New Team Member Orientation

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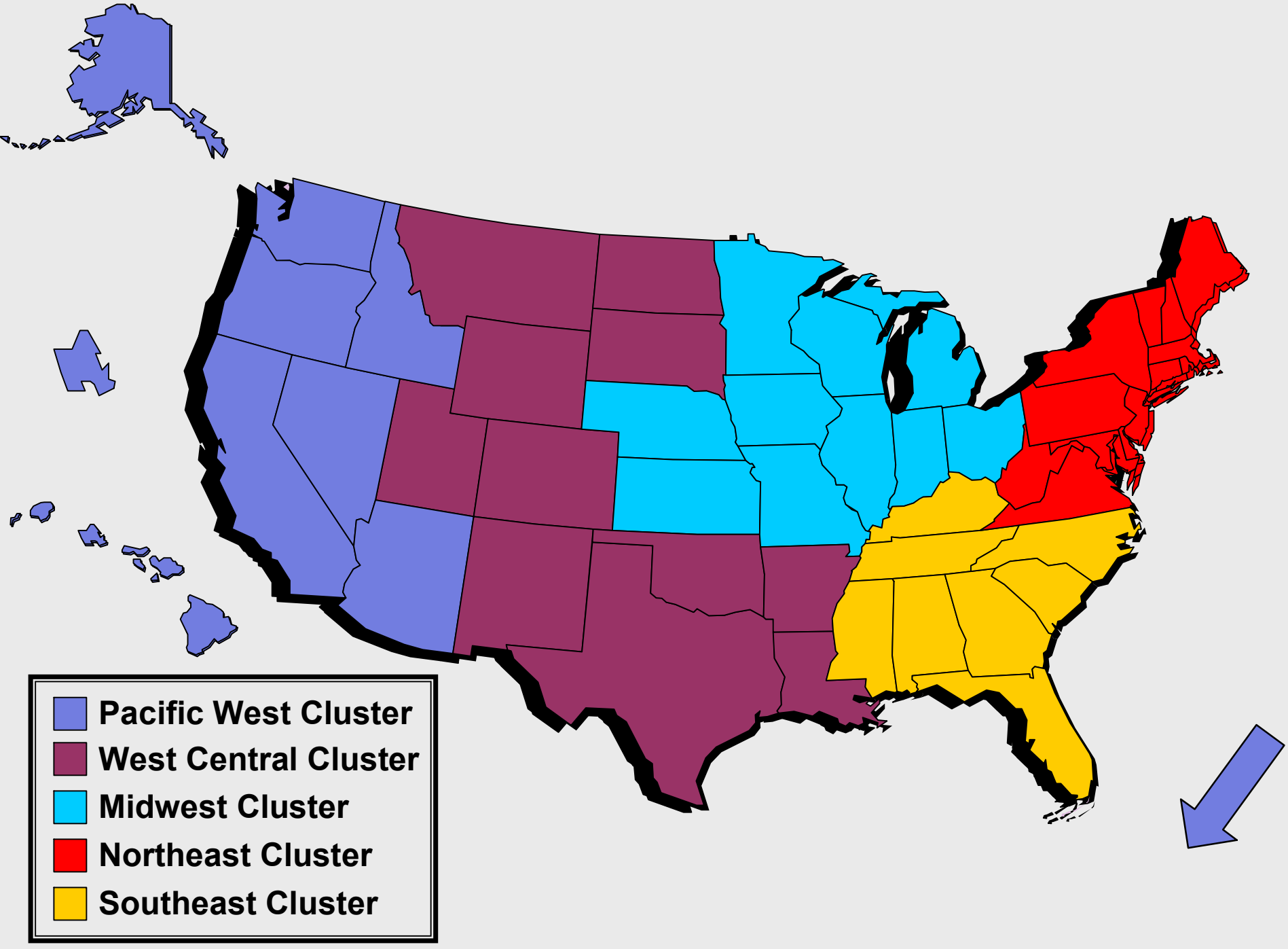
Items to be discussed:

- What is the collaborative process or the "Learning Model"?
- The Chronic Care Model
  - Components
  - Interrelationships
- The Model for Improvement
  - 3 questions: Aims, measures, tests of change
  - PDSA cycles


Pacific West Cluster
West Central Cluster
Midwest Cluster
Northeast Cluster
Southeast Cluster

The Breakthrough Series (Learning Model)

An improvement method that relies on spread and adaptation of existing knowledge to multiple settings to accomplish a common aim.

BTS is not:

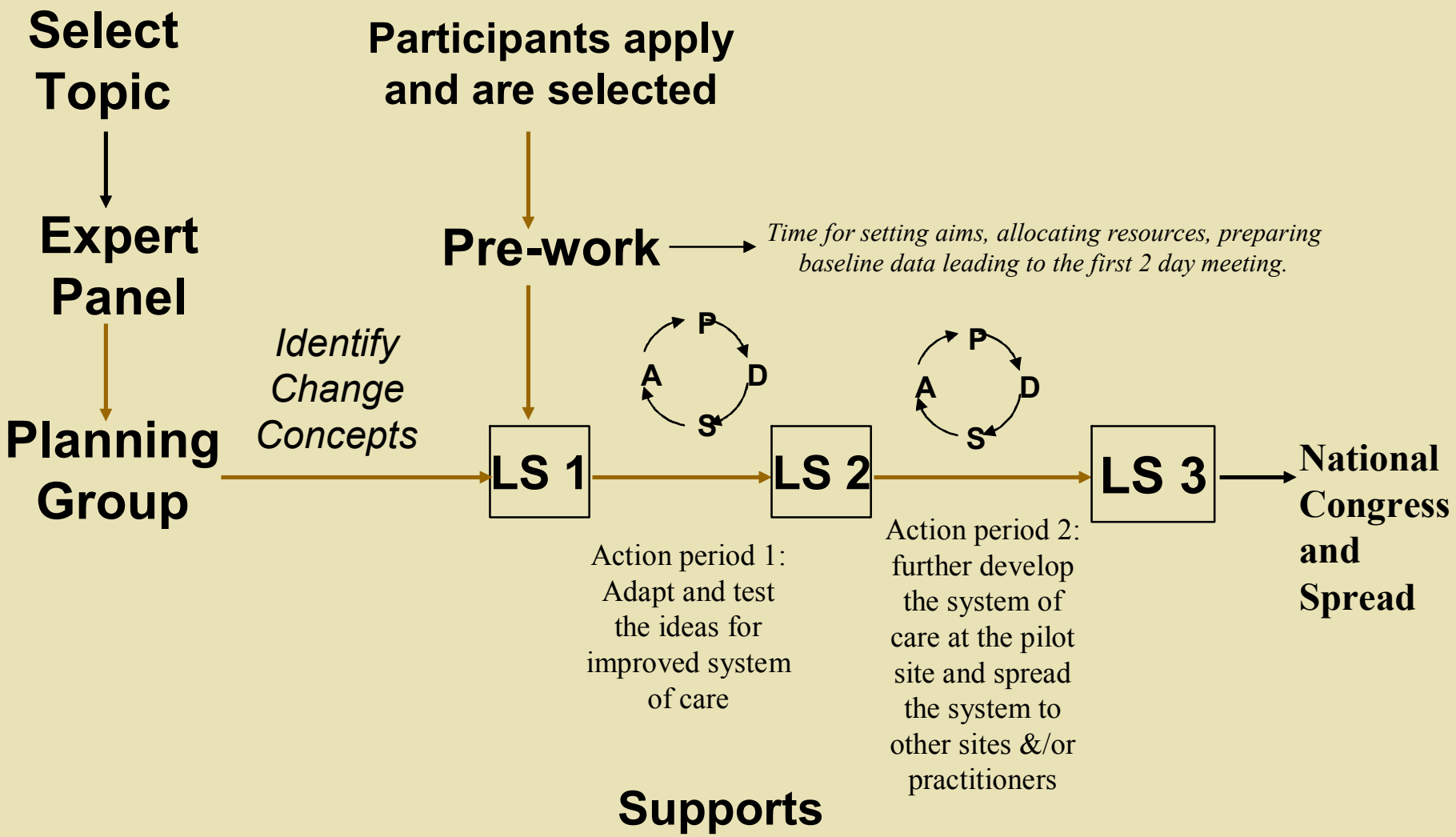
- Research for new knowledge
- Single-setting (team) focus
- Small changes to existing systems
- Benchmarking project

Breakthrough Series Premises

- There are gaps between knowledge and practice.
- There are large variations in practices.
- “Best practices” exist all over the world.
- All improvement requires change, but not all change leads to improvement.
- Every system is perfectly designed to achieve the results it achieves.
- We can learn a lot more working together than we can working separately.

