Setting the Standard: A Foundation Initiative to Advance Best Practices in Diabetes Management

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NYS HEALTH FOUNDATION

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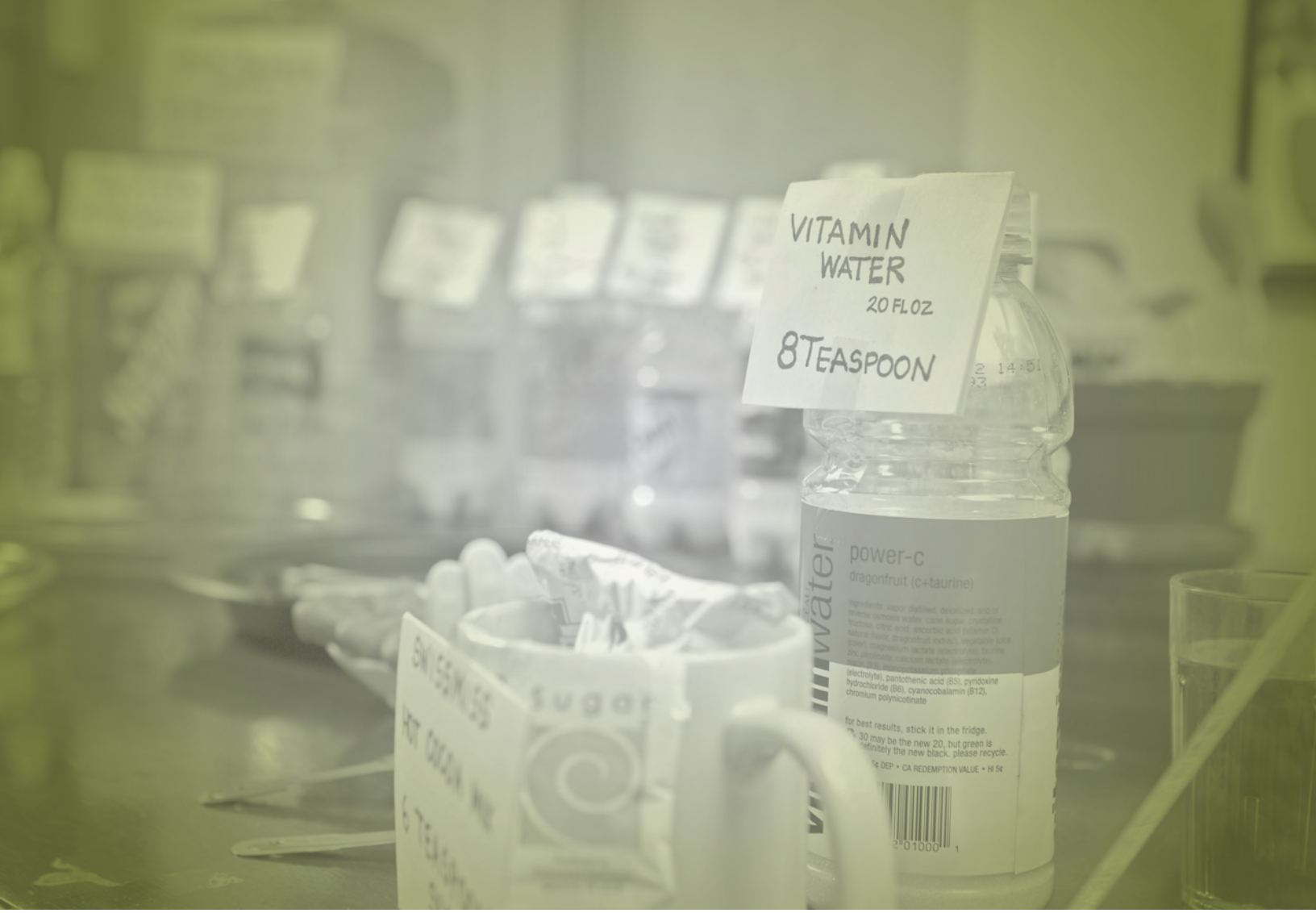

Contents

Background

In 2007, the New York State Health Foundation (NYSHealth) commenced efforts to improve care for New York State residents at risk for or diagnosed with diabetes, which was and still is a growing public health problem nationally and across the State. According to the Behavioral Risk Factor Surveillance System, 8.2% of adults in New York State had diabetes in 2007; this number grew to 8.9% by 2010. Type 2 diabetes accounts for the majority of these cases.

