The HRSA Patient Safety & Clinical Pharmacy Services Collaborative (PSPC)
PSPC 3.0 Guide & Workbook
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About This Workbook

The purpose of this workbook includes the following:

1) To help lay a foundation for the activities for your teams Patient Safety and Clinical Pharmacy Collaborative (PSPC);

2) To assist teams in completing pre-work in preparation for Learning Session 3/1;

3) To complement the work your team will be involved with as you move through your improvement journey in the Patient Safety and Pharmacy Collaborative (PSPC) 3.0; and

4) To introduce and provide links to tools and resources found within the PSPC supported web-based knowledge management system at www.healthcarecommunities.org.
Chapter 1: Overview & Introduction to PSPC 3.0

The Patient Safety and Clinical Pharmacy Services Collaborative (PSPC), sponsored by the Health Resources and Services Administration (HRSA), is a breakthrough effort to improve the quality of health care across America by integrating evidence-based clinical pharmacy services into the care and management of high-risk, high-cost, complex patients. In our third year, the PSPC is continuing the rapid spread of leading practices found to most effectively improve patient safety and health outcomes in a health home model, and is building on the lessons learned and successes while greatly expanding the work on a national scale.

PSPC uses a fast-paced, iterative improvement method designed to support teams in testing and spreading leading practices found to significantly improve health outcomes and patient safety through the integration of clinical pharmacy services. Key to the method’s effectiveness is that the leading practices are drawn from real practice in organizations that have achieved outstanding results. Through an intensive series of Learning Sessions and Action Periods, PSPC teams learn the leading practices from expert national faculty and from each other as team’s progress. During the Action Periods, which occur between each Learning Session, PSPC teams test, refine, adapt and implement changes within their health care organizations. Teams track and share monthly progress on multiple improvement measures, which include health outcomes and adverse drug events. Improvements are shared throughout the Collaborative learning process for mutual benefit of all participant organizations.

PSPC teams focus on small panels of high-risk, high-cost, complex patients whose needs are beyond the reach of the current delivery system. By focusing on small panels of patients who are at the highest risk for poor health outcomes and adverse drug events, the teams are able to accomplish two goals. First, PSPC teams are able to identify the pertinent challenges for the patient population, allowing them to systematically address issues related to providing high quality, patient-centered care. Second, teams are able to conduct small scale testing that enables them to refine and adapt practices to their unique organizational needs; ensuring systematic changes are accepted and sustainable by the expanded health care team. Over time this enables teams to detect improvements in their defined patient population.

PSPC teams are transforming the primary healthcare delivery system by establishing effective, interdisciplinary teams of care providers and integrating clinical pharmacy services into a patient-centered health home. Vibrant partnerships have been created through the PSPC among providers in the community that previously did not exist. PSPC teams have also demonstrated improved health outcomes and patient safety in high-risk, high-cost, complex patients.

Collaborative Aim

"Committed to saving and enhancing thousands of lives a year by achieving optimal health outcomes and eliminating adverse drug events through increased clinical pharmacy services for the patients we serve.” Central to this aim is providing safety-net organizations and their
community-based partners with the tools and skills to improve care, decrease errors and realize cost savings. This Collaborative will improve quality of healthcare by spreading the leading practices of "high performers" that have achieved outstanding health outcomes for their patients by employing interdisciplinary, patient-centered approaches to integrate the provision of clinical pharmacy services and safe medication practices at each point of care.

**Collaborative Goals**

The transformational goal of the PSPC is to integrate the healthcare delivery system across multiple healthcare partners while create a service delivery system for high-risk patients that will produce breakthroughs in the following three areas:

1. Improved patient health outcomes
2. Improved patient safety
3. Increase cost-effective clinical pharmacy services

The Collaborative focuses on one very significant risk area: the experience of high-risk patients as they encounter multiple providers and different medication practices within their healthcare delivery systems. The highest payoff for the PSPC is expected to be with patient populations that have the following high risk characteristics:

- One or more chronic conditions
- Encounters with multiple service providers and prescribing opportunities
- Use of high risk medications
- Use of multiple medications
- Poor patient medication control and self management or low health literacy

A national score card will track performance on the multiple performance aims that each community-based team will set for itself to meet the overall Collaborative goal. Quantitative and qualitative goals for the collaborative will be ambitious and will be achieved through true systems change.

**Collaborative Methods**

The Collaborative is made up of community-based teams with members from primary service delivery organizations and community based partners. Team members will represent the service providers such as: primary health care homes, clinical pharmacy services, specialty services, hospital services, educational systems and more. The flow of patients, especially uninsured and low income patients, will be a key factor in determining which organizations should participate together as a Collaborative team.

The Collaborative uses an "action learning system" designed to spread leading practices that have been shown to produce the intended results. In a 12 month process, improvement efforts are organized around regular Learning Sessions where teams come together for several days to learn about leading practices.
A PSPC Change Package details the leading practices that result in successful performance. The Change Package has been developed through site visits to "high performing" organizations. It serves as the catalogue of the leading practices that teams will adapt in an accelerated improvement process.

Action Periods follow the Learning Sessions where teams return home to apply what they have learned. Teams use the Model for Improvement, a fast paced, iterative improvement method. Continuous, small scale, rapid testing leads to adaptation of leading practices to fit local conditions.

**Testing Changes to Make Improvements**

The PSPC Collaborative uses *The Model for Improvement* developed by the Associates in Process Improvement that has been tested and used in many Collaboratives. When used with the Change Package, the improvement model provides a process to improve the quality of care at an accelerated pace.

Adapted from Institute for Health care Improvement (www.ihi.org)

The Improvement Model is based on three fundamental questions:

*(1) What are we trying to accomplish?*
The first question is meant to establish an aim for improvement that focuses the team’s efforts. Using data and what patients and other customers, such as payers, believe are important helps define an aim. Aims should be as concise—sometimes it takes a few trials of testing to refine the 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 the aim. When shared aims and data are used, learning is further enhanced because it can be shared with other organizations in the Collaborative. Documented performance and best practices are quickly identified and disseminated to enable others to benchmark on the shared success.

(3) **What changes can we make that will result in an improvement?**
Testing and Learning: The PDSA Cycle (Plan, Do, Study, Act) is a trial-and-learning (learn by testing) method to discover an effective and efficient way to change a process. 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.

**The Purpose of PDSA**

The purpose of PDSA is to organize your work creating and testing rapid changes on a small scale that allow the team to collect and use the data from the small scale tests to justify implementing the changes on a larger scale within an organization.

PDSAs enable proper documentation of the work being done as well as lay the foundation in an easy to understand story line for those who will learn from you, both in your organization and the community at large.

Effective PDSAs allow a lay reader to understand exactly what you were trying to accomplish and why, how when and where you were going to test what you are trying.

It should include:
- The details of what actually took place and the gathered data.
- What was learned based on the objective
- The objective and plan to achieve
- What you plan to do, alter/ modify, try next, based on what you learned from initial testing, in order to meet the objective.

**Think of the articulation of a PDSA cycle being similar to the administrative equivalent of a SOAP note**
Each cycle should be dated. A lay reader should be able to see your objective written in your PLAN.

**PLAN** (WRITTEN IN FUTURE TENSE): should answer WHY; WHO; WHAT; WHEN; WHERE; HOW. Be sure to include in your PLAN, a prediction of what you expect to happen with this test.

**DO** (WRITTEN IN PAST TENSE): The reader should be able to read exactly what your team DID. It should have the details of what actually took place, including the data that was gathered, i.e. "out of the 14 charts pulled, 10 were labeled with the collaborative sticker…"

**STUDY**: should reflect what the team learned by what they DID as they had PLANNED to meet the OBJECTIVE. It is the conclusion you draw based on the data and should tell you whether or not you met your objective.

**ACT** (WRITTEN IN FUTURE TENSE): should describe what your next steps will be to meet the objective based on what you learned according to the plan to meet the objective.

Most PDSA’s will have multiple cycles. Once a small change appears to work, the team should move toward designing steps to implement. Remember, implementation indicates that you have tested something enough that the results over time prove it to be successful enough that you write policy and procedure to implement it into the organization’s standard operating procedures.