Learning Model

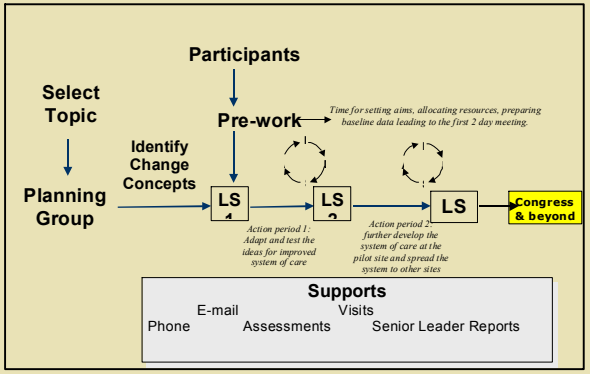
(adapted from the IHI breakthrough series)



BPHC Health Disparities Collaboratives

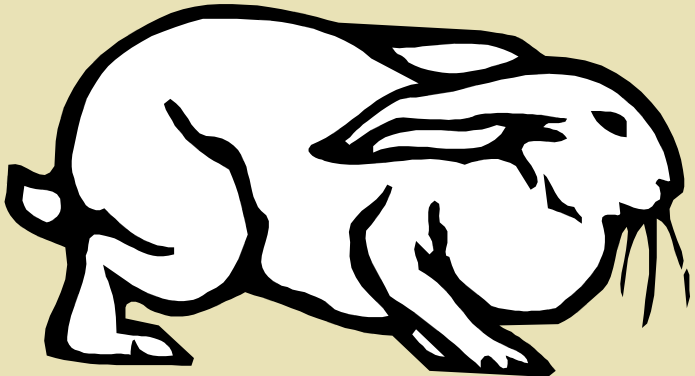
You are here

Phase 1



Phase 2

1. Sustain and Spread
2. Continued reporting and progress toward national goals
3. Integration of models into the organizational structure
4. Increasing registry size
5. Continued support and interaction



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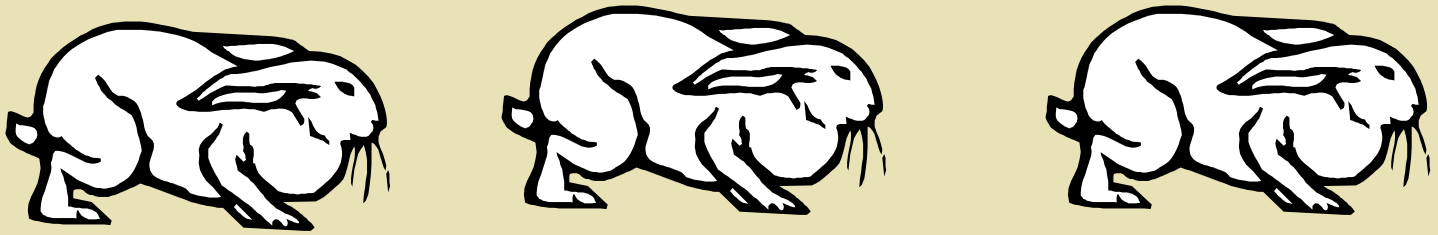

Fundamental Elements for Success

- Will (to change the system)
- Knowledge (of the gap and what changes are necessary to close it)
- Execution (actions that close the gap)

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Chronic Care Model

"The model of care is a population-based model that relies on knowing which patients have the illness, assuring that they receive evidence-based care and actively aiding them to participate in their own care."

System Change Concepts
Why a Chronic Care Model?

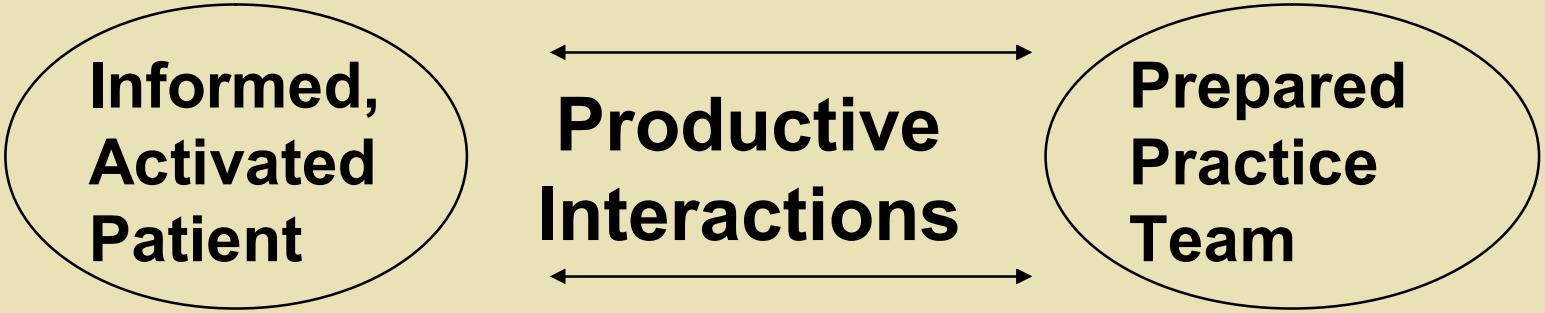
- Emphasis on physician, not system, behavior
- Characteristics of successful interventions weren't being categorized usefully
- Commonalities across chronic conditions unappreciated.

Model Development 1993

- Initial experience at GHC
- Literature review
- RWJF Chronic Illness Meeting -- Seattle
- Review and revision by advisory committee (40 members (32 active participants)
- Interviews and site visits with 72 nominated “best practices”
- Model applied with diabetes, geriatrics, asthma, CHF, CVD, and depression with over 500 health care organizations in national and regional collaboratives

Improved Outcomes

Essential Elements of Good Chronic Illness Care



What characterizes a "prepared" practice team?

