A Teachable Method for Changing Unhealthy Behavior

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Sherbrooke Consulting, Inc.

Jolie Bain Pillsbury, PhD

Robert D Pillsbury, PhD

This report was submitted on April 5, 2008 as part of our Phase II proposal. It is extracted here for inclusion in our Phase I closeout.

Phase I Final Report

During Phase I, we developed an ETK, workshop curriculum, and TA that made it feasible for diabetes educators and their partners to use the RBF method to convene, facilitate, and conduct follow-up from a successful local performance partnership summit (PPS). The workshop curriculum and a few sample screen shots of the ETK are shown in Appendix 1.

Project Duration and Key Personnel:

The SBIR Phase I effort begin April 1, 2007, and concluded March 31, 2008. Jolie Bain Pillsbury, President, Sherbrooke Consulting, Inc., and principal investigator spent a total of, 284 hours on the project. Robert D. Pillsbury, Treasurer and Senior Consultant, Sherbrooke Consulting, Inc. (SCI), spent a total of 421 hours on the work. In addition, from the Smoking Cessation Leadership Center (SCLC) of the University of California at San Francisco, Connie Revell, Deputy Director, Catherine Saucedo, Director of Strategic Marketing, and Reason Reyes, Technical Assistance Manager worked approximately 80 hours. Victoria Goddard-Truitt, Senior Consultant, GT Consulting, spent a total 70 hours on the evaluation, and workshop. Dr. Roderick King, Next Generation Consulting, was unable to work the project due to scheduling constraints brought on by the delayed start. As mentioned below, the reprogramming required by the delayed start meant a larger amount of the contract went to workshop costs.

Specific Aims of Phase I:

Phase I of the study explored a means for efficiently spreading the use of Performance Partnership Summits to prepare a few diabetes educators and their partners to recruit front-line healthcare professionals as interventionists in educating patients about and referring them to successful smoking cessation programs and interventions. The specific Phase I aims were to answer the following broad questions:

1. Did use of the ETK, attendance at workshop, and receiving TA enable the healthcare professionals and partners to use the RBF method by implementing successful local Summits?
2. What combination of ETK, workshop, and TA optimizes the skill building for diabetes educators and their partners?

Phase I Implementation:

The strategy for teaching the RBF method was a comprehensive, multifaceted learning approach that consisted of three components: an ETK that provided needed tools to implement the local summits. The second was a workshop to train subjects in the RBD method. The last component was the TA.

The local partnerships had several key elements in common with national partnerships that were the model for the application of the RBF method. They were nonhierarchical and allowed SCLC staff to participate as full partners. They employed multiple (rather than competing) strategies, all working toward a measurable target adopted at the summit. They were fluid and flexible in strategy development and implementation to take advantage of a constantly shifting backdrop within public health and tobacco control. They benefited from the connection to the original statewide summit that launched diabetes educator's efforts in smoking cessation. They answered the four key questions:

1. **Where are we now?** Examine the baseline data about cessation efforts in the region.
2. **Where do we want to be?** Establish the goal or target to be attained in the next three to six months.
3. **How do we get there?** Develop the strategies for getting there and make the commitments needed.
4. **How will we know we are getting there?** Choose the measures of success that can be tracked.

Using the RBF method the steps of a successful performance partnership summit were organized into three stages. They are: **A**sk, **A**nswer, and **A**ct. The summit invitees are **A**sked to attend, **A**nswer the four questions during the summit, and **A**ct on the action plan developed during the summit to increase number of smoking cessation interventions.

One of the breakthroughs in the design of the toolkit and the workshop curriculum was to define three distinct roles to implement a performance partnership summit. Originally, the research design focused on providing longer, more in-depth two day training to one healthcare professional, who would learn all aspects of implementing a summit. In the development of the tool kit it became apparent that there was too much information for one person to learn in one day, which was the amount of time diabetes educators could be available for a smoking cessation leadership workshop. The redesign made participation feasible for the subjects, e.g., a one day workshop with a team of three people each learning a separate role and supporting each other in the application of the RBF method.

This redesign allowed us to organize the elements of the ETK and the curriculum into a separate toolkit for each role, greatly simplifying the training and transfer of information and skills. The team members were introduced to all the roles but they self-selected the specific role(s) that they wanted to play. This reduced their work load, learning curve, and anxiety level. A further benefit was the peer support the team members provided each other during and post workshop, enhancing the possibility of success.

The purpose of performance partnerships is to produce a measurable increase in tobacco cessation interventions by diabetes educators and their partners. The summit is the venue and environment for partners to produce an action plan and make commitments to increase cessation efforts in three to six months. During the first nine months of the project, the team of SCI, SCLC, and GTC developed an ETK, attendant workshop curriculum, and TA that allowed 18 of 21 healthcare professionals and their partners to convene and facilitate five local performance partnership summits, and follow-up on the action plans generated.

Fig 1 – Phase I Counties w/ Summits in Pink w/o Summits in Blue

The 21 volunteer subjects were recruited through the partnership with the Diabetes Educators DoYouCAARD Task Force. The recruitment process included a mutual exchange about the complementary purpose of the research and the Task Force 2007 objectives, a definition of what would be useful and feasible for diabetes educators to attend the workshop and commit to holding a local PPS in their counties within three to six months. Of particular importance was a design that minimized the time spent at the workshop and implementing the summit and maximized the benefit of learning new skills while earning CEU's. The 21 participants formed into seven teams representing seven of the fifty-eight California counties. Fig. 1 shows the counties represented at the workshop.

Phase I Achievements:

Phase I validated the utility of the ETK, workshop, and of TA in supporting summits and demonstrated that the RBF method can be taught. Further, the Phase I results indicated that all three modules, ETK, workshop and TA in combination optimized skill building.

The workshop, conducted in San Diego in October 2007, taught the subjects the conceptual background and competencies needed to establish and support their summit. The ETK was introduced at the workshop and was used throughout as the focus of both didactic information and simulated work in role to provide a rich, experiential learning experience. The goal of the workshop was to prepare teams to implement summits within three months of the workshop.

Subjects completed both pre-workshop and post-workshop self-assessments that used a 7 point Likert scale to assess their knowledge of the RBF method and their confidence that they could perform one of the three roles at their own local performance partnership summit. The average pre-post increase in knowledge and confidence in using the RBF method was 52% from 3.77 to 5.71. A comparison of the results of the pre- and post-workshop self-assessments is shown in Figure 2.

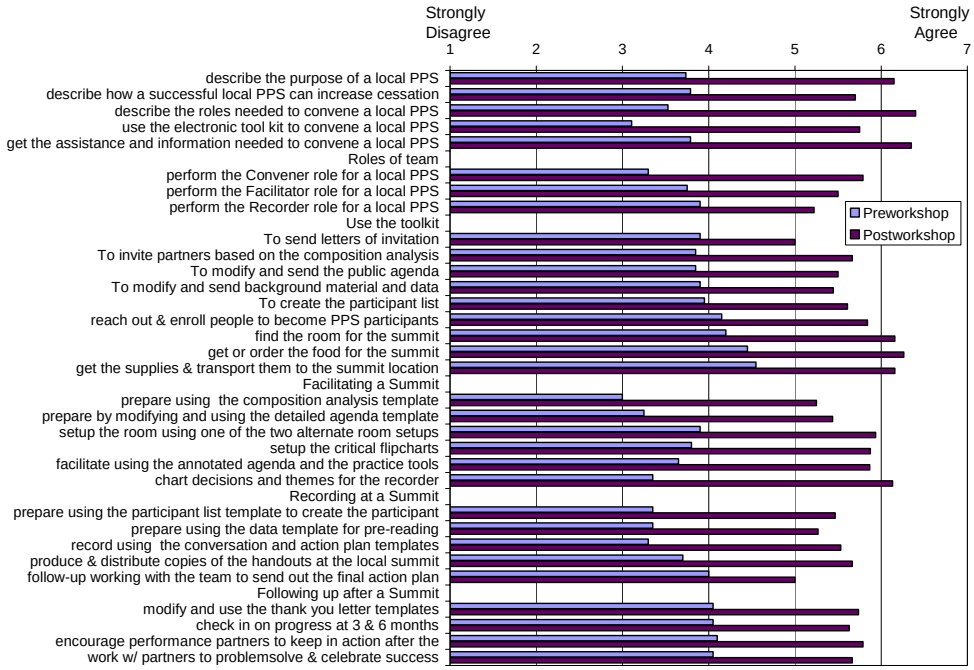


Figure 2 – Pre- and Post-workshop Self-assessment

Five of the seven implementation teams (18 of the 21 subject - 86%) were successful in using the RBF meted to convene and conduct local Performance Partnership Summits within three months. The time and effort that the subjects invested in using the ETK, the workshop, and TA had an immediate utility and application with peer support of a team. Immediate applicability in the practice environment with support of peers is a way to improve the ability of practitioners to integrate new skills.

Two teams did not conduct Summits during the period of the research. One team had two members who experienced job changes in the weeks following the workshop that prevented continuing with convening their local summit. One team had scheduled their Summit but had to cancel due to a death in one of the team members' family. At this time, it has not been rescheduled. Each of the five Performance Partnership Summits produced an action plan that is currently being implemented by the healthcare professionals and their partners. Each action plan set targets for increasing quitline calls between 10% and 25% within a year.

The Electronic Toolkit: The ETK was developed during the late summer of 2007. Applying RBF method information was structured to make accessible the structure of the three A's, the three roles, and the four questions. In total there were 80 pages or screens. One of our findings was this was too many for the participants to absorb and use easily. Each workshop participant was given a hard-copy printout of the screens, as well as, password protected ("totworkshop") access to the website http://www.sherbrookeconsulting.com/PPS%20TOOLKIT.

Included in toolkit was the current California Helpline data for the counties represented at the workshop. Figure 2 is an example for one of these. This data is available in the ETK to the team for use in answering question #1 during their summits. Data of interest to the participants included the total number of calls for their county (3a), the number of calls where the caller was referred to the Quitline by a healthcare professional (3b), and the number of callers who voluntarily self-identified as having diabetes (3c).