Complications related to Type 2 diabetes are extensive, with heart disease and stroke as the leading cause of death among people with diabetes. The risk for heart disease and stroke is two to four times higher among adults with diabetes than adults without diabetes. In 2005, New Yorkers with diabetes accounted for nearly 400,000 hospital discharges, more than 5,000 nontraumatic lower extremity amputations, 2,900 new cases of kidney failure, and 2,560 new cases of blindness annually.[1] Nationally, an estimated one out of every ten health care dollars is spent on diabetes and its complications.

Despite the resources invested in the treatment of diabetes and its complications, 55% of people with diabetes receive inadequate care[2] and are not receiving the support they need to make necessary healthy lifestyle changes to manage the disease. The clinical treatment of diabetes requires that providers and patients maintain constant vigilance for symptoms that signal unhealthy changes in their glucose levels, follow a daily foot-care regimen, engage in regular aerobic exercise, and attend frequent medical appointments.[3]

Better clinical management of diabetes is achievable, and effective practices have been well documented. Proven frameworks such as the Chronic Care Model (CCM) [4]—which emphasizes the importance of delivering evidence-based, planned care that incorporates strategies for diabetes self-management—have been shown to work. While some organizations and institutions in New York State have successfully embedded the CCM framework into their systems and principles of care, a remaining challenge has been widespread adoption and institutionalization of improvements to establish and sustain coordinated systems of care. Such institutionalization requires fundamental care redesign and support through public policy and financial incentives.

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[1] New York State Department of Health (2006). Diabetes Surveillance in New York State.

[2] McGlynn, E.A.; Asch, S.A.; Adams, J.; Keesey, J.; Hicks, J.; DeCristofaro, A.; and Kerr, E. (2003). The Quality of Health Care Delivered to Adults in the United States. *New England Journal of Medicine*, 348, 2635-2645.

[3] Gonder-Frederick, L. A.; Cox D. J.; and Ritterband, L. M. (2002). Diabetes and Behavioral Medicine: The Second Decade. *Journal of Consulting and Clinical Psychology*, 70(3), 611-625.

[4] RAND Corporation, "Does Participation in a Collaborative Improve Quality of Care for Diabetes?" http://www.rand.org/content/dam/rand/pubs/reprints/2005/RAND_RP1173.pdf, accessed June 2013.

Background *(continued)*

The need to address these health system shortcomings was clear to NYSHealth staff and Board members in early 2007. Research and interviews with public health and primary care experts, State and local government health officials, and executive directors of relevant community-based organizations also confirmed NYSHealth staff's and Board members' sense that the Foundation could address these shortcomings by working directly with health care providers across the State to improve clinical care for patients with diabetes.

Background *(continued)*

The 2007 *Setting the Standard: Advancing Best Practices in Diabetes Management* request for proposals (RFP)[5] was among the Foundation's first efforts to motivate New York State's primary care system to adopt and spread these best practices and establish a select cadre of organizations as standard-setters for the care of patients with diabetes. The Foundation expected the grants made under the *Setting the Standard* RFP to advance existing programs, start new ones, and/or build each organization's systemwide capacity to support, sustain, and institutionalize these efforts. The CCM was a major reference point in the RFP.

This report summarizes the group of *Setting the Standard* grants funded by NYSHealth from 2007 to 2009. Under this grant initiative, the Foundation awarded 12 grants totaling $3.4 million to a diverse set of organizations, including hospital systems, community-based organizations, and provider organization partnerships. The Foundation supported these grantees to use a range of approaches and serve a broad spectrum of populations, including those hardest hit by diabetes, such as Asian and Latino New Yorkers, and those with co-existing conditions such as mental illness.

As part of the *Setting the Standard* initiative, the Foundation funded Joslyn Levy & Associates, LLC and Patrizi Associates to assess the outcomes of 10 of the 12 grant projects (Table 1).[6] They applied two perspectives in studying the projects: **(1)** assessing how well each grantee advanced against its stated objectives and **(2)** assessing how well each grantee performed and progressed along the dimensions of the CCM. This overall assessment draws from the evaluators' report.

In general, grantees that showed the most evidence of advancing the CCM within their system had already laid the groundwork for this model within their organizations—in essence readying themselves for further progress during this grant period. Many of the grantees did not have sufficient prior experience with the CCM, however, and struggled both to understand and implement the model. One of the most significant lessons the Foundation learned from this initiative is that some grantees needed longer project periods and technical assistance support to implement and sustain the CCM successfully. The Levy & Associates/Patrizi Associates evaluation report also notes that the diversity of projects embodied in the initiative raised significant challenges to the assessment of impact, including lack of comparable interventions and inconsistent data quality.

