



Quality Improvement Collaborative

*Improving the health and health
care of the people and communities
of western and central New York*





Quality Improvement Collaborative

A Qualitative Study

What is a Quality Improvement Collaborative?

A Quality Improvement Collaborative (QIC) is a short-term learning program that brings together teams from multiple sites across a region to seek improvement in a focused topic area. The goal is to raise the bar on Quality Improvement (QI) skills and competencies of providers and organizations serving frail elders and children living in communities of poverty across western and central New York.

Since 2005, the Health Foundation for Western and Central New York (formerly the Community Health Foundation of Western and Central New York) has conducted seven Quality Improvement Collaboratives (QIC).

Through QICs, the Health Foundation hoped to improve the quality of care and services for these vulnerable populations and achieve better health outcomes.

QICs were developed and popularized by the Institute for Healthcare Improvement (IHI) and are one of the leading approaches to quality improvement worldwide. They are most commonly applied in clinical settings, but less is known about how they work in social service settings or in seeking improvements involving multiple agencies. QICs focus on evidence-based practices and teach methods of using data and measurements.

Health Foundation Quality Improvement Collaboratives

The Health Foundation's two target populations, frail elders and children living in communities of poverty, face a range of challenges to their health and well-being that require support and coordination from multiple medical and social service providers.

Care for frail elders is often fragmented, shifting from one level of care to another with little attention to the patient's needs or preferences.

An estimated 17% of children under 18 have behavioral or developmental challenges. Early identification, prevention and intervention in children's social, emotional and behavioral development can prevent serious problems later in life.

Because many organizations in western and central New York serving these populations lack expertise in care coordination and improvement, they were good candidates for QIC. In addition, these organizations tend not to have QI backgrounds and they struggle in their efforts to serve high-risk populations and remain in business.

Health Foundation Collaboratives incorporated all key components and the philosophical approach of the IHI Breakthrough Series Collaboratives. The Breakthrough Series model is a structured, targeted improvement project using QI training, collaboration and peer learning opportunities.

The Model for Improvement teaches participants to test and implement best practice improvements and includes:

- Developing specific project goals
- Conducting small tests of change
- Applying the Plan-Do-Study-Act (PDSA) approach to measurement
- Measuring performance over time

Participants worked in teams and received QI training, faculty support, collaboration and peer learning opportunities. Teams focused on a topic for improvement and completed a series of activities, including three two-day Learning Sessions. Teams measured progress every other month.





The Health Foundation modified the IHI approach to address the complex health needs of its vulnerable target populations. The Health Foundation Collaboratives also aim to build individual, organizational and regional capacity in competencies identified by the Institute of Medicine in its 2003 report, *Health Professions Education: A Bridge to Quality*, including:

- Collaboration across organizations
- Working in interdisciplinary teams
- Employing evidence-based practice
- Applying QI tools and measurement to guide decision-making and improvement, and;
- A patient and family-centered focus

The Health Foundation Collaboratives also incorporated a high level of support from Collaborative faculty and the Health Foundation, including small grants to participating organizations and individualized team coaching. Faculty worked closely with teams to help them apply the Model for Improvement, use data to show improvement, address gaps in team leadership and engage senior executives.

Of the seven Health Foundation Collaboratives, six aimed to improve the health and well-being of frail elders; three focused on improving care transitions and three addressed falls prevention. One Collaborative, *The Right Start*, targeted the social, emotional and behavioral well-being of young children in communities of poverty.

The Health Foundation evaluates all of its Collaboratives. This report focuses on the evaluation of four that were funded between 2005 and 2011, including three that addressed care for frail elders and one addressing children in communities of poverty.

The four Collaboratives that were evaluated included 50 teams representing 91 organizations.

The QICs are:

QIC 1 – Improving Frail Elder Care: September 2005 to October 2006

Goal: Stimulate improvement in practice patterns and care-delivery systems for frail elders.

The emphasis in this first QIC was teaching teams best practices to im-

prove transitions of care and palliative care (pain management, medication management, hydration/nutrition and caregiver support.)

Six teams focused on improving transitions; two teams focused on improving palliative care. Each team included representatives from at least two organizations. Eight teams representing 16 organizations completed the QIC.

