
- Will be available as a medical consultant resource and support person

## Collaborative Director (ADH)

- Is a project management expert who understands improvement
- Manages the overall collaborative.
- Coaches planning group monthly.

- Creates and facilitates meetings and conference call agenda
- Scores the monthly report with the improvement leader
- Coaches organizations at learning sessions and during action periods
- Makes on-site visits to coach teams in achieving goals

## Improvement Advisor (AFMC Office of Projects & Analysis)

- Is an expert in improvement theory and methods
- Teaches and coaches teams on application of the model for improvement
- Assesses progress and recommends strategies to achieve Collaborative goals
- Makes on-site visits to coach team in achieving goals as feasible by AFMC, ADH, and CHC collaborative coordinators

## Collaborative Coordinators (ADH, CHC)

- Track project, timelines, and minutes of meetings
- Write and edit correspondence, meeting materials, and marketing materials
- Manage action period activities; such as, e-mail, conference call, fax, reporting process, and listserv
- Manage registration, payments, project membership, and continuing medical education (CME)
- Coordinate compliance with CME and continuing education unit requirements-CME
- Coach teams in achieving goals during on-site visits
- Coordinate correspondence for planning meetings
- Record and report data.

## Participating Organizations

- Perform prework activities to prepare for the first learning session
- Connect the goals of the Chronic Illness Collaborative work to a strategic initiative in the organization
- Provide a senior leader to serve as sponsor for the collaborative team and to serve as champion for spread of the changes in practice within his or her health care system, and attend at least the first learning session
- Send a team to all learning sessions.
- Provide resources to support their team, including resources necessary for learning sessions, time to devote to testing and implementing changes in the practice (approximately 1 full-time equivalent for the duration of the Collaborative), and active senior leadership involvement
- Perform tests of change leading to implementing changes in the organization and conduct of their office practice. An interrupted time series design will be used to assess the impact of these changes
- Make well-defined measurements that relate to their aims at least monthly and plot them over time for the duration of the Collaborative (Key changes will be annotated on these graphs of the measures)
- Share information with the collaborative, including details of changes made and data to support these changes during and between learning sessions





# Section Four

## Implementing Your Action Plan

### SECTION SUMMARY

Once you have developed interventions and priorities, the next step is to establish and implement the action plan. This section addresses

- Implementation strategies.
- Key ingredients to successful implementation

### IMPLEMENTATION STRATEGIES

There are three major ways to implement a program:

- Use a pilot process.
- Phase in the program in small increments.
- Initiate the total program all at once.

#### Pilot testing

Pilot testing is a crucial step. It identifies any problems or barriers to the program and provides an opportunity to work out any issues that might exist before total implementation. Piloting a program allows for

- An initial assessment of whether the program activities worked as planned
- An opportunity to work out program logistics
- A critique of the program from participants that provides insight into how to revise the program

#### Phasing In

A program can be phased, which provides more control over the program and helps to keep it manageable. Phasing in programs or components of a program allows problems to be identified and resolved early in the process, thereby maintaining program effectiveness. The implementation process may

also include pilot testing the program and then working toward full program implementation in phases

### WISCONSIN COLLABORATIVE QUALITY IMPROVEMENT PROJECT

In 2002, the Cardiovascular Health Program approached Wisconsin Collaborative Quality Improvement Project members about developing a project aimed at lipid management. Members of the Collaborative include the Diabetes Prevention and Control Program, Division of Health Care Financing, the University of Wisconsin—Madison, MetaStar (the state quality improvement organization), and health plans. Several of the health plans were interested, and from this collaboration the Cardiovascular Risk Reduction Project was created, which resulted in the development of Cardiovascular Risk Reduction Guidelines for professionals and a personal “Heart Care Card” for patients (available in English, Spanish, and Hmong).

To overcome health plans’ concern about data confidentiality, a contract with the University of Wisconsin Department of Population Health Sciences was drafted. Participating health plans send the Health Plan Employer Data and Information Set data to the Department of Population Health Sciences, where they are de-identified and then shared with the Collaborative partners.

#### Full Implementation

Full implementation of a program requires substantial resources and effort

Each of these strategies has advantages and disadvantages

Strategy	Advantages	Disadvantages
Pilot	<ul style="list-style-type: none"> <li>• Opportunity to test program</li> <li>• Close control of program.</li> <li>• Shorter implementation period</li> </ul>	<ul style="list-style-type: none"> <li>• Few people directly involved.</li> <li>• Hard to generalize about results</li> </ul>
Phased in	<ul style="list-style-type: none"> <li>• Easier to cope with work-load</li> <li>• Gradual investment.</li> </ul>	<ul style="list-style-type: none"> <li>• Not meeting all needs.</li> </ul>
Full Implementation	<ul style="list-style-type: none"> <li>• More people involved.</li> </ul>	<ul style="list-style-type: none"> <li>• Big commitment.</li> <li>• No chance to test program.</li> <li>• Longer implementation period.</li> </ul>

## KEY INGREDIENTS TO SUCCESSFUL IMPLEMENTATION

To ensure successful implementation of your health systems change, you need to address three main issues: 1) ensuring that adequate resources are available to enact the program, 2) building local ownership or “buy-in” from the staff responsible for implementing the program, and 3) ensuring that clinical and administrative systems are in place to facilitate staff adherence to the program

### 1) Adequate Resources

A primary challenge is to ensure that adequate resources are available to enact the plan. If sufficient funds and staff are not committed to the program, there is little hope of successful implementation. Inadequate resources have been identified as a leading cause of implementation failure.

### 2) Building Local Ownership/Buy-In

Staff affected by implementing the program must be committed to its success. Ways to foster commitment include:

- *Using opinion leaders* or well-respected and effective champions who are committed to the process of implementing the program plan
- *Educating staff* about all facets of the program, including why it is necessary, its specific goals and objectives, how the goals and objectives will be achieved, and how success will be measured
- *Focusing on local implementations* and how the implementation process will affect day-to-day activities; solicit input from staff on their concerns about implementation of the program and ways to improve it
- *Using staff at all levels* in the implementation process who will have some direct or indirect role in establishing or maintaining the program
- *Using data* to the greatest extent possible to demonstrate the need for the program
- *Focusing on staff attention on program goals* and how establishing the program successfully from the start can ameliorate any future breakdowns

### 3) Ensuring Systems Are in Place

Implementing health systems change requires more than the enthusiasm and commitment of individual members. To achieve lasting improvements, staff, administrative, and clinical resources need to be coordinated. For systems change to be effective, existing systems must be modified or new systems established to facilitate desired practice changes. Following are several ways to accomplish this goal:

- *Emphasizing systems over individual behavior.* When communicating with staff, stress that the systems change is about supporting clinical behaviors rather than policing the actions of individual staff.
- *Understanding current processes.* Map out all clinical and administrative processes relevant to the systems change. This will provide a clearer understanding of exactly where you stand in relation to the recommended systems change.
- *Identifying needed changes.* Use your understanding of the current practices to identify where changes need to be made. If you do not have enough information to identify needed changes, work with the clinical staff to gather it (which also helps build staff buy-in).
- *Involving a variety of staff members in changing systems.* Clinical systems often involve multiple levels of staff. Involve representatives from each level (e.g., physicians, nurses, ancillary, and support staff) in designing and carrying out changes. You will get better results and will build staff support.
- *Using process data to measure change.* Measure changes in the care processes targeted by your new system so you can track your progress and respond quickly to unexpected results.

### Lessons Learned

The following will help with systems change:

- For major systems change, consider a phased-in approach to make it more manageable and to improve success.
- Successful systems change requires the buy-in and commitment of senior management and staff who are implementing it.
- Ensure that the implementation is based on a sound plan, including clear goals, objectives, activities that need to be accomplished, and identification of staff responsible for carrying out those systems change activities.
- Before the systems change is implemented, you need to address potential barriers with all health care staff who will be affected by the change. Barriers should also be discussed during regularly scheduled work group meetings. For example, the systems change may involve implementing standard orders and discharge instructions for post-acute myocardial infarction care in a hospital, but if an audit 2 months after the initiation finds that only half of the staff are consistently using those documents, the work group will need to identify the barriers and address them.
- You need buy-in from everyone on the team who has to implement the systems change. Do not rely solely on the physician champion. The champion may inadvertently become the point person if the systems change is not successful.
- Make evaluation a part of the plan.

