Primary Care Practice Facilitation Curriculum

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Primary Care Practice Facilitation Curriculum

Prepared for:
Agency for Healthcare Research and Quality
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Primary Care Practice Facilitation Curriculum Preface

"The Agency for Healthcare Research and Quality recognizes that revitalizing the Nation's primary care system is foundational to achieving high-quality, accessible, efficient health care for all Americans. The primary care medical home, also referred to as the patient centered medical home (PCMH), advanced primary care, and the healthcare home, is a promising model for transforming the organization and delivery of primary care." These words, found in the welcome message on AHRQ's PCMH Resource Center Web site, have served as the guiding principle for the development of this curriculum and other resources to help support the transformation of primary care practice from older models of care delivery to 21st Century models that provide better care, smarter spending, and healthier people.

Practice facilitation is one evidence-based approach to assisting practices with making the substantive, meaningful, and ongoing changes needed to adopt these new models. Practice facilitation can also support other proven quality improvement techniques including data feedback and benchmarking, expert consultation and shared learning or learning collaboratives. The trusted relationships of practice facilitators with practice leaders, clinicians, and staff empower practices to improve delivery of evidence-based care, increase patient engagement, and decrease the burnout rate of primary care health professionals.

This expanded Primary Care Practice Facilitation Curriculum is AHRQ's latest and most extensive effort to support the education and training of practice facilitators. David Meyers, M.D., AHRQ's Chief Medical Officer and former Director of the Center for Primary Care, Prevention and Clinical Partnerships envisioned the curriculum as the way to endow practice facilitators with the skills necessary to advance quality improvement in primary care. The Curriculum builds on two previous AHRQ products, *Integrating Chronic Care and Business Strategies in the Safety Net: A Practice Coaching Manual* and the *Practice Facilitation Handbook: Training Modules for New Facilitators and Their Trainers*.

We are grateful to AHRQ's Cindy Brach, who was pivotal to both of these seminal products, for her continuing guidance on the Curriculum as well. The Curriculum is also designed to complement AHRQ's *Developing and Running a Primary Care Practice Facilitation Program: A How-to Guide*-- an effort led by much of the same team that led the development of this curriculum. In addition, the Curriculum dovetails nicely with other AHRQ initiatives focused on quality improvement at the practice level, such as AHRQ's TeamSTEPPS, HIT tools and resources, and Practice-based Research Networks. (More information on these products and initiatives can be found at pcmh.ahrq.gov.)

Development of this curriculum was a Herculean, 2-year effort with many contributors, but special thanks go to the members of the Technical Expert Panel who gave so very generously of their time to conference calls and numerous requests for reviews of the content. (For panelist names, see the box at the end of this preface.) Deepest gratitude goes to Jay Crosson, Ph.D., from Mathematica Policy Research (MPR) and Lyndee Knox, Ph.D., from LA Net Community Health Resource Network. Without their leadership and writing expertise this project never would have come to fruition. Thanks also to the many contributing authors and the teams at Mathematica and LA Net who supported the work, especially Alex Bohn at MPR who effectively and cheerfully coordinated dozens of moving parts. Finally, thanks to the team at AHRQ who helped make this vision become a reality, especially the editorial team of Margi Grady, Kathy McKay, and Doreen Bonnett.

Our hope is that this curriculum will be taken up in whole or parts and used to prepare the next generations of practice facilitators to assist the physicians, nurse practitioners, physician assistants, nurses, medical assistants and office staff with their efforts to transform the way primary care is delivered. We also believe that portions of this curriculum can be helpful in health professions education programs to build competencies in practice-based learning and improvement, systems-based practice and other competency domains where knowledge and skills of quality improvement methods are needed. Only through working together can we be successful at truly revitalizing primary care, and thereby improving the health of the Nation.

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Introduction

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INTRODUCTION

About AHRQ's Primary Care Practice Facilitation Curriculum

The Primary Care Practice Facilitation (PCPF) Curriculum is designed to support the development of a PCPF workforce prepared to help transform and revitalize primary care by supporting widespread adoption of new models of care delivery and the use of continuous quality improvement to improve health care outcomes. This PCPF curriculum can serve to train both new and experienced practice facilitators in the knowledge and skills needed to support meaningful improvement in primary care practices.

This curriculum builds on and expands earlier training resources for PCPF developed by the Agency for Healthcare Research and Quality (AHRQ). Some of the curriculum modules are new, and others are updated versions of material available in the *Practice Facilitation Handbook.* The objective of this curriculum is to provide a more comprehensive practice facilitator training curriculum. In conjunction with other practice facilitation training resources available from AHRQ (see text box below), this curriculum can be used to develop a comprehensive PCPF training program.

Other Practice Facilitator Training Resources from AHRQ

The Practice Facilitation Handbook: Training Modules for New Facilitators and Their Trainers
This handbook is the previous version of the training materials provided here.
http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/index.html

Developing and Running a Primary Care Practice Facilitation Program: A How-to Guide
This resource includes information on hiring, training, and supervising practice facilitators. The guide has information on the background and basic skills that practice facilitators should have prior to training.
http://pcmh.ahrq.gov/sites/default/files/attachments/Developing_and_Running_a_Primary_Care_Practice_Facilitation_Program.pdf

Integrating Chronic Care and Business Strategies in the Safety Net
This is a step-by-step guide to for primary care teams working on quality improvement focused on implementing the chronic care model.
http://www.ahrq.gov/professionals/systems/primary-care/businessstrategies/index.html

This PCPF curriculum consists of 32 training modules. As described below, Module 1 provides information for instructors on adult education methods. Modules 2 through 32 focus on specific competencies and skills. Each module begins with an Instructor's Guide, which identifies the PCPF competencies addressed in the module, the time that learners will need for preparation (including reading background material) and for the instructional session, the objectives of the module, and suggested instructional approaches. Each module contains instructional text on the topic written for both the instructor and learners.

The PCPF curriculum is organized into five parts:

- **Part 1: Use of Adult Education Methods in Teaching PCPF Core Competencies, Module 1.** Focuses on adult education methods and is intended for use by instructors. It offers an overview of recommended training approaches and describes how each subsequent module contributes to the development of competencies that practice facilitators need for supporting primary care practice improvement.
- **Part 2: Introduction to Practice Facilitation, Modules 2 through 7.** Provides a basic introduction to practice facilitation and work with primary care practices and includes an overview of a typical facilitation process. This part of the curriculum also introduces the importance of professionalism in the practice facilitation process.
- **Part 3: Core Competencies for Practice Facilitators, Modules 8 through 16.** Presents core competencies for practice facilitators. This part aims to build expertise that is valuable for facilitators regardless of the specific improvement topic. Core competencies include quality improvement techniques and measurement skills.
- **Part 4: In the Practice, Modules 17 through 23.** Provides training in common tasks a facilitator may undertake in practice settings, such as assessing readiness for change, preparing a practice to work with a facilitator, holding kickoff meetings, working with and supporting practice leaders, and running effective meetings.
- **Part 5: Implementing the Care Model and Patient-Centered Medical Home, Modules 24 through 32.** Includes information for facilitators working with practices that are implementing the Care Model or are transforming into patient-centered medical homes (PCMHs). Both the Care Model and the PCMH promote changing delivery systems to encourage responsiveness to patients' needs and preferences.

A complete list of the modules included in each of the PCPF Curriculum's five parts is provided below.

Contents of the PCPF Curriculum

Part	Modules
Part 1: Use of Adult Education Methods in Teaching PCPF Core Competencies	Module 1: Instructor's Guide to Using the PCPF Curriculum
Part 2: Introduction to Practice Facilitation	Module 2: Practice Facilitation as a Resource for Practice Improvement Module 3: The Primary Care Landscape Module 4: An Introduction to Practice Organization and Management Module 5: Special Considerations When Working With Safety Net Practices Module 6: An Overview of the Facilitation Process Module 7: Professionalism for Practice Facilitators
Part 3: Core Competencies for Practice Facilitators	Module 8: Approaches to Quality Improvement Module 9: Using Appreciative Inquiry with Practices Module 10: Mapping and Redesigning Workflow Module 11: Using Root Cause Analysis to Help Practices Understand and Improve Their Performance and Outcomes Module 12: An Introduction to Assessing Practices: Issues to Consider Module 13: Measuring and Benchmarking Clinical Performance Module 14: Collecting Performance Data Using Chart Audits and Electronic Data Extraction Module 15: Preparing and Presenting Performance Data Module 16: Academic Detailing as a Quality Improvement Tool
Part 4: In the Practice	Module 17: Introducing a Practice to Facilitation Module 18: Assessing Practice Readiness for Change Module 19: Conducting a Kickoff Meeting Module 20: Creating Quality Improvement Teams and QI Plans Module 21: Working With and Supporting Practice Leaders Module 22: Running Effective Meetings and Creating Capacity for Practices to Run Effective Meetings Module 23: Documenting Your Work With Practices

Part	Modules
Part 5: Implementing the Care Model and Patient-Centered Medical Home	Module 24: Introduction to the Care Model Module 25: The Patient-Centered Medical Home: Principles and Recognition Processes Module 26: An Introduction to Electronic Health Records and Meaningful Use Module 27: Helping Practices Optimize EHRs for Patient-Centered Medical Home Transformation and Quality Improvement Module 28: Using the AHRQ Care Model Toolkit with Practices Module 29: Implementing Care Teams Module 30: Building Teams in Primary Care Module 31: Facilitating Panel Management Module 32: Improving Self-Management Support and Engaging Patients in Care and Practice Improvement Topics

How to Use This Curriculum

This curriculum is designed to be used by an instructor as a resource when preparing new and experienced facilitators to work with primary care practices. Practice facilitators may also use the curriculum independently for self-study by omitting the instructor's guide at the beginning of each module. As with any curriculum intended for use with adult learners, the use and sequence of the modules should be tailored to learners' needs. Not all facilitators may benefit from all modules and, in general, the modules do not need to be completed sequentially. In those cases where modules build explicitly on learning from other modules, the instructor's guides clearly indicate the proper sequencing of learning. For example, Module 30 on "Building Teams in Primary Care" builds directly on the more specific case of "Implementing Care Teams" discussed in Module 29. Additionally, Modules 13-to-15 cover the full spectrum of skills that facilitators need for helping practices use data in their improvement and transformation efforts and, in most cases, should be completed sequentially.

Follow principles of adult education. The instructional exercises provided in the instructor's guide of each module follow the principles of adult education: **Individuals learn best when the educational process is interactive, and when the existing expertise and experience of the learner is recognized and used as a resource in the educational process.** Instructors are encouraged to incorporate the exercises suggested in each module into their teaching as well as others they may have used in the past. Whenever possible, instructors are also encouraged to invite experienced practice facilitators to co-teach specific modules and to discuss their "real world" experiences from working with practices. Learners will need get into the field and use their new skills as they help practices transform, and then reflect on their experiences as part of their ongoing professional development.

Tailor instruction to the needs of each learner. Instructors should tailor the sessions to meet the needs of the learners as well as the facilitation program that is sponsoring the training. The modules may be delivered as an intensive workshop of multiple hours or days, or in a series, such as weekly forums. The materials are designed primarily for onsite delivery to a group of learners but can be adapted for delivery through virtual conferencing. To deliver the curriculum virtually, the instructor will need to modify the interactive elements of each module to fit the virtual environment.

Encourage group activities. Working with a group of learners allows for interactive learning methods such as group discussions and role plays. However, the modules can be adapted for individualized self-study. In these cases, the learners may choose modules tailored to their specific needs. Interactive sections that require group participation can be eliminated or modified. For example, the learners could record responses to discussion questions in a journal.

Develop additional materials to support instruction. While the curriculum is intended to be comprehensive in its content and provide a solid introduction to the basics of facilitation, instructors will need to develop additional materials to complement those provided here. For example, the content of each module can be used to create presentations to support lectures and group activities.

Primary Care Practice Facilitation as an Emerging Profession

The PCPF workforce is an emerging profession with a developing body of knowledge and set of standards. The Agency for Healthcare Research and Quality has played an important role in supporting the development of this emerging workforce by:

- commissioning training materials, PCPF program handbooks, a national PCPF listserv and periodic e-newsletter,
- consensus reporting by experts, and
- research on the effectiveness of different facilitation approaches.

This curriculum for PCPF training builds on and expands this prior work.

Primary Care Practice Facilitation Curriculum

Module 1. Instructor's Guide to Using the Primary Care Practice Facilitator Curriculum

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Module 1. Instructor's Guide to Using the Primary Care Practice Facilitator Curriculum

The Primary Care Practice Facilitation (PCPF) curriculum is designed to help build a number of core competencies in new practice facilitators (PF) working with primary care practices. The curriculum also may be useful for training more experienced PFs in particular competencies that they have not yet mastered.

This module is composed of two parts:

1. *Overview of Core Competencies of Primary Care Practice Facilitation.* This section provides an overview of the core competencies addressed in the curriculum's 32 modules and includes a matrix showing where to find each competency in the curriculum. Instructors may wish to present all modules to their students or use the competency matrix to target or prioritize certain modules, depending on the needs of their learners.

2. *Incorporating Adult Learning Methods.* This section provides an overview of the general principles of adult learning, tips on applying these principles to training PFs, approaches for assessing adult learners and providing feedback, and references for additional information on adult learning. More information on how to incorporate adult learning principles when adapting the PCPF curriculum for online use is provided near the end of this module.

Overview of Core Competencies of Primary Care Practice Facilitation

Primary care PFs need to develop a number of core competencies to work effectively with primary care practices and help them engage in continuous quality improvement, become patient-centered medical homes (PCMH), and fundamentally transform the way they provide care. To identify PCPF core competencies, we engaged in a thorough review process (see box below) and compiled a list of widely accepted competencies needed by facilitators. Our technical expert panel members also contributed their "real world" experiences training practice facilitator. For example, competencies developed by programs like the North Carolina AHEC Practice Support program and HealthTeamWorks to train their facilitators were important resources in this process.

The PCPF core competencies identified here build on prior work funded by the Agency for Healthcare Research and Quality (AHRQ). The *AHRQ 2010 Consensus Meeting on Practice Facilitation for Primary Care Improvement* (Knox 2010) developed a list of competency areas needed by PCPFs; this included a mix of content mastery (including knowledge of primary care practice, diffusion of innovations theory, and organizational change) and applied skills (such as quality improvement methods, use of health information technologies, and communication). A subsequent guide, *Developing and Running a Primary Care Practice Facilitation Program* (Knox et al. 2011), refined these core competencies to focus on interpersonal skills, generating and using data, and quality improvement or change management methods. Building on these prior resources, the 2013 *Practice Facilitation Handbook* (Knox and Brach 2013) added practice assessment and health information technology optimization to the list of core competencies and began the process of creating instructional resources to support these competencies.

In preparing the PCPF curriculum presented here, we examined these prior resources as well as the practice facilitation resources offered by 21 different PCPF training programs or organizations in the United States. We then documented 11 commonly identified PCPF competencies as well as some areas that, while not commonly identified, are nonetheless important to PCPF.

For purposes of this curriculum, PCPF competencies are grouped into four distinct domains of knowledge and skill that are needed for supporting primary care practice transformation:

1. **Foundational knowledge**—familiarity with key topics important for improving and redesigning primary care, including:

    - organizational change processes,
    - the goals of QI for improving patient care,
    - the principles of the PCMH and the logic through which it intends to affect health care outcomes,
    - strategies for diffusion of innovations and organizational learning,
    - familiarity with the changing primary care practice environment (including regulatory and policy changes),
    - knowledge of health systems and the local primary care market,
    - understanding of payment models and their relationship to care delivery, and
    - knowledge of culturally and linguistically competent care delivery.

2. **General skills**—competence in applying foundational knowledge to various transformation tasks, including:

    - QI methods (for example, understanding of plan-do-study-act cycles);
    - organizational assessment (for example, assessing practice readiness for change);

- change management; and
- people, project, and meeting management.

3. **Specialized skills**—competence in the use of specific techniques to support change, including:

    - data collection and analysis to inform QI,
    - use of information technology systems, and
    - work process engineering methods.

4. **Professional skills, knowledge, and commitment,** including:

    - competence in the use of effective communication techniques;
    - interpersonal and facilitative skills;
    - skills in establishing trust with practice staff members;
    - knowledge of practice facilitation as a profession and as a national community of practice; and
    - commitment to self-evaluation, lifelong learning, and transparency.

The PCPF curriculum offers a series of modules for developing the competencies across each of these four domains (Table 1.1).

Table 1.1. Competencies addressed in the PCPF curriculum

Module Number	Module Title	Foundational Knowledge	General Skills	Specialized Skills	Professional Skills
2	PF as a Resource for Practice Improvement	Organizational change, spreading successful innovations across differing practice settings			
3	The Primary Care Landscape	Primary care environments			
4	An Introduction to Practice Organization and Management	Primary care environments			
5	Special Considerations When Working With Safety Net Practices	Primary care environments		Coaching skills for working with safety net practices	
6	An Overview of the Facilitation Process	Facilitation process and purpose			
7	Professionalism for Practice Facilitators				Professionalism, commitment to continuous learning
8	Approaches to Quality Improvement		QI methods, change management		
9	Using Appreciative Inquiry with Practices			QI methods, practice assessment	
10	Mapping and Redesigning Workflow			QI methods, change management	
11	Using Root Cause Analysis to Help Practices Understand and Improve Their Performance and Outcomes			QI methods, change management	
12	An Introduction to Assessing Practices: Issues to Consider		Practice assessment		

Module Number	Module Title	Foundational Knowledge	General Skills	Specialized Skills	Professional Skills
13	Measuring and Benchmarking Clinical Performance			Practice assessment	
14	Collecting Performance Data Using Chart Audits and Electronic Data Extraction			Practice assessment	
15	Preparing and Presenting Performance Data			Preparing and presenting performance data	
16	Academic Detailing as a Quality Improvement Tool			Academic detailing	Cultural competency
17	Introducing a Practice to Facilitation	Facilitation process and purpose			Professionalism, cultural competency
18	Assessing Practice Readiness for Change		QI methods, practice assessment		
19	Conducting a Kickoff Meeting		Meeting management		
20	Creating Quality Improvement Teams and QI Plans		QI methods		Cultural competency
21	Working With and Supporting Practice Leaders	Organizational change Organizational cultures	Leadership coaching		Cultural competency
22	Running Effective Meetings and Creating Capacity for Practices to Run Effective Meetings		Meeting management, change management, leadership coaching		
23	Documenting Your Work with Practices				Professionalism
24	Introduction to the Care Model	The Care Model			
25	The Patient-Centered Medical	Principles of the			

Module Number	Module Title	Foundational Knowledge	General Skills	Specialized Skills	Professional Skills
	Home: Principles and Recognition Processes	PCMH			
26	An Introduction to Electronic Health Records and Meaningful Use	Primary care environments	Use of information systems		
27	Helping Practices Optimize EHRs for Patient-Centered Medical Home Transformation and Quality Improvement	PCMH and electronic health record systems to support PCMH		Optimizing electronic health record systems to support PCMH	Cultural competency
28	Using the AHRQ Care Model Toolkit with Practices		QI methods		
29	Implementing Care Teams		QI methods		Cultural Competency
30	Building Teams in Primary Care		Meeting management, leadership coaching, QI methods Change management		
31	Facilitating Panel Management		Change management	Facilitating panel management	
32	Improving Self-Management Support and Engaging Patients in Care and Practice Improvement Topics	Primary care environments		Patient engagement	Professionalism

As a whole, the PCPF curriculum is intended to build the competencies that many consider necessary for effective practice facilitation. These competencies, however, need to be combined with the following professional standards:

- **Transparency**—to clearly communicate the facilitator's own interests in the change process (for example, who employs them and the objectives of the employer) to the practice members he or she is working with

- **Self-evaluation**—use of critical self-reflection to support ongoing development of skills to identify and address knowledge gaps and the need for new techniques

- **Commitment to continuous learning**—to continue to develop skills and adapt to changes in the primary care landscape or policy environment by pursuing self-directed learning

- **Commitment to quality improvement**—to spread knowledge and best practices within the primary care community to improve population health

Incorporating Adult Learning Concepts as You Teach this Curriculum

In teaching these core competencies to PFs, the PCPF curriculum is designed to support the use of established adult learning principles. These instructional principles are based on the knowledge that adult learners are internally motivated and self-directed, bring life experience and prior knowledge to learning, are goal oriented, seek information relevant to the work they plan to do, want practical applications for learning, and want to be treated as equals. While the PCPF curriculum incorporates various elements of adult learning principles, it is nonetheless critical for you, as the instructor, to consider and use these elements as you teach this curriculum.

The four key principles of adult learning (Knowles, 1984) suggest that instruction must be relevant and useful to learners, should be problem centered and action oriented, should incorporate the experiences of learners, and should include opportunities for performance feedback.

Instruction must be relevant and useful to learners. Adult learners are motivated to learn primarily by the knowledge that what they are learning will be useful to them in their work. Each of the modules in the PCPF curriculum has an instructor's guide that includes specific learning objectives to ensure the usefulness of the content. Sharing learning objectives with your learners is one way to make sure that they understand the purpose of the content you are teaching and allows an opportunity for you to underscore how the content may be useful to them.

Some ways to ensure that your instruction is relevant include:

- identifying and discussing practical applications of the knowledge, skills, or techniques you are covering
- having learners play a key role in identifying what aspects of the curriculum will most clearly and directly address their own gaps in knowledge and skill

- conducting a needs assessment of each learner to tailor instruction to the learners' immediate needs

Instruction should be problem centered and action oriented. Adult learners are task oriented and focused on solving real-world problems. For this reason, the PCPF curriculum is organized around helping PFs develop the knowledge and skills they will need and can then directly apply to their work with primary care practices.

Some ways to ensure that your instruction is problem centered and action oriented:

- use the problem-centered simulated cases presented in many of the modules so that PCPF trainees can try out new skills before they use them in the field
- create your own simulated cases and in-class exercises focused on solving problems commonly encountered in PCPF work

Instruction should incorporate the experiences of your learners. Adult learners bring a wealth of past experiences that can inform their work as facilitators. Bringing this experience into the instructional setting will benefit other learners and make sessions more engaging for everyone. Therefore, these experiences can be an important resource for enriching your instruction. In some cases, however, prior experience, beliefs, and attitudes can lead to incorrect assumptions about what is needed in PCPF work or about how to approach a specific issue. Discussion of these prior experiences, beliefs, and attitudes is an essential part of developing the self-evaluation skills of those you are training.

Some ways to ensure that your instruction incorporates the prior experiences of your learners:

- Leave adequate time to discuss how their prior experiences apply to working with primary care practices.
- Have experienced facilitators (either from among those you are training or from outside the group being trained) work with you to develop simulated cases and in-class problem-solving exercises directly from their prior experiences.

Guidance on Assessment and Evaluation of Learners

Instruction should include opportunities for performance feedback. Adult learners want feedback on the practical application of the new skills that they are developing or on old skills they are working to enhance. Creating opportunities for performance feedback in the classroom reinforces the need for ongoing professional development and self-evaluation.

Each module includes suggested exercises that will allow formative assessment (i.e., progression of learning) of learners before, during or after the session. These exercises can be adapted to the needs of the program, instructor or the learner. While a summative assessment (e.g., at completion of learning) tool is not provided, each module includes learning objectives to guide development of such tools as needed by the program. In addition, the core competencies provide a blueprint for evaluation of new PF performance in the practice setting.

Some ways to ensure that your instruction creates opportunities for performance feedback:

- Provide direct observation of your learners as they work with primary care practices, followed by specific, objective, and improvement-focused feedback.
- Create opportunities for PF trainees to report back on their experiences, using new skills in practice, and then self-evaluate their work.

For additional resources on adult learning, see the list of references and resources at the end of this module.

Considerations in Using the PCPF Curriculum for Online Instruction

The content of this curriculum is designed for use in both in-person classrooms and in online or virtual classrooms. In some cases, using the content of the modules will require modification for use in a virtual classroom. For information from some exemplar online training programs, review the resources in the text box below. To determine what modifications you need to make to use of a specific module in a virtual setting, you should review the suggested exercises and activities detailed at the beginning of each module and consider how to accommodate your audience. Before you consider modifying any content, there are three things you should review: (1) the learning objectives from the module and your comfort level in teaching its content, (2) the expectations of learners for the training, and (3) the functions and limitations of your web platform.

Case Studies of Exemplary Primary Care Practice Facilitation Training Programs
http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfcasestudies/index.html

Training Program Summary: Millard Fillmore College Practice Facilitator Certificate Program
http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfcasestudies/fillmore.html

Hands-on activities and group exercises work well for adult learning, but are difficult to conduct in a virtual environment. Some activities may require the trainer to use multimedia, such as video presentations, chat box features, electronic surveying, etc. and shift from lecture to hands-on activities in a single training session. As a trainer, you need to have some comfort level with technology, or at the very least have technical support at your disposal. Become familiar with piloting virtual classrooms through mock sessions with a colleague. You will also need to adapt your virtual training based on the technology available to you and your learners. Some computer systems may not be compatible with specific software programs. Always ask learners to test run a system prior to the day of the session in efforts to avoid any technical difficulties during training and consider technological learning curves for the student. The box below contains an example of how to adapt a specific module (Module 4) for on-line learning environments.

Adapting Module 4: "An Introduction to Practice Organization and Management" for Online Use

Module 4 is intended to provide new PFs with an introduction to practice structure and administration. After thoroughly reading the module, accessing its resources, and becoming familiar with its exercises, your next step is to decide on a method for delivering the planned group exercise for the module. The options are to assign the activity prior to the training session or to work with the group as a whole during the session. In this example, the module requires learners to construct a *vision map* to assess areas where they believe clinic staff can affect quality improvement (see Module 4 instructor's guide). The exercise asks learners to break into groups of three to complete this exercise. Instead, you can request that each participant conduct this activity with a colleague, or alone, prior to the session. On the day of the training session, learners should come to the online session prepared to discuss the results of this activity. Prior to the session, you should confirm that your web platform allows learners to share their screens, or you could have learners send results to you in advance and assemble them prior to the online training.

A virtual environment can make it difficult to assess learner understanding. The inability to read and express body language or facial expressions—as one would in person—can further lead to misinterpretations or gaps in awareness. To avoid this, think through effective ways to probe your audience and gain feedback from your learners. Many platforms have polls, surveys, and chat functions that will allow for frequent check-ins to ensure learners understand the information communicated. Some questions you might ask the group throughout the training:

- Does anyone have any questions?
- Can anyone think of their own example and share with the group?
- [Name], what are your thoughts on this subject?
- I've just reviewed the outline for this training, are there any particular components the group would like to focus on for today's session?
- What is your experience with this?
- What is your understanding of the term "[term]"?

When conducting virtual trainings, gauge participants' vested interest and reach out to each of the learners prior to the session to make sure they are comfortable with participating (Mittleman, Briggs, and Nunamaker 2000). Trainers can expect to deal with several virtual-classroom specific issues, such as: participant feedback, attendance, team building, unpredictable networks, and time differences. Here are some exemplary practices used by instructors to address virtual training barriers:

- Send your training schedule in advance and ensure that all students have the materials needed for their participation.
- Speak concisely and clearly throughout.
- When possible, always show your face on screen in the virtual room.
- Remind participants about etiquette and virtual room features (i.e. silence cell phones/pagers and use of chat box function).
- Always start with the program outline and introductions.
- Be sure to welcome attendees who arrive late, or ask them to introduce themselves.
- Do not monopolize discussions; use this opportunity to explore others' experiences and importantly, ensure you offer enough time for others to respond to content.
- Continue to engage those who participate regularly and encourage those have not commented.
- Call on learners by name.
- Provide explicit feedback, proactively check in with participants every 10–15 minutes or when appropriate, and utilize back channels (such as a chat box).
- Use names and remind participants who is attending.
- Use collaboration tools as needed and use process support tools to focus group attention on specific information (for example, using shared screens).
- Engage in a dialogue rather than giving a summary, start dialogue with someone you know, and shift focus among the participants.
- Ensure that you have clearly defined terms.

Selecting a Platform. To launch a virtual training, you will need a video conferencing platform. If you do not already have access, you will need to select one and become comfortable using its features. There are a number of excellent platforms you can use online. The minimum requirements needed to deliver a virtual training session are: audio, video and screen share, and chat box features. Ideally, select a platform that includes virtual breakout rooms for small work groups.

Here are some ways to use a video conferencing platform during training:

- Have each user share a webcam feed for a more personalized experience.
- Alternate screen share between yourself and users.
- Download documents to share for view (some platforms distribute documents to the group after the session).
- Use chat boxes to distribute survey links and as an opportunity for participants to write comments/questions.
- Take control over participant's keyboard and cursor when granted permission (this may be helpful when demonstrating training activity on a learner's computer for a more personalized experience).

- Record the training session to keep on file or post for others to view.

Building Connections With Students. The relationships formed between instructors and learners are affected by their ability to connect and effectively communicate with each other. Interactions between learners and instructors can be difficult even in person, and a virtual setting is no different. Providing consistent check-ins and responding to chat box messages are helpful approaches in making connections with learners. Mittleman et al. (2000) suggest that instructors check-in with learners every 10–15 minutes by asking them questions like "Tom, are you with us? Do you agree with the items just discussed?" Not only does this engage learners, but it also reminds them that the training is intended to be interactive.

Also, be mindful of the chat box. Scan for messages as they are sent, especially since messages can be sent sporadically throughout the session. Read comments and questions as they are sent. When reading these messages, be sure to read them aloud. Note that some learners may send you private messages meant for you alone, and in other cases they may be sent to the entire group. Either way, you will want to share relevant comments and questions. For those that send you a private message, you might state, "*Someone* just posted a comment that reads. . . ." In using the term "someone," you get the learners to focus on the subject and not so much the individual. After reading a message, further engage learners and ask for their reactions or understanding of the remark. This level of engagement will aid your efforts in building connections with learners.

References

Knowles MS. *Andragogy in Action:* A*pplying Modern Principles of Adult Learning*. San Francisco: Jossey-Bass; 1984.

Knox L, ed. *Report on the AHRQ 2010 Consensus Meeting on Practice Facilitation for Primary Care Improvement*. (Prepared by LA Net through a subcontract with the University of Minnesota under Contract No. HHSA290200710010 TO 3.) Rockville, MD: Agency for Healthcare Research and Quality; 2010.

Knox L, Taylor EF, Geonnotti K, Machta R, Kim J, Nysenbaum J, Parchman M. *Developing and Running a Primary Care Practice Facilitation Program: a How-to Guide.* (Prepared by Mathematica Policy Research under Contract No. HHSA2902009000191 TO 5). Rockville, MD: Agency for Healthcare Research and Quality; December 2011. AHRQ Publication No. 12-0011.

Knox L, Brach C. *The Practice Facilitation Handbook: Training Modules for New Facilitators and Their Trainers.* (Prepared by LA Net through a subcontract with the University of Minnesota under Contract No. HHSA290200710010 TO 3). Rockville, MD: Agency for Healthcare Research and Quality; June 2013. AHRQ Publication No. 13-0046-EF

Mittleman DD, Briggs RO, Nunamaker Jr. JF. Best practices in facilitating virtual meetings: some notes from initial experiences. *Group Facil.* 2000;(2):6-15.

Resources

Global Learning Partners. Downloadable Resources. Available at http://www.globallearningpartners.com/resources/downloadable-resources.

Primary Care Practice Facilitation Curriculum

Module 2. Practice Facilitation as a Resource for Practice Improvement

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Module 2. Practice Facilitation as a Resource for Practice Improvement

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Foundational knowledge of organizational change
- Foundational knowledge in spreading successful innovations across differing practice settings

Time

- Pre-session preparation for learners: 30 minutes
- Session: 85 minutes
- Follow-up by instructor: 30-60 minutes

Objectives

After completing this module, learners will be able to:

1. Describe the function and key activities of a practice facilitator.
2. Describe the core competencies of practice facilitators.
3. Create a Practice Facilitator Professional Development and Training Plan based on information from this module.

Exercises and Activities To Complete Before, During, and After the Session

Pre-session preparation. Ask the learners to read items 1-2 (30 minutes)

1. The content of this module.
2. Baskerville NB, Liddy C, Hogg W. Systematic review and meta-analysis of practice facilitation within primary care settings. Ann Fam Med, 2012;10(1):63-74. Available at http://annfammed.org/content/10/1/63.full.pdf.

During the Session. Presentation (25 minutes)

1. Present key concepts from the module.

Discussion. Ask questions and explore answers with learners. (15 minutes)

1. What is the purpose and goal of practice facilitation?
2. What skills do facilitators need?
3. Discuss the Baskerville article and the evidence supporting practice facilitation.

Activity for learners (45 minutes)

Introduce the Practice Facilitator Professional Development and Training Plan form to the

learners.

1. Explain that the form will be used to design training, both didactic and experiential, tailored to their specific learning needs.
2. Explain that the form is based on core competencies that practice facilitators need to introduce continuous quality improvement in a practice and to support implementation of the Care Model, the patient-centered medical home, and meaningful use.
3. Ask each learner to complete the Practice Facilitator Professional Development and Training Plan using the paper form contained in the Appendix.

NOTE: It is helpful to enter the items into an online survey platform and use this to collect and monitor this information for participants.

Activities to complete after the session. (For instructor only—30 to 60 minutes, depending on number of learners)

1. Review the Practice Facilitator Professional Development and Training Plans completed by the learners during Module 2.
2. Use the Practice Facilitator Professional Development and Training Plans to identify learners who rate themselves as "very confident" in specific areas to engage as co-leaders for future training sessions.
3. Use results of plans to determine which topics to emphasize in future trainings and to identify areas where existing training materials may need to be supplemented with additional content.

Module 2.

Practice facilitation, sometimes also referred to as quality improvement coaching, is an approach to supporting improvement in primary care practices that focuses on building organizational capacity for continuous improvement (Knox, 2010). As a practice facilitator, you will establish a long-term relationship with your practices, becoming a resource for ongoing quality improvement (QI) and evidence translation.

This module provides a brief overview of practice facilitation. For an in-depth discussion, see *Developing and Running a Primary Care Practice Facilitation Program: A How-to Guide* (Knox, et al., 2011). The guide can be accessed at http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483/pcmh_implementing_the_pcmh_practice_facilitation_v2.

Who Are Practice Facilitators?

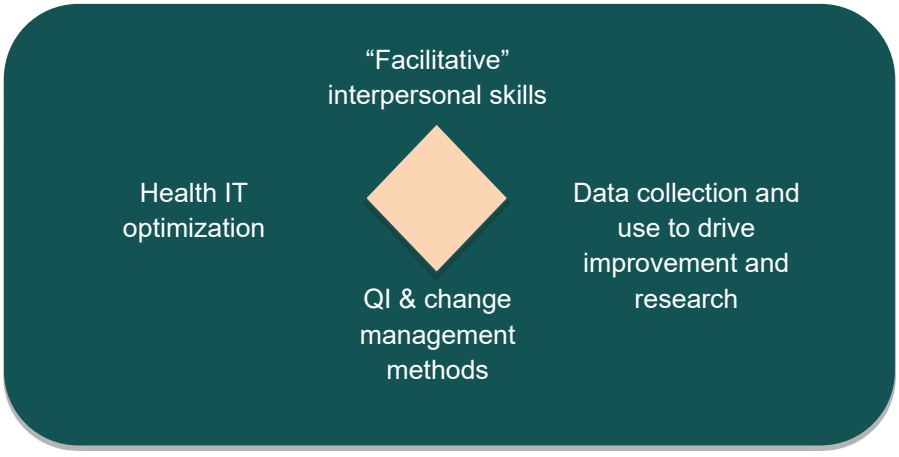
Practice facilitators (also known as a practice coaches, QI coaches, and practice enhancement assistants) are specially trained individuals who work with primary care practices "to make meaningful changes designed to improve patients' outcomes. [They] help physicians and quality improvement teams develop the skills they need to adapt clinical evidence to the specific circumstance of their practice environment" (DeWalt, et al., 2010). As a practice facilitator, you need competencies in four areas:

1. Interpersonal skills to build support for and facilitate change
2. Methods for accessing and using data to drive change
3. QI and change management strategies
4. Health information technology (IT) optimization

In addition, you will need expertise in the specific content of an intervention (e.g., patient- centered medical home [PCMH] transformation, guideline implementation).

Figure 2.1. Four core competencies of practice facilitators

Practice facilitators are generalists who support QI and other related activities in a practice or



health care organization. They may work alone or lead a practice facilitation team made up of the facilitator, a health IT expert, and a data manager, as well as additional experts. These may include individuals with expertise in specific clinical or technical content required by the intervention.

You may also engage physicians, chief executive officers, nursing staff, and others from practices that have already worked with a practice facilitator or that have already undergone improvement in the desired areas to serve as peer mentors to the practice. For example, let's say you are supporting implementation of advanced access (a method of shortening wait times for appointments). In addition to providing general facilitation support to your practice, you may engage a consultant with expertise in this area as a member of your practice facilitation team. This consultant can provide support to a practice undergoing this specialized transformation.

When a team approach is indicated, as generalist and lead facilitator, you will form and manage this team to ensure that a practice has the resources it needs to make the desired changes. Your role will be to identify individuals with the needed expertise, engage them, and then manage the team to ensure it meets the needs of the practice most cost-effectively.

Facilitation Goals

The goal of your work with practices is to build their capacity for continuous quality improvement and their ability to implement new evidence-based treatments and bring health service models into practice. The ultimate aim of all of these activities is to improve patient outcomes and experience and lower the overall costs of care.

To build these capacities, as a facilitator, you will help your practices establish QI teams, create improvement plans, assess practice systems and processes, develop performance monitoring systems, and use strategies such as benchmarking to motivate practices to change and compare their performance to other similar groups. You will provide training to your practices on QI approaches such as the Model for Improvement and assist them in using methods such as Plan Do Study Act cycles to test, spread, and sustain changes in the practice. You will also provide training to your practices on the contents of specific improvements or engage experts, such as academic detailers, to provide training. In addition, PFs help practices modify policies, procedures, and job descriptions to sustain changes.

You will also:

- map workflows and assist practices in redesigning them to support changes,
- help staff modify policies and procedures to ensure sustainability of changes,
- identify exemplar processes in your practices and spread them to others,
- identify resources to implement improvements that extend beyond the scope of your skills or the particular facilitation intervention,
- help practices integrate all of the improvement work occurring within them into a cohesive whole, and

- form and maintain a long-term relationship with your practices.

In addition to your work building capacity for change in the practice, you will work toward specific improvement goals. These improvement goals may be:

- determined by the practice,
- determined by your facilitation program, or
- as often is the case, specified by the funder for the intervention.

These goals can vary significantly in their complexity. Some are tightly focused on improving care for a specific condition, such as implementing treatment guidelines for chronic kidney disease. Others are focused on whole practice transformation, such as implementing tenets of PCMHs or the Care Model (see Module 24). The scope and complexity of the desired changes will dictate the type and intensity of your support. Finally, you will facilitate engagement of a practice in its improvement work.

It is important to remember that practice improvement is not about an outside entity telling a practice to change, but rather about helping practices establish their own motivations for improvement and the knowledge, skills, and systems to effect positive change.

Facilitation Intensity and Length

Facilitation interventions vary in length and number of support hours delivered. These are typically linked to the particular goals being pursued and the capacity of the practice at the start of the intervention. Complex improvement goals will require more hours of support and a longer delivery schedule; goals that are more narrowly focused or are smaller in scope will require fewer hours or shorter duration.

Practices with higher levels of capacity for improvement will require less support and a less intensive intervention schedule. Practices with little existing capacity for improvement will require more. Efforts to introduce a particular practice guideline might require only a few months of support. Whole practice transformation such as that required by the PCMH may require a year or more. That said, intensity of services often depends on funding realities.

As a practice facilitator, you will support practices based on the particular facilitation process and intervention model your program is using. Within this framework, you will want to tailor your approach to suit the needs of each practice based on its size, organizational structure, patient population, geographic location, and health care context.

Ideally, you will form a long-term relationship with the practices that extends beyond a single project or QI initiative. In the best sense of the word, you will become a long-term resource for the practice, not employed by them but available to support implementation of new health service models, treatments, and improvements to patient care.

Onsite and Virtual Facilitation

Experts consider some degree of onsite support, with a predictable schedule of onsite visits by the facilitator, to be almost essential to successful facilitation as it helps to establish and maintain an effective working relationship between you and your practice. Some interventions will need intensive onsite support while others may allow for a combination of onsite and virtual support. Virtual support can include check-in sessions and trainings on basic information on QI and new models of clinical care delivery. Onsite support is more appropriate for activities such as:

- Internal capacity building for ongoing QI, practice assessment, and data collection,
- Workflow mapping and redesign,
- Implementation of complex changes, and
- Conflict resolution.

What Practice Facilitators Do

Practice facilitators promote a culture of learning and QI within practices and set the stage for continuous quality improvement that extends beyond the period of active facilitation. Practice facilitators can be thought of as "catalysts for change," supporting transformation at the individual, team, organizational, and systems levels (Department of Health and Community Services, 2006). In addition to general skills in QI, change management, data collection, and optimization of health IT systems, some may acquire expertise in specialized areas such as supporting attainment of meaningful use of health IT to improve patient care. Table 2.1 lists some of the key activities practice facilitators undertake.

Table 2.1. Practice facilitator activities

Topic	Activities
Creating infrastructure for continuous improvement	• Form and manage an external facilitation team with expertise tailored to practice needs • Form or optimize a central QI team for the organization or practice • Ensure diverse membership on the QI team or specific project teams • Help teams create or update QI plans • Help teams create or enhance performance monitoring systems • Help teams use performance data to set improvement goals, make changes, and monitor progress
Building skills in leadership and QI teams that support continuous improvement	• Provide executive coaching to leadership in change management, human factors, conflict resolution, and project management • Build priority for change in practice and leadership using data, academic detailing and social learning, introduction to new ideas, and best evidence • Train staff on QI approaches and methods (e.g., Model for Improvement, small tests of change, workflow mapping and redesign, benchmarking, EHR data/chart reviews, audit and feedback, root cause analysis) • Train team on concept of data-driven improvement and data collection and management • Teach skills for running effective QI meetings • Teach skills for encouraging culture of continuous QI in organization
Managing projects	• Provide project and change management support, and build capacity for the same in practice • Set up and use collaboration software for change process management • Support accountability for action items and follow-through on improvement plans • Help practice coordinate, integrate, and realize synergies in all improvement work occurring across the organization
Assessing organizations and monitoring progress	• Assess organizational/practice readiness for capacity building and improvement work • Conduct initial assessment of practice's core systems (administrative, clinical, health IT, data, and human resources) using an assets-based approach (i.e., identify both strengths and weaknesses) • Collect data from multiple sources, including surveys, paper records, registries, and electronic health records • Implement report generators and other systems that create capacity for routine performance reporting and train staff to maintain and expand these processes

Topic	Activities
Optimizing health IT for performance monitoring and population management	• Help practice interact with health IT vendors • Help practice engage expert consultants in health IT as needed • Share best practices in use of particular electronic health record (EHR) products from other practices as appropriate • Help practice structure EHR to maximize population management capacity • Set up registry tracks and create workflows for maintaining registries • Identify and correct data errors in EHR and registry • Set up connections between labs and EHRs, standalone registries and EHRs, and other relevant IT platforms and products • Help staff set up and manage templates and point-of-care decision support • Train staff to optimize EHR functions to enhance care team communication (e.g., tasking) • Train staff to create and generate performance reports for QI
Supporting implementation of targeted changes and improvements	• Train and support practices in implementing new health service models such as the PCMH, new processes, treatments, evidence, or best practices. For example, provide training and support on: • Team-based care • Empanelment and panel management • Planned care • Action plans with patients • Self-management support • Care coordination • Risk stratification and use of this information to guide care • Other related topics • Engage external experts as needed to provide peer-to-peer and expert training to practice on new models of care, treatments, and other targeted improvements • Make changes to policies, procedures, and job descriptions to support changes
Supporting knowledge generation and research in the practice	• Manage research studies • Assist in data collection for research • Train staff to participate in research
Identifying and spreading exemplar practices	• Document exemplars and best practices and share with program, facilitation community, and practices • Develop training to support spread of exemplar processes
Identifying and communicating system-level barriers to improvement	• Document system-level barriers to improvement and communicate to program, funders, policymakers, and health care community

Topic	Activities
Performing administrative tasks and maintaining professionalism	• Comply with privacy rules • Maintain appropriate documentation of work with practices and monitor practice progress • Maintain appropriate documentation of project/funder-related work and monitor progress toward deliverables • Participate in supervision and group learning with other facilitators • Participate in continuous education • Form and manage your external facilitation team for each site • Manage time effectively • Evaluate effectiveness and quality of your work with your practices

Technical Versus Soft Skills in Facilitation. To carry out these activities, PFs need to possess technical knowledge and skills such as how to collect, analyze, and display data; how to train practices to run effective meetings; how to teach and facilitate root cause analyses by practice members; how to optimize health IT systems to support improvement; and how to create QI plans. In addition, PFs need "soft skills," such as being able to build relationships that facilitate change, communicating effectively with others, helping practice members build hope and confidence in their ability to effect change, and helping members manage conflict effectively to drive improvement. While PFs can often acquire technical knowledge and skills through training, soft skills may be more difficult to acquire through traditional training processes.

Evidence on Practice Facilitation

While some believe practice facilitation is a relatively new approach to supporting practice improvement, its origins can be traced back more than 30 years. It was used from 1982 to 1984 in the Oxford Prevention of Heart Attack and Stroke Project in England as the primary intervention to help clinicians improve screening for cardiovascular disease (Fullard, et al., 1984; Department of Health and Community Services, 2006). Evaluations of the project demonstrated the value of facilitation support for improving clinical processes and cardiovascular care.

Following this early success, England became an early adopter of practice facilitation and used it as part of a comprehensive approach to support primary care. In the 1990s, Australia, Canada, the Netherlands, and the United States began using the facilitation model to support practice improvement (Nagykaldi, et al., 2005).

Since then, organizations such as practice-based research networks, State health departments, professional associations, and health plans have used practice facilitation to support QI, as well as knowledge generation and discovery in primary care practices. Settings range from small, private practices to large multispecialty group practices, from urban to rural to frontier settings, and from safety net to non-safety net providers. The common element of all practice facilitation

programs is the use of specially trained individuals who establish long-term relationships with practices and work to help them implement the targeted improvements.

Effectiveness. The evidence base demonstrating the effectiveness of practice facilitation as a method for improving primary care practice is growing. Nagykaldi, Mold, and Aspy completed the first review of practice facilitation in 2005. Analyzing 25 studies of practice improvement conducted between 1966 and 1984, the authors found that practice facilitation contributed to increases in the delivery rates of preventive services. It also improved relationships and communication among health care professionals, assisted clinicians with chronic disease management, provided professional education, and facilitated system-level improvements. Parchman, et al., (2013) concluded that practice facilitation resulted in significant and sustained improvement in delivery of care.

Baskerville, Liddy, and Hogg (2012) published a meta-analytic review of 22 studies involving 1,429 practices in which they found evidence of the effectiveness of practice facilitation compared to nonintervention controls. Primary care practices receiving practice facilitation were almost three times as likely as control practices to adopt evidence-based guidelines. Supporting work also describes the effectiveness of using practice facilitation as an approach to quality improvement, specific to implementing clinical guidelines (Mold, et al., 2014).

The researchers also shed light on factors associated with greater practice facilitation effect. For example, the researchers found that as the number of practices supported by a facilitator increased, the effect size of facilitation decreased. In addition, practice facilitation interventions delivering a higher dose of support (e.g., total number of hours and duration of the intervention) were associated with larger effects.

Sustainability of change. Studies also examined the sustainability of changes implemented using practice facilitation support. While an early study found that the effects were not sustained past the intervention period (McCowan, et al., 1997), multiple studies conducted since then found that the effects of practice facilitation were sustained for as long as 12 months post intervention (Dietrich, et al., 1994; Hogg, et al., 2002; Stange, et al., 2003; Hogg, et al., 2008).

As early as 1995, Bryce and colleagues evaluated the impact of an audit facilitator on patterns of diagnosis and treatment of childhood asthma in 12 practices. At a 2-year follow-up, there were significant increases in asthma consultations, new diagnoses of asthma, and reaffirmation of past diagnoses in intervention versus control practices.

Cost benefit. Others looked at the cost effectiveness of practice facilitation. Hogg, Baskerville, and Lemelin (2005) examined the cost savings associated with practice facilitation in reducing inappropriate and increasing appropriate screening tests in 22 primary care practices serving approximately 100,000 patients. The team conducted a cost-consequences analysis. Within the Canadian context, the intervention resulted in an annual savings per physician of $3,687 and per facilitator of $63,911. The estimated return on intervention investment was 40 percent.

Patient-centered medical home implementation. Most recently, researchers studied the impact of practice facilitation on efforts to meet PCMH criteria. The National Demonstration Project (NDP) study compared two implementation approaches: facilitated and self-directed. Thirty-six family practices that were deemed ready and highly motivated to adopt the NDP model of the PCMH were selected for the study. The practices were randomly assigned to self-directed or facilitated change conditions. The practice facilitation intervention was mainly delivered remotely with one or two onsite visits over the course of the study. The research team found that facilitation increased the practices' capability to make and sustain change and increased their adaptive reserve, their organizational capacity to engage in ongoing QI (Nutting, et al., 2010). Differences in actual PCMH implementation were not significant by group. This likely reflects the fact that both groups were already highly motivated to change and the practice facilitation intervention was primarily virtual, so of relatively low intensity.

There are web-based tools that can assist with such facilitation efforts. For example, Coach Medical Home includes tools, resources, guidance for transformation work, and suggestions for building learning communities (available at: http://www.coachmedicalhome.org). In a companion article, Johnson et al. (2014) describes the development of Coach Medical Home curriculum to support medical home transformation through coaching. Table 2.2 provides a brief list of training programs for practice facilitators.

Table 2.2. Training programs for practice facilitators

HealthTeamWorks: a nonprofit dedicated to system redesign in health care delivery, promoting integrated communities of care and the use evidence-based care	www.healthteamworks.org/
Institute for Healthcare Improvement: this institute uses models for improvement as a framework to guide improvement work	www.ihi.org/resources/Pages/HowtoImprove/default.aspx
State University of New York Buffalo and CoCoNet2 Practice Facilitator Certificate Program: a virtual training program for PFs using materials adapted from the AHRQ Practice Facilitation Handbook (an earlier version of this curriculum)	www.millardfillmorecollege.com/practice_facilitator_ad
The Dartmouth Institute Microsystem Academy: ecoach-the-coach: a 5-month intensive virtual and in-person training on practice coaching	https://clinicalmicrosystem.org/ecoach-the-coach/

Case Studies: from the Agency for Healthcare Research and Quality, these case studies profile exemplary primary care practice facilitation training programs	www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfcasestudies/index.html
Implementing the PCMH: a how-to guide on developing and running a practice facilitation program	http://pcmh.ahrq.gov/page/practice-facilitation

Note: this module is based on Module 1 of the Practice Facilitation Handbook. Available at http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/

References

Baskerville NB, Liddy C, Hogg W. Systematic review and meta-analysis of practice facilitation within primary care settings. Ann Fam Med 2012;10(1):63-74.

Department of Health and Community Services, Government of Newfoundland and Labrador. Guiding facilitation in the Canadian context: enhancing primary health care. St. John's, Newfoundland: Department of Health and Community Services; 2006.

DeWalt D, Powell J, Mainwaring B, et al. Practice coaching program manual. Washington, DC: Aligning Forces for Quality (AF4Q), George Washington University Medical Center; 2010.

Dietrich A, Sox C, Tosteson T, et al. Durability of improved physician early detection of cancer after conclusion of intervention support. Cancer Epidemiol Biomarkers Prev 1994;3:335-40.

Fullard E, Fowler G, Gray M. Facilitating prevention in primary care. BMJ (Clin Res Ed) 1984;289(6458):1585-7. Hogg W, Baskerville N, and Lemelin, J. Cost savings associated with improving appropriate and reducing inappropriate preventive care: cost-consequences analysis. BMC Health Serv Res 2005;5:20.

Hogg W, Baskerville N, Nykiforuk C, et al. Improved preventive care in family practices with outreach facilitation: understanding success and failure. J Health Serv Res Policy 2002:7,195-201.

Hogg W, Lemelin J, Moroz I, et al. Improving prevention in primary care: evaluating the sustainability of outreach facilitation. Can Fam Physician 2008; 54:712-20.

Johnson KE, Coleman K, Phillips KE, et al. Development of a facilitation curriculum to support primary care transformation: the "Coach Medical Home" curriculum. Med Care 2014;52(11 Suppl 4);S26-S32.

Knox L, ed. Report on the AHRQ 2010 consensus meeting on practice facilitation for primary care improvement. (Prepared by LA Net under Contract No. HHSA2902007100110.) Rockville, MD: Agency for Healthcare Research and Quality; 2010.

Knox L, Taylor EF, Geonnotti K, et al. Developing and running a primary care practice facilitation program: a how-to guide (Prepared by Mathematica Policy Research under Contract No. HHSA290200900019I TO5.) Rockville, MD: Agency for Healthcare Research and Quality; December 2011. AHRQ Publication No. 12-0011.

McCowan C, Neville R, Crombie I, et al. The facilitator effect: results from a four-year follow-up of children with asthma. Br J Gen Prac 1997;47,156-60.

Mold JW, Fox C, Wisniewski A, et al. Implementing asthma guidelines using practice facilitation and local learning collaboratives: a randomized controlled trial. Ann Fam Med 2014;12(3);233-40.

Nagykaldi Z, Mold J, Aspy C. Practice facilitators: a review of the literature. Fam Med 2005;37:581-8.

Nutting P, Crabtree B, Stewart E, et al. Effect of facilitation on practice outcomes in the National Demonstration Project Model of the patient-centered medical home. Ann Fam Med 2010;8:S33-S44; S92.

Parchman ML, Noel PH, Culler SD, et al. A randomized trial of practice facilitation to improve the delivery of chronic illness care in primary care: initial and sustained effects. Implement Sci 2013;8(93).

Stange K, Goodwin M, Zyzanski S, et al. Sustainability of a practice-individualized preventive service delivery intervention. Am J Prev Med 2003;25(4):296-300.

Primary Care Practice Facilitation Curriculum

Module 3. The Primary Care Landscape

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Module 3. The Primary Care Landscape

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Foundational knowledge of primary care environments

Time

- Pre-session preparation for learners: 60 minutes
- Session: 75 minutes

Objectives

After completing this module, learners will be able to:

1. Define primary care and describe the key components of primary care.
2. Describe at a high level how the Affordable Care Act affects primary care practices.
3. Describe key emerging primary care delivery models.
4. Describe public and private payers and the different payment models they use.
5. Locate resources to learn about new developments in primary care.

Exercises and Activities to Complete Before, During, and After the Session

Pre-session preparation. Ask the learners to review the following information (60 minutes).

1. The content of the module.
2. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q. 2005;83(3):457-502.

During the session. Presentation (15 minutes)

1. Present key concepts from the module.

Discussion. Ask questions and explore answers with learners (60 minutes).

1. Why is primary care a central component of the U.S. health care system?
2. What potential implications does the primary care professional shortage have for practices?
3. How have recent public policies affected primary care practices?
4. How can practice facilitators help practices understand the implications of new public policies?
5. Who are the major public and private payers for primary care services? How do they differ?
6. What are the key payment models for primary care (including both traditional and evolving models)? How do they affect care delivery?
7. What is a Primary Care Medical Home (PCMH)? What is an Accountable Care Organization (ACO)? What is primary care's role within these models?

After the session.

1. Ask learners to review additional resources provided at end of the module.

Module 3

Primary care is a fundamental part of the health care system and plays an essential role in the health of the population. According to the Agency for Healthcare Research and Quality (AHRQ), primary care is "foundational to achieving high-quality, accessible, efficient health care for all Americans." In this module, we provide an overview of the primary care landscape, especially as it relates to practice facilitation. We also discuss how current policies and the payment environment affect primary care practices.

What Is Primary Care?

> Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.
>
> *-Institute of Medicine (1996)*

The function of primary care is to provide basic services essential to supporting and maintaining patients' health. Effective primary care is built on a continuous, trusting relationship between patients and their physician and care team. Primary care is frequently the first point of entry for patients in the health care system. Primary care clinicians can include family medicine physicians, general internists, pediatricians, nurse practitioners, and physician assistants, all of whom work alongside other team members. In certain cases, specialists such as gynecologists, geriatricians, cardiologists, and oncologists may also fill the role of a primary care provider. Primary care providers frequently help patients access secondary and tertiary levels of care delivered by subspecialists, coordinate the care patients receive from physical and behavioral health care providers, and connect patients to community services or resources that can support their health (Starfield, et al 2005).

Many definitions of primary care have been proposed, focusing on different attributes such as the care setting and the types of clinicians involved. One comprehensive definition, developed by the Institute of Medicine, characterizes primary care as having a number of key aspects (IOM, 1996). First, primary care is integrated and accessible. This means that the care provided in this context is not only comprehensive and coordinated but also ideally available to a large segment of the population. Second, primary care addresses a wide range of health problems, including acute and chronic illnesses and prevention services as well as other physical and behavioral health issues. Finally, primary care relies on clinicians developing a partnership with patients and their caregivers to work together to manage patient health, with the clinician responsible for the patient's ongoing care. All these characteristics make primary care the foundation of an effective health care system. Practice facilitators are well-positioned to assist primary care practices in improving delivery of services in each of these areas.

Current Issues in Primary Care

In the past few decades, the U.S. health care system has seen increased demand for primary care services coupled with a shortage of primary care health professionals. Primary care physicians generally receive lower pay than specialist physicians; this has contributed to fewer physicians choosing to enter primary care than specialized fields. The United States will face a projected shortage of approximately 52,000 primary care physicians by 2025 (Petterson, et al. 2012). At the same time, increases in health care coverage resulting from the Patient Protection and Affordable Care Act (also known as the Affordable Care Act or ACA) and an expanding and aging population will increase demand for primary care services. As a result, most primary care professionals face substantial time and cost pressures, potentially reducing their work satisfaction.

Primary care practices are also dealing with more patients with complex care needs, such as behavioral health issues and chronic illnesses. An estimated 117 million people, about half of all adults in the United States, have a chronic disease and many have more than one chronic illness (Ward, et al. 2014). Meeting the needs of these patients is a major challenge for primary care professionals. It requires a proactive model of care delivery that differs from the more reactive approach typically used in the past to manage patients with chronic conditions.

Given these challenges, payers, primary care professionals, policymakers, and others are recognizing the need for new models of care delivery that are more proactive and patient-centered and focus on managing care for all patients in the practice, not just those who make appointments. Some health plans and insurers are promoting models of high-performing primary care that encourage health care professionals to deliver more services, such as care management and care coordination, patient self-management support, integration with behavioral health care, and expanded access to care (including evening and weekend office visits and 24/7 availability of patient health records) by providing additional payments for these services. One of the most prominent new models is the patient-centered medical home (PCMH), which is built on the chronic care model of care (see Module 25). AHRQ defines the PCMH (see http://www.pcmh.ahrq.gov/page/defining-pcmh), as encompassing five primary care functions.

- *Comprehensive care*, with the PCMH meeting the large majority of each patient's physical and mental health care needs
- *Patient-centered care,* which is relationship-based with an orientation toward the whole person
- *Coordinated care,* which includes coordination across all elements of the entire medical neighborhood
- *Accessible services*, which provide enhanced hours for office visits (such as evening or weekend hours), short wait times for urgent care appointments, and telephone or electronic access to providers around the clock
- *Quality and safety*, with the PCMH demonstrating an ongoing commitment to quality and quality improvement

These functions or attributes are intended to meet three aims: to improve the overall quality of care by making it more patient-centered, accessible, and safe; to improve the health of patients and, by extension, the health of the population; and to reduce the overall costs of care by improving coordination to reduce unnecessary services.

As described below, a number of initiatives and approaches that build on the PCMH are emerging that are intended to revitalize and strengthen primary care in the United States.

The new health policy landscape and approaches to primary care payment. It is important for practice facilitators to understand the policy context in which primary care practices function and their relationships with payers and insurers. You will need to stay on top of how both public programs (such as Medicare and State Medicaid programs) and private insurers are shaping the policy and payment context for primary care. For example, State-level decisions in the Medicaid programs can significantly affect this context and practice facilitators need to understand their State-level Medicaid system to fully support a primary care practice. These contextual factors shape a practice's approach to delivering care and its ability to implement transformational activities. Typically, primary care practices work on a low profit margin and rely on patient visit volume to meet payroll and other obligations. Therefore, practices can benefit tremendously from practice facilitator support as they work to increase capacity to meet patient needs in a challenging environment.

Health policy is constantly evolving, and it is helpful to stay attuned to new developments in primary care by visiting Web sites periodically and keeping up to date on the latest State and Federal legislation. Some helpful resources include:

- AHRQ's PCMH Resource Center: http://www.pcmh.ahrq.gov
- Patient-Centered Primary Care Collaborative (PCPCC): http://www.pcpcc.org/
- Health Affairs primary care blog: http://healthaffairs.org/blog/category/primary-care/
- The Commonwealth Fund: http://www.commonwealthfund.org
- Robert Wood Johnson Foundation: http://www.rwjf.org
- Kaiser Family Foundation: http://kff.org/

Affordable Care Act. Signed into law in 2010, the ACA is among the most significant pieces of health care legislation in U.S. history and the culmination of many previous efforts at comprehensive national health care reform. There are a number of provisions in the ACA that are relevant to primary care. Perhaps the most important is the expansion of health insurance availability to many who previously did not have coverage. As previously uninsured or underinsured Americans gain health insurance coverage, more people will seek access to primary care services. Moreover, the ACA aims to decrease financial barriers to health coverage by eliminating co-payments for preventive health services and regulating insurance rate increases. In addition, the ACA allocates substantial funds to support primary care infrastructure in the United States, including provisions aimed at significantly increasing the number of primary care providers and expanding the primary care workforce. Table 3.1 summarizes the key provisions of the ACA relevant to primary care.

Table 3.1. ACA components related to primary care

Area	Description of ACA Provision	Possible Implications for Primary Care
Expanded and more affordable health insurance coverage.	Expansion of health insurance coverage to an additional 34 million people. Most plans required to cover preventive services free of charge.	Increased demand for primary care services.
Enhanced payment for primary care services.	Increases Medicaid payments for primary care services provided by primary care physicians for 2013 and 2014 to match Medicare reimbursement levels; provides value-based bonus payments in Medicare from 2011 through 2015.	Improved operating margins for primary care practices.
Improved support for primary care training.	Increases the number of residency and training positions for primary care. Implements community-based teaching health centers.	Increased numbers of primary care clinicians joining the workforce.
Support for Medicaid health homes.	Creates optional benefit for States to establish health homes to coordinate care for Medicaid recipients with chronic conditions.	Support for care management and care coordination.
Improved funding for medical students in primary care.	Expands availability of low-interest student loans and scholarships for medical students entering primary care. Improves State loan repayments programs.	Increased number of medical students choosing primary care.
Established the Center for Medicare and Medicaid Innovation.	Conducts demonstration and pilot projects aimed at improving the health care delivery system.	Development and testing of innovative care delivery and payment models in primary care.
Established the Patient-Centered Outcomes Research Institute.	Supports evidence-based comparative clinical effectiveness research.	New research to assist primary care providers and patients in making informed health care decisions.
Authorized the primary care extension program (not yet funded as of July 2015).	Assists primary care physicians with implementing PCMHs; develops primary care learning communities.	If funded, could contribute significantly to primary care transformation and dissemination of new evidence to practices.

Adapted from American Academy of Family Physicians. Primary Care in the Affordable Care Act. http://www.aafp.org/dam/AAFP/documents/advocacy/coverage/aca/ES-PrimaryCareACA-061311.pdf .

Although the ACA includes provisions to build the primary care workforce, expanded health insurance coverage is also expected to increase the number of patients accessing primary care services. This means that practice facilitators must be prepared to support practices in meeting increased demand, potentially without significantly increased resources.

Below, we describe the key models of primary care delivery that have been emerging since the ACA. These models have the potential to significantly improve the way primary care is delivered by incentivizing high-value care and promoting integrated care and care coordination. For additional context, we begin by discussing the key payers, or health insurance providers, and health plans in the United States.

Public and private payers. The health insurance market can be categorized into public payers and private payers.

Public payers include, but are not limited to:

- **Medicare**, the federal health insurance program for people who are age 65 or older, certain non-elderly people with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).
- **Medicaid,** a Federal-State program that covers low-income children and some non-elderly low-income parents, low-income pregnant women, some individuals with disabilities, and some low-income seniors (in conjunction with Medicare).
- **The Children's Health Insurance Program (CHIP),** which provides health coverage to children in families who cannot afford private coverage, but who have incomes too high to qualify for Medicaid.
- **Tricare,** the Department of Defense program that provides health care coverage for military families and retirees.
- **Federally Qualified Health Centers (FQHCs),** which are community-based health centers that provide health services to underserved populations. Although not technically a payer, FQHCs provide services to all individuals regardless of their insurance status. The ACA substantially increased federal funding to FQHCs.
- **The Indian Health Service and Veterans Health Administration** are responsible for providing health care to American Indians and Alaska Natives and to U.S. military veterans, respectively. While they are not payers, they are integrated health care delivery systems that deliver care to their target populations.

Private payers include insurance carriers that provide commercial plans (which are either sponsored by groups such as employers or associations or purchased by individuals), administrative services only (ASO) plans (in which an employer purchases only administrative services from the insurer and assumes all risk). In addition, some publicly funded health plans are administered by private health insurers such as Medicare Advantage, Medicaid Managed Care, and some plans for State employees and retirees.

How payers pay for care. Both public and private payers use a range of models to pay health care providers for services delivered. (Providers here can refer to individual health care professionals, practices, hospitals, systems, or other institutions.) A few of the most common payment mechanisms include:

- **Fee-for-service (FFS).** The provider is paid a pre-determined fee for each office visit, procedure, or service (such as a diagnostic test or imaging) that the patient receives.
- **Capitation payments.** The provider is paid a specific amount for each enrolled patient during the month or year (such as $20 per member per month). The amount the provider receives is the same whether or not the patient seeks care.
- **Care management (or care coordination) fee.** In addition to the contracted FFS amounts, the provider is paid a per member per month fee for the other "non-code-related" services that enhance the value of care, such as self-management support, proactive outreach to address gaps in care, collaborating with specialists on care for a patient, or the costs of maintaining a registry and electronic health record.
- **Bundled payments.** The provider receives a single lump sum payment for each episode of illness or episode of care. For instance, providers may be paid a specific amount for all the care a patient receives in the course of treatment of a heart attack or knee fracture. Bundled payments can be viewed as a condition- or illness-specific capitation payment.

In some cases, payers use a combination of approaches, such as offering capitation payments for certain types of services but paying FFS for others. For example, they may make capitation payments for most of the care provided, but "carve out" certain types of specialty or behavioral health care and pay FFS for them. Similarly, payers may use FFS payments for most care while experimenting with bundled payments for a small number of selected conditions. Payers may also pay FFS for most or all services, but offer bonus payments for high-quality care (as measured through patient experience, claims-based quality measures, or other metrics). In addition, practices typically have patients covered by different payers, creating a complex web of incentives and compensation approaches that may affect how practices are able to make change and improve care for all their patients.

Managed care plans versus indemnity (FFS) plans. Private payers may organize themselves in several different ways to pay for patient care. Managed care organizations (MCOs) are health plans that contract with provider networks for the care of their enrolled members. There are three major types of managed care plans:

- Health maintenance organizations (HMOs)
- Preferred provider organizations (PPOs)
- Point-of-service plans (POS)

Historically, HMOs have most closely managed the care received by their patients (for example, sometimes requiring referrals or prior authorization for services and only paying for prescription drugs included on their formulary), whereas PPO and POS plans have allowed patients more flexibility (including seeing providers outside the network) and do not manage care as closely.

As managed care has evolved, however, the distinctions between these managed care plan types have become less clear. For example, HMOs of the past tended to pay primary care physicians a set amount for each member assigned to them each month regardless of the services each patient received. This meant that practices had to cover costs above any per-member-per-month payments. Today, PPO and POS plans may also bundle services into a single payment and then pay bonuses that reflect "shared savings" achieved by effective primary care management of a patient (that is, the primary care practice or clinician may receive a portion of any savings in health care costs, relative to some benchmark) over the course of a contract year.

In contrast to managed care plans, indemnity plans, which are sometimes called FFS plans, typically do not actively manage the delivery of care or contract with provider networks. Instead, they allow patients to choose whatever providers they like. The amount that the indemnity plan reimburses the provider may be less than billed charges, and the patient may have to pay the difference. Therefore, indemnity plans can expose patients to greater financial risk than managed care plans. Patients in POS plans may also face this greater financial risk since they may have to pay extra when they go out of network.

New care delivery models that promote primary care. In both the public and private spheres, care delivery models have emerged that emphasize the importance of primary care in delivering more efficient, high quality, patient-centered services. As discussed above, the patient-centered medical home is one of the most prominent approaches to improving primary care. In some PCMH initiatives, primary care practices may be tasked with achieving PCMH recognition or accreditation (see Module 25), whereas other PCMH initiatives may require practices to make specific changes in care delivery but not necessarily achieve a particular recognition or accreditation. These PCMH pilots, demonstrations, and initiatives take various approaches to payment reform. Although some pay nothing, most provide a per member per month payment in addition to traditional payments, and some provide an opportunity to share any resulting savings or provide bonuses for improved quality and patient experience. Payments are sometimes adjusted based on the risk level of the patient and the level of additional services provided or PCMH capabilities demonstrated by the practice.

Accountable care organizations (ACOs) are another model for improving care delivery. ACOs, which combine care delivery and payment reform, are networks of providers that deliver coordinated care to a defined group of patients and are financially accountable for the health of those patients. A key feature of this care delivery model is that providers and health systems, as opposed to insurance companies, become responsible for coordinating and managing care. The broad scope of ACOs potentially allows them to invest in primary care, patient self-management and care coordination, and reap the savings of decreased hospital admissions and readmissions and decreased emergency department use. (Edwards, et al. 2014). ACOs and PCMHs are not exclusionary models. Many ACOs use PCMHs to delivery primary care.

Demonstration programs are one way that the federal government experiments with new ways of organizing and paying for primary care. The Centers for Medicare & Medicaid Services (CMS) is conducting a number of demonstration programs related to primary care redesign. Two

prominent programs are the **Comprehensive Primary Care Initiative (CPCI) and the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration.** As part of CPCI, participating practices receive bonus payments for providing improved care coordination, access, and care management for their patients and have an opportunity to share in Medicare cost savings. Each CPCI practice site provides services in the following areas: (1) risk-stratified care management, (2) access and continuity, (3) planned care for chronic conditions and preventive care, (4) patient and caregiver engagement, and (5) coordination of care. More than 2,300 providers are participating in the demonstration, serving approximately 2.6 million patients.

The MAPCP demonstration is a multipayer initiative sponsored by Medicare, Medicaid, and private health plans and implemented in eight States across the country. Its purpose is to evaluate the impact of the PCMH and changes in provider payments on improving quality of care and reducing costs. Participating practices receive a monthly care management fee to cover costs associated with services such as care coordination, patient education, and improved access.

Primary care payment reform. Payment reform goes hand in hand with these new care delivery models and is also of great interest to both public and private payers. For instance, several CMS demonstration programs focus on testing the development of innovative new payment models. Examples include the CPCI and MAPCP demonstrations discussed above, the Federally Qualified Health Center Advanced Primary Care Practice Demonstration and the Bundled Payment for Care Improvement Initiative. More information about these programs can be found on the CMS Medicare Demonstration Projects and the Center for Medicare and Medicaid Innovation Web sites.

In 2015, Medicare will begin to pay physicians for provision of chronic care management services. Eligible providers will receive a separate monthly payment of $41.92 for each Medicare beneficiary with multiple significant chronic conditions. To qualify for this payment, physicians must provide 24/7 access to the chronic care management services, create a comprehensive care plan in collaboration with patients, enhance opportunities for patient-provider communication, and manage patients' transitions between care settings. Patients must agree to receive this service and will have to pay a copayment or deductible.

In addition, the Medicare value-based modifier (VBM) program rewards physicians based on provision of high-quality, low-cost care. The goal of the VBM, which is a provision of the ACA, is to encourage high-value health care by increasing or decreasing Medicare payments to providers based on their performance scores. This program is being rolled out to a limited set of providers in 2015 but is slated for widespread implementation in 2017.

In April 2015 the sustainable growth rate (SGR) formula was repealed. SGR was originally designed to counter increases in health care spending driven by fee-for-service with cuts in Medicare fees to all providers for all services. The new legislation replaces the SGR with an approach that encourages improving quality of care and supporting alternative payment models like ACOs and PCMHs. A central feature of the new model is a merit-based incentive payment

system (MIPS) that replaces three previous incentive programs. MIPS will be implemented in 2019.

Conclusion

Primary care is a central component in achieving improved health outcomes, controlling health care costs, and optimizing value in the health care system (Friedberg, et al, 2010). It is important for practice facilitators to understand the broader context, as well as State, regional, policy, and payment contexts in which their practices exist in order to help them meet the challenges of efficient and effective primary care delivery.

Resources

Primary care definitions and general information

- http://www.aafp.org/about/policies/all/primary-care.html
- http://books.nap.edu/openbook.php?isbn=0309053994&page=27
- http://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-primary-care-policy-center/definitions.html
- https://primarycare.hms.harvard.edu/news

AHRQ Web sites

- http://www.ahrq.gov/professionals/systems/primary-care/
- www.pcmh.ahrq.gov

Centers for Medicare & Medicaid Services

- http://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/
- http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/mapcpdemo_Factsheet.pdf
- https://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/
- http://innovation.cms.gov/
- http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1612-P.html
- http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html

Health Resources and Services Administration (HRSA)

- http://bphc.hrsa.gov/

Primary care associations and organizations

Listing of State primary care associations:

- http://bphc.hrsa.gov/qualityimprovement/supportnetworks/ncapca/associations.html

Listing of State primary care offices (typically housed in State departments of health):

- http://bhpr.hrsa.gov/shortage/hpsas/primarycareoffices.html

Behavioral health care in primary care

- http://www.nimh.nih.gov/about/organization/dsir/services-research-and-epidemiology-branch/primary-care-research-program.shtml
- http://www.pcpcc.org/resource/behavioral-health-integration-pcmh

Information on ACOs, primary care initiatives, and payment reform

- http://www.accountablecarefacts.org/topten/what-is-an-accountable-care-organization-aco-1
- http://www.aafp.org/practice-management/payment/acos.html
- http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/ACO
- http://www.kaiserhealthnews.org/stories/2011/january/13/aco-accountable-care-organization-faq.aspx
- http://www.chqpr.org/downloads/BuildingBlocksofSuccessfulPaymentReform.pdf

Other resources and emerging trends in primary care

Coordinating care across the medical neighborhood:

- http://pcmh.ahrq.gov/sites/default/files/attachments/Coordinating%20Care%20in%20the%20Medical%20Neighborhood.pdf

Primary care extension:

- http://healthextensiontoolkit.org/toolkit-modules/primary-care/

Patient-Centered Primary Care Collaborative:

- http://www.pcpcc.org/

Robert Graham Center Community Oriented Primary Care Curriculum:

- http://www.graham-center.org/online/graham/home/tools-resources/copc.html

Emerging trends in primary care:

- http://forces4quality.org/af4q/download-document/11242/5013

References

Edwards ST, Abrams MK, Baron RJ, et al. Structuring payment to medical homes after the affordable care act. J Gen Intern Med. 2014 Oct;29(10):1410-3.

Friedberg MW, Hussey PS, Schneider EC. Primary care: A critical review of the evidence on the quality and costs of health care. Health Aff. 2010; 29(5): 766-72.

Institute of Medicine Committee on the Future of Primary Care. Primary Care: America's Health in a New Era. Washington, DC: National Academy Press; 1996. http://iom.edu/Reports/1996/Primary-Care-Americas-Health-in-a-New-Era.aspx.

Petterson SM, Liaw WR, Phillips RL Jr, et al. Projecting U.S. primary care physician workforce needs: 2010-2025. Ann Fam Med. 2012 Nov-Dec; 10(6):503-9.

Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q. 2005;83(3):457-502.

Ward BW, Schiller JS, Goodman RA. Multiple chronic conditions among US adults: a 2012 update. Prev Chronic Dis. 2014;11:130389. DOI: http://dx.doi.org/10.5888/pcd11.130389.

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Module 4. An Introduction to Practice Organization and Management

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- General knowledge of the organization of primary care practices and their management
- Knowledge of practice management resources
- Cultural competency

Time

- Pre-session preparation for learners: 2 hours
- Session: 90 minutes

Objectives

After completing this module, learners will be able to:

1. Describe the work of a primary care practice and the way it is commonly organized and managed.
2. Identify the different types of staff commonly employed in primary care practices.
3. Describe common revenue sources for practices and their implications for quality improvement work.
4. Discuss the role of practice managers and administrative staff in quality improvement.

Exercises and Activities To Complete Before, During, and After the Session

Pre-session preparation. Ask the learners to review the following information. (2 hours):

1. Read the module.
2. Review/scan information on practice administration and set-up:
3. Burns P, Hirschfield J. So You Want to Start a Health Center…? A Practical Guide for Starting a Federally Qualified Health Center. Bethesda, MD: National Association of Community Health Centers; 2011. Available at: http://www.nachc.com/client/documents/So%20you%20want%20to%20Start-Final%20July%202011.pdf
   a. Reiboldt M. Starting, Buying, and Owning the Medical Practice (Practice Success Series), 1st ed. Chicago, IL: American Medical Association; 2012. (Available for purchase through the American Medical Association.)

4. Review/scan information on practice interaction with their medical neighborhood (care coordination and accountable care organizations):
    a. Taylor EF, Lake T, Nysenbaum J, et al. Coordinating Care in the Medical Neighborhood: Critical Components and Available Mechanisms. White Paper AHRQ Publication No. 11-0064. Rockville, MD: Agency for Healthcare Research and Quality; June 2011. Available at: https://pcmh.ahrq.gov/sites/default/files/attachments/Coordinating%20Care%20in%20the%20Medical%20Neighborhood.pdf
    Toward Accountable Care Consortium. The Physician's Accountable Care Toolkit. The Physician's Foundation; North Carolina Medical Society; 2012. Available at: http://www.ncmedsoc.org/non_members/legislative/ac/ACO-GuideNC.pdf

During the session. Presentation (20 minutes)

1. Present key concepts from the module.

Discussion. Ask questions and explore answers with learners. (15 minutes)

1. What were some important lessons you learned in the module and pre-work?
2. Based on the module, what types of information should you collect from a practice you are beginning to work with on its organizational structure, management, financial model, and operations?
3. What implications do these have for quality improvement work?

Activity. Vision map of areas where practice organization and management affect quality improvement (30 minutes)

1. Ask learners to divide into groups of three.
2. Ask each group to identify a facilitator for the activity.
3. Have the facilitator lead their group in creating a crosswalk that shows how practice structure, financial model, administration, and management map to:
    a. Ability to implement the five key elements of the patient-centered medical home (PCMH; see Module 25, The Patient-Centered Medical Home: Principles and Recognition Processes, for a list of key elements)
    b. Capacity for continuous quality improvement

4. At the end of the exercise, ask each group to present their crosswalk to the larger group and discuss any important insights they had in completing the exercise that can inform their work as PFs with practices.

Optional activities after the session for further learning

1. Ask the learners to explore and complete training available through the National Association of Community Health Centers based on interest or need. The trainings are available at: https://www.nachc.com/complete-list-of-trainings.cfm

Module 4.

Practice organization and management form the foundation of all primary care practices. As a practice facilitator (PF), it is important to have a solid understanding of how primary care practices are organized and managed, and how they get paid. This knowledge will help you make more comprehensive assessments of a practice, better tailor quality improvement (QI) approaches and interventions to the practice, and build practice capacity for continuous QI.

This module describes the work of a primary care practice, its workforce and their roles, and the most common daily workflows. Next it reviews common business structures used when forming a primary care practice, common organizational charts, financial models, and billing.

This module is intended to provide new PFs with an introduction to practice structure and administration. More experienced PFs and those with prior experience should look for opportunities to contribute additional information to discussions about the contents of this module.

The Work of Primary Care

Deliver a comprehensive range of services. The delivery of a comprehensive range of primary care services is the principal work of a primary care practice (Donaldson, Yordy, Lohr, et al., 1996; Starfield, 1992). Primary care services are typically thought of as being divided into three categories:

1. *Preventive care* is when primary care practitioners work with patients to reduce risk for disease and prevent development of disease. They do this by providing periodic health assessments, risk assessments, screening, counseling, and patient education. This also includes screening patients to detect those in the early stages of a disease to enable early care (Donaldson et al., 1996).
2. *Acute care* is when a patient seeks health care because of symptoms. Health concerns can range from relatively minor illnesses (such as a cold virus) to a complex set of symptoms that could be serious or even life threatening. Symptoms can be physical, mental, or a combination of both.
3. *Chronic care* is when primary care practitioners work with patients to manage chronic health conditions, such as diabetes and heart disease, and maximize the patient's wellness within the context of these conditions, often over long periods.

Primary care practices are typically organized to provide care across all three of these categories.

Practices may also provide additional services in house or refer patients to services in the following areas:

- Health education and coaching services
- Laboratory services
- Radiology services
- Pharmacy services
- Transportation assistance
- Dental services
- Social services
- Behavioral health services
- Care coordination and/or care management
- Community support services and schools
- Child care
- Early intervention programs
- Other services

As a PF, you will want to understand the range of services each practice you work with provides, who provides them, which are offered in-house and which are referred out to the "medical neighborhood," and how the services are organized.

If you are working with federally qualified health centers (FQHCs), rural health centers (RHCs), or similar organizations, these practices are required to provide a wider range of services for their patients. These organizations receive grants from the federal government and increased reimbursement rates for care to support this expanded care. For more information about the services these organizations are required to provide see http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/qualified.html.

Larger practices may create "clinics"—typically defined by a particular time of day, location in the practice, and set of clinicians—for delivering specialized care, such as women's health services or pediatrics. If the organization is large enough, it may have administrative divisions for adult services, pediatric services, or senior care among others.

Coordinate patients' care across the medical neighborhood. Another essential task of primary care is the coordination of patient care internally, across the medical neighborhood, and across social and other services related to patients' health. This means primary care practices must have appropriate staff and resources to coordinate care with their patients across any other health care settings with which the patients interact (Donaldson et al., 1996). The goal of this coordination is to assure patients' needs and preferences are met and the best possible outcomes are attained at the lowest cost (Agency for Healthcare Research and Quality, 2014).

Increasingly practices are hiring specialized staff to assist with care coordination. Care coordinators or care managers are specifically charged with coordinating care by facilitating referrals, transitions between hospitals and outpatient settings, and access to needed ancillary

services. A practice may also use persons with non-medical backgrounds who can help patients navigate various health care specialties and settings. These individuals may be community health workers or nurses outside of the practice or a member of the staff whose role is to advocate for the patient across all levels of care and often to coordinate with social services and other supports.

As a PF, you will want to be familiar with successful models of care coordination and understand how each of the practices you work with have organized themselves to coordinate the care of their patients.

Arrange for the patient to receive care from the same clinicians whenever possible. Primary care practices should be organized to support continuity in patient care. This means that patients see the same clinician or care team for most visits, as this will build a relationship with these professionals. To accomplish this, practices assign or "empanel" patients to specific care teams. The care team builds a relationship with the patients, gets to know their preferences, and works in partnership with the patients to help them attain their health goals (Donaldson et al. 1996; Starfield 1992; Willard and Bodenheimer, 2012).

As a PF, you will want to understand how each practice you work with supports this continuity and how well this is working. For example, does the practice empanel patients to clinicians or care teams? If so, how effective is this empanelment process and on what percentage of visits are patients seen by a member of the care team they are assigned to? Is the staff trained to schedule patients with a member of their care team, and can patients get an appointment to see someone when they need and want to or do they have to wait for extended periods of time? All these and many more factors impact continuity. Good continuity of patient care can be very difficult to accomplish.

In small one- and two-provider practices continuity occurs by default, but even in these instances it is easily disrupted. Patients may seek care at other practices because they could not get an appointment when they wanted. The clinician may rely heavily on referrals to the medical neighborhood if the services he or she provides are fairly narrow, which can also impact continuity. Patients may come on and off insurance coverage or may switch to a plan where the primary care physician they were seeing is not a provider, thereby interrupting continuity. When patients do not feel a connection to a clinician or practice they may seek care wherever it is most convenient (e.g., seeking care from organizations with competing models of primary care delivery, such as retail and urgent care clinics that emphasize speed and convenience over comprehensiveness).

Some primary care practices serve as training sites for medical residents and include them on care teams. Once residents' training is complete, they move on. This can disrupt continuity if the practice does not have a plan in place for managing the frequent changes in staff.

Many factors work to disrupt continuity. As a PF, you will want to become familiar with the

degree of importance that a practice places on continuity, how they are organized to support it, how successful they are at achieving their goals in this area, and any factors that impact their ability to maintain continuity. Even if the practice is not interested in working with you on this particular issue, you should keep this in mind as it has implications for PCMH transformation and many other aspects of practice operations, staffing, and workflow. As a PF, you typically will start your work with the practice in the areas that are the greatest priority for them. But as you work with them over time, you will also want to encourage them, through conversation, education, and introduction to exemplars, to consider other issues and areas that are not a priority to them, but that are important for overall practice improvement. In other words, you will want to help them "grow" the value they place on these other important areas.

Provide administrative, organizational, and technical services that make it possible for clinicians to deliver comprehensive, coordinated, continuous primary care. Clinicians and care teams need support to provide primary care to patients. Administrative activities such as hiring, training, QI, physical plan maintenance, marketing, billing, financial management, regulatory compliance, information technology (IT), interaction with the medical neighborhood, and workflow are essential to the delivery of good primary care. Without these supports and functions, clinicians and care teams could not do their job, and patients would not be able to engage effectively with the practice. These supportive activities and structures are discussed in a later section of this module, but it is important for PFs to recognize that the enterprise of primary care is a "team sport"—not just in the exam room but also in the administrative offices and behind the scenes. Table 4.1 provides a summary of the clinical and supportive administrative "work" of a primary care practice.

Table 4.1. The work of a primary care practice

Administrative Work
Human resources
Physical plant and materials management
Information technology management
Financial management and billing
Reporting and regulatory compliance
Quality improvement
Business development and marketing
Designing and managing workflow
Risk management
Administrative clerking and scheduling
Oversight and leadership
Transportation
Security
Medical records
Clinical Work
Medical care, including radiology, pharmacy, and lab

Behavioral and mental health care
Integration of care
Health education
Self-management support
Specialty care referral management
Population management
Medication management
Patient and care team communication management
Connecting patients to community resources
Coordinating patients' care across multiple settings and specialties

Who Plays What Roles in a Primary Care Practice?

Consistent with the two types of "work" that take place in a primary care practice, there are also generally two types of staff: administrative staff and clinical staff. *Administrative staff members* provide supportive services to clinical staff and to the organization, including management, finance, billing, human resources, health information technology, regulatory reporting, business development, marketing, risk management, and quality improvement. *Clinical staff members* deliver care to patients.

Administrative staff. In addition to the Chief Executive Officer, Chief Finance Officer, Chief Operations Officer, and Chief Medical Officer, who are typically both administrators and clinicians, other administrative staff include administrative clerks, office staff, book keepers, IT directors and staff, and other positions. Support services provided by the administrative staff include:

- **Human resources.** These services include hiring and evaluating employees, overseeing benefits, and making sure clinicians and staff are properly trained and licensed for the tasks they perform. Human resources also includes assuring positive morale, monitoring compliance with employment law, and maintaining appropriate and effective work relationships among employees.
- **Physical plant and materials management.** This position involves overseeing the upkeep and maintenance of the building and exterior spaces, cleaning, and assuring that needed materials and equipment are present and operating correctly**.**
- **Information technology management.** IT activities involve the maintenance of hardware, network, and software functions. Smaller practices often use consultants to carry out these functions, and this can be a problem if the consultant is not available. These individuals also oversee the security of data systems and will be important to you if your work involves accessing data or improving electronic health record (EHR) systems. As a PF you should become familiar with who in the organization fulfills the IT functions and the scope of this work.

- **Data manager for QI.** A relatively new role emerging in practices is the QI data manager. This position helps practices bridge their EHR and data management with QI. This can include developing reports that link data to improvement efforts. It can also include helping to make EHR changes that support QI goals such as implementing Clinical Decision Supports and alerts and helping the care team generate actionable reports on service gaps for their patients.
- **Financial management and billing.** This position manages the organization's budgets, cash flow, payroll, and financial obligations to vendors. It also incorporates coding and billing, establishing contracts with payers, monitoring eligible and allowable services, and providing feedback on visits to help clinicians understand how their productivity affects the financial solvency of the practice. The axiom "no money, no mission" holds true in every business, and a primary care practice is no exception. As a PF you should have a basic understanding of a practice's financial situation. This is important for you to assess how feasible certain work will be with the organization, and also to prioritize your work with them. If the practice is experiencing serious financial problems, then your first task may need to be to locate expertise that can help them assess and improve their financial situation before you move into other types of work with them.
- **Reporting and regulatory compliance.** This function is essential to keeping a practice in business. It includes creating insurance carrier reports and responses to their requests for information, as well as using data to produce reports on patient visits, demographics, and services. The staff involved in these activities creates the reports used for quality reporting and required by insurers and federal and state agencies. This function also includes preparation for and management of compliance audits, which may include billing and coding audits, biannual facility audits, and program-specific audits.
- **Administration and scheduling**. These two roles often touch both administrative and clinical functions. Front desk staff are often patients' first contact with the practice and their clinical team when they come for care and, as such, play a particularly important role in setting the tone for the visit and the overall experience, yet these staff may have less training and support than others. Practices may fail to recognize the pivotal role front desk staff play in the patient experience.
- **Quality improvement.** Typically QI is thought of as a function of clinical staff, but in truth it should involve the entire organization. As mentioned earlier, primary care is a team effort—not just among clinical care team members but across all staff. Administrative functions such as hiring, staff training and evaluation, physical plant design and maintenance, scheduling, and coding and billing have a significant impact on the process and quality of patient care. Because of this, QI necessarily bridges both clinical and administrative staff and functions and should include both.
- **Risk management.** This essential function is often delegated to a risk management team that reviews patient safety issues, events, and other areas that could create legal exposure for the practice. Sometimes practices view risk management and quality improvement as synonymous. They are not. Risk management focuses on reducing mistakes and related legal exposure. Quality improvement, while it may encompass work that can reduce risk,

extends far beyond this. As a PF, you should become familiar with how each of your practices organizes these two functions and be alert for indications that a practice is attempting to combine these two functions. When this occurs, you should take note and look for an opportunity to engage leadership around the need to separate (but coordinate) these two functions.

- **Business development and marketing.** This function is critical to the enterprise of primary care. The practice may have a sophisticated approach to marketing themselves and internal staff that support business development work. Often though, practices will rely on a local medical service organization (MSO) or one or more independent practice associations (IPAs) to assist them in these functions. As a PF, you will want to understand how they carry out these functions and what organizations or groups if any they have engaged to assist them. Staff from MSOs and IPAs can be a resource as you work with the practice. With permission from the practice, of course, you may find it helpful to visit with them and get their observations of the practice's strengths, challenges, and ideas they may have for supporting the practice.
- **Oversight and leadership**. These functions may be filled in larger organizations by chief executives, finance, and operations officers, or in smaller organizations by the actual owner. In addition to organizational leadership, there are also leadership functions at the clinical level that are often filled by a medical director while a practice or office manager oversees the administrative staff.

The administrative staff in a practice is a vital part of any improvement work. The practice's financial officer and operations director and their staff can be valuable sources of information about financial drivers for the practice, incentive programs available through the different health plans, rules around eligible and allowable services, and administrative resources and issues that can support quality improvement of clinical care. Many believe that QI work should be housed in the administrative section of the practice and work across both administrative and clinical areas.

Consider engaging administrative staff as members of the QI team and as advisors to the practice's QI team's work. To facilitate this, get to know the administrative staff at the same time you are building relationships with clinical staff. Introduce yourself and set up times to meet to get their ideas. Ask for their input on the planned improvements. Of course, you should do this in collaboration with your practice champion, so you do not jump ranks or create unnecessary conflicts.

Clinical staff. Clinicians in a primary care practice include physicians, physician assistants, and nurse practitioners. Other clinical staff includes registered nurses, licensed practical nurses, and nurse midwives. In some practices, behavioral health professionals, dentists, pharmacists, pharmacy technicians, and some specialty providers (such as podiatrists and eye care professionals) may be part of the practice team or come into the primary care setting periodically.

Medical assistants (MAs) assist physicians and other clinicians in delivering patient care by greeting patients, updating and filling out medical records and other forms, taking vital signs, drawing blood, and preparing patients for exams, among other tasks.

Other individuals on the clinical staff may include care coordinators (who may have a nursing or other background), clinical pharmacists, social workers, health educators, health coaches, and nutritionists or dieticians.

Some practices also include lay persons on their staff. These individuals often serve as community health workers, health promoters, or peer coaches for patients.

Functions carried out by clinical staff include medical care, behavioral and mental health care and integration, health education, referral management, population health management (or managing care for specific groups of patients), self-management support, medication management, communication management, referral to specialty care with followup, and connecting patients to community resources.

Table 4.2 provides definitions of some clinical disciplines and types of staff found in primary care practices. State and local professional associations can be a good source of additional information about the different professionals.

You will want to become familiar with the scope of practice of each clinical professional. This becomes particularly important when a practice is implementing team-based care and working on redesigning workflows to allow people to work at the "level of their license," meaning they can practice to their full professional capability. More information is available on this topic in Module 29: Implementing Care Teams.

The scope of practice is typically defined at the state level. It is helpful to know where to look to determine scope of practice. This can be particularly useful when you are helping a practice form care teams, redefine clinical roles, or add new services. Often you can look to the state association for the specialty or professional degree for information on laws governing scope of practice.

For unlicensed assistive personnel like Medical Assistants (MAs), this information is usually also available through the professional association for the discipline. It is worth noting that the scope of practice of MAs is particularly important, as they play a key role on care teams, but their scope is very much dependent on the rules of the specific practice. As a PF, it will be important to understand the rules governing the practice of MAs and other assistive personnel

and of resources that you can share with the practice that they can use to assure they are in line with these determinations.

Table 4.2. Clinical staff and descriptions

Discipline/ Degree	Description
Physicians: Medical doctor (MD) and doctor of osteopathy (DO)	Physicians include both medical doctors and doctors of osteopathy. Both types are licensed to deliver medical care and prescribe medications. Both MDs and DOs complete 4 years of medical school, an internship and a residency. Each must pass exams to be licensed in their state and practice in healthcare facilities that are licensed and accredited.
Family physician	Family physicians are specialists in family medicine and deliver care to individuals of all ages and both sexes. Family physicians emphasize continuity of care and comprehensiveness of care. Family physicians are trained in the biopsychosocial model of care and provide care that considers the individual in the context of their family and community.
Internist	Internists are specialists in internal medicine, a specialty that provides medical care to adults.
Pediatrician	A pediatrician delivers basic medical care to children.
Physician assistant (PA)	PAs are licensed health professionals who practice medicine with physician supervision. They can diagnose and treat illnesses, and in most states can also treat patients and write prescriptions.
Nurse practitioner	Nurse practitioners are licensed health professionals who can diagnose and treat health care conditions that fall within their specialty and can prescribe medications. Depending on the state, NPs may practice autonomously or under the supervision of a physician. NP training places particular emphasis on care management, preventive care and patient education.
Registered nurse (RN)	An RN has graduated from an accredited nursing school and passed a state licensing exam. An RN assesses, plans, and implements nursing care for patients, and may also provide care management support.
Licensed practical nurse (LPN)	LPNs work under the supervision of an RN or physician and administer most medications, care for wounds, take vital signs, keep medical records, and collect samples.
Licensed pharmacist	A licensed pharmacist has completed their doctorate in pharmacy at an accredited school and passed a national and sometimes also state licensing exam. They dispense medications and other remedies to patients, and advise clinicians and patients on the safe and effective use of medications.

Medical assistant (MA)	MAs are trained in standard clinical laboratory procedures. They perform venipuncture, injections, electrocardiograms, measurement of vital signs, and more. Certified MAs have passed an additional certification test. With the advent of team-based care, the role of MAs has been expanding. Expanded roles include: pre-visit planning, reconciling medications, panel management, motivational interviewing and coaching, performing tests and procedures to the degree allowed by their license and the rules of the state, and serving as a primary point of contact for patients with the care team.
Behavioral health provider	Behavioral health providers are licensed mental health professionals (such as Ph.D. psychologists or licensed clinical social workers). They assist patients in managing emotional and mental illnesses alone and in combination with other medical diagnoses.
Social worker	Social workers are licensed professionals with masters or doctoral degrees who are trained to assist individuals and families with psychosocial needs. Some also do care coordination support.
Care coordinator	Care coordinators help patients access care, help coordinate care, and facilitate exchange of information with patients and across settings.
Health educator	Health educators are individuals trained to educate patients on factors that support wellness, manage illness, and reduce risk for disease.
Certified diabetes/asthma educator	Certified diabetes educators and asthma educators are licensed health care professionals, including registered nurses, registered dietitians, and pharmacists who have completed specialty training in diabetes or asthma health education.
Health coach	Health coaches are individuals trained in health education, peer support, and motivational interviewing. They help clients set and attain health goals through behavior and life style change.
Community health worker	Community health workers are members of the local community who are engaged to help others from their community attain and maintain good health. They are often trained in communication skills, social support, motivational interviewing, and health education skills.

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Practice managers. Practice managers are special in the world of primary care administration. They work across clinical and administrative areas and oversee the practice's day-to-day processes and activities. Smaller practices often do not need or have the resources for separate staff for human resources and other administrative functions, so the practice manager may serve all these roles. This can include hiring, training, and managing nonclinician staff; aiding the medical director in managing clinical staff; and overseeing workflow issues. The work of a practice manager also includes supporting improvements to clinical and administrative processes.

A special note about practice managers and QI. While all employees of a practice play important roles in carrying out the work of primary care, the practice manager deserves special mention as a resource for supporting quality improvement. Introduce yourself to the practice manager and

arrange a time to meet with him or her early in your involvement with the practice. This will enhance your chances of engaging the practice manager as a key support for your work with the practice.

Practice managers can provide insight into practice culture and offer ideas on improvement priorities, as well as who might be good members of the QI team, and the feasibility of changes being considered by the team. They also serve as a gatekeeper to key staff and clinicians in the practice, so establishing a strong relationship with the practice manager is key. They can help you and the improvement team gather performance data, conduct root cause analyses, design and implement new workflows, and develop plans for sustaining changes. Solicit their input on improvement goals and methods and look for ways to include them in the improvement work.

Special staffing issues in small practices. The mix of clinicians that a practice employs impacts the practice's ability to schedule patients and deliver care to walk-in patients. In small- and medium-sized practices, the absence of a single physician can have a huge impact on the practice's ability to see certain patients and patients' ability to access care. These types of issues have significant implications for your work in quality improvement. They can help you understand why it is difficult for clinicians to participate in QI meetings. More importantly, you will need to have a good understanding of the practice's vulnerability in these areas as you work with them to redesign key workflows and introduce new approaches to care, such as group visits.

You will want to pay attention to the clinician mix, as it has implications for your work to build capacity and improve quality. For example, it may be that on Mondays, the only clinicians available are internists, so pediatric visits cannot be scheduled those days. Or perhaps the practice has an obstetrician/gynecologist who practices a half-day on Wednesdays, so women's health visits might be concentrated on those days. Or, the pediatrician may be available on Wednesdays and Thursdays, so pediatric visits are scheduled for those days. Scheduling is more flexible for practices with family medicine physicians who can see both children and adults.

In smaller practices, individuals may play several different roles in the organization. For instance, a physician from a small private practice may act as both the lead physician and the director of quality improvement. The practice manager may also be part of the front desk staff. In addition, smaller practices may not have the human resources available to support QI work. For example, many solo and small practices cannot afford to have an IT expert on staff or even as a consultant. These staffing and resource constraints will determine what can be leveraged to support QI.

Your role with the practice and the types of supports you and your team provide as you help them build organizational capacity and improve quality will vary based on the resources available in each practice. You may find you will need to provide a different type and range of support to smaller practices than you do to larger practices with more clinical and administrative staff. For example, if a small practice does not have an IT staff, you may need to provide hands-on support to the practice to help them optimize their IT systems until you can help them find an outside IT consultant or build their own internal capacity to provide these functions themselves.

This will take time. In contrast, in a larger practice with already existing in-house IT support, your job will be different and require skills for engaging and coordinating with the existing staff.

Practice Workflow

The work of primary care is carried out through administrative and clinical workflows that are often complex and have evolved over time, sometimes without the opportunity to reflect on the effectiveness or efficiency of the workflow itself. The idiosyncratic nature of workflows across practices is why comments like, "If you've seen one primary care practice, you've seen one primary care practice," ring true.

Workflows for clinical tasks are typically based on visit types. Examples include: new patient visits, initial health assessment for a Medicare patient, newborn check, and comprehensive diabetes care visits for diabetic patients. The unique patient and payer mix of each practice determines the relative frequency and importance of each of these. In addition, each visit type may have unique variations based on each patient's payer. Moreover, with the advent of EHRs, substantial portions of many clinical workflows involve "clicks" on an EHR. Thus, understanding and mapping workflows requires understanding and mapping how clinicians and staff navigate through their EHR for each visit type. Module 10 in this curriculum provides information on workflow mapping and redesign. A few examples of common primary care workflows are:

- Patient check-in
- Office visits by visit type
- Prescribing and medication refills
- Appointment scheduling
- Lab orders
- Lab orders results management
- Referral generation
- Office discharge

Similarly, **workflows for administrative tasks** are typically organized around key tasks, such as scheduling, billing, financial reporting, and new staff orientation.

Much of your time will be spent helping practices understand and evaluate their existing workflows, and then helping them enhance or redesign their workflows to improve quality, efficiency, and incorporation of key elements of the PCMH. As such, you will need to become familiar with the key workflows for each of the practices you work with and knowledgeable about exemplary workflows you can use to help practices improve theirs.

Business Structures in Primary Care

The most common business structures for primary care practices are privately owned businesses, nonprofit organizations and free clinics, hospital-owned practices, and federally qualified organizations including FQHCs, FQHC lookalikes, RHCs, and community health centers (CHCs). Primary care practices can also be part of integrated health systems, such as Kaiser Permanente or the Veterans Health Administration.

As a PF, you will want to learn the structure of each practice you serve. This will have implications for the types of resources they have, the types of reporting they are required to do, and the forms of payment they are eligible to receive, as well as the leadership required for the particular practice structure.

Private or independent practices (IPs) are practices owned and operated by one or more physicians and, in some instances, also physician assistants and/or nurse practitioners. IPs have the flexibility to structure and govern their internal systems as they deem appropriate, while abiding by regulations. IPs vary in size from very small solo clinician practices to larger group and multispecialty practices.

Private practices are often entrepreneurial in nature. Small private practices in particular are often family owned and operated. This creates unique challenges for your work, and you will want to become familiar with the unique needs and dynamics of a family-owned business.

Nonprofit practices are typically mission driven and focused on caring for a particular vulnerable group of patients defined by geographical location (such as a low-income community) or a special need (such as geriatrics). Nonprofit practices vary in size from the small solo practices to larger organizations with ten or more primary care providers. They must maintain a board of directors that provides oversight of the organization's management and financial operations.

Some nonprofit practices are eligible for and apply for designation as a FQHC or RHC based on their location or the underserved population cared for; this allows them to receive a higher rate of reimbursement for patient care and other benefits. FQHCs are required to provide a range of comprehensive primary health care services that includes health education, transportation, care management, dental care, and services in addition to medical care. They are also required to provide regular reporting to the federal government's Health Resources and Services

Administration and complete yearly audits of their services (Health Resources and Services Administration, n.d.).

Organizational Charts

Organizational charts of primary care practices vary widely. Smaller practices may be relatively flat, with the owner/physician as the practice director and an office manager in charge of administrative activities. Larger multisite organizations typically have several layers of leadership, including a set of senior executives that include a chief executive officer, chief financial officer, and chief medical officer, and then a second layer of leadership at each practice. Figures 4.3 and 4.4 show examples of organizational charts from a small and a large primary care practice.

Figure 4.3. Organizational chart for a solo practitioner practice

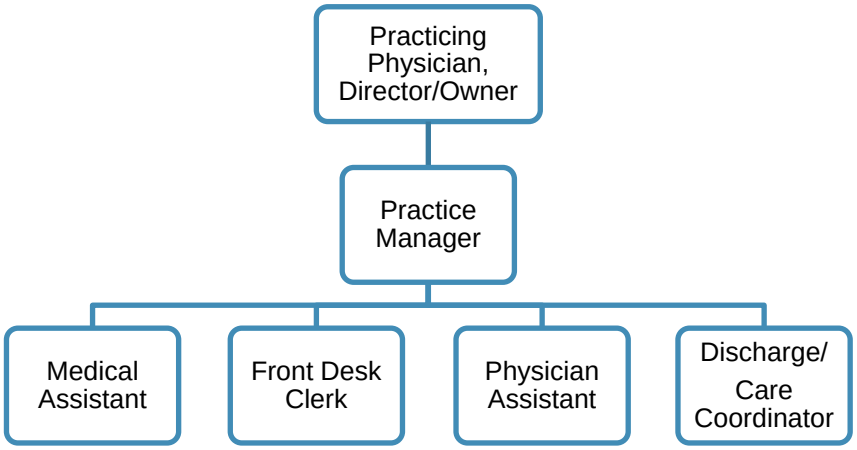
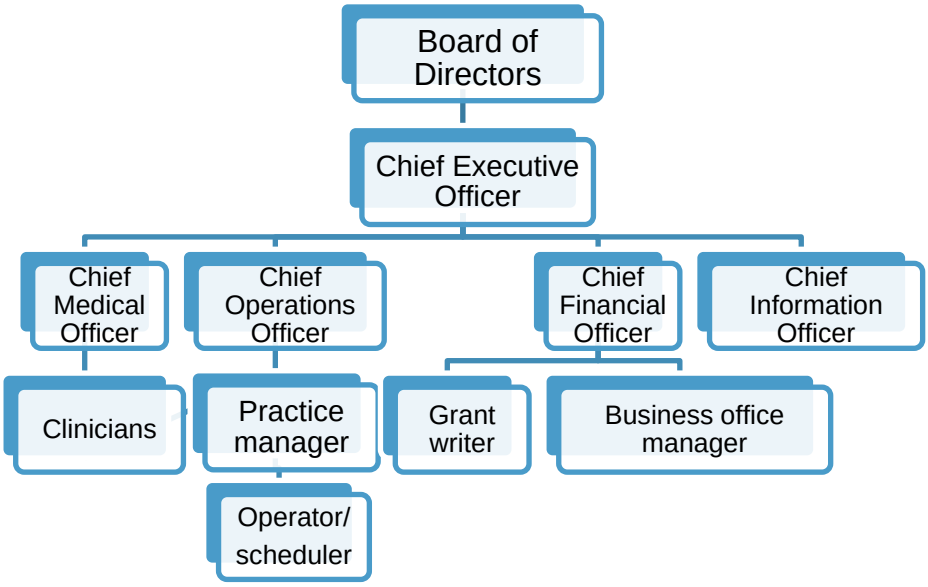


Figure 4.4. Organizational chart for a large practice with multiple sites



Organizational or Corporate Culture

Organizational culture is the foundation for all practice activities. It is determined by a variety of factors ranging from the organization's formal business structure (nonprofit or for-profit); the leadership style of top management; its location; the demographics of its patients; the skills, experience, and personalities of its staff and clinicians; its organizational history and mythology; and its financial situation and revenue model, among many other things. Every practice has its own unique culture, and this culture will be an important factor in any work that you undertake with the practice. Because of this, you will want to observe and be aware of the corporate culture in each practice and fit the methods you use to it.

Where Does the Money Come From To Pay Salaries and Overhead?

Practices generate revenues in a variety of ways. Their primary source of revenue is, or course, payment for the direct care of patients. The most common models of payment include self-pay, fee-for-service, capitated payments, blended payments, FQHC/CHC models, and emerging models such as direct pay.

In **self-pay**, patients pay out of pocket for their care. FQHCs are required to provide a sliding fee scale for patients based on ability to pay and federal and state formulas for poverty.

In the **fee-for-service** model, practices are paid by a third party for service encounters with a patient at a negotiated rate.

In **capitated contracts**, practices receive a set payment per-member per-month (PMPM) that covers a specified set of services. Practices receive this payment regardless of whether a patient comes in for care or not.

Blended payments combine capitation with fee-for-service or pay-for-performance programs. Clinicians receive a PMPM fee for each patient under their care to cover a set of services.

Direct payment is specific to a new type of primary care practice that has emerged over the past few years called **concierge or boutique practices**. Concierge practices are ones where clinicians have opted out of insurance plans, and patients pay out of pocket for services provided to them by these practices. For example, a patient might pay $2,000 for a year of concierge primary medical care from a physician. This fee would cover doctor visits and care coordination but not labs and specialty care, which would be covered by the patient's insurance.

Payment for health care is rapidly changing. New models are emerging, such as shared savings models and bundled payments, and are being tried in various places around the country. In addition, models for supplemental or enhanced payment, such as pay for performance and pay for value, are growing in popularity across the country.

As a PF, you should be familiar with not only the payer mix of each practice you work with, but also the various models by which they are being paid. These may have implications for the work you undertake with each practice.

A note about coding and billing. Practices must comply with specific rules and regulations regarding allowable and eligible services. For example, the rules that prevent a practice from billing for more than one service per patient in a day were set by the federal government and depend on how the term "encounter" is interpreted. Other rules are determined by individual payer organizations.

When a patient receives care from the practice, the clinician documents the services in the EHR (if the practice has an EHR). A super bill is also created for each visit that includes visit type, diagnoses, conditions for which the patient was seen, procedures conducted during the visit, and labs ordered. Practices can receive reimbursements in just a few weeks or wait months or sometimes years to receive payments (Weida and O'Gurek, 2014). Table 4.3 provides a list and description of commonly used coding systems.

Table 4.3. Coding systems

International Classification of Diseases (ICD) codes	ICD codes are used by health care professionals to indicate diagnosis for all patient encounters. Available at: http://www.cms.gov/Medicare/Coding/ICD10/index.html.
Current Procedural Terminology (CPT) codes	In CPT coding, numbers are assigned to all services and tasks health care providers deliver to a patient. CPT codes were developed by the American Medical Association (AMA) and are continually evolving.
Healthcare Common Procedure Coding System (HCPCS)	HCPCS is an alternate to the AMA CPT codes used by Medicare, Medicaid, and other health insurers. HCPCS incorporates the American Medical Association's CPT codes.

Other sources of practice revenue. In addition to payment for medical services, many practices may have other sources of revenue, such as program grants and research. FQHCs and RHCs also receive federal grants to cover costs of some services.

As a PF, you should have a basic understanding of each practice's revenue model and payer mix, as this will have implications for improvement work at the practice. For example, where does the practice generate most of its income? Are most of its patients self-pay, or do they have Medicare? Medicaid? Commercial insurance? What pay-for-performance programs are available to practices that you might help them qualify for? Finally, what payer regulations might limit what is possible in terms of new or modified services?

While it is not necessary or realistic for every PF to become an expert on each practice's financial and revenue models and systems, it is important to know what questions to ask and who to ask as you work with them. Sample questions that PFs might ask to understand financial and payer issues in the practice include:

- Is the practice financially stable, or is it having trouble meeting financial obligations?
- Does the practice have the financial expertise available either on staff or through consultants to ensure a solid financial system and approach? What is the payer mix of the

practice? What are the implications of this on service delivery? What are the implications for practice workflow? Who receives what services from the practice, and who is referred out?

- What pay-for-performance programs exist for each payer, and what are the requirements for each? Do any of these overlap with the QI work that you are supporting? Is there a way to align current QI work to support these activities?
- What, if any, service grants does the practice hold? Is there any value in aligning current QI work with these grants?
- Are there implications of improvements being considered for practice finances? What are the expected costs? Are there any payer restrictions that could create barriers to implementing the proposed changes? Are there ways to resolve these? How have other practices that have implemented similar improvements resolved them and could these be used here?

External Resources for Primary Care Practices

Practices may also participate in and receive support from external service organizations that function to support primary care practices. For example, both private and nonprofit practices may become members of organizations such as independent practice associations that provide services for them. IPAs negotiate contracts with payers on the behalf of their membership and may also help organize care for provider members, inspect and credential providers, establish referral processes, distribute payment to practices, and support utilization management and reviews (Wolper, 2004).

Management service organizations also may provide support to a primary care practice. The MSO may be contracted for services through a practice's IPA or independently by the practice. MSOs assist with claims processing, credentialing, determining eligibility and benefits for patients, quality and risk management, and utilization management. They can also function as a liaison between payers and providers, keeping them informed of new policies and procedures, and provide business development support to their members (Wolper, 2004).

Primary care associations and state primary care offices are other resources for primary care practices. They offer training and other supportive information and resources for primary care practitioners and practices. National cooperative agreements are service organizations that receive funds from the Health Resources and Services Administration to support FQHCs and lookalikes. State primary care offices are another resource. Lists of these organizations by state can be found at: http://bphc.hrsa.gov/qualityimprovement/supportnetworks/index.html

The National Association for Community Health Centers and local community clinic and rural health care associations are other sources of resources for FQHCs, RHCs, and CHCs.

Summary

The organizational structure, staffing structure, and payer mix of a primary care practice has significant implications for your work with a practice. These factors help define priorities for the practice, its capacity for transformation and improvement, and the types of facilitation support that may most benefit it. As a PF, it will be helpful to you and each practice you work with to understand these features and how they relate to your work with practices on improving quality.

References

Agency for Healthcare Research and Quality. Care coordination. Rockville, MD: AHRQ; Oct. 2014. Available at: http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html

Donaldson M., Yordy K, Lohr K, et al., eds; Committee on the Future of Primary Care, Institute of Medicine. *Primary Care: America's Health in a New Era*. Washington, DC: National Academies Press; 1996.

Health Resources and Services Administration. Primary Care: the Health Center Program. Available at: http://www.bphc.hrsa.gov/

Starfield B. *Primary Care: Concept, Evaluation and Policy*. New York, NY: Oxford University Press; 1992.

Weida T, O'Gurek DT. (2014) Coding from the bottom up. *Fam Pract Manag* 2008 Nov-Dec;15(9):22-25.

Willard R., Bodenheimer T. The Building Blocks of High-performing Primary Care: Lessons from the Field. Oakland, CA: California HealthCare Foundation; 2012.

Wolper L., ed. Health Care Administration: Planning, Implementing, and Managing Organized Delivery Systems. Sudbury, MA: Jones and Bartlett Publishers; 2004.

Primary Care Practice Facilitation Curriculum

Module 5. Special Considerations When Working With Safety Net Practices

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Module 5. Special Considerations When Working With Safety Net Practices

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Foundational knowledge of primary care environments
- Basic coaching skills for working with safety net practices

Time

- Pre-session preparation for learners: 80 minutes
- Session: 65 minutes

Objectives

After completing this module, learners will be able to:

1. Identify three characteristics of an exemplar safety net practice based on the Clinica Family Health Services case study.
2. Describe two current challenges facing most safety net organizations today and two potential strengths of safety net organizations.
3. Describe how these challenges might affect a practice facilitator's work with these organizations.

Exercises and Activities To Complete Before and During the Session

Pre-session preparation. Ask learners to review information in items 1-3 (90 minutes)

1. The content of this module.
2. Hall MA. Rethinking safety-net access for the uninsured. N Engl J Med 2011 Jan 6;364:7-9. Available at http://www.nejm.org/doi/full/10.1056/NEJMp1011502.
3. Bodenheimer T. Clinica Family Health Services (formerly Clinica Campesina). Notes from April 18, 2011, visit. UCSF Center for Excellence in Primary Care. See Appendix.

During the session. Presentation (20 minutes)

1. Present key concepts from the module.

Discussion. Ask questions and explore answers with learners (45 minutes).

1. What are some pressures and challenges safety net organizations are facing nationally and in their community, and what are the implications of these for your work?
2. What are three lessons you learned from the Clinica case study, and how might these inform your work?

Module 5.

Safety net practices are defined by the Institute of Medicine (IOM) as "those providers that organize and deliver a significant level of health care and other needed services to uninsured, Medicaid and other vulnerable patients" (Lewin & Altman, 2000).

The IOM identifies "core safety net providers" as providers that maintain an "open door" to patients regardless of ability to pay and whose case mix primarily includes uninsured, Medicaid, and other vulnerable patients. These core providers include:

- public hospital systems
- state and locally supported community health centers
- Federally Qualified Health Centers (FQHCs)
- local health departments and special service providers such as:
    - family planning clinics
    - school-based health programs
    - Ryan White AIDS programs
    - some communities' teaching and community hospitals
    - private physicians who care for predominantly uninsured or Medicaid patients
    - other ambulatory care sites with demonstrated commitment to serving poor and uninsured patients (Lewin & Altman, 2000)

Because of their patient populations and mandate to serve poor and uninsured populations, safety net practices differ from traditional practices. They have unique needs and drivers that will affect your work with them, and that you, as a practice facilitator, will need to be prepared to meet.

Challenges of Working With Safety Net Practices

Demand exceeds supply. Safety net practices often have more patients needing care than they have the clinical capacity to serve. As provider of last resort, they do not turn patients away but they may lack the resources to hire more staff to meet demand for services. In addition, many patients who are cared for in the safety net have more complex health issues, which need more clinical time to adequately address. Therefore, demand for service often exceeds supply, which can result in overcrowded waiting rooms, stressed clinicians and staff, and practices that view anything that takes time away from direct patient care, including quality improvement (QI), as a problem.

