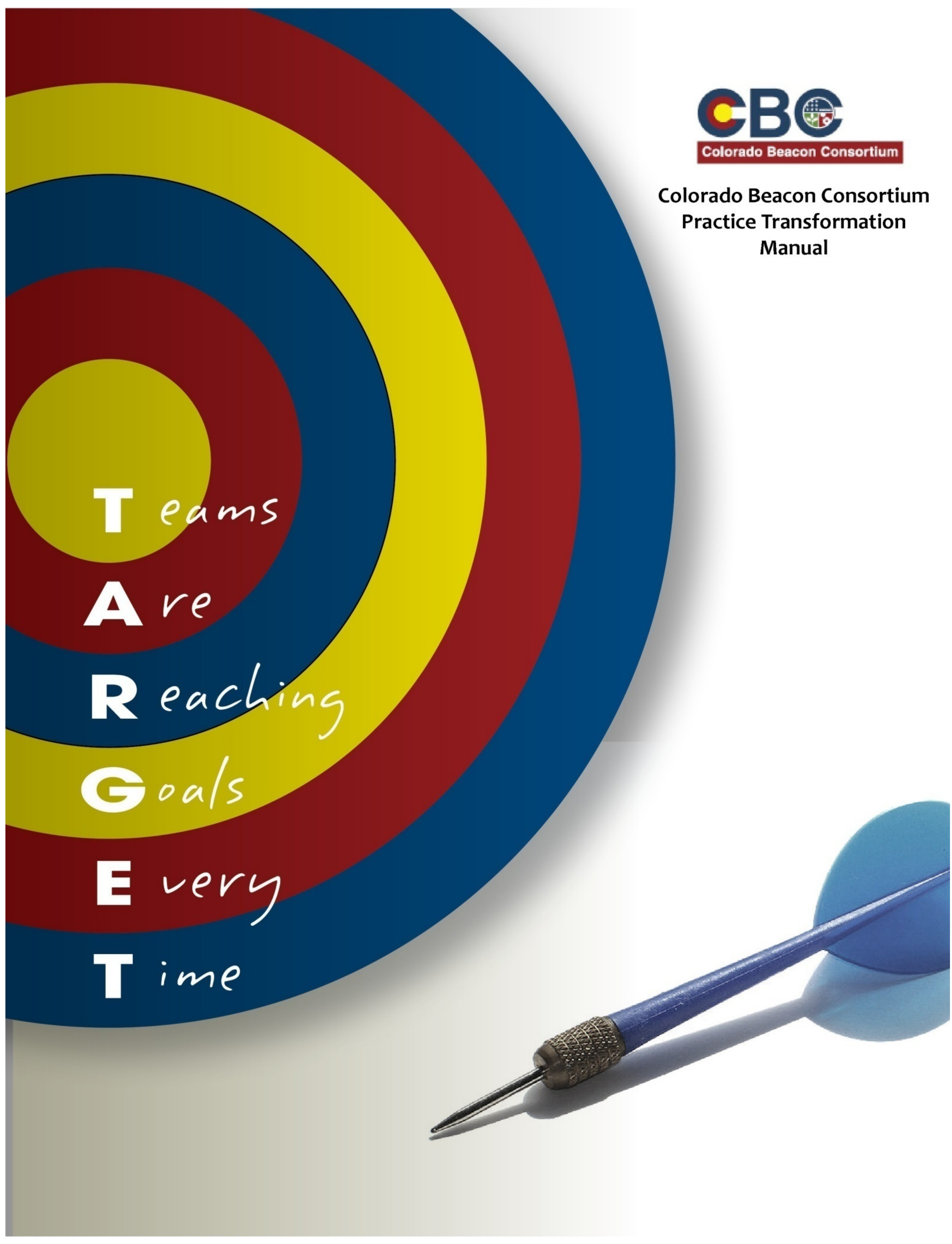
Cohort #4



Colorado Beacon Consortium
Practice Transformation
Manual

About This Manual

The purpose of this manual is to help lay a foundation for the activities leading up to the first Learning Collaborative (Kick-Off meeting). These activities include establishing a practice Quality Improvement Team, obtaining baseline measures via registry functionality, developing an AIM or goal statement, completing team self-assessments, and summarizing your work in progress with a storyboard. The manual also outlines the year long Learning Collaboratives, action periods and Quality Improvement Advisor support that will be provided by the Colorado Beacon Consortium Practice Transformation Program.

Getting Started

Welcome to the Colorado Beacon Consortium (CBC) Community Collaborative! Achievement of the collaborative goals requires changing the way health care is delivered. A fundamental change from a provider-oriented to a patient/family/community-oriented system of care is needed. The collaborative care and improvement models that you will be learning and implementing are key elements in the Colorado Beacon Consortium (CBC) strategy to improve the value in health care delivery by implementing systems which positively impact cost and quality. The goals and measures in this program are evidence-based and congruent with national measurement systems in the health industry. The structure of the program is to support value-based health and health care delivery for your patient population. Several specific areas of wellness, prevention and chronic disease will be a focus of the Beacon program; however the tools, principles and techniques can be utilized for any patient population as you continue on your improvement journey. This approach links and aligns health care delivery with community population health. This serves to broaden the impact of safe, effective, evidence-based care delivery to the community and starts to bridge the gap of current health care disparities particularly for underserved populations. The proactive approach to screening and follow-up for prevention, cancer, depression and chronic disease supports the care of high-risk underserved populations. Data management supported by the use of Health Information Exchange (HIE) and Health Information Technology (HIT) will be emphasized during the Beacon program as key component systems, processes and work flows that support care delivery. This section provides you with an overview of the program, a schedule of activities, and a list of pre-work activities and tasks for your teams to accomplish before the first Learning Collaborative.

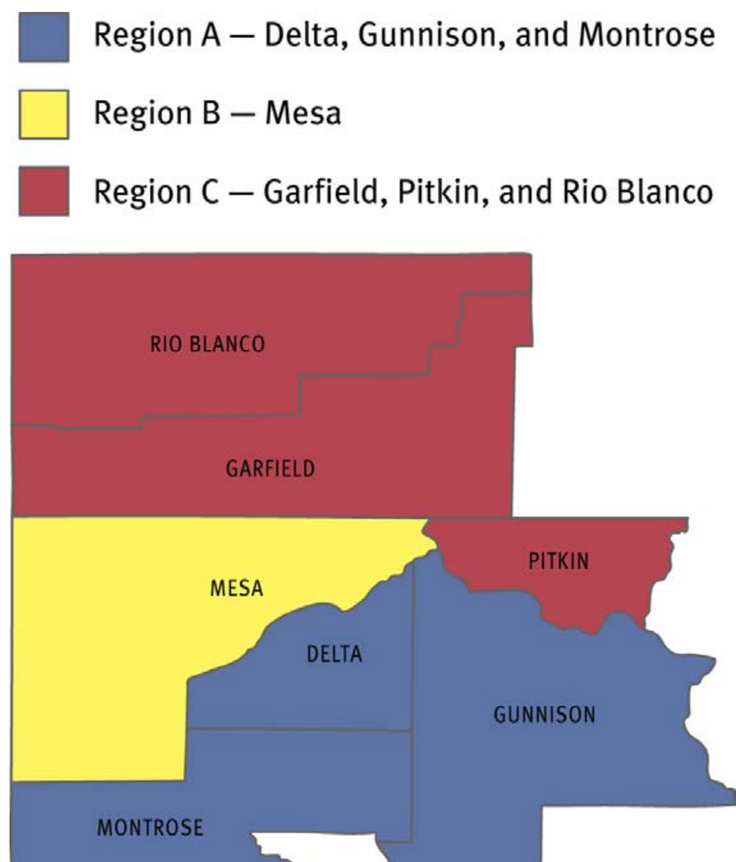
Overview

A Collaborative is a systematic approach to healthcare quality improvement in which organizations and practice teams test and measure practice innovations, then share their experiences in an effort to accelerate learning and widespread implementation of successful change concepts and ideas. Quality Improvement Advisors (QIAs) will be assigned to each practice. The QIAs facilitate the practices in incorporating quality methodologies and performance improvement techniques into daily practice. The QIAs will support the practices in maximizing technology for reliable, systematic and evidence-based care delivery. QIA's understand the foundational role that Health Information Exchange (HIE) plays in the project and will help move practices toward successful adoption and use of HIE.

Overall Structure of the CBC Community Collaborative

The Beacon Community Collaboratives focus on family medicine, internal medicine and pediatrics and involve seven counties on the Western Slope of Colorado: Delta, Montrose, Gunnison, Mesa, Garfield, Pitkin and Rio Blanco.

The counties have been segmented into three regions:



The Collaborative practices will participate in four Learning Collaboratives. Participants maintain continual contact with each other, the collaborative leadership team, faculty and Quality Improvement Advisors through email, website (www.coloradobeaconconsortium.org), conference calls, and site visits. HIE will be in varying stages of availability in the region so the participating practices will likewise have varying degrees of adoption. Regardless of the level of HIE availability in the participant's area, the work of the Community Collaborative will occur. The Beacon grant will be constantly developing and achieving electronic additions to the region and they will be adopted for use as they are made available for your use.

Quality Improvement Advisors

A facilitator or advisor is someone who uses knowledge of group processes to formulate and deliver the needed structure for meeting interactions to be effective. The advisor focuses on effective processes (meeting dynamics) allowing the participants to focus on the content or the substance of their work together. The focus of the Beacon Collaborative is for practices to learn performance improvement tools and techniques, transform practice to deliver patient-centered, evidence-based care and to implement fully HIE and HIT.

The Role of the Quality Improvement Advisor:

1) To support the team by:
   - sharing the broad view
   - encouraging innovation and high performance
   - encouraging team development and team member participation
   - teaching QI techniques, data review and meeting skills and processes
   - helping with team members' role development
   - bringing in other "experts" as requested
   - suggesting alternative methods and procedures
   - remaining a neutral representative of the team

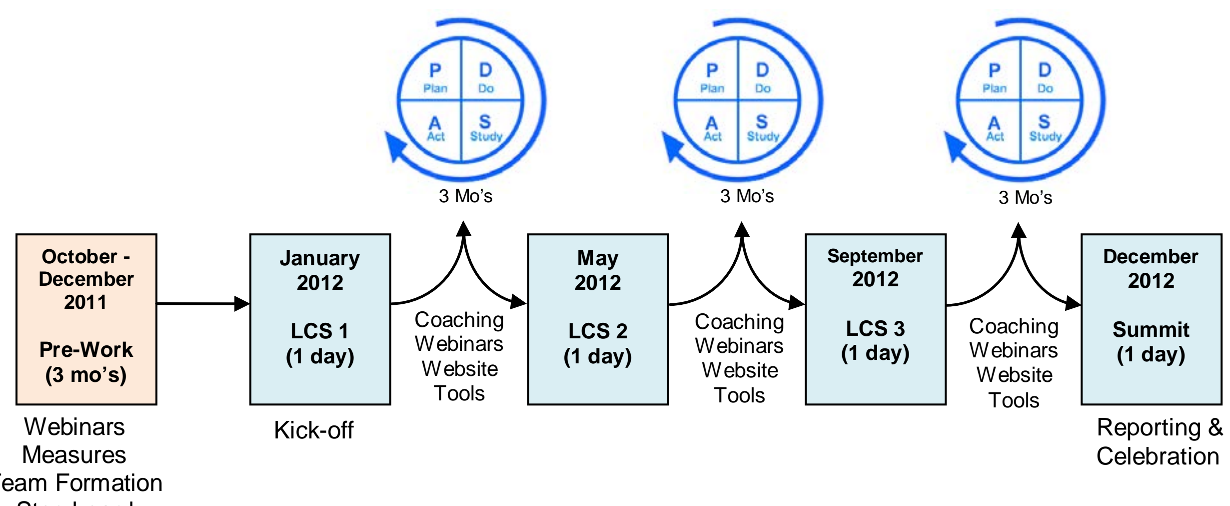
2) To act as a process facilitator by:
   - offering the practice Quality Improvement Teams feedback
   - guiding team formation and progress
   - empowering the team to make quality and performance improvement a "habit" in daily practice

3) To facilitate the effective use of data made available by HIE by:
   - integrating data into the practice level quality improvement activities
   - maximizing use of HIE auto processing functionality

Collaborative Milestones

There are four basic milestones within the Collaborative process. These components are pre-work activities, learning sessions, action periods, and the Collaborative Summit. These milestones correspond with the key elements of the Learning Model, adapted from the Institute for Healthcare Improvement's Breakthrough Series.

