



FINAL PROGRAM REPORT

SAN FRANCISCO QUALITY CULTURE SERIES

TRANSFORMING LEADERSHIP TEAMS ACROSS THE SAN FRANCISCO SAFETY NET

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INTRODUCTION

San Francisco clinics face unique challenges in delivering quality care for a growing population of under- and uninsured people. These challenges require clinic leadership teams to be equipped with effective skills and competencies to respond to the rapidly changing health care environment. Studies on high-performing organizations frequently name leadership commitment and alignment as key foundations for success, as well as the ability to lead effectively as a team. In an analysis of leadership effectiveness data from nearly 35,000 people working in health care, the Center for Creative Leadership (CCL) identified the ability to lead employees and to work in teams as the top priority for leadership development in the healthcare sector.¹

Redwood Community Health Coalition (RCHC), a consortium of clinics in four North Bay counties, created the original Quality Culture Series based on the Intermountain Health quality improvement training program.² RCHC saw a dramatic acceleration of improvement in several areas and attributes their success to the fact that the entire leadership team attended all sessions and effectively spread what was learned through training their clinic staff. Medical directors from three San Francisco agencies, San Francisco Department of Public Health - Community Oriented Primary Care (SFDPH-COPC), San Francisco Community Clinic Consortium (SFCCC) and San Francisco Health Plan conceived the San Francisco Quality Series based on the RCHC model.

The intent of the San Francisco Quality Culture Series (SFQCS) was to build the capacity of San Francisco clinic leadership teams to create a clinic environment where quality is championed in every regard, through the development of knowledge and skills in the areas of teamwork, leadership, management and the Model for Improvement.

PROGRAM LEADERSHIP

The development and implementation of the program was a collaborative effort, achieved through a partnership between the following:

PROGRAM ADVISORS

The medical directors from the three San Francisco partner agencies noted above served as program advisors, providing strategic direction and vision throughout the duration of the program. Their high level of engagement and commitment was essential to both obtaining buy-in and securing commitment from all clinic teams, as well as ensuring that the program was appropriately tailored and delivered in a manner that resonated with San Francisco safety net clinics.

PROGRAM OFFICE

The Center for the Health Professions (Center) administered the program and oversaw all day-to-day operations. The Center worked closely with the program advisors and learning session faculty in the development of the learning session structure and curriculum materials. The Center was responsible for tracking program progress and overseeing the evaluation process.

¹ Center for Creative Leadership, 2010: Addressing the Leadership Gap in Healthcare. Available at <http://www.ccl.org/leadership/research/sharing/index.aspx#whitePapers>

² <http://intermountainhealthcare.org/qualityandresearch/institute/courses/atp/Pages/home.aspx>

LEAD COACH

The lead coach coordinated the development of the theory and measurement strategy for each of the quality improvement project topic areas, and managed the data from all 21 quality improvement projects. This role served as the central contact for all program coaches, ensuring the coach perspective was represented in the program planning.

Program coaches, learning session faculty, and San Francisco Health Plan health improvement staff served as advisors to the program when needed.

Participants

PARTICIPANTS

ORGANIZATIONS

25 leadership teams enrolled at the start of the program in January 2011: 23 from clinics, and 2 administrative leadership teams from SFCCC and SFDPH -COPC. Prior to the start of the first learning session, each team member was required to sign a memorandum of understanding (MOU) indicating agreement with the program requirements and his/her commitment to attend all learning sessions and leading a quality improvement project.

Early in the program, two clinic teams withdrew due to organizational changes.

21 primary care clinics and the 2 leadership teams completed all program elements. The clinic affiliations for the final 21 clinic teams were as follows:

SFDPH - Community Oriented Primary Care	11
SFDPH - Hospital Based Clinics	5
San Francisco Community Clinic Consortium	4
Other - Hospital Based	1

TEAMS

Team size ranged from 3 - 6 members based on the size of the clinic. The composition of the teams also varied depending on clinic affiliation. For example, clinic teams affiliated with SFCCC were generally comprised of the executive director, medical director, clinic or administrative director, and QI manager. Clinics affiliated with the SFDPH were generally comprised of a medical director, a second physician leader, nurse manager, and principal clerk. Additional team members representing social work or behavioral health positions were included depending on the clinic's scope of services.

While there was some staff turnover over the course of the program year, the composition remained the same for the majority of teams. The most significant modifications occurred among the SFDPH-COPC clinics as 3 clinic teams experienced a change in medical director.

“Going to QCS was really good - for the first time in 15 years I felt valued as a manager. Principal Clerks aren't even called managers”

- PRINCIPAL CLERK

INDIVIDUALS

103 individual participants made up the 23 teams. In general, individual participants were well-seasoned health care professionals with a considerable amount of institutional knowledge having worked at their organization an average of 11 years. (Table 1.)

Table 1: SFQCS Participant Demographics (n=86*):

* This represents demographics of 83% of participants who started the program

Sex	Female: 77% (65) Male: 23% (21)
Race/Ethnicity	White: 50% (43) Asian: 30% (26) Hispanic/Latino: 20% (17) African American: 7% (6) American Indian/Alaskan Native: 6% (5) Native Hawaiian/Pacific Islander: 5%(4)
Length of Time in Current Position	Range: 1 month - 29 years Mean: 5.5 years Median: 4 years
Length of Time at Current Organization	Range: 1 month - 37 years Mean: 11 years Median: 10 years
Length of Time Working in Health Care	Range: 1 month - 40 years Mean: 17.9 years Median: 18 years

PROGRAM ELEMENTS

LEARNING SESSIONS

A series of eight learning sessions were the core of the SFQCS program. These full-day sessions were held once per month over the course of 9 months starting January 2011 and ending September 2011 (no August session). Sessions were taught by expert faculty who worked closely with program advisors and staff to tailor their content and teaching format to enhance the relevance of the material for this group, ensure there was adequate time for teams to work together on specific exercises, and make certain that each session was responsive to participant feedback obtained at the conclusion of the prior session. The quality of the partnership between the program advisors, staff, faculty and coaches allowed for this ongoing iterative process to occur seamlessly.

Primary topics presented at each learning session are presented in Table 2.

Table 2: Learning Session Topics

Session # 1	- Developing & Building Teams - Using a QI Plan to Organize Your Journey
Session # 2	- Model for Improvement (Aims, Measurement, PDSAs)
Session # 3	- Project Management - Teaching QI
Session # 4	- Communication - Working With and Through Others - Managing and Leading Change
Session # 5	- Fundamentals of Operations Management - Sustainability and Reliability
Session # 6	- Making the Business Case for Change - Giving and Receiving Feedback - Decision Making
Session # 7	- High Performing Teams - Emotional Intelligence - Managing Conflict
Session # 8	- Developing a QI Training Plan - Spread and Sustainability

In addition to the topics noted above, each learning session included other activities to facilitate the sharing of challenges, successes, and best practices among teams.

Attendance at the learning sessions was extraordinary, especially considering the intensity of the program:

- 91% overall attendance rate
- 100% of teams had at least 2 members at every session
- 100% of individuals attended at least 6 out of 8 sessions

QUALITY IMPROVEMENT PROJECT

As part of their participation in the program, each team was required to undertake a quality improvement project in one of four strategic priority areas for the San Francisco safety net: 1) improving appointment access, 2) achieving Meaningful Use of Electronic Health Records (EHR) as a tool for quality and safety, 3) improving the patient experience, and 4) integrating behavioral health into primary care. Teams were asked to indicate their preferred topic prior to the start of the program.

The breakdown of topic areas among the 21 clinic teams were as follows:

Improving Access	11
Meaningful Use of EHR	7
Improving the Patient Experience	2
Integrating Behavioral Health into Primary Care	1

Teams were asked to select their project measures from a suite of required and optional measures for each topic area; the set of measures for each topic was created by the coaches with input from the program advisors. Some teams modified the measure set to fit with their internal priorities or their data collection capacity, which sometimes lead to a less than uniform set of final measures. Each team shared their project data with their respective coach according to the terms established by the coach and clinic team at the start of the program. Teams were required to submit data to the Program Office on a quarterly basis.

It was the expectation that clinic teams would continue to work on their project after the program officially ended. Project “completion,” vis-à-vis the guidelines for program participation, was defined as each team having completed the following:

1. Project Charter, adapted from a template developed by the Institute for Healthcare Improvement, asked teams to outline the following: the aim of their project and why was it important; the measures to be tracked and the plan to collect the data; and the activities they would undertake including potential PDSA cycles, project timeframe, and communication plan. In addition, to help reinforce messages and exercises from the first learning session regarding the formation of teams, the charter included an area for teams to indicate their team values and their overall purpose.
2. Baseline data submitted to coach and program office.
3. Quarterly reports, including progress on project measures, submitted to coach and program office.
4. 10 hours of intersession coaching with assigned QI coach.
5. Final data and narrative report submitted to coach and program office.

COACHING

Each team was assigned a coach to provide them with additional guidance in the execution of their quality improvement project. In addition to assisting teams with the mechanics of their projects, many coaches also helped their team reflect on the content delivered at the learning session and helped teams navigate leadership, management, and team dynamic issues that arose during the course of the program. With the exception of two teams who had a coach in a remote location, the coaching was done in person whenever possible.

All coaches had expertise in the Model for Improvement and the implementation of quality improvement initiatives in clinic settings. To the extent possible, coaches were assigned to clinics based on their familiarity with the clinic and their expertise in the chosen topic areas.

Each team was asked to use at least 10 hours of coaching and was allowed to use up to 25 hours over the course of the program year. Due to availability of extra funds towards the end of the program, a few clinics extended their hours past the 25 hour maximum.

The summary of coaching hours used is as follows:

% of clinics reaching 10 hr minimum	100%
Range of hours used	10.25 hrs – 28.25 hrs
Mean hours used	20.6 hrs.

WEBINARS

Recognizing that many teams were in need of additional content knowledge and support specific to their quality improvement project topic and outside of what could be provided during learning sessions and by their coach, two webinar series were held addressing key knowledge and skill gaps related to improving appointment access and preparing for EHR implementation.

The Improving Access Webinar Series provided content and a shared approach to improving access to appointments. The 6-part series was held over a period of 4 months and was led by one of the coaches with expertise in this area.

Forty-six SFQCS team members participated in the webinar series - the topics for the 6 webinars were as follows:

Webinar # 1	Advanced Access: What's it all About?
Webinar # 2	Measurement Webinar – Review access measures
Webinar # 3	Establishing Patient Panels and Promoting Continuity
Webinar # 4	Advanced Access; How to Make it Work Part 1
Webinar # 5	Advanced Access; How to make it Work Part 2
Webinar # 6	Open Forum

The EHR Preparation Webinar Series provided additional content on critical techniques and processes related to preparation for and implementation of EHRs. The 3-part series was held over a period of 3 months and was led by one of the meaningful use coaches.

Thirty-six SFQCS team members participated in the following webinars:

Webinar #1	Chart Abstraction: an overview of techniques, recommendations and best practices for populating the electronic chart with key information from the paper chart before, during and after “go-live.”
Webinar #2	Workflow Redesign: an overview of how process analysis and process mapping can support efficiencies.
Webinar # 3	Implementation and Training Strategies: a presentation of several ways to introduce the EHR into “production,” the benefits and challenges of each approach relative to training, access and provider productivity.

