

Learning Collaboratives - FAQs

1. *What is the Collaborative?*

The Partnerships for Health Collaborative is an action-oriented learning program to assist the project participants in improving care for their care delivery systems. The Collaborative brings together the project participants for approximately one year of structured guidance to bring about rapid improvements in care with a focus on care for patients with diabetes.

2. *How will the collaborative assure quality delivery of care for patients?*

Participating teams are taught systems redesign strategies using Ontario's chronic disease and prevention framework, and rapid cycle change concepts using a change model. In addition, the Canadian Diabetes Association clinical practice guidelines are used. Learning sessions utilizing these two models, with expert staff and the chance to work with other teams within the project, provide an opportunity for teams to exchange ideas and share best practices to improve patient care.

3. *How does the collaborative fit with trends in health care?*

The challenge in health care is to improve service *and* clinical quality care. Implementation of the collaborative process allows for this. Teams learn that simple changes can have big impacts in patient and service outcomes. The use of short rapid cycle tests of change allows for many different changes to be tried without expending costly time, energy, and resources to implement changes on a large scale that might not work.

4. *What data is available to show that collaboratives work?*

The use of a health care model that specifies essential elements of excellent patient care has already shown impressive results, as noted in the following examples. In the pilot Depression collaborative, improvements in patient care in one clinic resulted in greater than one half of the pilot population showing more than 50% improvement in the detection of depression symptoms as measured by the primary care physician. In 18 organizations with a combined total of 1200 patients, the percent of persistent asthma patients receiving appropriate treatment with maintenance anti-inflammatory medications increased from 10% to 70% in the first 10 months of the collaborative. The percentage of patients receiving two A1C tests per year increased threefold during the course of the Collaborative. These results are documented by the RAND Corporation at their web site: <http://www.rand.org/health/projects/icice/>

5. *We are already participating in a number of CQI activities. What else can be learned? What are the benefits to participating in a collaborative?*

This is an integrated process for changing the way health care is delivered. The benefits are the chance to work with expert faculty and the chance to network with other teams. Implementing this process can lead to improved patient care & outcomes, decreased chaos in practice and increased patient, provider, and staff satisfaction.

6. *Is there funding available to support our involvement in the collaborative?*

The Partnerships for Health project has funding to help offset the costs related to this work, such as the costs of training sessions, phone conferences, and technical support are covered as well as any travel and accommodation costs.

7. *How much time is involved in collaborative work? What is the time commitment necessary to be successful?*

It is hard to estimate the time investment. Initially, setting up the team and learning the process requires more time. Teams should be given time weekly to meet for planning, implementing testing processes, data entry, and communicating results.

8. *How many staff, and which staff, should participate? What types of staff need to be identified?*

This varies from clinic to clinic. Senior Leaders including medical directors and executive directors should participate. Other staff includes providers, nurses, support staff, and health educators. The important thing is to identify people who are agents for change—those who are innovators or early adaptors. The team should have a Senior Leader, a Clinical champion (usually a provider who carries the message to other providers), and a day-to-day leader who coordinates the efforts and completes the reporting, and any others who might be enthusiastic participants. A care team to pilot the tests of change is also needed.

9. *What are the resources available to implement change? What training, resources, and tools will be provided?*

The Project will provide training and technical support for the six participating sites. One site will be selected to ultimately implement an IT solution. All sites will be asked to work with a variety of reporting templates and other forms. A collection of materials will be made available to Project participants.

10. *What are the key elements to assure success in a collaborative?*

The key elements to assure success are Senior Leadership/management support of the collaborative, provider and staff involvement, patient registry utilization, enthusiastic provider champions and creative teams. Regular team meetings are also very important to ensuring success.

11. *What tracking system is used and is it compatible to other systems already being used?*

Some teams may not need a registry since the data to track improvement can be extracted from their EMRs. For those using the registry, every effort will be made to connect it with legacy systems so that teams can make use of existing data.

12. *Who is leading this work?*

The Partnerships for Health has retained Mike Hindmarsh who will be supported by Marg McAlister. Mike is an expert in chronic disease management and preventive care, and will be available to the teams at the learning sessions and at the practice site. Mike and Marg will help the improvement teams during the course of the Learning Collaborative. They will reinforce teachings in the collaborative, assist with registry implementation and help problem solve barriers to improvement.

For more information:

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