**Tips for Testing Change**
The following suggestions may be used for effectively testing changes:

- Keep the changes small but continue to test
- Involve care teams that have a strong interest in improving care
- Study the results after each change. All changes are not improvements, If a change does not work; discontinue testing until a modification in the process is made.
- If help is needed, involve others who are doing the work—even if they are not on the improvement team
- Ensure overall performance is improving; changes in one part of a complex system may result in a need to improve other components of the delivery system

It is always suggested that teams keep track of the PDSA cycles they are working on. A simple tool to help support teams track their PDSA can be accessed through the following link, PDSA Worksheet.
Chapter 2: The Infrastructure Supporting Improvement

Collaborative Leadership

The Collaborative is being led by HRSA’s Healthcare Systems Bureau’s Office of Pharmacy Affairs. Nationally recognized leaders comprise the national faculty drawn from the safety-net community and individuals experienced in primary health care, and those who have managed, participated, and/or implemented successful disease management system design improvements. Their work is guided by experts from world-class organizations and those with a proven track record of conducting Collaboratives that generate results of significant magnitude. In addition, many national and state based organizations (pharmacy organizations, federal partners, quality organizations, nursing organizations, safety-net organizations, educational institutions and others) are partnering with HRSA on this effort.

PSPC Adjunct Faculty

The PSPC Adjunct Faculty support teams by sharing their clinical and operational experience and by providing expertise in the areas of quality improvement, patient safety, systems redesign, health outcomes, and clinical pharmacy. They work closely with the PSPC Faculty, the PSPC Core Team, and Faculty Coaches to respond to the needs of the teams involved and for the progress of the Collaborative as a whole. The committed professionals are assigned to assist teams in successful implementation of the PSPC aims. They participate in the planning and implementation of learning sessions by sharing their experience and addressing needs of teams participating in the collaborative.

PSPC Faculty Coaches

PSPC Faculty Coaches serve as a useful resource to support the advancement of the PSPC teams in their collaborative experience. Assisting on a personal level, but with the broader overview of the purpose of the program, coaches help their teams develop the improvement story and articulate the impact of the PSPC.

Coaches are selected by virtue of their dedication and commitment to improving the health and safety of all patients, and their demonstrated expertise in areas such as diabetes care, care of the HIV patient and care of patients on Coumadin. Their expertise can arise from faculty positions, credentials and experience, or from being successful team leaders in PSPC and other Collaboratives. Faculty Coaches have diverse backgrounds, training and experience. They remain a collective body bound by their shared vision of the PSPC, to enhance the care of patients through close relationships with community organizations and partners. All new PSPC 3.0 teams will automatically be assigned a coach. Returning teams will be assigned a coach on an as needed basis.
An updated list of the PSPC faculty has been included in Appendix A. PSPC teams are encouraged to call on the faculty; specifically their coaches for support, assistance and guidance throughout their PSPC collaborative experience.

The Leadership Coordinating Council

The Leadership Coordinating Council (LCC) is comprised of nearly 150 professionals from national healthcare organizations and key stakeholders who provide support to the HRSA Patient Safety and Clinical Pharmacy Services Collaborative (PSPC) and its teams of frontline caregivers. The PSPC is a breakthrough effort to improve the quality of health care across America by integrating evidence-based clinical pharmacy services into the care and management of high-risk, high-cost, complex patients.

The LCC is committed to supporting and facilitating the goals of the Collaborative to increase patient safety and improve health outcomes through the integration of clinical pharmacy services into a primary health home. In addition to providing resources and support to teams, many of the LCC members actively serve as unofficial ambassadors, spreading news about the PSPC, encouraging additional organizations to become involved, and tapping into and amplifying the knowledge, practices, leaders and methods generated as a result of this work.

Professional organizations from various disciplines, national organizations, and other stakeholders have joined the LCC to provide support and leadership to the Collaborative. The LCC is helping to accelerate the success of the PSPC to ensure that leading practices will be disseminated more broadly throughout the healthcare system to improve patient safety and quality of care. The LCC convenes periodically to receive updates on teams’ progress and explore strategies for involving their respective constituents to achieve greater success moving forward.

Key Partners

The PSPC is structured using a team approach to support communities that are building partnerships around the patients they serve. CHCs, hospitals, clinics, School of Pharmacy, Health Departments, State Offices of Rural Health, and more are partnering together to accomplish the Aim. These partnerships are a key outcome of the PSPC and the success of the teams.

In addition, we work closely with our federal partners, Safety Net organizations, State Organizations, Pharmacy Organizations, Quality Organizations and Poison control Centers. A list of these partners can be found below:

- Federal Partners
  - Health Resource Services Organization (HRSA) Bureaus & Offices
  - Food and Drug Administration (FDA) Office of Women's Health
  - Agency for Healthcare Research and Quality (AHRQ)
  - Centers for Medicare & Medicaid Services (CMS)

- State Organizations
- Primary Care Associations (PCA)
- State Medicaid Offices
- Primary Care Organizations (PCOs)
- State Office of Rural Health (SORHs)
- State Hospital Associations
- Health Foundations

- Safety Net State Providers
  - Community Health Centers (CHCs)
  - Federally Qualified Health Centers (FQHCs)
  - Disproportionate Share (DSH) Hospital
  - Rural Health Clinics

- Safety Net Organizations
  - National Association of Community Health Centers (NACHC)
  - National Rural Health Association (NRHA)
  - Safety Net Hospitals for Pharmaceutical Access (SNHPA)
  - 340B Coalition

- Pharmacy Organizations
  - American Public Health Association (APhA)
  - American Association of Colleges of Pharmacy (AACP)
  - American Society of Health-System Pharmacists (ASHP)
  - American College of Clinical Pharmacy (ACCP)
  - Academy of Managed Care Pharmacy (AMCP)
  - National Association of Chain Drug Stores (NACDS)
  - Pharmacy Quality Alliance (PQA)
  - Institute for Safe Medication Practices (ISMP),
  - Pharmacy Services Support Center (PSSC)
  - 340B Prime Vendor

- Quality Organizations
  - National Quality Forum (NQF)
  - Institute for Healthcare Improvements (IHI)
  - Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
  - Poison Control Centers
Chapter 3: Change Package & Readiness for Action

The PSPC Change Package

The PSPC Change Package details the leading practices that together address the Aim and Goals of the PSPC. They are executed by the teams as they strive for transformation of their organization's healthcare delivery system. The Change Package has been developed through site visits to high performing organizations that have achieved significant results. It has been reviewed and vetted by a panel of national experts and serves as the catalogue of leading practices that teams will adapt using an accelerated improvement process.

The Change Package is an evolving document that has been honed as teams test and refine the leading practices in their patient care settings. It continues to improve as we move forward together as a learning community of practice.

PSPC Change Package Strategies and Change Concepts

The five major strategies and 15 change concepts found to be key components of high-performing organizations are as follows:

1. Leadership Commitment: Develop organizational relationships that promote safe medication-use systems and optimal health outcomes
   a) Foster a culture of quality and safety with a vision of integrated clinical pharmacy services to improve safety and health outcomes.
   b) Form partnerships to achieve a compelling vision by aligning and leveraging resources.
   c) Build the business case and foundation for the sustainability of integrated clinical pharmacy services.

2. Measurable Improvement: Achieve change using the value and power of data-driven improvements
   a) Collect, analyze, and disseminate the data that are necessary to guide improvement in process and results.
   b) Manage the delivery system on safety improvement by implementing safe practices and tracking safety outcomes.
   c) Manage the delivery system for improvements in health outcomes for high-risk patients.

3. Integrated Care Delivery: Build an integrated health care system across providers and settings that produces safety and optimal health outcomes
   a) Develop a delivery system with an established medical home and linkages with other providers and settings.
   b) Develop an integrated multi-professional care team that includes clinical pharmacy services.
   c) Coordinate care transitions among providers and settings, with medication reconciliation at each care transition.

4. Safe Medication Use Systems: Develop and operate by safe medication-use practices


a) Systematically introduce and institutionalize safe medication-use practices and monitoring procedures.
b) Establish on-site clinical pharmacy services.
c) Implement pharmacy services and safe medication practices in the absence of an on-site pharmacist.