## **Getting Started**

Before getting started, the following is recommended:

- Make sure those involved in implementing the systems change are committed to it and have a clear understanding of their roles and responsibilities
- Work with partners to ensure that the necessary resources are available and committed
- Develop a plan for monitoring the systems change, once implemented, to identify and resolve problems early

## **Resources And Tools Rand**

Corporation publication *Getting To Outcomes 2004: Promoting Accountability Through Methods and Tools for Planning, Implementation, and Evaluation* is available at <http://www.rand.org/publications/TR/TR101/>

*Getting To Outcomes 2004* outlines the steps needed to plan, implement, and evaluate programs. It walks the reader through capacity, planning, process, and outcome evaluation; continuous quality improvement; and sustainability.

# Arkansas Agenda for a Chronic Disease Collaborative

Time	Title	Speaker	Speaker CONTACT INFORMATION
9:00a m – 10:00a m	Registration and Storyboard Setup Continental Breakfast	None	
10:00a m – 10:15a m	Welcome and Introductions	Arkansas Chronic Illness Planning Team	
10:15a m – 10:45a m	Shared Vision for the Collaborative/Changing Practice/Changing Lives (Video)		
10:45a m – 10:55a m	Break		
10:55a m – 11:55a m	A System of Care for Chronic Conditions		Institute for Healthcare Improvement National Collaborative Director Health Resources and Services Administration Health Disparities Collaboratives 815-754-9606 (ph) 815-754-0107 (fax) chupke@nibcomp.com
11:55a m – 1:00p m	Lunch	None	
1:00p m – 1:45p m	(Condition Clinical Plenary Cardiovascular)		
1:45p m – 2:30p m	(Condition Clinical Plenary Diabetes)		
2:30p m – 2:45p m	Break and Storyboard Viewing	None	
2:45p m – 3:30p m	The Model for Improvement	Cindy Hupke	
3:30p m – 4:15p m	Community Linkages	Joy Chadwick	Boston Mountain Rural Health Marshall, Arkansas
4:15p m – 4:30p m	Break and Storyboard Viewing	None	
4:30p m – 5:15p m	Delivery System Design	Lynn Terral	Hope Migrant Community Health 205 smith Road Suite D Hope, Arkansas 71801 870-777-8420
5:15p m – 5:30p m	Question and Answer Session		



# Letter of Invitation to Participate in a State-based and Sponsored Collaborative

November 5, 2003

Dear Professional:

## IT IS TIME TO GET ON BOARD!!!!

Have you or any of your staff ever experienced a sense of frustration when it comes to ensuring that all of your patients receive consistent care? Does your staff struggle with finding time to spend on patient education? Are you unable to keep your practice aligned with current medical guidelines?

If you answered “yes” to one or more of these questions, we want to encourage your staff to **Come Aboard** and sign up for the **2003–2004 Arkansas Chronic Illness Collaborative (CIC)**. The Arkansas CIC is a statewide organization committed to improving the delivery of care to our state’s **chronically ill population**. This is an organization directed by a number of our state’s leaders in health care, including the Arkansas Department of Health and University of Arkansas for Medical Science (UAMS).

The collaborative provides an opportunity for primary care teams to come together to share ideas, experiences, successes, and barriers while striving to improve care for your practice’s chronically ill patients. The clinical topics for this year’s collaborative will be *diabetes and cardiovascular disease*. We will have clinical experts in these areas teaching evidence-based care, along with national quality improvement experts teaching application and implementation of the Model for Improvement and the Care Model.

Our first learning session is scheduled for November 14<sup>th</sup>, at the Radisson Hotel, 617 Broadway in Little Rock. Please come join us! A registration form is attached. Complete the form and fax it to (501) 661-2070, or call (501) 661-2093 for more information. Your registration fee of \$75.00 may be paid at the sign-in desk.

### Arkansas Chronic Illness Collaborative Planning Committee

Arkansas Foundation for Medical Care

Cardiovascular Health Program, Arkansas Department of Health

Community Health Centers of Arkansas, Inc

Diabetes Prevention and Control Program, Arkansas Department of Health

UAMS Rural Hospital Programs



# Informational Meeting for a Request For Application to Promote Systems Change in Health Care Settings (Conducted By The Maine Cardiovascular Health Program)

## Program

Improving Care for Patients with Hypertension and High Cholesterol in the Primary Care Setting

July 26, 2004

## Agenda

Welcome and Overview Request-for-Proposal (RFP) Requirements Questions & Answers

## Bidder's Conference

This meeting is to provide an opportunity for interested parties to discuss and have clarified the requirements of this RFP

## Maine Cardiovascular Health Program Goal

To have the people in Maine be heart-healthy and stroke-free

Working through a network of community, government, and health partners, the Maine Cardiovascular Health Program explores prevention opportunities in neighborhood, school, work site, and health care settings

## State Response

The purpose of this RFP is to solicit proposals from qualified primary care practice sites to promote system change in health care settings and assure quality of care. The primary goal is to control hypertension and high blood cholesterol through patient and provider adherence, and to recognize cardiovascular disease primary and second-

ary prevention guidelines (i.e., American Heart Association and American College of Cardiology). The Maine Center for Disease Control and Prevention seeks proposals that will test innovative strategies for assisting providers to work as partners with their patients in a collaborative care process. The effective strategies funded through this initiative will be evaluated and the findings disseminated to encourage implementation and replication by other primary care practices in Maine.

## Eligible Applicants

Must be one of the following:

- A primary care practice affiliated with a hospital, health system, or practice network
- Private primary care practice.
- Federally qualified health center.

Applicants are encouraged to apply in partnership with their local Healthy Maine Partnership (Attachment B)

For the purpose of this RFP, a primary care practice is defined as family practice or internal medicine practice

## Must Have

Ability to collect data electronically via an electronic medical record, disease/risk factor registry, or other system

## Priority Population

The patients involved in this practice must

be adults and diagnosed with

- High blood pressure (>140/90) and/or
- High blood cholesterol (>200 mg/dL)

Preference will be given to **underserved** populations with demonstrated disparities in cardiovascular health status (e.g., socioeconomic status, gender, geographic, racial/ethnic)

### **Participants in Collaboratives**

Participants in a Collaborative (based on the Institute for Healthcare Improvement model) are encouraged to apply to develop **new** or **expand** work on implementation of the Chronic Care Model

### **Available Funding**

Up to approximately \$120,000 is available to fund primary care physicians (PCPs) and collaborating local health management plans (HMPs). Applicants can apply for up to \$25,000 if applying singly but up to \$30,000 if applying with a collaborating HMP. Without the collaboration of a HMP, a maximum of \$25,000 is available in total to the practice.

### **Contract Period**

Grants awarded under this RFP are for a 12-month period, starting November 1, 2004, and ending October 31, 2005. Grant funds will be paid to grantees in three intervals during the 12-month grant: November 15, 2004; March 15, 2005; and July 15, 2005.

### **Procurement Timetable Milestone Date**

Bidders' Conference July 26, 2004

Deadline for Written Questions

July 30, 2004

Response to Written Questions (mailed)

August 4, 2004

Letter of Intent Deadline

August 27, 2004

Proposal Submission Deadline

Sept 27, 2004

Notification of Award (letters mailed)

October 8, 2004

Desired Effective Date of Contracts

Nov 1, 2004

### **Today's Informational Meeting**

Any information resulting from this meeting deemed by the department to be important and of general interest, or that changes the requirements of this RFP, will be sent to all parties who request an application package. The department is not bound by information provided verbally. A report of the informational meeting, which will include the questions and answers, and any other supplemental information provided by the department as a result of either today's meeting or the submitted written questions, will be prepared and mailed to the list of persons who have requested applications for this RFP. If you pick up the RFP application today you must provide your name and address so that we can provide you with a copy of today's report. All attendees to today's meeting must sign in.