[5] Read the original RFP at http://nyshealthfoundation.org/grant-seekers/rfps/setting-the-standard-advancing-best-practices-in-diabetes-management.

[6] The remaining two grantees—Seneca Nation Health Department and Jericho Road Ministries—did not attempt to implement the CCM in their projects.

Expected Outcomes

The specific objectives of the *Setting the Standard* initiative were to:

- Expand existing diabetes management initiatives;
- Demonstrate the cost effectiveness of diabetes management programs; and
- Develop viable approaches to sustain best practices in diabetes management.

Grant Activities

Overall, *Setting the Standard* provided resources to primary care practices to augment or accelerate their current efforts to improve care for patients with diabetes by implementing and/or advancing elements of the CCM. *Setting the Standard* funds also supported consulting services to both investigate current practices and make recommendations for the future, as well as training programs for certified diabetes educators (CDEs).

TABLE 1: GRANTEES PARTICIPATING IN THE *SETTING THE STANDARD* EVALUATION

GRANTEE	PROJECT TITLE	PROJECT START DATE	PROJECT END DATE	GRANT PERIOD	GRANT EXTENSION	GRANT AMOUNT
Beth Israel Medical Center	Queens/South Asian Action for Diabetes Education Programs and Treatment	1/2/08	12/31/09	24 months	—	$245,861
Charles B. Wang Community Health Center, Inc.	Chinatown Diabetes ACTION (Accelerating Collaboration to Improve Health Outcomes Now)	1/1/08	12/31/09	24 months	—	$230,000
Dr. Martin Luther King, Jr. Health Center, Inc.	The Dr. Martin Luther King, Jr. Health Center Diabetes Management Initiative	1/1/08	12/31/09	24 months	3 months	$214,210
Family Health Network of Central New York, Inc.	Take Charge of Diabetes: A Collaborative Approach	1/1/08	12/31/09	24 months	3 months	$250,912
Glens Falls Hospital, Inc.	Sustainable Strategies for Diabetes Self Management	1/1/08	12/31/09	24 months	3 months	$149,127
Institute for Community Living, Inc.	Integrated Wellness: Improving the Assessment and Management of Type II Diabetes in Adults with Serious Mental Illness	12/1/07	11/30/09	24 months	—	$567,066
Jamaica Hospital Medical Center	Initiating a Diabetes Management Program for Underserved Populations	3/1/08	8/31/09	18 months	6 months	$138,531
Seton Health System, Inc.	DEFY DIABETES!	1/7/08	12/31/09	24 months	3 months	$562,554
UB Family Medicine, Inc. (Gold Choice PCMP IIA)	Improving Diabetes Outcomes in Behavioral Health Care Recipients	1/1/08	12/31/09	24 months	—	$317,863
UNITE Health Center, Inc.	Development and Implementation of an Innovative Primary Care Model for Low-Income Retired Patients with Diabetes	1/1/08	12/31/08	12 months	—	$460,042

Grant Activities *(continued)*

A brief overview of the 12 selected projects follows:

- **Beth Israel Medical Center** developed a partnership with the South Asian Health Project to improve the high rates of diabetes among members of the South Asian community. Beth Israel employed two principal strategies: **(1)** community-based educational outreach, including screening and information at health fairs and community-based educational workshops and **(2)** the provision of an itinerant CDE with regularly scheduled office hours at each of the eight community-based practices that agreed to participate. Read a more detailed description of this project and its outcomes.
- **Charles B. Wang Community Health Center** used NYSHealth funding to build on its previous diabetes improvement work by integrating diabetes registry functions into its electronic medical records (EMRs), expanding diabetes self-management supports, and enhancing its capacity to bill for evidence-based diabetes education and self-management services. Throughout the grant period, the project team tested new workflow approaches and innovations, such as group visits. Read a more detailed description of this project and its outcomes.
- **Dr. Martin Luther King, Jr. Health Center** endeavored to integrate community health workers (CHWs) into its treatment plan for patients with diabetes. Redesign of the care team was central to its approach. Read a more detailed description of this project and its outcomes.
- **Family Health Network** used NYSHealth funding to expand an existing diabetes program launched in 2006 as a result of its participation in the Bureau of Primary Health Care Health Disparities Collaborative. NYSHealth support allowed Family Health Network to expand its two original locations to include additional care teams and locations. With NYSHealth support, it also delved into components of the CCM that had been relatively neglected in its previous collaborative work, particularly self-management support, community linkages, and clinical information systems. Read a more detailed description of this project and its outcomes.
- **Glens Falls Hospital** attempted to implement a Web-based diabetes registry at six of its twelve primary care sites to increase the efficiency and effectiveness of care provided to its patients with diabetes. It also worked to incorporate CDEs and nutritionists into primary care practices. The project included a community outreach component to bring services closer to where people live by conducting a variety of self-management workshops and diabetes education classes at easily accessible locations in the community, such as family health centers and libraries. Read a more detailed description of this project and its outcomes.
- **Gold Choice** used NYSHealth funding to enhance care and improve outcomes for patients who have both diabetes and serious mental illness and/or substance use problems. The project employed two primary strategies: **(1)** the use of practice enhancement assistants to provide clinical information support to primary care practices serving Gold Choice members with