Financial challenges. Reimbursement rules may create barriers to implementing new treatments and care models. Reimbursement structures and rules vary across States and regions but a common thread across all is that safety net practices are often under resourced. Many safety net practices receive capitated payments to care for publicly insured or uninsured patients. Often, the costs of delivering this care exceed payments received.

While providing flexibility, these payment structures can create disincentives for practices to provide indicated but expensive or time-consuming procedures or treatments. Practices may refer patients out for services or care that are too costly for them to deliver. For example, safety net practices may refer patients out for pneumococcal vaccinations because of the difficulties they encounter receiving reimbursement for this service.

The practice's ability to provide important services, such as health education and self-management support training, may also be affected by reimbursement structures. In some cases, practices are only reimbursed for physician services, not for ancillary service providers. This payment model requires physicians to deliver services that others could handle and creates barriers to implementing new models of patient care such as team-based care. In other cases, practices may only be reimbursed for a single visit in a day. Having the patient see multiple clinicians the same day may be the best approach to improving the care and health of the patient but can create real financial challenges for the practice.

As a practice facilitator, you will need to become familiar with the financial barriers that may affect your practices' ability to implement new approaches to care and new treatments.

Improvement can create costs for both safety-net and non-safety net practices alike. While improvement can be cost neutral, at least at the beginning, improvement activity can result in increased costs for the practice. For example, estimates of the costs of implementing the Care Model (see Module 24) vary from $6.41 to $23.93 per patient (Huang, et al., 2007). Under fee-for-service reimbursement, savings associated with implementing the Care Model ($685-$950 per patient [Bodenheimer, et al., 2002]) mostly accrue to payers, such as health plans, rather than to practices (Huang, et al., 2007).

As a practice facilitator, you will need to familiarize yourself with the financial environment in which your practice operates. In the current climate, many organizations need their clinicians to see patients every 10 to 15 minutes to generate sufficient revenue for the organization to remain open. This can create barriers to implementing new models of care if these new models increase the amount of time a clinician must spend with a patient.

For example, engaging patients as partners in care can take more of the clinician's time. Implementing care teams is one way to alleviate this problem. Ancillary members of the care team can handle routine tasks through standing orders and other means. This frees the clinician to spend more time with more complex patients and carry out important activities such as wellness planning and proactive care. But care team roles must sync with reimbursement mechanisms and requirements.

Reimbursement structures also affect the ability to implement guidelines. Guidelines may call for lab tests that insurers may not cover or that patients cannot afford. The tests also may be too expensive for practices to routinely obtain under capitated contracts. You will need to work with the practice to develop work-arounds to overcome this financial barrier to guideline implementation. For example, the practice might modify guidelines if appropriate. Another option is to expand your role to help practices reach out to health plans to modify terms so that the practices can deliver care not currently supported by existing payment structures.

As a facilitator, you will need to remain aware of the pressure clinicians and staff are under and modify your methods and approaches appropriately. Optimal models of care may be intellectually interesting to clinicians in these contexts but may be met with skepticism by those who struggle to deliver even basic care to patients in short periods of time.

You will need to work with your program and the practice to evaluate how the improvements you support can improve or at least not negatively affect the practice's financial standing (e.g., streamline care, increase efficiency, secure payments for performance or QI). Resources such as the AHRQ toolkit *Integrating Chronic Care and Business Strategies in the Safety Net* can help you analyze the financial drivers of a safety net practice and can help you and your program identify strategies for improving practices' bottom line. More information on understanding primary care practice management is in Module 4. You may also want to look to financial "exemplars" in your area—practices that have found creative ways to solve some of these problems—and set up site visits or learning sessions for your practices to exchange ideas with them.

For example, group visits can be a way to increase access when demand exceeds supply. They can also improve patient experience and outcomes by connecting patients to peers and strengthening their social networks. However, while group visits can improve patient care, depending on the state and area, a practice may have difficulty implementing them because of reimbursement rules for patient visits. Practices that have been early adopters of group visits have often found ways to overcome barriers to reimbursement. These practices can be a resource for practices interested in adopting group visits.

Administrative challenges. The unique organizational and structural designs of safety net practices can lead to special challenges with administration, clinician staffing, management and human resources.

Complex and layered administrative structures. Safety net organizations, particularly FQHCs, often operate more than one practice site. Many have 3 or more sites and some as many as 40 or 50. In these cases, practice-level and organizational-level leadership structures exist. Organizations may have chief executive officers, chief financial officers, and chief operating officers in addition to site medical directors and practice managers. Sometimes what central leadership wants to change in the organization may be at odds with the needs of staff and clinicians at individual practice sites.

You will need to know the leadership and reporting structure of the organization and the priorities of both central leadership and the individual practice sites you will support. One important role for you will be to optimize communication between administration and frontline practitioners and staff. You may serve as an advocate for clinicians and staff at the practice level, helping to communicate their challenges and needs to the organization's leadership. Similarly, you can help central leadership adapt and modify interventions so they are effective at each practice site.

Complex staffing patterns. Many staff and clinicians who work in the safety net are mission driven and derive great satisfaction from caring for poor and underserved patients. In addition, care provided through FQHCs and similarly organized practices can be some of the best available anywhere. However, working in the safety net has downsides.

Clinicians in safety net settings are typically paid less than clinicians in non-safety net settings. To attract and maintain clinicians in these practices, clinic leadership often offer flexible schedules and job-sharing types of arrangements. These present challenges to scheduling, empanelment, and team-based approaches to care. For example, an organization with the full-time equivalent (FTE) of 15 clinicians may actually employ 40 individuals for varying percentages of time to make up the 15 FTEs.

Turnover can also be a problem for the safety net. Intense workloads, pressure to see a patient every 15 minutes, and lower pay can create stress, job dissatisfaction, and early burnout. Thus, practices may rely heavily on temporary staff. Furthermore, some safety net practices use volunteers who, in addition to having unpredictable schedules, may not be as responsive to directives of the practice leadership.

You will need to consider the impact of complex staffing issues on your work with your practices as it has implications for everything from forming lasting relationships with staff and clinicians to how you schedule and structure your support sessions with a practice. These issues also have implications for core changes such as empaneling patients, implementing care teams, and ensuring that improvements are sustained over the long term. You will need to work closely with practice leadership to understand staffing issues at each practice and to determine the best way to address these challenges.

Limited management experience of practice leadership. Physicians and others practitioners who occupy leadership roles in safety net practices are often excellent clinicians but may lack administrative, leadership, and change management skills. You will need to be aware of this and not assume that an individual's title implies management or leadership skills. In some cases, you may need to provide executive coaching support for leadership to build their skills in these areas.

Insufficient staff and human resources. It will come as no surprise that safety net practices may lack the financial resources to hire staff to provide self-management support for patients, manage patient panels, or ensure health information systems at the practice are optimized. Some organizations solve this problem by obtaining grant funds to cover a health educator or to support a *promotora* program. However, these are often not sustainable solutions.

Thin staffing will have implications for any improvement work you engage in with a practice and the ability of staff to take on additional activities or roles related to the targeted improvements. You will need to remain aware of this issue and work with the QI team and leadership at the practice to design or modify improvements so that they are feasible, do not cause staff burnout, and can be sustained in the long term.

Suboptimal health information technology. Health information technology (IT) resources present yet another challenge not only for safety net practices but for all types of primary care practices. Improving quality of care often requires robust, well-organized, and intuitive health IT systems that enable clinicians to manage panels of patients, plan and track all care, and identify and track patients with special needs. These systems should also provide decision supports at point of care that can be easily updated as new evidence is produced and treatment guidelines change.

Electronic health records (EHRs) have been implemented with great speed in FQHCs and other safety net settings due to financial incentives and technical support made available by the U.S. Government. However, few, if any, of the systems easily support team-based or population-based approaches to care, both of which are central to the Care Model and the Patient-Centered Medical Home. Indeed, most EHRs need substantial modification after implementation to support even the most basic population management functions.

Many times, practices opt to maintain parallel standalone registries because of the inadequacies of EHRs. This is an additional cost to the practice and can require dual data entry or expensive software to enable EHRs and the registry product to exchange data. As a facilitator, you will need to become familiar with the EHR and registry systems your practices use. You will also need to be aware of the available technical support and develop a working relationship with the staff at the organization or practice charged with overseeing their EHR or registry.

Much of the work you will do as a facilitator, especially at the start of an improvement project, involves collecting data and setting up performance reporting systems. Depending on the focus of the improvement intervention, your work may also include helping practices structure their EHRs to support panel management and cross-team communication.

Obtaining the training you need to accomplish these tasks can be difficult. Product vendors are motivated to protect information about modifying their product because technical assistance is a revenue stream. Similarly, except in organizations that can afford dedicated IT staff, practice staff charged with maintaining health IT systems are often inexperienced working with health IT products and limited in their knowledge and skills.

As you continue your training, you will need to look for opportunities to increase your knowledge and skills working with the EHR and registry products most commonly used in your area. You can acquire this training by:

- Sitting in with your practices when they receive vendor-led training,
- finding and connecting with practice staff who have become "exemplars" in the use of a particular product and learning from them, and
- seeking assistance from the Regional Extension Center (REC) in your area. The Federal Government established RECs as part of the Health Information Technology for Economic and Clinical Health (HITECH) Act to support implementation of EHRs nationwide. RECs can provide technical support to practices related to EHRs. More information on the RECs is available at www.healthit.gov/providers-professionals/regional-extension-centers-recs. Also see Modules 26 and 27.

Patient challenges. Many patients who receive care through the safety net have low incomes, come from cultures with different health beliefs and practices, may lack fluency in English or prefer to speak a different language, and have limited health literacy. Interventions that work with more affluent, health literate, or cultural majority populations may not work with patients from a safety net practice. For example, a depression management program involving nurse follow-up calls with patients that was effective with middle class patients was difficult to implement in a safety net practice. When nurses would call to follow up with patients, the patients did not understand the purpose of the call and ended up coming into the practice to "see what was wrong," creating anxiety for the patient and additional work for practice staff.

In addition, many patients receiving care in the safety net have more complex and serious illness. These conditions often result from environmental stressors, delayed access to health care and treatment, limited access to healthy food and spaces for exercise, and exposure to stressful life situations and environments.

As a practice facilitator, you will need to develop a deep understanding of the patients coming to the practice, their daily lives, and the factors affecting their health and ability to participate as partners in their care. This is particularly important as care moves to becoming more "patient centered" and activating and engaging patients as partners in care becomes the gold standard. You will need to work closely with your practices to assess the degree to which they are addressing the cultural and health literacy needs of their patients and effectively engaging patients as partners in their care.

Various resources are available to help practices improve their ability to address the health literacy needs of their patients. The Agency for Healthcare Research and Quality (AHRQ) has an excellent toolkit for assisting practices to improve in this area, available at http://www.ahrq.gov/qual/literacy/healthliteracytoolkit.pdf. The Health Resources and Services Administration (HRSA) supports the National Center for Cultural Competence, which offers a free online training on health literacy and cultural and linguistic competence, available at http://www.hrsa.gov/publichealth/healthliteracy/index.html (HRSA, undated). The Institute of Medicine's discussion paper provides a roadmap for becoming a health-literate organization (Brach, et al., 2012). Finally, you will need to learn about the National Standards for Culturally and Linguistically Appropriate Services (HHS, 2013), available at https://www.thinkculturalhealth.hhs.gov/Content/clas.asp and build them into your work.

You may also want to work with your practices to include patients on their QI teams. Module 30 on Building Teams in Primary Care provides a brief introduction to this area and links to resources.

Challenges accessing specialty care and community support services. Safety net patients can experience great difficulty accessing specialty care depending on their insurance status. Similarly, clinicians working in the safety net can have problems getting specialists to respond to requests for case consultation. In the words of one safety net provider, "They are not interested in working with us because we don't send them patients that pay." This can create barriers to implementing targeted improvements in your practices and can have a significant impact on patient outcomes and experience.

You can help a practice develop productive relationships with specialty practices by conducting outreach and building communication protocols between the practices and specialists. Specialists may have misconceptions about the practices' patients, which you can dispel, or you can enlist the help of an opinion leader in the community to gain specialists' cooperation. You can play a similar role in helping a practice develop relationships and effective referral protocols with community support programs.

You can also help practices improve referral processes and follow-up by evaluating the effectiveness of the current processes and helping the practice redesign workflow. Collecting data on wait times and unmet requests for specialty care services can provide valuable information that practices can use to advocate for increased support from area health plans and health departments. In addition, you can help your practices explore programs designed to improve specialty care access, such as Project ECHO (available at http://echo.unm.edu), or to participate in telehealth initiatives in your area; and also consider similar initiatives to improve access to community-based services.

Assets in Safety Net Practices

As you grapple with challenges, you will also benefit from the assets safety net organizations offer. Most staff and clinicians in FQHCs, look-alikes, and other community health centers are mission driven and are committed to improving the lives of underserved individuals and their families. Therefore, these practices can bring the best and brightest clinicians into their field.

Similarly, many of these organizations and practices have benefited from resources provided through HRSA, the Centers for Medicare & Medicaid Services, and others. These may have included opportunities to participate in learning collaboratives and early access to patient registries to support population management. Most practices are also required to report quality metrics to HRSA, health plans, and county, state, and local officials, so they have some data systems in place to use for QI and practice transformation work.

FQHCs and larger community health centers often provide a wider range of care and more comprehensive care than many traditional, non-safety net practices. For example, FQHCs often have full dispensaries and some have licensed pharmacies onsite. Many have health education programs and social services that link patients to outside resources. Still others have implemented telemedicine and e-consultation programs to facilitate specialty care access. They may also serve as training sites for residents from local medical schools and residency programs, which can help keep them abreast of developments in medicine and care. It is important that you view your practices through an assets-based lens.

While these things may be less true of private, for-profit practices in the safety net, clinicians and staff in these practices may welcome the support and connections you offer as a facilitator, as well as the opportunity to participate in a learning community of other practices. While quality and motives can be a concern in some of these practices, some may look similar to community health centers and FQHCs in their area and offer comprehensive and high-quality care to their patients. For example, a private safety net practice in Los Angeles provides a full range of health education programming for its patients and access 7 days a week. The practice also opens its doors in the evening for parenting and youth groups and is active in a number of QI projects that are also taking place in the area FQHCs.

As a practice facilitator, it is important for you to be aware of the challenges your practices face in delivering care to vulnerable populations. But you also need to pay attention to the manystrengths these organizations have that can be leveraged to support continuous QI and implementation of new models of patient care (Kretzmann & McKnight, 1993). This is important not only in providing resources, but also in building your practices' confidence and hope in their ability to improve. Module 9 on Appreciative Inquiry will introduce you to a process that can help you and your practices pay attention to organizational strengths instead of weaknesses.

Note: this module is based on Module 2 of the Practice Facilitation Handbook. Available at http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/.

References

Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness: the chronic care model, Part 2. JAMA 2002 Oct 16;288(15):1909-14.

Brach C, Keller D, Hernandez LM, et al. Ten attributes of health literate health care organizations. Washington, DC: National Academy of Sciences; June 2012. Available at http://nam.edu/perspectives-2012-ten-attributes-of-health-literate-health-care-organizations/. Accessed July 20, 2015.

Huang ES, Zhang Q, Brown SES, et al. The cost-effectiveness of improving diabetes care in U.S. federally qualified community health centers. Health Serv Res 2007 Dec;42(6 Pt 1):2174-93; discussion 2294-2323.

Kretzmann J, McKnight, J. Building communities from the inside out: a path toward finding and mobilizing a community's assets. Evanston, IL: Asset-Based Community Development Institute, Northwestern University; 1993.

Lewin ME, Altman S, eds. America's health care safety net: intact but endangered. Washington, DC: National Academy Press; 2000. Available at http://books.nap.edu/catalog/9612.html.

U.S. Department of Health and Human Services, Health Resources and Services Administration. Effective communication tools for healthcare professionals. Available at http://www.hrsa.gov/publichealth/healthliteracy/index.html. Accessed October 7, 2014.

U.S. Department of Health and Human Services Office of the Secretary. National standards on culturally and linguistically appropriate services (CLAS) in health and health care. 2013. Available at https://www.thinkculturalhealth.hhs.gov/pdfs/EnhancedNationalCLASStandards.pdf Accessed July 20, 2015.

Primary Care Practice Facilitation Curriculum

Module 6. An Overview of the Facilitation Process

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Module 6. An Overview of the Facilitation Process

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Foundational knowledge of facilitation process and purpose

Time

- Pre-session preparation for learners: 15 minutes
- Session: 60 minutes

Objectives

After completing this module, learners will be able to:

1. List the stages in a typical facilitation process and describe their purpose and content.
2. Name and describe three characteristics of effective facilitation.
3. Identify at least three frequently encountered challenges to improvement.

Exercises and Activities To Complete Before and During the Session

Pre-session preparation: Ask the learners to review information in item 1 (15 minutes)

1. The content of this module.

During the Session: Presentation (30 minutes)

1. Present key concepts from the module.
2. Hindmarsh M. Using self-management support in your coaching approach. QIIP Practice Facilitator Training; 2008 May 12-13; Toronto, ON. See Appendix.

Discussion: Ask questions and explore answers with learners (30 minutes)

1. What are the different stages of a facilitation intervention?
2. What challenges might you experience during the different stages of the facilitation process? Which stage do you expect will be easiest for you? The most difficult?
3. Discuss the Hindmarsh slide deck. Ask learners the following questions:

    a. In what ways are the 5 A's for self-management support applicable to practice facilitation?
    b. How does this change (or not change) your understanding of facilitation and the work you will be doing with practices?

Module 6.

Facilitators support change in practices by focusing a practice's attention on the process of change and by empowering members of the practice to engage in the change process together. They work to create an environment that supports continuous improvement and introduces values such as respect, inclusion, and neutrality, and where people feel they are involved in the decisionmaking process. Facilitators help demystify improvement methods, evaluation, and research and support data-driven and evidence-based decisionmaking and actions. They create opportunities for practices to learn from each other and help create communities of practice that bring together peers to share best practices and lessons learned. They use participatory methods and have expertise as adult educators and facilitators of change (Department of Health and Community Services, 2006).

Most facilitation interventions pass through a series of predictable stages. Figure 6.1 shows the six stages of most practice facilitation interventions.

Figure 6.1. Common stages in a practice facilitation intervention (Adapted from Knox, 2010)

Stage 1: Recruitment and Assessing Readiness

The first stage involves recruiting practices to participate in improvement and evaluating their readiness to engage in this work. This phase takes place before active facilitation starts and will typically involve you and other members of your program. It includes several activities:

- Inviting practices to participate in improvement work.
- Orienting practices to the concept of practice facilitation and what facilitators do.
- Conducting an assessment of the practice's readiness and ability to undertake the proposed improvement effort. Completing preliminary paperwork such as business associate agreements that will allow you to access clinical data for measuring and monitoring practice performance.
- Setting goals with the practice early.
- Identifying the champion for the improvement effort at the practice and beginning to build a working relationship with him or her.
- Identifying other practice members who will be key participants in the improvement work.
- Beginning the process of identifying an individual who might eventually be developed as an "internal facilitator" that you will work to train in core competencies of practice facilitation. Identifying this individual typically will take some time, but you should begin evaluating individuals in the practice for this role from day one.

Stage 2: Kickoff Meeting

Stage 2 is the launch of the formal intervention. Typically, it involves an initial meeting with the project champion, you, and other individuals from the practice whom the champion and practice leaders have identified as important to the improvement effort. In this phase, you will work with the project champion to identify his or her quality improvement (QI) team and help ensure that the team includes representatives of staff in operational areas that will help implement the desired improvements.

You will help convene and facilitate a kickoff meeting for the improvement effort and will work with the QI team to further define and refine the improvement goals identified during stage 1. In this meeting you will also work with the QI team to understand your role and goals as the facilitator or the roles and goals of your team if you use a team approach to facilitation. If the improvement project involves implementation of new treatments or care processes, you may also include a physician academic detailer (a peer from another practice who shares experiences and effective strategies) in the meeting.

Effective facilitation is based on effective relationships. You will need the trust and respect of the practice to succeed. Many of the strategies that salespeople use to develop and maintain customers can be useful as you get to know a new practice.

Keeping a card deck with information about each clinician and staff person in the practice can help you remember the preferences, concerns, and interests of the individuals with whom you will work. Creating a map of the practice and key locations within it can also help. As one expert says, "You'll know when you've established an effective relationship with a practice when they give you the combination to the back door."

Stage 3: Assessment and Goal Setting

During stage 3, you will work with the QI team to conduct an initial assessment of the practice in areas related to the improvement effort. You will help the team review and use these data to finalize their goals and performance indicators for the effort.

One of your roles will be to help the practice identify a few easy goals to begin with that can allow you and them to build skills in using the Model for Improvement (MFI) and Plan Do Study Act (PDSA) cycles to test and spread change. It also will help them use tools such as a key driver model (see Module 20) to focus on and select from among the thousands of changes possible those that are most likely to be "high yield" and lead to the greatest improvements for the practice and its patients.

During this stage, you will also continue to identify an individual or individuals in the practice who can be developed as "internal facilitators" to support the practice when the intensive work you are doing with the practice for this improvement effort is over. Throughout this and the following stages, you will work with this/these individual/s and the improvement champion and team to develop their knowledge, skills, and capacity for adopting new evidence and continually improving quality at the practice.

Stage 4: Active Facilitation

Stage 4 is the heart of the facilitation intervention. One of your earliest and most important jobs in this phase is to help practices build their capacity to generate performance data on the metrics that matter to them and their patients. For many, this step is uncomfortable at first. Clinicians and staff often resist performance reporting; afraid they or their practice will be singled out as underperformers. Most have legitimate concerns about the accuracy of the data that are used in performance reports.

During this stage, you will assist the practice in monitoring its progress toward its improvement goals by conducting monthly chart audits and other assessments and providing feedback to the QI team on the results. To do this, you will need to know how to access data from registries and different electronic health record (EHR) systems, as well as how to conduct paper chart audits. You will need to know how to manage and conduct simple analyses of data, and you will need to have a solid understanding of the role of denominators and numerators in performance reporting.

Another important activity you will engage in during this stage is workflow mapping. You will map existing workflows and assist the QI team and practice to redesign various workflows to support desired improvements. You will train the team in the MFI and assist them in designing

and carrying-out PDSA cycles to test changes. (See Module 8.) You will train staff and clinicians on key change concepts, provide support and training to staff to build skills and knowledge for assuming new roles or activities, and engage expert consultants and academic detailers to provide additional support, training, and mentoring when needed.

You will work with the EHR and registry managers to create reporting systems designed to monitor performance in the targeted areas. In addition, you will work with them to introduce modifications to the practice's EHR and related workflows to support care innovations such as panel management and use of care teams. When you and the practice's IT staff cannot produce the desired modifications, you will help the practice engage their vendor or will add facilitators with expertise in EHR optimization to your team. The additional facilitators can provide technical assistance to the practice in this area.

You will work with the QI team and your "internal facilitator" to build knowledge, skills, and practice systems to support improvement work, and help keep them and the practice on track with the improvement work and ensure that it does not get lost in the crush of busy workweeks. You will help convene meetings and ensure that they are well facilitated, help the practice create systems for holding team members accountable for deliverables, and help manage and mediate conflicts and disagreements that often arise during change.

Finally, you will work with members of the practice to incorporate a new language of change into their day-to-day vocabulary that reinforces their commitment to continuous improvement and the changes and gains that have been made. For example, when a practice successfully makes a change, you can encourage the use of statements such as "This is the way we do business in our practice" that reinforces that change. You will also want to work with the practice to implement a language of possibility for future changes. For example, encouraging them to say, "we haven't made that improvement 'yet'" rather than "we haven't improved." The language a practice uses helps shape its culture and actions. Helping practices adopt a language of change is an important part of creating organizations with a culture of continuous quality improvement.

Stage 5: Holding the Gains

Once a practice has achieved its desired changes, attention will drift to other issues. Your job in stage 5 will be to assist the QI team and practice leadership to maintain their gains by creating the conditions needed to sustain the changes long term. You will help them continue performance monitoring and determine how the performance data will be used to ensure that the changes are sustained. You will work with them to incorporate the changes into the practice's or organization's policies and procedures, job descriptions and evaluations, and staff orientation and training.

Stage 6: Completion and Transition to Maintenance

While most active facilitation interventions last for less than a year, a priority of your work should be to establish a long-term relationship with your practices. Your ability to achieve this

relationship will be determined by your program and by available funding. But the promise and power of practice facilitation lies in the relationships facilitators establish with their practices and the fact that these relationships remain in place over time. Long-term relationships enable a facilitator to rapidly and efficiently re-engage with a practice as needed to support implementation of newly developed treatments, guidelines, and models of care.

In the final stage of an active intervention with a practice, you will focus on closing out the existing improvement intervention and ensuring that:

- the practice has access to all the resources and tools engaged to support the improvement work,
- the practice develops a clear and empowering narrative or "story" about the improvement effort that it can incorporate into its history and organizational memory, and
- the QI team and practice at large have an opportunity to reflect on and react to this story.

Finally, you will work with the practice to transition from active facilitation to maintenance where you will no longer work with the practice on a regular basis, but instead will check in once every 3 to 4 months. To do this, you will work with the individual/s you have been training to serve as internal facilitators and the QI team to identify the next set of goals that they may want to work on, which should include continued monitoring of the improvements recently put in place. In an ideal scenario, you will have had a chance to provide sufficient training to the "internal facilitators" so that you can step back and allow them to facilitate these discussions and decisionmaking processes for the QI team with support from you only as needed.

Finally, you should create a means of maintaining a relationship with the practice while they are not part of an active facilitation effort. This might involve sending periodic emails to the QI team, or if appropriate, engaging them to participate as academic detailers or "exemplars" to another practice that is in active facilitation. You also could drop by every few months to check in.

Note: this module is based on Module 3 of the Practice Facilitation Handbook. Available at http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/

References

Department of Health and Community Services, Government of Newfoundland and Labrador. Guiding facilitation in the Canadian context: enhancing primary health care. St. John's, Newfoundland: Department of Health and Community Services; 2006.

Knox L, ed. Report on the AHRQ 2010 consensus meeting on practice facilitation for primary care improvement. (Prepared by LA Net under Contract No. HHSA2902007100110.) Rockville, MD: Agency for Healthcare Research and Quality; 2010.

Primary Care Practice Facilitation Curriculum

Module 7. Professionalism for Practice Facilitators

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Module 7. Professionalism for Practice Facilitators

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Professionalism
- Commitment to continuous learning

Time

- Pre-session preparation for learners: 60 minutes
- Session: 90 minutes

Objectives

After completing this module, learners will be able to:

1. Identify key behaviors and actions that connote PF professionalism.
2. Demonstrate professional behaviors in interactions during class and in the field.
3. Develop a plan for continuous learning for the coming year.

Exercises and Activities To Complete Before, During, and After the Session

Pre-session preparation for learners. Ask the learners to review the following information. (60 minutes)

1. The content of the module.

During the session. Presentation (30 minutes)

1. Present key concepts from the module.

Activity (45 minutes)

Let's Keep It Professional activity (45 minutes)

1. Hand out the case on professionalism in Appendix A to learners.
2. Ask learners to break into pairs.
3. Tell the learners to consider any of the professionalism topics described in this module and think of an issue they had to confront with practices as a PF or in similar previous work that required them to exhibit professional conduct.

    a. For learners who do not have an experience to share, the case in Appendix A can be used to

spark discussion.

4. Ask learners to write down their understanding of the issue, solution, and outcome.
5. Ask learners to take turns sharing their experiences with their partner *without* sharing the solution and outcome.
6. Ask each learner to reflect on their partner's story and share with the larger group how the issue could have been resolved and what elements of professional conduct are contained in the solution.
7. After the learner has shared the partner's story and thoughts on possible solutions for it, the partner will then reveal the actual solution and outcome.
8. Ask learners to regroup and each lead a discussion of the following questions (15 minutes for each learner?):

    a. What did you learn about your partner from this exercise?
    b. Did your solution match your partner's? If not, how did they differ?
    c. What aspects of professional behavior and conduct were evident in the actual solution?
    d. What will you take away from today's activity?

Module 7.

What is professionalism? *Merriam-Webster* (2014) defines it as the "skill, good judgment, and polite behavior that is expected from a person who is trained to do a job well." Behaving professionally as a practice facilitator (PF) will help you build credibility with the practices you work with and for the profession generally. Professionalism is more than what you wear and what you say; being professional also reflects your attitude and demeanor.

Professionalism is particularly important for you to establish credibility with your clients. As a PF, you will work with diverse groups of individuals, including both highly educated medical practitioners and patients who may not have finished high school. You will need to interact professionally with people from all these groups. In addition, much of your work takes place in your clients' work settings. This means almost everything you do will be visible and under the scrutiny of your clients. Because PFs often start as outsiders, you must earn credibility in the practice. This places unique demands on you as a PF. Finally, most of your work will take place outside your office and you will often work almost as an independent agent. Because of this, the need for professionalism is even greater. Responsibility will fall on you to make sure that you implement the intervention model your program uses with fidelity and communicate with your leadership about any modifications you believe are necessary.

There are a variety of rules and behaviors you will want to follow when you are working in practices. These include:

1. Professionalism in Personal Behavior
2. Professional Interactions with the Practice
3. Maintaining Professional Relationships
4. Professionalism Within Your PF Program
5. Commitment to Continuous Learning and Professional Development

While many of these principles may seem self-evident, it is helpful to review them before you start working with your practices.

Professionalism in Personal Behavior

First impressions matter. Most often you will be entering a new practice as an unknown, and one of your first tasks will be to build trust, confidence in your abilities to work with a practice, and interest in what you have to offer. The first impression you create is an important part of building rapport with a practice. For this reason, it is important that you pay attention to how you represent your skills to a practice, your attire, and your timeliness. Each of these communicates who you are to a practice and shapes their initial impressions of you.

Know your skills and experience and be transparent about them. PFs will vary in their skills and levels of experience. While all PFs are expected to have basic skills in quality improvement

(QI), work with practices may require additional skills, depending on the goals of the intervention and the needs of the practice.

You will want to accurately assess and represent your skills to the practices that you work with. It is important to be transparent about what you are able to offer and what other skills the members of your larger PF team have. Being transparent about these skills will build trust, help you manage practice expectations, and help practices know where they might best engage you as a resource. Since even a novice PF can bring value to an advanced practice, being transparent about your skill and experience level does not mean being apologetic about your abilities.

It is important to think strategically about what a practice needs, how this fits with your skills, and how you might engage your PF teammates to fill any skills gaps. In instances where your knowledge and skill are not to the level needed by a practice, you can become a co-learner with members of the practice by finding training opportunities for them that you also participate in. A core skill of a PF is to be a "switchboard operator." You may not know *how* to do something, but should know *who* in the community might be able to help or how to locate this type of individual or resource for the practice.

For example, if your practice needs assistance with empanelment and you lack this skill, you might engage an outside expert or arrange for the practice to participate in a training on empanelment that you also attend and then assist them in implementing their new knowledge in the practice. For example, Vermont's Blueprint for Health co-trains practice facilitators and their practices on key concepts of patient-centered medical homes (PCMHs), and then the PF returns to the practice to assist members in implementing what was learned at the training. More information is available at http://pcmh.ahrq.gov/sites/default/files/attachments/Vermont_020413comp.pdf

Key points on assessing and communicating your skills and experience:

- Accurately assess your skills and experience.
- Communicate your skills and experience to practices and your own organization.
- Consider a co-learner approach.

Dress appropriately. There are common dress codes in health care settings that you should adhere to. It can be helpful to read the practice's employee handbook regarding its dress code, observe the dress of clinicians and other practice staff, and ask your main contact at the practice about any rules regarding dress you should be aware of. A rule of thumb you can use to determine appropriate dress is to dress similarly to the office manager.

Like it or not, you will be judged in part by your appearance. Your dress should always be professional and neat. In general, you will want to adhere to the dress code of the practices you are working in. Ideally, your attire should enable you to blend in to the professional crowd rather than stand out. But be aware of how your attire can send messages to patients and staff. Overly formal dress in an informal setting can set you apart. In some instances, this can be positive,

helping to enhance your credibility (for example, in a first meeting with a practice). In other cases, this can make you appear out of touch or solidify your outsider status. Your goal is to be appropriate in your attire, matching it to what is usual in the practice setting.

Key point on dressing professionally:

- Adhere to the practice's dress code.

Be on time. One of the first opportunities for you to demonstrate professionalism is to be on time for meetings and appointments. Not only is this an important part of professionalism, but it is also an important way to build trust and credibility with a practice. You will discover that practice staff and clinicians often are not able to be punctual. The demands of patient care often make it difficult for them to stay on time. Patient visits may run late; emergencies will happen. In addition, they may not consider the work you are assisting with to be a priority and may communicate this by running late. Do not take this as permission for you to reciprocate in kind. Whether they are punctual or not, you must be committed to maintaining professionalism by showing up on time, even if this means you will be waiting. Be flexible. Work around the schedules of the practice staff and clinicians. Later, as you build a relationship with the practice, you may decide to use their chronic lateness as a means for having a staff member or clinician reflect on any ambivalence about the process, the culture in the organization that enables chronic lateness, and other challenges such as understaffing or clinical staffing emergencies that make it difficult to attend on time.

A good way to prepare for and manage waiting time is to arrive prepared with other work tasks. Since PFs can anticipate that clinicians may be running late and that there may be lag time between encounters, you will want to use this opportunity to document encounters and work on other practice facilitation tasks.

You should also consider arriving early for meetings. Arriving early gives you time to set up and provides an opportunity to address any last-minute tasks. Over time, establishing this as part of your routine can build a positive impression of commitment and accountability to others. This also provides the opportunity for "water cooler" conversations and chance encounters in the hallways with practice members.

These accidental encounters can be a very important way of obtaining additional information about a practice, learning about important concerns, and also building relationships. For example, a PF working with a Federally Qualified Health Center to "fix" their empanelment process discovered what was creating the problems through casual observation of a staff person one day when she was passing through the building. This observation led to additional study, identification of the underlying cause, and a successful re-launch of empanelment by the practice after two previous failed attempts.

Key points on punctuality:

- Be flexible and sensitive to practice staff and clinician schedules.

- Go prepared with other practice facilitation work to complete while you are waiting.
- Consider arriving early.

Professional Interactions With the Practice

In addition to your general comportment, you also signal your professionalism and reliability by the way you interact with your practices. Keep in mind that the impression you create with your practices will reflect not only on you, but also on your larger PF program. In most cases, you will begin work with your practices as an outsider. Your credibility will be based on the reputation of your employer. Often someone from your PF program already has an existing relationship with the practice and can introduce you to key personnel there. This helps create some initial credibility for you as you begin your work with the practice. However, the basis of the practice's assessment of you will quickly shift to a judgment of your actions, and this will begin with their observations of your reliability, consistency, and how well you recognize their basic rules of etiquette and operation. As a practice is getting to know you, you will want to identify yourself to them. This is an easier process in a smaller practice; in larger practices, it can take weeks, sometimes months, until people begin to recognize you. You will want to be respectful of practice resources and follow proper rules and etiquette in meetings, when using workspaces and practice resources, and when parking. These issues may seem inconsequential, but poorly considered moves on these seemingly small items can have big effects on your reputation and the practice's receptivity to you.

Announce your arrival and departure and clearly identify yourself while on site. Out of professional courtesy, be sure to inform the practice of your arrival. In an ideal world, you will visit each practice on a regular and predictable schedule. A common schedule for PF programs is half-day a week during active intervention periods. When you arrive for your routine visit, you still will want to "make the rounds" and let people know you are on site. If you are consistent, they will anticipate and prepare for your visit.

In addition to reminding staff members of your work at the practice, announcing your visit allows them to keep track of your time at the practice. They may do this either informally or through a sign-in sheet. As the staff becomes more familiar with you, they will begin to seek you out. Letting them know you are on site makes that easier. You should also announce yourself for ad hoc visits, again out of professional courtesy.

Announcing your departure serves a similar function. Let the team members you've been working with and your primary point of contact know when you are leaving. This supports continued relationship building with a practice and gives you one last opportunity to connect with practice members during your visit. You can also use this as an opportunity to remind them when you will be back for a next visit and begin planning for this. After a long day (and a drive home ahead), it can be tempting just to slip out the back door. Taking the time to say goodbye (just like saying hello) can be an important step in building rapport with practices.

During your time at the practice, consider wearing an ID badge that indicates your name and your PF program. This helps signal your role to practice staff and clinicians, and helps them associate your face and presence with PF work. In larger practices with many consultants coming and going, it is especially important to identify yourself clearly, which will help practices remember you and why you are there.

Key points about announcing your arrival on site:

- Notify practice staff whenever you are on site.
- Touch base when you are leaving as a way to continue to develop relationships.
- Wear an identification badge, if appropriate.

Get to know clinicians and staff. Another important part of building relationships in a practice is getting to know the staff and clinicians you are working with on both a professional and personal level. While it is important to maintain professional boundaries, showing interest in and remembering important personal information about practice members' hobbies, important life events, and family can go a long way towards building relationships. If the practice manager has a new grandchild and you remember her name and ask about her each visit, you will soon become a favored visitor.

When you first start working with a practice, it may be useful to create a map of the practice that shows where each staff person and clinician works. It can also be helpful to create an index card or e-record (perhaps in your contacts program) that contains the individual's name and important information about them. Because you may be working across many practices with many different individuals, you can use these to help you remember important details about each person in a practice you work with to support development of trusting relationships with practice members.

Key points in getting to know practice members:

- Create a map of the practice showing where key staff and clinicians work.
- Create index cards or e-records for each staff person and clinician you will be working with, which you can use to help you remember this information in future visits.
- Maintain appropriate professional boundaries but also get to know and remember important events, like the birth of a grandchild or other significant event, in staff's and clinicians' lives to help build relationships.

Use practice resources sparingly. Practice staff often will go out of their way to provide resources to the PF. It is up to you to demonstrate professionalism while on site and use these resources responsibly. For example, you should limit activities such as using their printers and copiers. If you need to make last-minute copies of agendas, you should plan to replace the resources you use. Ideally, paper documents should be brought into the practice preprinted. Always clean up after yourself. If you need to make personal calls or calls related to another practice, use your cell phone; limit internal phone use to issues specifically for the practice. Food and beverages should only be taken when offered, but you may also need to set limits on a case-

by-case basis. In fact, you may want to consider bringing small gifts to staff as a way to communicate your interest and care for them and their work. A basket of cookies or the occasional box of donuts can help build relationships.

Key points regarding using practice resources:

- Come prepared with your own resources and equipment.
- If you do use practice resources, be sure to keep consumption to a minimum.
- Return the favor when possible.

Keep meetings professional and distraction-free. Avoid using devices such as cell phones or computers that may create distractions during meetings unless they are an explicit part of the session. These devices can distract the user and also signal a lack of engagement in the meeting proceedings to those around you. Even taking notes on a laptop can give others the impression that you are distracted. Others may not know this is what you are doing, and the noise of the keyboard can interfere with discussion. Using paper and pen to take notes is much less distracting and therefore usually preferred.

Key point regarding electronic devices:

- Avoid using devices that create distractions at meetings

Be considerate with workspace and parking at practices. Workspace is an important consideration when entering a practice. Your site workspace is the physical space you will use to complete tasks related to the practice's practice facilitation intervention. Often, your workspace will change from visit to visit. Regardless, most of the time any workspace assigned to you is not actually yours and will likely be shared with others in the practice. PFs can expect to work in shared cubicle spaces, empty conference rooms, lunchrooms, waiting rooms, or sometimes even in their car in the parking lot. Come prepared to set up a portable workspace (that is, a fully charged laptop with Wi-Fi access). Be sure to confirm with the office manager or practice staff that the space you intend to use is available and appropriate for you to occupy. Always leave your workspace in the same condition in which you found it.

You will probably be working alongside other practice staff. Once you set up your workspace, you will need to be mindful of your surroundings and the people in them. For example, if you are working in the lunchroom; do not take up additional space by placing your computer bag in an empty chair. Be mindful of noises that will distract others. If you need to make calls, be sure not to disrupt others. If you need to make or receive a call about something unrelated to the work at the practice, step out of the building to take the call or defer it for a later time. Taking calls for issues other than those in service of the practice at hand sends a message that you are not giving their practice your full attention and commitment.

Remember, you are entering the practice space as a stranger, and the staff often will inquire why you are there and be curious to find out what you are up to. Be prepared to answer these questions. Be friendly and introduce yourself. Then let them know which project you are

working on and with whom. Be sure to follow your response with a reciprocal question. Ask the staff member his or her name and role in the organization. You will soon find yourself building relationships.

Parking can be a surprisingly thorny issue for PFs. Some practices have plenty of parking and there will be no problems with parking on site. Others have very limited space that they need to reserve for their staff and patients. If you are working with safety net practices, you may be in areas of town that are not safe and where it may not be wise to park or walk on the street. Be sure to check with your primary contact about where you should park before your arrive at the practice for your first visit. As a default option, always park away from the main entry or even on the street, if it is safe, to save the parking spaces for patients and staff until you are clear on where you should park.

Key points regarding workspace:

- Station yourself wherever space is made available.
- Do not take calls unrelated to the practice you are visiting.
- Respond to practice staff inquiries and be friendly.
- Prior to your arrival, ask where you should park.

Maintaining Professional Relationships

You will interact with many different types of people as you work with a practice: practice staff, clinicians, external consultants, patients, other PFs, and your own program staff. It will be important that you interact professionally with this diverse range of audiences and partners.

As you begin working with a practice, you will want to help the practice members get to know you. This helps build relationships and create the trust you will need to support the practice in improvement work. You should introduce yourself in a way that helps the staff person build a solid professional connection with you. When you are introducing yourself to staff persons such as clerks and medical assistants, you can share aspects of your professional development and work that are most likely to connect with them; this will also help them see that you understand the type of work they do and the challenges they face. You might share experiences you have had in the past with other clerks or medical assistants and what you have accomplished (protecting confidentiality, of course). Do not emphasize areas that might create barriers. For example, do not mention that you have a Ph.D. if you think this might create a barrier with the staff. On the other hand, this might be appropriate and even useful to share with clinicians or practice leadership.

Learn the names and roles of practice staff and clinicians. Learning and remembering the names and roles of individuals at the practice can take you a long way in building relationships and establishing yourself as an effective professional. Be able to look someone in the eyes and call them by name or—even better—remember important information about them that they may have shared with you. Create a notebook, index cards, or other digital documentation for each

practice to record descriptions and names of staff members, making sure to update it as necessary. These files can contain project information for each participant in the practice. This will be a helpful tool for both you and your team.

Key points regarding remembering practice staff's names and roles:

- Remember names and roles as an important part of both establishing relationships and your presence as a professional.
- Use a notebook or other methods to record names, information, and location of practice staff.

Interact professionally with consultants at the practice. You may encounter other consultants who are working with the practice at the same time you are. These may include information technology (IT) staff or a QI consultant with specialized knowledge in a particular area, such as electronic health record implementation. You will want to extend professional courtesies to these individuals. Often the items they are working on are relevant to the work you are doing with the practice. Introduce yourself. Explain your role. Ask about the work they are doing and explore any synergies. Provide them with your business card or information on how to contact you. You may want to get their information as well, in case you need to reach out to them.

At the same time, you should balance the importance of establishing communication with them with appropriate interpersonal boundaries. You will want to clear any proposed involvement or work with your primary contact and practice leadership. Practices often contract with consultants for a limited scope of work, and additional time spent with your team could result in unexpected charges. In addition, you will want to maintain appropriate boundaries with the consultant. Avoid the temptation to gossip or become overly familiar, even in stressful situations.

Key points on working with a practice's consultants:

- Interact professionally.
- Introduce yourself and explore any synergies in roles that you might be able to leverage to support the practice.
- Maintain appropriate interpersonal boundaries.

Interact professionally with patients and their families. While most of your interactions will be with practice staff and clinicians, you may also work with patients and their families. Patients and their families are the customers who should be at the center of any improvement work. They are an important source of information about a practice and can serve as "partners" to you in QI interventions and facilitation. All PF work should include engagement of patients and families in improvement activities.

One important way to collect information about a practice is to observe a health care visit from start to finish. Shadowing a patient through a visit should be a habit you develop as a PF, as it allows you to learn a great deal about a practice. Other ways you may interact with patients

include collecting or reviewing survey data about patient satisfaction, experience, and needs; interviewing patients; and conducting focus groups of patients.

In general, you should never approach a patient before you have received permission from your primary contact and practice leadership. Once you do, you should apply the same principles of professionalism that you use in the practice to these encounters. Whenever you interact with patients, you should introduce yourself and provide a brief explanation of your role. For example, you might say: "Hi, my name is Samantha. I am a practice facilitator working with the practice to help them improve patient experiences when they come here. Could you share some of your thoughts about the practice with me?"

Your communications with the patient should be respectful and efficient. You will want to make the patient feel comfortable and listen carefully to their input. Observe appropriate boundaries with patients. Do not share negative information about the practice. Defer patients' questions to their primary care clinician or another appropriate staff person if they have a specific question about the practice. If you defer their questions to the clinician or another staff person, be sure you alert the clinician that the patient has questions he or she would like to discuss.

When working with patients or practice members from cultures, backgrounds, or experiences different from your own, you should familiarize yourself with cultural norms of communication and recognize that these may be different from yours. Remember to be attentive to cultural norms and linguistic preferences.

Key points on patient interactions:

- Interact with patients only after you have permission from the practice leadership.
- Introduce yourself and your role at the practice to the patient.
- Avoid sharing negative information or making negative statements about the practice.
- Refer patients to their clinician or other staff person if they have questions you cannot answer or do not feel it is appropriate for you to answer.
- Whenever possible, make the patient feel comfortable by using their preferred language.

Maintain professional boundaries. As you establish working relationships with clinic staff and clinicians, you should minimize socializing outside of work with staff and clinicians. Socializing can intrude upon your ability to remain objective in your work with the practice and lead to difficult interpersonal situations. There are, of course, exceptions to this rule. Some events, such as fundraisers for the practice, are appropriate to participate in to show support for the practice.

Avoid all comments that can be viewed as sexual, gender biased, or racially/ethnically biased. Do not participate in discussions with staff and clinicians that contain this type of dialogue. Always be cautious with physical contact, such as hugging. Some individuals are uncomfortable with this type of contact and view it as unwanted touching and harassment.

In the event that you experience unwanted physical contact from someone at the practice, you should make it clear that this is unwanted and ask the individual to stop. In these cases, you must

report this immediately to your supervisor for further direction and support. Depending on the severity of the issue, the supervisor can work out this issue with appropriate clinic authorities. In these instances, it can be especially awkward or difficult for you to confront such an issue, especially when you are attempting to establish work-related relationships. PFs should always remember that their safety is important, and they should address any unprofessional interactions by others (and let their PF supervisors know immediately about these issues).

Key points regarding maintaining professional boundaries:

- In general, do not accept non-work-related invitations or fraternize with staff outside the practice setting.
- Be careful with physical contact, and recognize that some individuals may misinterpret or misconstrue such contact.
- Report inappropriate behavior to your supervisor, and ask the individual engaging in these behaviors to stop.

Maintain professional objectivity. As you begin to establish your professional relationships at clinics, you will need to exercise distance and objectivity. Distance and objectivity allow you to do your work. The fact that you are external to an organization is part of your power as a PF. You are able to observe the practice and its operations separate from internal politics and entanglements. The moment you begin to lose objectivity and get drawn into internal office gossip and politics, you become less effective and less of a resource to your practice. In the extreme, you can actually begin to contribute to the problems, solidifying dysfunctional interaction patterns. Personal entanglement will make it challenging for you to make the difficult calls and have the difficult conversations. At the same time, your success as a PF is based on trust and building a relationship with a practice.

You will need to balance these contradictory issues in order to work effectively with practices. Because practice facilitation work is relationship driven, and PFs are often naturally empathic, it can be easy for a PF to get entangled into the politics of a practice. Avoid this. It will render you much less objective and useful to the practice. This will require self-restraint and discipline. Ask yourself: "How will the information shared and the information I communicate help me help the practice reach its improvement goals?" If it does not help, it is best to leave it alone.

Key points for maintaining professional distance and objectivity:

- Be aware of the ease with which PFs can lose objectivity and become too enmeshed with a practice.
- Use self-assessment to monitor this and prevent it.

Keep internal information about the practice confidential. Professionals hold themselves accountable for their words and actions, especially when they have made a mistake. Such personal accountability is closely tied to honesty and integrity, and it is a vital element in professionalism. Throughout your encounters with practice staff, you will come across private

information about the practice. For example, you will inevitably see site performance data that may or may not be favorable to the practice and its work. You may also discover through staff chatter that a key staff person is resigning, or you may find out that the practice reached National Committee for Quality Assurance Level 3, the top level, on PCMH recognition. Whether the information you gain is factual, hearsay, through observation, or even seemingly good news, it is crucial that you keep these discoveries to yourself, unless otherwise publicized. It is in the PF's best interest for you to exercise professional behavior and avoid sharing information about the practice, whether negative or positive.

Always be sure to avoid critiquing or denigrating other practices, as you will be construed as someone who gossips and fails to maintain the privacy of other practices. This type of unprofessional behavior will get in the way of good relationships with members of the practice.

As a rule, you should follow the same rules of confidentiality and privacy about your practices and their internal issues and workings that you would for patients. You should not share internal information about a practice with others, except with your PF team members and staff. The information you share should lead to improving support to the practice and be provided in a spirit of respect and professional care.

Occasionally, you may encounter a practice that asks you to sign a non-disclosure agreement (NDA). NDAs require that you do not reveal certain information about the practice without explicit permission and approval. Practices may ask for these when they have developed a unique process or program that they believe gives them a competitive edge, or when they view certain information as proprietary. These types of requests need to be handled by your organization's program director and supervisor. You can thank the individual making the request, ask for a copy of the agreement, and let them know that your program director handles such requests and will be in contact about it.

Key points about maintaining practice confidentiality:

- Do not speak negatively with others about any of your practices.
- Do not share internal information about a practice with anyone except your PF team members and program staff.
- Engage your organization's program director and supervisor if the practice requests an NDA; this is a program-level issue.

Obtain permission to share "exemplar" workflows you have identified at the practice. As a PF, you may observe some promising elements from one practice that you might want to share with other practices. For instance, you may observe a specific process from a disease management coordinator in his or her daily routine for preparing lab reminders that can help another coordinator at a different practice. Or you may encounter a practice manager that has generated telephone-visit brochures and strategically placed them in the patient waiting and exam rooms. As an active observer, you will want to make note of these practices, as they may help in your work with other practices. In these instances, you will want to ask the practice

manager/coordinator whether it is permissible for you to share their "exemplar" workflows and processes with other practices. You will also want to ask them if they would be open to a site visit from practices that are interested in replicating their processes. While verbal permission for observations is usually sufficient, you will need to obtain written permission for documentation sharing. Most practices are open to and find it rewarding to have the opportunity to share the good work they are doing with others.

Key points on sharing information:

- Before sharing information about best practices you observe, confirm that the practice has agreed to this (this agreement will often be discussed during the kick-off meeting and initial paperwork completion).

Respect lines of authority at the practice. Professional behavior includes respecting the lines of authority at the practice. Upon entering a practice for the first time, make sure that you become familiar with the organizational chart and lines of report. In most instances, you should start your discussions with your primary point of contact, usually called your practice champion.

Avoid circumventing your practice champion's reporting lines and going directly to his or her director. Any communications at that level should be coordinated with your practice champion. Otherwise the champion may view this as compromising his or her position, and this will introduce distrust into your relationship with them. However, there may also be instances where you will need to circumvent established reporting lines—and this needs to be handled delicately. This may occur when a project gets stuck, a practice champion repeatedly fails to follow through, or you observe unprofessional behavior. When you believe this is necessary, it is time to engage your supervisor and program director to discuss the issue and seek their assistance and advice.

Following lines of report is also important when clearing work you are doing for a practice with your own PF program director/supervisor. There may be times when you are asked to take on tasks that you are unsure about. Sometimes it will be okay to take on additional tasks that fall outside your original goals and scope of work; in other instances, it may not. If you are unsure, you can use statements like, "That sounds interesting, but I'll need to check with my supervisor" to respond to the practice member. Then you can check with your supervisor and get back to them. Having a statement like this at the ready can help buy you time (and get additional input) on tasks that you're uncertain about, while remaining respectful and supportive to the practice member.

Key points for respecting lines of authority:

- Know the reporting lines for the practice.
- Respect these lines and coordinate with your practice champion when you need to engage leadership.

- When you need to engage leadership without the support of your practice champion, do this in collaboration with your supervisor and program director.
- Have a plan for dealing with requests from practice members that you are unsure are appropriate for you to engage in.

Communicate judiciously with your practices. As a PF, you will have many reasons to communicate with individuals at the practice. You will want to manage these communications professionally and monitor them so the staff does not feel overwhelmed by them. This is a balancing act: you need to strike the right balance with open, frequent, and persistent communication, while being careful not to overburden or annoy practice staff. You can cluster questions for a practice in one email, rather than sending multiple inquiries. Focus on keeping your emails succinct; you can elaborate on details as needed during calls or in-person visits. In addition, written communications should be professional, well crafted, and without any spelling errors or slang terms. Phone messages should be similarly professional in content.

Key points regarding length and number of communications:

- Consider and limit the number of times you reach out to communicate to practice staff.
- Consider and limit the length of encounters and messages.

Interact professionally with difficult personalities. Practice facilitators will find themselves working with a variety of personalities. Some may be outgoing and easygoing. Others may be stressed, unfriendly, isolated, complaining, controlling, or display any number of unpleasant traits. Either way, addressing the needs of each of these personalities will take some interpersonal skill and practice. This requires patience. It is important to be able to depersonalize this behavior and recognize that these behaviors are not "being done to you"; they are simply "being done." Effective PFs often need a "thick skin" that helps them deal with criticism and other difficulties.

No matter what the communication, remind yourself that you are interacting with a human being, and humans require some level of nurturing and space to develop. Remember that you are a visitor, and as such you are not fully aware of the history and reasons people feel and behave as they do. Nor do you need to have this information.

Some skills that can help you in managing these interactions include:

- Listening actively to the other individual.
- Acknowledging and honoring the different opinions expressed by the individual.
- Recognizing the other person's feelings and concerns as valid.

For more information on these skills see the National Health Service Leadership Academy's Healthcare Leadership Model. Available at: http://www.leadershipacademy.nhs.uk/discover/leadership-framework/working-with-others/building-and-maintaining-relationships/

Even with good command of these competencies, you will encounter difficult personalities and will need to deal with them. Some suggestions and tools for working with difficult personalities are provided in Appendix C.

Key points regarding interacting with difficult persons:

- Depersonalize behaviors and comments to help you stay objective and calm when working with difficult personalities.
- Follow a set of prescribed steps to help you navigate work with difficult personalities.

Special considerations for professionalism in virtual facilitation. Virtual practice facilitation presents some unique challenges in the area of professionalism. In addition to many of the items discussed above, maintaining professionalism during virtual facilitation involves some additional considerations.

Virtual PFs interact with practices through video conferencing, email, phone calls, and other electronic means. You will need to consider how and where you will conduct these calls and get information on the practice members' location and resources. Background noise at both locations must be considered, as well as privacy issues. If a webcam is being used, be sure the background and your attire are both professional. In the case of virtual facilitation you will also need to consider time zones and time differences. Be respectful of these and do your best to work around clinics schedules.

Virtual PFs will want to have much more rapid response times than in-person PFs, whose response times are more scheduled. A quick or immediate response sends the clinic a message that they matter and that you are responsive to their needs. If you provide useful responses immediately, you will build a reputation as a valuable resource.

Additionally, virtual facilitation often makes it difficult to build a network of contacts within the practice. In some instances, you may be confined to a single point of contact. If this individual is not available, then it becomes impossible for you to provide support or help move the practice forward. For this reason, you will want to build a broad network of contacts in the practice. This might include the leadership, the practice manager, a medical assistant, a nurse, your key point of contact, and the IT person, among others. If possible, you can establish this with a site visit at the start of the intervention. Be especially mindful about getting everyone's business cards and contact information. You can continue to build a network through "snowball sampling"—asking each individual who else they think would have resources to add to the project. In this way you can expand the resources available to your site champion as he or she carries out the work on site. However, before using a snowball approach, clear this with your practice champion and be sure that you respect the culture and lines of authority at the practice. You want to avoid appearing to undermine the practice champion. In the same way you would handle in-person visits, keep a notebook of persons, personalities, roles, responsibilities, and contact information.

Key points regarding virtual facilitation:

- Wear professional attire when using a webcam.
- Consider the background view and noise of the web conference or call.
- Accommodate clinic schedules, including time differences.
- Increase your response time compared to in-person facilitation work.
- Use "snowball sampling" or an initial site visit to build a network of contacts at the practice.

Professionalism Within Your PF Program

In addition to the professional behaviors listed above, you will need to apply professionalism within your own PF program. This includes being sure that you are informed of and adhere to your program's policies and procedures; that you use the resources provided to you for your work in the field; and that you interact professionally with program leadership, staff, and fellow PFs. Behaving professionally will facilitate a positive work climate, promote teamwork, and help assure that the intervention model is implemented with fidelity. Some important areas of consideration are described below.

Adhere to your PF program's policies and procedures and intervention design. As a PF, you work independently up to 90 percent of your time. Thus, it is particularly important that you adhere to your program's intervention model or approach, as well as its policies and procedures for interacting with and reporting progress with practices. Failing to do this can greatly weaken the effectiveness of your PF team and your program overall. Be sure that you understand the intervention model your program is working with or the approach you are being asked to use. If you do not understand it, or do not agree with it, take responsibility for meeting with your supervisor and program leadership to discuss your concerns. As you work in the field, you may discover new issues with the intervention model. For example, you may find that a particular approach is not working in the practices because of a change in reimbursement. Or it is difficult to adhere to your program's requirement that you update practice records before you leave the site because there is no physical space in the practice for you to do this, and you are in an unsafe neighborhood so it is not wise for you to do this in your car. It is your responsibility to bring these issues to the attention of leadership and work with them to generate alternative solutions.

Key points on professionalism in your PF program:

- Adhere to your program intervention model/approach and its policies and procedures.
- Bring problems with both to the attention of your supervisor and program director.
- Offer a solution for each problem you bring and help your program leadership address these problems.

Use your PF program resources effectively. As a PF, you will need a variety of resources to do your job. As a professional, you will want to make optimal use of these resources and to

communicate with your supervisor and director about the resources that you need but do not have access to in order to do your job. Some of these resources include:

- *Tracking and reporting systems*—Documentation is the key in supporting your fieldwork and assists in delivering reports. Be sure to allot time during your day to document tasks completed for every practice site. Documentation should be done in a timely fashion—ideally within 24 hours of an encounter, if not sooner. In an ideal world, you might make these notes prior to leaving the practice or while still in the practice parking lot. Many PFs use their cars as a moveable office. Delays in entering information can affect your PF team and program staff, as they may rely on this information to know what is needed next at a particular practice, to determine resources that PFs need, or to devise the content of upcoming PF trainings.
- *Electronic mailing lists*—Your PF program may use an electronic mailing list to enable you and your fellow PFs to ask questions, share resources, and communicate best practices with one another. The program may also use it as a way to keep your supervisor and PF program director informed of issues as they arise in the field. They are only useful to the extent you and your fellow PFs use them. Before you use the electronic mailing list, be sure you know its purpose and function and who will have access to the information you post on it. Keep communications professional and participate regularly.
- *Computers, cell phones, and other supplies*—Be responsible for these supplies and keep them in good condition.
- *Staff support*—Your program may provide support staff to you and your teammates, such as data management staff and administrative support. Make appropriate use of these resources and maintain professional behaviors with these staff persons. They are key members of your PF team.

Key points on using program resources:

- Complete documentation in a timely manner.
- Regularly share ideas and resources with your PF partners on program electronic mailing lists and other shared spaces.
- Maintain your supplies in good working order.
- Engage program staff appropriately to support your work, using the same professionalism you apply with your practices.

Communicate your schedule to your PF team and staff. It is important to keep your PF program staff aware of your location and visit schedule for each week. Again, this is a professional courtesy and a responsibility to your PF program. If you are working as a member of a PF team, your teammates will need to know your schedule so they can coordinate their work with you. Your supervisor or program director may have items they need you to address with a particular practice, and it helps for them to know when you will be on site to assist them with these issues. Your program will most likely provide you and the rest of the PFs with a shared calendaring system that will help you coordinate visits and work. If not, you may want to ask

your PF program director about making a resource like this available. You will want to make sure you keep your calendar accurate and updated so that others can view it and trust the information that is contained in it. It can help to include a brief statement of the focus of the visit. This can also help your PF teammates stay in touch with and coordinate with your work.

Key point regarding visit/work schedule:

- Keep your calendar updated and accurate to help your PF team and staff coordinate with you in the field.

Interact professionally with your supervisor and program director and keep them informed. As a PF, you are responsible for conducting yourself professionally and engaging in open communications with your supervisor and program director. Be aware that PFs can easily become so involved in their work with their practices that they feel more connected to their practices than their own PF program. When this happens, it can be easy to slip into an "us versus them" mode of thinking—especially when your program director has to make decisions that may interfere with some of your work with your practices.

It is important to resist this impulse. The fidelity and strength of a practice facilitation intervention and the work of its PFs are dependent on effective communication, training, work coordination, and idea sharing. Remember, the leadership for your PF program relies on the information you share to make organization-wide decisions about intervention designs, funding, resource allocation, and training.

You are responsible for behaving professionally with your supervisor and program director. Come to meetings prepared and ready to contribute. Complete documentation about your practice encounters and success or difficulties in delivering the PF intervention on time. Take responsibility for contacting your supervisor between sessions when there is an urgent need.

Another issue that you may encounter is conflicts in reporting that arise when you are working on multiple projects with a practice or set of practices. This can lead to the situation of having multiple "bosses" that you report to, depending on the improvement project involved. This can create conflicts when project directors give conflicting directions. While this is an issue that your PF program leadership should manage, you will want stay aware of the challenges this can create for your work and communicate any problems that arise to the program managers and PF program leadership team. The same also holds for communicating opportunities you identify for collaboration across the different projects that project managers and PF leadership may have missed.

Finally, it is your responsibility to alert your supervisor if you need additional resources to do your work or if you need to brainstorm solutions for challenges you are encountering. When bringing up challenges, it can help to come prepared with an idea for a solution for each problem you raise. This can help you maintain professionalism even when you bring up difficult internal program issues.

Key points on professional behavior with your supervisor and program team:

- View your program office staff and supervisors as a team and resource.
- Report regularly to your supervisor through meetings or internal communication systems, and always arrive prepared.
- Keep supervisor and leadership informed of major events.
- Communicate any conflicts that arise across projects as well as possible opportunities for collaboration.
- Be responsible for communicating problems and resource needs to program leadership and assisting in identifying solutions to internal programmatic issues.

Interact professionally with your fellow PFs. Practice facilitation is a "team sport." Fellow PFs are some of your best resources for good ideas and for support. They are a central part of your team. You will want to maintain professional behavior with your fellow PFs. All the rules outlined above also apply to your interactions with fellow PFs.

An important part of professionalism is sharing "exemplar practices" and resources you encounter in your work. To do this, you will need to document these things in your encounter notes and in your personal notes in a way that you can locate them easily. As mentioned above, many PF programs provide electronic mailing lists or other means for PFs to communicate with each other while they are in the field. It is your responsibility to use these sources to communicate your observations and resources to your fellow PFs. You are never in competition with them.

Come to supervision and training meetings prepared and ready to participate. Share with your fellow PFs the lessons you have learned and the problems you are encountering. This will help them learn from your experience and help them feel supported as they work with their practices.

Key points regarding interacting with fellow PFs:

- Apply the same rules of professionalism with your fellow PFs as with your clients.
- Make a habit of documenting and sharing good ideas, exemplar practices, and resources with your fellow PFs.
- Come prepared to actively participate in supervision and trainings.
- Be willing to share the challenges you are encountering and your lessons learned, with other PFs in your program.

Conduct your own internal continuous quality improvement process. In the same manner that you are assisting practices to continually evaluate and improve their performance and processes, you will want to do the same with your own PF work and professional processes. You should develop a process for evaluating your own performance with your practices and how effective you are in helping them attain their improvement goals.

While your PF program is likely to provide resources to help you do this as part of the program's internal QI process, you can create a personal process to monitor and continually improve your own professional abilities and effectiveness. An easy way to do this is to set professional development goals and then regularly assess your progress towards achieving them. You can apply the PDSA cycles that you teach practices to the development of your own professional skills and processes (for example, running personal PDSA cycles to test a new approach to documenting your encounters with a practice or convening and coordinating the work of your PF teammates if your program uses a team-based PF intervention model). You can gather informal feedback from your practices on your work with them—including where they believe it is the most effective and areas they think could be improved—and then use this feedback to guide your own professional development.

If your PF program does not have a formal process for assessing the quality of work by its PFs, you can encourage your supervisor or program director to consider soliciting feedback from practices about work with their PF through short on-line surveys completed monthly or quarterly, or through informal conversations with practice leaders. While it can be uncomfortable to receive this type of feedback, it will help you continue to develop professionally, and also keep you "in tune" and more empathetic to your practices who are helping to develop and use similar QI processes. In an ideal world, your own professional work mirrors what you then teach your practices to do.

Key points regarding your own internal quality improvement as a professional:

- Conduct regular assessments of your professional skills and processes.
- Set personal goals and monitor your progress towards them.
- Use QI processes similar to those you are teaching your practices to guide your own professional development.
- Encourage your PF program director to implement routine feedback on PF work to support PF professional development and the overall quality of the program.

Commit to continuous learning and professional development. Like any professional, you should be committed to a program of continuous learning and development of your own knowledge. You will want to stay abreast of changes in the field of healthcare—for example, new things on the horizon, such as health service models, requirements around meaningful use, and changed thinking around chronic care. Annual performance evaluations are a good time to reassess your skills. Many programs will have you complete a professional assessment each year as a way to guide their training program and support your professional development. If your program does not do this, you can do it on your own. You can use each of these opportunities to identify areas in which you can continue to develop and grow as a professional. Consider attending professional conferences and trainings to expand your skills and take advantage of trainings offered through your program. Not only does this help you become increasingly more effective as a PF, but it can also keep the field alive for you and help stave off burnout. A list of some resources for continuous learning is provided in Appendix B.

Key point regarding continuous learning:

- Continually seek out additional training and education to enrich the skills and resources you can provide to your practices.

Maintain HIPAA and other certifications and adhere to their requirements. As a PF, you should complete Health Insurance Portability and Accountability Act (HIPAA) certification and maintain this certification a part of your ongoing professional development and continuing learning. There are numerous online training programs on HIPAA that provide certificates. These typically charge a small fee for this service. Your supervisor is likely to have identified a source for you to complete to obtain your HIPAA certification. If not, you can find one online by using an online search. Additional information about HIPAA and online training is available from the Federal website http://www.hhs.gov/ocr/privacy/hipaa/understanding/training/.

You will work with patient data as part of your work with practices. Be stringent in assuring you adhere to HIPAA regulations.

Table 7.1 Technical safeguards section of the HIPAA Security Rule

1. Access Controls. A covered entity must implement technical policies and procedures limiting access to systems containing electronic protected health information (ePHI) only to personnel with sufficient access rights (§ 164.312 (a))
2. Audit Controls. A covered entity must implement software that record and examine activity in information systems that contain or use ePHI. (§ 164.312 (b))
3. Integrity. A covered entity must implement policies and procedures to protect ePHI from improper alteration or destruction. (§ 164.312 (c))
4. Person or entity authentication. A covered entity must implement procedures to verify that a person or entity seeking access to ePHI is the one claimed. (§ 164.312 (d))
5. Transmission security. A covered entity must implement technical security measures to guard against unauthorized access to ePHI that is being transmitted over an electronic communications network.

Source: Summary of the HIPAA security rule. Available at http://www.hhs.gov/ocr/privacy/hipaa/understanding/srsummary.html.

Mistakes here will have serious effects both on your reputation as a professional and on the practice. Whenever possible, you should work with patient records containing protected health information (PHI) while at the practice. If they are transmitted, PHI should be removed. In instances where this is not possible, such as producing performance reports or missed opportunities reports for practices, you will want to assure use of a secure and HIPAA-compliant method of transmitting this information. Your program and the practice are likely to have policies around this. You will want to be familiar with these and work with the practice director and site champion to make sure you comply with their rules. Protecting patient confidentiality and adhering carefully to HIPAA requirements is a central part of PF professionalism. For detailed information on how HIPAA applies to PF work see the following resources:

- For researchers and implementers: http://www.healthit.gov/policy-researchers-implementers/hipaa-and-health-it
- For business associates and other covered entities: http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/index.html

Email is still sometimes used to transmit data on patients. Because the contents of a regular email are stored in multiple places (including the computer, mail server, recipients' computers, and mail servers), they are vulnerable to unauthorized access. You need some means of reducing this vulnerability, such as email encryption. Your program is likely to have policies and procedures in this area. Be sure you are familiar with these and that you address these issues with your PF supervisor, program director, and the practice.

In addition, you may want to consider obtaining other certifications that will enable you to provide a wider range or deeper level of support. For example, certification in human subjects would allow you to provide support to research studies occurring at a site. Certification in specialized quality improvement processes such as "Lean" or in processes such as appreciative inquiry (see Module 11) for an introduction to appreciative inquiry) can enable you to provide a deeper level of support in these areas and will increase your ability to serve as a resource to your program and team.

Key points regarding HIPAA:

- Ensure that your HIPAA certification is up to date.
- Follow HIPAA requirements around transmission of information.
- Consider other certifications that can increase your scope of support and ability to support your practices and your program.

Summary and Conclusions

Practice facilitation is a relatively new profession that grows out of a long tradition of assisting organizations and groups from many different sectors to improve and transform. Professionalism is a key component of any profession and assures a certain level of conduct and quality of work. Adopting professional behaviors as PF will help you build effective change-oriented relationships with your practices, your PF program, and other PFs. In addition, being a professional can only serve to advance the emerging field of practice facilitation.

References

Merriam-Webster Dictionary. Definition of professionalism. Available at http://www.merriam-webster.com/dictionary/professionalism

Primary Care Practice Facilitation Curriculum

Module 8. Approaches to Quality Improvement

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Module 8. Approaches to Quality Improvement

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Basic quality improvement (QI) and coaching skills
- Applied practice assessment for diagnosing practice problems

Time

- Pre-session preparation for learners: 40 minutes
- Session: 90 minutes

Objectives

After completing this module, learners will be able to:

1. Describe the key components of the Model for Improvement.
2. Describe best practices research and how practice facilitators can use it for practice improvement.
3. Identify resources for additional training on QI tools, including using Plan Do Study Act (PDSA) cycles, workflow analysis, root cause analysis, and preparing run charts.

Exercises and Activities To Complete Before and During the Session

Pre-session preparation. Ask the learners to read information in items 1 and 2 and explore items 3and 4. (40 minutes)

1. The content of this module.
2. Mold JW, Gregory ME. Best practices research. Fam Med 2003 Feb;35(2):131-4. Available at: http://www.stfm.org/fmhub/fm2003/feb03/pm.pdf.
3. Visit Institute for Healthcare Improvement's Open School on QI. Available at: http://app.ihi.org/lms/onlinelearning.aspx.
4. Select modules from this training curriculum and from the Open School to complete based on gaps identified in your learning assessment from Module 2 and list these to report to the group. (Complete modules as you are able over the next few sessions.)

During the session. Presentation (10 minutes)

1. Present key concepts from the module.

Video for learners (15 minutes)

1. Introduction of the Model for Improvement. Available at: http://www.aafp.org/practice-management/transformation/pcmh.html.

Discussion. Ask questions and explore answers with learners. (15 minutes)

1. What experience have you had in using the Model for Improvement?
2. What are the key points of the Model for Improvement?
3. What implications do these have for your work with your practices?

Activity for learners (20 minutes)

1. Break into pairs or small groups. Assign roles: Practice Facilitator and Participant(s) (optional).
2. Complete a PDSA worksheet for an improvement they would like to make to this training program.

Discussion. Ask questions and explore answers with learners. (10 minutes)

1. Describe the PDSA you propose for improving an aspect of this training program.
2. What lessons did you learn in completing the PDSA template that you will want to apply when you go out to work with your practices?

Review with learners. (10 minutes)

1. Mold JW, Gregory ME. Best practices research. Fam Med 2003 Feb;35(2):131-4.

Discussion. Ask questions and explore answers with learners. (10 minutes)

1. What experience have you had using a best practices approach to improving a process in a practice or another setting?
2. How might you use best practices research with your practices to improve their processes?

Module 8.

In health care, quality improvement (QI) is the framework we use to systematically improve the ways care is delivered to patients. Processes have characteristics that can be measured, analyzed, improved, and controlled. QI entails continuous efforts to achieve stable and predictable process results, that is, to reduce process variation and improve the outcomes of these processes both for patients and the health care organization and system. Achieving sustained QI requires commitment from the entire organization, particularly from top-level management.

History of the Current Quality Improvement Paradigm

In the United States, there has been an evolution from quality assurance, where the emphasis was on inspection and punishment for medical errors (the "bad apple" theory), to QI, where we ask, "How did the system fail to support the worker involved in an error?" Table 8.1 contrasts these two frameworks.

Table 8.1. Quality assurance vs. quality improvement

Quality Assurance	Quality Improvement
Individual focused	Systems focused
Perfection myth	Fallibility recognized
Solo practitioners	Teamwork
Peer review ignored	Peer review valued
Errors punished	Errors seen as opportunities for learning

This evolution to a QI framework began in earnest with the publication of two landmark Institute of Medicine (IOM) reports:

- *To Err Is Human: Building a Safer Health System* (1999) focused on patient safety and brought to the public's attention the fact that 44,000 to 98,000 deaths occur each year due to medical errors.
- *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001) built on *To Err is Human.* It called for a fundamental change in the health care delivery system through a complete redesign of patient provider relationships and revised patient care processes, leading to improved health care outcomes.

Before these reports, some pioneering individuals had been advocating for the use of measurement and data to judge how effective processes were at achieving desired outcomes. Notably, W. Edwards Deming talked about the science of improvement in his management theory known as the System of Profound Knowledge in the early 20th century.

Dr. Deming was a statistician who used statistical process control tools to determine sources of variation that led to waste in manufacturing. His approach to improvement shifted focus from individuals to underlying processes as the primary source of error and variation. This concept of process improvement helped pave the way for today's view of QI.

In his 1982 book *Out of the Crisis*, Deming laid out his philosophy for transformation of organizations, emphasizing the concept of total quality management and the importance of understanding the type of variation in a process. The more variation, the more waste and inability to consistently produce the outcomes desired. His 14 points, shown in Table 8.2, still resonate today. Although written for manufacturing, they have become part of health care thinking and are inherent in all QI methodologies.

Table 8.2. Deming's 14 points

1. "Create constancy of purpose towards improvement." Think long-term planning, not short-term reaction.
2. "Adopt the new philosophy." Management as well as the workforce should actually adopt this philosophy.
3. "Cease dependence on inspection." If variation is reduced, there is no need for inspection since defects (errors) will be reduced or eliminated.
4. "Move towards a single supplier for any one item." Multiple suppliers mean variation.
5. "Improve constantly and forever." Focus on continuous quality improvement.
6. "Institute training on the job." Lack of training leads to variation among workers.
7. "Institute leadership." This draws the distinction between leadership, which focuses on vision and models, and supervision, which focuses on meeting specific deliverables.
8. "Drive out fear." Management through fear is counterproductive and prevents workers from acting in the organization's best interests.
9. "Break down barriers between departments." Eliminate silos. All departments are interdependent and become each other's customers in producing outputs.
10. "Eliminate slogans." It is not people who make most mistakes—it is the process in which they are working.
11. "Eliminate management by objectives." Production targets encourage shortcuts and the delivery of poor-quality goods.
12. "Remove barriers to pride of workmanship." This leads to increased worker satisfaction.
13. "Institute education and self-improvement."
14. "The transformation is everyone's job."

Source: W. Edwards Deming Institute, 14 Points for Management, Available at: www.deming.org.

The Model for Improvement

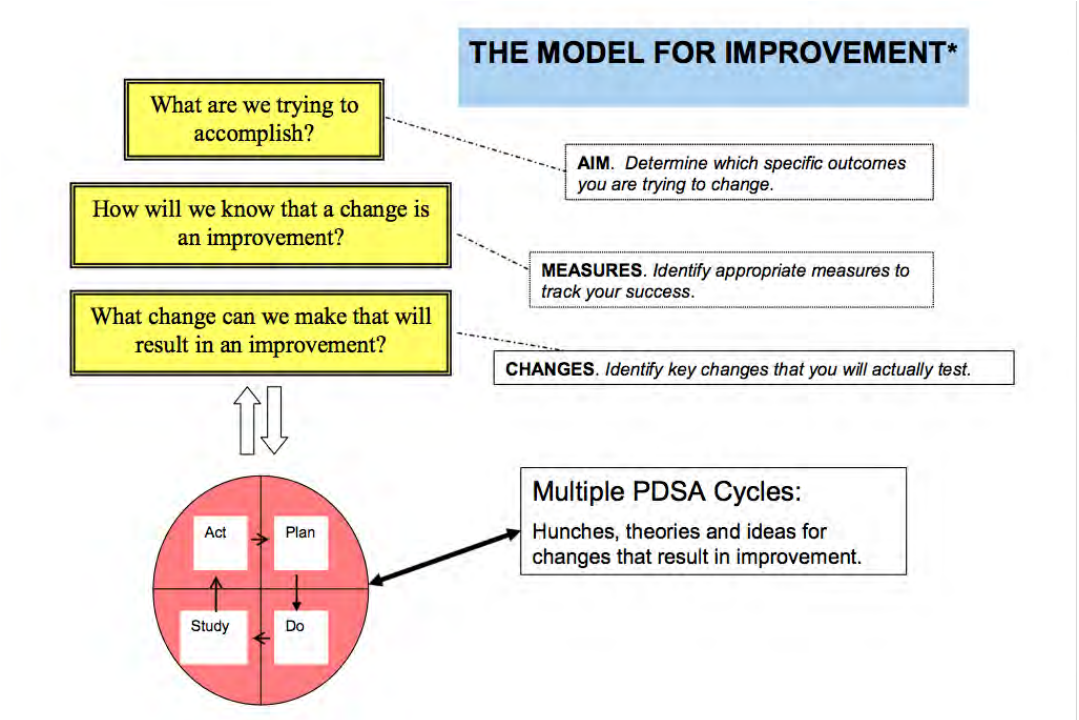
The Model for Improvement (MFI) is the most commonly used QI approach in health care and one you will want to teach your practices. The MFI was developed by the Institute for Healthcare Improvement (IHI) in 1996 and published in *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (1996).

The MFI uses a rapid cycle process called Plan Do Study Act (PDSA) cycles to test the effects of small changes, make those changes, and ultimately spread the effective changes through the practice or organization (see Figure 8.1). The MFI begins by asking three simple questions:

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in improvement?

Quality improvement teams then introduce and test changes designed to achieve the improvement aims using successive PDSA cycles until they arrive on a change they believe will produce the desired results and is ready for implementation and spread. This process is depicted in Figure 8.1.

Figure 8.1. The Model for Improvement



Source: Langley GL, Nolan KM, Nolan TW, et al. (1996). The improvement guide: a practical approach to enhancing organizational performance. San Francisco: Jossey-Bass. Used with permission.

* The Plan Do Study Act cycle was developed by W. Edwards Deming. See Deming WE. The new economics for industry, government, education. Cambridge: Massachusetts Institute of Technology; 1994.

You will need to be prepared to teach your practices how to use the MFI, and specifically, how to carry out repetitive and systematic processes for testing and implementing improvements, the PDSA improvement cycles. Your goal will be to instill these as habits in your practices. Every improvement activity they decide to undertake should be an opportunity to encourage them to take a systematic and data-driven approach to implementing, testing, and sustaining the change.

An essential part of introducing a culture of quality in a practice is assisting the practice to shift its focus from individuals to processes. Organizations can often get mired in finding individuals to blame for less than optimal outcomes, an approach that can produce a punitive and problem-focused work environment. You can use the MFI and the basic tool of PDSA cycles to assist practices in making a shift to thinking about their processes and systems and how they can be modified to produce better outcomes.

Too often organizations go "charging off in all directions" in an enthusiastic effort to improve. But without discipline and the ability to assess the real effects of the improvements, these enthusiastic efforts can yield little in terms of real outcomes. One of your roles will be to help practices develop the discipline of using a systematic process to develop and test improvements.

The MFI and PDSA cycles are a simple yet effective "discipline" that you can help practices develop. One of the best ways to do to this is to encourage the practice to go through the discipline of completing an improvement form based on the MFI. The mere act of completing the form helps reinforce the idea and build the internal discipline and skill to use a defined process for testing and adopting changes to the usual course of business.

You will also need to know how to introduce the MFI to your practices. This can be difficult in a practice that is enthusiastic about making improvements. It can also be difficult in a practice where buy-in to improvement efforts is low. The enthusiastic practice may lack patience for systematic improvement work and may have difficulty instituting the discipline needed to use the PDSA process. Practices where buy-in is low may lack the commitment and associated energy needed to engage in a systematic approach to change.

Using the Model for Improvement

To use the MFI, first you will need to help your practices identify their "aims" or goals for improvement. Often this will require you to listen "between the lines" and help a practice identify actionable goals within its larger discussions of practice improvement. Large and lofty goals are excellent for inspiration and rallying troops, but the actual work of improvement can be mundane and tedious, and involves small changes that are tested, and then spread, in sequence until the goal is attained. In addition, you will want to help your practices assure that the changes they are making and the outcomes they plan to measure are aligned.

Because the MFI and PDSA processes have been the primary approach to practice improvement over the past 10 years, you may also encounter practices that have been "overexposed" to the

approach. They will need to be skilled in navigating their reactions to processes they may have used with limited success in the past. While there can be barriers to getting a practice to use the MFI and PDSA cycles in their improvement work, it is a "habit" that is very helpful for practices to develop. Without some type of systematic approach, improvement work can become chaotic, ineffective, and unlikely to produce the outcomes desired.

In addition to the MFI and PDSA cycles, there are a wide variety of QI tools that you will find helpful in your work with practices. Some of these are covered in subsequent modules and include workflow mapping, audit and feedback, benchmarking, academic detailing, and best practices research.

Best Practices Research

Best practices research is a powerful but less well-known QI approach that you should make an effort to become familiar with and comfortable using. Best practices research is a method of identifying the "best way to do X" in practice that is based on identifying and studying individuals or practices that are "exemplars" in the process or part of the process under question. This approach is called positive deviance. The approach can be used to identify the best processes for activities such as managing lab test results, managing prescription refills, delivering adult immunizations, managing walk-ins, and caring for diabetic patients.

The conditions for successfully translating evidence into practice include: development of practitioner skills relating to care delivery, creation of an operational infrastructure, and development of public policy to facilitate action (Nutbeam, 1996). Your role as a PF will largely rely on your skills as a facilitator and the guidance of evidence-based care models. Deciding on the model can be quite cumbersome. To address this area, consider the following steps.

1. Clearly define the process you are seeking to improve and break it down into discrete elements or subprocesses.
2. Define what constitutes a best practice for each element or subprocess.
3. Identify exemplars in the overall process or for each element or subprocess through peer nomination, and then confirm through performance audit or chart audit reviews.
4. Combine the methods used by exemplars into a best approach.
5. Test and then spread the "best practice" to other clinicians and practices.

The systematic spread of good ideas is one of the most important contributions you will make as a facilitator to both your individual practices and to health care as a whole (Mold and Peterson, 2005; Mold and Gregory, 2003). Best practices research is an approach that can help you identify exemplar practices appropriate to spread.

Note: this module is based on Module 4 of AHRQ's Practice Facilitation Handbook available at: http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/

References

Demming, WE. *Out of the Crisis*. Cambridge, Mass: MIT Press, 2000.

Mold JW, Gregory ME. Best practices research. Fam Med 2003 Feb, 35(2):131-4.

Mold J, Peterson K. Primary care practice-based research networks: working at the interface between research and quality improvement. Ann Fam Med 2005;3(Suppl 1):S12-S20.

Nutbeam D. Achieving "best practice" in health promotion: improving the fit between research and practice. Health Educ Res 1996 Sep;11(3):317-26.

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Module 9. Using Appreciative Inquiry With Practices

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Module 9. Using Appreciative Inquiry With Practices

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Basic quality improvement and change management skills
- Practice assessment

Time

- Pre-session preparation for learners: 1 hour
- Session: 2 hours

Objectives

After completing this module, learners will be able to:

1. Describe how Appreciative Inquiry (AI) differs from the problem-solving approach to quality improvement.
2. Describe how common facilitation activities are modified when taking an AI approach with a practice.
3. Decide when to use an AI approach with a practice.
4. Deliver an introductory training to a practice on the AI approach, its methods, and its assumptions.

Exercises and Activities To Complete Before, During, and After the Session

Pre-session preparation. Ask the learners to read and watch the following information. (1 hour)

1. Module
2. Video introduction to Appreciative Inquiry https://www.youtube.com/watch?v=ZwGNZ63hj5k

During the session. Presentation (30 minutes)

1. Present key concepts from the module.

Discussion. Ask questions and explore answers with learners. (30 minutes)

1. How would AI change the way you approach practice assessment? Your use of performance data? Root cause analysis? Goal setting with the quality improvement team and leadership?
2. If you are currently working with a practice, what would you need to modify to implement an AI intervention?
3. How likely are you to want to use AI with your practices? What do you like about it? What concerns you?

Exercise 1 (30 minutes total)

Conduct an Appreciative Inquiry interview. (20 minutes)

1. Ask the group to break into pairs and select roles (interviewee or practice facilitator [PF]).
2. Provide each pair with a copy of the basic AI interview guide (see table 9.4).
3. Ask the PF in each pair to conduct the interview. The AI affirmative topic should be: improving this class/course.
4. Remind PFs to stimulate in-depth narrative and storytelling during the interview.

Discuss the experience. (10 minutes)

1. Ask pairs to report back to the large group what they learned from conducting the interview.

    a. What lessons did you learn about conducting an AI-focused interview?
    b. What was comfortable?
    c. What was more difficult?
    d. How did this compare to interviews and data collection you've done in the past?
    e. How do you envision using this with your practices?

Exercise 2 (30 minutes total)
Have learners practice creating a provocative proposition. (20 minutes)

1. Ask learners to break into groups of three-to-five.
2. Ask each group to identify someone to play role of facilitator.
3. Have each group to create a provocative proposition for their ideal PF training program using the process described in this module.
4. Ask each group to develop a skit that "acts out" their provocative proposition or to create a drawing that illustrates it.
5. Have each group present their skit or drawing to the rest of the class.

Discuss the experience. (10 minutes)

1. After all skits and drawings have been shared, ask each learner to share one lesson learned about working with a group to create a provocative proposition that they can use in their work with practices.

After the session. Ask the learners to prepare. (2 hours)

1. A presentation that they can use to introduce a practice to AI.

Optional post-session activities for learners
AI is a complex approach to organizational change that requires more than this module to master. There are certification programs available for PFs who would like to develop additional competencies in this area. Some places to look include:
Case Western Reserve
http://weatherhead.case.edu/executive-education/certificates/appreciative-inquiry
The Center for Appreciative Inquiry
http://www.centerforappreciativeinquiry.net
Appreciative Inquiry Commons
http://appreciativeinquiry.case.edu/intro/default.cfm

Module 9

"The significant problems we face cannot be solved at the same level of thinking that created them."

—Albert Einstein

Appreciative inquiry (AI) is an approach to organizational improvement that focuses on identifying organizational strengths and leveraging them to create system-wide change. AI builds on the idea of positive deviance or focusing on what is working rather than what is not working, and on the use of inquiry to drive change. It offers an alternative to traditional, problem-focused models of organizational improvement that start with identifying organizational problems and weaknesses, and develop interventions to eliminate the weaknesses.

AI emphasizes the important role of questions and language in the change process. It suggests that one of the most important roles of a change agent is to construct and ask affirmative questions. Affirmative questions lead to appreciative discourse and focus organizational work on collective strengths and desired outcomes. The questions determine how an issue is framed and understood, and this information becomes the foundation for the transformation work. If the questions are poorly formed or hastily considered, the ensuing work may lead to unintended or unhelpful outcomes. If the questions are well formed, and well considered, the ensuing work is more likely to enhance motivation for change and produce desired goals (Ludema, et al., 2003).

This module will introduce you to AI and its primary method, the 4D cycle and suggest ways you might use it to support practices' efforts to improve patient care. Knowing the core AI principles can broaden your understanding of human organizing and organizational change. This enhanced understanding may translate into practical ways of introducing, framing, and motivating positive organizational change when using a variety of improvement approaches.

After completing this module, you should be able to describe AI to a practice and introduce elements of the AI approach into your work with practices. However, this module is not intended to make you proficient in the use of AI as a practice improvement approach. You will need to consult the resources mentioned in this module, and obtain additional training to build enough proficiency to use AI as your primary approach to improvement work.

The Basics of Appreciative Inquiry

Appreciative inquiry has its roots in the positive psychology movement that began in the 1980s and is grounded in "hope theory," which posits that people are most likely to change when they have: (1) an elevating purpose, (2) a sense of collective confidence to accomplish it, and (3) a set of practical steps for moving forward (Hammond, 1998; Ludema, et al., 2003).

The key guiding principles of AI (adapted from Whitney and Trosten-Bloom, 2010) include:

- Dialogue and words form one's understanding and view of reality.
- Questions create change.

- What we choose to focus on or study, whether the positive or the negative, will determine what we learn.
- Creating images of the future can guide and inspire action.
- Positive questions promote positive change.
- People perform better when given a choice about how and what they contribute.
- Every organization has at least one thing they do well. Focus on finding this and building on this area of "positive deviance."
- What the organization pays attention to will increase, so pay attention to areas where the organization is exceling and seek to expand them.

The AI approach was developed by students and faculty from Case Western University as part of their work to improve organizational effectiveness at the Cleveland Clinic. Since then, hundreds of organizations around the globe have used AI to improve effectiveness and AI has emerged as a new paradigm for organizational improvement (Carter, et al., 2007; Cooperrider, et al., 2008).

Table 9.1 shows how AI compares to traditional problem-focused approaches. The key differences between the two are that AI emphasizes identifying organizational strengths and building on them whereas traditional problem-focused approaches stress identifying and addressing causes of poor performance.

AI interventions can involve all members of a practice or organization and focus on system-wide improvements. Alternatively, they can be used with small groups within a practice, such as the quality improvement team, and focus on more circumscribed changes such as improving diabetes care or patient engagement (Hammond, 1998).

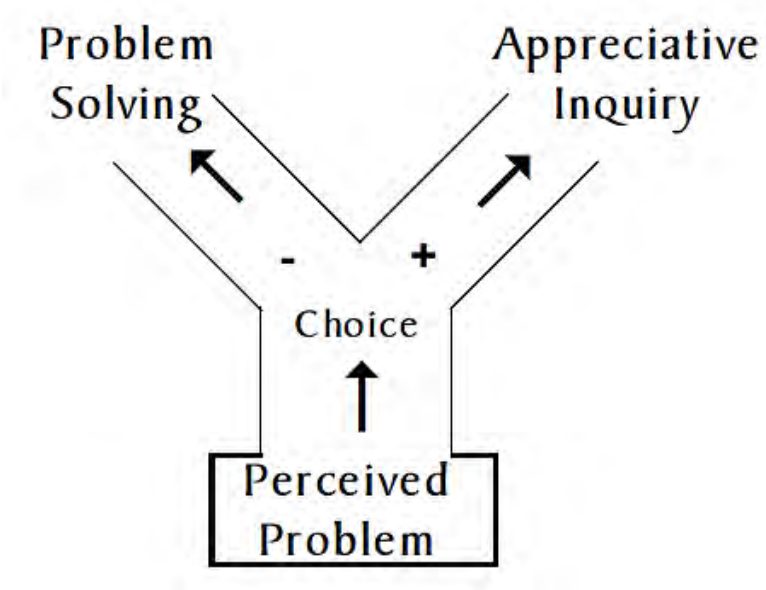
You may choose to take an AI approach with all your practices, or you may decide to use AI as an alternative approach for practices in which traditional problem-focused improvement efforts have failed. AI can be particularly helpful in instances in which practice morale is low, the organizational culture is punitive or not conducive to ongoing quality improvement, or a practice has failed to improve using traditional problem-solving approaches in the past.

Table 9.1. Focus of Appreciative Inquiry compared to traditional problem-focused approaches

Problem Focused	Appreciative Inquiry
Felt or identified "need" or problem	Appreciating the "best of what is"
Identifying root causes underlying problem	Imaging the "possible"
Use of quantitative performance data with limited attention to personal stories	Use of storytelling and personal narrative in addition to quantitative data
Developing solutions to problems	Determining what "should or could be" and pursuing this; spreading positive deviance to other topics/areas
Inclusive process involving individuals from all over practice or small group	Inclusive process involving individuals from all over the practice
An organization is a problem to be fixed	An organization is an asset to be appreciated and engaged

Adapted from Ludema, et al., 2003. Used with permission.

Figure 9.1. AI compared to traditional problem solving



Reproduced from: Taylor J. An introduction to Appreciative Inquiry. Rolyat Corp. Red Deer, AB. http://www.atlantic.edu/about/board/documents/IntrotoAI.pdf

Appreciative Inquiry Process

"Appreciative inquiry gets much better results than seeking out and solving problems. We concentrate enormous resources on correcting problems… but when used continually over a long time, this approach leads to a negative culture and a descent into a paralyzing sense of hopelessness. We can't ignore problems, we just need to approach them from the other side."

—Thomas H. White, President, Telephone Operations, GTE Wireless
(quoted in Ludema, et al., 2003)

The first and most critical step in the AI process is to identify the focus for the improvement work that will be undertaken. In AI terminology, this is called the appreciative (or affirmative) topic. The appreciative topic must be strategic for practice goals, attractive to practice members and key stakeholders, and motivational and engaging. Examples might be "Revolutionary Customer Response" or "Magnetic Work Environment" or more expansive topics such as transforming to a patient-centered medical home. Good topics are bold. They are a stretch beyond the status quo, they are desired, and they use energizing words (Carter, et al., 2007; Misak and Carter, 2010).

The appreciative topic is identified through discussions with practice leadership, staff, and other key stakeholders about the organization's goals and the problems it is experiencing. In a practice setting, appreciative topics are analogous to goals in more traditional improvement models, but should be positively worded, compelling, and something that the organization wants to change and considers a priority (Carter et al., 2007).

After the topic is identified, the next step is to **develop it into a positive question that stimulates discussion and reflection.** For example, "How can we develop a comprehensive diabetes care program that consistently exceeds quality performance measures and also creates a positive, engaging experience for our patients and staff?" (Carter, et al., 2007).

Step 2. Implement the 4D Cycle. The 4D cycle is the main process used in AI. It includes four phases: discovery, dreaming, designing, and destiny. Figure 9.2 depicts the phases, their relationships to each other, and a sample of methods used during each phase. The four phases of the 4D cycle can be carried out over the course of an organizational retreat, or during 5 to 10 shorter sessions. The AI retreat is the preferred method. The shorter sessions lose momentum and require rebuilding the positive energy at each session (Ludema, et al., 2003). The rest of this section provides a more detailed description of each stage in the cycle and suggests useful tools you can use to help your practices move through these stages.

Each step of the 4D cycle has a particular focus:

- **Discovery:** Determining "best of what is"
- **Dream:** Imagining what "could" be
- **Design:** Co-constructing what "should" be

- **Destiny:** Empowering, adjusting, innovating to bring the "should" into reality and sustaining it

Figure 9.2. The 4D cycle and methods

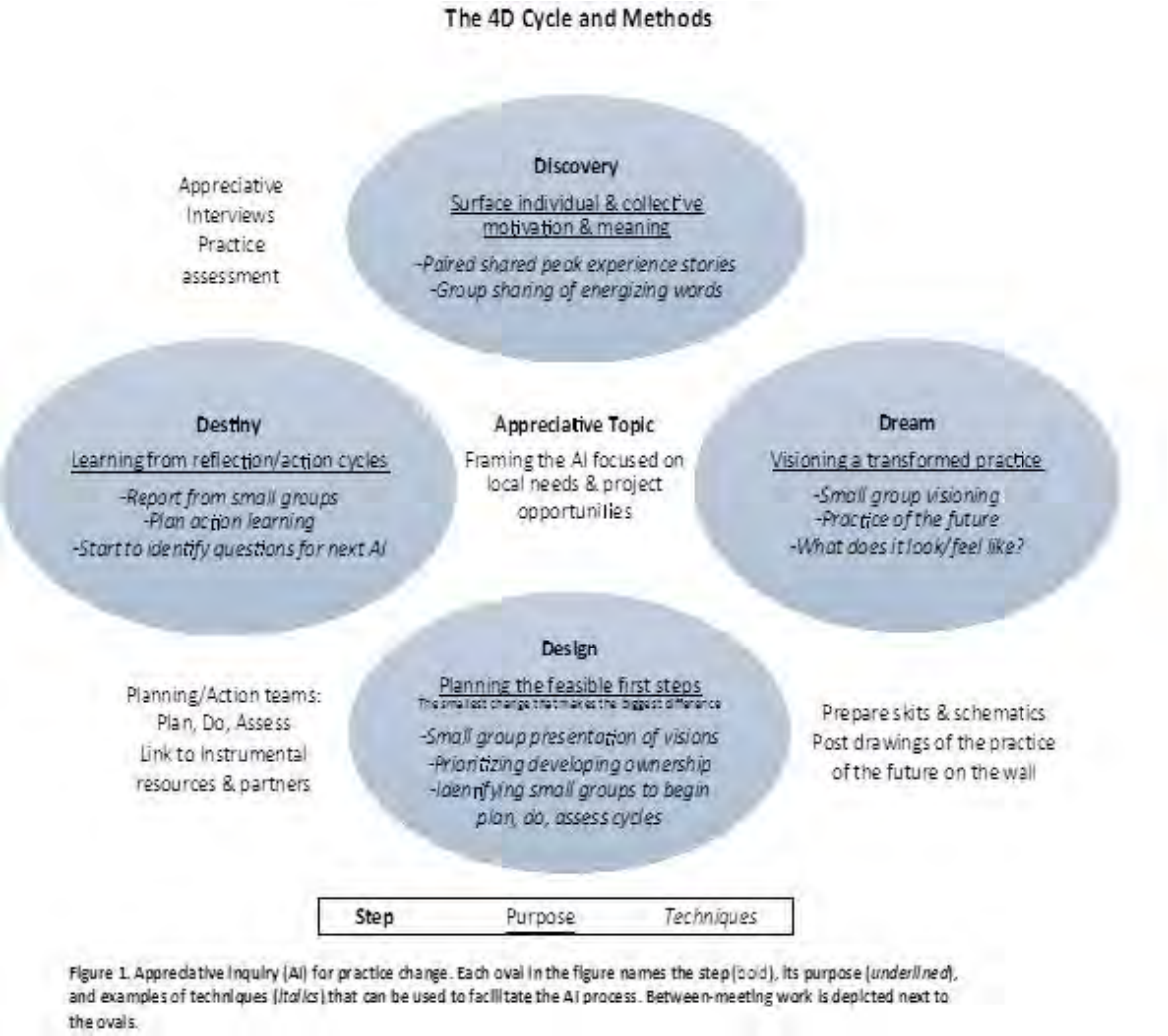


Figure 1. Appreciative Inquiry (AI) for practice change. Each oval in the figure names the step (bold), its purpose (*underlined*), and examples of techniques (*italics*) that can be used to facilitate the AI process. Between-meeting work is depicted next to the ovals.

Source: Carter, et al., 2007; Ludema, et al., 2003. Used with permission.

Step 1. Discovery. Discovery is the data collection phase of the 4D cycle. It focuses on a search for the "best of what is." This includes identifying areas of strength for the organization and factors that energize it (Cooperrider et al., 2008).

As a practice facilitator (PF), you can use traditional performance data as part of the discovery process. In these instances, the starting place will be those areas where the practice is performing the best or shows clear strengths. Root cause analyses of these data (see the Root Cause Analysis Module 11) would focus on identifying the factors that are contributing to these successes.

At the heart of the discovery phase in AI, however, are individual narratives or stories. AI emphasizes that a "narrative-rich" environment is necessary for change to occur. This means an environment where storytelling and qualitative information emphasize an understanding of the

practice and its goals, instead of just focusing on numeric data. Thus, AI focuses on gathering compelling stories from staff and clinicians. These stories help identify the strengths of the organization as well as the root causes for areas of success. They serve as inspiration for individuals as they identify changes they would like to make in the organization. They also engender hope and energy. An underlying assumption in AI is that good, detailed stories help participants see the possible in what seems to them at the moment to be impossible (Ludema, et al., 2003; Whitney and Trosten-Bloom, 2010).

Gathering stories. In working with a practice, you can gather these stories through interviews with individuals from all parts of the organization. Individuals across the organization and key stakeholders can interview each other. It is preferable to interview someone that you do not routinely interact with or work closely with; for example, a clinician might interview a front desk person or a medical assistant might interview an administrator.

In the AI framework, the types of questions asked set the direction for everything to follow. They determine what individuals will focus on over the course of the intervention. To be consistent with the strengths-based approach of AI, questions should be worded affirmatively. The "art" is in crafting effective questions. Well-constructed interview questions stimulate constructive storytelling from the interviewees, as well as reflection and learning from positive past experiences (Cooperrider, et al., 2008; Ludema, et al., 2003).

Examples of typical AI discovery questions (adapted from Ludema, et al., 2003; Whitney and Trosten-Bloom, 2010) include:

- Tell me about your past experiences with this practice. What brought you to work here? What did you like about the organization? Why do you stay? What keeps you showing up day after day?
- What do you value the most about this practice, the organization, yourself (or your care team) and the work you are doing here?
- I'd like you to think back and remember a time when you and your care team were operating at your very best. What do you think produced that level of performance? Can you tell me a story about a particular time your team was functioning at its best? Tell me with lots of details—like it is a movie script, so I can "see it."
- Tell me about what patients experience at your practice. Can you remember a time when your team went the extra mile to improve a patient's experience? Tell me about it. What made this possible? What did you do? What did your team members do? What did others in the organization do? What other factors in your organization made this possible?

Direct observation. Direct observation is another source of information for AI. As a PF, you can carry out direct observations of the practice to develop a greater understanding of the organization. Consistent with the AI approach, your observations should focus on identifying organizational and individual strengths and areas of effective functioning (Ludema, et al., 2003; Whitney and Trosten-Bloom, 2010). For example, you might follow a patient through a visit to observe staff and care team interactions with him or her.

Additional ways to gather information. Below are more ways to gather information on organizational strengths. Further information about each of these techniques can be found in the resources provided at the end of this module.

- Convene small groups of staff, clinicians, and patients to discuss "who are we at our best?"
- Create "positive core maps," which involve convening a group to map out the strengths, hopes, possibilities, relationships, alliances, and other assets of the organization.
- Conduct a continuity search, by working with a group to develop a timeline of industry, environmental, organizational, and individual factors that have sustained the practice over time and are desirable for the future.

(Cooperrider, et al., 2008; Hammond, 1998; Ludema, et al., 2003)

Reporting results of discovery back to the practice. Once these data have been gathered, you can organize the findings into themes and report them to the practice. Performance reports from an AI framework identify practice high points and strengths. Much of the data come in the form of stories, and you can share these using story boards, drawings, or excerpts of text that tell the story well. The reports do not include areas of under-performance or problems observed (Carter, et al., 2007; Misak and Carter, 2010). Figure 9.3 below is an example of an appreciative inquiry interview guide.

Figure 9.3. Example of an Appreciative Inquiry interview guide used during Discovery

Most positive experience of the organization. Tell me about a time when this (practice, team) was functioning at its very best, a 10 on a 1-to-10 scale. A time when you felt the most proud or positive about the work you were doing together. What factors led to this? Who was involved? What was your role? What roles did others play? Describe it to me with enough detail that I can see what happened as if I were watching a movie.

Organizational Values
Tell me what you value most about yourself and the work you do. About your co-workers and what they do? Your practice leaders and what they do? Your patients and what they do?

Resilience. If you had to name one thing that has helped (you, your team, and your practice) make it through difficult times, what would that be?

Three wishes. If you had a magic wand and could make three wishes to change anything you wanted, what would you wish for (yourself, your team, and your practice)?

Adapted from Mohr and Watkins, 2002. Used with permission from Leverage Networks, Inc.

Step 2. Dream. Dreaming is the second phase in the 4D cycle. In this phase, the practice is encouraged to dream or create a vision of what it could be. This means identifying new possibilities for how the organization functions and delivers care. The use of positive questions in the discovery phase focuses practice members on the possible rather than the problem, and

primes them for participation in this phase of the 4D process. This stage focuses on creating a vision of the future but not the actual design or implementation (Ludema, et al., 2003).

As a PF, you can facilitate meetings and discussions that encourage dreaming. Even if you are not leading the full AI intervention, you can incorporate these questions into your traditional improvement work with your practices. Some questions you can pose to participants to stimulate this type of dreaming include:

> *I want you to think about the future of your practice as it could be. Imagine that you have been away from your practice for a year on a trip around the world. You return and you see your practice operating and looking like you always dreamed it would. What is happening? How is the practice different from when you left? Give me lots of details so I can see it, too.*

Some other helpful questions to stimulate dreaming include:

- What does the world need our practice to be?
- What does our city, county, or state need our practice to be?
- What does the local health system need our practice to be?
- What does our community need our practice to be?
- What do our patients need our practice to be?
- What do their families need our practice to be?
- What do area businesses, schools, and so on need our practice to be?
- What are the most exciting opportunities for our practice in the future?
- What inspires us? What energizes our practice?

As the vision is developed, it should be shared with the organization using creative methods such as picturing a visual image, conducting a skit, or writing a poem or a letter to a family member to describe this practice of the future. Creative methods of communication are preferred. At this stage, it is not a list (Carter, et al., 2007; Misak and Carter, 2010).

Step 3. Design. The third phase of the 4D cycle focuses on designing the social, administrative, and clinical infrastructure and processes that are needed to make the vision defined during the dream phase possible. This includes defining and designing the social norms, values, policies, methods, processes, and procedures to realize the vision. Design is about moving a vision into a plan.

During this phase, you will talk with peoples from across the practice. That helps them to define and design this infrastructure. It is critical that all parts of the system are represented in the design. The design phase boils down to answering three main questions about pursuing a vision: what, who, and how.

What? The first question to answer during the design phase is "What?" That is, what are we designing? A new patient care process? A new organizational culture? A new strategic partnership? A new way of delivering care to our diabetic patients? A new way to deliver care as

a team? The answer to this question will guide all the remaining design work. It should be consistent with the practice's overall agenda for change, and with the Appreciative topic identified for its AI process. Note that this step focuses on the content of the design of the intervention, not on selecting the topic for the AI work, which occurs at the beginning of the process.

Who? The second question to answer is "Who?" Who should be involved in these discussions? All members of the practice? A key group of stakeholders? Patients? It is important to include all individuals who will be affected by the changes being considered. In addition, it can be helpful to include individuals with unique expertise or life experience relevant to the changes.

How? The third question is "How?" During the design phase, you will work with the practice to craft "provocative propositions" or design statements for each element of the desired changes. These statements become cognitive bridges between the best of what the practice currently is and what it will become (Carter, et al., 2007; Cooperrider, et al., 2008; Misak and Carter, 2010).

Figure 9.4 is a sample worksheet you can use with your practices to help them craft provocative propositions. Provocative propositions are based in the idea that "Words create worlds." They should be stated in the present tense, grounded in what works, stretch the organization beyond its status quo, and take the organization in the direction it wants to go (Cooperrider, et al., 2008; Ludema, et al., 2003).

An example of a provocative proposition is: South Side Family Health is an organization where patients, staff, and clinicians are constantly learning. Opportunities for learning and for building health behaviors are present in every area of the organization, and in every part of the patient encounter. The organization provides training and resources to its staff, clinicians, and patients that allow them to become exemplars in management of healthy behaviors. It is open to new ideas and innovation and has a way to reflect on these and use them to continually enhance its learning opportunities over time.

Step 4. Destiny. The fourth and final stage of the 4D process is destiny, which is the implementation phase. This stage answers the question "What's next?"

Reflect and celebrate. The first part of the destiny stage involves reflecting on and celebrating the progress made up to this point. It also includes recognizing any improvisational changes that have emerged spontaneously during the AI process (Hammond, 1998; Ludema, et al., 2003; Nace, et al., 2009).

Form innovation teams and start discussions. Next you will help the practice form innovation teams in the core areas identified in the dream and design phases. The teams should be made up of individuals who volunteer based on their interest in the topic. The teams will help move the organization toward its newly defined dream and design. Each team will work with the larger practice to generate ideas for action. You can have as many innovation teams as needed for the changes being considered. Realizing the provocative proposition may require a single team, or several.

A useful question for starting the discussions about implementation is: "What ideas do you have for tangible actions, steps, and activities to bring the design (or design element) into reality?" (Ludema, et al., 2003; Misak and Carter, 2010).

Create implementation plans. The next step is for each innovation team to create an implementation plan. A sample framework for the plan is provided in Figure 9.4. The planning framework should include (Whitney and Trosten-Bloom, 2010):

- Project name
- Purpose or vision for the project
- Team members and the team leadership
- Overview of what, when, where, and how of project implementation
- Short-, mid-, and long-term action items, resources needed, and timeline

It can also be helpful to connect the practice back to the Plan Do Study Act cycle at this point and incorporate this process into the action plan (see Module 8).

Figure 9.4. Planning framework template for short-, mid-, and long-term action items

Project Name/Description		
Purpose/Vision	Group Members *(circle designated "lead")*	
Project Overview *(what, when, where, how, etc.)*		
Short-term Action Plan (2 months)		
Action	*Help Needed*	*Due Date*
Mid-term action Plan (2-12 months)		
Action	*Help Needed*	*Due Date*
Long-term Action Plan (>1 year)		
Action	*Help Needed*	*Due Date*

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Encourage collaboration among innovation teams. During this stage, it is also important to stimulate sharing and collaboration among the innovation teams so teams do not work in "silos." A useful technique for doing this is to hold a "gallery walk." For a gallery walk, each innovation team works together for one or two hours and completes the implementation plan using the template above or a similar format (Ludema, et al., 2003).

One person from Team A stays behind to present the plan to members of other teams. Other Team A members then visit Teams B and C to listen to their presentations. All teams then give feedback on each presentation by writing responses on a flip chart or color-coded index cards available at each presentation. You can use prompts for the feedback such as:

- What I love about the plan is…
- Ideas to strengthen the plan are…
- Potential redundancies with other plans are…
- Available resources are…

Each presentation lasts 15 to 20 minutes. The presenters for each team repeat their presentation several times until all representatives from the other teams have had a chance to attend.

After completing the rounds, members return to their teams, discuss what they learned, talk about the feedback received on their own implementation plan, and discuss possible changes to their plan to improve it based on what they learned and the feedback they received (Ludema, et al., 2003).

Promote continued collaboration. As the innovation teams work to implement changes, the practice leadership will need to provide support to help them carry out their work and to help them collaborate with other teams. This can occur through electronic resources such as project management systems and cloud-based document storage and exchange, through regular "all-team" meetings, and through recognition and celebration of the work the teams are carrying out (Ludema, et al., 2003).

In addition to driving specific improvement work in a practice, AI can also be used to help the organization increase its capacity for continuous improvement. Ideally, you can work with the practice leadership to introduce the strengths and best practices-based paradigm of AI to all areas and activities of the practice. Whitney, et al., (2013) suggest that AI builds change capacity in an organization by stimulating the conditions needed for individuals to engage meaningfully in the change process. These include what Whitney, et al., (2013) describe as the six freedoms. These are freedom to:

- Be known in a relationship
- Be heard
- Dream in community
- Choose to contribute
- Act with support
- Be positive

Implications of AI for Practice Facilitation

AI can be used successfully in PF interventions. It is similar in spirit and methods to best practices research or positive deviance approaches to identifying and spreading exemplar practices. It also shares some similarities in spirit and approach to motivational interviewing. Whereas, AI places particular emphasis on stimulating narrative and storytelling, most PF data collection tools and methods can be used as part of AI, with some significant changes.

For example, you can reframe many existing techniques to incorporate AI approaches.

- For analyses of performance data: focus on identifying strengths and exemplary practice, rather than on identifying problem areas.
- For root cause analyses: focus on factors that contribute to successful performance, rather than factors that contribute to poor outcomes.
- For fall-out analyses: examine cases where the patient "fell out into exceptional care" rather than cases of failed processes.

In addition, you can use new methods, such as interviewing individuals about their "high points" and analyzing these interviews to identify strengths for the practice.

AI is not just a set of methods but rather an entire paradigm about what enables organizational change. Therefore, it is difficult to do a partial AI intervention. As a PF, it will be important to determine early on whether you will take an AI approach. If you opt to do so, be prepared to provide several trainings for practice leadership to help them understand how AI differs from traditional improvement approaches and ensure their buy-in.

Summary

Appreciative Inquiry is a strengths-based approach to organizational improvement that offers an alternative to traditional problem-focused approaches to improvement. It can provide an alternative approach to working with practices. You may choose to adopt the AI model as your primary method for working with practices. Or, you may choose to use it when more traditional approaches have failed or where punitive organizational culture makes improvement work difficult or impossible.

References

Carter CA, Ruhe MC, Weyer S, et al. An appreciative inquiry approach to practice improvement and transformative change in health care settings. *Qual Manag Health Care* 2007;16(3):194-204.

Cooperrider D, Whitney D, Stavros J. *Appreciative Inquiry Handbook*: 2nd ed. Brunswick, OH: Crown Custom Publishing, Inc.; 2008.

Hammond SA. *An Introduction to Appreciative Inquiry*: 2nd ed. (Vol. 63). Plano, TX: Thin Book Publishing; 1998.

Ludema JD, Whitney D, Mohr BJ, et al. *The Appreciative Inquiry Summit: A Practitioner's Guide for Leading Large Group Change*: 1st ed. San Francisco, CA: Berrett-Koehler Publishers, Inc.; 2003.

Misak J, Carter C. An Appreciative Inquiry Approach to Patient-Centered Medical Home Practice Change. *The Ohio Family Physician, Summer* 2010;62(2):38-40.

Mohr BJ, Watkins JM. The Essentials of Appreciative Inquiry: A Roadmap for Creating Positive Futures. Westford, MA: Pegasus Communications, Inc.; 2002.

Nace DK, Crawford JM, Nohrden C. Meaningful Connections: A resource guide for using health IT to support the patient centered medical home. Washington, DC: Patient-Centered Primary Care Collaborative. 2009.

Whitney D, Trosten-Bloom A. *The Power of Appreciative Inquiry: A Practical Guide to Positive Change*: 2nd ed. San Francisco, CA: Berrett-Koelher Publishers, Inc.; 2010.

Primary Care Practice Facilitation Curriculum

MODULE 10. Mapping and Redesigning Workflow

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Module 10. Mapping and Redesigning Workflow

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- General skills in basic quality improvement and coaching

Time

- Pre-session preparation for learners: 45 minutes
- Session: 85 minutes

Objectives

After completing this module, learners will be able to:

1. Describe the purpose and process for mapping workflow.
2. Identify activities that take place in a primary care practice setting that may be important to map.
3. Create a workflow map of common and complex activities.
4. Use the redesign reflection questions to help a practice redesign a workflow.

Exercises and Activities To Complete Before and During the Session

Pre-session preparation. Ask the learners to review information in item 1 and access item 2. (45 minutes)

1. The content of this module.
2. AHRQ's workflow or process mapping tools. Available at: http://healthit.ahrq.gov/portal/server.pt/community/health_it_tools_and_resources/919/workflow_assessment_for_health_it_toolkit/27865.

During the session. Presentation (30 minutes)

1. Present key concepts of this module.
2. Guide on Workflow Mapping. L.A. Net Community Health Resource Network; 2013. See Appendix.

Activity for learners. (20 minutes)

1. Break into pairs or small groups. Ask learners to assign roles: practice facilitator and participant(s) (optional).
2. Provide learners with large paper, pencils, and sticky notes for mapping.
3. Exercise 1. Map a simple process. Ask learners to: create a workflow map from memory of the participant making a call with his or her cell phone.
4. Map the same workflow a second time while the practice facilitator observes the process and corrects the map.
5. Exercise 2. Create a Swimlane workflow map of a complex process from a practice. Ask learners to map handling patient calls to clinicians (or another multi-individual, multistage process with which the learners are familiar).
6. Create a workflow map of handling patient calls to clinicians (or another multistage, multi-individual process with which the learners are familiar).

Discussion. Ask questions and explore answers with learners. (10 minutes)

1. What did you learn from the mapping exercise?

    a. Highlight lessons such as:

        i. Mapping the process as it is, rather than what you think it is or think it should be.
        ii. Having the person who owns the process map their part of the process.
        iii. Understanding the role of the facilitator in supporting the mapping process.

Activity for learners. (15 minutes)

1. Reconvene pairs or small groups. Have learners evaluate and redesign a workflow from Exercise 1 or 2.

    - Use Redesign Reflection questions from Table 10.1 in module to redesign workflow.

Discussion. Ask questions and explore answers with learners (10 minutes)

1. What changes did you make to your workflows and why?
2. What did you learn about working with a group to redesign a workflow?
3. How will you use this with a practice?

Module 10.

Workflow is defined as a series of steps, frequently performed by different staff members and often dependent on related workflows, that accomplishes a particular task. Workflows represent how work actually gets done, not the protocols that have been established to do the work.

Clinicians and staff in busy practices suggest that one of the most helpful things a facilitator can do for them is help them map key workflows. Workflow mapping is a way of making the invisible "visible" to a practice so they can look for ways to improve their processes to increase efficiency, reduce errors, and improve outcomes. As a facilitator, you will have the skill, time, and vantage point to help a practice map its key workflows and then to lead discussions about improving them.