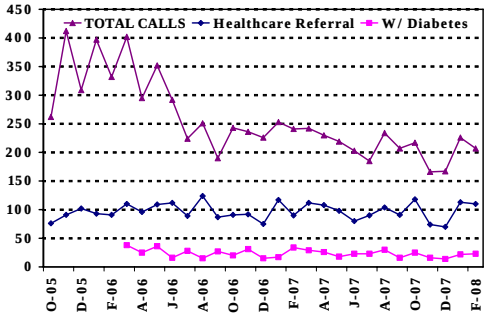


Fig. 3 - Typical Quitline Data

Through our partnership with the California Helpline, we are able to get this data in a timely manner for updates to the implementation team. During Phase II, we plan to get monthly updates for all the regions and publish these to the web and enhance the curriculum and tools to provide support to overcome the barriers to action plan implementation. Enhancements include tools to ensure Action Plans are distributed within 48 hours of the summit. Most teams had difficulty in meeting that goal. Reducing this lag time will address the barrier discussed in the post-summit calls that each individual can easily be distracted by their ongoing normal work burden, and without a concrete reminder of the commitments made at the summit will not be able to get them done.

Additional materials in the ETK included templates for all preparatory steps to implement the summits, background and educational materials on diabetes, smoking cessation, and effective smoking cessation interventions including quitlines, background on the performance partnership model, and all materials needed to support the summit and produce an action plan. The ETK had links to the partner sites that were the source of much of the material. The feasibility of the RBF method is increased when partners supply the relationships and resources that translate into a customized approach tailored for the specific locality.

The Workshop: A workshop to train the teams on how to hold a performance partnership summit and the use of the ETK was held in October 2007. Starting with a reception and working dinner, followed by a full-day training session, the teams practiced the skills and used the ETK to prepare for local summits. The workshop environment was designed to be as similar to the summit environment as possible. The teams also practiced roles, learned the skills, and used the tools in simulations and actual preparatory activities directly applicable to their implementation process. Important elements of the workshop experiential approach included structured feedback and coaching on the use of specific skills especially for the facilitator. Phase I results from both the pre-and post workshop survey and the pos- summit interviews highlight the value of the RBF feedback and coaching for the facilitator and the need in Phase II to apply the RBF method more rigorously to further develop the coaching and feedback for role of convener and recorder. The subjects took the pre-and post-test at the workshop and signed up for post- summit interviews.

The workshop ended with the teams committing to hold their summits in the next three to six months and publicly sharing their next steps for implementation. The workshop evaluations had an average rating of 4.3 out of 5.0 and included rating of the content, the faculty, and the environment.

The Participants: Twenty-one individuals agreed to attend the workshop. A breakout of the gender of the participants by racial/ethnic diversity is shown in Table 1. The group was self-selected from the California Diabetes Educators.

Table 1 – Race/Ethnicity/Gender of Subjects

Category	Female	Male	Total
Black or African American	1	0	1
Hispanic or Latino	2	2	4
White	13	3	16
TOTAL	**16**	**5**	**21**

The Local Performance Partnership Summits: Since the workshop, Fresno County, Monterey County, Orange County, Sacramento County, and San Diego County have all had their summits. San Francisco County will have one. Lake County had theirs scheduled, had to cancel, and has yet to reschedule. In addition, a telephone interview with the implementation team was scheduled (the actual scheduling was done at the workshop).

Action Plans: Included in the ETK was a summit Action Plan Template, set up so the Recorder could fill in the results of the key conversations. A summary of the Action Plans from the five summits is shown in Table 2 below. It can be seen that the summit size was fairly uniform. As mentioned later, there was a large difference between the number of participants expected and the number actually attending the summits. This ranged from 50% to 136%!

Table 2 - Summary of the local Performance Partnership Summit Action Plans

County	Attendees	Quitline Calls Target	Examples of Key Strategies
Fresno	16	15% Increase	• Increase awareness of CSH • Educate Public Health Nurses
Monterrey	12	25% Increase	• Provider Education • Patient Smoker Awareness; • Coverage.
Orange	10	20% Increase	• ID smokers in DM assessment, offer info • Check with Helpline to see how many actually call
Sacramento	13	20% Increase	• Marketing; • Education/Awareness; • Partnerships.
San Diego	13	10% Increase	• Fax Referral & Ask, Advise, Refer Pocket Guide; • Coordinate with New Policy Implementation; • Have a Recognizable Spokesperson/Champion.

Each of the Summits expanded on the Key Strategies with the How? Who? and When? Several of the Action Plans had the strategies organized by committees. Each committee or major strategy had a number of subsidiary strategies for implementation.

Excerpts from the Action Plan from one of the counties are shown below. Since they all started from the same template and answered the same four questions, the action plans were all very similar.

[Excerpts from the] [redacted] ***County Tobacco Cessation Summit Action Plan***

Participants: ***[****The listing of the names of participants omitted].*

Summary: A group of community representatives from organizations with key roles in promoting healthier lives gathered together to address the need for increased tobacco cessation being offered to [redacted] County tobacco users. Realizing that further integration of the participating organizations would help achieve this goal, all the participants eagerly moved forward to form an action plan. First , they identified a baseline as the total call volume for [redacted] County, as well as referrals from healthcare providers over the period of November 2006 through October 2007. Ideas and strategies shared and created at the summit have been reviewed and incorpora ted into a draft Action Plan, which will serve as a strategic model for the summit participants as they move forward with the initiative. T he summit participants unanimously agreed to work together to implement the Action Plan, as well as help guide and keep track of initi ative efforts. Below is the Action Plan to be reviewed by the summit participants.

ACTION PLAN

1. **Baseline - "Where Are We now?"**

The following baseline data most appropriately reflected the consensus of the group.

- Average monthly Helpline call volume for [redacted] County over period of one year (currently 223 per month)
- Average referrals from healthcare providers in [redacted] County is approximately 100 calls per month, or 45% of total calls.

2. Target - "Where Do We Want To Be?"

Keeping in line with the measurable baseline the specific target will be to:

- **Increase total call volume from [redacted] County by 10% in a year.**

3. Multiple Strategies – "How Will We Get There?"

The group brainstormed many creative ideas. The group chose to focus on four different strategies. The list below represents both short-term more simple, concrete and doable strategies as well as longer term goals. *[Excerpts from a single strategy are shown here, and the WHO column has been omitted for privacy.]*

[selected] **Strategy: Coordinate with New Policy Implementation**

WHAT	HOW	WHO	WHEN
Communication between policy and CSH		*Omitted*	
Branding meeting: signage; talking points; Encinitas; tagline; -coordinating media buys (see below)		*Omitted*	January meetin g
ACS news releases include CSH info	-CSH provide taglines; -ACS/ALA incorpor ate into news release templates	*Omitted*	immediate/ ong oing
Helpline attend city council meetings with ALA policy staff and/or provide talking points	-Let CSH know when issue comes before Encinitas council	*Omitted*	Ongoing
Advocate to have CSH number on no smoking signs		*Omitted*	
Distribute information cards with laws/CSH number to park rangers, law enforcement, parks and rec staff		*Omitted*	
Distribute Pocket Guides to doctors offices, especially for new laws such as in Encinitas		*Omitted*	Ongoing
Distribute CSH materials to senior centers, especially for new laws such as in Encinitas		*Omitted*	Ongoing

4. Measurement "How will we know we are getting there and how will we know we got there?"

The group agreed upon monthly reports from the Helpline that include:

1. Total call volume for [redacted] County
2. Number of providers trained
3. Number of materials ordered
4. Number of fax referrals that come in (if adopted)
5. Number of news releases with Helpline information
6. Number of publications with mention of Helpline services

For reporting purposes, the group agreed to keep the Helpline apprised of any Summit-related activities, such as training providers

Next Steps

The group decided to meet quarterly to check the progress of the work plan and that face-to-face meetings were preferred over conference calls. The group agreed to check their schedules and select a time to meet at the Helpline in March 2008

Post-summit Interviews: After the completion of Performance Partnership Summits, telephone conference call interviews were held with each team to discuss their experience in using the toolkit, the effectiveness of technical assistance and the utility of the workshop in the implementation of an actual Summit. The interview included specific inquiries regarding individual team members' perspectives on how and to what extent each of the learning venues met the needs of the team to successfully implement their Summit. Interviews occurred within eight to sixteen weeks after the Summit. A single interviewer conducted the interviews using a five-point Likert scale, and open and closed ended questions (see Appendix 2: Interview Protocol). The focus of research questions addressed in the interviews can be seen in Table 3.

Table 3: Research Questions

Process Questions

1. Did the Workshop—
   a. Support the practice of skills and electronic tools prior to planning for the Summit?
   b. Support the use skills and tools in the actual preparation, implementation and follow-up of the Summit?
   c. Increase the participant s sense of "self-effectiveness" (sense of confidence and comfort) to use the skills and tools?

d. Meet your needs and expectations as a learner?

2. Did the Electronic Toolkit—
   a. Contain the information needed to implement the local or statewide Summit?
   b. Provide the tools and materials needed to support the use of skills in the preparation, implementation and follow-up of the S ummit?
   c. How useful were the individual templates?
   d. Meet your needs and expectations (what worked well, what was missing, what was unnecessary)?
3. Did the TA—
   a. Support the use and practice of skills in the preparation, implementation and follow-up of the Summit?
   b. By telephone and email provide the problem-solving support needed to successfully prepare for and implement local or statewide Summits?
   c. Get provided in a timely manner?
   d. Meet your needs and expectations (was it useful)?

Outcome Questions

1. Did teams plan and implement a local or statewide Summit within three months of the workshop? Did they use skills learned in t he workshop, tools provided in the electronic toolkit and/or information from the workshop, TA or toolkit to problem-solve?
2. What number and percent of participants in the local or statewide Summit make action commitments?