diabetes and **(2)** the use of a telephonic nurse care manager to work specifically with this population. Read a more detailed description of this project and its outcomes.

- **Institute for Community Living** sought to confront the challenge of poorly controlled diabetes in people with serious mental illness. It partnered with eight nonprofit multiservice agencies serving the same population to create the Diabetes Co-Morbidity Initiative, a program to help behavioral health agencies staff provide diabetes care management to their patients. Read a more detailed description of this project and its outcomes.

Grant Activities *(continued)*

- **Jamaica Hospital Medical Center** attempted to improve its diabetes care by co-locating related specialists at multiple clinic sites to facilitate visits for patients with diabetes; hiring CHWs to provide individualized support outside of a medical setting for patients with diabetes; hiring a bilingual CDE to provide diabetes education and supervise CHWs; creating a diabetes registry; and educating medical and family practice residents about the CCM and evidence-based diabetes care. Read a more detailed description of this project and its outcomes.
- **Jericho Road Ministries** had two primary goals: **(1)** embedding CDE trainees who were representative of their communities and linked to community practices and **(2)** establishing a diabetes health ministry outreach resource center. Read a more detailed description of this project and its outcomes.
- **Seneca Nation Health Department** used NYSHealth funding to hire an outside evaluator to review its current programs; determine the programs' relative strengths and weaknesses; compare the programs to others within tribal and general population communities in the United States; and provide direction on how to improve these programs and recommendations for further program development. Read a more detailed description of this project and its outcomes.
- **Seton Health System** used NYSHealth funding to **(1)** train local faith-based community parish nurses to conduct diabetes workshops in the community and provide one-on-one self-management support for their parishioners and **(2)** train nurses in diabetes best practices and self-management support to become nurse champions at their primary care sites and to promote improved care at those sites. Read a more detailed description of this project and its outcomes.
- **UNITE HERE Health Center** used NYSHealth funding to test Bridge Care, a model of collaborative care adapted from UNITE HERE's existing chronic care program that featured a new role for medical assistants. UNITE HERE used the grant to enhance the role of its on-site pharmacist and incorporate the pharmacist into the care management team. The project included an examination of clinical outcomes and of the business case for this model. UNITE HERE's goal was to demonstrate to its payers the efficacy and cost-effectiveness of such an approach to obtain enhanced reimbursement that would permit it to sustain the care delivery model. Read a more detailed description of this project and its outcomes.

Did Grantees Achieve Their Individual Goals?

This section examines to what extent individual grantees achieved their stated goals in relation to how well the grant initiative as a whole advanced the standard of care for diabetes. In retrospect, the Foundation could have strengthened the work of the grantees and ensured more positive outcomes if it had invested in technical assistance and learning collaboratives for the grantees. In addition, the Foundation should have examined grantees' stated objectives and workplans more carefully during the early phase of the projects to ensure that all projects were sufficiently focused in scope from the onset. This could have prevented some grantees from starting out with an overly ambitious set of goals that could not be attained within the grant time period or budget.