While many practices will have participated in workflow mapping for implementing electronic health records, many will not have used these processes with the idea of improving quality and outcomes. Workflow mapping is the process of documenting the specific steps and actions that take place in completing a particular task. Creating a workflow map enables you and the practice to see what is currently happening, identify opportunities for improvement or change, and design new, more effective processes.

You and the quality improvement (QI) team will need to consider workflows associated with the following three processes:

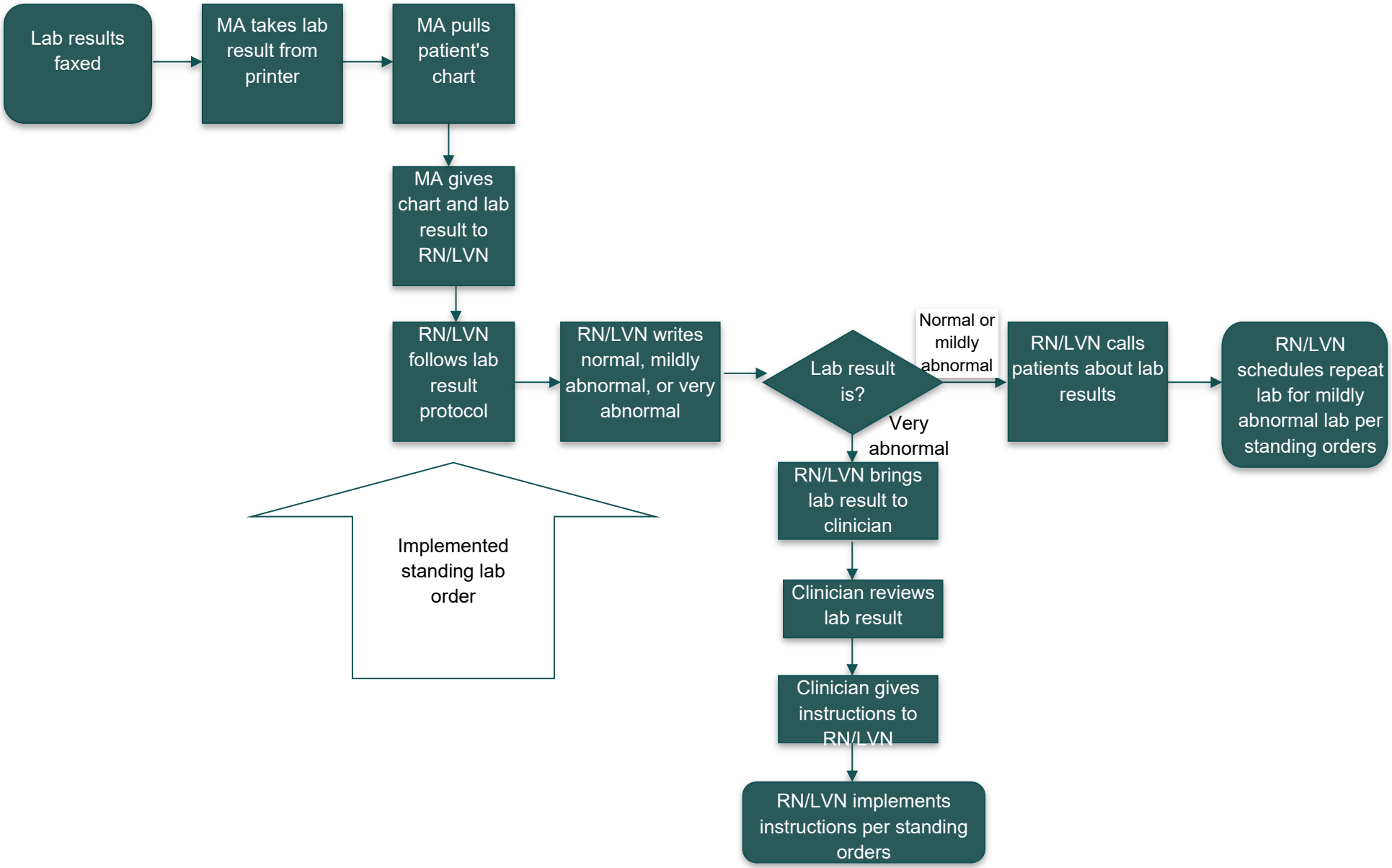
- Perceived process (what we think is happening);
- Reality process (what the process actually is); and
- Ideal process (what the process could be).

The perceived process can be obtained by having the group map what they believe the current process is. The reality process is obtained by having various group members validate the former through direct observation; the ideal process should reflect the workflow the improvement group aspires to and wants to implement.

Workflow Maps

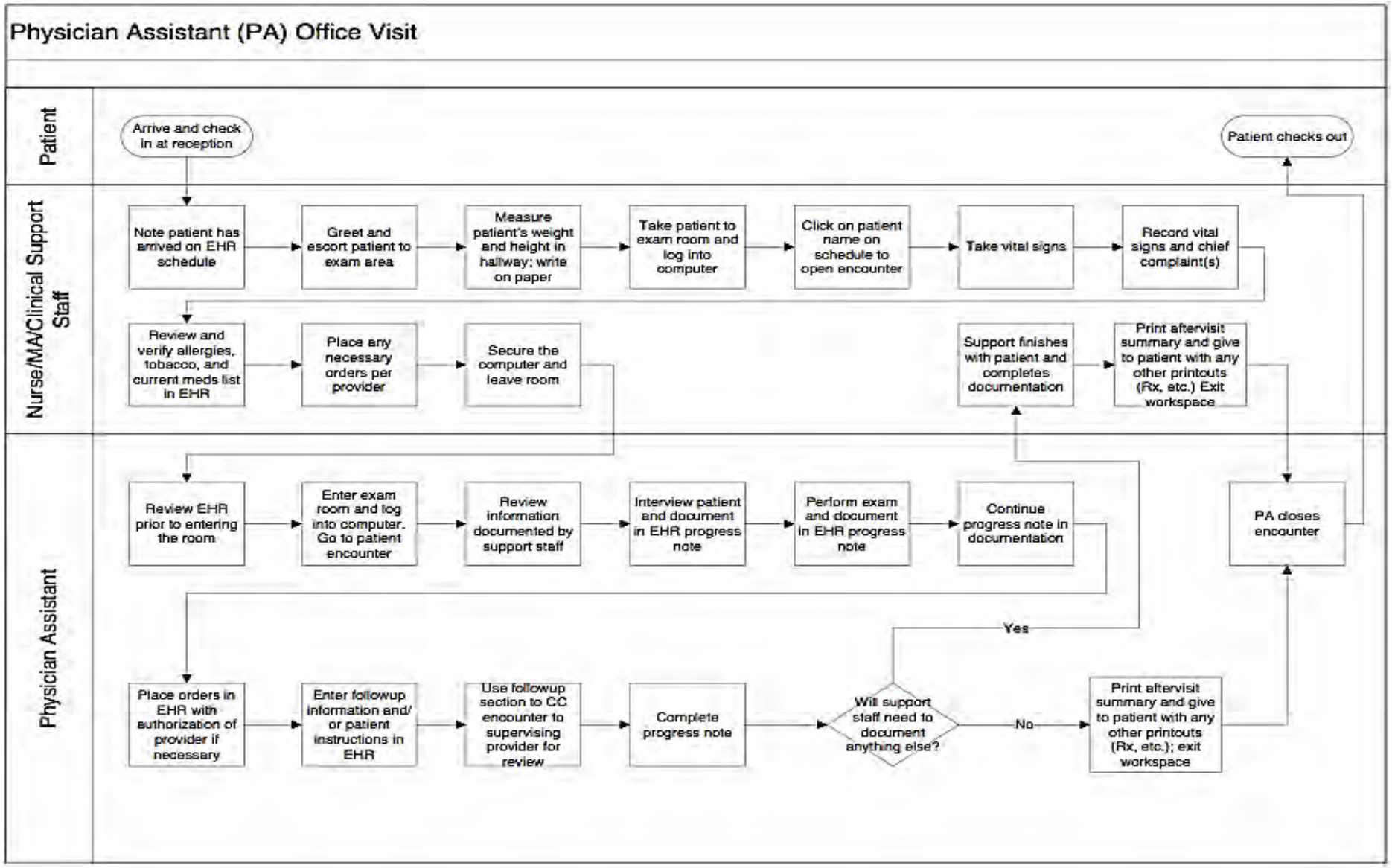
Creating a workflow map is not difficult. However, it is very important to map what is *actually* happening, not what the practice "thinks" is happening or wants to happen. Figure 10.1 shows an example of a detailed workflow map. You will need to identify every step of the activity and who performs it. It is important that each individual involved in a process can describe how a particular activity takes place. In addition to a traditional form of detailed workflows, Swimlane workflows are also an option. Swimlane mapping is performed when you want to illustrate a single process that involves more than two roles simultaneously across time. Figure 10.2 is an example of a Swimlane workflow. When mapping a workflow, you should not rely on a single person to describe a process unless that person controls and executes all steps of the process being mapped.

Figure 10.1. Sample workflow map: lab result follow-up



Source: Bodenheimer T. Workflow mapping: a tool for achieving meaningful use. University of California San Francisco, Department of Family and Community Medicine, Center for Excellence in Primary Care. Reprinted with permission. See Appendix 8.

Figure 10.2. Sample Swimlane workflow map: office visit



Adapted from "Physician Assistant (PA) Office Visit," Health Resources and Services Administration.

To be effective in helping your practice map and redesign workflow, you will need a good working knowledge of the practice's electronic health record and information technology systems so that you can assist them in redesigning workflows that use these systems. A good way to map complex processes is to observe the process in action. You may find that there is not a single process for carrying out a particular task, but several variations in how the activity takes place.

An important rule of thumb when mapping a process is "the person who controls the process controls the pen." This means the person who actually carries out a particular process is the one who maps that step of the process.

Important Workflows in Primary Care Practices

Important processes that you will need to be prepared to help a practice map include:

- Answering phones
- Making appointments
- Scheduling procedures
- Making referrals
- Providing health advice by phone or e-mail
- Assigning patients to panels
- Completing new patient workups
- Educating patients and family
- Managing patient panels
- Planning patient visits
- Coordinating referrals
- Conducting patient outreach
- Checking formularies
- Entering lab results into the information systems
- Making referrals for specialty care and community services
- Consulting with specialists

Many additional activities carried out by a practice will need to be redesigned when it transitions to team-based care. These include:

- Registration
- Appointment scheduling
- Medical assistant role (pre-visit, vitals, agenda setting, checking chronic and preventive care needs, ordering)
- Receipt of test results by clinician (lab, x ray, other)
- Receipt of test results by patient (normal, slightly abnormal, very abnormal)
- Internal messaging (which messages go to whom, what action is required)
- Prescription refills (chronic meds, acute meds, secure script meds)

- Billing workflow
- Form completion (clinician role, other team member role)

You should also be prepared to assist in mapping and redesigning clinical care processes for specific patient groups:

- Preventive care
- Acute problems (major/minor)
- Chronic conditions (diabetes, hypertension, asthma)
- Complex care needs
- Mental health
- Chronic pain
- Women's health
- Pregnancy
- Well child care
- Palliative/end-of-life care

Many resources available online for free or at a small cost can assist you in preparing polished maps. Maps can also be handwritten or constructed with sticky notes to allow a practice to move activities around and redesign workflow. These types of maps are better during the active mapping stage. Your program may provide these resources or ask that you use them, or you may want to explore them on your own.

Helping practices redesign workflows. Redesigning workflows has two goals: improving performance and increasing efficiency. Once you document the reality process, you will need to assist the QI team and other members of a practice to redesign the workflow to incorporate the desired improvements and then test these changes using the Plan Do Study Act (PDSA) process.

When redesigning workflow, it is essential to have all key players involved in the process. The frontline staff who are currently or will be implementing the workflow will have recommendations and ideas for how to maximize efficiency and effectiveness.

It is rare that a workflow is completely independent of other processes in the practice. In most cases, workflows for one activity will overlap or depend on the execution of another activity or process. It is important to identify and consider these dependencies when redesigning workflow, as the effects of redesigning a workflow can be positive or negative.

It will be important for the team to be able to determine the potential peripheral effects of redesigning workflows. The Model for Improvement and PDSA can help a practice identify unanticipated effects of redesigned processes and correct them before taking them to scale.

New workflows will often require realigning jobs, changing staff time allocation, roles, and responsibilities to fit the redesigned workflows. This in turn will require changes to policies and procedures, job descriptions, training, and accountability/reporting systems for ensuring tasks are completed.

When working with a QI team and practice staff on redesigning workflow, you will need to provide them with a copy of the existing workflow. This should be large enough for everyone on the team to view together and to mark up as they design new processes. Table 10.1 contains some questions that can be useful in starting a team on the redesign process. Review the following questions with the practice:

Table 10.1. Redesign reflection questions

- Is there a problem with current performance? Do you need better results?
- Have you been skipping any critical steps?
- Are all steps necessary? Are there areas of unnecessary duplication or redundancy?
- How often do you have to do each step?
- Are there areas that rely on an individual to remember to do something? Any process that relies on memory is prone to error.
- What happens if the process breaks down? Do you need a fail-safe mechanism?
- Can some steps be done simultaneously?
- Is there a more logical way to sequence the steps?
- What skills are necessary to perform each step?
    - If more skills are required, can current staff be trained or do duties need to be shifted to more qualified staff?
    - Could someone with fewer skills perform this step? Would they need training or support?
    - Could someone be hired to perform this step?
    - Could this step be outsourced?
- Is there any technology that would make this process more efficient or easier to do? Are you thinking outside the box? Is there an entirely different way to get this done?
- Who do you know that handles this task very well (an exemplar)? Can you study their workflow?

Implementing and sustaining new workflows. Once the team has developed a new workflow, it will need to be implemented and evaluated. The PDSA process from the Model for Improvement can be a good way to test the effectiveness of a new workflow. You will need to be prepared to assist the QI team in implementing and evaluating the impact of a new workflow as part of the PDSA cycle. You also need to include them in thinking through the different administrative changes that will be required to fully implement and sustain newly redesigned workflows.

Throughout this process, your goal as a facilitator will be to build the team and practice's capacity to engage in these processes in the future, as understanding and modifying existing workflows is an essential component of any improvement process. AHRQ's *Integrating Chronic Care and Business Strategies in the Safety Net* toolkit contains resources from Clinical

Microsystems for training practices in workflow mapping. This toolkit is available at: http://www.ahrq.gov/populations/businessstrategies/.

Note: this module is based on Module 5 of AHRQ's 2013 Practice Facilitation Handbook. Available at: http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/

Reference

Sample flowcharts related to primary care services. Available at http://healthit.ahrq.gov/health-it-tools-and-resources/workflow-assessment-health-it-toolkit/all-workflow-tools/flowchart.

Primary Care Practice Facilitation Curriculum

Module 11. Using Root Cause Analysis To Help Practices Understand and Improve Their Performance and Outcomes

Prepared for:
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services
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Module 11. Using Root Cause Analysis To Help Practices Understand and Improve Their Performance and Outcomes

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Basic quality improvement methods and skills
- Change management

Time

- Pre-session preparation for learners: 3 hours
- Session: 85 minutes

Objectives

Learners will be able to:

1. Use the "5 Whys" process with a group to identify factors that contribute to less-than-optimal performance on a specified performance metric.
2. Use a fishbone diagram (also called a cause-and-effect diagram) to identify factors that contribute to less-than-optimal performance on a key performance metric.
3. Conduct a fall-out analysis to determine why individuals did not receive an indicated service.

Exercises and Activities To Complete Before, During, and After the Session

Pre-session preparation. Ask learners to review the following information (3 hours) and conduct the exercises:

1. Module.
2. View video on root cause analysis and review materials at: http://www.mindtools.com/pages/article/newTMC_80.htm.
3. Read about the use of root cause analysis to improve patient safety at http://www.psnet.ahrq.gov/primer.aspx?primerID=10.
4. Conduct a 5 Whys analysis for a problem or error that is occurring repeatedly in their home or place of work. For example, regularly failing to have milk in the refrigerator.
5. Create a fishbone diagram beginning with information discovered using the 5 Whys.
6. Scan: Langley GJ, Moen R, Nolan KM, Nolan TW, Normal CL, Provost LP. *The Improvement Guide: A Practical Approach to Improving Organizational Performance*. 2009. Jossey-Bass.

During the session. Presentation (20 minutes)

1. Present key concepts from the module.

Discussion. Ask questions and explore answers with learners. (20 minutes)

1. What did you learn from completing the 5 Whys and the fishbone exercise before this session?
2. How could you use this information in your home or work to improve a process or

performance?

3. Have you used fishbone diagramming in a workplace or with a practice? If so, please describe what you did and the three most important lessons you learned using the process.
4. How could you envision building capacity in a practice to conduct root cause analyses of performance data and problems in the practice? Who would you train? How would you help them incorporate root cause analyses into their quality improvement processes?

Conduct exercise (45 minutes). Facilitate the 5 Whys process to identify root causes of a problem or strength associated with this class.

1. Ask learners to break into small groups.
2. Have each group select one person to serve as the PF for the group.
3. Ask the PF to facilitate identifying a problem with the class or course.
4. Facilitate a 5 Whys analysis.
5. Facilitate creation of a beginning fishbone diagram.
6. Ask each member to provide feedback to the PF on the strengths and weaknesses of his or her facilitation of these two processes.
7. With the large group, ask a member of each group to share two lessons learned from facilitating or observing the facilitation of the exercise that they can apply to their own work with practices.

Module 11.

Helping a practice obtain data on its performance is an important part of improvement work. Modules 13, 14, and 15 in this curriculum discuss collecting and presenting performance data. But collecting data is not enough to improve. In order to make meaningful change, practices must understand the underlying factors producing the performance; in other words, the root causes of the performance issue or problem.

Just as it is important to properly diagnose a patient's condition before prescribing a treatment, when working to improve practice performance, it is important to accurately diagnose the factors that contribute to practice outcomes.

Sometimes organizations rush to solve problems based on performance data without adequately analyzing the factors that are contributing to the performance. This can lead to interventions that do not address the real reasons for the problem, and to unsuccessful improvement efforts.

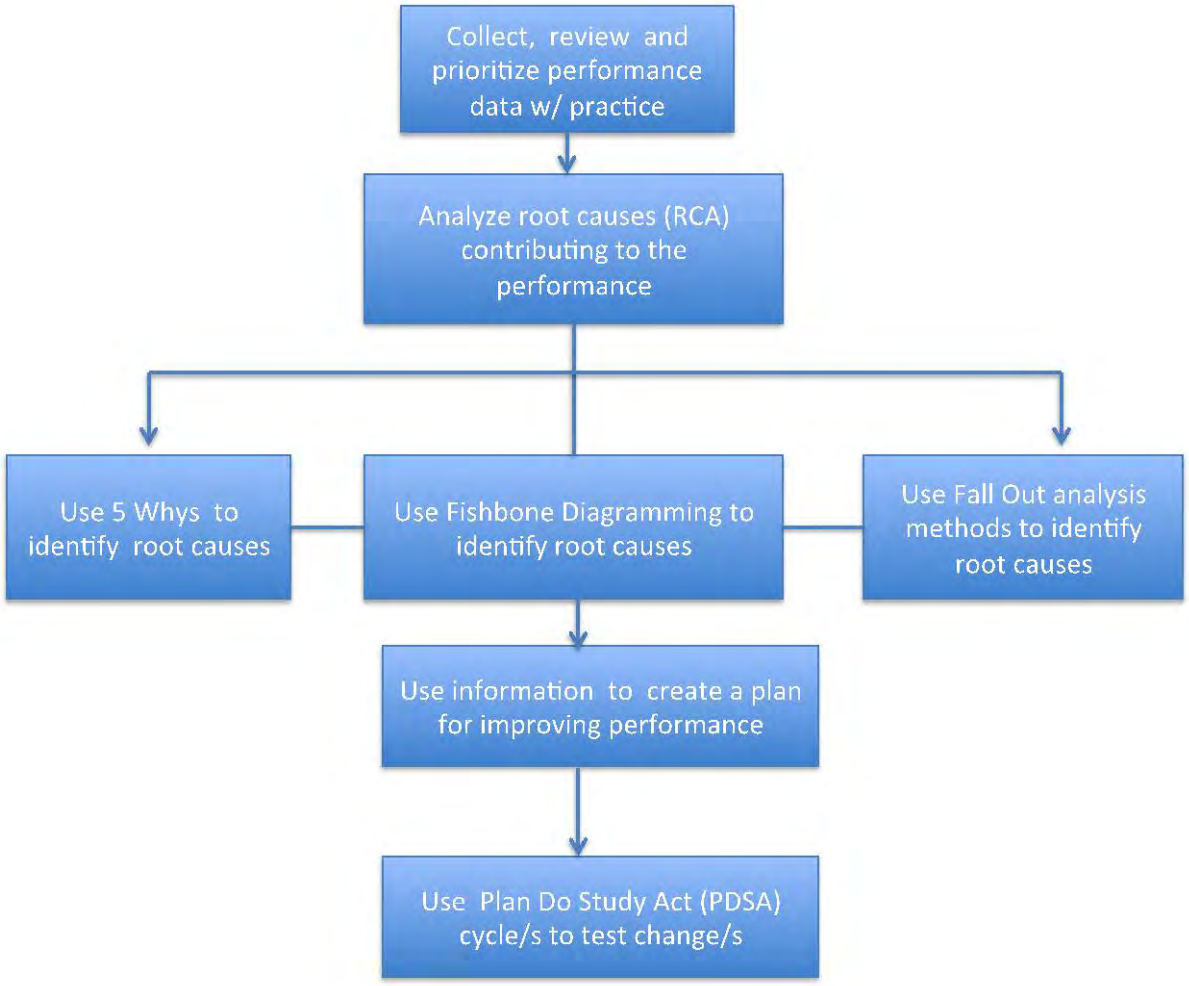
As a practice facilitator (PF), you will want to help your practices take a step back from their data and use a systematic approach to exploring the root causes of their performance before deciding on any changes to improve the performance. This is called root cause analysis. It is the key to helping practices accurately diagnose the issues affecting their performance.

This module provides you with three tools you can train practices to use and incorporate into their quality improvement processes to help them better understand factors underlying their performance or the problems they are trying to resolve. These are:

- The 5 Whys process
- Fishbone diagrams
- Fall-out analyses

After training practices to use these tools, you can work with them to modify the root causes they identify and improve their performance using the Plan Do Study Act cycles (see Module 8). For example, in a typical scenario you might work with a practice to gather, present, and review performance data (see Modules 13, 14, and 15); help them use a performance metric to improve; work with them to identify the root causes of their performance using the 5 Whys, fishbone diagramming, or fall-out analysis; and then help them use the information they discover from analyzing root causes to design a Plan Do Study Act cycle to improve the process. Figure 11.1 depicts the interactions between these root cause analysis techniques and PDSA cycles.

Figure 11.1. Typical sequence for introducing root cause analysis to a practice



After you complete this module, you should be able to:

- determine when to use the root cause analysis processes presented here,
- facilitate practices in using these tools, and
- train practice members to use these tools in your absence as a routine part of their quality improvement work.

Root Cause Analysis

Root cause analysis is the identification and analysis of factors that are contributing to a specific outcome or problem. It is an essential tool for quality improvement.

Three categories of causes may underlie a problem: human, physical, and organizational. Human causes involve someone doing something wrong, not doing something that should be done, or doing something that doesn't need to be done. Physical causes include failures of materials such as broken or missing equipment. Organizational causes include processes, procedures, and policies that are contributing to the problem (AHRQ, 2014; Mindtools, 2014; NHS, 2008; Joint Commission, 2010). See the text box for examples of these types of causes.

Understanding the Three Categories of Root Causes: Examples

Human causes: Medical assistant is entering information in the wrong place in the electronic health record. Physician is using old guideline recommendations and has not updated prescribing practices.

Physical causes: The point-of-care HA1c machine is malfunctioning; the door to the building is not wheelchair accessible.

Organizational causes: The empanelment procedures do not include training and monitoring the appointment schedulers who are scheduling patients with any open clinician rather than a member of the patient's assigned care team.

The 5 Whys, fishbone diagrams, and fall-out analyses are processes you can use with your practices to identify the different factors that are at play with a given performance issue.

The 5 Whys. The 5 Whys is a technique developed by Sakichi Toyoda to help identify the causes underlying a problem. It is a simple process that involves asking and answering a series of five *why* questions about a problem in an effort to uncover the causes (Joint Commission, 2010). It can be a good way to get an individual or group thinking more deeply about the factors underlying their performance before deciding how to approach improvement efforts.

As a PF, you will want to be comfortable using this simple process with your practices to identify factors contributing to their performance data. You should be able to teach the process to practice members so they can use it on their own, and also encourage them to develop the habit of using the 5 Whys process as a regular part of their quality improvement work.

The 5 Whys process involves three steps. First, work with practice members to define the issue they want to improve or the problem they wish to prevent. Second, engage the group in asking and answering the question *why* five times or until the group agrees that they have identified the root causes of the problem. It is important to remember that the answers need to come from the practice members, not from you or others on your PF team. You can guide and stimulate the discussion, and provide some input based on your observations of the processes being analyzed, but the substance of the discussion must come from the practice. See Figure 11.2 for an example of this exercise. Third, if an actionable "root cause" is not evident after five *whys*, then the group should continue to ask additional *whys* until a root cause becomes evident. You will know the

group has arrived at a root cause when no other *why* can be asked that would lead to a meaningful answer or action.

At the end of the exercise, the changes needed to improve the process or prevent the undesired outcome should be self-evident. You can use these to lead the practice into a Plan Do Study Act cycle to test the suggested solutions; or if more analysis is indicated, the information can be used to jump-start a fishbone diagramming process. This more elaborate process is described in the next section.

Steps for conducting the 5 Whys.

1. Work with practice members to identify the problem they want to solve or prevent.
2. Ask the question *why* five times until the group members agree they have identified the root cause of the performance issue or problem.
3. Identify and implement solutions based on findings.

Figure 11.2. Sample 5 Whys process

Problem: Recently, patients have stopped coming to health education class.

Why 1?: Patients forget to come or are not sure when classes are happening.

Why 2?: Staff member who usually makes reminder calls to patients is not making the calls.

Why 3?: She does not have the list of patients to call.

Why 4?: Current lists are not being created.

Why 5?: The person assigned to create these lists from the electronic health record system is out on leave.

Solutions suggested by the 5 Whys:

1. Assign an additional staff person to fill in and create reports when the person responsible is out.
2. Give the outreach caller direct access to the data and train her to generate her own up-to-date lists.

The group can then discuss these solutions and consider testing them using the Plan Do Study Act process.

Below are some recommendations to help make a 5 Whys process go smoothly with your practices.

Make sure the group's answers are rooted in facts and not based on what someone thinks or wishes had happened. You can do this by asking speakers to give specific examples of when they've seen the event occurring. For example, you could ask "Can you describe for me a

specific time when you saw this taking place?"

Include all individuals who are involved in the processes being improved in the 5 Whys Exercise. It is one thing to have leadership or quality improvement team members imagine or guess which factors or challenges are contributing to an issue. It is another thing to have the individuals directly involved with the process respond to these questions. It is almost always more effective for those directly involved with the process to help identify root causes underlying problems and performance.

Remember that the 5 Whys is a simple process for getting groups to think and does not replace more comprehensive processes, such as fishbone diagramming, which consider multiple causes for a problem. Although simplicity is a strength of the 5 Whys, it can also generate an overly simple image of problems if not conducted in concert with other processes, such as fishbone diagramming (Anderson, 2009).

Fishbone Diagramming. The fishbone diagram (also called a cause-and-effect or Ishikawa diagram) is another engaging and effective tool you can use to help practices identify root causes for their performance problems (AHRQ, 2014; Mindtools, 2014; NHS, 2008; Joint Commission, 2010). You can use fishbone diagrams to help practices understand that effects have multiple causes, avoid overly simplistic solutions to problems, and see the relationships between causes and effects This will help them select the most appropriate intervention to use to correct the problems (Institute for Healthcare Improvement, 2004).

Creating a fishbone diagram involves the following eight steps:

1. Schedule a 30- to 90-minute meeting with your practice team.
2. Introduce fishbone diagramming briefly to the practice team as a tool to identify root causes of performance problems. (Provide an example from another project, such as the one in Figure 11.3 below.)
3. Have team members clearly define a measurable performance issue they want to analyze and write this in the box at the head of the diagram (the fish head). For example, patient wait times for women's health visits are averaging 30 minutes.
4. Have the categories of causes already pre-filled with people, environment, materials, methods, equipment. Some practices may want to add more categories, but limiting the number of categories you use usually helps the process move along more effectively.
5. Ask participants to brainstorm factors that may be causing the problem within each category. Remind participants about the rules of brainstorming: (1) all ideas are good ideas at this stage, and (2) limit cross-talk until everyone has had a chance to share their ideas.
6. Write the group's ideas of causes on the diagram under the appropriate category headers (the diagonal lines). In some instances, one or more categories may remain empty but it is important that you ask the team to think about each category even if they cannot immediately think of causal factors in that category. Include secondary causes by adding lines off from each cause.

7. Engage the group in discussions about the results of the diagram process and its implications for next steps in improving the targeted metric or process. If there are multiple causes contributing to the problem, which is common, engage the group in discussing how each of the causes and types of causes interact and the implications of this for making changes to improve performance. Discussing the effect on performance of the interactions among the causes may take some time. It is important to discuss each cause and its interactions carefully before forming a plan for improvement, or the intervention will be superficial and will eventually fail.
8. Once the group members have fully explored all the causes and their connections to one another and the problem they are trying to solve, have them identify changes they would like to try based on what they learned completing the diagram. Use this opportunity to initiate a Plan Do Study Act cycle to test the changes.
   Note: If the group gets stuck brainstorming about causes under each category of the fishbone diagram, you can use the 5 Whys process to facilitate their thinking.

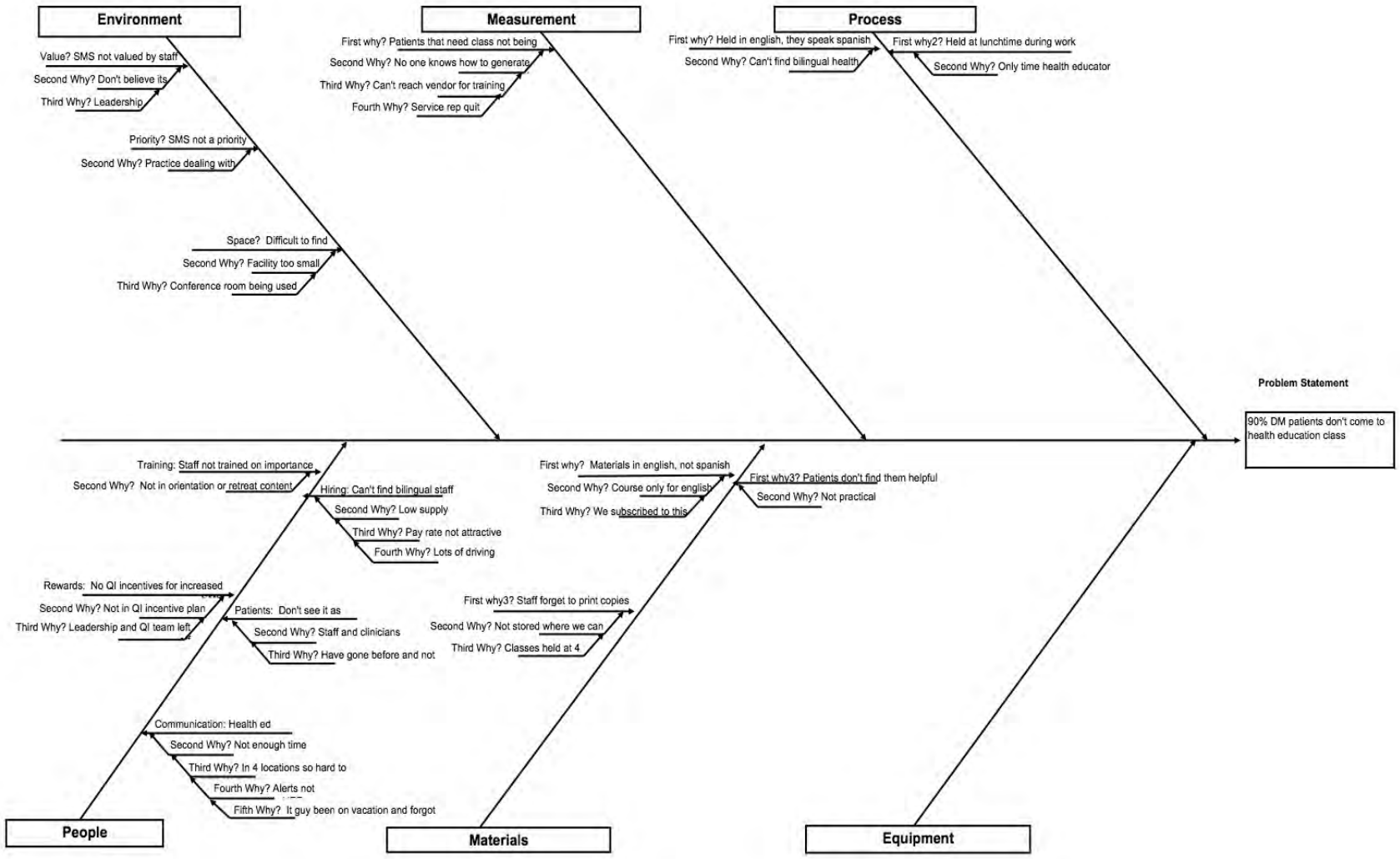
As a PF, you should be skilled in helping practices create these diagrams, and training clinicians and staff to incorporate them into routine quality improvement work.

General recommendations. Include individuals involved in the outcome under study in the mapping process, as they are more likely to know of contributing causes than others who are not directly involved in the process. This can include receptionists, practice managers, physicians, nurses, physician assistants, medical assistants, community health workers, health educators, and coaches. The practice may also want to include patients, depending on the nature of the problem.

Make it easy for everyone participating in the analysis to see and contribute to the diagram as it is being developed. For example, draw the empty diagram on a whiteboard or flipchart. You can write the goal (at the head) and standard categories and then add items as group members suggest them. Depending on the situation, you may want to invite a member of the group to serve as the scribe for the process, so you can focus your attention on the group, or you may want to serve as scribe yourself for efficiency.

Encourage quiet participants to add their ideas. They may be the ones with the “missing pieces” or the causes that others miss. You can encourage them to participate by calling on them directly, “Sally, you have been quiet during our discussion. What would you add to this diagram?”

Figure 11.3. Sample fishbone diagram



You may also want to train a member of the practice to facilitate root cause analysis for the practice in the future. You can use this module to train the staff member or as a starting point for developing your own training session. It can be helpful to have this person colead a 5 Whys or fishbone diagramming process with you so he or she can gain experience using the process with the practice and build some credibility as a resource for this type of analysis.

Helpful tools for fishbone diagramming are available at:

- http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/FishboneRevised.pdf
- http://www.mindtools.com/pages/article/newTMC_03.htm

Fall-Out Analysis. A third process you can use with your practices to identify root causes is fall-out analysis. A fall-out analysis is used to evaluate why an individual "fell out" of a particular performance metric. For example, why did a patient with diabetes not have an HbA1c lab value in his or her chart for the past 12 months? A fall-out analysis can be conducted as a stand-alone process or as a way to further examine some of the causes raised during fishbone diagramming.

Fall-out analysis is different from the 5 Whys and fishbone diagram processes discussed earlier because it relies mainly on objective data and focuses on one particular type of problem—determining why patients did not receive an indicated service.

To conduct a fall-out analysis, you will need to be able to analyze patient datasets for trends and patterns, conduct observations of care processes, and review medical charts for clues for reasons patients may not have received the indicated care.

To begin a fall-out analysis, you should confirm that the performance data you will be analyzing are correct and that the results are not invalidated by mapping or other data errors. After validating the findings, generate a list of the patients who failed to receive the recommended service. Next, identify four to five patients from that list and conduct reviews of their medical records to identify potential factors that contributed to their failure to receive the service. For example, in the case of missing lab data, you might examine the records with the following questions in mind: Did the patient come in for services in the performance period? Did his or her clinician order the lab test? If so, what happened next? Is there evidence the patient tried to follow through? Did the lab result arrive and not get entered into the record?

As you complete this initial review, write down any potential causes that you uncover. Next, visit with clinicians and staff and brainstorm about the possible causes you identified and others they think might be contributing. You may start to see an early pattern of causes emerge. Continue this process until you have generated a comprehensive list of causes or until a clear pattern or reason for the fall-out is identified. There is often not a single cause, but several. One of your roles as a PF should be to discourage practices from rushing to quick, overly simplistic solutions, and help them consider all possible causes to the problem.

You will also want to examine data for the entire sample if available. You can do this using

Excel or a statistical software program. Typically, you don't need to do more than run frequencies to take a basic look at the data. In many instances, conducting a successful fall-out analysis will require input from a clinician, as many of the factors that contribute to a patient's falling out of a metric may not be evident to you if you do not have a clinical background.

Steps for Completing a Fall-Out Analysis

1. Identify two-to-five patient cases that "fall out" of the performance metric in question.
2. Review the content of these patients' medical records and other related documents to identify potential causes for their falling out of the metric.
3. List reasons that you identify and discuss these with staff and clinicians for additional input.
4. Continue with an iterative cycle of reviewing cases and discussing with clinicians and staff until a clear root cause or set of root causes is identified.
5. Encourage the practice to use the Plan Do Study Act cycle to implement and evaluate improvements based on the findings of the fall-out analysis.

Example: Using fall-out analysis to improve diabetes care in a federally qualified health center. A small family practice in the Midwest is trying to figure out why more than 200 of its patients with diabetes do not have the required HbA1c values recorded in their medical records. When brainstorming about potential causes during a fishbone exercise, most clinicians and staff believed the main cause was patient noncompliance, in other words, the patients are failing to go to the lab to get the requested tests.

Based on this assessment, the practice began discussing the idea of implementing a patient education program to teach patients about the importance of getting their prescribed lab work done. The PF suggested that, in addition to the fishbone exercise, the group also conduct a fall-out analysis of a few patient cases to see if the findings supported what the group had identified in the fishbone exercise, and whether there were any other potential causes they might have missed.

The PF obtained medical records for 10 patients who did not have the required lab work recorded and discovered that the last HbA1c for 6 of them had been within normal limits. As the PF explored further, she discovered that the patients' physicians had failed to order the lab tests in the past 12 months. When she interviewed the physicians, they said they did not order the lab tests because the patients' last lab values had been normal.

She then analyzed lab data for the remaining 194 patients and found that 70 percent had previous HbA1c results within normal limits. These analyses uncovered an "unknown" cause for the

practice's poor performance on HbA1c documentation and suggested the need for an entirely different type of intervention to address the problem.

Summary

Obtaining performance data is just the beginning of a quality improvement process. What a practice does next is especially important if, for example, performance assessment finds that care is not meeting important HEDIS measures, or wait times to see a clinician have lengthened to more than 20 minutes per patient, or patients are not receiving indicated care for chronic kidney disease. PFs need to be highly skilled in using processes for analyzing root causes of performance, and helping their practices incorporate these processes as a regular part of their quality improvement work. The findings from a root cause analysis are invaluable to crafting solutions to performance problems. The 5 Whys, fishbone diagrams, and fall-out analyses are processes that PFs and practices can use to analyze root causes to problems, and help practices make good decisions about factors to change to improve performance.

References

Agency for Healthcare Research and Quality (AHRQ). INSTRUCTIONS: Gap Analysis. 1-2. 2014. http://www.ahrq.gov/professionals/systems/hospital/qitoolkit/d5-gapanalysis.pdf .

Agency for Healthcare Research and Quality. Root Cause Analysis. Patient Safety Primers. http://www.psnet.ahrq.gov/primer.aspx?primerID=10 . Accessed August 21, 2014.

Anderson, S. Quality Digest – Root Cause Analysis: Addressing Some Limitations of the 5 Whys. 2009. http://www.qualitydigest.com/inside/fda-compliance-news/root-cause-analysis-addressing-some-limitations-5-whys.html . Accessed August 21, 2014.

Application Programming Interface. How to Use the Fishbone Tool for Root Cause Analysis. 2014. http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/FishboneRevised.pdf .

Institute for Healthcare Improvement. Process Analysis Tools. Cause and Effect Diagram. 2004. http://www.ihi.org/resources/Pages/Tools/CauseandEffectDiagram.aspx . Accessed August 21, 2014 .

Joint Commission. Root Cause Analysis in Healthcare: Tools and Techniques. Richard J. Croteau (ed.). Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations; 2010.

MindTools. Cause and Effect Analysis: Identifying the Likely Causes of Problems. 2014. http://www.mindtools.com/pages/article/newTMC_03.htm . Accessed October 16, 2014.

National Health Service (NHS). Root Cause Analysis Using Five Whys. Quality and Service Improvement Tools. 2008. http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/identifying_problems_-_root_cause_analysis_using5_whys.html .

Primary Care Practice Facilitation Curriculum

Module 12. An Introduction to Assessing Practices: Issues to Consider

Prepared for:
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Module 12. An Introduction to Assessing Practices: Issues to Consider

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Foundational knowledge for data-driven improvement and use of performance reports
- Application of practice assessment to determine practice readiness

Time

- Pre-session preparation for learners: 60 minutes
- Session: 70 minutes

Objectives

After completing this module, learners will be able to:

1. Describe the key principles of data-driven improvement and why this is a central concept in improvement work and facilitation.
2. List the different aspects of a practice that might be assessed as part of a practice improvement intervention.
3. Identify some common tools for assessing practices.
4. Access Health Resources and Services Administration (HRSA) Uniform Data System (UDS) reports for Federally Qualified Health Centers.

Exercises and Activities To Complete Before and During the Session

Pre-session preparation. Ask the learners to review information in items 1-3 and explore items 4-5 (60 minutes)

1. The content of the module.
2. Review and explore online resources for assessing practice systems and sample assessment tools listed above.
3. Download and review a copy of a UDS report on a safety net practice in your area.
4. Access to Clinical Microsystem Assessment Tool. Adapted from Assessing, Diagnosing and Treating Your Outpatient Primary Care Practice. Available at https://clinicalmicrosystem.org/workbooks/.
5. Access sample assessment tools:

    - Status of Care Model implementation
        - Implementation of the Care Model-Practice Systems. Assessment of Chronic Illness Care (ACIC): http://improvingchroniccare.org/index.php?p=Survey_Instruments&s=165

    - Patient Assessment of Care for Chronic Conditions (PACIC): http://www.improvingchroniccare.org/index.php?p=PACIC_Survey&s=36

- Patient satisfaction and experience:
    - CAHPS® (Consumer Assessment of Healthcare Providers and Systems): https://cahps.ahrq.gov/surveys-guidance/cg/about/index.html

- Provider and staff satisfaction:
    - Primary Care Staff Satisfaction Survey: http://www.improvingchroniccare.org/downloads/2.1_primary_care_staff_satisfaction_survey.doc

- Organizational capacity for improvement:
    - Change Process Capability Questionnaire (CPCQ) developed by Leif Solberg. See Appendix.

- Patient-centered medical home status:
    - Medical Home Index: http://www.medicalhomeimprovement.org/knowledge/practices.html
    - National Committee for Quality Assurance: http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH/PCMH2.aspx
    - PCMH-A Assessment at http://www.safetynetmedicalhome.org/sites/default/files/PCMH-A.pdf

- Other resources for practice data
    - HRSA Uniform Data System report on safety net practices in your area: http://bphc.hrsa.gov/datareporting/index.html

During the session. Presentation (25 minutes)

1. Present key concepts from the module.

Exercise for learners (30 minutes)

1. Complete the CPCQ for one of your practices (or the TheOnlyOneforMiles case example). See Appendix.
2. Complete the ACIC for one of your practices (or for TheOnlyOneforMiles case example). Available at http://improvingchroniccare.org/index.php?p=Survey_Instruments&s=165.

Discussion. Ask questions and explore answers with learners (15 minutes)

1. What lessons did you learn from completing these surveys and reviewing the UDS data reports?
2. What have been your experiences and lessons learned assessing systems in practices (or other organizations)?
3. How might you use these tools with practices you are working with?

Module 12

Effective improvement work is data driven. Information on the practice and its performance on key measures is used to:

- create buy-in for improvement work.
- identify areas in need of improvement and strengths that can be leveraged to support improvement work.
- compare the practice's performance to that of others (benchmarking). Prioritize improvement efforts and activities.
- set improvement goals.
- track progress toward improvement goals.
- monitor maintenance of improvements once achieved.

Identifying What To Assess

What you assess should be determined by the scope and goals of the facilitation intervention. You will need to work closely with your practices to prioritize areas for assessment as you begin to work with them. Table 12.1 contains some important metrics you will need to talk to your practices about assessing.

Table 12.1. Assessment metrics

Assessment Topic	Metrics
Access and continuity	• Same day access • Nontraditional visits to traditional • Third next available appointment • Patients seeing own provider or care team •
Clinical information systems and progress toward meaningful use	• Registries • Problem lists • Medication lists • Flow sheets • Checklists of tests and interventions • Decision support tools •
Clinical performance	• Key performance and outcome metrics for: o Coronary artery disease (CAD) o Heart failure (HF) o Diabetes mellitus (DM) o Preventive care (PC) o Hypertension (HTN) o Other clinical performance metrics relevant to the particular practice

Assessment Topic	Metrics
Implementation of key elements of aspirational care models	• Elements of the Care Model • Elements of the patient-centered medical home
Finance	• Monthly expenditures • Expenditures per visit • Debt ratio • Working capital •
Patient experience	• Patient satisfaction • Patient engagement with care team • Visit cycle time • Patient support and empowerment as owners of their own health
Quality improvement systems	• Quality improvement plan content • Implementation of plan • Presence of performance reporting systems and their use
Safety and reliability	• Medication error monitoring and prevention • Adverse event monitoring and prevention •
Staff morale and satisfaction	• Staff satisfaction • Staff burnout

Identifying Assessment Tools

A variety of tools exist to assess a practice. They fall into four categories:

- Surveys and rating scales (patient, provider, staff, whole practice)
- Chart/medical record audits
- Direct observation and interviews
- Document review

Assessments can look at practice processes. For example, the Clinical Microsystems Assessment is a comprehensive assessment package for assessing multiple domains of a practice from clinical systems and performance to patient satisfaction and experience to financial issues.

Specialized tools exist for assessing particular aspects of practice performance and functioning. For example, the Assessment of Chronic Illness Care (ACIC) tool evaluates the degree to which a practice's processes and methods are consistent with the different elements of the Care Model. (See Module 24 on Care Model.) Similarly, the Medical Home Index evaluates the degree to which a practice reflects aspects of the patient-centered medical home.

Surveys let you gather information in a systematic fashion. You may want to survey staff satisfaction about the work environment, skills staff members have, and time management. You can identify sources of stress, ways staff may be underutilized, and ideas for improvement.

Surveys of patient satisfaction or experiences with care are another important source of information. Patient surveys can be broad (e.g., clinician/group CAHPS®) or specific to certain types of transformations (e.g., Patient Assessment of Chronic Illness Care, CAHPS® Patient-Centered Medical Home Survey). Qualitative methods, such as focus groups, can also be useful in gauging patient opinions.

Chart or electronic health record audits can examine how the practice performs on specific metrics for clinical performance and patient outcomes. Different groups have defined sets of quality metrics available to guide your assessments in these areas. Your practices will most likely be familiar with them and may already be tracking their performance on some of these metrics. A few examples are listed below:

- National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS) indicators (www.ncqa.org).
- Measures endorsed by the National Quality Forum (http://www.qualityforum.org/).
- Measures approved by the AQA Alliance (www.aqaalliance.org/).

Direct observation will be one of the most powerful assessment tools available to you as a facilitator and something that can make you very valuable to your practices. Direct observation can be used to gather information about patient experience at the practice. For example, you might use a "secret shopper" approach to better understand what a patient experiences in a practice if this is an area of focus for a practice. You may spend time in the waiting room or observe the interaction of a care team to better understand and assess how they work together. You may use observation to assess factors affecting staff workflow or satisfaction or to evaluate the implementation of new policies or procedures by staff in the practice environment. Observations of specific elements of the practice can be captured using field notes or checklists and then provided to the quality improvement (QI) team to use in designing improvements.

Document review is another important tool for assessing a practice. Examining documents and archival information produced as part of clinical care or various aspects of care can provide valuable insight into what is working and not working with a practice's systems. You can use document review and observation as tools to conduct "fall-out" assessments, where a forensic analysis of system "failures" identifies the reasons for the failure and suggests improvements. For example, in a practice interested in improving its lab reporting process, observation and document reviews can help track patients who failed to receive their lab results within the specified time period and identify failures in the system. The practice can use these data to correct and improve the process and reduce failures in the future.

Many different tools are available to examine different domains of practice functioning, from clinical care processes to administrative systems and financial stability. You will need to work

with each practice to pick the tools and approaches that not only fit the goals for the facilitation intervention and those of the practice, but are most likely to yield information that can be acted on to make improvements.

Choosing Assessment Tools

Your facilitation program may have a set of basic assessment tools and measures that it expects you to use to assess the practices you will be working with. You may choose to augment the tools your program has selected with additional assessments that you find helpful or the practices you are working with would like you to use.

The goal is to select a set of measures that will yield information that is "actionable" for the practice, but not to overwhelm them with data. Many variables might be interesting to assess but are not essential. Part of your job will be to help the practice focus the assessment on those items that are relevant to the improvement goals.

Identifying Assets as Well as Challenges

It is important to approach the assessment from an asset-based rather than deficit-based perspective. You are probably working with a practice because it is having difficulty implementing desired changes on its own. Thus, the tendency can be to focus only or mainly on the practice's problems and weaknesses. This can result in a negative dynamic in which the practice facilitator feels as though he or she must "rescue" the practice. This approach is debilitating to the practice and inhibits the sustained improvement and increased practice capacity that are goals of facilitation.

To avoid this scenario, try to develop an "asset" map of the practice that includes a list of the skills and talents of staff and clinicians as well as the resources the practice may already have that are relevant to practice improvement. The book *Building Communities from the Inside Out: A Path Toward Identifying and Mobilizing a Community's Assets* (1993) can assist you in shifting the paradigm from one that is deficit driven to one that is asset based. Incorporating an Appreciative Inquiry (AI) approach into your work can also help with this. Module 9 provides an introduction to AI concepts that you may want to incorporate into your work with practices.

Leveraging Existing Data Resources

Practices, especially those in the safety net, already collect a considerable amount of performance and patient data for the Federal Government and third-party payers. In addition, practices may collect information for other QI work going on at the practice. Therefore, practices may be resentful if you try to impose new data collection on them that is seen as duplicative.

Leverage the data the practice is already collecting whenever possible. Sources of assessment and monitoring data include:

- Disease registries: patient characteristics, quality of care metrics, possible use as population management tool
- Electronic health records: patient characteristics, quality of care metrics, possible use as population management tool, utilization
- Patient surveys: patient experience
- Health Resources and Services Administration (HRSA) Uniform Data System (UDS): quality of care and clinical outcome metrics
- Reports required by health plans: quality of care and clinical outcome metrics, utilization, other process indicators specific to plan
- Existing QI reporting: various metrics
- Data collected for prior research or QI efforts: various metrics
- Workflow maps
- Staff surveys: various metrics

Be sure to take an informal inventory of data sources before recommending any new data collection. This inventory should include the resources listed above and extend to data collection required by their different payers and projects they may be participating in with local researchers. For example, HRSA's UDS (http://bphc.hrsa.gov/datareporting/index.html) is a requirement for grantees of HRSA Primary Care Programs. A variety of data elements are included, such as patient demographics, services provided, staffing, clinical indicators, utilization rates, costs, and revenues. See the Appendix for a sample data inventory form.

Using Assessment Tools To Stimulate Reflection and Discussion

The MacColl Center for Health Care Innovation's assessment tool, the ACIC, can help stimulate productive discussions about the needs and improvement goals of the practice. Table 12.2 summarizes the elements of the ACIC.

Table 12.2. Elements of the Assessment of Chronic Illness Care (ACIC)

Component	Content
Health delivery system	• Organizational leadership is in place for Care Model • Organizational goals exist for Care Model • Improvement strategies exist for Care Model • Incentives and regulations are in place for Care Model • Senior leadership supports quality improvement in Care Model • Benefit structure supports patient engagement in Care Model
Community linkages	• Patients are linked to outside resources • Practice partners with community organizations • Health plans coordinate guidelines, measures, and resources at

Component	Content
	practice level
Self-management support	• Needs are assessed and documented • Self-management support is provided to patients • Concerns of patients and their families are addressed • Behavioral interventions and peer support are provided
Decision support	• Evidence-based guidelines are available through reminders and other methods • Specialists provide guidance to enhance primary care clinician capacity • Provider education is provided for Care Model on issues such as population management and self-management support • Patients are informed about guidelines
Delivery system design	• Effective practice teams deliver team-based care • Team leadership is clearly defined and empowered • Appointment systems support effective care • Follow-up is tailored and guideline driven • Planned visits are used for regular assessments, preventive care, and self-management support • Continuity of care is a priority and includes coordination of care across providers
Clinical information systems	• Registry is used and tied to guidelines and provides prompts and reminders about services • Reminders to providers include information to team about guideline adherence at time of visit • Feedback is timely, specific to team, and aimed at improving team performance • Information about patient subgroups is given to providers to support planned care • Treatment plans are established collaboratively with patients
Integration of Care Model components	• Patients are informed about guidelines • Registries include results of patient assessment and self-management goals developed with patient • Community programs provide feedback about patients' progress • Practice uses data and feedback from teams to plan population care and self-management support programs and monitors success over time • Specific staff are charged with supporting routine follow-up • Team reviews guidelines with patient to guide self-management and behavior modification appropriate to patient goals and readiness

Adapted from Assessment of Chronic Illness Care (ACIC). Copyright 2000, The MacColl Center for Health Care

Innovation, Group Health Cooperative.

Building Practice Capacity for Data Collection and Use in a Practice

While you will most likely collect and analyze data early in an improvement intervention, from the very beginning you will need to plan how you will build capacity in the practice to continue producing performance measures over the long term. Consider the following questions:

- What information systems do they have or need to support this effort?
- How can you help them develop the systems they lack and learn to mine data from those they have?
- Who in the practice will do this?
- What data will they collect? How often?
- What skills will they need and how can you help them develop these skills?
- What systems and software will they need to analyze and interpret the data for use in QI work? What will the workflow be for staff who will collect and analyze these data? How long will it take to complete this task each reporting period?
- Can this activity be incorporated into other required reporting activities, such as reports to health plans?
- Will leadership provide protected time to staff for these activities?
- What factors are likely to interfere with or prevent staff from completing this key activity?
- How can this get written into their job descriptions?
- How will new staff filling this role in the future be trained?
- What systems will be put in place to hold them accountable for completing these tasks?
- What schedule will they follow for collecting the data and reporting them to the QI team?
- How will the data be displayed so they are meaningful and actionable to the QI team?
- Can they "automate" parts of this process to make it easier for staff to obtain data and produce periodic reports?

As you work with the data, you will need to begin working on the answers to these and other relevant questions. Your objective is to build internal capacity in the practice to do the things with data that you are doing now and to sustain this work over time.

Note: this module is based on Module 6 of the Practice Facilitation Handbook. Available at: http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/

Reference

Kretzmann J, McKnight J. Building communities from the inside out: a path toward finding and mobilizing a community's assets. Evanston, IL: Asset-Based Community Development Institute, Northwestern University; 1993.

Primary Care Practice Facilitation Curriculum

Module 13. Measuring and Benchmarking Clinical Performance

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Module 13. Measuring and Benchmarking Clinical Performance

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Specialized skills in data collection, benchmarking, and analysis of clinical performance

Time

- Pre-session preparation for learners: 55 minutes
- Session: 75 minutes

Objectives

After completing this module, learners will be able to:

1. Identify sources for selecting performance measures for primary care.
2. Describe the importance of the numerator and denominator in defining performance measures.
3. Describe benchmarking and its use by facilitators to support improvement work.

Exercises and Activities To Complete Before and After the Session

Pre-session preparation. Ask the learners to review the following information (55 minutes)

1. The content of the module.
2. Bagley B. How does your practice measure up? Fam Pract Manag 2006 Jul-Aug;13(7):59-64. Available at http://www.aafp.org/fpm/2006/0700/p59.html.
3. Damberg C, Sorber M, Lovejoy S, et al. An evaluation of the use of performance measures in health care. RAND Health Q 2012;1(4):3 Available at http://www.rand.org/pubs/periodicals/health-quarterly/issues/v1/n4/03.html.
4. Benchmarking. Available at https://en.wikipedia.org/wiki/Benchmarking.

During the session. Presentation (15 minutes)

1. Present key concepts from the module.

Discussion. Ask questions and explore answers with learners (15 minutes)

1. Discuss your experience developing and using performance metrics in clinical or other settings. What did you learn? How will you use this in your work with practices?

Activity for learners (30 minutes)

1. Divide into pairs.
2. Use online resources identified in this module and previous modules to develop a list of metrics for a practice to use to assess its clinical performance in primary care for diabetes mellitus and chronic kidney disease.
3. Use online resources to identify national or local external benchmarks for performance on these metrics.

Discussion. Ask questions and explore answers with learners (15 minutes)

1. What did you learn from the exercise?
2. How will you use this in your work with your practices?

Module 13.

Performance measurement involves collecting and reporting data on practices' clinical processes and outcomes. Measuring clinical performance can create buy-in for improvement work in the practice and enables the practice to track its improvements over time. This information should also be used to identify and prioritize improvement goals and to track progress toward those goals. In addition, these data should be used to monitor maintenance of changes already made.

As a PF, it is important to understand that initially staff and clinicians in a practice may not like the idea of gathering data and doing quality reporting. You will want to be sensitive to this and prepared to support your practices in working through their concerns. The reasons for practice concerns vary. Some practices may feel threatened by the idea, worried that it may present the practice or its staff in a negative light. Others may challenge its usefulness based on the belief (often true) that the data are too messy and flawed to provide an accurate picture of their performance. Others may be concerned that metrics currently being used to evaluate quality in practices are too simplistic and do not adequately capture the care for more complex patients (also often true) or correlate with any real outcomes (also often true). Finally, others may feel gathering these data duplicates work that they are already required to do for other reasons and so is not a good use of human or data resources at the practice. Addressing these objections and helping practice members understand the importance of this work for improving care is a key part of your role.

Selecting Clinical Performance Measures

You will work with your practices to identify the areas of clinical performance they want to assess. The areas of clinical performance should connect to the improvement goals the quality improvement (QI) team has set as well as any mandates from the funder. Common sources for performance measures are the Healthcare Effectiveness Data and Information Set (HEDIS), quality indicators developed by the National Committee for Quality Assurance, and criteria selected by health plans.

In addition to selecting a set of performance measures that the practice wants to track, the QI team will need to decide how frequently to collect and analyze data. Data collection timelines should allow sufficient time for change to occur. Data also should be generated frequently enough to show progress over time through the use of run charts and other methods of comparing data collected across multiple time periods.

Refining Clinical Performance Measures: Defining the Numerator and Denominator

Many performance measures are rates with the numerator indicating how many times the measure has been met and the denominator indicating the opportunities to meet the measure. For example, let's say your practice wants to measure how well it is complying with annual comprehensive foot exam recommendations for its patients with diabetes.

In specifying the numerator, the practice will need to define what constitutes the desired performance. Will monofilament testing alone be adequate or will it need to be combined with visual inspection, testing for sensation, or palpation of pulses? Or will any one of these approaches be deemed adequate? How accurately these events are documented will be important in determining the usefulness of the available data.

In specifying the denominator, the practice will need to establish what constitutes an opportunity to deliver the desired action. For this example, you might define the denominator as the number of patients with diabetes who have had a health care encounter in the past 12 months. Or you might define the denominator more broadly from a population health perspective as any patients with diabetes in a clinician's panel regardless of the status of their most recent visit.

Denominators in particular are important in understanding and interpreting data, so it is very important that you are careful to use the appropriate denominator. For example, if you are working with a practice to determine what percentage of its patients with diabetes have hemoglobin A1c (HbA1c) values of 8 or higher, you would want to use for the denominator only those patients with diabetes who have HbA1c values available in their medical record. If you include all patients with diabetes regardless of whether they have an HbA1c value available, the percentage of patients who have elevated HbA1c values will be artificially depressed.

As you and the practice monitor progress in improving performance on this metric over time, you will need to consider how the denominator may change. For example, a monthly audit of performance on this metric might use patients with diabetes who received care in the previous month as the denominator and the number of these same patients who had received a foot exam within the past 12 months as the numerator.

It can be tricky defining an appropriate denominator. If you do not select the correct denominator, you may under- or overstate performance. For example, when calculating the percentage of patients with diabetes who have low-density lipoprotein (LDL) below 100, you would specify the denominator as the number of patients with diabetes with an LDL test, not just the number of patients with diabetes. Similarly, if you were tabulating the percentage of patients who gave the most positive response to a question on a survey, you would specify the denominator as the number of patients who answered that question, not the number who were surveyed.

You will also need to help the practice decide which, if any, subgroups they want to evaluate. For example, you may want to measure performance for patients who have had a visit in the past quarter or who have been in treatment for at least six months. You will also need to decide whether you want to stratify performance measures for different populations. For example, you might want to compare performance for patients based on age, gender, race or ethnicity, disease severity, or treatment status.

Benchmarking

Benchmarking is the process of comparing a practice's performance with an external standard. Benchmarking is an important tool that facilitators can use to motivate a practice to engage in improvement work and help members of a practice understand where the practice's performance falls in comparison to others. Benchmarking can stimulate healthy competition, as well as help members of a practice reflect more effectively on their own performance. See Figure 13.1 for an example of a benchmarked practice report card.

You will need to work with your practices to identify appropriate benchmarks. Benchmarks can be generated from similar practices in the same area or by comparing them to a larger group of practices from across the country. They can also be drawn from standards set by an authoritative body. Good sources for benchmarks include local quality collaboratives where several practices collect similar performance data and compare among themselves. Community clinic associations often host this type of local effort, typically through multi-organization QI projects on a particular condition such as asthma, and may benchmark across the participating sites as part of their work with their members.

Other sources for benchmarks include required data reports to Federal agencies and funders, such as the Health Resources and Services Administration's Uniform Data System reports required from Federally Qualified Health Centers. National associations and the National Committee for Quality Assurance are other potential resources for benchmarking, as well as State and local health and public health agencies.

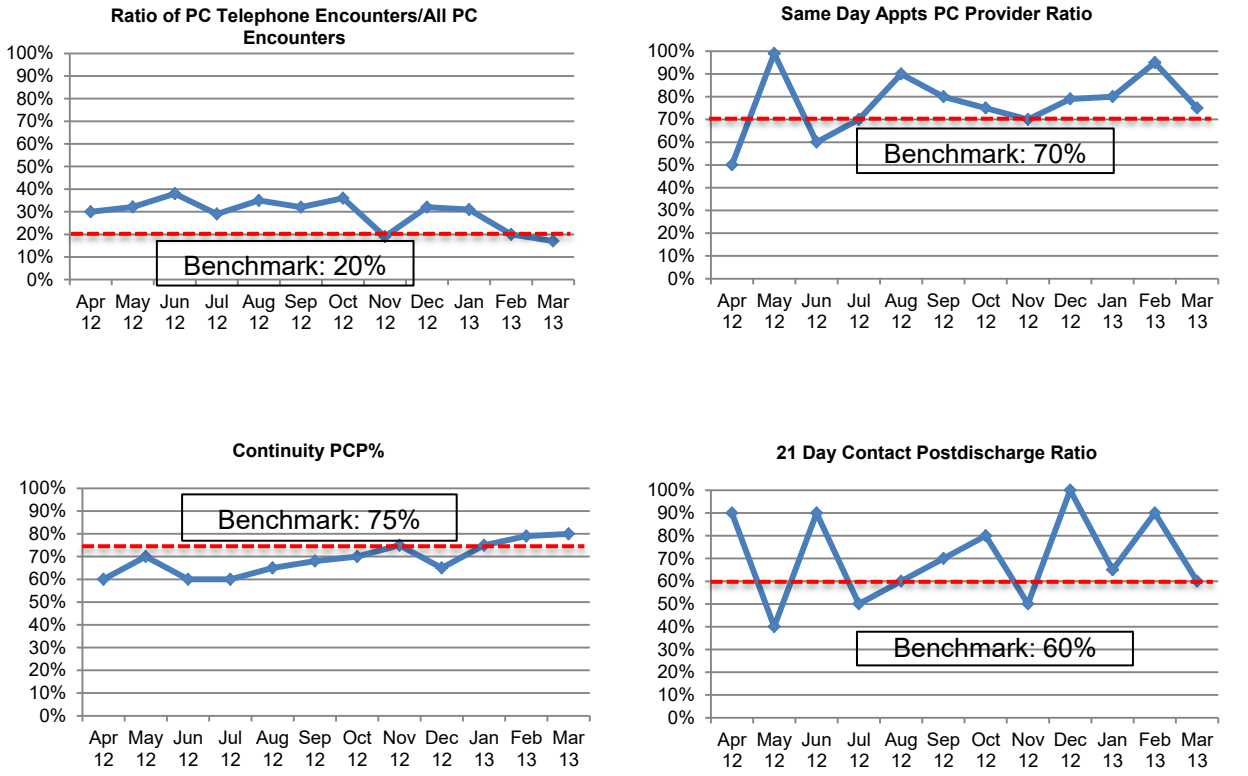
Health information technology vendors are emerging as a source of benchmarks when they allow comparison across organizations using their systems. Large data networks such as DARTNet and SAFTINet funded by AHRQ may also become a resource for both local and national benchmarking. Figures 13.1–13.3 are examples of the types of reports produced by these organizations.

> Pay attention to numerators and denominators when benchmarking. It is important to ensure that you are making "apples to apples" comparisons.

Figure 13.1. Sample benchmarked practice report card

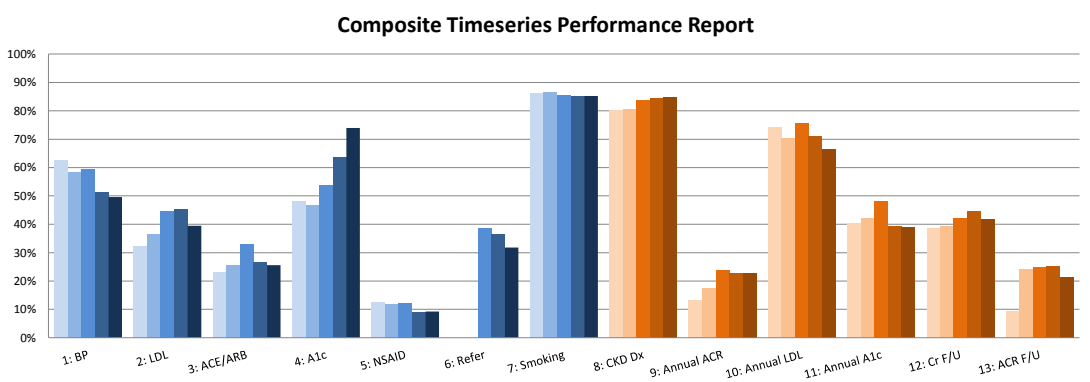
Category	Metric	Apr 12	May 12	Jun 12	Jul 12	Aug 12	Sep 12	Oct 12	Nov 12	Dec 12	Jan 13	Feb 13	Mar 13
Panel Management	PC Provider Panel Assignments	312	313	310	315	309	310	305	312	317	301	310	302
	PC Patients Enrolled	10	10	12	11	9	12	11	13	15	12	10	10
Access	Ratio PC Phone/Video Encounters to All Encounters	30%	32.1%	38%	29%	35%	32%	36%	19%	32%	31%	20%	17%
	Primary Care Telephone Encounters	57	99	85	74	79	59	42	25	59	42	30	20
	Total Primary Care Encounters	169	245	202	237	205	190	180	140	140	150	130	150
	Same Day Appts/PC Provider Ratio	50%	99%	60%	70%	90%	80%	75%	70%	79%	80%	95%	75%
Email	Total Email Communications	49	50	40	60	90	40	60	80	90	80	90	100
	Total PC Patients Enrolling w/Email Option	25	30	40	40	50	45	50	60	70	60	50	60
Continuity	Continuity w/Care Team	60%	70%	60%	60%	65%	68%	70%	75%	65%	75%	79%	80%
Coordination of Care	21 day Followup	90%	40%	90%	50%	60%	70%	80%	50%	100%	65%	90%	60%
	Total Discharges	5	6	9	9	5	8	9	10	8	8	2	5

Figure 13.2. Sample composite practice report for patients with chronic kidney disease



Sample Clinic

TRANSLATE CKD
Improving Evidence-Based Primary Care for Chronic Kidney Disease



Report date ranges: 12 months to... **Baseline =** 1/15/13; **Q1** = 4/15/13; **Q2/Q3 (combined) =** 11/15/13; **Q4 =** 2/15/14; **Q5 =** 5/15/14

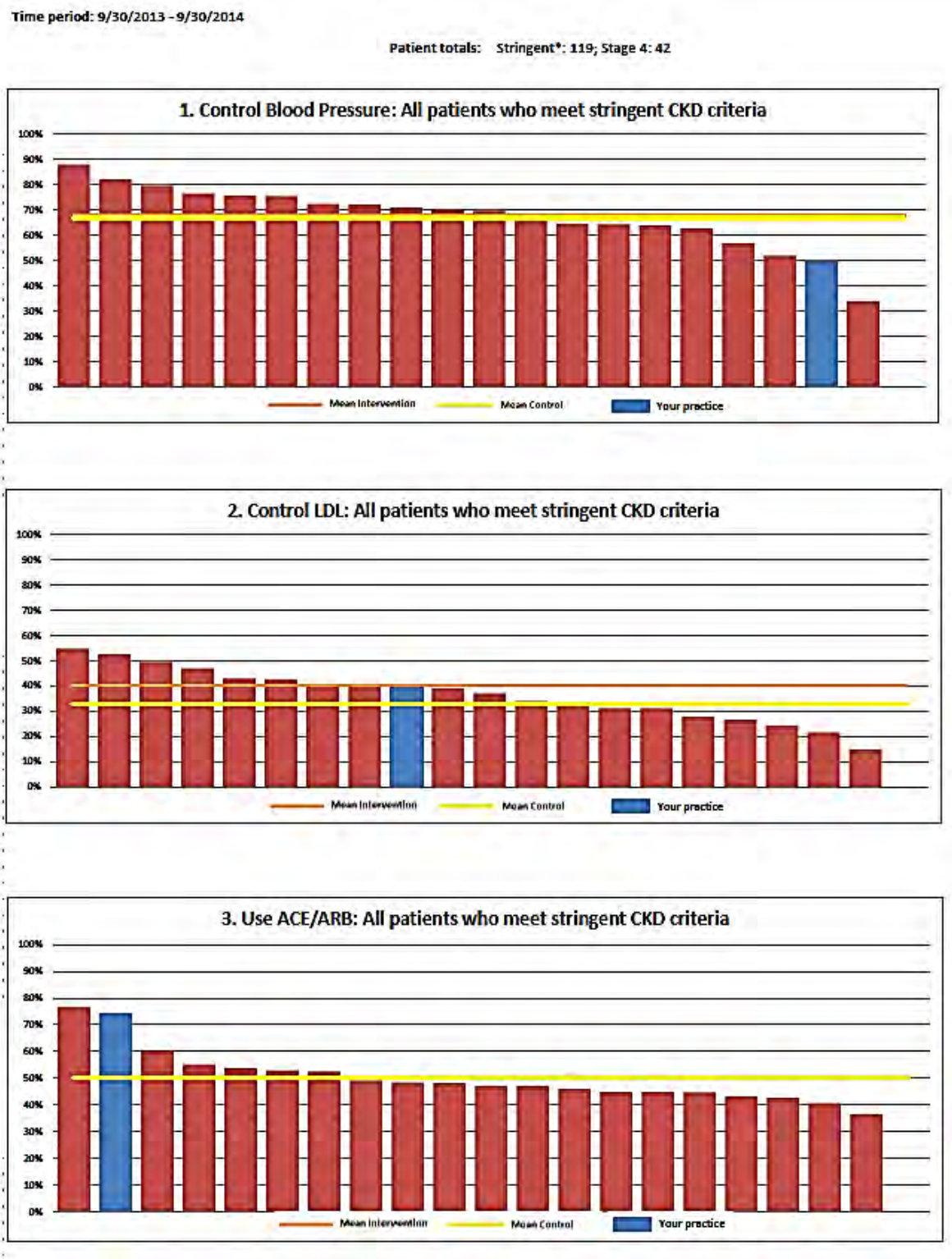
Key:

Report	Measure Name	Cohort	Target	Cohort Definition	Formula
1	**Control Blood Pressure**	All patients who meet stringent CKD criteria	140/90	Percentage of patients with average of last 3 BP <= 140/90	Mean of last three systolic and diastolic BP; will be based on last one or two if fewer than three available
2	**Control LDL**	All patients who meet stringent CKD criteria	<100	Percentage of patients with average of last two LDL measures < 100	Mean of last two LDL; last LDL if only one is available
3	**Use ACE/ARB**	All patients who meet stringent CKD criteria	Yes	Percentage of patients with a current ACE/ARB prescription	Documentation in EHR/pharmacy of prescription; yes/no for each time period
4	**Control HbA1C**	Patients who meet stringent CKD criteria and have a Dx code of 250*	<7.0	Percentage of diabetic patients with A1c < 7.0	Last HbA1c;
5	**Have Not Eliminated NSAID/Cox-2 use**	All patients who meet stringent CKD criteria	No	Percentage of patients with a current prescription for NSAID/Cox 2	Yes/no for each time period
6	**Refer to Nephrologist**	Patients with at least one GFR < 30	Yes	Percentage of patients with at least one eGFR < 30 who have been referred to nephrology	Referral documented, if applicable
7	**Eliminate Smoking**	Patients with smoking status documented	Non / Former smokers	Percentage of patients with a documented smoking status who are non smokers or former smokers	Yes/no for each time period
8	**Diagnosis of CKD**	Pts who meet stringent CKD criteria	Appropriate CKD Dx	Percentage of patients who meet CKD criteria who have CKD Diagnosis (ICD-9	Dx Codes (ICD-9 = 585.xx and 250.4.x)
9	**Annual ACR Measure**	Pts who have ICD9 of 250.xx	Annual measurement	Percentage of patients who have MicroCR in prior year	Lab done
10	**Annual LDL**	Pts who meet stringent CKD criteria	Annual measurement	Percentage of patients who have LDL in prior year	Lab done
11	**Annual A1c**	Patients with diabetes	Annual measurement	Percentage of patients who have A1c in prior year	Lab done
12	**Follow up creatinine measure**	Pts who have 1 eGFR < 60	Appropriate Follow-Up Measurement	Percentage of patients who have a follow up creatinine measure > 90 and < 360 days after the first eGFR < 60	Lab done
13	**Follow up ACR measure**	Pts who have 1 ACR > 30	Appropriate Follow-Up Measurement	Percentage of patients who have a follow up ACR measure > 90 days and < 360 days after the first ACR > 30	Lab done

Page 1 of 1

Source: Sample Composite Practice Performance Report. Leawood, KS: DARTNet Institute; 2015.

Figure 13.3. Sample benchmarked practice report for patients with chronic kidney disease



Source: Sample Composite Practice Performance Report. Leawood, KS: DARTNet Institute; 2015

Note: this module is based on Module 7 of the Practice Facilitation Handbook. Available at http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/

Primary Care Practice Facilitation Curriculum

Module 14. Collecting Performance Data Using Chart Audits and Electronic Data Extraction

Prepared for:
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services
540 Gaither Road
Rockville, MD 20850
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Module 14. Collecting Performance Data Using Chart Audits and Electronic Data Extraction

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Specialized skill in conducting medical record reviews using paper audits or electronic systems

Time

- Pre-session preparation for learners: 110 minutes
- Session: 60 minutes

Objectives

After completing this module, learners will be able to:

1. For paper-based data: Conduct a paper chart audit using a data abstraction form.
2. For electronic data: Create a sample set of instructions for an electronic data pull for a performance audit.

Exercises and Activities To Complete Before and During the Session

Pre-session preparation. Ask the learners to review information below and complete activity (110 minutes)

1. The content of this module.
2. Gregory B, Van Horn C, Kaprielian V. Eight steps to a chart audit for quality. Fam Pract Manag 2008 July-Aug;15(7):A3-A8. Available at: http://www.aafp.org/fpm/2008/0700/pa3.html

Activity for learners (paper-based data) (50 minutes)

1. Have learners conduct chart abstractions of diabetes Healthcare Effectiveness Data and Information Set indicators for three different time periods for the clinic WeServeEveryone. Have them use the mock patient records and data abstraction form in the Appendix.

    - The date of abstraction for the following patients is October 27, 2010:
        - Billy Gato
        - Cherie Amore
        - Wendy See
    - The date of abstraction for the following patients is January 10, 2011:
        - John Donut
        - Adam Pie
        - Tom Gelato

- The date of abstraction for the following patients is April 14, 2011:
  - Steve Apple
  - Bill Windows
  - Monica Latte

During the session. Presentation (10 minutes)

1. Present key concepts from the module.

Large group discussion. Ask questions and explore answers with learners. (15 minutes)

1. What experience have you had conducting paper chart audits or working with electronic systems to collect performance data?
2. What were three of your lessons learned for each medium?
3. What were your experiences conducting the paper chart audits for today's session? What aspect was easiest for you? What was the most challenging? What did you learn from this pre-session assignment that you would apply to your work with practices?

Activity for learners (25 minutes)

1. Divide into pairs or small groups.
2. Have learners work together to create instructions for the staff person managing the practice EHR or patient registry system to pull a report from the electronic system that parallels that of the paper audit the learner conducted pre-session. Have the learners use the sample Data Pull Instructions template to create the request.

Discussion. Ask questions and explore answers with learners. (10 minutes)

1. What did you learn from creating the instructions for IT and an electronic performance data pull?
2. How will you use this with your practices?

Module 14.

One of the most important functions of a facilitator is to help practices obtain, present, and interpret data in a meaningful and compelling way and translate the findings into action. Data collection, however, is laborious. Facilitators can spend much of their time with a practice simply building the practice's capacity to access accurate and reliable data from its information systems and to use these data to guide improvement work.

With data being key to quality improvement (QI), it is important that you feel comfortable collecting, analyzing, and reporting data. Once data have been collected, they will need to be cleaned, analyzed, and presented to both the practice team involved with the project and to practice staff, clinicians, and leadership. The use of data and feedback systems allows practices to see improvements during an intervention, make adjustments, and stay engaged. Also consider Appreciative Inquiry as an approach to collecting valuable performance feedback (for more information, refer to Module 9).

Considerations When Collecting Clinical Performance Data

Many practices, especially small ones, continue to use paper medical records, often even when they have implemented an electronic health record (EHR) system. Others have transferred their record keeping completely to an EHR system. Still others use a combination of paper and electronic, for example, maintaining paper charts but also running a manual electronic registry. In other instances, the practice has gone completely digital but has only entered part of its patient records into its EHR system, so to access information, including information from prior years, you will need to pull data from both their EHR system and paper records to create a full picture. Given this, as a PF, you will want to be skilled in collecting, managing and reporting data from both paper and electronic mediums and in training practice staff and clinicians to do the same.

In general, an audit of 30 to 60 patient records seen during the target time periods is sufficient to generate usable performance data for a practice. You will need to collect data multiple times so the practice can track its progress.

For the initial performance audit, it is usually most effective to conduct an audit of the previous 12 months and organize these data by quarter to show fluctuations in performance over that time, but you will want to work with the practice to determine the time period. A 12-month period is useful because fluctuations across the period can be a valuable source of information about factors that may be affecting clinical performance. During active improvement work, monthly performance audits of patients seen during that period can help a practice monitor its progress toward improvement goals and make adjustments to processes and procedures when progress has not occurred.

When a practice is engaged in a Plan Do Study Act (PDSA) cycle, daily performance audits may be needed to assess how effective the modification is in improving the targeted performance metric, and for deciding if a modification is ready to be spread wider in the practice. For a

practice that has achieved an improvement goal, quarterly audits can be used to help them ensure that the improved performance is maintained. They also can alert the practice to the need for adjustments when performance unexpectedly declines.

Procedures for Paper Chart Audits

When you are collecting data from a paper-based system, you will want to create a form for abstracting information from the practice's paper records. If you are collecting data from electronic systems, such as an EHR or patient registry, you will need to prepare a performance data request with specifications about what needs to be pulled from the system. In general, you will want to prepare both abstraction forms and data requests in collaboration with the practice's QI team (if one exists) as well as with staff at the practice that prepare reports for payers and insurers and other groups. As you work with them to define the information that will be collected, you will want to ask about data they already collect and report and consider whether these data and reports could be used in addition to, or in lieu of, new data collection.

If you are abstracting from paper charts, you will enter the data into the abstraction spreadsheet. Figure 14.1 contains an example of an abstraction spreadsheet. You will most likely work with medical records staff to access the patient charts. Ideally they can provide you with a private place to sit and review the charts that is close to where the records are kept, so it is easy to return them to staff when you complete the abstraction. In practices with paper-based systems, it is very important to return charts in a timely way, as a staff person or clinician may need them for patient care or other purposes. Nothing is more disruptive to care than not being able to find a patient record when you need it.

Unlike with electronic data, where you should be able to collect data on the universe of patients in your target population, you will have to sample patients when doing audits using paper records. For performance audits, a random sampling of 30 to 60 charts or patient records for the initial performance audit can be sufficient to provide information on the practice's performance. Smaller samples are vulnerable to random variability.

Another approach can be to sample 10 percent of eligible charts or to take a convenience sample from a single day of patients who meet the inclusion criteria (such as patients with certain chronic conditions). For monthly performance monitoring, an audit of the records of 10 patients seen during that month can be sufficient for a practice to evaluate progress toward an improvement goal.

You will need a list of patient records that you want to review. These lists can be generated using billing data with diagnostic codes and information on other inclusion and exclusion criteria. You will then need to give these patient record numbers to medical records staff, who can pull the charts and provide them to you for audit.

You will need to work closely with the QI team and practice manager to ensure that you do not create an undue burden on medical records staff and that you do not pull and retain charts of patients being seen that day.

Procedures for Electronic Health Record Audits

When requesting pulls of electronic data, you will typically create a data or report request and give this to the person in charge of producing reports from the practice's EHR or registry systems. These data can be provided in a summary format (such as a report of the percentage of patients meeting certain criteria) or in raw form in a spreadsheet of patient-level data that you can manipulate later. In general, the raw form is helpful when getting started as it will allow you to drill down into the data and identify potential errors and underlying causes for these errors. Identifying errors in data such as mis-mapping and multiple locations for the same variable will take up much of your initial time with a practice. Having data in a raw format like an unprocessed spreadsheet will help you do this.

When accessing electronic data, you will usually work with staff at the practice who are in charge of creating reports for the practice. This can be a health educator who has been assigned to manage reporting, a QI staff person, a designated "super-user" for the practice, a clinician, or the front-desk clerk. Whoever this individual is, he or she will become an important part of the QI work you do with the practice, and also ideally a member of the QI team. You will learn from them, and they will learn from you. Over time your goal will be build their knowledge of the type of information and reports to produce to support QI work at the practice; and you will learn from them and build your knowledge about working with data in the particular IT systems they are using.

For your practices that use EHRs and electronic patient registries, you will want to become familiar with the reporting capabilities of these IT systems. Some of the needed functions, however, may require new programming. And depending on the way you want the data arrayed, it could be beyond the functionality of the EHR system. It is worth a significant investment of your time to learn as much as you can about how to coax data from the system. Developing a relationship with those who are in charge of the IT system(s) and can reconfigure reports to meet your needs will have a high payoff.

With electronic patient data, you can work with practice staff to create standing reports on key performance metrics that can be run repeatedly over time. These reports make it easy for the practice to continue performance reporting after the active facilitation intervention is finished.

Information to Include in a Data Pull Request

- List of performance variables/metrics
- Patient inclusion (for example, patients with certain chronic conditions or patients seen in the office in the past 12 months)
- Patient exclusion criteria (for example, patients with ESRD)
- Time period covered (start and end date)
- Format of data

Equally important is training staff to develop their own reports and modify existing reports so they can easily add new performance metrics over time or change the parameters of old ones.

In addition to providing a list of the performance variables you want included in the data pull, inclusion and exclusion criteria for the patient records that will be queried, and time period for the data, you will need to specify the format for receiving the data, such as a spreadsheet with individual patients or visits as rows and the variables as columns. The advantage of performance audits using data from EHRs is that you can often pull data on the entire population of patients seen during the specified time period, rather than limiting the audit to a subset of 30-to-60 patient records. Provide the IT staff, or whoever will pull the data, precise written descriptions of the criteria for inclusion and exclusion. A sample of instructions for IT for a performance audit data pull is provided in the Appendix.

Balancing Capacity Building and Hands-On Support in Getting Data

It is worth adding a note of caution here. First, it is unrealistic to expect that as a PF, you will have expertise in extracting data from every IT system you encounter in the practices you work with, as this can easily reach 40 or more systems across your panel of practices. Your goal should be to engage and build capacity of practice staff to do this, and help them access resources for training if they do not have this knowledge already, rather than doing the work for them yourself. Of course, if you have expertise in the particular IT system, by all means you can provide the training. And you will also need to help with much of the heavy lifting in identifying sources of errors in the data and helping the practice staff fix it permanently – for example, engaging the IT vendor to correct mapping errors in the system, or to eliminate duplicate entry options for patient information.

You will want to resist taking on the function of extracting and cleaning data for the practice, as it is an essential skill they will need to acquire in order to sustain QI work once you leave or put them on a maintenance schedule of support. This said, in some practices, especially very small ones with limited resources to direct to data collection, you may need to take this task on initially to increase their capacity to eventually do this on their own. For example, you may set-up report templates for the practice that staff can use over and over again, and automate their production as much as is feasible.

Figure 14.1. Sample abstraction spreadsheet for paper-based records

Diabetes Chart Audit Form

Practice Site:	**Date of Audit:**	**PF Reviewing:**

a	b	c	d	e	f	g	h	i	J
Pt. ID (do not include names)	HbA1c in the past 3 months? 0=NO 1=YES	HbA1c less than 7.0? 0=NO 1=YES	BP documented at last visit? 0=NO	BP less than 130/80 mm Hg? 0=NO	LDL-C in past 12 months? 0=NO 1=YES	LDL-C less than 100mg/dL? 0=NO	Eye exam in the past 12 months? 0=NO	Foot exam in the past 12 months?	Other indicator (per practice): 0=NO

Privacy and Data Security

All data collected from a practice are highly sensitive. Whether the data are from patient records or staff surveys, the practice facilitator must keep data secure at all times. You should take a number of measures to protect confidential information. First and foremost, never take identified patient data offsite from a practice.

Never take identifiable patient data (data with patient names or other identifiers) from a practice or store data with PHI on your computer. Lost or stolen laptops are a common cause for **data breaches.**

Electronic data are particularly difficult to secure, especially in the era of cloud computing. Any data transmitted to or stored on your computer, tablet, or laptop should be deidentified with all personal health information (PHI) removed. A list of what is considered protected PHI can be found in the Health Insurance Portability and Accountability Act (HIPAA) descriptions. For more information on HIPAA compliance, see Module 7, Professionalism for Practice Facilitators.

A key code connecting patient PHI, including medical record number, to data you maintain on your computer or any that you are transporting offsite will need to be created to allow you to re-identify data if needed. This key code should be housed at the practice and never taken offsite. In addition, you will need to set the security on your laptop to require a password to access any practice information stored on it. Any data transmitted through email or stored on cloud applications should similarly be deidentified, with the master code maintained only at the practice.

You will need to be familiar with and comply with all regulations of HIPAA as it relates to performance data and access to patient data. In addition to protecting sensitive patient information used in assessing clinical performance, you also need to be concerned about privacy and confidentiality of a practice's performance data.

Assessing clinical performance can be a threatening and sensitive process for a practice. While sharing aggregated performance data and best practices across practices is a critical part of facilitation and of quality improvement in general, you will need to confirm that you have a practice's permission to share information about their performance and improvement work before you do this. You will also need to clarify the conditions under which this is acceptable to the practice. Typically, these discussions will occur with practice leadership and your program director, and will be clarified at the start of an improvement intervention. But you will need to remain sensitive to these issues as you work across your practices and with other facilitators.

Note: this module is based on Module 8 of the Practice Facilitation Handbook. Available at: http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/

Primary Care Practice Facilitation Curriculum

Module 15. Preparing and Presenting Performance Data

Prepared for:
Agency for Healthcare Research and Quality
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Module 15. Preparing and Presenting Performance Data

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Specialized skills for preparing and presenting performance data

Time

- Pre-session preparation for learners: 60 minutes
- Session: 120 minutes

Objectives

After completing this module, learners will be able to:

1. Manipulate performance data to check for out-of-range values and missing values, and then do any necessary cleaning of the data.
2. Produce simple frequencies from data.
3. Prepare a graphic display of performance data.
4. Benchmark the data against an external standard.

Exercises and Activities To Complete Before and During the Session

Pre-session preparation. Ask the learners to review item 1 and complete the activities in items 2-3 (60 minutes)

1. The content of this module.
2. Using data abstracted from Module 14, have learners calculate Healthcare Effectiveness Data and Information Set performance metrics for the clinic WeServeEveryone, for each of the three time periods using the Performance Metric Calculator contained in the Appendix to Module 14. For a set of potential benchmarks, see the National Committee for Quality Assurance (NCQA) Web site. Available at: http://www.ncqa.org/tabid/123/Default.aspx.
3. Have learners prepare a presentation of the chart audit findings across the three time periods for the "practice." Have them include run charts and other graphic displays of the performance data in the presentation. Learners may use the Performance Report Generator (available at: http://www.lanetpbrn.net/wp-content/uploads/Performance-Report-Generator_1.xlsb) or another method of their choosing to generate displays.

During the Session. Presentation (15 minutes)

1. Present key concepts from the module.

Discussion. Ask questions and explore answers with learners (25 minutes)

1. What experience have you had in the past collecting and presenting performance data to an organization?
2. What did you learn?
3. What were your experiences preparing your data to present at the session today? What aspect was easiest for you? What was most challenging? What did you learn from the pre-work assignment?

Activity for learners (60 minutes)

1. Have learners break into pairs or small groups. Designate a Practice Facilitator for each group. Have the Practice Facilitator present findings to the group and guide a discussion about the data using the questions contained in the module:

    - How accurately do you believe these data reflect your practice?
    - Are there problems with the data to be considered or corrected before use?
    - What findings did you expect?
    - What findings were surprising?
    - What do these data suggest to you regarding setting goals for improvement at your practice and prioritizing these goals?

Discussion. Ask questions and explore answers with learners (in pairs or small groups). (20 minutes)

1. Have learners provide feedback to their Practice Facilitator using the Start, Stop, Keep format:

    a. Start doing—Something you might start doing in your presentation of data is:
    b. Stop doing—Something you might stop doing is:
    c. Keep doing—Something you should continue doing is:

2. For learners playing the "practice" roles, discuss what it was like to receive data about your practice's performance.

    a. What were your concerns?
    b. What was most helpful to you about the data?
    c. What was most helpful to you about your interactions with the facilitator?
    d. What did you learn from this exercise, and how will you use this in your work with your practices?

Module 15.

Preparing and reporting data to a practice or its quality improvement (QI) team is one of the most important steps in data-driven improvement and one of your most important roles as a facilitator. To prepare, you will need to ensure that the data you have collected are accurate. You will also need to make sure that you have summarized them and presented them in a way that makes it easy for members of the practice to understand them and where their performance falls in the context of other similar practices or patient populations. Finally, you will need to be prepared to respond to members' questions and challenges about the data and to help them reflect on the findings and use the findings to stimulate meaningful action toward improving the practice.

Cleaning and Validating Data

An important step toward presenting data to your practice is preparation. Once the data have been collected and you have entered them into a database, you will need to review them for missing entries, internal inconsistencies, or out-of-range values (e.g., systolic blood pressure of 1125 mm Hg). These need to be corrected or removed from the spreadsheet.

One way to clean and validate data is to manually check the data in your data collection spreadsheets. Look at the data and ask yourself: Is each number plausible? Does the sequence of dates make sense? Do any of the data elements conflict with each other?

Another method is to run frequencies using a statistical program. A number of good online training programs teach basic skills for working with data using statistical software programs. These programs can identify data outliers and inconsistencies.

You will need to talk to staff and clinicians at the practice to better understand the validity or other problems with the data you are collecting. With electronic health records (EHRs) in particular, there can be data elements filled with meaningless data, entered simply to fill a required field. Talk to practice staff to find out whether there are any "junk codes" where the data are not what they appear to be. Much of your early work setting up performance systems is likely to focus on getting data and fixing data so they are accurate.

It is also common for entry fields on EHRs to have been inadvertently mapped to the wrong variable labels in the underlying databases, which are used to generate reports on patient care and practice performance. These mistakes can be difficult to identify but can introduce significant errors into any patient and performance reporting. Clinicians and staff can alert you to areas where these mapping mistakes may exist. When results are inconsistent with what is expected, or seem "strange" to clinicians and staff, this should be a red flag to check for mapping errors.

Describing Your Methods

When preparing reports, be sure to include a description of the methodology. How was the patient sample generated? What time period was used? What were the search parameters? Were any potential respondents or data sources excluded and why? This information is essential for interpreting the results accurately.

Failure to provide sufficient detail when you report data to the practice team can make the data difficult to interpret and validate. Providing too much detail, on the other hand, can bury the team in information and make it difficult for them to make inferences based on the data (Gregory, et al., 2008). For each performance metric, you should clearly describe the methods you used to obtain the data, the exclusion and inclusion criteria, and the denominators and numerators used to generate percentages. Part of your job as a facilitator is to help practices organize their performance data so that it can be easily understood and so that it is actionable.

Displaying Data

A picture paints a thousand words and nowhere is this truer than in presenting performance data. Graphic displays of the data are extremely effective in reporting data to the QI team. Visuals allow people to absorb large amounts of data quickly. Spreadsheets can be programmed to generate visual displays of key system and clinical performance data quickly and efficiently, which can make generating performance reports easier for both you and your practices. Ideally, you will be able to work with the information technology (IT) manager at the practice to build reporting processes and templates through information funneled from the EHR, registry, and practice management systems.

When developing reports, you should include both raw numbers and percentages on the graphic whenever possible to make them easy to interpret. Also include the total number (or N) for each summary statistic. Make sure that values are clearly labeled and legends provided. Data are most compelling when mapped over time through the use of trend lines. QI teams can use these data displays to monitor progress over time and make decisions about QI priorities, training for staff, and revision of processes based on these cumulative data.

A number of applications now exist to help you and your practices generate compelling displays from raw data. These systems take raw data and generate graphic displays such as bar graphs and pie charts and can be used to generate reports on clinical performance. Systems like Crystal Reports require some heavy programming up front but are often used by larger practices to help with this process. A number of new applications are now available under the category of "business analytics" that require less upfront programming and may be useful to you and your practices for these tasks. As a PF, you will want to be familiar with some of these programs and their capabilities as potential resources for your practices to consider as they build their performance reporting capabilities.

Different graphics are effective for presenting different types of data. Data that represent a single point in time can be presented using static displays such as bar graphs and pie charts. Data from multiple time points designed to track trends or changes over time are best displayed in more dynamic formats such as run charts. When possible, use graphics to make the data more accessible to your practices.

Helping Practices Reflect and Act on Data

Many if not most times, practices' information systems contain errors. Errors mapping data entered into an EHR to the database variables are frequent. Expect clinicians and other members of the practice to question the data you present to them. When this happens, it is important that you listen carefully to their discussion of the errors that they believe exist in the data. You will then work with clinicians and often their IT staff to correct these errors and the corresponding performance data. It is not unusual for a practice facilitator to spend a considerable amount of time during the early stages of working with a practice correcting mapping errors in EHRs and other data systems.

Once you have helped the practice correct these errors and can present the corrected data again, you will be able to engage members of the practice in a productive discussion of the findings. Often clinicians and staff believe that they are performing better than they actually are, so the data you present are likely to stimulate robust discussion. It is important that you not become defensive or take challenges from practice members as a personal attack. Instead, it can be helpful to see yourself as an "ally" in helping them to acquire, reflect on, and use these data to help them improve performance.

When presenting performance data to a practice for the first time, it can help to enlist a leader from the practice as the main presenter, or as a co-presenter with you. It can also help to come prepared with a series of questions designed to help members of the practice reflect on the data. Some useful questions to ask include:

- How accurately do you believe these data reflect your practice?
- Are there problems with the data that should be considered or corrected before use? What findings did you expect?
- What findings were a surprise?
- What do these data suggest to you regarding setting goals for improvement at your practice and prioritizing these goals?

Note: this module is based on Module 9 of the Practice Facilitation Handbook. Available at: http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/

Reference

Gregory B, Van Horn C, Kaprielian VS. Eight steps to a chart audit for quality—a simple chart review can help your group answer the question on everyone's mind: "How are we doing?" Fam Pract Manag 2008 Jul-Aug;15(7):A3-A8. Available at: http://www.aafp.org/fpm/2008/0700/pa3.html. Accessed July 16, 2015.

Primary Care Practice Facilitation Curriculum

Module 16. Academic Detailing as a Quality Improvement Tool

Prepared for:
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services
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Contract No. HHSA2902009000191-Task Order No.6

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Who Should Participate? 5
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Module 16. Academic Detailing as a Quality Improvement Tool

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- General skills in conducting an academic detailing session
- Cultural competency for communicating effectively at all levels

Time

- Pre-session preparation for learners: 40 minutes
- Session: 50 minutes

Objectives

After completing this module, learners will be able to:

1. Define academic detailing and its purpose in a quality improvement intervention.
2. Become familiar with the content of the *Introductory Guide to Academic Detailing* and the National Resource Center for Academic Detailing (http://www.narcad.org/) as resources.

Exercises and Activities To Complete Before and During the Session

Pre-session preparation. Ask the learners to review information in the following: (40 minutes)

1. The content of this module.
2. Farrell S, Fischer M, Avorn J, et al. Introductory guide to academic detailing. Boston, MA: National Resource Center for Academic Detailing and Alosa Foundation; 2011. Available at http://www.narcad.org/wp-content/uploads/2010/12/Academic-Detailing-Guide.pdf

During the session. Presentation (20 minutes)

1. Present key concepts from the module.
2. Highlight key points from Introductory Guide to Academic Detailing.

Discussion. Ask questions and explore answers with learners (30 minutes)

1. What experience have you had working with an academic detailer? What did you learn from this experience?
2. When would you want to bring in an academic detailer to work with a practice? What would you see your role being during an academic detailer's visit?
3. What were the three most important "takeaways" for you from the reading?

Module 16.

Academic detailing is peer-to-peer educational outreach. Academic detailing has its roots in pharmaceutical detailing, which was designed to improve prescribing practices by physicians. The peer-to-peer format of these commercially oriented encounters has now been adapted for use to improve care quality, as well as to build priority for change in clinicians and leadership.

The goals of academic detailing have traditionally been to improve clinical practice in a targeted area, usually one involving patient care. The National Resource Center for Academic Detailing trains physicians interested in becoming academic detailers, and several states have implemented academic detailing programs to improve patient safety and quality of care.

Academic detailing sessions are not limited to physicians. They can involve peer-to-peer exchanges in any discipline. You may opt to convene academic detailing sessions for chief executive officers, clinical managers, nurses, medical assistants, health educators, chief financial officers, and others to support transformation work taking place at a practice. For example, an expert nurse care coordinator could deliver academic detailing support to another nurse beginning the same activity to improve his or her performance.

Why Use Academic Detailing?

Academic detailing's peer-to-peer visits can help build leadership's buy-in to proposed practice changes. Academic detailers can also help staff understand the role of practice facilitators, what facilitators can and cannot do, and how they can help practices implement changes. Practice staff are more likely to accept a message if it comes from someone with their same professional background.

At the beginning of a facilitation intervention, an academic detailer can help accelerate development of trust between the practice facilitator and the practice. An academic detailer can also serve as a role model, someone who has gone through the same process and managed to make improvements in their own practice. This shows the practice that it can be done and barriers can be overcome.

When Should You Use Academic Detailing?

You can't start too early. As noted in Module 19, an academic detailer can be an asset at the kickoff meeting. Additional academic detailing sessions can be held during the facilitation intervention as needed to support clinical and other types of changes. You can also use them when you run into roadblocks to progress. The detailer can help "shake things loose" in the practice and provide an additional perspective on the project.

Be judicious, however, in calling on your detailers. They are busy people taking time out of their own duties to help others improve quality of care. Make sure you schedule meetings at times that are convenient to them. By the same token, detailing visits should not last too long. Generally, an hour is sufficient. Although an in-person visit is preferable, consider telephone or video conferencing as an alternative, especially if it is for later visits.

How Do You Identify and Prepare Academic Detailers?

You will need to identify physicians and others willing to serve as academic detailers for your practices. An ideal detailer will:

- have experience in the changes you will be supporting at the practice
- have experience working with a practice facilitator
- have experience being a detailer
- be approachable
- be a clear communicator with effective educational techniques
- have credibility in the community
- be an innovative thinker
- be empathetic

If you cannot find a detailer to fit the bill, try asking:

- your program director
- other facilitators—find out with whom they work
- the practices you facilitate—find out whom they look up to
- professional associations

You can also keep an eye out for speakers at conferences or webinars. Even if you don't need a particular area of expertise, keep track of skilled speakers for future reference.

In addition, because so many practice changes require coordinated work of the teams within the practice, from the person who schedules patient visits to the care coordinator at the end of the visit, you will want to make sure that the detailers you engage are prepared to incorporate working with teams into their detailing work.

Before they meet with the practice, brief your detailers on the practice and its goals for facilitation and quality improvement. If your detailer has not been trained and has not been a detailer before, provide him or her some guidance before the first encounter. Ask your detailer to:

- prepare a few key messages before the session.
- tell stories. Paint a picture of what it was like in his or her practice.
- be open to questions.
- be honest. Don't minimize the challenges, but show the practice how they can be overcome.
- be patient. Sometimes it takes practices a while to figure out what they want to know.

Who Should Participate?

Ideally, the visit takes place with the quality improvement team. At times, however, only a single member or a few members of practice staff will meet with the detailer. This is most appropriate when the detailer is an expert in a specific process that only involves a few individuals in the practice.

What Is the Facilitator's Role?

Once you identify an academic detailer, ask the leader of the quality improvement team to convene the team to participate in the session. You will facilitate the meeting. Regardless of the detailer's degree or experience, remember that you are the head of the facilitation team and the primary point of contact with the practice. The work you request from the detailer should support the work in which you are already engaged or are preparing to engage with the practice.

Shortly after the detailer's visit, debrief with the practice. Find out what they learned and how they might apply this new knowledge to their practice. Expect to hear, "We can't do that here." Help them think through adaptations that would make it work. Focus them on the assets of their practice and encourage them to think outside the box.

In summary, consider using the following steps in working with an academic detailer:

1. Identify the detailer.
2. Orient the detailer to the improvement project and goals and his or her role in peer-to-peer exchange to create practice buy-in and increase knowledge.
3. Decide who from the practice should participate in an academic detailing visit.
4. Remain the point person or primary point of contact with the practice.
5. Listen to the practice's encounters with the detailer and help translate learning and ideas into practice in partnership with the practice's quality improvement team.

Note: this module is based on Module 10 of the Practice Facilitation Handbook. Available at http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/

Primary Care Practice Facilitation Curriculum

Module 17. Introducing a Practice to Facilitation

Prepared for:
Agency for Healthcare Research and Quality
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Module 17. Introducing a Practice to Facilitation

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Knowledge of practice facilitation
- Cultural competency for communicating effectively at all levels
- Professional competency in transparency

Time

- Pre-session preparation for learners: 75 minutes
- Session**:** 60 minutes

Objectives

After completing this module, learners will be able to:

1. Give a succinct description or "elevator speech" that explains practice facilitation.
2. Tell two stories that illustrate the activities of facilitators in practices.

Exercises and Activities To Complete Before and During the Session

Pre-session preparation. Ask the learners to review information in items 1 and 3 and complete the activity in item 2 (75 minutes)

1. The content of the module.
2. Have learners draft two short stories illustrating facilitator activities in practices that are appropriate for use in explaining facilitation to practices and be prepared to share with others during the session.
3. Video on practice enhancement assistants (practice facilitators) at https://www.youtube.com/watch?v=k5hDkEYm2XI

During the session. Presentation (30 minutes)

1. Present key concepts from the module.
2. Ask learners to develop a two- to four-minute "elevator speech" that describes what practice facilitation is for use with their practices. In pairs, have learners role-play their elevator speeches and stories with each other.

Discussion. Ask questions and explore answers with learners (30 minutes)

1. What did you learn from this exercise?
2. How will you use this information with your practices?

After the session. Review the resources at the end of the module for additional information on practice facilitation (optional)

Module 17.

A very important early step in starting a facilitation intervention is teaching your practice how to work effectively with you. Practices sometimes comment, "I wish I had understood sooner how to use the practice facilitator." The practice facilitator can help with many things, but often it is only toward the end of facilitation that practices really understand what a practice facilitator does or is. As best as possible, you should try to make sure that the practice has a good understanding of the purpose and functions of a practice facilitator.

> "I wish I had understood sooner how to use the practice facilitator."
>
> —*Community Health Center in Southern California*

Understand Facilitation Versus Consultation

Most practices are used to working with consultants who are brought in to solve a specific problem or provide expertise in a very focused area. Practice facilitators are different from consultants. You provide more generalized support to a practice, aimed at building the practice's overall capacity for change. This is not to say that you are not also providing specialized support to introduce new processes of care associated with a specific project. But the range of support is much broader than a typical consultant.

For example, you might help a practice develop workflows to support team-based care or help optimize health information systems after they have been implemented to support population management. Or you might help a practice find another practice that is using group visits and set up a site visit with them or train the quality improvement (QI) team in workflow analysis and performance reporting.

Unlike consultants, practice facilitators expect to form a long-term relationship with a practice and support ongoing QI work at the practice. Also unlike consultants, practice facilitators focus on introducing a culture of continuous QI and learning in the practice. They also help build the internal capacity of the staff to develop positive attitudes toward ongoing and sustainable changes.

Teach the Practice How To Work With You

The practice is unlikely to know how to use or work with you unless you teach them. Several strategies are effective for helping practices understand how to work with you:

- Ask about their understanding of what facilitators do and prior experience with facilitators.
- Provide fact sheets on your practice facilitation services.
- Tell stories about the work you've done with other practices.
- Describe the skill sets of other facilitators on your team who could be brought in to help.
- Have an academic detailer talk about how to work effectively with a practice facilitator.

Keep Leadership Aware of Your Work

Practice leadership can be influential in making sure the practice is getting the most of out of facilitation, but to wield their influence they have to remain engaged. Clinical and administrative directors are extremely busy. You may think they remember what you are doing and are aware of any progress that is being made, but often they will have forgotten. It is essential that you check in with leadership regularly and often.

You cannot rely on members of the QI team to keep leadership informed. This is not the time to be shy. These checks-ins can be in person, by phone, or electronic. A combination of in-person and email updates, such as a weekly email and a monthly in-person meeting, is effective. Emails should be short and to the point and draw attention to any items that require action. In-person meetings are essential to allow practice leadership to respond to the improvement and request changes.

> Keep people at multiple levels of the practice informed and engaged.

A short progress report each month in the form of a performance data display can be a useful way to keep key players in the loop. Another good way to keep people at multiple levels of the practice informed and engaged is through project management software. This software is available through subscription and can be used to update the practice QI team, practice leadership, and facilitation team. The software can generate many kinds of output such as reports and notifications on pending and completed tasks.

A critical part of any change or transformation is the "narrative" that people develop around the project. This narrative—that is, the stories people tell about the work that is going on—is what they will eventually use to judge the success of the effort. Your communications with the practice should help develop a "story" about the improvement work at the practice and your role in it, continually reminding the practice about the ways you can help them move forward.

Note: this module is based on Module 11 of the Practice Facilitation Handbook. Available at http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/

Resources

Geonnotti K, Taylor EF, Peikes D, Schottenfeld L, Burak H, McNellis R, Genevro J. Engaging Primary Care Practices in Quality Improvement: Strategies for Practice Facilitators. AHRQ Publication No. 15-0015-EF. Rockville, MD: Agency for Healthcare Research and Quality. March 2015. Available at http://www.pcmh.ahrq.gov/page/engaging-primary-care-practices-quality-improvement-strategies-practice-facilitators

Grumbach K, Bainbridge E, Bodenheimer T. Facilitating Improvement in Primary Care: The Promise of Practice Coaching. New York: The Commonwealth Fund; June 2012. Available at http://www.commonwealthfund.org/Publications/Issue-Briefs/2012/Jun/Facilitating-Improvement-in-Primary-Care.aspx

Van Borkulo N, Coleman K. A Practice Facilitator's Guide to Visiting Clinical Teams. 1st ed. Safety Net Medical Home Initiative. Qualis Health and the MacColl Center for Health Care Innovation; Seattle, WA: February 2011. Available at http://www.safetynetmedicalhome.org/sites/default/files/Facilitator-Guide-Site-Visit.pdf

Primary Care Practice Facilitation Curriculum

Module 18. Assessing Practice Readiness for Change

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Agency for Healthcare Research and Quality
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Rockville, MD 20850
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Module 18. Assessing Practice Readiness for Change

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Assessing practice readiness for change
- Basic skills in quality improvement and coaching

Time

- Pre-session preparation for learners: 40 minutes
- Session: 50 minutes

Objectives

After completing this module, learners will be able to:

1. Identify four factors experts believe are associated with practice readiness to engage in facilitated improvement.
2. Use a formal or informal readiness assessment with a practice.

Exercises and Activities To Complete Before and During the Session

Pre-session preparation. Ask the learners to review the following. (40 minutes)

1. The content of this module.
2. The Practice Improvement Capacity Rating Scale, available at http://www.rwjf.org/en/library/research/2014/01/practice-improvement-capacity-rating-scale.html
3. Geonnotti K, Taylor EF, Peikes D, Schottenfeld L, Burak H, McNellis R, Genevro J. Engaging Primary Care Practices in Quality Improvement: Strategies for Practice Facilitators. AHRQ Publication No. 15-0015-EF. Rockville, MD: Agency for Healthcare Research and Quality. March 2015. Available at http://www.pcmh.ahrq.gov/page/engaging-primary-care-practices-quality-improvement-strategies-practice-facilitators

During the session. Presentation (15 minutes)

1. Present key concepts from the module.

Read. (15 minutes)

1. Have learners read the fictional case example in Module 12 Appendix C and use the practice assessment in the appendix to this module to answer the discussion questions.

Discussion. Ask questions and explore answers with learners. (20 minutes)

1. Is this practice ready for facilitation? Why or why not?
2. What additional information might you want on this practice to determine readiness for facilitation?
3. What strengths or assets could you leverage in your work with this practice? What factors might be challenges? What should you look out for when you reassess readiness at the 3-month mark?

Module 18.

Practice facilitation is a scarce resource and it is important to make careful and informed decisions about where to direct it. It is important to avoid spending valuable facilitation time attempting to facilitate change in a practice that is not ready or able to benefit from the support. This is not only a waste of a valuable resource, but also frustrating to both the practice facilitator and the practice (Knox, 2010; Knox, et al., 2011).

Focus on practices that are most likely to benefit from facilitation.

Figure 18.1 presents a model that can be used to triage facilitation resources. It reflects the view of some PF experts that resources should focus on practices most likely to benefit from facilitation.

Two categories of practices might receive little benefit from practice facilitation: those operating in "survival mode" that cannot effectively implement any of the strategies the practice facilitator suggests and those already functioning very effectively that have fewer opportunities for improvement. The latter group, however, is a valuable resource as a supply of role models and professional mentors to practices undertaking improvement work and as a source of "best practices" to spread. The two remaining levels, functioning practices and low-functioning practices, are most likely to benefit from practice improvement facilitation and are the likely audience for your work.

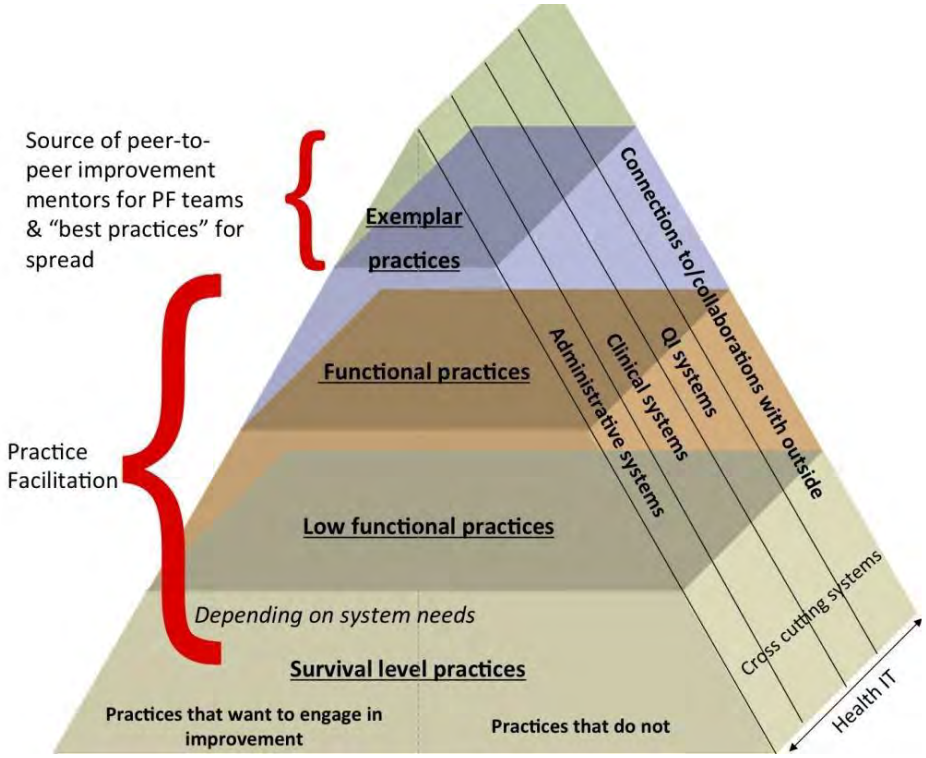

Figure 18.1. Model for triaging allocation of practice facilitation resources
Source: Knox L, 2010

You might not want to follow the triage model in some cases. For example, in a rural community with few primary care providers, it may be critically important to shore up and support whatever practices are in the area, even if they are so preoccupied with daily operations that it is difficult to engage them in improvement activities. Because they lack the basic administrative and clinical systems needed to function effectively, the form and expectations of facilitation efforts will have to be different with these practices.

Conducting an assessment of a practice's readiness for facilitated improvement work is an important first step when enrolling practices in an intervention. Readiness assessment is an inexact process, and at this point, somewhat informal. It is helpful to talk to other practice facilitators and to your program supervisor as you begin to assess practice readiness, especially if you have limited experience working with practices at this time.

Initial Readiness Assessment

Determining a practice's readiness to implement an intervention is a critical first step to beginning facilitation. Several assessment tools are available to help you in assessing practice readiness. The Practice Improvement Capacity Rating Scale—developed as part of the Robert Wood Johnson Foundation's Aligning Forces for Quality Initiative—is a useful resource for this purpose. It is available at http://www.rwjf.org/en/library/research/2014/01/practice-improvement-capacity-rating-scale.html.

In addition, Figure 18.2 contains an informal list of criteria that participants in the 2010 AHRQ Practice Facilitation Consensus Meeting found useful for assessing a practice's readiness to undertake improvement work with a practice facilitator (Knox, 2010).

Figure 18.2. Checklist for assessing practice readiness

- ❑ Practice or organizational leadership is interested in specific or general improvement as evidenced by request for assistance or receptivity to receiving facilitation to support improvement.
- ❑ Practice or organizational leadership is willing to participate in ongoing communication with the practice facilitator and participate on the quality improvement team.
- ❑ Practice or organization is willing and able to identify an improvement champion who will be the practice facilitator's point person.
- ❑ Leadership is willing to provide protected time for key staff to engage in improvement work.
- ❑ Team members are willing to meet regularly as a quality improvement team, and members follow through.
- ❑ Team members are willing to gather and report data on practice performance on key metrics.
- ❑ Practice has sufficient organizational and financial stability to avoid becoming too distracted or overwhelmed by competing demands or financial concerns.
- ❑ Practice is not engaged in other large-scale improvement projects and does not have other demanding competing priorities.

The last item on the checklist evaluates practices for "improvement fatigue." Due to the many parallel improvement and transformation activities taking place in health care today, practices can be overwhelmed by change and reluctant to engage in additional improvement work. In these cases, it may be possible for the practice facilitator to integrate the other improvement projects and leverage this activity or it may be more appropriate to delay this intervention.

Practices that meet most of these basic readiness criteria are thought to show evidence of readiness for working with a facilitator on practice improvement. This does not mean that every practice meeting these criteria will be successful in a facilitated improvement intervention, nor does it mean that practices that do not meet these criteria will fail. These criteria simply provide a starting point for thinking about the readiness of practices interested in engaging in improvement work with a facilitator. For more information on a readiness assessment tool, refer to the Module 24 Instructor's Guide.

Three-Month "Real-Time" Readiness Assessment

Practices that appear "ready" and are enrolled in the intervention should be reassessed at 3 months to confirm readiness. In addition to items on the Checklist for Assessing Practice Readiness, this assessment should consider the following:

- Attendance at project meetings, including leadership presence at kickoff and initial meetings
- Progress in developing quality improvement plans
- Follow-through on action items

As a practice facilitator, you have several possible courses of action for practices that do not meet readiness criteria at 3 months:

- Continue the intervention. As the practice builds its relationship with you and as you create priority for improvement in practice leadership and build the practice's capacity for improvement, their engagement in the improvement process will increase.
- Consider stepping back from active intervention with the practice until a time when they are better prepared to engage.
- Ramp up the intensity of the intervention. This is often done by bringing in an academic detailer (i.e., peer support) to help problem solve and create buy-in among practice leaders.