Learning Model
Colorado Beacon Collaborative Series



Pre-work

Pre-work is the period between signing the Beacon Memoranda of Understanding (MOU) and Learning Collaborative (Kick-off). During this time, your team has several important tasks to accomplish; including participation in a series of pre-work webinars. These tasks are listed on page 18 of this manual.

Learning Collaboratives

Learning Collaboratives are the major integrative events of the program. Interdisciplinary teams from each practice attend four highly interactive Learning Collaboratives, where they learn the elements of good planned care for patients and a method for testing and implementing changes. As practice teams move through the series of Learning Collaboratives they will have the chance to share innovative ideas and best practices with other teams. Through plenary sessions, small group discussions, interactive learning, and team meetings, attendees have the opportunity to:

- Learn from faculty and colleagues
- Receive individual coaching from Quality Improvement Advisors
- Gather new knowledge on the subject matter and process improvement
- Share experiences and collaborate on improvement plans
- Problem-solve improvement barriers
- Implement and use HIE
- Develop and implement ideas for Community Collaboration

*All Learning Collaboratives will take place in Grand Junction, CO.

Action Periods

The time between Learning Collaboratives is called an **Action Period**. During Action Periods, Practice Quality Improvement Team members work within their practice to test and implement an organizational approach and transformation for providing planned care to their patients. Teams try out multiple changes in their practice and collect data to measure the impact of the changes. Although participants focus on their own practice setting, they remain in continuous contact with other teams enrolled in the program, Quality Improvement Advisors and Beacon staff. This communication takes the form of conference calls or webinars, email, social media, accessing the CBC website and region specific meetings. In addition, Practice Improvement Team members share the results of their improvement efforts in monthly reports. Participation in action period activities is not limited to those who attend the Learning Collaboratives. It is encouraged and expected that there will be participation of other team members and support persons in your organization, including other key stakeholders and leaders in Action Period activities. HIE/HIT and related workflow changes will be maximized for implementation of some of the change effort.

Schedule

The sequence of events for cohort 4 is as follows:

Preparation, or Pre-work	October 2011 – January 2012
Learning Collaborative 1	January 13, 2011
Action Period 1	January 2012 – May 2012
Learning Collaborative 2	May 11, 2012
Action Period 2	May 2012 – September 2012
Learning Collaborative 3	September 14, 2012
Action Period 3	September 2012 – December 2012
Beacon Collaborative Outcome Summit	December 7, 2012

Transition Phase (Action Periods 3 and 4)

At approximately six (6) months into the Beacon Program your practice QI team will begin to transition to a virtual program that will provide support for your continued transformation efforts. You will continue to meet as a QI Team twice monthly. Your QIA will meet with you once a month or as needed.

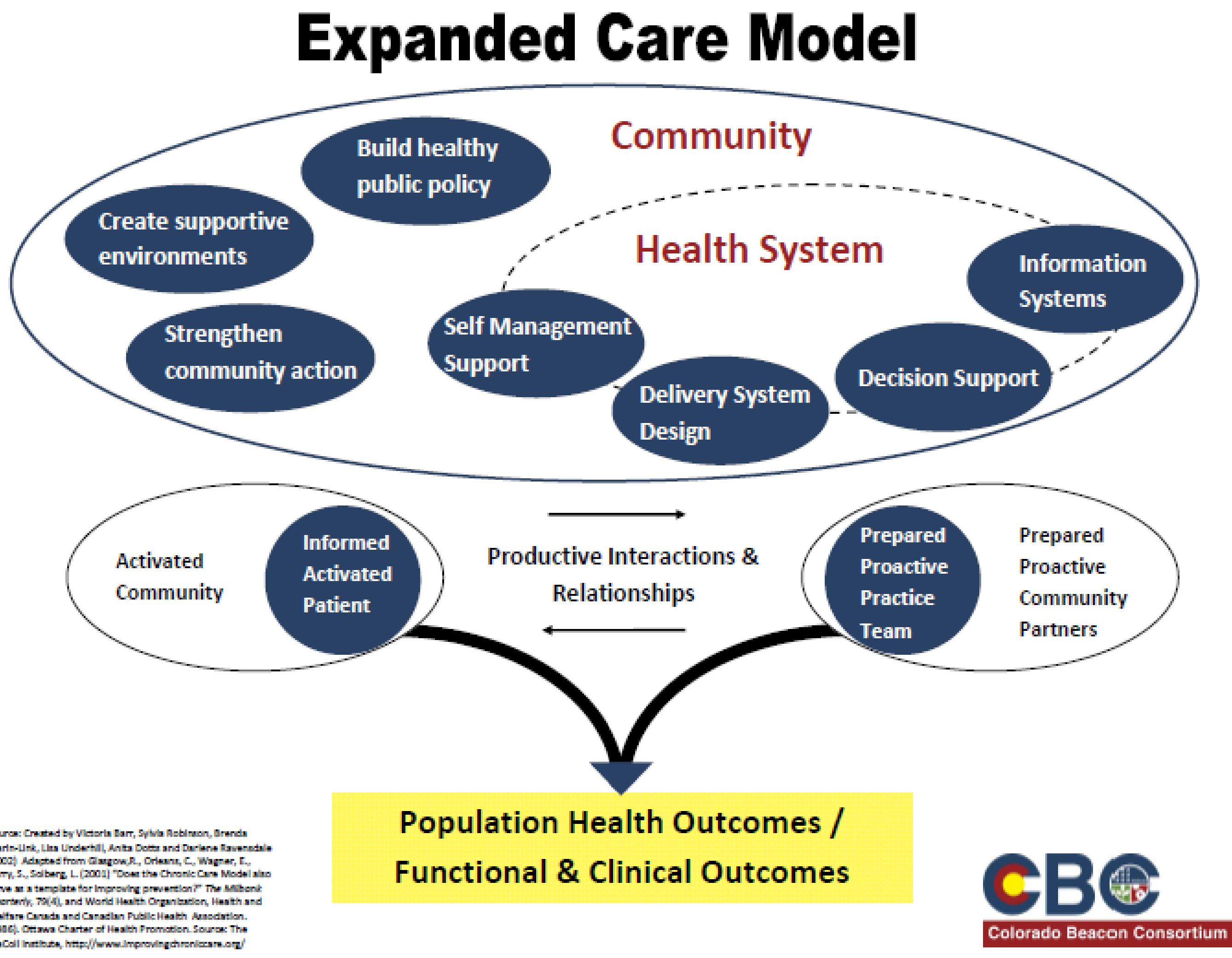
Additional resources will be available to your practice that will take your practice to the next level of practice transformation.

- Monthly Forums / Webinars with specific topics that allow your QI team to meet with other practice's QI teams and share experiences in quality improvement and practice transformation. Topics may include the following but are subject to requests of the participating practices.
  - Best Practices in QI Communication with the Rest of the Practice Team
  - Patient Centered Medical Home (PCMH)
  - Front Office Work Flow – Best Practices in Quality Care
  - Back Office Work Flow – Best Practices in Quality Care
  - Best Care Obesity Management
  - Primary Care from a Patient's Perspective
  - Physician Engagement in Practice Transformation
  - Immunizations – Best Practices in Getting Kids Immunized
- A Web and Action Series – "Developing Quality Improvement Leaders"
  - A three-part series for quality improvement champions wanting to lead a practice to from better to best
- Continued training for Beacon Measures to ensure the information is given "just in time."
- Continued support in reporting Beacon Measures by Data Analysts and Quality Improvement Advisor
- Additional training as requested

The Models of the Collaborative

The Care Model

Theme: *An organizational approach to caring for people with chronic disease in a primary care setting. The system is population-based and creates practical, supportive, evidenced-based interactions between an informed, activated patient and a prepared, proactive practice team. The Care Model emphasizes evidence-based, planned, and integrated collaborative chronic care. More recently, the Care Model has expanded to include the ability to manage all patient populations including prevention, wellness and chronic disease.*



Care Model Change Concepts

Health Care Organization

- Include measurable goals for population health and chronic illness in the business plan
- Senior leaders visibly support improvement in population health and chronic illness care
- Use effective improvement strategies aimed at comprehensive system change and community transformation
- Promote population health and good chronic illness care through benefit packages
- Encourage better population health and chronic illness care through provider incentives
- Maximize health care reform incentive programs such as PQRI and Meaningful Use
- Engage the community in establishing health and health care systems that are available to all citizens
- Consider establishing an Accountable Care Organization model within your community

Community Resources and Policies

- Identify effective community programs; inform and encourage patients and families to participate
- Form partnerships with community organizations to support or develop evidence-based programs
- Support and promote implementation and use of HIE at a community level
- Coordinate services with broader community and medical neighborhood for effective care transitions
- Implement Care Compacts with specialist partners

Self Management Support (SMS)

- Emphasize the patient's central role in managing their health and illness
- Incorporate patient and family preferences in shared care plan development
- Assess patient self-management knowledge, behaviors, confidence, and barriers
- Implement tools for assessing patient’s ability to be successful in their change such as the Patient Activation Measure
- Provide effective behavior change interventions and ongoing support with peers or professionals
- Assure collaborative care-planning and problem-solving by the team

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
- Implement Clinical Decision Support Tools in Health Information Technology (HIT)
- Integrate available population and practice-based data into standardized practice work flows