WHAT WENT WELL

- **Implementing workplans:** Seven of the twelve grantees either implemented all of their proposed work or a scope of services reflecting adjustments made midway through the grant period.
- **Developing a business case for the CCM:** One grantee gathered cost data to document what level of reimbursement arrangements would be required to make its approach sustainable. While this grantee was unsuccessful at engaging its major payer in negotiations for new reimbursement arrangements by the close of the grant period, it was able to negotiate reimbursement for non-billable diabetes care with another union as part of a pilot project. In addition, it received National Committee for Quality Assurance (NCQA) diabetes recognition and was certified as a level-three patient-centered medical home (PCMH), and thus anticipated that payment for these specialized services would be available shortly under new PCMH mechanisms.
- **Reaching proposed number of sites, providers, and patients:** All but one of the twelve grantees reached their goals in terms of the number of sites involved in the project. Six out of ten grantees successfully reached or exceeded the number of consumers or patients that they targeted in their proposals, and three others came very close to their targets. Seven grantees successfully engaged clinicians as intended.
- **Implementing a disease registry:** Three grantees already had robust diabetes registries and used registry data and tools to their fullest to improve care processes and patient outcomes.
- **Realizing positive clinical outcomes:** Five of the twelve grantees that tracked outcomes were able to demonstrate positive clinical outcomes for one or more indicators.
- **Replicability in other parts of New York State:** One higher-level outcome the Foundation desired for each grantee was that its project would be replicable in other parts of the State.

Did Grantees Achieve Their Individual Goals? *(continued)*

One grantee provided sufficient evidence of positive results to suggest that its model should be considered for replication.

- **Creating a platform for PCMH recognition:** Seven grantees used the lessons learned from their grant projects and integrated them into their process to achieve NCQA level-three PCMH recognition. They were among the first in the State to do so.

WHAT DID NOT GO AS PLANNED

- **Developing a business case for the CCM:** Four grantees proposed to develop a business case for implementing and sustaining the CCM, but only one grantee was able to do so. Two grantees either did not have enough data to accomplish this task within the grant period or did not have a well-developed plan for doing so. One grantee made some progress in this area by the close of the grant period.
- **Reaching proposed number of sites, providers, and patients:** Though most grantees reached their goals in terms of the number of sites involved in the project, a number of grantees did not fully implement their work in all of those sites. In some instances, the grantees may have sacrificed full implementation for the sake of reach. Five grantees did not engage the number of clinicians intended, and one grantee did not reach the targeted number of consumers or patients.
- **Implementing a disease registry:** While most grantees referenced the use of a registry in their proposals, the term was used loosely. Registries ranged from tools for tracking patients seen and recording their lab values to full-fledged clinical management tools. Some grantees that undertook work to initiate or enhance an existing rudimentary population-based registry found the task daunting, and one grantee abandoned its registry plans altogether because of the perceived resource and time requirements needed to implement them successfully.
- **Realizing clinical outcome goals:** Only five of ten grantees that tracked outcomes were able to demonstrate positive clinical outcomes for one or more indicators. At least four of the grantees' efforts to assess impact were hindered by the limited number of patients with more than one primary care clinical encounter or prolonged project participation during the grant period. Other grantees were able to provide data for only a subset of patients, thereby rendering the data insufficient for evaluating impact. It is important to note that, in a few instances, weak data collection and analysis either obscured improvement or contributed to incorrect assumptions for the grantees.
- **Replicability in other parts of New York State:** While five of the grantees received support to either demonstrate the effectiveness of new models or test successful models in a new setting, only one grantee provided sufficient evidence of positive results to suggest replicability. Three grantees lacked adequate evidence to know if replication was warranted, and one grantee was unable to demonstrate effectiveness, despite having adequate data.

Did Grantees Make Progress Based on the Chronic Care Model?[7]

The CCM, in many ways, sets the standard for quality diabetes care. Six of the twelve grantees sought explicitly to advance the CCM at their institution: Charles B. Wang Community Health Center, Dr. Martin Luther King, Jr. Health Center, Family Health Network, Glens Falls Hospital, Jamaica Hospital Medical Center, and UNITE HERE Health Center. For these grantees, key activities included subsets of the following: the use of diabetes registries; clinical performance measurement; care redesign to emphasize planned care; self-management support; development and enhancement of linkages with community-based organizations; and collaboration with organizational leadership to institutionalize best practices in diabetes care. Seton Health System's proposal did not reference the CCM, but its work aligned with at least two components of the model. All of these grantees attempted to implement at least one component of the model, such as use of a registry or building elements of community-based care within the context of a care delivery system.

The aggregate results of this initiative suggest several important lessons that relate to implementation of the CCM, as well as grantmaking in this area. These lessons are addressed in detail in the closing section of this report.