Prepared Practice Team

At the time of the visit, they have the patient information, decision support, people, equipment, and time required to deliver evidence-based clinical management and self-management support

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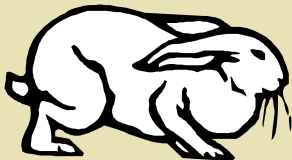
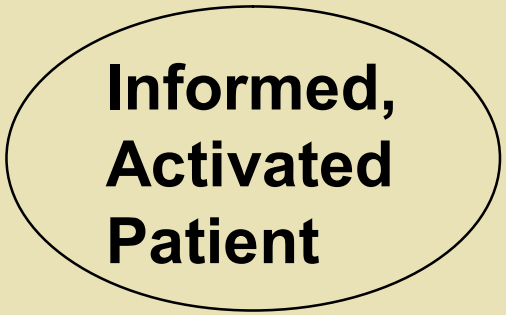


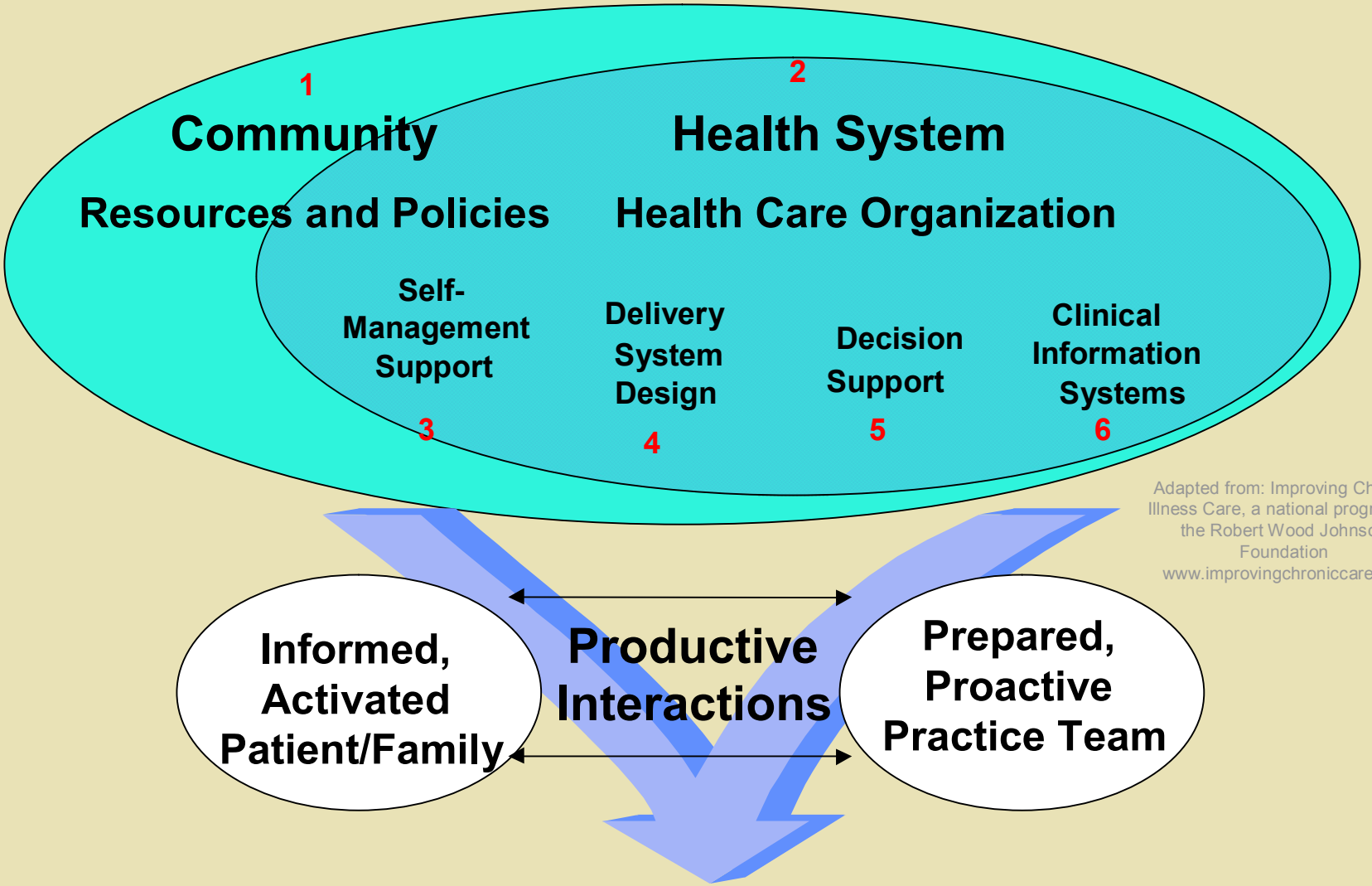
What characterizes a "informed, activated" patient?



Patient understands the disease process, and realizes his/her role as the daily self manager. Family and caregivers are engaged in the patient's self-management. The provider is viewed as a guide on the side, not the sage on the stage!

Designing Our Strategic Plan

The Care Model - A Systems Approach



Adapted from: Improving Chronic Illness Care, a national program of the Robert Wood Johnson Foundation
www.improvingchroniccare.org

Health Care Organization

- Include measurable goals for chronic illness in the business plan.
- Senior leaders visibly support improvement in chronic illness care.
- Use effective improvement strategies aimed at comprehensive system change.
- Promote good chronic illness care through benefit packages.
- Encourage better chronic illness care through provider incentives.

Community Resources and Policies

- Identify effective programs and encourage patients to participate.
- Form partnerships with community organizations to support or develop evidence-based programs.

Self-management Support

- Emphasize the patient's central role in managing their illness.
- Assess patient self-management knowledge, behaviors, confidence, and barriers.
- Provide effective behavior change interventions and ongoing support with peers or professionals.
- Assure collaborative care-planning and problem-solving by the team.

Delivery System Design

- Define roles and delegate tasks amongst team members.
- Use planned visits to support evidence-based care.
- Build “effective” case management functionality into practice
- Assure continuity by the primary care team.
- Assure regular follow-up.

Decision Support

- Embed evidence-based guidelines which describe stepped-care into daily clinical practice.
- Integrate specialist expertise into primary care.
- Use proven provider education modalities to support behavior change.
- Inform patients about guidelines pertinent to their care.

Clinical Information System

- Include clinically useful and timely information on all patients in a registry.
- Provide reminders and feedback for providers and patients.
- Identify relevant patient subgroups and provide proactive care.
- Facilitate individual patient care planning through the registry.

Health System

Organization of Health Care

Strategic Plan/ Senior leadership support

Community

Resources and Policies

Partnerships

Coordination

Self-Mgt Support

Care planning and problem solving

Delivery System Design

Planned Visits

Clinical Information Systems

Registry

Decision support

Provider education

Evidence-based Guidelines

Specialist Expertise

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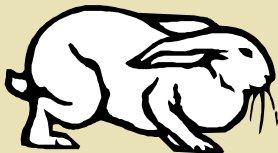

Change Concepts

General ideas that have been found to be useful in developing specific improvement activities. Best if based on evidence.