Delivery System Design

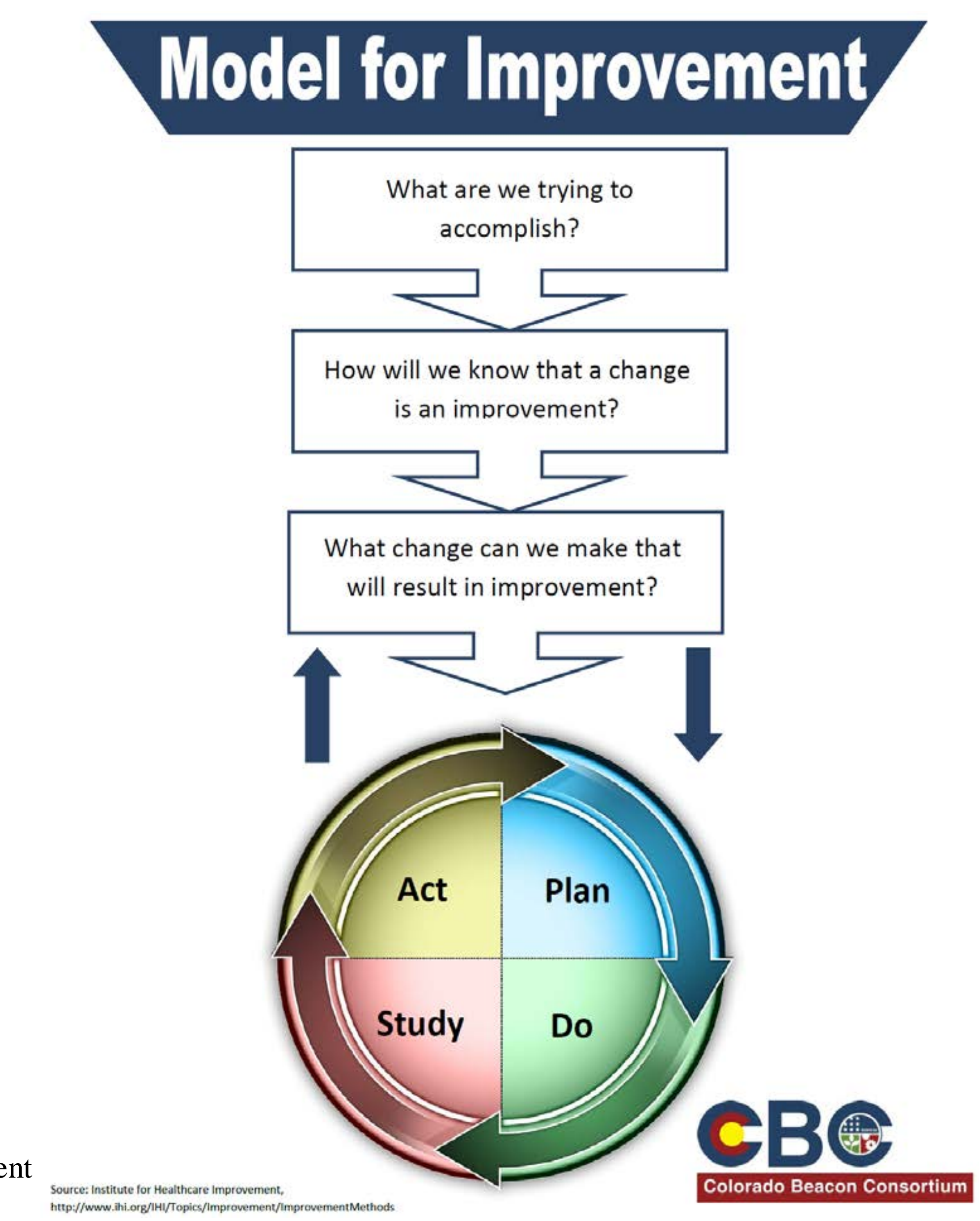
- Define roles and delegate tasks among team members
- Maximize team to implement standardized care processes
- Use planned visits to support evidence-based care
- Build “effective” care coordination and case management functionality into practice
- Assure continuity by the primary care team
- Assure assessment and appropriate follow-up

Clinical Information Systems

- 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 functionality
- Implement technology standards identified by Meaningful Use including e-Prescribing
- Maximize HIT technology in practice to support safe, evidence-based care delivery

The Model for Improvement

In addition to the Care Model, the Beacon program uses an improvement model developed by the Associates in Process Improvement that has been tested and used in other collaborative settings. When used with the Expanded Care Model, the Improvement Model provides a process to improve the quality of care at an accelerated pace.



The Improvement

(1) What are we trying to accomplish?

The first question is meant to establish an aim for improvement that focuses group efforts. Using data and what patients and other customers, such as payers, believe are important helps to define an aim. Aims should be as concise as possible – sometimes it takes a few trials of testing an aim before it becomes truly focused.

(2) How will we know that a change is an improvement?

Measures and definitions are necessary to answer this question. Data is needed to assess and understand the impact of changes designed to meet an aim. When shared aims and data are used, learning is further enhanced because it can be shared with other organizations in the program. In this way, superior performance and best practices are more quickly identified and disseminated through benchmarking.

(3) What changes can we make that will result in an improvement?

Testing and Learning: The PDSA Cycle- PDSA stands for Plan, Do, Study, Act and is a trial-and-learning (learn by test) method to discover what is an effective and efficient way to change a process. The "study" part of the cycle may require some clarification; after all, we are used to planning, doing and acting. The emphasis on study is the key to learning and establishes knowledge. It compels the team to learn from the data collected, its effects on other parts of the system and on patients and staff, and under different conditions, such as different practice teams or different sites. Most importantly, the study phase is an ideal time to think through how the Care Model helps to generate new ideas and approaches to positive change. In addition, the PDSA cycles are short and quick.

*A PDSA Worksheet is available in the **Resource Section** of this manual.

Collaborative Practice Transformation Assessment

Patient-Centered Medical Home- Clinician Assessment (PCMH-CA)

The PCMH-CA is adapted from Improving Chronic Illness Care Assessment of Chronic Illness Care (ACIC) by Dr. Perry Dickinson from the UC-Denver Family Medicine Department. The content of the ACIC was derived from specific evidence-based interventions for the six components of the Care Model (community resources, health organization, self-management support, delivery system design, decision support and clinical information systems). Like the Care Model, the ACIC addresses the basic elements for improving chronic illness care at the community, organization, practice and patient levels. Dr. Dickinson has taken the concepts of the ACIC and incorporated the core principles of Patient-Centered Medical Home into the survey.

Instructions for Completing Pre-Work Activities

The following pages provide information about how to complete each pre-work activity.

1. Collaborative Charter

Take the time to read the Collaborative Charter, which is at the end of this manual. The Charter defines the mission of the Collaborative and summarizes the evidence that will direct your work, outlines methods that your team will use to achieve the mission, and lists what teams can expect from Collaborative leadership and what leadership can expect from each of the teams.

2. Forming a Quality Improvement Team

a. Creating a Team

Your practice will form a Quality Improvement (QI) Team that will help support and promote your improvement process. Including the right people on your process improvement team is critical to a successful improvement effort.

The Quality Improvement Team is a team with 3-5 members who represent all areas of the office.

- Clinical Champion (Physician/Provider leader)
- Day to Day Leaders (Nursing Staff and/or Front/Back Office Staff)
- Medical Assistant (MA)
- Information Systems Representative, if applicable

b. Characteristics of a Team Member

For each potential team member ask the following:

- ✓ *Is the person's judgment* ***respected*** *by a range of staff?*
- ✓ *Does he/she enjoy a reputation as a* ***team player?***
- ✓ *What is the person's* ***area of skill or technical proficiency?***
- ✓ *Is he/she an* ***excellent listener?***
- ✓ *Is this person a good* ***verbal communicator*** *within and in front of groups?*
- ✓ *Is this person a* ***problem-solver?***
- ✓ *Is he/she* ***disappointed with the current system and processes*** *and wants to improve things?*
- ✓ *Is this person* ***creative, innovative, and enthusiastic?***
- ✓ *Is he/she* ***excited about change*** *and new technology?*

Practice Improvement Team Members

Name of Beacon Practice, fax, and Mailing Address:			
Team Member Name	***Team Member Title***	***Phone Number***	***Email Address***

c. Responsibilities of the Team

All Team Members:

- Consider their participation as a priority responsibility, not an intrusion on their "real jobs". Management has indicated their commitment by setting up the project and involving them as team members**. The project has now become part of their day-to-day work or "real job."**
- Are responsible for contributing fully to the project, sharing knowledge and expertise.
- Participate in all meetings and discussions about the project.
- Carry out their assignments between the meetings and meeting deadlines.
- Report back to the team at each meeting on their assignments.
- Should be cross-trained. For example: how to produce monthly summary reports and graphs as well as writing the senior leader narrative, data entry for the registry, documenting tests of change and changes implemented, how to lead a team meeting, etc.
- **Be Creative and Have Fun!**

Team Leader or Key Contact:

- Calls and facilitates meetings.
- Visible/available, responsive, reliable, formal/informal authority, respected.
- Handles or assigns administrative details.
- Orchestrates all team activities.
- Oversees preparation for reports and presentations.
- Meets timelines of the project.
- Shares responsibilities with other team members.
- Trusts the group to arrive at the best solution.
- Acts as the contact point for communication between the team members, other office staff and the CBC Team.
- Acts as the official keeper of team records, including correspondence; records of meetings and presentations; meeting minutes and agendas; and charts, graphs and other data related to the project. The Team Leader is responsible for formally documenting the project – or assigning a team member to do so.

d. Expectations of the Team

- All pre-work will be completed prior to the Kick-Off Learning Collaborative on January 13, 2012.
- The Quality Improvement Team will attend all four Learning Collaboratives.
- The team or an identified team member will submit monthly measures and monthly narrative reports on time each month. **Reports are due THE FIFTH WORKING DAY OF EACH MONTH.**
- The team will have regularly scheduled team meetings and all members will attend.
- The team will learn the models used in the Collaborative and share their knowledge with the rest of the staff.

3. Maintenance of Certification (MOC) Credit

The Colorado Beacon Consortium program has been approved by the American Board of Family Medicine, the American Board of Pediatrics and the American Board of Internal Medicine, as an external provider of Part IV Maintenance of Certification Practice Performance Improvement credit. Contact your Quality Improvement Advisor for more information.

4. Participation Pre-work Webinars

There are 4 webinars designed to assist the practice improvement team in completing their pre-work assignments. The Beacon team has set up a schedule of webinars to assist in your practice improvement team training and preparation for the Kick-Off Learning Collaborative. It is vital that all practice Quality Improvement Team members be actively involved in the pre-work phase in order to develop as a team, learn the terminology of the program, learn the models and methodology used, and begin to relate it to everyday life in your practice. One of the mechanisms to accomplish that task is to attend these first webinars since this is the foundation that you as a team will build on. Once the groundwork has been laid, teams will find their own method of covering webinars and accomplishing the work to meet their aim.

Forming Your Quality Improvement Team
Wednesday, November 16, 2011
12:15-1:00pm

Registry Functionality
Wednesday, November 30, 2011
12:15-1:00pm

Storyboard and Narrative Reports
Thursday, December 14, 2011
12:15-1:00pm

Measures
Wednesday, December 28, 2011
12:15-1:00pm

5. Developing an Aim Statement

The Model for Improvement is based on these three questions:
(1) What are we trying to accomplish?
(2) How will we know that a change is an improvement?
(3) What changes can we make that will result in an improvement?