The evaluators assessed grantee performance on three levels: the degree to which grantees demonstrated understanding of the CCM; if grantees had the core capacities to implement the CCM; and if there was evidence that they in fact implemented the CCM and did so at a sufficient level for the effects to be evident.[8]

Each element of the CCM is described below, along with an analysis of whether and how each grantee implemented the model's elements into its system.

AVAILABILITY AND USE OF CLINICAL INFORMATION SYSTEMS

The evaluators looked at how the grantee organized patient and population data to facilitate efficient and effective care, including whether and how it provided timely reminders on elements of care; whether and how it identified relevant subpopulations that needed special

[7] Five grantees (Institute for Community Living, Beth Israel Medical Center, Gold Choice, Seneca Nation Health Department, and Jericho Road Ministries) aimed to improve diabetes outcomes by implementing a specific project that was outside of the care delivery system. These grantees are therefore excluded from the following CCM discussion.

[8] Major components of the CCM are outlined at **http://www.improvingchroniccare.org**, accessed June 2013.

Did Our Grantees Make Progress Based on the Chronic Care Model? *(continued)*

care; and how it facilitated individual patient care planning and shared information with patients and providers to coordinate care. Evidence of a more advanced element of this CCM dimension was whether and how the grantee continuously monitored the performance of the practice team and care system to support improvement.

Grantees that had a well-established disease registry system—whether integrated with an EMR system or not—had better results implementing this aspect of the CCM. They were able to coordinate care and organize its flow; alert providers to elements of care needed or that might be out of date; monitor provider/care team performance; and identify systematic problems to be addressed by leadership. Other grantees with less sophisticated registries were unable to maximize their use. Without a strongly implemented registry, it is not possible to use clinical information to provide continuous performance feedback in a format and context that could be used to support improvement. While reporting of isolated results is a useful statement of fact, it becomes far more useful when it is linked to previous performance results.

Most grantees underestimated the amount of work required for capturing, analyzing, and using clinical information. However, those that experienced greater challenges implementing and working with registries generally took advantage of the opportunity to learn more. As a result, these grantees have a better understanding of the kind of data they want to capture in the future and how the data will be used. In contrast, several grantees that successfully implemented working registries did not recognize how their registries can and should support care and improvement work. Therefore, the full potential of the registries was not realized during the NYSHealth grant project period.

An important note for any health center planning to implement an EMR is that a site needs to be prepared and willing to commit to investing substantial resources in registry development, implementation, and maintenance to be successful.

DELIVERY SYSTEM REDESIGN

The evidence for successful implementation of this CCM element would emerge from the delivery of effective, efficient clinical care and self-management support. This includes well-defined roles for team members, the provision of clinical case management for complex patients, and assurance of regular follow-up.

The addition of a new team member, such as a CDE, care manager, or registry coordinator, does not constitute delivery system redesign in and of itself. Effective redesign occurs only when other system components must also be adjusted to ensure the optimal integration of this new team member. Grantees that were very deliberate about this redesign aspect realized the benefit of their new team members to the greatest effect.

Delivery system design is not a collection of fragmented good ideas, but rather requires achieving a degree of systematic planning and builds on the effective integration of other model components. For example, true redesign requires not only having a registry, but also mapping out workflows to understand how the registry can be used to change the way care is delivered and how roles need to be redefined to maximize its utility. Approaching change in this way is not necessarily intuitive and requires a set of skills and a conceptual framework that may need to be taught. Several grantees expanded roles for nonphysician team members and displayed sincere belief in the value of the care team. They shared performance feedback data with the care team as opposed to the doctor only. These grantees proved to be more advanced in their system redesign efforts.

The delivery of planned care, a key objective of delivery system redesign, was most effectively achieved by grantees that used their registries to anticipate the needs of individual patients prior to their health care encounters and prepared to address those needs during patient visits.

PATIENT SELF-MANAGEMENT SUPPORT

The purpose of this CCM element is to empower and prepare patients to manage their health and health care, placing emphasis on patients' central role in managing their care. Grantees that made progress along this dimension showed use of effective self-management support strategies, including assessment, goal setting, action planning, problem solving, and follow-up. An important corollary of this work is the degree to which grantees organized their internal and community resources to provide ongoing self-management support to patients. Strong examples of this CCM element emerged from several grantee projects:

- One grantee formalized patient-directed one-on-one goal setting and follow-up and created a template for documenting self-management goals in EMRs so that all care team members could access patient goals and track progress toward meeting them.
- On another grantee project, CHWs provided patient-directed one-on-one goal setting and follow-up on progress between clinical visits. The care team was kept informed of patient goals and progress.
- Another grantee used a model where the registry coordinator and CDE provided one-on-one self-management support, and the CDE conducted group self-management education classes using the Stanford Chronic Disease Self-Management Model.