Four interview conference calls were conducted. The fifth is being rescheduled and has not been held as of this report. Each of the interviews was with three members of the implementation team (convener, facilitator, and recorder). One summit had a fourth person acting as a co-convener who was not able to make the call. Overall the calls were filled with a sense of excitement and accomplishment. The interviews lasted for approximately one hour. Opening questions were put to the full team. Then each team responded to a set of questions from the point-of-view of their role. Table 4 presents a synopsis of the responses.

Table 4 – Synopsis of Post-summit Interviews

	Convener			Facilitator			Recorder		
D = Strongly Disagree or Disagree N = Neither Disagree or Agree A = Strongly Agree or Agree	**D**	**N**	**A**	**D**	**N**	**A**	**D**	**N**	**A**
Workshop content was useful.			4			4		1	3
The workshop helped me prepare for the actual summit.		1	3			4			4
I felt more confident because of the role playing done at the workshop that helped apply skills and tools.			4			4		1	3
I used skills learned in the workshop to problem solve.		2	2			4			4
The toolkit templates were useful.			4		1	3			4
The toolkit included the materials needed to implement the Summit.			4		1	3			4
The toolkit provided the tools and materials needed to support me in preparing, implementing and following-up.		1	3	1	1	2			4
I used the templates to make decisions and problem solve for the Summit.		1	3	1	2	1	1	1	1
Did you use TA?	Yes 2 No 2			Yes 1 No 3			Yes 0 No 4		
TA was useful in preparing, implementation and follow-up of the Summit.			1			1			
TA provided the problem-solving support needed to successfully prepare for and implement the Summit.			1			1			
TA was provided in a timely manner.			1			1			
TA met my needs and expectations.			1			1			
The combination of workshop, toolkit, and TA were helpful.			4			4			

All of the conveners found the workshops to be useful, increasing both skill and confidence. The ETK was also useful and provided materials needed. Two participants neither agreed nor disagreed that the workshop assisted with problem-solving. A combination of the toolkit, workshop and availability of technical assistance provided necessary tools and practice to successfully implement Performance Partnership Summits. All of the facilitators also found the workshops to be useful. The most celebrated occurrence at the workshop was role playing. The role playing included receiving the RBF method of coaching and feedback. The coaching is just in time and interrupts the role play to provide specific guidance. The feedback from those being facilitated gives specific information as to the differential impact of the facilitator's use of skills. This RBF method of using role playing for skill building provided practice, problem solving, and increased sense of confidence for the facilitators. For at least one participant it also provided a mental model that she reflected on outside of the workshop, used in the summit and applied to other meetings related to her job. The ETK was useful and provided materials needed but was not as helpful in problem- solving. One participant felt the ETK did not provide materials for all phases of the Summit and did not help in her problem solving. She felt the ETK was probably most helpful for the recorder. Again, the combination of ETK, workshop and TA was thought to be necessary in learning how to implement the Performance Partnership Summits.

The recorders also found the workshops to be useful but felt that there could have been more role playing and practice for them in role. Of the three Summit roles, the recorder found the ETK most helpful. Again, using the ETK to solve problems was not rated as highly, although the workshop provided the team with assistance to solve problems. The combination of the three approaches being essential to implementation of successful Summits was reported by participants in the recorder role. The interview concluded with an open-ended question regarding additional insights and comments. The responses can be summarized as follows:

- The workshop supported the Summit implementation team and provided them with the tool set needed to conduct summits. The single most helpful learning experience was role playing with team members. Two of the teams specifically requested that more role-playing be available for the conveners and the recorders. In one instance the actual roles assumed in preparing for the Summit were reversed because of scheduling. So, the person who was going to facilitate ended up being the convener and the original convener became the facilitator. One of the things that helped the facilitator be successful in her role was remembering the role playing and feedback and calling on this information to guide her in her role. This implies that role playing may create a mental model that serves to provide means for reflective practice and problem solving months after the completion of the workshop. This notion is further supported by another facilitator who stated that "during the Summit, I kept recalling and reflecting on what I did and learned in role playing at the workshop." Another participant praised the feedback strategy used and said that she wished she had more time for additional feedback because it accelerated her learning and provided a window into how her presence impacted participants—something she had not considered before.
- The ETK was also seen as very helpful. For the recorder the templates were most frequently cited as being the most useful tools. For the facilitator the most useful tool seemed to be the annotated agenda and the "4 Questions" which helped to maintain focus. The conveners were most likely to note the letters but felt that the toolkit was not as helpful as the workshop.
- Technical assistance was used less frequently but was useful to those who used it. The SCLC provided the technical assistance over the phone, primarily during the "Ask" or convening phase. A SCLC staff person participated in two summits playing a non-hierarchical partner role, similar to that played in the National Summits and also provided a few minutes of coaching and feedback to the team during the day. The teams who experienced this extra level of TA found it valuable, and the three teams that did not have that benefit were equally able to implement the RBF method. This is an indication that the in person provision of TA and the participation of SCLC in a summit is a helpful but not necessary condition for success.
- The Summit implementation team members were unanimous in their belief that the three modules—workshop, toolkit, and technical assistance needed to be offered and that no one module could stand alone. The ETK was invaluable in providing the instruments and tools needed. It expedited work and assisted with

consistency. The workshop provided an opportunity to learn to use the ETK, meet with team members and to role play together. The latter was deemed most important. In addition the workshop provided a context for networking and collaborative learning resulting in deeper understanding and insights. Although, technical assistance was not widely used, it is deemed essential to have it available on an as needed basis.

Key Findings: A number of key findings came out of the Phase I effort. In summary, they were:

1. By using the ETK, the workshop, and timely TA, it is possible to give diabetes educators and their partners the knowledge and skill set needed to convene, facilitate, and follow-up from a local Performance Partnership Summit. The three pronged approach was effective and efficient, with five Summits attended by more than 45 health providers. Each of the five summits adopted action plan commitments. The following are highlights from the interviews about the Summits and action plan commitments:
    a. Five of the seven teams, conducted a Summit within four months of the workshop, one team had to reschedule and has not yet conducted a summit, and one team decided after the workshop that they could not conduct a summit due to changes in their job responsibilities. The teams that did not conduct a summit were similar to each other, and different from the other five teams in a number of ways:
        i. They were invited to the workshop late in the process;
        ii. The invitation was not extended directly by a member of the project team;
        iii. Their orientation prior to the workshop was abbreviated;
        iv. There were only two members on each team instead of three or more; and,
        v. The formation of one of the teams occurred at the workshop.

        Phase II will include an enhanced invitation and orientation process for workshop attendees to address these issues and increase the number of teams able to conduct summits. Phase II, the honorarium for participating in the research will be offered after the post-summit interview, and the mini-grant to support the summit will be distributed after the letters of invitation go out rather than distributing these funds at the workshop as was done in Phase I.
    b. Attendance at the Summits ranged from six to nineteen and included a mix of healthcare providers and their partners. Examples include diabetes educators, directors of tobacco cessation organizations, diabetes council groups, physicians, nurses and dieticians. Actual attendance represented a range of 50% -136% of individuals invited. The ETK, workshop and TA supported appropriate summit participation.
    c. Each of the Summits resulted in the adoption of an action plan and commitments by participants. Commitments included a variety of action such as the following:
        i. The Public Health Department is educating all their PCNs in the organization;
        ii. Rural clinics will present information at in-service, meetings to health educators and providers;
        iii. The two Native American representatives will present information at a native youth pow-wow;
        iv. Modify education records to document the provision of smoking cessation information and follow-up;
        v. Each member of the Summit will invite one person to help implement the action plan; and,
        vi. Develop a campaign kit, a fact sheet, and a one-liner/tagline for the campaign.
2. Dividing the key roles of Convener, Facilitator, and Recorder among a three member team made the one-day workshop possible and kept participants from being too overloaded. This division also gave the ETK a natural structure of sub-toolkits for each role. Further development of the workshop curriculum and ETK for the convener role will occur in Phase II. Three of the four teams addressed challenging issues at the beginning of their Summits. Though the skills supported them in addressing the issues, additional coaching during the workshop in the use of the skills in these situations was seen as desirable.

3. The model may be expanded to include the role of logistician. Currently, it is a shared role that required more time than expected and for some summits on-site activities during the summit that made it harder for those sharing the role to perform their functions as convener, facilitator and note taker during the summit.
4. The teams were self-selected and ended up ranging from 2 to 6 members. The larger teams had shared or split roles. This led to some confusion and, in Phase II we propose a maximum team size of four. The two person teams were not successful and Phase II will also have a three person minimum team size.
5. The simplification of the summit process into a small number of conversations each answering a key question, made learning the roles feasible. However, the "Ask, Answer, Act" model was confusing for some due to it's similarity to the "Ask, Advise, Refer" brief smoking intervention. Similarly, the framing of three stages (Ask, Answer, and Act) seemed too complex when combined with the 4 questions. Phase II will further simplify the nomenclature and structure of the ETK and workshop curriculum.
6. Though the ETK was useful and supp0rted the teams, the 80 page ETK was difficult to navigate and some links were not sufficiently tested. In Phase II simplified content and easier navigation will be developed. Other feedback from the interviews that will inform Phase II ETK upgrades:
    a. provide a simplified version of forms for the recorder
    b. Include an annotated table of contents to provide context for each section
    c. Include a PowerPoint presentation template for information to aid the explanation of key points,
7. The workshop prepared the teams to implement the summits successfully, and the interviews provided insights for improving the workshop in Phase II as follows:
    a. More role playing for the convener and more practice for the recorder in documentation
    b. More opportunity to learn about how the roles connect and relate to each other
    c. Share learning from other Summits and more time practicing the development of action plan strategies.
    d. More information and deeper discussions about holding the neutral role of the facilitator
8. A set of pre-workshop screening tools is needed to help participants choose roles for which they are technically equipped. Several of the Recorders were not comfortable with computers and word-processing and thus unable to do the rapid turn-around of intermediate (and, even final) parts of the action plan. Also, for the Facilitators an ability to hold their role and give work back to the group rather than dominate the group with their expertise is critical. Phase II efforts will include a web-based screening tool for potential Recorders to watch/listen to video clips of conversations and record the key points. They then can compare their efforts to the ideal and either practice, if required, or take on a different role, if it appears too daunting. An assessment will also be developed to help people assess the fit for them of the facilitator role.
9. Three of the four teams were interested in conducting additional summits. One facilitator is using the skills in her daily work and perceives the value of further training. In addition, a number of teams expressed an interest in learning from the other teams in a peer to peer learning exchange. The Orange County team submitted an abstract to the AADE for the National Convention for Diabetes Educators. They are hopeful of being accepted as a poster session, if not, a presentation. Phase II will examine the possibility of further in-depth training, peer learning networks, and opportunities for diabetes educators and their partners to publish and/or present their work.
10. Of crucial importance to engaging diabetes educators and their partners in the project was an understanding that the amount of time and effort required to be successful was feasible within the context of their daily schedules and that participation would result in a tangible benefits. Benefits for themselves as professionals, for their colleagues who would attend the summit, and for the community and patients they served. The four teams estimated the amount of time they spent pre-summit, at the summit, and post-summit. The biggest differences between our original estimates of the time needed and the actual were: conveners spent an average 16 hours pre-summit compared to our estimate of 10; and facilitators averaged 11 hours pre-summit versus 5 estimated. It took the average total time of: 25, 21, and, 12 hours for the convener, facilitator, and recorder, respectively. Although, this amount of time was feasible for the diabetes