MICROSOFT OFFICE SKILLS CLASSES

Half-day trainings in Microsoft Excel, PowerPoint, and Word & Email Handling were offered to all SFQCS participants outside of the 8 learning sessions. These three in-person classes were offered on a first-come first-serve basis and were taught by a Certified Microsoft Office Instructor. 23 people participated in the Excel class; 19 participated in the PowerPoint class; and 15 participated in the Word and Email handling class.

“MANAGEMENT 101” BOOKS AND TRAININGS

Each participant received 5 management books along with structured interactive training around the core concept presented in the books. The books and exercises were designed to teach basic skills in running effective meetings (Patrick Lencioni, *Death by Meeting*), using metrics as a tool to improve accountability and morale (Patrick Lencioni, *Three Signs of a Miserable Job*), basic time management (David Allen, *Getting Things Done*), effective recruitment and hiring (Geoff Smart, *Who*) and building effective teams (Patrick Lencioni, *Five Dysfunctions of a Team*).

EVALUATION

STRUCTURE

The program was evaluated in the areas of participant perception of the program, individual and team changes, and clinic level changes (Table 3).

Table 3: Evaluation Elements

LEVEL	WHAT WAS ASSESSED	MECHANISM
Participant Perceptions of Program	Quality and value of individual learning sessions.	Learning session evaluations completed by individuals
	Quality and value of coach	Coaching evaluation completed by each team
	Quality and value of overall program	Program evaluations completed by individuals Narrative reports completed by each team.
Individual and Team Changes	Employee engagement	Gallup 12
	Team functioning	Team Development Survey Individual program evaluations Narrative reports completed by each team
Clinic Changes	Clinic capacity for quality	BCCQ Clinic Capacity for Quality Assessment Individual program evaluations Narrative reports completed by each team
	Training sessions for staff	Narrative reports completed by each team
	Quality improvement project metrics	Quality improvement project data collected by team and submitted to program office

There are limitations to the evaluation data to keep in mind. First, as with most leadership program evaluations, the degree to which participants can distinguish between improvements due to their participation in SFQCS and other outside factors is not always clear. Secondly, with the exception of the data related to the quality improvement projects, data are self-reported. However, given the high response rate across evaluation activities, we feel the results present an accurate story about SFQCS.

RESULTS

Perceptions of Program

Learning Sessions – Participant Feedback

Individual participants completed session evaluations at the conclusion of each of the 8 learning sessions. Participants rated each individual session and associated faculty member(s) on 7 domains, and the overall learning session on 3 domains.

There were a total of 15 individual sessions spread over the 8 learning sessions. The mean ratings for all 7 items across the 15 sessions were very high, falling between 4 (very good) and 5 (excellent). (Figure 1) The most highly rated sessions were Giving and Receiving Feedback and Decision-Making. Participants also rated the overall sessions very highly, with the mean of the 3 items assessed across all 8 sessions also falling between 4 and 5. (Figure 2)

Figure 1: Ratings of 15 individual sessions included in the 8 learning sessions

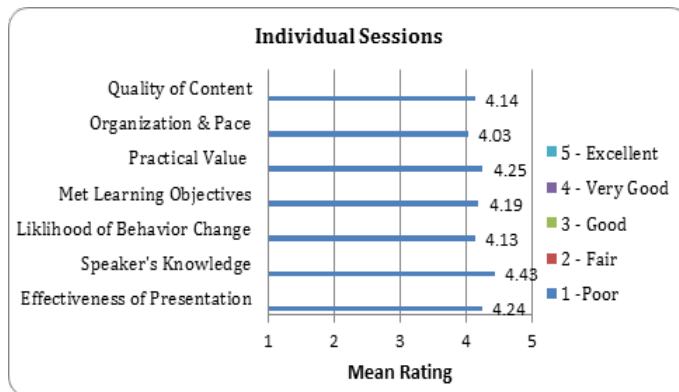
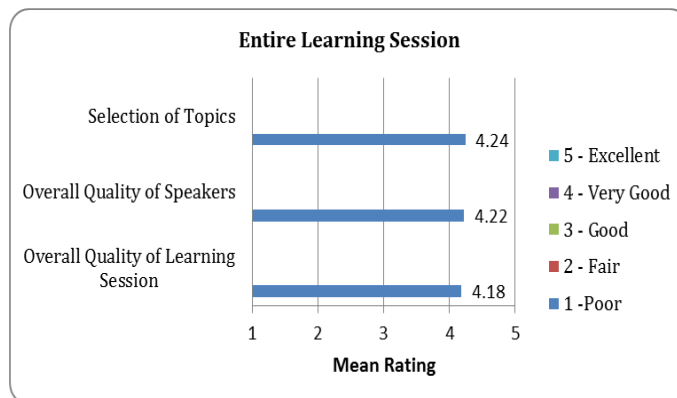


Figure 2: Overall ratings of each of the 8 learning sessions



OVERALL PROGRAM – PARTICIPANT FEEDBACK

At the conclusion of the last learning session, participants were asked to rate the overall quality of the entire program, as well as the degree to which they believed the culture of quality at their clinic had improved as a result of their teams' participation. Culture of quality was defined as follows: "The culture of the clinic is one that champions quality in all regards. The clinic can successfully adopt new practices, protocols and technologies that optimize clinical quality, patient and employee satisfaction, operational efficiencies and revenue."

100% of participants who completed the evaluation rated the quality of the program as very good or excellent (Figure 3), and 97% of participants agreed or strongly agreed that their teams' participation helped to improve the culture of quality at their clinic. (Figure 4)

Figure 3: Overall Quality of Program (N= 67)

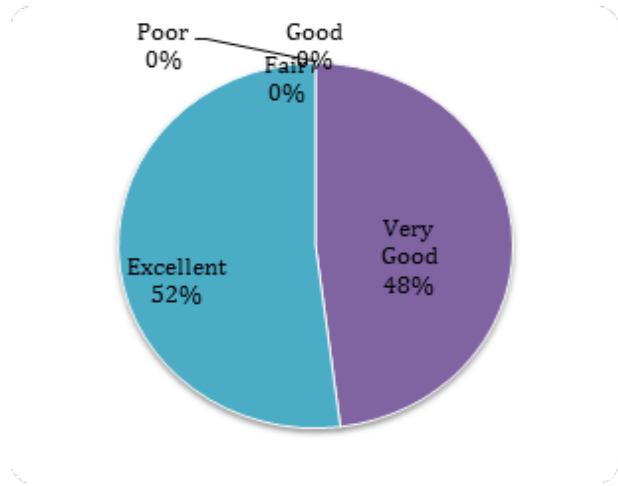
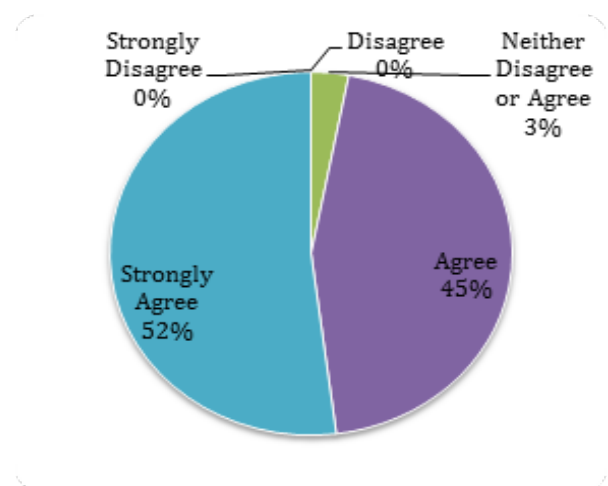


Figure 4: Improved Culture of Quality (N=66)



Additional feedback about the program was obtained at the last learning session as well as from the final narrative reports submitted by all teams in January 2012. Key themes were as follows:

MOST HELPFUL ASPECTS

- Knowledge and skills that helped enhance teamwork and strengthened team effectiveness.
- Having protected time at learning sessions for the team to work on clinic issues together.
- Tangible tools and resources, including the books that helped teams apply the learning session content.
- Opportunity to network with other clinics and creation of a sense of unity among the safety net clinics.

SUGGESTIONS FOR IMPROVEMENT

- Too much content. More depth, less breadth.
- More opportunities for different or more staff to participate.
- More coach involvement. More coaching hours and/or having coaches at every learning session.
- More opportunities for interaction and discussion among clinic teams at learning sessions.

“SFQCS helped our team understand the importance of integrating quality into all aspects of work at our clinic and highlighted the essential role that leadership must play in fostering a quality culture. In addition, the program provided the tools and professional development opportunities required to turn these lessons into action at our own organization. We would not have progressed so far in our quality journey without the support of the San Francisco Quality Culture Series.”

- EXECUTIVE DIRECTOR

COACHING - PARTICIPANT FEEDBACK

At the conclusion of the program, each individual team completed an evaluation of their coach. Teams were asked to rate their level of agreement with 10 items including key areas where practice coaching has shown to be of benefit.³ While a few teams did not have a positive experience with their coach, overall, teams rated their coaches highly and felt that they were integral to the success of their QI projects. (Table 4)

“ We found encouragement and objectivity of a person outside of the management team, who knew our goal and our dynamics very helpful. We love the idea of ongoing coaching ”

- CLINIC TEAM

Table 4: Results of Coach Evaluation

Our QCS coach...	Strongly Disagree (1)	Disagree (2)	Neither (3)	Agree (4)	Strongly Agree (5)	Mean
...helped our team apply the content provided at the 8 SFQCS learning sessions.	0	1	3	10	7	4.10
...encouraged our team to test changes that we may not have done on our own.	0	1	3	10	7	4.10
...helped extend the perspective of our team by providing outside experiences and sharing information from other clinic settings.	1	0	2	7	11	4.29
...helped us build a better and more effective team.	1	2	4	8	6	3.76
...was committed to our team's success.	0	0	3	6	12	4.43
...bonded with our team through his/her motivation and encouragement	0	3	2	4	11	4.15
...empowered our team by setting the stage and then giving us permission to do things on our own.	0	1	2	9	8	4.20
...was a valuable resource because of his/her knowledge and expertise in the specific strategy we chose to work on.	1	0	3	6	11	4.24
...helped hold our team accountable to SFQCS deliverables.	0	0	1	10	10	4.43
...was integral to the successful execution of our SFQCS QI project.	1	2	2	5	11	4.10

Teams also commented on the most helpful aspect of having a coach, what specific actions they took because of their coach, what challenges they faced with their coach, and how the coaching component of the program could be improved. (Table 5)

³ Coleman, K., Pearson, M., Wu, S. Integrating Chronic Care and Business Strategies in the Safety Net: A Practice Coaching Manual. 2009. Agency for Healthcare Research and Quality.