The first question is meant to establish an aim for your practice's improvement efforts related to the goals of the Colorado Beacon Consortium's Community approach. The aim should be as concise as possible – sometimes a practice Quality Improvement Team must test an aim before it becomes truly focused.

Aim Statements should be written in the **SMART** goal format which stands for:
S-Specific
M-Measurable
A-Attainable
R-Realistic
T-Timely

The Aim Statement helps a Quality Improvement Team define the care you want to provide, set goals for achieving that care and understand how your systems and processes help to support reaching your goal.

The Aim Checklist:

⇒ What is expected to happen?
⇒ What is the time period to achieve the aim?
⇒ Which systems will be improved?
⇒ What is the target population?
⇒ What are the specific numerical goals?

6. Defining the Population of Focus – Pediatrics or Adults Measures

Practices are encouraged to enroll all of their patients (total population) related to the areas of focus for the Colorado Beacon Consortium in their registry for population-based planning and measurement purposes. Ideally, this is a population of 100-200 patients to best note the effect of improving care processes. However, some practices will have fewer patients and some practices will have more patients. The overall goal is to be implementing evidence-based care guidelines on the entire population and to utilize the measures as a proxy for whether your process is helping the practice team achieve the established Aim.

7. Creating an Electronic Registry of Your Patients

Identifying the patient population is the backbone to the population-based care delivery system. Without identification of the patients included in the population, changes cannot be achieved. To identify patients within the population of focus (as discussed above), a team needs to be able to access data that pertains to this group of patients. The tools used to collect and access information about a specific group of patients is often referred to as a registry. Simply stated: a registry is a mechanism for keeping all pertinent information about a specific group of patients at your fingertips. The information can be used to schedule visits, labs, educational sessions, as well as generate reminders and guidance of the care of patients (both in groups and individually). Your Quality Improvement Advisors and Data Analysts will work closely with you to determine the mechanism and workflow for you to implement registry functionality and pull your measures monthly. This process will include review of your current health information technology systems, if applicable.

Objective	Clinical Focus	Annual Rate of Improvement or Target
Pediatric Measures		
Increase the Use of Appropriate (guideline concordant) Medications for People with Asthma. Ages 5-11	Asthma	Practices will close gap by 50% from practice baseline and target of 94%
Increase Weight Assessment (Screening) and Counseling (Nutrition and Physical Activity) for Children (3-11 y/o and 12-17 y/o)	Obesity	Practices will close gap by 50% from practice baseline and target of 50%
Increase Childhood Immunizations All immunizations up to date by age 2	Preventive	Practices will close gap by 50% from practice baseline and target of 1) Combo 2 by 75% and 2) Combo 3 by 70%
Reduce Asthma Admission Rate	**Cost**	Reduce community baseline rates by 1%
Reduce Inpatient re-admission within 30 days	**Cost**	Reduce community baseline rates by 2%
Reduce Emergency Room Visits	**Cost**	Reduce Community Baseline Rates
Adult Measures		
Improve Comprehensive Diabetes Care (BP<140/90)	Diabetes	Practices will close gap by 50% from practice baseline and target of 70%
Improve Comprehensive Diabetes Care (HbA1c>9)	Diabetes	Practices will close gap by 50% from practice baseline and target of 20%.
Improve Cholesterol Management for Ischemic Vascular Disease (IVD) Conditions	Cardiovascular	Practices will close gap by 50% from practice baseline and target of 50% with 70% screening
Tobacco Use Assessment and for identified tobacco users provide Cessation Intervention	Tobacco Cessation	Practices will close gap by 50% from practice baseline and target of 75%
Increase Breast Cancer Screening	Preventive	Practices will close gap by 50% from practice baseline and target of 60%
Increase Depression Screening using a standardized tool for IVD and diabetic patients	Mental Health	Practices will close gap by 50% from practice baseline and target of 50%
Increase Adult Weight Assessment and follow up for those with BMI outside parameters (18-64 y/o and over 65 y/o)	Obesity	Practices will close gap by 50% from practice baseline and target of 50%
Reduce Diabetes Short-Term Complication Admission Rate	**Cost**	Reduce community baseline rates by 1%
Reduce Diabetes Long-Term Complications Admission Rate	**Cost**	Reduce community baseline rates by 1%
Reduce Uncontrolled Diabetes Admission Rate	**Cost**	Reduce community baseline rates by 1%
Reduce Hypertension Admission Rate	**Cost**	Reduce community baseline rates by 1%
Reduce Inpatient re-admission within 30 days	**Cost**	Reduce community baseline rates by 2%
Reduce Emergency Room Visits	**Cost**	Reduce Community Baseline Rates

Colorado Beacon Consortium Collaborative Measures Measurements: Guidelines for Getting Started

Your Clinical Information System/registry will be key to establishing population-based measures for use in the Beacon program. It is important to begin collecting data prior to the first Learning Collaborative. At the collaborative, we will discuss ongoing measurement strategies. Expect to continue summarizing data from your system and reviewing your data on a monthly basis throughout the entire Beacon program. The measures are a subset of guideline-based care delivery and in no way should detract from implementing guideline-based care on your patient population. The measures serve as a proxy for how well the systems and processes you have established are supporting your aims. The practice level goals of the Learning Collaborative and Practice Transformation efforts are to "close the gap" from the individual practice baseline to the program goals by 50%. These will be outlined more specifically for each practice once the practice baseline measures have been obtained.

Some measurement concepts to help keep the use of data simple and effective during the Collaborative:

1. **Plot data over time.** Improvement in care of patients will require testing and implementing throughout the Beacon program. Most of the information about performance of your system and how it has improved can be learned by observing trends and patterns in simple time series charts of key measures directly related to the aim. Annotated run charts (time order plots) will be the minimum standard for the Beacon program. Data points for each measure should be plotted at least monthly on a run chart. Please note: the graphs are generated automatically from data entered into an Excel template provided to you. Post these measures on a data wall for your entire staff to see the impact of your process changes.

2. **Focus on measures directly related to your aim.** Measures that can be used to evaluate performance of the system relative to your team's aim should be maintained throughout the Beacon program and reported on a regular basis. Additional balancing measures (measures that track the effect that changes in one part of a system have on other parts of the system) and measures of specific components of your system may be required at different times during the program, but these do not need to be reported regularly.

3. **Use the registry as the basis for your measures.** This registry is a basic part of the clinical information system that will be part of your practice redesign and will also be used to develop most of your key measures on the patient population of interest. See the tables listing the key measures for the Colorado Beacon Consortium program.

4. **Integrate measures into routine processes.** Whenever possible, collect useful data as part of the normal performance of work. Update the registry after each patient visit. Develop simple data recording forms that are integrated into the patient visit.

Begin data collection immediately. Ideally, you will come to the first Learning Collaborative with the beginning of time series graphs of the key measures related to your practice improvement team's aim. If historical data are available, plot the data, using whatever frequency is available.

8. Preparing a Storyboard

At each Learning Collaborative, your team will create a storyboard to present what it has accomplished and learned so far. Storyboards help create an environment conducive to sharing and learning from the experiences of others.

At the first Learning Collaborative on September 9, 2011, your storyboard will be a way to introduce your team to the other Collaborative participants. The storyboard is an opportunity to have some fun and show the unique character of your clinic and your QI team.

The storyboard should be clear and concise. The audience for storyboards consists of other teams, the Beacon leadership, observers, and faculty who are not familiar with your organization, your aim, and your work. Additional information will be communicated by your Quality Improvement Advisor, with a template to use for the storyboard.

Your Storyboard

Suggested contents for your first storyboard:

- Practice name, team members and their titles
- Brief description of the clinic and population served
- Draft aim statement
- Draft description of your Population of Focus
- Baseline data/measures
- Description of progress so far
- Lessons learned
- Partnerships
- What you would like to learn from others
- If implemented, how are you using QHN

Utilize photos, figures, colored paper, and other CREATIVE materials as desired! Have fun, think outside the box! This is your chance to showcase your practice.

Checklist of Pre-work Activities

- [ ] Select practice Quality Improvement Team with the guidance of the Quality Improvement Advisor
- [ ] Complete team roster and submit to Quality Improvement Advisor
- [ ] Review manual with all team members
- [ ] Participate in the four (4) Pre-Work Curriculum Webinars
- [ ] Work with the Beacon Data Analyst on your individualized data reporting plan
- [ ] Hold first team meeting and make decisions about team roles and regular meeting time
- [ ] Develop an Aim Statement, with the assistance of Quality Improvement Advisors
- [ ] Define a Population of Focus with the assistance of Quality Improvement Advisors
- [ ] Discuss key required measures with team members and select additional measures as required/desired
- [ ] Complete the Patient Centered Medical Home-Clinician Assessment (PCMH-CA) Survey
- [ ] Register the team for the Kick-Off Learning Collaborative on September 9, 2011. Information will be available through your Quality Improvement Advisor
- [ ] Prepare and bring a storyboard to the Learning Collaborative, using the format that is provided to you by the Beacon team
- [ ] If necessary, begin to populate your registry functionality with patient data
- [ ] Obtain first baseline measures report prior to or by the first Learning Collaborative
- [ ] Schedule Cycle Times with Quality Improvement Advisor

Methods

As described in the *Getting Started* section, the major events of the Beacon program are the Kick-off Meeting, Learning Collaboratives, Action Periods and the Outcomes Summit. Quality Improvement Advisors (QIAs) will serve as facilitators for practices in implementing systematic evidence-based approaches to care delivery. The times between the Learning Collaboratives are called "Action Periods."

During action periods, your team will use the Model for Improvement and the Expanded Care Model to re-design and improve your office practices. Learning these methods will support any performance improvement initiative that you choose to implement based on the needs of your patient population. The Model for Improvement is a strategy for testing, implementing and spreading practice innovations. It includes use of Plan-Do-Study-Act (PDSA) cycles or rapid cycle improvement. The Expanded Care Model is a picture and description of an ideal system of health care for chronic conditions. Consisting of six essential components, the model can also be applied to preventive health. Both the Model for Improvement and the Expanded Care Model will be discussed on pre-work conference calls and also covered in detail at the first Learning Collaborative on January 13, 2012.

Work flow or Process Mapping will be a skill you will learn during your participation in the program. Process mapping is a technique to look at your "current state" for a particular process and then to vision what "future state" will look like. The goals of the future state are to remove redundant processes, inefficient processes and any waste of time in your process so that your team is maximized. This is a technique that can support clinical processes as well as business processes in a practice. Removing the steps that cause wasteful use of resources can be devoted to processes that lead to value-added time.

Throughout the Collaborative you will interact with other teams, your Quality Improvement Advisor and with the Beacon leadership through Learning Collaboratives, listservs, webinars, a web site for the program (www.coloradobeaconconsortium.org), and sharing of reports. During action periods, the listserv and virtual office will be helpful for sharing tools and lessons learned, obtaining answers to your questions, generating ideas for removing barriers, and identifying resources.