educators and their partners, it proved demanding. Thus, in Phase II enhancements will be made in the ETK, workshop, and TA to reduce the time needed for the effort. Overall, Phase II will build on the experience of Phase I to enhance even more the value to the diabetes educators and their partners of producing a smoking cessation action plan, building a network of colleagues in their own community, and learning transferable skills were considered an appropriate return on their investment of time and effort.

Bibliography and References

1. Pillsbury, J, Results Based Facilitation Workbook V5.51, Sherbrooke Consulting, Inc., Aug 2007.
2. California Diabetes Program Fact Sheet, California Department of Health, http://www.caldiabetes.org/get_file.cfm?contentID=1029&ContentFilesID=9
3. California Health Interview Survey (CHIS), 2005; http://www.chis.ucla.edu/
4. Willi, C, Bodenmann, P, Ghali, W, Faris, P, Coruz, J, *Active Smoking and the Risk of Type 2 Diabetes,* JAMA.2007;298(22):2654-2664.
5. Ovretveit, J et al**,** *Quality Collaboratives: Lessons From Research*, Qual Safe Healthcare 2002;11:345-351. http://www.ihi.org/NR/rdonlyres/ECBA4673-88F9-488B-8621-9E1D2D4AC083/0/OVretveitQualitycollabslesnsfromrsrch.pdf
6. Bloom, *Effects of continuing medical education on improving physician clinical care and patient health: A review of systematic reviews*; International Journal of Technology Assessment in Health Care (2005), 21: 380-385 Cambridge University Press
7. Mokdad, AH, et al, *Actual Causes Of Death In The United States, 2000*. JAMA. 2004;291:1238-1245. www.csdp.org/research/1238.pdf
8. Centers for Disease Control and Prevention. **Cigarette Smoking Among Adults—United States, 2000**. Morbidity and Mortality Weekly Report [serial online] 2002;51(29):642–645. Available from: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5129a3.htm.
9. *Coffay, A, Smoking cessation: Tactics that make a big difference* Journal of Family Practice, October 2007 Vol. 56, No. 10: 817-824
10. *An L, Foldes S, Alesci NL, Bluhm JH, Bland PC, Davern ME, Schillo BA, Ahluwalia JS, Manley MW. The impact of smoking-cessation intervention by multiple health professionals. Am J Prev Med 2008;34(1):54-60*
11. *Schroeder, SA.What to do with a patient who smokes, Smoking Cessation leadership Center, University of California, San Francsico*
12. *Schroeder, SA "What to do with a patient who smokes"* JAMA, *July 27, 2005 (v.294 n.4)*
13. *Fiore et al. Effective Tobacco Dependence Treatment JAMA.2002; 288: 1768-1771.*
14. National Conference of State Legislatures, *Tobacco Use Cessation: The Effectiveness Of Quit Lines* http://www.ncsl.org/programs/health/tobaccostop.htm
15. Fiore MC, Bailey WC, Cohen SJ. Treating Tobacco Use and Dependence, Clinical Practice Guideline. Rockville, MD: US Department of Health and Human Services, Public Health Service;2000.
16. Zillich A, Aquilina, M, and Farris K, *Knowledge and Attitudes About Smoking Cessation Among Pharmacy Technician*s, J Am Pharm Assoc, 2994:44:578-582.
17. American Academy of Family Physicians. Year 1 Accomplishment Report to Smoking Cessation Leadership Network. Oct. 1, 2005 to Sep. 30, 2006.
18. Friedman, M, Trying Hard Is Not Good Enough, Fiscal Policies Study Institute, ISBN 1-4120-6397-3.
19. Luke, J, Catalytic Leadership: Strategies for an Interconnected World, Jossey Bass, 1998
20. Haas, C and Sibthorp, J, Making the *benefits last: transferring learning from park and recreation programs* Parks & Recreation, June, 2004
21. Pillsbury, J, *Strategy Development: What Works*, Sherbrooke Consulting, Inc, http://www.sherbrookeconsulting.com/Collaboration.pdf
22. Balas EA, Boren SA. Yearbook of Medical Informatics*: Managing Clinical Knowledge for Health Care Improvement.* Stuttgart, Germany: Schattauer Verlagsgesellschaft mbH; 2000

23. Butterfoss FD, Morrow AL, Webster JD, Crews C. The Coalition Training Institute: Training for the Long Haul. *Journal of Public Health Management and Practice*, 9(6):522-529, 2003.

24. Zhu SH**,** Stretch V**,** Balabanis M**,** Rosbrook B**,** Sadler G**,** Pierce JP**,** *Telephone counseling for smoking cessation: effects of single-session and multiple-session interventions.* **:** J Consult Clin Psychol. 1996 Feb; 64(1):202-11

25. Brown M, Anderson C, Black K, Hansen K, MacAller T, Silverman W, Tang H. *Be Proactive: A Campaign to Promote Smoking Cessation among People with Diabetes via Health Care Providers*. CA Department of Public Health Diabetes Program, CA Smokers' Helpline, and CA Department of Public Health Tobacco Control Section, August 2007.

26. Community Intervention Trial for Smoking Cessation (COMMIT): I. cohort results from a four-year community intervention. Am J Public Health 1995 February; 85(2):183-192.

27. Lew R, Tanjasiri SP, Kagawa-Singer M, Yu JH. Using a stages of readiness model to address community capacity on tobacco control in the Asian American and Pacific Islander community. Asian Am Pac Isl J Health. 2001 Winter-Spring;9(1);66-73.)

28. http://www.mondovisio.com/~appealfo/pages/Cross_Cultural_Leadership51.php?project_id=51)

29. California Diabetes Program Diabetes Educator Tobacco and Diabetes Survey 2006 and 2007

30. The California Smokers' Helpline, http://www.californiasmokershelpline.org

31. CSTATS: County and Statewide Archive of Tobacco Statistics, California Department of Public Health http://www.cstats.info/

32. American Diabetes Association, news release, Jan. 23, 2008 http://www.diabetes.org/for-media/pr-devastating-toll-of-diabetes-reaches-174-billion-012308.jsp

Appendix 1: Phase I Workshop Detail Agenda and Sample Electronic Toolkit Screen Shots

Annotated Agenda
Performance Partnership Summit (PPS) Workshop
October 12 -13, 2007
San Diego, CA

PPS Workshop purpose:

To increase diabetes educators ability to convene local performance partnership summits designed to involve healthcare professionals and their partners in cessation intervention with their patients who have diabetes.

PPS Workshop results:

By the end of the PPS workshop the participants will be able to:

1. *Describe the purpose of a local Performance Partnership Summit (PPS)*
2. *Describe how a successful local PPS can help increase tobacco cessation interventions.*
3. *Describe the roles needed to convene a local PPS.*
4. *Use the electronic tool kit to convene a local PPS.*
5. *Get the technical assistance and information needed to convene their local PPS.*
6. Choose the role they will play in convening their local PPS.
7. Use the skills and tools necessary for their chosen role.
8. Take the next steps needed to convene their local PPS within the next 3-6 months.

The workshop results in italics are those included in the program announcement developed for CEU credits.