QIC 2 – Improving Care Transitions: April 2007 to October 2008

Goals: Improve transitions of care for frail elders in their communities by stimulating change in practice and care-delivery systems as frail elders move from one care setting to another; improve continuity, reduce errors and delay and increase patient control of health decisions.

Teams were taught the Care Transitions Intervention (CTI), a demonstrated best practice for improving frail elder care transitions.



Through CTI, patients with complex care needs, and family caregivers, receive specific tools and work with a transition coach to learn skills that will ensure their needs are met during care transitions. CTI encourages a more active role for patients and caregivers during transitions and a focus on the Four Pillars: medication self-management, use of a personal health record, timely primary care/specialty care follow-up and knowledge of red flags that indicate a worsening condition and how to respond.

Each team included representatives from the sending and receiving care provider in the target transition. Thirteen teams representing 25 organizations completed the QIC.

QIC 3 – Engaging Family Caregivers in Care Transitions: April 2009 to October 2010

Goal: Improve transitions of care through Family Caregiver Partnerships (FCP) for frail elders.

Two earlier Health Foundation Collaboratives suggested that by expanding the knowledge, capacity and role of family caregivers, transitions of care for frail elders



would improve. The FCP aimed to improve care transitions and to develop more informed caregivers, improve caregiver resources and create effective partnerships between health care providers and caregivers. FCP best practices are the CTI and Next Step in Care (NSIC).

Fourteen teams representing 19 organizations completed the QIC.

QIC 4: October 2009 to March 2011 - The Right Start

Goals: Improve the social, emotional and behavioral well-being of children 0 to 5 and their families; increase effective participation of multiple providers and systems, and the family, in decisions about care and service; improve care and service coordination by improving communications and striving for family-focused communication; improving provider understanding of the benefits of effectively engaging other providers and systems and children/families in care and services; and expand the QI capacity of participants and their organizations.

Fifteen teams representing 31 agencies completed the QIC.

The three QICs involving frail elder care taught QI methods and applied them toward the primary goal of implementing frail elder care best practices. The Right Start QIC placed greater emphasis on QI learning and capacity building.

For these collaboratives, the Health Foundation evaluated six goals:

Goal 1: Assess the QIC approach as a mechanism for learning and for improving communication among participants.

Goal 2: Assess the impact of the QIC on participating organizations: What has changed? How is the organization different? Does staff approach QI differently?

Goal 3: Assess the impact of the QIC on the target population.

Goal 4: Assess the effectiveness of the QIC in sustaining QI gains after the QIC ends.

Goal 5: Assess the effectiveness of the QIC approach in spreading knowledge gained from the QIC to new areas within the organization,

new topics or beyond the organization.

Goal 6: Assess how the findings inform the field and guide the Health Foundation in developing a standardized evaluation approach and set of tools for future QICs. The final goal will be discussed in the conclusion.

Evaluation of Quality Improvement Collaboratives

Goal 1: Assess learning and communication

QIC 1 – Improving Frail Elder Care:

All eight teams reported learning about frail elder care best practices.

All teams gained QI knowledge and successfully applied new QI knowledge to test and implement their intervention.

Most thought the QI training was highly effective.

Participants rated training/coaching from faculty and peer-to-peer learning among QIC's best benefits.

Participants described the QIC approach as an excellent mechanism for improving communication, and five leads reported the QIC helped overcome barriers to collaboration.

Teams rated the use of multi-agency teams to foster communication and collaborative improvement as the most effective QIC attribute. Participants also cited the role of peer learning in developing informal professional networks and relationships across care settings and providers in the region.





QIC 2: - Improving Care Transitions:

All 13 teams reported learning the CTI, including the transition coach model and the Four Pillars – strategies for improved patient self-management and medication management during care transitions.

All teams gained QI knowledge and succeeded in applying knowledge to test and implement CTI.

Ten leads said communication improved as a result of the QIC. Six of these identified improved communication and collaboration as a primary outcome and seven said QIC 2 helped to overcome barriers to collaboration, such as time and resources. Many teams noted that collaborative efforts also expanded to include new provider organizations and county agencies working to improve care transitions. Participants also cited improved collaboration with families and family caregivers.

