A Framework for Evaluating Practice Transformation

When Dr. Kevin Peterson, from the University of Minnesota, wanted to implement the chronic care model to improve diabetes care in multiple primary care practices, he did a literature search to see what had been demonstrated to work. From that, he found nine distinct elements in the literature that were shown to improve care when implemented in primary care offices. These nine elements he put together in a framework with the acronym TRANSLATE. He then tested the framework in a large randomized controlled trial sponsored by NIH and showed clinically significant improvement care in multiple measures within one year. The Upstate New York Practice Based Research Network (UNYNET) utilized the TRANSLATE framework to do a comparative effectiveness pragmatic clinical trial in chronic kidney disease (CKD) comparing point of care computer decision support without facilitation to point of care computer decision support with all nine elements of the TRANSLATE model. The model was adapted and a four point evaluation rubric was developed to test which elements were strong and which elements needed to be bolstered to allow the practice to achieve clinical transformation. (See excel spreadsheet)

An explanation of each of the elements of the acronym, it’s expanded definition, and its implication for practice are presented in the table below with appropriate literature references that define the evidence base.

<table>
<thead>
<tr>
<th>Element (References with Evidence)</th>
<th>Expanded definition</th>
<th>Implications for practice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target</strong></td>
<td>Goal setting. They need to be evidence-based, clear, measurable and feasible</td>
<td>Practices often set too many goals or none at all. Set at the ABCS for this study</td>
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| **Reminders**                     | Having actionable information at the point of care for all team members. | 3 types:  
  - Patient Reminders  
  - Point of Care Reminders  
  - Automated Reminders (Standing orders) |
| **Administrative buy-in**          | Resource Allocation | Without this, the project does not move forward. It a necessary but not sufficient factor. |
| **Networked Information Systems**  | Registries          | Necessary for population health |
Site Coordinator \textsuperscript{2,13}  
Local accountability  
Need a point person, other than the doctor, at the practice who will make sure the project moves forward.

Local Clinician Champion \textsuperscript{14}  
Thought leadership  
The Physician needs to “bless” the project. Others can accomplish the work.\textsuperscript{15}

Audit and Feedback \textsuperscript{16}  
Done on a regular basis. Can show longitudinal change or benchmark against other practices cross-sectionally  
Provides data for PDSA cycles according to the Model for Improvement\textsuperscript{17}

Team Approach \textsuperscript{18}  
Based on success of Toyota quality circles \textsuperscript{19}  
Preferably non-hierarchical\textsuperscript{20}

Education  
Training in all its forms  
CME, academic detailing, collaborative learning groups, in-service training etc.