October 12, 2007 -- Convening Working Dinner			
Time	**Task/Meeting Result**	**RBF Reference**	**ETK**
3:00 pm	**Room set Up (Jolie, Bob, Reason)** • computers with wireless connectivity for each team = 6 computers. • 1 flip chart for each team (sat.) • 2 flip charts up front (sun. and sat.) • 4 team tables: o Central coast (5) (o North Valley (4) o South Central Valley (3) & San Diego (4)=7 o Orange (3) & San Francisco (2) = 5 • one coach facilitator table with computer & printer?: one computer and LCD for front • blank name tents, markers, tape, post its, stress toys on each table • posters on the wall? • folder with public agenda and handouts, note paper, pen for each person registration table, resource table, food table	Room set	ASK: summit location Post Digital picture of room for etk

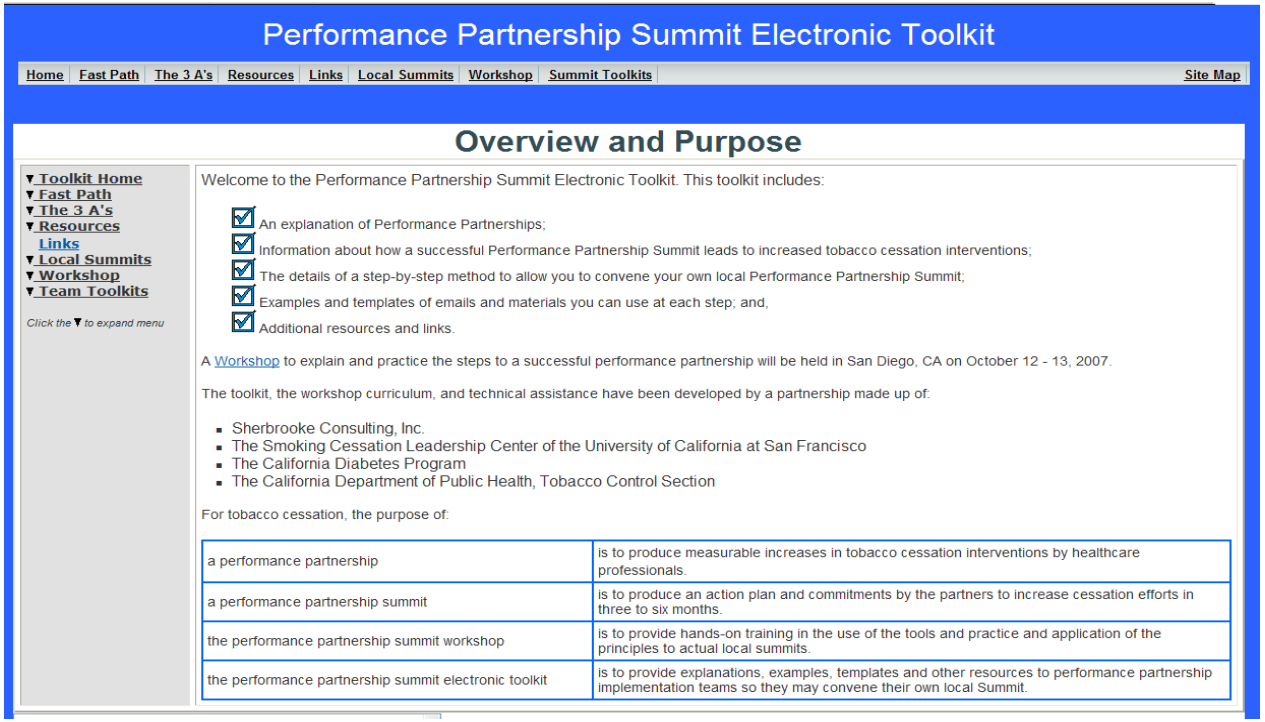
	Meeting Result: Room set up for PPS workshop AND as model of PPS set up.		
5:00 pm	**Final Room Set Up and implementation team meeting** • PI check-in (Jolie, Bob, Vicki, Connie, Catherine, Reason, Linda) • Review roles for evening session • Review "huddle" times • Prepare to welcome	PIT	
6:00 pm	**Welcoming reception** • registration table – Bob • Welcoming – Jolie, Vicki, Connie, Catherine, Reason, Linda, & Tami? & Majel? & Kirsten?		
6:30 pm	**Welcome to dinner & Introductions** • Welcome & Purpose of the PPS workshop • Jolie quick intros of coach facilitator & each person introduces self: name, where from and "day job", interest in PPS. (10 min) **Meeting result: people ready to work**	Context/ EQ/LF	
7:00 pm	**1.0. PPS Purpose, objectives and benefits** a. Pre-test (5-10 mint) b. Set up for next discussion – informal half-circle – c. Jolie facilitates discussion by training team, that allows each person to have opportunity to share information through the discussion a. Describe PPS and the benefit to diabetes educators of implementing a PPS as extension of DoYouCAARD Campaign b. Describe PPS objectives and benefits to the PPS participants c. Review the role of PPS participants d. Discuss the roles on the implementation team d. Jolie facilitate the affirmation by the teams of who will be practicing which roles and further discussion and Q & A e. People invited to review role descriptions and other materials over night..	Meeting Results	3 A's FAQ DoYouCAARD PDF toolkit DE website link Team People will have made preliminary choice re role prior to arrival.
	Meeting Result: Understand the purpose of the local Performance Partnership Summit (PPS), the role of PPS participants, and the benefits of implementing a local PPS. & Choice of PPS team role & completion of pretests		
8:15 pm	Closing Remarks		
8:30 pm	Adjourn		

October 13, 2007			
Time	**Task/Meeting Result**	**RBF Tool**	**ETK**
7:00 am	**Final Room Set Up and implementation team meeting**		
7:30 am	**Welcome and breakfast**		
8:30 am	**2.0 . PPS Preparation and Team Roles** **This section teams at their table, combination of large and small group discussion.** • Jolie and Vicki facilitate check-in and overnight reflections re roles. • Each team member reviews and discusses with their team mates what they are interested in learning at the workshop and initial thoughts about their role at each stage (Ask, Answer, Act) o facilitator(s) have flip chart, markers, tape	B/ART Neutral Facilitator Note taker SBI & SBI forms – enough for people to give written feedback after each practice	Site map Ask, ACT, Answer Team roles (FastPATH & Timeline) Notetaker tips

	○ recorder has access to a computer ○ convener has stationary and envelopes? access to cell phone (hopefully theirs…) a. Discuss how the team will work together.—maybe develop with facilitator taking role and notetaker capturing. Introduce SBI and practice		
	Meeting Result: Understand the steps needed to prepare for a PPS and the role of each member of the PPS implementation team.		
9:00 am	3.0. ASK: Composition analysis - PPS Participants Each team with people in role: a. Brainstorm potential participants and create initial list. b. Use invitation letter from electronic tool kit to invite potential participants – customize the letter and practice using it for at least one invitee c. Practice enrollment conversations with potential participants a. role play with participants helping the convener practice by enacting a potential invitee. d. Use participant invitation workplan template from electronic tool kit to identify next steps for invitation e. SBI	3 R's	ASK Composition analysis template Materials: extra name tents to put in selected roles for ANSWER practice.
	Meeting Result: Identify potential PPS participants and use electronic toolkit templates to invite and enroll potential participants		
10:15 am	Break		
10:30 am	4.1 ANSWER: PPS Facilitation & Note taking a. Each member of team picks up role. For each conversation the table as a whole participates, with people "taking turns" in the 6 summit conversations. b. Teams prepare to use RBF skills integrated into the practice, notetaking skills integrated into practice. People also continue with SBI to have deeper appreciation of PPS. Conveners encouraged to do reflective practice that will support their convener role & pick up role of catalytic leader in the enactments. c. During the period of time from 10:45 through 3PM, the teams will practice facilitation of the PPS agenda questions and the capturing of the answers to create an action plan. During that time coach facilitators pick up following roles:	The conversations of a Summit each link to one or two RBF skills. The conversations are: A. Check-in: Interest in the result B. Where are we now? C. Where do we want to be? D. How will we get there? & How will we know we are successful? Check-out: Commitments to Action & How will we work together	Answer Public Agenda Annotated Agenda Data trend lines PPS notetaker template
	Meeting Result: Use the *Results Based Facilitation* competencies to facilitate participant problem-solving and decision-making at a PPS. Use the electronic templates to capture key decisions, action items and commitments for PPS.		
10:45 am	A. **Check-in: interest in the result.** EQ: name, role, interest in smoking cessation smoking cessation. The facilitator practices check-in conversation, flip charting" interest" with notetaker creating list. SBI (30 minutes)	Skills: 1) "listen for" – 2) flip chart 3) sequence 4) summarize 5) recorder: brevity & speed – follow the flip chart!	Annotated agenda Action plan template

11:15 am	**B. Where are we now?** **ANSWER Q. #1: agree on trend line .** • Each county using their own data. • Notetaker practicing with template.	Skill: 1) give work back to group 2) **Proposal Based Decision Making (reaching agreement)**	Annotated agenda Action plan template
11:45 am	C. Where do we want to be? - ANSWER Q #2: agree on target. • Each county using their own data. • Notetaker practicing with template.	Skill: 1) EQ & ARE 2) **Proposal Based Decision Making** (developing options & reaching agreement)	Annotated agenda Action plan template
12:15 pm	**Lunch**		
1:15 pm	**D.** How do we get there & how will we know we are successful?	**Skills:** **1)** holding role (neutral) **2)** Synthesize **3)** Eq's: What, who, when, & how & how will we know **4)**	Annotated agenda Action plan template
2:15 pm	Check-out: Commitments to Action & How will we work together		
2:45 pm	**Break**		
3:00 pm	5.0 PPS PowerPoint and resources a. In teams and in large group: • Discussion and questions, • use of electronic tools, • feedback. b. each team develops their next step work plan to prepare for PPS:		templates time line
	Meeting Result: Use the electronic templates to prepare PowerPoint to be used at the PPS (including baseline, best practices, and smoking cessation resources) & use electronic templates to plan next steps and make commitments to implement PPS.		
4:00 pm	Post-test, Next steps, and evaluation a. post-test – 5-10 minutes b. discussion of TA and resources available 10 min c. Evaluation 5 minutes d. CEU certificates e. Next steps and commitments as "check-out) f. Appreciative closing comments.	Check-out	Materials: Post test Evaluations CEU certificates
4:30 pm	**Adjourn**		

Screen Shots of Selected ETK Pages



Performance Partnership Summit Electronic Toolkit

Home | Fast Path | The 3 A's | Resources | Links | Local Summits | Workshop | Summit Toolkits | Site Map

Overview and Purpose

▼ Toolkit Home
▼ Fast Path
▼ The 3 A's
▼ Resources
Links
▼ Local Summits
▼ Workshop
▼ Team Toolkits

Click the ▼ to expand menu

Welcome to the Performance Partnership Summit Electronic Toolkit. This toolkit includes:

- ☑ An explanation of Performance Partnerships;
- ☑ Information about how a successful Performance Partnership Summit leads to increased tobacco cessation interventions;
- ☑ The details of a step-by-step method to allow you to convene your own local Performance Partnership Summit;
- ☑ Examples and templates of emails and materials you can use at each step; and,
- ☑ Additional resources and links.