Once per month you will assess your progress and complete your narrative report. The purpose of the report is to summarize your progress and identify barriers to improvement. The audience for the report is your Quality Improvement Team, Quality Improvement Advisor, Beacon leadership, and CBC Executive Committee.

Expectations

Colorado Beacon Consortium Program Team

- Provide Learning Collaboratives to support community-based learning opportunities.
- Provide quality improvement expertise, leadership and evidence-based information and tools for making improvements in population health, prevention and chronic disease.
- Teach participating practices how to use quality improvement methods to adapt and implement changes to achieve reliable processes for prevention and chronic illness care.
- Offer support from Quality Improvement Advisors to primary care practices at Learning Collaboratives and individually through a regionally assigned QI Advisor.
- Offer coaching and assistance in how to establish practice-based population registries for patients.
- Support implementation of QHN as the community HIE to support robust utilization of data for care delivery.
- Coordinate communication activities to keep participants connected to colleagues during the improvement program.
- Develop a framework for testing changes in care delivery.

- Provide communication strategies, such as a web site and listservs, for organizations and colleagues during the program.
- Analyze monthly reports and provide timely follow-up to participating health centers, and the national and cluster steering groups.
- Offer an incentive model to provide financial support for program training activities and each Learning Collaborative.

Participating Practice Quality Improvement Team Responsibilities:

Participating **Primary Care Practice Improvement Teams** are expected to:

- Involve all staff as appropriate in achieving the performance improvement goals.
- Select a team, including a physician champion, to participate in the performance improvement initiative. The team will meet regularly (bi-weekly), with the QI Advisor to apply strategies to improve care.
- Complete all pre-work requirements prior to the Kick-off – Learning Collaborative 1 on September 9, 2011.
- Assure that the entire Quality Improvement Team participates at all Learning Collaboratives, four times a year for 1 day sessions.
- Select a day-to-day leader who will be the primary contact for the CBC Team and QIA. This person will be responsible for communication on data submission deadlines, requests for information, Learning Collaborative registration, etc.
- Agree to implement the change package in a uniform approach across the practice and test additional changes required to achieve the outcome goals for the targeted patient populations.
- Implement registry functionality to track patients and their care.
- Provide resources and support to enable the practice team the time needed for improvement activities (including support to attend the workshops, time to devote to testing and implementing changes, and active senior leadership involvement).
- Assure that the team participates in webinars as scheduled by the faculty/QIAs.
- Share information with program participants through a monthly measures report and narrative report due on the 5th work day of each month that includes data on the outcomes and process of care for the population and details of changes made. Sharing data and experiences openly is key to rapid creation of knowledge and learning across the program cohorts.
- Present a storyboard at each Learning Collaborative that documents data, progress and experience of the participating practice.
- Collaborate with appropriate community, state and local programs.

Colorado Beacon Communities Incentive Program

To support practices in participating in the Beacon Practice Transformation Program, an incentive program has been developed.

The methodology contemplated leads practices to be successful in three domains - Participation, Process, and Outcomes over the course of approximately 15 months of active Beacon program participation. The available $10,000 per practice will be paid out at the practice level according to the following schedule of milestone completion:

Participation (25% or $2500)
Checks will be distributed at the conclusion of the first Learning Collaborative, representing completion of the following required activities:

- Pre-work complete and fully executed MOU (see attached).
- Baseline measures collected and reported to Beacon Operational Leadership Team.
- Identified and registered Practice Quality Improvement Team.
- Story boards developed and displayed at first Learning Collaborative.
- QI Team successfully completes participation in first Learning Collaborative.
    - Attendees must include at least one physician

Process (25% or $2500)
Checks distributed by QI Advisors at approximately the 6 month point, representing successful, ongoing utilization of health information technology by submitting to the Beacon Operational Leadership Team:

- monthly narrative reports
- monthly measure reports

Outcomes (50% or $5000)
Checks will be distributed to eligible practices at the Outcomes Summit (4th Learning Collaborative) for their cohort, December 7, 2012, based on their performance on applicable Quality and Population Health measures.

- Goal is to close the gap between baseline measurement and goal by 50%.
- Pro-rated based on the number of measures that meet the goal.
- There will an alternative activity for practices unable to report data.

Beacon Change Package

I. Performance Improvement Change Package

Steps for Performance Improvement

1) Choose a measure.
2) Determine a baseline.
3) Evaluate your performance.
4) If performance is not what you would like, develop a performance aim.
5) Make changes to improve performance.
6) Monitor performance over time.

High Leverage Changes Overview

Use Quality Improvement Tools, Models and Resources

- ☐ Review & use the Expanded Care Model (a.k.a Care Model)
- ☐ Review & use the Model for Improvement
- ☐ Team-based Care Delivery
- ☐ Monthly Measure and Narrative Reporting
- ☐ Community Learning Collaboratives
- ☐ Quality Improvement Advisors

Step 1: Determine source of Registry Functionality

a. Evaluate options for Population Health reporting
b. Validate and test registry source information

Step 2: Implementing a Registry Functionality

a. Select and install a registry tool or maximize EHR
b. Determine total population based on measure set including numerators/denominators
c. Determine staff workflow to support registry use
d. Populate registry with patient data
e. Routinely maintain registry data

f. Use registry to manage patient care and support population management
   1. Pull measures from registry

2. Review patients against evidence-based protocols for gaps in care
3. Outreach to patients who are out of compliance on protocols
4. Compare measures by individual provider and with other providers monthly

Step 3: Use Planned Care Template

a. Select template tool from registry/EHR or create a flow sheet
b. Determine staff workflow to support use of template
c. Use template with all patients
d. Ensure registry updated each time template used
e. Monitor use of templates

Step 4: Use Protocols

a. Select and customize evidence-based protocols to practice
b. Determine staff workflow to support protocols, including standing orders
c. Use protocols with all patients
d. Monitor use of protocols

Step 5: Self Management Support

a. Obtain patient education materials (e.g., asthma action plans)
b. Determine staff workflow to support SMS
c. Provide training to staff in SMS techniques
d. Set patient goals collaboratively
e. Document & monitor patient progress toward goals
f. Link with community resources (schools, service organizations)
g. Implement the patient activation measure

Step 6: Use HIE Protocols

a. Implement community HIE
b. Implement auto processing protocols
c. Standardize staff work flow
d. Maximize use of data points from HIE
e. Monitor use of standard workflow
f. Maximize functionality for Meaningful Use

ASTHMA-SPECIFIC PROTOCOL

- Assess and document asthma severity and control
- Prescribe appropriate asthma medications & monitor overuse of beta agonists
- Use asthma management plans
- Establish visit frequency protocol
- Assess and treat co-morbidities
- Assess, counsel, and prevent exposure to environmental triggers

DIABETES-SPECIFIC PROTOCOL

- Check and treat BP <140/90
- Check and treat cholesterol
- Check A1C and treat hyperglycemia
- Assess aspirin need and prescribe if not using
- Assess need for eye exam and make referral if needed
- Assess nephropathy risk
- Perform feet exams
- Provide appropriate vaccines
- Assess tobacco use and counsel to stop tobacco use
- Assess symptoms of Depression using PHQ2 and then PHQ9 as appropriate

CARDIOVASCULAR DISEASE PROTOCOL

- Check BP
- Assess BMI
- Check lipid and LDL levels

- Assess tobacco use and counsel to stop tobacco use
- Assess symptoms of Depression using PHQ2 and then PHQ9 as appropriate

DEPRESSION PROTOCOL

- Administer PHQ2
- If positive, administer PHQ9
- Confirm diagnosis and establish baseline measure with PHQ9
- Determine method of treatment

PREVENTION PROTOCOL

- Alcohol misuse screening and brief counseling
- Cholesterol screening
- Colorectal cancer screening
- Immunizations
- Cervical cancer screening
- Tobacco screening and counseling
- Adult obesity screening and counseling
- Childhood obesity screening and counseling
- Breast cancer screening

II. Practice Transformation Change Package

* Indicates High Leverage Change Package Elements

Patient & Family Engagement and Proactive Care Team*

- ☐ Patient “linked” with Care Team for questions, scheduling and follow-up
- ☐ Patient & Family Experience Survey which informs process improvement
- ☐ Patient & Family as a member of the QI Team
- ☐ Implement shared care plan and develop understanding of preference sensitive care

Clinical Information System

- ☐ Registry-broaden to other patient populations
- ☐ E-Prescribing
- ☐ HIE implementation and use*
- ☐ Reporting to various national and local Incentive Models
- ☐ Computer Physician Order Entry (CPOE)
- ☐ QHN Clinical Summaries

Self Management Support

- ☐ Shared decision making
- ☐ Patient self-efficiency and individualized assessment
- ☐ Patient self management support
- ☐ Stages and processes of change
- ☐ Motivational interviewing
- ☐ Health coaching
- ☐ Patient satisfaction/experience

Decision Support

- ☐ Evidence-Based Guidelines
- ☐ Maximize technology clinical decision support
- ☐ Use of HP/Archimedes/QHN Data for Proactive Care Delivery

Delivery System Design

<u>Team Based Care*</u>

- ☐ Maximize staff to the "top of their license"
- ☐ Huddles

<u>Care Coordination</u>

- ☐ Test and referral tracking
- ☐ Establish medical neighborhood*
- ☐ Establish Care Coordinator role*
- ☐ Develop and implement Care Compact
- ☐ Transitions of Care
- ☐ Create referral network using HIE
- ☐ Utilizing CCD via QHN

<u>Access and Scheduling</u>

- ☐ Increase points of access
- ☐ Demand and supply capacity
- ☐ Open/Traditional access scheduling
- ☐ E-Visits

<u>Service Enhancement</u>

- ☐ Co-located Services

Community Resources

- ☐ Healthier Living Colorado*
- ☐ AHEC Support Services
- ☐ Public Health Department
- ☐ Health Plans and hospital systems
- ☐ Faith based organizations
- ☐ Academic centers
- ☐ Web Based and online resources
- ☐ Regional Extension Center Services*

Organization of Health Care - Organization of Practice

- ☐ Leadership/culture
- ☐ Peer mentoring and Learning Collaborative faculty

- ☐ Team-building
- ☐ Job Descriptions reflecting QI roles and responsibilities*
- ☐ Culturally competent care delivery
- ☐ Financial practice health
- ☐ Lean principles

Glossary of Terms and Concepts

Action Period
The period of time between Learning Collaboratives when teams work on improvement in their organizations. They are supported by the Beacon leadership team, faculty, and other Beacon team members via a variety of resources such as listservs, virtual offices and web sites, teleconferences, etc.

Aim or Aim statement
A written, measurable, and time sensitive statement of the accomplishments a team expects to make from its improvement efforts. The aim statement contains a general description of the work, the Population of Focus, and the numerical goals.

Annotated Run Chart
A line chart showing results of improvement efforts plotted over time. The changes made are also noted on the line chart at the time they occur. This allows the viewer to connect changes made with specific results.

Care Model
A model that represents the ideal system of healthcare for people with chronic disease and an approach to re-designing healthcare to mirror that ideal system. Developed by Improving Chronic Illness Care, the model has six components: community resources and policies, healthcare organization, self management support, decision support, delivery system design, and clinical information systems.

