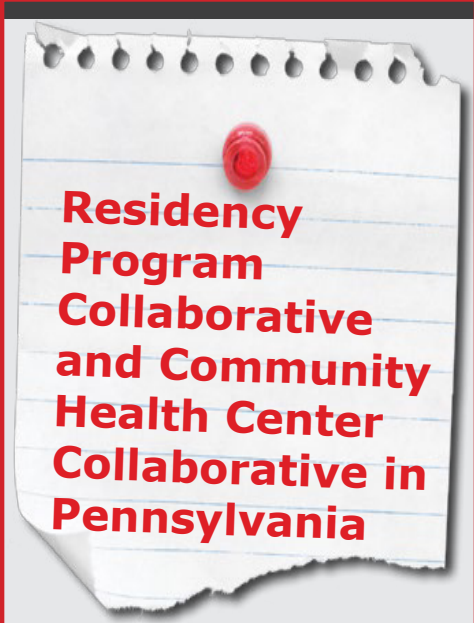


Field Notes



Residency Program Collaborative and Community Health Center Collaborative in Pennsylvania

Program:

The Residency Program Collaborative and Community Health Center Collaborative (RPC-CHC Collaborative) is a statewide program in Pennsylvania to enhance patient care at medical residency program sites and community health centers. Using the patient-centered medical home and chronic care models, the RPC-CHC Collaborative aims to expose residents and practices to quality improvement and patient-centeredness approaches.

Problem:

Primary care practices are facing a growing number of patients with chronic diseases—especially cardiovascular disease. There is an increasing need to support practices and health providers to transform into patient-centered medical homes and to implement evidence-based practices to improve the quality of patient care and ultimately obtain better health outcomes.

For more information contact

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Overview

The RPC-CHC Collaborative was launched in June 2010 as a statewide, primary care collaborative by the Pennsylvania Academy of Family Physicians (PAFP) Foundation. The PAFP is a state-based, professional organization that brings together primary care providers, residents, clinical support staff, and administrative staff from family and internal medicine residency programs and community health centers to learn and share strategies for practice transformation in a primary care setting. The RPC-CHC Collaborative was developed as a quality improvement program to enhance patient care, initially targeting family and internal medicine residency program practices.

The Approach and Core Components of the RPC-CHC Collaborative

The RPC-CHC Collaborative uses a physician-to-physician communication and feedback approach. Physicians (called faculty mentors) give tailored guidance to Quality Improvement (QI) teams. These teams have the flexibility to implement data-driven changes specific to their practice. The faculty mentors are family or internal medicine physicians who have previous experience with planning and implementing QI strategies within their practices, and have been through the National Committee for Quality Assurance Patient-Centered Medical Home (NCQA PCMH) submission and recognition process. QI teams were taught how to apply and use strategies for systems change to improve healthcare delivery within their practice and improve patient health outcomes through Live Learning Sessions and monthly conference calls. Live Learning Sessions are day-long, in-person sessions offered three times each year to provide participants with the opportunity to have face-to-face interaction and networking with other primary care practitioners. The monthly conference calls with the QI teams reinforce material related to quality and enable information-sharing among teams. QI teams also were required to report practice-level data on a specific list of quality measures for certain disease states on a monthly basis, and faculty mentors reviewed data submissions and provided tailored feedback to participating QI teams. This cyclical process, which included data review and testing of QI strategies within a practice, helped to guide QI teams in improving the quality of care delivered to patients in their practice. The following is a brief description of the core components of the RPC-CHC Collaborative:

- ✦ **Delivery of Collaborative Activities:** QI teams participate in three Live Learning Sessions each year and monthly conference calls. Data reporting responsibilities allow teams to monitor their progress over time.
- ✦ **Practice-Level Transformation:** QI teams apply what they learn from the collaborative to implement systems change strategies within their practices using the Plan-Do-Study-Act (PDSA) approach. QI teams receive feedback and guidance from faculty mentors on the data they report to the collaborative.
- ✦ **Expand Reach in Practices:** QI teams engage primary care staff, outside of those individuals that participate in the collaborative, to spread the concepts learned through the collaborative to help facilitate true practice transformation. This spread helps practices to sustain what is learned through the collaborative, even after participation has ended.
- ✦ **Management of Collaborative Implementation:** PAFP provides day-to-day management for the collaborative, oversees the development and implementation of all key activities, and conducts data management so that teams can track their progress over time.



Field Notes (cont.)

Goals and Expected Outcomes

The RPC-CHC Collaborative aims to accomplish systems change in primary care practices and community health centers by teaching quality improvement principles and patient-centered care to primary care staff and assisting practices in becoming NCQA PCMH recognized. The RPC-CHC Collaborative intends to shape the delivery of primary care by reinforcing the principles of quality improvement and patient-focused care through training in family and internal medicine residency programs and community health centers. Each year the RPC-CHC Collaborative focuses on one specific clinical topic with subsequent years adding additional topics. For example, the year 1 focus for QI teams was diabetes measures, year 2 continued with diabetes and added CVD measures, and year 3 added measures related to depression and obesity.

Intended Participants

By engaging practice staff members at all levels, a practice is able to conduct systems change and improve the quality of care delivered to patients. Each QI team represents a practice and consists of a minimum of three practice staff members (physician, resident, and nonclinical staff) who participate in collaborative activities. Staff participating in the collaborative at the practice level varied over the course of implementation, but one lead physician from each practice had consistent involvement.

Progress Toward Implementation

The RPC-CHC Collaborative was developed as a quality improvement program to enhance patient care, initially targeting residency program practices. In 2011, the collaborative expanded to include community health centers. All core components of the RPC-CHC Collaborative have been implemented. Funding to support the implementation of the RPC-CHC Collaborative came from various sources, including pharmaceutical companies and the Pennsylvania State Department of Health. As of 2015, PAFP continues to work with family and internal medicine residency programs and community health centers in the state.

Reach and Impact

There are 45 QI teams (24 family and internal medicine residency program teams and 21 community health center teams) involved in the RPC-CHC Collaborative across Pennsylvania. These 45 QI teams represent 80% (24 out of 30) of family medicine programs and 11% (21 out of 200) of community health centers operating in Pennsylvania. Selected outcomes achieved include

- 📌 **Group learning through the Live Learning Sessions contributed to achieving NCQA PCMH recognition.** Participation in a higher number of Live Learning Sessions resulted in a significant increase in NCQA PCMH recognition attainment among residency program teams, which reflect 80% of the total number of family medicine programs in the state. QI teams that attended two to four Live Learning Sessions were 3.6 times more likely to obtain PCMH recognition when compared with teams that attended one or no sessions.
- 📌 **Practice involvement resulted in higher quality care for patients.** Among all practices, longer enrollment in the collaborative resulted in practices meeting their goal of more patients meeting targets for several diabetes process measures. This includes a 1%-5% increase in the number of patients receiving eye exams, eye referrals, and foot exams, and the number having self-management goals.
- 📌 **Improvements in blood pressure control were seen in a relatively short period of time.** Practices saw improvements when RPC-CHC Collaborative targeted a specific clinical outcome while still pursuing other clinical outcomes. For example, when practices focused on improving blood pressure control in diabetic patients, practices were able to achieve significant improvements (an increase of 5% more patients having controlled blood pressure) in the number of diabetic patients with controlled blood pressure during a 4-month period.

This collaborative model offers primary care practices a unique opportunity to share information and successful strategies across practices.

Definition for Collaborative:

A collaborative is an educational model that brings teams representing different clinical practices together to work on specific clinical areas, guided by experts in process improvement to facilitate the sharing and dissemination of effective strategies. These strategies improve the quality of care.