Table 5: Additional feedback from coaching evaluation

<p style="text-align: center;">MOST HELPFUL ASPECTS</p> <ul style="list-style-type: none"> • Helped teams focus and stay on task • Provided useful feedback from outside perspective • Helped teams reflect and plan for future • Held team accountable – helped individuals hold each other accountable. • Reinforced QI skills and processes (e.g., doing PDSAs, process mapping) 	<p style="text-align: center;">SPECIFIC ACTIONS</p> <ul style="list-style-type: none"> • Met as a team more frequently • Faster implementation of changes • More frequent data collection • Process mapping • Structured PDSAs
<p style="text-align: center;">CHALLENGES</p> <ul style="list-style-type: none"> • Making the time to meet with coach • Coordination of schedules • Identifying the best use of coach’s time • Needed more active engagement from coach • Mismatch between team needs and what coach could provide • Needed more flexibility in coach’s approach 	<p style="text-align: center;">SUGGESTIONS FOR IMPROVEMENT</p> <ul style="list-style-type: none"> • More coaching hours and greater involvement • Access to coaches as alumni • Better clarification about the role of the coach and how best to utilize him/her • More focus on issues like teamwork, communication, rather than QI mechanics • Better assessment of where teams are starting from and on what coach should focus

INDIVIDUAL AND TEAM CHANGES

Employee Engagement

The Gallup 12 survey was used to assess individual participants’ level of engagement at the start of the program and again at the conclusion of the learning sessions. The Gallup 12 is a widely used instrument consisting of questions covering the twelve domains related to employee engagement shown to be most important in sustaining workplace excellence.⁴ An additional question was added at the end of the 12 standard questions assessing overall job satisfaction.

The results demonstrated modest improvement in most items and level of overall engagement among program participants, and helped identify areas in need of continued focus. (Table 6) While additional staff from each clinic did not complete this particular survey, many of the clinic teams used the Gallup 12 on their own to assess employee engagement with their entire clinic staff.

“ We have greater staff engagement; they are more vocal in making and trying changes independently. We don’t have a quiet group anymore, all good! ”

- MEDICAL DIRECTOR

4 <http://www.gallup.com/consulting/52/Employee-Engagement.aspx>

Table 6: Pre/Post results of employee engagement survey

* Items were rated on a scale of 1 (strongly disagree) to 5 (strongly agree)	Time 1 (N=87)	Time 2 (N=96)	Change
I know what is expected of me at work.	4.23	4.25	.02
I have the materials and equipment I need to do my work right.	3.43	3.47	.04
At work, I have the opportunity to do what I do best every day.	3.61	3.66	.05
In the last seven days, I have received recognition or praise for doing good work.	3.45	3.58	.13
My supervisor, or someone at work, seems to care about me as a person.	4.24	4.20	-.04
There is someone at work who encourages my development.	3.67	3.91	.24
At work, my opinions seem to count.	4.15	4.26	.11
The mission/purpose of my organization makes me feel my job is important.	4.28	4.43	.15
My co-workers are committed to doing quality work.	4.16	4.04	-.12
I have a best friend at work.	2.97	3.36	.39
In the last six months, someone at work has talked to me about my progress.	3.33	3.71	.38
In the last year, I have had opportunities at work to learn and grow.	4.16	4.38	.22
Overall Engagement	3.88	3.94	.06
My organization is a better place to work than it was twelve months ago.	3.54	3.86	.32

TEAM FUNCTIONING (TEAM DEVELOPMENT SURVEY)

The Campbell-Hallam Team Development Survey (Vangent) (TDS) was used to assess the functioning of each clinic team. This instrument asked team members to report how they felt about issues such as innovation, organizational support and mission clarity, among others, and measured 19 dimensions of team functioning falling under 4 main themes: resources, improvement, efficiency, team success. The TDS was administered prior to the start of the learning sessions as well as 10 months later following the final learning session.

Each team received a comprehensive report on their results from the initial assessment at the first learning session. At the conclusion of the program, each team received a comprehensive report on their results from the follow-up assessment in addition to a comparison report indicating their team’s change in each of the 19 dimensions.

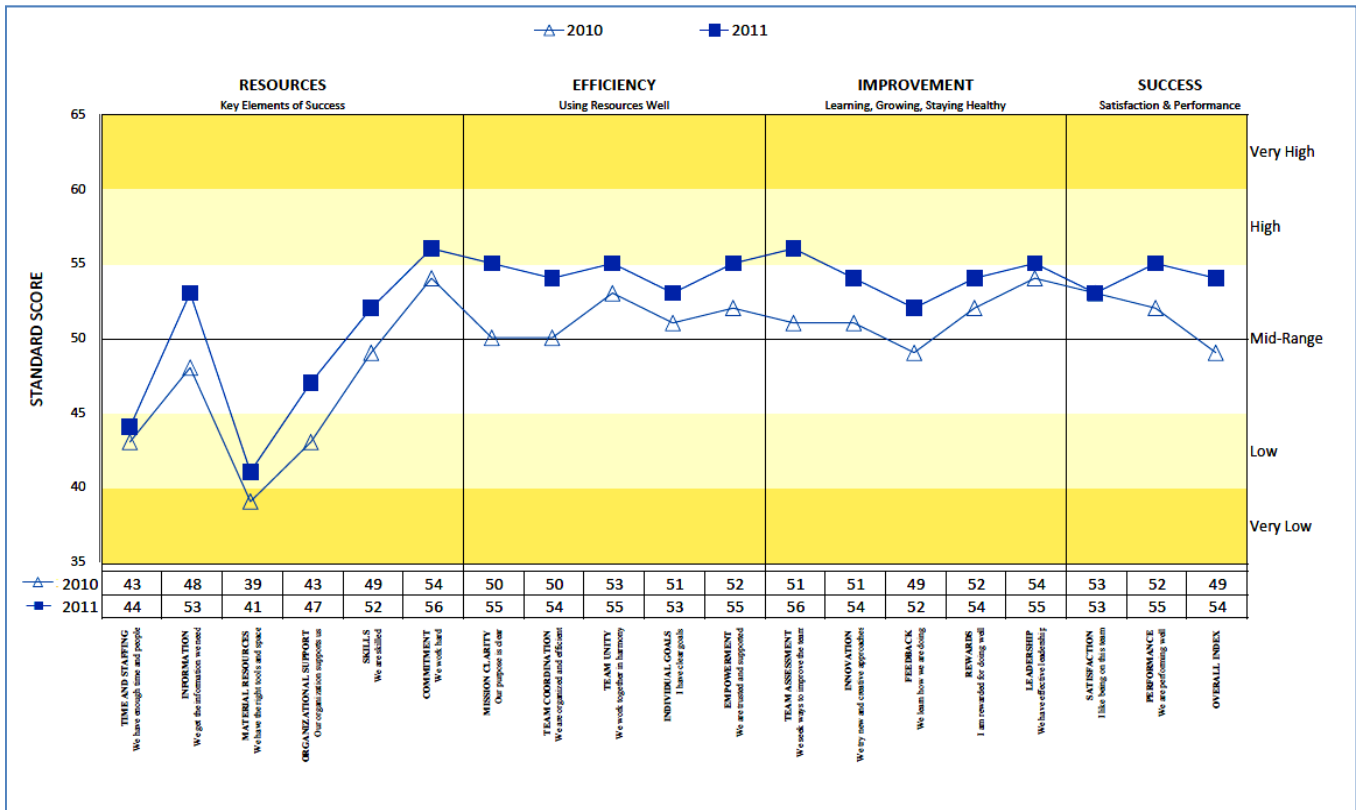
“The management team is functional and much more cohesive, beginning to take ownership for the overall direction, functioning and outcomes in the clinic”

- MEDICAL DIRECTOR

A comparison report was also generated for the aggregate of all teams. (Figure 5) As a group, there was improvement in 18 out of 19 dimensions, with the largest improvement (5 points) seen in Mission Clarity (“our purpose is clear”), Information (“we get the information we need”), Team Assessment (“we seek ways to improve our team”) and the overall index score. (See Appendix B for copy of report)

Even though there was not a 100% response rate for the pre and post surveys, each team met the minimum number of respondents to generate individual team results.

Figure 5: Pre/Post Comparison of Team Development Survey Aggregate (N=96; N=89)



In the last learning session evaluation and in their final reports, participants were also asked to identify the most important changes in their team resulting from their participation in the program. Key themes most frequently referenced were as follows:

- Enhanced communication
- Improved meetings in terms of frequency and effectiveness
- Greater cohesion
- Increased focus and commitment to quality improvement

“Before we had the experience of attending SFQCS, our management team did not really function like a team. It was a management group who met to exchange information and put out fires and try to figure out how to get the two main clinic groups to ‘get along’. Although all were committed to the clinic, there was no framework for tackling issues together. Now we have added a clinician and are using many of the teamwork tools and processes we learned at SFQCS.”

- NURSE MANAGER

CLINIC CHANGES

Clinic Capacity for Quality

Each clinic's capacity for quality was assessed using a tool developed by the Building Clinic Capacity for Quality (BCCQ) Program. The BCCQ program adapted it from several different instruments including the Chronic Illness Care Survey v. 3.5, Quality Culture Series Health Center Culture Of Quality Assessment, Tools for Quality Program Community Clinic CDMS Adoption Self-Assessment, and the Doctor's Office Quality - Information Tech EHR Readiness Assessment. The intent of the tool was to measure clinics' level of preparation in twelve areas related to quality. Clinics were rated on their level of preparedness (1 - Not yet prepared to 6 - Highly prepared) on 12 items (Table 7). Together with their coach, each team completed the assessment prior to the start of the program in December 2011 and once again following the conclusion of the program in December 2012. (See Appendix A for copy of instrument).

“Our infrastructure for QI is dramatically expanded. We have new IT tools, new data management and reporting processes and standards, and a refined ability to test and manage change.”

- CLINIC TEAM

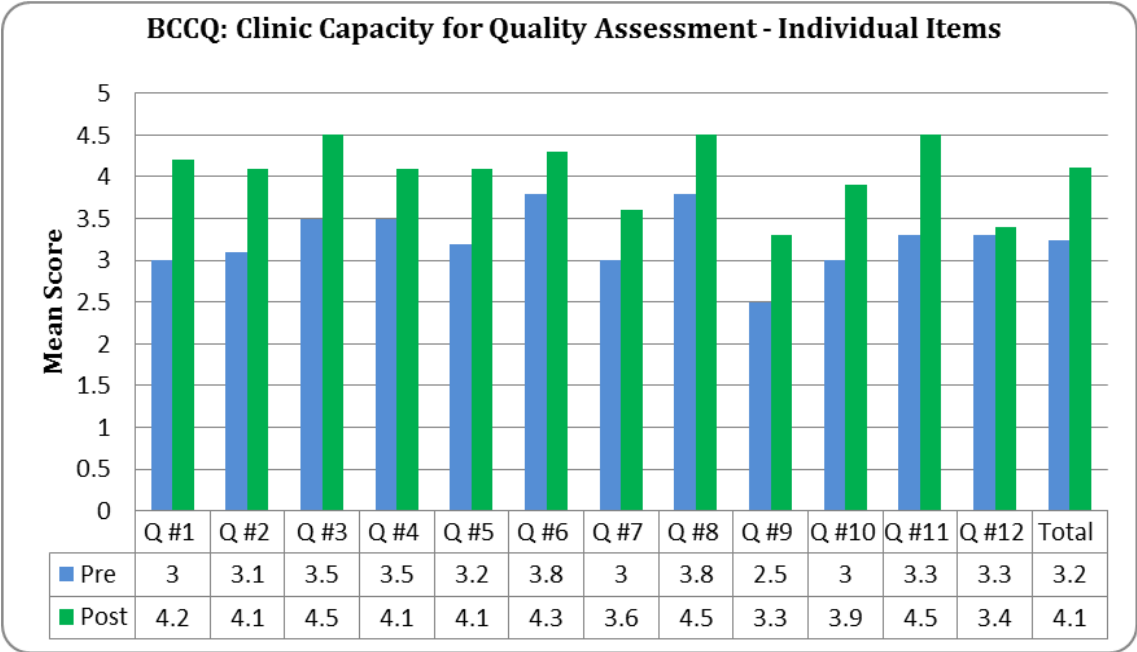
Table 7: Questions from the Clinic Capacity for Quality Assessment

#	QUESTION
1	Organization wide vision for quality improvement
2	Strategic planning and implementation of quality improvement, population health management and workflow efficiency initiatives
3	Management of quality improvement initiatives and chronic care coordination
4	Management reports show organizational performance
5	Staff appreciation of importance and understanding of the use of data and information flow
6	Clinician involvement in quality improvement initiatives
7	Patient involvement in chronic care treatment
8	Development and sharing of best practices and standards for quality improvement
9	Training plans involving quality improvement processes and staff understanding of these processes
10	Integration and use of data elements necessary to manage chronic care
11	Frequency of data driven decision making
12	UDS and OSHPD and other data reporting requirements

* Question #12 referred to UDS and OSHPD reporting. Because the individual DPH clinics are not responsible for this (DPH does it on behalf of all clinics) all DPH clinics were rated as 3.5 on both the pre and post assessments.