You will need to discuss these options with your supervisor or fellow practice facilitators before making a decision.

Note: this module is based on Module 12 of the Practice Facilitation Handbook. Available at http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/

References

Geonnotti K, Taylor EF, Peikes D, Schottenfeld L, Burak H, McNellis R, Genevro J. Engaging Primary Care Practices in Quality Improvement: Strategies for Practice Facilitators. AHRQ Publication No. 15-0015-EF. Rockville, MD: Agency for Healthcare Research and Quality. March 2015. Available at http://www.pcmh.ahrq.gov/page/engaging-primary-care-practices-quality-improvement-strategies-practice-facilitators

Knox, L, ed. Report on the AHRQ 2010 consensus meeting on practice facilitation for primary care improvement. (Prepared by LA Net through a subcontract with the University of Minnesota under Contract No. HHSA290200710010 TO 3.) Rockville, MD: Agency for Healthcare Research and Quality; 2010.

Knox L, Taylor EF, Geonnotti K, et al. Developing and running a primary care practice facilitation program: a how-to guide. (Prepared by Mathematica Policy Research under Contract No. HHSA2902009000191 TO 5). Rockville, MD: Agency for Healthcare Research and Quality; December 2011. AHRQ Publication No. 12-0011. Available at http://pcmh.ahrq.gov/sites/default/files/attachments/Developing_and_Running_a_Primary_Care_Practice_Facilitation_Program.pdf

Primary Care Practice Facilitation Curriculum

Module 19. Conducting a Kickoff Meeting

Prepared for:
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Module 19. Conducting a Kickoff Meeting

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Basic skills in professional behavior with people, project, and meeting management

Time

- Pre-session preparation for learners: 10 minutes
- Session**:** 60 minutes

Objectives

After completing this module, learners will be able to:

1. Understand the purpose of a kickoff meeting.
2. Facilitate an effective kickoff meeting.

Exercises and Activities To Complete Before and After the Session

Pre-session preparation. Ask the learners to review information in item 1. (10 minutes)

1. The content of this module.

During the session. Presentation (15 minutes)

1. Present key concepts from the module.

Discussion. Ask questions and explore answers with learners. (15 minutes)

1. What is the purpose of a kickoff meeting?
2. What is the role of the facilitator?

Activity for learners (30 minutes)

1. Divide into groups of three and conduct a "mock kickoff" session.
2. Designate one person the practice facilitator, one the practice staff, and one the observer.
3. Have each triad report to the entire group about "lessons learned" from the mock kickoff session.

Module 19.

A kickoff meeting is an important part of initiating an improvement project at a practice. It symbolizes a formal start to the project, creates a deadline for the practice to pull together an initial quality improvement (QI) team (see Module 20), and gives you an additional opportunity to educate staff and clinicians about your role as a practice facilitator (PF).

This module is designed to assist PFs in conducting a kickoff meeting. More information on running effective meetings in general and building practice capacity in this area is available in Module 22.

A kickoff meeting for a practice facilitation should involve the practice leadership, your "practice champion," and the QI team for the practice. It is important to note that this is not an "all-practice" meeting. It is only for those that will be helping to lead the improvement work. This is not to say that other staff and clinical members won't be added to this leadership group as the project evolves and you and the core team identify other key personnel who should be involved. But for now, the focus should be on the initial group of staff that will be leading the effort.

The goal of the practice facilitation kickoff meeting is to introduce the QI team and practice leadership to the resource of "practice facilitation," identify the core practice team that you will be working with, confirm their participation in the improvement effort, and identify their initial priorities and goals for the work you will do together. When the facilitated improvement work is part of an externally funded project, this is a time to introduce the requirements of the externally funded project and to discuss the commitments and priorities of the practice and the funders. More information on working with leaders and practices to set priorities and goals is also provided in Module 21.

This kickoff meeting also provides an opportunity to conduct an initial training with the QI team on the content of the improvement project if the focus of the work is already defined, for example improving asthma care. When appropriate, you can incorporate informal academic detailing into the first session to help build enthusiasm among clinicians and jumpstart the project. You can do this by including a physician in the meeting who has already completed the improvement work in his or her own practice and who can share experiences with the others. This individual can serve as a co-presenter with you at the meeting as well as a member of the facilitation team for the practice. Module 16 provides more information on working with academic detailers and resources for identifying detailers in your area.

Also at this meeting, you will want to collect administrative paperwork from the practice. For example, your program may require informal or formal agreements with the practice, as well as other administrative documentation such as data use agreements or business associate agreements.

Meeting Logistics

You will be responsible for scheduling the kickoff meeting, which should occur at the practice or a nearby location and last about 60 minutes. Whenever possible, the meeting should be conducted in person. If you are facilitating from a remote location, you may want to conduct some initial pre-work by phone and then schedule an in-person kickoff meeting.

One of the challenges of coordinating the kickoff meeting is scheduling a day and time to meet. Consider the schedules of all potential attendees, including other facilitators, the academic detailer, practice leadership, and the QI team members. A number of online scheduling resources can help you gather information on all participants' availability and set up the meeting.

Meeting Agenda

Don't try to cover too much information at the kickoff meeting. If your facilitation is focused on a particular improvement project, such as implementing the Care Model or the Patient-Centered Medical Home, you can give a brief overview of the project (see Module 24). If you are bringing an academic detailer, provide enough time for the detailer to share experiences with facilitation and its impact on his or her practice and patients.

You should give an overview of the goals of the facilitation intervention and your role and function as facilitator. Make sure that the practice members have the opportunity to ask questions and encourage them to identify some preliminary goals for the upcoming intervention. You may need to reserve time to attend to some paperwork, such as executing a memorandum of understanding (MOU) or a business associate agreement (BAA), for sharing protected health information. This can be completed at the end of the meeting. A sample agenda of the kickoff meeting is provided in Table 19.1.

Table 19.1. Sample agenda for kickoff meeting

12:00-12:10	Welcome and Introductions Goals of meeting
12:10-12:30	Review of key elements of the facilitation intervention Academic detailer presents experiences with facilitation or with implementing the target changes in his/her practice and presents the case for change (goal is to build support for prioritizing improvement activities)
12:30-12:40	Confirmation of practice's intent to participate and initial goal setting for intervention
12:40-12:50	Review of roles and expectations for practice facilitator and practice during intervention
12:50-1:00	Review and completion of administrative paperwork (business associate agreement, memorandum of understanding, and other documents as relevant, such as a Federalwide Assurance for the protection of human subjects if research is being conducted as part of the facilitation) intervention)

Note: this module is based on Module 13 of the Practice Facilitation Handbook. Available at http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/

Primary Care Practice Facilitation Curriculum

Module 20. Creating Quality Improvement Teams and QI Plans

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Module 20. Creating Quality Improvement Teams and QI Plans

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Basic coaching skills in quality improvement (QI) methods and change management
- Cultural competency in primary care practice

Time

- Pre-session preparation for learners: 90 minutes
- Session: 120 minutes (30 minutes optional)

Objectives

After completing this module, learners will be able to:

1. Identify the main elements of a QI plan for a primary care practice.
2. Create a practice-level key driver model.
3. Use the QI Plan Generator with a practice to help them create a preliminary QI plan for their practice.

Exercises and Activities To Complete Before and During the Session

Pre-session preparation. Ask the learners to review information in items 1-2. (90 minutes)

1. The content of this module.
2. Developing and Implementing a QI Plan. Health Resources and Services Administration; April 2011. Available at: http://www.hrsa.gov/quality/toolbox/methodology/developingandimplementingaqiplan/index.html.

During the session. Presentation (30 minutes)

1. Present key concepts from the module.
2. Present key concepts from Developing and Implementing a QI Plan.

Discussion. Ask questions and explore answers with learners. (15 minutes)

1. What are your experiences developing QI plans for organizations and your lessons learned?
2. What are the key take-home points from HRSA's Developing and Implementing a QI Plan and this Module about developing a QI plan and program that you can use with your practices?
3. What is a key driver model, and why can it be helpful to you in your work with practices?

Activity for learners (30 minutes)

1. Divide into pairs or small groups. Assign roles: Practice Facilitator and Participant(s) (optional).
2. Ask learners to create a practice-level key driver model for the WeServeEveryone Clinic (see Appendix), which is interested in improving diabetes care.
3. Have the Practice Facilitator "facilitate" the process.

Activity for learners—optional (30 minutes)

1. Still in pairs or small groups, create a draft QI plan for the WeServeEveryone Clinic using the QI Plan Generator (see Appendix).
2. Have the Practice Facilitator "facilitate" the process.

Discussion. Ask question and explore answers with learners. (15 minutes)

1. What did you learn from the previous exercise(s)?

Module 20.

Forming a Quality Improvement Team at a Practice

Improvement work invariably involves work across multiple systems and disciplines within a practice. The quality improvement (QI) team or committee is the group of individuals within a practice charged with carrying out improvement efforts. The team often reports to the organization's chief executive officer, but sometimes to another practice leader. To be effective, the team should include individuals representing all areas of the practice that will be affected by the proposed improvement, as well as patient representatives. This module covers the formation of QI teams; for more on optimizing teams, refer to Module 30, Building Teams in Primary Care. See also Module 22, Running Effective Meetings and Creating Capacity for Practices to Run Effective Meetings.

The QI team meets regularly to review performance data, identify areas in need of improvement, and carry out and monitor improvement efforts. For these activities, the teams will use a variety of QI approaches and tools, including the Model for Improvement (MFI), Plan Do Study Act (PDSA) cycles, workflow mapping, assessments, audit and feedback, benchmarking, and best practices research.

The QI team should have a clearly identified "practice champion" who is committed to the ideal and process of continuous improvement. This individual should be interested in building capacity in the practice for ongoing improvement and implementing effective processes that will enable improvement. Such processes may include gathering and reflecting on data, seeking out best practices, and engaging those individuals involved in all aspects of each process or activity. The role of the QI team champion is to ensure that the team functions effectively and fulfills its goals for the organization.

Who Should Be on a Quality Improvement Team?

The Institute for Healthcare Improvement (IHI) recommends that every QI team include at least one member who has the following roles[1]:

- **Clinical leadership.** This individual has the authority to test and implement a change and to problem solve issues that arise in this process. This individual understands how the changes will affect the clinical care process and the impact these changes may have on other parts of the organization.
- **Technical expertise.** This individual has deep knowledge of the process or area in question. A team may need several forms of technical expertise, including technical

[1] Adapted from the Institute for Healthcare Improvement. Science of Improvement: Forming the Team. Available at: http://www.ihi.org/knowledge/Pages/HowtoImprove/ScienceofImprovementFormingtheTeam.aspx.

expertise in QI processes, health information technology systems needed to support the proposed change, and specifics of the area of care affected. For example, a team implementing an intensive care management clinic for people with poorly controlled diabetes might need technical expertise in change management, the clinic's electronic health record, and the patient treatment protocols that will be used.

- **Day-to-day leadership.** This individual is the lead for the QI team and ensures completion of the team's tasks, such as data collection and analysis and change implementation. This person must work well and closely with the other members of the team and understand the full impact of the team's activities on other parts of the organization as well as the area they are targeting.
- **Project sponsorship.** This individual has executive authority and serves as the link to the QI team and the organization's senior management. Although this individual does not participate daily with the team, he or she may join meetings periodically and stays apprised of its progress. This member can assist the team in obtaining resources and overcoming barriers to implementing improvements.

The optimal size of a QI team is between five and eight individuals, although this may vary by practice. The most important requirement is not size, but diversity of the participants. The team needs a diverse group of individuals who have different roles and perspectives on the patient care or other processes under consideration. This group should include whenever possible input from the end user of health care, the patient.

Potential members of a QI team might be:

- Chief executive officer
- Medical directors
- Physicians
- Nursing staff
- Physician assistants
- Medical assistants
- Patient representatives
- Operations manager or director
- Health educators
- Community health workers
- Peer mentors
- Patients
- Community representatives
- Directors of clinical services
- Practice managers
- Medical records staff
- Receptionists
- Lab technicians

- Pharmacy or dispensary staff
- Case managers
- Physical plant operations
- Billing department staff
- Finance director

Creating a Quality Improvement Plan With a Practice

One of the first tasks for the QI team is to identify goals and associated performance metrics for its improvement work. It is useful to have preliminary performance data available for setting improvement goals whenever possible. Goals are fluid and will likely change as more information is gathered on practice performance and functioning and as the team achieves preliminary goals and is ready to move on to new ones.

Resource for Developing a QI Plan with Community Health Centers
From the National Association of Community Health Centers

Establish a Quality Management Plan:
http://www.nachc.com/client/documents/clinical/Clinical_NMD_Your_QM_Plan.pdf

Using Key Driver Models to Focus Quality Improvement Plans

Key driver models are roadmaps to particular outcomes that help focus the work of a facilitation program, and of facilitators and facilitation teams. Key drivers define the pathway to a desired transformation. Key driver models graphically display the strategies and activities needed to achieve goals and aims of the practice improvement effort (DeWalt, et al., 2010).

Facilitation programs typically use two levels of key driver models:

- one at the *programmatic level* that outlines the facilitation program's overarching goals and underlying model for change, and
- one at the *practice level*, which tailors the programmatic model to the needs and priorities of individual practices.

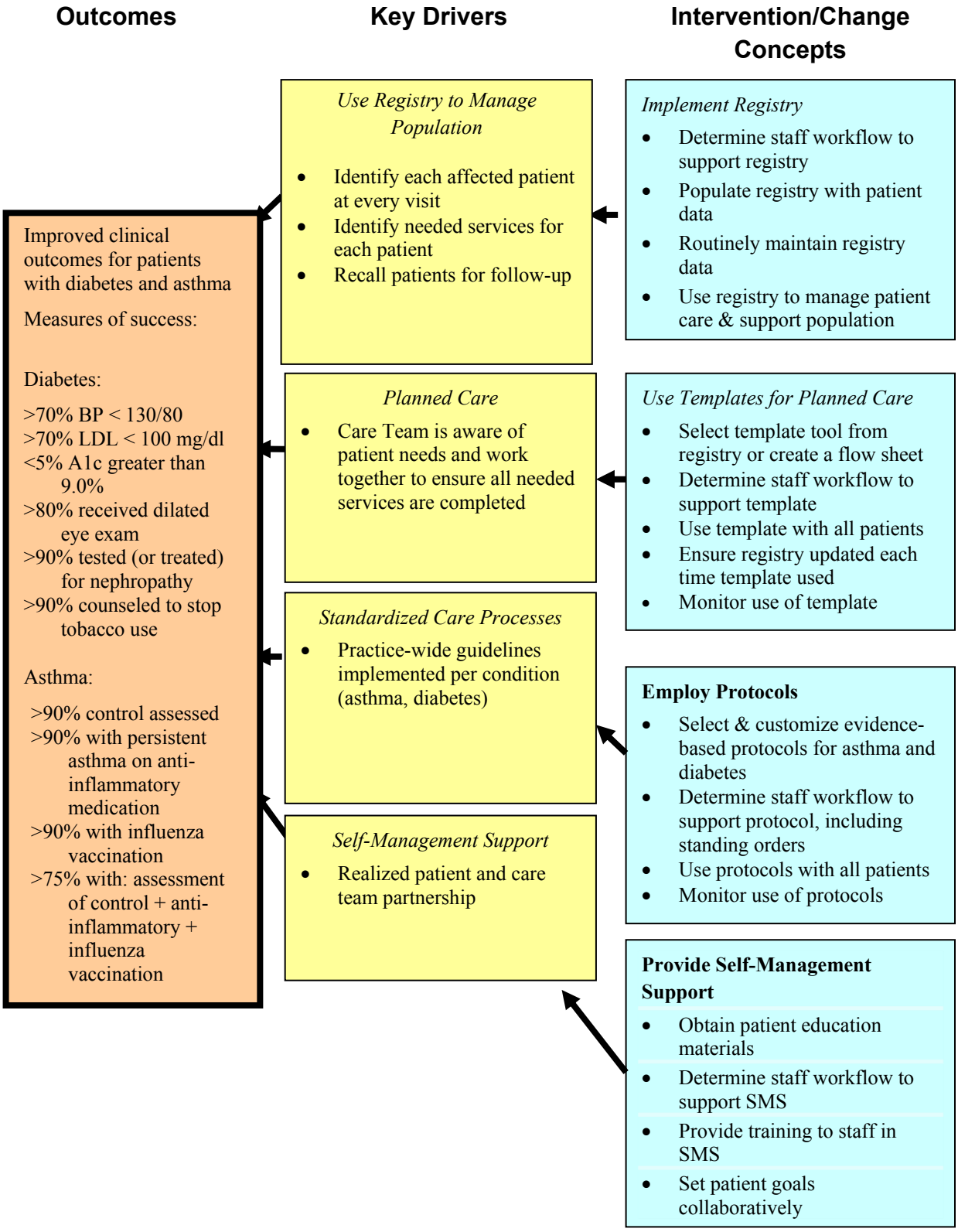
Program-level and practice-level key driver models include:

- **desired outcomes** for the practice improvement effort,
- **big changes or "key drivers"** that are most likely to accomplish these goals, and
- **specific changes or actions** that must occur to produce the desired big changes.

Example of a key driver model. Figure 20.1 shows a program-level key driver model for improving outcomes for patients with diabetes and asthma based on the Care Model (see Module 24). This key driver model was developed for the Improving Performance in Practice Initiative funded by the Robert Wood Johnson Foundation.

The far left column shows specific QI goals. The middle column contains the organizational and care processes thought to improve care and patient outcomes. These key drivers function as a menu from which practices can choose where to start to achieve their goals. The far right column contains the "change concepts" or action items/steps to implement a particular key driver.

Figure 20.1. Key driver model for Care Model implementation (sample based on Margolis et al. 2010).



Using a key driver model with a practice. Typically, your program or project funder will create the key-driver model for the facilitation intervention you will be helping to implement in your practices. You will want to review the model with the practices you are working with and get their input into it. In some instances, you will make some modifications to it based on their feedback and you will want to communicate this information to your program director and supervisor so they can continue to refine the model.

You can use the key driver model to help your practices think about the overall improvement effort, and the different processes and areas involved in achieving improved performance and outcomes. You can also use it to help practices identify areas in which they feel they need to improve and want to focus their efforts and also areas in which they believe they are excelling and might serve as exemplars for others in your practice panel. You can also use the model to help leadership and QI team members think about the sequence in which changes should be implemented. Which improvements or changes need to take place before others? What does that mean for staffing and planning the work? Which areas will require outside expertise?

In general, the QI plan for the improvement work you will be doing with the group should be based on the practice-level key driver model to reflect the change concepts included in the model. You will also want to ask the practice to identify items not represented on the key driver model that they are interested in changing and make these additions accordingly.

If your facilitation program does not have a key driver model for the change work the practice wants to do, consult the guide *Developing and Running a Primary Care Practice Facilitation Program* (Knox, et al., 2011). You will find guidance on creating a key driver model, including a couple of samples showing different forms key driver models can take.

A first step in developing a key driver model is to choose goals that are clearly defined. Goals and outcomes should be SMART:

- Specific
- Measurable
- Attainable or Achievable
- Relevant
- Time bound

When defining its change goals, the practice should include numeric targets. It is important to distinguish between goals that will be accomplished during the period you are facilitating (if it is time limited) and longer-term goals. They should be based on the results of the practice assessment and focus on the areas needing improvement.

As you work with the practice on developing its practice-level key driver model, point out materials and resources to support the improvement activities and tasks associated with each key driver. For example, the *Integrating Chronic Care and Business Strategies in the Safety Net Toolkit* (AHRQ, 2008) contains many tools useful to practices implementing the Care Model.

You will need to familiarize yourself with resources that you can use to support these changes in the practice.

As part of developing this plan, you will also need to help the practice establish an inventory of the resources, assets, and personnel talents that currently exist in their practice and can be leveraged to support Care Model implementation and its associated key drivers and change concepts.

Creating a Quality Improvement Plan

A practice-level QI plan should provide guidance to the practice on who will participate from the QI team, how often the group will meet, and what its goals and key activities will be. In addition, the plan should lay out the process that will be used to drive improvement in the practice, such as the MFI and PDSA cycles, how these are to be documented, and the way current and ongoing status is going to be monitored using data. Among other things, a good QI plan includes:

- A statement of the quality vision.
- A description of the program structure.
- A diverse membership for the QI team or committee.
- A meeting schedule.
- A defined process for how QI will be conducted.
- A list of improvement goals or priorities that are specific, measurable, achievable, relevant, and time bound.
- A plan for how both the plan and the goals will be evaluated.
- A plan for how performance data will be acquired and reported.

An important role you can play as a practice facilitator is to assist practices in developing a plan or to review the plan they already have. In addition to practice-level QI plans, you can also work with practice members to develop project-level plans that specify participation, methods, and goals for particular improvement projects or initiatives. The contents of these plans can mirror that of the practice-level plan but focus on the details of the specific improvement project.

Monitoring Progress on the Quality Improvement Plan

With newly formed QI teams, another role you can play is to help the team develop systems that will allow them to track progress toward their improvement goals and monitor their performance on key quality indicators. To do this, you will need to work with practice leadership and staff to set up data systems that can produce practice performance reports on key quality metrics on a monthly or quarterly basis. As much as possible, you should assist the practice to automate the development of these reports to minimize staff burden or to design the data collection process so staff can carry it out in addition to their existing duties. An elegant system that cannot be sustained is no better than having no system at all.

You will need to work with the QI team to develop a standard template for the performance report and identify the time period for reporting. You will also need to help them identify the staff needed to prepare the reports and the time they will need for this task. In addition, you will need to work with the team to revise staff job descriptions and performance evaluation to include this task. You will also need to help them train staff on these tasks.

A QI dashboard or data wall can be a useful tool for QI teams to help them track progress toward key improvement goals. QI dashboards or data walls are one- to three-page summary reports that provide a graphic summary of progress toward key process and outcome metrics. Often they include a "stoplight" system of red, yellow, and green color-coding to signal that an activity or performance metric is on track, partially off track, or having serious problems. It can be helpful to include a dashboard of progress toward the elements of the key driver model if such a model was included as part of the QI plan. In addition, it can be useful to include copies of any PDSA cycles that are underway or completed with the dashboard to enable the QI team to easily review its progress.

The performance reports will create a written record of the team's progress and help increase ownership and accountability in the QI team and the practice for follow-through on improvement work. It also can help you identify QI teams that have hit a roadblock and may need some additional assistance from an expert consultant or a facilitator with a different set of skills. You can add this expertise to your facilitation team if it is needed.

Note: this module is based on Module 14 of the Practice Facilitation Handbook. Available at: http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/

References

DeWalt D, Powell J, Mainwaring B, et al. Practice coaching program manual. Princeton, NJ: Aligning Forces for Quality (AF4Q), George Washington University Medical Center; 2010.

Integrating Chronic Care and Business Strategies in the Safety Net. AHRQ Publication No. 08-0104-EF. Rockville, MD: Agency for Healthcare Research and Quality; September 2008.

Knox L, Taylor EF, Geonnotti K, et al. Developing and Running a Primary Care Practice Facilitation Program: a How- to Guide. December 2011. AHRQ Publication No. 12-0011. Available at: http://pcmh.ahrq.gov/sites/default/files/attachments/Developing_and_Running_a_Primary_Care_Practice_Facilitation_Program.pdf. Accessed October 7, 2014.

Margolis PA, DeWalt DA, Simon JE, Horowitz S, Scoville R, Kahn N, Perelman R, Bagley B, Miles P. Designing a large-scale multilevel improvement initiative: the improving performance in practice program. J Contin Educ Health Prof. 2010 Summer;30(3):187-96. doi: 10.1002/chp.20080.

SMART Objectives. The Smart Bites Toolkit, p. 16-18. Institute of Medicine. Available at: http://www.iom.edu/About-IOM/Making-a-Difference/Community-Outreach/~/media/Files/About%20the%20IOM/SmartBites/SmartBitesToolkit.pdf. Accessed October 7, 2014.

Primary Care Practice Facilitation Curriculum

Module 21. Working With and Supporting Practice Leaders

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Module 21. Working With and Supporting Practice Leaders

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- General leadership coaching skills
- Foundational knowledge of organizational change
- Cultural competency—knowledge of organizational cultures

Time

- Pre-session preparation for learners: 1–2 hours
- Session: 60–90 minutes

Objectives

After completing this module, learners will be able to:

1. Describe leadership structures commonly found in primary care practices.
2. Describe how to keep leaders engaged in practice transformation.
3. Explain adaptive leadership concepts to practice leaders.
4. Use questions to encourage new thinking about problems.
5. Connect leaders to leadership support resources.

Exercises and Activities To Complete Before, During, and After the Session

Pre-session preparation for learners. Ask the learners to review the following information. (1–2 hours):

1. The content of the module.
2. Suchman A, Sluyter D, Williamson P. Leading Change in Healthcare: Transforming Organizations With Complexity, Positive Psychology and Relationship-centered Care. London: Radcliffe Publishing; 2011.
3. Jordan ME, Lanham HJ, Crabtree BF, et al. The role of conversation in health care interventions: enabling sensemaking and learning. *Implement Sci*. 2009;4:15. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2663543/
4. Metasysteme Coaching. Coaching questions. Available at http://www.metasysteme-coaching.eu/english/toolbox-ii-question-skills-in-coaching/
5. Leonard, I. The Art of Effective Questioning: Asking the Right Question for the Desired Result. Available at http://www.coachingforchange.com/pub10.html

During the session. Presentation (30 minutes)

1. Present key concepts from the module.

Discussion. Ask questions and explore answers with learners. (15 minutes)

1. What is your leadership style?
2. What is the leadership style of one or two of the practice leaders you have worked with?
3. What are some adaptive challenges you are encountering in your work environment?
4. What are some technical challenges you are encountering in your work environment?

Role-play. Help a leader think more clearly about an issue. (40 minutes)

- Divide learners into pairs.
- In each pair, assign one learner the role of practice facilitator (PF) and the other learner the role of practice leader.
- Ask the leaders to describe a problem they are having at their workplace or home that they would like facilitation support to address.
- Ask the PFs to use open-ended questions, appreciative inquiry, and other types of questions to help the leaders think more comprehensively about the problem. (15 minutes)
- Have learners trade roles and repeat the exercise. At the end, ask the leaders to provide additional feedback to the PFs on what worked, and what needs improvement in their interaction and presentation.
- Have pairs debrief during last 5 minutes, either with each other or the large group:
    - What did they learn from this exercise?
    - How might they use these lessons with their practices?

Module 21.

The ability to work with and support practice leaders is a core skill for practice facilitators (PFs). Any significant practice improvement efforts must involve practice leaders, and these efforts may necessitate new ways of doing things within the same clinical environment. PFs need to be skilled in engaging leaders and keeping them engaged during facilitated improvement work. In turn, leaders in health care settings need certain skills to promote change in their organizations effectively, and PFs can play a role in helping practice leaders acquire these skills.

In this module, we present information that can help you connect with and keep leaders engaged in the work you do for a practice. We also present information that you can use with practice leaders to help them expand their skills in leading change. These skills can also be useful to other members of the practice (as well as to you as you carry out your own work), so while they are presented here in the leadership module, you will want to consider where else you might apply this information. To support practice leaders in making improvements, you will need a solid understanding of the structure of practice leadership and the overall organization, the types of challenges faced in making improvements, and the most effective leadership approaches for implementing them.

Understanding Leadership Structures in Practices

As a PF, you can provide support to leaders who are working directly with a practice to produce improvements; typically, these might include the medical director, the lead physician, and the office manager. For larger practices, it is important to distinguish the work done at the level of the practice site from work at the corporate level. Generally, your activities will not include work with corporate offices and leadership in larger organizations. Most likely, PF program leaders would undertake this rather than PFs working at the practice level. However, you might work with the chief executive officer of a medium-sized practice.

To work well with practice-level leaders, it is helpful to know about their context. First, you will want to **understand how the leadership structure in the practice is organized**. This organization determines how workflow, accountability, and authority work together within a practice or health care system. It is impossible to make a sustainable change at the practice level without also making changes at the leadership level.

Leadership in small practices. Although a solo physician office or small practice may at first appear to have the simplest leadership structure, this is often not true. Limited staffing frequently results in a structure that requires significant cross-functional authority and flexible hierarchies. In many such cases, the physician performs a variety of executive tasks—frequently in a part-time role—while also maintaining a clinical practice. As a result, the office manager typically also has an important leadership role in small practices. Because the office manager is not sequestered in patient rooms for a majority of the working day, he or she may actually lead the change within the practice, supported by the vision and authority of the physician.

Leadership in multisite practices. Even in multisite or multigroup practices, the office managers often play a large role. Just as in the small practice, they may find themselves fulfilling the role of change leader, but with far greater leadership reporting requirements. In many cases, they will report to clinical leaders at the practice level and to administrative leaders functioning across sites.

Leadership in larger systems. Within larger health care systems, which may include multisite practices as well as other health care facilities, hierarchical leadership models, using a top-down, pyramid-shaped power structure, are typical. However, nonhierarchical leadership structures using a more decentralized authority structure and fewer layers of leadership have also begun to gain favor.

While the size of the organization does not dictate the leadership structure in place, **larger organizations more commonly use leadership structures with multiple layers** such as:

- A chief executive officer who has oversight for the organization and oversees its administration
- A chief financial officer who manages finances
- A chief operating officer who oversees practice operations
- A chief medical officer who oversees clinical care and clinical staff
- A chief technology or information officer who oversees information technology in the organization

In addition to the local practice-level leadership and the executive-level leadership, some organizations may have mid-level leadership, such as division heads (for example, heads of pediatric medicine, women's health, and so on).

Tips for learning a practice's leadership structure. It is critical to **review the organizational charts for your practices** and understand where your primary point of contact or change champion—the clinician or staff member responsible for the intervention work you are undertaking—resides in the leadership structure. You will need to understand to whom he or she reports, whose approval or support he or she will need to advance the quality improvement work, and who should be kept informed and engaged as you facilitate the practice.

While an organizational chart is a good place to start (if the practice has one), it may not reflect the actual leadership structure of the practice. The actual leadership structure lies in how work is determined and who actually has authority to make change. A practice's official leader(s)—those with leadership titles—are not always the ones who take on the day-to-day leadership responsibilities and get things done. You can begin to identify the de facto leadership structure in a practice through observation and by asking individuals to whom they go to get certain things done. Recognizing these informal leaders and gaining their involvement and support can be essential in your work.

Keeping Practice Leaders Engaged in Improvement Interventions

As a PF, you need to build a strong working relationship with the leaders in a practice and maintain regular communication with them—even if they prefer to delegate the day-to-day improvement work to someone else at the practice. Your ability to stay in regular communication with practice leadership is critical and should usually be considered a prerequisite for working with a practice. It is also an important indicator of practice readiness to engage in facilitated improvement.

If leadership is not willing to commit to periodic check-ins with you or your PF program, it will likely be difficult to achieve sustainable improvements at that practice. This red flag may signal the need to put your work with a practice on hold until the leadership is more available and able to engage directly with the improvement process.

Developing Relationships With Practice Leaders

To be an effective PF, you must be skilled in developing an effective working relationship with practice leaders. You will first need to **identify the leaders in a practice and then be comfortable and on point when engaging them.** Part of the skill of supporting practice and system leaders is determining their leadership style and preferred communication methods.

Schedule a kickoff meeting and be transparent about your experience and skills. Kickoff meetings can be a good place to begin relationships with practice leaders since they often attend these sessions. (See Module 19 for more information on kickoff meetings.) As you begin the relationship with a practice and its leaders, be transparent about your experience level and the types of support you can and cannot provide their practice. Being upfront about your limitations and your skills will help build trust and confidence. Misrepresenting or overstating experience will eventually erode trust and can create serious problems for the project. While the kickoff meeting is a good place to begin these discussions, you will need to continue them throughout the project.

Remember, as a PF you are not expected to have all the answers. Rather, you are supposed to have the knowledge and skills to facilitate the practice finding their own answers. You can begin the discussion by asking the leaders to clarify their vision, goals, and expectations before diving directly into what types of support they think they need (see Module 11 on Appreciative Inquiry). Only after you have allowed them to lay out their ideas should you begin to discuss with them the types of support you can offer either directly or through another member of your PF team. If you have additional prior experience in leadership or other areas that are relevant to the needs the leader outlines, you can share these as well.

Establish regular communication. Some leaders may wish to have regular meetings, while others would prefer regular "update" emails. Never underestimate the value of a handwritten note about a particular topic to a practice or system leader. Aside from formal reporting mechanisms, it is sometimes valuable to leverage "soft-touch" meeting methods, such as

"accidental" hallway encounters or touching base with leaders briefly after unrelated meetings you are both attending.

Be mindful of practice hierarchies. Be aware of practice hierarchy and avoid the appearance of going around your practice champion or jumping ranks. As a facilitator, one of your greatest tasks is to learn from your practice champion (as well as your program supervisor how, when, and why to engage the practice leader(s). Jumping ranks can undermine your relationship with this key member of the practice and potentially jeopardize your efforts at facilitating change.

Understand the motivations of practice leaders. When working with practice leaders, you will want to understand the following:

- the unique challenges and constraints each leader is facing,
- each leader's priorities for the practice, and
- each leader's style and relationship with practice staff.

You should use this information as a starting place in your work with them. This will allow you to determine what types of resources the leader might find useful. As your relationship with the practice leader develops, it may become appropriate for you to offer suggestions for different types of support and training based on your observations of the practice and the leader's approach.

Leading Change

The most common cause of failure in leadership is produced by treating adaptive problems as if they were technical problems.

(Heifetz, Grashow, and Linsky, 2009)

There are two primary types of challenges practice leaders encounter when undertaking practice improvement: technical challenges and adaptive challenges.

- *Technical challenges* have clear solutions based on technology or process engineering. An example of a technical challenge would be adding a patient registry to a practice's electronic health record. Stand-alone practice registries exist and there are experts who know how to install and populate these registries.
- *Adaptive challenges* are situations where there is no clear, technical answer. They involve issues such as changing roles, competencies, or the ways individuals talk and work together. Adaptive challenges will often require solutions created by the practice. An example would be shifting from a physician-centric approach to care to a team-based approach.

In short, technical and adaptive challenges are quite different from one another—although some issues may involve both types of challenges (Table 21.1). Because adaptive challenges may involve staff values and deeply held beliefs and loyalties, they can stimulate intense emotions. As a result, organizations may avoid addressing the adaptive aspects of an issue and focus

instead on only the technical solutions. But avoiding adaptive challenges undermines practice success—especially over the longer term. As a PF, you must be able to facilitate the solution of both types of challenges.

Table 21.1. The differences between technical and adaptive problems

Kind of Challenge	Problem Definition	Solution	Locus of Work
Technical	Clear	Clear	Leadership
Technical and adaptive	Clear	Requires learning	Leadership and stakeholders
Adaptive	Requires learning	Requires learning	Stakeholders

Note: Stakeholders are any individuals in the organization that have a role in or are impacted by the challenge. Adaptive leadership emphasizes involving all stakeholders in defining and in crafting solutions to challenges to assure an accurate understanding of the challenge, solutions that will be effective in the field, and buy-in of individuals that will be involved in implementing the solution.

Source: Heifetz R, Grashow A, Linsky M. The Practice of Adaptive Leadership: Tools and Tactics for Changing Your Organization. Boston: Cambridge Leadership Associates; 2009. Reprinted with permission.

Because adaptive challenges are often much more complex than technical ones, they typically require different leadership skills. Traditional leadership skills—which tend to be directive and authoritative—can work for well-defined problems with clear solutions, but adaptive leadership skills—which recognize the inherent complexity and "messiness" of adaptive challenges and draw on many people to make change—are often needed to make progress on the complex issues facing many practices. Practice leaders who hold conventional views of leadership may have difficulty tackling adaptive challenges if they only have traditional skills to draw on. You can help them develop adaptive leadership skills along with an appreciation of when to rely on which skill sets (traditional or adaptive). While it is important to make it clear to practice leaders that both sorts of leadership skills are needed, the key point is figuring out when to use which sort. Table 21.2 compares and contrasts traditional and adaptive leadership skills.

Table 21.2. Traditional vs. adaptive leadership skills

	Conventional View of Leadership	Complex, Adaptive Leadership
Leadership is…	A position or role of authority	An activity or behavior that can arise anywhere in a human system
Leadership flows…	In one direction: from the top-down	In all directions
Leadership is exercised…	By individuals with special leadership traits	Collectively by groups or individuals informed by the collective
Effective leadership comes from…	Accurately anticipating a predictable path to a predetermined outcome	Recognizing and influencing patterns that are present in human systems at all levels
Leadership requires…	Certainty, clear vision, and the power of persuasion and control	Willingness to embrace uncertainty, listen to all voices and take adaptive action, often in collaboration with others
Leadership creates…	Harmony and stability	Conditions that are conducive to groups moving forward, which sometimes means disrupting the habitual patterns of engagement so that groups, communities, or organizations can set the conditions for a preferred future
The purpose of leadership is to…	Fix problems and leverage opportunities to achieve goals	Enable adaptability, learning, and innovation so that groups make progress on the issues they care about, even in unpredictable and changing conditions
Leadership can make a difference through….	One large strategic intervention designed to fix a problem or achieve a goal	Recognizing emerging patterns in human systems and making meaning out of many small changes

Source: Heifetz R, Grashow A, Linsky M. The Practice of Adaptive Leadership: Tools and Tactics for Changing Your Organization. Boston: Cambridge Leadership Associates; 2009. Reprinted with permission.

Technical challenges can be addressed with traditional approaches to leadership that are directive and authoritative (that is, old style "command and control"). This involves the leader identifying the problem, identifying the solution to the problem, and then using his or her authority as a leader to implement the solution. This is also the most consistently used style within the traditional hierarchical approach to leadership commonly used in medicine: the physician in charge making most of the important decisions and directing the actions of all other staff. As a result, clinicians and practice leadership may rely heavily on this model, even for addressing

adaptive challenges. The PF must leverage such situations to bolster the organization's ability to address adaptive challenges by encouraging the leadership to engage a range of staff in the problem and potential solutions and then delegate much of the work around the problem to the lowest possible level of staff. Doing so both empowers employees (thus improving morale and loyalty) and reduces the administrative tasks that distract leaders from high-level planning and strategy.

Adaptive challenges often require a different set of leadership skills. Since there is rarely a single correct answer to adaptive challenges, leaders are not able to rely simply on authority but must use a facilitative process to achieve the optimal solution for their clinic. This may be one of the most challenging situations faced by a PF. While your training has focused specifically on developing the skills necessary to help resolve challenges and find solutions, the sustainability of the organization relies upon your ability to help guide leadership while *they* facilitate the solution. To be successful, leaders must be skilled in engaging others in finding solutions, exploring the collective knowledge of staff from all levels of the organization, and helping staff redefine their values and norms while learning new habits and roles. Traditional, hierarchical leaders may initially be uncomfortable using conflict to develop better solutions and must learn to promote a culture of curiosity and the shared search for solution, rather than a culture of compliance.

Key adaptive leadership skills include the ability to:

- De-couple individuals and their personalities from problems being experienced in the organization.
- Refocus attention on what is working and not working in the system.

These are critical skills that practice leaders must develop. As an "outsider," helping leaders develop these skills may be easier for you than it would be for practice members. A strong adaptive leader prevents personalization of problems that the organization is experiencing and encourages staff to think instead about the systems and processes within the practice that are contributing to the problem. In other words, adaptive leaders must have the mindset that, "It's not the person, it's the process."

For some leaders, adaptive leadership will require a significant shift in their thinking. Leaders often focus on individuals and their performance as the source of problems in the organization. While this is sometimes the case, such thinking can bring improvement work to a full stop. Many times, individual performance is linked to underlying processes. For example, if a care team cannot access comprehensive data on their patients, it will be difficult for them to provide proactive patient care. If the workflow for informing patients about their lab results is flawed, performance in this area will suffer. While it is sometimes true that problems are the result of a specific individual's behavior, more often than not the reasons for performance problems typically are more complex and reflect—at least in part—issues with underlying workflows and processes.

Shifting from a traditional leadership system that relies on a leader's authority and expertise is difficult. It requires leaders to stop leading by providing solutions, yet this is often the reason the individual has risen to a place of leadership. Leadership in the face of adaptive challenges requires the leader to:

- Relinquish the role of content expert and problem solver.
- Become the master of the process of engaging others in shared problem solving.

The practice leader will need to involve the collective experience and knowledge of individuals from all levels in the practice. As the PF, helping practice leaders develop these types of leadership skills will be the most frequent educational need at the leadership level.

Working With Leaders To Enhance Leadership Skills

As described earlier, there are many ways that you can engage and support practice leaders to build practice capacity for change. First, you can serve as a sounding board for practice leaders and help them think about problems by listening well and using powerful questioning (see Module 11 for more information on these methods). You can train leaders in new tools for making more effective diagnoses of the problems in their organizations. You can help them enhance their communication with staff and their leadership team. You can introduce them to strategies for using meetings to change culture (see Module 22 for more information on meetings and their role in influencing organizational culture), and you can help them enhance accountability in improvement work by providing training on making effective delegations (see the Appendix to this module for one approach to this).

Ways you can work with and support leadership in a practice include:

- Identify leadership priorities and map these to the practice's improvement work.
- In cases when leaders have delegated the project to others in the organization, keep leadership appropriately informed and engaged in the work you are undertaking.
- Train leaders in the difference between adaptive and technical challenges and the leadership skills needed to address each.
- Serve as a sounding board for leaders and use powerful questioning to help leaders think more clearly about problems and improvement.
- Coach leaders in communicating effectively with their staff about change.
- Coach leaders on running effective meetings, using meetings to change organizational culture, and encouraging the co-creation of solutions for adaptive challenges.
- Coach leaders on making effective delegations that enforce accountability.
- Connect leaders to leadership resources including executive coaching.

If I had an hour to solve a problem and my life depended on it, I would use the first 55 minutes determining the proper question to ask, for once I know the proper question, I could solve the problem in less than five minutes.

—Albert Einstein

Use change-promoting questions to help leaders think "better" about a challenge. As a PF, the questions you ask are some of your most powerful tools for supporting practice leadership. Effective, change-promoting questions can help practice leaders think more deeply about a problem and also about the process of leading their practice to a solution. The purpose of this type of questioning is not to obtain more information from the leaders, but rather to get them to think differently about the issues at hand. Change-promoting questions help leaders expand the possible solutions they are considering, reveal underlying assumptions, and stimulate creativity and curiosity (Sobel and Panas, 2012).

A variety of question types can be used. Open-ended questions are one of the best ways to get leaders to think more broadly about a problem. Open-ended questions cannot be responded to with a "yes" or "no" answer and encourage deeper thought on the part of the respondent. Closed-ended questions are also useful to help a leader hone in on a solution or make decisions. However, they must be timed effectively. If asked too soon in the discourse, they can prematurely close off thinking through all possibilities.

Use neutral questions. Neutral questions are effective in getting leaders and other practice members to open up their thinking. For example, asking "How do you feel about this?" gives them the option to identify any number of feelings. While the question still leads them to consider feelings rather than causes or solutions, it leaves the options more open. Later, after all the possibilities have been laid out, you may want to ask more leading questions that help the leader focus on particular issues or topics.

Avoid leading questions. Leading questions contain the answer in the question and encourage the respondent to provide answers consistent with the questioner's line of thought. While usually not effective in the beginning, once of the respondent has identified some new ideas, you can use leading questions to help him or her drill down into the issue more deeply. An example of a leading question would be, "Are your patient access issues related to clinic hours?" This type of question limits the respondent's field of focus.

Use simple questions. Simple questions are typically more effective than complicated ones. Complicated "double-barreled" questions that include multiple questions within the same statement are hard to remember and respond to. Moreover, they can inhibit the respondent's ability to think about the issues and explore them in an open-ended way.

Avoid negative questions. Negatively worded questions are typically ineffective. Such questions tend to focus the respondent on the barriers to effective action rather than new solutions or ideas. For example, avoid questions such as, "Why don't you just change clinic hours?"

Frame questions in a solution-oriented manner. Solution-oriented questions are often effective both in stimulating new thinking about an issue and encouraging positive thinking. "What will you change?" or "What have you not modified yet?" are examples of solution-oriented questions. Using the word "yet" creates a positive implication for future change.

Truly effective and powerful questions provoke leaders to think about their current problem in a new way. Such questions can completely change how leaders view an issue or can help them think more completely and comprehensively about it.

Consider other forms of questioning. "Ideal" and "magical" questions are another effective form of questioning. Examples include, "What is your ideal solution to this problem?" or "If you had a magic wand, what would you do?" or "If you had superhuman powers, what would you do?"

"Appreciative inquiry" is another method that encourages a practice leader to focus on and learn from previous effective action in the practice. Appreciative inquiry uses questions to help leaders identify what they did to be effective in one area that can then be applied to improve outcomes in another area of the organization (see Module 11 for more information on this approach).

Useful Questions to Use With Leaders to Help Them Think Through Challenges

- Tell me about a past experience where you made a successful change. What was happening there?
- If you had a magic wand and could do anything to solve this problem, what would you do?
- What patterns are you seeing here in your practice around this problem? Or around change?
- What are you and your staff doing to help these [good] patterns continue?
- What can we do to change these patterns?
- If you came back in 5 years after a sabbatical and this problem had been solved, what would you see? What would be different?
- What are we pretending not to know?
- We say we want this, but it keeps not happening. What gets in the way?

Using Diagnostic Tools To Understand and Solve Organizational Problems

An essential skill for any leader is the ability to accurately diagnose a problem. Adaptive leadership encourages the integration of both distance and "micro" perspectives of a problem in making the diagnosis. Heifetz calls this process taking a view "from the balcony," where the entire process can be seen, and patterns and systems are evident. Leaders must also be able to see things "from the dance floor," meaning an up-close view of the individuals, including their values, habits, patterns, and concerns, and the microprocesses involved. A leader must be adept at seeing the overall context for change as well as, where appropriate, recognizing how

individual patterns of behavior and functional and dysfunctional reactions to change contribute to the overall context (Heifetz, Grashow, and Linsky, 2009).

The first step in making an accurate diagnosis of a problem is to **clarify the definition of the actual problem and determine whether it is truly a "problem"** or merely a misinterpretation of a situation based on perspectives. Once the problem has been identified and clarified, it must be identified as an adaptive challenge, a technical challenge, or a combination of both.

While practice leaders can often tackle technical challenges with traditional leadership strengths, they frequently require assistance in developing and using the tools needed to effectively address adaptive challenges. Therefore, it is important to **determine whether a problem involves technical challenges, adaptive challenges, or both.** To identify adaptive challenges, leaders must look at areas in which there have been repeated cycles of failure. To uncover adaptive challenges that may be misidentified as technical challenges, Heifetz suggests leaders ask themselves the following questions:

Questions To Use in Better Understanding Adaptive Challenges

1. Think of a problem you have tried (and failed) to fix multiple times. What solution have you attempted to use? What story have you been telling to explain why the problem remains unfixed?
2. Identify a major challenge facing your organization. Which elements of the challenge are technical, and which are adaptive? Which are so intertwined as to be indistinguishable at first glance? Consider the relative degree of difficulty you are facing in trying to manage the technical versus the adaptive elements of the challenge you have identified.

Source: Heifetz R, Grashow A, Linsky M. The practice of adaptive leadership: tools and tactics for changing your organization. Boston: Cambridge Leadership Associates; 2009. Reprinted with permission.

Once the problem has been clarified, defined, and recognized as technical, adaptive, or both, practice leaders then must **gather information on the problem**. A quick answer frequently overlooks the underlying causes and a myriad of potential solutions. Instead of jumping to a conclusion about how to immediately address a chronic problem, it is imperative to delay judgment to gain additional knowledge and understanding of the causes and potential solutions. This can be accomplished through observation of what is and is not working from a human systems perspective. Consider the following questions:

- Where are the conflicts and the issues of power and control?
- What are the issues with values, norms, competencies, and changing roles and perspectives?
- Which of these needs to change in order to transform care?
- Which of these will be affected by the proposed technical improvements?

The inner-voice exercise as a means of information gathering. One technique for gaining a micro perspective on adaptive challenges is the inner-voice or inner dialogue exercise. (Table 21.3) Originally called the left-hand column exercise by Heifetz and team (2009), this process can be helpful when general discussions are not fruitful or devolve into conflict, or when you suspect that individuals are not comfortable sharing what they are really thinking with leadership. The exercise can help structure discussions about challenges in the practice and help participants articulate their concerns to leadership and the quality improvement team. While your ultimate goal is for the leader to develop the ability to use this tool, you will likely need to conduct the exercise the first time to allay concerns about possible retribution.

The first step in an inner-voice exercise is to ask participants to take a sheet of paper and draw a line down the middle. Ask them to write comments that others make and their own verbal responses on the right-hand side. Then ask them to write down what they were really thinking when the comment was made on the left-hand side. In hesitant or hierarchical cultural organizations, you can serve as a safe conduit for these comments. While you can ask participants who are willing to share what was said and then state their internal response, the reaction to this question will tell you a great deal about the unstated culture of the organization.

Table 21.3. Example of an inner dialogue or inner-voice table: What I thought and what was said

What I Thought	**What Was Said**
	Susan, CEO: "We need to increase revenue from the practice. I'd like to explore how we can see more patients." **Me:** "There are some things we can do to increase visits."
"Oh no. She's going to want us to shorten visit times. Our clinicians are already stressed and saying visit times are too short."	
What cannot be said: The organization is top heavy with administrators; administrative costs could be lowered to solve the problem instead of putting more pressure on my providers.	

Source: Adapted from Heifetz R, Grashow A, Linsky M. The Practice of Adaptive Leadership: Tools and Tactics for Changing Your Organization. Boston: Cambridge Leadership Associates; 2009. Reprinted with permission.

Working With Leaders To Design Solutions

Once the practice leader has gathered the big-picture (macro) and up-close (micro) perspectives and diagnosed a problem, the next step is to consider solutions. At this point, the leader can pose three questions to start the process of designing a solution:

1. Which parts (procedures, policies, workflows, staffing) of the organization must be changed?
2. Which parts of the organization must stay the same? and
3. How will we come up with creative ideas for new ways to doing things that better support patient safety, quality, and patient and staff satisfaction?[1]

In traditional leadership approaches, the practice leader might answer these questions and make the decisions. In an adaptive leadership approach, it is not a leader's job to answer these questions. Rather, the task is to have the team address these questions. If a leader imposes answers and solutions, the leader is not practicing adaptive leadership.[2]

PFs must use a myriad of tools to help the practice leader facilitate the practice reaching a solution. Once leaders have recognized and supported a solution, getting the solution in place depends on the communication style and skills of the leader. As a PF, you can be of great assistance to leaders in developing these skills.

Giving Leaders a Tool for Discussing Change

Productive conversation among leaders, staff, and clinicians is essential for change. Leaders need to know how to create opportunities for meaningful conversations about change and use those conversations to manage anxiety and change organizational culture (Jordan et al., 2009). As a PF, you can introduce leaders to methods for improving the quality of conversations in their practices.

Dialogic leadership is a method that leaders in health care organizations have found useful for promoting productive and meaningful conversations around organizational change. Developed by William Isaacs (1999a) and based on the work of family therapists David Kantor and William Lehr, dialogic leadership identifies four different roles that individuals pursue within dialogue.

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[1] Adapted from Connor M, McMorrow B, Orecchio P. The Harvard experiment: recognizing and conquering adaptive challenges. *Principal Connections* 2008;12(1):20-21.

[2] Note that it is okay to use traditional leadership for technical problems, but leaders working to develop adaptive leadership skills may need support to discourage reliance on traditional leadership techniques when addressing adaptive problems.

These are:

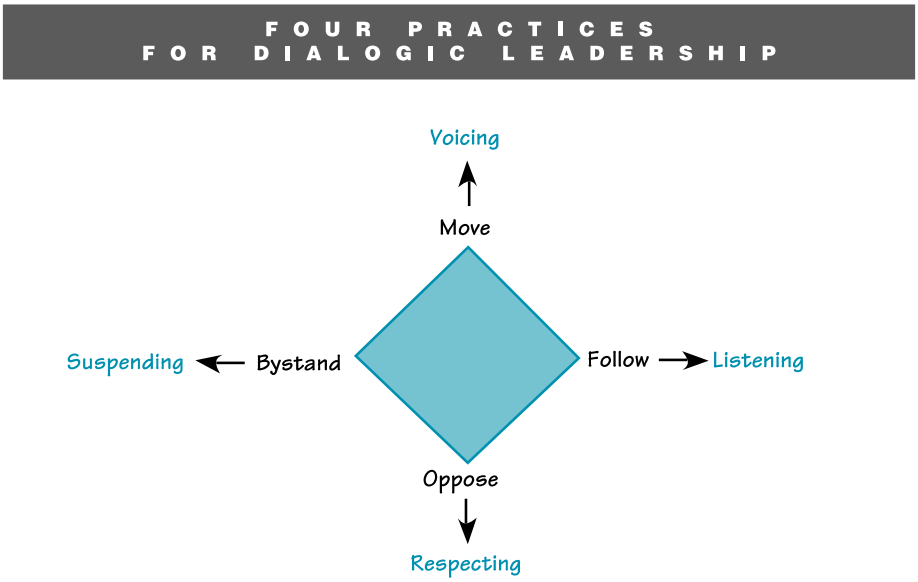
1. Move.
2. Follow.
3. Oppose.
4. Bystand.

The person who moves starts ideas and provides direction for the next steps. The individual who follows clarifies and completes ideas and supports what is being discussed. The person who opposes confronts and challenges what is being discussed and points out the problems. The individual who bystands observes what is taking place and provides perspective.

To facilitate meaningful conversation or dialogue, the leader must be skilled in welcoming and facilitating each role; the leader and group members should be aware of the roles each are assuming at different points in the conversation and in different conversations. There are four abilities that leaders need to support meaningful dialogue in their organization. These include the ability to:

1. elicit people's true voices
2. respect their positions as legitimate
3. listen deeply
4. suspend judgments and certitudes

Figure 21.1. Four practices for dialogic leadership



Four practices can enhance the quality of conversation: speaking your true voice and encouraging others to do the same; listening as a participant; respecting the coherence of others' views; and suspending your certainties.

Reproduced from: Isaacs W. (1999). Dialogue and the art of thinking together. Reprinted with permission.

Elicit people's true voices. When individuals speak with their true voice, they say what is true for them regardless of external pressures. While people often speak based on their title or role within an organization, speaking with a true voice requires them to step outside their role, suspend self-censorship, and speak what they really think about an issue. Leaders need to be skilled both in doing this and in facilitating it in others. Encouraging others to do the same enriches a conversation by bringing all voices to the table. This is a critical skill for leaders and one that is also essential when responding to adaptive challenges. To facilitate this, leaders must be able to create an environment that encourages authentic discussion. This includes encouraging dissent and a certain degree of conflict within a group. Forcing true voices within an unaccepting culture can do significant damage, so the PF must carefully observe and nourish a culture of safety and respect.

Respect their positions as legitimate. Respect is the ability to see people as "legitimate others." It enables everyone to remain open and look for the sense of what others are saying during dialogue, even if there are disagreements. To facilitate meaningful dialogue, a practice leader needs to be skilled in modeling respect for others ideas within a dialogue and facilitating this same ability among other participants in the dialogue.

Listen deeply. Listening deeply shows respect for others' ideas and thoughts. According to Isaacs, listening deeply requires being aware of our internal thoughts about what is being said and developing the ability to observe them but not act on them. To listen deeply, you must be skilled in "sticking to the facts" of what is being said and must avoid making inferences and assumptions (Isaacs, 1999a).

Suspend judgment and certitudes. This allows you to consider others' ideas. Suspending requires internal awareness that you are forming judgments about the others, plus the ability to delay or suspend these judgments for a period, thereby giving others the opportunity to have their ideas heard nonjudgmentally (Isaacs, 1999a).

Helping Leaders Engage Staff in Change

An essential skill of leadership is the ability to make effective delegations and then hold staff accountable for outcomes. A central principle of delegation is that, while authority may be delegated, ultimate responsibility is not. As a result, leaders at the beginning of their career are likely to hold decisionmaking close and may have never received formalized training in delegation or staff accountability. However, advanced skills in leadership provide a level of comfort that allows for empowerment of staff, within clear parameters, to determine and implement solutions at the appropriate level within the organization. An effective leader focuses not on simply making the decision, but instead on providing the support and knowledge required for individuals at the appropriate level to make the best decision. By doing so, leaders expand their influence and capacity to lead. As a PF, helping practice leaders develop these skills is a powerful driver of sustainability for quality improvement in the practice.

As you work with practice leaders, you may find opportunities to help them build these essential skills. Effective empowerment occurs in three stages:

1. Investment of time at the start by setting goals, identifying resources needed, and determining the acceptability and goodness of fit of the staff person making the decision.
2. Regular check-ins with the staff person and comparison of outcomes with the goals carefully defined in stage 1.
3. Handling unsuccessful delegations. This stage involves reflection on poor outcomes of the delegation, the system-level contributors to these outcomes, and a withdrawal of the delegation.

A curriculum for training practice leaders on making effective delegations is included in this module as part of the Appendix.

Summary and Conclusions

As a PF, you need to be aware that practice leadership is an essential part of your practice improvement work and will play a huge role in its ultimate success. To be effective, you need to know how to engage leaders in improvement work and how to keep them engaged in these processes long term. In addition, you can also be a direct resource to practice leadership. You can provide an introduction to new ideas about leading organizational change, serve as a sounding board to leaders by using powerful questioning, and provide training that can help them enhance leadership skills needed to guide change. Finally, you can serve as a bridge to additional resources, such as experienced executive coaching, if needed.

References

Connor M, McMorrow B, Orecchio P. The Harvard experiment: recognizing and conquering adaptive challenges. *Principal Connections* 2008;12(1):20-21.

Heifetz R, Grashow A, Linsky M. The Practice of Adaptive Leadership: Tools and Tactics for Changing Your Organization. Boston: Cambridge Leadership Associates; 2009.

Isaacs W. Dialogic leadership. *The Systems Thinker* 1999a Feb;10(1):1-5.

Isaacs W. *Dialogue: The Art of Thinking Together*. New York: Doubleday; 1999b.

Jordan ME, Lanham HJ, Crabtree BF, et al. The role of conversation in health care interventions: enabling sensemaking and learning. *Implement Sci* 2009;4(15).

Sobel A, Panus, J. *Power Questions: Build Relationships, Win New Business, and influence others.* Hoboken, NJ: Wiley & Sons; 2012.

Suchman A, Sluyter D, Williamson P. *Leading Change in Healthcare: Transforming Organizations with Complexity, Positive Psychology and Relationship-centered Care*. London: Radcliffe Publishing; 2011.

Primary Care Practice Facilitation Curriculum

Module 22. Running Effective Meetings and Creating Capacity for Practices to Run Effective Meetings

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Module 22. Running Effective Meetings and Creating Capacity for Practices to Run Effective Meetings

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Meeting management
- Change management
- Leadership coaching

Time

- Pre-session preparation for learners: 2 hours
- Session: 2 hours

Objectives

After completing this module, learners will be able to:

1. Describe how meetings can be used to change culture in a practice and the particular activities in and approaches to meetings that enable and encourage change
2. Identify four types of meetings
3. Demonstrate three elements of running effective meetings
4. Train practice leaders to run effective meetings and relationship-centered meetings

Exercises and Activities To Complete Before and During the Session

Pre-session preparation. Ask the learners to review information in items 1–3 and complete the activity listed in item 4 below. (2 hours)

1. The content of the module
2. Training curricula on relationship-centered meetings (Suchman, et al., 2011) in appendix 22 A
3. How to conduct an effective quality improvement team meeting: http://www2.aap.org/member/chapters/caqi/cqn/Projectmaterials/Tools/QITeamMeetings.pdf
4. Prepare a 10-slide presentation for practice members on running effective meetings and key concepts of relationship-centered meetings using materials from the modules.

During the session. Presentation (60 minutes)

1. Present key concepts from the module.

Activity for learners (45 minutes)

1. Ask learners to divide into groups of two or three.
2. Assign roles: practice facilitator (PF), practice members.
3. Have PF introduce and deliver training on effective meetings.
4. Ask other members of small groups to provide feedback to PF on the presentation: What was most effective? Recommendations for improving presentation if delivering to a practice?
5. Switch roles.
6. Have new PF introduce and deliver training to small groups.
7. Ask other members of small groups to provide feedback to PF on the presentation: What was most effective? Recommendations for improving presentation if delivering to a practice?

Large group discussion. Ask questions and explore answers with learners. (15 minutes)

1. Based on what you learned from this exercise and the module, what would you do differently with the meeting if you had a chance to do it over again?
2. What are three lessons you learned from this exercise that you would use with your practices?
3. The training you just completed is a type of meeting. What messages would this meeting send to the participants about the organizational culture? How would these messages support or impede formation of a culture of quality improvement in a practice?

Module 22.

Meetings are one of the primary tools that you, as a practice facilitator (PF), will use to help practices improve. Meetings are not only important for organizing improvement work but also can be used to change a practice's culture. During your work with a practice, you will participate in numerous meetings convened by the practice, by you, or by your program. These meetings can be one-on-one or with a group. They can take place in person, virtually, or a combination.

The types of meetings that PFs commonly participate in include:

- Kick-off meetings to start facilitation work at the practice (see Module 19 on Kick-off meetings)
- Quality improvement team meetings
- Meetings with practice leadership (and, in some instances, system leadership)
- Meetings with practice managers
- Whole-practice meetings
- Meetings to review performance data
- Meetings to plan and manage the Plan Do Study Act (PDSA) improvement process (for example, PDSA "huddles")
- Meetings to gather information
- Meetings to train practice members in a new skill

This module provides basic information on running effective meetings. It also describes how meetings can be used to introduce changes into practice culture. In addition, it provides resources you can use to train your practices on these topics.

Meetings as a Tool for Changing Culture

"The structure, aliveness, deadness, whisper or shout of a meeting teaches and persuades us more about the culture of our workplace than all the speeches about core values and the new culture we are striving for … What we call meetings are critical cultural passages that create an opportunity for engagement or disengagement."

—Axelrod, 2010

Meetings serve many functions. They provide a space for planning and managing the progress of a project. They offer a forum for identifying and solving problems. They can create a space to celebrate progress. They provide a way for building relationships among staff. They are a means of sharing information and communicating with others.

Meetings are also a powerful tool for defining or transforming organizational culture. A meeting leader can set the stage for teamwork beginning with the invitation list—such as, by engaging diverse members of the practice, including office staff, medical assistants, clinicians, and practice staff in discussions about the practice—and by introducing the habit of repeatedly

asking members to reflect on how specific changes, actions, and ideas might affect patient experience (Axelrod, 2010). Meetings can also be used to signal a partnership with patients by including selected patient representatives as partners in the discussions.

In your work as a PF, meetings are a primary tool for supporting change and building capacity in a practice. You can use them for many purposes, including to:

- Keep the ball moving on improvement interventions.
- Facilitate discussion among practice members about their strengths and weaknesses.
- Review performance information and define goals and design changes.
- Train staff in new skills.
- Build teamwork and buy-in.
- Model effective meeting management for practice staff.
- Change organizational culture, in partnership with practice leaders and others.

Appendix 22 A includes resources for training practice staff and leadership in an approach to meetings that can be used to promote a quality culture. The approach is grounded in theories of adaptive leadership and organizations as self-organizing systems. It encourages individuals to connect and adopt a spirit of inclusiveness and curiosity in planning, problem solving, and exchanging information. This approach to meetings can help strengthen relationships and teamwork among diverse staff and introduce a set of processes and norms that can support organizations in implementing complex changes (Suchman, et al., 2011).

Purposes of Meetings

There are four primary purposes for meetings. Understanding where each meeting you hold fits within this typology can help you set appropriate goals for a meeting and its content and methods (Bens, 2012). The four types of meetings are:

- *Information sharing.* During information-sharing meetings, groups get together to give updates, share research, and brainstorm for new ideas. Typically, no decisions are made in an information-sharing meeting.
- *Planning.* Planning meetings involve taking ideas to the next step. Participants can collaborate on goals, visions, priorities, and needs, and define next steps.
- *Problem-solving*. During problem-solving meetings, teams collaborate on developing solutions to problems within the practice. Participants gather data, identify problems, analyze the situation, and plan for action.
- *Relationship building.* This type of meeting serves as a time for people to get to know and build relationships with one another.

Empowerment of Participants

As a PF, it is important to figure out the level of empowerment a particular group has and incorporate this information into the plans for the meeting. It can be frustrating and even

demoralizing for meeting participants to be asked to engage in analyzing a problem or crafting a solution if they know that the decision has already being made elsewhere in the organization and they are simply being informed of the change.

The four levels of empowerment are as follows (Bens, 2012):

- Leadership decides and then informs staff.
- Leadership seeks input from staff before making a decision.
- Staff and clinicians decide and make recommendations to leadership.
- Staff and clinicians decide and act.

One of your roles as a PF will be to help meeting conveners in the practice become aware of these different empowerment levels and use this awareness to guide development of meeting agendas and processes.

PF Roles in Meetings

As a PF, your role in meetings will vary. Typical roles that PFs play include: convener, leader, facilitator, trainer, participant, and observer. Being clear on your role in each meeting will enable you to play the role effectively and let the practice know what to expect from you and how to engage you as a resource. It can also help you determine how to prepare for the meeting. Below we discuss these roles.

Convener. A meeting convener typically calls the meeting or session and is in charge of engaging initial participants (Bens, 2012). A PF often serves as the convener for early meetings with a practice to determine improvement needs and goals and to plan the creation of quality improvement infrastructure in practices where this is lacking. As a PF, you are also likely to be the convener for meetings to report back on the results of performance data. As an outsider to the practice, you will want to coordinate any convening with your primary point of contact in the practice to ensure that you are working in partnership with the practice and working toward building capacity within the practice rather than simply taking on these tasks yourself.

Leader. A meeting leader or chair typically oversees the focus and content of the meeting. The leader shepherds creation of the agenda—even if it is created collaboratively with other practice members—and guides the group through desired content during the course of the meeting (Bens, 2012). Although leaders have primary responsibility for the content of the meeting, in many instances, they also serve as facilitators for the meeting process. Combining these functions can be difficult, but is often necessary when no one is available to facilitate. A meeting facilitator focuses on the process of meetings. The facilitator works closely with the leader and ensures that all attendees have an opportunity to participate, helps "unstick" meetings when they get bogged down, and prevents meetings from going off on tangents (Bens, 2012).

Facilitator. PFs often assume the role of facilitator for meetings. To be an effective facilitator for meetings, you will want to become an expert in observing the process rather than the content

of a meeting. Typically, in this role, you should not contribute to the content of the meeting, as this can interfere with your ability to observe and guide the process of the meeting.

You will want to become skilled in reflecting on meeting process. For example, you will want to know how to identify and reflect on group processes that are occurring during the meeting and bring them to participants' awareness. Examples of reflective comments include statements like:

- "It seems like the group is hesitant to talk about this issue. Do you see this, too? What do you think is creating this hesitation?"
- "I notice that the physicians have been doing most of the talking today so far. For meetings to be the most effective, we want to hear from everybody. Sally (the medical assistant in the group) what are your thoughts about the ideas being discussed?"
- "Tom, I hear how concerned you are about the patient wait times. This is a very important issue that the group needs to discuss and I am glad you are bringing it forward. The agenda today is focused on improving the reports we are generating from the EHR. Can we put patient wait times in the parking lot for today, and the QI chair and I will touch base with you after the meeting to set up a different meeting time to discuss it?"

You should be skilled in managing individuals who may dominate a session, and encouraging participation from quiet members or those with lower professional status who may be afraid to offer their opinion. You will also want to become adept at summarizing the content of discussions to encourage and clarify input and move the discussion forward. ("So, Tom, it sounds like you are saying that staff do not have enough time to process paperwork. Is this what the rest of the group is hearing?")

In some instances, you may find yourself being pulled into facilitating a meeting that is floundering when you have not been explicitly assigned this role. If this occurs, it can be helpful to reflect on this with the group and check in with them about what type of support they need to have more effective meetings. You can briefly summarize the elements of effective meetings, and if appropriate, suggest that you facilitate a few meetings for them so they can observe the facilitation process and make progress on meeting content.

Trainer. Another role that PFs can assume in meetings is that of trainer. As a trainer, your goal is primarily educational. You are focused on building attendees' skills and competencies on a certain topic. You may fill this role through a presentation of interactive educational methods and modeling (Bens, 2012).

Participant. PFs can also take part in meetings as a participant. In these instances, you contribute to the discussions along with other participants.

Observer. Finally, PFs may serve as outside observers. This role can be particularly useful when you are beginning work with a practice as a way to learn about its culture, how staff members work together as a team, and the issues that are concerning them. Be aware that observing a meeting may change meeting dynamics somewhat, but will still enable you to observe how meetings are run, whether participation is diverse, the dynamics of the meetings, and the content

of the sessions. When you attend as an observer, you will want to make sure the leader or facilitator introduces you briefly and explains your purpose for observing in order to put participants at ease (Bens, 2012).

At times, you may assume several different roles in the same meeting. For example, you may help facilitate a session for the medical director and also provide a brief training to the group on a practice-specific topic such as meaningful use criteria or ways to use meetings to change culture. Think about which roles you will fill during the meeting and check with the leader, facilitator, and other participants about the roles they would like you to assume. One easy way to do this is to ask the meeting convener what role he or she would like you to assume in the session. For example: "Dr. Jones, I'm looking forward to the meeting tomorrow. Tell me briefly what you are hoping to get out of the meeting and what you would like me to do during the meeting. Would you like me to observe, facilitate, or fill some other role?" Then, clarify your role to the group at the beginning of the meeting.

Role of PF in joining established meetings. As a PF, you will face unique challenges in working with practices to improve their meeting processes. It is typically easiest when you are involved from the beginning with forming a team and establishing its meeting process and norms. This provides you and the practice with a blank slate to introduce new processes, develop new skills, and establish norms among the meeting team members.

More frequently, you may find yourself joining in and working with an existing team and participating in meeting processes that are already established. Introducing new skills and processes in this scenario can be more challenging. Unless the practice staff ask you to train them in running more effective meetings, you will want to observe how the existing team runs its meetings for a number of sessions before you offer training.

When you offer to provide training, be careful that your suggestion does not come across as a criticism of the team or meeting leader. It can be helpful to speak with the meeting leaders individually to discuss their assessment of the meeting process and ask whether they are interested in improving these processes. If so, then you can offer to provide training either to the meeting leader individually or to the entire group. Other options you can consider are to (1) direct team members to some of the resources you have found most useful, or (2) offer to help them prepare for and run the next meeting and use the opportunity to model effective meeting processes.

Effective Meetings 101

As a PF, you will want to know the basics of running an effective meeting. One key to effective meetings is for facilitators and leaders to give as much attention to the process of the meeting as its content. There are many excellent online resources and training programs that you can use to improve your skill in facilitating meetings and training practices in the same processes. The information provided below is a summary of basic information about effective meetings and meeting facilitation.

Preparing for the meeting. Effective meetings don't just happen. They require a considerable amount of preparation and thought. This includes clearly defining the purpose and goals of the meeting, inviting the appropriate people, and selecting a location that is comfortable, accessible, and conducive to meaningful exchanges among participants. It also includes determining the appropriate duration for the meeting; creating the agenda; selecting process tools to help participants engage in meaningful analysis, discussion, and decisionmaking; and preparing the meeting materials and meeting room.

Define the purpose of the meeting. An important first step in planning for a meeting is to clearly define its purpose to avoid confusion among participants. Work with the group leader to determine whether the meeting is for information sharing, planning, problem solving, or relationship building. You will also want to define expectations for participants' involvement. Are participants simply helping to inform decisions that will ultimately be made by someone else, or will they help make actionable decisions during the meeting? Based on this information, you can then define the specific goals and desired outcomes for the meeting. For example:

Sample Meeting Purpose and Goals

> **Purpose:** To share information about the patient registration process. Information will inform decisionmaking by the QI director.
>
> **Goals:** To identify problems in the registration process, gather ideas from staff about how to improve this process, and inform the QI director's decision about whether to embark on a formal LEAN process for improving registration.

Select participants. Meeting participants should be determined by the purpose of the meeting. When changes are being planned, it is important to include individuals from all areas of the practice that will be affected—from administrative clerks to medical assistants, clinicians, practice leaders, and even patients. When convening a group for a meeting, you will want to work with your practice champion to develop the invitation list. This will ensure that (1) you invite everyone who should be included, and (2) you do not overstep any boundaries. It will also provide an opportunity for you to model skills in creating effective meetings. When you invite individuals to participate, make sure that they understand the goals of the meeting, the time commitment, and the reason they have been invited.

Determine the best modality for the meeting. Meetings can be held in-person, virtually, or through a combination of both. In-person meetings are preferable for making difficult decisions, planning complex changes, or relationship building. Virtual meetings work for check-ins and to keep projects moving along when it is not easy for a team to get together. Meetings that combine in-person and virtual modes are more difficult to facilitate but are quite common in health care because staff are often located at different practices, and attending meetings at another site can be difficult and costly for them. Combined in-person and virtual meetings are also useful when you are engaging an outside expert.

Meetings that combine in-person and virtual modes are the most difficult to run effectively. It can be difficult to keep the virtual attendees engaged as in-person attendees discuss issues. In addition, virtual attendees can pull the focus of the meeting away from the in-person participants. You will want to monitor these meetings carefully, to balance the need to include virtual participants but not disrupt the in-person interactions and discussions.

When using virtual methods, use video conferencing if possible. Participants in virtual meetings are often hesitant to turn on their cameras. When feasible, encourage them to do so, as the visual feed can help improve interactions and connections with other meeting participants. Be sure to test connectivity and the platform you will be using before the meeting.

Set the meeting location. Select a location that is easily accessible to participants. Choose a room that has enough space for participants to sit comfortably, usually in a circle or semi-circle, and that provides a table or other surface for participants to write on. Pay attention to issues such as glare from windows, room temperature, ambient noise, availability of restrooms, and places for participants to step out to take calls if necessary. Make sure that participants have easy access to power outlets when needed.

Determine the meeting duration. Meeting length in primary care environments is often determined by external realities such as the need to be present for patient care. Duration should also be determined by the purpose of the meeting.

Check-in meetings for work already underway can be short. For example, a team working on a Plan Do Study Act cycle might only need to do a PDSA Huddle of 15 minutes, with each individual briefly reporting on the progress on the cycle.

Meetings that involve decisionmaking and in-depth planning require more time. You should plan on 60 to 90 minutes for these types of meetings. Meetings longer than two hours can be less productive, as participants typically are unable to focus for more than 90 minutes.

When longer meetings are scheduled (for example, for a practice retreat), you can manage them by breaking the time into a series of shorter meetings, with breaks in between. You should be sure to include a number of interactive processes to keep individuals engaged and actively participating.

A few tips to keep in mind:

- Meetings that are too short can be wasted time. Little gets accomplished, especially when you have to catch up latecomers on what they missed. It may be a while before you can get this group together again and you do not want to be unable to make project progress between meetings.
- Meetings that are too long also can be wasted time. If your meeting is too long, participants can get distracted as their attention threshold approaches. Group members may begin to feel that they are neglecting other tasks, and they may be hesitant to attend your next meeting.

- Meetings have a cost. Be sure to consider the cost of meetings that you and others schedule from a payroll perspective. How many hours each day, week, or month has the director allocated for staff or clinicians to participate in this project, and how much of that time do you want to use for meetings? How much time are clinicians being asked to be out of clinic and what is the revenue lost during this period as well as the impact on patient access? On the other hand, there are also costs to not meeting. What is the impact on teamwork, organizational planning, and quality of care if the group does not meet, communicate, and solve problems? Thinking about these costs can help motivate groups to make optimal use of meeting time.

Create the meeting agenda. Agendas are an essential part of effective meetings. They alert participants to the purpose and topics of the meeting as well as its goals. They also provide a structure and can help the chair or facilitator keep the meeting on track.

Ideally, agendas should be developed well in advance of the meeting and distributed to participants with sufficient time before the meeting to enable them to come prepared. This said, you should assume that participants will not necessarily have prepared and incorporate this into your meeting plan.

For established working groups that already have a solid idea of their scope of work and the related issues, the meeting convener can set the agenda alone or use a more participatory approach. In a participatory approach to agenda setting, you circulate a tentative agenda and ask group members to react to it and submit changes and additional items they would like to discuss. This approach will give you a good idea of issues that participants are thinking about and want to discuss and allow you to prepare to address them during the meeting or defer them to another time.

For short meetings, such as PDSA check-ins, you can use a standing agenda structure that might be provided in paper format at first until the group learns the order of items (see Figure 22.1 for an example). After the standing agenda has been well established, you can switch to directing the meeting verbally.

Figure 22.1. Sample of combined meeting agenda and minutes sheet

(DATE AND TIME)	(LOCATION)	**Facilitator:** **Timekeeper:** **Note-taker:**
Participants:		
TOPIC	**DECISIONS/ACTION ITEMS**	
Introduction and welcome		
Review of meeting goals and purpose (Who/Time)		
Review and discussion of recent performance data (Who/Time)		
Review of PDSAs (Who/Time)		
Discussion of plan for coming week (Who/Time)		
Assignment and review of action items (Who/Time)		
Wrap-up and next meeting (Who/Time)		
PARKING LOT ISSUES *(Topics brought up during the meeting that need further discussion at a later date)*		
Action items, deadlines, and responsible parties		

Select process tools. Effective meetings include processes for accomplishing the goals set for the meeting. The processes you or others use during a meeting should be defined prior to the meeting and included in the agenda. There are a number of different processes that you can use to help participants to make progress toward their goals, or that you can train members of the practice to use during their meetings. Examples of these processes are:

- Root cause analysis (see Module 11)—for analyzing problems and generating solutions
- 5 Whys (see Module 11)—for analyzing problems and generating solutions
- Appreciative inquiry (see Module 9)—for developing a vision of the future and planning

Other processes you may want to become familiar with include:

- Strengths Weaknesses Opportunities Threats Analysis (SWOT)—for assessing what the organization is doing well and what it could improve on
- Force field analysis—for evaluating factors that are facilitating or impeding progress
- Needs and Offers—for building understanding among participants and creating collaborative solutions
- Brainstorming in person or in writing—for generating new ideas and soliciting ideas from all participants

Facilitating with Ease: Core Skills for Facilitators, Team Leaders and Members (Bens, 2012) provides a summary and basic instructions for more than 20 processes you may want to use to facilitate effective analysis, problem solving, and collaboration in meetings. As a PF, you should be comfortable with using at least 3 or 4 of these processes.

Gather materials and set up meeting room. It can be helpful to create a checklist of everything you will need to run your meeting smoothly. You will also want to consider the unique challenges of planning for meetings in practice environments. You should plan on supplying materials and equipment yourself in the beginning, and not count on the practice's ability to furnish them. Over time, you will want to help the practice equip itself with the tools to run effective meetings:

- Projector and screen (if indicated)
- Flip chart and pens (paper with adhesive on the back is useful so you can hang completed pages on the wall)
- Dry erase markers for dry boards (if available)
- Paper copies of the meeting agenda and any handouts
- Paper and pens for participants to make notes
- Post-it notes (different sizes)
- Refreshments (if indicated)
- Nametags (if indicated) (sticky types or ones that use lanyards are preferable since they do not damage clothing)
- Place cards (if indicated)
- Internet connection

- Power cords and power strips
- Laptop
- Thumb drive
- Water bottles
- Omni-directional speaker or conference phone for any phone-in participants

You will also want to attend to the environment and set-up of the meeting room. Be sure that the temperature is comfortable, and that windows have coverings or some way of reducing glare if needed. There are a number of ways to arrange the room to support meeting goals. Room set-ups for trainings might look like a traditional classroom. Set-ups for meetings that will involve discussion and collaboration among group members might use a horseshoe or circle configuration. Be sure that the white board or flip chart or screen can be seen by everyone, and that participants will be able to hear each other well (Schwarz, 2002; Adams, et al., 2007; Bens, 2012).

Running the meeting.

Distribute the agenda. Provide everyone with a copy of the agenda at the start of the meeting.

Welcome participants. Welcome participants to the meeting to signal the start of the session. Quickly review the purpose, goals, and timeline of the meeting, and the role assignments for the meeting. Reassign if necessary.

Check-in with participants. When running a relationship-centered meeting, the next step is a quick "check-in" with participants. In this phase, you ask each individual to share how they are doing that morning or afternoon and whether there are any issues in their life that may distract them from the meeting. The purpose of the check-in is to build relationships among participants, and also recognize that individuals have a variety of issues in their lives that may affect their ability to be present or participate in the session. This helps members better interpret each other's statements, actions, and participation. See Appendix 22 A for in-depth information on relationship-centered meetings.

Define the ground rules. When a group of individuals is meeting for the first time, or new members have joined the group, it is helpful to define "ground rules" for the meetings. These rules create consistency and predictability for meeting participants, and help create the safety that is needed for members to participate fully in the sessions.

There are many recommended meeting rules. Typically, they address issues such as the use of technology during meetings, the ways individuals address each other and deal with conflict, and general rules such as arriving and ending on time. You should aim to establish enough rules to provide guidance and safety, but not so many that the group becomes bogged down in procedural issues. One of the best ways to create these rules is to define them collaboratively with participants. To begin the definition process, you could provide participants with a list of rules other groups have used and ask them to react to these to form their own.

If you are working with an existing team or standing meeting, you will want to ask the meeting chair if the group has already established ground rules for their meetings. If they have not and the group is experiencing difficulty during the meetings or in moving forward, you might suggest that they use your joining the group as an opportunity to take a step back and create some rules and guidelines. This will allow you to model good meeting practices and can help the team enhance the effectiveness of their meetings.

Some meetings may require a special set of norms to ensure that time is spent effectively. This can be particularly true if difficult issues are being discussed during a meeting. In these instances, you or the meeting facilitator can ask the group to identify the rules needed to ensure solid participation. For example, the facilitator might say to the group, "The agenda today includes some difficult topics. What, if any, rules or norms do we need to put in place today to ensure that we have productive discussions rather than unproductive arguments?" (Bens, 2012).

An example of meeting rules is provided in Figure 22.2.

Figure 22.2. Sample of meeting ground rules

1. Arrive on time, end on time.
2. Everyone has something to contribute and participates.
3. Avoid making assumptions.
4. Explain your reasoning.
5. Discuss un-discussable items.
6. Leave cell phones and other distractors at the door.
7. Focus on progress toward the overall goal, not individual positions.
8. Embrace positive conflict and dissent as a way of improving decisionmaking.
9. Adopt a mindset of curiosity and exploration, not fault finding.

*Assign roles***.** Assigning roles to meeting attendees can build capacity in the practice for running effective meetings, encourage more participation by attendees, and help make meetings run more smoothly. It also helps engage participants in the meeting.

A clever way to introduce the idea of roles and assign them to participants is to use the "Role Cards" provided in Appendix 22 B —the Dartmouth Institute Microsystem Academy, Cystic Fibrosis Foundation, and the Children's Hospital of the King's Daughters created these cards to define and help remind each person of their role within a meeting (Dartmouth Institute Microsystem Academy, et al., 2012). The first time you use roles, you will want to provide a brief training to your meeting participants on the different roles and their purposes, and invite participants to volunteer for each role. In the absence of a volunteer, you can assign them. After this initial introduction, you and the group can decide to pre-assign these roles and include them on the agenda to save time at subsequent meetings. The roles include:

Timekeeper. The timekeeper is responsible for alerting the leader, facilitator, and participant of the time, and helping to keep the meeting running on track. The timekeeper should provide cues to the group when there are 5 minutes left and 2 minutes left to keep an item from running over

time. When a particular agenda item is running over time, the meeting leader and facilitator can work with the group to decide whether to extend the time allotted for the particular discussion or activity and amend the rest of the agenda for the meeting, or stick with the original agenda.

Facilitator. The meeting facilitator does not offer opinions on meeting items or topics, but instead focuses on managing the group process. The facilitator observes who is participating and who is not, calls on quiet or silent members, and redirects individuals who may be dominating the discussion. The facilitator can suggest that items that are off topic be placed in a virtual "parking lot" for discussion at a later time. (A parking lot is a place you record important ideas, comments, and issues that need to be dealt with but are not appropriate to address during the meeting at hand because of time limitations or because they distract from the current topic. These are often written on a visible flipchart or its virtual counterpart.) The facilitator may also suggest putting topics that are generating unproductive conflict in the parking lot for consideration later when the group has time to consider them or emotions have calmed down. The facilitator can also alert group members when they are avoiding a topic or going off topic, and encourage them to reflect on what is happening to the meeting process and why.

Leader. The meeting leader sets the agenda, welcomes the group, defines the purpose and goals of the meeting, and leads the meeting through the agenda. The leader focuses on the content of the meeting, and monitors progress toward meeting goals. He or she calls on participants for their ideas and input and works to include all members of the meeting in the discussion. He or she calls on the facilitator for assistance when needed.

Participant. Meeting participants follow ground rules, participate in the meeting, provide ideas and input, and report on progress toward action items.

Recorder. The recorder documents the meeting discussion. This can be a challenging role as it is not always obvious what should be documented. You will want to provide recorders with guidance on what you want them to document before the meeting starts. You can also cue them to take down important points throughout the meeting. For example, "Sally can you be sure to include the group's decision about Point of Care A1cs in the meeting minutes?" The recorder can use a structured form such as the one provided in Figure 22.1, or use a note pad, flip chart, white board, or computer. The recorder should also note items that are placed in the meeting parking lot and specific action items and to whom they are assigned. Whenever possible, parking lot items should be written up so the entire group can see them. This reassures members that their ideas are being taken seriously and not being dismissed, which builds trust and reduces anxiety among members.

Facilitate engagement of all participants. Effective meetings are the ones in which all members openly participate and contribute ideas without concern about being criticized or ignored. They also encourage a spirit of curiosity and teamwork. Facilitating this type of open participation can take some effort, but is one of the most valuable skills you can possess as a PF. Teaching practice leadership to do the same is also challenging, but can help introduce important changes in the culture of the organization. Some people may find this type of open participation threatening because it requires more time, which practices almost always feel is in short supply; typically generates more discussion and, therefore, more conflict; and can lead to individuals' sharing information that leadership may not want to hear or may have heard and dealt with already.

Useful techniques for facilitating participation of all members include: calling on quiet members directly, redirecting dominant participants and engaging them in encouraging participation of others, and honoring all contributions.

Call on quiet participants. You can engage the quiet members by asking them direct open-ended questions such as: "Mary, how does this affect the staff in your department?" or "Thomas, I'd be interested in hearing your thoughts about what is being discussed. What problems do you see?" Often, the quiet member is the one with a critical observation or important idea. Avoid asking quiet individuals questions that require deep technical knowledge unless you know they already know the answer, as these types of questions can put them on the spot and cause them to avoid participating in meetings in the future.

Appreciate and redirect dominant participants. It can be tempting to become frustrated with and even critical of individuals who dominate discussions in meetings. But you should avoid this temptation. These individuals bring energy and commitment to the meeting that, if properly managed, can be channeled to energize the group and produce better thinking and outcomes from the session. If not handled well, these same individuals can completely derail a meeting. The outcome depends on your skills in facilitating their involvement. A useful tool when working with dominant individuals is to reframe them as "passionate" and energetic participants rather than a problem. Your task is to channel their energy and passion to make the session more effective.

One technique for doing this can be to reflect on what the individual is saying, acknowledge his or her contribution, and then segue to another participant for input. For example: "Jim, so you are suggesting that we schedule patients for the women's clinic on Saturdays as well as during the week? This is an interesting idea. Let's hear what others have to say on this topic. Janet, what are your thoughts on operating hours for the women's clinic?"

When this technique does not work, you can consider a more direct approach: "Jim, you've had a lot of interesting and helpful ideas about this today. I'm curious to hear what others are thinking about what you've said and the other issues raised. Let's hear from them now."

Finally, if despite your best efforts, you are having difficulty managing the meetings and ensuring they are productive because of this individual, you can consider meeting with the individual outside of the meeting time and asking for his or her help getting the meetings on track. “Jim, I appreciate your passion in the meetings. But I need your help. I’ve observed that others are not speaking up and this leaves you as one of the only contributors. Help me think through how we can get more people participating and sharing their thoughts in the meeting.”

Honor each contribution. In all your interactions with meeting participants, it is important that you respond respectfully and acknowledge each of their contributions. Open criticism or dismissal of even one idea can shut the group down and discourage others from participating, afraid they may meet the same fate when they speak up.

Document the meeting. Be sure to document each meeting. This is traditionally done by taking meeting minutes. Documentation helps participants remember what took place during the meeting and gives them an opportunity to clarify any items that they feel are not accurately represented in the minutes. It can also provide a means for confirming and introducing accountability for action items assigned to various participants. Figure 22.3 provides an example of a combined agenda and minutes sheet. Combining agenda and minutes can be an efficient way to document meetings, and to keep track of and monitor follow-through on action items.

Figure 22.3. Sample agenda with a process tool for analyzing performance data

Tuesday, March 10	Conference room A	Facilitator: Sally Thomas Timekeeper: Margarita Ramos Note-taker: Tom Jones
Participants: Sally, Margarita, Tom, Jose, Grace, Jehni, Kevin		
TOPIC	**DECISIONS/ACTION ITEMS**	
Introduction and welcome Sally (10 minutes)		
Review of meeting goals and purpose – Review performance data on asthma management and develop a PDSA. Sally (10 minutes)		
Presentation of recent performance data Grace (15 minutes)		
Open discussion of performance data Tom (15 minutes)		
Process: Root cause analysis (RCA) in small groups Sally (30 minutes)		
Discussion of results of RCA as large group Grace (30 minutes)		
Wrap-up Sally (10 minutes)		
PARKING LOT ISSUES *(Topics brought up during the meeting that need further discussion at a later date)*		
Action items, deadlines and responsible parties		

Source: Dartmouth Institute Microsystem Academy, Cystic Fibrosis Foundation, Children's Hospital of the King's Daughters, Norfolk, Virginia (2014). Used with permission.

Summarize meeting and confirm action items. At the end of each meeting, the leader should provide a quick summary of what occurred during the meeting, including decisions and proposed action items. The leader should also ask for corrections and input from the group, and facilitate assignment of action items and definition of next steps.

Evaluate the meeting. Consider conducting a quick evaluation of the meeting at the end of the session. Except in situations such as a retreat or training, the evaluation does not need to be formal. Simple is often the best in these instances. A tried-and-true method for collecting helpful information is to ask people to give a quick verbal rating of the session and then briefly explain about what would make the session more effective. For example, you might say, "With 1 being not at all effective, and 10 being extremely effective, how would you rate today's meeting?" (Go around room.) "If you rated it a 10, what made it a 10? If you rated it less than a 10, what needs to happen next time to make it a 10?" If you are concerned that individuals may censor their feedback in front of you or others in the room, you can ask them to jot down their answers to the questions on a sheet of paper and hand it in as they leave the meeting, or you can send them a brief online survey to complete after the meeting. Doing these types of simple evaluations every few sessions can provide you and the meeting leader with important feedback about improving the meeting process. It also models internal quality improvement and continuous performance monitoring.

Managing conflict during meetings. Conflict is an important part of effective decisionmaking and effective meetings. Without it, groups can veer into a false consensus or harmony and make less-effective, even counterproductive, decisions. As a PF you should view conflict as your friend and grow concerned if you do not encounter it during meetings or in the course of your work with a practice.

That said, conflict can be distressing both to you and to others in the organization. One of the skills you bring is the knowledge of how to navigate conflict effectively. Conflict that takes place during meetings can offer you a window into what happens on the practice floor and in the organization.

As a PF, you can observe the points of conflict, and help practices learn to use conflict as a resource for making better decisions. Practices that avoid or over-manage conflict do not encourage a culture of quality. Differences of opinion are normal, especially in a diverse work group, and should be approached with an attitude of curiosity.

You should become comfortable with teaching practice members how to engage in productive conflict and how to harness conflict to make more effective decisions. A first step in doing this is helping practices redefine conflict. Instead of a problem or something to be avoided, conflict should be viewed as a resource for making better decisions. A second step is to help practices tell the difference between productive and destructive conflict. Productive conflict encourages better, more-diverse thinking about a problem. Destructive conflict shuts down discussion and problem solving, and can prevent a group from moving forward.

One method for helping a group become comfortable with conflict is to observe it directly. You can help create safety for the group by letting them know that you are aware of the conflict and are not ignoring it. At the same time, you are signaling the group that it is okay to openly disagree.

You can manage conflict by making simple observations. For example:

> "I want to make a quick comment about group process. Tom and Jim clearly have a difference of opinion about how we should manage the clinic registration process."
>
> "These kinds of discussions can be uncomfortable but they also can lead to better decisions and a better process in the end."
>
> "Tom and Jim, I'd like to check in with you. Is discussion helping you move forward with your thinking about the registration process? Can you share some of the ways it is helping you in your thinking about this? Or is this distracting you both from the purpose of our meeting?"
>
> "Let me also check in with the group. Is this discussion helping you clarify your ideas and thinking? If yes, how? Or is it distracting us from the task at hand?"

By commenting on what is occurring without judgment, you signal the group that productive conflict is acceptable and even desirable in meetings.

If participants in a group seem uncomfortable with the conflict that is occurring, you can observe this also. For example, "I see some people squirming a bit. It seems like people are getting uncomfortable with the discussion. Have you all had discussions like this in the past? How did they turn out?" This gives members a chance to share their fears or concerns, and provides you with information about how conflict has been managed in the past.

You can then work with the group to determine how best to proceed in this particular instance. For example, in a group that has had a great deal of unproductive conflict, you might chose to stop the current debate and suggest the team take a step back at the next meeting and revisit the group's goals and the rules for their meetings.

Depersonalize conflict by redirecting discussions about blame from the person to the process. One cause of destructive conflict is the common tendency to focus blame on a person rather than a process. Groups can get hung up on "scapegoating," blaming a team member, leader, or other individual for the problems they are experiencing. This almost always brings effective problem solving to a halt, as it is difficult to force change in others' behavior, and the problems are almost always more complex than a single individual's behavior. If the problem is a single individual, it is a human resource issue and it is typically not useful for a practice improvement group to focus on it.

As a PF, you can encourage group members to shift focus from the individual to the process. Encouraging the group to reflect on the dynamic will help them interrupt it. For example, you

might say, “It seems like the group keeps focusing on April as the cause of the problems, and the mistakes they believe she is making. This may or may not be true. Let’s shift the focus for now from individual people to processes. Let’s talk about the processes and systems involved here and what could be changed that could help reduce errors and improve performance.”

Set guidelines for encouraging productive conflict. In some instances, it can be helpful to define for participants the differences between productive and destructive conflict and debate and engage them in creating rules to guide conflict during meetings.

Interrupt a conflict when it becomes personal or destructive. The exception to the use of conflict to encourage more effective problem solving is when participants become verbally aggressive or disrespectful with each other. This happens from time to time, especially when an organization is under considerable stress or undergoing significant change, so do not be surprised by it.

In these instances, it is important to intervene in a calm, respectful manner. You will want to interrupt the unproductive discussion, reflect on the process, and ask the involved individuals to agree to put the issue to the side until a later time (place it in an emotional parking lot).

If participants refuse, then you may find it necessary to ask them to take a break and return to the meeting when they have calmed down, or to disband the meeting until later. While this is a rare event, it does happen. Even in these instances, you should view the events as information about the degree of stress that individuals in the organization are under and as energy that can eventually be redirected to support improvement work. Resist the urge to criticize or write difficult participants off. Often the most difficult participants become the strongest supporters in the end.

Use a parking lot to diffuse unproductive conflict or to keep a meeting moving forward. Another useful tool for managing unproductive conflict is the written parking lot. The meeting facilitator, whether it is you or a member of the practice, can simply state, “Tom, that is an interesting idea. If it’s okay with you and the group I’d like to put it in the parking lot for now, and come back to it in another meeting.”

The facilitator then should check with the meeting chair and participants to see if they are in agreement with waiting on this item. If they are, then the item should be written down on a flip chart or a white board at the meeting that the entire group can see. If this is not possible, the facilitator can write it on a sheet of paper.

It is important, however, that the facilitator follow up with the commitment at the end or immediately following the meeting. This builds confidence and reduces participants’ anxiety by keeping the meeting on track while making sure that their ideas and concerns will be heard and discussed in the near future.

Unsticking stuck meetings. Sometimes meetings do not gel. Participants can get “stuck” on a particular topic or participation in discussions can be lackluster. Everyone will have a failed or stuck meeting from time to time, and there are some tools you can use to help “unstick” them.

Know the signs that a meeting is getting stuck. First, you need to recognize that the meeting is bogging down. Signs of this are individuals making the same comments over and over or debating the same issue without arriving at a decision or clear action items. Other indicators are flat conversations, low participation, and participants who look bored or distracted (or who even walk out of the meeting). These are difficult moments for a PF and for meeting leaders. It is important that you not personalize these events when they happen. This can interfere with your ability to maintain enough objectivity to observe and facilitate the process.

Ask the participants how to unstick it. One of the most effective tools for dealing with a stuck or bland meeting is also the simplest. Ask the group. You can mention that the meeting seems stuck and then ask participants if they are observing the same thing. Ask them what they think needs to happen to get the meeting back on track. For example, you can say:

> "This meeting feels stuck to me today. Not many people are talking and many of you look like you are bored. Is anyone else observing this same thing? Sally, are you observing this? Tom? What do you think is going on that this meeting is stuck? What do you think we can do to 'unstick' it?"

Note that the check-in technique works best with small- to medium-sized groups, and ones that are an hour or more. It is less effective with larger groups of 15 or more because the contributing interactions and dynamics are often at the subgroup level rather than whole group level. Thus, it is difficult to get members to reflect accurately on the processes within the whole group. With shorter meetings, there is typically not sufficient time for underlying dynamics to become obvious to the group, and for the group to discuss them.

Responses to stuck meetings. Often you will discover that a meeting is stuck because a pressing issue or concern has occurred that day and is distracting the group from focusing on the task at hand. In these instances, it may be appropriate to refocus the meeting to address the hot button issue, or to cancel the meeting for the day. In other cases, the meeting may be stuck because it is redundant, poorly planned, or focused on a low priority issue that group members have little interest in discussing. If so, you will want to work with the group leader and members to identify an appropriate and useful topic for the group to focus on.

Training practice members to run effective and culture-changing meetings. One of the most important contributions you can make to a practice is to help members improve their meeting processes. Meetings are an essential tool in practice improvement and culture change. You should be prepared to train members of the practice to lead effective meetings when appropriate. You can do this one-on-one or in-group training. Individuals who might benefit from this training include the practice leaders, the director or chair of the quality improvement committee or team, and the practice manager, among others.

You can use this module as the basis for the training, or the training resource on relationship-centered meetings in Appendix 22 A.

To get individuals excited about improving their skills in running meetings, you can talk about how meeting process can be used to improve organizational culture, prepare inclusive invitation lists, invite open dialogue, encourage curiosity rather than fault finding, and listen to and honor participants' contributions. The goal is for leaders and staff to begin to see meetings as a powerful tool for change rather than a necessary evil.

Remember that one of the best methods you have for training practice members in running effective meetings is modeling. When you lead meetings, be aware that you are indirectly training your practices on meeting techniques. A training curriculum for leading relationship-centered meetings is contained in Appendix 22 A. You can use this resource to hold a special training at the practice on meeting skills or to train individuals such as the practice leader.

Summary and Conclusions

Meetings are an essential tool in the PF's toolbox for supporting change and building capacity in a practice. As a PF, you may run meetings for practices—but more importantly, you will model and teach practices to run their own meetings more effectively. Finally, you can help practice leaders learn to use meetings as a tool for changing practice culture and introducing processes and norms that support a culture of continuous improvement. Good meetings can change everything. Bad meetings can, too. It is essential that you be an expert at leading and facilitating meetings and teaching practice members to do the same.

References

Adams T, Means J, Spivey MS. The Project Meeting Facilitator: Facilitation Skills to Make the Most of Project Meetings. San Francisco, CA: Jossey-Bass; 2007.

Axelrod RH. Terms of Engagement: New Ways of Leading and Changing Organizations. San Francisco, CA: Barrett-Koehler Publishers, Inc.; 2010.

Bens I. Facilitating with Ease! Core Skills for Facilitators, Team Leaders and Members, Managers, Consultants, and Trainers. San Francisco, CA: Jossey-Bass; 2012.

Brown J. A Leader's Guide to Reflective Practice. Victoria, BC: Trafford Publishing; 2007

Dartmouth Institute Microsystem Academy, Cystic Fibrosis Foundation, Children's Hospital of the King's Daughters. *Meeting Role Player Cards*. 2012.

Schwarz R. The Skilled Facilitator: A Comprehensive Resource for Consultants, Facilitators, Managers, Trainers, and Coaches. San Francisco, CA: Jossey-Bass; 2002.

Suchman AL, Sluyter DJ, Williamson PR. Leading Change in Healthcare: Transforming Organizations Using Complexity, Positive Psychology, and Relationship-Centered Care. London, England: Radcliffe Publishing Ltd.; 2011.

Primary Care Practice Facilitation Curriculum

Module 23. Documenting Your Work With Practices

Prepared for:
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services
540 Gaither Road
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Module 23. Documenting Your Work With Practices

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Professional method of process for working with practices

Time

- Pre-session preparation for learners: 45 minutes
- Session: 40 minutes

Objectives

After completing this module, learners will be able to:

1. Use the facilitator practice record to document a practice encounter.
2. Understand the importance of documentation for internal quality improvement and performance monitoring.

Exercises and Activities To Complete Before and After the Session

Pre-session preparation. Ask the learners to review information in item 1 and complete the activity in item 2. (45 minutes)

1. The content of this module.
2. Ask learners to use the sample facilitator practice record to enter data about a fictitious encounter with practice TheOnlyOneforMiles.

During the Session. Presentation (20 minutes)

1. Present key concepts from the module.

Discussion. Ask questions and explore answers with learners. (20 minutes)

1. What experience did you have using the practice record in preparation for this session?
2. What experiences have you had in the past documenting improvement work with other organizations?
3. How can you use a practice record to support and improve your work with a practice?
4. How can you use a practice record to communicate with your supervisor and other facilitators within your facilitation program?

Module 23. Documenting Your Work With Practices

Practice facilitators work independently in the field much of the time and must manage improvement work across multiple practices and organizations at the same time. It is important to document the content and outcomes of your encounters with practices routinely to help:

- monitor the progress of practices through a particular improvement program or project and
- keep track of the different priorities and activities across multiple organizations.

This documentation will help your program director know which issues to focus on during training and supervision sessions. It can also help both of you identify practices that may be experiencing difficulty in a particular area and need additional help.

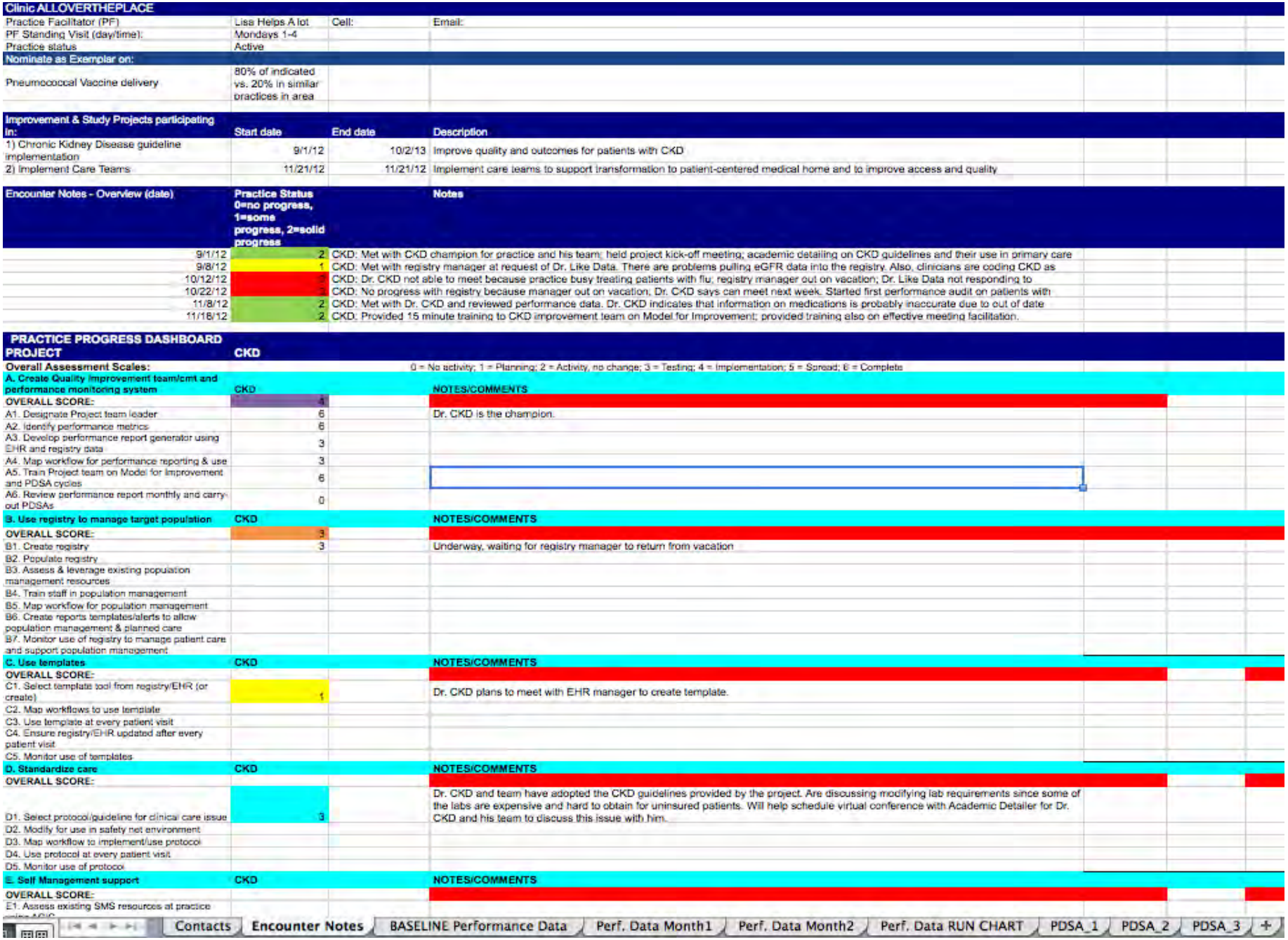
Good documentation supports team approaches to facilitation by providing a way for team members to stay up to date on developments at a practice and to communicate their progress at the practice with each other. In addition, it provides a historic record of your work with a practice that can support handoff of the practice to another facilitator if you leave the organization for any reason. Finally, it helps maintain continuity between the practice and the facilitation program.

Identifying Tools for Documenting Encounters and Progress

Facilitators use a variety of methods to document encounters and track progress with their practices. You can create paper-based forms or simple spreadsheets on a computer or you can use online spreadsheets and survey programs. Online solutions can be a good option because they are dynamic and can be accessed by both you and your program supervisor. Figures 23.1-23.3 provide an example of how to document encounters with and progress of a practice.

The process you use to track your own encounters with each of your practices in many ways will parallel the process used by your practices. Instead of documenting patient visits, however, you will document practice visits; and instead of managing a panel of patients, you will manage a "panel" of practices.

Figure 23.1. Sample facilitation practice record—summary sheet with encounter notes, exemplar practices, and key drivers



Clinic ALLOVERTHEPLACE			
Practice Facilitator (PF)	Lisa Helps A lot	Cell:	Email:
PF Standing Visit (day/time):	Mondays 1-4		
Practice status	Active		
Nominate as Exemplar on:			
Pneumococcal Vaccine delivery	80% of indicated vs. 20% in similar practices in area		

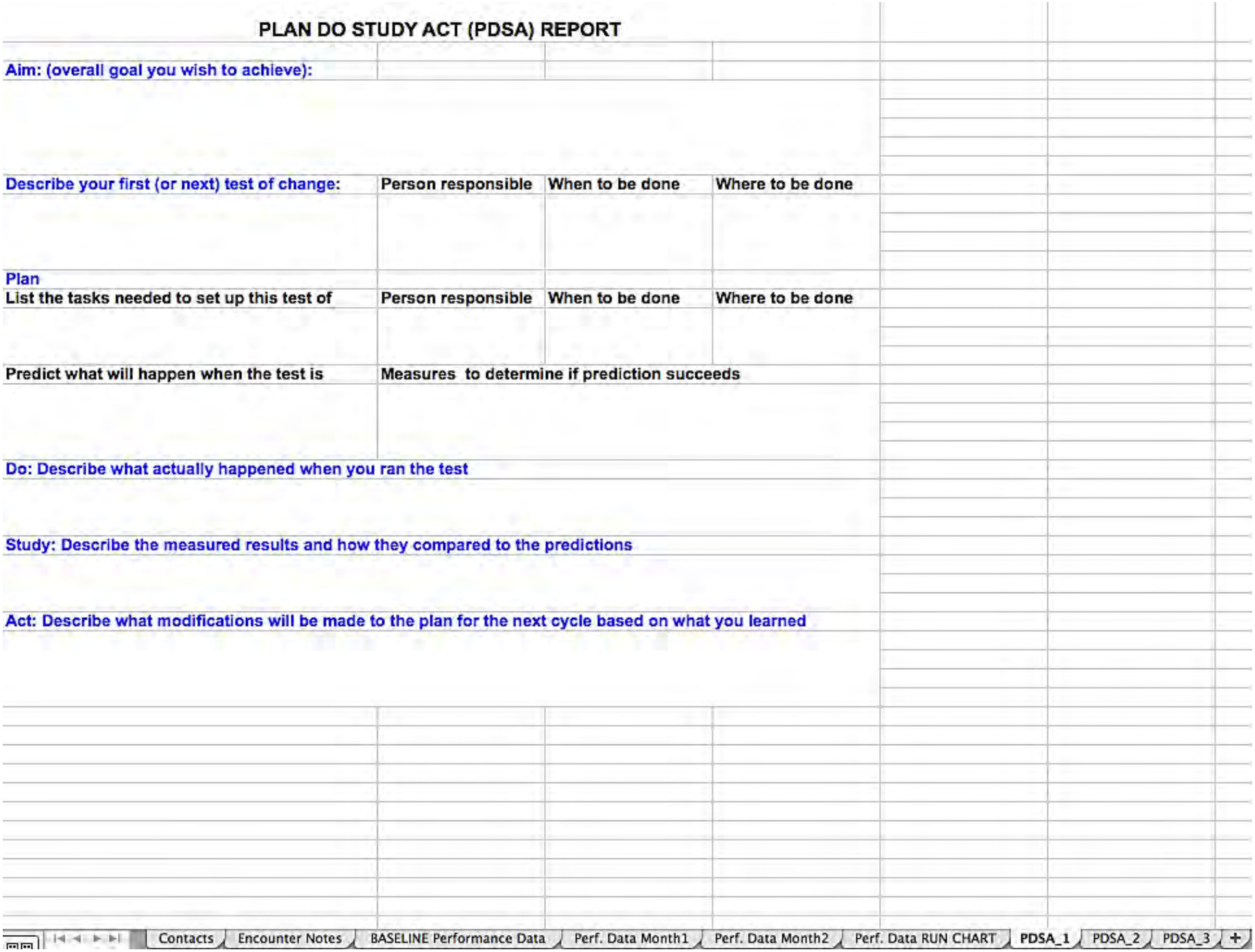
Improvement & Study Projects participating in:	Start date	End date	Description
1) Chronic Kidney Disease guideline implementation	9/1/12	10/2/13	Improve quality and outcomes for patients with CKD
2) Implement Care Teams	11/21/12	11/21/12	Implement care teams to support transformation to patient-centered medical home and to improve access and quality

Encounter Notes - Overview (date)	Practice Status 0=no progress, 1=some progress, 2=solid progress	Notes
9/1/12	2	CKD: Met with CKD champion for practice and his team; held project kick-off meeting; academic detailing on CKD guidelines and their use in primary care
9/8/12	1	CKD: Met with registry manager at request of Dr. Like Data. There are problems pulling eGFR data into the registry. Also, clinicians are coding CKD as
10/12/12	0	CKD: Dr. CKD not able to meet because practice busy treating patients with flu; registry manager out on vacation; Dr. Like Data not responding to
10/22/12	0	CKD: No progress with registry because manager out on vacation; Dr. CKD says can meet next week. Started first performance audit on patients with
11/8/12	2	CKD: Met with Dr. CKD and reviewed performance data. Dr. CKD indicates that information on medications is probably inaccurate due to out of date
11/18/12	2	CKD: Provided 15 minute training to CKD improvement team on Model for Improvement; provided training also on effective meeting facilitation.

PRACTICE PROGRESS DASHBOARD PROJECT	CKD	
Overall Assessment Scales:		0 = No activity; 1 = Planning; 2 = Activity, no change; 3 = Testing; 4 = Implementation; 5 = Spread; 6 = Complete
A. Create Quality Improvement team/cmt and performance monitoring system	**CKD**	**NOTES/COMMENTS**
OVERALL SCORE:	4	
A1. Designate Project team leader	6	Dr. CKD is the champion.
A2. Identify performance metrics	6	
A3. Develop performance report generator using EHR and registry data	3	
A4. Map workflow for performance reporting & use	3	
A5. Train Project team on Model for Improvement and PDSA cycles	6	
A6. Review performance report monthly and carry-out PDSAs	0	
B. Use registry to manage target population	**CKD**	**NOTES/COMMENTS**
OVERALL SCORE:	3	
B1. Create registry	3	Underway, waiting for registry manager to return from vacation
B2. Populate registry		
B3. Assess & leverage existing population management resources		
B4. Train staff in population management		
B5. Map workflow for population management		
B6. Create reports templates/alerts to allow population management & planned care		
B7. Monitor use of registry to manage patient care and support population management		
C. Use templates	**CKD**	**NOTES/COMMENTS**
OVERALL SCORE:		
C1. Select template tool from registry/EHR (or create)	1	Dr. CKD plans to meet with EHR manager to create template.
C2. Map workflows to use template		
C3. Use template at every patient visit		
C4. Ensure registry/EHR updated after every patient visit		
C5. Monitor use of templates		
D. Standardize care	**CKD**	**NOTES/COMMENTS**
OVERALL SCORE:		
D1. Select protocol/guideline for clinical care issue	3	Dr. CKD and team have adopted the CKD guidelines provided by the project. Are discussing modifying lab requirements since some of the labs are expensive and hard to obtain for uninsured patients. Will help schedule virtual conference with Academic Detailer for Dr. CKD and his team to discuss this issue with him.
D2. Modify for use in safety net environment		
D3. Map workflow to implement/use protocol		
D4. Use protocol at every patient visit		
D5. Monitor use of protocol		
E. Self Management support	**CKD**	**NOTES/COMMENTS**
OVERALL SCORE:		
E1. Assess existing SMS resources at practice		

Contacts | Encounter Notes | BASELINE Performance Data | Perf. Data Month1 | Perf. Data Month2 | Perf. Data RUN CHART | PDSA_1 | PDSA_2 | PDSA_3 | +

Figure 23.2. Sample facilitation practice record—PDSA sheet



PLAN DO STUDY ACT (PDSA) REPORT

Aim: (overall goal you wish to achieve):

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done

Plan

List the tasks needed to set up this test of	Person responsible	When to be done	Where to be done

Predict what will happen when the test is	Measures to determine if prediction succeeds

Do: Describe what actually happened when you ran the test

Study: Describe the measured results and how they compared to the predictions

Act: Describe what modifications will be made to the plan for the next cycle based on what you learned

Contacts | Encounter Notes | BASELINE Performance Data | Perf. Data Month1 | Perf. Data Month2 | Perf. Data RUN CHART | PDSA_1 | PDSA_2 | PDSA_3 | +

Knowing Which Encounters To Document

It is important to document all "meaningful" encounters with a practice. This means any substantive work that supports the practice's improvement goals. This work includes onsite visits, virtual support, email exchanges, and independent research or information gathering you may do for the practice in support of its quality improvement (QI) goals. The key words are *substantive* and *meaningful*.

Sharing the Practice Record With Your Practices

Depending on the system your facilitation program uses for documenting and tracking progress at the practice level, you may be able to involve individual practices in updating and maintaining their practice record. This is most feasible when you use Web-based or cloud-based information systems that allow multiple people to access and collaborate on the same document. For example, a quality improvement group in Los Angeles uses a combination of Smartsheets and Google Docs to create a dynamic practice record that both the facilitator and each practice can access and contribute to.

Inviting practices to contribute to their practice record increases the transparency of the process and helps the practice track its own progress with its improvement work. The practice record can also serve as a shared space and project management and collaboration platform between the facilitator and the practice.

Protecting Confidentiality and Privacy

When you opt to share and jointly maintain the practice record with an individual practice, remember that much of the information you work with as a facilitator at a practice is sensitive in nature. You need to be careful about the type and level of detail of the information you enter into the practice record. For example, you should not include detailed notes about personal conversations with a staff person about a conflict with another staff person at the practice.

In this case, you will need to find another way to capture and convey sensitive information of this type to your supervisor and address the issue in the shared practice record in a manner that preserves the privacy of the persons involved. For example, you can include a comment in your notes that the QI team may want to consider training on conflict resolution. But leave out any specific information about the staff persons involved or the content of the conflict that might make it possible to identify the parties involved.

Similarly, do not post any identifiable patient data on the practice record or information about other practices you are working with that has not been cleared for sharing. You will need to remind your practices and their QI teams about these limits as well.

