



# New Health Partnerships: Improving Care by Engaging Patients

## An RWJF national program

### SUMMARY

*New Health Partnerships: Improving Care by Engaging Patients* explored whether primary care centers could deliver comprehensive patient- and family-centered self-management support to patients with chronic conditions. Self-management support is the help that health care providers give patients with chronic conditions to encourage them to make decisions that improve health-related behaviors and health outcomes.

The national program of the Robert Wood Johnson Foundation (RWJF) consisted of two collaborative learning communities: *Quality Allies* and *New Health Partnerships* (the former face-to-face and the latter virtual). Teams at 29 primary care centers—20 teams in *Quality Allies* and nine teams in *New Health Partnerships*—participated.

The program was part of the RWJF strategy to improve care for people with chronic conditions by helping them manage their conditions.

### Key Results

The national program office reported these results to RWJF:

- Twenty-nine teams from primary care centers participated in either a traditional or virtual learning community and achieved positive results, including providing self-management support to an estimated 2,300 patients.
- The *New Health Partnerships* [website](#) provides support, information and resources for patients, family members and health care providers who want to work together to improve health, health care and quality of life for people with chronic conditions.
- Organizational partners at leading national organizations helped spread self-management support by disseminating the program's information and tools.

### Key Findings

Evaluators at White Mountain Research Associates in Danbury, N.H., reported these findings in *Adoption, Sustainability and Spread of Self-Management Supports: An*

*Evaluation of the Impact of the New Health Partnerships and Quality Allies Learning Communities on Systems of Clinical Care Delivery and Patient Outcomes* (July 2008).

- Both, the *New Health Partnerships* and *Quality Allies* learning communities had a clear and positive impact on adoption of change processes to facilitate supportive self-management at the organizational level.
- Teams from both learning communities reported dramatic increases in both provider training and implementation of self-management supports with more patients.
- A virtual format may be a more cost-effective approach to self-management support training.

## **Program Management**

The Institute for Healthcare Improvement in Cambridge, Mass., served as the national program office for *New Health Partnerships*. Doriane Miller, M.D., section head of general internal medicine at Rush University and associate division chief of general internal medicine at Stroger Hospital of Cook County (Chicago), was the program director.

## **Funding**

The RWJF Board of Trustees authorized *New Health Partnerships* in January 2005 for up to \$3 million for 36 months. The program ended in August 2009.

During *Quality Allies*, the California HealthCare Foundation funded five California-based teams to participate in the program.

## **CONTEXT**

More people are living long lives with complex, chronic health conditions such as asthma, diabetes, high blood pressure and HIV. The U.S. health care system, however, is designed to respond to conditions and events that end—such as heart attacks, injuries and diseases that can be cured—not to care for patients with chronic conditions.

Patients with chronic conditions need to manage and cope with their condition every day. This includes:

- Monitoring their condition
- Taking medications and giving themselves treatments
- Evaluating and managing symptoms
- Making adjustments in physical activity and diet

- Coping with the emotional aspects of having a chronic condition
- Learning how to overcome obstacles to working, studying or being part of a family

### **Self-Management Support**

Research shows that patients who are more actively engaged in managing their conditions have better clinical and functional outcomes. But they cannot do it alone. When patients and health care providers work together, patients can learn to manage their chronic conditions. This is called self-management support.

It is the help that health care providers give patients with chronic conditions to encourage them to make decisions that improve their health-related behaviors and health outcomes. It involves the systematic use of education and support to increase patients' skills and confidence in managing their health.

Health care providers, who are trained to diagnose, prescribe and take charge, must learn to partner with patients to help them play an active role in their own care. New approaches to care are needed to implement self-management support. No single clinician is responsible; rather, clinical teams provide self-management support to patients and/or family members.

### ***Provider Skills and Competencies***

Self-management support should include:

- Patient-centered approaches that build trust, shared understanding and strong provider-patient relationships
- Individualized assessment of patient needs, values and preferences
- Collaborative goal setting and action planning
- Skill building and problem solving
- Linkage to community resources and programs
- Repeated follow-up contacts

### ***The Need to Broaden Awareness of Self-Management Support***

Research, including a 2003 analysis by RAND's Evidence-Based Practice Center for the Centers for Medicare & Medicaid Services, showed that self-management support has a significant positive effect on important health and behavior outcomes. Yet, many clinicians, health plans and payers were not aware or convinced of the effectiveness of self-management support.

## RWJF's Interest in the Area

The Foundation's interest in self-management support began as an offshoot of its strategy to improve care for people with chronic conditions. This work, which began in the 1980s, centered on the belief that patients who better managed their chronic conditions would have better outcomes and that when patients and health care providers were involved with self-management, they both would be more satisfied. It included programs and projects that supported chronic care providers and helped patients manage their chronic conditions.

The Foundation's signature chronic conditions program, *Improving Chronic Illness Care*, incorporated self-management support as part of its Chronic Care Model, calling for clinicians to "set a tone of collaboration with chronic patients, and encourage their participation in setting goals and fine-tuning treatments." *Improving Chronic Illness Care* helped health systems—especially those that serve low-income people—improve their care by implementing the Chronic Care Model, which summarizes the basic elements for improving care in health systems at the community, organization, practice and patient levels.

RWJF has funded many types of programs and projects related to self-management:

- Tools and models to help patients manage and control their health care, particularly care related to chronic conditions
- Programs to restructure care delivery systems to become more patient centered
- Efforts to leverage information and communication resources to make health care data more accessible and to foster self-management support.

See [Appendix 1](#) for examples of this work.

In 2002 the Foundation decided to plan and test a self-management support learning network for health care providers working in primary care centers.

## THE PROGRAM

### Overview

*New Health Partnerships: Improving Care by Engaging Patients* was a national program to explore whether primary care centers could deliver comprehensive patient- and family-centered self-management support to patients with chronic conditions. Launched after a planning phase, the program consisted of two collaborative learning communities: *Quality Allies* and *New Health Partnerships* (the former face-to-face and the latter virtual).

Teams at 29 primary care centers—20 teams in *Quality Allies* and nine teams in *New Health Partnerships*—participated. These teams represented:

- Academic medical centers
- Community health centers
- Federally qualified health centers
- Hospital-based clinics
- Integrated health systems

The teams included doctors, nurses, health educators, a senior leader who served as a champion for the project within the organization, front office staff (sometimes) and at least one patient/family representative. Including patients and family members made the work "more relevant and powerful," said Laurel Simmons, S.M., the program's deputy director.

The participating primary care centers cared for patients in urban, rural and mixed settings and addressed a variety of clinical areas, including:

- Cognitive impairment and dementia
- Cystic fibrosis
- Depression
- Diabetes
- High blood pressure
- HIV
- Multiple sclerosis
- Obesity (pediatric and adult)

For a list of the participating primary care centers, see [Appendix 2](#).

### ***The Program Model***

The primary emphasis of both learning communities was supporting the implementation of self-management support tools and techniques in primary care centers, leading to system-level changes in health care providers' approaches to managing care. The centers followed an adaptation of the Chronic Care Model (see the [Figure 1](#)) and the Model for Improvement.

The Chronic Care Model (developed through the RWJF national program *Improving Chronic Illness Care*) summarizes the basic elements for improving care in health systems, including self-management support. The idea behind the model is that following it will lead to productive interactions between an informed, activated patient and a prepared, proactive health care team.