It is important to note that there were instances where a high-performing clinic viewed the assessment through a more critical lens than a less experienced clinic. While there were no clinics with scores that were substantially different from what was anticipated, the subjective nature of this instrument should be considered when reviewing raw scores and comparing clinic by clinic performance. It is most useful to look at the change in clinic scores from pre to post test. Across all clinics, there was improvement in the mean score of each of the 12 items. (Figure 6) The greatest improvements (1.2 pts) were in the areas of organization-wide vision for QI (Q#1) and the degree to which data is used to drive decision-making (Q#11).

Figure 6: Mean of each item from Clinic Capacity for Quality Assessment (N=20, N=21)



“Prior to SFQCS, we were not collecting or monitoring data in a standardized way. Our SFQCS project, and the training we received from SFQCS and our SFQCS coach, has dramatically enhanced our organization’s capacity to collect, analyze, monitor and respond to our data.”

- CLINIC TEAM

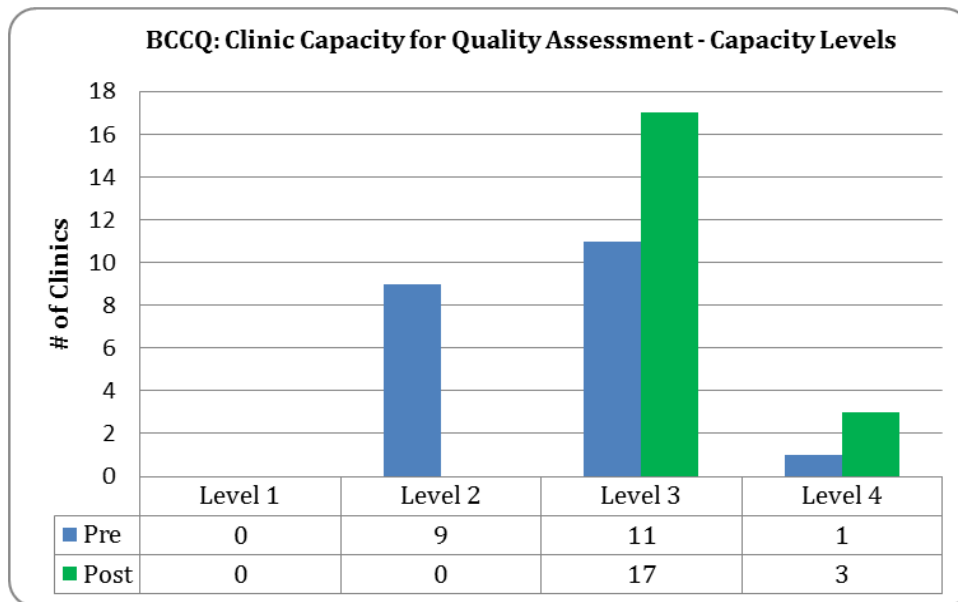
In addition to looking at performance in each individual item, this assessment tool provided a “capacity level” for each clinic based on the sum score of all 12 items. Descriptions of the four capacity levels and the sum score they represent are in Table 8.

Table 8: Explanation of Clinic Capacity Levels

LEVEL	EXPLANATION	SCORE
1	The clinic has no standardized QI program. While the organization may have implemented small scale projects to address specific issues, there is no QI oversight, committee structure or measurement program.	1 - 15
2	The clinic's efforts are compliance or quality assurance related and focus on providers and peer review. Any existing oversight, committee structure, or measurement strategy focuses on maintaining compliance with regulatory guidelines.	16 - 35
3	QI is embraced by all clinic staff and is somewhat integrated into clinic operations but is limited in scope, for example, to the management of one chronic condition. Measurement is done manually or with limited use of technology.	36 - 55
4	QI permeates the clinic's vision and operations and includes staff at all levels. The clinic has robust QI oversight, committee structure and measurement systems with specific goals known to all staff. Work of the QI Committee is directly linked to the strategic plans	56 - 72

At follow-up, there was also an increase in the number of clinics characterized as level 3 and 4, with no clinics remaining at level 2. (Figure 7)

Figure 7: Capacity Level of Clinics Pre and Post



Overall, a total of 11 clinics moved up at least one level, 8 clinics maintained their level and 1 clinic moved down a level. (Figure 8) The clinic that moved from a 4 to a 3 was going through an EHR rollout during the program period. This impacted their ability to address certain aspects of the capacity assessment as effectively as they were at the start of the program.

Figure 8: Capacity Level Change from Pre to Post

PRE-TEST LEVEL		POST-TEST LEVEL
# of CLINICS MOVING UP LEVELS		
LEVEL 2	8	LEVEL 3
LEVEL 2	1	LEVEL 4
LEVEL 3	2	LEVEL 4
# of CLINICS STAYING AT SAME LEVEL		
LEVEL 3	8	LEVEL 3
# of CLINCS MOVING DOWN A LEVEL		
LEVEL 4	1	LEVEL 3

“ Instead of planning and planning and planning some more to accommodate and to anticipate every pitfall, we have learned it is ok and even more valuable to just try as is and then make revisions as necessary. Data is now viewed as something positive, something that validates the hard work we are doing.”

- CLINIC TEAM

In the last learning session evaluation and in their final reports, participants were also asked to identify the most important changes in their clinic resulting from their participation in the program. Key themes most frequently referenced were as follows:

- Increased staff involvement in QI initiatives including broader use of PDSA cycles.
- Greater buy-in and motivation for change
- Enhanced orientation to data and its use in decision-making
- Improved staff satisfaction

“ Our clerical and registration staff have commented that they feel a part of the clinic and the clinic-wide efforts to improve the quality of care for our patients and are applying their experience and expertise to improving our workflows and care.”

- CLINIC TEAM

BRINGING THE TRAINING HOME

The intent of this program was not only to provide teams with knowledge and skills to make needed changes back at their clinics, but to also encourage and support them in their efforts to train other staff using the learning session content.

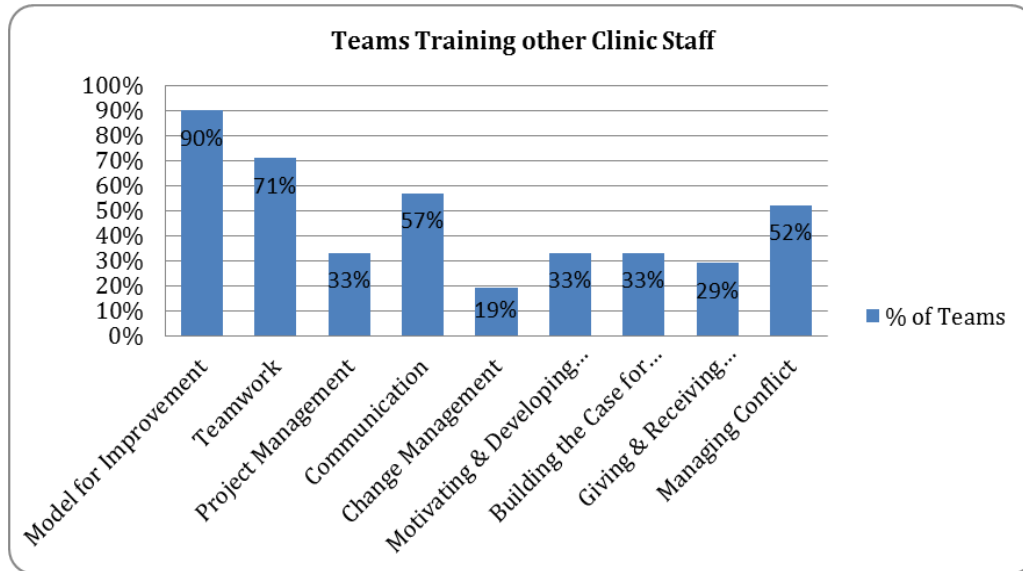
At the conclusion of the program, each clinic team was asked to indicate what types of trainings they had completed with other clinic staff since the start of the program and to provide detail about how

“ ...the entire SFQCS was a wonderful experience for the entire team. And I mean the entire team, as the learned lessons have been spread throughout the organization.”

- EXECUTIVE DIRECTOR

it was delivered. All 21 clinics completed trainings in at least 1 topic area (Range 1-8; Mean 4.3), with the majority of teams having completed trainings in the Model for Improvement, Teamwork, Communication, and Managing Conflict. (Figure9)

Figure 9: Clinic Trainings on Learning Session Content



QUALITY IMPROVEMENT PROJECT METRICS

All 21 clinic teams successfully completed their QI projects as defined by the criteria noted earlier. There was variability in terms of project rigor and the degree to which clinics met their project goals. This was due in part to the fact that clinics were encouraged to be ambitious in their goal setting, which sometimes resulted in teams not meeting goals even though they made significant improvements. Variability in project success was also a result of the ongoing program emphasis on building skills in leadership, management, operations and QI, with the project functioning as “homework” and a way to practice those skills, rather than as an end in itself. Throughout the program, SFQCS leadership continued to emphasize the importance of building the team and skills of the leaders, and advised the teams not to let the demands of the project distract them from building these skills and finding ways of spreading the trainings to their staff. The leadership team felt that this emphasis would ultimately have more lasting impact than that of a single one-year project. Nevertheless, despite a lesser emphasis on project outcomes, there was still a great deal of improvement in key measures across all teams. Results for specific measure outcomes are below.

ACCESS AND PATIENT SATISFACTION

Among teams focusing on access or patient satisfaction, there was improvement in 4 out of 6 measures across all clinics. (Figures 10- 17) These two topic areas were combined since there was overlap in measures used (e.g., cycle time).