e.g., All patients with asthma should have severity regularly assessed

Fundamental Elements for Success

- Will (to change the system)
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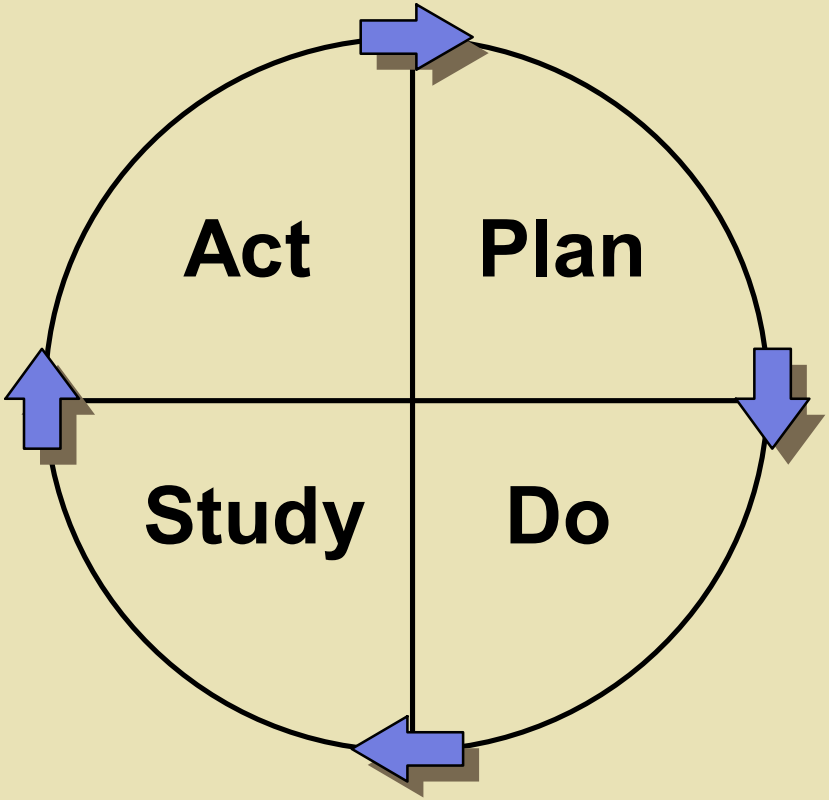
Let’s Put it into
Practice !

Why test?



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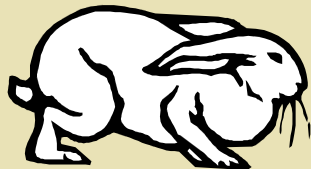
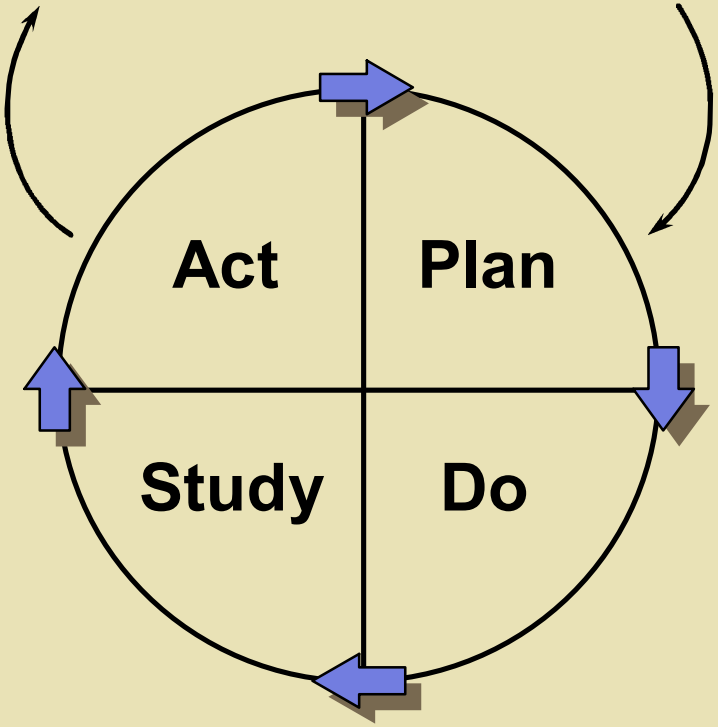


Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?



Tools you already have…

- Goals that define excellent practice; Care Model
- Description of Key Measures
- Change Concepts and Ideas organized by elements of the Care Model

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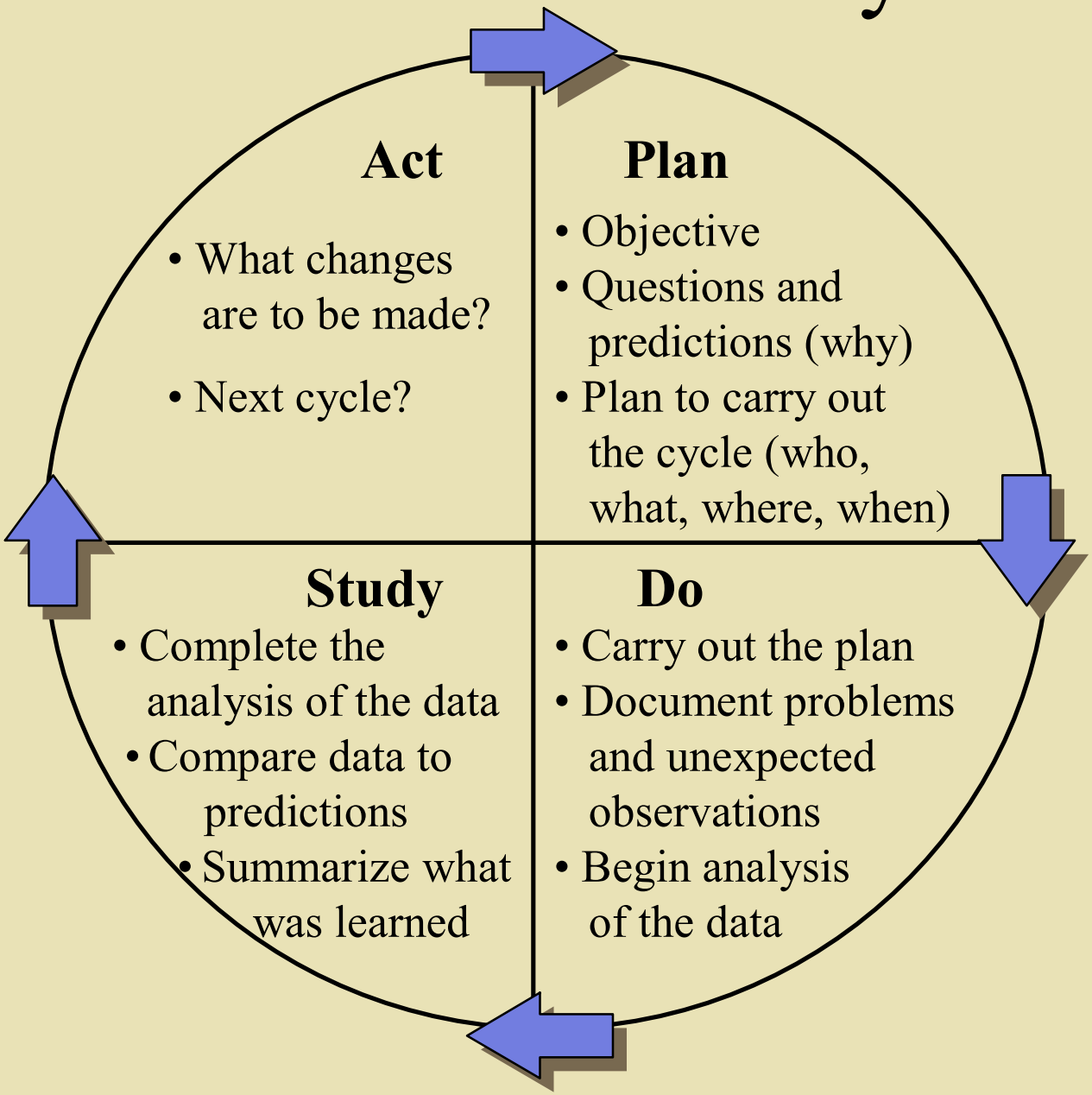
The PDSA cycle provides the means to apply, adapt and implement the change concepts in your practice.

What is the PDSA Cycle?