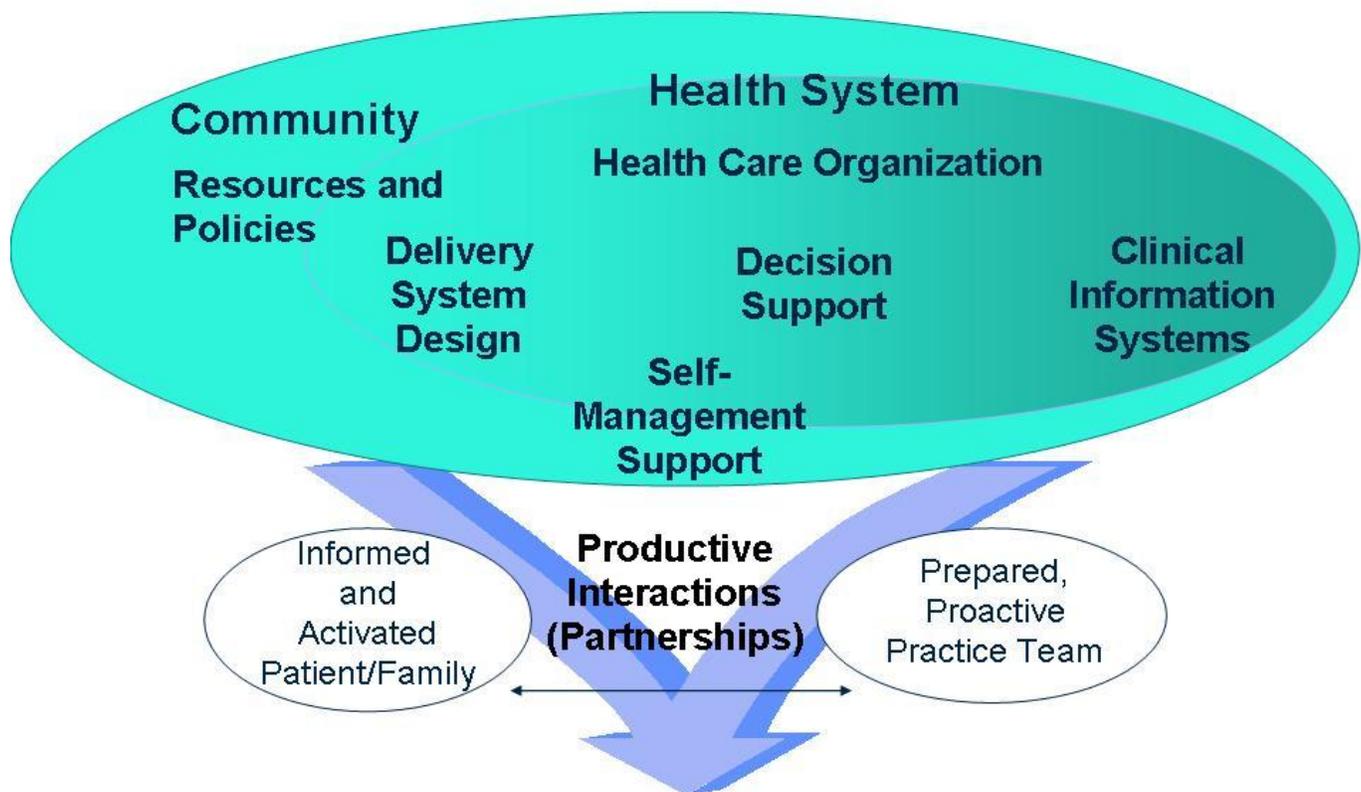


Figure 1

**Adaptation of the chronic care model to enhance self-management\***

\* Adapted from the Chronic Care Model, developed by Edward H. Wagner, M.D., of the MacColl Institute for Healthcare Innovation in partnership with colleagues at the *Improving Chronic Illness Care* program.

The Model for Improvement is a tool developed by Associates in Process Improvement to help organizations accelerate improvement of processes and outcomes. (Associates in Process Improvement helps organizations build capability for ongoing improvement.) It has two parts:

- Three fundamental questions, which can be addressed in any order:

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in improvement?
- The Plan-Do-Study-Act (PDSA) cycle tests the change in a real work setting to determine if it is an improvement. (The PDSA cycle is shorthand for testing a change by planning it, trying it, observing the results and acting on what is learned.)

### **The Curriculum**

The curriculum, developed by the program faculty (see [Appendix 3](#) for a faculty list), focused primarily on self-management support to promote or recognize the patient as the expert in managing his/her health and care at every interaction.

"Self management support is the part within the chronic care model that has proven to be one of the most challenging because it does involve more than just pulling resources and even training together," said *New Health Partnerships* Faculty Chair Michael Goldstein, M.D., from the Bayer Institute for Health Communication in West Haven, Conn. "It's a matter of changing the culture of care in the participating organizations."

The curriculum also covered the other elements of the chronic care model since self-management support cannot be implemented in a vacuum. The learning sessions were designed to prepare the teams to deliver evidence-based care using a patient- and family-centered approach to activate and empower patients to better manage their health.

The program faculty participated in the learning sessions, site visits and other program meetings.

### **The Planning Phase**

From November 2002 to February 2005, RWJF funded a planning and testing phase of the self-management support learning community in primary care centers. Program Director Miller and her team at the Health Research and Educational Trust (Chicago), an affiliate of the American Hospital Association:

- Synthesized a practical model of self-management support that focused on the self-management support component of the chronic care model
- Researched barriers to implementation of self-management support, through a subcontract with the Sutton Group, a social marketing and research firm
- Developed a curriculum for training health care providers in self-management support through learning sessions
- Formed the Pilot Collaborative on Self-Management Support

- Made plans for face-to-face and virtual learning communities

A steering committee reviewed and refined the concept for the pilot collaborative and provided strategic advice on the program's future direction. Committee members included patients, providers, health plans and payers, purchasers/employers, researchers and self-management experts.

### ***Pilot Collaborative on Self-Management Support***

Teams from six primary care centers participated in the seven-month Pilot Collaborative on Self-Management Support, which began in October 2003 (see [Appendix 2](#) for a list of the participating centers). Miller and her team solicited organizations through the Institute for Healthcare Improvement and project consultants.

The goal of the pilot collaborative was for at least three teams to show improvement in their ability to provide self-management support through collaborative goal setting, ensuring implementation of an action plan and follow-up. The teams, which did not include patient or family representatives, attended three learning sessions and presented their results at a meeting. They received grants of about \$25,000 for participating.

The learning sessions were based on the Institute for Healthcare Improvement's Breakthrough Series collaboratives, a short-term (6- to 15-month) learning system that brings together hospital and clinic teams to work on improving a focused topic area. These collaboratives are designed to help health care organizations make "breakthrough" improvements in quality while reducing costs.

### **Results of the pilot collaborative**

Four teams showed improvement in their ability to provide self-management support. Three of these teams achieved significant improvement, defined as implementing most of the components of self-management support, evidence of sustained improvement in the required measures and a plan to spread the improvement.

"The pilot demonstration provided an excellent testing ground for the curriculum and highlighted effective ways to adopt collaborative self-management support and also the most important challenges for organizations that wish to improve their capacity for self-management support," said Miller.

### **The Implementation Phase**

Based on the results of the planning phase, RWJF launched the national program *New Health Partnerships: Improving Care by Engaging Patients*, comprised of *Quality Allies* (the face-to-face learning community) and *New Health Partnerships* (the virtual learning community). The Institute for Healthcare Improvement, which served as the national

program office, solicited applications from primary care centers through its network using its website as the primary means of communication.

Both teams from the pilot collaborative and consultants from the Institute for Family-Centered Care stressed the importance of including patients and family representatives in this work. As a result, the program added patient and family representatives to the national advisory committee, the faculty and the teams in both learning communities.

As in the pilot, both learning communities were modeled on the Institute for Healthcare Improvement's Breakthrough Series collaboratives.

### **Quality Allies**

From November 2005 to October 2006, 20 primary care centers participated in *Quality Allies*. RWJF funded 15 of the primary care centers, and the California HealthCare Foundation funded five additional California-based, teams. See [Appendix 2](#) for a list of the participating centers.

### **Self-Management Support and the California HealthCare Foundation**

The California HealthCare Foundation was beginning to work in self-management support and heard about *Quality Allies* from program faculty. Veenu Aulakh, M.S.P.H., senior program officer, contacted Anne Weiss, RWJF senior program officer, and they agreed to partner on the program.

Aulakh also saw funding the California teams as an opportunity to expose them to a national effort. "Sometimes it's hard to know how the innovation and things we're doing in the state compare to the larger scheme of things and for the teams to get exposure to national teams and learn from them," she said.