QIC 3 – Engaging Family Caregivers in Care Transitions:

All 14 teams reported learning best practices in family caregiver partnership to support frail elder care transitions, including CTI and Next Step in Care.

Most teams reported gains in QI knowledge and have successfully applied it to test and implement QIC intervention on a small scale.

While many participants reported QI training was effective, almost half of the leads (particularly those that participated in previous HFWCNY Collaboratives) suggested differentiating QI training based on participant experience in order to maximize learning.

A year after the QIC ended, more than half of the participating teams identified new or expanded collaborations. Participants identified new partnerships with other providers, community-based organizations, counties and insurers. Six organizations began discussions to create a large regional collaborative focus on improving care transitions. In one county, providers and agencies are working together to improve care transitions.

“This taught me to take a step back from the doing, and to empower the caregiver instead.”

"This experience really improved my data analytic skills."

"The team approach helped, especially with the high turnover we experienced."



QIC 4 – The Right Start:

Teams said the Right Start QIC led to increased effectiveness in working with young children and their families, expanded roles and a new way of thinking about improvement.

Teams reported QI learning, including the Model for Improvement, QI methods and data input and analytics to support implementation.

All organizations learned and implemented new programs or improvements to foster the social, emotional and behavioral well-being of young children in the pre-school setting and at home.

Organizations also learned to work together to address the complex needs of this population and to provide coordinated services.

The Right Start improved communication between and among young children, teachers and parents, among teams and organizations serving young children and families in communities of poverty. Many leads improved communication and successfully engaged senior leaders in their organizations.

Goal 2: Assess impact on participating organizations

QIC 1 – Improving Frail Elder Care:

All but one team accomplished their QIC goal, therefore new transition and palliative care processes were implemented in all but a few participating organizations.

While organizational and culture change were not explicit goals, respondents also reported that the QIC was moderately effective in fostering organizational change to support QI; most said their organization supports QI.

"... proper and necessary patient information is now routinely received and available during care transitions."



“Our medication form made a difference for residents being discharged. It gave them useful information about their medication history, medication use, health care proxy and other important information for care transition.”

QIC 2: - Improving Care Transitions:

Nine leads said the QIC had an impact on how their organization approaches QI and most indicated that goal setting, use of PSDA cycles/ small tests of change and purposeful measurement of change were still in use a year after the QIC.

Impact related to QI is particularly noteworthy because QI learning was a secondary goal.

Successful changes included a new procedure for medication discrepancies at discharge. At one organization that applied this tool through a transition coach, only one of 19 patients was readmitted within 30 days.

At another agency, support from the transition coach showed small improvements in quality of life measures for patients with advanced cancer and the number of emergency calls and doctor’s visits declined. Another cited improved identification of hospital patients with dementia and memory loss, and 90 percent of caregivers reported improved understandings of triggers for hospitalization.

In another case, an agency that developed self-management tools for congestive heart failure and COPD patients reported that only 18 percent of patients with coach support were readmitted within 30 days, and only 10 percent were readmitted within 60 days.

QIC 3 – Engaging Family Caregivers in Care Transitions:

All leads and CEOs identified new organizational capacity to improve care transitions and to engage and support family caregivers.

A year after the QIC, organizations reported expanded staff training; expanded caregiver training and training referral networks; better transition outcomes; reduced rates of hospital readmissions and emergency room visits; lower cost of care; and increased patient satisfaction.

QIC 4 – The Right Start:

Right Start team achievements resulted in new organizational capacity and new and improved services. Hundreds of teachers and staff were trained in early childhood education and behavior management.

Most organizations gained QI technical skills and learned how to implement Model for Improvement, and many learned to improve and use data to evaluate impact.

In addition, most organizations also developed the resources to continue this training. Organizations also learned how to effectively partner with other agencies.

Participants also reported the ability to conduct effective follow-up and referrals and broader engagement of parents, teachers and staff.

Goal 3: Assess impact on target population

QIC 1 – Improving Frail Elder Care:

Six of eight teams achieved a positive impact on ~~the~~ target population.