### **Written Questions & Answers**

All questions, clarifications, or requests for additional information regarding the RFP must be submitted **in writing by mail or fax by 4:00 p.m. local time on July 30, 2004**. After that date, no questions will be permitted. Under no circumstances will questions be accepted, unless they are in writing. The department is not bound by information provided verbally. A complete set of the questions and the department's responses to today's meeting will be mailed out on August 4, 2004, to those who have requested an RFP.

### **Letter of Intent**

A letter of intent is required. Letters are not binding — they do not obligate you to submit an application. The purpose of the letter

of intent is to provide minimal information that demonstrates a prospective bidder's ability to comply with the requirements of the contract. The PCP site and the partnering HMP (if applicable) must be identified in the letter of intent. Letters must be received no later than 4:00 p.m. local time on August 27, 2004. Letters of intent must be mailed or faxed (no e-mails). Grant proposals will not be accepted from organizations that do not submit a letter of intent.

### **Proposal Submission Requirements**

Applicants must provide all information requested in this RFP package at the time of submission. Failure to provide required information may result in disqualification of the proposal or in a lower rating for incomplete sections. Proposals must be received at the Bureau of Purchases at the Burton Cross Building, no later than **2:00 p.m. local time on September 27, 2004**. Please note **postmarks are not sufficient, and faxing or e-mailing of the proposal is not permitted**. Applicants submitting proposals by mail are responsible for allowing adequate time for delivery. Proposals should be clearly marked: **RFP FY05 – BOH/MCVHP 604261**.

Applicants must adhere to the instructions and format requirements outlined in this RFP. One original and five copies of all proposals must be submitted on white 8½" x 11" paper, with a minimum font size of 10 point. Recommended maximum page allowances for each section are listed in Proposal Content. Proposals must include

- Cover sheet (Attachment E).
- Proposal narrative as specified in Section IV
- Applicant experience and capability (approx. 5 pgs)
- Proposed work plan and timeline (approx. 10 pgs)
- Proposal budget (Attachment F).
- Letters of support (Section III, E).

### **Disclaimer**

Issuance of the RFP in no way constitutes a commitment by the department to

- Award a contract.
- Pay costs incurred in the preparation of a response to this request
- Pay costs incurred in procuring or contracting for services, supplies, physical space, personnel, or any other costs incurred by the applicant

### **Rejection of Proposal**

The department reserves the right to reject any or all proposals received in response to this RFP. The department reserves the right to amend the RFP prior to the proposal submission deadline.

- All prospective applicants who have submitted a letter of intent by the required date shall be notified of any amendments
- Applicants will have the opportunity to revise their proposals to accommodate the RFP amendment
- The department reserves the right to withdraw the RFP in whole or in part at any time

### **Proposal Evaluation and Selection**

The department will select successful bidders through a formal evaluation process. Only materials included in the proposal and attachments will be considered in the evaluation. An evaluation team will be responsible for reviewing and rating proposals, using evaluation criteria, and using a numerical scoring system developed for this RFP.

Applicant capability and qualifications

**25 points**

Scope of work **50 points**

Budget **25 points**

**(100 total points possible)**

### **Notification of Award**

All applicants will receive written notice, by certified mail, of their selection or non-selection. The department expects to mail letters no later than October 8, 2004. No applicant shall make any press conference, news release, or announcement concerning selection or nonselection for a contract prior to the department's public release of said information or prior to written approval of the department. Violation of this provision may be considered grounds for disqualification.

### **Incorporation**

The RFP, any amendments thereto, and the successful applicant's proposal will be incorporated by reference into any contract award as a result of this procurement.

### **State Use of Proposed Idea**

The state reserves the right to use any and all ideas presented in any proposal in response to this RFP unless the applicant presents a positive statement or objection to the use of the proposal. In no event will such an objection be considered valid with respect to the use of such ideas that are not the proprietary information of the applicant and so designated in the proposal, or that were known to the state before submission of such proposal or properly became known to the state thereafter through other sources or through acceptance of any proposal.

### **Disclosure of Information**

Maine's Freedom of Access Law, found at 1 MRSA Section 401-412, provides that documents submitted by the bidder become public documents once they are in the state's possession. The bidder bears the risk of disclosure when submitting material that the bidder believes may be protected by copyright, patent, or proprietary interest. The bidder may choose to submit information of this nature and mark it clearly as "Confidential." However, the state makes

no representation that such material can be protected once it is in the possession of the state. If a contract is awarded to the applicant, the state shall have the right to use or disclose the information to the extent otherwise provided in the contract or by law. The state does not assume liability for use of the information, whether marked or not.

### **The Chronic Care Model**

The Chronic Care Model identifies the essential elements of a health care system that encourage high-quality chronic disease care. These elements are the community, the health system, self-management support, delivery system design, decision support, and clinical information systems. Evidence-based change concepts under each element, in combination, foster productive interactions between informed patients who take an active part in their care and providers who have resources and expertise.

### **RFP Intent**

In this RFP, the Maine Cardiovascular Health Program addresses systems that will enhance the use of evidenced-based guidelines in the care and treatment of patients with cardiovascular disease risk factors. These systems will address the management of cardiovascular-related conditions (e.g., hypertension and high cholesterol) and the management of risk factors (e.g., lack of physical activity, obesity) as well as the provision of clinical preventive services.

### **Performance-Based Contracting**

Contracts awarded as a result of this RFP are subject to the Maine State Law: "An Act to Establish a System of Performance-Based Agreements for the Provision of Certain Social Services" (22 MRSA Section 12-A). The law defines performance-based contracting as follows:

“An agreement for the purchase of direct client services employing a client-centered, outcome-oriented process that is based on measurable performance indicators and desired outcomes and includes the regular assessment of the quality of services provided”

### Scope of Work

#### Performance Goal

The performance goal of the Maine Cardiovascular Health Program is to promote the primary and secondary prevention of heart disease and stroke and to eliminate related health disparities

#### Objectives

The objective of this RFP is to improve blood pressure and/or blood cholesterol control among those patients known to have high blood pressure and/or high blood cholesterol in the primary care practice setting

### Scope of Work

The focus is on these strategies: 1) the support of patient **self-management** in practice settings, and 2) **community linkages** between providers and Healthy Maine Partnerships. **Decision support** is also addressed, because a practice must define and consistently use evidence-based medicine to effectively support patient self-management. Applicants are expected to provide examples of the specific approach that will be implemented in their practice. Each applicant must address **patient self-management** and **linkages with community resources**. Applicants must also strengthen their proposals by providing evidence of existing **decision support tools** (e.g., guidelines), activities (e.g., education), and tools (e.g., PDAs) or propose such activities in their application. In all cases, the practice must **identify the guidelines** (reference to a professional organization or Web site is acceptable) to which they will adhere. A brief response to **process** and **clinical measures** is also required.

### Healthy Maine Partnerships

This RFP encourages providers to link with the Healthy Maine Partnership in their community and use existing resources to assist their patients. In addition, providers and Healthy Maine Partnerships are encouraged to work together toward the development of new options for patient self-management support. Some activities may take place in the provider's office, such as chronic disease management group visits, while others may be available in community-based settings, such as health information centers.

### Measures

**Process Measures.** The applicant should discuss, at a minimum, the following process measures. The final measures will be defined in collaboration with the project officer.

- Patient and provider participation.
- Patient and provider satisfaction.
- Patient adherence to self-management plan.
- Provider adherence to care plan.
- Evidence of Healthy Maine Partnership collaboration, if there is a collaborating Healthy Maine Partnership.