### **Additions to *Quality Allies***

*Quality Allies* added the following components:

- Tools and technical assistance to assess the business case for self-management support
- More content on health literacy and mental health
- A strong voice for patients and family members
- A change packet tailored around a strong conceptual framework (the adaptation of the Chronic Care Model and the Model for Improvement)
- The opportunity for each participating center to learn from other participants through one visit to another site

- Senior leadership engagement and participation in the learning sessions and in spreading self-management support

### Participating in the learning community

Participants collaborated through:

- Three in-person learning sessions. Each learning session included:
  - Presentations (e.g., patient- and family-centered care and core competencies of collaborative self-management support)
  - Breakout sessions (e.g., monthly data collection and reporting, assessing and supporting depression in chronic care and assessing patient education/information needs)
  - Team meetings and presentations
  - Coaching
- Monthly conference calls, which focused in more detail on topics covered in the learning sessions, such as motivational interviewing, building the business case for self-management support and including patients and family members.
- Connection with one or two faculty coaches, who worked with the teams at the learning sessions and called them on a regular basis to see how things were going and help solve problems. For a list of faculty members, see [Appendix 3](#).

The centers received up to \$30,000 to help defray project-related costs (e.g., attending meetings and personnel costs).

### ***New Health Partnerships***

Building on *Quality Allies*, RWJF launched a virtual learning community with nine sites in March 2007 and re-named the initiative and its new website *New Health Partnerships: Improving Care by Engaging Patients*. The new name was intended to appeal to patients and their family members, a key target audience of the website along with health care providers. See [Appendix 2](#) for a list of the participating centers.

*New Health Partnerships* was designed to foster the spread of self-management support by enabling providers to participate without having to spend the time and money required in a live learning community. "It's really hard in busy clinical schedules to have people come and spend time. We decided to test the feasibility of implementing this curriculum virtually rather than face to face," said Miller.

RWJF's Weiss noted that at the time doing a virtual learning community seemed radical. But it turned out to be "smart and ahead of its time," she said.

The 16-month virtual learning community provided a "one-stop shop" for expert advice, evidence-based research, care planning and patient education tools to support providers in implementing self-management support.

### Website offers information and resources about self-management support

The website, divided into sections for health care providers and patients, provides information and resources to enable providers, patients and their families to work together to improve health, health care and quality of life for people with chronic conditions.

The Institute for Family-Centered Care developed the initial content for the patient and family members' section. Participating doctors and other health care providers referred their patients to the section.

RWJF was especially interested in engaging patients and family members. "For chronic conditions, it's clear that patients need to be deeply engaged if you're going to have better outcomes," said Weiss. "They live with this 24/7 and they're only in the delivery system for a few hours a year." Weiss noted that delivery system changes to improve care are more likely to occur if patients and family members become engaged in their care.

Providing resources to nonparticipating health care providers and interested patients or family members was another goal of the website. "We needed to have a resource available for organizations that wanted to learn a little bit more about how to do this work," said Miller.

### Other changes in the virtual learning community

The evaluation of *Quality Allies* and feedback from the teams led project staff to make several changes when designing *New Health Partnerships*. These included:

- More time at the beginning of the learning community to orient patients and family members participating on the teams
- Coaching and technical assistance tailored to the needs of individual participating centers
- Communications training for health care providers. "Self-management support requires that nurses and doctors ask patients what they want to do and what they think is important. This is quite different from professional training, which emphasizes instructing patients," said Simmons, the deputy director. This had been difficult for *Quality Allies* providers to learn.

Through a series of training calls, Goldstein, the faculty chair and an expert in health care communication, used scenarios and role playing exercises to let the teams practice talking with patients. "These sessions were well received and we came to

believe that communications training for providers is an essential element of self-management support improvement," Goldstein said.

### Participating in the virtual learning community

Teams collaborated through five Web- and telephone-based learning sessions and through conference calls on targeted topics. They also received individual coaching from faculty members and could visit one other site that was using self-management support. For a list of faculty members, see [Appendix 3](#).

Each learning session had a specific focus:

- Building community, engaging patients and family and understanding the model for improvement basics
- Implementing self-management support
- Deepening self-management support competencies and support from outside the practice team
- Moving into the system and population-based care
- Transitioning to implementation, consolidating learning and spreading self-management support within each team's organization

Topics covered in the monthly conference calls included building patient and family communications, engaging senior leadership and building core competencies.

The teams and their patients had access to the program [website](#) (link goes to family and patient section). Teams used the program's extranet, restricted to teams and program faculty and staff, for online discussions, tracking data and sharing resources and tools.

### Challenges in recruiting participants

Participating centers paid a \$3,000 fee to participate—with a 50 percent discount for safety-net providers. (Safety-net providers deliver a significant level of health care to uninsured, Medicaid and other vulnerable patients.) "We asked sites to pay as a sign that they bought into the concept," said Weiss.

This strategy affected participation in *New Health Partnerships*. The national program office had planned to recruit 20 centers, however, only nine centers applied. "We believe the \$3,000 fee kept small practices from applying," said Miller. She also noted that *New Health Partnerships* was able to "achieve a critical mass" with the nine centers.

With fewer teams participating, the national program office fostered the spread of self-management support by engaging national organizations to disseminate information

about self-management support and the program's tools and resources. Staff subcontracted this work to Sojourn Communications in McLean, Va.

## Management

### **National Program Office**

Miller managed *New Health Partnerships* from its inception. During the planning and testing phase, she was senior director for quality and clinical research at the Health Research and Educational Trust, the research and educational arm of the American Hospital Association in Chicago.

By the time the implementation phase started in March 2005, Miller had joined Rush University (Chicago), where she is section head of general internal medicine and associate division chief of general internal medicine at Stroger Hospital of Cook County.

Miller is also a faculty member at the Institute for Healthcare Improvement in Cambridge, Mass., which became the national program office for *New Health Partnerships*. The institute is an independent, not-for-profit organization helping to improve health care worldwide. In choosing the Institute for Healthcare Improvement as the national program office, RWJF noted its expertise in collaborative improvement and the spread of innovation. Miller added that the institute was also working on programs that put patients at the center of their care.

Jean Lim was deputy director from November 2002 to November 2003. After she left, Judith Schaefer, M.P.H., a research associate at the MacColl Institute for Healthcare Innovation, helped with some of the work as a consultant. Simmons joined the program as deputy director in 2007.

### **Partners**

The MacColl Institute for Healthcare Innovation at the Group Health Cooperative of Puget Sound Center for Health Studies (Seattle, Wash.) helped develop the adaptation of the chronic care model for use in the pilot collaborative. The MacColl Institute works to improve health and health care through leading-edge research, innovation and dissemination. The Chronic Care Model was developed by Edward H. Wagner, M.D., M.P.H. See Wagner's [Grantee Profile](#) and [Figure 1](#) for more information.

The Institute for Family-Centered Care (Bethesda, Md.) managed the curriculum, trained the participating patients and family members and developed the content for the patient and family members section of the program's website. The institute provides leadership to advance the understanding and practice of patient- and family-centered care in hospitals and other health care settings.

Angela Hovis, a faculty member at the Institute for Healthcare Improvement, who is based in Wimberly, Texas, served as the quality improvement advisor for the program.

### **National Advisory Committee**

A national advisory committee—comprised of representatives of patients, providers, health plans and payers, purchasers/employers, researchers and self-management experts—provided developmental feedback on *Quality Allies*. See [Appendix 4](#) for a list of members.

## **PROGRAM RESULTS**

### **National Program Office Reported Results**

The national program office reported these results from *New Health Partnerships* (which refers to both the *Quality Allies* and *New Health Partnerships* learning communities) to RWJF. Perspectives from RWJF and program teams and faculty are also included.