In addition, three grantees addressed the specific cultural needs of their target audience by providing educational materials and counseling in the patient's native language and addressing cultural beliefs about health.

DECISION SUPPORT

This CCM dimension promotes clinical care that is consistent with scientific evidence and patient preferences. Progress on this dimension includes observations on whether evidence-based guidelines are embedded into daily clinical practice and whether they are shared with patients. The evaluators looked for the degree to which decision support was systematically organized through the use of tickler files, standing orders, and point-of-care alerts. They also looked for integration of specialist expertise into primary care, as well as good use of evidence-based provider education methods, such as measurement and feedback, academic detailing, and ongoing training in clinical best practices.

The evaluators found that few grantees had institutionalized feedback to physicians and/or care teams on their performance, and recommendations to improve care were provided with little regularity.

Did Our Grantees Make Progress Based on the Chronic Care Model? *(continued)*

The evaluators also observed that:

- Decision supports are most readily implemented when they can be embedded in EMRs. This was deemed helpful, but not essential.
- Decision support tools are valuable not only for prompting appropriate care, but also for clinical training.
- Some of the sites relied heavily on chart audits and feedback. While this type of feedback is instructional, it is limited in its ability to be transformative. Educational interventions are best augmented with point-of-care decision supports.

DEVELOPING LINKS TO COMMUNITY RESOURCES

Progress along this CCM dimension included evidence that grantees were mobilizing and linking in community resources to meet the needs of patients. The evaluators looked for whether patients were encouraged to participate in effective community programs; whether grantees were forming partnerships with community organizations to provide access to needed services; whether grantees were extending their practices' reach into the community; or whether grantees were developing interventions to fill gaps in needed services.

Success for this CCM component is best measured by the degree to which the health provider develops the means to link patients to services in the community in an ongoing and consistent manner. Outreach events, presentations, and health fairs do not constitute building this dimension of the model. While these events may be a valuable service to the community, they do not achieve the goal of developing solid linkages between community services and individual patients.

Grantees experimented a great deal in working with their communities. For some, it meant deploying staff members into the community. The most fully articulated model in the grant cohort successfully employed CHWs to link patients to community resources (e.g., housing or child care), accessed additional self-management support services, and brought knowledge of the patient's life and self-care challenges back to the care team.

Other grantees, although not working on implementing the CCM, focused on reaching out to special populations with variable success. One grantee focused on the South Asian community, while another linked community-based mental health services with primary care. Some grantees addressed the particular challenge of reaching geographically isolated communities and patients through linkages and partnerships with community-based organizations and local school-based walking programs.

OVERALL LEADERSHIP TO TRANSFORM THE SYSTEM OF CARE

This CCM dimension examines how an organization supports this work, beginning with senior leadership. It promotes the development of a comprehensive system of change, and encourages open and systematic handling of quality problems and incentives based on quality of care. The CCM aims to create an organizational culture supported by mechanisms that promote safe, high-quality care within and across organizations. An important part is the degree to which a business case is developed and used to build support for the delivery of care. In addition to leadership, implementing new approaches to care also requires formal allocation of time and function, and cannot be done only when time allows.

Some grantees had a strong vision, dedicated leadership, a disciplined approach to quality improvement, and a strong view toward the business case for this work. Others did not have

Did Our Grantees Make Progress Based on the Chronic Care Model? *(continued)*

as much focus and discipline, but showed a great deal of promise as a result of strong internal support from their leadership.

Several grantees that stood out the most in this area demonstrated an advanced understanding of the economics of primary care delivery and used their improved system of care to expand their reimbursable services and take advantage of incentive opportunities.

The evaluators also observed that several of the grantees viewed the development of an enhanced diabetes care team as an example of their efforts to dedicate resources for diabetes improvement; they did not recognize quality improvement itself as an activity that requires its own allotment of resources. Their sole focus was on delivering more care in an improved way. To achieve quality improvement, grantees must incorporate some fundamental supports into the grant, such as allocation of grant funds or documentation of in-kind contributions.

The evaluators also noted that leadership commitment to quality improvement requires a combination of clinical, administrative, and day-to-day leadership. When one is missing, the work is compromised severely.