**Clinical Measures.** A minimum of one measurable clinical goal and one behavioral outcome should be selected by the applicant. These examples are provided as guidance:

- Reduce blood pressure by 20% in at least 50% of patients involved in project.
- Reduce low density lipoprotein cholesterol by 20% in at least 60% of patients involved in project.
- Reduce weight by 10 lb in 50% of patients involved in project who have body mass index > 30.

### **Applicant Requirements and Program Monitoring**

Grantees will be required to meet the following expectations in connection to contracts awarded under this RFP

**Personnel.** At least two physicians in a practice must commit to implementing the proposed intervention (if solo practice, one physician and one practice-based staff person can be identified) One of the physicians or another practice-based staff person must be identified as the contact person An Healthy Maine Partnership staff person also must be identified if there is a collaborating Healthy Maine Partnership

### **Applicant Requirements and Program Monitoring**

**Support.** Primary care practice support must be documented through a letter of support from senior management

**Collaboration.** If applying in collaboration with a Healthy Maine Partnership, a letter of support should be included in the application highlighting the role of the Healthy Maine Partnership in the project

**Networking Sessions.** Grantees will be expected to attend two, half-day networking sessions to be held in a central location Each practice will be required to send two or more representatives as well as a representative from the collaborating Healthy Maine Partnership, if applying in collaboration with a Healthy Maine Partnership (The first meeting will be held in early November and the second meeting will be approximately 9 months later It is anticipated that continuing medical education credits will be available )

**Reporting.** Grantees will receive training in reporting methods

- Submit brief monthly progress reports using the “Plan, Do, Study, Act” cycle of improvement
- Chart and submit monthly baseline and outcome data on selected clinical and behavioral outcomes
- Provide a basic description of the study population, including demographics, risk factors, cardiac history (e g , events) once the study population is identified

**Site Visits.** Participate in two, 1-hour site visits to be conducted with Bureau of Health staff The first site visit will be conducted within 90 days of the project start date

### **Content of Proposal**

Applicants must adhere to the instructions and format requirements outlined in this RFP Please submit one original and five copies for a total of six complete proposals

### **Applicant Experience and Capability**

(approx 5 pgs )

- 1 Describe the practice (i e , practice model, ownership, type of practice, specialty, staffing) and the population served (i e , size, payer mix, age, gender, ethnicity, socioeconomic status)
- 2 Identify two or more physicians who will implement the proposed intervention (if solo practice, one physician), as well as any nurse practitioners or physician assistants
- 3 Describe the type of electronic medical record or other computer database that will be used in conjunction with this project

- 4 Describe the duties of staff members who will work directly on the project and the responsibilities of the other members of the “care team ”
- 5 Describe other quality improvement initiatives in which the practice has or had involvement, including the outcomes
- 6 Describe other community collaborative projects in which the practice or staff had involvement
- 7 Describe any tools, materials, protocols, etc that are currently in use that will be part of this project

### **Proposed Work Plan and Timeline**

(approx 10 pages)

Describe the practice’s ability to deliver the services as outlined in the scope of work for each of the three components. The proposed intervention must last at least 6 months. In addition to describing the proposed practice-based strategies and linkages to the community, the following information should be included in the proposal:

- 1 Describe target population
- 2 Identify the evidence-based guidelines that will guide clinical care
- 3 Demonstrate an understanding of the barriers to patient self-management
- 4 Identify the collaborating Healthy Maine Partnership, contact person, and anticipated collaborative relationship, if applicable
- 5 Indicate how many people the project will reach. This could be all patients with high cholesterol and/or hypertension or a subset. (It is understood that higher-intensity interventions will reach fewer people.)
- 6 Describe the roles of the members of the “care team ”

- 7 Select measures and set target levels according to the guidelines described in the section
- 8 Describe the applicant’s plans for linking with community resources such as Healthy Maine Partnership
- 9 Specify the methods for ensuring effective team and practice-wide communication about this project

### **Proposed Budget**

Grantee funds may not be used for diagnostic medical testing, patient rehabilitation, pharmaceutical purchases, facilities construction, lobbying, basic research, or controlled clinical trials. Applicants must use the forms provided to prepare the line item budget, and budget pages must be included in the same order as they appear in attachment F. Forms are available (in Excel) electronically at your request. Include all forms. If a particular form does not apply to your agency or project, include it and write on it “Not Applicable” or “None,” whichever is appropriate.

Please read the instructions for the budget forms carefully. If you don’t understand the instructions please provide us with your written questions by July 30, 2004.

We can’t help you complete the forms.

### **Putting the Application Together Order of Application**

Use the following order when preparing the RFP:

- Cover page.
- Proposal narrative.
- Applicant experience and capability.
- Proposed work plan and timeline.
- Budget forms.
- Letters of support.

### **Questions**

Please write your questions on the index cards provided and hand them in. A complete set of the questions and the department's responses to today's meeting will be mailed out on August 4, 2004, to those who have requested an RFP. The department is not bound by information provided verbally.

**Thank you for joining us today!**

# North Carolina Scholarship Application for Potential Participants in the Chronic Disease Management Collaborative

## APPLICATION AND ASSURANCE FOR SCHOLARSHIP PARTICIPATION

North Carolina Heart Disease and Stroke Prevention Branch  
Chronic Disease Management Collaborative  
Scholarship Program 2004–2005

The Scholarship Program will cover the registration cost only for a four-person team to participate in the NC Chronic Disease Management Collaborative. The scholarship does not cover the cost of hotel accommodations, meals not covered by the conferences, mileage, and any other expenses incurred as a result of participation in the collaborative.

- The participating health care organizations must meet the following criteria:
  - Nonprofit status
- Service to a target population of which at least 20% is underserved and/or high-risk (uninsured, Medicaid eligible, ethnic minority)
- Identification of 50–100 people with cardiovascular disease for the population of focus.
- Ability to adequately describe the financial need of the organization.
- Agreement to comply with all stipulations outlined in the NC Chronic Disease Management Collaborative Memorandum of Agreement
- Support for participation by the Health Director, CEO, or other lead administrator as evidenced by signing the attached *Assurance* form

### Complete the following regarding participation:

- I certify that \_\_\_\_\_  
(*name of organization*) is a nonprofit organization and that the target population served comprises at least \_\_\_\_\_% (*list percent underserved*) underserved and/or high-risk patients
- Through participation in the NC Chronic Disease Management Collaborative, we plan to target and track approximately \_\_\_\_\_ (*list number*) patients with cardiovascular disease
- Further describe the financial need of the organization (may add up to one 8 x 11 sheet of paper)

As a nonprofit primary care provider or practice participating with the NC Chronic Disease Management Collaborative to improve the quality of care for people with cardiovascular disease, I agree to do the following activities:

- 1) To sign and comply with the requirements outlined in the Memorandum of Agreement with the North Chronic Disease Management Collaborative, administered by the North Carolina Community Health Care Association;
- 2) To support the team in participation by providing adequate time and resources for planning and development of the Collaborative process; and
- 3) To reimburse the North Carolina Heart Disease and Stroke Prevention Program for the full amount (\$1,000) of the scholarship in the event of failure to comply with items 1 and 2 above

The following team members will participate in the NC Chronic Disease Management Collaborative:

_____	_____
(Name)	(Title)
_____	_____
(Name)	(Title)
_____	_____
(Name)	(Title)
_____	_____
(Name)	(Title)

Lead Contact: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Telephone No: \_\_\_\_\_ Fax No: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

\_\_\_\_\_

**Health Director, CEO or Medical Director Signature**

**Date**

# Washington State Collaborative General Application

## General Information

### Application Submission

The attached application can be filled out electronically or printed and manually completed. Please return it to Ellen Pearlman, Collaborative Coordinator, at the e-mail or fax address below. If you need assistance, please contact Ellen at (800) 949-7536, ext. 2606.

- E-mail: [wsc@qualishealth.org](mailto:wsc@qualishealth.org)
- Fax: (206) 440-2644

**Admission applications must be received by Monday, May 3, 2004.** You will be notified regarding the status of your application within 2 weeks of submission.