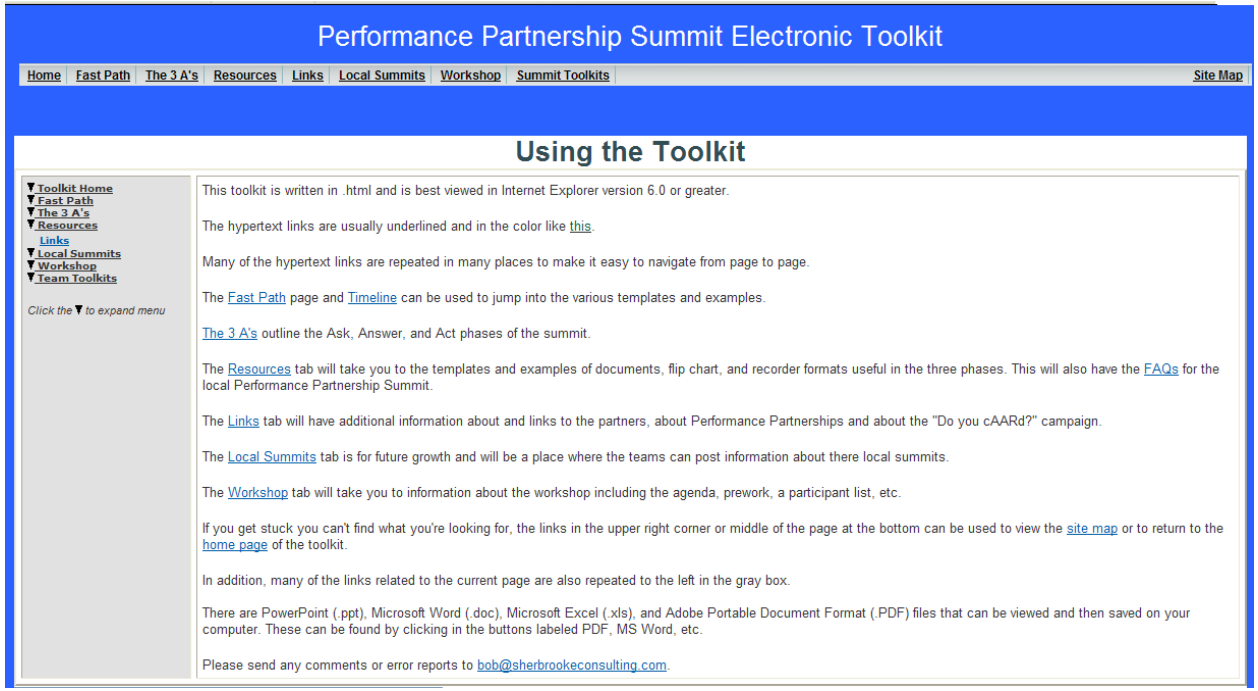
A Workshop to explain and practice the steps to a successful performance partnership will be held in San Diego, CA on October 12 - 13, 2007.

The toolkit, the workshop curriculum, and technical assistance have been developed by a partnership made up of:

- Sherbrooke Consulting, Inc.
- The Smoking Cessation Leadership Center of the University of California at San Francisco
- The California Diabetes Program
- The California Department of Public Health, Tobacco Control Section

For tobacco cessation, the purpose of:

a performance partnership	is to produce measurable increases in tobacco cessation interventions by healthcare professionals.
a performance partnership summit	is to produce an action plan and commitments by the partners to increase cessation efforts in three to six months.
the performance partnership summit workshop	is to provide hands-on training in the use of the tools and practice and application of the principles to actual local summits.
the performance partnership summit electronic toolkit	is to provide explanations, examples, templates and other resources to performance partnership implementation teams so they may convene their own local Summit.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Click the ▼ to expand menu
This toolkit is written in .html and is best viewed in Internet Explorer version 6.0 or greater.
The hypertext links are usually underlined and in the color like this.
Many of the hypertext links are repeated in many places to make it easy to navigate from page to page.
The Fast Path page and Timeline can be used to jump into the various templates and examples.
The 3 A's outline the Ask, Answer, and Act phases of the summit.
The Resources tab will take you to the templates and examples of documents, flip chart, and recorder formats useful in the three phases. This will also have the FAQs for the local Performance Partnership Summit.
The Links tab will have additional information about and links to the partners, about Performance Partnerships and about the "Do you cAARd?" campaign.
The Local Summits tab is for future growth and will be a place where the teams can post information about there local summits.
The Workshop tab will take you to information about the workshop including the agenda, prework, a participant list, etc.
If you get stuck you can't find what you're looking for, the links in the upper right corner or middle of the page at the bottom can be used to view the site map or to return to the home page of the toolkit.
In addition, many of the links related to the current page are also repeated to the left in the gray box.
There are PowerPoint (.ppt), Microsoft Word (.doc), Microsoft Excel (.xls), and Adobe Portable Document Format (.PDF) files that can be viewed and then saved on your computer. These can be found by clicking in the buttons labeled PDF, MS Word, etc.
Please send any comments or error reports to bob@sherbrookeconsulting.com.

Performance Partnership Summit Electronic Toolkit

Toolkit Quick Links

Performance Partnership Summit Electronic Toolkit

Site Map

Sherbrooke Consulting, Inc. - Home

Overview & Explanation

- Toolkit - Home
  - Background
  - Summit Team
  - Toolkit Use
  - Quick Links
- Fast Path
  - Timeline
- The 3 A's
  - Ask
    - Convener Toolkit
      - *Who to Ask*
      - *Summit Location*
      - *Enroll Participants*
      - *Invitation Letter*
      - *Summit Agenda*
      - *Summit Data*
      - *Pre-reading*
    - Answer
      - The Summit
      - Annotated Agenda
      - Facilitator Toolkit
      - Recorder Toolkit
  - Act

Summit Toolkits, Tips, Help & FAQ's

- Convener Toolkit - Pre-summit
  - *Who to Ask*
  - *Summit Location*
  - *Enroll Participants*
  - *Invitation Letter*
  - *Summit Agenda*
  - *Summit Data*
  - *Pre-reading*
  - *Summit Participant List*
  - *Map*
  - *Summit Check List*
- Convener Toolkit - Post-summit
  - *Thank you Letter*
- Facilitator Toolkit
  - *Annotated Agenda*
- Recorder Toolkit
  - *Action Plan*
  - *Conversation A*
  - *Conversation B*
  - *Conversation C*
  - *Conversation D*
  - *Conversation E*
  - *Conversation F*
  - *Recorder Tips*
- Who can Help?
- FAQs

Workshop & Local Summits

- Links
  - California Diabetes Educators
  - California Smoker's Helpline
  - California Department of Public Health/Tobacco Control Section
  - Sherbrooke Consulting, Inc.
  - Smoking Cessation Leadership Center
- Local Summits
  - Fresno County
  - Monterey County
  - Orange County
  - Sacramento County
  - San Diego County
  - San Francisco County
- Workshop
  - Agenda
  - Prework
  - Registration
  - Self-assessment
  - Consent Form
  - Participant List
  - Evaluation
  - Workshop FAQs

Performance Partnership Summit Electronic Toolkit

Action Plan

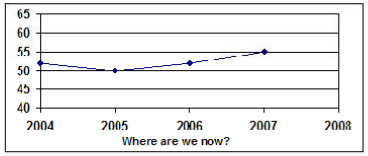
PDF | MS WORD

[Arlington County
Tobacco Cessation Summit
November 22, 2007]

Where are we now? (Conversation B)

The partners affirmed the baseline data to be as below:

Year	Data
2004	52
2005	50
2006	52
2007	55
2008	

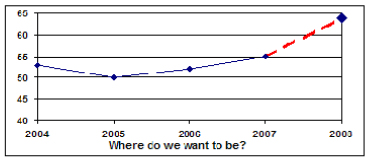


A few data points can be added from the quitline data into an Excel spreadsheet and typed into the template before the summit. The graph is generated in Excel (see the Excel template).

Where do we want to be? (Conversation C)

The partners affirmed the target to be: [64 for 2008]

Year	Data
2004	52
2005	50
2006	52
2007	55
2008	**64**



This means an [increase] of [16%] from the present levels.

How do we get there: What works? (Conversation D)

Listen for: experiences, best practices, advances cessation management. Low cost/no cost solutions

Step 1: What Works? and What can people contribute?

What Works:	Contributions:	Strategies:
▪ [Health providers using AAR] ▪ Pharmacists handing out quitline cards]	▪ [Can work with local Pharmacists to distribute cards]	▪ [Health care provider education]

Step 2: Proposed Strategies:

1. [Educate health care providers]
2. [Pharmacist Outreach]
3. …
4. …
5. …
6. [Distribute cAARd and materials]
7. ….

Step 3: Agreed Upon Strategies:

1. [Educate health care providers]
2. [Pharmacist Outreach]
3. [Distribute cAARd and materials]

Step 4: Strategy Groups are formed and Strategy Development Template is handed out:

WHAT	GOAL	HOW	WHO	WHEN
Drop off packs of cards weekly to pharmacies				
Utilize and promote quitlines				Immediate

How do we get there: How we will know we are successful? (Conversation E)

Listen for: who will do what, when, and with what impact and how the impact will be measured:

Step 1: Strategy groups record their action plan on flipchart.

Strategy: [Enroll Pharmacists]					
ACTION ITEMS	HOW	WHO	WHEN	IMPACT	MEASURE
Begin to compile list of pharmacies in the target area	Use the internet and local BBB	John Public	By Novr 29, 2007	More cards distributed to smokers	# pharmacists handing out cards

Copy table for each strategy.

Appendix 2: Post Summit Interview Protocol

Interviewee Information
Convener
Facilitator
Recorder
Others
Comments
Interviewer

DATE

SUMMIT INFORMATION

Date:

Location:

Participants: Invited Attended %

Names/Affiliations

Number of team members involved in the process of convening, facilitating, note taking and follow-up:

How much time was spent by persons in each role for preparation and follow-up?