5. Patient-Centered Care: Build a patient-centered medication-use system
   a) Engage patients and families in achieving safe care and optimal health outcomes.
   b) Establish patient self-management as a practice that is tracked and improved over time.
   c) Provide culturally appropriate services by developing the understanding and competencies that providers need to engage their patients.

Readiness

The “Readiness Stage” is the first stage in the development of clinical pharmacy services (CPS). In the Readiness Stage, the health system is committed to providing CPS and organizing their resources to implement. In this stage, there is little or no use of Plan - Do - Study - Act (PDSA) test cycle. The following guidance should be considered when assessing an organizations readiness:

1. Perform quick self-assessment using change package within this guide
   - What are the relationships I need to develop to perform on each strategy?
   - Who should we partner with?
   - What are the assets we have to carry out each strategy?
   - What are the assets we need to line up?
   - Who are the people to move this forward?
   - What will show it is working?

2. Organize information on the need for, and the benefits of, CPS
   - Have a case for the need for change
   - Use success story from another community
   - Identify acknowledged problem situations that would be improved by CPS
   - Use readily available data to make case for CPS.

3. Reach out and set communications with other interested parties up front
   - Use training to engage Senior Leaders
   - Identify individual provider interests
   - Talk to IT early and understand capacity for improvement through IT
   - Identify physician champions
   - Introduce case for CPS in strategic and operational planning
   - Ask leadership to charter the effort

4. Move partners and champions into place (organizations and providers)
   - Convene people that “want a change, have ideas for change”
   - Involve interested providers
• Involve patients and families on a planning committee
• Discuss information on benefits to CPS
• Document and share needs and interests
• Prepare for “first things first”

5. Identify potential high-risk populations of focus and map CPS
• Survey staff on what health status and medication risks to focus on
• Develop estimates of baseline patient flows.
• Draft referral criteria
• Draw CPS as a workflow integrated into current practice.
### Readiness for Improvement

On the Assessment Scale Checklist check off any item that applies to your team. What rating did your team assign itself, and why? In order to rate yourself at the next level, what does your team need?

<table>
<thead>
<tr>
<th>Assessment/Description</th>
<th>Definition</th>
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| **1.0 Forming team**   | - Team has been formed.  
  - Population(s) of focus identified.  
  - Data collection system being set up to track performance. |
| **1.5 Planning for the project has begun** | - Team is meeting, discussion is occurring.  
  - Components of the change package are being set up for testing.  
  - Baseline measurement has begun. |
| **2.0 Activity, but no changes** | - Team actively engaged in development, information gathering.  
  - No more than one change has been tested. |
| **2.5 Changes tested, but no improvement** | - Multiple changes are being tested in more than one component of the change package, but no improvement in measures has been noted.  
  - Data on key measures are reported. |
| **3.0 Modest improvement** | - Initial test cycles have been completed.  
  - Implementation has begun for more than two strategies in the change package.  
  - Evidence of moderate improvement in the consistent delivery of clinical pharmacy services to population of focus. |
| **3.5 Improvement** | - Some improvement in outcome measures.  
  - Process measures continuing to improve.  
  - PDSA test cycles on multiple components of change package. |
| **4.0 Significant improvement** | - Evidence of sustained improvement in outcome measures.  
  - Halfway toward accomplishing all of the goals.  
  - Plans for spread of the improvement are in place. |
| **4.5 Sustainable improvement** | - Sustained improvement in most outcome measures.  
  - 75% of goals achieved in population of focus.  
  - Spread to a larger population has begun. |
| **5.0 Outstanding sustainable results** | - Major changes in several strategic areas have been implemented.  
  - All goals of the team’s aim have been accomplished.  
  - Outcome measures at national benchmark levels.  
  - Spread to another facility is underway. |
Chapter 4: What PSPC 3.0 Teams Can Expect

Purpose: Guide teams in understanding what to expect through their participation in the PSPC 3.0 with the support of the HRSA PSPC faculty coaches.

Developing an Aim Statement

An Aim statement is a written, measurable, and time-sensitive statement of the expected results of an improvement process. It includes a numerical measure for a future target or goal and defines the specific population that will be affected. Having an aim statement that all team members agree upon helps align interests to experience success. Throughout the PSPC, the aim statement will serve as a compass—it will guide the teams during their improvement effort by clearly describing the parameters of what they want to accomplish.

How to Set the Team’s Aim. Be sure to do the following:

1. Involve senior leaders. Leadership must align the Aim with the strategic goals of the organization.

2. Base the Aim on both data and organizational needs. Examine the data within the organization to help guide the establishment of an appropriate Aim. Refer to the measurement section and focus on issues that matter to the organization.

3. PSPC improvement teams using the Change Package should make sure the Aim mentions “redesign of the system of care based on the Change Package.” The Change Package provides the framework for changing (redesigning) the system of care integrating clinical pharmacy services. If you are using another quality model such as the Care Model to organize your changes as well, you may consider incorporating in your Aim statement. State the Aim clearly and use numerical, measurable goals. Teams will have a clear picture of the changes that need to be made if the Aim is unambiguous and clearly stated. We encourage you to list the measures you will track in your Aim.

**Adapted from Healthcare Communities Knowledge Base Article (10/27/2009)**

Determining a Population of Focus (POF)

The PoF is a panel of patients whose care the team can track and manage. It should be design to make it easy to detect improvements. The panel can be closed (once a certain number is reached no more patients are added) or it can be open (always adding patients). The “first visit” for integrated CPS enrolls the patient in the panel and creates the base line conditions for calculating improvement. Teams are advised to pick high risk patients whose conditions are out of control at baseline. Subsequent visits are expected to bring the health status and safety conditions under control.
**Population of Focus at Scale Up**

The Population of Focus at Scale Up: the total number of patients with same PoF health status marker conditions and risk. As a team advances in the PSPC collaborative process, they begin to scale the Populations of Focus up (initial spread) to serve all patients with the same risk and health status markers.

**Population of Service (POS)**

In most cases the PoF is a small proportion of the total high risk population with the health status marker. There are other high risk groups served by organizations that can benefit from Clinical Pharmacy Services (CPS) interventions. As a team advances in the PSPC collaborative process they begin to scale the Populations of Focus up to serve all patients with the same risk and health status markers. At some point teams spread the program to other high risk groups defined by different health status markers. This is referred to as the Population of Service (POS).

**Population of Care (POC)**

The Population of Care (POC): the total population of care for the primary health care home. This would include those patients who could benefit from CPS interventions as well as patients who do not need the more integrated, intensive attention from CPS.
POF Example
The example below helps illustrate the process steps a team will take to determine their Population of Focus.

Sunshine Healthcare's POF Statement:
Our population of focus will initially consist of 50 diabetic patients who have an HbA1c >9% and are on 4 or more prescription medications.
Chapter 5: Clinical Pharmacy Services

Because medications play an integral role in improving patient care and related health outcomes, the primary emphasis in this Collaborative is on the improvement and integration of healthcare delivery systems which maximize use of clinical pharmacy services and safe medication practices that ultimately result in improved patient outcomes. This includes transitions and handoffs between provider organizations, outpatient health center care and inpatient hospital care settings.

A key component of the Collaborative is to increase awareness of the benefits of clinical pharmacy services among healthcare providers and to promote the integration of clinical pharmacy services into the interdisciplinary healthcare team which includes building effective partnerships amongst both the public and private sector. PSPC defines clinical pharmacy services as patient-centered services that promote the appropriate selection and utilization of medications to optimize individualized therapeutic outcomes. Clinical pharmacy services are provided by an inter-disciplinary professional healthcare team through individualized patient assessment and management. These services are best provided by a pharmacist or by another healthcare professional in collaboration with a pharmacist. Listed below are examples of strategies concepts and action items associated with the Change Package teams have used in providing CPS to their patients.