## Financial Aid

There are a limited number of scholarships available. To receive an application and/or information about financial aid, please contact Ann Kelley at the Foundation for Healthcare Quality.

- Phone: (206) 682-2811, ext. 23
- E-mail: [akelley@qualityhealth.org](mailto:akelley@qualityhealth.org)

**Financial aid applications must be received by Monday, May 3, 2004.**

## About the Collaborative

Collaborative participants learn how to develop, test, and implement quality improvement measures. This process requires a significant time commitment. If you would like more information, please contact:

Helan Lee or Kathleen Clark  
Qualis Health WA Dept of Health  
(206) 364-9700, ext. 2341 (360) 236-3608

## Cost

There is a fee of \$200 per person for each event (three learning sessions and an outcomes congress), plus travel expenses.

Collaborative events will be held at the Doubletree Hotel Seattle Airport, Seattle, WA.

### Schedule

Admission application deadline	May 3, 2004
Scholarship application deadline	May 3, 2004
Prework period	May–June
Learning session 1	June 28–29, 2004
Action period	July–Sept.
Learning session 2	Sept. 20–21, 2004
Action period	Sept.–January
Learning session 3	Jan. 10–11, 2005
Action period	January–June
Outcomes congress	June 27–28, 2005

The Washington State Collaborative is cosponsored by:

- Qualis Health
- Washington State Department of Health
- Improving Chronic Illness Care

Note: Use the “Tab” key to navigate through the informational fields in the application  
Check boxes can be selected by clicking on the box

Organization Name \_\_\_\_\_ Contact Name \_\_\_\_\_

Mailing Address \_\_\_\_\_ Contact Credentials \_\_\_\_\_

Contact Title \_\_\_\_\_ Phone \_\_\_\_\_

Fax \_\_\_\_\_ E-mail \_\_\_\_\_

In which track do you want to participate?  Diabetes  Cardiovascular disease

Percent of patients on Medicare: \_\_\_\_\_

Are you accepting new Medicare patients?  Yes  No

Are you a Washington Breast and Cervical Health Provider?  Yes  No

Has a team from your company participated in a prior Collaborative?  Yes  No

Is your organization involved with other initiatives, quality improvement projects, or major changes that require a significant amount of staff time above and beyond their regular duties?

Yes *If yes, please explain:* \_\_\_\_\_  No

Will your team have the ability to spread changes to other conditions or parts of the organization?

Yes  No

Will your team have daily access (preferably in a clinical area) to a printer and a computer running Microsoft Windows 95 or later?

Yes  No

Will your Washington State Collaborative team members have direct access to the Internet and individual e-mail at work?

Yes  No

Please review the following statements to indicate that you have read and understand these expectations:

Our team will fully participate for approximately 13 months Three team members are required to attend all three learning sessions and an outcomes congress; the senior leader is expected to attend at least the first and third learning sessions as well as the outcomes congress Our team is committed to testing and measuring practice innovations and sharing experiences with other teams

Why do you want to participate in the collaborative? \_\_\_\_\_

What do you want to accomplish as an organization in this collaborative? \_\_\_\_\_

How will these accomplishments help you carry out the mission of your organization?

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Who in your organization will be participating in the collaborative? (Please list names and positions )

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During the collaborative, which medical or administrative leaders will your team be able to rely on to remove obstacles that may arise or to obtain resources?

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# Washington State Collaborative Scholarship Application 2004–2005

## Overview

Scholarships for the Washington State Collaborative (WSC) will be awarded through a competitive application process and allocated based on need and availability of funds. The funding period is June 1, 2004, through June 30, 2005, and the **deadline for submission of scholarship applications is May 21, 2004**. See “Completing the Application” for activities supported by the scholarship program.

## Eligibility

Eligible clinical practice teams must meet the following criteria:

- Are enrolled in the collaborative.
- Have a minimum of 50 patients with diabetes or cardiovascular disease.
- Are the only clinic within a multiclinic system to apply for a scholarship. Other clinic sites within a multiclinic system are encouraged to participate in the WSC but are not eligible for funds in this award cycle.

All returning teams or organizations will be required to address Adult Preventive Services (APS) measures. Returning teams or organizations that choose targeted APS measures may qualify for funds designated to support preventive care.

Note: Funds received through this scholarship cannot be used to replace or supplant funds from federal or state sources that are received for the same purpose. If your clinic receives federal or state funds for diabetes, including Indian Health Service diabetes grants (this does not include reimbursement for medical care your clinic provides to patients), you may still apply for these scholarship funds, but they must be used for different purposes than the work for which you currently receive funding.

## Completing the Application

Please provide the following information:

- 1) Provide a budget indicating anticipated expenses related to the activities below. Please note that only these activities are eligible for scholarship funds, and you may request assistance for more than one activity.
  - Abstraction and data entry of medical charts for your pilot population in order to obtain baseline data necessary to set your team’s goals
  - Tuition, travel, and lodging expenses for your team to attend the learning sessions and outcomes congress
  - Staff replacement time to cover team members’ attendance at learning sessions.
- 2) Provide letters of support from both administrative and clinical leaders to document your organization’s commitment to participate in the WSC.

- 3) Complete the attached three-page application form
- 4) *Optional.* Submit a one-page narrative describing other factors unique to your clinic that contribute to the need for funding

**Determination of Awards**

Applications will be reviewed by May 28 and clinics will be notified regarding the disposition of their application in early June. Applications are scored based on demonstrated need (20 points for budget), documented commitment to participate in the collaborative through letters of support from medical and administrative leaders (20 points), and other factors noted in the optional narrative (10 points). The questions on the application form (50 points total) provide additional assessment information; such as,

- Readiness for change, assessed via the Collaborative enrollment interview.
- Returning or new WSC participant.
- Serving subpopulations at elevated risk.
- Providing care to underserved populations/priority locations.
- Currently accepting Medicare/Medicaid patients.
- Addressing critical health measures targeted by funders.
- Receiving other sources of funding for participation in the collaborative.

Scholarships will be based on the amount requested, scores on the above criteria, and scholarship funds available. The amount of each award will be determined through negotiation between the Foundation and the contracting medical offices. Final funding decisions will rest with the Foundation.

**Award Disbursement**

Scholarship funds will be disbursed by the Foundation for Health Care Quality based on documented completion of the activities below. Disbursement of awards is subject to receipt of funds from donors, and the Foundation reserves the right to adjust funding during the term of the contract, subject to availability of donor funds. Please refer to “Preparing Your Budget” on page A3 for information about identifying and presenting budget information.

Activity	Documentation Required
Abstraction and data entry for your pilot population	Baseline measures produced from the registry
Tuition, travel, and lodging expenses for attendance at learning sessions	At least three members of the practice team present at each learning session
Staff replacement time for team members’ attendance at learning sessions	Report of staff replacement hours OR copy of contract/invoice with fees paid to replace staff

# Application Checklist

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The following documents are required in order for your application to be considered. Please confirm that all of them are included before sending your application packet. **All application materials must be postmarked or received (e-mail/fax) no later than 5:00 p.m. on May 21, 2004.**

- Two-page Application Form
- Project budget
- Letter of support/commitment from clinic administrator
- Letter of support/commitment from clinic medical director
- Optional narrative of unique factors affecting your team's need for funding

**Send your application packet to:**

Ann Kelley, MHA

Foundation for Health Care Quality

705 Second Avenue, Suite 703

Seattle, WA 98104

Fax: (206) 682-3739

E-mail: [akelley@qualityhealth.org](mailto:akelley@qualityhealth.org) (Please follow with signed copies of support letters)

**Questions?**

**Scholarship application:**

Ann Kelley, MHA

Scholarship Program Administrator

Foundation for Health Care Quality

206 682 2811, ext 23 or [akelley@qualityhealth.org](mailto:akelley@qualityhealth.org)