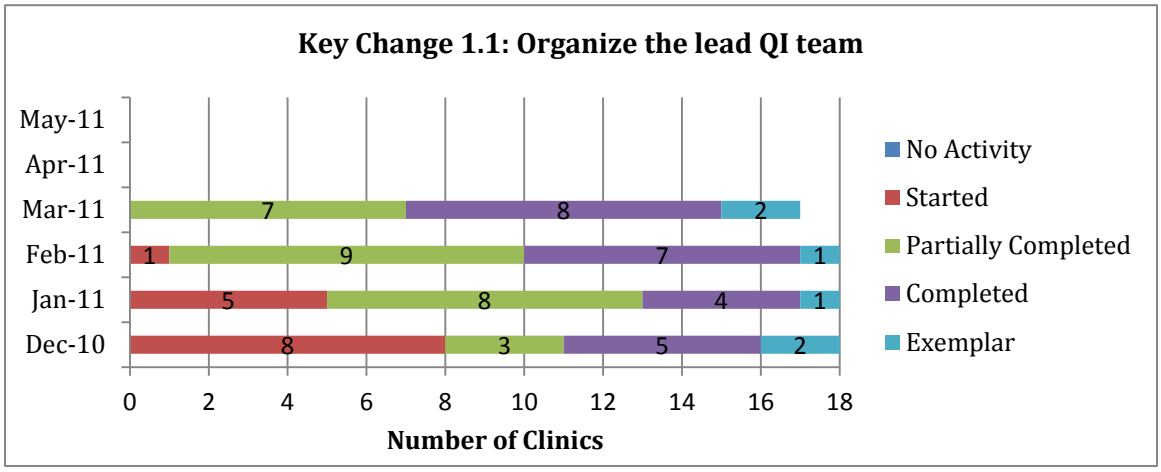
Transparency and the ability to collaborate and share information are essential to effective improvement work. At the same time, sharing too much information or the wrong type of information can derail the process. A good rule to use is: If you are in doubt about sharing a

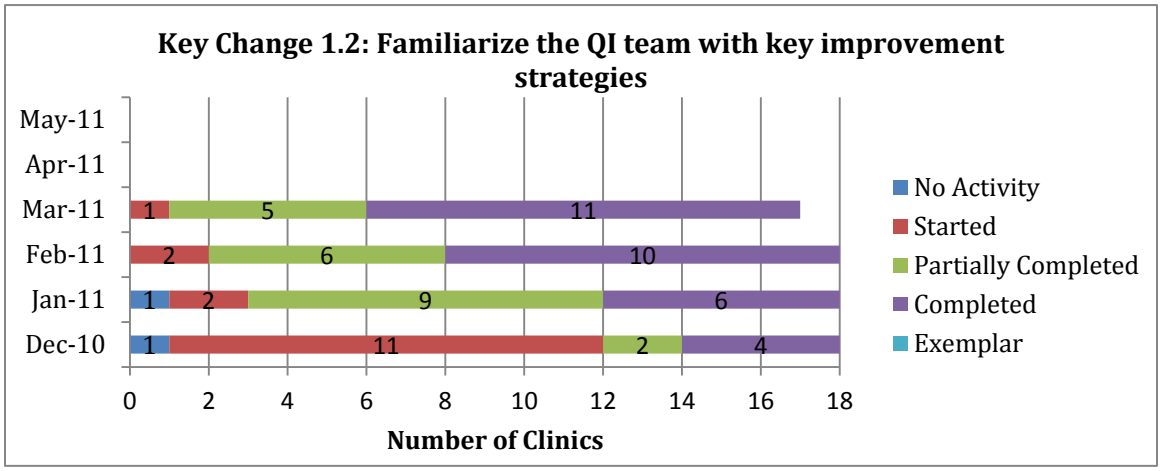
piece of information, don't. You can always make it available later, but you cannot retract it once it has been shared.

Reporting Progress Across Your Practices

You will need to report to your supervisor how your practices are faring as a group. Figure 23.4 shows one way of conveying the big picture by charting practices' progress in implementing key changes. Note that progress is not linear. Practices that completed a key change in one month may backslide the following month.

Figure 23.3. Sample graphic showing progress across a panel of practices





Note: this module is based on Module 15 of the Practice Facilitation Handbook. Available at http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/

Primary Care Practice Facilitation Curriculum

Module 24. Introduction to the Care Model

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Module 24. Introduction to the Care Model

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Foundational knowledge in the Care Model

Time

- Pre-session preparation for learners: 115 minutes
- Session: 60 minutes
- Post-session for learners: 30-90 minutes

Objectives

After completing this module, learners will be able to:

1. Describe the key elements of the Care Model.
2. Identify the key elements of a patient centered medical home (PCMH).
3. Understand how the Care Model and PCMH relate.

Exercises and Activities To Complete Before and During Session

Pre-session preparation. Ask the learners to review information in items 1-4. (115 minutes)

1. The content of this module.
2. Ed Wagner's *Improving Chronic Illness Care Across the Population* online video. Available at http://www.youtube.com/watch?v=jJe7Y9-cRgw.
3. National Committee for Quality Assurance (NCQA) video on the PCMH. Available at http://www.youtube.com/watch?v=ZC4YCLG4h5k&feature=player_embedded.
4. Building Blocks of Primary Care: Webinar featuring Thomas Bodenheimer, M.D. Available at http://vimeo.com/93514997.

During the session. Presentation (15 minutes)

1. Present key concepts from this module.
2. Review the Building Blocks of Primary Care Assessment (BBPCA) with learners and read through instructions for completing the assessment. Available at http://www.annfammed.org/content/suppl/2014/03/04/12.2.166.DC1/Bodenheimer_Supp_Apps.pdf.

Discussion. Ask questions and explore answers with learners. (45 minutes)

1. What are the core elements of the Care Model?
2. What are the core elements of the PCMH?
3. What is the relationship between the Care Model and the PCMH?
4. What does research say about the effects of implementing the Care Model or the PCMH in safety net practices on patient outcomes? Patient experience? Costs of care for the practice?

Costs of care for the payer?

Post-session. Activity for learners (range of 30-90 minutes, depending on number of persons completing the assessment and delivery)

1. Ask learners to schedule a meeting or at least email a contact from a participating site to complete the BBPCA.
2. The learner will explain the purpose and provide instructions to the person(s) completing the assessment. Ideally, more than one person from the practice would complete the assessment to arrive at greater perspective, but this is not always the case.
3. Follow up with the practice to provide feedback from the BBPCA.

Note: the person(s) completing the assessment should be well versed in both back- and front-end functions of their primary care organization.

Module 24.

Practice facilitation has frequently been used in disease-specific or other discrete quality improvement projects. Increasingly, facilitation is being used to effect a transformation of the primary care setting.

Currently the U.S. health care system is organized to deliver short-term medical treatment for an acute health condition, not to promote health and well-being or management of chronic health conditions. The Group Health Cooperative of Puget Sound, with funding from the Robert Wood Johnson Foundation, developed the Care Model (originally called the Chronic Care Model) as an alternative to the acute care-focused delivery system (Wagner, et al., 2001).

The Care Model

As shown in Figure 24.1, the Care Model depicts three overlapping spheres in which chronic care takes place: community, health systems, and provider organization (Bodenheimer, et al., 2002). The Care Model consists of five core elements: health systems, delivery system design, decision support, clinical information systems, and self-management support. These in turn produce productive interactions between informed, activated patients and prepared, proactive practice teams.

Figure 24.1. The Care Model

Developed by the MacColl Center for Health Care Innovation. ®ACP-ASIM Journals and Books. Used with permission.

The Care Model calls for an organized and planned approach to improving patient health. This approach focuses on particular patient populations (e.g., individuals with coronary artery disease) to ensure that every patient receives optimal medical care. It also encourages a shift from care

delivered mainly by the physician to one that encourages care delivered through teams. Each team member brings unique and needed expertise to the table.

The Care Model has gained international recognition for identifying the essential elements of a health care system that encourages high-quality care. Numerous studies suggest that redesigning care using the Care Model leads to improved patient care and better health outcomes (Coleman, et al., 2009).

Patient Centered Medical Home

The Care Model was formative in the development of the patient-centeredness movement. Over the past decade the patient-centered medical home (PCMH) has become a popular framework for transforming primary care. Briefly, the Agency for Healthcare Research and Quality has characterized the PCMH by five functions and attributes:

- Comprehensive care
- Patient centeredness
- Coordinated care
- Accessible services
- Quality and safety

To underscore the compatibility of the two approaches, the Care Model has been expanded to explicitly include elements of PCMH (see Figure 24.2).

Figure 24.2. Expanded Care Model

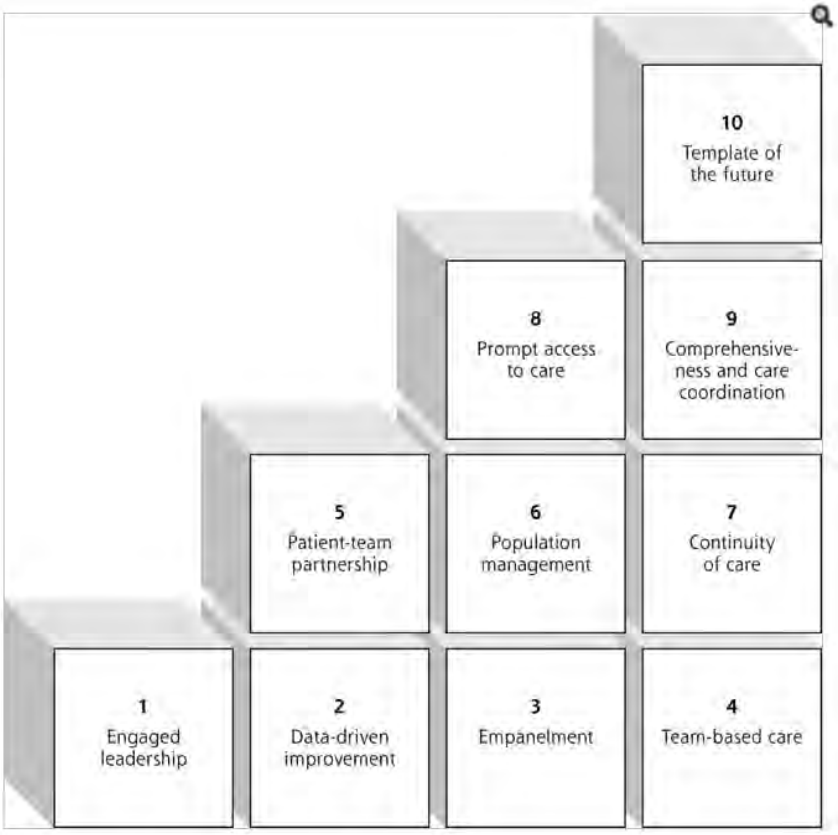
Source: 1996-2011 The MacColl Center for Health Care Innovation. The Improving Chronic Illness Care program is supported by The Robert Wood Johnson Foundation, with direction and technical assistance provided by Group Health's MacColl Center for Health Care Innovation. Used with permission.

Many organizations that seek to become a PCMH use the Care Model to operationalize the broad principles and the aspirational vision of the PCMH. Facilitators assisting practices striving to attain PCMH status can rely heavily on the tools that have been produced to aid in Care Model implementation.

The Ten Building Blocks of Primary Care

Ten areas in primary care were identified by Bodenheimer, et al. (2014) as the building blocks for high performance. These areas are shown in Figure 24.3; the blocks incorporate both the Care Model and PCMH principles. When working with your practices in quality improvement work, consider this model and how each building block forms a foundation to a high-performing practice.

Figure 24.3. The ten building blocks of high-performing care



Ten Building blocks of high-performing primary care.

Source: Bodenheimer T. (2014). The 10 Building Blocks of High-Performing Primary Care. © 2014 Center for Excellence in Primary Care. Used with permission.

Note: this module is based on Module 16 of the Practice Facilitation Handbook. Available at: http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/

References

Agency for Healthcare Research and Quality. Defining the PCMH. Patient Centered Medical Home Resource Center. Available at: http://pcmh.ahrq.gov/page/defining-pcmh. Accessed October 7, 2014.

Bodenheimer T, Ghorob A, Willard-Grace R, et al. The 10 building blocks of high-performing primary care. Ann Fam Med 2014;12(2):166-71.

Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness. JAMA 2002 Oct 9;288(14):1775-9.

Coleman K, Austin B, Brach C, et al. Evidence on the Chronic Care Model in the new millennium. Health Aff (Millwood) 2009;28(1):75-85. Available at http://content.healthaffairs.org/content/28/1/75.full. Accessed October 7, 2014.

Wagner EH, Austin BT, Davis C, et al. Improving chronic illness care: translating evidence into action. Health Aff (Millwood) 2001 Nov-Dec;20(6):64-78.

Primary Care Practice Facilitation Curriculum

Module 25. The Patient Centered Medical Home: Principles and Recognition Processes

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Module 25. The Patient Centered Medical Home: Principles and Recognition Processes

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Foundational knowledge in the principles of the patient centered medical home (PCMH)

Time

- Pre-session preparation for learners: 60 minutes
- Session: 75 minutes

Objectives

After completing this module, learners will be able to:

1. Describe the five core principles and functions of the PCMH.
2. Describe the main PCMH recognition programs, as well as the factors that should be considered when a practice selects a recognition program.
3. Locate resources available for ongoing PCMH initiatives.
4. Describe the major PCMH payment models currently in use.
5. Locate sources to stay apprised of new developments related to the PCMH.

Exercises and Activities To Complete Before, During, and After the Session

Pre-session preparation. Ask the learners to review the following information. (60 minutes)

1. The content of the module.
2. Agency for Healthcare Research and Quality. Patient Centered Medical Home Resource Center: Defining the PCMH. Available at http://pcmh.ahrq.gov/page/defining-pcmh.
3. National Academy for State Health Policy. States with medical home activity for Medicaid/CHIP since 2006. Available at http://nashp.org/medical-homes-map/.
4. Information under the "Medical Home" tab of the Patient-Centered Primary Care Collaborative website. Available at http://www.pcpcc.org/about/medical-home.

Preparation (1 hour)

1. Prepare a presentation that introduces the principles of PCMH, provides the basics of PCMH recognition programs, and describes the ways in which the PF will work with practices on PCMH-related activities.

During the session. Presentation (15 minutes)

1. Present key concepts from the module.

Discussion. Ask questions and explore answers with learners. (60 minutes)

1. What are the core principles of the PCMH? Why is it important for a primary care practice to align the care it provides with these principles?
2. What are the major PCMH recognition programs? How can a practice facilitator help practices determine which recognition program is most suitable?
3. What are some of the resources a practice facilitator can use to identify ongoing PCMH initiatives that might be relevant to a particular practice?
4. What are some of the payment models that payers are currently using to incentivize practices to obtain PCMH recognition or adopt various elements of the PCMH?

After the session

1. Ask learners to review the additional resources provided at end of the module.

Module 25.

The patient centered medical home (PCMH) model has become a cornerstone of primary care redesign. While the concept of the medical home was first introduced for pediatric settings by the American Academy of Pediatrics in 1967, the major primary care physician associations developed and endorsed the joint principles of the PCMH in 2007. Since then, the PCMH concept has become increasingly important as Medicare, Medicaid agencies, health plans, and other payers seek to improve the quality of care they purchase and to control costs. Based on recent information collected by the Patient-Centered Primary Care Collaborative (PCPCC), there are nearly 500 public and private medical home initiatives across the United States (PCPCC, 2014). Payers and others are working to gather evidence of the effects of different approaches to implementing the medical home model, so the model can be refined and adapted to the varied needs of patients, practices, and regions.

Several major programs offer PCMH recognition or accreditation for medical practices. The most commonly used recognition program is that of the National Committee for Quality Assurance (NCQA). NCQA has recognized roughly 5,700 practice sites (which include about 28,000 clinicians) as medical homes. Other recognition entities include the Joint Commission, URAC (formerly the Utilization Review Accreditation Commission) and the Accreditation Association for Ambulatory Health Care. In addition, some states and payers have their own medical home recognition programs.

This module is designed to:

- increase your knowledge of and familiarity with the principles and concepts of the PCMH,
- provide you with an introduction to some of the PCMH recognition programs in which practices may be participating, and
- familiarize you with a range of models that some private and public payers use to incentivize practices to adopt the PCMH model of care (including examples of ways these models are being implemented in different states).

This module will provide information and resources for working with practices as they seek and attain PCMH recognition, which is the process through which a practice achieves its status as a medical home. This process is also sometimes referred to as “accreditation” or “certification.” Understanding the principles of the PCMH will help you support practices through the recognition process, which can be challenging, while ensuring that the objectives of true practice transformation to a PCMH do not get lost as practices document processes to achieve PCMH status.

Principles and Concepts of the PCMH

According to the Agency for Healthcare Research and Quality (AHRQ) and the Patient-Centered Primary Care Collaborative (which based their definition on AHRQ’s), the PCMH is built

around five core principles and functions: comprehensive care, a patient-centered approach, coordinated care, accessibility of services, and quality and safety.

- **Comprehensive care.** The PCMH is oriented toward the "whole person" and is responsible for addressing all the patient's physical and mental acute, chronic, and preventive health care needs. This involves the direct provision of the appropriate care when possible or arranging for other qualified professionals (such as specialists) to provide care when necessary. Care within the primary care setting is delivered by a team rather than a single clinician, so professionals with different skill sets are available to meet the patient's needs. (Module 28 has more information on team-based care and working with practice teams.)
- **Patient-centered approach.** The PCMH provides care that is relationship based and tailored to best meet each patient's needs, values, culture, and preferences. Each patient has the opportunity to build ongoing, trusting relationships with a team of health care professionals. Clinicians seek to engage patients in their health care; provide the support, education, and information they need to make informed health care decisions; and recognize them as important members of the care team. PCMH clinicians and health care professionals use their cultural competence to treat patients with dignity, respect, and compassion, and they seek to meet patients where they are so that care is delivered in the way that best suits the patient's needs.
- **Coordinated care.** All of a patient's health care is coordinated by the PCMH, including care received in hospitals, from specialists (including mental and behavioral health specialists), and through community or home-based services and supports. Coordination of care may be facilitated by patient registries, use of health information technology (such as electronic health records), and other methods. To ensure that care is properly coordinated, the PCMH strives to build strong communication with patients and among all members of a patient's care team. The goal of coordination is greater efficiency through avoidance of duplication of services, synchronization of services so that they have a maximum impact, and ensuring connection of patients to needed services.
- **Accessibility of services.** To ensure that patients are able to access care when they need it, the PCMH offers short wait times for urgent care, enhanced hours, and around-the-clock access to the care team via telephone or electronic methods (email, patient portal, etc.). Care teams also seek out and respond to patient preferences regarding access and communication (e.g., whether patients prefer to communicate via email or telephone, and what language they prefer to use when getting care).
- **Quality and safety.** To achieve optimal patient health outcomes and the highest quality of care, the PCMH is committed to quality improvement (QI), performance improvement, patient satisfaction, and population health management. Practices use evidence-based medicine and decision support tools to guide shared decisionmaking and use patient registries to track the health status of their entire patient panel. Practices use data-driven QI methodologies to continuously monitor performance in a variety of care areas. Patients are engaged in QI processes and involved in practice decisionmaking to ensure

that care is provided in accordance with patient wants and needs. (Module 8 has information on and resources for supporting QI work.)

These principles closely align with the core values of primary care, which are defined by the Institute of Medicine as providing integrated, accessible health care services to meet the majority of personal health care needs in a sustained partnership with patients in the context of family and community (see Module 3, Primary Care Landscape and Context, for more details).

Key sources of information on the PCMH

- www.pcmh.ahrq.gov
- www.pcpcc.org
- www.medicalhomeinfo.org

PCMH Recognition Programs

Currently, at least four major programs offer practices the opportunity to document the ways they provide care aligned with the principles of the medical home, thereby achieving PCMH or medical home recognition. In addition, some payers and states offer their own recognition programs. If a practice you are working with is interested in PCMH recognition, one way that you can help is by encouraging practice leaders to think carefully about which recognition program is most appropriate for the practice.

Table 25.1 outlines four major PCMH recognition programs, along with links to resources that provide more information on each. The practices you are working with may be participating in a program through a state or payer that is not on this list. Nonetheless, since the PCMH principles are common across many programs, the resources available from these organizations will likely be helpful to you and the practices you work with. Program requirements and other details change regularly, however, so you should regularly consult the links provided here to gather the most up-to-date information on various programs.

Table 25.1. Four patient centered medical home recognition programs

Selected Patient Centered Medical Home Recognition Programs			
Accrediting Body	**Recognition Program**	**Program Elements**	**Resources**
The National Committee for Quality Assurance	Patient Centered Medical Home 2014 Standards	• Patient-centered access • Team-based care • Population health management • Care management and support • Care coordination and care transitions • Performance measurement and quality improvement	http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx
URAC (formerly the Utilization Review Accreditation Commission)	Patient Centered Medical Home Accreditation Version 2.0	• Quality care management • Patient-centered operations management • Access and communications • Testing and referrals • Care management and coordination • Electronic capabilities • Quality performance reporting and improvement	https://www.urac.org/accreditation-and-measurement/accreditation-programs/all-programs/patient-centered-medical-home/
Accreditation Association for Ambulatory Health Care	2013 Medical Home Standards	*Not publicly available.*	http://www.aaahc.org/en/accreditation/primary-care-medical-home/
The Joint Commission	Primary Care Medical Home 2014 Standards and Elements of Performance	*Not publicly available.*	http://www.jointcommission.org/accreditation/pchi.aspx

To determine which recognition program is most appropriate or suitable for a given practice, the American Academy of Family Physicians recommends that practices take the following three steps:

1. **Determine whether any initiatives are underway in the state or region to help practices become certified as a PCMH.** See the section below on "PCMH Initiatives and Payment Models" for more information on this topic.
2. **Learn whether the practice is required to become recognized as a PCMH by an outside group or entity.** For example, a practice may be asked to become a PCMH by an accountable care organization or may be required or incentivized to do so by a government agency, such as the Health Resources and Services Administration (HRSA) or the Centers for Medicare & Medicaid Services (CMS). Often such programs and initiatives require that participating practices achieve PCMH recognition with a *specific* program (that is, practices cannot necessarily choose which PCMH program to pursue).
3. **Assess what PCMH recognition programs are preferred or incentivized by the major payers with whom a practice contracts,** such as Medicaid, private health plans, Medicare, or other payers.

A practice will likely also want to consider the costs of attaining PCMH recognition. Some recognition programs charge fees, which may or may not be covered by a payer or other entity. However, in addition to recognition program fees, the overall cost also includes staff resources dedicated to achieving recognition, which can be extensive. In addition, some recognition programs require that practices have electronic health records that meet meaningful use standards. As a practice facilitator, it will be important for you to help practices understand that the recognition process will require a great deal of staff time, effort, and resources.

Once the practice has selected the recognition program that it will use and obtained the set of standards for the chosen program, the practice can start the work of documenting its current performance and making any necessary changes to practice processes and care delivery to achieve PCMH recognition.

Most PCMH recognition processes have many components, requiring input and cooperation from almost all members of the practice. Having an established QI or practice transformation team in the practice is an important part of successfully completing the process. (See Module 8 on QI and Module 28 on teams, which offer information on how to support this step.)

In the past, the Urban Institute (www.urban.org) and the Medical Group Management Association (www.mgma.com) compiled documents that compare and contrast medical home recognition programs. The information in these documents may not be current, but these organizations may offer updated comparisons in the future, so it is helpful to become familiar with their Web sites and perhaps join any mailing lists that would provide updated information.

PCMH Initiatives and Payment Models

Many payers across the country are implementing new payment systems that incentivize practices to achieve full PCMH recognition or implement certain aspects of medical home (such as care management or the use of care teams). These payers include private health plans and state Medicaid programs (about half of which had implemented new payment structures that reward practices for performing the functions of a PCMH as of 2012) (National Academy for State Health Policy, 2015; Takach, 2012). Some states have also implemented multipayer initiatives that provide enhanced payment to PCMHs (Edwards et al., 2014).

Identifying PCMH initiatives. Several resources are available to help practice facilitators identify PCMH initiatives in their state or region:

- The National Academy for State Health Policy provides a detailed list of medical home initiatives in each state: available at http://www.nashp.org/med-home-strategies/initiative-overview
- The Patient-Centered Primary Care Collaborative provides a primary care innovations and PCMH map, which is searchable by location or program name: available at http://www.pcpcc.org/initiatives/list
- The National Center for Medical Home Implementation provides a list of national demonstration projects and state initiatives: available at http://www.medicalhomeinfo.org/national/projects_and_initiatives.aspx

Understanding payment models of PCMH initiatives. Payers use a variety of financial incentives and payment models to encourage primary care practices to become medical homes.

The Safety Net Medical Home Initiative has outlined five potential payment models that public and private payers might consider to incentivize PCMH activity (Bailit et al., 2010). Table 25.2 describes these models and provides examples of each model.

Table 25.2. PCMH payment models

Model Type	Description
Fee-for-service (FFS) with adjustments	FFS with specialized codes for PCMH services or higher FFS rates.
FFS Plus	This model includes several possible approaches, such as: • FFS models with lump-sum payments to cover the work necessary to obtain PCMH recognition. • FFS with a per-member per-month (PMPM) payment, sometimes called a monthly care coordination or care management payment. • FFS with a PMPM payment and pay for performance based on predetermined performance measures.

Model Type	Description
Shared savings	This model includes all approaches with a shared savings component (for example, FFS with some share of savings distributed to practices that reduce costs compared to a benchmark – these programs usually include quality of care standards to ensure that reductions in cost do not reduce care quality).
Comprehensive payment	Similar to a capitated (per-person) payment model but includes enhanced payments to support PCMH activities.
Grant-based payment	Grant-based payments are awarded to cover PCMH transformation costs.
Other models	• Administrative support to help practices transform. • Central utility models that allow practices to share important PCMH resources (for example, care coordination services, QI programs).

Note: This table was adapted from one available at http://www.safetynetmedicalhome.org/sites/default/files/Policy-Brief-1.pdf .

Understanding the growing role of multipayer initiatives. Multipayer initiatives align incentives across payers and provide guidance to primary care practices on how to redesign and improve care. For example, the Center for Medicare and Medicaid Innovation (CMMI), part of CMS, launched the Comprehensive Primary Care (CPC) initiative in 2012. CPC is a 4-year initiative designed to test practice redesign models and a multipayer payment model (For more information, see http://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/). In this initiative, Medicare works with commercial payers and Medicaid agencies to provide enhanced payments that are not based on visits and shared savings, performance feedback, and shared learning activities to primary care practices that take on the task of providing their patients with comprehensive primary care. A number of states (such as New York and Oregon) have also pursued multipayer initiatives focused on the PCMH or related transformation activities.

Summary and Conclusions

Given the growing use of PCMH recognition programs and new payment models to improve the quality of primary care, you will likely encounter many practices in various stages of the medical home recognition process. As a PF, you can help practice staff stay focused on the overall goals and objectives of the PCMH embodied in the principles and concepts described here as they make their way through the recognition process. After a practice achieves PCMH recognition, you can play a key role in helping the practice maintain a QI infrastructure and continually refine and improve its approach to delivering patient care.

Resources

- Definitions and joint principles of the PCMH
    - http://pcmh.ahrq.gov/page/defining-pcmh
    - http://www.pcpcc.org/about/medical-home
    - http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf
- Payment Approaches
    - http://www.pcpcc.org/sites/default/files/media/payment_brief_2011.pdf
    - http://www.safetynetmedicalhome.org/sites/default/files/Policy-Brief-1.pdf
- Toolkits
    - http://www.pediatricmedhome.org/
    - http://www.medicalhomeimprovement.org/
    - http://www.aafp.org/practice-management/transformation/pcmh/recognition.html

References

Bailit M, Phillips K, Long A. Paying for the medical home: payment models to support patient-centered medical home transformation in the safety net. Seattle: Bailit Health Purchasing and Qualis Health; October 2010. Available at http://www.safetynetmedicalhome.org/sites/default/files/Policy-Brief-1.pdf

Edwards S, Button A, Hong J, et al. Patient centered medical home initiatives expanded in 2009-12: providers, patients, and payment incentives increased. *Health Aff* 2014;33(10):1823-1831.

National Academy for State Health Policy. States with medical home activity for Medicaid/CHIP since 2006. January 12, 2015. Available at http://nashp.org/medical-home-patient-centered-care-maps/index.html#x1-tab

Patient-Centered Primary Care Collaborative. "Mapping the medical home movement: PCPCC launches map highlighting enhanced primary care programs and patient-centered medical homes." June 9, 2014. Available at http://www.pcpcc.org/2014/06/06/mapping-medical-home-movement

Takach M. About half of the states are implementing patient-centered medical homes for their Medicaid populations. *Health Aff* 2012;31(11):2432-2440.

Primary Care Practice Facilitation Curriculum

Module 26. An Introduction to Electronic Health Records and Meaningful Use

Prepared for:
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Module 26. An Introduction to Electronic Health Records and Meaningful Use

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Foundational knowledge of primary care environments
- Basic skills in use of information systems

Time

- Pre-session preparation for learners: 2 hours and 15 minutes
- Session: 50 minutes

Objectives

After completing this module, learners will be able to:

1. Navigate basic workflows on an electronic health record (EHR).
2. Describe meaningful use and direct a practice to helpful resources for attaining it.
3. Help a practice generate a meaningful use report from their EHR system and validate these data.

Exercises and Activities To Complete Before and During the Session

Pre-session preparation. Ask the learners to review the following information. (2 hours and 15 minutes)

1. Review the content of this module.
2. Become familiar with EHR functions by simulating key workflows on an EHR.
   a. Learners should reference Figure 26.1 in this module.
   b. Select three workflows to simulate.
   c. Learners should be prepared to discuss their experience in learning to do this.

   If learners do not have access to an EHR to use in preparing for the session, they can consider practicing on a free or low-cost EHR available online. Practice Fusion® and Office Ally™ are examples of two low-cost or free EHRs that can be accessed online. Other systems such as Epic offer EHR simulators for those who have access to these systems.

During the session. Presentation (30 minutes)

1. Present key concepts from this module.

Discussion. Ask questions and explore answers with learners. (20 minutes)

1. Describe your experience and what you learned from working on the EHR or EHR simulator in preparation for this session.
2. What is meaningful use?
3. What workflows are typically impacted by EHRs?
4. If you are working with practices now, describe a challenge one of them is facing related to their EHR and quality improvement.

Module 26.

The need for skills in health information technology (IT) in primary care has never been greater. With the increasing implementation of electronic health records (EHRs) and the use of disease registries to monitor and track patient populations, practice facilitators will need to have a working knowledge of EHRs and how to use them most effectively.

This module will introduce you to EHRs and provide a brief review of some of their most important functionalities. You will need this information to be culturally and technologically competent when you work with your practices. The module will also introduce you to meaningful use requirements for the use of health information technology that have been established by the Federal government, and relevant Federal and state incentive programs available to practices. This module is intended to accompany Module 27 on EHRs and the Patient-Centered Medical Home (PCMH).

Figure 26.1. Information on certified EHRs

http://healthit.gov/policy-researchers-implementers/certified-health-it-product-list-chpl

A Brief Overview of EHRs

An electronic health record (EHR) (PCC EHR Solutions, 2014) is an electronic version of a patient's paper record. EHRs offer the advantage of making information about patient care available, in a secure way, to multiple authorized users. Although EHRs vary in content and functionality, they are often designed to include the medical and treatment histories of the patient, as well as the patient's diagnoses, medications, immunization dates, allergies, radiology images, and laboratory and test results, among other information. EHRs have the potential to integrate information from multiple sources and provide a more comprehensive view of patient care although this has proven challenging to achieve in actual practice. EHRs also may provide access to tools like clinical decision support reminders and reports that aid clinicians and teams in delivering care based on the best-available evidence.

EHRs make it possible to share and manage information across multiple providers, labs, specialists, imaging facilities and organizations through health information exchange (HIE) platforms so that information is available to and from all clinicians involved in a patient's care (HealthIT.gov, 2013). However, not all practices have achieved this level of use,

The Office of the National Coordinator of Health Information Technology (ONC) is the Federal entity charged with overseeing implementation of EHRs throughout the U.S. health care system.

An Introduction to EHRs

As a PF, you need general knowledge about EHRs and the ability to direct your practices to information on certified EHRs, resources for evaluating and planning for implementation of an EHR, and the ability to connect practice members to experts on EHR implementation as appropriate. For practices that are just beginning their journey towards going digital, providing them with basic introductory training on EHRs can be helpful.

Figure 26.2. Training materials on EHR selection for practices (CME approved)

American Medical Association

http://www.ama-cmeonline.com/health_IT/ama_health_it_transcript.pdf

Practices face a dizzying array of choices of EHR products. Once they have made a selection, learning how to use their EHR effectively is also a laborious process. As a practice facilitator, you will need to be familiar with various EHR products and how to extract data from them.

Regardless of which EHR a practice selects or is already using, you should immediately determine how the hardware and software will be (are) supported and by whom. If all or a portion of the EHR is supported by the organization that purchased the EHR, the internal IT support person is often the key to leveraging the EHR for project needs. He or she should be the first contact for IT-related questions. This is an important relationship to establish, as this person will also know if the practice needs additional external support.

Many resources are available for both you and your practices on EHR implementation. One is the Health Resources and Services Administration's Health IT Adoption Toolbox, available at http://www.hrsa.gov/healthit/toolbox/healthitimplementation/index.html. Another resource is the Health Implementation Toolbox for Pediatric Care at http://www.hrsa.gov/healthit/toolbox/childrenstoolbox/. These toolboxes provide a compilation of planning, implementation, and evaluation resources to help community health centers, other safety net providers, and ambulatory care providers implement health IT applications.

Another type of resource is the 62 regional extension centers (RECs), which were established to help primary care providers adopt and use EHRs. While these organizations are no longer funded, staff and external consultants to these entities may still be active in your area. Some RECs may have been integrated into health plans; others may have become part of organizations running your local or state health information exchange (HIE). These can be good places to look for technical experts in EHR implementation as well as expertise in accessing data from EHRs. A list of the original RECs is available here: http://www.healthit.gov/providers-professionals/regional-extension-centers-recs. Another good resource for supporting EHR implementation is the "How to Implement EHRs" guide available from the Health IT.gov website: http://www.healthit.gov/providers-professionals/ehr-implementation-steps.

Some Basic Functions and Elements of EHRs

While EHRs were initially developed to document clinical care, most can perform additional functions that can support good quality care. You should have a working knowledge of what functionalities most systems possess and what functionalities are often missing or ineffective and require add-on software to address. For example, many EHRs lack good patient registries and population or panel management systems. If an EHR does contain these functionalities, they are often clumsy and difficult to use. This section introduces the common basic functions and some more advanced functions that you are likely to encounter in your work with practices.

Common functions of EHRs include (Health Resources and Services Administration, 2014a).

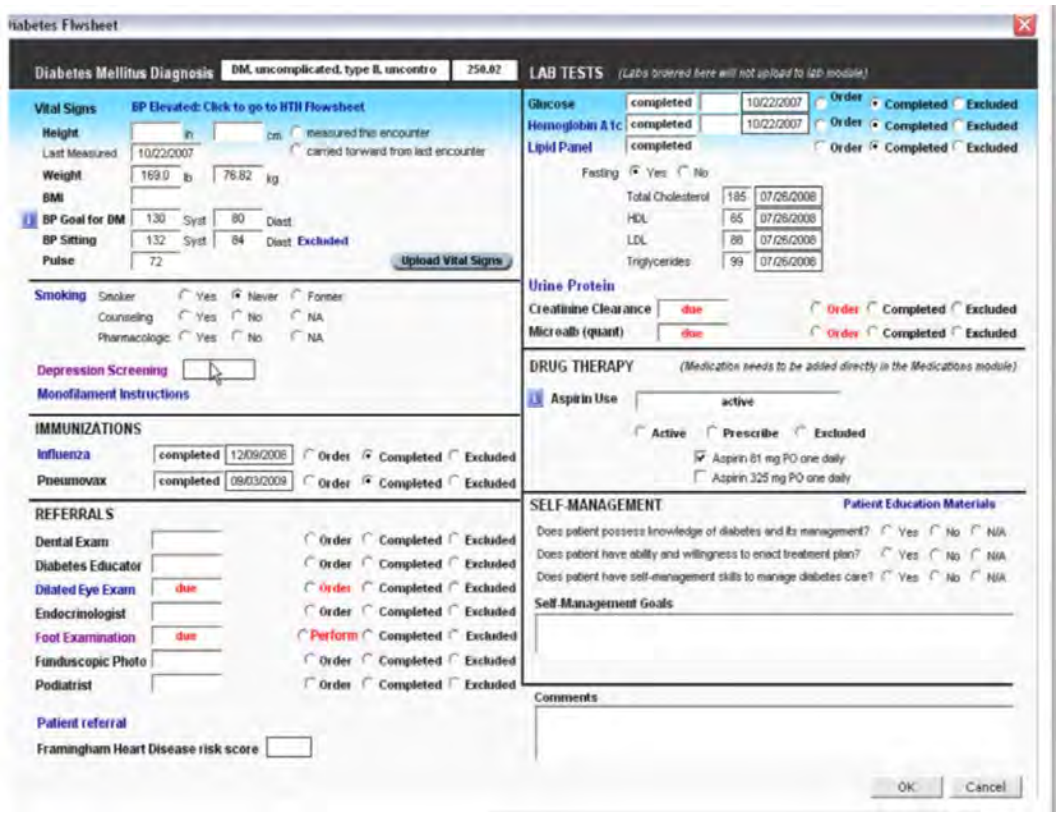
- recording patient demographic and care management data on patient visits.
- clinical decision supports.
- reports required for financial management, quality assurance, chronic disease management, and public health data collection.
- consents, authorizations, and directives.
- interfaces and interoperability required to exchange health information with other clinicians, laboratories, pharmacies, patients, and government disease registries.
- e-prescribing.
- alerts and reminders.
- medication reconciliation.
- commonly used screening tools and checklists.
- commonly used forms for schools, camps, and sports participation.
- patient education.

Some systems might also include integrated practice management support that enables functions like billing, online scheduling, and patient portals.

Examples of some basic elements of EHRs are provided below. This list is not exhaustive and designed to provide a glimpse into EHRs and some of their capabilities.

Flow sheets. Flow sheets integrate and organize important patient information into a summary screen and are standard parts of ambulatory EHR systems. They can organize data on vital signs, smoking status, immunizations, referrals, laboratory tests, drug therapy, and diabetes self-management. Flow sheets can also support clinical decision support (CDS) and alerts. The sample flow sheet below combines data display, alerts and reminders, documentation templates, and info-buttons related to diabetes care. They can also include hot links that enable clinicians to leave the flow sheet and go directly to the section of the patient's medical record supporting the needed action (Health Resources and Services Administration, 2014a). Flow sheets can be used to organize patient information, identify gaps in patient care, and suggest actions based on CDS and alerts.

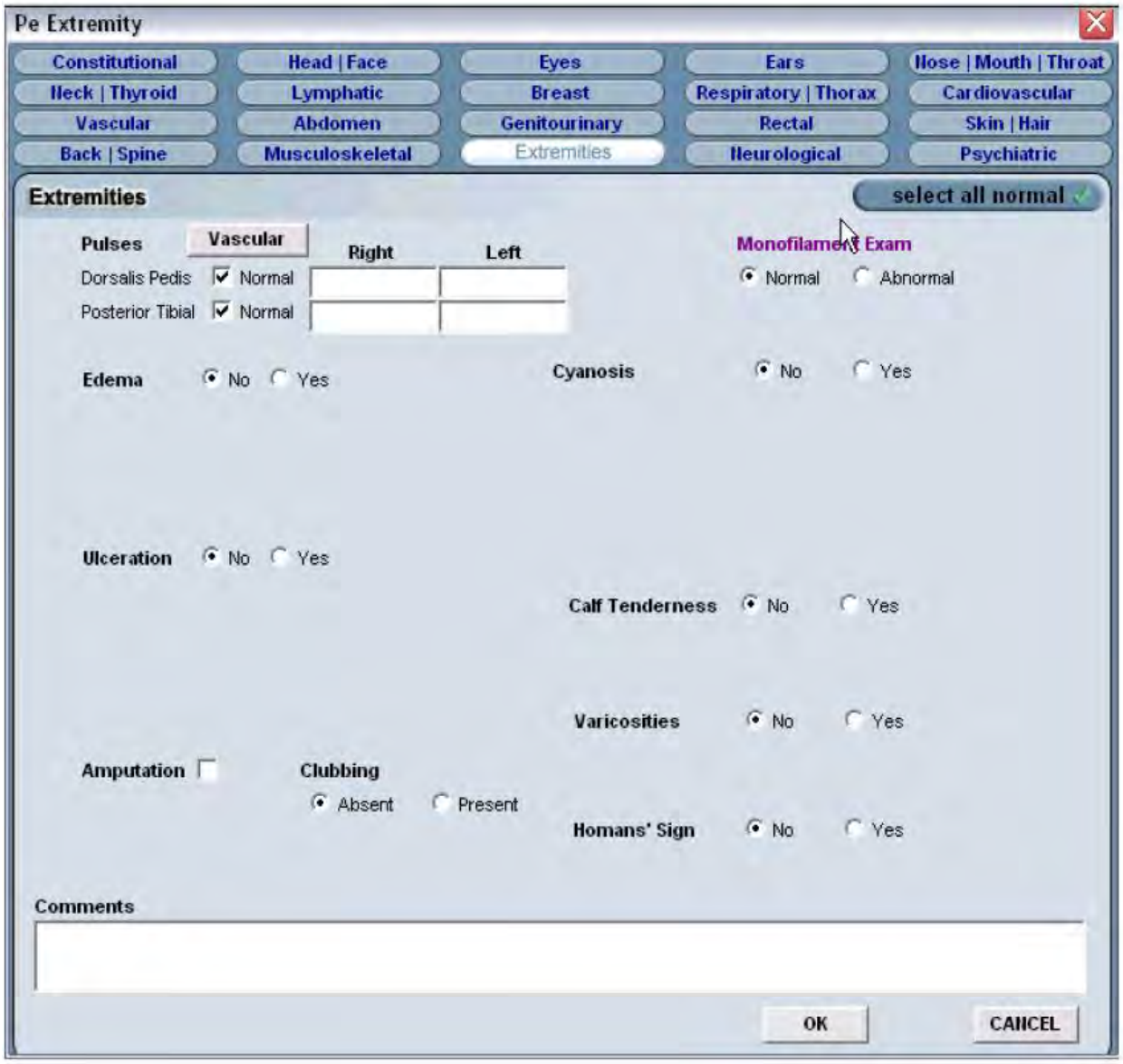
Figure 26.3. Sample flow sheet for comprehensive diabetes visit



Source: HealthIT.gov, 2014. CDS Starter Kit: Diabetes follow-up care. http://www.healthit.gov/sites/default/files/del-3-7-condition-example-diabetes.pdf

Templates. Templates are pre-structured entry forms in EHRs used to capture a standard set of data for specified visits types. Templates organize, present, and capture clinical data within the system. Depending on which EHR the practice is using, information can be entered into templates using a variety of methods including dictation, typing, auto-fill, or drop down menus.

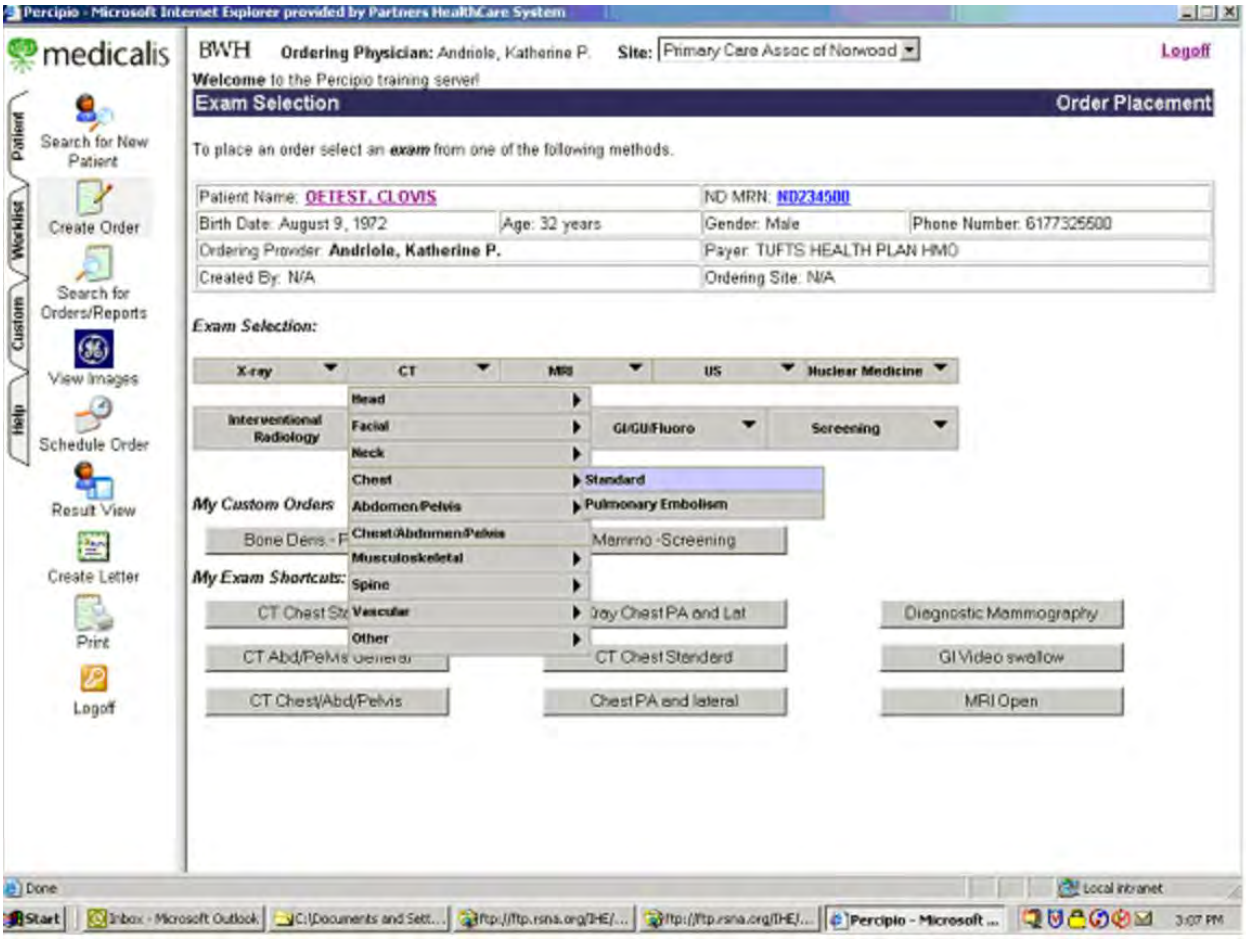
Figure 26.4. Sample documentation template for foot exam



Source: HealthIT.gov, 2014. CDS Starter Kit: Diabetes follow-up care. http://www.healthit.gov/sites/default/files/del-3-7-condition-example-diabetes.pdf. (HealthIT.gov, 2014a)

Computerized provider order entry. CPOE systems allow health care providers to directly enter medical orders electronically into EHRs as a replacement for paper, fax, telephone and verbal order methods. CPOE systems allow providers to electronically enter medication orders as well as laboratory, admission, referral, and procedure orders. CPOE systems are frequently integrated with clinical decision support systems that help ensure evidence-based care and improve patient safety with rules to check for drug-drug interactions, allergies, medication contraindications, and dosing. (Agency for Healthcare Research and Quality, February 2014). Figure 26.5 provides an example of a CPOE screen.

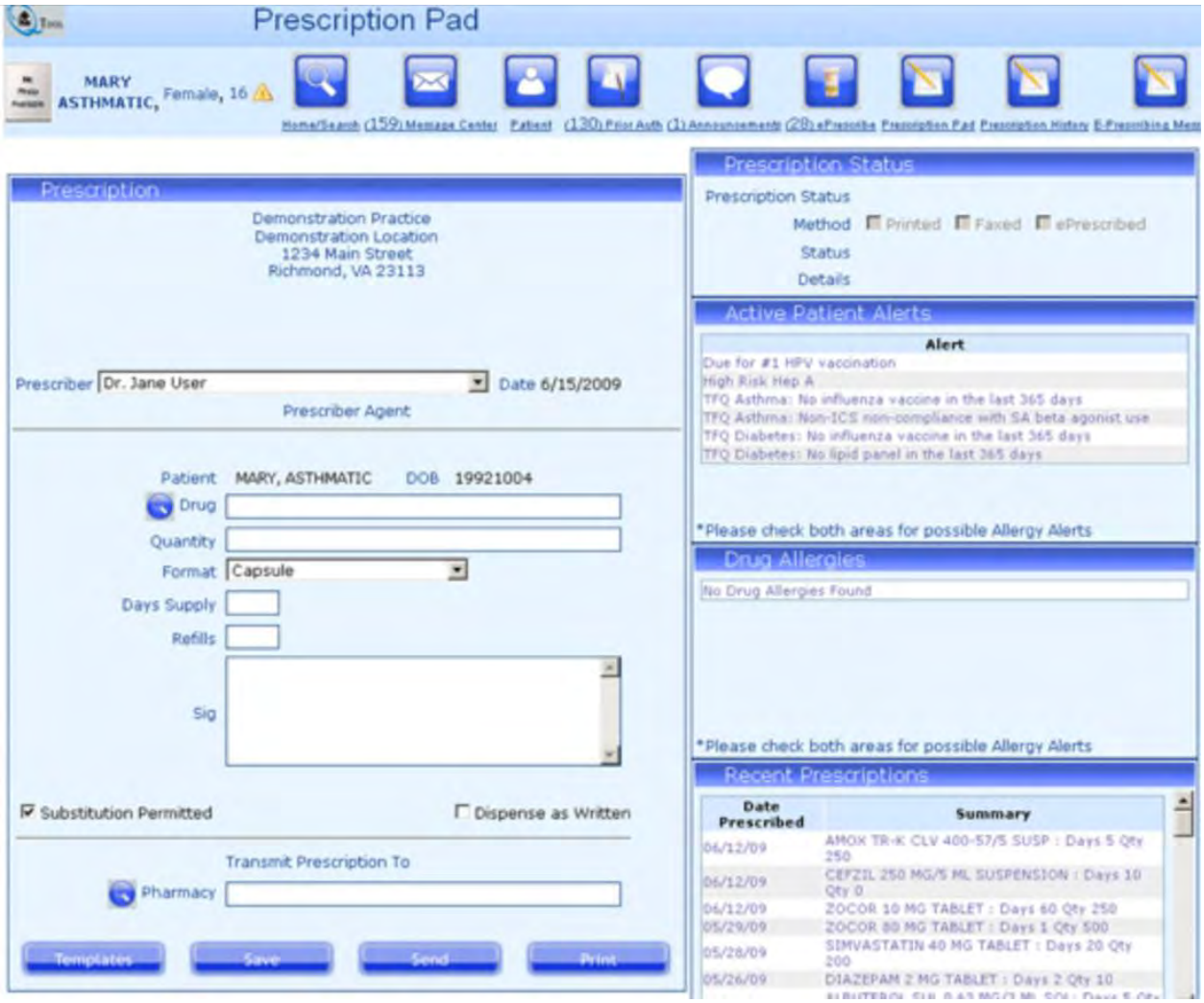
Figure 26.5. Computerized Physician Order Entry example



Source: Hostetter, M. (2009). Alabama's Together for Quality Program—Putting Health IT to Work for Medicaid Beneficiaries. Used with permission.

Electronic prescribing. E-prescribing is the ability for a clinician to send accurate, understandable prescriptions directly to the pharmacy from point-of-care. Research has demonstrated significant reductions in medication errors as a result of e-prescribing. Figure 26.6 provides an example of an e-prescribing screen.

Figure 26.6. E-Prescribing example



Source: Hostetter, M. (2009). Alabama's Together for Quality Program—Putting Health IT to Work for Medicaid Beneficiaries. Used with permission.

Reporting. Understanding the types of reports the practice's EHR can generate is essential to helping a practice actively manage patients, track operational indicators, and meet meaningful use regulatory and accreditation requirements. Reports typically can be generated at the practice or provider level. However, starting with the practice level report is a good way to identify "red flags" that require further investigation into reports at the level of the individual provider. For example, if compliance with the Stage 1 meaningful use mandate of maintaining an up-to-date problem list for 80 percent of patients is at 60 percent for the practice, the next step should be to assess provider-specific compliance.

These data can be powerful motivators for provider change as providers see how they perform against the practice as a whole and other providers, as well as positive reinforcement for those exceeding expectations. More information on how to help practices with reporting is provided in Module 28.

Get to Know a Practice's Health IT Systems

One of the first things you will want to do when you start work with a practice, regardless of the goals of the work, is to gather some basic information about its IT infrastructure and the staff supporting it. You will want to know where the practice is in the process of implementing an EHR. (Hsiao & Hing, 2014). Are practice staff planning implementation? Are they in the middle of the process? Did the implementation of the EHR happen some time ago and have practice staff had a chance to adjust to the changes? Are they expecting a system upgrade soon? Implementing EHRs can disrupt patient care, staff productivity, and the patient and staff experience. Upgrades can create stress as well so it is critical to know where the practice is in the process. (Nemeth, Ornstein, Jenkins, Wessell, & Nietert, 2012).

If the practice is already using an EHR, you will need to know what system they are using (including the version) and whether they use other health IT systems such as a registry or a population management system. If the practice uses these other systems, you will need to find out if and how the various systems are integrated. Do they share data electronically? Or does someone in the practice manually enter the data from one system into the other?

You will also need to know who in the practice is most knowledgeable about the EHR and other health IT systems. Practices often have an individual (or in larger practices, multiple individuals) who is designated an EHR "super user." Super users have typically completed advanced training on the EHR system (or other health IT systems) and may be either a staff member or a clinician. (Halbesleben, 2009). In addition, some practices employ outside consultants to help with IT-related tasks such as maintaining networks, updating software, or designing reports. If the practice you are working with has access to such consultants, you need to get to know them and get them engaged in the work you are doing with the practice.

In addition, you need to identify who in the practice (or which outside consultant) is charged with creating reports, implementing new EHR functions such as clinical decision supports, and creating templates for recording data. For example, what automated and ad hoc reports are run in the practice and who is responsible for creating and running these reports? How often are these reports run? Common reports that practices might run are meaningful use reports, electronic Clinical Quality Measures reports, population health reports, and internal reports to support QI efforts (Donaldson, 1996).

Finally, you will need to know who manages the relationship with the EHR vendor. This individual will be a key resource to you when there is a need for modification or technical assistance from the vendor.

Table 26.1. Information to collect about a practice's EHR

- Name and version of EHR system
- When implemented
- Other products like registries that the practice is using
- Name of the super user for the EHR
- Other key people that work with the EHR
- Reports the practice produces regularly
- Person/people in charge of creating the reports
- Method for creating the report (analytics software, internal production, subcontract)
- Technical support hours included in the EHR vendor contract
- Point of contact between practice and vendor
- Users groups for the EHR and related products
- Is there an HIE? What data does it have? Does it push information to the practice or only pull information to a central database that the practice must then log in to in order to get information on their patients?
- Where to get information about care that patients receive outside of the clinic
- How the practices interface with the "primary" or multiple hospitals where patients get care

If your practices have selected EHRs that do not have the full functionality needed to support the PCMH, you will need to help the practice supplement their care management capacity. For example, if their EHRs cannot identify a population of patients due for a chronic care service, the practice will need to maintain registries, much as they would have to do if they did not have EHRs.

A registry is a database of patients with specific diagnoses, conditions, or procedures. While an EHR contains patient-specific information about all patient encounters within a practice, a registry is a subset of the patients in the practice. A registry is generally easier to use for tracking patients' progress and outcomes than an EHR. Although a registry can be a standalone application, it is often populated by an EHR to avoid entering key data items twice. More information on the functionalities of EHRs and their need to support the PCMH is provided in Module 28.

EHR Workflows

Implementing EHRs in a practice produces lots of changes in its operations. Almost every workflow is affected either directly or indirectly. Figure 26.7 provides a list of workflows that are typically affected. As a PF it is helpful to know what these workflows are. You should observe them as you have the opportunity and be available to help your practices improve or optimize these workflows when appropriate.

Figure 26.7. Workflows commonly affected by EHRs

- Recording patient demographics.
- Recording vital signs electronically.
- Maintaining up-to-date problem lists.
- Maintaining active medication lists.
- Maintaining active allergy lists.
- Recording smoking status.
- Providing patients with clinical summaries for each office visit.
- E-prescribing.
- Checking for drug-drug and drug-allergy interactions.
- Exchanging electronic information with other sites of care.
- Implementing a decision support rule and tracking compliance with the rule.
- Maintaining systems to protect privacy and security of patient data.
- Reporting clinical quality measures to CMS or States.
- Obtaining signatures on electronically generated forms (school, camp, sports participation)
- Generating lists of patients for QI or outreach.
- Providing electronic health education resources.
- Performing medication reconciliation between care settings.
- Generating summary of care record for referrals and transitions.
- Providing immunization data to regional registries.
- Providing surveillance data to public health agencies.
- Using patient reminders for prevention/chronic care.
- Providing patient access to lab results, problem and medication lists, and allergy information.
- Performing drug formulary check.
- Entering lab results into EHR.
- Scanning incoming documents for integration into the system

Adapted from Bodenheimer T. Personal communication, January 2011.

Source: Agency for Healthcare Research and Quality Web page, 2014. Module 17. Electronic Health Records and Meaningful Use. (Knox & Brach, 2013)

The HITECH Act

An area of special interest to many practices and something you will want to become well versed in is meaningful use. In February 2009, President Obama signed into law the American Recovery and Reinvestment Act (ARRA) as an economic stimulus package providing investment in the Nation's infrastructure, employment, transportation, education, and other fields. (Recovery.gov, 2014). Within ARRA, the Health Information Technology for Economic and Clinical Health (HITECH) Act specifically targets health care by providing the means to structure a paperless national health information network. The HITECH Act provides more than $40 billion, including:

- $20+ billion for incentive payments to hospitals and providers
- $650 million for RECs to help providers adopt health IT
- $560 million for State governments to lead the development of health information exchanges (HIEs)
- $4.7 billion for the adoption and use of broadband and telemedicine advancement
- $500 million for the Social Security Administration and $85 million for the Indian Health Service

- $50 million for IT within the Veterans Benefit Administration

The ARRA HIT Policy Committee further proposed "meaningful use" as the key criteria providers (hospitals and eligible providers, known as EPs) must meet to unlock tens of millions of dollars of Federal health care IT subsidies under ARRA. Meaningful use is utilizing EHRs and related technologies to improve quality of care, improve patient safety, and increase efficiency. It includes using technology to more effectively engage patients and their families in their health, and to enable care coordination and population management. (HealthIT.gov, 2014e). Meaningful use also includes the electronic exchange of information and the use of certified EHR technology to submit quality and other measures. (Health Resources and Services Administration, 2014b).

For primary care clinicians, this funding is directly tied to documenting important factors in primary patient care such as smoking status and current medications. Practice facilitators must be familiar with these factors, since EHR funding is tied to meeting meaningful use criteria.

To qualify for Federal incentive dollars, a practice is required to implement an EHR that is certified by the ONC. These standards are intended to establish a certain level of quality and shared functionality across the nation's health information systems. To be certified by the ONC, an EHR must (HealthIT.gov, 2014c).

- collect and store clinical health data, including medical history, problem lists, and patient demographics
- deliver clinical decision support
- provide a means to run reports on quality of care
- provide a means for exchanging information with other sources (such as lab reports from another organization)
- complete testing and receive certification by the ONC

A list of certified EHRs and the criteria they are required to meet is available at: http://www.healthit.gov/policy-researchers-implementers/certification-programs-policy.

ONC provides guidance for selecting or upgrading to a certified EHR at: http://www.healthit.gov/providers-professionals/ehr-implementation-steps/step-3-select-or-upgrade-certified-ehr .

Health Information Exchange

In addition to meaningful use, the HITECH Act also funds States and communities to support and accelerate the development of effective health information exchange (HIE). Health information exchange enables clinicians and health care staff and patients to access and share patients' medical information. Electronic HIE can improve the completeness of patients' records, which improves safety of care, quality of care, and effectiveness of care while also lowering costs.

Examples of two States that have made significant progress in connecting providers electronically can serve as exemplars for the State you work in:

1. The NY eHealth Collaborative (New York eHealth Collaborative, 2014) serves as a model for coordinating all exchange efforts throughout the State of New York. As an increasing number of private practices, nursing homes, clinics, and hospitals implement EHRs, these providers have the option to connect to information hubs in their region of the State for sharing patient data. eHealth then links all the regional nodes to a statewide network that primary care physicians can securely access for complete and accurate information about their patients.
2. The Massachusetts eHealth Institute (MeHI) (Massachusetts eHealth Institute, 2014) at the MassTech Collaborative is improving health care for the Massachusetts population through the use of IT. The institute runs the Massachusetts health information highway (HIway), the statewide HIE for clinical information among a variety of providers, including medical offices, hospitals, laboratories, pharmacies, skilled nursing facilities, and health plans. It also serves as the REC for helping providers achieve meaningful use goals. In addition, the institute works with MassHealth, the State insurance program for low- and moderate-income Massachusetts residents, on the Medicaid EHR Incentive Payment Program. This program supports the goal for all providers to have access to a Federally-certified EHR that communicates with other certified EHRs.

Incentive Programs

CMS and the Office of the National Coordinator (ONC) have implemented two programs to encourage practices to attain meaningful use. Eligible providers (EPs) who demonstrate attainment of one or more of three stages of meaningful use of certified EHR technology can receive up to $44,000 from Medicare over 5 consecutive years. Medicaid incentives, which are larger, are paid by the States, and timeframes for applying vary by State. Table 26.2 provides a comparison of the two incentive programs. EPs cannot receive incentives from both programs in the same year. If an EP qualifies for both programs in a single year, they must select one program from which to receive payments.

Table 26.2. Comparison of EHR incentive programs

Medicare EHR Incentive Program	Medicaid EHR Incentive Program
Run by CMS.	Run by your State Medicaid agency.
Maximum incentive amount is $44,000.	Maximum incentive amount is $63,750.
Payments over 5 consecutive years.	Payments over 6 years; does not have to be consecutive.
Payment adjustments will begin in 2015 for providers who are eligible but decide not to participate.	No Medicaid payment adjustments.

Overview

Providers must demonstrate meaningful use every year to receive incentive payments.

In the first year providers can receive an incentive payment for adopting, implementing, or upgrading EHR technology. Providers must demonstrate meaningful use in the remaining years to receive incentive payments.

CMS recently published a final rule that specifies the Stage 2 criteria that eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) must meet in order to continue to participate in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.

If you have not participated in the Medicare or Medicaid EHR Incentive Programs previously, or if you have never achieved meaningful use under the Stage 1 criteria, please visit the CMS EHR Incentive Programs website (www.cms.gov/EHRIncentivePrograms) for more information about how to take part in the program.

Three Stages of Meaningful Use

Stage 2 Timeline

To obtain incentive funds, EPs must show that they are using their EHRs in a meaningful way for patient care, safety, and quality. The incentive program has three stages. Stage 1 focuses on transferring data to EHRs and being able to share information. Stage 2 focuses on more rigorous health information exchange, sharing information with patients, and activities such as e-prescribing and electronic labs. Stage 3 will focus on achieving patient outcomes. Once an EP is enrolled in stage 1, the timeline is set for proceeding through stage 2 and stage 3 reporting. Figure 26.8 shows the timeline for attestation for the three stages.

Figure 26.8: Meaningful use timeline based on year started

1st Year	Stage of Meaningful Use										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2011	1	1	1	2	2	3	3	TBD	TBD	TBD	TBD
2012		1	1	2	2	3	3	TBD	TBD	TBD	TBD
2013			1	1	2	2	3	3	TBD	TBD	TBD
2014				1	1	2	2	3	3	TBD	TBD
2015					1	1	2	2	3	3	TBD
2016						1	1	2	2	3	3
2017							1	1	2	2	3

Source: Centers for Medicare and Medicaid. 2012. Stage 2 Toolkit. http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2_Toolkit_EHR_0313.pdf. Reprinted with permission.

Note that providers who were early demonstrators of meaningful use in 2011 will meet three consecutive years of meaningful use under the Stage 1 criteria before advancing to the Stage 2 criteria in 2013.

However, we have delayed the onset of Stage 2 criteria 1 year so that the Stage 2 criteria will be effective in fiscal year 2014 for eligible hospitals and CAHs or calendar year 2014 for EPs. The table below illustrates the progression of meaningful use stages from when a Medicare provider begins participation in the program.

More detailed information about each stage is provided below.

Stage 1. Stage 1 began in 2011 and remains the starting point for all providers. It consists of transferring data to EHRs and being able to share information, including the capability of producing electronic copies of medical records upon a patient's request and printing a copy of a visit summary for patients at the end of their visit. The focus is on data gathering and sharing. Stage 1 has the following measures (Table 26.3 has some example measures):

1. A core set of 15 measures that must be met through structured data entry, including patient demographics, computerized physician order entry (CPOE) for medication orders, updated problem/medication/allergy lists, recording of vital signs and smoking status, and a printed visit summary given to the patient after each visit.
2. An additional menu set of 24 measures of which 19 must be met through structured data entry, including patient-specific education resources, medication reconciliation, and patient electronic access.
3. Clinical quality measures to be submitted to the Centers for Medicare & Medicaid Services (CMS), including hypertension management, preventive care and screening measures, and childhood immunization status.

Table 26.3. Examples of Stage 1 measures

Meaningful Use Aim	Measure
CPOE used for medication orders.	More than 30% of all unique patients seen by the eligible provider with at least one medication in their medication list have at least one medication order using CPOE
Up-to-date problem list of (current and active) diagnoses	More than 80% of all unique patients of an eligible provider have at least one entry in the EHR or an indication that no problems are known, and this is recorded as structured data.
Prescriptions are transmitted electronically	More than 40% of all (permissible) prescriptions written by the eligible professional are transmitted electronically using certified EHR technology.
Active medication list is maintained and current	More than 80% of unique patients seen by the EP have at least one entry or an indication that the patient is not currently prescribed any medications, recorded as structured data.
Smoking status for patients 13 years or older is recorded	More than 50% of all unique patients who are 13 years or older and seen by an eligible provider have smoking status recorded as structured data.

Adapted from: An Introduction to the Medicare EHR Incentive Program for Eligible Professionals, CMS. Available online at: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/Beginners_Guide.pdf. Reprinted with permission.

Stage 2. Stage 2 (implemented in 2014), includes new standards such as online access for patients to their health information and electronic health information exchange between providers. Stage 2 builds on stage 1 measures, with an emphasis on using clinical decision support (reminders to ensure adherence to evidence-based guidelines) to improve performance on high-priority health conditions. For a detailed overview see: https://www.cms.gov/eHealth/downloads/eHealthU_EPsGuideStage2EHR.pdf .

Stage 3. Stage 3 implementation is expected in 2016 and includes demonstrating that the quality of health care has been improved for the population served. Examples of addressing conditions that affect a large proportion of the underserved population include improving outcomes for low birth weight babies and reducing hospital admissions for ambulatory care-sensitive conditions such as diabetes and childhood asthma.

Registration

Providers must apply online to register for meaningful use incentive programs. An overview of these steps are available on the CMS Web site at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html.

EPs will need a National Provider Identifier and a National Plan and Provider Enumeration System (NPPES) number to register. They will also need to be enrolled in the Provider Enrollment, Chain, and Ownership System (PECOS). There are instructions for providers who do not have accounts telling them how to enroll. Information on the NPPES is available at https://ehrincentives.cms.gov/hitech/loginCredentials.action.

An overview of each of the steps each EP will need to go through to register and begin the attestation process is provided below.

Step 1. The first step to applying is for the provider to determine whether to apply for Medicare or Medicaid incentives.

Step 2. In step 2, the practice must determine how many Eligible Professionals (EPs) there are in the practice. EPs are different by program.

EPs under the Medicare program

- MDs and DOs
- Doctors of Dentistry

EPs under the Medicaid program

- Physicians
- Nurse practitioners
- Certified nurse midwives
- Dentists

- Physician assistants who deliver care at a Federally Qualified Health Center or Rural Health Clinic that is led by a physician assistant

In addition, to be eligible for the Medicaid program, 30 percent of the EP's patients must be Medicaid (20 percent must be Medicaid if the EP is a pediatrician), or the EP must practice at a FQHC or Rural Health Center and have a minimum of 30 percent of patients who are low-income.

An online assessment tool for the determining eligibility is available at: http://cms.gov/apps/ehealth-eligibility/ehealth-eligibility-assessment-tool.aspx

Step 3. The third step involves registering on the CMS Web site. There is an option to reassign incentive payments directly to the organization using the group EIN rather than the EP's social security number which can save time spent updating provider agreements. You and your practices can use the CMS Registration Users Guide to assist with this process. The guide is available at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/EHRMedicaidEP_RegistrationUserGuide.pdf

Step 4. In step 4, the EP or practice will need to determine if their EHR is fully certified or only partially certified. If the EP is not using a fully certified EHR he or she will need to add on other certified products to create a combined system that meets all the criteria.

Step 5. To register for the Medicaid incentive program, EPs must register with their state. When registering, they will need their EHR certification number and in some instances a letter from their vendor that the product is certified. Information on state programs is available at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/MedicaidStateInfo.html.

Links to state incentive programs and the dates the programs started are available at https://www.cms.gov/apps/files/statecontacts.pdf .

EPs register for the Medicare program on the Federal Web site at https://ehrincentives.cms.gov/hitech/login.action .

Attesting to Meaningful Use

EPs must meet attestation requirements for each year. The first year requires EPs to adopt implement or upgrade to a fully certified ambulatory EHR. The second year requires reporting 90 days of meaningful use data (and for the Medicaid incentive program, financial proof that 30 percent of patients were Medicaid). For years 3 through 6, the EP will need to attest to 12 months of meaningful use each year. Detailed guidance about these requirements is available at: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html.

CMS provides a meaningful use attestation calculator that EPs can use to determine if they meet qualifications for stage 1 or 2 meaningful use.

Stage 1 Attestation calculator and assessment tool: http://www.cms.gov/apps/stage-1-meaningful-use-attestation-calculator/meaningful-use-core-measures-professionals.aspx.

Stage 2 Attestation calculator and assessment tool: http://www.cms.gov/apps/stage-2-meaningful-use-attestation-calculator/

Helping Practices Attain Meaningful Use

As a PF, you will be in a position to help your practices meaningfully use their EHRs. If the practice is pursuing incentive dollars, you will want to begin this work with the criteria that the practice needs to meet to reach stages 1, 2, and eventually 3 for meaningful use.

A helpful approach to this can be to map "as is" EHR workflow for processes relevant to meaningful use and then create "future" workflows. The ONC's National Learning Consortium has developed some template EHR workflows that you can use as a starting place with your practices and then modify these key process templates to fit their particular needs.

Figures 26.9 and 26.10 provide examples of EHR related templates available in the document. The templates can be accessed online at http://www.healthit.gov/providers-professionals/frequently-asked-questions/411#id80.

Figure 26.9. Medication prescribing

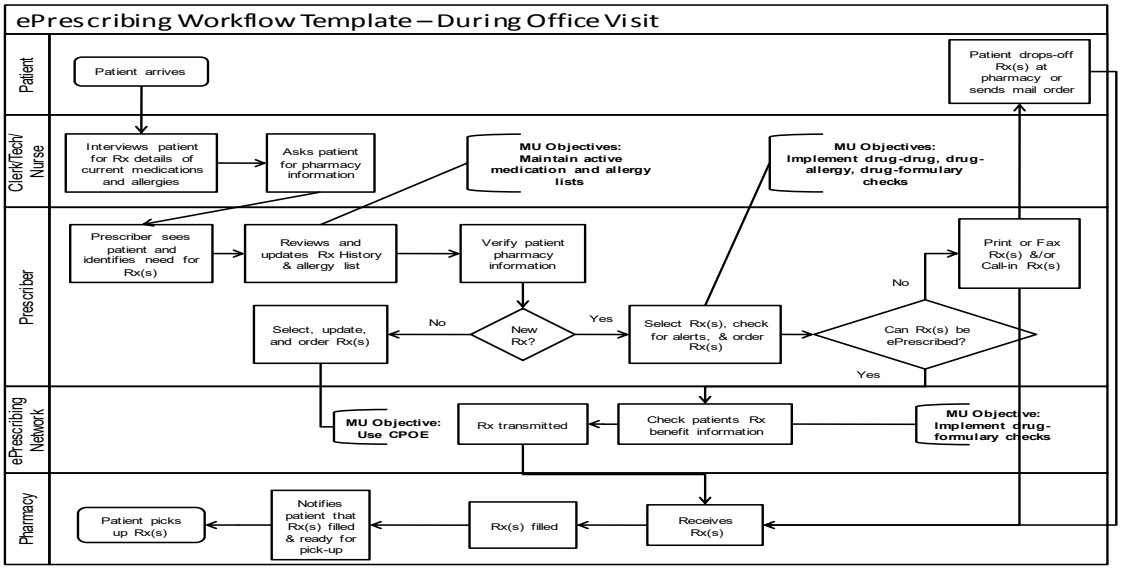
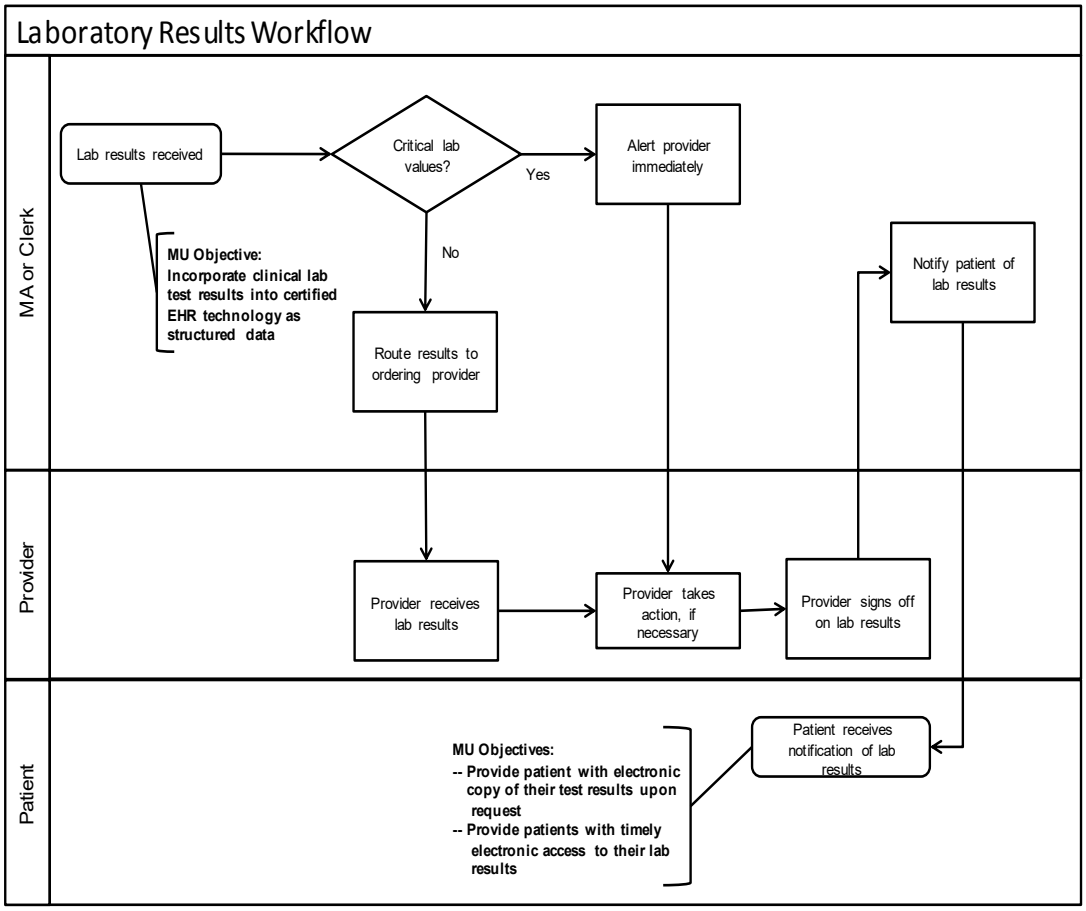


Figure 26.10. Lab results workflow



Many additional resources for assisting your practices to achieve meaningful use can be found on the National Learning Consortium Web site. You will want to review resources on this site and select those that best fit the needs of your practices.

Meaningful Use and Quality Improvement

Meaningful use reinforces the concept of meeting patient needs as outlined in the landmark Institute of Medicine study *Crossing the Quality Chasm: A New System for the 21st Century* (Institute of Medicine, 2001) care that is safe, efficient, effective, timely, person-centered, and equitable.

The same technology that can qualify providers for meaningful use incentive payments can also serve to implement the Care Model or achieve PCMH status. Table 26.4 displays how various meaningful use criteria and health IT capabilities relate to Care Model and PCMH features.

Table 26.4. Crosswalk between meaningful use and health IT capabilities and Care Model and PCMH features

Meaningful Use and Health IT Capability*	Care Model Domains	PCMH Standards
Maintain up-to-date problem lists	Clinical Information Systems	Plan and Manage Care
Generate lists of patients with a specific condition	Delivery System Design	Identify and Manage Patient Populations
Incorporate lab results	Decision Support	Identify and Manage Patient Populations
Participate in HIE	Community Resources	Provide Community Resources
Send reminders	Self-Management Support	Plan and Manage Care
Use clinical decision support	Decision Support	Measure and Improve Performance
Use CPOE for medication, radiology, and laboratory orders	Clinical Information Systems	Plan and Manage Care
Record demographics Provide patient education materials in non-English languages	Self-Management Support	Identify and Manage Patient Populations
Make health information accessible to patients	Informed, Empowered Patient and Family	Provide Self-Care Support

* Includes proposed stage 3.

Summary

Today, EHRs are central to the operations and clinical care of almost every practice. As a PF, you will need to be familiar enough with key elements of EHRs to be culturally and technologically competent when working with practices. You will also want to be familiar with and able to guide your practices through the meaningful use attestation process.

References

Agency for Healthcare Quality and Research. (February 2014). Computerized Provider Order Entry. *Health Information Technology.* Retrieved December 10, 2014

American Medical Association. (2014). EHR Selection Considerations. *Health Information Technology*, 8-11.

Bell, Karen M., & Patterson, W. David. (2014). Understanding EHRs: Common Features and Strategic Approaches for Medicaid/SCHIP. http://healthit.ahrq.gov/sites/default/files/docs/page/understanding_ehrs___common_features_and_strategic_approaches_for_medicaid_schip_5.pdf

Centers for Medicare & Medicaid Services. (2014, 02/26/2014 1:44 PM). E-Prescribing. Retrieved December 10, 2014, from http://www.cms.gov/Medicare/E-Health/Eprescribing/index.html?redirect=/eprescribing

Donaldson, Molla, S., Yordy, Karl, D., Lohr, Kathleen, N., & Vanselow, Neal, A. (1996). *Primary Care: America's Health in a New Era*. Washington, D.C.: Institute of Medicine, National Academy Press.

Gateway Community Health Center, Inc. (Producer). (2004, October 15, 2014). Gateway Community Health Center, Inc. Organizational Chart. Retrieved from http://www.gatewaychc.com/images/organizational chart 2004.pdf

Halbesleben, Jonathon R. B., Wakefield, Douglas S., Ward, Marcia M., and Crandall, Donald . (Jan 2009). Staff "super users" who train others on clinical information systems help shape positive employee attitudes. (09-RA010, No. 347), 82-96. http://archive.ahrq.gov/news/newsletters/research-activities/jul09/0709RA26.html

Health Resources and Services Administration. (2014a). Common EHR Functions. Retrieved December 10, 2014, from http://www.hrsa.gov/healthit/toolbox/healthitimplementation/implementationtopics/selectcertifiedehr/selectacertifiedehr_5.html

Health Resources and Services Administration. (2014b). What is “Meaningful Use”? Retrieved December 10, 2014, from http://www.hrsa.gov/healthit/meaningfuluse/MU Stage1 CQM/whatis.html

HealthIT.gov. (2014a). CDS Starter Kit: Diabetes follow-up care. http://www.healthit.gov/sites/default/files/del-3-7-condition-example-diabetes.pdf

HealthIT.gov. (2014b). Certification Programs & Policy. from http://www.healthit.gov/policy-researchers-implementers/certification-programs-policy

HealthIT.gov. (2014c). Certified EHR Technology and Certification Process. Retrieved December 10, 2014, from http://www.healthit.gov/providers-professionals/certification-process-ehr-technologies

HealthIT.gov. (2014d). Certified Health IT Product List (CHPL). Retrieved December 10, 2014, from http://healthit.gov/policy-researchers-implementers/certified-health-it-product-list-chpl

HealthIT.gov. (2014e). Meaningful Use Definition and Meaningful Use Objectives of EHRs. Retrieved December 10, 2014, from http://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives

HealthIT.gov. (2014f). Regional Extension Centers (RECs). from http://www.healthit.gov/providers-professionals/regional-extension-centers-recs

HealthIT.gov. (2013). What is an electronic health record (EHR)? Retrieved December 10, 2014, from http://www.healthit.gov/providers-professionals/faqs/what-electronic-health-record-ehr

Hostetter, Martha. (2014). Case Study: Alabama's Together for Quality Program--Putting Health IT to Work for Medicaid Beneficiaries. Retrieved December 10, 2014, from http://www.commonwealthfund.org/publications/newsletters/quality-matters/2009/july-august-2009/case-study

Hsiao, C, Jr, & Hing, E. (2014). Use and characteristics of electronic health record systems among office-based physician practices: United States, 2001-2013. *Data Brief*. Hyattsville, MD: National Center for Health Statistics.

Institute of Medicine. (2001). Crossing the Quality Chasm: A New Health System for the 21st Century. 1-8.

Knox, Lyndee, & Brach, Cindy. (2013). Module 17. Electronic Health Records and Meaningful Use. Retrieved October 9, 2014, from http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod17.html

Massachusetts eHealth Institute. (2014). The Massachusetts eHealth Institute - Health Care Technology and Innovation. Retrieved December 10, 2014, from http://mehi.masstech.org/

Nemeth, Lynne S., Ornstein, Steven M., Jenkins, Ruth G., Wessell, Andrea M., & Nietert, Paul J. (2012). Implementing and Evaluating Electronic Standing Orders in Primary Care Practice: A PPRNet Study. http://www.jabfm.org/content/25/5/594.long doi:10.3122/jabfm.2012.05.110214

New York eHealth Collaborative. (2014). What We Do. Retrieved December 10, 2014, from http://nyehealth.org/what-we-do/

PCC EHR Solutions. (2014). Meaningful Use Measures Report. from http://learn.pcc.com/Content/PCCEHR/Reports/MUReport.htm

Recovery.gov. (2014). The American Recovery and Reinvestment Act: The Recovery Act. Retrieved December 10, 2014, from http://www.recovery.gov/arra/About/Pages/The_Act.aspx

Primary Care Practice Facilitation Curriculum

Module 27. Helping Practices Optimize Electronic Health Records for Patient-Centered Medical Home Transformation and Quality Improvement

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Module 27. Helping Practices Optimize Electronic Health Records for Patient-Centered Medical Home Transformation and Quality Improvement

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- General knowledge of patient centered medical home (PCMH)
- General knowledge and skills for optimizing electronic health record (EHR) systems to support PCMH
- Cultural competency with practices related to their health information technology (IT)

Time

- Presession preparation for Learner: 2–5 hours
- During the session: 1 hour, 45 minutes

Objectives

After completing this module, learners will be able to:

1. Help practices explore ways to optimize their EHR to support key PCMH functions.
2. Identify key EHR-related workflows.
3. Describe meaningful use reports.
4. Describe clinical decision supports and how they support PCMH and quality.
5. Describe patient portals and how they support PCMH and quality.
6. Describe ways that EHRs (and related systems such as registries) can support PCMH and quality.
7. Understand roles PFs can play in helping practices optimize their EHRs for these purposes.
8. Understand important decisions PFs need to make when helping practices with their EHRs.
9. Access information to support practices in creating reports, using clinical decision supports, and implementing patient portals.

Exercises and Activities To Complete Before, During, and After the Session

Presession preparation for learners. Ask the learners to read items 1–5 and then explore items 6–9 below. (2–5 hours)

Prerequisite modules

1. Module 25. The Patient Centered Medical Home: Principles and Recognition Processes
2. Module 26. An Introduction to EHRs and Meaningful Use
3. Module 27. Using Electronic Health Records to Support Patient Centered Medical Home Transformation (this module is the primary focus of this session)
4. How EHRs affect quality in a practice: http://www.healthit.gov/providers-professionals/improved-diagnostics-patient-outcomes
5. How EHRs support transformation to a PCMH: http://www.hrsa.gov/healthit/toolbox/Childrenstoolbox/BuildingMedicalHome/healthitmedicalhome.html
6. An introduction to clinical decision support: http://www.healthit.gov/sites/default/files/clinical-decision-support-0913.pdf
7. Toolkit for implementing clinical decision support: http://www.healthit.gov/policy-researchers-implementers/cds-implementation
8. Small practice considerations in clinical decision support implementation: http://www.healthit.gov/sites/default/files/cds/3_5_10_sm_practice_considerations.pdf
9. An exemplar patient portal use case: http://www.healthit.gov/node/462

Optional reading

1. The role of electronic health records and other forms of health information technology in quality improvement. Available at http://healthit.ahrq.gov/sites/default/files/docs/page/ahrq-pathways-report-20130912.pdf
2. Higgins T.C., J. Crosson, D. Peikes, R. McNellis, J. Genevro, and D. Meyers. "Using Health Information Technology to Support Quality Improvement in Primary Care." AHRQ publication no. 15-0031-EF. Rockville, MD: Agency for Healthcare Research and Quality, March 2015. Available at http://www.pcmh.ahrq.gov/page/using-health-information-technology-support-quality-improvement-primary-care

During the Session. Presentation (30 minutes)

1. Present key concepts from the module.

Discussion. Ask questions and explore answers with learners. (15 minutes)

- What is your experience working with practices to use their EHRs for reporting and PCMH- and quality-related functions described in this module?
- What is your own experience as a patient interacting with IT systems in a practice?
- How can EHRs support the key elements of PCMH?
- How can EHRs support quality improvement?

Activity. Create a vision chart for enhancing PCMH with a practice HER. (45 min)

1. Divide learners into groups of three to five people.
2. Provide each group with a copy of the PCMH-EHR vision chart.
3. Have each group identify a "PF" for the activity.
4. Ask PFs to facilitate their group to identify a practice to focus on for the exercise

    - A practice that one member of the group is working with already.
    - Practice case study in the appendix.

5. Have PFs facilitate their group in creating a *vision chart* for the practice.
6. At end of the exercise, have PFs and groups reflect on the facilitation process with their group:

    - What worked well in facilitating the group and the process?
    - What changes would you make next time?

Large group report out (15 minutes)

- What two lessons did your group learn about EHRs supporting PCMH? What are their implications for your work?
- What two lessons did you learn about facilitating these types of exercises with teams? What are their implications for your work?

Activities for Learners to Complete After the Session for Additional Learning (Optional)

Learners who wish to build more extensive competencies in this area can complete the training videos developed by the Office of the National Coordinator for Health IT, available via the National Training and Education Resource at the link below **(40 hours–optional):** :
https://www.nterlearning.org/web/guest/course-details?cid=3744

Module 27.

This module provides an introduction to the ways electronic health records (EHRs) support key elements of the patient centered medical home (PCMH) and support quality improvement. It discusses how PFs can help practices better use their EHRs to establish a PCMH and improve quality. This module builds on two other modules, which you should complete before beginning this module:

- Module 25: The Patient-Centered Medical Home: Principles and Recognition Processes
- Module 26: An Introduction to EHRs and Meaningful Use

Ways to Help Practices Use Their EHRs to Support PCMH and Quality

As a PF, one of your most important roles will be to help practices evaluate and optimize their EHR and related information technology (IT) systems to support the PCMH. Some of the actions you can take to support practices include:

- help practices assess current use of their EHR and create an action plan for enhancing its use for the PCMH
- help practices improve workflows involving their EHR
- help practices improve the quality, efficiency, and usefulness of their reporting
- work with practices to select and deploy clinical decision supports (CDSs)
- work with practices to deploy patient portals to engage patients and improve access

Providing EHR Support to Practices

Deciding how much hands-on support you should provide to a practice with its EHR and reporting systems can be difficult. As a PF, your main goal is to build internal capacity in your practices to continuously improve and to operate according to the principles of the PCMH. Given this, you will focus on (1) helping practices to assess and improve their systems, (2) providing them with information and other resources, (3) sharing exemplar practices, (4) facilitating implementation of improvements using Plan Do Study Act (PDSA) cycles and other processes, and (5) providing training when appropriate.

In the course of your work with each practice, you will need to decide how much direct hands-on support you should provide. In other words, you need to figure out how much you should take on yourself (such as generating reports) versus teaching the practice how to do it.

Some experienced PFs warn about the challenges of providing direct hands-on support in this area as you can easily get pulled into "fixing" a practice's EHR rather than helping the practice improve quality and build internal capacity.

Others believe it is sometimes necessary for a member of the PF team to provide hands-on support to get a practice over the "hump." This may be particularly true for smaller practices that have limited access to experts on EHRs and other health IT systems.

You will have to determine when this type of direct support is necessary and whether you or members of your team have the knowledge and skills to provide it.

When a practice's needs fall outside your team's capabilities, you will want to know where to find the right expertise. One place you and your practices can look for this external expertise is the health information exchange (HIE) in your area. Go to http://www.healthit.gov/providers-professionals/health-information-exchangehwhat-hie for more information on HIEs and a list of them by state. Other resources include the National Association of Community Health Center's connection to the Health Information Management System Society's HIMSS JobMine® at http://www.nachc.com/HealthITJobMine.cfm.

Obtaining In-Depth Training on Specific EHRs

The amount of training you need to work with the practices you are supporting will vary. If you are working with a single practice or a group of practices that use the same EHR, it can be useful for you to complete in-depth training on the system. In some instances, you may want to obtain training to become a "super user" for a specific EHR. Vendors are often unwilling to provide non-customers with this training, but you may be able to access the training because you provide services to the practice. Another way to access training can be to go through Community Health Center Controlled Networks (https://www.nachc.com/HCCNs.cfm). Becoming a super user can be particularly helpful in your work with solo practitioners and small practices that may have little or no support for their EHR outside of technical assistance from the vendor.

If you are supporting practices that use many different EHRs, it will not be feasible for you to become a super user for each system. Instead, you will need to rely on super users within the practices for expertise about the systems and their functionalities.

Regardless of whether you receive in-depth training on a particular EHR, you should focus on building capacity in practice staff rather than getting directly involved in the work of the practice. Many of the changes that are needed to EHRs will help increase capacity, such as building report templates that can be used multiple times or implementing a CDS.

Coordinating With Technical Experts on EHRs and Data

Another important skill is knowing where your work with an EHR and related systems starts, because the work of technical experts stops. This line is not always clear. Ideally, the quality improvement facilitator, technical EHR expert, and data experts coordinate their activities. EHR implementation or upgrades can provide an opportunity to improve workflows and quality, and efforts to improve quality and redesign workflow often require changes to EHR setups. Just as daily practice huddles are a good way to plan for patient care, huddling with others who support the EHR in the same practice is a good idea. It helps all those providing support to increase their efficiency and to reduce the number of distractions and duplicate questions.

Learn when to call on colleagues or consultants for assistance. Some facilitation programs use a team approach. In these instances, as the quality improvement facilitator, you will have a

good idea of when to call in your colleagues—as you will be in frequent communication, know their skill sets, and understand what they can do for your practices. If you are working independently or as part of a facilitation program that does not include technical experts, you will need access to consultants with these competencies. If you are working as part of a program, your program director should provide these resources for you. Take time to get to know the consultants and understand the types of technical expertise they can provide to you and your practices.

Coordinate your work with that of consultants. You will want to meet with the consultants and make sure you are not duplicating one another's work. Ideally, you can develop an improvement plan together with the practice and the technical experts and assign roles based on this plan as a means of coordinating activities. Regular communication, updates, and joint meetings will assist you in coordinating the work. Refer to Module 7 on Practice Facilitator Professionalism to read about working with consultants.

Ways That EHRs Support the PCMH

As described in Module 25 about the patient-centered medical home, the PCMH is a team based model where the primary care team is responsible for coordinating and ensuring the comprehensiveness and quality of each patient's overall care. The PCMH model encompasses five core principles:

- "A **patient-centered orientation** toward the whole person that requires understanding the patient's and the family's preferences and providing the patient's entire range of care needs.
- **Comprehensive, team-based care**, which relies on a (not necessarily physically co-located) team of providers that might include physicians, nurses, pharmacists, nutritionists, social workers, information technology specialists, and practice managers, in order to meet the patient's care needs.
- **Care coordinated and/or integrated across all elements of the complex system** (both medical and behavioral health care), including specialists, hospitals, and skilled nursing facilities; home health workers; community services and supports; and the variety of other clinicians and providers who see the patient.
- **Continuous access to care** with shorter waits to get appointments, enhanced hours, and alternative methods of communication such as email and telephone.
- **A systems-based approach to quality and safety**, some important aspects of which are: (a) the practice uses evidence-based medicine and clinical decision-support tools to guide decisionmaking; (b) the practice and patients and families participate in performance measurement and improvement; (c) patient experience and feedback are measured, with data from these measurements acted upon; and (d) the practice participates in population health and management (Meyers, Quinn and Clancy, 2011)."

For a more detailed definition of the PCMH model, visit http://www.pcmh.ahrq.gov.

EHRs and related systems support the PCMH by collecting, storing, and managing personal health information, collecting patient-generated information through patient portals, and facilitating care team communication through functionalities like tasking. Clinical decision support (CDS) capabilities and well-structured flow sheets and templates facilitate delivery of guideline-based care. Patient registries facilitate population management. Tasking functions support communication among care team members. Secure messaging and telehealth can improve access. Internal health education materials and care plans can support self-management and patient engagement (Meyers et al., 2011; Nance et al, 2014). Table 27.1 provides an overview of how EHRs and other health IT systems can support the PCMH.

Table 27.1. Technological capacities for supporting the PCMH

Medical Home Principle	Technological Capability	Required Health IT Functionality	Examples of Health IT Applications
Patient-centered, whole-person orientation	- Uniquely identify patients, including language preferences - Identify the patients' care preferences and preferred learning mode, and facilitate their self-management with input from providers	- Access to patient health records and preferences - Support for patient self-management	- EHRs - PHRs - Telemedicine
Comprehensive, team-based care	- Collect, store, manage, and exchange relevant general medical and behavioral health information	- Collect standardized, accurate, and essential data elements - Facilitate medication reconciliation - Allow registry views for monitoring by patients	- EHRs - PHRs - Patient registries - Telemedicine
Coordinated care	- Collect, store, manage, and exchange relevant general medical and behavioral health information	The above, plus: - Support care coordination - Incorporate data from outside systems - Allow linking to other resources	- EHRs - PHRs - Patient registries - Telemedicine
Continuous access to care	- Communication among practice team and patients	- Allow access via secure Web portal, E-mail, or PHR	- Web portals - Secure E-mail - PHRs - Telemedicine
Systems-based approach to quality and safety	- Collect, store, measure, and report on the processes and outcomes of individual and population performance and quality of care - Uniquely identify patients in the practice - Support providers' decisionmaking on tests and treatments	- Allow automated quality measurement - Allow improved interfaces with public health services - Allow outcomes evaluation - Allow evidence-based CDS at the point of care - Allow risk stratification of patients for performance measurement	- EHRs - Patient and population registries - Pay-for-performance outcomes databases - Telemedicine - PHRs with decision support tools

Source: Mathematica's adaptation from the Patient-Centered Primary Care Collaborative, 2009, pp. 7-14.
Key: CDS = clinical decision support; EHR = electronic health record; PHR = personal health record.

Reproduced from: Moreno L, Peikes D, Krilla A. (2010). Used with permission.

Helping Practices Optimize EHR Use

While many practices have implemented EHRs, few are using them to their full potential (Higgins et al., 2015). In part, this is due to the design of many EHRs. They can be difficult and non-intuitive to use and can disrupt the way clinicians and staff traditionally interact with each

other and use clinical information. Often this is also due to a lack of time and capacity in the practice for staff to reflect on how their EHR and its use can be enhanced to support better care.

As a PF, you can help create a time and space for your practices to reflect on how they interact with and use their EHR and how they can optimize its use to support better care, better patient experience, and better staff experience.

Helping practices determine whether they need to optimize their EHR use. To help practices determine whether and where they need to improve their EHR use and workflows, listen to staff members' and clinicians' complaints about the EHR. The issues they raise can help you identify areas that need attention first.

Direct observation is another way to assess areas that need improvement. It can help you determine whether employees are following established workflows or using workarounds. Workarounds may indicate that staff need more information and training or that something in the EHR process is not working well. Before you conduct observations, work with staff to map current workflows; then, compare what they are actually doing against what was mapped to identify discrepancies and workarounds.

Another sign that enhancements are needed is if performance on quality indicators does not improve. For example, if the number of patients leaving with a printed care plan does not increase or if the number of patients not receiving indicated care increases, then you will want to consider whether current use of the EHR may be contributing to the problems (National Learning Consortium, 2013).

Helping practices design a plan to optimize their EHR use. You can use approaches such as appreciative inquiry, discussed in Module 9, to help practices think about and design improvements. For example, you could have practice staff create a "vision" for how they could use their EHR and related systems to more fully realize key principles of the PCMH and optimize patient care. Table 27.2 shows a worksheet you can use to help practices create a vision and plan for optimizing their EHR to support the PCMH.

Table 27.2. Sample vision chart template

Medical home principle	Alignment with meaningful use	Functionalities in our EHR and related systems that support this	How we use these now	How we might use these in the future
Patient centered care				
Comprehensive team-based care				
Coordinated care				
Continuous access to care				
System-based approach to quality and safety				

Working with practices to map EHR workflows. For a practice to optimize use of its EHR, practice staff must understand what they are currently doing. You can work with clinicians and staff to create a list of problematic EHR workflows, and map and redesign them.

The four main steps involved are:

1. Identify a specific EHR workflow that needs improvement.
2. Map out the details of the workflow "as it is."
3. Evaluate and redesign the workflow.
4. Implement, test, and refine the workflow using PDSA cycles.

We discuss these steps in turn below.

Figure 27.1. Useful Resources for Mapping EHR Workflows and Optimizing EHR Use

California HealthCare Foundation EHR Workflow Resource
http://www.chcf.org/publications/2010/03/ehr-deployment-techniques

Physician Foundation Workflow Toolkit
http://www.physiciansfoundation.org/uploads/default/EHR_Workflow_Toolkit_-_Margret_Amatayakul.pdf

Office of the National Coordinator for Health Information Technology
http://www.healthit.gov/providers-professionals/implementation-resources/workflow-process-mapping-electronic-health-record

AHRQ Health Information Technology Resource Center
http://healthit.ahrq.gov/health-it-tools-and-resources

Step 1. Identify EHR workflows that need improvement.

Map patient interactions. One way to identify workflows is to map a patient's interactions with the practice from start to finish. For example, you can follow every patient interaction with the practice from scheduling an appointment, to checking in, to receiving service, to checking out, through following up, and identify the EHR workflows that accompany each action and stage.

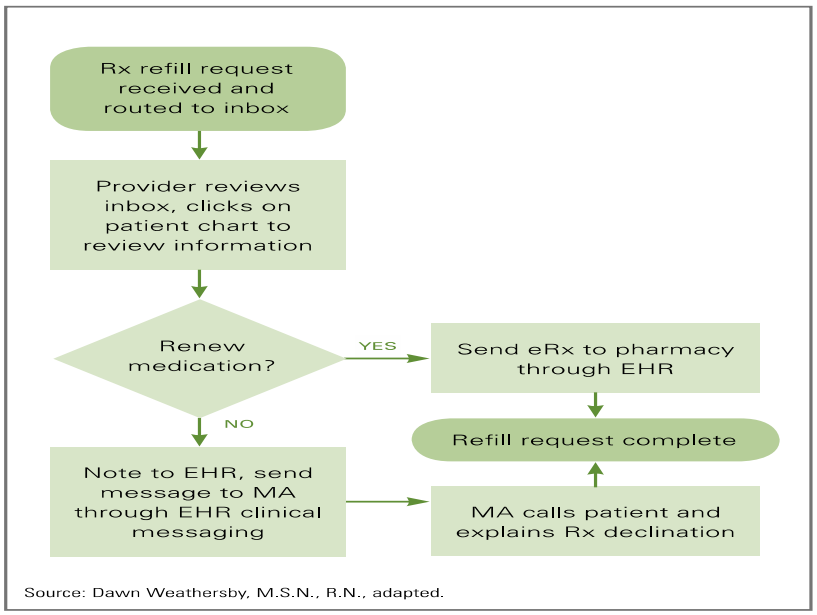
Patient flow can vary based on type of visit, type of insurance, age of patient, whether the person is a new patient or existing patient, and whether the visit is a scheduled or walk-in visit—so you will want to consider these factors and perhaps focus on a specific visit type. This approach is usually preferable because it focuses on the patient's experience rather than the work of the practice and provides an opportunity to identify missed or new opportunities to advance PCMH principles using EHRs.

Create an inventory of processes. Another way to identify EHR-related workflows is to work with clinicians and staff to create an inventory of processes. Be aware that the number of processes can grow quickly. One clinician identified more than 150 processes at his practice that involved EHR use. Examples of processes include scheduling, check-in, behavioral health, case management, billing, group visits, in-house labs, post-visit follow-up, health education attendance, and medication refills (Kushinka, 2011).

Focus on meaningful use. Many of the practices you work with will be pursuing meaningful use. You can use the required functionalities for the stage they are currently pursuing as a starting place for this work. See Module 26 from this curriculum for more information on meaningful use. Useful resources can be found at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html and http://www.healthit.gov/providers-professionals/ehr-implementation-steps/step-5-achieve-meaningful-use.

Step 2. Map the current workflows. Once the practice staff and clinicians have identified current EHR workflows that need enhancement, you can work with them to map these workflows. One of the best ways to do this is to observe the clinician or staff person actually using the system. You can use the mapping methods described in Module 10 on Workflow Mapping or use other toolkits and resources for this purpose. Figure 27.1 provides links to two workflow mapping toolkits that are easy to use and effective. Figure 27.2 provides an example of an EHR-based workflow for refilling prescriptions.

Figure 27.2. Workflow map for refilling prescriptions



Source: Dawn Weathersby, M.S.N., R.N., adapted. Copyright permission granted by the California Healthcare Foundation.

Step 3. Redesign or optimize the workflows. After mapping a workflow "as is," work with the practice to develop an enhanced workflow or set of workflows. Help the practice consider what changes are possible within the constraints of its existing EHR, whether any of the changes will require vendor support or can be carried out in house, and the costs of the modifications, and then incorporate these in the decisionmaking process. You can use the questions from Module 10 on Workflow mapping to help your practices redesign EHR related workflows or the ones provided in Figure 27.3 of this module. You will also want to work with the practice to determine whether it is worth working with the vendor to customize the EHR to support the newly optimized workflow.

Following are some additional ideas about how to help a practice optimize EHR use and workflows:

Helping practices generate ideas for redesigning an EHR workflow. One way to do this is to have participants on the redesign team brainstorm ideas for changing the workflows to more fully reflect PCMH principles. For example, you can ask them to think of ways to redesign the process to enhance patient experience or the five principles of PCMH. This type of initial brainstorming can help practices think systematically about how to improve their PCMH. Below we describe some ways to generate ideas.

Observe the workflow. Another way of stimulating ideas for redesigning the process is to observe a clinician or staff person carrying out the targeted workflow. As you observe, you can note reasons for any difficulties that arise. Are there issues with inadequate training? Does a template need to be redesigned? Are data capture methods such as copy/paste and cloning (auto-generation of frequently entered text) needed? Are so many alerts being generated that clinicians

ignore them? Based on this, what changes are needed to improve the flow? (National Learning Consortium, 2013)

Observe the physical environment. Note what type of hardware clinicians are expected to use to make entries. Do they use tablets or computer terminals? Are they easy to use? Are there enough of them or do clinicians and staff have to wait to use them? Are terminals located in areas where distractions and privacy are issues? Do they function well or are there frequent problems with hardware? Based on this, what changes are needed to improve the process? (National Learning Consortium, 2013)

Examine the data requirements. Consider whether any data requirements are unnecessarily burdensome. Some clinicians complain about having to collect much more information than is necessary or than they did in the past with paper charts. In some cases, this may reflect improvement in documentation. In other instances, templates may contain redundant or rarely used fields that slow down data entry and increase the burden on clinicians. In these cases, the practice may want to eliminate the redundancies and make rarely used fields optional. The practice will also need to consider whether the changes will affect collection of data needed for claims, quality reporting, or other purposes. (National Learning Consortium, 2013)

Access existing data. Look for ways to reduce the burden of data entry by pulling data from other parts of the system. For example, could information that rarely changes and appears in one area of the record (such as patient demographics) be used to fill fields in other areas? Are there opportunities for patients to enter these data themselves, removing some burden from staff? What improvements are indicated based on the answers to these questions? (National Learning Consortium, 2013)

Assess the value of the data and determine whether the data can be obtained from other sources. Does the importance of the data justify collecting them? Is the practice collecting any data that have no clear purpose or use? Clinicians should be involved in determining what information is needed and what might be eliminated. (National Learning Consortium, 2013)

Assess impact on patients. The practice should also consider the effects on patients of the current workflow and the proposed redesign. Will the changes enhance or detract from the patient experience? Is the process patient-centered? Does it support coordinated care? Improved access? Patient engagement? A positive customer experience? One way to determine these impacts is to shadow a patient through a visit or be a not so "secret" shopper and emulate the interaction of a patient with the old and redesigned processes. Figure 27.3 contains a list of questions you can use to help your practices assess and redesign existing EHR-related workflows.

Figure 27.3. Questions to stimulate thinking about EHR workflow redesign

- ❑ Are there any parts of the current process that present risk to the clinic?
  - ☐ Variation in practice
  - ☐ Action not documented in chart (e.g., excessive or inconsistent use of "sticky" notes)
  - ☐ Incomplete documentation (in chart, on orders, for communications)
  - ☐ Inadequate security (e.g., prescription pads, sample drugs, access to information)
  - ☐ Lack of documented policy
  - ☐ Delays in provision of care over which clinic has no control
  - ☐ Loss or misplacement of documents resulting in duplicate testing, lost charges, payment denials
  - ☐ Role ambiguity
  - ☐ Other
- ❑ Are there any parts of the current process that may result in significant loss of productivity?
  - ☐ Unnecessary phone calls, emails and texts
  - ☐ Waiting for chart or other information
  - ☐ Unnecessary steps
  - ☐ Delays due to manual procedures that do not impact quality of care or patient safety
  - ☐ Other
- ❑ Are there any aspects of the process you believe are particularly prone to error? Why?
  - ☐ Lack of training
  - ☐ Lack of time
  - ☐ Lack of documented procedure
  - ☐ Lack of staff
  - ☐ Lack of quality controls
  - ☐ Lack of information
  - ☐ Other
- ❑ Are there any aspects of the process in which you would like to see more improvements, given the opportunity presented by an EHR?
  - ☐ Eliminate bottlenecks, backtracking
  - ☐ Reduce workarounds due to errors
  - ☐ Reduce duplication of effort
  - ☐ Reduce number of steps or amount of time
  - ☐ Adopt new models of care planning (e.g., standing orders, medical home)
  - ☐ Improve chronic care management (e.g., patient recall, home monitoring, disease management)
  - ☐ Improve compliance (e.g., ABN, E&M coding, HIPAA/HITECH, meaningful use incentives, etc.)
  - ☐ Adopt proactive preventative care practices
  - ☐ Adopt or improve value-driven care processes (e.g., generic drug utilization)
  - ☐ Support consumer empowerment (e.g., personal health record access, automated self-assessment, report cards)
  - ☐ Improvement quality measurement and reporting
  - ☐ Improve health plan contract negotiation
  - ☐ Improve patient safety reporting (e.g., post-market drug surveillance, communicable disease)
  - ☐ Adopt new revenue opportunities (e.g., medical concierge, alternative therapies)

Reproduced from: Amatayakul M. (2011). EHR Workflow Toolkit for Physician Practices; 2011. Used with permission.

Step 4. Test and refine the redesigned workflows. The practice can use PDSA cycles to test the new workflows and make further improvements. As part of this process, you can suggest that clinicians and staff role-play any workflows that involve patients. This will help them (1) become comfortable with the new workflow and (2) identify any "kinks" in the process that need to be addressed before they use it with real patients. You can also work with staff and clinicians to create scripts for introducing the process to patients or improve interaction with patients around the new process when appropriate. (National Learning Consortium, 2013)

Step 5. Create visual users guides for clinicians. You can create a guide by taking screen shots of each "click" a clinician must make in the course of different types of visits (be sure no real patient data are displayed) when carrying out a task such as e-prescribing. Then assemble the screen shots into a spiral-bound booklet. Clinicians and staff can use the guides to help them navigate through non-intuitive processes, and human resources and the office manager can use them to train new hires. This small intervention can help you build credibility with clinicians and staff as a source of practical support.

Enhancing reporting from EHRs. Practices need actionable data to carry out activities central to the PCMH, such as population management and continuous quality improvement. EHRs are not the only source of these data. Effective reporting programs in a practice typically involve use of data from multiple systems, including practice management systems, patient registries, and financial systems in addition to EHR data. However, a practice's EHR plays a central role in reporting and is an essential source of these data.

Most EHRs include a built-in automated reporting function to generate a number of useful reports. Federally certified EHRs must include the ability to generate reports on core meaningful use measures and a minimum of three additional clinical quality measures.

As a PF, you will need a solid understanding of the following:

- The reporting needs of each of your practices
- How they generate these reports
- The reporting capabilities of the practices' EHR and related systems

You should become familiar with other types of reports the practice generates regularly. Table 27.3 provides a list of some common reports. When you are working with many practices that use different EHRs, it may not be feasible for you to know how to generate reports in all of them. You may become proficient on one or two EHR systems; otherwise, it will be important for you to know whom to contact for help, both inside and outside the practice.

Table 27.3. Reports commonly generated from EHRs

Quality improvement and management

- Number of open or closed encounters (per day, week, and month)
- Productivity (number of patients seen per hour)
- Referral patterns, both internal, for supportive services (e.g., social work, nutrition) and specialists, and external, for specialists and community-based organizations
- Patient flow, as measured by wait time and cycle time
- Health and functional status by patient and population
- Educational materials provided
- Adherence to recommended treatment guidelines, decision support use, and literature searches
- Performance on key Healthcare Effectiveness Data and Information Set (HEDIS) measures
- Missed opportunity reports for followup and impact on HEDIS and other quality metrics
- Gaps in care reports for individual patients for use to recall patients and fill gaps in care
- Privacy and security audit logs

Third-party and regulatory reporting

- Physician Quality Reporting System (PQRS) required by CMS for Medicare
- Patient centered medical home (PCMH) required by PCMH accreditors
- Uniform Data System required by HRSA from FQHCs
- Clinical quality measure reporting (CQM) required by CMS
- Accountable care organization (ACO) reporting requirements
- Specific health plan reporting requirements

Clinical care

- Open referrals
- Incomplete lab reconciliations
- Provider panel reports
- Population reports
- Risk stratification reports
- Gaps in service reports
- Missed opportunities reports

Other

- Meaningful use attestation reports
- Patient centered medical home (PCMH) accreditation

Source: Hodach R, Handmaker K. Training and Technical Assistance: Connecting Health IT Professionals with Community Health Centers; 2014. Permission granted.

As a PF, you can help a practice create an inventory of its reporting needs and existing methods for generating reports. You can work with the practice to identify any overlaps and redundancies in reports and to find ways to make the processes more efficient. Table 27.4 contains an example of a report inventory form that a PF might use for this purpose.

Table 27.4. Sample inventory form

Reporting need/requirement	Frequency	How generated (EHR, external software, hand audit, etc.)	Overlaps with other reporting (Y/N)	Person responsible for running report

Help practices generate meaningful use reports. To work with a practice on its reporting needs, you can begin with meaningful use reporting, if applicable. Be prepared to help practice staff develop effective workflows for reporting on the clinical quality measures (CQMs) they have selected for meaningful use (HealthIT.gov, 2014a).

In some instances, you may first need to help the practices select the CQMs they intend to report. To do this, you can first help them determine which CQMs have automated reports available in their EHR. You can do this by reviewing the vendor's Web site and contacting their support desk. In larger practices, you may be able to consult with the practice's health IT staff or EHR super users.

Next, you can help the practice staff determine which of these measures they will report on for meaningful use. Here are some questions you can use to help them select their CQMs (HealthIT.gov, 2014b):

1. Do any of the eligible CQMs align with quality improvement work the practice is undertaking? If so, selecting these measures can support not only meaningful use but also the quality improvement work.
2. Do any of the CQMs align with the demographics or conditions of patients whom the practice commonly sees? If so, these CQMs can help the practice better understand its patients and their care.
3. What measures are the practice's EHR certified to submit? Do these meet the above criteria?
4. Can the practice submit CQMs electronically (which is a requirement of 2014 for Stage 2 and higher)?
5. What other reporting programs does the practice engage in that might be partially met with the CQMs? More information on overlap of different reporting requirements is available at http://www.ihs.gov/meaningfuluse/cqmoverview/cqmreporting2014/.

Figure 27.4. Useful resources on CQM for you and your practices

HealthIT.gov's web-based tool on How to Implement EHRs: Clinical Decision Support

http://www.healthit.gov/providers-professionals/clinical-decision-support-cds

Help practices generate population health management reports. Population health management (PHM) is a central element of the PCMH and something that was very difficult to achieve before the advent of electronic data systems. PHM uses information on groups of patients to support proactive care, fill gaps in care, and monitor quality of care with the goal of improving the health outcomes of specified groups such as patients with diabetes, elderly patients, or patients with asthma (Cusack et al., 2010; Institute for Health Technology Transformation, 2012).

To implement PHM, a practice must be able to use its EHR and related data systems to identify and track patient cohorts by condition, demographic variables, or risk level; monitor adherence to care plans; track medication use; and monitor progress toward treatment goals.

One way to do this is to create patient or population "registries" that gather information and provide reports on specific groups of patients defined by the practice, such as patients with hypertension or diabetes. Some EHRs include registry functions but many practices opt to run separate, specialized population management systems along with their EHRs. These systems may automatically pull data from the EHR, labs, and other data systems, and then use this information to generate reports by condition, clinician, or other variables. These reports can then be used for patient monitoring, outreach, and care gap identification. Some systems can also generate point-of-care reminders for indicated services. In some practices, the interface between all of these systems is handled by manual data entry by the staff (Hodach and Handmaker, 2014).

In addition to tracking patient care and health status, practices also need the capacity to classify patients by their current health status and risk—to enable health care professionals to intervene appropriately with high-risk patients and those who might become high risk. You can work with your practices to identify the analytics that will be most helpful to them in service planning and managing their patient populations. Then you can help them build the skills for generating these analyses or identify external resources to do so. Table 27.5 provides an example of a basic report on a patient panel that a medical assistant might use to make outreach calls.

Table 27.5. Sample panel management report

SM = Self Management Indicates if an action plan was created.

1	2	3	4	5	6	7	8	9	10	11	12
Name	DOC SM	BP DATE	BP/s	BP/d	LDL Date	LDL	A1c DATE	A1c	DIABETIC	SMOKER	DATE ASKED IF SMOKES
Patient A	NO	2/21/2011	127	70	11/30/2010	93			NO	NO	11/20/2010
Patient B	YES	2/15/2011	110	55	2/15/2011	145	9/25/2010	11.3	YES	YES	2/15/2011
Patient C	NO	4/7/2010	158	87	4/11/2010	81	4/11/2010	6.7	YES	NO	3/15/2008
Patient D	YES	1/20/2011	148	95	12/14/2010	170	12/14/2010	8.9	YES	YES	12/12/2009
Patient E	NO	10/28/2010	129	72	12/10/2010	54	12/10/2010	9.6	YES	YES	3/30/2010
Patient F	NO	8/21/2010	125	88	4/20/2010	125			NO		
Patient G	YES	6/24/2010	149	85	4/16/2009	102			NO	NO	12/2/2008
Patient H	NO	3/5/2011	147	90	3/5/2011	81	3/5/2011	12.1	YES	NO	3/5/2011
Patient I	NO	1/29/2010	120	64	2/3/2010	65			NO	NO	12/22/2004
Patient J	YES	1/5/2011	117	81	1/5/2011	112	1/5/2011	5.9	YES	YES	7/5/2010
Patient K	YES	7/24/2008	152	85	7/14/2008	157			NO		

Most current date that blood pressure measured

Most current date that LDL cholesterol measured

Most current date that HbA1c measured

Indicates the most recent date patient was asked about smoking

Source: Knox and Brach (2013). Used with permission.

Help practices generate customized reports. Practices' reporting needs often go beyond the data that are available through automated reporting in their EHR. In such cases, you can help your practices increase their capacity to generate ad hoc reports to meet these needs.

Examples of useful reports that are often customized include care gap reports that can be used by care teams to call patients back in for missed services and risk stratification reports that can help practices identify patients who are high utilizers or at risk for avoidable hospitalizations.

You will want to understand how each practice produces these customized reports and understand the skills and resources they have for doing so. In some cases, practices may require outside assistance, which you can help them access. Once the reporting process is created, it can be used repeatedly and become part of the practice's overall capacity to generate actionable information.

If your facilitation team includes EHR or data experts, you can these team members to assist the practice in creating this reporting capacity. Then you can work with the practice to change its workflow so the reports are generated routinely.

Some EHRs require additional analytics software. For example, some community health centers use Crystal Reports, a data integration and analytics software, to pull data from their EHR and practice management system and generate reports for population management, panel management, and business management. You should be knowledgeable about these supplemental products and the ways practices use them to create actionable information that supports quality and PCMH.