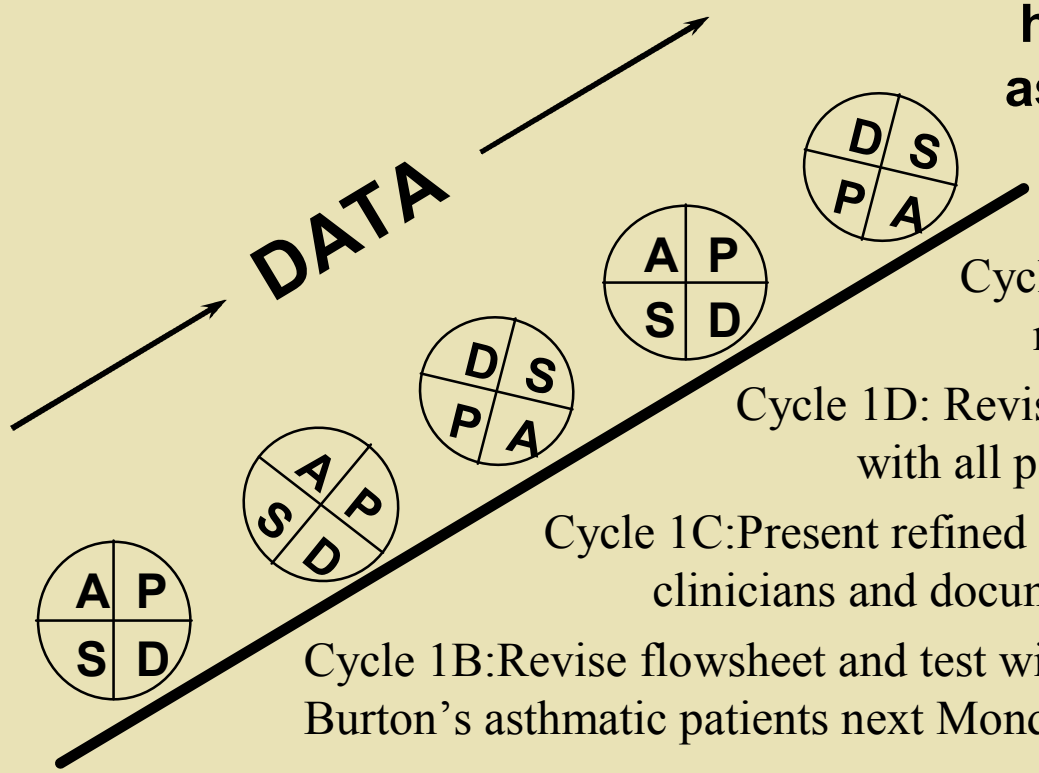
Testing on a Small Scale

- Test the change on the members of the team that helped developed it before introducing the change to others.
- Incorporate redundancy in the test by making the change side-by-side with the existing system.
- Conduct the test in one facility or office in the organization, or with one patient.
- Conduct the test over a short time period.
- Test the change on a small group of volunteers.

Testing a Change

- Increase your belief that the change will result in improvement in your organization.
- Opportunity for “failures” without impacting performance.
- Document how much improvement can be expected from the change.
- Learn how to adapt the change to conditions in the local environment.
- Evaluate costs and side-effects of the change.
- Minimize resistance upon implementation.

Aim: Increase the number of patients having severity assessed by incorporating the use of a national standards-based flowsheet



90% of patients have severity assessment in record

Cycle 1E: Implement and monitor the standards

Cycle 1D: Revise and test flowsheet with all patients for one week

Cycle 1C:Present refined flowsheet to all 3 clinicians and document feedback

Cycle 1B:Revise flowsheet and test with all of Dr. Burton's asthmatic patients next Monday

Cycle 1A:Adapt flowsheet and test with one of Joanne's patients

Use of flowsheet will improve care to known standards

Do ⟶ Study

- **Reasons for failed tests**
  1. Change not planned and/or executed well
  2. Support processes inadequate
  3. Hypothesis/hunch wrong:

     - Change executed, well but did not result in local improvement

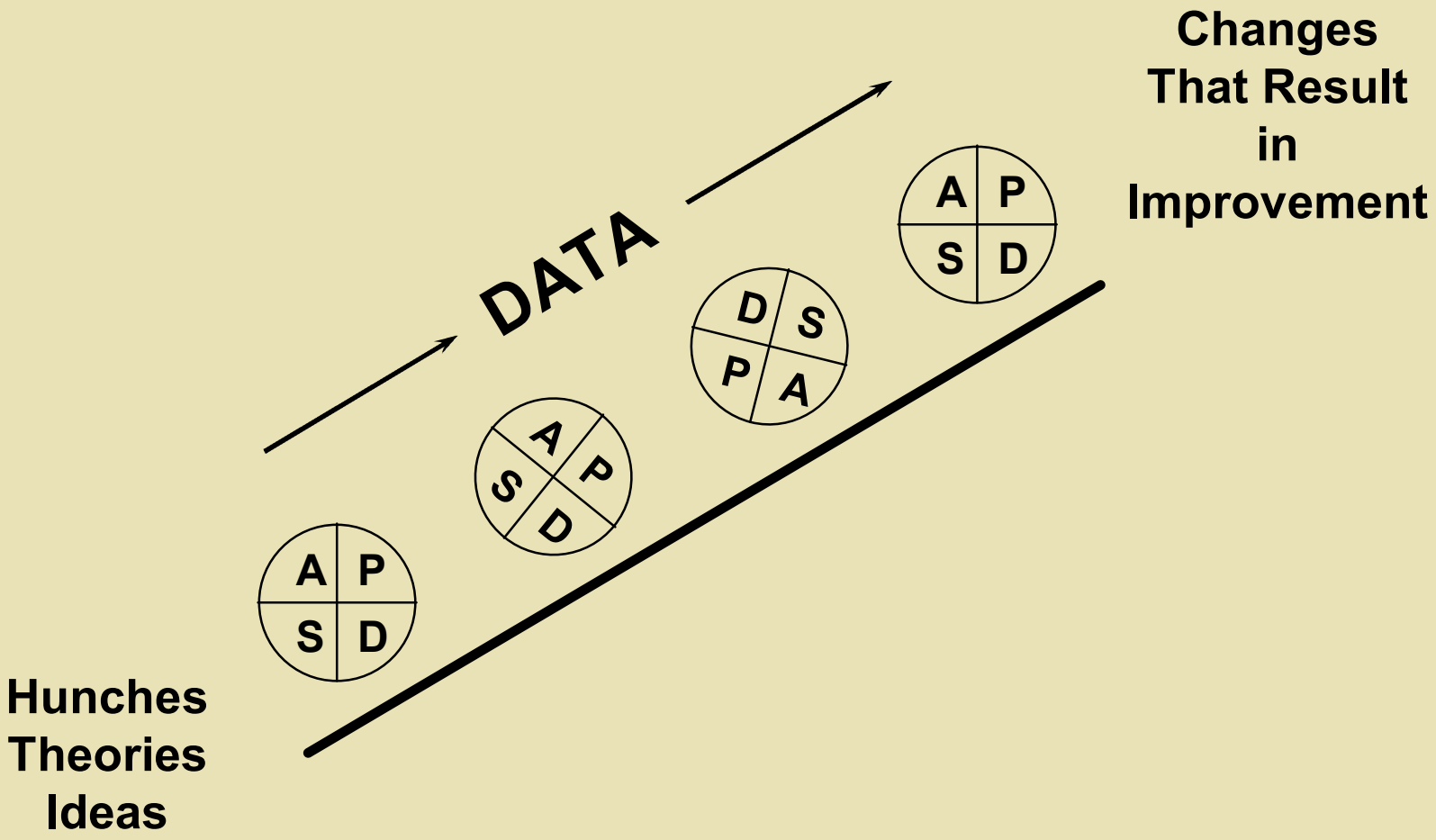
     - Local improvement did not impact the component of the CCM

- Collect **data** during the Do Phase of the Cycle to help differentiate the these situations.