Chair
The leader of the team/sub group, usually an expert in the topic.

Champion
An individual in the organization who believes strongly in quality improvement and is willing to work with others to test, implement and spread changes. Teams need at least one clinical champion. Champions in other disciplines who work on the process are important as well. This champion should have a good working relationship with colleagues and with the day-to-day leader(s) and be interested in driving change in the system.

Change Concept
A general idea for changing a process, usually developed by an expert panel based on literature and practical application of evidence. Change concepts are usually at a high level of abstraction, but evoke multiple specific ideas for how to change processes. "Simplify," "reduce handoffs," "consider all parties as part of the same system," are all examples of change concepts.

Change Idea
An actionable, specific idea for changing a process. Change ideas can be tested to determine whether they result in improvements in the local environment. An example of a change idea is, "Simplify process for data entry by having front desk staff enter visit information daily from a duplicate copy while the original is filed in the chart."

Change Package
A collection of change concepts and key changes.

Clinical Information System
A Clinical Information System (CIS) incorporates the development of a comprehensive, integrated information system that is "patient-centered," includes patient registries, a practice management system including billing system, an electronic health record and personal health records.

Collaborative
A systematic approach to healthcare quality improvement in which organizations and providers test and measure practice innovations, then share their experiences in an effort to accelerate learning and widespread implementation of best practices. "Everyone teaches, everyone learns."

Collaborative Leadership and Faculty
The group of experts on the topic who assist the chairmen in developing the Collaborative and in teaching and coaching participating teams.

Collaborative Team
All individuals from the participating organizations who drive and participate in the improvement process. A core team of three to four individuals attends the Learning Collaboratives, but a larger team, often from various disciplines, participates in the improvement process in the organization.

Quality Improvement Team Members
The members are those individuals who attend the Learning Collaboratives and meet on a regular basis for performance improvement work.

Cycle
See "PDSA cycle".

Data Collection Plan
A specific description of the data to be collected, the interval of data collection, and the subjects from whom the data will be collected. The plan is included in all senior leader reports.

Early Adopter
In the improvement process, the opinion leader within the organization who brings in new ideas from the outside, tries them, and uses experiences with positive results to persuade others in the organization to adopt the successful changes.

Early Majority/Late Majority
The individuals in the organization who will adopt a change only after it is tested by an early adopter (early majority) or after the majority of the organization are already using the change (late majority).

Electronic Health Record (EHR)
An electronic health record (EHR) is an official health record for an individual that is shared among multiple facilities and agencies. Digitized health information systems are expected to improve efficiency and quality of care and, ultimately, reduce costs.

Electronic Medical Record (EMR)
An electronic medical record (EMR) is a digital version of the traditional paper-based medical record for an individual. The EMR represents a medical record within a single facility, such as a doctor's office or a clinic.

Electronic mailing list, email list, or "listserv"
A communication system that allows teams to stay connected with the leadership team and each other during the action periods. Sharing information, getting questions answered, and solving problems are all part of e-mail list activity.

Health Information Exchange (HIE)

The mobilization of healthcare information electronically across organizations within a region, community or hospital system which provides the capability to electronically move clinical information among disparate health care information systems while maintaining the meaning of the information being exchanged.

Health Information Technology (HIT)
The umbrella framework to describe the comprehensive management of health information and its secure exchange between consumers, providers, government and quality entities, and insurers. Health information technology (HIT) is, in general, increasingly viewed as the most promising tool for improving the overall quality, safety and efficiency of the health delivery system.

Implementation
Taking a change and making it a permanent part of the system. A change may be tested first and then implemented throughout the organization.

IS
Refers to the information system of an organization, usually the computerized information system.

IS Specialist
An individual in the region working with the Region Director and Region Coordinator to assist the teams with registry development and upkeep, reporting graphs, email, listservs and presentations.

Key Changes
The list of essential process changes that will help lead to breakthrough improvement. Key changes are more focused and detailed than change concepts, but they are not specific to the local environment like change ideas. An example of a key change is, "Enter data into registry regularly."

Key Contact
The individual on the practice's Quality Improvement Team who takes responsibility for communication between the QI team and Beacon staff, including reporting monthly and disseminating information to QI team members.

Learning Collaborative
A one day meeting during which participating practice QI teams meet with faculty and collaborate to learn key changes in the topic area, including how to implement them, an approach for accelerating improvement, and a method for overcoming obstacles to change. Teams leave these meetings with new knowledge, skills and materials that prepare them to make immediate changes.

Listserv
An automatic mailing list. When e-mail is addressed to a LISTSERV mailing list, it is automatically broadcast to everyone on the list. The result is similar to a newsgroup or forum except that the messages are transmitted as e-mail and are therefore available only to individuals on the list.

Measure
A focused, reportable unit that will help a team monitor its progress toward achieving its aim. The Beacon program has a list of required key measures for each condition, as well as a list of additional key measures that have been found to be helpful to the team in achieving excellent results.

Model for Improvement

An approach to process improvement, developed by Associates in Process Improvement, which helps teams accelerate the adoption of proven and effective changes. The model includes use of "rapid-cycle improvement," successive cycles of planning, doing, studying, and acting (PDSA cycles).

PDSA Cycle
Another name for a cycle (structured trial) of a change, which includes four phases: Plan, Do, Study, and Act. The PDSA cycle will naturally lead to the "plan" component of a subsequent cycle.

Population of Focus (POF)
A designated set of patients who will be tracked to determine whether changes have resulted in improvements. The ideal size to track for most chronic disease populations is between 100-200 patients (this is a dynamic number and will fluctuate slightly from month to month). It is this sub-population that will then be the initial focus of the change in practice.

Pre-Work
The time before the first Learning Collaborative when teams prepare for their work in the Beacon program. Pre-Work activities include attending webinars, forming a QI team, registering for the first Learning Collaborative, scheduling initial meetings, preparing an aim statement, defining a Population of Focus, selecting measures, and beginning to populate a registry.

Registry
A list or database set of records that contain individual patient information. The registry should provide the following: clinically useful and timely information, reminders and feedback for providers and patients, identify relevant patient subgroups and support proactive care, and facilitate individual patient care planning. "Registry size" refers to the count of patients represented in the list.

Run Chart
See "annotated run chart."

Spread
The intentional and methodical expansion of the number and type of people, units, or organizations using the improvements. The theory and application comes from the literature on the concept of Diffusion of Innovation.

Storyboard
The board that displays information about a QI team and its progress and is displayed at Learning Collaboratives to help create an environment conducive to sharing and learning from the experiences of others. For more information, see the *Completing Pre-Work* section.

Team
The group of individuals, usually from multiple disciplines who drive and participate in the improvement process. A core team of three individuals attend the Learning Collaboratives, but a larger team of six to eight people participate in the improvement process in the organization.

Technical Expert
The team member in the organization who has a strong understanding of the process to be improved and changes to be made. A technical expert may also provide expertise in process improvement, data collection and analysis, and team function.

Test

A small-scale trial of a new approach or a new process. A test is designed to learn if the change results in improvement, and to fine-tune the change to fit the organization and patients. Tests are carried out using one or more PDSA cycles.

Website
A communication system that allows teams to stay connected with the Leadership Team and each other during the action periods. Sharing information, getting questions answered, and solving problems are all part of website activity.

Resource Section

Team Dynamics

All teams, as part of their development, go through different stages as they develop into a high performing team. It is helpful to recognize these stages and not let them deter from the program work.

Source: The One-Minute Manager Builds High Performance Teams

Stage 1 Orientation

- Eager with high expectations.
- Anxiety about fit and expectations.
- Testing situation and central figures.
- Depending on authority and hierarchy.
- Needing to find a place and establish one's self.

Stage 2 Dissatisfaction

- Discrepancy between hopes and reality.
- Dissatisfied with dependency on authority.
- Angry about goals, tasks and action plans.
- Feeling incompetent and confused.
- Negative towards leaders and teams.
- Competing for power and/or attention.
- Experiencing dependence/counter-dependence.

Stage 3 Resolution

- Decreasing dissatisfaction.
- Resolving discrepancies between expectations and reality.
- Resolving animosities and polarities.
- Developing harmony, trust, support and respect.
- Developing self-esteem and confidence.
- Being more open and giving more feedback.
- Sharing responsibility and control.
- Using team language.

Stage 4 Production

- Excited about participation.
- Work collaboratively and inter-dependently.
- Feeling team strength.
- Showing high confidence in accomplishing tasks.
- Sharing leadership.
- Feeling positive about task successes.
- Performing at high levels.

Teams are not static

- Teams can get stuck.
- Teams can regress.
- Teams can skip stages.
- Large teams = more complex relationships and communications with more subgroups.
- Team members must move from individual rewards/behavior to team behavior/rewards.

Getting the Most From Your Team

Leaders have a lot to consider in developing the appropriate environment for improvement. In addition to setting up an environment for improvement, leaders also must build an infrastructure to drive and support improvement in an organization. The infrastructure should drive, manage and support organization improvement. A model for such an infrastructure would contain the following key activities:

- Strategic Planning – establish and communicate the purpose of the organization, conduct planning for improvement and integrate it into the business plan.
- Develop a cooperative, connected network – view the organization as a system.
- Build capacity for improvement – design and manage a system for gathering information for improvement and sustaining the changes.
- Executive Sponsorship – charter and coach individual and team improvement activities.
- Technical support – advice from the experts outside the team.
- Knowledge Management – developing a system to synthesize, integrate and spread knowledge so everyone in the organization is on the same page.

Building Capacity for Improvement

Occasionally improvement occurs and nobody knows why, then it disappears and nobody knows why. Sustained improvement is accomplished by premeditated planning and testing and by deliberate action to integrate the change into the system. An improvement team may find all the needed improvements, but if the changes are not integrated into the system they won't produce long-term results. The investment of organizational resources to the team demands that the results are sustainable and duplicable. Teams in organizations just like yours have taken these skills, tools and models back to their organization, trained other staff and have made significant improvement in outcomes in other diseases other than the initial one they started with – diabetes, asthma, depression and cardiovascular disease. In other words, the skills and models they will learn are applicable to all improvement efforts and need to be incorporated into the performance improvement plan of the practice and everyone needs to learn how to use them. Actions the leader can take to build capacity for improvement:

- Publicize the work of the team: storyboards and Senior Leader reports, for example, can be posted in staff break rooms, hallways or bathrooms.
- Involve and train other staff: the core team has a responsibility to train others in the skills and tools of the Beacon program.
- Support the team: if the senior leader clearly acknowledges the importance of the work of the team it becomes an organizational priority.
- Integrate the models into the performance improvement plan: the models must become a way of organizational improvement life; practice transformation and performance improvement work cannot be a stand alone if it is to be sustained.
- Reporting the team's progress to the Board provides oversight required for accreditation and external reviews. It may also provide community opportunities that the team may be unaware of.
- Plan for how you intend to spread the work of your team throughout the whole organization.