Figure 10: Time to Third Next Available (N=5 Clinics)

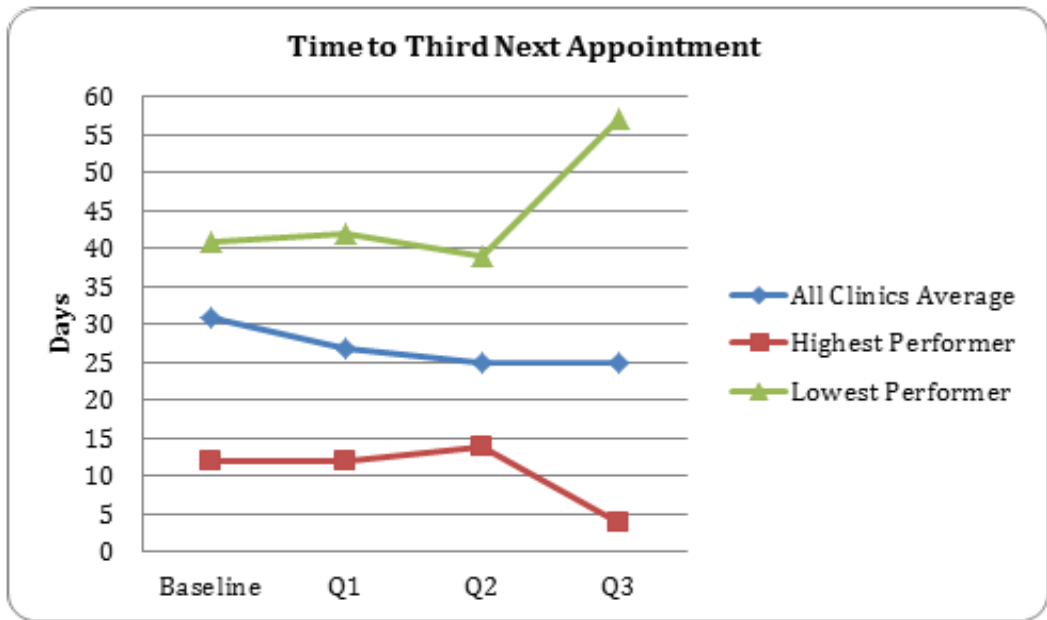


Figure 11: Time to Third Next Available w/o Outlier (N=4 Clinics)

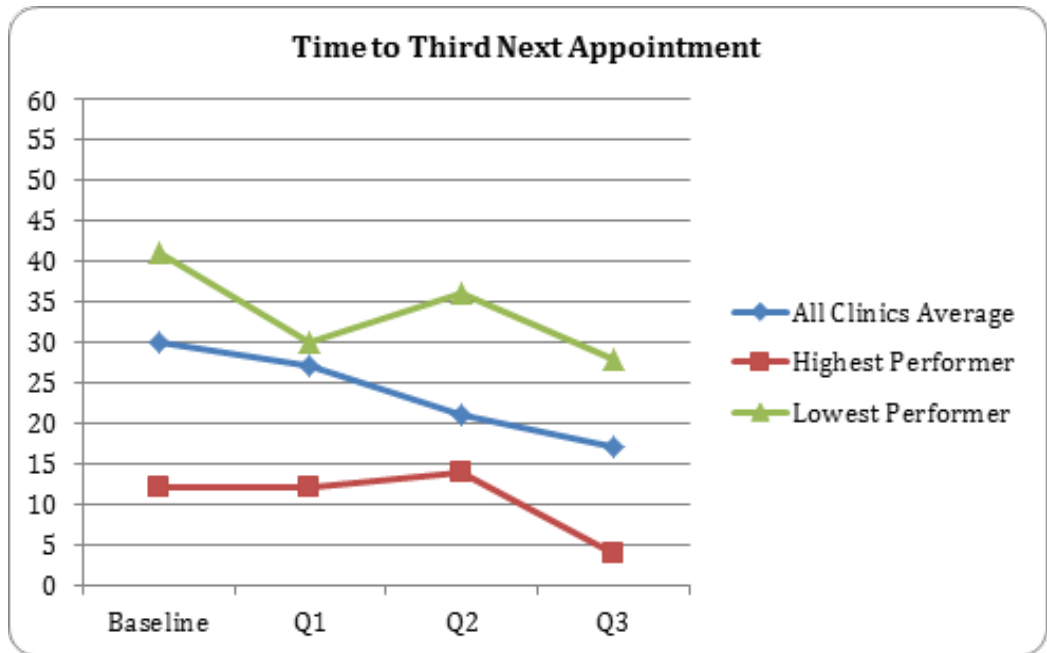


Figure 12: No show rate (N=5 Clinics)

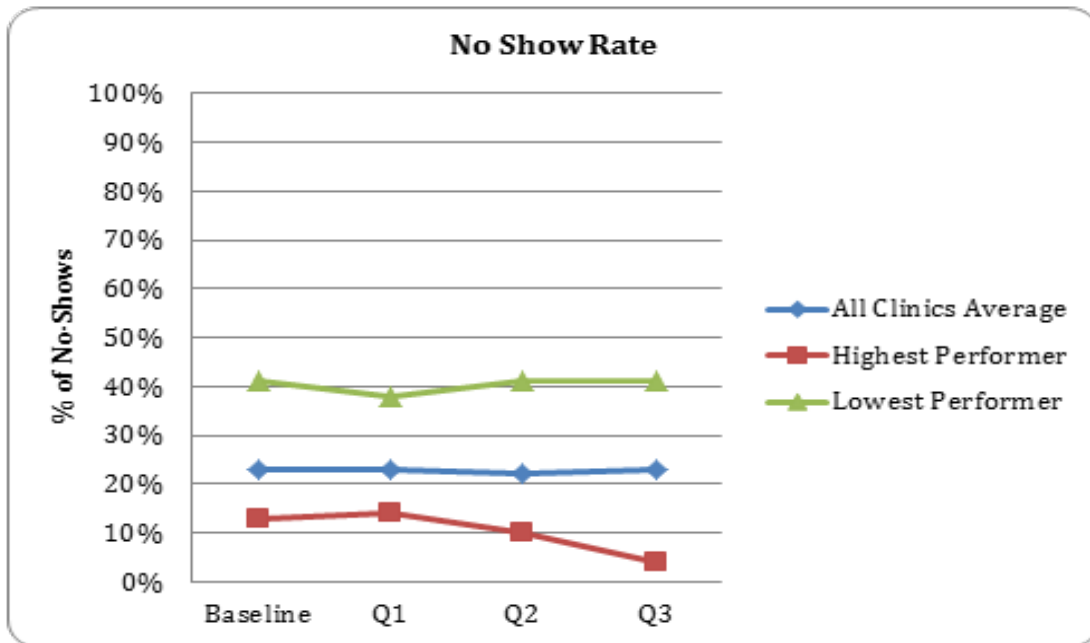
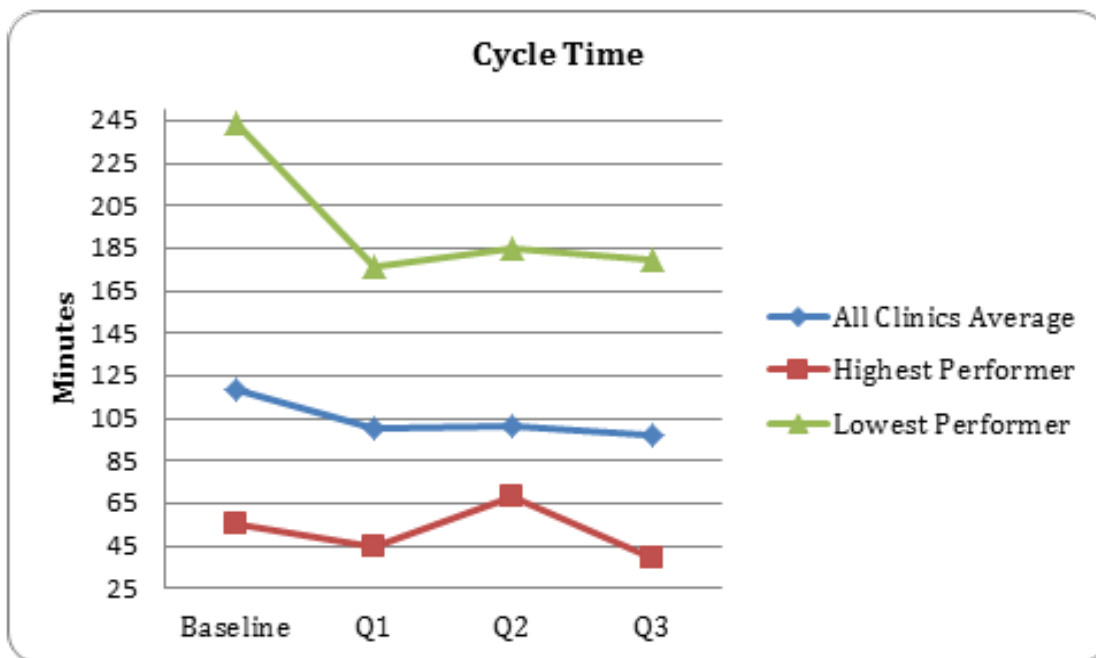


Figure 13: Cycle Time (N=4 Clinics)



* The lowest performer and outlier above was an urgent care clinic because they reported on cycle time for patients with acute ankle injuries that required triage and sometimes required X-rays or splinting. Primary Care Cycle time below is much shorter.

Figure 14: Cycle Time for Primary Care Clinics Only (N=3 Clinics)

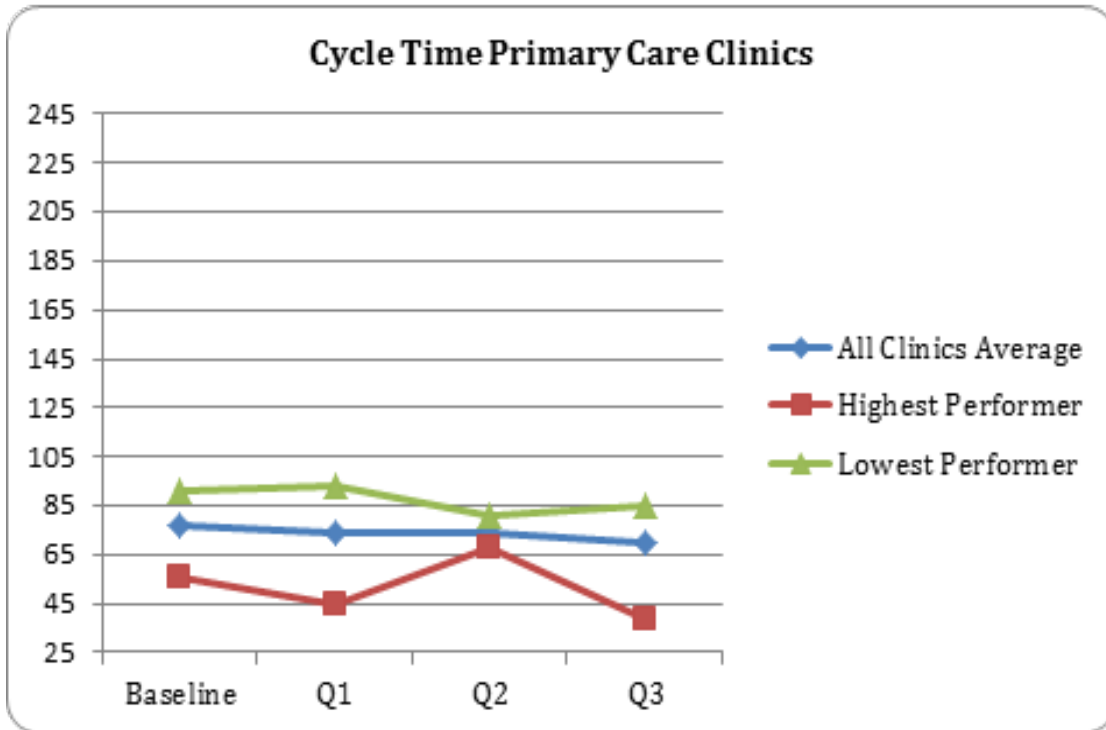


Figure 15: On time start (N=1 Clinic)