- **Twenty-nine teams from primary care centers completed either a traditional (*Quality Allies*) or virtual (*New Health Partnerships*) learning community and achieved positive results.** The teams provided self-management support to an estimated 2,300 patients.
  - The program "demonstrated that effective, sustainable, self-management support can be delivered to patients with chronic and long-term conditions in the primary care environment using simple tools and a team-based approach to care. Success depends on staff training, system redesign and a patient- and family-centered approach," said Miller. She also noted that the cultural shifts within the practices "should resonate for years, affecting many more [people]."
  - *New Health Partnerships* "bore out the notion that self-management support can make a difference and that there are a lot of interesting organizational choices to make in doing it," said RWJF's Weiss. "If you do it well, it results in better outcomes and a better experience for patients and providers."
  - "Now we have this body of knowledge in the organization and will continue to use it," said one team leader in *Quality Allies*. "It is tied into our organization's philosophy to partner with patients and families. We were already committed to this—now we're learning how to do it."
  - Creating partnerships with patients and family members changed the way team members viewed their patients and their practices, said Deputy Director Simmons. "They developed a greater appreciation for the contribution patients and family members can have and it re-energized them."

— One team leader said, "We are so grateful to have had the opportunity to work with *New Health Partnerships*. "I personally have gained so much by being a part of the collaborative. It has truly enhanced my job and I feel it has made me a better person and a better health care provider."

- **The *New Health Partnerships* website provides support, information and resources for patients, family members and health care providers who want to work together to improve health, health care and quality of life for people with chronic conditions.** All resources on the website, which the national program office launched in 2007, are available free. The two main sections are "Health Care Providers" and "Patients and Families."

Web content for [health care providers](#):

— *Partnering in Self-Management Support: A Toolkit for Clinicians* introduces busy clinical practices to activities and changes that support patients and families in the day-to-day management of chronic conditions. The toolkit includes tested resources and tools and examples of changes. It also provides ways to begin trying changes with a small number of patients.

The national program office completed the toolkit and added content to the website (primarily resources for health care providers) during a dissemination grant RWJF awarded after the close of the program (ID# 064669, September 2008 through May 2009). Staff also conducted two teleconferences for *New Health Partnership* participants and made presentations at eight conferences and meetings under this grant.

The toolkit is also available on the *Improving Chronic Illness Care* [website](#). This program, also funded by RWJF, has used the Chronic Care Model developed by Wagner, who was the program's director.

- An [introduction to self-management support](#) and ways to support patient self-management, through sections on:
  - Supporting self-management support
  - Delivery system redesign
  - Decision support
  - Clinical information systems
  - Health care organization
  - Community support
  - Resources (external resources)

Web content for [patients and families](#):

- An introduction to self-management and ways to get involved, through sections on:
  - Being active in health care
  - "You're not in this alone" (learning how to find, ask for and accept help from family members and health care providers)
  - Getting started with self-management
  - Staying on track
  - Helping others self-manage
  - Improving health care for others
  - Resources (external resources)

The website also has:

- [Best Practices](#), highlighting people and projects in self-management support
- [Idea Exchange](#), with a blog, forums and a Wiki.

After *New Health Partnerships* ended, the Institute for Healthcare Improvement integrated the program's website into its own website.

- **Organizational partners at leading national organizations helped spread self-management support by disseminating the program's information and tools.** The organizations represented health care providers, patients, family members, regulators and policy-makers. They were:
  - AARP
  - American Academy of Family Physicians
  - American Academy of Pediatrics
  - Asthma and Allergy Foundation of America
  - Home Health Quality Improvement Organization Support Center
  - Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations)
  - National Committee on Quality Assurance
  - National Family Caregivers Association
  - National Partnership for Women and Families

- National Quality Forum
- Society of Behavioral Medicine
- Society of General Internal Medicine

Most of these organizations provided links to *New Health Partnerships* on their websites. Program faculty also made presentations at the national meetings of these organizations.

*New Health Partnerships* also influenced the work of some of these organizations related to self-management support. For example:

- The National Committee on *Quality Assurance's* Patient-Centered Medical Home program emphasizes the use of systematic, patient-centered, coordinated care management processes. Medical practices that meet the standards receive recognition as a Patient-Centered Medical Home, a health care setting that facilitates partnerships between individual patients and, when appropriate, the patient's family, and their personal physicians. Many standards are related to engaging patients in their care.

Greg Pawlson, executive vice president of the National Committee on Quality Assurance, says that *New Health Partnerships* provided examples of how practices could engage patients and how it influenced the program's emphasis on patient engagement. He recalled a key moment at one of the program's meetings: "One of the patients who spoke said they now felt the practice was part of the health care team and they were part of the practice. That was a clear and strong message," said Pawlson.

- For the *American Academy of Family Physicians*, *New Health Partnerships* provided "almost an instant way to have some really good resources," said Bruce Bagley, M.D., medical director for quality improvement. The academy provided a link to the *New Health Partnerships* website in its section on "Resources for Redesigning your Practice."
- The academy then began to develop its own Web content around self-management support, including a video, "[Improve Care with Self Management Support](#)," (scroll down to Patient Self-Management Support), featuring Miller.

"We're promoting self-management support as much as we can. It's an absolutely essential element to the medical home concept," said Bagley.

RWJF's Weiss considers the national spread of self-management support through this work to be "a great success."

## THE EVALUATION

### Conducting the Evaluation

The national program office subcontracted with White Mountain Research Associates, L.L.C. (Danbury, N.H.) to evaluate *Quality Allies* and *New Health Partnerships*. Seth Emont, Ph.D., was the lead evaluator. The evaluation focused on documenting the impact of the initiative on systems of clinical care delivery and patient outcomes by:

- Documenting the extent to which new "change processes" were adopted in these primary care centers to facilitate the use of self-management support, and the role patients and family members played
- Examining the extent to which participation in the learning communities facilitated the adoption, sustainability and spread of self-management support services among participating sites
- Documenting long-term success in patient perceptions of care, health behavior and clinical outcomes. (Participating centers were not required to track changes in clinical outcomes. Although a few centers did this on their own, there were not enough data for the evaluators to report on the impact of the program on clinical outcomes.)

### Evaluation Methodology

The evaluation focused on the quality measures that the teams were tracking as part of their participation in the program. Some measures were required while others were optional. Required measures included:

- *Self-efficacy*: Percentage of patients who are confident that they can take actions to manage their health
- *Behavior change*: Percentage of patients who have made behavioral changes
- *Documented goals*: Percentage of patients with documented self-management goals
- *Collaborative goal setting*: Percentage of patients who worked with provider to set goals
- *Patient Satisfaction*: Percentage of patients who are extremely satisfied with self-management support

Evaluators gathered additional data for the evaluation through surveys and interviews. During *Quality Allies*, 12 of the 20 centers also chose to participate in a nine-month extension called the Tier Incentive Program to collect more data. These data were included in the overall findings for *Quality Allies*. See [Appendix 5](#) for more information about the evaluation and its methodology.

## EVALUATION FINDINGS

Evaluators reported these findings in *Adoption, Sustainability and Spread of Self-Management Supports: An Evaluation of the Impact of the New Health Partnerships and Quality Allies Learning Communities on Systems of Clinical Care Delivery and Patient Outcomes* (July 2008). Findings in this section also offer some perspective from RWJF program staff.

- **The *New Health Partnerships* (virtual) and *Quality Allies* (face-to-face) learning communities had a clear and positive impact on adoption of change processes to facilitate supportive self-management at the organizational level.** This was particularly true for:
  - Changes that emphasized provider skills (e.g., providing education and training or using staff skills in new ways)

"Physicians are realizing that other health care staff has valuable input for patients. They are starting to empower patients to do self-management," said one *Quality Allies* team leader.
  - Using the expertise of patients and families (e.g., in developing resources and materials or serving in advisory or leadership roles)

"We brought patients in to look at all our processes. I have been in health care all my life and thought I knew what patients wanted. But I was not really aware. Now we have two meetings per month with our patient advisers," said one *New Health Partnerships* team leader.
  - Using patient-level data for quality improvement

Virtually all participants thought that using the change processes emphasized in the learning communities (the adaptation of the Chronic Care Model and the Model for Improvement, described under [The Program](#)) was beneficial to their sites.