Organizing the Team

The First Team Meeting

Establishing the Ground Rules: Ground rules are the rules a team makes to 'govern' themselves and their behavior as team members. **THIS IS AN IMPORTANT STEP – DON'T SKIP IT!**

Basic Ground Rules To Be Addressed:

- **Attendance:** a high priority is set on attendance. Discuss what are legitimate reasons for missing a meeting and establish a procedure for informing the team leader of the member's absence.
- **Promptness:** meetings start and end on time. Everyone is on time for meeting, but no waiting for anyone.
- **Meeting time and place:** specify a regular meeting time and place, establish a procedure for notifying members of the meetings.
- **Participation:** every team member's contributions are important; establish the importance of speaking freely and listening attentively.
- **Basic conversational courtesies:** listen attentively and respectfully to others; don't interrupt – one conversation at a time. The team leader holds the right to halt members who do not adhere to these rules.
- **Assignments:** since much of the team's work is done between meetings, members must be accountable for completing their assignments on time and report back to the team.
- **Interruptions:** based on the 100 mile rule determines when interruptions will be tolerated and when they won't.
- **Rotation of chores:** determine a rotation of routine housekeeping chores for all team members, so no one feels overwhelmed or stuck.
- **Agendas, minutes, & records:** although the team leader is ultimately responsible for these activities, others may be assigned the tasks. You will need to decide how these will be handled on your team.
- **Other ground rules:** add any others that the team may feel are appropriate.

Note: Team members who show a pattern of breaking the rules of the group may need to be replaced. The intensity, amount of work and timeframe of the Beacon program require **ALL** members to carry their weight AND be committed to the work of the team.

Set the Meeting Schedule

In order to accomplish the work of the Beacon program, the team will need a time and place **set aside to meet on a regularly SCHEDULED basis.** It is vital that a regular meeting schedule be developed. Haphazard meeting times or hallway meetings will not produce a highly effective team. Initially, the team will need to meet more frequently, but as the work progresses the meetings will be less frequent.

General Meeting Rules

Consider these as you set your ground rules:

- Use and stick to agendas.
- Start and end on time.
- Have a facilitator (team leader's role) to keep things on track.
- Take minutes.
- Draft next agenda at the end of meeting.
- Evaluate the meeting: obtain feedback at the meeting; were objectives met? Did the meeting move you closer to your aims? Did you plan or study a test cycle? Did you utilize the EPIC model?

- **Adhere to the 100-MILE RULE –** no one should be called from the meeting unless the interruption is so important that it would still occur if the meetings were 100 miles away.

Effective Discussion Skills for Team Members

- Ask for clarifications: keep it simple and clear.
- Act as gatekeepers: no one dominates the discussion, expect equal participation among members.
- Listen: actively explore other's ideas rather than debating or defending each idea.
- Summarize: compile what has been said and restate it to the group with a question to check for agreement.
- Contain digression: disallow over long examples or irrelevant discussions.
- Manage time: stay on time with the agenda, if items go over, recognize that others will be cut short.
- End the discussion: learn to tell when nothing further can be gained and end it.
- Test for consensus: state decisions made and check that the team agrees.
- Constantly evaluate the meeting process. Ask yourselves:
    1. Are we getting what we want from the discussion? If not, what can we do differently in the remaining time?
    2. Are we on track?
    3. Are we being effective?

Organizational Team Documentation

Documentation of the team's work is an important part of the practice transformation process. The team needs the documentation to track their progress and what has been tested. Anticipated documentation includes:

- Agendas and minutes for team meetings.
- Storyboards.
- Monthly Measures.
- PDSA worksheets.
- Monthly Narrative.

Team Meeting Documentation

- **AGENDAS:** Purpose is to structure the meeting, provide a timeline for the meeting and document topics of discussion at meetings.

Agenda Example

AGENDA EXAMPLE (1)
Team Meeting
(Date)

(Time)

Review Action items

Discussion

Set next agenda

Leader or facilitator:

Recorder:

Time keeper:

Additional Notes:

Team Meeting Agenda (Example 2)			**Date** **TIME**
Participants	**Local Team**	**External Team**	**Guest**
Meeting Purpose	**Purpose of the Meeting:**		
Agenda	- item 1 - item 2		
Discussion			
Next Meeting	Date, time		
Upcoming Projects/Mtgs			

✓	PDSA	CCM	ACTION Item	Who	When	Updates

- **MINUTES:** Purpose is to document discussion, actions, findings and decisions of the team, as well as future actions required.
    1. Provide historical information for future teams looking at a similar process.
    2. Best format is one that allows for documentation of:
        - Topic(s) discussed
        - Discussion
        - Conclusions/findings
        - Actions required
        - Responsible person
        - State expected for completion of actions

Minutes Example

<table>
<tr><td rowspan="9">PARTICIPANTS

Minutes taken by:
(Team member name)</td><td>X</td><td colspan="2">Team member name</td></tr>
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<tr><td></td><td colspan="2">Team member name</td></tr>
<tr><th>AGENDA ITEM</th><th colspan="2">DISCUSSION</th><th>DECISION / ACTION</th></tr>
<tr><td>1. Agenda Item</td><td colspan="2">Any key items of discussion or how something is to be done.</td><td>What is to be done.

By whom.

Date expected to be done.</td></tr>
<tr><td>2. Agenda Item</td><td colspan="2"></td><td></td></tr>
<tr><td>3. Agenda Item</td><td colspan="2"></td><td></td></tr>
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<tr><td>7. Agenda Item</td><td colspan="2"></td><td></td></tr>
<tr><td>8. Agenda Item</td><td colspan="2"></td><td></td></tr>
<tr><td>9. Next Meeting/Call</td><td colspan="2"></td><td></td></tr>
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Example CBC Collaborative Monthly Narrative Report
[insert the name of your practice here]
[insert the month/year of this report]

Beacon Narrative Report Instructions: Please keep adding on to this report each month. The idea is to keep a running report throughout the course of your work, so you can more easily track your progress and see the breadth and depth of your tests of change and their implementation and spread within your practice. Just change the date at the top of the report each month and keep adding dates and lines to your report. To add lines to the tables, put your cursor in the last cell of the table and hit the "tab" key. If you have questions, please call your Quality Improvement Advisor.

Aim Statement:
Our practice will redesign its system as needed to provide improved care for all of our patients. We will accomplish this through the implementation of the Care Model. We will focus initially on delivery system and clinical information system aspects of the Care Model. Once the changes have been implemented, we will focus on Community, Self-Management, Decision Support, and Health Systems.

By (Date) our practice will aim to close any gaps between our baseline performance and the goals by 50%, as shown by the monthly Registry reports.

List the members of the team responsible for the incorporation of the care and improvement models into your organization. Add more lines as needed.

Team Member Name	Role/Title	Email Address	Phone/Extension
Amy Friend	Practice Manager	xxxxxx	xxxxxx
Joe Soldhan	MD	xxxxxx	xxxxxx
Joy Bird	PA	xxxxxx	xxxxxx
Laura Newcomb	Front Desk Reception	xxxxxx	xxxxxx

Describe your practice as follows.

Total # Physicians/Providers	4
Total # Clinical Staff	7
Total # Office Staff	14
Total # Patients in Practice	9000
If EMR, what vendor/version?	All Scripts
What registry system using?	None

Define your Population of Focus (POF). (Whose patients? how many compared to your total population?)
We are focusing on our estimated 150 diagnosed diabetics between the ages of 18 and 75.

What was your best practice or innovative change this month as a result of your collaborative participation?

Month/Year	Best Practice/Innovative Change
1/2010	We entered 50 patients and their clinical data into the registry
2/2010	We implemented a foot exam PDSA to increase diabetic foot exams
3/2010	All 150 patients were entered into registry, and we increased foot exams by 5%

What has been your biggest challenge to sustaining and spreading your work this month?

Month/Year	Biggest Challenge
1/2010	Identifying who our diabetic patients were by their charts
2/2010	Organizing staff around implementing foot exam PDSA
3/2010	Finding clinical data in charts for input into registry

What do you plan to do next month? Make a prediction about how your work will affect at least one key measure.

Month/Year	Next Steps	Prediction
4/2010	We plan to continue foot exam PDSA and monitor the use of the new work plan	We will increase foot exams by 5% again

Describe your tests of change (PDSAs) in each Care Model area, noting successive tests to refine your processes. Note which changes are actually implemented and have become adopted into your policies, procedures and daily routine. Note also your plan for and accomplished spread within your organization.

Delivery System Design			
Month/Year	**Description of PDSAs**	**Changes Implemented**	**Spread**
2/2010	We implemented a work plan for MA's to assist with foot exams	M.A.'s will now ask patients with diabetes to remove their socks and shoes at weigh in and to keep them off for the exam	We started with 2 M.A.'s and it went well, so we explained at the staff meeting what we were doing and asked all M.A.'s to participate

Decision Support			
Month/Year	**Description of PDSAs**	**Changes Implemented**	**Spread**
3/2010	Write and implement standing orders for flu vaccinations	M.A. was given standing order to assess appropriateness for flu vaccine and to administer when appropriate	Working on spread now – will have all M.A.'s follow standing orders

Clinical Information Systems			
Month/Year	**Description of PDSAs**	**Changes Implemented**	**Spread**

Self Management Support			
Month/Year	**Description of PDSAs**	**Changes Implemented**	**Spread**

Community Linkages			
Month/Year	**Description of PDSAs**	**Changes Implemented**	**Spread**

Organization of a Health System			
Month/Year	**Description of PDSAs**	**Changes Implemented**	**Spread**

Maintenance of Certification

Check which board you are focused on:

□ American Board of Family Medicine
□ American Board of Internal Medicine
□ American Board for Pediatrics

Name of Provider	Description of Involvement	Notes

*Adapted from Improving Chronic Illness Care Monthly Narrative Report Template

CBC Collaborative PDSA Template

Model for Improvement
PDSA Planning Worksheet

Team Name: ____

Cycle: ___________ **Date:**_______________________

PLAN

Act
Plan
Study
Do

Objective for this cycle:

Questions:

Predictions:

Plan for change or test: who, what, when, where:

Plan for collection of data: who, what, when, where:

DO Carry out the change or test. Collect data and begin analysis. Describe observations, problems encountered, and special circumstances.

STUDY Complete analysis of data. Summarize what was learned.

ACT Are we ready to make a change? Plan for the next cycle.

.

Colorado Beacon Consortium
Memorandum of Understanding

Expectations:

1. Agree to create a practice quality improvement (QI) team that meets bi-monthly regarding Quality Improvement/Practice Transformation initiatives.

2. Participate in Pre-Work Activities in preparation for the first learning collaborative session (Kick-off Meeting). Activities include:
   a. Implementing registry functionality
   b. Collecting baseline measures
   c. Program practice surveys
   d. Practice Storyboard
   e. Pre-work webinars

3. QI Team will participate in four one-day Learning Collaboratives over the course of one year. Team is defined as a Physician Lead, Clinical lead and Office Manager and/or Front/Back office staff member.