Improvements included better processes, reduction in transfer-related error rates, redundancy and time delays; better communication across provider settings during caret transitions; better tools for transition; improved pain management; and increased patient, caregiver and family member knowledge.

Two leads described “minimal” or “very little” impact on their target population. However, all but one team continued to see the impact of QIC improvements on the frail elder population.

QIC 2: - Improving Care Transitions:

All teams reported positive impacts on the target population.

Leads described improvements including lower hospital readmission and ED rates; increased patient and family knowledge about transitions, hospitalization triggers and medication management; better patient communication and increased satisfaction with care providers; and improved quality of life.



All but three reported continued impact of improvements on their target population.

The other three reported initial impact on target population, but reported no long-term impact or sustainability of activity after the QIC ended.

“Through this project we gave patients a voice, we put patients first.”

“Through early identification of hospice care eligibles we helped people be more aware of their options for end-of-life care and we increased focus on advance planning.”

“Through the coach role, we eased the transition to hospice for patients and families.”

QIC 3 – Engaging Family Caregivers in Care Transitions:

The Collaborative coached 862 older adults and coached and/or educated 710 caregivers.

Caregivers reported that staff helped them better understand their role in care transitions. Patients and families said the NSIC material was helpful in understanding what to expect when transitions occur, keeping track of medication changes, increasing their knowledge of symptoms and having a central location for information. Coached patients reported feeling more prepared for care transitions.

A year after the QIC, all but two teams reported an increase in the number of lives touched through FCP interventions. All but a few participants identified continued significant impacts on their target populations, including continued reduction of readmissions among patients coached, or whose caregivers were coached.

QIC 4 – The Right Start:

A year later, all teams reported new learning among target populations.

Hundreds of teachers were trained in early childhood curriculum best practices and at least 3,000 parents and young children were trained in self-awareness skills, behavior management, conflict resolution, empathy and pro-social skills.

One team reported a decrease in the average amount of time spent discussing classroom behavior, and a decrease in the total number of

children who displayed behavior that teachers needed to discuss. Another team reported translating its program forms and other documents into the native languages of the populations served, including Mali, Burmese and Arabic. That team also purchased three electronic translators to help communicate with clients, and another team began using iPads to communicate with non-native English speakers.

Other accomplishments included literacy screening for children and created a model for effective play therapy techniques.

Goal 4: Assess effectiveness in sustaining QI gains

QIC 1 – Improving Frail Elder Care:

Six of the eight teams reported sustained QI gains, including better processes, better tools, and better communication across provider settings and improved pain management.

QI methods still in use include development of aim statements, rapid cycle improvement/PDSA and less intensive approaches to measurement for improvement.

In nearly all teams, senior leaders played an active role in the QIC, likely reflecting pre-existing leadership commitment to quality.

QIC 2: - Improving Care Transitions:

Ten leads reported that CTI gains have been sustained, and eight leads said transition improvement efforts were expanded. QI methods in use after QIC ended include development of aim statements, use of rapid cycle improvements /PDSA and measure for improvement.

Several participants noted that new Center for Medicare and Medicaid Services (CMS) policies implemented after the QIC -- new conditions of participation QI requirements for hospice and new CMS reimbursement incentives aimed at preventing avoidable readmissions -- will help foster sustainability and spread of QIC 2 gains.

Many leads pointed to cost savings as a result of reduced hospital admissions and fewer ED visits following care transitions, fewer medical errors, increased use of hospice and other cost avoidance opportunities as a result of better care transitions and more informed, active patients and families.





Evaluation pointed to the need to consider strategies for sustainability early in the QIC process. In order to sustain improvement, organizations need leadership support, organizational support and a culture that rewards innovation and a focus on improvement.

QIC 3 – Engaging Family Caregivers in Care Transitions:

All but two teams reported that a year after the QIC, they were continuing the initiatives of the Collaborative. The two that did not continue indicated they intended to do so when staffing and funding allowed. Two other organizations were able to continue some, but not all of, the components of the CTI model.

Several participants noted that new CMS reimbursement policies benefited their work and will continue to reinforce efforts to improve care transitions. They expected other CMA and other payer policies emerging to support Accountable Care Organizations or bundled payments for episodes of care would provide additional incentives to reduce hospitalization rates.