*The list below is only examples, and that these examples may not apply to every organization.*

1. **Medication Access Services to Patients**
   Utilization of drug programs and strategies with the goal of obtaining a sustainable source of medications for patients that will improve access to care

2. **Patient Counseling**
   Patient routinely interacts with a licensed health care provider when medication is picked up

3. **Preventive Care Programs**
   Refer appropriate patients for evaluation and treatment

4. **Drug Information Services to Patients**
   Written or verbal patient-friendly and culturally competent drug information

5. **Medication Reconciliation Services**
   Identification of one accurate list of medications and recommendations and changes to optimize therapy as appropriate. Facilitation of communication of accurate medication list between patient, prescribers and other health care professionals

6. **Provider Education**
   Deliver evidence-based medical information to providers that focus on the place in therapy and adverse effects associated with medication

7. **Retrospective Drug Utilization Review**
Periodic chart reviews in coordination with quality improvement for purpose of evaluation organization performance in areas of medication prescribing and/or monitoring

8. **Medication Therapy Management (MTM)**
   Non-drug specific, non-disease specific and may include poly-pharmacy management, high risk/high alert medication management, and/or adherence/compliance education

9. **Disease State Management**
   Provision of medication-related assessment and education within defined medical conditions or therapeutic indications

10. **Prospective Chart Review and Provider Consultation**
    Prospective review of patient medical chart for purpose of providing recommendations to prescribing practitioner regarding medication adjustments on the day of a medical encounter.
Chapter 6: Healthcare Communities (HC)

The Healthcare Communities website is a knowledge management system. The components collectively assist users in their current and future improvement activities. The components include the following: 1) communication portal; 2) National Results Sharing Site (NRSS); and 3) Help Desk. The communication portal is used by the PSPC to share tools, ideas, best practices, results, etc. among healthcare delivery organizations with each other. It consists of areas used to share information with the general public, such as the public Resource Center and Tag Cloud and restricted area for the PSPC community of practice where users have access to post forum topics, manage improvement resources, collaborate across teams using a the PSPC Teams listservs and manage events in the PSPC calendar.

The NRSS (http://results.healthcarecommunities.org/) enables teams to share qualitative and quantitative outcomes in a secure non-judgmental, learning environment. Results are aggregated at the state, region, and national level.

The National Help Desk provides multiple levels of web based quality improvement support facilitated by community based subject matter experts and serves as a centralized repository of issues commonly faced, along with some tested resolutions, all in an easy to navigate area. The help desk serves one method to ask any type of questions to be answered by the PSPC Faculty Coaches. Processes have been incorporated to archive issues resolved and make the same available in a knowledge base article.

A significant variable in a team’s success is communication and the ability to learn from others that have tested similar strategies for a similar population or healthcare delivery system. The PSPC Collaborative is based in “All Teach All Learn”. PSPC Teams have the ability to offer support and make requests utilizing the knowledge management system. Teams should request membership at www.healthcarecommunities.org. If you are a member of PSPC1.0 or PSPC2.0 or previously created a HRSA Knowledge Gateway account, please enter your email address in the user name field and enter the same password you used the KG in the password field. If you do not remember this password, click “Forgot Password?” This is the first step in confirming your access to the PSPC Community. Additional instructions for creating a new account can be found in the Registration How to Video on the Help page of the website.
Once you are logged into the site, if you are not already a member of the PSPC Community you should locate the PSPC Community by navigating to My Communities, Choose the Available Communities tab, scroll down to PSPC and then and Request to Join.
Once registered, PSPC Community members have access to the following: 1) Announcements; 2) Emerging Content; 3) Discussion Board (Community Forums); 4) Upcoming Events; 5) Community Calendar; 6) Browse and Upload Documents; 7) Suggest A Resource; and 8) Listserv. The illustration below is a snapshot of the PSPC Community.
National Results Sharing Site

The National Results Sharing Site is used to share qualitative and quantitative data. PSPC Teams will share qualitative results through the Monthly Progress Report. Quantitative outcomes are shared through the team specific template of measures.

Teams enter their results in a Microsoft Excel based spreadsheet. This spreadsheet provides the team with measures specific graphs of their results. As teams upload their results by the 10th of the month, the NRSS aggregates the outcomes at the state, region, and national level.

Teams will be asked to define their Population of Focus and determine at least one health outcomes to measure. Each month (by the 15th) teams will upload their results from the previous month. For example – by October 15th, a team should upload their results template for the population outcomes achieved in September.

Teams participating in the Patient Safety and Pharmacy Collaborative are asked to share and report their progress on a monthly basis. The reporting process is useful to the team, faculty and the broader PSPC Collaborative. The PSPC Faculty accesses their team’s individual results through the Reports. The faculty is more equipped to design and provide the technical support teams need to advance their improvement efforts.

Monthly Progress Report

The team’s monthly progress report is one tool to help communicate the work of the team, activities, and progress toward stated goals. The report is intended to help teams track their PDSAs, communicate lesson learned, and document the improvement process and strategies tested throughout the PSPC Collaborative learning year. The team’s activities and progress toward stated goals are organized to share information with the organization’s leadership, partnering organizations such as schools of pharmacy, team members, coach and the HRSA core team. The Report may be completed and uploaded by any member of your PSPC team. The report reflects the efforts of the entire team. Teams have reported that this process enables all members of the team to contribute to its content. Within the NRSS – the Monthly Progress Report is referred to as the Senior Leader Report (SLR).

The monthly progress report consists of five sections each of which is described in detail below. Section one a list of your partnering organizations, team members, aim statement and your POF or POS to whom you are targeting your current improvement. Section two records the team’s test of change performed in the month. Section 3 is the 30-second status report. Teams should complete and update this each month. Section 4 results of the “readiness for improvement” rating. Section 5 team can highlight anything else impacting their work in PSPC. This may include successes, barriers, lessons learned from testing and implementing changes, and the impact of the collaborative on your team of organizations.
For ease of retrieval, it is recommended that you save your files in a consistent format. A team may save their monthly progress report file using their User Name Code, Month and Year (i.e. MA201mprOCT10.doc). In a similar manner, a team may save their Excel Key Measure Spreadsheet using their User Name Code, Month and Year (i.e. MA201dataOCT10.xls).

The following pages will provide a view into the National Results Sharing Site. Additional detail will be provided.

- New PSPC 3.0 Teams will be provided a User Name and Password for access to the NRSS. This is a team based User Name and Password. It is different from the team member individual accounts in the main site.
- Additional team members can be added through the Utilities function. Select Utilities > Improvement Organization > Users > Associates.
• Download the Team Specific Excel Based Template of Measures

• Upload the Team Specific Excel Based Template of Measures
If a team receives an error when uploading their results, they can select Help from the drop down menu and sends a message to the website team.

FAQs can be accessed under Help.
How-to Guide for Improvement Organizations

Q: How do I upload my Monthly Reports?
A: To upload your monthly reports follow these steps:

1. Point to the Files menu and choose Upload
2. Under the Date header, make sure you choose the month that corresponds to the date for which you are reporting.
   If your report was due April 1, 2009, you should choose Apr 2009
3. After you have selected the proper date, click the Browse button next to the appropriate upload box to locate the report you are attempting to upload. For example, if you are uploading your Excel Key Measures Spreadsheet for the MEDS Quality Measures choose the Browse button next to that item
4. Once you have located and selected the file, you should see the local path to your file populated in the box to the left of the Browse button
5. Continue to follow these steps for any additional files you need to upload. Once you have browsed to each of the files you need to upload, click the Upload Files button at the bottom of the page
6. Wait for the confirmation that the files were uploaded, 'Files Uploaded'
7. If you receive any message other than the one indicated above 'Files Uploaded', your files have not been uploaded.
PSPC Help Desk

The Help Desk enables team members to ask questions or make a request to the PSPC faculty Coaches. The request generates a Help Desk ticket and sends a message to the coaches. Coaches may answer directly allowing others coaches to benefit from the interest/ request and knowledge shared. Coaches may also conference on a topic and generate dialogue concerning the improvement topic with their group of teams. The ticket that is generated is only complete when the team member has indicated that the issue has been resolved.

Measurement & Collection of Measures

PSPC teams will track and share improvements as a result of providing Clinical Pharmacy Services (CPS) in two areas: health and safety. The faculty coaches and Core Team are available to provide teams guidance on collection tools and strategies to capture the necessary data and how to use data to estimate improvement due to CPS. Below you will find a brief overview of core health outcomes markers as well as a discussion on the safety measures teams will be expected to track. Teams are invited and encouraged to track additional measures in addition to these core measures. Core measures are collected to measure the impact the PSPC is having on the high risk populations we serve. Teams will collect and share their measurement results on a monthly basis.
Outcome Measures

Teams should choose at least one health outcome marker to track for the patients receiving CPS in their PoF. The data will be used by the team to estimate improvements in health as they receive CPS over time.