4. Monthly reporting of program measures and monthly narrative report.

5. Participate in Learning Community Webinars and Educational Sessions.

6. Meet with Quality Improvement Advisor on a regular basis.

7. Implement the Program Change Package, Care Model, Model for Improvement and Plan Do Study Act (PDSA) Cycles.

8. Serve as faculty at the Learning Collaborative sharing Lessons Learned and Best Practices.

9. Implement fully the regional Health Information Exchange (HIE).

Benefits:

1. Individualized ongoing consultation in your practice:
   - Work flow analysis to support practice efficiency
   - Technology support for monthly measures reporting

- Free Tools and Resources
- Implementation of quality improvement techniques required for Meaningful Use, Maintenance of Certification and PQRI
- Maximize Health Information Exchange and QHN functionality

2. Learning Collaboratives tailored to your needs and presented by experts in the field.

3. CME credits (up to 20 Performance Improvement credit hours) available, depending on level of participation in initiative activities.

4. Maintenance of Certification Part IV points and credits from the American Board of Family Medicine, the American Board of Pediatrics and the American Board of Internal Medicine.

5. Collaboration with Regional Extension Centers on achieving Meaningful Use Incentives

6. Financial incentive opportunity-up to $10,000

Each person named below should sign and date, keep one copy for practice files, and return one copy to the Colorado Beacon Consortium.

____
(Practice Name)

____ _________________
(Practice Representative) Date

____ _________________
(Colorado Beacon Consortium Representative) Date

Program Start Date____________ *Program End Date_____________

*If the practice decides to discontinue participation in the Beacon program before the scheduled end date, resources and incentives provided by the Colorado Beacon Consortium will be discontinued as of the last date of program participation.

Collaborative Charter Executive Summary

Mission

The mission of the CBC is to *optimize the health and quality of life for all members of the community through the meaningful use of health information technology, and to improve the quality and cost-effectiveness of their health care, regardless of personal means or coverage status.*

To achieve excellence in the delivery of primary health care through the following goals: (1) to transform practice through models of care, improvement and learning; (2) to develop infrastructure, expertise and multi-disciplinary leadership to support and drive improved health status; and (3) to build strategic partnerships.

CBC Practice Transformation MISSION STATEMENT

Maximize the use of data through Practice Transformation to bend the cost curve, improve health and the healthcare experience for individuals, families and communities.

Practice Transformation is achieved through the desire and leadership to deliver quality patient-centered care by the adoption and use of advanced technology with the support of coaching and collaborative learning.

NATIONAL PROJECT GOAL:

The Grand Junction, Colorado health care system is a nationally-recognized model of care, which functions as an Accountable Care Organization that is founded upon an "operational sense of community". This area includes 300,000 residents, 12 hospitals, two FQHCs and 17,500 square miles. The CBC project will: expand and strengthen our already robust infrastructure for clinical data exchange; integrate data more effectively at the practice-level; achieve specific cost, quality and population health outcomes; and demonstrate sustainability as a model for replication in other communities.

Expanded Care Model

Community
Build healthy public policy
Create supportive environments
Strengthen community action
Health System
Information Systems
Self Management Support
Delivery System Design
Decision Support
Activated Community
Informed Activated Patient
Productive Interactions & Relationships
Prepared Proactive Practice Team
Prepared Proactive Community Partners
Population Health Outcomes / Functional & Clinical Outcomes

Source: Created by Victoria Barr, Sylvia Robinson, Brenda Marin-Link, Lisa Underhill, Anita Dotts and Darlene Ravensdale (2002) Adapted from Glasgow,R., Orleans, C., Wagner, E., Curry, S., Solberg, L. (2001) "Does the Chronic Care Model also serve as a template for improving prevention?" *The Milbank Quarterly*, 79(4), and World Health Organization, Health and Welfare Canada and Canadian Public Health Association. (1986). Ottawa Charter of Health Promotion. Source: The MaColl Institute, http://www.improvingchroniccare.org/

CBC
Colorado Beacon Consortium

Collaborative Learning Series Plan

Quality Improvement through Teamwork

The Colorado Beacon Consortium (CBC) will implement a multi-faceted action plan to achieve specific **Cost, Quality and Population Health Improvement** objectives. Our *Collaborative Learning Series*[1] will integrate physician and patient engagement, clinical process improvements, technology deployments, data aggregation & analysis in a phased process across the entire, seven (7) county CBC region (Mesa, Delta, Montrose, Gunnison, Pitkin, Garfield and Rio Blanco).

The *Care Model* (on previous page) will be the basis of all CBC collaborative learning, technology development and quality improvement activities.[2] Our offerings to physicians, hospitals and community service agencies will include the following key components:

- **Practice Advising** - CBC will provide skilled quality improvement advisors to assist physician practices and clinics in the adoption of health information technology, to improve quality and work processes, and maximize ***Meaningful Use*** incentives—both now AND later, as government criteria tightens.

- **Technology** - The CBC will provide assistance in extracting data from current EHR systems.

- **Financial Incentives** - Direct financial support, from a pool of private funds donated by Rocky Mountain Health Plans, to help ***primary care practices and clinics*** who elect to complete the entire *Collaborative Learning* curriculum and participate in quality improvement activities. Additional funding will be made available by *Quality Health Network* to ***assist hospitals*** in interfacing with physicians and the communities they serve through health information exchange.

Our Plan

The CBC will commence community organizing, leadership development and physician practice recruitment activities for the Collaborative Learning Collaborative on **September 9, 2011.** Rather than work iteratively, practice-by-practice, the CBC staff and participating practices will work within three (3) regional *Learning Collaboratives* and one Outcome Summit throughout the CBC service area, in multi-practice cohorts, to complete the entire quality improvement curriculum.

Additionally, the CBC will not work with a narrow, "self-selected" group of participants. Rather, the CBC will tailor its offerings to reflect the unique needs of each physician and clinic.

[1] *See* the Institute for Healthcare Improvement (IHI) for evidence regarding the effectiveness of collaborative learning for quality improvement efforts:

http://www.ihi.org/IHI/Results/WhitePapers/TheBreakthroughSeriesIHIsCollaborativeModelforAchieving+BreakthroughImprovement.htm

[2] Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? Effective Clinical Practice. 1998; 1(1): 2-4

Additionally, the CBC curriculum will be offered on a *quarterly basis*, so that participants have maximum flexibility to join the process when they are ready to do so— as shown in the chart below:

CBC Curriculum Phase	2010 Sep - Dec	2011 Jan - Apr	May - Aug	Sep - Dec	2012 Jan - Apr	May - Aug	Sep - Dec
Pre-work	**Cohort 1**	**Cohort 2**	**Cohort 3**	**Cohort 4**			
Learning Sessions 1		**Cohort 1**	**Cohort 2**	**Cohort 3**	**Cohort 4**		
Learning Sessions 2			**Cohort 1**	**Cohort 2**	**Cohort 3**	**Cohort 4**	
Learning Sessions 3				**Cohort 1**	**Cohort 2**	**Cohort 3**	**Cohort 4**
Curriculum Complete					**Cohort 1**	**Cohort 2**	**Cohort 3**

Throughout the series, the CBC will conduct semi-annual *Regional Summits*, in which all cohort teams participate in a 1-day information sharing and progress reporting activity—regardless of where they are in the curriculum. The first Regional Summit and CBC "Kick Off" Collaboratives will occur on **September 9, 2011.**

Our Curriculum

As noted in the chart above, the CBC Curriculum consists of both a "Pre-Work" and cumulative "Learning Collaborative" process. These curriculum phases included the following activities:

- **Data Collection and Baseline Setting -** CBC Quality Improvement Advisors will work with participating practices to set performance baselines and input data in a patient registry. In this context, the term "registry" refers to a list or database set of records that contain individual patient information. Registry and data aggregation tools will be provided by the CBC to practices as necessary to complete the curriculum. Clinical data collected within the practice registry, and made accessible via the Health Information Exchange, will be utilized to assess and understand the impact of changes designed to meet specific quality improvement aims. When shared aims and data are used, learning is further enhanced because it can be shared with other organizations in the Collaborative. In this way, superior performance and best practices are more quickly identified and disseminated among participants.

- **Learning and Action Sessions** - The Learning Collaboratives will adopt an ongoing "PDSA" Cycle. PDSA stands for Plan, Do, Study, Act, which is a trial-and-learning method to discover the most effective way to improve a process. An emphasis on study is the key to learning and establishes knowledge. It enables a practice team to learn from the data collected on an ongoing basis. Most importantly, the study phase is an ideal time to think through how the Care Model helps to generate new ideas and approaches to positive change. In addition, the PDSA cycles are short and quick.

Model for Improvement
What are we trying to accomplish?
How will we know if a change is an improvement?
What changes can we make that will result in improvement?
ACT
PLAN
STUDY
DO

Bringing it All Together

The Collaborative Learning process will enable the CBC to merge multiple quality improvement, process improvement and technology adoption activities *into a single, efficient process and set of services*. Most importantly, participation in the CBC program will enable health providers within western Colorado to demonstrate outcomes in four (4) critical areas— all of which are necessary to succeed with upcoming payer incentives and reform initiatives.

- **Cost Reductions**
    - Reduced ER Use
    - Reduced IP & Re-Admits
    - Advanced Correlations of Cost and Quality (via powerful new analytic tools).

- **Quality Improvement**
    - Reduce Variation
    - Achieve Substantial Improvement
    - Chronic condition management
        - Hypertension
        - Depression
        - Diabetes
        - Cardiovascular Disease

- **Prevention and Population Health**

  - Tobacco Counseling and Cessation
  - Cancer Screening
  - Obesity Interventions

- **Adoption and Meaningful Use**

  - 60% of Eligible Professionals adopt HIT and Participate in HIE by 2012 (necessary to achieve Meaningful Use).
  - All Hospitals (12) in CBC Region interfaced with Quality Health Network.

What Participants Will Get Out of This Project
Health care providers, and the western Colorado communities they serve, will receive several positive benefits from participating in the CBC project. These include:

- Better information about their patients, and better tools to make sure their patients get the most appropriate care at the most appropriate time. The CBC will enable physicians to collaborate and communicate much more closely, at a reduced cost, with other physicians, clinics, hospitals, and patients in their "medical neighborhoods" and throughout the region.

- A clear pathway to Meaningful Use, and support to ensure that their investments of time and money in health record and patient registry technology creates efficiency— not new operational burdens.

- An opportunity to get ahead of the curve on coming reforms that will reward quality and health outcomes, but require new reporting mechanisms.

- Regaining the joy of medicine and the feeling of having the time to deliver the care every practice desired to deliver.

PRINCIPLES

Six Institute of Medicine Aims
Institute for Health Care Improvement Triple Aim
Care Model
Model for Improvement

COLORADO BEACON CONSORTIUM

LEARNING COMMUNITIES

Mesa • Delta • Montrose • Gunnison • Pitkin • Garfield • Rio Blanco

COMMUNITY

Community Services • Medical Leadership • Culture • Environmental Factors • Community Registry • HIE • Integrated Care Delivery

PRACTICE TEAM

Pt. Centered • Technology & Data Driven • Financial Incentives • CQI • Team Based

HIE • Evidence Based • Leadership & Culture

PATIENT/ FAMILY

GOALS

Health Information Exchange – Adoption and Use
Increase Quality-Prevention/Population Health
Decrease Costs
Community Satisfaction/Experience
Connected Communities