Role	**Preparation**	**Summit**	**Follow-up**
Convener			
Facilitator			
Recorder			

Was an action plan adopted? YES ☐ NO ☐
Comments

Were commitments made? YES ☐ NO ☐
Comments:

Other comments/thoughts/ideas about the Summit:

Are there likely to me more Summits?

Convener					
	Strongly Disagree	Disagree	Neither Agree nor	Agree	Strongly Agree
Workshop content was useful.	☐	☐	☐	☐	☐
The workshop helped me prepare for the actual summit.	☐	☐	☐	☐	☐
I felt more confident because of the role playing done at the workshop that helped apply skills and tools.	☐	☐	☐	☐	☐
I used skills learned in the workshop to problem solve.	☐	☐	☐	☐	☐
The toolkit templates were useful.	☐	☐	☐	☐	☐
The toolkit included the materials needed to implement the Summit.	☐	☐	☐	☐	☐
The toolkit provided the tools and materials needed to support me in preparing, implementing and following-up.	☐	☐	☐	☐	☐
I used the templates to make decisions and problem solve for the Summit.	☐	☐	☐	☐	☐
Did you use TA? YES ☐ NO ☐					
TA was support was useful in preparing, implementation and follow-up of the Summit.	☐	☐	☐	☐	☐
TA provided the problem-solving support needed to successfully prepare for and implement the Summit.	☐	☐	☐	☐	☐
TA was provided in a timely manner.	☐	☐	☐	☐	☐
TA met my needs and expectations.	☐	☐	☐	☐	☐
The combination of workshop, toolkit, and TA were helpful.	☐	☐	☐	☐	☐
How necessary were each?					
What was most useful in the tool kit? • Enrollment • Composition analysis, etc.					
What would you add, omit or modify related to the toolkit?					
What was most useful in the workshop?					
What would you add, omit or modify about the workshop?					

ADDITIONAL COMMENTS

There were identical tables of questions for the Facilitator and the Recorder. They are omitted here for brevity.

Appendix 3 – Sample Phase I Action Plan
[redacted] County Smoking Cessation Summit
[redacted]

Thursday - January 10, 2008

SUMMIT ACTION PLAN

WHERE ARE WE NOW?

Affirmation of Baseline

Primary Measure:

- **2007: Exactly x calls were made to the California Smokers' Helpline 1 800 NO BUTTS from [redacted] county resident tobacco users.**

  Data summary

  - [redacted] County quitline counseling referrals are lower than the average for the state of California. This may be affected by the cultural diversity found in [redacted] County as well as the level of acculturation and literacy levels found in such subpopulations.
  - In 2006, 29 calls to the smoking counseling hotline were made.

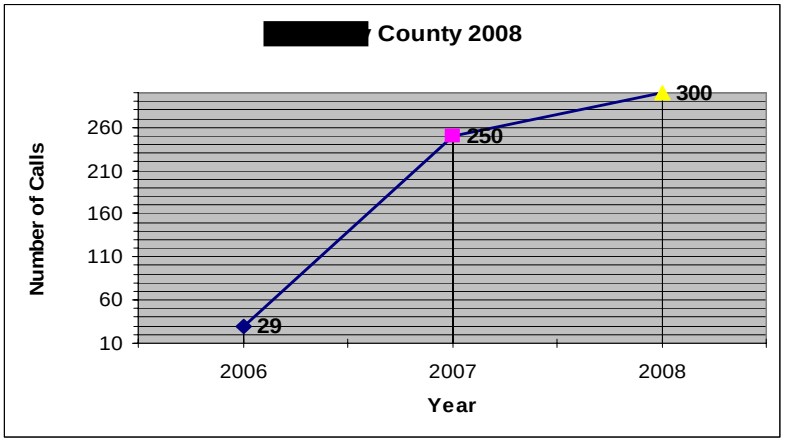
WHERE DO WE WANT TO BE?

Affirmation of Target

Primary Goal:

- **Increase smoking cessation in [redacted] County by increasing the number of calls to 300 in 2008 – 50 more calls than 2007.**

2006	2007	**2008**
29	250	**300**



HOW WILL WE KNOW WE ARE GETTING THERE?

Evaluation - track calls to the helpline on a monthly basis – Helpline will provide data

- Process measures:
  - Survey providers re knowledge of program – Task force will survey providers during presentations and other venues
  - Track orders from [redacted] county of No Butts gold cards and other items from the helpline – Helpline will provide data
  - Track Number of presentations – Task force will gather information

- Evaluate progress every 3 months.

HOW WILL WE GET THERE?

Strategy Action Plan

Committee	Strategy	Commitment	Time Frame
PROVIDER EDUCATION	▪ Educate healthcare personnel about the 1-**800 No Butts card program**	Task force members	
	▪ Increase provider awareness that AAR (Ask, Advise, Refer) is **billable/reimbursed.**		
	▪ Spread the news!!! Order and give out the 1-800 No Butts card.	Task force members	ASAP
	▪ Work with quitline to get a **speakers bureau** in [redacted] County	[redacted]	
	▪ **Provide CEU/CME** format – use existing approved CME's such as accredited Do You cAARd? presentation and the UCSD accredited CA. Smokers' Helpline	[redacted]	Start scheduling as soon as packets are ready
	▪ Inform providers about quitline and free CME at **monthly MD group meetings** 1. CSVS provider meeting 2. [redacted] County Med Association 3. [redacted] 4. [redacted] County clinics	[redacted]	Get on agendas ASAP
	▪ **Encourage attendance** by presenting at local restaurant		
	▪ **Look for possible sponsors** such as Chantix (Pfizer), American Cancer Society, American Lung Association, CADM programs, Breathe Central Coast, etc.		
	▪ **Invite an outside high profile speaker** to encourage attendance and educate clinicians		
	▪ Provide list of smoking **cessation web sites** to providers and patients (www.smokefree.gov, www.becomeanex.org etc.)	[redacted]	
Patient/Smoker Awareness	▪ Increase phone access for patients-consider hospital bedside phones when patients are admitted		
	▪ Place 1 800 No Butts posters in waiting areas, ER, exam rooms etc.		
	▪ Place 1 800 No Butts Teen posters at High schools		
	▪ Look into gov. rate or free advertising for buses, bus stops, movie theatres, restaurants, bars, etc.		
Coverage	▪ Provide one sheet on coverage for the main insurance carriers	[redacted]	
	▪ Address rules regarding counseling and medication with insurances.		
Reward Program	▪ Develop incentives for providers and patients to refer or call quitline		
	▪ Starbucks gift cards?		

	▪ F/u with [redacted] nursing units and the 1-800 No Butts card distribution		
	▪ ?Call center at [redacted]: ? [redacted] smoking cessation group for outpatient follow up.		
Increase partners	▪ Include mental health department- may help persuade mental health patients to receive counseling.		
	▪ Contact CAFP/AAFP (family physician)		
	▪ Contact CAPA (Physician assistant)		
	▪ Recruit MD champions- Attending directors such as [redacted] ([redacted] pulmonologist)		
	▪ Possibility of incorporating smoking cessation teaching with DM ed.		
	▪ Contact [redacted] county officials to see how they have increased their number of referrals? See about partnering to learn from each other.		
Outpatient cessation clinic	▪ Create outpatient smoking cessation program at [redacted]		
	▪ Contact UCSF for ideas		
Simplify access to Quitline Materials	▪ **Provide No Butts materials** on smoking cessation to providers for waiting room, exam rooms		
	▪ Establish a **materials coordinator** to make sure all orders are replenished on a regular basis		
	▪ Handout Quitline order forms at all meetings		
Education Packet	▪ Develop an education packet that includes: 1. Pharmacy List/Prices of NRTs 2. Billing info.- 3. No Butts Program outline-Fact sheet 4. Order form for materials-[redacted] 5. Resource List with web sites- 6. Data on current statistics-[redacted] 7. Provider Surveys-[redacted] 8. Folders – [redacted]	[redacted]	Deliver info to John by 2/5/08
3 month Blast!	▪ Create Packet ▪ Hand out at all existing monthly provider meetings ▪ Present Do You cAARd? CME at existing meetings ▪ Offer pre-post survey during CME/Meeting ▪ Work with materials coordinator to keep quitline marketing supplies coming	Task force members	

IMMEDIATE NEXT STEPS:

- [redacted]:
  1. Share data
- [redacted]:
  1. refer dm inpatients to helpline
  2. get copies of quitline order forms for packet
  3. Send Do You cAARd? powerpoint to summit participants/task force.
- [redacted]:
  1. f/u with CCAH regarding medicine (NRTs) coverage and counseling

2. help create NRT pharmacy bargain rate sheet
3. F/u with [redacted] County health clinic providers to see about presenting at monthly meeting
4. Continue distributing gold cards during regular visits!
5. Order quitline materials for clinic waiting and patient rooms.

- [redacted]:
  1. present information to CSVS providers
  2. provide update on summit and quitline at morning report for [redacted] Mds and Residents
  3. Beginning steps to create an outpatient cessation class at hospital
  4. Continue distributing gold cards during regular visits!
  5. Order quitline materials for clinic waiting and patient rooms.
- [redacted]
  1. High School outreach
- [redacted]
  1. f/u with case management and providing cards at [redacted] units.
  2. Remind summit participants to send materials to create folder
  3. help coordinate folder, stuffing etc.
- [redacted]-
  1. Establish a liaison within STEPS to help coordinate free Quitline cards and other materials.
  2. See about reimbursement information for providers in community.
- [redacted]-
  1. establish liaison from PA program
  2. connect to AAFP information/cme presentations,
  3. provide pre-post survey questions,
  4. provide updated action plan template
  5. connect quitline speakers bureau
  6. provide folders
- [redacted]-
  1. NRT pricing(most cost effective for the pt)
  2. Continue distributing gold cards during regular visits!
  3. Order quitline materials for clinic waiting and patient rooms.

NEXT MEETING DATE????