The majority:

- Indicated that the change strategies were, for the most part, easy to implement and a good fit with what their center was doing before participating in the learning community
- Planned on spreading the supportive self-management methods to other providers and/or other types of patients at their site after the learning community ended

Team leaders in *New Health Partnerships* were enthusiastic:

- "This is spreading to other units. The physicians are less likely to simply tell the patient what to do. The nurses are on board with it—they want to go back to doing patient care, rather than administrative or phone work."

- "We want to spread it to all of primary care—everyone is interested!"
- Emont noted that the change strategies in *Quality Allies*, where 12 sites collected data for an additional year after the program ended, were sustained.
- **The greatest impact of both learning communities was on adoption, sustainability and spread of supportive self-management strategies.** The largest improvements emphasized topics discussed during the learning sessions:
  - A systems-level focus around provider education and training
  - An emphasis on patient-centered care around the clinical encounter
  - A process for documenting change

Most teams in both learning communities adopted goal setting, individual assessment, joint review of a patient's progress and the involvement of family members in the support process—self-management support strategies that were consistent with the major goals of the learning communities.

In addition, a majority of participants in *New Health Partnerships* reported initiating or expanding the use of all nine self-management support strategies introduced in the learning community. Participants in *New Health Partnerships* reported initiating or expanding about twice as many strategies as the *Quality Allies* participants. See [Appendix 6](#) for a list of the nine self-management support strategies.

Comments from team leaders in *New Health Partnerships* show the extent of the cultural change in interactions with patients:

- "We are looking outside the box. Rather than looking at peer research, we are focusing on how to make it work for the patient."
- "We are a different culture now—taking key steps to become a learning culture .... We no longer study a change for three months, but nothing happens. Now, we see effective ways of making small changes."
- **Teams from both learning communities reported dramatic increases in both provider training and implementation of self-management support with more patients.**

"Many teams from both initiatives engaged other clinics, departments, providers and/or patient population and spread these change strategies," said Emont. Such spread is essential for programs like these to have a population-based impact. These results showed equally high levels of spread for the in-person and virtual learning communities.

Between the start of each phase and follow-up (near the end of the phase), the percentage of teams that:

- Trained half or more of their providers in self-management support more than doubled for both learning communities
- Provided self-management support to more than half of their patients:
  - Increased from 4 percent to 64 percent in *New Health Partnerships*
  - More than doubled in *Quality Allies*
- **The pattern of findings for patient-level measures in *New Health Partnerships* (virtual) and *Quality Allies* (face-to-face) is similar and demonstrates considerable variation among the teams in documenting improvements.** Sites performed best on the percentage of patients with documented goals:
  - 83 percent of the *New Health Partnerships* centers reported significant improvements in this measure.
  - 83 percent of the *Quality Allies* centers reported significant improvements or were "at goal" for the percentage of patients with documented goals.

Lesser improvements occurred for behavior change, collaborative goal setting, patient satisfaction, information sharing, problem-solving and the provider's recognition of patient values and preferences:

- In *New Health Partnerships*:
  - About half of the centers demonstrated improvement or sustained goal levels on measures of behavior change, collaborative goal setting and patient satisfaction.
  - Some 40 percent of centers demonstrated improvements in information sharing, problem solving and provider's recognition of values and preferences.
- About a third of the *Quality Allies* teams demonstrated moderate improvements in self-reported behavior change, collaborative goal setting, patients' perceptions of how well providers assess their values and preferences and patient satisfaction.

About half of the *Quality Allies* teams that collected an extra year of data showed improvement or sustained improvement over that period in behavior change, collaborative goal setting, documenting self-management goals and patient satisfaction.

The variation among the teams in documenting improvements may be due to organizational factors (e.g., staff time and turnover) and differences in team-based data collection methods. Over time, however, many teams expressed an increased understanding of the value of using patient data for quality improvement efforts, and

developing appropriate and effective measures of patient outcomes remained a critical area for them.

- **The majority of participants in both learning communities believed that there were more benefits to providing self-management support for both patients and providers than disadvantages.** Participants reported that using self-management support led to:

- More efficient and easier patient care
- Improvements in patient-provider relationships, patient satisfaction and, in the future, patient outcomes

Most teams had plans to continue or expand their change strategies around self-management support.

- **The *New Health Partnerships* and *Quality Allies* learning communities fostered fundamental organizational changes among teams toward improving the quality of self-management support.**

- Participants were positive about the usefulness of the collaborative learning meetings even though the *New Health Partnerships* meetings were virtual rather than live.
- They were enthusiastic about their participation in visits to other sites using self-management support.
- Teams that used coaching generally found it to be quite helpful.
- Participants were positive about the tools available on the extranet.
- Comments about the monthly team phone calls were mixed (some positive and some negative).

- **A virtual format may be a more cost-effective approach to self-management support training.** The overall findings about participants' opinions of the learning communities were similar for *New Health Partnerships* and *Quality Allies*, suggesting that a virtual format may be a cost-effective approach to providing self-management support training.

- "The outcomes between the previous in-person phase and the virtual learning community didn't seem to be any different," said Weiss, who noted that RWJF now holds most meetings virtually. "Given other factors in the economy, the health care system and travel, you almost have to do things virtually. When we try to do things in person, we get very low participation."
- Team members said that the virtual format enabled more staff to attend the learning sessions and had an appreciably lower overall cost, including staff downtime, than in-person meetings.

Many teams suggested that the ideal format would be a combination of one in-person meeting to get to know others followed by regular virtual meetings to continue the work.

## Measuring Change at the Patient Level

- **While the overall initiative was successful in fostering system-level changes in the provision of self-management support and teams made considerable progress in both sustaining and spreading these changes, many factors could impede long-term sustainability.** The top two challenges were provider time and reimbursement of self-management support services:
  - About half of *New Health Partnerships* teams and nearly three-quarters of *Quality Allies* teams said that providing self-management support required more provider time to work with each patient and was a moderate to major disadvantage to their centers.

For most centers, the 15-minute clinic visit is not enough time to encourage collaborative self-management support relationships between patients and providers or to orient patients toward this new way of looking at their health and help them develop a realistic action plan for changing daily habits.
  - About a third of the teams reported that the costs of providing self-management support were not reimbursed.

"We only get reimbursement for a regular clinical visit—there is no code for self-management support in Medicare. With the current reimbursement, we can't require 30 minutes for each patient visit. We have to adopt it to the everyday visit, in the shorter time available," said a team leader in *New Health Partnerships*.
  - About a third of the teams reported that some providers or staff members did not believe that using self-management support is worth the time and effort.

## LESSONS LEARNED

### Lessons About Working with Patients, Family Members and Other Members of the Public

1. **Involve patients and family members in redesigning and improving health care.** Teams in the pilot collaborative noted the need to include patients and family members in implementing self-management support. *New Health Partnerships* used the expertise of patients and families in implementing self-management support, with patients serving on the national advisory committee, the faculty and the teams. (Report from the national program office to RWJF)
2. **Expect to expend extra effort to orient members of the public who serve in leadership positions in programs.** Patients and family members served as team

members in the primary care centers participating in this project. During *Quality Allies* (the face-to-face program), some of these patients/family members were disoriented from the need to travel to project meetings and were not prepared for long meeting days.

In *New Health Partnerships* (the virtual program), the faculty added patient and family advisory recruiting and orientation activities in the first four weeks of the program. (Report from the national program office to RWJF)

### Lessons About Working With Primary Care Practices

- 3. Provide simple, effective tools for primary care practices.** This program focused on helping primary care practices redesign their practices to provide self-management support. Many primary care practices are not ready to do this, but they do want simple, effective tools to enhance self-management support. Through its website, the national program office provided the tools. (Report from the national program office to RWJF)
- 4. Explore ways to attract small primary care practices to participate in programs.** One purpose of the virtual learning collaborative was to draw small primary care practices, which are under-represented in health care improvement programs. However, no small primary care practices participated in *New Health Partnerships*.

"It is possible that stipends, perhaps combined with more targeted marketing to small practices, would increase participation of small office practices. Creating a network of small office practices in particular geographical regions might also engage practices to centralize improvement expertise and capacity," said a report from the national program office to RWJF.