<table>
<thead>
<tr>
<th>Health Outcome</th>
<th>Primary Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticoagulation</td>
<td>Patients in the PoF on warfarin whose INR is within the treatment range (example INR Range 2.3)</td>
</tr>
<tr>
<td>Asthma</td>
<td>Patients in the PoF with persistent asthma on controller therapy (e.g., ICS, LTRA, Cromolyn)</td>
</tr>
<tr>
<td>Depression/Mental Health</td>
<td>Patients in the PoF with a positive depression status based on valid measurement tool</td>
</tr>
<tr>
<td>Patients with Diabetes</td>
<td>Primary: Patients in the PoF with an A1C &gt; 9%</td>
</tr>
<tr>
<td></td>
<td>Secondary: Patients in the PoF with an A1C &lt; 7%</td>
</tr>
<tr>
<td>Dyslipidemia</td>
<td>Patients in the PoF whose LDL is at goal (example: LDL goal for primary prevention patients with DM: &lt;100 mg/dL)</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Patients in the PoF with AIDS who are on HAART</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Patients in the PoF whose blood pressure is at goal given comorbid conditions (example: no comorbidities BP &lt; 140/90 mmHg or DM/CKD/CAD or high risk CAD &lt; 130/80 mmHg)</td>
</tr>
<tr>
<td>Hemophilia</td>
<td>Patients in the PoF with hemophilia with no bleeding episodes since the last visit</td>
</tr>
</tbody>
</table>

Safety Measures - Adverse Drug Events and Potential Adverse Drug Events (ADE & pADE)

Teams should track the number of ADEs detected and the number of pADEs detected and prevented for their PoF patients as they receive CPS. The data will be used by the team to estimate improvements in safety over time.

**ADEs:** Events that result in harm or injury to the patient due to medication use. Example: Heart failure symptoms as a result of Actos (pioglitazone) administration.

**pADEs:** Potential harm that was identified and avoided with appropriate interventions before reaching the patient. Example: A care team member notices a duplication of drug therapy
(lisinopril and ramipril) and intervenes to have one of the medications discontinued before the patient receives the medication.

**Spread**

Spread refers to the intentional and methodical expansion of the number and type of patients, units, or organizations using the improvements. The theory and application comes from the literature on the concept of Diffusion of Innovation. In clinical quality improvement work, this expansion could be to other patients, providers, and sites. In the graphic below, note the two orange arrows representing very different forms of spread in Example B and Example C. **Example B** indicates a visual of what a PSPC team may initially focus their spread efforts. In this example, the team is following the same disease marker integrating Clinical Pharmacy Services (CPS) but are now including all patients diagnosed with this disease marker into their

**Population of Focus at Scale Up** or Spread.

**Team Example B: Population of Scale Up/Initial Spread**

**Sunshine Healthcare's PoF at Scale up or Initial Spread:**

*During our initial spread of CPS, we will spread lessons learned from working with our initial POF and spread*
Example C indicates a team who may have already "scaled up" or spread to all their patients diagnosed with a specific disease marker and now want to incorporate CPS to include another high risk population, focusing on an additional disease marker. Most teams, when incorporating a new disease marker will develop a new Population of Focus.

Team Example C: Population of Service to Identify Spread

<table>
<thead>
<tr>
<th>Population of Care (PoC):</th>
<th>Sunshine Healthcare serves 10,000 patient per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population of Service (PoS):</td>
<td>Sunshine Healthcare initially focused on 50 of their highest risk patients with diabetes and on 4 or more prescription medications. They then successfully took lessons learned and spread CPS to all of their patients diagnosed with diabetes. Sunshine Healthcare has now identified patients with hypertension as another population who could benefit from Clinical Pharmacy Services (CPS).</td>
</tr>
<tr>
<td>Population of Focus at Scale Up: Initial Spread</td>
<td>500 of Sunshine Healthcare's high risk patients (PoS) have diabetes</td>
</tr>
<tr>
<td>Population of Focus (PoF) during initial year of PSPC</td>
<td>Sunshine Healthcare’s population of focus initially consisted of 50 diabetic patients who had an HbA1c &gt;9% and were on 4 or more prescription medications</td>
</tr>
</tbody>
</table>

Population of Service for CPS Spread:

Through involvement in the PSPC Collaborative, Sunshine Healthcare initially focused on 50 of their highest risk patients with diabetes and on 4 or more prescription medications. They then successfully took lessons learned and spread CPS to all of their patients diagnosed with diabetes. They will now take lessons learned and begin to spread to patients diagnosed with hypertension. They will initially focus on spread to 50 of those hypertensive patients out of control with a co morbid condition of diabetes and on multiple prescription medications.

Note: Teams should continue to track progress on their initial POF and population of scale up (or disease state). Teams want to ensure they hold the gains made. Continued tracking and reporting of these populations allows the team to work with patients should the measures "slip" before a patient is seriously ill or impacted by adverse events.
Excel Key Measures Spread Sheet

Data is reported on the Excel Key Measures Spread Sheet. This excel report is customized for each of the PSPC teams. The report contains a core measure as selected by the team based on the disease state(s) chosen for their improvement efforts, as well as safety measures relating to Potential Adverse Drug Events pADE’s and Adverse Drug Events (ADE’s). Additionally, teams may request to follow optional additional measures or add measures as they move forward with their improvement efforts. This report or template is available after you log in with your organizational level login to the National Results Sharing Site under the “Utilities” menu on the “Download Template” page. Below please find an example of one organization’s Excel Key Measures Template.

<table>
<thead>
<tr>
<th>Month</th>
<th>DIABETES MELLITUS</th>
<th>ANTI-COAGULATION THERAPY [INR CONTROL]</th>
<th>PATIENT SAFETY (ADEs and pADEs)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percentage of patients in the PwP whose most recent hemoglobin A1c level is greater than 9%</td>
<td>Percentage of patients in the PwP whose most recent hemoglobin A1c level is less than 7%</td>
<td>Percentage of patients in the PwP who are on anticoagulant therapy, whose most recent INR is within goal</td>
</tr>
<tr>
<td></td>
<td>Percentage Change/Percentage Improvement (Percentage of patients with HbA1c &gt; 9%)</td>
<td>Number of patients in the PwP whose most recent hemoglobin A1c level is less than 7%</td>
<td>Total number of patients from the PwP on anticoagulants</td>
</tr>
<tr>
<td></td>
<td>Number of patients in the PwP whose most recent hemoglobin A1c level is greater than 9%</td>
<td>Number of patients in the PwP whose most recent hemoglobin A1c level is greater than 9%</td>
<td>Total number of patients with anticoagulants with INR within therapeutic range</td>
</tr>
<tr>
<td></td>
<td>Number of Patients receiving the CPS</td>
<td>Number of ADEs detected in the month</td>
<td>Rate of ADEs detected per patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total number of patients screened for ADEs in the month</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Number of pADEs identified and prevented in the month</td>
</tr>
</tbody>
</table>

As entries for the numerator and denominator for each measure is entered, the resulting calculation is provide. This function in combination with the graphs tab enables teams to review the result entries and use these outcomes to plan appropriately.
Chapter 7: Grantsmanship

Grantsmanship is a great way to either launch or expand your integrated Clinical Pharmacy Services. Grants of all sizes are available locally and nationally through government agencies, professional organizations, pharmaceutical companies, charitable foundations, etc. Some grants are extremely competitive and require very strict formatting, extensive documentation, and a formal study design (e.g., NIH grants), while others are relatively simpler and align very well with the goals of safety net organizations (e.g., charitable foundations, professional organizations). If you are a team that is new to searching for grant opportunities, a great place to start is [http://www.foundationcenter.org/findfunders/](http://www.foundationcenter.org/findfunders/). This website helps you locate foundations that offer grants in your geographic region; you can search for foundations by name, state, or zip code. Zip code is preferred because some foundations offer grants to specific subsections of a city.