“We worked to institutionalize the program in our organization.”

“The Collaborative forced us to measure impact and to evaluate whether we were successful.”

“The project continues. Leadership supports it and the CFO loves it!”

QIC 4 – The Right Start:

By the end of the Collaborative, all teams had established a plan for sustaining programs and improvements. Learning, organizational impact and capacity developed in the Collaborative were effective enough to sustain programs a year later in all but a few organizations.

Those most likely to sustain programs had strong and stable team leadership, team commitment and senior leadership support and had developed policies and procedures into standard organizational practice.

Goal 5: Assess effectiveness in spreading knowledge

QIC 1 – Improving Frail Elder Care:

Although spread of QI methods within participating organizations was not an explicit goal, 50 percent of participating organizations report such spreads. Six teams reported sharing/spreading best practices with organizations beyond the QIC and describe expanded collaboration to improve care for frail elders.

Several participating organizations received recognition for their QIC work. One organization was one of three national recipients of the 2008 AMDA Foundation/Evercare Award for excellence in long-term care and was featured in the national Hospice News. Several other organizations had local media coverage of their QIC innovations.



QIC 2: - Improving Care Transitions:

Eleven leads cited evidence that the QIC spread knowledge, primarily the spread of the transition coach model to new patient populations, new staff in the organization, new provider partners and family caregivers.

Several QIC 2 participants emerged as regional and national trainers of the transition coach model. Some participants spread knowledge through an international conference, a CMS national collaborative, a regional workshop and policy briefing, and media and other public recognition.

“The collaborative approach to improvement was our key takeaway.”

QIC 3 – Engaging Family Caregivers in Care Transitions:

Although many teams reported their intention to spread knowledge from the Collaborative, a year later eight teams reported their improvements had spread and six reported that they had not yet done so. Barriers to spreading knowledge included time, lack of trained staff, money and the rural location of many caregivers. One organization noted that its success in reducing readmission rates through a focus on care transitions limited the ability to maintain the program because it is eliminating the problem.



Most teams reporting successful spread attribute it to steps such as extending the intervention to other patient diagnoses or discharges, new caregiver outreach activities, identifying new referral sources and presenting their programs to other organizations.

QIC 4 – The Right Start:

One year later, all but a few of the teams had spread of Right Start programs within participating organizations or to other organizations, and the rest were working toward that goal. Most teams reported sustained widespread use of QI methods.

What We Learned

The sixth goal was to assess how the findings inform the field and guide the Health Foundation in developing a standardized evaluation approach and set of tools for future QICs.

Evaluation of the four Health Foundation Collaboratives show the QIC approach is a powerful tool for fostering learning, communication and collaboration among grantees working toward improvement. Participants cited the collaborative structure, learning sessions, peer interaction, use of data and faculty coaching as most beneficial aspects of QICs.

They also reported benefits to themselves, the teams, their organizations, organizations beyond the QIC and to the target populations. All but a few organizations succeeded in implementing best practices and expanding care/services/knowledge to target populations.

In addition to gaining knowledge and achieving positive outcomes for target populations, a few participants emerged as leaders in care transitions improvement in the region and the nation, reflecting the QIC approach's opportunities for excellence and leadership.

The overall findings are significant because of the prevalence of the Collaborative method as a strategy for improvement, the large number of organizations in the U.S serving frail elders and young children in poverty, the limited improvement resources these

organizations typically possess, and the important role these agencies play in providing coordinated health and social services for high-risk populations in western and central New York and the nation.

Based on the IHI Assessment Scale for Collaboratives, 47 of 50 teams achieved a 3.0 in a five-point scale for measuring faculty assessment of team success, which reflects modest improvement in fostering team achievement, sustainability and spread of best practices. Forty-one teams scored 3.5, showing improvement, and 31 teams scored 4.0 or higher, showing significant improvement in the areas evaluated. IHI faculty say that teams that reach a score of 4.0 or higher are likely to sustain and spread improvement gains a year after the Collaborative ends.

Across all four Collaboratives, an average of 88 percent of teams reported sustaining best practices and improvements one year later. An average of 78 percent of teams reported spread of best practices and improvements one year later.