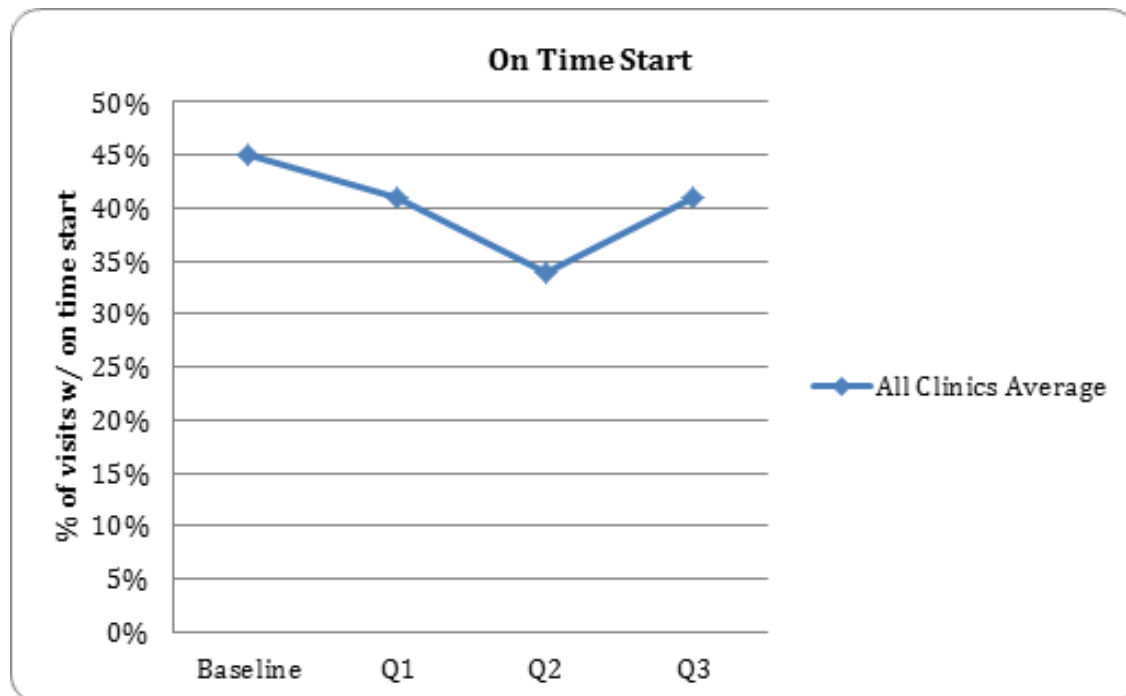


Figure 16: Patient Satisfaction with Clinician (N=1)

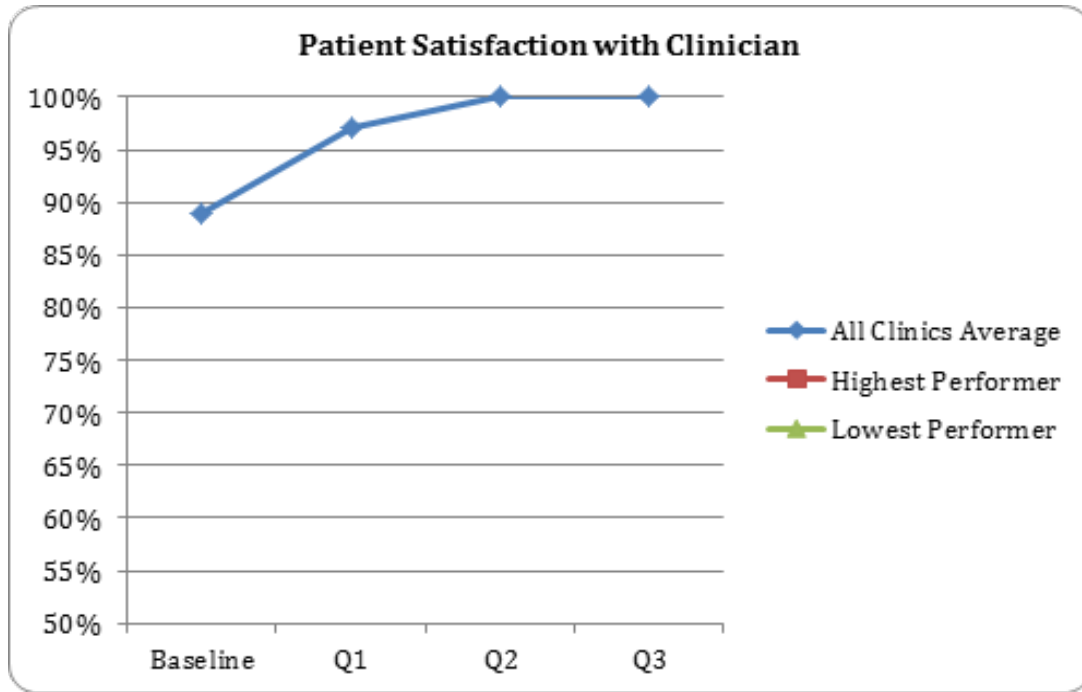
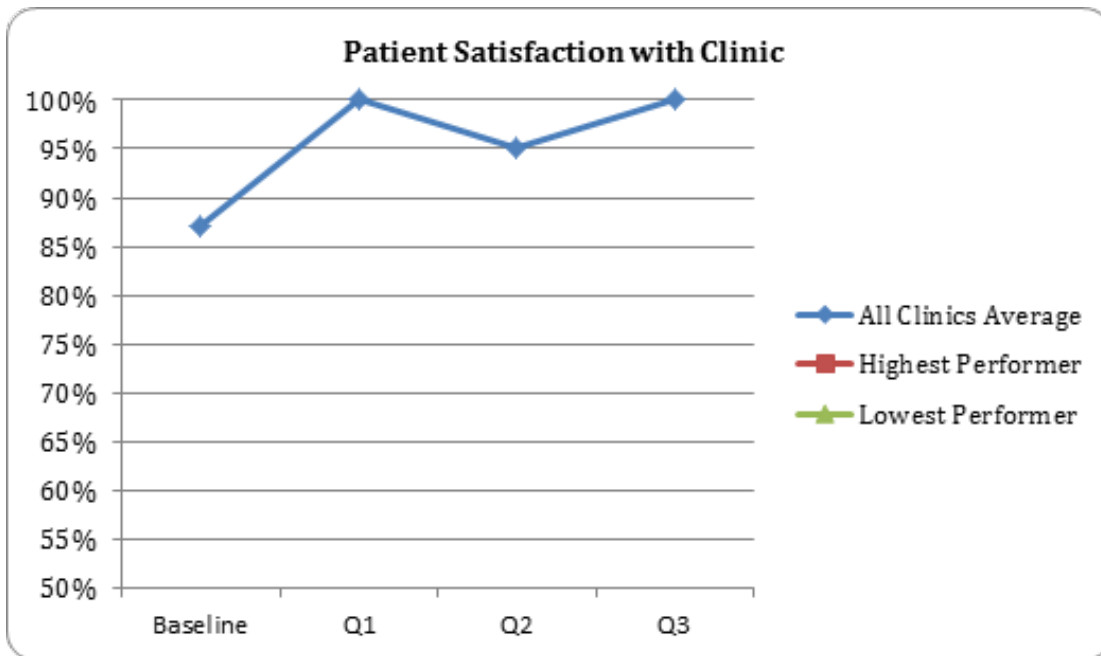


Figure 17: Patient Satisfaction with Clinic (N=1)



MEANINGFUL USE OF EHR

All clinics were in pre- implementation of an EHR until August 2011. Thus, measurement was primarily focused on improving electronic documentation in other HIT systems. Among teams focusing on demonstrating meaningful use of EHRs, there was substantial improvement in 4 electronic documentation measures (BMI, blood pressure, smoking and problem list) while other measures, such as documentation of allergies, were near goal at the onset of the project and remained stable throughout the year. (Figures 18 - 21)

Figure 18: Electronic documentation of BMI (N= 4 Clinics)

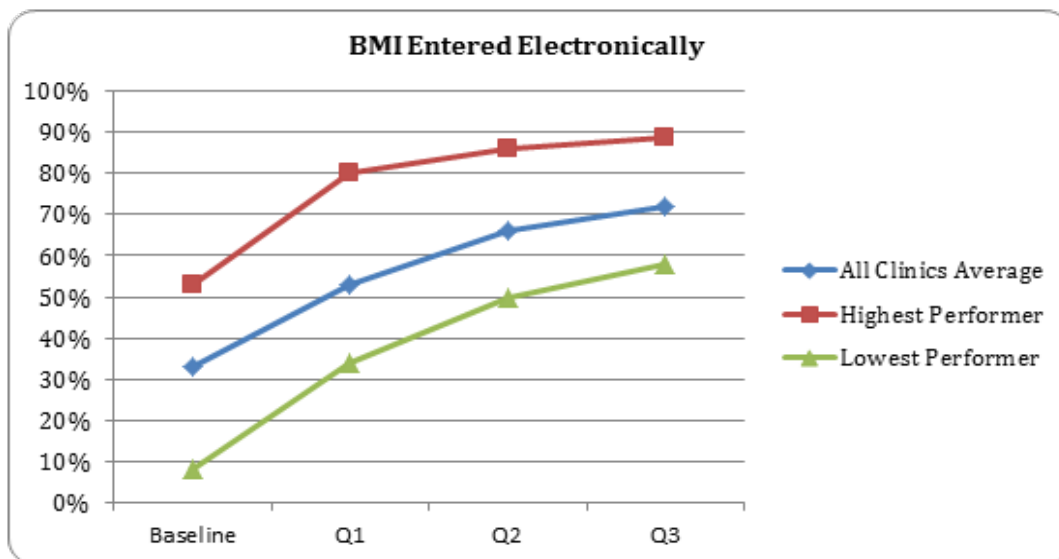


Figure 19: Electronic Documentation of Blood Pressure (N=6 Clinics)