Regardless of which granting agency you choose, there are several key elements to consider that will maximize your chances of getting funded:

- **Communicate with the grant program officer** - The job of the program officer is to ensure that the grant funds are awarded to deserving applicants. The program officer can help clarify the goals of the Request for Proposal and, if the goals of the applicant organization are clearly aligned with the foundation, then the program officer can help give you feedback on how to maximize the strength of your proposal. In addition, the program officer will often speak to the review committee.

- **Clarify restrictions on use of grant funds** - Grant opportunities may limit how funds can be spent. Some grants may restrict funds to supplies and equipment only, while others allow for personnel costs.

- **Consider partnering with a school of pharmacy** - Partnering with a school of pharmacy on a grant proposal offers many advantages to a PSPC team, as well as the pharmacy school. First of all, schools of pharmacy typically have resources and expertise dedicated to Grantsmanship and can take the lead on preparing and submitting the proposal. In addition, pharmacy schools are often able to identify the best pharmacists or pharmacy residents to provide grant-funded CPS. For pharmacy schools, pursuing grants are a core part of their mission, and partnerships with community clinics may provide an opportunity for pharmacy students and residents to participate in the care of patients while learning about clinical therapeutics, cultural competency, health literacy, etc.

- **Sustainability of program after grant funding is complete** - Funding for clinical programs from granting agencies almost always requires a sound plan for sustaining the programs after grant funds have been depleted. The plan may include funding by the community clinic as a result of a return-on-investment analysis, cost-sharing with collaborating organizations, additional grant funding for a second phase, etc. Funding agencies want
assurance that they are making a wise investment that will grow and spread rather than a short-term experiment.

Chapter 8: Publishing the Performance Story

Who needs to hear the story about your team’s impact and performance? Everyone! Spreading the news about your successes will generate broad awareness among payers, patients, providers, and elected officials of the impact that integrated clinical pharmacy services have on patient health outcomes, medication safety, and cost savings. It may also attract new teams into PSPC, both as school and clinic participants and as supporters/collaborators. However, getting your story circulated can sometimes be challenging. Here are some tips on how to be successful:

- **Develop a public relations strategy**: The strategy you employ should emphasize the transformation you have gone through to integrate clinical pharmacy services into your organization, focusing on the complexity of medication regimens today in light of the increased prevalence and incidence of chronic diseases, particularly among the underserved and elderly. You can also promote the umbrella theme that integrated clinical pharmacy services help improve health care quality while lowering costs in the form of more efficient and cost-effective drug formularies and less use of health care resources including primary care provider visit frequency, urgent care visits, and hospitalizations.

- **Seek local targets**: While we would like to see PSPC shared in the national media, which is happening through the complement of teams in major markets, teams should focus on local targets - local newspapers (including suburban rags), weeklies, TV, radio. Further, getting the story shared through trade groups and associations is a good approach to reaching the target audiences in local markets. For example, reaching out to Chambers of Commerce and similar groups provides an opportunity to showcase the value of integrated clinical pharmacy services and gives local media a reason to cover the story.

- **Employ effective public relation tactics**:
  - Identify “media stars” on your team (physicians, pharmacists, patients, payers) and develop a media advisory (one pager - who, what, where, why, how). Patient testimonials can be particularly powerful for the general media, particular those involving a major transformation in health care associated with clinical pharmacy service integration. Make available interviews with the players on the team. Make available clinic photo / video shooting.
  - Offer a Q & A for local print media, radio, TV with your clinical pharmacy service professionals on a hot topic that is dealt with in the clinic (getting patients immunized, diabetes management, smoking cessation, childhood obesity, cost savings, etc). Tell the story of the clinic while also providing readers/viewers/listeners with clinical pharmacy service expertise applicable to the needs of the general public as well.
• **Keep everything should be in simple terms:** For example-
  
  o Today's medicines are complex and the “traditional” role of physicians as solo practitioners has resulted in a rushed and overworked system of health care.
  
  o Adding clinical pharmacy services to the health care team for medication therapy management in clinics nationwide is improving patient health outcomes, avoiding dangerous medication side effects, and saving money. (Give simple #s - XX patients reached therapy goals while clinics saved XX dollars)
  
  o If speaking of the competency of pharmacists: Pharmacists undergo an intensive 4-year postgraduate education, resulting in a Doctor of Pharmacy degree, that focuses on ensuring that the right drug is given to the right patient at the right dose, while minimizing or avoiding dangerous side effects and drug interactions.
  
  o Integrating clinical pharmacy services into medical homes is nothing new, it has been done for decades in the Department of Veterans Affairs, Kaiser Permanente, and medical practices across the country in states that have supported an expanded role for pharmacists. PSPC is just expanding these past successes to meet today's needs - helping the most vulnerable in clinics across the country but also working shoulder-to-shoulder with physician colleagues in clinics, hospitals, and community pharmacies.

• **Interested in publishing in a health care journal?** Partner with a health care professional school! Publishing in health care journals can be complicated, particularly if you are not familiar with which journals match best with your story, or the process of peer review or manuscript submission. Fortunately, journal publication is essential for every academic institution, so why not let an academic institution manage the complexities of the manuscript submission process? Schools of pharmacy are the natural partners, but you should also reach out to schools of medicine, nursing, or any health care professional school that represents a member of your PSPC team.

**Chapter 9: Pre-work for LS 3/1 & Team Exercises**

A team goes through several stages to integrate Clinical Pharmacy Services (CPS) into their delivery system. Prior to being able to track progress the team will:

1. **Define and focus on a very high-risk patient population**
2. **Describe patient population quantitatively with fast data collection methods**
3. **Organize the group as a patient panel to be managed for performance**
4. **Integrate Primary Care with CPS and set expected patient service schedules**
5. **Spread CPS to additional patients outside the initial POF or disease marker**
6. **Begin to share your teams PSPC Improvement Story**
PSPC 3.0 teams will complete Pre-work for LS 3/1 around Stages I – VI that will help your team prepare for the PSPC3.0 Learning Period. Since teams are at various levels integrating CPS into their organizations, teams will be broken up and provided assignments. Your team will find their assignment by color code that outlines the pre-work your team is to complete below. You will note there are a number of exercises. Some of these exercises will be completed during pre-work and others will be assigned to teams throughout the learning year. Teams will learn which exercise to complete and report each month on the Monthly PSPC ALL Team calls. These calls occur the second Tuesday of each month at 12:00 pm - 1:00 pm EST. Listserv reminders are generated for teams regarding this call series.

**Pre-work Assignments**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>
| **Green Teams** | **Complete Exercises 1 - Aim & POF**  
**Complete Exercise 15 - Change Package Assessment Tool** |
| **Orange Teams** | **Complete Exercise 13 - Publishing your Performance Story (A)**  
**Complete Exercise 15 - Change Package Assessment Tool** |
| **Blue Teams**  | **Complete Exercise 14 - Publishing your Performance Story B**  
**Complete Exercise 15 - Change Package Assessment Tool** |

The purpose of the **Team Exercise** is to offer a vehicle to organize your work in a systematic and logical process. Each of the **Team Exercises** that will occur throughout the collaborative has been organized numerically below. These exercises will be highlighted on various PSPC team calls. During these calls, teams will receive instructions on how to complete each exercise as well as which exercise is appropriate for their team as categorized by the team color structure. Providing the exercise in advance allows teams the opportunity to see upcoming events and even "work ahead" with the support of their faculty coach where appropriate.

Each exercise ensures proper documentation of the work being done as well as lays the foundation in an easy to understand story line for those who will learn from you, both in your organization and the community at large.

**Team Exercises:**

1: Team Composition, Team Aim & POF  
2: Urgency, the high-risk nature of the population of focus  
3: CPS, the new service we are putting in place to make a difference  
4: Strategic significance: Magnitude of the possible scale-up and spread of CPS  
5: Health status improvement baseline and expected trends  
6: Safety improvement baseline and expected trends
Monthly performance trends in delivering service and improvements
Cost and Revenue Experience
The integrated primary care & CPS delivery systems model being adopted
Performance factors for scale up and spread
Team Agenda: Expansion of CPS to the Population of Service
Grants
Publishing the Performance Story
Publishing the Performance Story
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Appendix B: Change Package Self Assessment Tool

The five major strategies and 15 change concepts found to be key components of high-performing organizations are listed below.