For practices pursuing meaningful use, basic reporting (such as generation of numerators and denominators) must be done directly through their EHR and not through an external product (Centers for Medicare and Medicaid Services, 2014). More information about this is available at CMS.gov under frequently asked questions at https://questions.cms.gov/faq.php?id=5005&faqId=3063.

Help practices validate data for reports. You can also help practices build capacity for validating the data in their reports. The old adage of "junk in, junk out" holds here. Things can and do go wrong at any point in the report generation process. When you are working with practices to produce reports, you should first validate the accuracy of the reports.

Regardless of the system, the basic functions of EHRs are the same. Each EHR includes graphic user interfaces, which staff and clinicians see when they enter information. The fields where data are entered map to underlying tables where these data are stored. Thus, each entry field in a graphic user interface maps to a particular data column in the underlying database table (Levy, 2014). The programming underlying an automated report tells the system to pull data from particular columns or places in the database, perform specific calculations with these data, and then display the results in a report template.

Common causes for errors in EHRs include the following:

- Incorrectly mapped data
- Mistakes in data entry
- Incorrect calculation of denominators
- Copy and paste errors (which occur when the user copies and pastes information from one location to another but fails to capture all of the text)
- Inaccurate speech-to-text entries (introduced by dictation software) that have not been validated

If it is the first time the practice is generating a particular report, the first step is to run a test report with only a few patients' data, and then compare the information produced for the report with what is contained in the patients' electronic health records.

The second step is to do validity checks on the reports to look for the following:

- "Out-of-range" values that do not make sense or are not possible to obtain for the variable being reported
- Results that are skewed in an unexpected direction
- Data in the wrong format (such as decimals that should be whole numbers and vice versa)

The third step is to check the denominators used. To do this, you will need to work with staff to determine what data were included in the denominator. For example, suppose a practice found that 23 percent of its patients with diabetes with HbA1c in the current year had an HbA1c test result, and clinicians at the practice insisted that this could not be correct. You would then want to explore possible reasons for this by asking the clinicians and staff how the information is

recorded in the health record. You might find that information on HbA1c testing is stored with lab results but HbA1c results obtained from point-of-care testing are stored in a different area of the EHR. If the denominator for the HbA1c performance calculation includes only one of these sets of information, the percentage of patients reported to have received the test will be inaccurate.

You can work with staff who are generating and using the reports to (1) validate the information, (2) train them in processes related to report generation, and (3) set up procedures for regularly validating the results of reporting.

Help practices improve workflow for generating reports. In small practices, the practice manager, billing staff, or another staff member with some technical skills often runs reports. In larger organizations, there may be personnel dedicated to this task, or staff may split time between other duties and running reports. Staff who run reports should be knowledgeable about clinical processes and workflows, understand what should go into denominators and numerators, be comfortable working with numbers and software, and have time in their schedule dedicated to generating reports.

In very small practices, make sure that the computer repair person or hardware expert is not put in charge of managing reporting or activities such as providing clinical decision support. These individuals typically do not understand the workflows related to these actions and so usually are not successful in this role. If this is the only option for a practice, then you should train this individual on related workflows to prepare him or her to assist.

In small practices, an emerging best practice is to put the practice manager in charge of running reports. The practice manager gives the reports to the PF and the practice improvement team to interpret and act upon them (personal communication, Kristi Bohling DaMetz, December 3, 2014).

Help practices take action on reports. Reporting is not useful if it does not lead to effective and meaningful action. Some practices have become adept at generating the reports necessary for patient care and quality improvement, but have difficulty using them to guide action. Another very important role you can play for your practices is to help them move information and data into action.

Once a practice has developed the capacity to generate reports on patient populations and on care team patient panels, how can staff and clinicians use these reports to support pro-active care, outreach, filling service gaps, or guiding decisions about services the practice needs to be providing? Using these data effectively may require training staff to fill new roles, modifying workflows, and redesigning job descriptions, roles, and evaluations. For example, are the medical assistants trained on panel management? Do they know how to generate the reports they need for this or who to get them from? Are there clearly defined processes and workflows for using these reports for patient outreach and to inform patient care? Does the medical assistant's job description and evaluation include these activities? Are root cause analyses conducted to

determine why patients did not receive recommended services and is this information fed back to the quality improvement team?

When reports on clinical quality measures are produced for meaningful use, are the findings incorporated into the quality improvement processes at the practice? Who receives this information? How is it used to improve care quality? Does the quality improvement team review the reports? When reports are produced for payers on HEDIS performance, does the quality improvement team review these reports and use them to improve care? Are root cause analyses conducted to identify the reasons for low (or exemplary) performance? Is this information then used to design and test improvements using PDSAs? Are future reports used to monitor progress?

As a PF, you can observe how practice staff use the reports they generate and help them reflect on and optimize their use of these data. Often practices lack the time and structure to use this information to improve their processes and care. You can help them build capacity in these areas by bringing these issues to their attention, sharing examples of how practices successfully develop and use reports, helping them develop a plan for improving their use of reports and data, and conducting PDSAs to test these plans.

Helping practices implement clinical decision supports.

Clinical decision support (CDS) systems are computerized tools to help clinicians make decisions at the point of care. They include reminders and alerts, clinical guidelines, condition-specific order sets, actionable patient summaries, support in making diagnoses, and reference information (HealthIT.gov, 2014).

CDS systems help practitioners manage complexities encountered during routine care for chronically diagnosed patients (HealthIT.gov, 2014). They reduce the need for clinicians to rely on memory to do the right thing and thus can support improved adherence to evidence-based treatment guidelines. They can also help care teams provide more proactive care—a process that is at the heart of

Figure 27.5. Information on Meaningful Use requirements for Clinical Decision Support

Centers for Medicare & Medicaid Services. Clinical decision support: More than just alerts. Tipsheet. September 2014, http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/ClinicalDecisionSupport_Tipsheet-.pdf (Centers for Medicare & Medicaid Services, 2014)

HealthIT.gov. Step 5: Achieve meaningful use stage 1: Clinical decision support rule. Web-based tool available at http://www.healthit.gov/providers-professionals/achieve-meaningful-use/core-measures/clinical-decision-support-rule

HealthIT.gov. Step 5: Achieve meaningful use stage 2: Clinical decision support rule. Web-based tool available at http://www.healthit.gov/providers-professionals/achieve-meaningful-use/core-measures-2/clinical-decision-support-rule

the PCMH—by alerting them to upcoming and missed preventive and chronic care needs of a specific patient (Nace, et al., 2014).

CDS can be active or passive. Active CDS requires a response by the user. Examples include alerts, reminders, required fields, and templates. They require clinicians to complete or override the request. This can be helpful or can become annoying to clinicians depending on how many times they are interrupted. Passive CDS does not require a response, but might provide patient data, links to knowledge sources, guidance triggered by a particular context or circumstance, and hypertext links. For example, an information button that appears during data entry the first time a clinician selects a particular drug would be passive CDS.

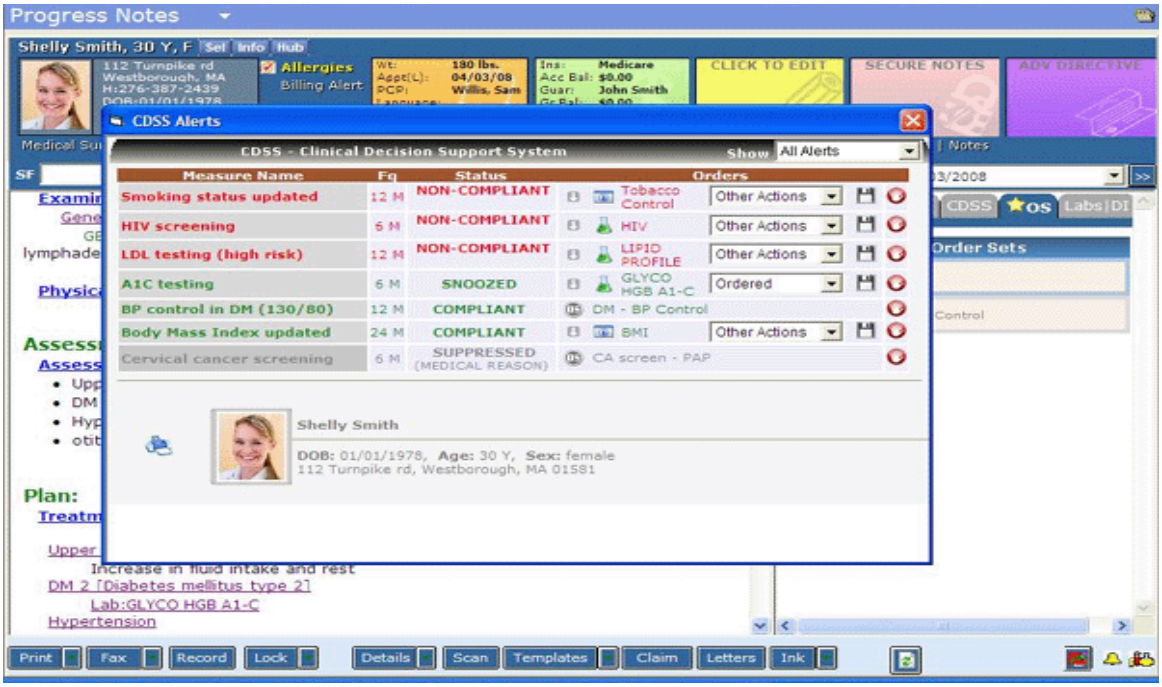
There are two levels of CDS guidance: evidence-based and normative-based. Evidence-based guidance is based on research and best evidence. Some clinicians find strict evidence criteria to be overly rigid and non-intuitive. Others find it helpful. The intent is to keep the clinician up to date with the latest research finding on the topic. More recently, evidence-based guidance has been used to encourage shared decisionmaking with patients. Some clinicians are not comfortable with this; others are. Normative-based CDS is used when there is no accepted best practice data. It is based on recommendations from a panel of experts to establish guidelines.

Practices are required to implement CDSs for meaningful use certification. Figure 27.5 provides links to Federal resources on CDS required to meet meaningful use requirements. As a PF, you should be familiar with the meaningful use requirements for CDS and be prepared to help your practices select and implement CDS appropriate to their populations or direct them to resources on this topic. You should also be knowledgeable about exemplars in the local area in the use of CDS who can share their experiences with your practices if needed.

You can introduce practices to the CDS "5 rights" framework developed by Osheroff and use this to help them evaluate their use of CDS for consistency with these emerging best practices in CDS use. The 5 rights framework suggests that in order for CDS to beneficial to patients it must provide:

1. "the right information (evidence-based guidance, response to clinical need)
2. to the right people (entire care team- including the patient)
3. through the right channels (e.g., EHR, mobile device, patient portal)
4. in the right intervention formats (e.g., order sets, flow-sheets, dashboards, patient lists)
5. at the right points in workflow (for decision making and action)" (Levick et al, 2012)

Figure 27.6. Sample CDS with alerts



Source: eClinicalWorks®, 2014. Clinical Decision Support alert image. Used with permission.

Helping practices improve use of patient portals. A patient portal is a secure Web site where patients can view some or all of their health information contained in the EHR. This includes visit summaries, lab results, immunizations, and allergies among other things. It can also include information on health education materials that the practice has provided to the patient. Some portals allow patients to exchange secure emails with their providers, make requests for prescription refills, make payments, and schedule non-urgent visits (HealthIT.gov, 2014d).

Figure 27.7. Additional resources on patient portals

General resources
http://www.healthit.gov/providers-professionals/faqs/what-patient-portal (HealthIT.gov, 2014e)

Case example involving low-literacy patients
http://www.healthit.gov/providers-professionals/meeting-needs-diverse-patient-population-through-patient-portals

Practices can use their patient portals to help them meet meaningful use requirements that would be difficult to meet otherwise. These include providing patients with:

- timely electronic access to changes in health information,
- electronic copies of their health record,
- clinical summaries after each office visit, and
- patient-specific education resources

As a PF, you can provide resources to your practices on the use of patient portals to improve access and communication and help them create a plan for implementing or optimizing use of

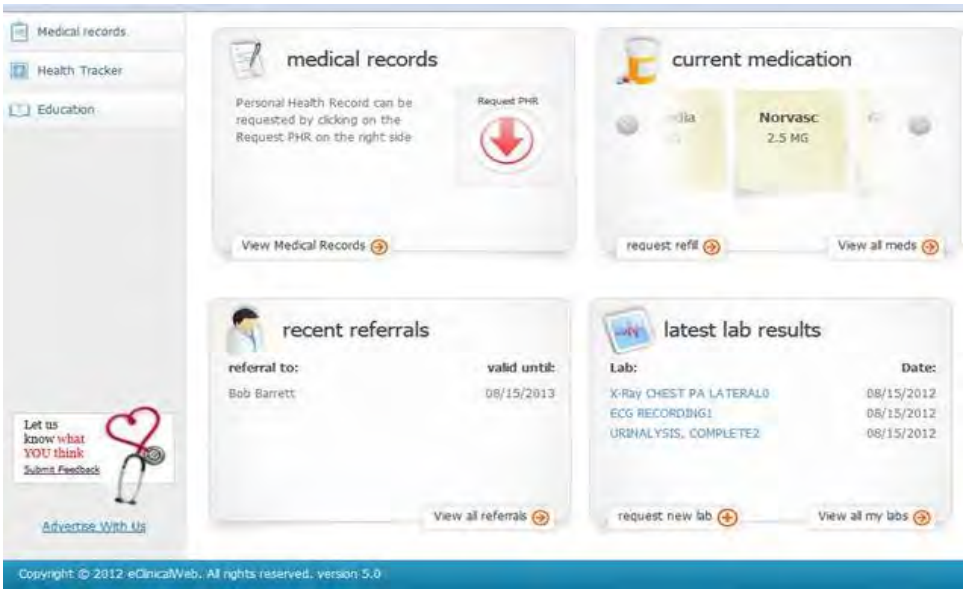
their portal. You can help practices that provide care to patients with low literacy and low health literacy think through appropriate uses of portals for these populations. Figure 27.7 provides links to some helpful resources on implementing and using patient portals.

You can also assist your practices in evaluating the portal that is included in their EHR and develop a vision for how they might use a patient portal to encourage patient engagement and to support meaningful use of their EHR. You can help them create a plan for including use of the portal in their clinical workflow, and help them pilot the portal with selected patients to obtain feedback about it. You can also help them design reports that track use of the portal and meaningful use-related metrics.

Finally, you can work with your practices to consider how their adolescent patients may interact with the portal, and what policies need to be in place to maintain their privacy. Some introductory resources on this important topic are available at

- http://www.medicalhomeinfo.org/how/clinical_care/HIT/HIT.aspx
- http://clinicians.org/adolescents-and-stage-2-meaningful-use/ and
- http://journal.ahima.org/2014/06/27him-frontlines-overcoming-the-challenges-of-adolescent-ehrs/.

Figure 27.8. Example of a patient portal



Source: eClinical Works®, 2014. Example of a patient portal. Used with permission.

The process of patient adoption of patient portals is slower than you might expect; to speed the process and meet meaningful use targets, you can suggest that practices develop a script and workflow to promote patient portal adoption, which may include having patient volunteers in the waiting room explaining why they like the portal and how they use it. Take advantage of a patient advisory council if the practice has one.

Understanding the Impact of EHRs on Patient Experience

EHRs can have both positive and negative effects on patient experience. They can reduce the paperwork patients need to complete, and make it easier for them to share their health information with other providers. They can help improve coordination of care and communication among care team members working with the patient. They can reduce unnecessary tests and procedures and provide patients with direct access to their medical information (HealthIT.gov, 2013). For more information on potential benefits of EHRs for patients, visit http://www.healthit.gov/patients-families.

However, if practices are not thoughtful in how they use EHRs during visits, EHRs can negatively affect the patient's experience. For example, EHRs can interrupt communication and relationship building among staff, clinicians, and patients. When front desk staff or clinicians interact with an EHR, they are not interacting with the patient. Eye contact is more difficult and the personal interactions that are central to building relationships and trust may be disrupted. A patient in one clinic complained that, "All I see is the tops or backs of heads. The person at the front desk just types away, pushing things to me over the countertop. The MA is busy looking at the screen in front of her. Even the doctor ends up looking at that screen hanging off the wall. It's like my kids and their TV. I can't pry them away. I know they are only doing their job, but it's become so impersonal. You know what I don't feel I ever see anymore? People's eyes. Their faces."

As a PF, you can help your practices think about how their use of the EHR and other health IT both improves and disrupts patient experience. One way to do this is to shadow a patient or replicate the experience by having someone on the practice team play the role of a patient. The "pretend" patient can document his or her experience before, during, and after a visit, and then the practice can use this information to adjust EHR and non-EHR workflows to improve patient experience, as well as identify areas where staff may need training to improve the way they interact with patients while using health IT.

Another very helpful process, called *experience-based co-design*, is to partner with one or two patients in the practice and work with them to describe and map a recent encounter with the practice. As a PF, you can facilitate and even lead these discussions. Make sure that the patient feels comfortable and that confidentiality is respected. Once you and the patient complete a map of the experience, you can engage practice or care team members and the patient in brainstorming about ways to improve the patient's experience. This is best done with at least two hours of time, in a small group with five to eight clinicians, one or two patients, and yourself. (Knox and Brach, 2013). Additional information and resources on experience-based co-design are available at http://www.kingsfund.org.uk/projects/ebcd .

In addition to the actions described above, it may be helpful to work with patient partners and staff to develop scripts that staff and clinicians can use with patients when they introduce them to a process for the first time. For example, you might help a practice create a script for explaining the patient portal to a patient and why they would like the patient to register and begin to use it. (National Learning Consortium, 2013)

Using EHRs in Quality Improvement

EHRs are an essential tool for quality improvement, and along with other health information technologies, are one of the nine quality levers identified by AHRQ's National Quality Strategy. Everything discussed in this module directly or indirectly affects quality of care. Generating accurate reports for population and panel management helps fill gaps in care and make proactive patient care possible. Well-designed and deployed CDSs assist clinicians to deliver evidence-based care and reduce gaps in care. Improved data validation processes ensure accurate and actionable data. Using IT functions like patient portals may increase patient engagement and access (Emont, 2011).

Figure 27.9. Resources from the National Quality Strategy

Overview of the National Quality Strategy three aims and 6 priority areas http://www.ahrq.gov/workingforquality/

Ideas for using EHRs to improve quality from HealthIT.gov: http://www.healthit.gov/providers-professionals/faqs/how-can-i-use-my-electronic-health-record-improve-quality

EHRs and related health IT can be used to support improvements in performance and outcomes in every area of the practice. This includes improving diagnoses, improving decisionmaking, increasing the safety of prescribing, improving adherence to guidelines, and improving billing and coding. When used properly EHRs can also help improve patient participation in their care (HealthIT.gov, 2014).

Performance reports generated through EHRs and other health IT can be powerful motivators for practices (Levy and Stephenson, 2014). If providers and staff can see how they are performing against the practice as a whole and compared to other providers, it can motivate them to improve their method (Ettorchi-Tardy, Levif M, et al, 2012). Being able to track their individual improvement over time can provide positive reinforcement for continuing and even exceeding expectations.

Helping Practices Enhance Use of Other Health IT Resources for PCMH

Other types of health IT also support key principles of the PCMH. As appropriate, you will want to be prepared to help your practices think about ways to use these health IT resources to implement and maintain their PCMH as well. For example, how might they use other existing or new health IT to support secure messaging for communications between care teams and patients, phone visits, telemedicine visits, and home monitoring devices?

Working with practices on these issues extends beyond the scope of this particular module but it is important for you to be aware of these issues as they will become increasingly significant in coming years.

A Note About Small Practices and EHRs

When you are working with small practices and EHRs, be aware that they face unique challenges. They have fewer skilled staff available to manage the EHR and, in some cases, may have little or no expert IT support. As their PF, you may be their only resource with any level of knowledge about using EHRs to improve care quality. At the same time because the practice is small, it may also be easier to implement improvements because there are fewer individuals to convince to change.

You may need to consider more strategies to assist small practices of one to three clinicians (Healthcare Information and Management Systems Society, 2011). Strategies may include finding external partners, consultants, and collaborators to expand the skill set available to the practice on a regular basis and adjusting the pace of improvement work to allow the small practice to adapt to the changes.

If the practice is a for-profit endeavor by a clinician-entrepreneur, the owner's professional career cycle is also important to consider. Those close to retirement may be more reluctant to make these types of improvements and shoulder the costs. You will need to understand—at a high level—the return on investment for these practices for implementing EHRs and other health

IT resources, and be able to explain these to the owner and leadership of the practice. It is helpful to understand the primary mission for a practice and connect to this as a source of motivation.

For any practice, leveraging outside assistance from payer groups, businesses, or hospitals interested in supporting improvement can help encourage leadership to invest in activities that support quality such as EHRs and health IT. Ultimately, any practice that is transforming to a PCMH and implementing meaningful use will need to follow the same process, regardless of size, which includes providing leadership, time, and resources.

Conclusions

As a PF, helping practices better use their EHRs may be one of the most important things you do. Effective use of EHR reporting, clinical decision supports, and other functionalities in health IT systems can make the difference between poor care and well-organized proactive care that improves patient outcomes. It can also make the difference between frustrated, demoralized staff who are overwhelmed with work and those who are efficient and well-prepared. Helping practices better use their EHRs to improve care is a key contribution of practice facilitation.

References

Amatayakul, M. EHR Workflow Toolkit for Physician Practices. Grant #90RC00003/01. Topeka, KS: Kansas Foundation for Medical Care; 2011.

Centers for Medicare and Medicaid Services. Frequently Asked Questions. 2014a. Accessed December 28, 2014, at https://questions.cms.gov/faq.php?id=5005&faqId=3063 .

Centers for Medicare and Medicaid Services. *Clinical decision support: More than just alerts. Tipsheet.* September 2014. http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/ClinicalDecisionSupport_Tipsheet-.pdf.

Cusack CM, Knudson AD, Kronstadt JL, Singer RF, Brown AL. Practice-Based Population Health: Information Technology to Support Transformation to Proactive Primary Care (Prepared for the AHRQ National Resource Center for Health Information Technology under Contract No. 290-04-0016.) AHRQ Publication No. 10-0092-EF. Rockville, MD: Agency for Healthcare Research and Quality. July 2010.

eClinical Works. Patient Portal. 2014. https://my.eclinicalworks.com/eCRM/jsp/index.jsp. Accessed October 30, 2014.

Emont S. Measuring the Impact of Patient Portals: What the Literature Tells Us. California HealthCare Foundation, Oakland, CA, May 2011. http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MeasuringImpactPatientPortals.pdf. Accessed December 19, 2014.

Ettorchi-Tardy A, Levif M, Michel P. Benchmarking: A Method for Continuous Quality Improvement in Health. Healthcare Policy 2012;7(4):e101-e119.

Healthcare Information and Management Systems Society. *Improving Outcomes with Clinical Decision Support: An Implementer's Guide*. "Small Practice Considerations." HIMSS; 2011. http://www.healthit.gov/sites/default/files/cds/3_5_10_sm_practice_considerations.pdf . Accessed December 19, 2014.

HealthIT.gov. Benefits of HealthIT. Information Technology in Tealthcare: The Next Consumer Revolution. February 2013. http://www.healthit.gov/patients-families/benefits-health-it .

HealthIT.gov. Clinical Decision Support (CDS). 2014. http://www.healthit.gov/policy-researchers-implementers/clinical-decision-support-cds. Accessed October 30, 2014.

HealthIT.gov. Clinical Quality Measures (CQMs). 2014. http://www.healthit.gov/providers-professionals/achieve-meaningful-use/core-measures/clinical-quality-measures. Accessed October 9, 2014.

HealthIT.gov. Improved Diagnostics and Patient Outcomes. 2014. http://www.healthit.gov/providers-professionals/improved-diagnostics-patient-outcomes .

HealthIT.gov. What Is a Patient Portal? 2014. http://www.healthit.gov/providers-professionals/faqs/what-patient-portal.

HealthIT.gov. Benefits of EHRs. Healthcare Quality and Convenience. March 2014. http://www.healthit.gov/providers-professionals/health-care-quality-convenience.

Higgins TC, Crosson J, Peikes D, McNellis R, Genevro J, Meyers D. Using Health Information Technology to Support Quality Improvement in Primary Care. AHRQ Publication No. 15-0031-EF. Rockville, MD: Agency for Healthcare Research and Quality. March 2015. Available at http://www.pcmh.ahrq.gov/sites/default/files/attachments/Using%20Health%20IT%20Technology%20to%20Support%20QI.pdf

Hodach R, Handmaker K. Three keys to achieving population health management. Population Health News, 2014;1(2):1-12.

Institute for Health Technology Trasnformation. Population Health Management: A Roadmap for Provider-Based Automation in a New Era of Healthcare. New York: 2012. http://ihealthtran.com/pdf/PHMReport.pdf Accessed December 19, 2014.

Knox L, Brach C. *Practice Facilitation Handbook: Training Modules for New Facilitators and Their Trainers.* Agency for Healthcare Research and Quality, Rockville, MD; June 2013. Module 17. Trainer's Guide: Electronic Health Records and Meaningful Use. http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/index.html.

Kushinka, SA. *Electronic Health Record Deployment Techniques*. Issue Brief. Sacramento (CA): California HealthCare Foundation, January 2011. http://www.chcf.org/publications/2010/03/ehr-deployment-techniques.

Levick D, Saldana L, Velasco FT, Sittig DF, Rogers KM, Jenders RA, Osheroff JA, Teich JM. Improving outcomes with CDS: an implementer's guide, Second Edition. Scottsdale Institute, AMIA, AMDIS and SHM. 2012.

Levy J, Stephenson D. EHR-enhanced QI: Insights from the NYC DOHMH experience: The Primary Care Information Project. Joslyn Levy and Associates,, LLC, July 2010; (49). https://www.pcpcc.org/sites/default/files/media/cmd_cehia_pcip_7-8-2010.pdf.

Levy S, Jr. Graphical user interface (GUI). *Encyclopaedia Britannica;* 2014. http://www.britannica.com/EBchecked/topic/242033/graphical-user-interface-GUI

Meyers D, Quinn M, Clancy CM. Health Information Technology: Turning the Patient-Centered Medical Home from Concept to Reality. Am J Med Qual. 2011 March/Apr;26:(2):154-156.

Moreno L, Peikes D, Krilla A. Necessary But Not Sufficient: The HITECH Act and Health Information Technology's Potential to Build Medical Homes. (Prepared by Mathematica Policy Research under Contract No. HHSA290200900019I TO2.) AHRQ Publication No. 10-0080-EF. Rockville, MD: Agency for Healthcare Research and Quality. June 2010 https://pcmh.ahrq.gov/sites/default/files/attachments/Necessary%20But%20Not%20Sufficient_The%20HITECH%20Act.pdf.

Nace D, Marchibroda J, Crawford J, Nohrden C. Meaningful Connections: A resource guide for using health IT to support the patient centered medical home. Patient-Centered Primary Care Collaborative:

Meaningful Connections, Washington, DC. 2014:43.
http://www.pcpcc.org/sites/default/files/media/cehia_mc.pdf.

National Learning Consortium. Strategies for Optimizing an EHR System: Checklist. Bloomington, NM. Health Information Technology Research Center (HITRC). Stratis Health; 2013.

Primary Care Practice Facilitation Curriculum

Module 28. Using the AHRQ Care Model Toolkit With Practices

Prepared for:
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services
540 Gaither Road
Rockville, MD 20850
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Contract No. HHSA2902009000191-Task Order No.6

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Module 28. Using the AHRQ Care Model Toolkit With Practices

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Basic skills in practice management and quality improvement

Time

- Pre-session preparation for learners: 75 minutes
- Session: 60 minutes

Objectives

After completing this module, learners will be able to:

1. Provide a summary of the content and chapters in Integrating Chronic Care and Business Strategies in the Safety Net toolkit.
2. Identify where the toolkit supports key drivers of improvement contained in the Improving Performance in Practice Initiative (IPIP).
3. Use the toolkit to support improvement work with practices.

Exercises and Activities To Complete Before and During the Session

Pre-session preparation. Ask the learners to review information in items 1-3. (75 minutes)

1. The content of this module.
2. Access and review *Integrating Chronic Care and Business Strategies in the Safety Net* toolkit. Available at: http://www.ahrq.gov/populations/businessstrategies/.
3. Document the elements in the toolkit that you have had experience using in the past and what you learned using them.

During the session. Presentation (20 minutes)

1. Present key concepts from the module.

Activity for learners (20 minutes)

1. Have learners map contents of this toolkit to the Assessment of Chronic Illness Care tool (available at: http://improvingchroniccare.org/index.php?p=ACIC_Survey&s=35) and to the IPIP key driver model contained in Module 20 on quality improvement approaches.

Discussion. Ask questions and explore answers with learners. (20 minutes)

1. What elements of the toolkit do you think will be most useful to your work with practices?
2. What experience have you already had using the tools contained in the toolkit? What did you learn using these tools?

Module 28.

To promote spread of the Care Model, the Agency for Healthcare Research and Quality (AHRQ) commissioned the development of a Care Model toolkit. The MacColl Center for Health Care Innovation, in partnership with RAND and the California Health Care Safety Net Institute, created *Integrating Chronic Care and Business Strategies in the Safety Net.* This "change package" is designed to help practices implement elements of the Care Model (AHRQ, 2008).

This Care Model toolkit can be a resource to both you and the practices you work with. The toolkit includes a recommended process for implementing the Care Model and links to tools that you and your practices can use to support those changes. It also includes recommendations for strengthening the financial status of practices while implementing the Care Model.

Contents of the Care Model Toolkit

The *Implementing the Care Model and Business Strategies in the Safety Net* toolkit describes the specific practice changes involved in Care Model implementation. Practices are expected to go through four phases for a total of 12 key changes. Within each phase, the key changes do not need to be implemented in any particular order but should be pursued based on the needs of each practice. Table 28.1 lists the phases and key changes recommended in the toolkit.

Table 28.1. Toolkit phases and key changes contained in the Care Model toolkit

Phase 1: Getting Started
Organize your quality improvement team.
Familiarize your entire team with key improvement strategies.
Phase 2: Assess Data and Set Priorities for Improvement
Use data to set priorities.
Select performance measures based on your needs assessment.
Build performance measurement capacity.
Phase 3: Redesign Care and Business Systems
Organize your care team.
Clearly define patient panels.
Create infrastructure to support patients at every visit.
Plan care.
Ensure support for self-management.
Phase 4: Continuously Improve Performance and Sustain Changes
Reexamine your outcomes and make adjustments for continued improvement.
Capture incentives based on quality of care.

Each key change includes a table with specific action steps and associated tools. The Care Model toolkit includes links to more than 60 tools commonly used for quality improvement with the relevant changes, and example stories from practices that have made quality improvement pay.

How Should You Use the Care Model Toolkit?

You can use the Care Model Toolkit to:

- Get ideas for how to stage your work with practices.
- Learn about what key changes are needed to implement the Care Model.
- Gain exposure to a wide range of implementation tools.
- Serve as a "training curriculum" for your practice.
- Share parts of the toolkit with practices when working on those key changes.
- Serve as a text or reference book to be used in conjunction with facilitation.
- Train the practices to use the toolkit as a resource.

The toolkit, of course, does not cover every aspect of Care Model implementation. Furthermore, new tools are being developed all the time. Supplement the toolkit with additional materials depending on the needs of your practices.

Suggestions for Using the Care Model Toolkit With Practices

A demonstration project that used the toolkit with 18 community health centers provided insight into using the toolkit with practices:

- **Tip 1:** The toolkit links users with tools through the Web. Because of the dynamic nature of the Web, URLs may have changed since publication of the toolkit. Test the links in the toolkit before you ask practices to use them.
- **Tip 2:** Some of the links in the toolkit require registration to access. Let your practices know ahead of time when registration is required and that you have ascertained there is no charge to access the tool.
- **Tip 3:** Make it easy for members of the practice to access the toolkit. Place an electronic copy of the toolkit on the computer desktops of key staff and clinician leaders at the practice for easy access. Use tablet readers and broadband cards if you want to make the toolkit accessible during your visit to a practice. Broadband cards can be a good way to go since many practices do not have wireless Internet or have firewalls that may block your access to the Internet when you are at the practice.
- **Tip 4:** Select and use only those portions of the toolkit that meet the needs of each practice. The toolkit covers a wide range of topics and can be overwhelming to a practice in total. If your goal is to have practices use the toolkit on their own, introduce it to them gradually.

- **Tip 5:** Pick and choose content to match the practice's needs. Some of the content contained under each key change in the toolkit may not logically follow the change process your practice will undergo. Do not feel obligated to follow the steps and sub-steps outlined by the toolkit.

Note: this module is based on Module 18 of the Practice Facilitation Handbook. Available at: http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/

Reference

Agency for Healthcare Research and Quality. Integrating chronic care and business strategies in the safety net: a toolkit for primary care practices and clinics. Rockville, MD: AHRQ; August 2008. AHRQ Publication No. 08- 0104-EF. Available at: http://www.ahrq.gov/populations/businessstrategies/ Accessed October 7, 2014.

Primary Care Practice Facilitation Curriculum

Module 29. Implementing Care Teams

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Module 29. Implementing Care Teams

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Application of quality improvement methods to build capacity in care teams
- Cultural competency in communicating effectively at all levels

Time

- Pre-session preparation for learners: 110 minutes
- Session: 50 minutes

Objectives

After completing this module, learners will be able to:

1. Describe characteristics of care teams in small and medium practices and their advantages and challenges.
2. Describe "exemplar" care team models.
3. Become familiar with two "care team" building exercises—the jelly bean exercise and the role visualization and definition exercise—with practice quality improvement teams.

Exercises and Activities To Complete Before and During the Session

Pre-session preparation: Ask the learners to review information in items 1-4. (110 minutes)

1. The content of this module.
2. Bodenheimer T. Building Teams in Primary Care: 15 Case Studies. Oakland: California HealthCare Foundation; July 2007. Available at: http://www.chcf.org/publications/2007/07/building-teams-in-primary-care-lessons-from-15- case-studies.
3. Continuous and Team-based Healing Relationships: Improving Patient Care Through Teams. Implementation Guide. Seattle, WA: Safety Net Medical Home Initiative; December 2010. Available at: http://www.safetynetmedicalhome.org/sites/default/files/Implementation- Guide-Team-Based-Care.pdf.
4. Access and review the Improving Primary Care: Team Guide. Available at: http://www.improvingprimarycare.org/team.

During the Session: Presentation (30 minutes)

1. Present key concepts from this module.
2. View: Active Care Teams (ACT): Embracing Daily Team Huddles by the California Safety Net Institute. Available at: http://safetynetinstitute.org/goals/enhancequalityofcare/embracing-daily-team-huddles/.

Discussion: Ask questions and explore answers with learners (20 minutes)

1. What are characteristics of effective care teams in small and medium practices?
2. What can a facilitator do to help practices implement or optimize their care teams?

Module 29.

Care teams are groups of primary care staff members who collectively take responsibility for a set of patients. Care teams blend multidisciplinary skills, focusing several people's insights, rather than a single physician's, on each patient's problems. Care teams involve the efficient delegation of responsibilities such that no team members perform duties that do not require their skills. A number of practices have demonstrated that many primary care visits, especially for chronic disease, involve relatively simple matters that could be handled by nonphysician team members via protocols or standing orders (Bodenheimer, 2007).

> "A team is a small number of people with complementary skills who are committed to a common purpose, performance goals, and approach for which they are mutually accountable."
> —J.R. Katzenbach in *The Wisdom of Teams*

The composition of a care team will depend on the size and resources of the practice and the needs of the patient population (Coleman & Reid, 2010). Teams are generally organized around a primary care provider (e.g., physician, advanced practice nurse, physician assistant). Nurses, pharmacists, nutritionists, social workers, educators, and care coordinators may also be part of the care team. In smaller practices, care teams have fewer members. Such practices may also build virtual teams by linking themselves and their patients to providers and services in their communities. For more information on optimizing teams, refer to Module 30.

Why Change to Care Teams?

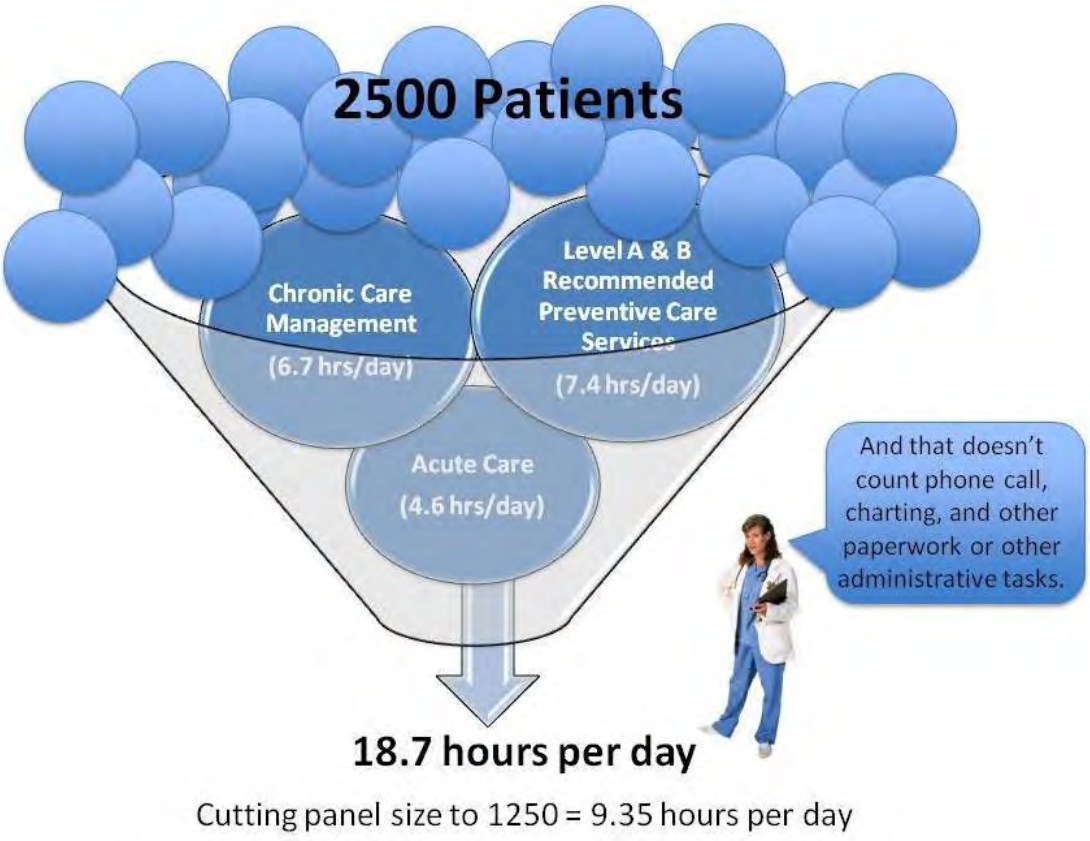
Mounting evidence demonstrates that a team of providers with multidimensional skill sets most effectively delivers health care. For example, many care and care-coordination activities are better provided by nonphysician members of a care team (Coleman & Reid, 2010). In fact, a 2006 evidence review of diabetes interventions found that providing team-based care was the single most effective intervention in improving intermediate diabetes outcomes (Shojania, et al., 2006).

Unless supported by a care team, physicians simply do not have the time to provide ideal care for all their patients, and many burn out trying. For example:

- Most physicians only deliver 55 percent of recommended care and 42 percent report not having enough time with their patients (Bodenheimer, 2008).
- Clinicians spend 13 percent of their day on care coordination activities and only half of their time on activities using their medical knowledge (Loudin, et al., 2011).

Figure 29.1 illustrates how the time demands of primary care visits exceed the available hours. Taking care of the top 5 common chronic conditions for 2,500 patients would take a physician working alone 6.7 hours per day (Østbye, et al., 2005). It would take an additional 7.4 hours to provide the panel of patients with the preventive services most strongly recommended by the U.S. Preventive Services Task Force (Grade A and B recommendations) (Pollak, et al., 2008). Add to that the 4.6 hours it takes to care for acute problems, and you find that a physician would have to work 18.7 hours a day to care for a panel of 2,500 patients. And that does not count time for phone calls, charting, and other administrative tasks.

Figure 29.1. Time demands in primary care



Based on data from: Yarnall KSH, Pollak KI, Østbye T, et al. Primary care: is there enough time for prevention? Am J Public Health. 2003 Apr;93:635-64; and Østbye T, Yarnall KSH, Krause KM, et al. Is there time for management of patients with chronic diseases in primary care? Ann Fam Med 2005 May;3:209-14.

How Do Care Teams Function?

Teams deliver comprehensive, first-contact care and address the needs of patients and families through a broad range of services delivered by multidisciplinary professionals. In the team-based care model, all care team members contribute to the health of the patients by working at the top of their licensure and skill set. For example:

- Nurses can conduct complex care management.
- Front desk staff can reach out to patients who need but have not received evidence-based care.
- Medical assistants (MAs) can provide patient self-management support.
- Pharmacists can conduct medication reconciliation and management.

The California HealthCare Foundation compiled case studies from a range of primary care practices on building teams in primary care practices, including material on expanding the role of medical assistants and innovative team roles in practice. For more reading go to: http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/B/PDF%20BuildingTeamsInPrimaryCareCaseStudies.pdf. Team-based care has the potential to decrease costs and increase revenue (Coleman & Reid, 2010).

Team-based care requires all team members to make adjustments. Primary care clinicians need to learn to delegate tasks that they traditionally performed. MAs in particular take on new and enhanced responsibilities for patient care. They need to learn to work side by side with clinicians and do more during the rooming process—from reviewing medicines to goal setting to patient education.

Elevating the involvement of and expectations for MAs, and the level of confidence of clinicians in MAs, is a key element of success. Offering special training to MAs can communicate that leadership supports the elevated role of the MA within the care team. Finally, all team members need to learn how to communicate effectively with each other.

How Can a Practice Facilitator Help a Practice Implement Team-Based Care?

Depending on the level of care provided at the practice, the practice facilitator might help the practice in one or more of the following activities:

1. Prepare for the transition to team-based care:

    - Help identify a change champion for team-based care who can lead the effort.
    - Increase the champion's knowledge about care teams and how teamwork differs from traditional approaches by providing training and resources.
    - Provide examples of best practices and set up virtual or in-person site visits.

2. Set up teams:

    - Create new workflows of how teams will deliver care.
    - Assign roles and responsibilities that enable working at level of licensure.
    - Create new ways of communicating that strengthen team approaches to care:

        - Pre-visit planning.
        - While patient is in the office.
        - Post-visit.
        - Performance and feedback.

3. Optimize already existing care teams by helping team members clarify roles, tasks, and expectations; redesign workflow based on these things; and improve communication and problem-solving skills.

4. Set up performance measures to monitor the care team's effectiveness (see Module 13 on performance measurement).

Activities To Do With Your Practices

The following are exercises that you can conduct with your practice. These two exercises will give your practice a better understanding of spreading workload and shifting job responsibilities, and the benefits to care teams. You can find copies of the exercise sheets that you can take with you to your practices in the Appendix 29A and 29B.

Activity 1: Team Visualization Exercise.[1] The goal of this exercise is to illustrate how the current models in most primary care practices do not function as team-based care. When working with your practice, be sure to get all care team members to participate. Each staff member will be given 60 jelly beans and a short, clear plastic cup. Also have a cup in the middle labeled "No one."

- Ask the group which staff member performs each of 10 tasks (listed below).
- Instruct all staff members to drop a jelly bean into the cup of **each** staff member who they think **currently performs** that task.
- Instruct staff members to drop a jelly bean into the "No one" cup if they don't think anyone currently performs that task. For example, if a staff member thinks a task is currently performed by two physicians, a nurse practitioner, and a physician's assistant, that staff member would put a jelly bean in each of the cups of those four clinicians.

[1] Provided by Carolyn Shepherd, M.D.

Ask which staff member**:**

1. SETS the intervals for blood monitoring for patients on warfarin?
2. DECIDES when to call a patient with diabetes to come in for a visit?
3. SELECTS the vaccines to be given to an 18-month-old baby?
4. DECIDES to arrange a diabetes retinal screening referral?
5. ORDERS the mammogram for a 55-year-old woman with severe hypertension and heart disease?
6. INITIATES diabetes microfilament foot testing to prevent amputations?
7. FINDS patients with severe persistent asthma who are not on controller medications and brings them in for an appointment?
8. DECIDES which children with Attention Deficit Hyperactivity Disorder should come for a visit?
9. DECIDES when a patient with major depression should come back for a visit?
10. ADMINISTERS Screening, Brief Intervention, and Referral to Treatment (SBIRT) screening to patients in your practice?

At the end of the exercise, the group will probably discover that most of the jelly beans end up in the primary care clinicians' cups. Facilitate a discussion using the following prompts:

- What did you observe about this exercise? What did you learn from it?
- What implications do you think this has for you all as a care team?
- Why are there jelly beans in the "No one" cup? What can you do about that?
- What should the distribution of jelly beans look like to indicate real team-based care?
- What changes would you need to make to how you are currently practicing to achieve this?
- How would this affect your workflow?
- Are there goals you want to include in your quality improvement (QI) plan based on this exercise?

Activity 2: In a Perfect World—Task Reassignment Exercise

This is a good follow-up exercise to the Team Visualization Exercise. By the end of this exercise, your practice will learn how responsibility could be reallocated among staff members to become more team oriented and efficient in caring for patients.

- Begin by completing the first column of the Task Reassignment Table (Table 29.1). You may choose tasks associated with a particular care process (e.g., care of patients with diabetes) or general workflow tasks (e.g., intake, documentation, follow-up). (See the example in Table 29.2.) You may want to confer with the leader of your practice's QI team on which tasks to list.
- Next, convene the practice's QI team and have team members fill out the middle and right columns of the Task Reassignment Table.

- Remind them that in the perfect world all care team members work at the top of their licensure and skill set.
- Encourage them to think how others can be trained to perform tasks they don't currently perform.
- Let them know that tasks currently performed by one person can be split among care team members as long as there are appropriate handoffs.

What your practice will learn from this exercise is the difference between the status quo and the ideal, and what responsibility shifts it will take to get from one to the other.

Table 29.1. Task reassignment table

Task	Who does it now?	In a perfect world, who would do it?

Adapted from Institute for Healthcare Improvement.

Table 29.2. Task reassignment table example

Task	Who does it now?	In a perfect world, who would do it?
Book appointments	RNs and clerical	Clerical support
Take incoming calls	Everyone	Clerical support
Chart preparations	Mas	Clerical support
Triage	RNs and MDs	RNs
Medication refill requests	RN, MD, clerical	Clerical with MD signature
Check-in	Receptionists	Receptionists
Suture removal	MD	RN
Dressing change	MD	MA
Flu shots	RN	MA
Other		

Note: this module is based on Module 19 of the Practice Facilitation Handbook. Available at: http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/

References

Agency for Healthcare Research and Quality. Patient Centered Medical Home Resource Center. Defining the PCMH. Available at: http://www.pcmh.ahrq.gov/page/defining-pcmh

Bodenheimer T. Building Teams in Primary Care: Lessons From 15 Case Studies. Oakland: California HealthCare Foundation; July 2007.

Bodenheimer T. The future of primary care: transforming practice. N Engl J Med 2008;359(20):2086-9.

Coleman K, Reid R. Safety Net Medical Home Initiative. Continuous and Team-based Healing Relationships: Improving Patient Care Through Teams. Implementation Guide. 1st ed. Burton T, ed. Seattle, WA: MacColl Center for Health Care Innovation at the Group Health Institute for Healthcare Innovation at the Group Health Institute and Qualis Health; December 2010.

Katzenbach J, Smith, D. The Wisdom of Teams: Creating the High-performance Organization. Cambridge, MA: Harvard Business School Press; 1993.

Østbye T, Yarnall KS, Krause KM, et al. Is there time for management of patients with chronic diseases in primary care? Ann Fam Med 2005;3:209-14.

Pollak KI, Krause KM, Yarnall KS, et al. Estimated time spent on preventive services by primary care physicians. BMC Health Serv Res 2008;8:245.

Loudin B, Gainer L, Mayor M, et al. Elevating the Role of the Medical/Clinical Assistant: Maximizing Team-based Care in the Patient-centered Medical Home. Seattle, WA: MacColl Center for Health Care Innovation at the Group Health Institute and Qualis Health; August 2011.

Shojania KG, Ranji SR, McDonald KM, et al. Effects of quality improvement strategies for type 2 diabetes on glycemic control: a meta-regression analysis. JAMA 2006:296(4):427-40.

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Module 30. Building Teams in Primary Care

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Module 30. Building Teams in Primary Care

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Meeting management
- Leadership coaching
- Basic quality improvement skills
- Change management

Time

- Pre-session preparation for learners: 1-2 hours
- Session: 1 hour

Objectives

After completing this module, learners will be able to:

1. Describe the role of the practice facilitator in optimizing teams in primary care practices.
2. Discuss how this work may differ based on the size of the practice and the type of team (clinical vs. nonclinical).
3. Discuss the five characteristics of effective teams and the relevance of each to primary care practices.
4. Use the Waterline Model to engage practice team members in self-assessment and reflection.
5. Deliver a short training on the characteristics of high-functioning care teams and common problems faced by these teams.
6. Access select online resources that are appropriate for helping a care team optimize its functioning.

Exercises and Activities To Complete Before and During the Session

Pre-session preparation. Ask the learners to read, review, or watch the following items. (1-2 hours)

1. The content of this module.
2. Module 29, Implementing Care Teams, which should be reviewed for the principles and processes of team-based care as a core element of the patient-centered medical home.
3. Video on the Waterline Model. Available at: https://www.youtube.com/watch?v=XTIBvQh3_zQ.
4. TED video on the marshmallow teambuilding exercise and lessons learned. Available at: http://www.ted.com/talks/tom_wujec_build_a_tower?language=en
5. Mitchell P, Wynia M, Golden R, et al. Core Principles & Values of Effective Team-based Health Care. Washington, DC: Institute of Medicine; 2012. Available at: https://www.nationalahec.org/pdfs/VSRT-Team-Based-Care-Principles-values.pdf.

During the session. Presentation (15 minutes)

1. Present key concepts from the module.

Activity for learners. (45 minutes)

1. Divide into groups of three or four. Assign roles: Practice Facilitator and Participants.
2. Have members of each group share details about a team they have been part of.
3. Have one member of each group lead a conversation about whether or not these teams were effective and why, using the "five features of effective teams" model.
4. Have Practice Facilitator report out findings to the larger group for discussion of common findings.

Module 30.

Teams and teamwork are a vital part of every primary care practice, no matter how small or large the practice. The functioning of these teams plays a large role in the quality of care and patient experience with care, as well as the morale and job satisfaction of clinicians and other staff in the practice. Moreover, the increased focus on team-based care in the past several years means that teams are more important than ever in primary care.

One of your roles as a practice facilitator (PF) is to help these teams improve how they function and work together to accomplish their goals. This module will introduce the information you will need to help these practice teams work well together. In this module, you will learn:

- The basics of team formation and functioning.
- The types of problems that prevent teams from accomplishing their goals.
- Some basic methods for helping teams improve their effectiveness.

Moreover, this module provides additional information and resources that you can use with your practices to optimize this essential team. This module is a companion to Module 29, Implementing Care Teams, which you should complete before beginning this module.

Ways That PFs Can Help Practices Improve Their Teams and Teamwork

You will find many types of teams within a primary care practice. The most obvious and relevant to the patient centered medical home are *patient care teams*, which are often made up of a clinician and a medical assistant but can include a variety of additional members, such as pharmacists, health educators, community health workers, and, of course, the patients themselves. Other teams found in primary care practices include *practice leadership, finance, health information technology (HIT), quality improvement (QI),* and *risk management teams*, as well as teams built around specific types of patients or specific patient services, such as women's health, diabetes care, or pediatrics. You will probably find yourself working most often with the practice's QI team, leadership team, or one or more of their patient care teams.

As a PF, you can help your practices improve the effectiveness of their teams in a number of ways. You can:

- Help practice leaders design and support effective teams (see Module 21: Working With and Supporting Practice Leaders, for techniques on how to engage these leaders).
- Train practice members on characteristics of teams and what makes them effective.
- Help teams assess their performance and functioning and use this information to identify changes that can improve their functioning.

- Help teams implement changes in the way they operate, such as:
    - Creating a clear definition of the team's purpose and goals
    - Clarifying members' roles
    - Adopting effective group norms and processes
    - Improving methods and skills in communication and addressing conflict
- Connect team leaders to resources on effective team leadership and coaching them in these areas.
- Help teams modify workflows to support better teamwork.

What Makes for an Effective Team?

The teams you work with will typically be focused on accomplishing specific tasks or objectives. For such teams, effectiveness requires the following five features (Hackman, 2002).

1. The team is a **real team**. A real team must have: a task for which the members are collectively responsible, a clear definition of who is on the team, a clear definition of what things the team (as individuals and a group) is accountable for, and a stable membership over time so that the team can develop a shared approach to the task they have been assigned.
2. The team has a **compelling direction**. Teams need a purpose that is compelling, challenging, and important. Once practice leaders have determined the purpose of a specific team, the team can focus on achieving specified objectives related to their purpose. For example, a team could be given the clear direction from practice leaders to ensure that a member of the clinical team follows up with patients who have been recently discharged from a hospital stay within four days to improve care and reduce unnecessary re-visits to the hospital. A practice leader who provides motivation to the team about followup is needed after hospital discharge can make the task even more compelling to team members.
3. The team must have an **enabling structure** to make it possible for them to accomplish their objectives. Specifically, teams should be diverse enough to offer different potential approaches to solving problems. You should advise practice leaders of this and help to ensure that they select team members with care. For example, having someone with data analysis skills on a QI team is essential for monitoring care improvements; having a clinician on the team is also essential for identifying clinically meaningful improvement targets. However, a team with lots of members often runs into difficulties completing the assigned tasks. Research on teams shows that the coordination required within the team goes up dramatically when a team has more than six members. For a large practice taking on a complex project, it likely will have to organize a large team into sub teams responsible for certain portions of the work to ensure that work gets completed and team members feel accountable for it.

4. The team also needs a **supportive environment** to be effective. You can work with practice leaders to set up effective recognition systems to reinforce good team performance. Some things you can do to help make an environment supportive include:

    - Advise the team on ways to gather information needed to make and monitor the changes they are working on.
    - Direct team members to technical assistance or training when needed (e.g., learning about specific techniques to engage patients or improve chronic illness care).
    - Help with or advise on securing the resources needed to make change (e.g., technologies, staff).

5. **Competent coaching** is an important resource that you can provide to the teams you work with. Your coaching should change in approach as the team develops over time. At the beginning, your coaching will largely be *motivational*, focusing on getting all members of the team to put forth the effort needed to solve the problem they are working on. Once the team is up and running, your efforts will be more *consultative*, focusing on getting the team to consider its work so far and to think about strategies for its upcoming work. You can be a resource for change strategies. Once a team has completed its assigned task, your coaching should be *educational,* focusing on facilitating a conversation about the lessons learned from the task they have successfully completed.

Practice leaders play a key role in making sure that the teams in their practice include these features, and you can play an important role in helping practice leaders understand the importance of these features of a successful team. Helping practices ensure their teams are well designed—for example, they are real teams that have a compelling direction, enabling structure, and a supportive environment—is an important place to start when you are working with a practice to optimize a team's functioning. For more information on the five features of effective teams, see Hackman (2004).

Assessing Teams

As a PF, you will need to become skilled at observing and assessing teams in your practices.

Common problems of teams and how to identify them. Teams get stuck or become dysfunctional for many reasons. They may run into problems because they lack the content knowledge or technical skills to accomplish the goals they have been charged with. Or the roles of individual team members may not be well defined, leading to confusion about how each member should participate on the team. A team might fail to value the input of all its members, perhaps dismissing input from lower-status members, or fail to elicit input from quieter members. Teams can also run into difficulties because of interpersonal conflicts among its members that are ineffectively handled. The Waterline Model, described below, offers a good approach to identifying these types of problems and working through them to help a team be more productive.

The Waterline Model. A tool that many PFs find particularly useful and practical in their work with practices is the Waterline Model (Harrison et al., 2001). This model is an interactive approach to identifying the source of problems in a team, which can help you and the team take steps to resolve the problems. It can also be used to help a team reflect on its functioning and look for ways to further enhance that functioning. As a PF, you can use the Waterline Model to help teams diagnose the reasons they are having problems attaining their goals and then use this information to take steps to resolve these problems (Harrison et al., 2001). A video that presents a good overview of this approach is available at: https://www.youtube.com/watch?v=XTIBvQh3_zQ.

Optimizing Patient Care Teams

Patient care teams are central to the PCMH. Module 29 in this curriculum discusses the initial implementation of care teams and provides you with a variety of related resources. This module deals with what comes next. Just because a practice implements care teams does not mean that the team members work together well or even at all. Sometimes clinicians and staff have fully bought into the idea of team-based care. In other instances, they are reluctant participants and are doing so only because it has been forced on them by their practice leaders.

Regardless of the level of buy-in, most care teams—just like members of a sports team—need training, support, and practice to hit their stride.

Some of the things you can do as a PF to help practices optimize the functioning of their patient care teams include:

- Helping team members more clearly define each member's role.
- Helping team members improve communication with each other about patient care.
- Helping team members improve their huddling process.
- Helping teams decide on and implement standing orders.
- Helping teams (and practices) modify workflows to better support teamwork.
- Helping practices better use their electronic health record (EHR) and other IT resources to support teamwork.
- Helping practices incorporate patients as members of the team.
- Helping teams gather feedback from patients about the experience of team-based care and using this information to improve processes.
- Helping teams develop scripts for explaining team-based care to patients.

An emerging approach in care team formation is the **teamlet plus expanded team member model**. Teamlets consist of a clinician (physician, nurse practitioner, or physician assistant) and one or more medical assistants that work together daily. Both the clinician and the medical assistants feel responsible for the panel of patients assigned to them. The teamlet forms the core of a larger team—the expanded team member model—that includes other practice members such as a registered nurse, a health coach, and a behavioral health clinician.

- Helping teams to expand their membership to include community health workers, pharmacists, nutritionists, patient advocates, and others important to patient care.
- Helping practices train their medical assistants, clerks, nurses, and other members of the team in the skills needed for their new expanded roles.

Characteristics of High-Performing Primary Care Teams

High-functioning care teams in primary care practices share a number of characteristics, as described in Table 30.1.

Table 30.1. Nine characteristics of high-functioning primary care teams

Characteristic	Description
Stable team structure	Team membership is consistent; the same people always work together. Schedules, language, and compatibility of work styles are considered when forming teams.
Co-location	Team members have adjacent workstations and spaces that enable them to share information in real-time about patients.
"Share the care" culture	The practice and care team have transitioned from the traditional "lone physician with helpers" or "I" model of care to a "share the care" or "we" approach. This involves reallocating responsibilities, not just tasks, and meaningful participation. It also means the patient panel is seen not just as the clinician's panel but the entire team's.
Defined roles with training and skills checks	Team members' roles are clearly defined, and they are provided with training to enable them to fill these roles. Each member's competencies in required skills are evaluated and additional training is provided to remediate skills deficits.
Use of standing orders and protocols	Clinicians (physicians, nurse practitioners, physician assistants) approve standing orders that enable nurses, medical assistants, and other nonclinician team members to provide routine services without taking up clinician time. Conditions under which staff can provide care are clearly spelled out.
Use of workflow mapping to clearly define workflows	Team members are clear on who does what tasks and functions, in what order, and how handoffs occur. The team maps its workflows and works together to improve them to ensure this clarity.
Staffing ratios are adequate for new roles	Sufficient nonclinician staff are available to assume additional responsibilities. Optimal staffing can be supported through revenue generated by reallocating work, thus enabling clinicians to see more patients per day, or through other payment arrangements, such as shared savings, care management fees, or per-member per-month payments (see Module 3, The Primary Care Landscape and Context, for additional information).

Characteristic	Description
Ground rules	Two sets of teamwork ground rules are needed: first, to enable productive team meetings that are respectful of all participants; second, to enable effective teamwork on patient care. Developing effective ground rules for teamwork may require addressing and overriding existing norms and work patterns that undermine teamwork.
Defined methods for communication	The team holds regular meetings of all its members to discuss issues. Daily huddles are held and used to coordinate how the team will work together to provide care for the patients being seen that day. Minute-by-minute communications are facilitated by co-location, clear roles, trust, and workflows.

Source: Adapted from Bodenheimer T, personal communication, November 2014.

As a PF, you can use these characteristics to help you evaluate the care teams you work with. You can also train primary care teams on these factors and help them reflect on the degree to which their team contains each of these characteristics. You can then work with them to plan and implement interventions to better align their structure and processes with these characteristics.

Common Challenges Faced by Primary Care Teams

As a PF, you should be familiar with the types of problems that can affect the effectiveness of care teams. Even if the practice has not engaged you specifically to address these issues, it is important for you to keep aware of them, given how central teams are to all aspects of the PCMH and practice functioning. In fact, they affect almost every aspect of the practice from who is hired, to staff training, workflow, IT, and patient experience.

Primary care teams face a number of common challenges.

The first is the **complexity of primary care itself**. The sheer scope of care and range of patient issues that care teams need to be able to address can make it challenging to define a manageable list of tasks and roles. Different workflows, processes, and teamwork can be required for different types of patients (pediatric, adult, elderly) and visits (wellness, acute, chronic).

Example of Care Team Principles from the Cambridge Health Alliance

Every patient is assigned to a care team that, at the very least, includes a primary care clinician, nurse, medical assistant, and receptionist.

The team huddles daily to care for patients in a proactive way.

The teams meet at least monthly to proactively manage the work of population health and to discuss high-risk patients. At most sites, teams meet weekly or biweekly.

The usual care team interfaces seamlessly with the complex care management team.

What payers will allow practices to bill for can create another barrier to teamwork. For example, in some instances, visits with physicians, nurse practitioners, and physician assistants are billable, but visits with other types of professionals on the team may not be. This can create a disincentive to "share the care" and offset any gains in physician time that result from the team-based approach. Practices may need to think creatively about how to address these barriers.

The history of medicine and the power structure within it can be another barrier. Team members, especially physicians who are often the leaders of their care teams, must learn to balance their degree and credentials with the need for all members to participate fully on the team for it to function well (Bodenheimer, 2007). Similarly, nonphysicians that may have been acculturated to wait for direction from the MD or DO must learn to form new relationships with physicians (and patients) and navigate the patient care process in a different way. The issue of power and its effects on communication and teamwork is pervasive in all areas of medicine—not just primary care—and has important implications not only for quality of care but also for patient safety. The Agency for Healthcare Research and Quality has developed some outstanding resources to improve communication around patient care issues called TeamSTEPPS (available at: http://teamstepps.ahrq.gov/). As a PF, you should become familiar with this program and its resources so you can draw on them as needed with your practices.

Issues with a practice's IT also can create additional barriers. The EHR used by a practice may create its own set of obstacles to team care. The system may not be configured to support team-based care or key functionalities may be missing or not enabled. For example, a small practice using a web-based system may have set up individual accounts for each clinician; this would make it difficult for others to view the patient's medical record. Another practice may not have enabled capabilities like tasking that could support communication among members of care teams.

A number of **other factors** can affect care team functioning. Unpleasant tasks may be "dumped" on nursing staff or medical assistants. Staff may resist expanded roles if they are already feeling overworked. Physicians may endorse the team approach intellectually but resist "sharing the care." Turf battles may occur between different staff members who fear that their role is being replaced. For example, medical assistants might feel threatened by inclusion of community health workers on the care team. Other common challenges include: unclear role definitions; insufficient time for teams to meet, reflect, and understand the meaning of their work together; inadequate training or skill development to perform tasks needed for team-based care; and reluctance to delegate tasks to team members because of concerns about competence.

Resources for Helping Care Teams Optimize Functioning

Improving Primary Care: Team Guide is available at: http://www.improvingprimarycare.org/team

TeamSTEPPS: http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/primarycare/index.html

TeamSTEPPS videos

http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/primarycare/video/index.html

In small family-run practices, there may be an unwillingness to replace ineffective staff because these staff often have both a professional and a personal relationship (for example, a nurse at a practice who is also the wife of the solo physician). There is sometimes less professionalism in small practices, such as a lack of meetings, job descriptions, performance reviews, merit pay, basic policies and procedures, and so on. Finally, and not surprisingly, people often resist change. Staff and clinicians may be comfortable with existing roles and resist changes.

Getting To Know the Care Teams in Your Practices

If assessing the functioning of a practice's care teams is going to be a major focus of your work, you may want to conduct a more in-depth assessment of its teams. There are a variety of tools available for formally assessing care teams, including:

The *Building Blocks Team Function Survey*, based on the 10 Building Blocks of High-Performing Primary Care model, provides a series of questions for assessing care team functioning. The Building Blocks survey is modeled after the Assessment of Chronic Illness Care.[1] It also assesses other areas of practice functioning beyond care teams (Bodenheimer, 2014).

Traditional performance reports can also be useful in getting a feel for how effective a care team is. You can work with the QI team at the practice to generate reports on care teams' performance on important quality metrics that you review with care team members and help them use to assess how well they are functioning as a team. These metrics should also include assessments of member morale and "joy at work." You can work with them to use tools like **The 5 Whys** (NHS Institute for Innovation and Improvement, 2008) and **fishbone diagrams** (Centers for Medicare & Medicaid Services, 2014) to identify root causes for problems they are encountering or—if you are taking a strengths-based approach—root causes for areas in which they are functioning particularly well (see Module 11 for details). Then you can help them use this information to develop and test interventions to improve their functioning using Plan Do Study Act cycles or a similar process.

Working With Care Teams To Engage Patients as Partners

Patients are an essential part of any care team. Clinicians and staff work collaboratively with patients to jointly attain defined health goals and outcomes. Both patients and their caregivers are members of the care team, each with their own areas of expertise. While clinicians and staff members are experts in medical treatments, patients are experts on their own lives and health care goals. You can work with clinicians and staff to ensure that the necessary conditions exist

[1] Assessment of Chronic Illness Care (ACIC). Copyright 2000, The MacColl Center for Health Care Innovation, Group Health Cooperative.

for effectively partnering with patients. According to the Institute of Medicine (2012), these conditions include:

- clarifying the role of patients on care teams with clinicians, staff, and patients;
- supporting shared and individualized decision making about health goals and care, and
- supporting effective communication among clinicians, staff, and patient care team members.

As a PF, you can support care teams as they work to create these conditions by helping them gather feedback and ideas from their patients; directing them to resources, including exemplar care teams; and helping them select and implement specific changes. Table 30.2 contains some resources that other PFs have found helpful for supporting this work.

Table 30.2 Resources for practices to use in engaging patients

Shared decision making
AHRQ's Shared Decision Making Toolkit, available at: http://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/index.html.
Engaging effectively with low literacy and low health literacy patients
AHRQ's Health Literacy Universal Precautions Toolkit, available at: http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html.
Engaging patients in redesigning care delivery
Partnering with patients to redesign care, see: http://www.hipxchange.org/patientengagement .
Experienced-based redesign, see: http://www.kingsfund.org.uk/projects/ebcd.

Summary

Teamwork is essential to effective practice operations and practice improvement, and to the PCMH. As a PF, you can help practices improve their teams and teamwork by helping teams learn about the process of becoming a team, evaluating their functioning, and designing and testing interventions to improve the effectiveness of all their teams.

References

Bodenheimer T. Building Teams in Primary Care: Lessons Learned. Oakland, CA: California HealthCare Foundation; 2007. Available at: http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/B/PDF%20BuildingTeamsInPrimaryCareLessons.pdf

Bodenheimer T, Ghorob A, Willard-Grace R, et al. The 10 building blocks of high-performing primary care. Ann Fam Med 2014;12(2):166-71.

Centers for Medicare & Medicaid Services. How to use the Fishbone Tool for Root Cause Analysis. Baltimore, MD: CMS; 2014. Available at: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/FishboneRevised.pdf

Hackman JR. Leading Teams: Setting the Stage for Great Performances. Boston, MA: Harvard Business School Press; 2002.

Hackman, JR. What makes for a great team? Psychological Science Agenda; June 2004. Available at: http://www.apa.org/science/about/psa/2004/06/hackman.aspx.

Institute of Medicine, Committee on the Learning Health Care System in America. Best Care at Lower Cost: the Path to Continuously Learning Health Care in America. Washington, DC: National Academies Press; 2012.

Mickan S, Rodger S. (2000). Characteristics of effective teams: a literature review. Aust Health Rev 2000;23(3):201-8.

Mitchell P, Wynia M, Golden R, et al. Core Principles & Values of Effective Team-based Health Care. Washington, DC: Institute of Medicine; 2012.

NHS Institute for Innovation and Improvement. Root Cause Analysis Using Five Whys. London; 2008. Available at: http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/identifying_problems_-_root_cause_analysis_using5_whys.html

Primary Care Practice Facilitation Curriculum

Module 31. Facilitating Panel Management

Prepared for:
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services
540 Gaither Road
Rockville, MD 20850
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Contract No. HHSA2902009000191-Task Order No.6

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Module 31. Facilitating Panel Management

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Specialized skill in facilitating panel management
- Basic skills in change management

Time

- Pre-session preparation for learners: 75 minutes
- Session: 80 minutes

Objectives

After completing this module, learners will be able to:

1. Identify steps involved in training a practice on key concepts of panel management.
2. Use panel management training by Bodenheimer and Ghorob to train key practice staff on panel management.

Exercises and Activities To Complete Before and During the Session

Pre-session preparation. Ask the learners to review information in items 1-2 and watch video. (75 minutes)

1. The content of this module.
2. Empanelment Part 1: Establishing Patient-provider Relationships. Implementation Guide. Seattle, WA: Safety Net Medical Home Initiative; May 2013. Available at: http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Empanelment.pdf
3. Video on outcomes of panel management. Available at: http://www.youtube.com/watch?v=qKiD-4deFPQ.

Note to instructor: Explain that the video shows an example of proactive care at Kaiser Permanente and demonstrates the difference good information systems, empowered staff, and proactive care can make.

During the session. Presentation (65 minutes)

1. Present key concepts from this module.
2. Bodenheimer T, Ghoreb A. Panel management. University of California San Francisco, Department of Family and Community Medicine; 2012. See Appendix B.

Discussion. Ask questions and explore answers with learners. (15 minutes)

1. Why does panel management matter?
2. What elements are necessary to effect panel management at a practice?
3. What role can a practice facilitator play in helping practices implement panel management?

Module 31.

A panel is a list of patients assigned to each care team in the practice. The care team (e.g., a physician, a medical assistant, and a health educator) is responsible for preventive care, disease management, and acute care for all the patients on its panel. This means that a patient will have the opportunity to receive care from the same clinician and his or her care team.

What Is Panel Management?

Panel management, also known in primary care as population management, is a proactive approach to health care. "Population" means the panel of patients associated with a clinician or care team. Population-based care means that the care team is concerned with the health of the *entire* population of its patients, not just those who come in for visits. For example, a care team with a panel of 1,500 patients would be concerned about the health care needs of the entire 1,500. The team would work on anticipating and planning for this care proactively (in advance) rather than reactively (when the patient shows up for a visit and requests care).

Why Is Panel Management Important?

Some practices do not use panels and operate more as acute care centers—services rendered to patients needing urgent medical attention (e.g., infection, injuries, or flu).

The Care Model and patient-centered medical home (PCMH) concepts require a different approach to care. Instead of thinking about patients episodically (a string of loosely connected appointments), practices must find ways to proactively reach out and develop continued relationships with their patients to provide continuity of care. Continuity of care is designed to provide higher quality of care to patients by providing consistent care over time through a primary care clinician.

> Empanelment must be an early change on the journey to becoming a PCMH because other key features such as continuous, team-based healing relationships; enhanced access; population-based care; and care coordination depend on the existence of such linkages..
>
> —Wagner, 2012

Assigning patients to particular clinicians or care teams helps change this approach. It designates teams responsible for caring for specific patients and supports continuous relationships between patients and their care teams. It also makes it possible for care teams to "manage" care not just for individual patients as they appear, but to plan care for all of the patients assigned to their panel.

Care teams oversee and track proactively the care needs of the patients on their panel and ensure that patients receive the services they need to optimize their health and well-being. Creating panels also makes it possible to monitor the performance of care teams with their assigned patients and monitor how effectively they are providing needed services to each patient in their panel.

Does Panel Size Matter?

The first question most practices will ask is, "Is patient panel size important?" The best answer is, yes, size matters. Imagine a clinician who is seeing too few patients. That may be great for him or her because the workload is lighter but not so great for other clinicians in the practice who are working into the evenings to keep up. You can imagine that it wouldn't take long for resentment to build among clinicians.

On the flip side, a clinician with a patient panel size that is too large is not effective. Patients may find it hard to get in to see their clinician, workloads may be deflected to others in the practice, and frustration will increase. The goal is to find balance in the practice between supply (time offered by the clinician) and demand (the need for the patient to be seen).

How Large Should a Panel Be?

The average panel size for a care team is 1,500 or 2,000 patients. Panel size is calculated by taking the clinician's "supply" of visit slots and dividing it by the average number of visits by a typical patient during a year. The result is the total number of unduplicated patients a clinician can care for in a year. For example:

- A clinician who works 230 workdays in a year and sees 24 patients a day has a "supply" of 5,520 slots a year (230 workdays × 24 patients/day).
- Patients average 3.19 visits to the clinician a year.
- This clinician could care for a panel of 1,730 average patients in a year (5,520 ÷ 3.19).

As noted in Module 29, however, a clinician working alone would not be able to care adequately for a panel that size. It is only through the delegation of care tasks among team members that a care team can provide high-quality care to this many patients. A resource for calculating panel size is the Family Practice Management Toolbox: Patient Panel Size Worksheet, available at: http://www.aafp.org/fpm/2007/0400/fpm20070400p44-rt1.xls

What Variables Affect Panel Size?

Empaneling the patients in a practice is not as simple as taking the total number of patients divided by the total number of care teams. In reality, dividing patients among care teams in a practice can entail using some complicated formulas that rely on additional information. You need to consider factors such as how many hours clinicians devote to patient care (vs. administrative duties or other responsibilities) and the types of patients they typically care for. For example, more complex patients require more frequent and longer visits. Similarly, obstetric patients have a period of high-intensity care. A clinician who sees many of these patients would be able to care for fewer patients.

The size and skill level of the care team will also affect panel size. A clinician who has teammates who can take over complex or specialized care tasks (e.g., dietitian, pharmacist,

phlebotomist, health educator) can see more patients in a day than a clinician who has a single medical assistant on the care team.

Finally, panel size will need to be adjusted to accommodate part-time clinicians and the unique practice requirements for residents if they are present in a practice.

How Do You Assign Patients to Panels?

There are several ways to assign patients to panels. Here are some steps for one of these methods:

1. Begin by reviewing patient visit records to determine if there are patients who have been seen by only one clinician. If so, assign those patients to those clinicians.
2. If a patient has been seen by more than one clinician, determine if there is a clinician whom the patient has seen more than the others. If so, assign the patient to the most frequently seen clinician.
3. If no particular clinician stands out for a patient, determine which clinician saw the patient for his or her last physical. Assign the patient to that clinician.
4. If there is no recent physical for a patient, assign the clinician the person saw last.
5. Incorporate the voice of the patient in this process as well. This can be done by training front office staff or the clinic's call center to ask patients which clinician they see regularly and assign them as they register.

At the end of this process adjustments will have to be made to ensure that panel sizes are manageable. For example, a clinician who is new to the practice will have fewer patients assigned to his or her panel through this process than a clinician with a long tenure. You may need to help the practice align panel size with each clinician's capacity, all the while keeping in mind patients' preferences.

What Policies and Procedures Are Needed?

Processes need to be established in the practice to ensure the sustainability of managing patient panels over time. For example, training materials and job descriptions need to be established with panel management processes embedded within them. The Safety Net Medical Home Initiative also has a set of procedures that can guide your clinic in implementing guidelines to better suit the needs of the clinic. Available at: http://www.champsonline.org/ToolsProducts/CrossDiscResources/PCMH/PCMHPandPs.html

Practices should develop a policy statement on panel management that covers topics such as changing clinicians, assigning new patients to clinicians, and staffing models to support clinicians based on the number of patients assigned to the panel. A sample of Policies and Procedures is contained in Appendix C.

How Does a Practice Monitor Empanelment?

Practices should monitor the effectiveness of their empanelment process on a regular basis and report to individual care teams and the practice as a whole. Suggested metrics are:

- Percentage of patient visits to their designated clinician.
- Percentage of patient visits to clinicians other than their designated clinician.
- Percentage of total patients unassigned to a panel.
- Size of panel by clinician and how it compares to target panel size for the practice.
- Percentage of patients who are new.
- Percentage of patients reassigned to another clinician.
- Number of overbooked appointments per week.
- An access measure, such as 3rd Next Available Appointment per clinician (the average number of days between a request for an appointment and the 3rd available appointment for that clinician).
- Patient satisfaction survey with specific questions on access and satisfaction.
- Staff satisfaction with the empanelment process, including clinicians, other clinical staff, and office staff.

Note: this module is based on Module 20 of the Practice Facilitation Handbook. Available at: http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/

References

Wagner, EH, Coleman K, Reid RJ, Phillips K, Sugarman JR. Guiding Transformation: How Medical Practices Can Become Patient-Centered Medical Homes. The Commonwealth Fund, February 2012. Available at: http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Feb/1582_Wagner_guiding_transformation_patientcentered_med_home_v2.pdf .

Primary Care Practice Facilitation Curriculum

Module 32. Improving Self-Management Support and Engaging Patients in Care and Practice Improvement Topics

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Module 32. Improving Self-Management Support and Engaging Patients in Care and Practice Improvement Topics

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Foundational knowledge of primary care environments
- Professionalism in patient culture

Time

- Pre-session preparation for learners: 110 minutes
- Session: 90 minutes

Objectives

After completing this module, learners will be able to:

1. Explain why self-management support is important to improving patient care outcomes and discuss how it fits in the Care Model and the patient-centered medical home.
2. List the actions facilitators can take to assist practices to improve self-management support for their patients.
3. Identify online resources that facilitators can use to increase practice member knowledge of self-management support.

Exercises and Activities To Complete Before and After the Session

Pre-session preparation. Ask the learners to review items 1-4 and explore item 5. (105 minutes)

1. The content of this module.
2. What, why, and how of self-management support videos. Available at http://www.orau.gov/ahrq/sms_what.html; http://www.orau.gov/ahrq/sms_why.html; http://www.orau.gov/ahrq/sms_how.html.
3. Helping patients help themselves: how to implement self-management support. California HealthCare Foundation; 2010. Available at http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/H/PDF%20HelpingPtsHelpThemselvesImplementSelfMgtSupport.pdf..
4. Helping patients manage their chronic conditions. California HealthCare Foundation; 2005. Available at http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/H/PDF%20HelpingPatientsManageTheirChronicConditions.pdf .
5. Partnering in Self-Management Support: A Toolkit for Clinicians. Institute for Healthcare Improvement. Available at http://www.ihi.org/knowledge/Pages/Tools/SelfManagementToolkitforClinicians.aspx.
6. AHRQ self-management support site. Available at http://www.orau.gov/ahrq/sms_home.html

During the session. Presentation (30 minutes)

1. Present key concepts from this module.
2. Transforming Practices into Medical Homes slide show by Safety Net Medical Home Initiative. PCI Pt. 2: Self-Management Support in the PCMH, showing capture of self- management goals in an electronic health record and case examples of health coach implementation. Available at http://www.safetynetmedicalhome.org/sites/default/files/Webinar-Patient-Centered-Interactions-2.pdf.

Activity for learners (30 minutes)

1. Have learners divide into pairs or small groups. Assign roles: practice facilitator and participant(s).
2. Review the Self-Management Support section in the Assessment of Chronic Illness Care (ACIC) tool. Complete the section on PracticeOnlyOneforMiles or practice with whatever tool the learner is already using. Have practice facilitator "facilitate."
3. Use Self-Management Support Roles and Assignments to model an enhanced self-management support program for the practice.

Discussion. Ask questions and explore answers with learners. (30 minutes)

1. What role can a facilitator play in assisting practices to improve self-management support and why does this matter?
2. What were some lessons learned from the Bodenheimer article on implementing self-management support?
3. What role does it play in the Care Model and the patient centered medical home?
4. What were the results of your ACIC assessment? What did you learn from using the tool?

Module 32.

An individual with chronic disease is in the medical office an average of 6 hours a year. The patient spends the remaining 8,754 hours a year outside the medical office. Self-management support is about helping patients improve or maintain their health during those 8,754 hours.

> An increasing number of people have at least one chronic illness that requires day to day management. Outcomes for these patients with chronic needs can be improved by helping them become more active in self care.
>
> —Agency for Healthcare Research and Quality

Self-management consists of all the activities and tasks that patients engage in to live with chronic illness including managing symptoms, treatment, emotional impact, physical and social consequences, and lifestyle changes. It includes patients' beliefs in their ability to manage their conditions, their ability to navigate and interact effectively with clinicians and the health care system to ensure they receive needed care, and the behaviors they engage in to manage their conditions and their care. Activities required for self-management can be divided into three categories: 1) actions needed to deal with physical aspects of the illness, 2) actions needed to manage the emotional aspects of the illness, and 3) actions needed to deal with the social impact of the illness (Strauss & Corbin, 1988).

Impact of Social Determinants and Poverty on Self-Management

A significant percentage of individuals who receive care through the safety net have chronic conditions. These individuals face special challenges to self-management. Low levels of health literacy can make it difficult for patients to understand instructions provided by clinicians about caring for their conditions. The perceived power differential between clinicians and patients can make it difficult for patients to ask questions or effectively advocate for their care. Norms of different cultural groups that view questions or engagement of clinicians as disrespectful also can inhibit effective communication.

Poverty and lack of insurance reduce access to needed specialty care services and medications. Patients' adherence to treatment recommendations can be affected by inaccurate information and myths in the patient community about treatments such as insulin, which sometimes results in amputations and death. Similarly, patients' views of illness in general and their ability to influence its course can be shaped by cultural norms that suggest an inevitability of outcome, inhibiting the patients' willingness to engage in what may be perceived as futile attempts at self-care.

Behaviors essential to healthy living may also be affected by cultural traditions, as well as the overabundance of fast foods and limited access to healthy low-cost foods and safe spaces for exercise in low-income neighborhoods. Social cohesion and support, vital to effective management of chronic conditions, may be compromised by fear. High crime rates and immigration enforcement actions can wreak havoc on social networks and support available to individuals living with chronic illness and their families.

How Can Practices Provide Self-Management Support?

In 2003, the Institute of Medicine defined self-management support as "the systematic provision of education and supportive interventions by health care staff to increase patients' skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support." Although in the early days self-management support primarily consisted of providing information, research has demonstrated that these educational interventions affected patients' knowledge but not their self-care behavior (Pearson, et al., 2007).

Coaching is needed by professionals who, in addition to teaching skills, have the psychosocial skills to facilitate a patient's change in behavior. Evidence is emerging that self-management support programs, which now often include an interactive, empowerment approach, improve a variety of outcomes for different chronic conditions (Pearson, et al., 2007).

Practices provide self-management support to patients in a variety of ways. According to the Agency for Healthcare Research and Quality (AHRQ), these include:

- providing empathic, patient-centered care
- involving the whole care team in planning, carrying out, and following up on a patient visit
- planning patient visits that focus on prevention and care management, rather than on acute care
- involving the patient in goal setting
- providing tailored education and skills training using materials appropriate for different cultures and health literacy levels
- making referrals to community-based resources, such as programs that help patients quit smoking or follow an exercise plan
- regularly following up with patients via email, phone, text messages, and mailings to support their efforts to maintain healthy behaviors. (Available from http://www.orau.gov/ahrq/sms_what.html)

Self-management support is a core feature of the Care Model and fundamental to the provision of patient-centered care. Effective self-management support, however, can be time intensive. Fortunately, self-management support programs are often offered in the community and can be used to augment practice staff activities.

Practices usually combine some in-house self-management support activities with referrals to community-based resources. Practices using this approach will need to identify and vet these community-based programs. A self-management program should be evidence-based, linguistically competent (meaning it is delivered in the preferred language of the patient), appropriate to the health literacy level of the patient, and culturally sensitive and appropriate.

How Can Facilitators Help?

As a facilitator, you can help practices with a variety of self-management support tasks, such as:

- assessing existing self-management support services
- mapping current roles and workflows related to self-management and helping the practice redesign them
- setting goals to improve these services
- using the Model for Improvement to design and test improvements to services (see Module 8, Approaches to Quality Improvement)
- identifying appropriate patient self-management support materials
- identifying self-management support training and resources for clinicians and other staff (e.g., AHRQ's Self-Management Support Resource Library)
- introducing and training staff on evidence-based and exemplar self-management support programs
- conducting an inventory of community-based programs
- developing referral relationships and protocols with community-based programs (DeWalt, et al., 2010, Health Literacy Universal Precautions Toolkit, Tool 20, Use Health and Literacy Resources in the Community http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/)
- establishing followup routines to check in with patients between visits.
- setting up performance reporting for monitoring the delivery and impact of these services

Self-management support involves the entire care team. As shown in Module 29, you can help your practice think through the various tasks involved in self-management support (SMS) and which staff members could perform those tasks. Case studies of care teams that incorporate self-management support in the work that they do day-to-day are available at http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/B/PDF%20BuildingTeamsInPrimaryCareCaseStudies.pdf. Table 32.1, adapted from the Institute for Healthcare Improvement, provides a template. You and your practices will need to customize the list of tasks and staff.

Table 32.1. Self-management support tasks and assignments

Task	Primary Care Clinician	Nurse/ Pharmacist	Medical Assistant	Clinical Care Manager	Nutritionist, PT, OT	Health Educator/ Dietitian	Clerical Staff & Other
Call patient in for visit							
Plan patient visit							
Introduce SMS and patient role							
Develop action plan with patient							
Educate and train patient							
Confirm patient understanding							
Refer patient to community resources							
Schedule followup visits							
Conduct followup with patient between visits							
Establish referral and information sharing protocols with community SMS programs							
Maintain inventory of patient education materials							
Maintain inventory of community resources							
Identify SMS-related training opportunities for staff							
Collect and report on SMS performance measures							

Adapted from Institute for Healthcare Improvement.

Note: this module is based on Module 21 of the Practice Facilitation Handbook. Available at http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/

References

Adams K, Corrigan JM, eds. Priority areas for national action: transforming health care quality. Institute of Medicine. Washington, DC: National Academy Press; 2003.

Agency for Healthcare Research and Quality. Self Management Support. Available at http://www.orau.gov/ahrq/sms_home.html. Accessed October 7, 2014.

Corbin JM, Strauss A. Unending work and care: Managing chronic illness at home. Jossey-Bass; San Francisco, CA: 1988.

DeWalt DA, Callahan LF, Victoria H. Hawk, et al. Health literacy universal precautions toolkit. Rockville, MD: Agency for Healthcare Research and Quality; 2010. AHRQ Publication No 10-0046-EF. Available at http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html. Accessed October 7, 2014.

Pearson ML, Mattke S, Shaw R, et al. Patient self-management support programs: an evaluation. Final Contract Report (Prepared by RAND Health under Contract No. 282-00-0005). Rockville, MD: Agency for Healthcare Research and Quality; November 2007. AHRQ Publication No. 08-0011.

Appendix 2. Practice Facilitator Professional Development and Training Plan

***1. Your name:**

***2. Today's date:**

Date: MM / DD / YYYY

***3. How much previous experience have you had working in healthcare environments?**

	No experience	Some experience	Substantial experience
Primary care (non-safety net)	◯	◯	◯
Primary care (safety net)	◯	◯	◯
Specialty care setting	◯	◯	◯
Hospital setting	◯	◯	◯
Ancillary service environment	◯	◯	◯

Briefly describe your experience:

***4. How much previous experience have you had supporting Quality Improvement in any environment?**

◯ No experience

◯ Some experience

◯ Substantial experience

Briefly describe any experience:

***5. How much previous experience have you had in collecting and analyzing data?**

- ◯ No experience
- ◯ Some experience
- ◯ Substantial experience

Briefly describe any experience:

***6. (General theories of change) Please rate how confident you are with your knowledge of the following topics:**

	Not at all confident	Somewhat confident	Confident	Very confident
Complexity theory	◯	◯	◯	◯
Solberg Practice improvement model	◯	◯	◯	◯
Diffusion of innovation	◯	◯	◯	◯
Empowerment theory	◯	◯	◯	◯
Asset based development	◯	◯	◯	◯
Adult learning theory	◯	◯	◯	◯

Please identify your learning goals for this area:

***7. (Practice facilitation) Please rate how confident you are with your knowledge in the following areas:**

	Not at all confident	Somewhat confident	Confident	Very confident
General background on practice facilitation	◯	◯	◯	◯
Research evidence about practice facilitation	◯	◯	◯	◯
Typical stages in the facilitation process	◯	◯	◯	◯
Core competencies of practice facilitators	◯	◯	◯	◯
Common approaches to practice facilitation	◯	◯	◯	◯
On-line resources for practice facilitators	◯	◯	◯	◯

Please identify your learning goals for this area:

***8. (Practice facilitation) Please rate how confident you are with your skills in the following areas:**

	Not at all confident	Somewhat confident	Confident	Very confident
Assessing a practice's readiness for engaging in improvement work with a facilitator	◯	◯	◯	◯
Preparing a practice to work with a facilitator	◯	◯	◯	◯
Engaging patients as part of an improvement team	◯	◯	◯	◯
Conducting a kick-off or first meeting with a practice	◯	◯	◯	◯
Building a relationship with a practice	◯	◯	◯	◯
Identifying ineffective facilitator-practice partnerships	◯	◯	◯	◯
Facilitating meetings	◯	◯	◯	◯
Project management	◯	◯	◯	◯

Please identify your learning goals for this area:

***9. (Knowledge of the safety net) Please rate how confident you are with your knowledge of the following areas:**

	Not at all confident	Somewhat confident	Confident	Very confident
General knowledge of the health system and how it operates	◯	◯	◯	◯
Federally Qualified Health Centers (FQHCs) and their structure, mandates and financial drivers	◯	◯	◯	◯
Community Health Centers and their structure and financial drivers	◯	◯	◯	◯
Private practices and their structure and financial drivers	◯	◯	◯	◯
Make-up and needs of their patient populations	◯	◯	◯	◯
The local healthcare system	◯	◯	◯	◯
The local healthcare environment	◯	◯	◯	◯
Payer community and their priority concerns	◯	◯	◯	◯
IPAs and other organizations supporting the primary care safety net in your area	◯	◯	◯	◯

Please identify your learning goals for this area:

***10. (Health Service Models and Meaningful Use) Please rate how confident you are in your knowledge of the following areas:**

	Not at all confident	Somewhat confident	Confident	Very confident
Chronic Care Model or Expanded Care Model (CM)	◯	◯	◯	◯
Patient Centered Medical Home (PCMH)	◯	◯	◯	◯
Patient Centered Medical Home recognition requirements (National Committee for Quality Assurance (NCQA), other)	◯	◯	◯	◯
Patient Aligned Care Teams (PACT)	◯	◯	◯	◯
Meaningful Use requirements	◯	◯	◯	◯

Please identify your learning goals for this area:

***11. (Quality Improvement Approaches & Tools-General) Please rate your confidence in your knowledge and skills in the following areas:**

	Not at all confident	Somewhat confident	Confident	Very confident
Model for Improvement (MFI)	◯	◯	◯	◯
Using Plan Do Study Act (PDSA) Cycles with practices	◯	◯	◯	◯
Basic concepts of LEAN	◯	◯	◯	◯
Basic concepts of Six Sigma	◯	◯	◯	◯
Academic detailing	◯	◯	◯	◯
Benchmarking	◯	◯	◯	◯
Workflow mapping	◯	◯	◯	◯
Decision support tools	◯	◯	◯	◯
Site visits	◯	◯	◯	◯
Learning collaboratives and local learning collaboratives	◯	◯	◯	◯
Identifying "exemplar" processes/practices and documenting them for spread	◯	◯	◯	◯

Please identify your learning goals for this area:

***12. (Workflow Mapping) Please rate your confidence in helping a practice map the following key processes:**

	Not at all confident	Somewhat confident	Confident	Very confident
Answering phones	◯	◯	◯	◯
Making appointments and triage process	◯	◯	◯	◯
Messaging	◯	◯	◯	◯
Scheduling procedures	◯	◯	◯	◯
Reporting diagnostic test results	◯	◯	◯	◯
Prescription renewals	◯	◯	◯	◯
Making referrals	◯	◯	◯	◯
Pre-authorization for services	◯	◯	◯	◯
Billing/coding	◯	◯	◯	◯
Phone advice	◯	◯	◯	◯
Assignment of patients to practice	◯	◯	◯	◯
Orientation of patient to practice	◯	◯	◯	◯
New patient work-ups	◯	◯	◯	◯
Education for patients/families	◯	◯	◯	◯
Prevention assessment/activities	◯	◯	◯	◯
Chronic disease management	◯	◯	◯	◯

Please identify your learning goals for this area:

*13. (Data Collection-General) Please rate your confidence in:

	Not at all confident	Somewhat confident	Confident	Very confident
Measuring organizational systems (capacity for improvement, functionality of key systems, leadership)	◯	◯	◯	◯
Measuring clinician and staff experience (satisfaction, burn-out, clinician-staff interaction (team work), practice climate	◯	◯	◯	◯
Measuring patient experience (how treated by practice, clinician-patient interactions in understanding, shared-decision making, relationship building)	◯	◯	◯	◯
Measuring team-patient interaction (transferring trust in clinician to trust in team)	◯	◯	◯	◯
Measuring implementation of the Care Model	◯	◯	◯	◯
Measuring implementation of the Patient Centered Medical Home	◯	◯	◯	◯
Assessing payment mechanisms (what works, what is dysfunctional, what will incentivize improvements needed)	◯	◯	◯	◯

Please identify your learning goals for this area

***14. (Data Collection-Clinical Performance) Please rate your confidence in your knowledge and skills in the following areas:**

	Not at all confident	Somewhat confident	Confident	Very confident
Use of HEDIS quality indicators	◯	◯	◯	◯
Use of HRSA's Uniform Data System (UDS) reports	◯	◯	◯	◯
Conducting paper chart audits	◯	◯	◯	◯
Creating reports through I2I or other patient registry	◯	◯	◯	◯
Creating reports through E Clinical Works	◯	◯	◯	◯
Creating reports through Next Gen	◯	◯	◯	◯
Creating reports through Epic	◯	◯	◯	◯

Please identify your learning goals for this area

***15. (Data Collection-Management and Display) Please rate your confidence in your knowledge and/or skills in the following areas:**

	Not at all confident	Somewhat confident	Confident	Very confident
Creating a database for survey and performance data	◯	◯	◯	◯
Managing and cleaning databases	◯	◯	◯	◯
How to determine denominators	◯	◯	◯	◯
Analyzing data for frequencies and central tendencies	◯	◯	◯	◯
Generating visual displays of data such as run charts	◯	◯	◯	◯
HIPAA rules and regulations for protecting personal health information	◯	◯	◯	◯

Please identify your learning goals for this area

***16. (Creating QI Infrastructure and Capacity in a Practice) Please rate your confidence in your knowledge and skills in the following areas:**

	Not at all confident	Somewhat confident	Confident	Very confident
Creating priority for change in practice/organizational leadership	◯	◯	◯	◯
Forming a QI committee or improvement team	◯	◯	◯	◯
Creating an improvement plan or QI charter	◯	◯	◯	◯
Optimizing team functioning	◯	◯	◯	◯
Using data to drive improvement (identify needs, monitor progress)	◯	◯	◯	◯
Creating systems for routing performance monitoring	◯	◯	◯	◯

Please identify your learning goals for this area

***17. (Managing Relationships) Please rate your confidence in your knowledge and skills in the following areas:**

	Not at all confident	Somewhat confident	Confident	Very confident
Building relationships with clinicians and staff	◯	◯	◯	◯
Managing and resolving interpersonal conflict	◯	◯	◯	◯
Motivating staff and clinicians to engage in improvement activities	◯	◯	◯	◯
Working with diverse individuals (MAs, RNs, MDs/DOs, patients, administrative staff)	◯	◯	◯	◯
Maintaining healthy communication (avoiding triangulation, etc)	◯	◯	◯	◯
Maintaining healthy boundaries with staff/clinicians (building capacity vs. doing for)	◯	◯	◯	◯

Please identify your learning goals for this area

***18. (Implementing Care Teams_General) Please rate your confidence in your knowledge and skills in the following areas:**

	Not at all confident	Somewhat confident	Confident	Very confident
Knowledge of best practices and exemplars in team based care	◯	◯	◯	◯
Training practices in concepts of team based care and associated culture change	◯	◯	◯	◯
Redefining clinical roles and responsibilities to support team based approaches to care	◯	◯	◯	◯
Licensing limitations for roles/clinicians (what each can and cannot do)	◯	◯	◯	◯
Redesigning workflow to support team based care	◯	◯	◯	◯

Please identify your learning goals for this area

***19. (Implementing Care Teams_Workflow for Specific Patient Groups) Please rate your confidence in your knowledge and skills in helping practices stratify patients and redesign workflow for team based care for:**

	Not at all confident	Somewhat confident	Confident	Very confident
Healthy/preventive care	◯	◯	◯	◯
Acute problems (major/minor)	◯	◯	◯	◯
Chronic conditions (diabetes, hypertension, CHF)	◯	◯	◯	◯
Complex care needs	◯	◯	◯	◯
Mental health	◯	◯	◯	◯
Chronic pain	◯	◯	◯	◯
Women's health	◯	◯	◯	◯
Pregnancy/well child care	◯	◯	◯	◯
Palliative/end of life care	◯	◯	◯	◯

Please identify your learning goals for this area

***20. (Implementing Care Teams_Workflow for Key Visit Related Administrative Activities) Please rate your confidence in your knowledge and skills in helping practices map and redesign workflow related to care team functioning in key visit related administrative activities:**

	Not at all confident	Somewhat confident	Confident	Very confident
Registration	◯	◯	◯	◯
Making appointments	◯	◯	◯	◯
MA role (pre-visit, vitals, agenda setting, checking chronic and preventive care needs and ordering them)	◯	◯	◯	◯
Receipt of test results-Clinician (lab, x-ray, other results)	◯	◯	◯	◯
Receipt of test results - Patient (normal, slightly abnormal, very abnormal)	◯	◯	◯	◯
Internal messaging (which emails go to whom, action required)	◯	◯	◯	◯
Prescription refills (chronic meds, acute meds, secure script meds)	◯	◯	◯	◯
Billing workflow	◯	◯	◯	◯
Filling out forms (clinician role, other team member role)	◯	◯	◯	◯

Please identify your learning goals for this area

Practice Facilitator Professional Development and Training Plan

***21. (Panel management) Please rate your confidence in your knowledge and/or skills in the following areas:**

	Not at all confident	Somewhat confident	Confident	Very confident
General knowledge of principles and processes of panel management	◯	◯	◯	◯
Knowledge of best practices and exemplars in implementing panel management	◯	◯	◯	◯
Training practices in concepts of panel management and creating culture change to support it	◯	◯	◯	◯
Training panel manager and creating protected time	◯	◯	◯	◯
Helping practice define what decisions panel managers can make (ordering labs, x-rays, titrating meds via protocol, referring patients to classes, etc)	◯	◯	◯	◯
Optimizing EHRs and creating patient registries and reporting systems to support panel management	◯	◯	◯	◯

Please identify your learning goals for this area

***22. (Creating Panels) Please rate your confidence in your knowledge and skills in the following areas:**

	Not at all confident	Somewhat confident	Confident	Very confident
Knowledge of best practices in creating patient panels	◯	◯	◯	◯
Training practices in key elements of assigning patients to panels	◯	◯	◯	◯
Optimizing HIT systems to support assigning patients to panels	◯	◯	◯	◯
Assisting practices in assigning patients to panels	◯	◯	◯	◯
Evaluating the implementation of panels	◯	◯	◯	◯
Implementing policies/procedures that support continuous empanelment	◯	◯	◯	◯

Please identify your learning goals for this area

***23. (Assessing & Improving Self-Management Support for Patients) Please rate your confidence in your knowledge and skills in the following areas:**

	Not at all confident	Somewhat confident	Confident	Very confident
Knowledge of best practices in self-management support including the use of health coaches	◯	◯	◯	◯
Assessing a practice's self-management support resources and processes	◯	◯	◯	◯
Helping practices enhance their self-management support services	◯	◯	◯	◯

Please identify your learning goals for this area

***24. (Care Coordination) Please rate your confidence in your knowledge and skills in the following areas:**

	Not at all confident	Somewhat confident	Confident	Very confident
Knowledge of methods of care coordination (specialists, ED, hospitalists (admission, during stay, discharge), pharmacy, lab/imaging, home care, hospice)	◯	◯	◯	◯
Training practices in general concepts of care coordination	◯	◯	◯	◯
Assisting practices to implement care coordination	◯	◯	◯	◯
Payment and care coordination	◯	◯	◯	◯

Please identify your learning goals for this area

***25. (Meaningful Use) Please rate your confidence in assisting practices in redesigning the following workflows to achieve Meaningful Use:**

	Not at all confident	Somewhat confident	Confident	Very confident
Recording patient demographics	◯	◯	◯	◯
Recording vital signs electronically	◯	◯	◯	◯
Maintaining up to date problem list	◯	◯	◯	◯
Maintaining active medication list	◯	◯	◯	◯
Maintaining active allergy list	◯	◯	◯	◯
Recording smoking status	◯	◯	◯	◯
Providing patients with clinical summaries for each office visit	◯	◯	◯	◯
E-prescribing	◯	◯	◯	◯
Drug-drug and drug-allergy interaction checks	◯	◯	◯	◯
Exchanging electronic information with other sites of care	◯	◯	◯	◯
Implementing a decision support rule and track compliance with the rule	◯	◯	◯	◯
Systems to protect privacy and security of patient data	◯	◯	◯	◯
Report clinical quality measures to CMS or states	◯	◯	◯	◯
Generate lists of patients for QI or outreach	◯	◯	◯	◯
Electronic health education resources	◯	◯	◯	◯
Medication reconciliation between care settings	◯	◯	◯	◯
Summary of are record for referrals and transitions	◯	◯	◯	◯
Immunization data to regional registries	◯	◯	◯	◯
Surveillance data to public health agencies	◯	◯	◯	◯
Patient reminders for	◯	◯	◯	◯

prevention/chronic care

Patient access to lab results, problem and medication lists, allergies	◯	◯	◯	◯
Drug formulary check	◯	◯	◯	◯
Lab results into EHR	◯	◯	◯	◯

Please identify your learning goals for this area

***26. (Professionalism) Please rate your confidence in your knowledge and skills in the following areas:**

	Not at all confident	Somewhat confident	Confident	Very confident
Documenting your encounters with your practice in a PF "practice registry" or encounter form	◯	◯	◯	◯
Communicating your challenges/needs and successes to your supervisor	◯	◯	◯	◯
Communicating your challenges/needs and successes to other PFs	◯	◯	◯	◯
Managing your time during practice encounters and administrative time	◯	◯	◯	◯

Please identify your learning goals for this area

27. Please describe any other skills/knowledge you have that are relevant to PF that may be resources for your program and other PFs in your program:

28. Please describe any other areas in which you believe you need training/support in order to feel confident as a PF:

Appendix 5. Clinica Family Health Services Case Study

Note: *This case study was developed by Tom Bodenheimer, M.D., Center for Excellence in Primary Care, Department of Family and Community Medicine, University of California, San Francisco, and is used with permission. It has not been modified or edited except to correct typographical errors, grammatical errors, or misspellings. Questions may be addressed to TBodenheimer@fcm.ucsf.edu.*

Clinica Family Health Services

Notes from April 18, 2011 visit

History and Demographics of Clinica by Thomas Bodenheimer

Clinica Family Health Services is a non-profit Federally Qualified Health Center serving the area northwest of Denver, Colorado.

Clinica was founded by Alicia Juarez Sanchez, a woman with a serious chronic condition who assisted other patients, driving them to their medical care providers. She realized that Latinos in Colorado needed a clinic to care for them, and organized community members to open a clinic which began one night a week in her kitchen. A local physician volunteered his time, and a nurse practitioner began seeing patients regularly. Within a year the clinic had moved to a store front, and was open 5 days a week. The nurse practitioner continued working for 30 years with the community as the organization grew. In 1981 the clinic became a federally funded community health center. The clinic was initially called Clinica Campesina, since many of its patients were farmworkers (campesinos). More recently, "campesina" was removed from the name since urbanization changed the occupations of most patients from farmworkers to service workers.

Since its inception, Clinica has grown enormously, now caring for one-third of low-income people in the communities in which it is situated, with 40,000 active patients, 170,000 visits per year, 46 physical health providers, 13 behavioral health providers, 4 dental providers, 2 full pharmacies, and a total staff of 320. Clinica has 4 sites, Pecos and Thornton in Adams County, and Lafayette and People's in Boulder County.

Fifty percent of Clinica's patients are uninsured, 40% are Medicaid recipients, and 3% have Medicare. 56% are below the federal poverty line and 98% are below 200% of the federal poverty line. The majority are Spanish-speaking only, and all providers and staff working directly with patients are bilingual.

In 1998, Clinica began its never-ending improvement journey, joining the Health Disparities Collaborative sponsored by the federal Bureau of Primary Health Care and led by the Institute for Healthcare Improvement and the MacColl Institute for Healthcare Innovation. Clinica worked on improving chronic illness care for patients with diabetes by focusing on making appointments available, tracking patients with diabetes with a registry, and implementing evidence based guidelines for delivering indicated care. In 2000 Clinica initiated more far-reaching changes in the clinic, redesigning its entire care model by drastically improving access to care, prioritizing continuity of care as the bedrock of the clinic, creating care teams, and

instituting group visits. From 2001 to 2004, Clinica re-designed its care of chronic conditions and preventive services based on its care teams, and changed the internal architecture of its clinics to allow co-location of care teams. A series of non-stop improvements followed, including behavioral health integration, a nurse and pharmacist-run anti-coagulation service, the implementation of the NextGen electronic health record with changes in dozens if not hundreds of workflows associated with a computerized primary care clinic, population management to provide outreach to patients overdue for chronic or preventive services, improved care coordination with specialists and hospitals, and the addition of case managers to care teams to provide self-management support to all patients with chronic conditions.

Clinica has amassed much wisdom that other primary care clinics and practices could learn from. This summary of how Clinica functions is based on an April, 2011 visit to Clinica's Pecos site.

Continuity of Care and Access to Care

Every patient is empaneled to a primary care provider (PCP -- physician, nurse practitioner or physician assistant) and a care team (called a pod). Each pod has a color, and patients know their pod by its color. Continuity of care is measured regularly by determining the percentage of patient visits that are visits to the patient's own PCP or to the patient's pod. Clinica's goals are 70% PCP continuity and 90% pod continuity, goals that are often reached.

PCP continuity is most easily achieved by having providers who work at least 80% time. Because of the difficulty recruiting excellent primary care providers, Clinica has chosen not to demand full-time status of its providers, and about half are part time, with others occasionally absent due to maternity leave or vacations. Given these conditions, 70% PCP continuity is about as good as one could get.

The secret to achieving continuity of care—which is important because it improves care, reduces costs, increases patient and provider satisfaction, and reduces unnecessary demand—lies in how clinic staff are trained. Clinica has a call center, located in the Pecos site, serving all four sites. The call center attendants, who are generally high school graduates trained by the call center director, have clear instructions how to balance the needs for both continuity and access. When a patient calls, the attendant will offer an appointment with the patient's PCP. Only if the patient wants to be seen today or tomorrow and the PCP is unavailable those days, will the patient be given an appointment with another provider on the same pod. In many practices, staff answering phones say to patients something like: "If you want to see your doctor, the next appointment is in 2 weeks, but you can see a different doctor tomorrow." This message essentially prioritizes access over continuity, while the Clinica message prioritizes continuity but allows patients to choose access if their PCP is not available promptly. All clinic personnel understand that continuity of care is the bedrock of good primary care. Clinica has a continuity of care improvement team, and the call center director participates on that team.

If achieving continuity of care is like climbing a 5,000-foot mountain, sustaining prompt access to care is like scaling one of Colorado's 14,000-foot peaks. For over ten years, Clinica has been able to provide almost all care to its patients within 5 days of their request for an appointment, usually within 2 days. How is this done?

The first challenge is to provide reliable phone access, which is done through the call center, which has sufficient call center attendants to handle a huge volume of calls, 1200-1500 per day, with a peak of 1100 calls before 11 AM Monday mornings. 98 to 100% of calls are handled (not dropped), and 80% are picked up within 90 seconds, with these metrics followed on a regular basis.

Call center attendants are well trained in the pod system, the NextGen EMR, how to use the clinical protocols, how to refer callers to outside resources, and customer service. The call center director listens to a certain percentage of calls and mentors the attendants. Initial training takes 2 weeks, and new attendants work with a trainer until they are ready to take calls alone. The attendants have protocols, for example, to have the patient call 911 in case of chest pain or other emergent symptoms, to call the cell phone of the RN on the patient's pod in case of urgent but not emergent symptoms, to send an electronic message to the RN on the pod for non-urgent clinical matters, and to make appointments using the continuity of care priority.

After phone access comes prompt access to appointments. Clinica measures Third Next Available Appointment (TNA), a well-recognized access metric. The appointment template is opened up for only 2 weeks; no appointments are made after 2 weeks. This allows all providers' schedules to be empty, meaning that TNA cannot exceed 14 days. Moreover, the no-show rate with schedules open for 2 weeks is about 8%. Clinica has experimented with opening up schedules for 3 weeks, but the no-show rate jumps to about 30%. Clinica attempts to fill providers' schedules only from 8 to 10 AM and to leave the remainder of the schedule open for same or next day appointments. This is not always possible during the first week, but for most providers many slots are open the second week. Clinica-wide, TNA in 2010 ranged from 2 to 6 days, often higher in flu season and in August/September with back-to-school physicals. TNA is also measured for each site, each pod, and each provider.

Call center attendants, in addition to their understanding that continuity is the first priority, are instructed that they never say No to a patient. Either patients receive an appointment within 2 weeks, or if patients request a later appointment they are asked to call back close to the time when they want the appointment, or their call is forwarded to the pod to squeeze them in that day.

Providers, when they are in clinic, have appointment slots every 20 minutes from 8:20 through 12:20—13 patients in the AM. Lunch is from 1-2 and huddle from 2-2:20. The afternoon runs from 2:20 to 5 with the last patient seen at 5. On days when the clinic is open until 8, many providers work 12-hour shifts, from 8 to 8. Those having evening clinic do not work in the morning. Providers have one 20-minute slot for each 5 slots for catch-up and care coordination, but many transfer that slot to the end of the day to get home earlier. Many do part of their documentation from home.

Full-time providers are expected to see 100 patients per week, a necessity because Clinica depends on visit-based FQHC reimbursement for patients on Medicaid. 80% providers need to see 80 patients per week. Providers can vary their schedule templates as long as they see enough patients per week. When a provider is participating in a group visit, the schedule is blocked for the time in the group visit.

An important policy supporting continuity of care is that providers are expected—within reasonable limits—to squeeze patients into their schedule for their patients, but not for another provider's patients. The RN on the pod, who also functions as pod coordinator, would receive a request from the call center to squeeze a patient in, and depending on the acuity of the patient and how backed up the providers are, would decide whether to squeeze in the patient or have a nurse encounter (in person or by phone).

If patients want appointments in, for example, 2 months, they are told to call back the week they want the appointment. If providers want to make appointments for their patients in 3 months, that is not possible, but two mechanisms are available to ensure that those patients will not drop through the cracks. First, many patients are entered into a chronic disease registry (see below under Panel Management), and will be called by a panel manager when they are due for care. Second, providers can task themselves or task the front desk (with an e-mail message through the EMR) to contact a patient who needs an appointment in 3 months—essentially an electronic tickler system within the EMR. In this way, providers are not anxious about patient needs being dropped. To allow this access policy to work, patients are informed about it on their first visit to Clinica, and by now patients are used to the policy and accept it.

Clinica is able to keep its TNA under a few days by matching demand and capacity, which is done in four ways: 1) limiting panel size to control demand, 2) adding capacity through RN and case manager care (see below under Care Teams), 3) adding capacity by extending the interval between visits if medically appropriate, and 4) adding capacity through group visits (see below under Group Visits).

Demand for appointments is determined by risk-adjusted panel size. Risk-adjustment is done by determining the number of visits per year of different strata in the clinic's population; for example, infants, young women (who often become prenatal patients) and the elderly require more visits per year. Clinica has made the decision to provide high-quality, comprehensive primary care with prompt access to its patients (40,000 of them) rather than to provide lower-quality urgent care to everyone. In other words, you cannot take care of the whole world, and if you have too much work, you simply have too much work and you cannot do it well. This is a policy decision each primary care clinic/practice needs to make. As a result, Clinica has a waiting list sometimes reaching 4,000 patients, who would like to receive care but cannot do so because panels are full. Average active panel size is about 1200, which takes into account the large number of infants and prenatal patients who require frequent visits. Panels are reviewed and tweaked regularly to determine if patients are actually seeing the provider to whom they are empaneled and whether a provider is over- or under-paneled. Patients who have not been to the clinic for 18 months are removed from active panels because many of these patients never return to the clinic.

Access to care must also balance the needs of patients with the needs of the clinic and clinic personnel. Clinica sees patients from 8-6 Mondays, 8-8 Tuesday, Wednesday, Thursday, and 8-5 Fridays. It is closed weekends. When the clinic is closed, a nurse line (run by the municipal Denver Health system which is paid by Clinica for this service) picks up calls and forwards them to the call center by e-mail or pages Clinica's on-call provider.

The clinic is closed from 1 PM to 2:20 PM, with one hour for lunch and 20 minutes for the afternoon huddle on each pod. Phones are also closed during this time, and call center attendants also have their huddle from 2 to 2:20, discussing any changes in scheduling or protocols, reviewing training, and going over problems that might have arisen. While the phones are off, the Denver Health nurse line picks up calls and forwards them to the call center by e-mail. Each call center attendant has a 15-minute break in the AM, but no break in the PM because the PM phone hours are 2:20 to 5 (2:20 to 4 on Fridays).

Using these policies and protocols, Clinica has been able to balance the goals of continuity and access, a huge challenge for any primary care organization.

Pods (Care Teams)

All clinical activity at Clinica centers around the pod. For patients, the pod (the same thing as the care team) is where they receive care. It is well known that patients prefer to receive their care in smaller health care settings. Breaking down a larger organization into smaller units—in the case of Clinica, pods—allows patients to feel comfortable because the members of the pod know them and they know the people on their pod. Clinica patients see themselves as patients of the Green Pod or the Blue Pod or the Purple Pod. Because Clinica is a good place to work, many physicians, nurses and medical assistants have worked there for 12 or 15 years, making longitudinal continuity of care possible and allowing pod members to truly know the patients on their panels.

Each of the four Clinica sites has several pods. The walls of each pod reveal the pod's color. Pods are both physical entities and organizations of people. Architecturally, each pod consists of a central open area—either a rectangle or a circle—surrounded by patient exam rooms. Pod members are co-located, working right next to one another so it is very easy to communicate. Not only can pod members easily interact with one another, they can also see all the patient rooms, which have multicolored flags (black is the MA, red is the provider, blue is the behavioral health provider, green is the case manager) telling everyone on the pod who is in which room.

The suborganization of the pod consists of a provider (physician, nurse practitioner or physician assistant) always (with rare exceptions) working with the same medical assistant (MA). The provider and MA sit facing each other on the pod. Each of the thirteen pods at Clinica's four sites has 3 full-time equivalent providers (generally 4 people due to part-timers), 3 MAs (one per provider at each session), 1 behavioral health professional, 1 RN, and 1 case coordinator, and one medical records person. Front desk personnel are part of the pod, and geographically sit between the physical pod and that pod's waiting room. The same people always (with rare exceptions created by vacations or other absences) work on the same pod. Patients are empaneled both to a pod and to a provider/MA dyad. For each dyad, a colorful business card shows patients the name of their provider and MA.

From 8 to 8:20 and from 2 to 2:20, each pod has a huddle, going over the patients scheduled for the day—the schedule is available in hard copy to take notes on—to plan what each patient might need. For example, the behavioral health provider and the case coordinator will gain an idea of which patients are likely to need their time, and MAs will know who will need a

procedure. If a group visit is scheduled, everyone will know which provider, RN and/or MA involved in the group visit will be off the pod for a certain period of time.

Two people on each pod have leadership roles. One MA is half-time MA and half-time MA team manager (training and supervising MAs, handling their time sheets, and doing their performance reviews). The pod's RN is also the flow coordinator, making sure that all runs smoothly and intervening to solve problems. Because everything can be seen from anywhere in the pod, problems that arise are easily seen. An example of a flow problem might be a provider who is running an hour behind due to unexpected complicated patients. In that case, the RN will initiate the visit with patients who are waiting, allowing the provider time to be greatly shortened. However, patients empaneled to a stressed provider are not switched to another provider in order to preserve the all-important continuity of care.

A striking visual impression of a Clinica pod is that everyone—providers, MAs, RNs, behavioral health providers—carries a laptop everywhere they go. The laptops are like a third arm, and no one dares go anywhere without them. In this way, the electronic medical record goes with each team member rather than having care team personnel go back to a computer to document care that is given.

Patient flow on the pod seems calm and organized. After patients have checked in with the pod's front desk person, that patient's MA receives an electronic message in her in-box, and she brings the patient into the exam room. Since each provider has 3 exam rooms, everything—pre-visit, visit, immunizations, lab work, behavioral health discussions, goal setting with the case manager—all happen in the same exam room.