Final Reflections and the Future

In 2007, *Setting the Standard* was the first diabetes portfolio initiative to emerge from the newly formed Foundation. As reported above, the results from the initiative are mixed in terms of measuring each grantee's individual performance against its own objectives, and the degree to which the initiative as a whole advanced the standard of care. Some of the shortcomings in both the grantee-specific and overall initiative results are reflective of the design and structure of the initiative.

Advancing the CCM is not a formulaic endeavor. Its implementation is a complex undertaking requiring efforts on multiple fronts simultaneously: a sizeable time commitment; strong and well-informed leadership; and a commitment to establishing the financial case within the institution and with its payers. The elements of the CCM are highly interrelated and interdependent.

In general, grantee successes were most evident in practices that had prior experience in instituting the CCM model, effectively preparing them for progress during the grant period. Those that were not as well versed in the model were less clear on how to put it into practice most effectively. Prior experience with improvement measurements made a positive difference as well.

Grantees that were experienced in working with data to improve care made the most progress on advancing the CCM. These grantees showed evidence of:

- Understanding the whole of the model, including all of its dimensions, the interrelationships among them, and the implications for their use;
- Demonstrating important core capacities to implement the model, including high levels of commitment, strong leadership, infrastructure, and experience in this work; and
- Implementing the model broadly and deeply enough so that better patient outcomes can emerge.

Four grantees were the most ready to engage in this work. Each had a good understanding of what was needed to produce change, having participated previously in an improvement collaborative of some form. Leadership was solidly behind the work, with strong medical and administrative support bolstering their efforts.

The most significant lesson that NYSHealth learned from this initiative stemmed from the remaining grantees that did not have sufficient prior experience with the CCM or had not demonstrated success in previous diabetes improvement efforts, which led them to struggle with advancing the model at their institutions within the grant period. With these grantees, a longer project period supported by technical assistance would have increased the likelihood of sustained advances. The evaluators found that even with very limited technical assistance two of the less experienced grantees showed progress.

Grantmaking Lessons

The goals of *Setting the Standard* were overly ambitious, which may have led NYSHealth to accept proposals that were overly ambitious as well. In addition, NYSHealth did not devote sufficient time at the beginning of the initiative to work with grantees to assess and refine their stated objectives and workplans. Too many of the grantees needed to adjust their workplans significantly at midterm and lost valuable time and energy pursuing fruitless directions. In the future, this problem can be averted by better specification of decision-making criteria. For example, one selection criterion that was in place for judging the RFP submissions was the feasibility of the proposed strategies and interventions, but this criterion was not spelled out sufficiently. A clear description of that criterion might have suggested that true feasibility means high-level physician involvement and leadership commitment. More thought about the grantee's ability to generate clinical data also would have provided a good measure for evaluating a grantee's ability do this work. These and other indicators would have helped in the selection process.

Far more clarity was needed about what constitutes replicability. Only one of the grantees came close to achieving this goal. To be replicable, a program needs to demonstrate both that it is effective and why it is effective, based on the following measures:

- Documentation of the essential and adaptive elements of the program;
- Data on participant characteristics;
- Project details, including key initiation, transition, and ending points;
- Data on intensity, dosage, and duration in the program; and
- Data from multiple points in time on individual outcomes.

The dual tasks of implementing clinical data systems for improvement and developing an approach to evaluation were often at odds. Some of the problems that surfaced included formulating conclusions based on data from unrepresentative samples; assessing satisfaction, but not participation; lacking available data to measure specific targets; and specifying outcome measures that could not be tracked reasonably during the project period.

Overall, NYSHealth will consider including a strong technical assistance component for similar future endeavors. Implementing the CCM is a challenging effort, yet many physician groups have gone through this process and much has been learned about how to help providers. Targeted assistance benefits most organizations engaging in this work and can shorten their learning curve. These lessons are applicable as the State seeks to embed PCMH models throughout the delivery system. In fact, NYSHealth has looked carefully at the results

of *Setting the Standard* to inform the Foundation's strategy to help advance primary care in New York State. NYSHealth learned firsthand that much of the work needed to implement the CCM must be done in phases. The projects that were most successful had previously gained experience through the Health Resources and Services Administration Disparities Collaboratives. The *Setting the Standard* grant gave them an opportunity to institutionalize the CCM framework, which was good preparation for ultimately achieving level-three PCMH recognition.

NYS HEALTH FOUNDATION

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