**WA State Collaborative:**

Kathleen Clark, MS, RD, CDE

Collaborative Co-Director

Washington State Department of Health

360 236 3608 or [kathleen.clark@doh.wa.gov](mailto:kathleen.clark@doh.wa.gov)

Helan Lee, MPH

Collaborative Co-Director

Qualis Health

206 364 9700, ext 2341 or [helanl@qualishealth.org](mailto:helanl@qualishealth.org)



# Scholarship Application

Date \_\_\_\_\_  
Clinic name \_\_\_\_\_  
Mailing address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
\_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_  
Contact person for this application \_\_\_\_\_  
Title \_\_\_\_\_ E-mail address \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_  
  
Clinic Administrator \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

## Which topic will your clinical practice team address in the Collaborative?

- Diabetes  
Estimated number of patients with diabetes for all providers in the clinic: \_\_\_\_\_
- Cardiovascular Disease  
Estimated number of patients with cardiovascular disease for all providers in the clinic:  
\_\_\_\_\_

## Are you a new or returning team?

- New—our organization has never participated in a Washington State Collaborative
- Returning—includes new teams from a returning clinic and practices affiliated or contracted with a clinic that participated in a previous Washington State Collaborative
- Note: Returning teams/organizations must address Adult Preventive Services (APS) measures  
Selecting one of the targeted APS measures below may qualify you to receive funds earmarked for these areas. Please check the measure(s) your team plans to address:
- Colorectal screening
- Women's Health (Pap testing and mammography; four measures)

*\*Note to returning Breast and Cervical Health Program (BCHP) contractors: You must address Women's Health to qualify for BCHP funds.*

Multiclinic systems: Are other clinics in your system applying for funds?  Yes  No

Clinic name \_\_\_\_\_

In what county is your clinic site located? \_\_\_\_\_

Is your clinic currently accepting Medicare and Medicaid enrollees?  Yes  No  
Do you provide care to underserved populations and/or locations?  Yes  No  
Do you emphasize care for groups at increased clinical risk?  Yes  No

List groups \_\_\_\_\_  
(e g , seniors, racial/ethnic minorities, diabetes, low-income)

Please check all of the following that apply to your practice site:

- Community, migrant, Indian, or rural health center/clinic
- Designated health care shortage area
- Serves low-income patients (i e , currently accepting Medicaid, sliding scale for uninsured patients)

Is your organization a contracted provider for the (BCHP)?  Yes  No

If your team is receiving support from other sources to participate in the collaborative, please describe the amounts, sources, and how support from other sources will be used (Please note that other funding does not make your team ineligible for this award )

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## Preparing Your Budget

In preparing your budget, you will want to factor in such costs as registration fees, staff salaries, locum tenens fees, equipment purchases, mileage, etc. Please enter the amount(s) you are requesting in the table below

Activity and Completion Criteria	Examples	Amount Requested
<p>Abstract charts for pilot population and enter data into the registry baseline measures. (More information on this will be provided in the WSC Handbook prior to learning session 1.)</p> <p>Measure of completion: Registry is implemented and baseline measures are reported out by learning session 1.</p>	<ul style="list-style-type: none"> <li>• Medical records abstraction</li> <li>• Data entry to develop registry</li> <li>• Staff training time</li> <li>• Software purchases/upgrades necessary to support the chronic disease electronic management system or other registry</li> <li>• Hardware purchases/upgrades necessary to support CDEMS or other registry</li> </ul> <p>Note: Ongoing data entry to maintain the registry is not covered by the scholarship program.</p>	
<p>Attend and participate in the three collaborative learning sessions and the outcomes congress.</p> <p>Measure of completion: Three or more members on-site during learning sessions.</p>	<ul style="list-style-type: none"> <li>• Registration (\$200/person per session)</li> <li>• Airfare or mileage</li> <li>• Lodging</li> <li>• Meals</li> </ul>	
<p>Staff replacement time while teams are attending learning sessions.</p> <p>Measure of completion: Report of staff replacement hours OR copy of contract/invoice with fees paid to replace staff.</p>	<ul style="list-style-type: none"> <li>• Locum tenens</li> <li>• Extra shifts</li> </ul> <p>Note: Lost productivity is not reimbursable under this scholarship program.</p>	
	Total Amount Requested	



# Washington State Collaborative: Instructions for Faculty at Learning Session Three

## FACULTY INSTRUCTIONS LEARNING SESSION 3: JANUARY 10–11, 2005

### Team Sharing — Day 1

*Activity.* Teams will discuss their progress toward improving the six components of the Chronic Care Model and integration of model components. They will self-assess their level of care on a scale from 1 to 11.

*Purpose.* Teams will be completing the Assessment of Chronic Illness Care (ACIC) survey and discussing their scores with the larger group. Teams' scores on the ACIC can help team members determine which of the concurrent sessions by model components may be particularly helpful for them.

*Faculty role.* The following activities should be completed:

- Write down team scores on the flip charts.
- Help facilitate group discussions (expanded instructions attached)
  - Ask the highest scoring team on each component why they feel that they are doing so well on component. Have they made progress on this component during the last few months, or were they always doing well? Did they have to overcome any barriers?

- Ask the lowest scoring team on each component why they are not doing as well, and if there are things they might be able to change in order to improve. What are their barriers?

- Ask other teams if they have suggestions on how to overcome any barriers that are mentioned.

- Remind teams to write these barriers down on the “Overcoming Barriers” worksheet.

- Answer any questions about six components of Chronic Care Model.

- At the end of the session, collect the carbon copy of the ACIC survey from teams and return it to the information desk.

## ORGANIZATIONAL TEAM MEETING 1

### Project Planning

*Activity.* Teams will use this worksheet to plan project goals for the six components of the Chronic Care Model for Action Period 3. Teams should particularly be focusing on spread plans.

*Purpose.* Learning sessions are one of the few times that all team members can sit down and plan future work together. This meeting time is for teams to think about the work that they want to get done and discuss the barriers that need to be removed for them to make more progress.

*Faculty role.* The following activities should be completed:

- Make sure teams make project plans in all of the Chronic Care Model components
- Encourage teams to begin planning for spread
- Things to look for include the following:
  - Do team plans fall in the range of their aim statement? It doesn't make sense to work on topics that have nothing to do with their goals
  - Are team plans broad enough and do they fall into the "correct" component?
- Start a conversation with teams about what they are doing—this is the best way to "know" if they need help. Perhaps you could begin with, "Could you share with me what your team is planning to do in health care organization (delivery system design, clinical information system, etc)?"
  - If you know a team is working on something another team is also working on, you can link the teams up
  - Often, a conversation will tell you whether a team needs help coming up with ideas for project planning. You can make suggestions like, "Have you thought about doing XYZ?"
  - Some teams may need help more than others. It may be a good idea to identify them and check in with them (see attached list of teams that may need additional attention)

## **Overcoming Barriers**

*Activity.* Teams identify barriers they need to overcome to improve care (e.g., training support staff to use registry)

*Purpose.* Teams may have barriers that they need to resolve before they can make progress. This is a time for teams to think about what sorts of change initiatives they want to do and what sorts of barriers stand in the way and make plans on how to remove those barriers.

*Faculty role.* The following activities should be completed:

- As teams are working on their project plans, remind them to also be thinking about how to remove barriers
- Anytime a team member says, "We can't do that because..." that barrier should be written down. Also, teams should be trying to remove barriers that they have talked about in their senior leader reports
- If the topic comes up, remind teams that some barriers cannot be removed right now. Focus on those barriers that the team can do something about

## **ORGANIZATIONAL TEAM MEETING 2**

- This is additional time for teams to meet with each other and think up project plans and ideas for overcoming barriers. Please see above for ideas on how to approach teams
- This is a good time to hook teams up that may have similar interests (e.g., group visits). Organizational team meeting 2 is a great time for teams to do some networking

## TEAM SHARING — DAY 2

*Activity.* Teams share with others their project plans for action period 3

*Purpose.* Teams share their plans with others so that peers can get some ideas, give feedback

*Faculty role.* The following activities should be completed:

- Ask teams to share project plans in one of the components. Then, ask teams to present one barrier that they plan to work on. Do a round-robin.
- Some suggestions on how to get the conversation rolling include the following:
  - After a team states its project plans, ask other teams if they have done something similar. Do they have any tips or advice for the team? Similarly, for barriers, ask other teams to provide feedback and guidance for the team that is sharing its plan.