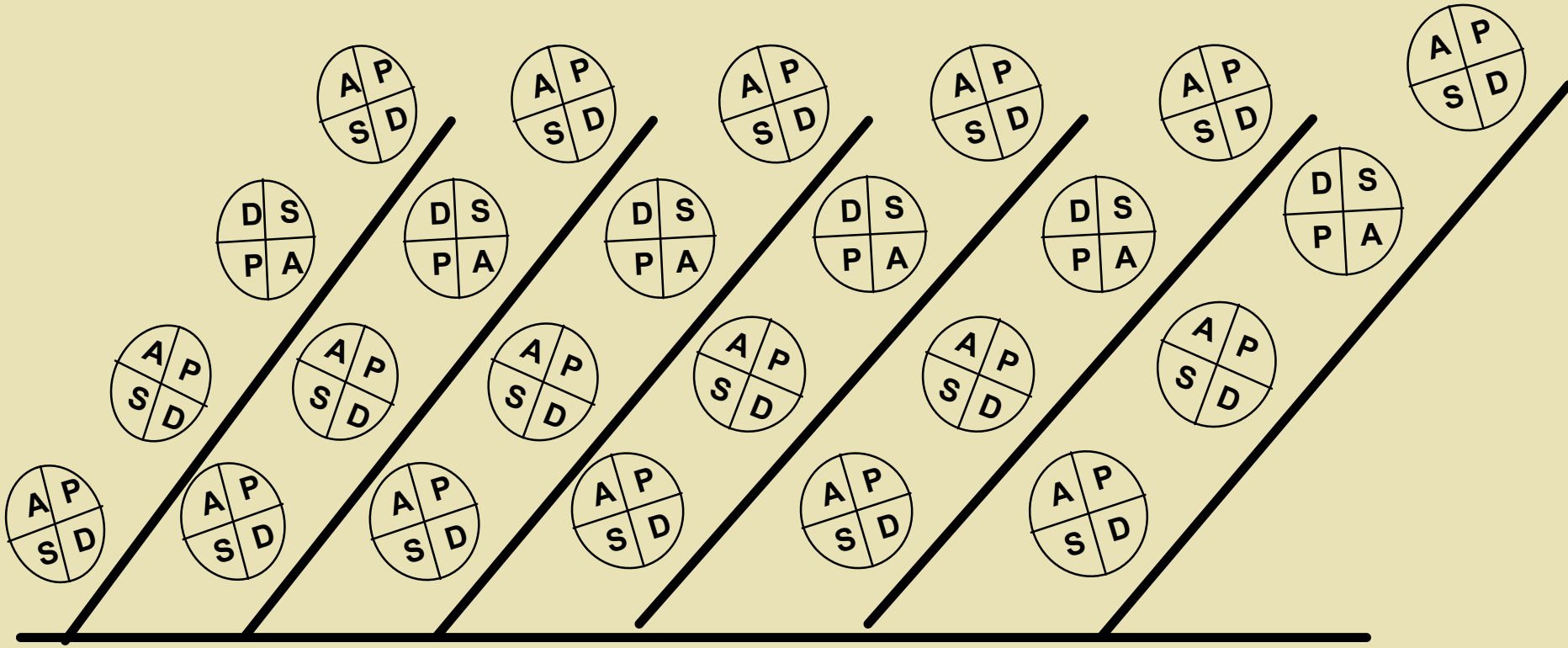
To Be Considered a PDSA Cycle

- ✓ The test or observation was **planned** (including a plan for collecting data).
- ✓ The plan was **attempted**.
- ✓ Time was set aside to **analyze** the data and study the results.
- ✓ **Action** was rationally based on what was learned.

Repeated Use of the Cycle



Overall Aim: Implement the Care Model for people with asthma



Strategies for Each Component of the Care Model

Population of Focus

- Narrative and numerical description
- Naturally defined population with normal growth (recommend 100-300)
- Example: “The POF is all of the patients seen by Dr. Good in 1999 with a diagnosis of diabetes. This will be approximately 155 patients.”

Suggestions for Measurement and Data Collection During PDSA Cycles

- Collect useful data, not perfect data. The purpose of the data is learning, not evaluation.
- Use a pencil and paper until the information system is ready.
- Use qualitative data rather than wait for quantitative.
- Record what went wrong during the data collection.

How will we know that a change is an improvement?

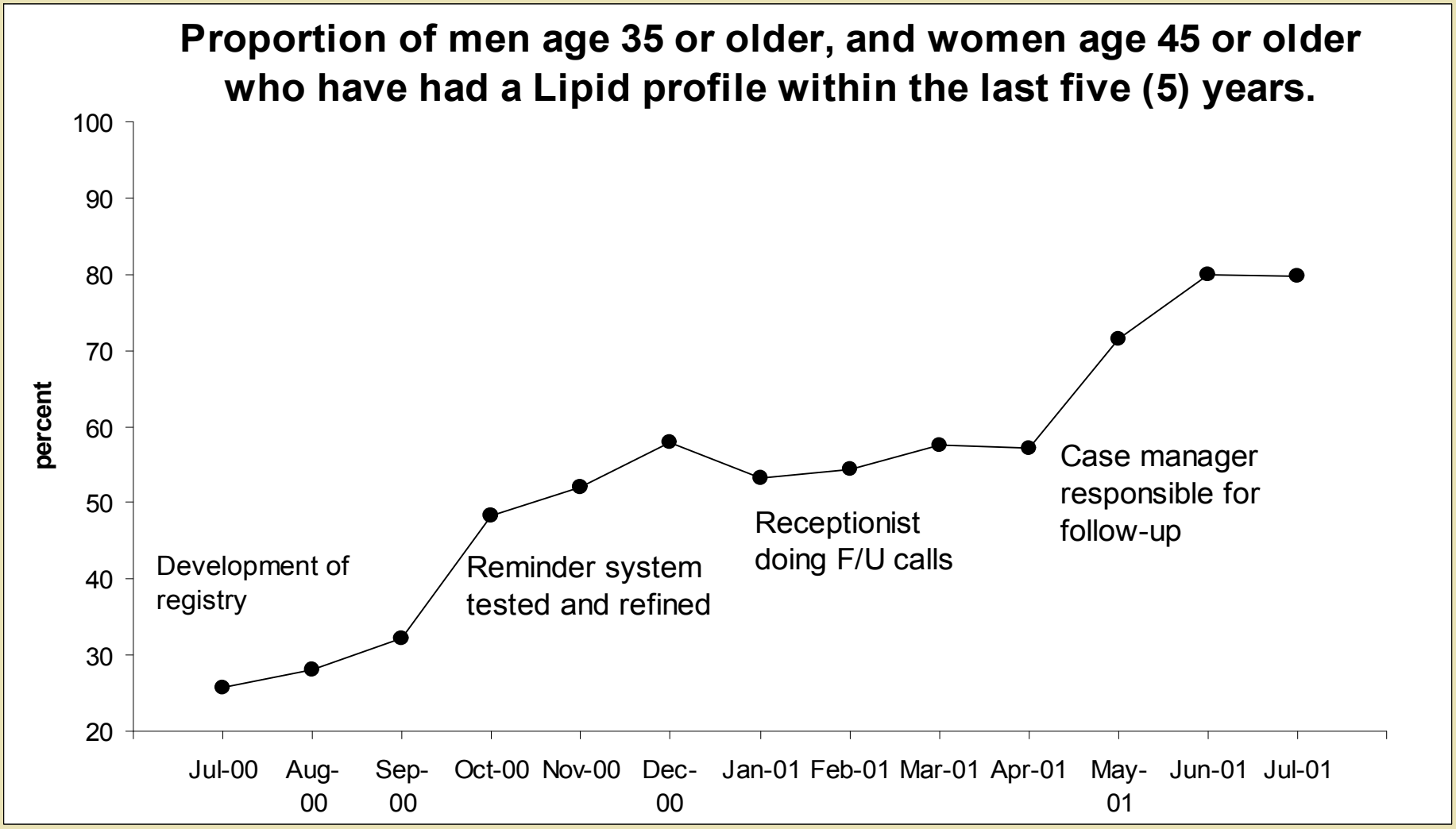
A collaborative is about changing a participating organization's approach to the topic of the collaborative