Two pods share a procedure room, which focuses on obstetric ultrasounds (read by primary care providers), sigmoidoscopies, culposcopies, vasectomies, circumcisions, skin biopsies, and IUD insertions and removals. While Clinica has plenty of complex patients, a large number of its patients are young women and children, which explains the predominant types of procedures needed. MAs set up the procedure room, using a detailed manual that describes exactly what is needed for each type of procedure, and assist with the procedures. Each provider does each type of procedure in the same way, demonstrating the standardization of care processes so evident at Clinica.

Medical assistant role

The MA brings the patient into the room, does vital signs, checks smoking status, and takes a detailed history using the template on the NextGen EMR. Templates exist for well child checks (templates may vary by age), diabetes, ADHD, asthma, anticoagulation, prenatal care, tobacco cessation, SBIRT screening, and complaint-specific history of present illness. In the case of patients with diabetes overdue for an HbA1c (done by a point-of-care machine) or a foot exam, or an appointment for a retinal exam (done with a retinal camera as a group visit), MAs perform those tasks. After the MA enters the history into the templated EMR, the EMR provides the history in a form easily reviewed by the provider. For children, the EMR includes decision support on which immunizations are needed, and the MA draws up the immunizations while the provider is seeing the patient and gives the shots in the post-visit. Providers are not involved in providing immunizations. MAs do not have time to do medication reconciliation or behavior

change counseling; those functions, if indicated, are provided by the case manager immediately following the provider visit. The MA pre-visit takes 10-15 minutes.

If the provider wants the MA to do a post-visit (immunizations, blood draws, or other activities), an electronic message is sent to the MA and the black flag is put into the MA-needed position. If an appointment is needed within 2 weeks, the MA would make the appointment.

RN role

Many primary care practices do not have RNs, and for other practices, the RN role may not fully utilize the depth and breadth of skills possessed by RNs. RNs at Clinica have clearly defined roles that allow and require them to work at the very top of their license. The RN role has three interrelated parts: 1) addressing situations that arise everyday in primary care, situations needing skill in assessment and decision-making, 2) handling less complex clinical matters that can be protocolized with physician-written and approved standing orders, and 3) serving as pod flow coordinator.

For the first area of work, RNs receive electronic or phone messages from the call center regarding clinical problems faced by patients. A patient may call about abnormal uterine bleeding, a severe headache, or a medication refill; a family may call because grandmother has fallen or suffered a brief episide of right leg weakness. Hundreds of such situations arise, and RNs need the clinical acumen to assess what is needed: 911? Emergency room? Appointment today? Prescription called into the pharmacy? Physician to call the patient within the hour? Clinica RNs make dozens of these decision everyday.

The second area of work is the management of certain specified acute problems. Clinica physicians have approved standing orders for RNs to treat positive strep throat infections, uncomplicated conjunctivitis and ear infections, head lice, sexually transmitted diseases such as chlamydia and gonorrhea, uncomplicated urinary tract and respiratory infections, and the management of warfarin dosing for patients needing anti-coagulation. Some of these problems can be diagnosed and treated by the RN—without the provider—based on a phone call or face-to-face RN visit. Others come to the RN's attention through certain lab results that are channeled to the RN's EMR in-box ("RN labs"), for example, positive strep cultures, urine cultures, or chlamydia cultures. The RN would call these patients, provide patient education, and order the appropriate medications according to the standing orders. Thus the RN is not diagnosing, but is initiating treatment based on a diagnosis provided by the lab. RNs taking on these responsibilities allows providers to spend more time caring for complex diagnostic and management problems, and building relationships with their patients.

RNs also take care of warfarin dosing for patients on anti-coagulation, checking the INR lab results (with an on-site INR machine) and titrating warfarin doses according to a dose calculator. Pharmacy students review the warfarin registry to look for drug interactions, patients who may be missing timely INR checks. As part of Clinica's robust self-management support philosophy, patients are asked to write down their warfarin doses and INR results on their personal anti-coagulation card, and are asked how confident they are, on a 0-10 scale, that they can self-manage their anti-coagulation treatment. Having patients do these simple things themselves helps activate them as participants in their care.

The RN role as pod flow coordinator often involves RNs performing patient visits if a patient drops in, if no appointments are available, or if a provider is running far behind. If the RN visit involves a clinical problem with an RN treatment protocol (standing order), the RN can do that visit herself. More often, these visits turn into co-visits with the patient's provider coming at the end of the visit to confirm a diagnosis, and approve, change, or make a care plan.

The RN is constantly assessing how things are going on the pod, checking her EMR in-box, making outgoing phone calls or taking incoming calls. At Clinica, RNs do not work as chronic care managers because they do not have time. For less complex patients, the pod's case manager assumes that function, and for more complex patients the task remains largely with the provider.

Case manager role

Case managers could also be called health coaches and navigators. They meet with patients with chronic conditions, doing patient education and smoking cessation counseling, providing health-related resources, and collaboratively setting goals and action plans with patients. In the twice-daily huddle, or in the provider visit, patients are identified who need a planned visit with the case manager. These visits ideally take place immediately after the provider visit. Because case managers are on the pod, they often hear or see things—for example, an overweight or obese patient or a patient with diabetes whose HbA1c is high on point-of-care testing—that indicate the need for case manager services that day. A case manager might spend from 5 to 30 minutes with a patient.

Clinica has created a self-management support template on the NextGen EMR, which case managers use for almost every patient. The template includes the patient's goal, the name of the patient's support person, the level of importance (0-10) the patient places on healthy behavior change, the specific action plan, the patient's level of confidence (0-10) in being able to achieve the action plan and the goal, and the barriers the patient anticipates. The case manager prints the action plan for the patient on a form that allows the patient to write how well he/she implemented the action plan each day.

The percentage of patients with diabetes who set goals has improved from 28 to 46% and continues to improve as the case managers place a priority on goal setting.

The EMR has the capacity to print out an after-visit summary, but for some patients with low literacy this summary is not so helpful unless the case manager reviews it with the patient. For patients who want the summary, the provider reviews it with the patient; in the future Clinica would like to have more case managers with one of their functions being to make sure that patients understand the care plan provided in the after-visit summary.

Behavioral health integration

Clinica has integrated behavioral health into primary care, with one behavioral health professional (licensed clinical social worker, psychologist, or licensed professional counselor) per pod. Behavioral health professionals (BHPs) have some 30-40 minute appointments, but are available much of the time for warm handoffs—providers introducing patients to the BHP who conducts a 10-15 minute unscheduled visit done in the exam room after the provider visit. Warm handoffs may be planned during the morning or afternoon huddle or may take place when the

provider uncovers a behavioral health problem. Common issues are depression, anxiety, and psychosocial problems. Like case managers, BHPs work with patients on goal setting and action plans. MAs taking patients' history may uncover depression symptoms and do the PHQ-9 depression screening questionnaire, and then contact the BHP, who would follow patients with positive depression screens over time by phone or follow-up visit. Providers would be involved if medications are indicated. Not all patients are screened for depression, but all postpartum women are screened. BHPs also have English and Spanish group visits for patients with anxiety, 1½ hour sessions for 6 weeks. Under the payment guidelines for federally qualified health centers, a BHP visit can be billed, but a provider and BHP visit on the same day can be billed only once. A psychiatrist comes to Clinica 2 days per month, each day seeing 3 new patients and 4 follow-ups in addition to consulting with providers and BHPs.

Front desk

Each pod has its own front desk staff, though they are generally situated between the pod space and the pod's waiting area. The front desk does not handle telephones, which are separated from the pods in the call center; the absence of constantly ringing phones contributes to the calm atmosphere at Clinica. Front desk staff check patients in, collect copays before the visit (uninsured patients are on a sliding scale), and may make follow-up appointments though MAs often perform that function during their post-visit. Front desk staff also make confirmation calls to remind patients of appointments, call to inform patients of normal lab or x-ray results, and comb lists and registries to do outreach panel management calls to remind patients with care gaps (see below under panel management).

Referrals

Each of the four Clinica sites has at least one referral coordinator, whose job is to arrange and track specialty and imaging referrals. Referrals are a challenge for Clinica because few specialists will accept Medicaid and fewer will take uninsured patients. Referral coordinators have a database of these specialists, arrange appointments, send clinical information to the specialist, inform the patient, and track in the EMR whether the referral was made, appointment kept, and specialty consultation referral letter returned to Clinica. A tracking report is run every week and if no consultation letter has arrived, the referral coordinator follows up to determine if the patient no-showed or if the letter has not yet been sent. Clinica does not arrange for referrals for patients who request referrals but whose providers do not feel that specialty care or imaging is indicated. A similar tracking program has been implemented for laboratory results.

Group Visits

Group visits are a central feature of care at Clinica, with well-designed group visit rooms at every site. Group visits are offered for prenatal care, well-child care, diabetes, chronic pain, cold/flu, allergy, anxiety, and other chronic conditions. Patients always have the option of receiving care in a group or one-on-one.

Different groups are led by different staff people—MA, RN, BHP, case manager—with a provider present in the group for most of the time. Each type of group visit has clear protocols and delineation of responsibilities and an established length (generally 1 or 1½ hours). The scheduling of personnel for group visits is carefully meshed with the one-on-one pod schedules.

Because providers spend some time with each group visit patient, the group visits are billable. A small exam room is available to the side of each group visit space for care requiring privacy.

An initial prenatal group is offered in English and Spanish to bring newly diagnosed pregnant women into care as early in their pregnancy as possible. Currently, 80% of women at Clinica receive their first prenatal visit during the first trimester, up from 30% in the past; this statistic is associated with better pregnancy outcomes. Clinica providers—with obstetric backup—deliver about 2,000 babies each year (almost six per day).

Following the initial prenatal group, pregnant women can choose to receive their prenatal care in a Centering Pregnancy group or one-on-one. Well child care can be done in a Centering Parenting group or one-on-one. For the Clinica's Pecos site, 10% all care and 14% of prenatal care takes place in groups. The Pecos site does 850 group visits per year (between 2 and 3 each day). During the time that providers are seeing patients in groups, they are 30-40% more productive (patients seen per hour) than seeing patients one-on-one. Thus groups are good not only for patients, who interact with other patients like themselves, but also for Clinica financially.

Pharmacy

Two of the four Clinica sites have full-service pharmacies. For patients at the other 2 sites, medications are sent by courier. Medications are sold at cost plus a $12 dispensing fee, with a sliding scale for very low-income families. Clinica receives pharmacy assistance from University of Colorado pharmacy students and some PharmD residents. Sometime in the future, Clinica would like to place pharmacists on the pods.

Dental

Two Clinica sites have dental suites with dentists, hygienists, and dental assistants. Clinica provides fillings and comprehensive dental exams, and acute care for dental emergencies, but its priority is prevention, especially for the three groups covered by Colorado Medicaid: children, pregnant women, and patients with diabetes.

Panel Management

Clinica has set up systems to improve the chronic and preventive care not only of its patients who come for appointments, but for all patients empaneled to Clinica's sites, pods, and providers. This is done by providing outreach to patients who are overdue for periodic services recommended by well-accepted clinical practice guidelines, for example, women between 50 and 75 years who have not had a mammogram in the past two years or patients with poorly controlled diabetes who have not had an HbA1c lab test in the past 3 months. This activity is known as panel management—managing the care of Clinica's panels of patients.

Outreach is done by making reminder phone calls to patients with care gaps, meaning patients overdue for a guideline-recommended service. Outreach could be performed with mailings, but in the low-income population served by Clinica, letters are relatively ineffective in reaching people. Cell phones work better. Outreach calls are entered into the registry and tracked. Pod

members share the outreach work—some calls are done by the front desk, others by case managers, others by BHPs. The patients needing outreach are identified through Clinica's many registries and lists.

Registries are lists of patients with a particular chronic condition (Clinica has registries for ADHD, anti-coagulation, asthma, chronic pain, depression, diabetes, abnormal Pap tests, and hypertension) or a life situation requiring monitoring (prenatal care and parenting). Registries include patients' demographic information and clinical data, including the dates when each indicated test or service was last done, with prompts indicating what is overdue. Clinical practice guidelines are embedded into the registries. Lists are simpler; for example, a mammogram list includes all patients overdue for the mammogram. The designated pod member responsible for outreach to patients identified on the registries and lists as having care gaps calls those patients to close the care gap. Providers are not involved in this routine work, thereby freeing up more time for providers to address patients' acute complaints and complex management issues. Currently, Clinica's IT department is working to unify the disease-specific registries into one large registry. Clinica does prioritize which care gaps are addressed since there is not time for outreach to every patient overdue for a service.

Panel management can also be done through in-reach, meaning that care gaps are addressed when patients come to the clinic. Clinica's NextGen EMR does have a health maintenance screen that shows care gaps in red; thus far MAs and case managers are regularly not using that screen to address care gaps when patients come to the clinic. Clinica is hoping to add in-reach to its panel management activities at some point in the future.

Complex care management

In most health care organizations 10% of patients incur about 70% of health care costs; these are usually patients with several chronic physical and mental health conditions who frequently use the emergency department and are admitted to the hospital. It is widely believed that with excellent primary care, many of these emergency department and hospital costs could be avoided, and Clinica is well situated to reduce these costs.

Clinica has plans to devote more resources to these patients by increasing the number of case managers and focusing on prompt follow-up for patients seen in the emergency department or discharged from the hospital. A pilot program for complex care management is starting with a Colorado Medicaid Accountable Care Collaborative.

EMR Implementation

Clinica adopted the NextGen electronic medical record in 2006. No one at Clinica would ever imagine going back to paper charts; the EMR has been a key contributor to the improvements in Clinica's workflows. When Clinica made the transition from paper to electronic records, only a small amount of data was transferred to the EMR: diagnoses, medications, allergies, and immunizations. As providers saw patients, they could flag other pieces of information they wanted in the EMR, for example, lab results, imaging reports, patient consents, advance directives, hospital discharge summaries, and specialty consults. These could be scanned, but more commonly providers would highlight the key conclusions of these reports and indicate

where in the EMR the information should go, and medical records personnel would input the information. If a paper chart has not been pulled for 18 months, it is sent to storage.

Clinica wisely kept its medical records staff, who now work on each pod to input information requested by providers. Because many institutions with which Clinica interacts are not electronic, a large amount of paper continues to enter Clinica and medical records personnel are needed to input provider-highlighted information.

With its disease-specific templates for conditions commonly seen at Clinica, and its decision support tools which make clinical practice guidelines quickly available to providers, the EMR has helped to standardize how common conditions are handled by Clinica's providers and care teams. Some practice guidelines were written by Clinica's physician leaders; others are available from Colorado HealthTeamWorks, which has developed a rigorous process for writing, approving, and disseminating guidelines.

Clinica is currently initiating a web portal so that patients and care team members can communicate electronically, which is expected to streamline care for those patients with access to computers.

Creating Workflows

Every process in primary care has an invisible or visible workflow: what are the steps in the process, who does each step, and how do the steps fit together to make the process function smoothly? Clinica has tried to make hundreds of workflows, which naturally changed after EMR adoption, as visible as possible to every person working in the organization.

Creating smooth workflows is a long, slow journey, in part because primary care is composed of so many specific workflows. Take incoming phone calls as an example. Who receives the call, what script is used to answer the call, and how are emergent, urgent, and non-urgent requests handled? What can be handled by the call center attendant, what needs to be referred to the RN (which ones by phone, which by e-mail), or to someone else? If the call is for an appointment how is that appointment made, how is the call documented, and how is the quality of the call (how long the phone rang before being picked up, how satisfied was the caller) measured and how were those measurements entered into the clinic's database? Multiply the steps in that workflow by the hundreds of workflows taking place in primary care; improve, try out, improve again, spread, and make visible and provide training on each step of each workflow: one can begin to appreciate how much effort is involved in elevating a clinic to a high level of efficiency and quality.

Not only does each clinic function (e.g., managing the appointment template to ensure prompt access, optimizing continuity, drawing blood, reviewing lab results, refilling prescriptions, and on and on and on) require workflow design, but for a couple of dozen common primary care clinical conditions, visible workflows are needed (e.g., for diabetes, creating the EMR template for the MA to follow, deciding who does foot exams, eye exams, HbA1c lab tests, who and how the diabetes registry is managed, which medications are available in the pharmacy, who does patient education and activation and how it is done, how and how often and by whom diabetes care is measured and discussed among the clinic staff, to mention a few of the many steps required).

Clinica has created, tested, improved, and implemented hundreds of workflow redesigns, taking one workflow at a time, requiring years of continuous improvement that never ends. Yet Clinica has found that the very act of improving a workflow, which needs to involve everyone taking part in that workflow, builds teamwork and makes visible how each person's job interacts with the job of one's teammates and reveals the part that each person plays in providing care to Clinica's patients.

Performance Data

For many years, Clinica has kept run charts that demonstrate how the organization as a whole, each site, each pod, and each provider has performed on a number of metrics. Moreover, a databoard on the wall of each pod shows everyone whether or not performance has reached Clinica-set goals and where improvement is needed. The databoards are updated every couple of weeks with metrics such as continuity of care, documentation of smoking status, percentage of smokers receiving counseling, and process and outcome measures associated with diabetes, hypertension, prenatal care, and other conditions. The twice-daily huddles are used to discuss areas needing improvement. Clinica is a data-driven organization.

		2006	2008	2010	YTD 2011	HEDIS Medical
Continuity for Patients with Diabetes	PCP	58.00%	63.25%	69.07%		
	Team	82.00%	78.75%	84.75%		
Access	Time to Third Available Appointment (Days)	6	4.9	4	3.6	
Prenatal	Trimester of Entry to Care (Patients Entering Care in 1st Trimester)	66.00%	58.95%	79.69%	82.74%	83.40%
	Low Birth Weight	6.07%	5.93%	6.00%	5.57%	
	C-section rates		20.34%	20.25%	20.40%	
	Pap Test in Last 3 Years (Women age 24-64)		76.51%	82.87%	83.76%	
	2 Year Old Immunizations		62.52%	81.30%	91.84%	
	Diabetes Patients with A1c 7%		33.86%	39.92%	41.32%	33.90%
	Diabetes Patients with A1c 9%		21.81%	20.67%	22.71%	44.90%
	Hypertension Patients with BP 140/90		56.40%	67.38%	67.69%	59.80%

Total number of medical visits for 2010 was 145,596.
HEDIS Medicaid is the average score for all Medicaid health plans in the US in 2009 (www.ncqa.org).
National data on % of births with low birth weight for Hispanics in 2008 = 7.0%.
National C-section rate among US Hispanics 2007 = 30%.

NCQA medical home accreditation

Community health centers across the United States are debating whether to seek NCQA designation as a patient-centered medical home. In some states, such designation brings increased revenue, in others not. Clinica decided to become NCQA accredited even without the payment incentive, feeling that the exercise of gaining designation forces a primary care practice to think about the areas in which improvement is needed. For Clinica, accreditation was simple because all NCQA elements were already in place.

Pay for performance

From 2003 to 2007, Clinica utilized a pay-for-performance system. The clinic did not receive additional external payments for high quality; rather the organization held some of its revenues in a pool to create internal incentives for improvement. In contrast with most organizations that bonus only providers for improved performance, Clinica gave bonuses to every person on high-performing pods, thereby demonstrating that improvement is made possible by the efforts of the team, not only the provider. Recently, Clinica put a hold on its pay-for-performance system because of debate whether the pod-level data is sufficiently accurate. Discussions of the effectiveness of financial incentives are ongoing.

Financing Clinica

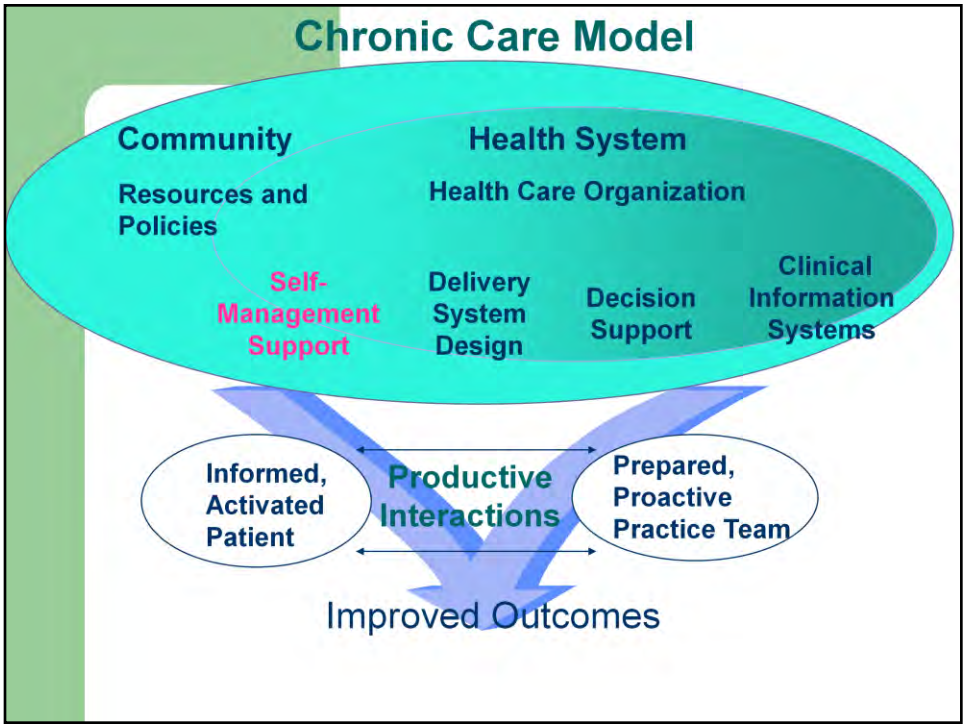
Clinica, like all community health centers in the United States, has a complex system of financing. As a federally qualified health center (FQHC), Clinica receives an enhanced payment for Medicaid because FQHCs are required to care for the uninsured, and the Medicaid payments provide funds that help to offset the losses incurred in caring for the uninsured. In addition, Clinica has received Public Health Service Act Section 330 grants, raises funds from local foundations and benefactors, collects sliding-scale payments from some uninsured patients, and benefited for years from the Colorado tobacco tax moneys. In the changing world of post-Accountable Care Act politics combined with federal and state budget crises, Clinica joins all community health centers in navigating through an uncertain world.

Learning From Clinica

Clinica has solved many of the problems facing primary care clinics and practices, and continues to confront the challenges that still remain. For clinics and practices whose improvement journey began later than that of Clinica, Clinica has much to teach. Why was continuity of care made the centerpiece? How was prompt access achieved and sustained for so many years? Who should be on care teams, how many of each job category, what are their job roles, what are the workflows, and why is co-location such an important feature of a successful care team? How is care for each common condition provided? How does care become a shared responsibility of all care team members rather than the sole responsibility of providers, and how does the shift from provider to team improve the quality of care for patients and the work life of clinic personnel? How is population-based care carried out, and measured, and how does data drive improvement? No clinics or practices will blindly copy Clinica’s answers to these questions, but all can learn from Clinica’s leadership.

Appendix 6


Using Self-Management Support In Your Coaching Approach
Mike Hindmarsh
Hindsight Healthcare Strategies
QIIP Practice Facilitator Training
May 12-13, 2008
Toronto, ON



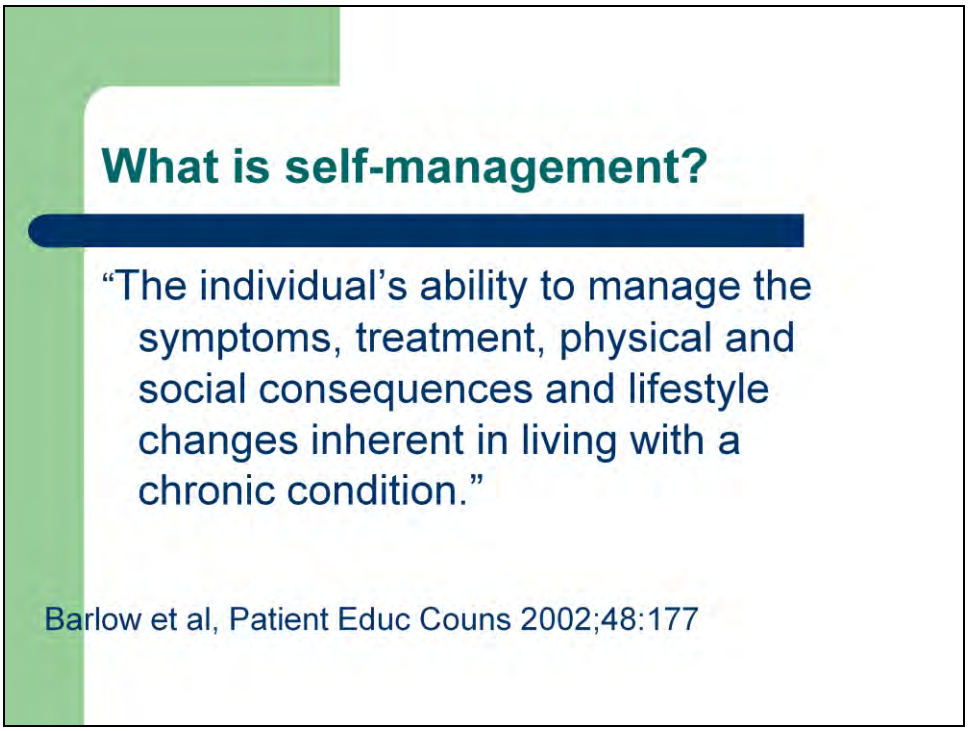
Wagner EH, Davis C, Schaefer J, Von Korff M, Austin B. A survey of leading chronic disease management programs: Are they consistent with the literature? *Managed Care Quarterly*. 1999;7(3):56-66.
Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness: the chronic care model, Part 2. *JAMA* 2002 Oct 16; 288(15):1909-14.
Wagner EH, Austin BT, Davis C, Hindmarsh M, Schaefer J, Bonomi A., Improving chronic illness care: translating evidence into action. *Health Aff* (Millwood). 2001 Nov-Dec;20(6):64-78.

Bodenheimer, Lorig, Holman, and Grumbach Patient self-management of chronic disease in primary care. JAMA 2002;288:2469-2475

Glasgow, Davis, Funnel and Beck, in submission

Whitlock et al. Evaluating Primary Care Behavioral Counseling Interventions: an Evidence-based Approach

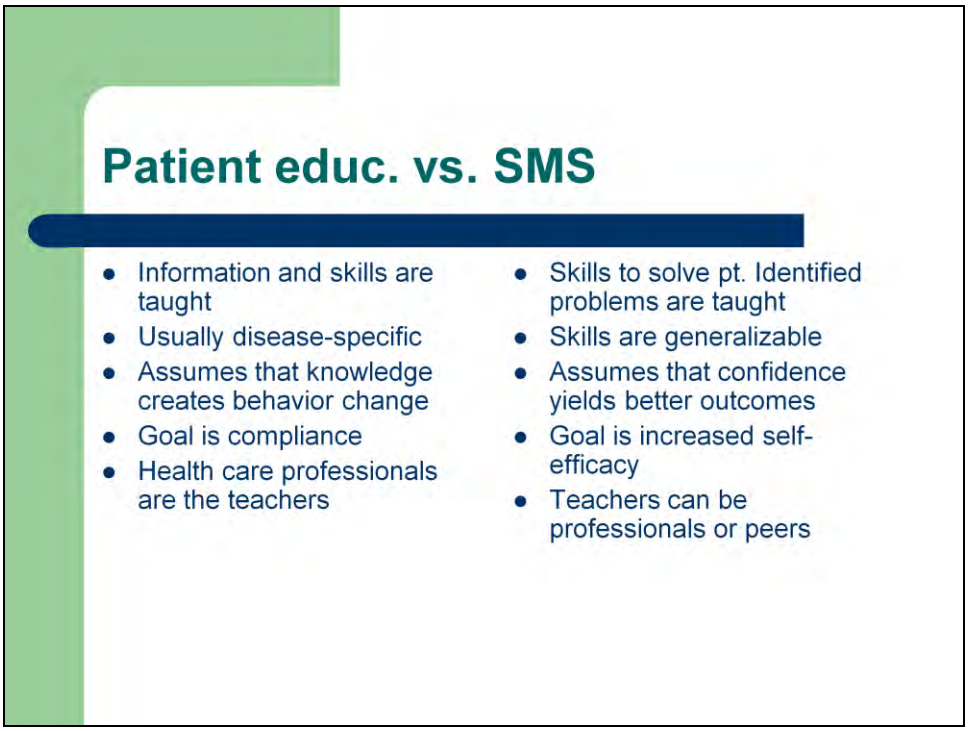
http://www.ahrq.gov/clinic/3rduspstf/behavior/behsum1.htm



Barlow goes on to say:

Efficacious self-management encompasses ability to monitor the condition and to effect cogitive, behavioral and emotional responses necessary to maintain a satisfactory quality of life.

It is a dynamic, continuous process of self-regulation.



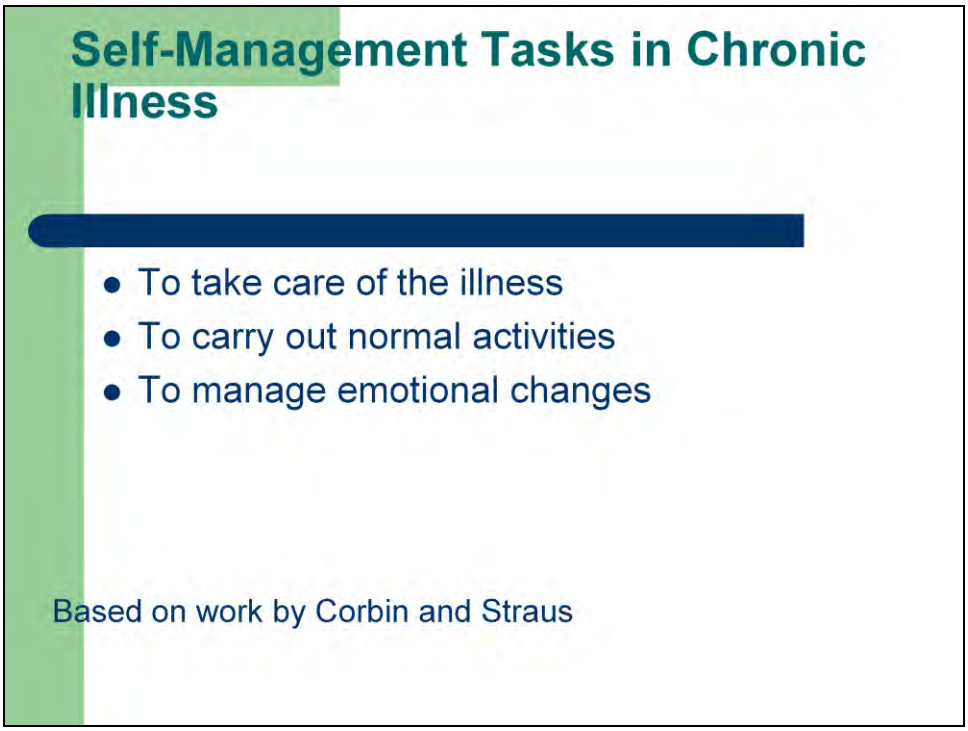
Both patient education and SMS are necessary.

Some aspects of patient education work well, some do not. Information is necessary and skills must be taught.

Knowledge does not create behavior change, and compliance is not a useful goal.

Adapted from Bodenheimer, JAMA 2002;288:2469

Norris et al. Effectiveness of self-management training in type 2 diabetes, Diabetes Care 2001;24:561-587.



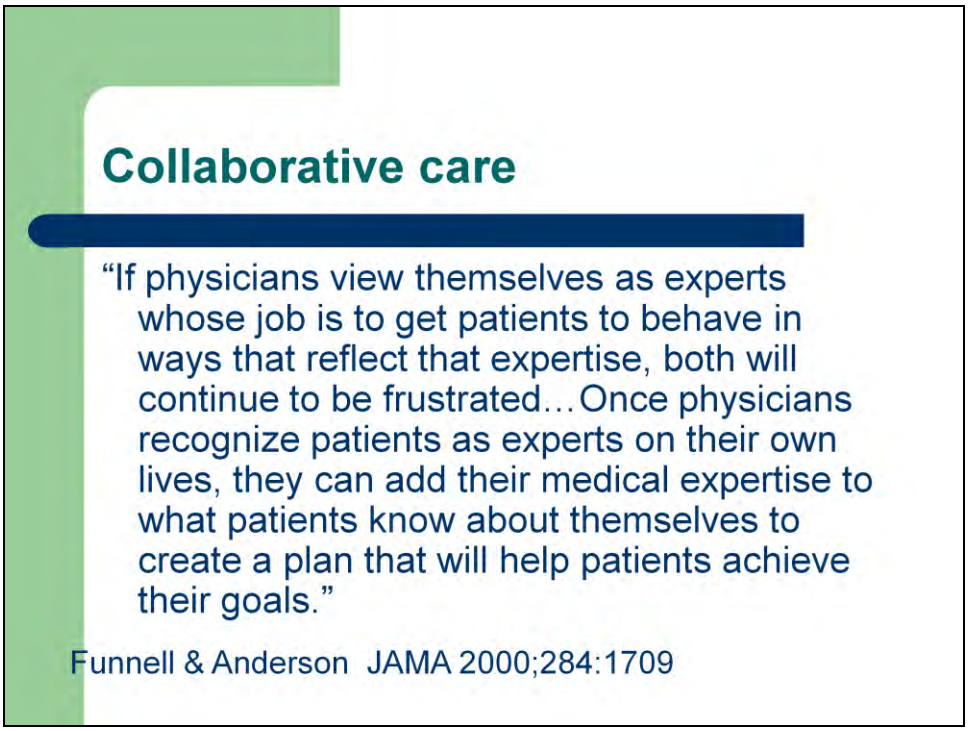
Take care of illness means handling medical management such as taking medication, changing diet, or self-monitoring.

Carrying out normal activities means creating and maintaining life roles, such as job, family, friends (how do I manage working night shift with diabetes? How do I play soccer and keep my asthma in control?)

Emotional changes are most frequently anger, fear and frustration, often depression. Changes view of future and relationships with others.

When you are interacting with a patient, or designing a system to support self-management, consider if you have touched on every task.

Corbin J, Strauss A. Unending work and care: managing chronic illness at home. San Francisco, Jossey Bass, 1988

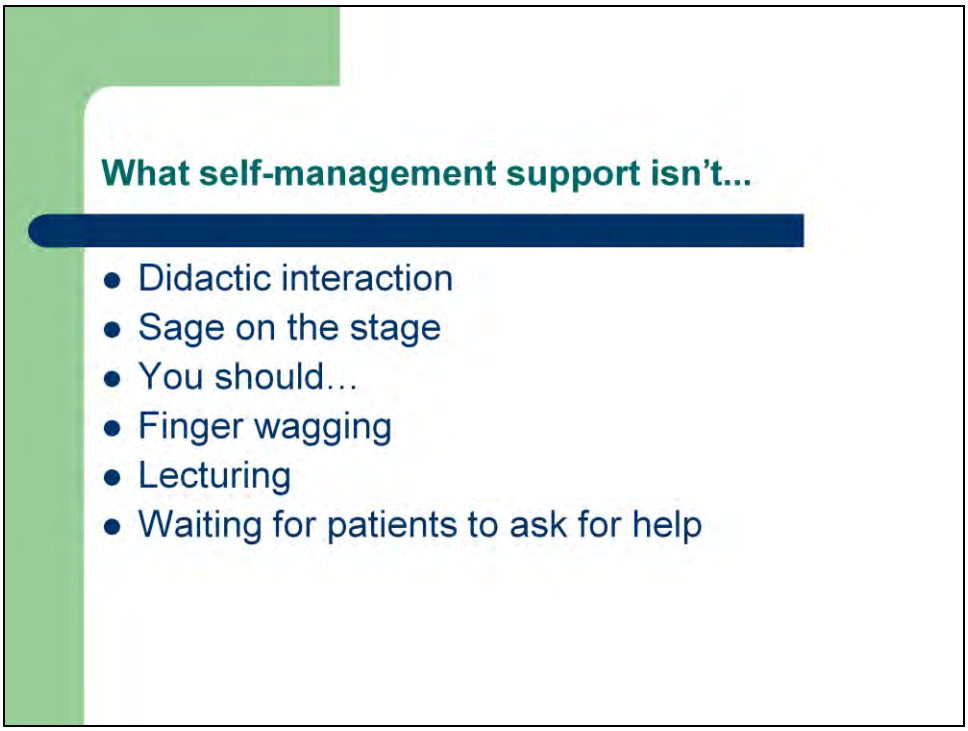


This describes the patient empowerment philosophy.

Need interaction of clinician's ideas and patient's ideas.

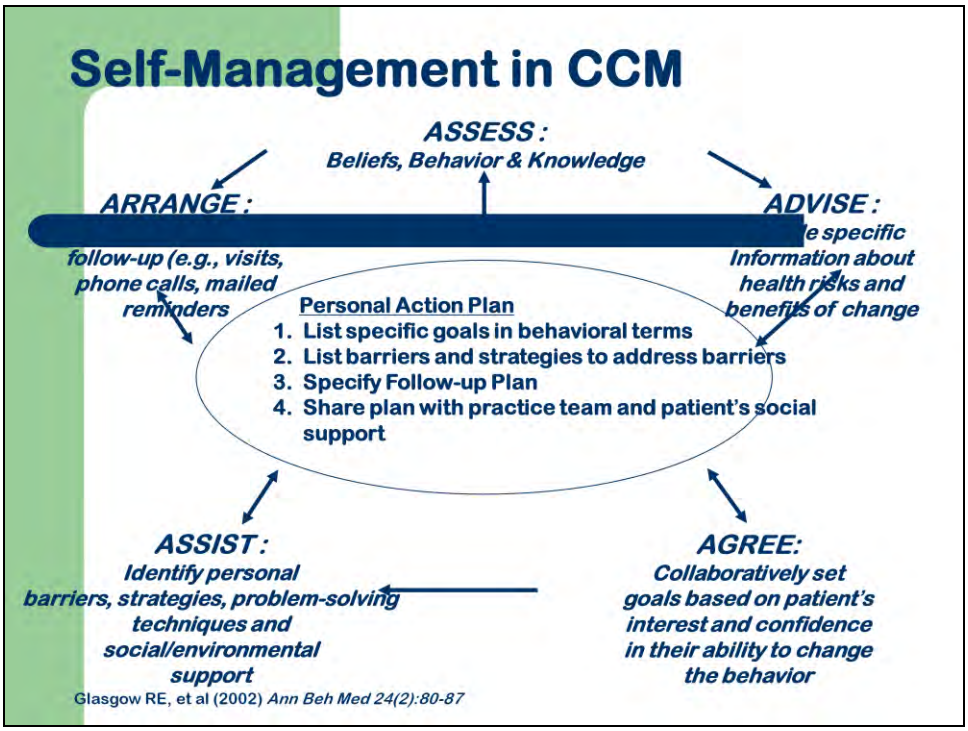
Professionals may blame pts for poor outcomes, attribute it to noncompliance, denial.

If we accept that pts define their problems, compliance and adherence aren't relevant concepts.



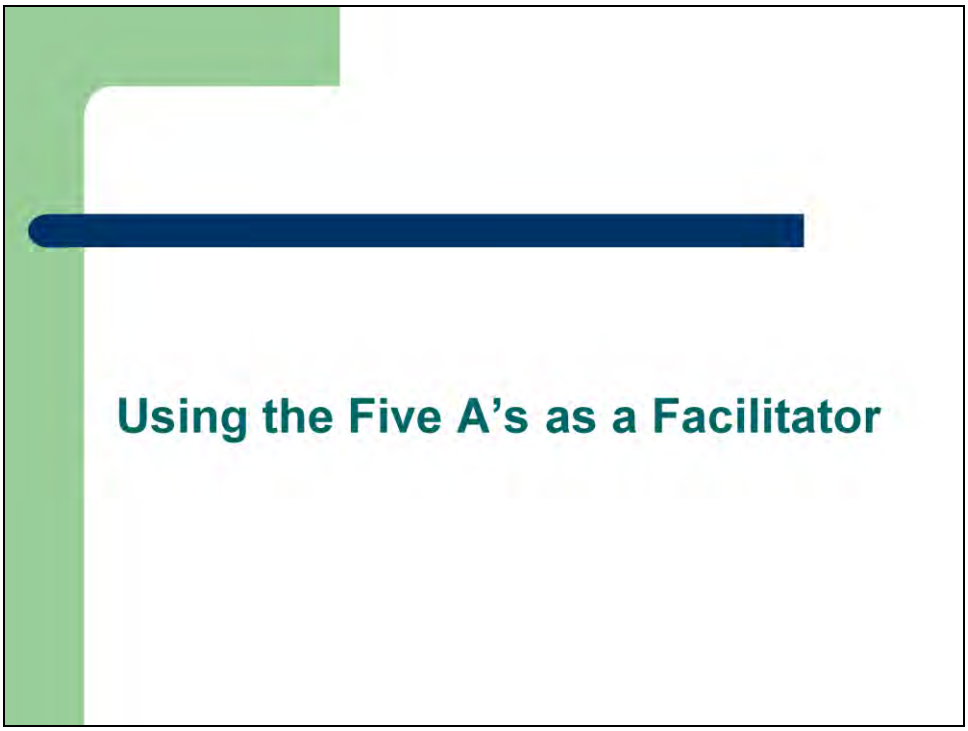
Not sage on the stage, but the guide on the side (Karen Artz)

Source: ICIC

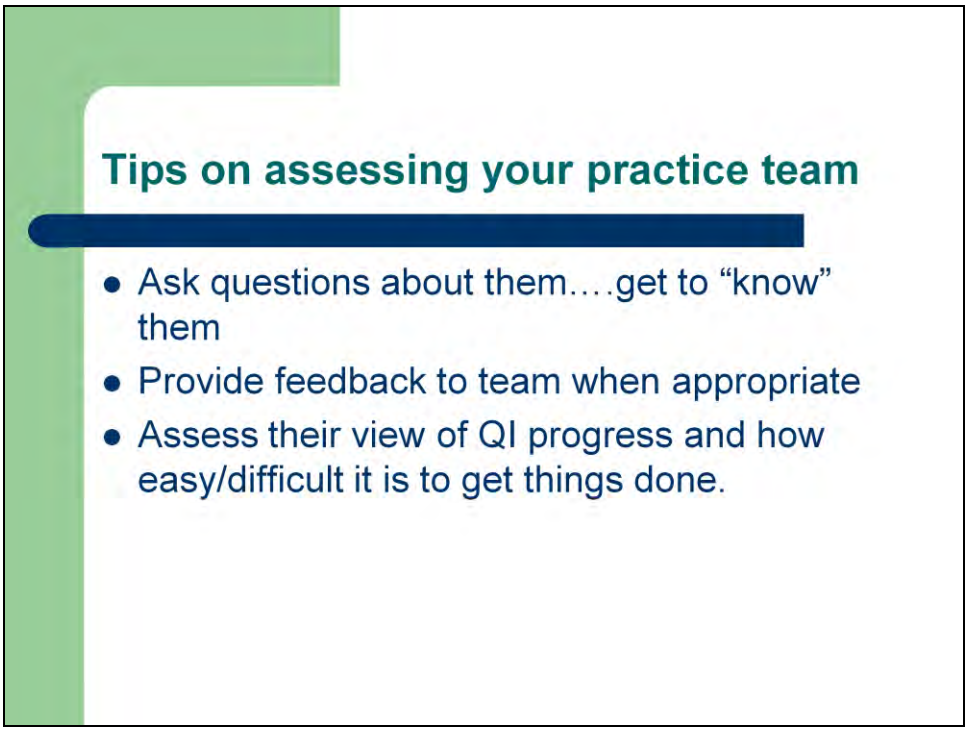


One way to make sure that you are using effective strategies is to incorporate the 5 A's into care.
Assess, Advise, Agree, Assist, Arrange.
This diagram draws on the 5 A's that some of you may be familiar with from smoking cessation brief counseling.
(Start at the top and go around the figure, reviewing each A.)
The central activity is the creation of a Personal Action Plan.

Glasgow RE, et al (2002) *Ann Beh Med 24(2):80-87*


Using the Five A's as a Facilitator

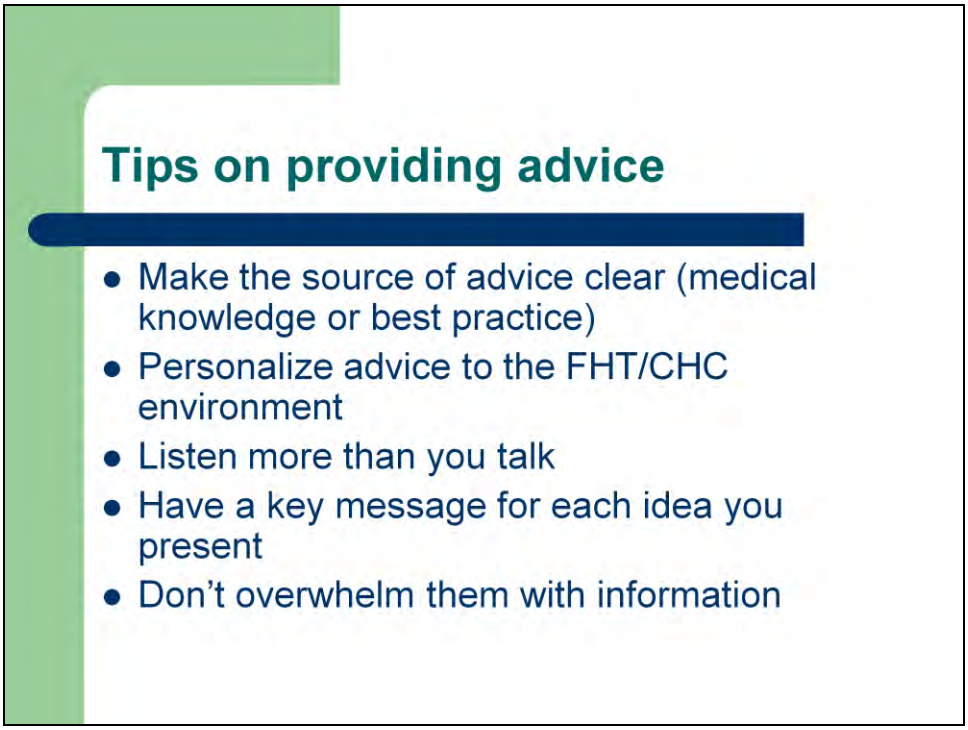
Now we will look at each of the A's in succession. They will help us organize our efforts in self-management support.



Here are some tips to consider during assessment.

Many of the patient choices are behaviors, but some are also attitudes about their illness.

The second A is Advise.

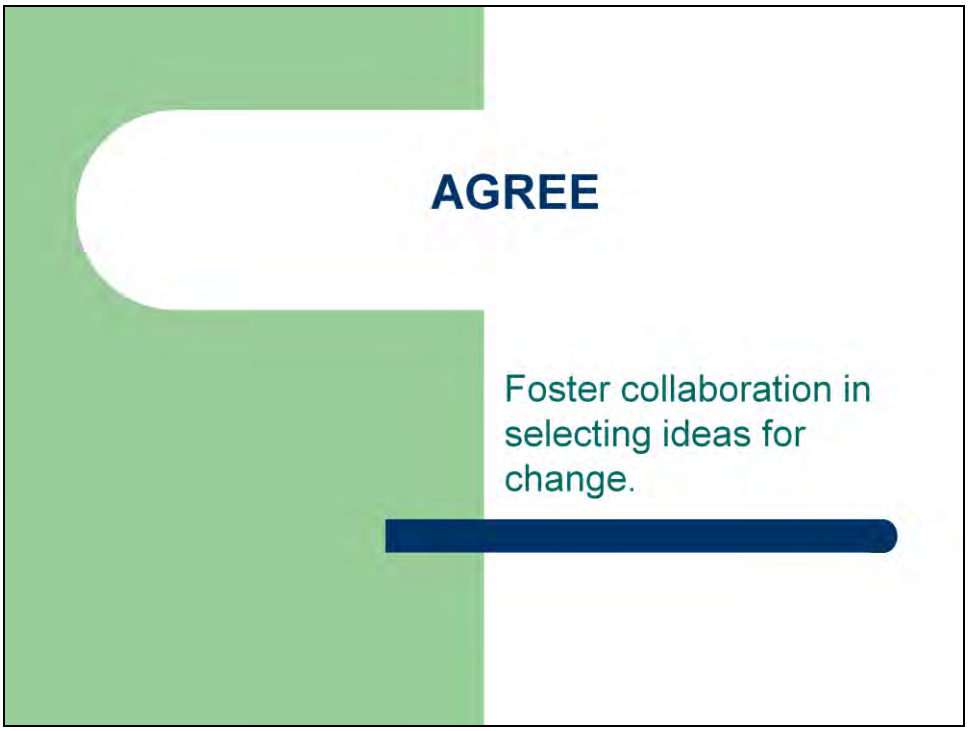


It is important to clarify what kind of information you are providing. Regarding clinical care, remember techniques from shared decision making. If it is in relation to some lifestyle decision, patients like to hear information from patients like them.

There is much evidence that supports the power of physician advice. (see Whitlock for refs)

One example of personalizing lab values is to graph them. For people with diabetes, draw a body with areas to put in their HbA1c, BP, microalbumin, eye exam, etc. Help patients understand how their choices influence their health status, for example how regular exercise contributes to better function for people with arthritis, or how trying new things contributes to a sense of confidence.

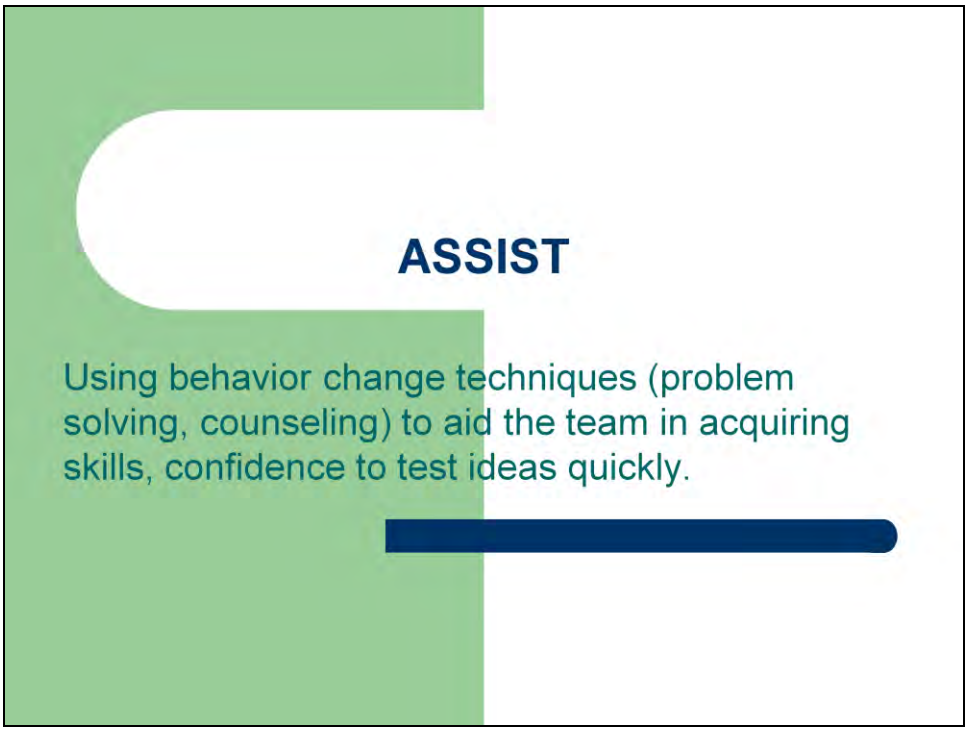
Source, Glasgow et al in submission



The third A is Agree.

Remember the goal is the patient's and we want them to be successful. Often the goal or plan does not seem related to the chronic illness from our point of view, but to the patient they make sense. Sometimes patients choose something small or apparently peripheral to do, but with success, they will take on more challenging and specific things to try.

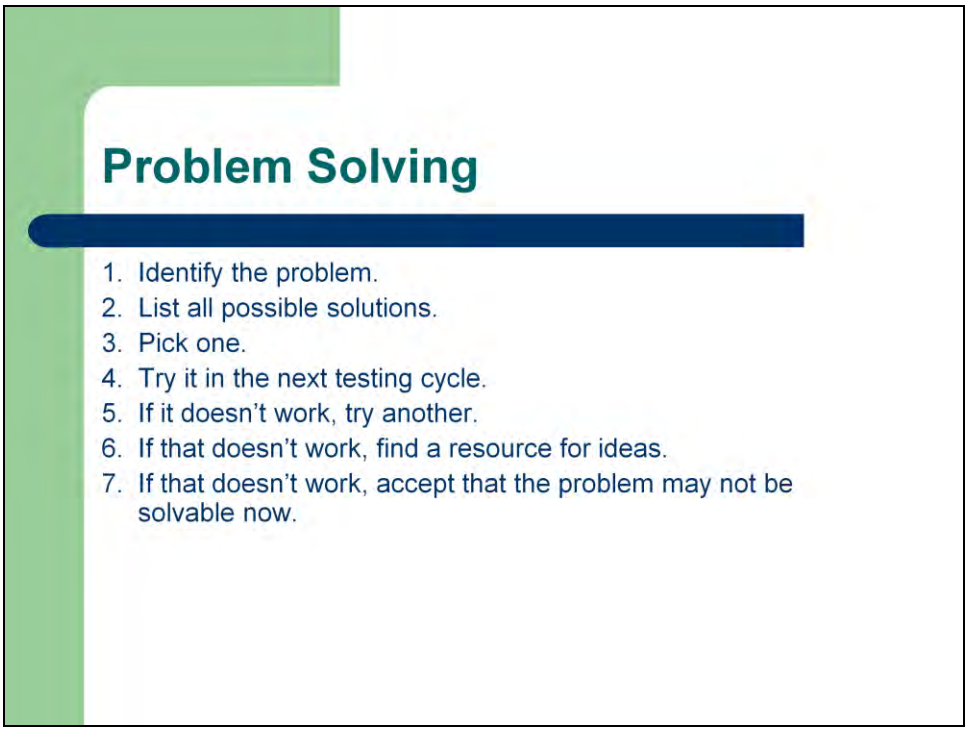
Source, Glasgow et al in submission



Agree and assist are the steps that lead to the creation of a personal action plan.

Tips on assisting patients

- Use other teams as examples
- Address helplessness
- Learn and use a problem-solving approach
- Link to the assessment of barriers and environment
- Avoid telling them what to do
- Avoid speeches
- Avoid cheerleading

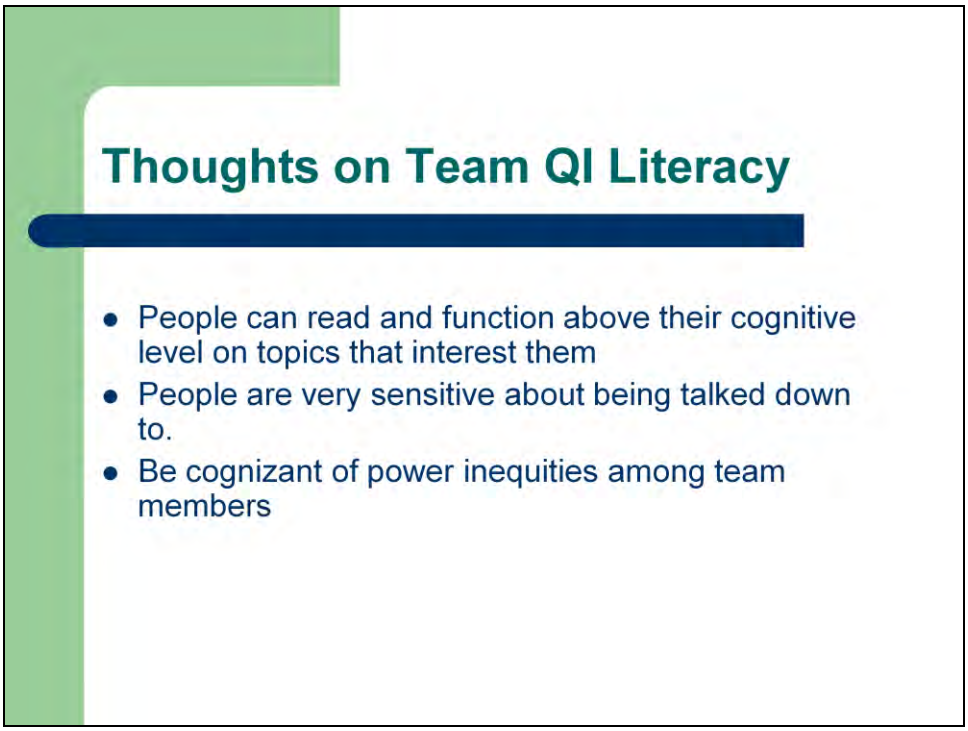


This is a very straightforward problem solving approach, which is used in many successful self-management programs. It can be done individually or as a group.

The first step may be tricky. If the patient can't think of ideas for the second step, ask them if they would like ideas from other patients like them. Check up on their progress.

From Kate Lorig, Chronic Disease Self-management program

Lorig K, Holman, H, Sobel D et al Living a Healthy Life with Chronic Conditions 2 ed, Palo Alto, Bull publishing, 2001

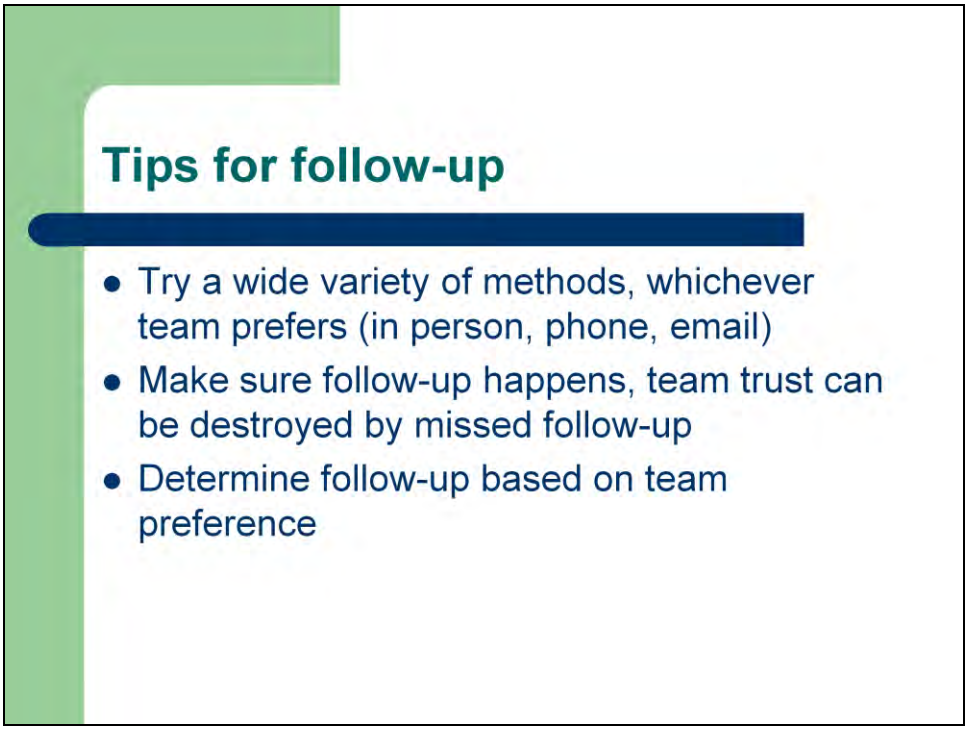


Key point is to give patients a choice on whether or not they want written material and to have options

From an email response of Kate Lorig to leaders of the CDSMP program, Sep 2002

The final A

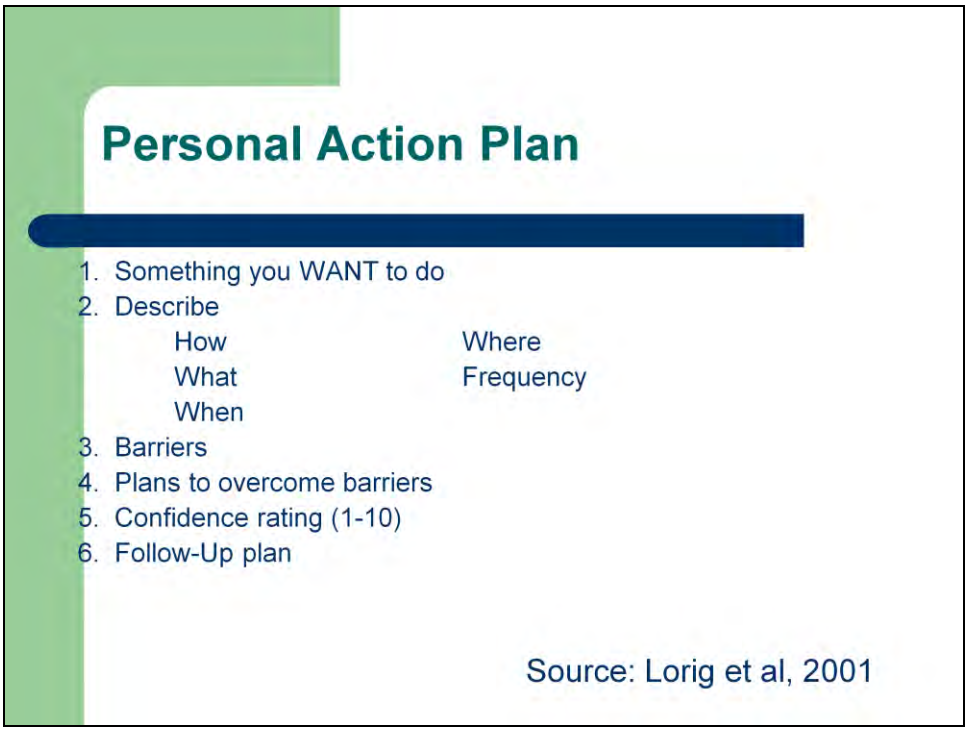
Whitlock et al



Glasgow et al in press.

Efficacy of other methods Whitlock et al Evaluating primary care behavioral counseling interventions: an evidence-based approach

http://www.ahrq.gov/clinic/3rduspstf/behavior/behsum1.htm



This is the center of the diagram.

Goals are too big to work on all at once, and need to be broken down into steps. Action plans should be made for 1-2 week periods of time.

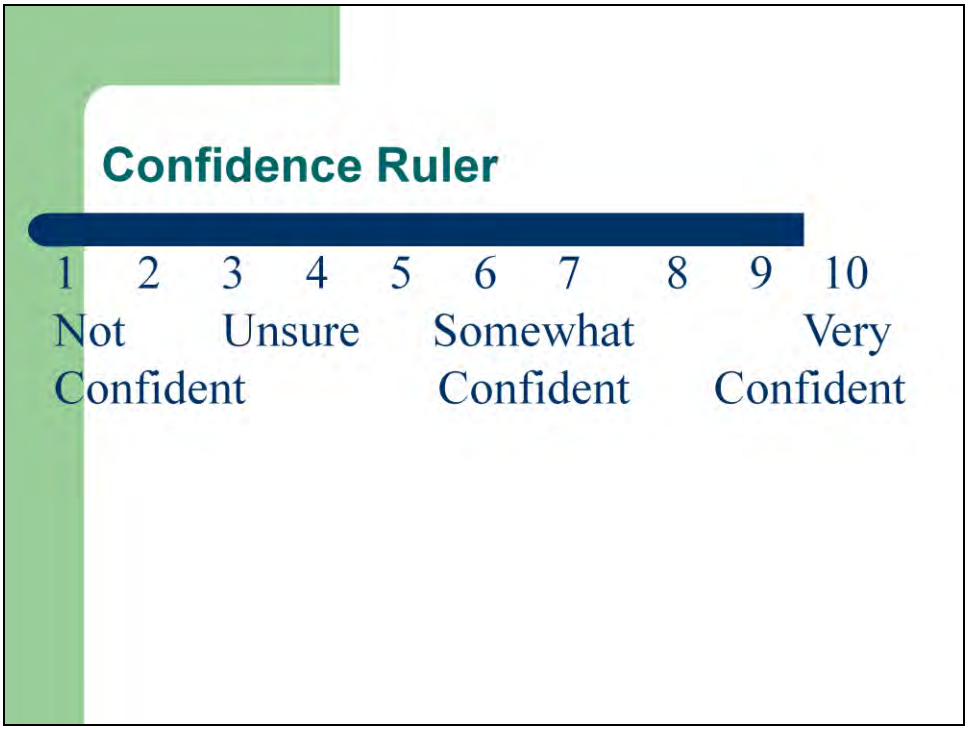
Need to be behavior-specific (someone could observe them doing it).

Confidence see next slide. Confidence is behavior specific. Can be very confident can take meds, but not confident can avoid salt at the church pot-luck if have CHF.

Follow up may be in person, on phone, email. Important to follow-up!!!

(From Kate Lorig, Chronic Disease Self-management program

Lorig K, Holman, H, Sobel D et al Living a Healthy Life with Chronic Conditions 2 ed, Palo Alto, Bull publishing, 2001



People can quickly learn to gauge their confidence.

You can ask, how confident are you that you can complete the entire plan we just set?

If their confidence is less than 7, look at the plan more closely. It is more important for patients to succeed than to have an ambitious plan. Review all the steps. Sometimes the confidence is low because the plan is not something that the patient wants to do. Sometimes they have been overly ambitious with the plan and chosen too much or too often. Remind the patient that they can always do more.

For More Information on Self-management Support

www.improvingchroniccare.org

thanks

Appendix 7A. Case Study: Practicing Professionalism When Confronted by a Difficult Work Event

The Situation

Bestever Medical Group had a two-year contract with an outside consultant to work on setting up a registry for their Diabetes Care Initiative. The practice facilitator (PF) was instructed by Bestever's quality improvement (QI) team to work with its consultant to update registry reports to track patients in its new Diabetes Managed Care Program. The PF and the consultant were never formally introduced but asked to work with each other. The PF attempted to meet with the consultant. Initially the consultant did not return her call and email to request a meeting. He finally did but sounded irritated and started questioning her about why she needed to meet with him and who at the practice had asked her to work on this.

The Response

Being fairly new to the QI team, the PF asked Bestever's lead clinician for a quick meeting and explained that it would be helpful if she could introduce the PF to the consultant and explain the PF's role and how she envisioned the PF and consultant working together. The PF shared that this would help the work with the consultant be more effective and efficient.

The Outcome

The clinician introduced the PF to the consultant and explained roles and activities. The PF discussed this further with the consultant after the initial introduction. Over the next few weeks, the consultant became more open to working with the PF and collaborated more effectively with her on the registry work.

Appendix 7B. List of Learning Resources for Practice Facilitators

Institute for Healthcare Improvement Open School

Courses offered at IHI are in the subjects of patient safety; improvement capability; quality, cost, and value; person- and family-centered care; triple aim for populations; and leadership.

http://www.ihi.org/education/ihiopenschool/Pages/default.aspx

ImpactBC

This not-for-profit organization in Vancouver provides health care partners coaching. They provide online learning resources that contain short modules and other resources to help guide and identify techniques used in quality improvement projects.

http://www.impactbc.ca/

AHRQ's Primary Care Practice Facilitation listserv

This listserv is used to share perspectives on questions and answers from members across the nation. Members include researchers, clinicians, practice facilitators, and others in the work of healthcare transformation.

To subscribe to the listserv please email PracticeFacilitation@mathematica-mpr.com and include "subscribe" in the subject heading

AHRQ's PCMH Resource Center

AHRQ has a webpage dedicated to resources on the patient-centered medical home and leveraging practice facilitation as a method for obtaining recognition as a PCMH. Included is a how-to guide for organizations interested in starting a PF program, case studies, and resources in primary care practice facilitation.

http://pcmh.ahrq.gov/page/practice-facilitation

Coach Medical Home curriculum

Coach Medical Home materials are a collaboration of Group Health, The Commonwealth Fund, and Qualis Health. The site provides training materials for facilitators who are working with safety-net practices.

http://www.coachmedicalhome.org/about/coaching-overview

Safety Net Medical Home Initiative

The Safety Net Medical Home Initiative aims to be a replicable model for implementing medical homes in the safety net. As part of the project, the partners developed a robust set of training materials for facilitators and other professionals. These include materials on sequencing change, recognition and payment, and collaborations, among others.

http://www.safetynetmedicalhome.org/resources-tools

Dartmouth Microsystem Improvement Curriculum

Dartmouth provides a series of training modules for health care professionals, including facilitators aimed at building skills for practice improvement.

http://www.clinicalmicrosystem.org/materials/curriculum/

Annual Conferences to Consider Attending

- Academy Health: https://www.academyhealth.org/
- Society of Teachers of Family Medicine Conference on Practice Improvement: http://www.stfm.org/Conferences
- North American Primary Care Research Group (NAPCRG) Practice-Based Research Network (PBRN): http://www.napcrg.org/Conferences
- Institute for Healthcare Improvement, National Forum on Quality Improvement in Healthcare and International Forum on Quality and Safety: http://www.ihi.org/education/conferences/Pages/default.aspx

Appendix 7C. Management Tips for Dealing With Difficult People

Harvard Business Review offers the following management tips for dealing with difficult people. These are some key tactics to remember:

1. **Give feedback:** provide the person you are having difficulties with some insight to what you are experiencing from the opposite side. Let this person know what you observe and how the situation is made difficult. It can be helpful to use a format such as "when you (details), I feel (details), what I need differently is (details)." Avoid using "you" statements or other approaches that can be viewed as critical or attacking.

2. **Focus on work and not the person:** some interactions are short and may not require any confrontation. In these instances, the best solution would be to remove yourself from negative emotion and simply focus your attention to the work.

3. **Ask for commitment:** remind the person you are confronting that you are committed to the project and ask that he/she also commit. Essentially, you are both working toward the same goal and objectively need to find a means for better interactions. The commitment is not made to each other, but to the project.

4. **Keep your composure, or walk away**: in a heated moment, it will be difficult to confront someone with a solution to a disagreement. If you find yourself upset beyond recovery, the best approach would be to keep your composure, and excuse yourself from the situation. Do this only when you absolutely need to, when you find yourself unable to communicate effectively. If you do walk away, make it a point to arrange a time to continue the conversation when you are both feeling calmer.

5. **Identify common ground**: perspective from either side may not be understood, but the PF should work with the difficult personality to identify common ground. Still, a PF may not necessarily use this tactic to work on difficult personalities as the inherent structure of the relationship between the PF and the practice abides by the needs and views decided on by the practice itself.

6. **Hear the other person**: sometimes all that needs to happen is for the other person to be heard, so listen.

7. **Propose a solution**: if you find a difficult personality within a team, the PF could propose a solution for dealing with this individual. Depending on the issue, this could include changing his/her role and responsibilities, have a one-to-one meeting discussing a potential solution, etc.

8. **Turn your competitors into allies**: In the example of the consultant, it is important to remove competitive emotion, and work with them to show how you can both gain from each other's expertise.

9. **Reflect:** Take a moment to consider the event and person from whom you had a confrontation or indication of difficult personality. Ask yourself how you can improve the relationship? Is there something you can address or easily approach with this individual? Are there patterns in his/her way of being?

10. **Get feedback**: the best place the PF can obtain feedback is at the PF program office or base. The PF should ask the advice of superiors and colleagues after detailing background and current circumstances.

Appendix 8. PDSA Worksheet for Testing Change

Aim

(overall goal you wish to achieve)

Every goal will require multiple smaller tests of change

Describe your first (or next) test of change:	**Person responsible**	**When to be done**	**Where to be done**

Plan

List the tasks needed to set up this test of change	**Person responsible**	**When to be done**	**Where to be done**

Predict what will happen when the test is carried out	**Measures to determine if prediction succeeds**

Do

Describe what actually happened when you ran the test

Study

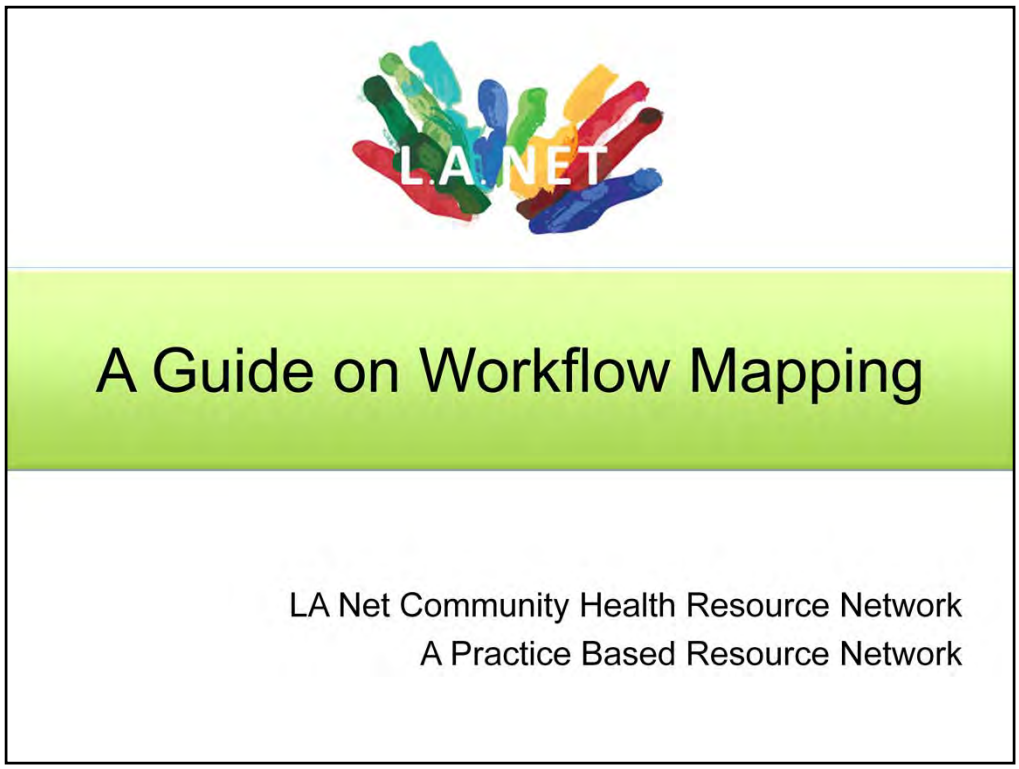
Describe the measured results and how they compared to the predictions

Act

Describe what modifications to the plan will be made for the next cycle from what you learned

Cambridge, MA: Institute for Healthcare Improvement. Adapted with permission.

Appendix 10A. A Guide to Workflow Mapping



This is an introductory course on workflow mapping. This session is meant to provide basic knowledge in workflow mapping, while demystifying the process.

Learning Objectives

- Identify the three types of flowcharts
- Explain the use for flowcharts
- Apply the 6 steps used to produce a flowchart
- Evaluate an organizational process using your flowchart

Workflow Mapping

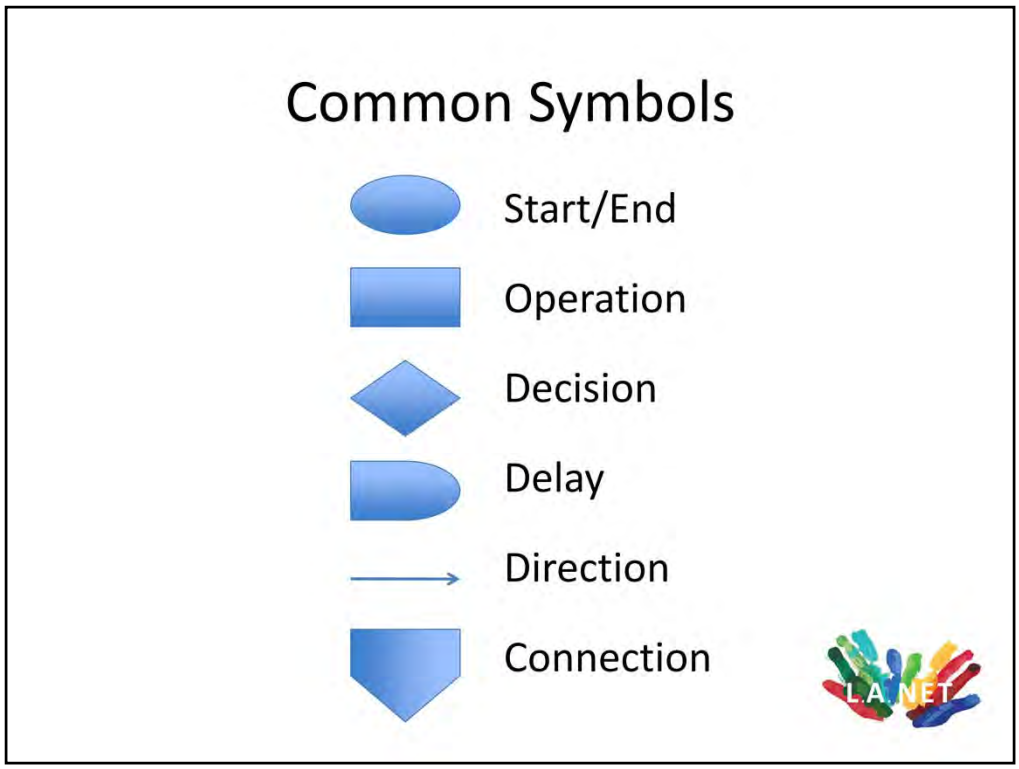
- Workflow maps are also referred to as flowcharts, flow maps, flow diagrams, flow sheets, and process maps
- A workflow map is defined as a visual representation of a process
- A process considers a sequence of operations with a start and end point

Use for Workflow Maps

- To map current practice flow
  Are we really doing what we say we do?
- Begin to identify areas for process improvement
- Visual aid and representation of roles and responsibilities
- Add-on to an organization's policies and procedures
- Process maintenance

Types of Flowcharts

1. **High-Level flowchart**: is a diagram that provides a brief overview of a process only highlighting major events in the process
2. **Detailed flowchart**: is a map that marks every step in a process, which includes decision points, waiting periods, and feedback loops
3. **Swimlane flowchart**: is a map that displays processes carried out for multiple roles across multiple stages



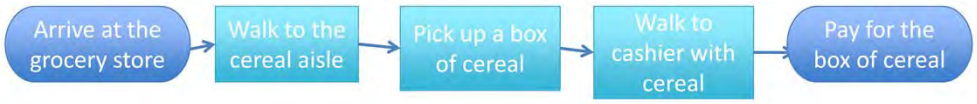
Become familiar with the following symbols. Your team will want to construct its workflow diagram to include these. The symbols offer an immediate visual representation of: start/end, decision point, delay, and direction.

1) Indicates the start or end of a process
2) A specific task or activity performed
3) A point in the process where a decision needs to be made to determine the path in the process
4) Indicates a point in the process where there is delay or wait in line
5) Arrows indicate the direction of flow
6) Use this as a cross reference from a process on another page

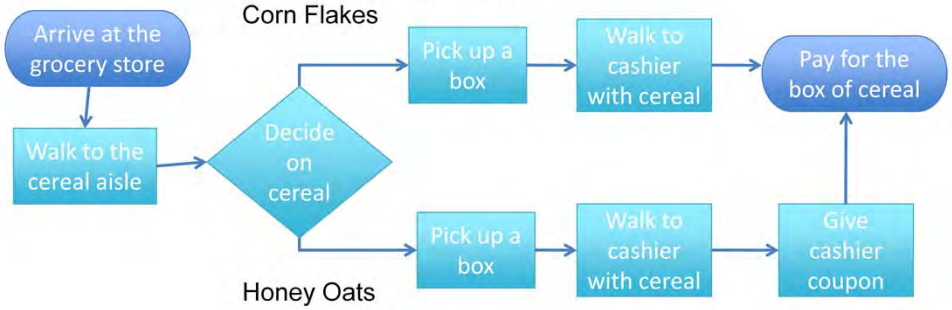
What it looks like

Example: The process of buying a box of cereal.

High-Level Flowchart

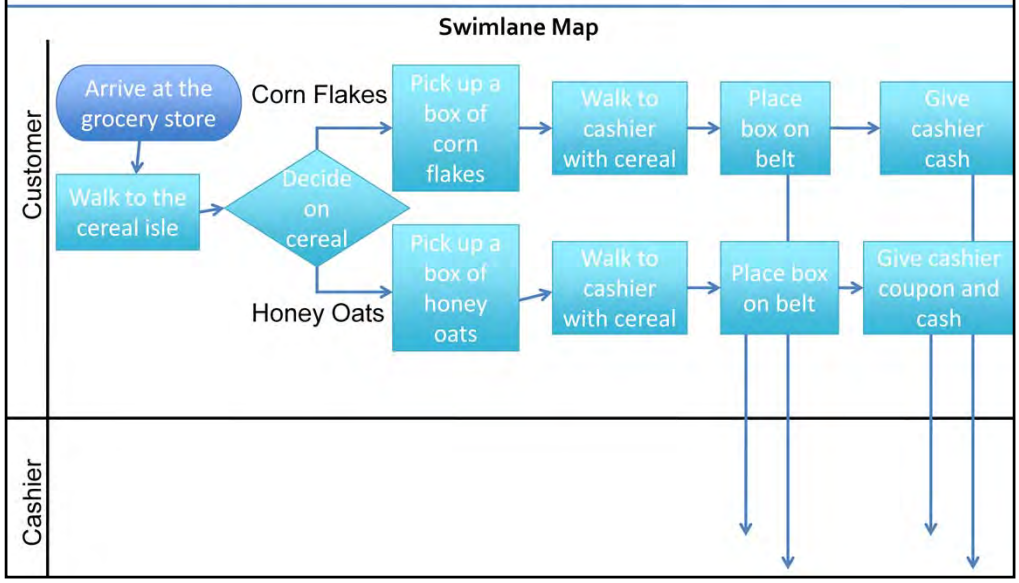


Detailed Flowchart



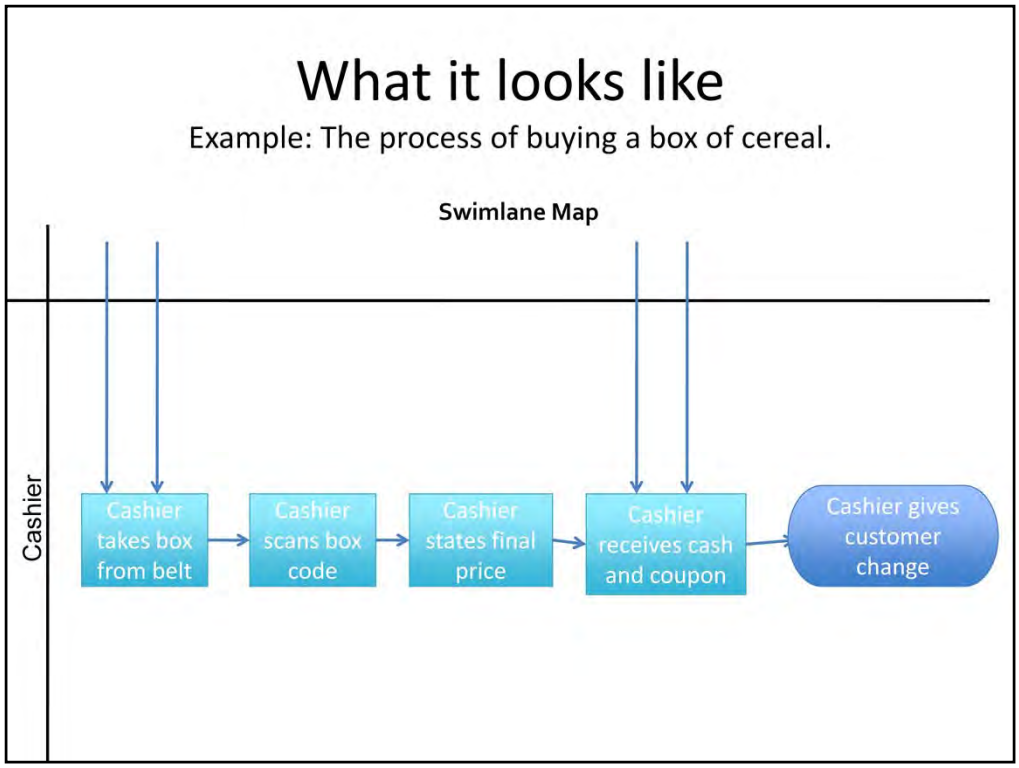
What it looks like

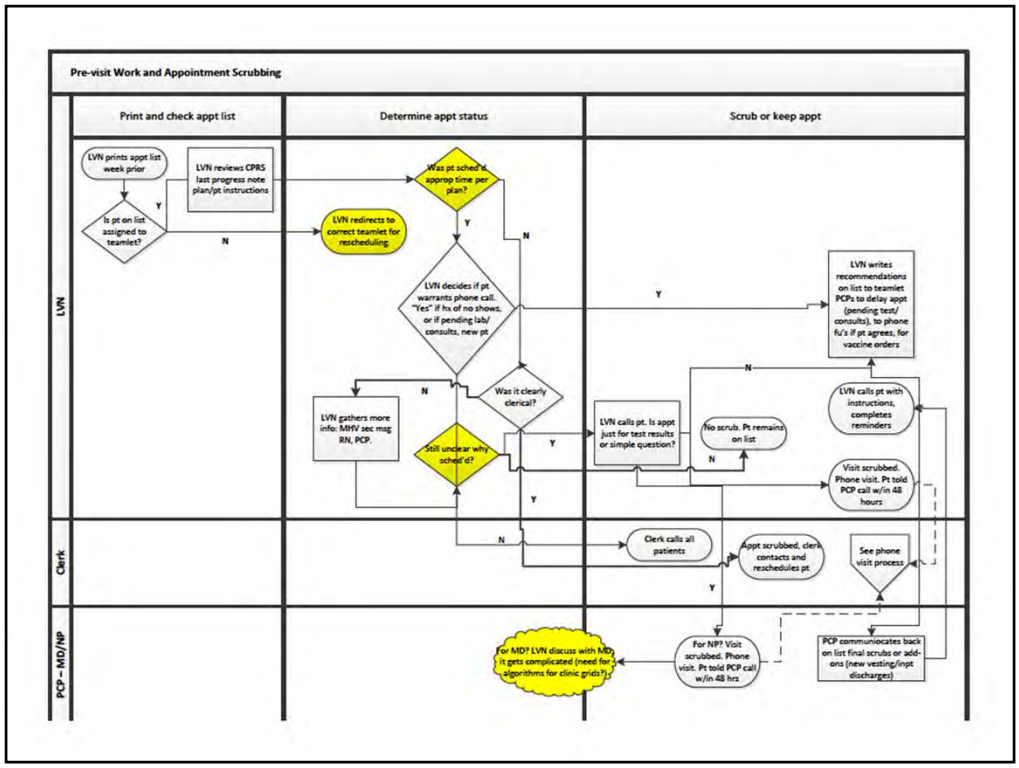
Example: The process of buying a box of cereal.



What it looks like

Example: The process of buying a box of cereal.





This is an example of what is referred to as a "swim lane map." A swim lane map displays processes that are carried out for multiple roles across multiple stages.

Each swim lane is representative of a role, in this case: PCP, Clerk, LVN.

The stretch of each lane is marked by the stages in the process. Here they are marked in the following order: 1) Appointment list review, 2) Appointment status, 3) scrubbing

Who is involved?

Involve all those who play a part in the process.

Tips:

- Start with a small group if it's a challenge to start with the entire group
- Pick a champion for this group
- Be sure to have all materials on-hand
- Provide the team with an overview of what the mapping process looks like
- Clearly state the objective and process selected for this exercise

The 6-Step Process

Step 1: Identify a process to map (use the Know Your Process template)

Step 2: Begin with a high-level flowchart

Step 3: Move into a detailed flowchart

Step 4: Walk through the process once or twice

Step 5: Validate the maps to ensure they truly reflect the current process

Step 6: Identify quick fixes and distinguish them from larger fixes (use LA Net's Impact & Complexity Grid)

(REMEMBER: A flowchart captures the process AS IS, not how it is supposed to be)

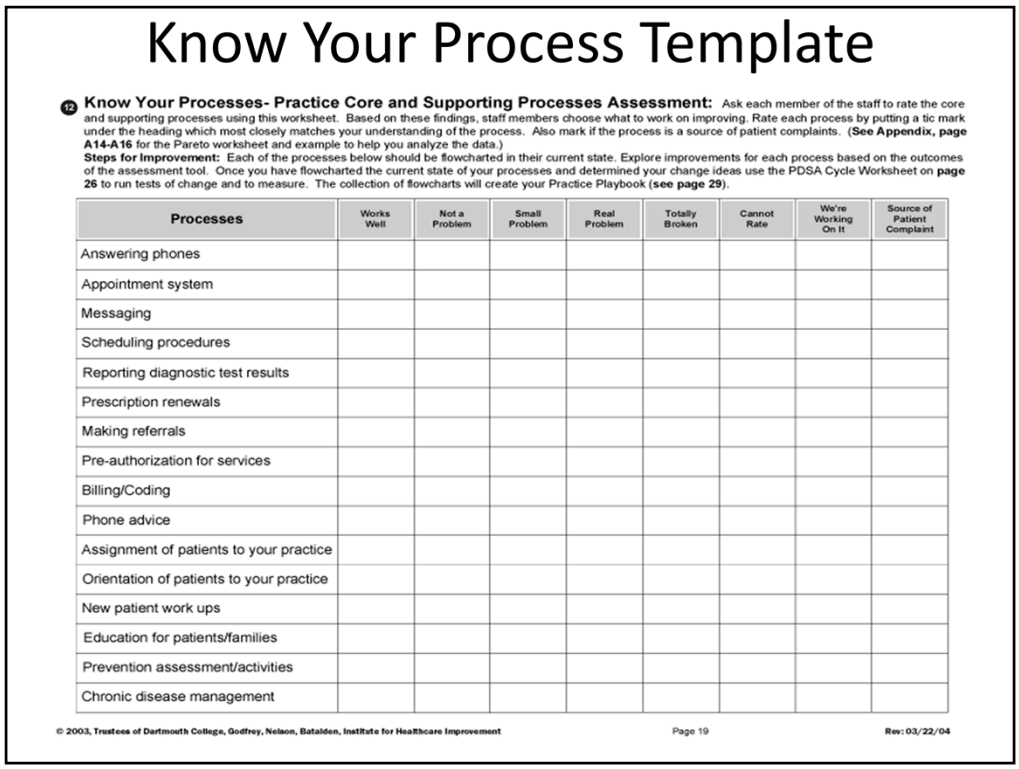
After Step 6 Your next step will be to PDSA one of the identified fixes for improvement

Step 1: Agree on a process to map: (HAVE A PLAN) Consider surveying your staff, patients, or others on which processes are the biggest problems Process that are the most time consuming, most labor-intensive, have the most complaints, etc.

Refer to your "Know Your Processes" assessment template for guidance.

Step 2: Agree on a beginning and end - IMPORTANT when you start high-level flowchart

Know Your Process Template



12 Know Your Processes- Practice Core and Supporting Processes Assessment: Ask each member of the staff to rate the core and supporting processes using this worksheet. Based on these findings, staff members choose what to work on improving. Rate each process by putting a tic mark under the heading which most closely matches your understanding of the process. Also mark if the process is a source of patient complaints. (**See Appendix, page A14-A16** for the Pareto worksheet and example to help you analyze the data.)
Steps for Improvement: Each of the processes below should be flowcharted in their current state. Explore improvements for each process based on the outcomes of the assessment tool. Once you have flowcharted the current state of your processes and determined your change ideas use the PDSA Cycle Worksheet on **page 26** to run tests of change and to measure. The collection of flowcharts will create your Practice Playbook (**see page 29**).

Processes	Works Well	Not a Problem	Small Problem	Real Problem	Totally Broken	Cannot Rate	We're Working On It	Source of Patient Complaint
Answering phones								
Appointment system								
Messaging								
Scheduling procedures								
Reporting diagnostic test results								
Prescription renewals								
Making referrals								
Pre-authorization for services								
Billing/Coding								
Phone advice								
Assignment of patients to your practice								
Orientation of patients to your practice								
New patient work ups								
Education for patients/families								
Prevention assessment/activities								
Chronic disease management								

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Rev: 03/22/04

Ask each member of the staff to rate the core and supporting processes using this worksheet.

Based on these findings, staff members chose what to work on improving.

Rate each process by putting a tic mark under the heading which most closely matches your understanding of the process.

Impact & Complexity Grid

- Build Complexity:
  - ✓ Low Complexity/High Impact
  - ✓ Low Complexity/Low Impact
- Next Stage:
  - ✓ High Complexity/High Impact
- Avoid Option #4:
  High Complexity/Low Impact

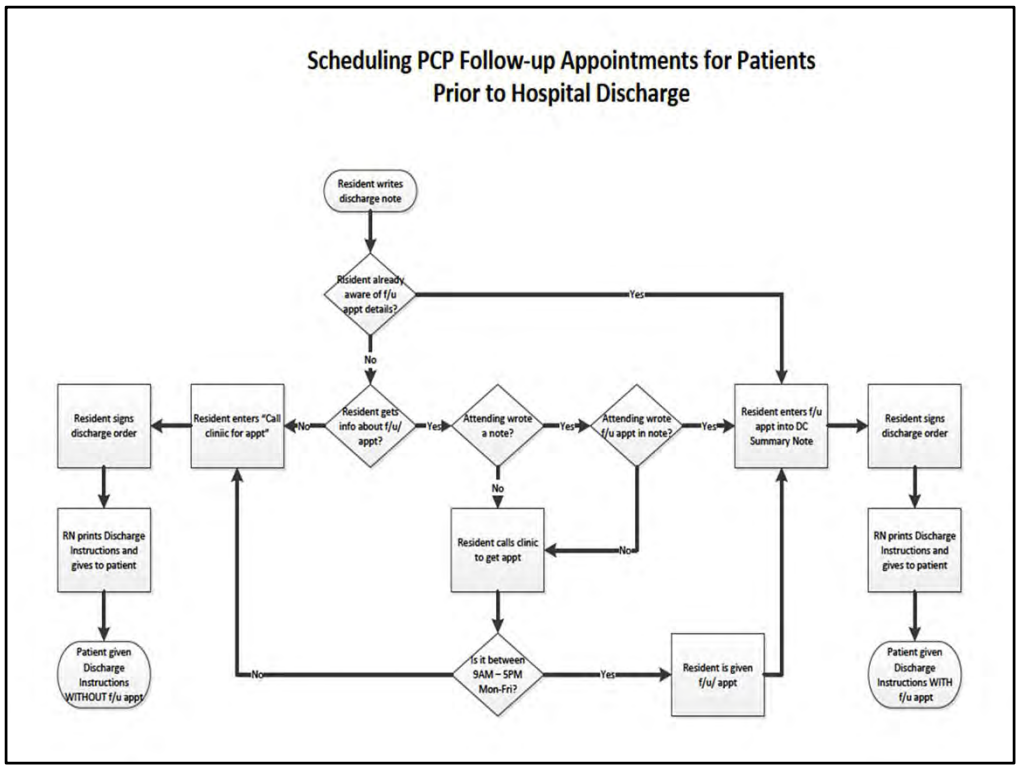
	Low Impact	High Impact
High Complexity	High Complexity/Low Impact (Option #4)	High Complexity/High Impact (Option #3)
Low Complexity	Low Complexity/Low Impact (Option #2)	Low Complexity/High Impact (Option #1)

8/4/2015

Give 2 examples from needs assessment to conduct

DO NOT USE WITH TEAMLET. Only one right answer. The reason we are showing this to you, is for you to use it and select low complexity processes. If for some reason, you have a highly functional team, then you might consider jumping into a higher complexity process. But what you do not want is taking on if not ready. Digest this.

To be successful, build hope that they can change something. IC should know that not all processes are created equal. Your job as an IC is to help teams


Scheduling PCP Follow-up Appointments for Patients Prior to Hospital Discharge
Resident writes discharge note
Resident already aware of f/u appt details?
Yes
No
Resident signs discharge order
Resident enters "Call cliniic for appt"
No
Resident gets info about f/u/ appt?
Yes
Attending wrote a note?
Yes
Attending wrote f/u appt in note?
Yes
Resident enters f/u appt into DC Summary Note
Resident signs discharge order
No
RN prints Discharge Instructions and gives to patient
Resident calls clinic to get appt
No
RN prints Discharge Instructions and gives to patient
Patient given Discharge Instructions WITHOUT f/u appt
No
Is it between 9AM – 5PM Mon-Fri?
Yes
Resident is given f/u/ appt
Patient given Discharge Instructions WITH f/u appt

How to Analyze my Map

You can use your process map to assess problem areas or potential areas for improvement by examining some of the following:

- ✓ Bottlenecks and other sources of delay
- ✓ Rework due to errors
- ✓ Role ambiguity
- ✓ Duplicated efforts
- ✓ Unnecessary steps
- ✓ Sources of waste
- ✓ Variation
- ✓ Hand-offs

Tips on Mapping

- Be sure to map current process
- Get key players involved and their input
- Recognize that any flowchart will take multiple attempts to complete
- Leverage existing experts and experiences

Workflow Mapping Exercise

- Break into groups of 5 to 6
- Be sure to have:
  - Poster board paper
  - Post-its (or 5x6 index cards)
  - Marker
- Pick a leader and a scribe
- Ground rules:
  - State process: Making coffee
  - Define beginning and end points
  - Assumptions: you already have coffee, a coffee pot, and you do not have a Keurig

Questions to Ask

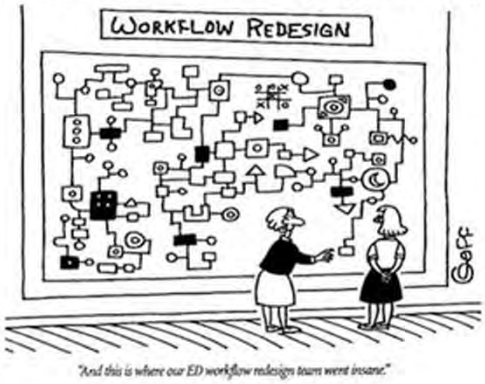
- Who knows what a workflow map is?
- Who has experience in workflow mapping?
- Did you consider your start and end points? What were they and how did your team come to this conclusion?
- How did you deal with process agreements/disagreements?
- Did everyone have input? If not, why?

In Conclusion

- The 3 types of flowcharts include: High-level, Detailed, and Swimlane flowcharts
- Flowcharts are used to map current processes, identify barriers and opportunities to increase efficiency, and to train newly hired staff of a process
- There are 6 major steps in mapping a flowchart
- There are a series of questions that need to be discussed after you develop your map that ask about repetition, role maximization, and decision points

Remember

Workflow maps serve as a tool to improve care for patients, improve efficiency in practice, and redistribute work and job responsibilities.



"And this is where our ED workflow redesign team went insane."

Thank You!

LA Net Community Health Resource Network

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www.lanetpbrn.net

Workflow mapping:
a tool for achieving meaningful use

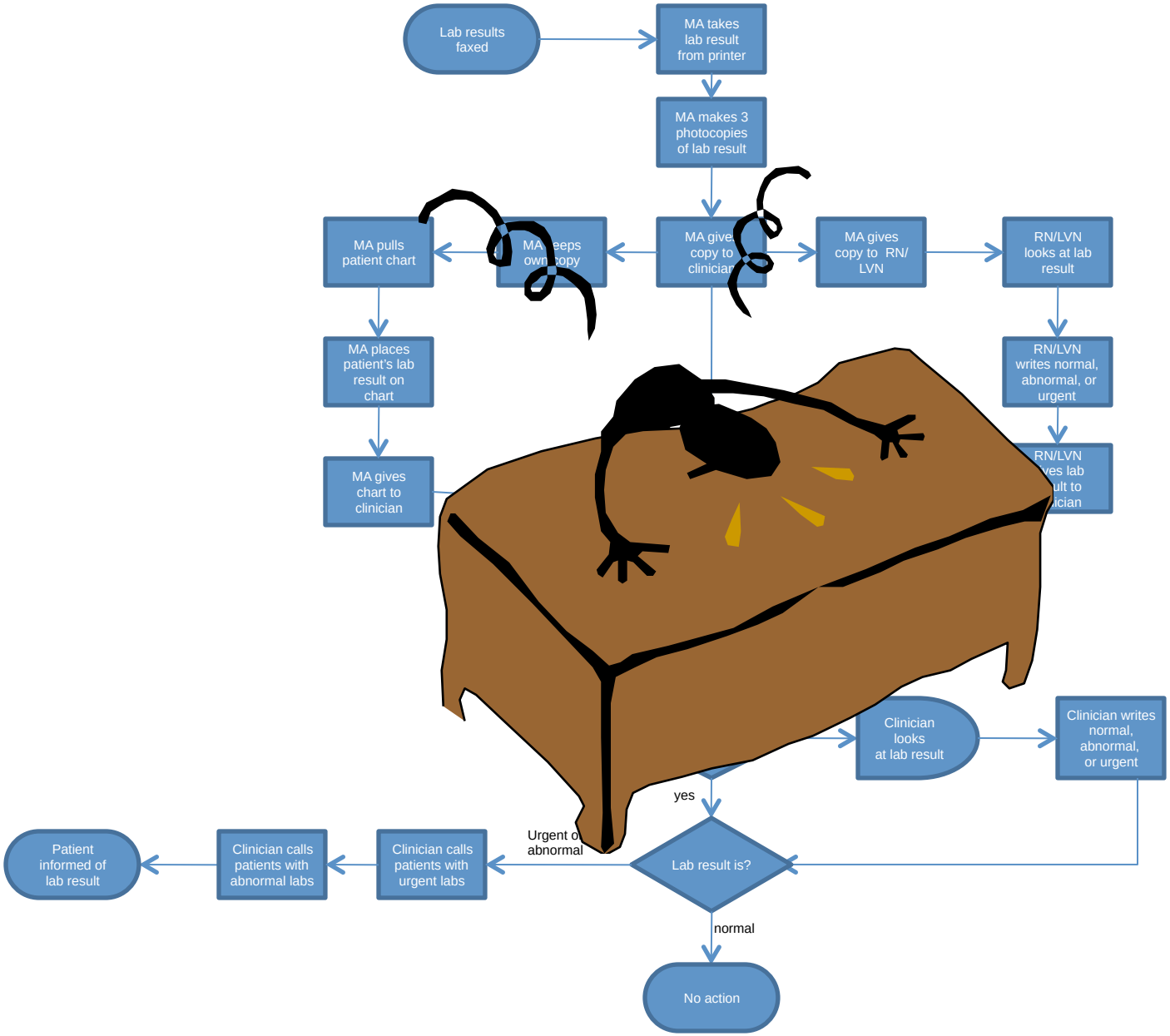
Center for Excellence in Primary Care
UCSF Department of Family
and Community Medicine

Tom Bodenheimer, MD

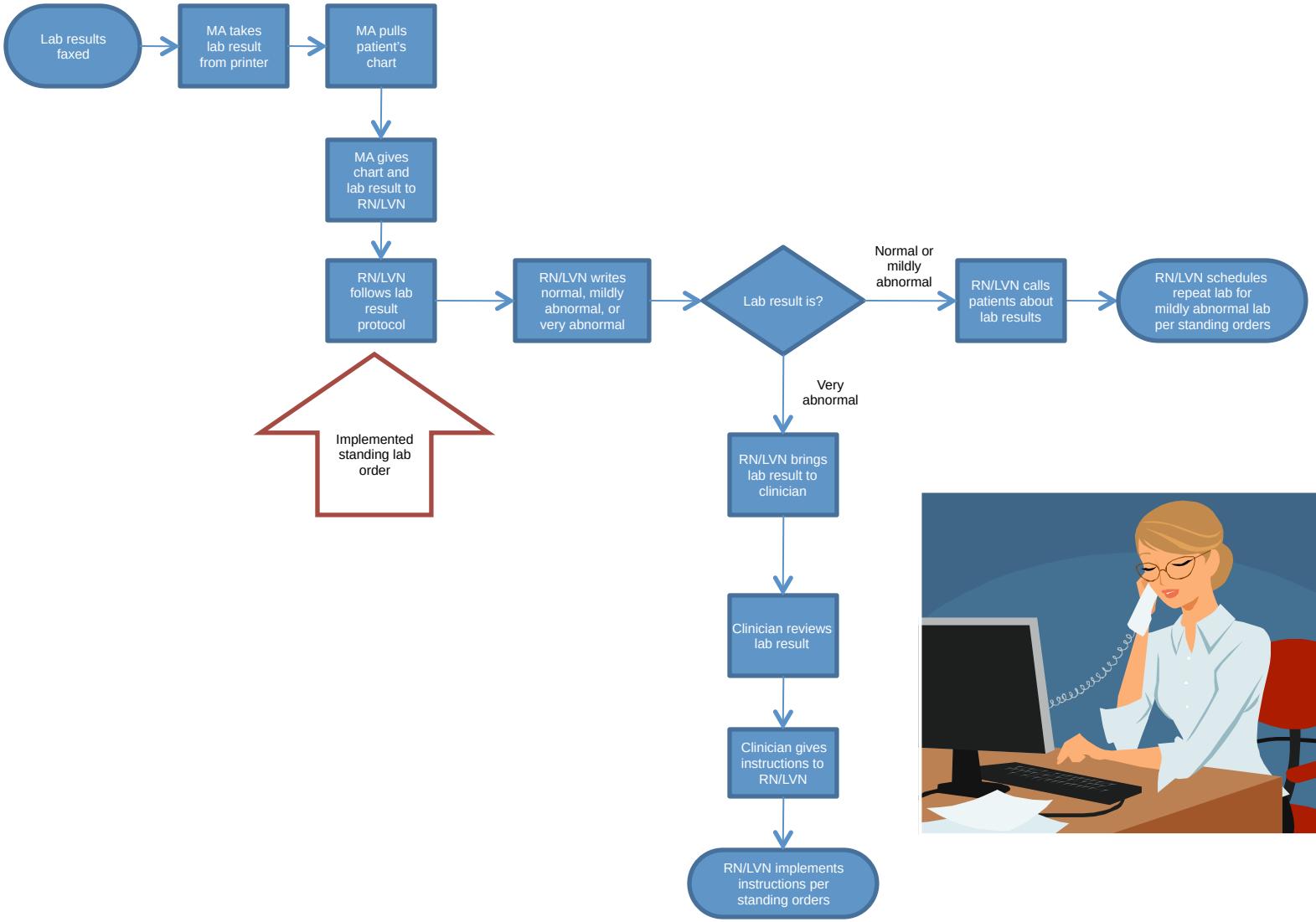
Goals

- Explain workflow mapping
- Discuss why workflow mapping is useful prior to and after EHR implementation
- Demonstrate how to create workflow maps
- Review some meaningful use workflow examples

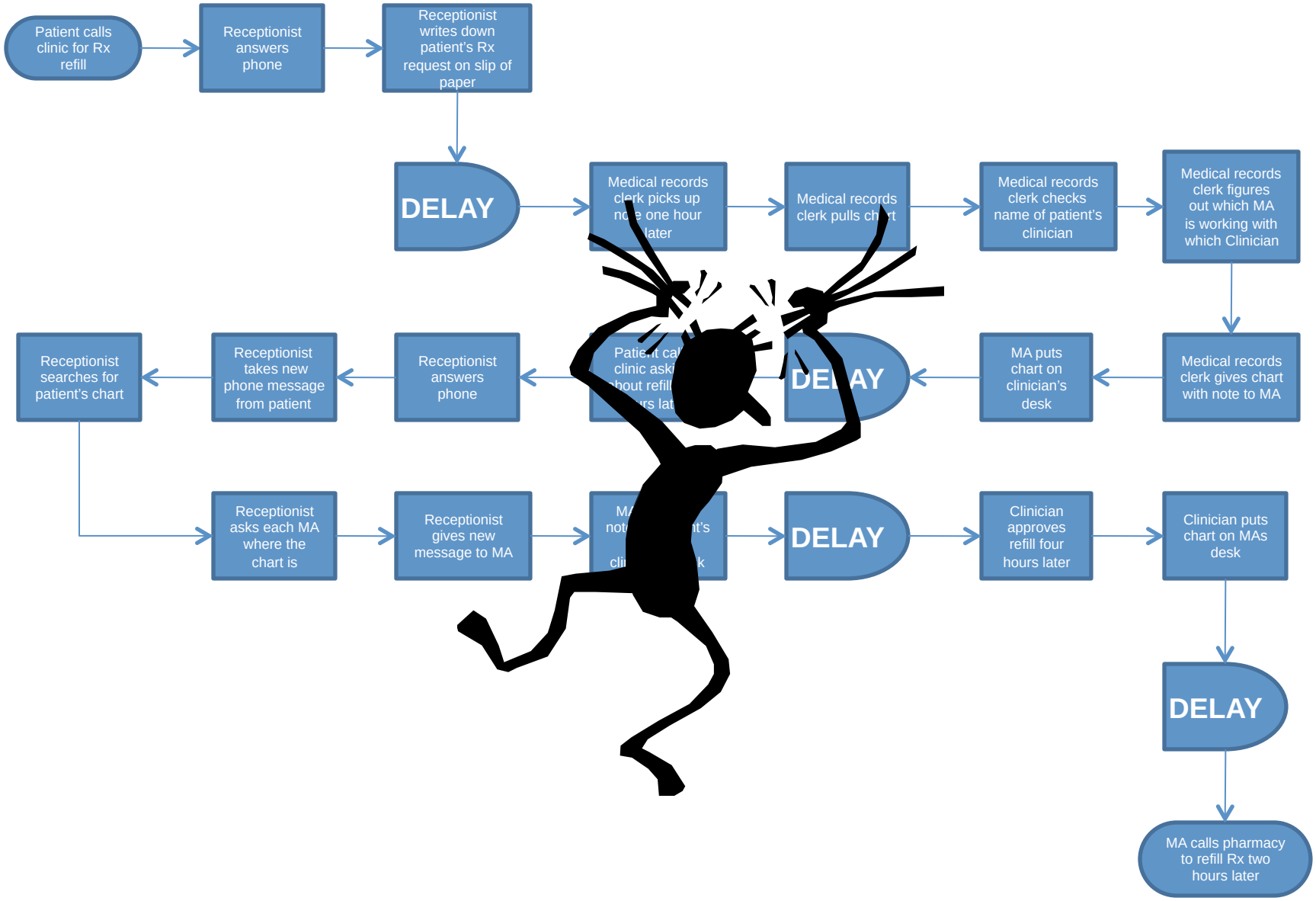
Example 1a: How *not* to provide lab results to your patients



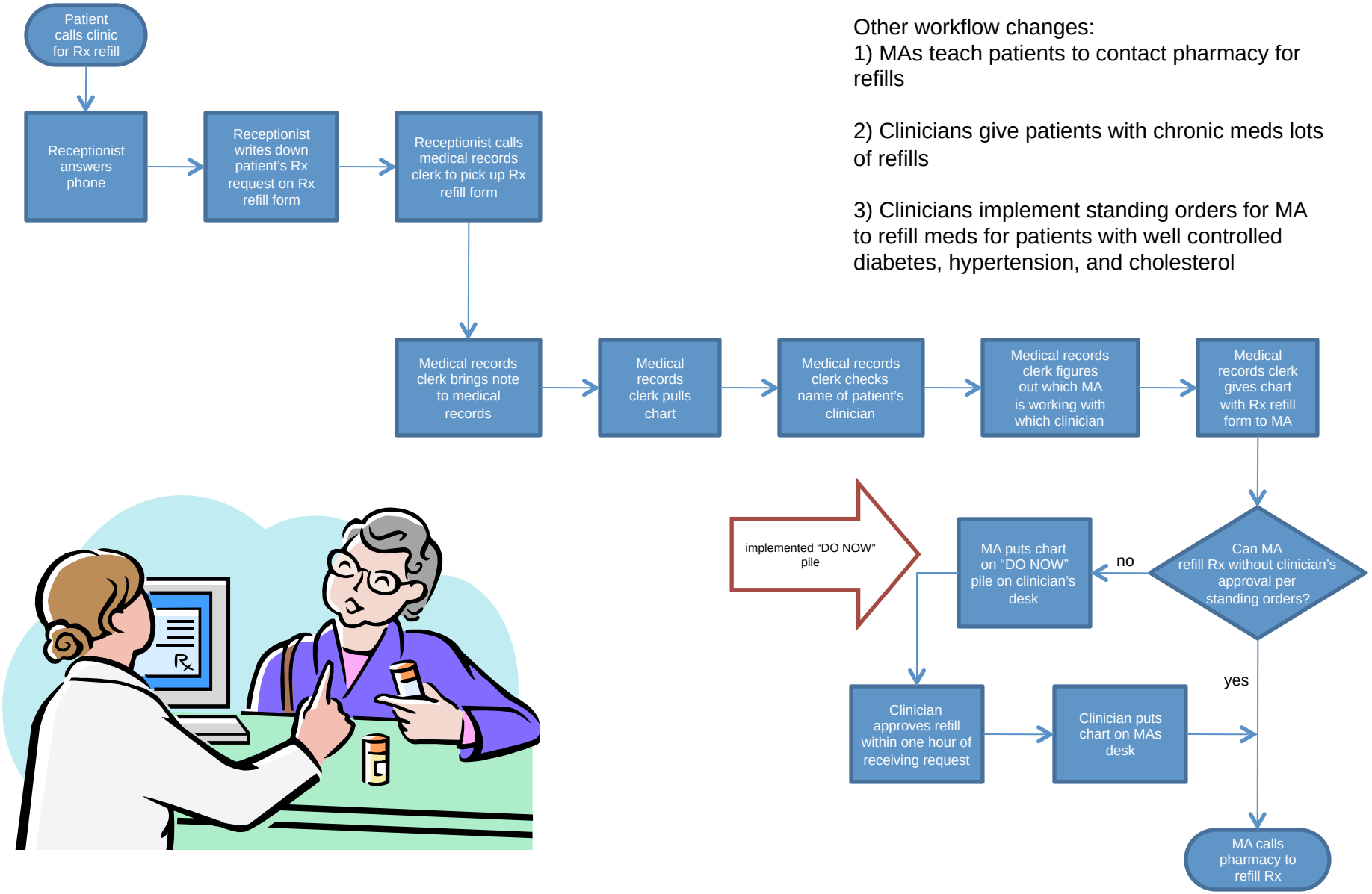
Example 1b: Lab result follow-up after workflow mapping



Example 2a: How *not* to do Rx refills



Example 2b: Rx refills after workflow mapping



Other workflow changes:
1) MAs teach patients to contact pharmacy for refills

2) Clinicians give patients with chronic meds lots of refills

3) Clinicians implement standing orders for MA to refill meds for patients with well controlled diabetes, hypertension, and cholesterol

What is a workflow map?

- **A visual representation of a process**
  - **A process is a series of actions, steps, or tasks performed in a certain order to achieve a certain result**
- **Defines the beginning of a process, the end of a process, and all the steps in-between**
- **Defines who does what in the process**
- **A measurement of what *IS***

Workflows before implementing EHR are different from those after

Practice Manager

EHR adoption

Practice Manager

Workflow mapping pre-EHR reveals inefficiencies and waste

- Workflow mapping helps practices
  - Identify inefficiencies, waste, and dangers
  - Eliminate wasteful steps
  - Streamline complicated workflows
  - Standardize how work is done
- Example 1 (lab results): workflow mapping uncovered unnecessary steps that could easily be eliminated, making life easier for physicians and staff
- Example 2 (rx refills): workflow mapping showed that big changes were needed to eliminate waste and reduce patient delays

Workflow mapping pre-EHR: Tailor EHR to meet practice needs

- Mapping out processes before EHR implementation helps practices decide how to use the EHR
- Workflow mapping demonstrates what protocols and standing orders are needed to redistribute work
- Workflow maps help practices work with their EHR vendor so that the vendor understands how each person will use the EHR
- Examples 1 and 2: protocols and standing orders written pre-EHR adoption delineate who does what, which facilitates implementation of the EHR

Workflow mapping post-EHR: EHR is a huge change

- **Going from paper to EHR changes every single thing in a practice**
- **Roles will change**
  - **What will medical records clerks do?**
  - **Medical assistants will enter vital signs electronically and provide more services in the rooming process**
  - **Clinicians will type progress notes and use templates**
  - **E-prescribing often shifts all refill work to Clinicians' inboxes**
- **Example 2 (rx refill): Post-EHR workflow can be set up so that Clinicians do not handle every refill. This depends on pre-EHR workflow redesign**

Workflows post-EHR: shows practices how best to use EHR

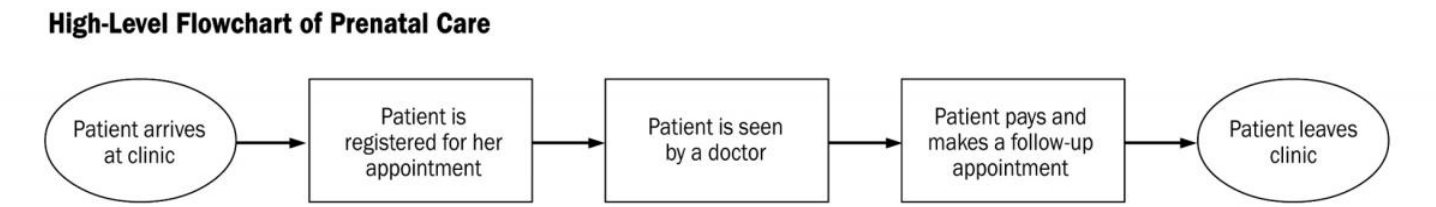
- EHR implementation tends to push work back onto the Clinician. Workflow mapping can prevent this
- Workflow mapping helps staff look at entire process and think how their work fits into a larger system
- Workflow maps help practices decide which personnel they need post-EHR
- Example 1 (lab results): If a practice does not have a RN or LVN, Clinicians need to review all labs. If the practice wants to delegate lab review to another team member, the practice would need a RN or LVN because MAs cannot review labs. Also, the practice will not need a medical records person.

Who's involved with workflow mapping?