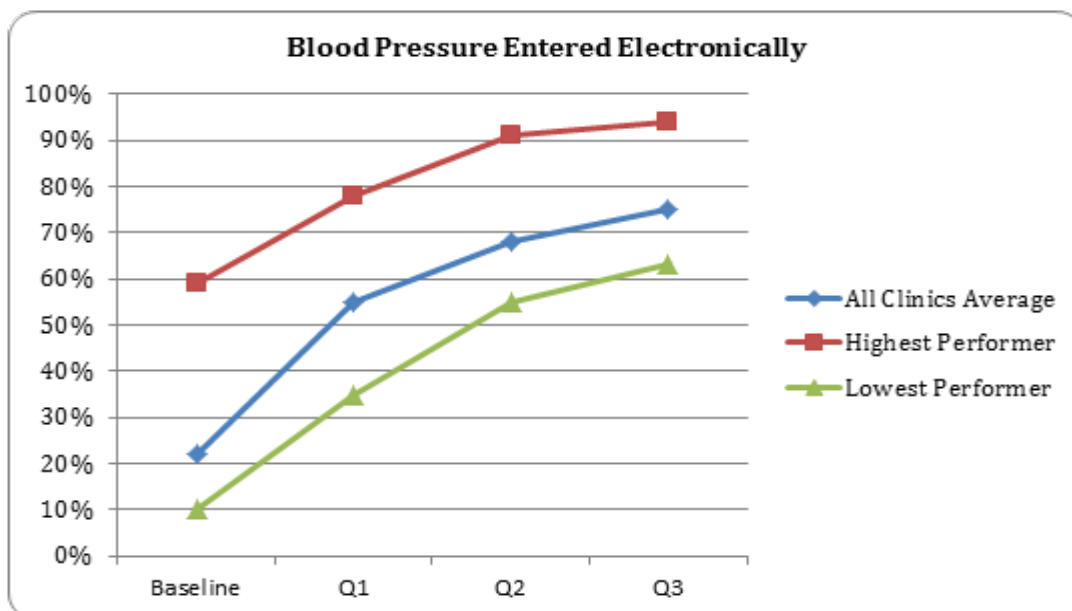


Figure 20: Electronic Documentation of Smoking Status (N=6 Clinics)

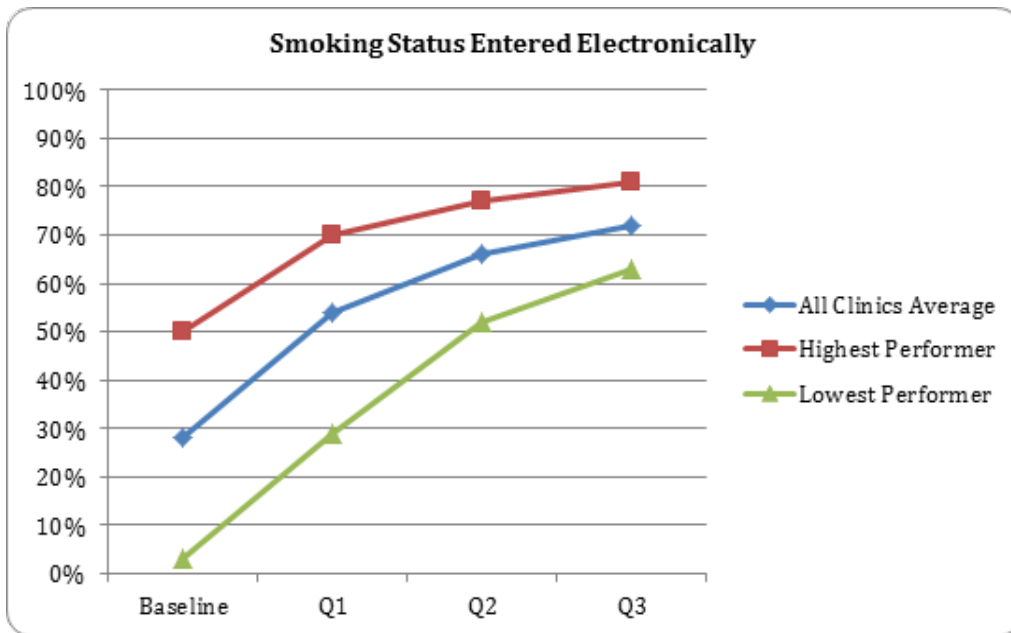
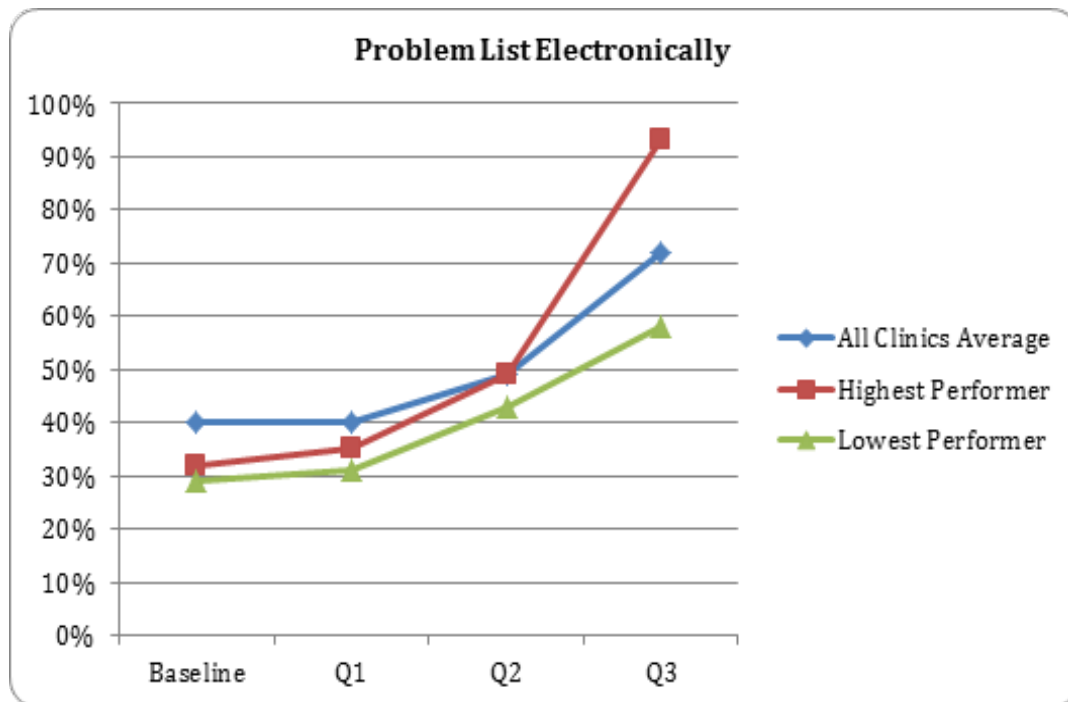


Figure 21: Electronic Documentation of Problem List (N=3 Clinics)



INTEGRATED BEHAVIORAL HEALTH

The one team that worked on behavioral health measures had operational challenges and was not able to meet their goal of creating a process for a warm hand-off between primary care and behavioral health. This organization was in a unique situation as they do not truly have an outpatient clinic in place; they were invited to SFQCS to build leadership capacity with the goal of having them become a primary care site in the future, once they have the infrastructure in place.

TEAM REFLECTIONS ON PROJECT

In their final reports, clinic teams were asked to reflect on what factors helped and prevented them from making desired improvements in their projects. Key themes most frequently referenced are below. (Table 9) The first four factors noted as facilitators were also noted as barriers to improvement. This helps underscore the perceived importance of these items and the need for continued reinforcement.

Table 9: Factors that Helped and Prevented Project Improvements

FACTORS THAT HELPED	FACTORS THAT PREVENTED
<ul style="list-style-type: none"> • Increased buy-in and support across clinic staff • More meetings and protected time • Better staffing • Leadership • Enhanced team functioning & commitment • Improved methods for data collection 	<ul style="list-style-type: none"> • Lack of buy-in from staff and resistance to change. • Competing priorities • Limited staffing • Leadership transition • Limited resources

Teams also shared what they felt was the most important concept or skill presented during the learning sessions that they were able to successfully apply to the implementation of their project, as well as what they would do differently to accelerate improvement if they were starting their project over. Key themes most frequently referenced are below. (Table 10)

Table 10: Learning Session Content Application & What to Do Different if Starting Over

APPLICATION FROM LEARNING SESSION	WHAT TO DO DIFFERENTLY
<ul style="list-style-type: none"> • Content and process for teaching staff • How, what, when of PDSAs • Communication • Project management • High functioning teams 	<ul style="list-style-type: none"> • More effort towards training staff • Start PDSAs sooner and do them faster • Greater involvement of more staff • Simplify the aim

EVALUATION SUMMARY

As noted earlier in this report, when looking at clinic results in aggregate, there was improvement in team functioning, clinic capacity for quality, and employee engagement. Figure 22 demonstrates individual team improvement in those same areas, along-side team performance related to their project. 67% (14) of teams demonstrated improvement in their own team effectiveness and employee engagement scores, and 78% (16) of teams improved in their clinic capacity for quality score.

As shown in Figure 22, the “Meaningful Use” teams had better project performance overall compared to teams focusing on one of the three other project topics. This can likely be attributed to several factors - the measures were better defined, the data collection was more immediate and more available (by definition the teams were working on electronic capture of data so they had more data, faster than some other teams that had to collect data manually or wait for a central report) and the behavior change was often simpler because it primarily relied on medical assistant behavior change rather than changes in multiple parts of the clinic (e.g., cycle time or TTNA).

As mentioned earlier, teams were encouraged to be ambitious in their goal setting, which contributed to less than optimal results regarding attainment of project measure goals. While only 19% (4) of teams met all of their project goals and 43% (9) teams met at least one goal, the majority of teams saw improvement in at least one key measure, with most of those teams coming very close to meeting at least one goal.

“When I first heard about the opportunity to participate, I knew our management team couldn't pass it up. To instill a culture of quality in our clinic has always been a goal of mine, but I struggled with how to do it. SFQCS not only gave us the knowledge and tools we needed, but it transformed the members of our management team in a way we would not have been able to achieve on our own, into a team of champions for high quality practice. Seeing how we really could change things for the better, and being given the time to dream big together was exactly what our leadership needed. We're starting to see the fruits as we pass on training to our staff. We're going beyond just identifying and complaining about problems, to doing something actively to solve them”

- MEDICAL DIRECTOR

Figure 22: Crosswalk of clinic performance on program assessments and project measures.