Next Steps Proposals:

Strategy	Feb 2008	Mar 2008	Apr 2008	May 2008
3 month blast	Establish packet	Distribute at Clinician monthly meetings	Provide CME either at meetings, or lunch/dinner at hospital or restaurant	Evaluate effort

Please add other ideas and commitments

NAME LAST	ORGANIZATION	STRATEGY	TIMELINE

Appendix 4 – Baseline Survey

This is an example of some of the survey questions for research subjects in the six California counties.

1. I am an: RDE ☐ RD ☐ RPh ☐ RN ☐ OTHER ☐_____(Specify)
2. I work in:
   ☐ Butte ☐ Shasta
   ☐ San Joaquin ☐ Stanislaus
   ☐ Riverside ☐ San Bernardino
   ☐ OTHER _____(Specify)
3. Ethnic or Racial Category:
   ☐ American Indian ☐ Native Hawaiian Other Pacific Islander
   ☐ Asian ☐ White
   ☐ Black or African American ☐ Other _____
   ☐ Latino or Hispanic
4. Gender: ☐ Male ☐ Female

	Strongly Disagree						Strongly Agree
QUITLINES							
5. Quitlines effective way to reduce tobacco use	☐	☐	☐	☐	☐	☐	☐
6. Referrals to quitlines a best practice in encouraging tobacco cessation	☐	☐	☐	☐	☐	☐	☐

	0%	25%	50%	75%	100%
CURRENT PRACTICE					
7. I refer my patients that use tobacco to quitlines ___ of the time	☐	☐	☐	☐	☐
8. I hand out Gold Cards ___ of the time to new colleagues and partners.	☐	☐	☐	☐	☐

	Strongly Disagree						Strongly Agree
LEADERSHIP							
9. I have the motivation, skills, tools and opportunity to lead healthcare professionals and partners to take action as tobacco cessation interventionists	☐	☐	☐	☐	☐	☐	☐
10. It is likely that I will lead tobacco cessation efforts in the next six months	☐	☐	☐	☐	☐	☐	☐

	Strongly Disagree				Strongly Agree
LOCAL PERFORMANCE PARTNERSHIP SUMMITS (PPS)					
11. I know what a local PPS is	☐	☐	☐	☐	☐
12. I am interested in being an implementation team member	☐	☐	☐	☐	☐

Appendix 5 – Phase II Pre-Workshop Self-Assessment

Overview:

In preparation for the Performance Partnership Summit Workshop, please fill out the self-assessment form. You will be asked to fill out a similar assessment at the end of the workshop. This information in the aggregate will be used to improve the electronic tool kit, the workshop curriculum, and define follow-up technical assistance.

Prior Experience Self-Assessment

Have you been a participant at a Performance Partnership Summit (PPS)? ☐ Yes ☐ No

1. If Yes, then were the:
   a) functions of Convener, Facilitator, and Recorder evident to you? ☐ Yes ☐ No
   b) four questions evident to you? ☐ Yes ☐ No
   c) baseline data and trend presented? ☐ Yes ☐ No
   d) action plan draft and commitments completed and handed out to participants? ☐ Yes ☐ No
   e) post-Summit follow-ups sent to you? ☐ Yes ☐ No
2. I reviewed the online information prior to the workshop ☐ Yes ☐ No
3. According to the pre-screening information, my role will be that of the:

   ☐ Convener ☐ Facilitator ☐ Recorder

Self-Assessment

A. Performance Partnership Summits

	Strongly Disagree						**Strongly Agree**
a) I can: describe the purpose of a local PPS	☐	☐	☐	☐	☐	☐	☐
b) I can describe how a successful local PPS can increase tobacco cessation interventions	☐	☐	☐	☐	☐	☐	☐
c) I can describe the roles needed to convene a local PPS	☐	☐	☐	☐	☐	☐	☐
d) I can use the electronic tool kit to convene a local PPS	☐	☐	☐	☐	☐	☐	☐
e) I can get the assistance and information needed to convene a local PPS	☐	☐	☐	☐	☐	☐	☐

Please answer the following questions even though you may not perform all three roles (convener, facilitator, and recorder) in convening and implementing a summit.

B. Roles of team:

	Strongly Disagree						**Strongly Agree**
1. I can perform the Convener role for a local PPS	☐	☐	☐	☐	☐	☐	☐
2. I can perform the Facilitator role for a local PPS	☐	☐	☐	☐	☐	☐	☐
3. I can perform the Recorder role for a local PPS	☐	☐	☐	☐	☐	☐	☐

C. Convening a Summit:

	Strongly Disagree						Strongly Agree
1. I can use the toolkit							
a) To send letters of invitation	☐	☐	☐	☐	☐	☐	☐
b) To invite partners based on the composition analysis	☐	☐	☐	☐	☐	☐	☐
c) To modify and send the public agenda	☐	☐	☐	☐	☐	☐	☐
d) To modify and send background material and data	☐	☐	☐	☐	☐	☐	☐
e) To create the participant list	☐	☐	☐	☐	☐	☐	☐
2. I can reach out and enroll people to become performance partners and attend the summit	☐	☐	☐	☐	☐	☐	☐
Logistics may be shared across roles, or held by one team member							
3. I can	☐	☐	☐	☐	☐	☐	☐
a) find the room for the summit	☐	☐	☐	☐	☐	☐	☐
b) get or order the food for the summit	☐	☐	☐	☐	☐	☐	☐
c) get the supplies & transport them to the summit location	☐	☐	☐	☐	☐	☐	☐

D. Facilitating a Summit:

	Strongly Disagree						Strongly Agree
1. **I can prepare :**							
a) using the composition analysis template	☐	☐	☐	☐	☐	☐	☐
b) modifying and using the detailed agenda template	☐	☐	☐	☐	☐	☐	☐
2. **I can Set-up**							
a) the room using one of the two alternate room setups	☐	☐	☐	☐	☐	☐	☐
b) the critical flipcharts	☐	☐	☐	☐	☐	☐	☐
3. **I can facilitate**							
a) using the annotated agenda and the practice tools	☐	☐	☐	☐	☐	☐	☐
b) charting decisions and themes for the recorder	☐	☐	☐	☐	☐	☐	☐

E. Recording at a Summit:

	Strongly Disagree						**Strongly Agree**
1. **I can prepare**							
a) using the participant list template to create the participant list	☐	☐	☐	☐	☐	☐	☐
b) using the data template for pre-reading	☐	☐	☐	☐	☐	☐	☐
2. **I can record**							
a) using the conversation and action plan templates	☐	☐	☐	☐	☐	☐	☐
b) produce, & distribute copies of the handouts at the local summit	☐	☐	☐	☐	☐	☐	☐
3. **I can follow-up**							
a) Working with the team to send out the final action plan	☐	☐	☐	☐	☐	☐	☐

F. Following up after a Summit:

	Strongly Disagree						**Strongly Agree**
Follow up may be shared across roles, or held by one team member							
I can:							
1. modify and use the thank you letter templates	☐	☐	☐	☐	☐	☐	☐
2. check in on progress at 3 & 6 months	☐	☐	☐	☐	☐	☐	☐
3. encourage performance partners to keep in action after the summit.	☐	☐	☐	☐	☐	☐	☐
4. work with partners to problem solve and celebrate success as the action plan is implemented	☐	☐	☐	☐	☐	☐	☐

G. Please provide us with feedback on the ETK, pre-workshop communications, and your overall assessment.

	Strongly Disagree						**Strongly Agree**
1. It was clear what will be required of me.	☐	☐	☐	☐	☐	☐	☐
2. It was easy to find what I needed in the ETK	☐	☐	☐	☐	☐	☐	☐
3. The pre-screening exercises were clear and useful	☐	☐	☐	☐	☐	☐	☐
4. Any comments on the ETK, communication or project							

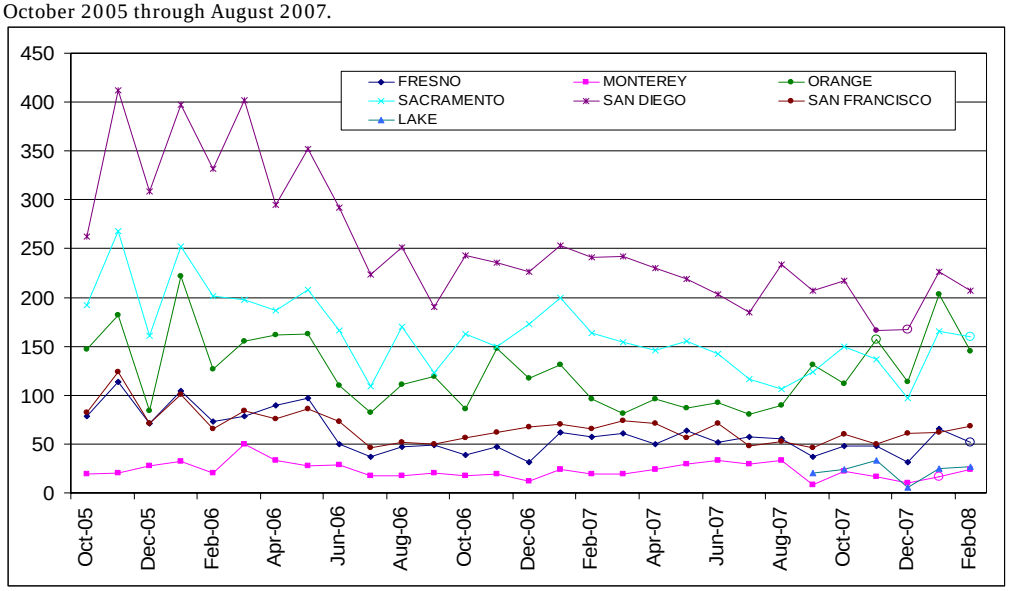
_____

_____

_____

Appendix 8 – Phase I and Phase II Quitline Call Volume

The California Helpline call volume for the period October 2005 through February 2008 is shown for the six of the Phase I counties. Lake County data was not available to us at the time of the proposal for the period October 2005 through August 2007.



The Quitline data for the six potential Phase II counties is shown below. Since the current design calls for three pairs of counties – one as the program group and one as the comparison group – the figure shows the average of the pair with variation between them shown as error bars.