### Lessons About Self-Management Support

- 5. Pay attention to the cultural shift that is necessary to achieve self-management support, as well as providing the tools.** Just providing the tools of self-management support is not enough. Self-management support also requires a shift in organizational culture. The national program office chose primary care practices that "were at least willing to try" to implement the changes required by self-management support. The faculty focused on cultural change as well as the processes and tools of self-management support. (Program Director/ Miller)
- 6. Include communications training for health care providers in programs and projects implementing self-management support.** Self-management support requires that doctors and nurses talk to patients rather than simply instruct them. After health care providers in *Quality Allies* (the face-to-face program) had trouble learning how to do this, *New Health Partnerships* added communications training for the teams. (Deputy Director/Simmons)

## Other Lessons

7. **Build a sense of community in a virtual setting by sharing photos of participants, team profiles and contact information and offering an avenue to post messages.**

"We tried to do this as much as possible as a truly virtual community, underscoring community, where people got a chance to know each other over the Internet," said Program Director Miller.

8. **Ensure that infrastructure is in place to manage stipends or grants.** During *Quality Allies*, the Institute for Healthcare Improvement distributed stipends funded by RWJF to the participating teams. However, the organization did not have an infrastructure to manage contracting, reporting and accountability for these stipends. It used existing contracting templates, reporting formats and financial systems.

"In the future, we would be more prepared for the added resources [that] managing this part of the project required," said a report from the national program office to RWJF.

9. **Include site visits in collaboratives.** While participating primary care centers interacted extensively with each other throughout the collaborative by telephone and Web-based learning, the most direct interactions occurred during scheduled site visits by teams to each other's centers.

"Some participants credited the site visits with providing their 'Ah ha!' moment—the point in the project where they saw the possibilities of redesigning chronic care," said a report from the national program office to RWJF. The faculty and the Institute for Healthcare Improvement now recommend site visits for all collaborative projects, whenever feasible.

10. **Start the evaluation at the beginning of the program.** The evaluators began working on their evaluation of *New Health Partnerships* during the planning phase and the evaluation content was integrated into the program. This enabled the evaluators to produce prompt findings that the teams could use to improve their work and the national program office could use to plan each phase of the program. (Evaluator/Emont)

11. **Include evaluators in program meetings and events.** During *New Health Partnerships*, the evaluation team attended major program staff meetings to share evaluation findings and to stay abreast of program changes. (Evaluator/Emont)

## AFTERWARD

After *New Health Partnerships* ended, the Institute for Healthcare Improvement integrated the program's Web content into the organization's website. Many of the participating primary care centers are continuing their work in self-management support, says Miller.

Within RWJF, Weiss notes that *New Health Partnerships* "put into our DNA the notion that you involved patients in improvement, that self-management support matters, that things like site visits and coaching matter."

### **RWJF's Aligning Forces for Quality**

*Aligning Forces for Quality*, RWJF's signature effort to lift the overall quality of health care in targeted communities, reduce racial and ethnic disparities and provide models for national reform, includes some work to involve patients and families in health care improvement. The \$300 million program involves 17 communities that cover 12.5 percent of the U.S. population. Each community alliance includes patients.

Many projects are working on patient-centered care. Three of the projects—Oregon Health Care Quality Corporation, Maine Quality Counts and the Institute for Clinical Systems Improvement in Minnesota—got grants from the *Aligning Forces for Quality* development fund. RWJF has contracted with the Institute for Family-Centered Care to provide technical assistance to these organizations.

Miller also worked with the Western New York *Aligning Forces for Quality* project to produce a documentary called "My Health Counts! Self-Management," available on the My Health Counts! [website](#) (scroll down to Watch the Program: My Health Counts! Self Management).

### **Related Work by the Institute for Healthcare Improvement**

The Institute for Healthcare Improvement has standardized the inclusion of patients and family members in its work to improve health care, according to Miller. The institute has also transferred learning from *New Health Partnerships* to other initiatives, such as a partnership with the Indian Health Service on the Chronic Care Initiative to improve outcomes for American Indians and Alaska Natives, with a focus on patient self-management.

### **Related Work by the California HealthCare Foundation**

In 2009 the California HealthCare Foundation began Team Up for Health, a \$2.87 million, three-year initiative to help provider organizations implement proven approaches to support self-care and develop new ways to engage with nonmedical resources, including community, family and peers. The initiative includes some components of *Quality Allies*, such as patient- and family-centered care, site visits and a robust faculty.

### **Related Work by the Veteran's Administration**

The Veterans Administration's (VA's) patient-centered medical home, launched in April 2010, includes self-management support, according to Goldstein, who has been providing

staff training. He is chief of mental health and behavioral sciences service for the VA Medical Center in Providence, R.I.

"Everything I learned in my role in *New Health Partnerships* is going to get translated into helping the VA adopt and spread self-management support and related innovations within the whole VA," said Goldstein.

The VA's patient-centered medical home uses seven key elements (patient-driven, team-based, efficient, comprehensive, continuous, communication and coordination) in the development of a medical home. The medical home provides accessible, coordinated, comprehensive, patient-centered care. Primary care providers manage the medical home with the active involvement of other clinical and nonclinical staff.

The medical home allows patients to have a more active role in their health care. It is associated with increased quality improvement and patient satisfaction, and a decrease in hospital costs due to fewer hospital visits and re-admissions.

### **Related Work by the Agency for Healthcare Research and Quality**

Schaefer is working with the Agency for Healthcare Research and Quality (AHRQ) to build tools and training materials on self-management support that will be available for free on the agency's website. The *New Health Partnership* toolkit is a key part of this work. Many team members from *New Health Partnership* are part of the technical expert panel established to guide the project.

### **Other Spread of Self-Management Support**

Miller and other program leaders and participants continue to spread self-management support. For example, as co-chair of the Institute for Healthcare Improvement's 2009 conference on Improving the Design of Clinical Office Practices, Miller was able to highlight the work of *New Health Partnerships*.

*New Health Partnerships* teams are serving as "ahead of the curve, exemplar teams" for initiatives such as RWJF's *Aligning Forces for Quality* and the Safety Net Medical Home Initiative, says Schaefer. The Commonwealth Fund, in collaboration with eight co-funders, launched the Safety Net Medical Home Initiative, which in May 2009 provided \$6 million to help 68 community health centers in five states transform into patient-centered medical homes.

Health centers in Colorado, Idaho, Massachusetts, Oregon and Pennsylvania will be given training and ongoing support to improve how they deliver care to patients. The other funders are:

- Colorado Health Foundation

- Jewish Healthcare Foundation
- Northwest Health Foundation
- Partners HealthCare
- Boston Foundation
- Blue Cross Blue Shield of Massachusetts Foundation
- Blue Cross of Idaho Foundation for Health
- Beth Israel Deaconnes Medical Center

*New Health Partnerships* team members are also serving as faculty or guest speakers for other learning sessions and meetings to help people understand how to implement self-management support.

Miller also noted that the Global Alliance for Self Management Support in the European Union is using the *New Health Partnerships* model.