For each change concept rate your team’s performance using the following 1-3 scale

1. No Activity
2. Started but not implemented
3. Implemented and moving forward

**Strategy: Leadership Commitment:**

*Develop organizational relationships that promote safe medication-use systems and optimal health outcomes*

___ Foster a culture of quality and safety with a vision of integrated clinical pharmacy services to improve safety and health outcomes.
___ Form partnerships to achieve a compelling vision by aligning and leveraging resources.
___ Build the business case and foundation for the sustainability of integrated clinical pharmacy services.

**Strategy: Measurable Improvement:**

*Achieve change using the value and power of data-driven improvements*

___ Collect, analyze, and disseminate the data that are necessary to guide improvement in process and results.
___ Manage the delivery system on safety improvement by implementing safe practices and tracking safety outcomes.
___ Manage the delivery system for improvements in health outcomes for high-risk patients.

**Strategy: Integrated Care Delivery:**

*Build an integrated health care system across providers and settings that produces safety and optimal health outcomes*

___ Develop a delivery system with an established medical home and linkages with other providers and settings.
___ Develop an integrated multi-professional care team that includes clinical pharmacy services.
___ Coordinate care transitions among providers and settings, with medication reconciliation at each care transition.

**Strategy: Safe Medication Use Systems:**

*Develop and operate by safe medication-use practices*

___ Systematically introduce and institutionalize safe medication-use practices and monitoring procedures.
___ Establish on-site clinical pharmacy services.
___ Implement pharmacy services and safe medication practices in the absence of an on-site pharmacist.

**Strategy: Patient-Centered Care:**

*Build a patient-centered medication-use system*

___ Engage patients and families in achieving safe care and optimal health outcomes.
___ Establish patient self-management as a practice that is tracked and improved over time.
___ Provide culturally appropriate services by developing the understanding and competencies that providers need to engage their patients.
# Appendix C: PDSA Worksheet

## CYCLE FOR LEARNING AND IMPROVEMENT

### Written by:

### Date:

### Objective:

### PLAN:

### PREDICTION:

### DO:

### STUDY:

### ACT:
Appendix D: Monthly Progress Report

Patient Safety and Clinical Pharmacy Services Collaborative 3.0

Team Name: __________________________
Login: __________________________
Name of Person Completing Report: __________________________
Email Address: __________________________

Monthly Progress Report (Upload by the 10th of each Month)

Section 1: Background

A. List of partner organizations and role

<table>
<thead>
<tr>
<th>Organization</th>
<th>Role</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

B. Team members

<table>
<thead>
<tr>
<th>Team Members Name</th>
<th>Organization</th>
<th>Role</th>
<th>Email Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

C. Team message/ motto:

D. Aim: (Give a 1-3 sentence expression of what you intend to accomplish as a team)

E. Population of Focus/Population of Spread: (Describe your population of focus by identifying the health outcome marker you will track and the most important safety issues you will focus on)

Section 2: PDSA Results utilizing Change Package

Instructions:

Please provide a description of the Three Tests of Changes that taught you the most this month. The chart on this and following pages is to be updated monthly. Categorize each test by the appropriate Strategy in the Change Package.
Include descriptions of cycles where changes to your system have been tested.

Be brief, but include enough detail to enable the reader to answer the following questions: 1) What change was tested? 2) who and what processes were involved? , what were the results? , and what is the next action step? Add new rows as needed.

There may be some overlap in the descriptions from month to month. Highlight the significant learning each month. Enter in Bold Letters the item that was the most successful and that the team would want to share with others.

You should add at least three new changes in play each month. They may fall into categories. All strategies do not need to be addressed in each month’s report.
<table>
<thead>
<tr>
<th>Change Package</th>
<th>Component Area</th>
<th>Concept and Action Item Tested</th>
<th>Improvement Outcome Result</th>
<th>Date (MO/YR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Readiness</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Things First</td>
<td></td>
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<tr>
<td><strong>Leadership Commitment</strong></td>
<td><strong>Partnerships</strong></td>
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<td></td>
<td><strong>Safety, Quality Culture</strong></td>
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<td></td>
<td><strong>Business Case</strong></td>
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<tr>
<td><strong>Measureable Improvement</strong></td>
<td><strong>Manage Health</strong></td>
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<tr>
<td></td>
<td><strong>Manage Safety</strong></td>
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<tr>
<td></td>
<td><strong>Performance Data</strong></td>
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<tr>
<td><strong>Patient Centered Care System</strong></td>
<td><strong>Patient Engaged</strong></td>
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<td></td>
<td><strong>Self Management</strong></td>
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<td></td>
<td><strong>Culturally Appropriate</strong></td>
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<tr>
<td><strong>Integrated Care Delivery System</strong></td>
<td><strong>Health Home</strong></td>
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<td></td>
<td><strong>Care Team</strong></td>
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<td></td>
<td><strong>Care Transitions</strong></td>
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<tr>
<td><strong>Safe Medication Use Systems</strong></td>
<td><strong>Best Practices</strong></td>
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<td></td>
<td><strong>CPS On-site</strong></td>
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<tr>
<td></td>
<td><strong>CPS Networks</strong></td>
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<tr>
<td><strong>Other</strong></td>
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</tbody>
</table>
Section 3: 30-Second Status Report (please update each month)

__ Yes  __ No  The data collection system is in place on the population of focus to track patient services and changes in their health status and safety.

__ Yes  __ No  Clinical pharmacy services are in place to service the population of focus in a systematic and disciplined way.

__ Yes  __ No  Our business strategy and plan is in place that will make the CPS financially sustainable in the near future.

Has your team been able to develop data** and comparisons** that you use to demonstrate:

__ Yes  __ No  Improvement in health status of the patient panel (population of focus) over time, as a result of clinical pharmacy services

__ Yes  __ No  Improvement in patient safety through the detection of pADEs and reduction of ADEs for the patient panel (population of focus) over time, as a result of clinical pharmacy services

Section 4: Readiness for Improvement Scale

On the Assessment Scale Checklist, found in your workbook check off any item that applies to your team and answer the three questions below.

<table>
<thead>
<tr>
<th>What rating did your team assign itself?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why did you assign this rating?</td>
</tr>
<tr>
<td>In order to rate yourself at the next level, what does your team need?</td>
</tr>
</tbody>
</table>

Section 5: Summary

Summarize any activities or events that have taken place over the past month that were not mentioned in the other categories of this report. Include what you are learning (i.e. successes, barriers, lessons learned from testing and implementing changes, and the impact of the collaborative on your organization). Use this category to communicate any additional information that will help to convey a clear picture of your efforts.
Appendix E: Glossary of Terms and Acronyms

340B DRUGS - The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act. Section 340B limits the cost of covered outpatient drugs to certain federal grantees, federally-qualified health center look-alikes and qualified disproportionate share hospitals. Significant savings on pharmaceuticals may be seen by those entities that participate in this program.

Action Period - Is the period between the learning sessions. During Action Periods, Collaborative participants work with their organizations and test on a small scale multiple changes from the Change Package. Teams test and adapt all changes to achieve their goals and work to spread the successful changes implemented. Teams remain in continuous contact with other Collaborative participants and faculty through conference calls, e-mails and webinars.

ADEs: Events that result in harm or injury to the patient due to medication use. Example: Heart failure symptoms as a result of Actos (pioglitazone) administration

ADAP - The AIDS Drug Assistance Program (ADAP) provides medications for the treatment of HIV disease. Program funds may also be used to purchase health insurance for eligible clients and for services that enhance access to, adherence to, and monitoring of drug treatments. The program is funded through Part B of the Ryan White HIV/AIDS Treatment Modernization Act (formerly known as the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act) which provides grants to States and Territories.

ADE / pADE - Adverse Drug Event and Potential Adverse Drug Event. See: Vocabulary and Glossary of Terms

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. See example Aim Statements and learn about How to Develop a Quality Improvement Aim Statement

Assessment Scale - A numerical scale that teams can use to assess the progress of participating teams toward reaching their aim. For example, 1 = forming, and 5 = outstanding, sustainable improvement. In a quality improvement project, teams can use this scale to evaluate the progress of the project as a whole as well as their own work towards it.

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 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** - Contains the key elements of high performing organizations. The Change Package is used to identify the changes that need to be seen to achieve the PSPC aim. The concepts included in the Change Package are compiled from ideas found in literature and from a study of high performing organizations.