Participants used a 10-point scale to rate the Health Foundation Collaboratives' effectiveness in fostering team achievement, sustainability and spread of best practices; a score of 10 is highly effective. On effectiveness in fostering team achievement, participants' scores ranged from 8.0 to 8.9. On sustainability of best practices, participants' scores ranged from 8.2 to 8.9. On spread of best practices, participants' scores ranged from 7.8 to 8.1.



All but a few organizations succeeded in learning and implementing best practices. Across all four Collaboratives, 50 to 80 percent of participants reported an increase in improvement capacity and a stronger organizational focus on improvement. Teams highlighted the Collaborative structure, Learning Sessions, peer learning opportunity and faculty coaching as the most beneficial Collaborative components. All but one team reported the experience was beneficial overall. Participants in more than one Health Foundation Collaborative observed the cumulative benefits of repeat participation.

The significant impact of Health Foundation Collaboratives is especially noteworthy because many of the participants did not fit the typical profile of Breakthrough Series Collaboratives, whose participants are traditionally hospitals and health care providers.



In addition, these organizations serve high-risk groups that are difficult to impact. Modifications introduced by the Health Foundation to the Collaborative structure, such as cross-organizational teams and collaboration, benefitted participating organizations and made it more likely that gains would be sustained and spread beyond the Collaboratives.

The evaluation also shed light on supporting factors and risks to team achievement in a Collaborative.

Factors supporting achievement include:

- Strong and consistent team leadership.
- Solid team partnerships.
- Support from senior leaders.
- QI departments and other staff present in participating organizations.
- Multi-agency collaboration allowed organizations to communicate effectively and break down silos to address the coordination that care transitions and other complex needs of high-risk populations require.
- Baseline QI knowledge.
- The extent to which oversight agencies like Medicare require similar QI approaches.

Senior leadership support was a particularly powerful influence on whether Collaborative programs were sustained, and an even greater influence over program spread because of the role senior leaders play in opening doors to collaborations with other organizations.

Risks to team achievement include:

- Team and organizational instability (changes in team leadership, team members or staff; reorganizations).
- Demands on staff time or too few staff involved.
- Teamwork or partnership challenges.
- Lack of clarity about team roles, project goals and expectations.
- Financial instability; no clear path to sustainable funding of improvement activity.
- Projects not aligned with the organizations' strategic priorities. The influence of supporting and risk factors suggest steps Collaborative participants and funders can take to improve results. Effective strategies for participating organizations include:

- Minimize team instability and turnover of team members, particularly team leaders.
- Engage a proactive, dedicated leader.
- Staff teams with mid-level or higher personnel.
- Select a partner organization(s) based on an established, prior relationship.
- Solidify partnerships early; define roles, responsibilities, project plans and expectations for working together as a team.
- Select measures early to demonstrate project results and support sustainability; use data to show improvement.
- Build CEO support early, beginning with project design.
- Communicate results to senior leaders and more broadly within the organization.
- Plan early for sustainability. Hard-wire and align improvements with ongoing programs; solidify staffing, training and funding for continuity after the Collaborative.
- Avoid organizational distractions and maintain focus on improvement.
- Foster support from senior leadership.



Findings also suggest strategies Collaborative funders can use to foster team success. Many of these evolved from lessons learned in prior Collaboratives, and are strategies that the Health Foundation later implemented to make successive Collaboratives more effective.

Strategies include:

- Select a unified Collaborative focus or set of topics to maximize peer learning potential.
- Provide a “Change Package” – a set of evidence-supported guidelines to guide improvement activity.
- Give participants early guidance about what to expect, including sponsor expectations.
- Inform teams about strategies to increase the likelihood of success.
- Build in a planning phase to allow time for learning to work together and determining how to apply best practices and the Model for Improvement.
- Provide how-to examples to support best practice implementation.