---

**Prepared by: Lori De Milto**

Reviewed by: Mary B. Geisz and Molly McKaughan

Program officer: Anne F. Weiss

RWJF Team: Quality/Equality

---

## APPENDIX 1

### RWJF's Work Related to Self-Management Support

RWJF supported the following programs and projects related to self-management:

- Oregon Health Sciences University conducted a review of studies examining the effectiveness of providing patients with self-care manuals as a way to reduce unnecessary use of health care services (ID# 033265). The study found that roughly half the people who receive self-care manuals used them, and in roughly half the studies, there was a decline in unnecessary use of health care services after self-care manuals were distributed. (See [Program Results](#) for more information.)
- RWJF provided funding to improve the self-care of people suffering from specific diseases such as cancer (see [Program Results](#)), asthma (see [Program Results](#)), mental illness (see [Program Results](#) on ID#s 035748 and 036805 and on ID# 042044) and diabetes.
- *Building Community Supports for Diabetes Care* (CSD) sought to enhance self-management for diabetes prevention and control. *Advancing Diabetes Self-Management* (IDC) complemented the work of CSD by testing self-management programs that could be delivered in a primary care setting. See [Program Results](#) on both programs, jointly called *The Diabetes Initiative*.
- RWJF supported a number of initiatives that use virtual learning opportunities and educational venues to promote and enhance self-care. Those efforts included three projects within the RWJF program, *Improving Chronic Illness Care*, a televideo (ID# 041869), Web TV (ID# 041870) and creating Web-based medical records (ID# 041871). RWJF also supported the development of online self-management tools (see [Program Results](#) on ID# 038198) and creation of videotapes (See [Program Results](#) on ID# 042044.)
- The Foundation for Accountability drafted a strategic plan and created Web-based resources to develop strategies for moving towards more consumer-oriented health care. Its strategic plan is entitled "Innovators and Evangelists: Strategies for Creating a Consumer-Centered Health System." (See [Program Results](#) for more information.)
- Researchers at the Stanford University School of Medicine developed and evaluated a disease management/patient self-care program for patients with chronic disease. The program, called Health Partners, offered patients a choice of enrolling in either self-management education workshops or group visits with physicians or both. (See [Program Results](#) for more information.)

Other more recent efforts utilizing technology are two programs:

- *Project HealthDesign: Rethinking the Power and Potential of Personal Health Records*, to expand a vision of personal health records and encourage the market to develop products that meet the diverse needs of patients.

- **Health e-Technologies: Building the Science of eHealth** to support systematic research on the evaluation of interactive eHealth applications for health behavior change and chronic disease management. (Also see [Program Results](#).)

## **APPENDIX 2**

### **Primary Care Centers Participating in New Health Partnerships**

#### ***Participants in the Pilot Collaborative on Self-Management Support***

- CareSouth Carolina, a private, nonprofit health and human services provider and a federally qualified health center in Society Hill, S.C.
- G.A. Carmichael Family Health Center, a community health center and a federally qualified health center in Canton, Miss.
- Holyoke Health Center, a community health center and a federally qualified health center in Holyoke, Mass.
- Iowa Health System, an integrated delivery system in Des Moines, Iowa
- Kaiser Permanente Northwest Region, Portland, Ore., a staff-model HMO in the Kaiser Permanente system
- Mercy Clinics, Inc., an integrated delivery system in Des Moines, Iowa

#### ***Participants in Quality Allies (the face-to-face program)***

- Bellin Health System in Green Bay, Wis., serving patients in urban and rural northern Wisconsin and Michigan
- Boston Mountain Rural Health Center in Huntsville, Ark., serving patients in north-central and northwest Arkansas
- The Brown University Family Care Center an academic teaching practice and an outpatient department of Memorial Hospital of Rhode Island in Providence, R.I., serving patients in Pawtucket and Central Falls
- Cambridge Health Alliance, an academic public health care system and integrated delivery network in Cambridge, Mass., serving Eastern Massachusetts
- Christiana Care, a not-for-profit private teaching hospital and health system in Wilmington, Del., serving patients in Delaware and neighboring counties
- Community Health Partners, a multi-site community health center in Bozeman, Mont., serving rural patients in south-central Montana
- The Cystic Fibrosis Foundation collaborating with the Cystic Fibrosis Center at Baylor College of Medicine in Houston, which evaluated self-management support

for patients at the cystic fibrosis outpatient clinics at the Texas Children's Hospital and Baylor Clinic

- Family Health Care Center, in Fargo, N.D., serving an ethnically diverse population in Fargo and Moorhead on the North Dakota border
- Humboldt Del Norte IPA, an integrated practice association in Eureka, Calif., serving an isolated and widely dispersed population in Humboldt County, Calif.
- La Clinica de La Raza, a community health center in Oakland, Calif.
- MaineHealth, a nonprofit integrated health care delivery system in Portland, Maine serving 10 counties in rural Maine
- Medical College of Georgia's Augusta Multiple Sclerosis Center, in Augusta, Ga., an academic teaching and specialty center serving 23 Georgia and South Carolina counties
- Morehead Family Health Care Center, a nurse-managed primary health care center operated by the University of Nebraska Medical Center College of Nursing in Omaha, Neb., serving patients in South Omaha
- The New York State Department of Health AIDS Institute, in partnership with the Harlem Family Center at Harlem Hospital in New York, caring for adult and pediatric HIV patients
- Ocean Park Health Center, in San Francisco, affiliated with the San Francisco Department of Public Health, providing care in the Sunset District's multicultural and largely immigrant population
- Park Nicollet Health Services in Minneapolis, an integrated care system offering care in 45 specialties and subspecialties at 25 clinics in Minneapolis and surrounding counties
- Roybal Comprehensive Health Center in Los Angeles, a medically certified ambulatory care facility and the home of a nurse-run Diabetes Management Program
- Santa Clara Valley Medical Center, in Santa Clara, Calif., part of the county health and hospital system, serving the medically uninsured and underserved in Santa Clara County
- United Community Health Center in Green Valley, Ariz., serving a diverse population in rural and border communities in Arizona
- West County Health Centers, a private nonprofit corporation consisting of two federally qualified community health centers in Guerneville, Calif., serving rural residents in Western Sonoma County

### **Participants in New Health Partnerships (the virtual program)**

- Baylor Family Medicine, the private practice of faculty physicians from the department of Family and Community Medicine at Baylor College of Medicine in Houston
- Children's Hospital of Alabama at the University of Alabama at Birmingham, part of a statewide pediatric healthcare system in Alabama
- Franklin C. Fetter Family Health Center, a community health center in Charleston, S.C.
- Gundersen Lutheran in Lacrosse, Wis., an integrated health care organization serving 19 counties in western Wisconsin, southeast Minnesota and Iowa
- Interior Health Authority—Penticton Regional Hospital in Penticton, British Columbia, which provides hospital services to residents of the South Okanagan
- Quality Community Health Care, which provides preventive, chronic and episodic care to residents of Philadelphia
- PeaceHealth's Center for Senior Health in Bellingham, Wash. PeaceHealth runs seven hospitals, medical groups, a chemical dependency program, health care joint ventures and other services in Alaska, Washington and Oregon.
- United Here Health Care in New York, a primary and specialty care center that treats low-wage immigrant workers in the garment, hotel, restaurant and laundry industries

## **APPENDIX 3**

### **Program Faculty**

#### **Faculty for Quality Allies (the face-to-face program)**

*(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)*

**Shari Gioimo**  
Medical Assistant  
St. Peter Family Medicine Residency Program  
Olympia, Wash.

Department of Health Policy and  
Administration  
School of Public Health  
University of North Carolina at Chapel Hill  
Chapel Hill, N.C.

**Beverley Johnson**  
President/CEO  
Institute for Family-Centered Care  
Bethesda, Md.

**Penny Lane**  
Director  
Center for Health Literacy  
Maximus  
Reston, Va.

**Kerry Kilpatrick, Ph.D.**  
Professor and Associate Dean for Academic  
Affairs

**Devin Sawyer, M.D.**  
Project Director

Advancing Diabetes Self-Management Grant  
Clinical Assistant Professor  
University of Washington  
St. Peter Family Medicine Residency Program  
Olympia, Wash.

**David Spero, R.N.**  
Self-employed  
San Francisco, Calif.

### ***Faculty for Quality Allies and New Health Partnerships***

**Marie Abraham, M.A.**  
Policy and Program Specialist  
Institute for Family-Centered Care  
Bethesda, Md.

Rush Medical College  
Chicago, Ill.

**Michael Goldstein, M.D.**  
Associate Director  
Clinical Education and Research  
Bayer Institute for Healthcare Communication  
West Haven, Conn.

**Judith Schaefer, M.P.H.**  
Director of the Innovation Community  
MacColl Institute for Healthcare Innovation  
Group Health Cooperative  
Seattle, Wash.