At the end of the session, be sure to remind teams of the following:

- Turn in one copy of their project planning and overcoming barriers worksheets to the information desk.
- January senior leader reports due the Monday following the learning session.



# Washington State Collaborative Learning Session Agenda

Washington State Collaborative:  
Diabetes and Cardiovascular Disease  
Learning Session 3  
**January 10–11, 2005**

## Monday January 10, 2005

Time/Place	Topic	Facilitator/Presenter
7:00–8:00 a m	Storyboard Setup and Continental Breakfast	
8:00–8:30 a m	Welcome and Progress	Jan Norman, RD, CDE
8:30–9:00 a m	Team Showcase I: Cardiovascular Disease	Pam Koza MultiCare Health System
9:00–10:00 a m	The Campaign Approach to Change	Barton Parrott, Center for Applied Research, Inc Anne Smith, PE, Anne Smith Consulting
10:00–10:15 a m	Break/Storyboard Review	
10:15–11:30 a m	Managing Spread	Peggy Evans, PhD Evan Oakes, MD, MPH, Community Health Centers of King County
11:30 a m – 12:45 p m	Lunch	
12:45–1:50 p m	Team Sharing <ul style="list-style-type: none"> <li>• <i>Teams complete and discuss ACIC survey scores and begin working on overcoming barriers worksheet.</i></li> <li>• <i>For location, see “room assignments” behind agenda in syllabus.</i></li> </ul>	
1:50–2:00 p m	Transition	
2:00–3:00 p m	CONCURRENT SESSIONS by Model Component	
	Delivery System Design	Colette Rush, RN, BSN, CCM Family Wellness Center Swedish Physicians — Ballard

**Monday January 10, 2005**

	Self-Management Support	Jeanne Harmon, RD, CDE The Clinic at Elma Swedish Physicians — Factoria
	Decision Support	Carol Wysham, MD B Fendley Stewart, MD Samish Indian Nation VA Puget Sound — American Lake The Polyclinic
	Community Resources	Kathleen Clark, MS, RD, CDE Central Washington Hospital — Internal Medicine Pacific Medical Centers — Lynnwood Family Medicine of Southwest Washington
	Clinical Information Systems	Barbara Flock, RHIT, CPHQ Garfield Co Hospital District — Pomeroy Medical Clinic Valley Clinic Columbia Basin Family Medicine
	Healthcare Organization	Rick MacCornack, PhD Barton Parrott, MBA; Anne Smith, PE SeaMar — Seattle
3:00–3:15 p m	Break	
3:15–4:15 p m	Concurrent Sessions by Track • Controversies in Second- ary Prevention: From (A)nti-platelet Drugs to E(Z)etimibe Management of Hypergly- cemia	B Fendley Stewart, MD Carol Wysham, MD
3:15–4:15 p m	Skill-Building Sessions (30 minutes each) • <i>Ankle/Brachial Index Assisting Your Patients to Transition to Insulin Therapy</i>	Heidi Boettner, RVT, MultiCare Health System Chris Pelto, RN, CDE, Joslin Center for Diabetes
4:15–5:00 p m	Organizational Team Meet- ing I <i>Teams work on project plan- ning worksheets, with special attention to spread</i>	Faculty
5:00 p m	Adjourn/Faculty Meeting	

## Tuesday January 11, 2005

7:00–8:00 a m	Storyboard Review and Continental Breakfast	
8:00–8:15 a m	Question and Answer Session	Kathleen Clark, MS, RD, CDE
8:15–9:00 a m	Team Showcase II: Diabetes	Nalini Singh, MD, VA Puget Sound — Seattle Anna Langland, ARNP; Kathy Henry, Roxbury Family Health Care
9:00–10:00 a m	Diabetes, Cardiovascular Disease, and Psychological Distress	Richard Rubin, PhD, CDE
10:00–10:30 a m	Hosted Storyboard Review/Break	
10:30 AM–noon	Health Plan Panel Discussion: Pay for Performance	Jonathan Sugarman, MD, MPH, Moderator
noon–1:30 p m	Lunch & Organizational Team Meeting II <ul style="list-style-type: none"> <li>• Box lunches</li> <li>• Scavenger hunt drawing!</li> </ul> Teams work on project planning and overcoming barriers worksheets	Peggy Evans, PhD
1:30–2:15 p m	Concurrent Sessions by Topic <p>Case Management</p> <p>Practical Approaches to Relieving Psychological Distress in Patients with Diabetes and Cardiovascular Disease</p> <p>Lean Thinking: Workflow Redesign</p> <p>Building Culturally Competent Individuals and Community Partnerships for Health</p> <p>Role of the Health Care Professional in Smoking Cessation and Lifestyle Change</p>	Judith Schaefer, MPH Richard Rubin, PhD, CDE  Naomi Maxey, MPA Ira SenGupta  Richard E Waltman, MD

2:15–2:25 p m	Transition	
2:25–3:10 p m	<p>Concurrent Sessions by Topic</p> <p>Case Management</p> <p>Practical Approaches to Relieving Psychological Distress in Patients with Diabetes and Cardiovascular Disease</p> <p>Lean Thinking: Workflow Redesign</p> <p>Building Culturally Competent Individuals and Community Partnerships for Health</p> <p>Role of the Health Care Professional in Smoking Cessation and Lifestyle Change</p>	<p>Judith Schaefer, MPH Richard Rubin, PhD, CDE</p> <p>Naomi Maxey, MPA Ira SenGupta</p> <p>Richard E Waltman, MD</p>
3:10–3:25 p m	Break	
3:25–4:30 p m	<p>Team Sharing</p> <ul style="list-style-type: none"> <li>• <i>Same room assignments as day 1.</i></li> <li>• <i>Teams share project plans.</i></li> <li>• <i>Teams plan for action period 3: What needs to happen over next 6 months.</i></li> </ul> <p><i>Teams submit completed worksheets</i></p>	

# Section Five

## Monitoring The Progress: What Impact Is Being Made?

### SECTION SUMMARY

After you have implemented your plan, your partners and others will want to know what progress you are making. You need to be able to respond with a clear, factual, and honest statement about what you have accomplished. To be able to do this, your team will need some mechanism for tracking progress and determining how well you are doing with the intervention you implemented. Evaluation should determine whether you are doing what you planned and the intervention is accomplishing or has met its intended goals and objectives. Often, program evaluation is an afterthought, and evaluations are designed and conducted only after an intervention has been implemented. Ideally, evaluation should be developed as part of the program-planning process and should begin as soon as the program is implemented.

This section focuses on

- Major types of evaluation.
- Steps in conducting an evaluation:
  - Developing an evaluation plan

### Types of Evaluation

As you plan for evaluation, it is important to include a combination of these evaluation measures so that you have a complete picture of what is happening.

The two main types of evaluation are process evaluation and outcome evaluation.

**Process evaluation** — assesses whether the program is being implemented as it was designed and whether it is reaching the people and settings you are trying to reach. This

type of evaluation will help ensure that everything you planned is taking place. Process evaluation tells you how or why your effect was achieved (or not achieved).

**Outcome evaluation** — evaluates the effects of the systems change on the intended audience or setting. This type of evaluation usually compares the knowledge, attitudes, and behaviors related to systems change by the intended audience before and after implementation (e.g., how many health care providers adopted systems change to improve patient outcomes). Outcome evaluation tells you what effect was achieved and whether your effort made a difference over a specified period of time.