- Encourage executive leaders to reinforce Collaborative activities as a priority within their organizations so that teams will have support and ability to focus.
- Coach teams to align Collaborative projects with ongoing programs and priorities of their organizations, and to use data to communicate improvement.
- Engage more staff/senior staff to increase the project footprint and influence on the staff and culture of participating organizations.
- Support sustainability -- provide information on effective strategies, public policy or funding opportunities to support sustainability of Collaborative improvements. These evaluations influenced future Health Foundation Programs. For example, PEDALS: Positive Emotional Development and Learning Skills grew out of successes and lessons learned in The Right Start.

Two organizations that participated in the Care Transition Collaboratives received funding for programs under the Affordable Care Act/Centers for Medicare and Medicaid Services for Community Based Care Transition Improvement. In addition, the Health Foundation's 2013 Health Leadership Fellows Program includes greater emphasis on learning about and managing improvement.

Some specific ways the Health Foundation could improve QIC impact:

- Provide an overview of current information, recent policy developments and best practices.
- Offer guidance in seeking future funding to support gains.
- Create efficiencies to improve QIC process by using virtual methods, conference calls and fewer in-person meetings. (Others made the case for more face-to-face interaction.)
- Some participants suggest the training focus more on practical applications than academic views.
- Improve access to website.
- Require a project budget to guide organizations in better using grant.



“As an organization, our listening and problem-solving skills improved dramatically through the QIC process.”

“The QIC was an excellent learning and growing experience for me. It challenged me to set a new bar for my work.”

“Peer-to-peer learning was rewarding. It helps reduce myopia, and it’s good to share your pain!”

“The simple, purposeful use of data was new to us – it is something we have embraced as an organization.”

“What was innovative was the latitude to try a new model and then to integrate it, to make it part of other programs.”

“Keep it going! The Collaborative approach works, and teamwork is the key ingredient!”

To learn more about the Health Foundations Quality Improvement Collaboratives and read the full evaluations, visit www.hfwcny.org.



Table 1: Overview of HFWCNY Collaboratives and Summary of Results

Improving Frail Elder Care Collaborative #1	Eight multi-organization teams focus on improving information transfer between organizations to support better care transitions and palliative care. All but one team accomplished this goal.
Improving Care Transitions Collaborative #2	Thirteen multi-organization teams focus on improving care transitions for frail elders by implementing the Care Transition Intervention (CTI). All 13 teams succeed in making CTI process improvements. Ten teams fully implement transition coaching. Many also reduce rates of hospital readmissions, ED visits, medication discrepancies and improve patient self-management.
Engaging Family Caregivers in Care Transitions Collaborative #3	Fourteen teams focus on improving the knowledge, role and level of engagement of family caregivers so that effective partnership between caregivers and care providers can support better transitions. Teams implement best practices (Next Step in Care and CTI). Outcomes include expansion of caregivers' role, knowledge, confidence and satisfaction and lower hospital readmission rates.
The Right Start Collaborative #4	Fifteen multi-organization teams implement best practices in early childhood education curriculum (including Second Step), behavioral assessment and parenting programs in 55 classrooms, and more than 261 staff are trained in these programs. Outcomes include evidence of new knowledge, improved behavior and social skills in the classroom and home.



Table 2: Improvement Achieved in HFWCNY Collaboratives

Assessment Score	Assessment Category	Number of teams reaching this score or higher	Percent of teams reaching this score or higher	Range of teams reaching this score across Collaboratives
3.0	Modest Improvement	47	94%	86% to 100%
3.5	Improvement	41	82%	77% to 100%
4.0 (or higher)	Significant Improvement	31	62%	46% to 88%



Table 3: Sustained Best Practice Improvement One Year Following Each Collaborative

Collaborative	Number and Percent of Teams Reporting Sustained Best Practices
1	7 out of 8 teams (88%)
2	10 out of 13 teams (77%)
3	12 out of 14 teams (86%) sustained some CTI components; 10 teams (71%) sustained all CTI components including transition coaching
4	15 out of 15 teams (100% of teams; all but 3 participating organizations reported sustained improvement)



Table 4: Spread of Best Practices One Year Following Each Collaborative

Collaborative	Number and Percent of Teams Reporting Sustained Best Practices
1	7 out of 8 teams (75%)
2	11 out of 13 teams (85%)
3	8 out of 14 teams (57%)
4	13 out of 15 teams (87%)



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