**Angela Hovis, M.A.**  
Improvement Advisor  
Institute for Healthcare Improvement  
Austin, Texas

**Laurel Simmons, S.M.**  
Deputy Director  
Institute for Healthcare Improvement  
Cambridge, Mass.

**Doriane Miller, M.D.**  
Section Head, General Internal Medicine

**Karen Tate**  
Family Consultant  
Children's Seashore House of the Children's  
Hospital of Philadelphia  
Philadelphia, Pa.

### ***Faculty for New Health Partnerships (the virtual program)***

**Alan Glaseroff, M.D.**  
Chief Medical Officer  
Humboldt-Del Norte IPA  
Eureka, Calif.

## **APPENDIX 4**

### **Members of the National Advisory Committee**

**David Ahern, Ph.D.**  
National Program Director  
Health e-Technologies Initiative  
Brigham & Women's Hospital Inc.  
Boston, Mass.

University of North Carolina at Chapel Hill  
Chapel Hill, N.C.

**Nancy DiVenere**  
Former Executive Director  
Parent-to-Parent Network  
Essex Junction, Vt.

**Linda Magno, R.N., M.P.A.**  
Director  
Medicare Demonstrations Program Group  
Centers for Medicare & Medicaid Services  
Baltimore, Md.

**Edwin Fisher, Ph.D.**  
Professor and Chair  
Department of Health Behavior and Health  
Education  
School of Public Health

**Reggie Mead**  
Patient Advocate  
Dana-Farber Cancer Institute  
Boston, Mass.

**George Mensah, M.D.**

Director  
Medicare Demonstrations Program Group  
Centers for Disease Control and Prevention  
Atlanta, Ga.

**Arnold Milstein, M.D.**

Medical Director  
Pacific Business Group on Health  
National Health Care Thought Leader  
San Francisco, Calif.

**William M. Mercer, M.D.**

Associate Clinical Professor  
University of California San Francisco  
San Francisco, Calif.

**M. Jeanne Miranda, Ph.D.**

Associate Professor in Residence in  
Behavioral Sciences and Psychiatry  
University of California Los Angeles  
Los Angeles, Calif.

**Gordon Mosser, M.D.**

Executive Director  
Institute for Clinical Systems Improvement  
Bloomington, Minn.

**David Sobel, M.D.**

Medical Director  
Patient Education  
Kaiser Care Management Institute  
Oakland, Calif.

**Jeannette E. South-Paul, M.D.**

Medical Director and Chair  
Community Health Services Division  
Department of Family Medicine  
University of Pittsburgh  
Pittsburgh, Pa.

**David Stevens, M.D.**

Vice President for Healthcare Improvement  
Institute for Clinical Care Improvement  
American Association of Medical Colleges  
Washington, D.C.

## APPENDIX 5

### Evaluation Methodology

All of the participating primary care centers in *Quality Allies* (the face-to-face program) and *New Health Partnerships* (the virtual program) participated in the evaluation. During *Quality Allies*, 12 of the 20 centers also chose to participate in a nine-month extension called the Tier Incentive Program to collect more data.

#### **Measuring Change at the Systems Level**

To measure change at the systems level, evaluators used:

- Primary Care Resources and Support Survey, a quality improvement survey done near the beginning and end of *Quality Allies* (December 2005 and September 2006) and *New Health Partnerships* (May 2007 and April 2008). Sites participating in the *Quality Allies* Tier Incentive Program also completed the survey in August 2007.
- An online survey focused on implementation and sustainability of changes surrounding self-management support. *Quality Allies* sites completed this survey in December 2006; the Tier Incentive Program sites also completed the survey in September 2007. *New Health Partnerships* sites completed this survey in May–June 2008.

- In-depth telephone interviews with team leaders or other key team contacts at the end of the program.

### ***Measuring Change at the Patient Level***

To measure change at the patient level, evaluators used:

- A patient feedback survey of changes in patients' perceptions of care and their health-related behavior. Teams in *Quality Allies* and its Tier Incentive Program and *New Health Partnerships* completed the survey with a certain number of patients each month, after the patients had completed a visit with a provider.
- Monthly reports from the sites giving the percentage of patients with documented self-management goals.
- Clinical outcome measures: Although not required, some sites tracked clinical outcomes (e.g., percentage of patients with well-controlled diabetes) each month. Teams participating in Tier 3 of the *Quality Allies* extension (explained below) continued to track one or more clinical outcomes.

### ***Quality Allies Tier Incentive Program***

*Quality Allies* Tier Incentive Program collected data to examine the impact of self-management support on patients and the sustainability of the self-management support within the centers. The 12 centers received a small payment for participation. They were:

- Bellin Health System in Green Bay, Wis.
- Boston Mountain Rural Health Center in Huntsville, Ark.
- The Brown University Family Care Center in Providence, R.I.
- Christiana Care, in Wilmington, Del.
- Community Health Partners, in Bozeman, Mont.
- The Cystic Fibrosis Foundation collaborating with the Cystic Fibrosis Center at Baylor College of Medicine in Houston
- MaineHealth, in Portland, Maine
- Morehead Family Health Care Center, in Omaha, Neb.
- The New York State Department of Health AIDS Institute with the Harlem Family Center at Harlem Hospital in New York
- Ocean Park Health Center in San Francisco
- Roybal Comprehensive Health Center in Los Angeles
- Santa Clara Valley Medical Center, in Santa Clara, Calif.

They could participate in any or all of three tiers:

- Tier 1, which assessed system-level changes
- Tier 2, which assessed patient-level, self-reported changes
- Tier 3, which assessed clinical outcomes and some changes at the system level

All 12 sites participated in Tiers 1 and 3. Nine sites participated in Tier 2. Data from the extended period of the Tier Incentive Program were included in the overall findings for *Quality Allies*.

## **APPENDIX 6**

### **Self-Management Support Strategies**

The following are the self-management support strategies introduced in the learning communities:

- Goal setting focused on the patient's actions to improve the condition
- Individual assessment of a patient's self-management needs and current status using a standardized and documented process
- Providing a two-week follow-up
- Patients and providers jointly reviewing progress toward goals in follow-up visits
- Involving family members/friends in supporting the patient's progress
- Using community resources
- Providing multiple types of providers
- Patient support strategies such as group visits and peer coaching
- Using lay health workers

## BIBLIOGRAPHY

### National Program Office Bibliography

#### Articles

Simmons L, Baker NJ, Schaefer J, Miller D and Anders S. "Activation of Patients for Successful Self-Management." *Journal of Ambulatory Care Management*, 32(1): 16–23, 2009. Available [online](#).

#### Education & Instruction

*Partnering in Self-Management Support: A Toolkit for Clinicians*, which introduces busy clinical practices to activities and changes that support patients and families in the day-to-day management of chronic conditions. The toolkit includes tested resources and tools and examples of changes in practice, including ways to begin trying changes with a small number of patients. Available [online](#).

#### World Wide Websites

[www.newhealthpartnerships.org](http://www.newhealthpartnerships.org). *The New Health Partnerships* website provides support, information and resources for patients, family members and health care providers who want to work together to improve health, health care and quality of life for people with chronic conditions. The two main sections are "Health Care Providers" and "Patients and Families." Cambridge, MA: Institute for Healthcare Improvement, Experience Corps, launched in 2007.

### Evaluation Bibliography

#### Reports

Emont S and Scheirer MA. *Implementing Self-Management Support Through the Quality Allies Learning Community: A Report From Interviews With Team Leaders*. Danbury, NH: White Mountain Research Associates, L.L.C., November 2006.

Emont S, Emont N and Scheirer MA. *Quality Allies Learning Community: Adoption, Sustainability and Spread of Self-Management Supports: An Evaluation of the Impact of the Quality Allies on Systems of Clinical Care Delivery and Patient Outcomes*. Danbury, NH: White Mountain Research Associates, L.L.C., February 2008.

Emont S, Emont N and Scheirer MA. *Adoption, Sustainability and Spread of Self-Management Supports: An Evaluation of the Impact of the New Health Partnerships and Quality Allies Learning Communities on Systems of Clinical Care Delivery and Patient Outcomes*. Danbury, NH: White Mountain Research Associates, L.L.C., July 2008. Available [online](#).