It is <u>not</u> about measurement. But ……

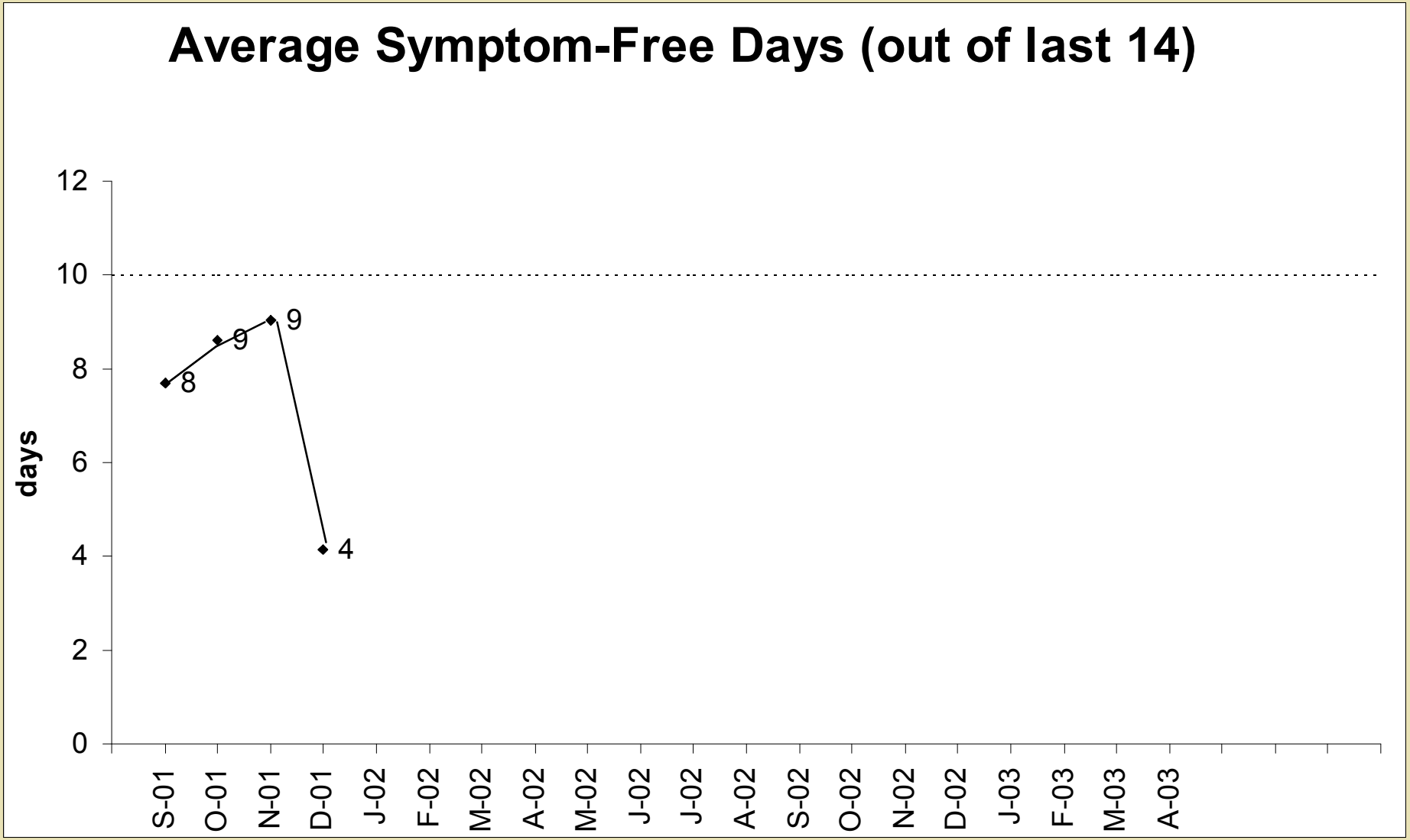
- Data base management and measurement are key components of the Care Model.
- Key outcome measures are required to assess progress on a team's aim.
- Specific measures are required for learning about the components of the Care Model.

Minimum Standard for Monthly Reporting in the Collaborative:

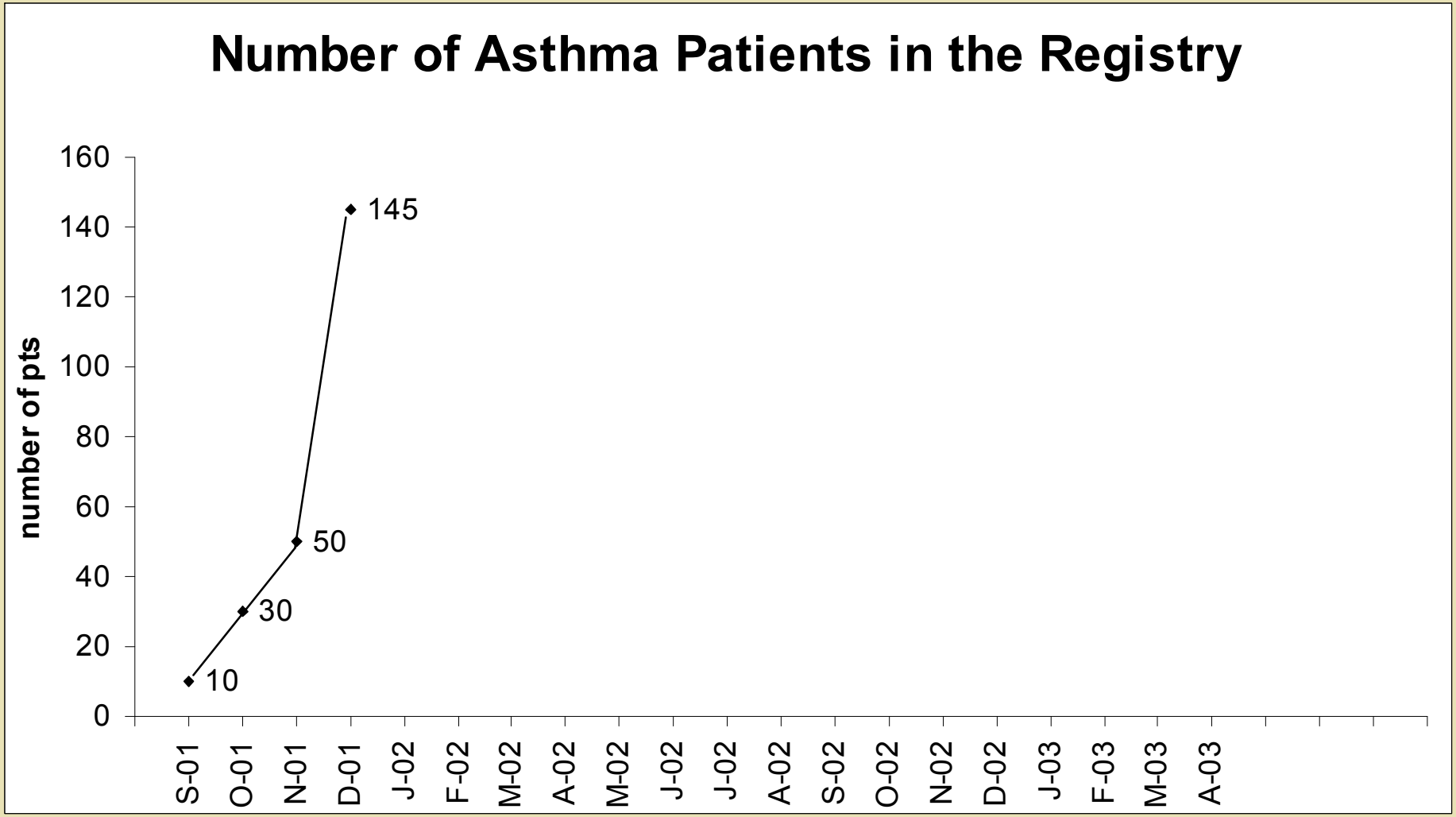
Annotated Time Series



What happened to this Clinic?



Does this help explain?



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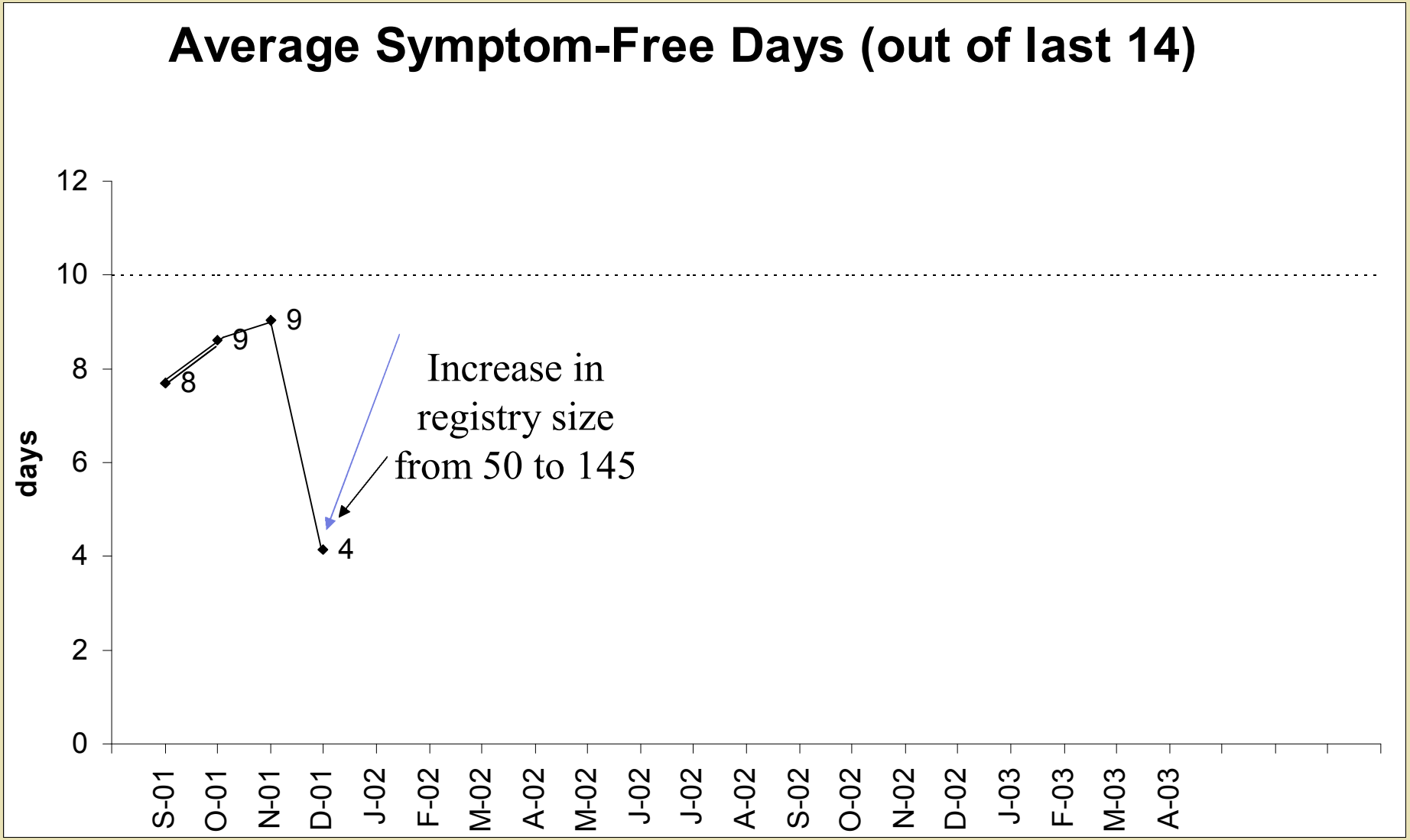
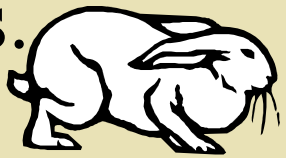


Cycles for Implementation

- The change is permanent - need to develop all support processes to maintain change.
- Learning is focused on integrating the change into the specific environment.
- High expectation to see improvement (no failures).
- Increased scope will lead to increased resistance.
- Generally takes more time than test cycles.



1.What are we trying to accomplish?	To have each member of the team touch the ball in sequence
2. Measures of performance	(a) Time to complete the cycle (faster is better) (b) How many times the ball hits the floor (zero is ideal)
3. What change can we make that will lead to improvement?	To be determined by group

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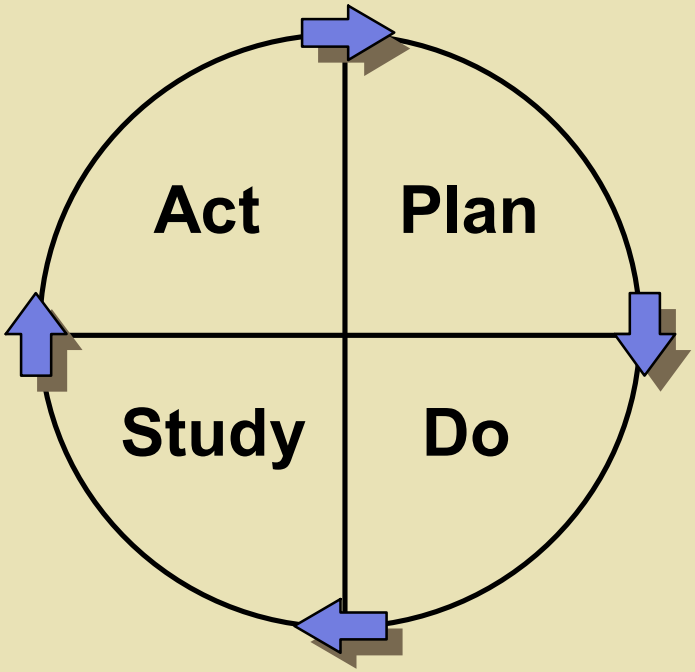

Report Components

- Aim
- Population of Focus/Spread
- Measures
- Description of tests of change/implemented changes
- Summary
- Assessment score

Use of Report

- Communication Tool- senior leaders, BOD, staff and community linkages
- Guidance for team
- Accrediting bodies (ie, JCAHO)
- Director/IS feedback
- Impact of tests and implemented change

Health Care for the Homeless Clinicians' Network

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