### MAINE: EVALUATING PRIMARY CARE PRACTICES

The Maine Heart Disease and Stroke Prevention Program provided grants to four primary care practices to address management of cardiovascular-related conditions (e.g., hypertension and high cholesterol) and their risk factors. As part of the evaluation, practices were required to supply process measures such as provider participation, provider satisfaction, and provider adherence to care plan as well as a minimum of one measurable clinical goal and one behavioral outcome (e.g., reduce blood pressure by 20% in at least 50% of patients involved in the project; reduce weight by 10 lb in 50% of patients who have a body mass index > 30).

## STEPS IN CONDUCTING AN EVALUATION: DESIGNING AN EVALUATION PLAN

Evaluation most often occurs once the action plan has been developed and the program is implemented. Very little attention is paid to evaluating the planning process or developing the action plan. However, it is important to consider evaluating the planning process to determine its effectiveness in developing the action plan. Evaluation of the planning process will help to identify any barriers to effective program planning and will provide insight into the effectiveness of the plan.

Planning and implementing an evaluation to assess systems change or the process of developing a plan for systems change requires a systematic approach. The first step should be to develop an evaluation plan to guide the process of conducting your evaluation. An evaluation plan should include eight components:

- 1) **Evaluation Questions.** What do you want to learn from the evaluation? What questions do you want the evaluation to answer?
- 2) **Indicators.** What type of data will you need to answer your evaluation questions?
- 3) **Data Source.** Where will you get the data you need?
- 4) **Data Collection Method.** How will you get the data you need?
- 5) **Time Frame.** When will the data be collected?
- 6) **Data Analysis.** How will the data be analyzed?
- 7) **Communication Plan.** With whom and how will evaluation results be shared?
- 8) **Staff Responsibility.** Who will oversee the evaluation process?

One way to develop your evaluation plan is to use a table that includes your eight components. Begin with thinking about your evaluation questions—what do you want to know from this evaluation? You may have one question to answer or several, depending on the uses and users of your evaluation.

Below is a template of an evaluation plan that may be helpful as you begin to develop your evaluation. Once your plan is developed, you can use it to guide the implementation of your action plan evaluation. You can find an example of a completed evaluation plan in the appendices.

## LESSONS LEARNED

The following are suggestions when beginning the evaluation plan:

- You should develop an evaluation plan before you develop or implement the action plan, and the evaluation should occur simultaneously with planning/developing or implementing that plan.
- Evaluation should include an assessment of how your partnership is functioning in terms of decision making, shared responsibility, leadership, and communication.
- Consider a combination of evaluation measures to give you a complete picture of your progress.
- The information collected during your assessment will provide a good baseline of where you were before developing or implementing your plan.
- All your evaluation results are useful. Evaluation will identify your successes as well as areas that did not show improvement or that need more effort and/or resources.
- Evaluation is necessary to describe your efforts, rationale, and successes. It also provides clear evidence you can use to encourage others to develop plans to adopt systems change.

## GETTING STARTED

To get started complete the following:

- As you consider data to use in the assessment phase (section two), think about what you can use to assist with the evaluation
- When thinking of potential partners, include someone who has expertise in evaluation of health care systems change
- Ensure that your evaluation plan is finalized and agreed upon by stakeholders before you develop or implement your action plan

## RESOURCES AND TOOLS

University of Wisconsin–Extension *Planning a Program Evaluation*

This guide provides a step-by-step process of program evaluation, such as deciding what to evaluate, data collection efforts, the use of data to drive program planning and implementation, and developing an evaluation plan. The document is available at <http://www.uwex.edu/ces/pdande/evaluation/evaldocs.html>

*W.K. Kellogg Foundation Evaluation Handbook*

The *Handbook* describes the three levels of evaluation the Kellogg Foundation uses: project-level evaluation, cluster evaluation, and program and policy making. The document also provides guidance on conducting evaluation with the assistance of an external evaluator. The document is available at <http://www.wkkf.org>

CDC Heart Disease and Stroke Prevention *Evaluation Framework*

CDC State Heart Disease and Stroke Prevention Program *Evaluation Framework*

The purpose of this evaluation framework is to help states and partners understand CDC's goals for program evaluation and the importance of using evaluation information in planning and program improvement while outlining suggested program activities and evaluation goals. This document is available at [http://www.cdc.gov/DHDSP/library/evaluation\\_framework/](http://www.cdc.gov/DHDSP/library/evaluation_framework/)

CDC *Framework for Program Evaluation*

The *Framework* summarizes and organizes the basic elements of program evaluation in public health practice. Additionally, it demonstrates the relationship between program activities and prevention effectiveness. The framework comprises **steps** in program evaluation practice and **standards** for effective program evaluation. Adhering to the steps and standards of this framework will allow an understanding of each program's context and will improve the way program evaluations are conceived and conducted. The document is available at <http://www.cdc.gov/eval/framework.htm>

CDC Heart Disease and Stroke Prevention (HDSP) *Program Evaluation Guides*

The guides are intended to offer direction, provide consistent definition of terms, and aid skill building for a wide range of general evaluation topics and selected specific topics. These guides clarify approaches to and methods for evaluation, provide examples specific to the scope and purpose of the state HDSP programs, and recommend resources for additional reading. Some guides are more applicable to evaluating capacity building activity and others are more focused on interventions. The document is available at [http://www.cdc.gov/dhdsp/state\\_program/evaluation\\_guides/](http://www.cdc.gov/dhdsp/state_program/evaluation_guides/)

Other suggested resources include the following:

- Writing SMART Objectives: Available at [http://www.cdc.gov/dhdsp/state\\_program/evaluation\\_guides/smart\\_objectives.htm](http://www.cdc.gov/dhdsp/state_program/evaluation_guides/smart_objectives.htm)
- Developing and Using a Logic Model: Available at [http://www.cdc.gov/dhdsp/state\\_program/evaluation\\_guides/logic\\_model.htm](http://www.cdc.gov/dhdsp/state_program/evaluation_guides/logic_model.htm)
- Developing an Evaluation Plan: Available at [http://www.cdc.gov/dhdsp/state\\_program/evaluation\\_guides/evaluation\\_plan.htm](http://www.cdc.gov/dhdsp/state_program/evaluation_guides/evaluation_plan.htm)

## Sample Evaluation Plan

<b>OBJECTIVE.</b> By 2007, increase the percentage of patients with high blood pressure (HBP) that is under control from baseline to remeasurement rate				
<b>Evaluation Question</b>	<b>Indicator</b>	<b>Data Source</b>	<b>Data Collection Method</b>	<b>Time Frame</b>
What is the current system?	Number and percent of patients with HBP who have it under control	Medical records	Abstraction of medical records	3/06
Were appropriate staff trained?	Numbers and type of staff trained in systems change	Training logs Registration forms	Staff register for training and sign in when attending training	5/06
Was the systems change adopted?	Numbers of staff who adopted the program (type of staff, level of staff in organization, etc )	Field notes  Staff feedback	Observation and documentation of staff adoption  Staff focus groups	6–7/06
What impact has the systems change had on controlling high blood pressure in the target population?	Percent change in patients with HBP who have it under control	Medical records	Abstraction of medical records	1/07

<b>OBJECTIVE.</b> By 2007, increase the percentage of patients with high blood pressure (HBP) that is under control from baseline to remeasurement rate			
<b>Data Analysis</b>	<b>Reporting of Results</b>		<b>Staff Responsible</b>
	<b>To Whom</b>	<b>How</b>	
Frequency count and percent of patients with HBP and cholesterol under control	State programs	Evaluation report	Staff Evaluator
Frequency count and percentage based on total staff	Partners	Presentation, Executive summary	
Identify major issues and themes; determine barriers/ facilitators to adoption	Health care setting staff	Presentation, Executive summary	
	Other health care settings	Presentation	
Frequencies and percent change from pre- and post-implementation	Policy makers Funding agencies Insurers	Executive summary, Policy brief	