**Collaborative Charter** - Is a document that describes the collaborative and is used to launch the collaborative, establishing a common vision for the work including: a problem statement, gap, mission statement with the business case for the improvement, specific goals and expectations.

**Collaborative/Quality Improvement Team** - All individuals from organizations participating in collaborative or other quality improvement projects that drive and participate in the improvement process. A core team of three to four individuals attends some project sessions, but a larger team, often from various disciplines, participates in the improvement process in the organization.

**Co-directors** - The leaders of the Collaborative who work with the faculty, teaches and plan and execute Learning Session and Action Period activities.

**Core Team Members** - The members are those individuals who attend the team sessions and are accountable to the senior leadership for the work of the quality improvement project.

**CHC** - A Community Health Center is committed to improving the health of its community. Health is broadly defined as a state of complete physical, mental and social well-being and not simply the absence of disease or infirmity. To achieve good health community health services strongly emphasize prevention, early intervention, rehabilitation and education, in addition to direct care.

**CPS** - Clinical pharmacy service is the branch of Pharmacy where pharmacists and pharmacologists provide patient care that optimizes the use of medication and promotes health, wellness, and disease prevention.

**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 typically 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.

**EMR** - An electronic medical record is usually a computerized legal medical record created in an organization that delivers care, such as a hospital and doctor's surgery.

**Faculty Co-chairs** - The faculty leaders of the topic being addressed by the Collaborative, drawn from high performing organizations.

**Faculty** - The group of experts in the topic area who assist the Co-chairs and Co-directors in teaching and coaching participating teams. Usually the group contains representatives from all the disciplines who are involved in the change process.
**FDA** - The Food and Drug Administration (FDA) is an agency of the United States Department of Health and Human Services, one of the United States federal executive departments, responsible for protecting and promoting public health through the regulation and supervision of food safety, tobacco products, dietary supplements, prescription and over-the-counter pharmaceutical drugs (medications), vaccines, biopharmaceuticals, blood transfusions, medical devices, electromagnetic radiation emitting devices (ERED), veterinary products, and cosmetics. Food and Drug Administration

**FQHC** - A Federally Qualified Health Center (FQHC) is a reimbursement designation in the United States, referring to several health programs funded under the Health Center Consolidation Act (Section 330 of the Public Health Service Act). Health programs funded include: Community Health Centers, Migrant Health Centers, Health Care for the Homeless Programs and Public Housing Primary Care Programs

**HC** - [HealthcareCommunities.org](http://HealthcareCommunities.org) (HC) is an enhanced portal replacing the current Health Disparities National Results sharing site (Healthdisparities.net). The new portal will include a number of enhanced features to make it easier to communicate, navigate and share information.

**HIV / AIDS** - Human immunodeficiency virus (HIV) / Acquired immune deficiency syndrome or acquired immunodeficiency syndrome (AIDS)

**HRSA** - The Health Resources and Services Administration (HRSA), is an agency of the U.S. Department of Health and Human Services. It is the primary Federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable.

**IHI** - The Institute for Healthcare Improvement (IHI) is a not-for-profit organization helping to lead the improvement of health care throughout the world. Founded in 1991 and based in Cambridge, Massachusetts, IHI works to accelerate improvement by building the will for change, cultivating concepts for improving patient care, and helping health care systems put those ideas into action.

**IT** - Information technology (IT) is "the study, design, development, implementation, support or management of computer-based information systems, particularly software applications and computer hardware.

**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.

**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.”

**Leading Practices** - Essential process changes that will help lead to breakthrough improvement, usually created by the Faculty and Chairs based on literature and their professional experience.

**Learning Sessions** - Are the major integrative events of the collaborative. During the Learning Sessions teams have the opportunity to learn from the collaborative faculty and colleagues, receive individual coaching from faculty, gather knowledge on the collaborative subject matter and process improvement, share experiences and built collaboration on improvement plans.
Listserv - An automatic e-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. See also “E-mail List.”

LCC - The Leadership Coordinating Council (LCC) is comprised of nearly 150 professionals from national health care organizations and key stakeholders who provide support to the HRSA Patient Safety and Clinical Pharmacy Services Collaborative (PSPC).

Measure - A focused, reportable unit that will help a team monitor its progress toward achieving its aim. Most quality improvement efforts have 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. Measures, for purposes of improvement, can be divided into three classifications: outcome, process, and balancing. Within these three groups, measures may be clinical (e.g. for diabetes, asthma, prevention, etc), operational (e.g. access) or financial (relating to the business case):

- **Outcome measures:**
  Outcome measures ask how the system is performing. What are the results? They are related to the customer or patient. For example, the average A1c level for population of patients with diabetes is an outcome measure.

- **Process measures:**
  Process measures ask if the parts or steps of a system are working as planned. They are related to the workings of the system. An example of a process measure is the number of asthma patients with a severity assessment at last contact.

- **Balancing measures:**
  Balancing measures ask if changes designed to improve one part of the system are causing new problems in other parts of the system. This allows the system to be reviewed from different dimensions or directions. For example, reduction of hospital length of stay should be balanced by measurement of readmission rates to be sure that the readmission rates are not increasing.

Measurement Strategy - The key measures that will be used to track improvement in the collaborative. The Measurement Strategy includes definitions of data elements and data collection strategies.

Model for Improvement - An approach to process improvement, developed by Associates in Process Improvement, which helps teams accelerate the adoption of proven and effective change.

MPR - Monthly Progress Report submitted by PSPC teams to quantify their process changes and to tell their local story.

MTM - Medication therapy management (MTM) is a partnership of the pharmacist, the patient or their caregiver, and other health professionals that promotes the safe and effective use of medications and helps patients achieve the targeted outcomes from medication therapy Medication Therapy Management.
**pADEs** - Potential harm that was identified and avoided with appropriate interventions before reaching the patient. Example: A care team member notices a duplication of drug therapy (lisinopril and ramipril) and intervenes to have one of the medications discontinued before the patient receives the medication.

**PDSA** - PDSA or "Plan Do Study Act" is a cycle of learning and improvement used by teams to test out small changes. A POSA is a trial and learning process where small changes are tested and support for the changes are established so that they become permanent.

- Plan: develop and objective, ask questions and make predictions, plan to carry out the cycle (who, what, where, when);
- Do: carry out the plan, document problems and unexpected observations and begin analysis of the data;
- Study: complete the analysis of the data, compare data to predictions and summarize what was learned;
- Act: decide what changes need to be made and think about the next logical PDSA cycle.

**Planned Care Model** - A model that represents the ideal system of healthcare for people with chronic disease and an approach to re-designing an ideal healthcare 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. Learn more about the Planned Care Model.

**Population of Focus (PoF)** - A designated set of patients who will be tracked to determine whether changes have resulted in improvements. It is this sub-population or pilot population that will be used to test changes in practice that can ultimately be implemented for the whole population.

**POS** - Population of Service. See Vocabulary and Glossary of Terms

**POC** - Population of Care. See Vocabulary and Glossary of Terms

**PSPC** - Patient Safety and Clinical Pharmacy Services Collaborative

**Senior Leader** - The executive in the organization who supports the team and controls all of the resources employed in the processes to be changed. The Senior Leader works to connect the team’s aim to the organization’s mission, provides resources for the team, and promotes the spread of work of the team to other sites, providers, and conditions.

**SLR** - The Senior Leadership Report is a term previously used for the Monthly Progress Report (MPR) submitted by PSPC teams to quantify their process changes and to tell their local story.

**SOAP** - The SOAP note (an acronym for subjective, objective, assessment, and plan) is a method of documentation employed by health care providers to write out notes in a patient's 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. In clinical quality improvement work, this expansion could be to other patients, providers, and sites.

**Team** - The group of individuals, usually from multiple disciplines, that drives and participates in the improvement process. A travel team attends the Learning Sessions, but a larger team of three to eight people participates in the improvement process within the organization.

**Team Leader** - The leader who is responsible and accountable to their organization for the performance and results of the team.

**Technical Expert** - The team member in the organization that 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. Learn more about testing Key Changes using the PDSA cycle in the presentation **Accelerating Improvement Testing and Adapting Key Changes**.