		Improvement - Team Development Survey	Improvement - Clinic Capacity for Quality	Improvement - Employee Engagement	Met all Project Goals	Met at least 1 Project Goal	Improvement in all Measures	Improvement in at Least 1 Measure
Access	Clinic # 1	x	x	x				x
	Clinic # 2	x	x	x		x		x
	Clinic # 3		x					x
	Clinic # 4	x	x	x				
	Clinic # 5		x					x
	Clinic # 6	x		x				x
	Clinic # 7	x	x					x
	Clinic # 8		x	x		x		x
	Clinic # 9	x	x	x				
	Clinic # 10		x					x
	Clinic # 11	x	x	x				x
Meaningful Use	Clinic # 12	x	x	x	x	x	x	x
	Clinic # 13	x		x				x
	Clinic # 14	x	x	x	x	x	x	x
	Clinic # 15					x	x	x
	Clinic # 16					x		x
	Clinic # 17			x		x		x
	Clinic # 18	x	x		x	x	x	x
PE	Clinic # 19	x	x	x				x
	Clinic # 20	x	x	x	x	x	x	x
IBH	Clinic # 21	x	x	x				x
		67%	76%	67%	19%	43%	24%	90%

KEY LESSONS LEARNED

The combination of the learning sessions, coaching, and practical application to a quality improvement project was synergistic. While each element by itself was unlikely to have been successful, together they helped spur important changes across safety net clinics. Key programmatic lessons, including suggestions for what to do differently, are as follows:

LEARNING SESSIONS

- Never underestimate how much time teams need to work on problems together. Clinics need substantial time to work together as a team including participation in interactive, engaging activities. Program planners tried to abide by the general rule of having no longer than 10 minutes of presentation without having an activity where the team worked together to solve a problem or work through an issue. Even though the planning team was very cognizant of that rule, teams always asked for more structured team time for planning without distractions.
- Likewise, teams also found tremendous value and benefit in the opportunity to network with and learn from other clinics and indicated their desire for even more. Opportunities for networking and sharing across clinics should be built into learning sessions as much as possible.
- Participants responded well to structure – structured activities, structured homework, reminders, and detailed instruction. This also includes a structure for closing the loop to make sure deliverables are met, of which there should have been more.
- The concept of accountability, and associated training tools, should be introduced as early in the program as possible and be continually be reinforced throughout the year.
- More emphasis on the “train the trainer” aspect of the program was needed including additional time dedicated during the learning sessions on the “how” of training key concepts and skills. Homework assignments related to training staff including opportunities to report back on experiences at subsequent sessions would have provided more skill building opportunities. The “homework” aspect would also reinforce participants’ accountability to program expectations (i.e. clinic teams training all staff).
- There was a lot of feedback about the sequencing of learning session content and a clear desire to have several different topics presented first. Launching the program with a two-day session might help address the need to cover a lot of material up-front. As part of the two-day session, a more comprehensive session on developing a QI plan would also be of benefit.

COACHING

- Coaches provided an additional push to clinic teams and were an important component of the program. However, there was a lack of clarity about the coach role and how clinic teams should best utilize their coach. A more comprehensive introduction of coaching at the start of the program, including modeling of a coach/clinic relationship, would have helped encourage clinics to make better use of the coaching resource.
- There was also a need for more clarity about the coach role among the coaches themselves, as there was a lot of variability in terms of what they expected from their clinic teams. More structured roles and clear expectations among the coaches would likely have helped them hold their clinic teams more accountable. A kick-off for the coaches would help ensure the coaches were starting on the same page.

QUALITY IMPROVEMENT PROJECT

- Projects could have been tightened up by decreasing the number of topics and having more clinics working on similar projects. This would have also helped facilitate the process of sharing strategies and lessons learned across clinics.
- There would also have been a benefit to having clinics measure things in the same way. Required measures were established but clinic teams were not always held accountable to meeting those requirements leading to slippage in measure standardization. Lastly, defining effective measures was challenging, made even more so by the breadth of projects.

LEADERSHIP STRUCTURE

- The structure for implementing the program was effective. A partnership consisting of a steering committee representing leadership of all involved clinics with leadership authority, a dedicated project manager to pull together all of the details, and a dedicated lead coach to manage the project data, serve as the central contact for coaches and ensure some uniformity of coach expectations, was essential. Establishing the lead coach role earlier in the planning process would have helped clarify expectations among coaches earlier on and provided additional expertise in planning and leading collaboratives.
- The relationship of the medical directors from SFDPH-COPC and SFCCC with their respective clinics was different due to the nature of the organizations they represent. The structure of SFDPH-COPC is such that its medical director has clear authority and built-in communication channels among the SFDPH-COPC clinics, whereas with SFCCC clinics, their medical director does not. This was somewhat of a hindrance for the SFCCC medical director and his ability to effectively maintain buy-in and hold SFCCC clinic teams accountable for program deliverables. Setting up an explicit role for the SFCCC medical director that would give him authority over the SFCCC clinics for the purpose of this program only, would have been helpful.

ENVIRONMENT

While the following factors in the environment were largely out of the control of program, they did impact the ability of some teams to make and sustain needed changes in their clinic settings.

- For the public sector clinics, the combination of unionization and civil service makes rapid change more difficult. Changes in job descriptions and roles happen slowly with city budgetary requirements contributing to the slowness. Leadership is unable to incentivize based on merit, and in civil service hiring is based on scores and tests rather than cultural fit. This can make the implementation of many of the suggested strategies for improving clinic culture extremely difficult.
- Several of the participating clinics were going through EHR implementation during the course of the program year. This process is highly disruptive to clinic operations and is often the one and only priority for clinic leadership, providers, and staff.

CONCLUSION

The year-long San Francisco Quality Culture Series was a transformative experience for clinic leadership teams. The excellent attendance rate, active engagement and program ratings across clinic participants demonstrate the high value they placed on their experience. This perceived value also translated to real changes. Almost all clinics reported improvements in their clinic's capacity for quality, the majority of teams saw improvements in team effectiveness and engagement, and almost all clinics saw improvement in at least one project measure. In addition, leadership teams continue to bring the content home and report increased engagement and participation in quality improvement activities across clinic staff.

People cannot drive quality improvements without being able to manage people, change, and conflict, among other leadership, teamwork, and management skills. Thus, the fusion of the learning session content (management training, leadership development, quality improvement basics) with training (train the trainer skills for adult learners) and technical assistance (shoulder-to-shoulder help applying the concepts to the realities of the clinics) was particularly effective. In addition, bringing managers to a common foundation of office skills and management techniques eliminated the validity of excuses such as "I don't do excel."

There is a clear shift in leadership across the safety net from a "blame-focus" to "systems focus" and teams across clinics have been strengthened by this process. A ripple effect was created that is changing how leaders view and shape their responses to problems. Opportunities for networking and sharing of best practices, and the creation of a leadership structure within a larger organization has led to greater role identification in a larger team of leaders. This experience has fostered a sense of safety net cohesion and unity across clinic teams. Organizations within a small city that once didn't know about each other now identify as "we are the safety net."

“SFQCS changed the focus and tone of our medical directors meeting. We no longer have a group of people griping about blaming individuals for chaos. We talk about system fixes to system problems. It has elevated the level of discussion dramatically, and created momentum for system change.”

- MEDICAL DIRECTOR, SFDPH-COPC

APPENDICES

APPENDIX A: BCCQ CLINIC CAPACITY FOR QUALITY ASSESSMENT*

	ELEMENTS	NOT YET PREPARED (1 ... 2)	MODERATELY PREPARED (3 ... 4)	HIGHLY PREPARED (5 ... 6)	SCORE (1-6)
1	Organization-wide vision for quality improvement...	has not been translated into specific goals and strategies. Current QI work is driven by individual clinicians and/or external factors such as funding opportunities and compliance requirements.	is being incorporated into a program reflecting the organization's short- and long term strategy, targeted at improving specific, limited clinical measures and patient satisfaction.	is incorporated into the organization's short and long-term strategy, informing a program with measurable objectives tied to clinical outcomes, and patient satisfaction.	
2	Strategic planning and implementation of quality improvement, population health management and workflow efficiency initiatives...	is limited to executive discussion around a specific event, project, or timeframe. A formal plan may exist, but may not be updated on a periodic basis.	are driven by a department or specific individuals, but is not a pervasive focus. Efforts may be specific to one department or target population, using data to inform clinical, operational, and financial objectives.	permeate all aspects of the organization. QI planning involves buy-in across departments, long-term financial planning and resource assessment, and accountability tied to incentives.	
3	QI initiatives (workflow efficiencies, population-based analysis and clinical process interventions) and chronic care coordination are managed...	on an ad hoc basis; physicians decide which best practices to incorporate into their daily work at their discretion.	by individuals with appropriate training; physicians share best practices with peers and let each individual decide what to include. Decisions made on a patient-by-patient basis.	by an integrated team where QI initiatives and chronic care is coordinated across departments, patients, information systems, etc. Team meets regularly.	
4	Current management reports show organizational performance...	only, with no benchmark comparisons and no trending over time.	compared with results from external data sources, but reports are focused in one area/topic.	compared with statistical norms from external benchmarking data, including dashboard indicators and trended data over months, quarters and/or years.	

5	Staff appreciate the importance of data and information flow in the patient care process by showing an understanding of ...	the general idea, but have not been formally educated on their role in relation to data and information flow.	their role in the patient care process, but have not been educated about the importance of data and information flow.	end-to-end data and information flow and their role in the patient care process.	
6	Clinician involvement in QI programs consists of...	one clinician advocate who drives QI initiatives across the organization; rarely engages physicians in efficiency and quality initiatives.	one clinician/provider who engages other clinicians in QI activities. Accountability for/ management of specific patient populations is not necessarily enforced.	providers across all levels communicating the value of, and engaging other providers in, improving care for patients, ensuring team accountability, and using data for point of care-decision making.	
7	Patients are involved in their chronic care treatment...	through receipt of patient educational materials.	through assessment and self-management goals that are documented in a standardized manner.	through regular assessments provided with treatment plans monitored by clinicians and tracked within an information system. Behavior change is supported through training and clinical educators. Services such as peer support are available through the clinic.	
8	Best practices and standards for QI...	are gathered from attendance at conferences, learning collaboratives, or educational sessions.	are developed by a QI lead and validated through attendance at clinical care and data-related meetings, such as consortium/network or medical director gatherings.	are developed by a cross-organizational team, based on industry-accepted measures. Clinic executives lead discussions of best practices or trends with community and peer meetings, e.g., gatherings with consortium/network, medical directors or health information technology executives.	
9	Training plans involving QI processes and staff understanding of these processes ...	involve on-the-job technology training for clinical and admin staff as needed, e.g., in conjunction with a new system implementation. Staff is familiar with these processes/principles.	are being developed or are part of orientation, acknowledging the current use of technology and skill-set gaps of clinicians and key staff. Periodic audits of data are used to inform training needs.	are part of all staff's orientation. Training acknowledges the current use of technology and addresses skill-set gaps across the organization. Staff are empowered to offer innovations to make process flow improvements.	

10	Data elements necessary to manage chronic care such as patient demographics, wait times, populations, diagnoses, lab results and problems...	reside in separate silos and are not clearly identifiable or are manually collected. Relationship between data fields and elements necessary for clinicians to track is unclear.	are identified and tracked using both paper and information systems (e.g., PMS). Linking data across systems requires manual effort. Error checking and data validation instill in staff a moderate level of confidence in the accuracy of reports.	are clearly identifiable, accessible across systems and integrated together to inform management, guide treatment plans, identify problems and track patient progress. Error checking and data validation instill in staff a high level of confidence in the accuracy of reports.	
11	Relative to decision-making, data is ...	not used regularly to prevent or solve problems.	viewed as one component of decision-making, but is not viewed as a preventative tool.	a key part of the management mindset and viewed as critical to preventing problems, improving efficiencies and care delivery.	
12	UDS, OSHPD and other reporting requirements are...	produced manually. Only federally or state mandated reports are produced in accordance with required timelines.	partially produced by mining data from current information systems on a scheduled basis (annually to quarterly).	produced by mining data from current information systems on a scheduled basis (quarterly to monthly).	

The original BCCQ Clinic Capacity for Quality Assessment Tool was created by Community Partners in July 2010 for the Building Clinic Capacity for Quality (BCCQ) Program, adapting the language from the following resources: the Building Clinic Capacity for Quality Phase I Assessment, Assessing Chronic Illness Care Survey v. 3.5, Quality Culture Series Health Center Culture Of Quality Assessment, Tools for Quality Program Community Clinic CDMS Adoption Self-Assessment, and the Doctor's Office Quality - Information Tech EHR Readiness Assessment

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