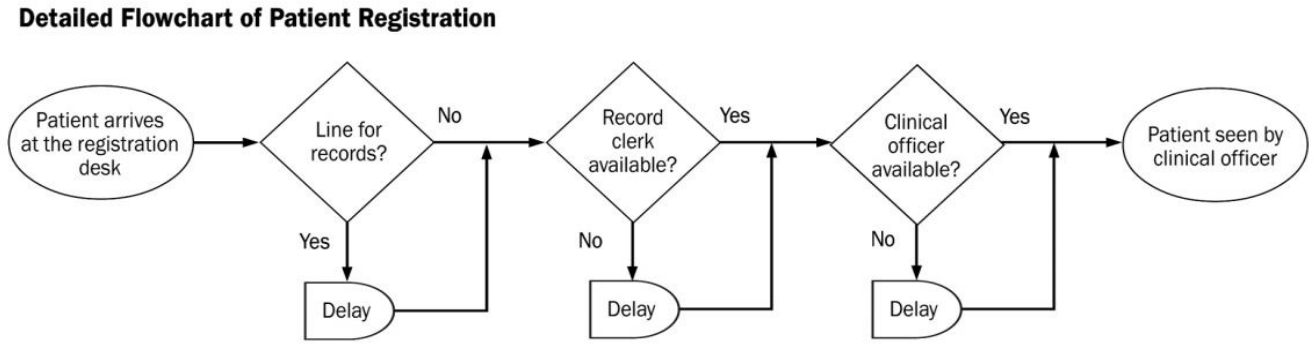
- **One designated person**
  - **Oversees the team and keeps tasks on track**
  - **Understands all aspects of the process in detail**
  - **Drafts the initial workflow map**
- **The team**
  - **Decides what processes to map**
  - **Everyone involved in a workflow should be part of the mapping process**
  - **Discusses accuracy of the workflow map after it's been drafted**
  - **Perfects the process and maps it out**

Types of workflow maps

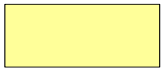
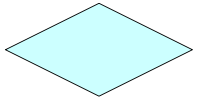
High-Level Flowchart: Shows the major steps of a process. A high-level (also called first-level or top-down) flowchart illustrates a "birds-eye view" of a process.



Detailed Flowchart: Provides a detailed picture of a process by mapping all of the steps and activities that occur in the process. This type of flowchart includes such things as decision points, waiting periods, tasks that frequently must be redone (rework), and feedback loops. This type of flowchart is useful for examining areas of the process in detail and for looking for problems or areas of inefficiency.



Know your symbols

	**START/END:** Indicates the start and end points of a process
	**OPERATION:** A specific task or activity that is performed
	**DECISION POINT:** A point in the process where a yes/no question or a decision is required before moving on to the next step
	DIRECTION: Arrows connect steps in the process and direct flow of information
	**DELAY:** Indicates the workflow goes into a wait
	**OFF-PAGE CONNECTOR:** Refers to a process located on another page
	**ON-PAGE REFERENCE:** Refers to a step in the process located on the same page
	**UNCLEAR:** Use this when a step in the process is unknown or not clear

Note: There are many more symbols than those listed, but these are the most commonly used ones

Simple steps for workflow mapping

- **Step 1. Pick a process to map out, pick which type of workflow to use, and agree on its purpose**
- **Step 2. Determine the beginning and end points**
- **Step 3. Identify each step in the process**
- **Step 4. Put the steps in order**
- **Step 5. Review and edit the first draft**
- **Step 6. After a day or two, review the flowchart with the team for input**

What to do with your workflow map

- **Look at your workflow map and examine it**
  - **Beginning and end points**
  - **Each activity and wait symbol**
  - **Decision points**
  - **Hand-offs (where one person finishes his or her part of the process and another person picks it up)**
- **Ask questions about the workflow map**
  - **Does that step really need to be there?**
- **Map out the improved process**

How *not* to do workflow mapping

- **Map out the processes you *wish* you had**
- **Interview a few key informants to understand the process instead of shadowing everyone involved in the process**
- **Ignore the opinions of those people who know the process best**
- **Put your workflow map on the shelf and don't look at it again**

Achieving meaningful use requires workflow change

- **Meeting meaningful use requires practice staff to perform functions they may not have performed before**
  - **Example: Practices will need to provide patients with an after visit summary**
- **Meeting meaningful use requires efficient high-quality and patient-centered use, not just any use, of the EHR**

Meaningful use criteria: Stage 1

Core requirement	Workflow changes needed?	Workflow change ideas
Record patient demographics	Yes	Someone in the practice needs to enter and update demographics
Record vital signs electronically	Yes	Medical assistant adds to rooming tasks: calculating BMI, entering height, weight, BP, growth charts into EHR
Maintain up-to-date problem list	Yes	Clinicians often fail to keep problem lists updated. MA reviews problem list during rooming and reminds clinician to update. MA does not make updates in EHR
Maintain active med list	Yes	MA does med-rec during rooming and makes or pends updates in EHR
Maintain active allergy list	Yes	MA has series of questions about allergies and is responsible for this task
Record smoking status	Yes	MA adds this to rooming task and could do brief counseling (readiness to change, perhaps call state quit line)

Core requirement	Workflow changes needed?	Workflow change ideas
Provide patients with clinical summaries for each office visit	Yes	The clinician does this and trains MA to carry it out
E-prescribing	Yes	For initial prescriptions, clinicians do the e-prescribing, but for some chronic refills, MA could do the refill based on standing orders from clinician
Drug-drug and drug-allergy interaction checks	No	
Exchanging electronic information with other sites of care	Yes	Care coordinator (probably RN) can assist clinicians with this, particularly tracking/follow-up. If there is no RN, a workflow map would show which steps could be performed by a non-clinician staff person
Implement a decision support rule and track compliance with the rule	Yes	Tracking compliance could be done by RN care manager
Systems to protect privacy and security of patient data	No	
Report clinical quality measures to CMS or states	Yes	Someone would be responsible, perhaps practice manager. The responsible person would need training in CQI, numerators and denominators, measures, etc.

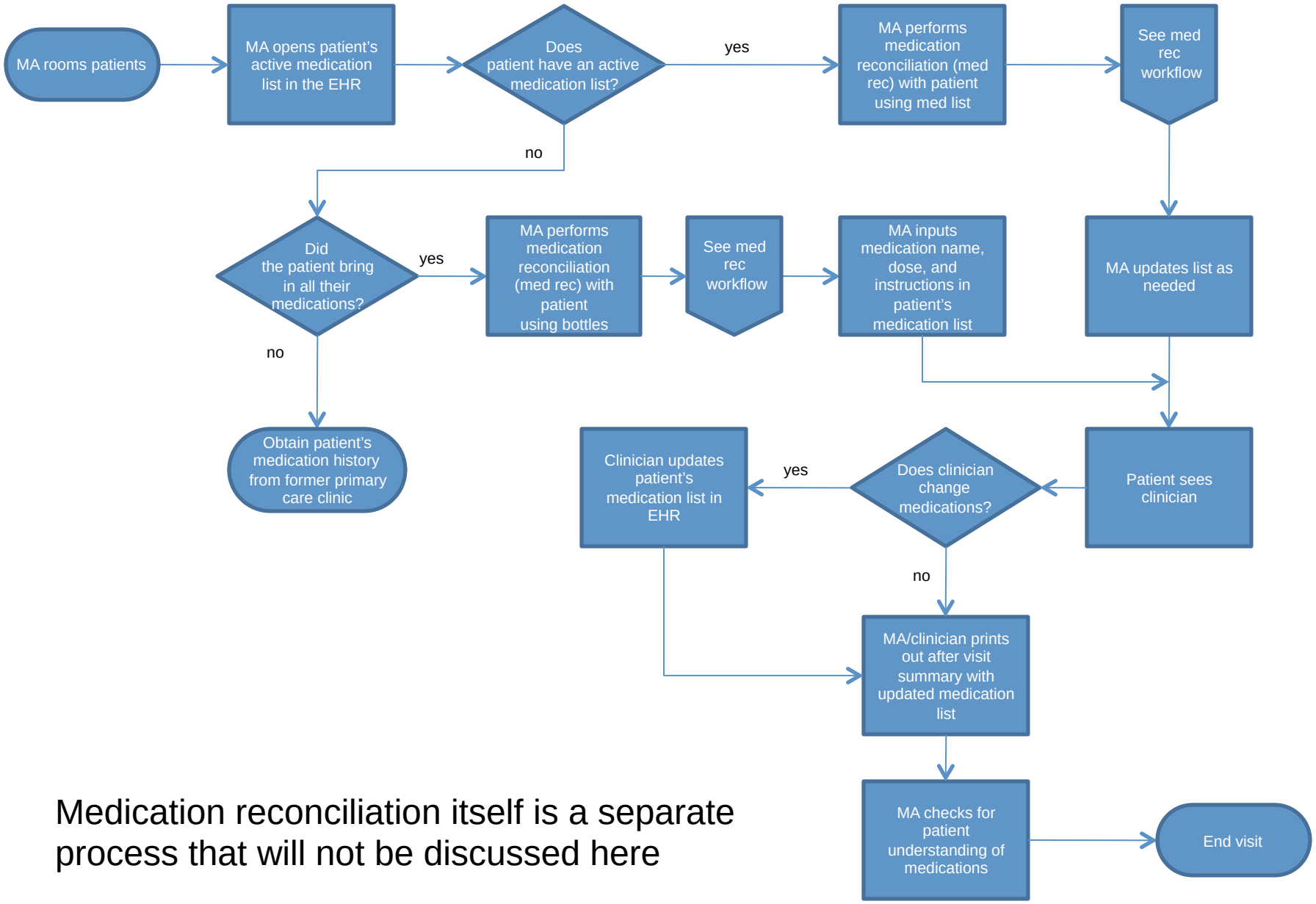
Menu of additional tasks (choose 5 out of 10)	Workflow changes needed?	Workflow change ideas
Drug formulary check system	No	
Lab results into EHR	No	
Generate lists of patients for QI or outreach (registry)	Yes	The generation of the lists is a technical issues, but panel managers will be needed to work the lists to see which patients need which services, and provide out-reach or in-reach. MAs could be the panel managers except their workload is becoming excessive. MAs would do in-reach.
Electronic health education resources	Yes	Health educator is responsible (if available), but clinicians/MAs would also provide the information to patients
Med reconciliation between care settings	Yes	Between settings is complex, but within the primary care practice, MA can do med-rec as part of rooming
Summary of care record for referrals and transitions	Yes	This is mainly a clinician function but it also needs to be tracked and reminders done (MA and/or RN care coordinator)
Immunization data to regional registries	Yes	Someone on team responsible
Surveillance data to public health agencies	Yes	Someone on team responsible
Patient reminders for prevention/ chronic care	Yes	This is a panel manager task
Patient access to lab results, problem and med lists, allergies	Yes	Creating a secure patient portal is technical issue, but actually providing the information would be an MA task

Suggested workflows for meaningful use

- **The following workflow are examples**
- **How your practice works may be different**
- **Pilot the EHR workflows with one MA or one receptionist and one clinician and a couple of patients to see if they work**

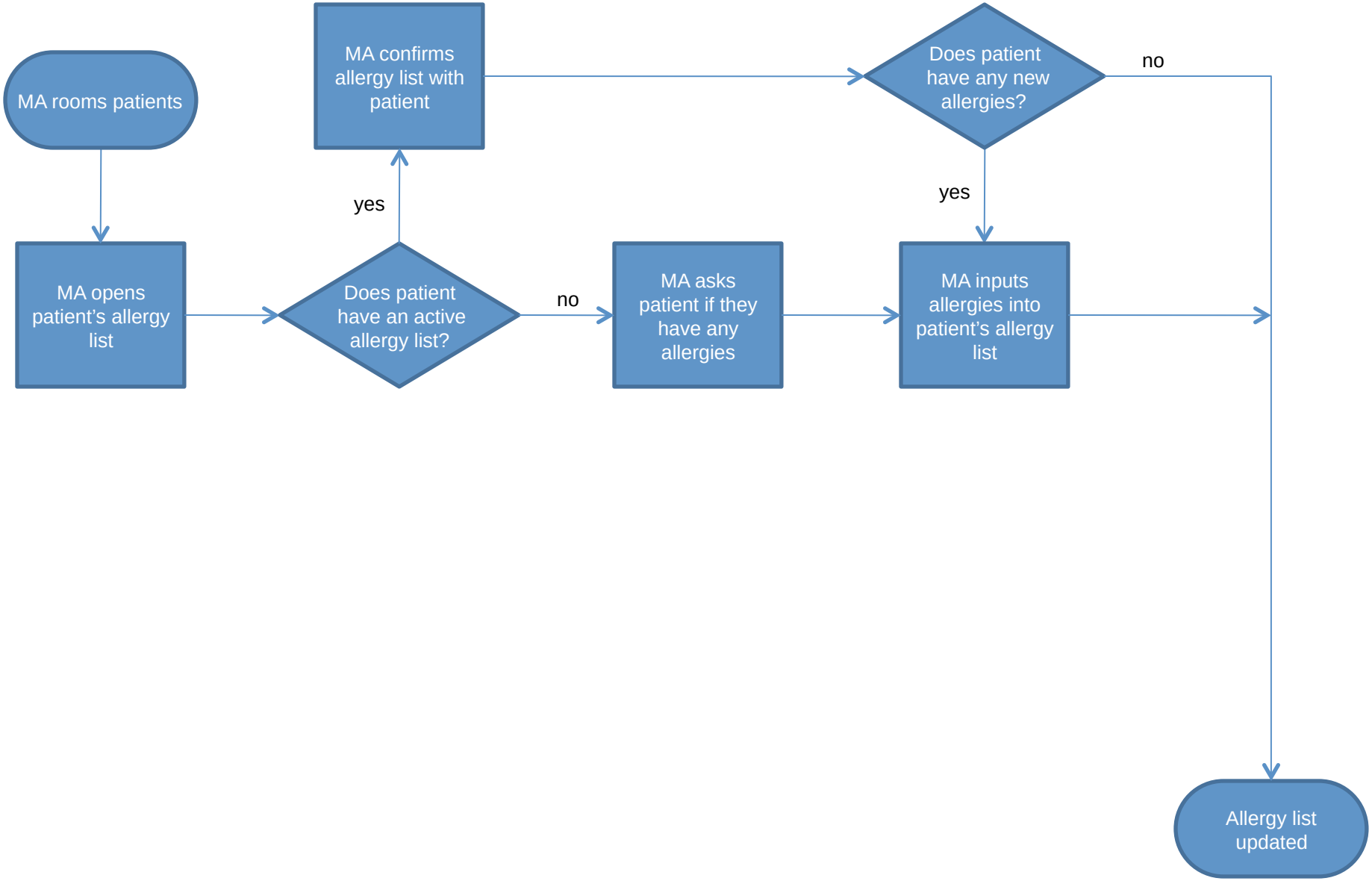
Example flowchart: documenting vital signs (example, blood pressure)

Example flowchart: maintaining active medication lists

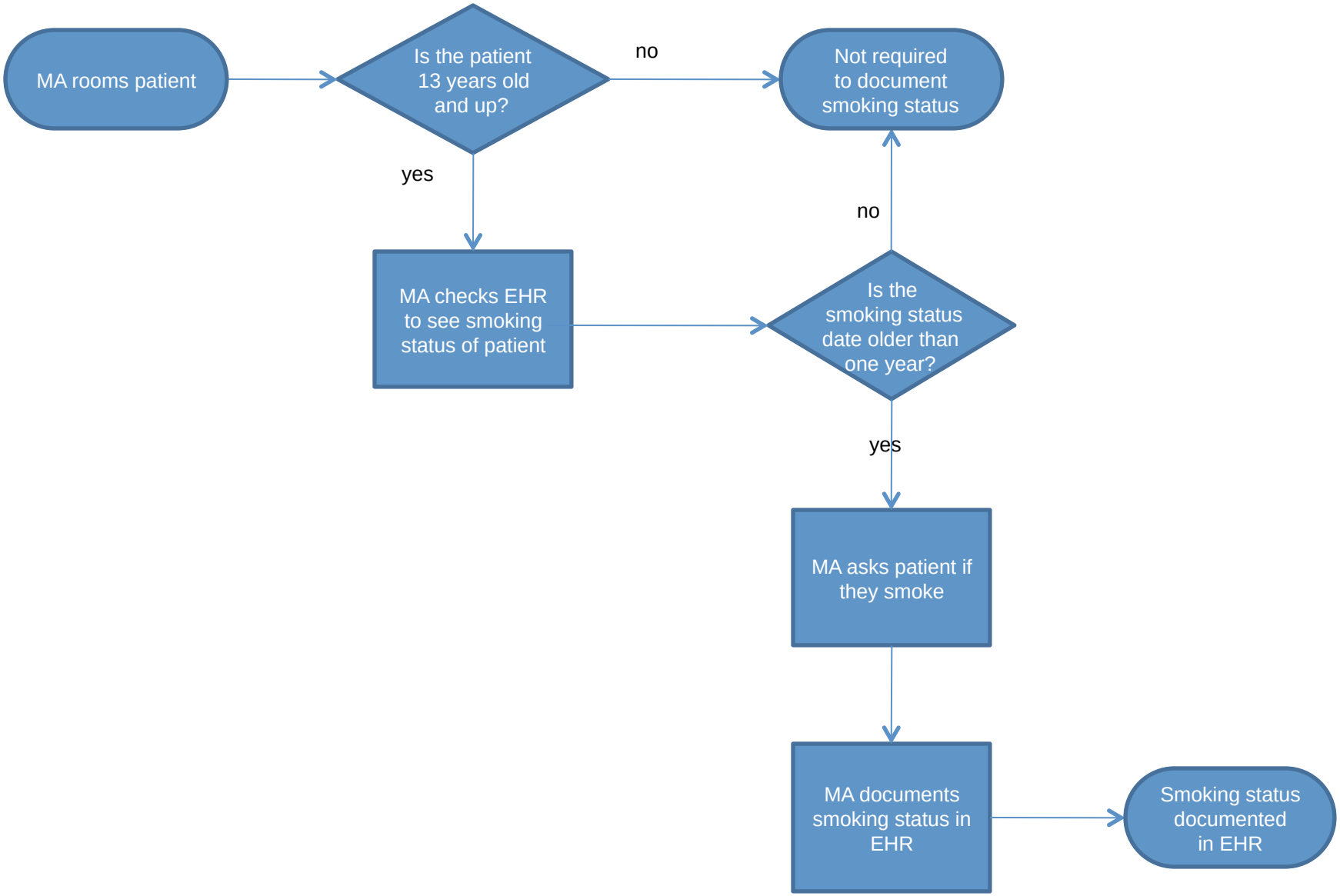


Medication reconciliation itself is a separate process that will not be discussed here

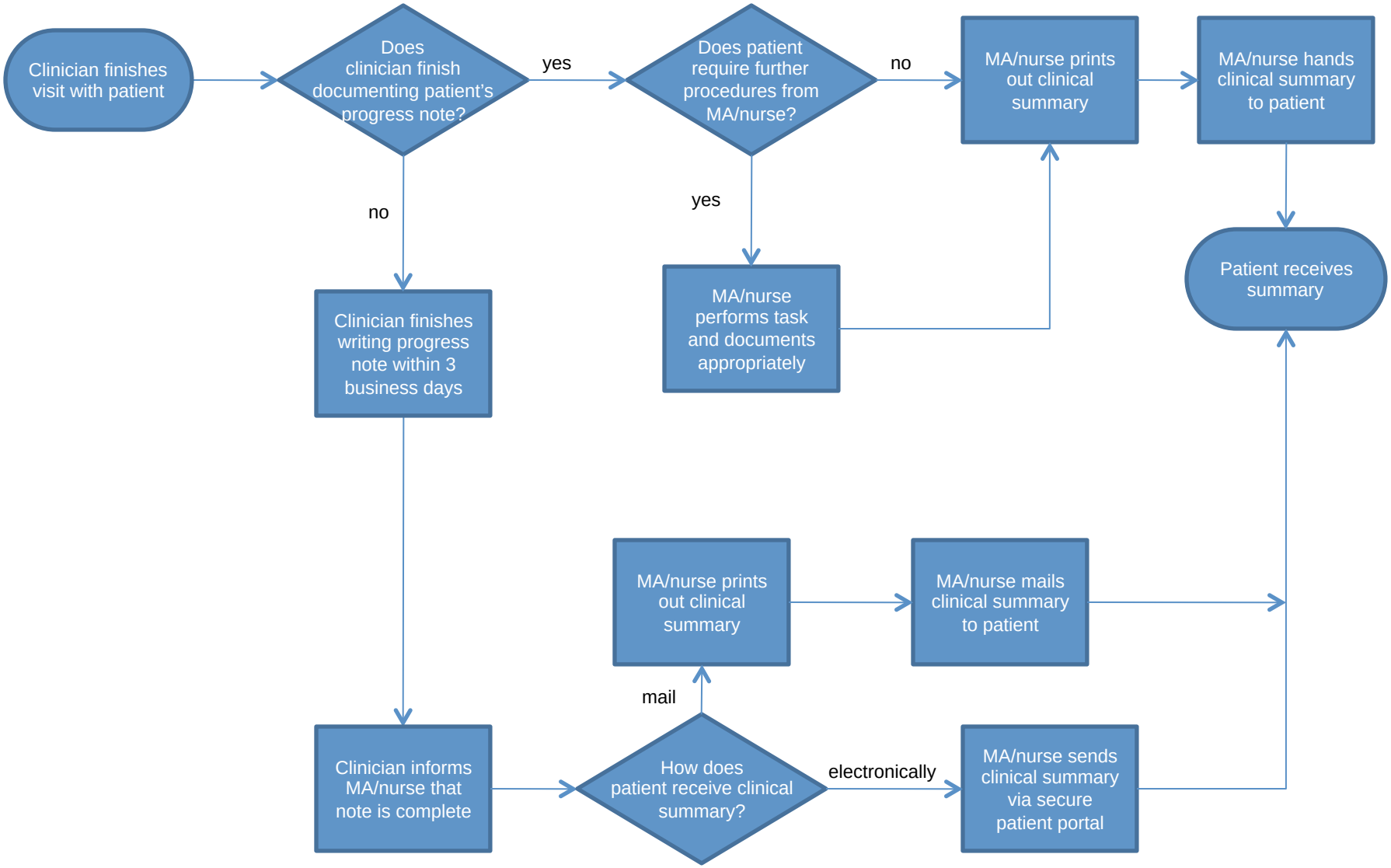
Example flowchart: maintaining active allergy lists



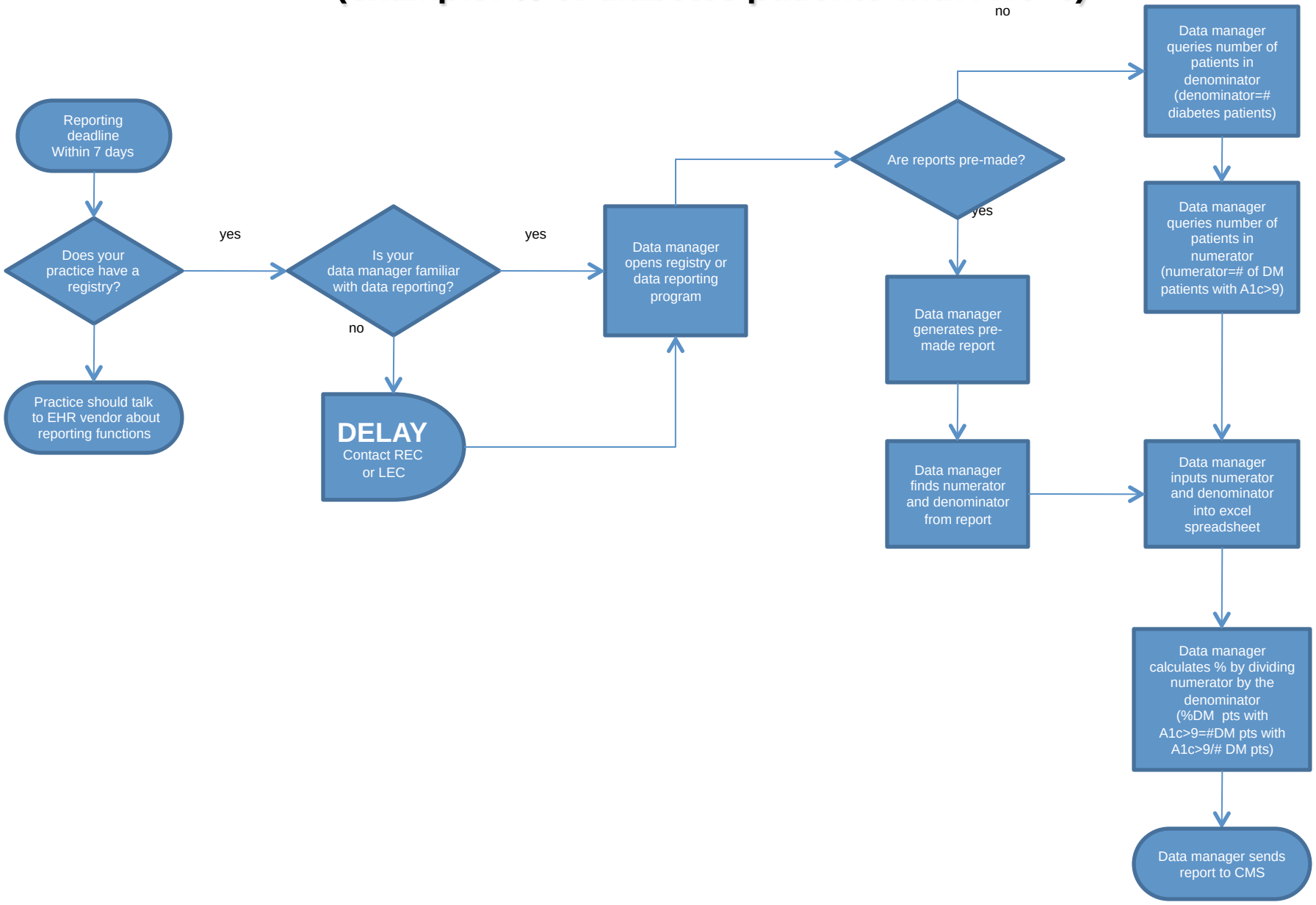
Example flowchart: documenting smoking status for patients 13 and up



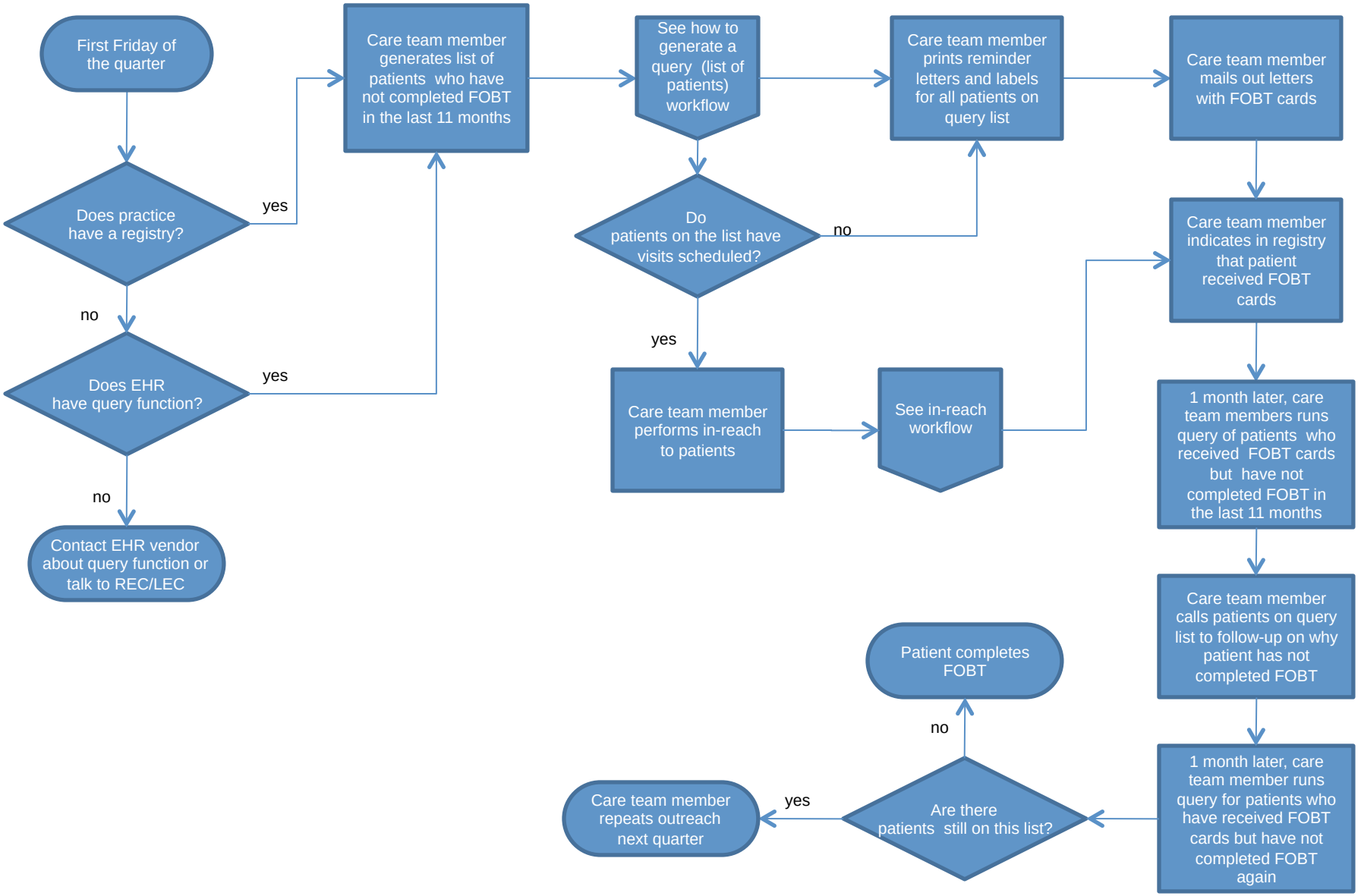
Example flowchart: providing clinical summaries at the conclusion of appointments



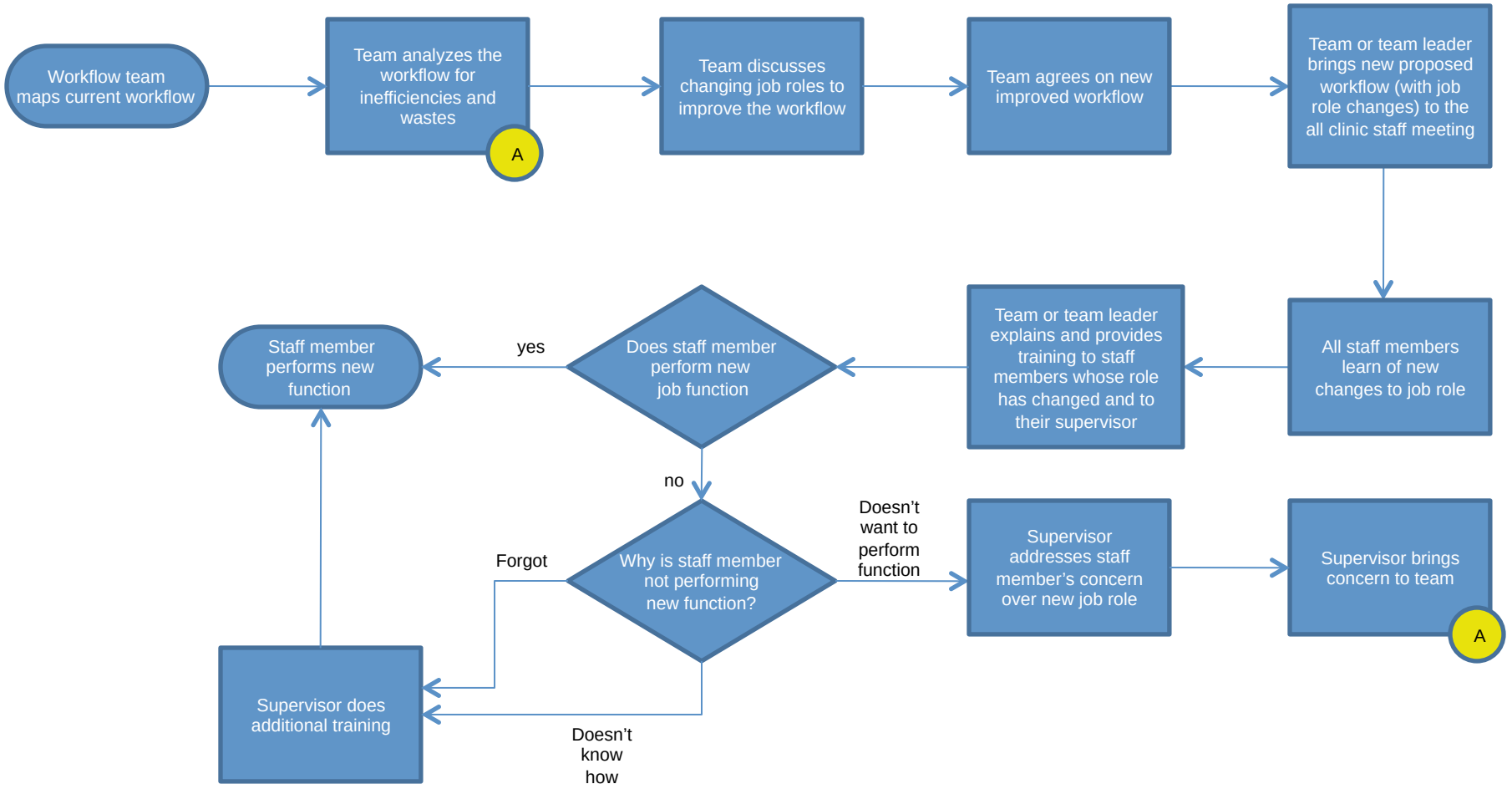
Example flowchart: reporting on clinical quality measures to CMS (example: % of diabetes patients with A1c>9)



Example flowchart: reminders to patients for preventive and follow up care (example: outreach to patients due for annual FOBT)



Example flowchart: how to change a job role using lab result follow up as an example



This is not a meaningful use requirement but will be needed to achieve meaningful use

Conclusion

- **Workflow mapping is a great tool to help implement EHR and achieve meaningful use**
- **EHR adoption does not equal meaningful use**
- **Workflow maps are a tool to improve care for patients, improve efficiency in practice, and redistribute work and job roles**

Appendix 12A. Change Process Capability Questionnaire (CPCQ)

How would you describe the approach to quality improvement in your medical group or clinic?

	strongly disagree	somewhat disagree	neither agree or disagree	somewhat agree	strongly agree	NA
1. Clinicians in our medical group/clinic believe that high quality care is very important	1	2	3	4	5	8
2. We have greatly improved the quality of care in the past year	1	2	3	4	5	8
3. We choose new processes of care that are more advantageous than the old to everyone involved (patients, clinicians, and our entire medical group/clinic)	1	2	3	4	5	8
4. Our resources (personnel, time, financial) are too tightly limited to improve care quality now	1	2	3	4	5	8
5. Our medical group/clinic operations rely heavily on organized systems	1	2	3	4	5	8
6. The thinking of our leadership is strongly oriented toward systems	1	2	3	4	5	8
7. Our medical group/clinic attaches more priority to quality of care than to finances	1	2	3	4	5	8
8. The clinicians in our medical group/clinic espouse a shared mission and policies	1	2	3	4	5	8
9. The clinicians in our medical group/clinic adhere to medical group/clinic policies	1	2	3	4	5	8
10. Our medical group/clinic leadership is strongly committed to the need for quality improvement and for leading that change	1	2	3	4	5	8
11. Our medical group/clinic has well-developed administrative structures and processes in place to create change	1	2	3	4	5	8
12. Our medical group/clinic is undergoing considerable stress as the result of internal changes	1	2	3	4	5	8

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	strongly disagree	somewhat disagree	neither agree or disagree	somewhat agree	strongly agree	NA
13. The working environment in our medical group/clinic is collaborative and cohesive, with shared sense of purpose, cooperation, and willingness to contribute to the common good	1	2	3	4	5	8
14. The clinicians in our medical group/clinic are very interested in improving care quality	1	2	3	4	5	8
15. We have many clinician champions interested in leading the improvement of care quality	1	2	3	4	5	8
16. Our medical group/clinic understands and uses quality improvement skills effectively	1	2	3	4	5	8
17. The leaders of our efforts to improve care quality are enthusiastic about their task	1	2	3	4	5	8
18. Our medical group/clinic has a well-defined quality improvement process for designing and introducing changes in the quality of care	1	2	3	4	5	8

Our medical group/clinic has used the following strategies to implement improved care quality…

	strongly disagree	somewhat disagree	neither agree or disagree	somewhat agree	strongly agree	NA
19. Providing information and skills-training	1	2	3	4	5	8
20. Use of opinion leaders, role modeling, or other vehicles to encourage support for changes	1	2	3	4	5	8
21. Changing or creating systems in the medical group/clinic that make it easier to provide high quality care	1	2	3	4	5	8
22. Removal or reduction of barriers to better quality of care	1	2	3	4	5	8
23. Organizing people into teams focused on accomplishing the change process for improved care	1	2	3	4	5	8
24. Delegating to non-physician staff the responsibility to carry out aspects of care that are normally the responsibility of physicians	1	2	3	4	5	8

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	strongly disagree	somewhat disagree	neither agree or disagree	somewhat agree	strongly agree	NA
25. Providing to those who are charged with implementing improved care the power to authorize and make the desired changes	1	2	3	4	5	8
26. Using periodic measurement of care quality for the purpose of assessing compliance with any new approach to care	1	2	3	4	5	8
27. Reporting measurements of individual or care unit performance for comparison with their peers	1	2	3	4	5	8
28. Setting goals and benchmarking rates of performance quality at least yearly	1	2	3	4	5	8
29. Customizing the implementation of any care changes to each site of care	1	2	3	4	5	8
30. Use of rapid cycling, piloting, pre-testing, or other vehicles for reducing the risk of negative results from introducing organization-wide change in care	1	2	3	4	5	8
31. Deliberately designing care improvements so as to make physician participation less work than before	1	2	3	4	5	8
32. Deliberately designing care improvements to make the care process more beneficial to the patient	1	2	3	4	5	8

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Appendix 12B. Sample data inventory form

Department:	
Date:	

Information being collected (Summary – Optional: attach copy of variables collected to this form)	**Source for data**	**For what patients or activities?**	**For what purpose?** (Fed govt., payer, practice internal QI, other) provide details	**Data source/ Method?** (Electronic registry (name), paper survey, etc.) Provide name and details	**When?** (Daily, monthly, quarterly)	**Being used in QI or clinical care at practice?** Y/N	**Location of data and person in charge of data collection?**	**What information on race/ ethnicity is being collected?** (Be specific – list variables)	**HOW is race/ ethnicity info being collected?** (Patient completes form, verbal question by receptionist, etc.)
EXAMPLE: Diabetes lab data, PHQ 9 data, visit data	Manual entry from PHQ 9 forms; auto input from billing system; auto input from lab feed	All diabetic patients at practice	Report to County PPP program; BPC disparities collaborative	I2I registry, Excel Spreadsheet	Daily as able	Partial: Patients with elevated PHQ 9s are flagged on a monthly basis and names are given to director of behavioral health	Computer in main office; Mary Gonzales	Ethnicity: Hispanic/ non-Hispanic Race: White African American Asian American Indian	Entered from information provided by patient on "first visit form"

LA Net Data Inventory Form, 2010; revised 2015

Appendix 12C. Case Example: OnlyOneforMiles

The practice OnlyOneforMiles is interested in working with you to implement panel management and to improve their diabetes care. The Chief Medical Officer is excited about the project and responds to your emails to them about the project within a day. You schedule a meeting with him. You ask him to identify key individuals who might participate on the Care Model project team for the intervention period. He says okay. When the day of the meeting comes, Dr. Enthusiasm shows up for the meeting. But no one else is with him. You ask where the others are and he says that everyone was too busy that day to join.

As the two of you visit about project expectations, he mentions that the CEO is not interested in participating and is concerned the project and changes will make the practice lose money. The practice is also implementing its EHR in the next two months and so staff and clinicians are stretched thin. Despite the challenges, the practice is financially fairly stable, and has a low rate of clinician and staff turnover. The practice recently began to transition to care teams from traditional physician-centric models, which has been causing some conflict, but so far things are going okay with that change.

Dr. Enthusiasm is excited about working with you as he thinks it complements the change to care teams and might help improve them. He also thinks that the practice should try to implement panel managers and wants a practice facilitator to help. He wants to know next steps to starting work with you. Dr. Enthusiasm's practice is located in a semi-rural community and is one of the only sources of primary care for low-income patients in the region.

Appendix 14A. Sample Data Abstraction

Diabetes Chart Audit Form

Practice Site:	**Date of Audit:**	**PF Reviewing:**

a	b	c	d	e	f	g	h	i	j
Pt. ID (do not include names)	**HbA1c in the past 3 months?** 0=NO 1=YES	**HbA1c less than 7.0?** 0=NO 1=YES	**BP documented at last visit?** 0=NO 1=YES	**BP less than 130/80 mm Hg?** 0=NO 1=YES	**LDL-C in past 12 months?** 0=NO 1=YES	**LDL-C less than 100mg/ dL?** 0=NO 1=YES	**Eye exam in the past 12 months?** 0=NO 1=YES	**Foot exam in the past 12 months?** 0=NO 1=YES	**Other indicator (per practice):** 0=NO 1=YES
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
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19.									
20.									
21.									
22.									
23.									
24.									
25.									
26.									
27.									
28.									
29.									
30.									
Totals	**Total(b)=**	**Total(c)=**	**Total(d)=**	**Total(e)=**	**Total(f)=**	**Total(g)=**	**Total(h)=**	**Total(i)=**	**Total(j)=**

Appendix 14B. Nine Mock Medical Records

1. Billy Gato (diabetes, hypertension)
2. Cherie Amore (diabetes)
3. Wendy See (diabetes, depression)
4. John Donut (multiple chronic conditions)
5. Adam Pie (multiple chronic conditions, DNR, allergy)
6. Tom Gelato (diabetes, DNR, allergy)
7. Steve Apple (diabetes)
8. Bill Windows (diabetes, DNR)
9. Monica Latte (diabetes, hypertension)

Appendix 14 B. Sample Medical Record: Billy Gato

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111 Chart Summary

Billy Gato
Home: 555-555-5555
Male DOB: 05/05/1955 0000-55555 Ins: Commercial Orange Shield

Patient Information

Name: Billy Gato
Address: 5555 Mountain Blvd
Animal, California
Patient ID: 0000-55555
Birth Date: 05/05/1955
Gender: Male
Contact By: Phone
Soc Sec No: 555-55-5555
Resp Prov: Carl Savem
Referred by:
Email:
Home LOC: WeServeEveryone

Home Phone:555-555-5555
Office Phone:
Fax:
Status: Active
Marital Status: Married
Race: Hispanic
Language: English
MRN: MR-111-1111
Emp. Status: Part-time
Sens Chart: No
External ID: MR-111-1111

Problems

DIABETES MELLITUS (ICD-250.)
HYPERTENSION, BENIGN ESSENTIAL (ICD-401.1)

Medications

PRINIVIL TABS 20 MG (LISINOPRIL) 1 po qd
Last Refill: #30 x 2 : Carl Savem MD (01/27/2010)
HUMULIN INJ 70/30 (INSULIN REG & ISOPHANE (HUMAN)) 20 units ac breakfast
Last Refill: #600 u x 0 : Carl Savem MD (01/27/2010)

Directives

Allergies and Adverse Reactions (! = critical)

! Benadryl

Services Due

FLU VAX, PNEUMOVAX

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Billy Gato Home: 555-555-5555
Male DOB: 05/05/1955 0000-55555 Ins: Commercial xxxxx

09/25/2010 - Office Visit: F/u Diabetes
Provider: Carl Savem MD
Location of Care: WeServeEveryone Clinic

OFFICE VISIT

History of Present Illness
Reason for visit: Routine followup to review medications **Chief Complaint:** No complaints

History
Social History: Quit smoking 10 years ago

Diabetes Management
Hyperglycemic Symptoms
Polyuria: no
Polydipsia: no
Blurred vision: no

Sympathomimetic Symptoms
Diaphoresis: no
Agitation: no
Tremor: no
Palpitations: no
Insomnia: no

Neuroglycopenic Symptoms
Confusion: no
Lethargy: no
Somnolence: no
Amnesia: no
Stupor: no
Seizures: no

Review of Systems
General: denies fatigue, malaise, fever, weight loss
Eyes: denies blurring, diplopia, irritation, discharge
Ear/Nose/Throat: denies ear pain or discharge, nasal obstruction or discharge, sore throat
Cardiovascular: denies chest pain, palpitations, paroxysmal nocturnal dyspnea, orthopnea, edema **Respiratory:** denies coughing, wheezing, dyspnea, hemoptysis
Gastrointestinal: denies abdominal pain, dysphagia, nausea, vomiting, diarrhea, constipation
Genitourinary: denies hematuria, frequency, urgency, dysuria, discharge, impotence, incontinence
Musculoskeletal: denies back pain, joint swelling, joint stiffness, joint pain
Skin: denies rashes, itching, lumps, sores, lesions, color change
Neurologic: denies syncope, seizures, transient paralysis, weakness, paresthesias
Psychiatric: denies depression, anxiety, mental disturbance, difficulty sleeping, suicidal ideation, hallucinations, paranoia
Endocrine: denies polyuria, polydipsia, polyphagia, weight change, heat or cold intolerance
Heme/Lymphatic: denies easy or excessive bruising, history of blood transfusions, anemia, bleeding disorders, adenopathy, chills, sweats
Allergic/Immunologic: denies urticaria, hay fever, frequent UTIs; denies HIV high risk behaviors

Vital Signs

Billy Gato

Home: 555-555-5555
Male DOB: 05/05/1955
0000-55555
Ins: Commercial xxxxx

Ht: **65** in. Wt: **180** lbs. T: **98.0** degF. T site: **oral** P: **70** Rhythm: **regular** R: **16** BP: **134/ 92**

Physical Exam

General Appearance: well developed, well nourished, no acute distress
Eyes: conjunctiva and lids normal, PERRLA, EOMI, fundi WNL
Ears, Nose, Mouth, Throat: TM clear, nares clear, oral exam WNL
Respiratory: clear to auscultation and percussion, respiratory effort normal
Cardiovascular: regular rate and rhythm, S1-S2, no murmur, rub or gallop, no bruits, peripheral pulses normal and symmetric, no cyanosis, clubbing, edema or varicosities
Skin: clear, good turgor, color WNL, no rashes, lesions, or ulcerations

Assessment

Problems (including changes): Blood pressure is lower. He is following his diet, by his account. He has not had any hypoglycemic episodes, no night sweats. Feet are inspected and there are no callouses, no compromised skin. No vision
complaints.

Impression: Sub optimal sugar, control with retinopathy and neuropathy, high glucometer readings. He will work harder on diet.

Home Glucose Monitoring:
AC breakfast 110 to 220
AC breakfast mean 142
AC dinner 100 to 250
AC dinner mean 120

Plan

Medications:
HUMULIN INJ 70/30 20 u ac breakfast
PRINIVIL TABS 20 MG 1 qd

Treatment: Will have annual foot exam at next visit.

Orders:
Ophthalmology consult
UA
HGBA1C
Metabolic Panel
Lipid Panel

Education/Counseling (time): 5 minutes

Coordination of Care (time): 10 minutes

Follow-up/Return Visit: 3 months

Disposition: return to clinic

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Billy Gato
Male DOB: 05/05/1955
0000-55555
Ins: Commercial xxxxx

Home: 555.555.5555

09/19/2010 - Lab Report: Metabolic Panel Provider: Carl Savem MD
Location of Care: Millennium Health System

Tests:

(1) Metabolic Panel (ML-03CHEM)

ALK PHOS	72 U/L	35-100
BG RANDOM	125 mg/dl	70-125
BUN	16 mg/dl	7-25
CALCIUM	9.6 mg/dl	8.2-10.2
CHLORIDE	101 mmol/l	96-109
CO2	27 mmol/l	23-29
CREATININE	0.7 mg/dl	0.6-1.2
PO4	2.9 mg/dl	2.5-4.5
POTASSIUM	4.5 mmol/l	3.5-5.3
SGOT (AST)	31 U/L	0-40
BILI TOTAL	0.7 mg/dl	0.0-1.3
URIC ACID	4.8 mg/dl	3.4-7.0
LDH, TOTAL	136 IU/L	0-200
SODIUM	135 mmol/l	135-145

(2) HbA1c Test
HbA1c level 7.0%
(3) Lipid Profile
Cholesterol, Total 210 mg/dl
Triglycerides 236 mg/dl
HDL Cholesterol 36
LDL Cholesterol 121

Billy Gato

Home: 555-555-5555

Male DOB: 05/05/1955
0000-55555
Ins: Commercial xxxxx

Flowsheet

	Date	**09/25/2010**
HEIGHT (in)		65
WEIGHT (lb)		180
TEMPERATURE (deg F)		98
TEMP SITE		oral
PULSE RATE (/min)		72
PULSE RHYTHM		
RESP RATE (/min)		16
BP SYSTOLIC (mm Hg)		134
BP DIASTOLIC (mm Hg)		92
CHOLESTEROL (mg/dL)		
HDL (mg/dL)		
LDL (mg/dL)		121
BG RANDOM (mg/dL)		
CXR		
EKG		
PAP SMEAR		
BREAST EXAM		
MAMMOGRAM		
HEMOCCULT		neg
FLU VAX		0.5 ml g
PNEUMOVAX		0.5 ml g
TD BOOSTER		0.5 ml g
Foot Exam		Complete
Eye Exam		**Complete**

Appendix 14B. Sample Medical Record: Cherie Amore

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Chart Summary

Cherie Amore

Home: 333-333-3333
Female DOB: 03/03/1940 0000-33333 Ins: Commercial xxxxx

Patient Information

Name: Cherie Amore
Address: 3333 Wonder Ave
Famous, California
Patient ID: 0000-33333
Birth Date: 03/03/1940
Gender: Female
Contact By: Phone
Soc Sec No: 333-33-3333
Resp Prov: Carl Savem
Referred by:
Email:
Home LOC: WeServeEveryone

Home Phone: 333-333-3333
Office Phone:
Fax:
Status: Active
Marital Status: Married
Race: White
Language: English
MRN: MR-111-1111
Emp. Status: Full-time
Sens Chart: No
External ID: MR-111-1111

Problems

DIABETES MELLITUS (ICD-250.)

Medications

HUMULIN INJ 70/30 (INSULIN REG & ISOPHANE (HUMAN)) 20 units ac breakfast
Last Refill: #600 u x 0 : Carl Savem MD (01/27/2010)

Directives

Allergies and Adverse Reactions (! = critical)

Services Due

FLU VAX

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Chart Summary

Cherie Amore
Home: 333-333-3333
Female DOB: 03/03/1940 0000-33333 Ins: Commercial xxxxx

10/18/2010 - Office Visit: F/u Diabetes
Provider: Carl Savem MD
Location of Care: WeServeEveryone Clinic

OFFICE VISIT

History of Present Illness
Reason for visit: Routine follow up to review medications **Chief Complaint:** No complaints

History
Social History:

Diabetes Management
Hyperglycemic Symptoms
Polyuria: no
Polydipsia: no
Blurred vision: no

Sympathomimetic Symptoms
Diaphoresis: no
Agitation: no
Tremor: no
Palpitations: no
Insomnia: no

Neuroglycopenic Symptoms
Confusion: no
Lethargy: no
Somnolence: no
Amnesia: no
Stupor: no
Seizures: no

Review of Systems
General: denies fatigue, malaise, fever, weight loss
Eyes: denies blurring, diplopia, irritation, discharge
Ear/Nose/Throat: denies ear pain or discharge, nasal obstruction or discharge, sore throat
Cardiovascular: denies chest pain, palpitations, paroxysmal nocturnal dyspnea, orthopnea, edema
Respiratory: denies coughing, wheezing, dyspnea, hemoptysis
Gastrointestinal: denies abdominal pain
Musculoskeletal: denies back pain, joint swelling, joint stiffness, joint pain
Skin: denies rashes, itching, lumps, sores, lesions, color change
Neurologic: denies syncope, seizures, transient paralysis, weakness, paresthesias
Psychiatric: denies depression, anxiety, mental disturbance, difficulty sleeping, suicidal ideation, hallucinations, paranoia
Endocrine: denies polyuria, polydipsia, polyphagia, weight change, heat or cold intolerance
Heme/Lymphatic: denies easy or excessive bruising, history of blood transfusions, anemia, bleeding disorders, adenopathy, chills, sweats
Allergic/Immunologic: denies hay fever

Vital Signs

Cherie Amore

Home: 333-333-3333
Female DOB: 03/03/1940 0000-33333 Ins: Commercial xxxxx

Ht: **63** in. Wt: **130** lbs. T: **98.0** degF. T site: **oral** P: **72** Rhythm: **regular** R: **16** BP: **118/ 60**

Physical Exam

General Appearance: well developed, well nourished, no acute distress
Eyes: conjunctiva and lids normal
Ears, Nose, Mouth, Throat: TM clear, nares clear, oral exam WNL
Respiratory: respiratory effort normal
Cardiovascular: regular rate and rhythm,

Problems (including changes):
She is following diet, by her account. Feet are inspected and there are no callouses, no compromised skin. No vision complaints.

Impression: Sub optimal sugar, control with retinopathy and neuropathy, high glucometer readings.

Home Glucose Monitoring:
AC breakfast 110 to 220
AC breakfast mean 142
AC dinner 100 to 250
AC dinner mean 120

Plan

Medications:
HUMULIN INJ 70/30 20 u ac breakfast

Treatment: Will have annual foot exam at next visit.

Orders:
Ophthalmology consult
UA
HGBA1C
Metabolic Panel
Lipid Panel
Hemoccult

Education/Counseling (time): 10 minutes

Coordination of Care (time): 10 minutes

Follow-up/Return Visit: 3 months

Disposition: return to clinic

Cherie Amore

Home: 333-333-3333
Female DOB: 03/03/1940 0000-33333 Ins: Commercial xxxxx

10/19/2010 - Lab Report: Metabolic Panel Provider: Carl Savem MD
Location of Care: Millennium Health System

Tests:

(1) Metabolic Panel (ML-03CHEM)

ALK PHOS	72 U/L 35-100
BG RANDOM	125 mg/dl 70-125
BUN	16 mg/dl 7-25
CALCIUM	9.6 mg/dl 8.2-10.2
CHLORIDE	101 mmol/l 96-109
CO2	27 mmol/l 23-29
CREATININE	0.7 mg/dl 0.6-1.2
PO4	2.9 mg/dl 2.5-4.5
POTASSIUM	4.5 mmol/l 3.5-5.3
SGOT (AST)	31 U/L 0-40
BILI TOTAL	0.7 mg/dl 0.0-1.3
URIC ACID	4.8 mg/dl 3.4-7.0
LDH, TOTAL	136 IU/L 0-200
SODIUM	135 mmol/l 135-145

(2) HbA1c Test
HbA1c level8.0%

(3) Lipid Profile

Cholesterol, Total	210 mg/dl
Triglycerides	236 mg/dl
HDL Cholesterol	36
LDL Cholesterol	125

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Flowsheet

Cherie Amore

Home: 333-333-3333

103-TEST011 Insurance: BHI (Futura) Group: BHI1595

Female DOB: 03/03/1940 0000-33333 Ins: Commercial xxxxx

Date	**10/18/2010**
HEIGHT (in)	63
WEIGHT (lb)	130
TEMPERATURE (deg F)	98
TEMP SITE	oral
PULSE RATE (/min)	72
PULSE RHYTHM	
RESP RATE (/min)	16
BP SYSTOLIC (mm Hg)	118
BP DIASTOLIC (mm Hg)	60
CHOLESTEROL (mg/dL)	
HDL (mg/dL)	
LDL (mg/dL)	125
BG RANDOM (mg/dL)	
CXR	
EKG	
PAP SMEAR	
BREAST EXAM	
MAMMOGRAM	
HEMOCCULT	neg
FLU VAX	
PNEUMOVAX	
TD BOOSTER	0.5 ml g
Foot Exam	
Eye Exam	

Appendix 14B. Sample Medical Record: Wendy See

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Wendy See

Home: 777-777-7777
Female DOB: 07/07/1943 0000-77777 Ins: Commercial Orange Shield

Patient Information

Name: Wendy See
Address: 7777 Candy Lane
Dessert, California
Patient ID: 0000-77777
Birth Date: 07/07/1943
Gender: Female
Contact By: Phone
Soc Sec No: 777-77-7777
Resp Prov: Carl Savem
Referred by:
Email:
Home LOC: WeServeEveryone

Home Phone: 777-777-7777
Office Phone:
Fax:
Status: Active
Marital Status: Single
Race: Asian
Language: English
MRN: MR-111-1111
Emp. Status: Full-time
Sens Chart: No
External ID: MR-111-1111

Problems

DIABETES MELLITUS (ICD-250.)
DEPRESSION (ICD-311)

Medications

HUMULIN INJ 70/30 (INSULIN REG & ISOPHANE (HUMAN)) 20 units ac breakfast
Last Refill: #600 u x 0 : Carl Savem MD (06/17/2010)
PROZAC CAPS 10 MG (FLUOXETINE HCL) 1 po qd
Last Refill: #30 x 2 : Carl Savem MD (06/17/2010)

Directives

Allergies and Adverse Reactions (! = critical)

! Benadryl

Services Due

FLU VAX

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Wendy See Home: 777-777-7777
Female DOB: 07/07/1943 0000-77777 Ins: Commercial xxxxx

9/22/2010 - Office Visit: F/u Diabetes
Provider: Carl Savem MD
Location of Care: WeServeEveryone Clinic

OFFICE VISIT

History of Present Illness
Reason for visit: Routine follow up
Chief Complaint: No complaints

History
Social History: Her husband died 2 years ago and she is more introspective.

Diabetes Management
Hyperglycemic Symptoms
Polyuria: no
Polydipsia: no
Blurred vision: no

Sympathomimetic Symptoms
Diaphoresis: no
Agitation: no
Tremor: no
Palpitations: no
Insomnia: no

Neuroglycopenic Symptoms
Confusion: no
Lethargy: no
Somnolence: no
Amnesia: no
Stupor: no
Seizures: no

Review of Systems
General: denies fatigue, malaise, fever, weight loss
Eyes: denies blurring, diplopia, irritation, discharge
Ear/Nose/Throat: denies ear pain or discharge, nasal obstruction or discharge, sore throat
Cardiovascular: denies chest pain, palpitations, paroxysmal nocturnal dyspnea, orthopnea, edema
Respiratory: denies coughing, wheezing, dyspnea, hemoptysis
Gastrointestinal: denies abdominal pain, dysphagia, nausea, vomiting, diarrhea, constipation
Musculoskeletal: denies back pain, joint swelling, joint stiffness, joint pain
Skin: denies rashes, itching, lumps, sores, lesions, color change
Neurologic: denies syncope, seizures, transient paralysis, weakness, paresthesias
Psychiatric: denies depression, anxiety, mental disturbance, difficulty sleeping, suicidal ideation, hallucinations, paranoia
Endocrine: denies polyuria, polydipsia, polyphagia, weight change, heat or cold intolerance
Heme/Lymphatic: denies easy or excessive bruising, history of blood transfusions, anemia, bleeding disorders, adenopathy, chills, sweats
Allergic/Immunologic: denies urticaria, hay fever

Wendy See

Home: 777-777-7777

Ht: **60** in. Wt: **120** lbs. T: **98.0** degF. T site: **oral** P: **72** Rhythm: **regular** R: **16** BP: **125/70**

Physical Exam

General Appearance: well developed, well nourished, no acute distress
Eyes: conjunctiva and lids normal, PERRLA, EOMI, fundi WNL
Ears, Nose, Mouth, Throat: TM clear, nares clear, oral exam WNL
Respiratory: clear to auscultation and percussion, respiratory effort normal
Cardiovascular: regular rate and rhythm, S1-S2, no murmur, rub or gallop, no bruits, peripheral pulses normal and symmetric, no cyanosis, clubbing, edema or varicosities
Skin: clear, good turgor, color WNL, no rashes, lesions, or ulcerations

Assessment

Problems (including changes): Blood pressure is lower.

Impression: Sub optimal sugar, control with retinopathy and neuropathy, high glucometer readings. He will work harder on diet. Will increase insulin by 2 units.

Medications:
HUMULIN INJ 70/30 20 u ac breakfast
PROZAC CAPS 10 MG 1 qd

Treatment: Will have annual foot exam at next visit.

Orders:

UA

Education/Counseling (time): 20 minutes

Coordination of Care (time): 5 minutes

Follow-up/Return Visit: 3 months

Disposition: return to clinic

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Wendy See
Male DOB: 07/07/1943 0000-77777
Home: 777-777-7777
Ins: Commercial xxxxx

Tests:

(1) HbA1c Test
HbA1c level 7.0%

(2) Lipid Profile

Cholesterol, Total	210 mg/dl
Triglycerides	236 mg/dl
HDL Cholesterol	36
LDL Cholesterol	90

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Chart Summary

Wendy See

Home: 777-777-7777

DOB: 07/07/1943 0000-77777 Ins: Commercial xxxxx

Flowsheet

Date	9/22/2010
HEIGHT (in)	60
WEIGHT (lb)	120
TEMPERATURE (deg F)	98
TEMP SITE	oral
PULSE RATE (/min)	72
PULSE RHYTHM	
RESP RATE (/min)	16
BP SYSTOLIC (mm Hg)	125
BP DIASTOLIC (mm Hg)	70
CHOLESTEROL (mg/dL)	
HDL (mg/dL)	
LDL (mg/dL)	90
BG RANDOM (mg/dL)	125
CXR	
EKG	
PAP SMEAR	
BREAST EXAM	
MAMMOGRAM	
HEMOCCULT	neg
FLU VAX	0.5 ml g
PNEUMOVAX	0.5 ml g
TD BOOSTER	0.5 ml g
Foot Exam	Complete
Eye Exam	**Complete**

Appendix 14B. Sample Medical Record: John Donut

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Chart Summary

John Donut
Male DOB: 01/01/1935 0000-11111

Home: 000-000-0000
Ins: Commercial xxxxx

Patient Information

Name: John Donut
Address: 1111 Donut Road
Fast Food, California
Patient ID: 0000-11111
Birth Date: 01/01/1935
Gender: Male
Contact By: Phone
Soc Sec No: 111-11-1111
Resp Prov: Carl Savem
Referred by:
Email:
Home LOC: WeServeEveryone

Home Phone: 000-000-0000
Office Phone:
Fax:
Status: Active
Marital Status: Widowed
Race: Black
Language: English
MRN: MR-111-1111
Emp. Status: Part-time
Sens Chart: No
External ID: MR-111-1111

Problems

DIABETES MELLITUS (ICD-250.)
HYPERTENSION, BENIGN ESSENTIAL (ICD-401.1)
HYPERPLASIA, PROSTATE (ICD-600)
DEPRESSION (ICD-311)
RETINOPATHY, DIABETIC (ICD-362.0)
POLYNEUROPATHY IN DIABETES (ICD-357.2)

Medications

PRINIVIL TABS 20 MG (LISINOPRIL) 1 po qd
Last Refill: #30 x 2 : Carl Savem MD (05/27/2010)
HUMULIN INJ 70/30 (INSULIN REG & ISOPHANE (HUMAN)) 20 units ac breakfast
Last Refill: #600 u x 0 : Carl Savem MD (05/27/2010)

Directives

Allergies and Adverse Reactions (! = critical)

Services Due

HEMOCCULT or SIGMOID, BP DIASTOLIC, BP SYSTOLIC, FLU VAX, PNEUMOVAX, MICROALB URN

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

John Donut Home: 000-000-0000
Male DOB: 01/01/1935 0000-11111 Ins: Commercial xxxxx

10/31/2010 - Office Visit: F/u Diabetes
Provider: Carl Savem MD
Location of Care: WeServeEveryone Clinic

OFFICE VISIT

History of Present Illness
Reason for visit: Routine follow up to review medications **Chief Complaint:** No complaints

History

Diabetes Management
Hyperglycemic Symptoms
Polyuria: no
Polydipsia: no
Blurred vision: no

Sympathomimetic Symptoms
Diaphoresis: no
Agitation: no
Tremor: no
Palpitations: no
Insomnia: no

Neuroglycopenic Symptoms
Confusion: no
Lethargy: no
Somnolence: no
Amnesia: no
Stupor: no
Seizures: no

Review of Systems
General: denies fatigue, malaise, fever, weight loss
Eyes: denies blurring, diplopia, irritation, discharge
Ear/Nose/Throat: denies ear pain or discharge, nasal obstruction or discharge, sore throat
Cardiovascular: denies chest pain, palpitations, paroxysmal nocturnal dyspnea, orthopnea, edema
Respiratory: denies coughing, wheezing, dyspnea, hemoptysis
Gastrointestinal: denies abdominal pain, dysphagia, nausea, vomiting, diarrhea, constipation
Genitourinary: denies hematuria, frequency, urgency, dysuria, discharge, impotence, incontinence
Musculoskeletal: denies back pain, joint swelling, joint stiffness, joint pain
Skin: denies rashes, itching, lumps, sores, lesions, color change
Neurologic: denies syncope, seizures, transient paralysis, weakness, paresthesias
Psychiatric: denies depression, anxiety, mental disturbance, difficulty sleeping, suicidal ideation, hallucinations, paranoia
Endocrine: denies polyuria, polydipsia, polyphagia, weight change, heat or cold intolerance
Heme/Lymphatic: denies easy or excessive bruising, history of blood transfusions, anemia, bleeding disorders, adenopathy, chills, sweats
Allergic/Immunologic: denies urticaria, hay fever, frequent UTIs; denies HIV high risk behaviors

Vital Signs

John Donut Home: 000-000-0000
Male DOB: 01/01/1935 0000-11111 Ins: Commercial xxxxx

Ht: **74** in. Wt: **190** lbs. T: **98.0** degF. T site: **oral** P: **72** Rhythm: **regular** R: **16** BP: **158/ 90**

Physical Exam

General Appearance: well developed, well nourished, no acute distress
Eyes: conjunctiva and lids normal, PERRLA, EOMI, fundi WNL
Ears, Nose, Mouth, Throat: TM clear, nares clear, oral exam WNL
Respiratory: clear to auscultation and percussion, respiratory effort normal
Cardiovascular: regular rate and rhythm, S1-S2, no murmur, rub or gallop, no bruits, peripheral pulses normal and symmetric, no cyanosis, clubbing, edema or varicosities
Skin: clear, good turgor, color WNL, no rashes, lesions, or ulcerations

Assessment

Problems (including changes): Blood pressure is lower. He is following his diet, by his account. He has not had any hypoglycemic episodes, no night sweats. Feet are inspected and there are no callouses, no compromised skin. No vision complaints.

Impression: Sub optimal sugar, control with retinopathy and neuropathy, high glucometer readings. He will work harder on diet. Will increase insulin by 2 units. BP better.

Plan

Medications:
HUMULIN INJ 70/30 20 u ac breakfast
PRINIVIL TABS 20 MG 1 qd

Treatment: Will have annual foot exam at next visit.

Orders:
Ophthalmology consult
UA
HGBA1C
Metabolic Panel
Lipid Panel
Hemoccult

Education/Counseling (time): 10 minutes

Coordination of Care (time): 10 minutes

Follow-up/Return Visit: 3 months

Disposition: return to clinic

John Donut Home: 000-000-0000
Male DOB: 01/01/1935 0000-11111 Ins: Commercial xxxxx

Ins: BHI (Futura) Grp: BHI1595

10/31/2010 - Lab Report: Metabolic Panel Provider: Carl Savem MD
Location of Care: Millennium Health System

Tests:
(1) Metabolic Panel (ML-03CHEM)

ALK PHOS	72 U/L	35-100
BG RANDOM	125 mg/dl	70-125
BUN	16 mg/dl	7-25
CALCIUM	9.6 mg/dl	8.2-10.2
CHLORIDE	101 mmol/l	96-109
CO2	27 mmol/l	23-29
CREATININE	0.7 mg/dl	0.6-1.2
PO4	2.9 mg/dl	2.5-4.5
POTASSIUM	4.5 mmol/l	3.5-5.3
SGOT (AST)	31 U/L	0-40
BILI TOTAL	0.7 mg/dl	0.0-1.3
URIC ACID	4.8 mg/dl	3.4-7.0
LDH, TOTAL	136 IU/L	0-200
SODIUM	135 mmol/l	135-145

2) HbA1c Test

HbA1c level	8.0%

(3) Lipid Profile

Cholesterol, Total	210 mg/dl
Triglycerides	236 mg/dl
HDL Cholesterol	36
LDL Cholesterol	102

John Donut

Home: 000-000-0000

Male DOB: 01/01/1935 0000-11111 Ins: Commercial xxxxx

Flowsheet

Date	10/31/2010
HEIGHT (in)	74
WEIGHT (lb)	190
TEMPERATURE (deg F)	98
TEMP SITE	oral
PULSE RATE (/min)	72
PULSE RHYTHM	
RESP RATE (/min)	16
BP SYSTOLIC (mm Hg)	158
BP DIASTOLIC (mm Hg)	90
CHOLESTEROL (mg/dL)	
HDL (mg/dL)	
LDL (mg/dL)	102
BG RANDOM (mg/dL)	125
CXR	
EKG	
PAP SMEAR	
BREAST EXAM	
MAMMOGRAM	
HEMOCCULT	neg
FLU VAX	0.5 ml g
PNEUMOVAX	0.5 ml g
TD BOOSTER	0.5 ml g
Foot Exam	
Eye Exam	

Appendix 14 B. Sample Medical Record: Adam Pie

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Adam Pie Home: 888-888-8888
Male DOB: 08/08/1948 0000-88888 Ins: Commercial xxxx

Patient Information

Name: Adam Pie **Home Phone:** 888-888-8888
Address: 8888 Crust Dr **Office Phone:**
Filling, California
Patient ID: 0000-88888 **Fax:**
Birth Date: 08/08/1948 **Status:** Active
Gender: Male **Marital Status:** Married
Contact By: Phone **Race:** White
Soc Sec No: 888-88-8888 **Language:** English
Resp Prov: Carl Savem **MRN:** MR-111-1111
Referred by: **Emp. Status:** Full-time
Email: **Sens Chart:** No
Home LOC: WeServeEveryone **External ID:** MR-111-1111

Problems

DIABETES MELLITUS (ICD-250.)
HYPERTENSION, BENIGN ESSENTIAL (ICD-401.1) HYPERPLASIA, PROSTATE (ICD-600)
DEPRESSION (ICD-311)
RETINOPATHY, DIABETIC (ICD-362.0)
POLYNEUROPATHY IN DIABETES (ICD-357.2)

Medications

HYTRIN CAP 5MG (TERAZOSIN HCL) 1 po qd
Last Refill: #30 x 0 : Carl Savem (10/27/2010)
PRINIVIL TABS 20 MG (LISINOPRIL) 1 po qd
Last Refill: #30 x 2 : Carl Savem MD (10/27/2010)
HUMULIN INJ 70/30 (INSULIN REG & ISOPHANE (HUMAN)) 20 units
ac breakfast
Last Refill: #600 u x 0 : Carl Savem MD (10/27/2010)
PROZAC CAPS 10 MG (FLUOXETINE HCL) 1 po qd
Last Refill: #30 x 2 : Carl Savem MD (10/27/2010)

Directives

DO NOT RESUSCITATE

Allergies and Adverse Reactions (! = critical)

! CODEINE

Services Due

HEMOCCULT or SIGMOID, BP DIASTOLIC, BP SYSTOLIC, FLU VAX, PNEUMOVAX,
MICROALB URN, FLU VAX, BP DIASTOLIC, BP SYSTOLIC, FUNDUSCOPY, DIAB FOOT CK,
ALBUMIN URIN, TSH,
CHOLESTEROL, HGBA1C, CREATININE.

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Adam Pie Home: 888-888-8888
Male DOB: 08/08/1948 0000-88888 Ins: Commercial xxxx

12/18/2010 - Office Visit: F/u Diabetes
Provider: Carl Savem MD
Location of Care: WeServeEveryone Clinic

OFFICE VISIT

History of Present Illness
Reason for visit: Routine follow up to review medications **Chief Complaint:** No complaints

History
Social History: His wife Marzapan died 5 years ago this month and he is more introspective.

Diabetes Management
Hyperglycemic Symptoms
Polyuria: no
Polydipsia: no
Blurred vision: no

Sympathomimetic Symptoms
Diaphoresis: no
Agitation: no
Tremor: no
Palpitations: no
Insomnia: no

Neuroglycopenic Symptoms
Confusion: no
Lethargy: no
Somnolence: no
Amnesia: no
Stupor: no
Seizures: no

Review of Systems
General: denies fatigue, malaise, fever, weight loss
Eyes: denies blurring, diplopia, irritation, discharge
Ear/Nose/Throat: denies ear pain or discharge, nasal obstruction or discharge, sore throat
Cardiovascular: denies chest pain, palpitations, paroxysmal nocturnal dyspnea, orthopnea, edema
Respiratory: denies coughing, wheezing, dyspnea, hemoptysis
Gastrointestinal: denies abdominal pain, dysphagia, nausea, vomiting, diarrhea, constipation
Genitourinary: denies hematuria, frequency, urgency, dysuria, discharge, impotence, incontinence
Musculoskeletal: denies back pain, joint swelling, joint stiffness, joint pain
Skin: denies rashes, itching, lumps, sores, lesions, color change
Neurologic: denies syncope, seizures, transient paralysis, weakness, paresthesias
Psychiatric: denies depression, anxiety, mental disturbance, difficulty sleeping, suicidal ideation, hallucinations, paranoia
Endocrine: denies polyuria, polydipsia, polyphagia, weight change, heat or cold intolerance
Heme/Lymphatic: denies easy or excessive bruising, history of blood transfusions, anemia, bleeding disorders, adenopathy, chills, sweats
Allergic/Immunologic: denies urticaria, hay fever, frequent UTIs; denies HIV high risk behaviors

Vital Signs

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Adam Pie
Male DOB: 08/08/1948 0000-88888

Home: 888-888-8888
Ins: Commercial xxxx

Ht: **70** in. Wt: **190** lbs. T: **98.0** degF. T site: **oral** P: **72** Rhythm: **regular** R: **16** BP: **158/ 90**

Physical Exam
General Appearance: well developed, well nourished, no acute distress
Eyes: conjunctiva and lids normal, PERRLA, EOMI, fundi WNL
Ears, Nose, Mouth, Throat: TM clear, nares clear, oral exam WNL
Respiratory: clear to auscultation and percussion, respiratory effort normal
Cardiovascular: regular rate and rhythm, S1-S2, no murmur, rub or gallop, no bruits, peripheral pulses normal and symmetric, no cyanosis, clubbing, edema or varicosities
Skin: clear, good turgor, color WNL, no rashes, lesions, or ulcerations

Assessment
Problems (including changes): Adam is voiding better since increasing Hytrin to 5 mg/day. Blood pressure is lower. He is following his diet, by his account. He has not had any hypoglycemic episodes, no night sweats. Feet are inspected and there are no callouses, no compromised skin. No vision complaints.

Impression: Sub optimal sugar, control with retinopathy and neuropathy, high glucometer readings. He will work harder on diet. Will increase insulin by 2 units. BP and symptoms of prostatism are better.

Home Glucose Monitoring:
AC breakfast 110 to 220
AC breakfast mean 142
AC dinner 100 to 250
AC dinner mean 120

Plan
Medications:
HUMULIN INJ 70/30 20 u ac breakfast
PRINIVIL TABS 20 MG 1 qd
HYTRIN CAP 5MG 1 qd
PROZAC CAPS 10 MG 1 qd

Treatment: Will have annual foot exam at next visit.

Orders:
Ophthalmology consult
UA
HGBA1C
Metabolic Panel
Lipid Panel
Hemoccult

Education/Counseling (time): 10 minutes

Coordination of Care (time): 10 minutes

Follow-up/Return Visit: 3 months

Disposition: return to clinic

WeServeEveryone Clinic

1111 First Street California
111-111-11111 Fax: 111-111-1111

Adam Pie

Home: 888-888-8888
Male DOB: 08/08/1948 0000-88888 Ins: Commercial xxxx

12/19/2010 - Lab Report: Metabolic Panel Provider: Carl Savem MD
Location of Care: Millennium Health System

Tests:

(1) Metabolic Panel (ML-03CHEM)

ALK PHOS	72 U/L	35-100
BG RANDOM	125 mg/dl	70-125
BUN	16 mg/dl	7-25
CALCIUM	9.6 mg/dl	8.2-10.2
CHLORIDE	101 mmol/l	96-109
CO2	27 mmol/l	23-29
CREATININE	0.7 mg/dl	0.6-1.2
PO4	2.9 mg/dl	2.5-4.5
POTASSIUM	4.5 mmol/l	3.5-5.3
SGOT (AST)	31 U/L	0-40
BILI TOTAL	0.7 mg/dl	0.0-1.3
URIC ACID	4.8 mg/dl	3.4-7.0
LDH, TOTAL	136 IU/L	0-200
SODIUM	135 mmol/l	135-145

(2) HbA1c Test

HbA1c level	6.0%

(3) Lipid Profile

Cholesterol, Total	210 mg/dl
Triglycerides	236 mg/dl
HDL Cholesterol	36
LDL Cholesterol	127

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Adam Pie Home: 888-888-8888
Male DOB: 08/08/1948 0000-88888 Ins: Commercial xxxx

FLOWSHEET

Date	12/19/2010	12/18/2010
HEIGHT (in)		70
WEIGHT (lb)		190
TEMPERATURE (deg F)		98
TEMP SITE		oral
PULSE RATE (/min)		72
PULSE RHYTHM		
RESP RATE (/min)		16
BP SYSTOLIC (mm Hg)		158
BP DIASTOLIC (mm Hg)		90
CHOLESTEROL (mg/dL)		
HDL (mg/dL)		
LDL (mg/dL)		127
BG RANDOM (mg/dL)	125	
CXR		
EKG		
PAP SMEAR		
BREAST EXAM		
MAMMOGRAM		
HEMOCCULT		neg
FLU VAX		0.5 ml g
PNEUMOVAX		0.5 ml g
TD BOOSTER		0.5 ml g
Foot Exam		Complete
Eye Exam		**Complete**

Appendix 14B. Sample Medical Record: Tom Gelato

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Chart Summary

Tom Gelato Home: 666-666-6666
Male DOB: 06/06/1938 0000-66666 Ins: Commercial xxxxx

Patient Information

Name: Tom Gelato
Address: 5555 Flavor Ave
Ice Cream, California
Patient ID: 0000-66666
Birth Date: 06/06/1938
Gender: Male
Contact By: Phone
Soc Sec No: 666-666-6666
Resp Prov: Carl Savem
Referred by:
Email:
Home LOC: WeServeEveryone

Home Phone: 666-666-6666
Office Phone:
Fax:
Status: Active
Marital Status: Divorced
Race: White
Language: English
MRN: MR-111-1111
Emp. Status: Part-time
Sens Chart: No
External ID: MR-111-1111

Problems

DIABETES MELLITUS (ICD-250.)

Medications

HUMULIN INJ 70/30 (INSULIN REG & ISOPHANE (HUMAN)) 20 units
ac breakfast
Last Refill: #600 u x 0 : Carl Savem MD (04/17/2010)

Directives

DO NOT RESUSCITATE

Allergies and Adverse Reactions (! = critical)

! CODEINE

Services Due

FLU VAX, PNEUMOVAX, MICROALB URN

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Tom Gelato Home: 666-666-6666
Male DOB: 06/06/1938 0000-66666 Ins: Commercial xxxxx

11/13/2010 - Office Visit: F/u Diabetes
Provider: Carl Savem MD
Location of Care: WeServeEveryone Clinic

OFFICE VISIT

History of Present Illness
Reason for visit: Routine followup
Chief Complaint: No complaints

History

Diabetes Management
Hyperglycemic Symptoms
Polyuria: no
Polydipsia: no
Blurred vision: no

Sympathomimetic Symptoms
Diaphoresis: no
Agitation: no
Tremor: no
Palpitations: no
Insomnia: no

Neuroglycopenic Symptoms
Confusion: no
Lethargy: no
Somnolence: no
Amnesia: no
Stupor: no
Seizures: no

Review of Systems
General: denies fatigue, malaise, fever, weight loss
Eyes: denies blurring, diplopia, irritation, discharge
Ear/Nose/Throat: denies ear pain or discharge, nasal obstruction or discharge, sore throat
Cardiovascular: denies chest pain, palpitations, paroxysmal nocturnal dyspnea, orthopnea, edema
Respiratory: denies coughing, wheezing, dyspnea, hemoptysis
Gastrointestinal: denies abdominal pain, dysphagia, nausea, vomiting, diarrhea, constipation
Musculoskeletal: denies back pain, joint swelling, joint stiffness, joint pain
Skin: denies rashes, itching, lumps, sores, lesions, color change
Neurologic: denies syncope, seizures, transient paralysis, weakness, paresthesias
Psychiatric: denies depression, anxiety, mental disturbance, difficulty sleeping, suicidal ideation, hallucinations, paranoia
Endocrine: denies polyuria, polydipsia, polyphagia, weight change, heat or cold intolerance
Heme/Lymphatic: denies easy or excessive bruising, history of blood transfusions, anemia, bleeding disorders, adenopathy, chills, sweats
Allergic/Immunologic: denies urticaria, hay fever, frequent UTIs; denies HIV high risk behaviors

Vital Signs

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Male DOB: 06/06/1938
0000-66666
Ins: Commercial xxxxx

Tom Gelato

Home: 666-666-6666

Ht: **66** in. Wt: **195** lbs. T: **98.0** degF. T site: **oral** P: **72** Rhythm: **regular** R: **16** BP: **131/ 94**

Physical Exam

General Appearance: well developed, well nourished, no acute distress
Eyes: conjunctiva and lids normal, PERRLA, EOMI, fundi WNL
Ears, Nose, Mouth, Throat: TM clear, nares clear, oral exam WNL
Respiratory: clear to auscultation and percussion, respiratory effort normal
Cardiovascular: regular rate and rhythm, S1-S2, no murmur, rub or gallop, no bruits, peripheral pulses normal and symmetric, no cyanosis, clubbing, edema or varicosities
Skin: clear, good turgor, color WNL, no rashes, lesions, or ulcerations

Assessment

Problems (including changes): Blood pressure is lower. He is following his diet, by his account. He has not had any hypoglycemic episodes, no night sweats. Feet are inspected and there are no callouses, no compromised skin.
No vision complaints.

Impression: Sub optimal sugar, control with retinopathy and neuropathy, high glucometer readings.

Home Glucose Monitoring:
AC breakfast 110 to 220
AC breakfast mean 142
AC dinner 100 to 250
AC dinner mean 120

Plan

Medications:
HUMULIN INJ 70/30 20 u ac breakfast

Treatment: Will have annual foot exam at next visit.

Orders:
Ophthalmology consult
UA
HGBA1C
Metabolic Panel
Lipid Panel

Education/Counseling (time): 10 minutes

Coordination of Care (time): 10 minutes

Follow-up/Return Visit: 3 months

Disposition: return to clinic

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Chart Summary

Tom Gelato
Male DOB: 06/06/1938 0000-66666

Home: 111-111-111
Ins: Commercial xxxxx

Tests:

(1) Metabolic Panel (ML-03CHEM)

ALK PHOS	72 U/L
	35-100
BG RANDOM	125 mg/dl
	70-125
BUN	16 mg/dl
	7-25
CALCIUM	9.6 mg/dl
	8.2-10.2
CHLORIDE	101 mmol/l
	96-109
CO2	27 mmol/l
	23-29
CREATININE	0.7 mg/dl
	0.6-1.2
PO4	2.9 mg/dl
	2.5-4.5
POTASSIUM	4.5 mmol/l
	3.5-5.3
SGOT (AST)	31 U/L
	0-40
BILI TOTAL	0.7 mg/dl
	0.0-1.3
URIC ACID	4.8 mg/dl
	3.4-7.0
LDH, TOTAL	136 IU/L
	0-200
SODIUM	135 mmol/l
	135-145

(2) HbA1c Test

HbA1c level	11.0%

(3) Lipid Profile

Cholesterol, Total	210 mg/dl
Triglycerides	236 mg/dl
HDL Cholesterol	36
LDL Cholesterol	102

Tom Gelato

Home: 666-666-6666

Male DOB: 06/06/1938 0000-66666 Ins: Commercial xxxxx

Flowsheet

Enterprise/Medicine/Internal Medicine

Date	11/13/2010
HEIGHT (in)	66
WEIGHT (lb)	195
TEMPERATURE (deg F)	98
TEMP SITE	oral
PULSE RATE (/min)	72
PULSE RHYTHM	
RESP RATE (/min)	16
BP SYSTOLIC (mm Hg)	131
BP DIASTOLIC (mm Hg)	94
CHOLESTEROL (mg/dL)	
HDL (mg/dL)	
LDL (mg/dL)	102
BG RANDOM (mg/dL)	125
CXR	
EKG	
PAP SMEAR	
BREAST EXAM	
MAMMOGRAM	
HEMOCCULT	neg
FLU VAX	
PNEUMOVAX	
TD BOOSTER	0.5 ml g
Foot Exam	
Eye Exam	

Appendix 14B. Sample Medical Record: Steve Apple

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Steve Apple Home: 222-222-2222
Male DOB: 02/02/1945 0000-22222 Ins: Commercial xxxxx

Patient Information

Name: Steve Apple
Address: 2222 Computer Dr
Laptop, California
Patient ID: 0000-22222
Birth Date: 02/02/1945
Gender: Male
Contact By: Phone
Soc Sec No: 222-22-2222
Resp Prov: Carl Savem
Referred by:
Email:
Home LOC: WeServeEveryone

Home Phone: 222-222-2222
Office Phone:
Fax:
Status: Active
Marital Status: Married
Race: White
Language: English
MRN: MR-111-1111
Emp. Status: Full-time
Sens Chart: No
External ID: MR-111-1111

Problems

DIABETES MELLITUS (ICD-250.)

Medications

PRINIVIL TABS 20 MG (LISINOPRIL) 1 po qd
Last Refill: #30 x 2 : Carl Savem MD (11/27/2010)
HUMULIN INJ 70/30 (INSULIN REG & ISOPHANE (HUMAN)) 20 units ac breakfast
Last Refill: #600 u x 0 : Carl Savem MD (11/27/2010)

Directives

Allergies and Adverse Reactions (! = critical)

Services Due

CREATININE

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Steve Apple Home: 222-222-2222
Male DOB: 02/02/1945 0000-22222 Ins: Commercial xxxxx

2/1/2011 - Office Visit: F/u Diabetes
Provider: Carl Savem MD
Location of Care: WeServeEveryone Clinic

OFFICE VISIT

History of Present Illness
Reason for visit: Routine follow up to review medications
Chief Complaint: No complaints

History

Diabetes Management
Hyperglycemic Symptoms
Polyuria: no
Polydipsia: no
Blurred vision: no

Sympathomimetic Symptoms
Diaphoresis: no
Agitation: no
Tremor: no
Palpitations: no
Insomnia: no

Neuroglycopenic Symptoms

Confusion: no
Lethargy: no
Somnolence: no
Amnesia: no
Stupor: no
Seizures: no

Review of Systems
General: denies fatigue, malaise,
Eyes: denies blurring, diplopia, irritation, discharge
Ear/Nose/Throat: denies ear pain or discharge, nasal obstruction or discharge, sore throat
Cardiovascular: denies chest pain, palpitations, paroxysmal nocturnal dyspnea, orthopnea, edema
Respiratory: denies coughing, wheezing, dyspnea, hemoptysis
Gastrointestinal: denies abdominal pain
Musculoskeletal: denies back pain, joint swelling, joint stiffness, joint pain
Skin: denies rashes, itching, lumps, sores, lesions, color change
Neurologic: denies syncope, seizures
Psychiatric: denies depression, anxiety, mental disturbance, difficulty sleeping,hallucinations, paranoia
Endocrine: denies polyuria, polydipsia, polyphagia, weight change, heat or cold intolerance
Heme/Lymphatic: denies easy or excessive bruising, history of blood transfusions, anemia, bleeding disorders, adenopathy, chills, sweats
Allergic/Immunologic: denies urticaria, hay fever

Vital Signs

Steve Apple Home: 222-222-2222
Male DOB: 02/02/1945 0000-22222 Ins: Commercial xxxxx

Ht: **71** in. Wt: **191** lbs. T: **98.0** degF. T site: **oral** P: **72** Rhythm: **regular** R: **16** BP: **118/70**

Physical Exam

General Appearance: no acute distress
Eyes: conjunctiva and lids normal, PERRLA, EOMI, fundi WNL
Ears, Nose, Mouth, Throat: TM clear, nares clear, oral exam WNL
Respiratory: clear to auscultation and percussion, respiratory effort normal
Cardiovascular: regular rate and rhythm, S1-S2, no murmur, rub or gallop, no bruits, peripheral pulses normal and symmetric, no cyanosis, clubbing, edema or varicosities
Skin: clear, good turgor, color WNL, no rashes, lesions, or ulcerations

Assessment

Problems (including changes): Feet are inspected and there are no callouses, no compromised skin. No vision complaints.

Impression: Sub optimal sugar, control with retinopathy and neuropathy, high glucometer readings.

Plan

Medications:
HUMULIN INJ 70/30 20 u ac breakfast
PRINIVIL TABS 20 MG 1 qd

Treatment: Will have annual foot exam at next visit.

Orders:

Lipid Panel

Education/Counseling (time): 15minutes

Coordination of Care (time): 5 minutes

Follow-up/Return Visit: 3 months

Disposition: return to clinic

Steve Apple
Male DOB: 02/02/1945 0000-22222

Home: 222.222.2222
Ins: Commercial xxxxx

2/1/2011 - Lab Report: Metabolic Panel Provider: Carl Savem MD

Patient: Steve Apple
Note: All result statuses are Final unless otherwise noted.

Tests:

(1) Metabolic Panel (ML-03CHEM)

ALK PHOS	72 U/L
	35-100
BG RANDOM	125 mg/dl
	70-125
BUN	16 mg/dl
	7-25
CALCIUM	9.6 mg/dl
	8.2-10.2
CHLORIDE	101 mmol/l
	96-109
CO2	27 mmol/l
	23-29
CREATININE	0.7 mg/dl
	0.6-1.2
PO4	2.9 mg/dl
	2.5-4.5
POTASSIUM	4.5 mmol/l
	3.5-5.3
SGOT (AST)	31 U/L
	0-40
BILI TOTAL	0.7 mg/dl
	0.0-1.3
URIC ACID	4.8 mg/dl
	3.4-7.0
LDH, TOTAL	136 IU/L
	0-200
SODIUM	135 mmol/l
	135-145

(2) HbA1c Test

HbA1c level	5.0%

(3) Lipid Profile

Cholesterol, Total	210 mg/dl
Triglycerides	236 mg/dl
HDL Cholesterol	36
LDL Cholesterol	87

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Chart Summary

Steve Apple

Home: 222-222-2222

Male DOB: 02/02/1945 0000-22222 Ins: Commercial xxxxx

Flowsheet

Date	2/1/2011
HEIGHT (in)	71
WEIGHT (lb)	191
TEMPERATURE (deg F)	98
TEMP SITE	oral
PULSE RATE (/min)	72
PULSE RHYTHM	
RESP RATE (/min)	16
BP SYSTOLIC (mm Hg)	118
BP DIASTOLIC (mm Hg)	70
CHOLESTEROL (mg/dL)	
HDL (mg/dL)	
LDL (mg/dL)	87
BG RANDOM (mg/dL)	125
CXR	
EKG	
PAP SMEAR	
BREAST EXAM	
MAMMOGRAM	
HEMOCCULT	neg
FLU VAX	0.5 ml g
PNEUMOVAX	0.5 ml g
TD BOOSTER	0.5 ml g
Foot Exam	Complete
Eye Exam	**Complete**

Appendix 14 B. Sample Medical Record: Bill Windows

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Chart Summary

Bill Windows
Male DOB: 09/09/1953 0000-99999

Home: 999-999-9999
Ins: Commercial xxxxx

Patient Information

Name: Bill Windows
Address: 9999 Computer Dr
Operating System, California
Patient ID: 0000-99999
Birth Date: 09/09/1953
Gender: Male
Contact By: Phone
Soc Sec No: 999-99-9999
Resp Prov: Carl Savem
Referred by:
Email:
Home LOC: WeServeEveryone

Home Phone: 999-999-9999
Office Phone:
Fax:
Status: Active
Marital Status: Married
Race: White
Language: English
MRN: MR-111-1111
Emp. Status: Full-time
Sens Chart: No
External ID: MR-111-1111

Problems

DIABETES MELLITUS (ICD-250.)

Medications

HUMULIN INJ 70/30 (INSULIN REG & ISOPHANE (HUMAN)) 20 units ac breakfast
Last Refill: #600 u x 0: Carl Savem MD (09/27/2010)

Directives

DO NOT RESUSCITATE

Allergies and Adverse Reactions (! = critical)

Services Due

BP DIASTOLIC, BP SYSTOLIC, FLU VAX, PNEUMOVAX, MICROALB URN, FLU VAX, BP DIASTOLIC, BP SYSTOLIC, DIAB FOOT CK, ALBUMIN URIN, TSH, CHOLESTEROL, HGBA1C, CREATININE.

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Chart Summary

Bill Windows Home: 999-999-9999
Male DOB: 09/09/1953 0000-99999 Ins: Commercial xxxxx

01/20/11- Office Visit: F/u Diabetes
Provider: Carl Savem MD
Location of Care: WeServeEveryone Clinic

OFFICE VISIT

History of Present Illness
Reason for visit: Routine follow up for Diabetes
Chief Complaint: No complaints

Diabetes Management
Hyperglycemic Symptoms
Polyuria: no
Polydipsia: no
Blurred vision: no

Sympathomimetic Symptoms
Diaphoresis: no
Agitation: no
Tremor: no
Palpitations: no
Insomnia: no

Neuroglycopenic Symptoms
Confusion: no
Lethargy: no
Somnolence: no
Amnesia: no
Stupor: no
Seizures: no

Review of Systems
General: denies fatigue, malaise, fever, weight loss
Eyes: denies blurring, diplopia, irritation, discharge
Ear/Nose/Throat: denies ear pain or discharge, nasal obstruction or discharge, sore throat
Cardiovascular: denies chest pain, palpitations, paroxysmal nocturnal dyspnea, orthopnea, edema
Respiratory: denies coughing, wheezing, dyspnea, hemoptysis
Gastrointestinal: denies abdominal pain, dysphagia, nausea, vomiting, diarrhea, constipation
Genitourinary: denies hematuria, frequency, urgency, dysuria, discharge, impotence, incontinence
Musculoskeletal: denies back pain, joint swelling, joint stiffness, joint pain
Skin: denies rashes, itching, lumps, sores, lesions, color change
Neurologic: denies syncope, seizures, transient paralysis, weakness, paresthesias
Psychiatric: denies depression, anxiety, mental disturbance, difficulty sleeping, suicidal ideation, hallucinations, paranoia
Endocrine: denies polyuria, polydipsia, polyphagia, weight change, heat or cold intolerance
Heme/Lymphatic: denies easy or excessive bruising, history of blood transfusions, anemia, bleeding disorders, adenopathy, chills, sweats
Allergic/Immunologic: denies urticaria, hay fever, frequent UTIs; denies HIV high risk behaviors

Vital Signs

Bill Windows

Home: 999-999-9999

Male DOB: 09/09/1953 0000-99999 Ins: Commercial xxxxx

Ht: **73** in. Wt: **200** lbs. T: **98.0** degF. T site: **oral** P: **74** Rhythm: **regular** R: **15** BP: **128/ 70**

Physical Exam

General Appearance: well developed, well nourished, no acute distress
Eyes: conjunctiva and lids normal
Ears, Nose, Mouth, Throat: TM clear, nares clear, oral exam WNL
Respiratory: respiratory effort normal
Cardiovascular: regular rate and rhythm
Skin: clear, good turgor, color WNL, no rashes, lesions, or ulcerations

Assessment

Problems (including changes): He is following his diet, by his account. He has not had any hypoglycemic episodes, no night sweats. Feet are inspected and there are no callouses, no compromised skin. No vision complaints.

Impression: Sub optimal sugar, high glucometer readings.
He will work harder on diet. Will increase insulin by 2 units. BP and symptoms are better.

Home Glucose Monitoring:
AC breakfast 110 to 220
AC breakfast mean 142
AC dinner 100 to 250
AC dinner mean 120

Plan

Medications:
HUMULIN INJ 70/30 20 u ac breakfast

Treatment: Will have annual foot exam at next visit.

Orders:
UA
HGBA1C
Metabolic Panel
Lipid Panel

Education/Counseling (time): 10 minutes

Coordination of Care (time): 10 minutes

Follow-up/Return Visit: 3 months

Disposition: return to clinic

Bill Windows
Male DOB: 09/09/1953 0000-99999

Home: 999-999-9999
Ins: Commercial xxxxx

01/20/2015 - Lab Report: Metabolic Panel Provider: Carl Savem MD
Location of Care: Millennium Health System

Patient: Bill Windows
Note: All result statuses are Final unless otherwise noted.

Tests:

(1) HbA1c Test

HbA1c level	6.0%

(2) Lipid Profile

Cholesterol, Total	210 mg/dl
Triglycerides	236 mg/dl
HDL Cholesterol	36
LDL Cholesterol	127

Bill Windows
Male DOB: 09/09/1953 0000-99999

Home: 999-999-9999
Ins: Commercial xxxxx

Flowsheet

Enterprise/Medicine/Internal Medicine

Date	01/20/2011	01/19/201
HEIGHT (in)		70
WEIGHT (lb)		190
TEMPERATURE (deg F)		98
TEMP SITE		oral
PULSE RATE (/min)		72
PULSE RHYTHM		
RESP RATE (/min)		16
BP SYSTOLIC (mm Hg)		128
BP DIASTOLIC (mm Hg)		70
CHOLESTEROL (mg/dL)		
HDL (mg/dL)		
LDL (mg/dL)	127	
BG RANDOM (mg/dL)	125	
CXR		
EKG		
PAP SMEAR		
BREAST EXAM		
MAMMOGRAM		
HEMOCCULT		neg
FLU VAX		0.5 ml g
PNEUMOVAX		0.5 ml g
TD BOOSTER		0.5 ml g
Foot Exam		Complete
Eye Exam		**Complete**

Appendix 14B. Sample Medical Record: Monica Latte

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Monica Latte Home: 444-44-4444
Female DOB: 04/04/1950 0000-44444 Ins: Commercial Orange Shield

Patient Information

Name: Monica Latte
Address: 4444 Coffee Ave
Chocolate, California
Patient ID: 0000-44444
Birth Date: 04/04/1950
Gender: Female
Contact By: Phone
Soc Sec No: 444-44-4444
Resp Prov: Carl Savem
Referred by:
Email:
Home LOC: WeServeEveryone

Home Phone: 444-444-4444
Office Phone:
Fax:
Status: Active
Marital Status: Divorced
Race: Black
Language: English
MRN: MR-111-1111
Emp. Status: Full-time
Sens Chart: No
External ID: MR-111-1111

Problems

DIABETES MELLITUS (ICD-250.)
HYPERTENSION, BENIGN ESSENTIAL (ICD-401.1)

Medications

PRINIVIL TABS 20 MG (LISINOPRIL) 1 po qd
Last Refill: #30 x 2 : Carl Savem MD (08/27/2010)
HUMULIN INJ 70/30 (INSULIN REG & ISOPHANE (HUMAN)) 20 units ac breakfast
Last Refill: #600 u x 0 : Carl Savem MD (08/27/2010)

Directives

Allergies and Adverse Reactions (! = critical)

Services Due

FLU VAX, PNEUMOVAX, MICROALB URN

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Monica Latte Home: 444-444-4444
Female DOB: 04/04/1950 0000-44444 Ins: Commercial xxxxx

3/18/2011 - Office Visit: F/u Diabetes
Provider: Carl Savem MD
Location of Care: WeServeEveryone Clinic

OFFICE VISIT

History of Present Illness
Reason for visit: Routine follow
Chief Complaint: No complaints

History

Diabetes Management
Hyperglycemic Symptoms
Polyuria: no
Polydipsia: no
Blurred vision: no

Sympathomimetic Symptoms
Diaphoresis: no
Agitation: no
Tremor: no
Palpitations: no
Insomnia: no

Neuroglycopenic Symptoms
Confusion: no
Lethargy: no
Somnolence: no
Amnesia: no
Stupor: no
Seizures: no

Review of Systems
General: denies fatigue, malaise, fever, weight loss
Eyes: denies blurring, diplopia, irritation, discharge
Ear/Nose/Throat: denies ear pain or discharge
Cardiovascular: denies chest pain
Respiratory: denies coughing, wheezing, dyspnea, hemoptysis
Gastrointestinal: denies abdominal pain, dysphagia, nausea, vomiting, diarrhea, constipation
Musculoskeletal: denies back pain, joint swelling, joint stiffness, joint pain
Skin: denies rashes, itching, lumps, sores, lesions, color change
Neurologic: denies syncope
Psychiatric: denies depression, anxiety, mental disturbance, difficulty sleeping, suicidal ideation, hallucinations, paranoia
Endocrine: denies polyuria, polydipsia, polyphagia, weight change, heat or cold intolerance
Heme/Lymphatic: denies easy or excessive bruising, history of blood transfusions, anemia, bleeding disorders, adenopathy, chills, sweats
Allergic/Immunologic: denies urticaria

Vital Signs

Monica Latte Home: 444-444-4444
Female DOB: 04/04/1950 0000-44444 Ins: Commercial xxxxx

Ht: **64** in. Wt: **140** lbs. T: **98.0** degF. T site: **oral** P: **72** Rhythm: **regular** R: **16** BP: **158/90**

Physical Exam

General Appearance: well developed, well nourished, no acute distress
Eyes: conjunctiva and lids normal, PERRLA, EOMI, fundi WNL
Ears, Nose, Mouth, Throat: TM clear, nares clear, oral exam WNL
Respiratory: clear to auscultation and percussion, respiratory effort normal
Cardiovascular: regular rate and rhythm, S1-S2, no murmur, rub or gallop, no bruits, peripheral pulses normal and symmetric, no cyanosis, clubbing, edema or varicosities
Skin: clear, good turgor, color WNL, no rashes, lesions, or ulcerations

Assessment

Problems (including changes): Blood pressure is lower. Feet are inspected and there are no callouses, no compromised skin. No vision complaints.

Impression: Sub optimal sugar, control with retinopathy and neuropathy, high glucometer readings. Will work harder on diet. Will increase insulin by 2 units.

Home Glucose Monitoring:
AC breakfast 110 to 220
AC breakfast mean 142
AC dinner 100 to 250
AC dinner mean 120

Plan

Medications:
HUMULIN INJ 70/30 20 u ac breakfast
PRINIVIL TABS 20 MG 1 qd

Treatment: Will have annual foot exam at next visit.

Orders:
UA
Metabolic Panel

Education/Counseling (time): 5 minutes

Coordination of Care (time): 20 minutes

Follow-up/Return Visit: 3 months

Disposition: return to clinic

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Monica Latte Home: 444-444-4444
Female DOB: 04/04/1950 0000-44444 Ins: Commercial xxxxx

03/18/2011 - Lab Report: Metabolic Panel Provider: Carl Savem MD

Tests:

(1) HbA1c Test

HbA1c level	6.0%

(2) Lipid Profile

Cholesterol, Total	210 mg/dl
Triglycerides	236 mg/dl
HDL Cholesterol	36
LDL Cholesterol	107

Monica Latte

Home: 444-444-4444

Female DOB: 04/04/1950 0000-44444 Ins: Commercial xxxxx

Flowsheet

Enterprise/Medicine/Internal Medicine

Date	03/18/2011
HEIGHT (in)	64
WEIGHT (lb)	140
TEMPERATURE (deg F)	98
TEMP SITE	oral
PULSE RATE (/min)	72
PULSE RHYTHM	
RESP RATE (/min)	16
BP SYSTOLIC (mm Hg)	158
BP DIASTOLIC (mm Hg)	90
CHOLESTEROL (mg/dL)	
HDL (mg/dL)	
LDL (mg/dL) 107	
BG RANDOM (mg/dL)	125
CXR	
EKG	
PAP SMEAR	
BREAST EXAM	
MAMMOGRAM	
HEMOCCULT	neg
FLU VAX	
PNEUMOVAX	
TD BOOSTER	0.5 ml g
Foot Exam	
Eye Exam	Complete

Appendix 14B. Sample Medical Record: John Donut

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Chart Summary

John Donut
Male DOB: 01/01/1935 0000-11111

Home: 000-000-0000
Ins: Commercial xxxxx

Patient Information

Name: John Donut
Address: 1111 Donut Road
Fast Food, California
Patient ID: 0000-11111
Birth Date: 01/01/1935
Gender: Male
Contact By: Phone
Soc Sec No: 111-11-1111
Resp Prov: Carl Savem
Referred by:
Email:
Home LOC: WeServeEveryone

Home Phone: 000-000-0000
Office Phone:
Fax:
Status: Active
Marital Status: Widowed
Race: Black
Language: English
MRN: MR-111-1111
Emp. Status: Part-time
Sens Chart: No
External ID: MR-111-1111

Problems

DIABETES MELLITUS (ICD-250.)
HYPERTENSION, BENIGN ESSENTIAL (ICD-401.1)
HYPERPLASIA, PROSTATE (ICD-600)
DEPRESSION (ICD-311)
RETINOPATHY, DIABETIC (ICD-362.0)
POLYNEUROPATHY IN DIABETES (ICD-357.2)

Medications

PRINIVIL TABS 20 MG (LISINOPRIL) 1 po qd
Last Refill: #30 x 2 : Carl Savem MD (05/27/2010)
HUMULIN INJ 70/30 (INSULIN REG & ISOPHANE (HUMAN)) 20 units ac breakfast
Last Refill: #600 u x 0 : Carl Savem MD (05/27/2010)

Directives

Allergies and Adverse Reactions (! = critical)

Services Due

HEMOCCULT or SIGMOID, BP DIASTOLIC, BP SYSTOLIC, FLU VAX, PNEUMOVAX, MICROALB URN

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

John Donut Home: 000-000-0000
Male DOB: 01/01/1935 0000-11111 Ins: Commercial xxxxx

10/31/2010 - Office Visit: F/u Diabetes
Provider: Carl Savem MD
Location of Care: WeServeEveryone Clinic

OFFICE VISIT

History of Present Illness
Reason for visit: Routine follow up to review medications **Chief Complaint:** No complaints

History

Diabetes Management
Hyperglycemic Symptoms
Polyuria: no
Polydipsia: no
Blurred vision: no

Sympathomimetic Symptoms
Diaphoresis: no
Agitation: no
Tremor: no
Palpitations: no
Insomnia: no

Neuroglycopenic Symptoms
Confusion: no
Lethargy: no
Somnolence: no
Amnesia: no
Stupor: no
Seizures: no

Review of Systems
General: denies fatigue, malaise, fever, weight loss
Eyes: denies blurring, diplopia, irritation, discharge
Ear/Nose/Throat: denies ear pain or discharge, nasal obstruction or discharge, sore throat
Cardiovascular: denies chest pain, palpitations, paroxysmal nocturnal dyspnea, orthopnea, edema
Respiratory: denies coughing, wheezing, dyspnea, hemoptysis
Gastrointestinal: denies abdominal pain, dysphagia, nausea, vomiting, diarrhea, constipation
Genitourinary: denies hematuria, frequency, urgency, dysuria, discharge, impotence, incontinence
Musculoskeletal: denies back pain, joint swelling, joint stiffness, joint pain
Skin: denies rashes, itching, lumps, sores, lesions, color change
Neurologic: denies syncope, seizures, transient paralysis, weakness, paresthesias
Psychiatric: denies depression, anxiety, mental disturbance, difficulty sleeping, suicidal ideation, hallucinations, paranoia
Endocrine: denies polyuria, polydipsia, polyphagia, weight change, heat or cold intolerance
Heme/Lymphatic: denies easy or excessive bruising, history of blood transfusions, anemia, bleeding disorders, adenopathy, chills, sweats
Allergic/Immunologic: denies urticaria, hay fever, frequent UTIs; denies HIV high risk behaviors

Vital Signs

John Donut Home: 000-000-0000
Male DOB: 01/01/1935 0000-11111 Ins: Commercial xxxxx

Ht: **74** in. Wt: **190** lbs. T: **98.0** degF. T site: **oral** P: **72** Rhythm: **regular** R: **16** BP: **158/ 90**

Physical Exam

General Appearance: well developed, well nourished, no acute distress
Eyes: conjunctiva and lids normal, PERRLA, EOMI, fundi WNL
Ears, Nose, Mouth, Throat: TM clear, nares clear, oral exam WNL
Respiratory: clear to auscultation and percussion, respiratory effort normal
Cardiovascular: regular rate and rhythm, S1-S2, no murmur, rub or gallop, no bruits, peripheral pulses normal and symmetric, no cyanosis, clubbing, edema or varicosities
Skin: clear, good turgor, color WNL, no rashes, lesions, or ulcerations

Assessment

Problems (including changes): Blood pressure is lower. He is following his diet, by his account. He has not had any hypoglycemic episodes, no night sweats. Feet are inspected and there are no callouses, no compromised skin. No vision complaints.

Impression: Sub optimal sugar, control with retinopathy and neuropathy, high glucometer readings. He will work harder on diet. Will increase insulin by 2 units. BP better.

Plan

Medications:
HUMULIN INJ 70/30 20 u ac breakfast
PRINIVIL TABS 20 MG 1 qd

Treatment: Will have annual foot exam at next visit.

Orders:
Ophthalmology consult
UA
HGBA1C
Metabolic Panel
Lipid Panel
Hemoccult

Education/Counseling (time): 10 minutes

Coordination of Care (time): 10 minutes

Follow-up/Return Visit: 3 months

Disposition: return to clinic

John Donut Home: 000-000-0000
Male DOB: 01/01/1935 0000-11111 Ins: Commercial xxxxx

Ins: BHI (Futura) Grp: BHI1595

10/31/2010 - Lab Report: Metabolic Panel Provider: Carl Savem MD
Location of Care: Millennium Health System

Tests:
(1) Metabolic Panel (ML-03CHEM)

ALK PHOS	72 U/L	35-100
BG RANDOM	125 mg/dl	70-125
BUN	16 mg/dl	7-25
CALCIUM	9.6 mg/dl	8.2-10.2
CHLORIDE	101 mmol/l	96-109
CO2	27 mmol/l	23-29
CREATININE	0.7 mg/dl	0.6-1.2
PO4	2.9 mg/dl	2.5-4.5
POTASSIUM	4.5 mmol/l	3.5-5.3
SGOT (AST)	31 U/L	0-40
BILI TOTAL	0.7 mg/dl	0.0-1.3
URIC ACID	4.8 mg/dl	3.4-7.0
LDH, TOTAL	136 IU/L	0-200
SODIUM	135 mmol/l	135-145

2) HbA1c Test

HbA1c level	8.0%

(3) Lipid Profile

Cholesterol, Total	210 mg/dl
Triglycerides	236 mg/dl
HDL Cholesterol	36
LDL Cholesterol	102

John Donut

Home: 000-000-0000

Male DOB: 01/01/1935 0000-11111 Ins: Commercial xxxxx

Flowsheet

Date	10/31/2010
HEIGHT (in)	74
WEIGHT (lb)	190
TEMPERATURE (deg F)	98
TEMP SITE	oral
PULSE RATE (/min)	72
PULSE RHYTHM	
RESP RATE (/min)	16
BP SYSTOLIC (mm Hg)	158
BP DIASTOLIC (mm Hg)	90
CHOLESTEROL (mg/dL)	
HDL (mg/dL)	
LDL (mg/dL)	102
BG RANDOM (mg/dL)	125
CXR	
EKG	
PAP SMEAR	
BREAST EXAM	
MAMMOGRAM	
HEMOCCULT	neg
FLU VAX	0.5 ml g
PNEUMOVAX	0.5 ml g
TD BOOSTER	0.5 ml g
Foot Exam	
Eye Exam	

Appendix 14 B. Sample Medical Record: Adam Pie

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Adam Pie Home: 888-888-8888
Male DOB: 08/08/1948 0000-88888 Ins: Commercial xxxx

Patient Information

Name: Adam Pie **Home Phone:** 888-888-8888
Address: 8888 Crust Dr **Office Phone:**
Filling, California
Patient ID: 0000-88888 **Fax:**
Birth Date: 08/08/1948 **Status:** Active
Gender: Male **Marital Status:** Married
Contact By: Phone **Race:** White
Soc Sec No: 888-88-8888 **Language:** English
Resp Prov: Carl Savem **MRN:** MR-111-1111
Referred by: **Emp. Status:** Full-time
Email: **Sens Chart:** No
Home LOC: WeServeEveryone **External ID:** MR-111-1111

Problems

DIABETES MELLITUS (ICD-250.)
HYPERTENSION, BENIGN ESSENTIAL (ICD-401.1) HYPERPLASIA, PROSTATE (ICD-600)
DEPRESSION (ICD-311)
RETINOPATHY, DIABETIC (ICD-362.0)
POLYNEUROPATHY IN DIABETES (ICD-357.2)

Medications

HYTRIN CAP 5MG (TERAZOSIN HCL) 1 po qd
Last Refill: #30 x 0 : Carl Savem (10/27/2010)
PRINIVIL TABS 20 MG (LISINOPRIL) 1 po qd
Last Refill: #30 x 2 : Carl Savem MD (10/27/2010)
HUMULIN INJ 70/30 (INSULIN REG & ISOPHANE (HUMAN)) 20 units
ac breakfast
Last Refill: #600 u x 0 : Carl Savem MD (10/27/2010)
PROZAC CAPS 10 MG (FLUOXETINE HCL) 1 po qd
Last Refill: #30 x 2 : Carl Savem MD (10/27/2010)

Directives

DO NOT RESUSCITATE

Allergies and Adverse Reactions (! = critical)

! CODEINE

Services Due

HEMOCCULT or SIGMOID, BP DIASTOLIC, BP SYSTOLIC, FLU VAX, PNEUMOVAX,
MICROALB URN, FLU VAX, BP DIASTOLIC, BP SYSTOLIC, FUNDUSCOPY, DIAB FOOT CK,
ALBUMIN URIN, TSH,
CHOLESTEROL, HGBA1C, CREATININE.

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Adam Pie Home: 888-888-8888
Male DOB: 08/08/1948 0000-88888 Ins: Commercial xxxx

12/18/2010 - Office Visit: F/u Diabetes
Provider: Carl Savem MD
Location of Care: WeServeEveryone Clinic

OFFICE VISIT

History of Present Illness
Reason for visit: Routine follow up to review medications **Chief Complaint:** No complaints

History
Social History: His wife Marzapan died 5 years ago this month and he is more introspective.

Diabetes Management
Hyperglycemic Symptoms
Polyuria: no
Polydipsia: no
Blurred vision: no

Sympathomimetic Symptoms
Diaphoresis: no
Agitation: no
Tremor: no
Palpitations: no
Insomnia: no

Neuroglycopenic Symptoms
Confusion: no
Lethargy: no
Somnolence: no
Amnesia: no
Stupor: no
Seizures: no

Review of Systems
General: denies fatigue, malaise, fever, weight loss
Eyes: denies blurring, diplopia, irritation, discharge
Ear/Nose/Throat: denies ear pain or discharge, nasal obstruction or discharge, sore throat
Cardiovascular: denies chest pain, palpitations, paroxysmal nocturnal dyspnea, orthopnea, edema
Respiratory: denies coughing, wheezing, dyspnea, hemoptysis
Gastrointestinal: denies abdominal pain, dysphagia, nausea, vomiting, diarrhea, constipation
Genitourinary: denies hematuria, frequency, urgency, dysuria, discharge, impotence, incontinence
Musculoskeletal: denies back pain, joint swelling, joint stiffness, joint pain
Skin: denies rashes, itching, lumps, sores, lesions, color change
Neurologic: denies syncope, seizures, transient paralysis, weakness, paresthesias
Psychiatric: denies depression, anxiety, mental disturbance, difficulty sleeping, suicidal ideation, hallucinations, paranoia
Endocrine: denies polyuria, polydipsia, polyphagia, weight change, heat or cold intolerance
Heme/Lymphatic: denies easy or excessive bruising, history of blood transfusions, anemia, bleeding disorders, adenopathy, chills, sweats
Allergic/Immunologic: denies urticaria, hay fever, frequent UTIs; denies HIV high risk behaviors

Vital Signs

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Adam Pie
Male DOB: 08/08/1948 0000-88888

Home: 888-888-8888
Ins: Commercial xxxx

Ht: **70** in. Wt: **190** lbs. T: **98.0** degF. T site: **oral** P: **72** Rhythm: **regular** R: **16** BP: **158/ 90**

Physical Exam
General Appearance: well developed, well nourished, no acute distress
Eyes: conjunctiva and lids normal, PERRLA, EOMI, fundi WNL
Ears, Nose, Mouth, Throat: TM clear, nares clear, oral exam WNL
Respiratory: clear to auscultation and percussion, respiratory effort normal
Cardiovascular: regular rate and rhythm, S1-S2, no murmur, rub or gallop, no bruits, peripheral pulses normal and symmetric, no cyanosis, clubbing, edema or varicosities
Skin: clear, good turgor, color WNL, no rashes, lesions, or ulcerations

Assessment
Problems (including changes): Adam is voiding better since increasing Hytrin to 5 mg/day. Blood pressure is lower. He is following his diet, by his account. He has not had any hypoglycemic episodes, no night sweats. Feet are inspected and there are no callouses, no compromised skin. No vision complaints.

Impression: Sub optimal sugar, control with retinopathy and neuropathy, high glucometer readings. He will work harder on diet. Will increase insulin by 2 units. BP and symptoms of prostatism are better.

Home Glucose Monitoring:
AC breakfast 110 to 220
AC breakfast mean 142
AC dinner 100 to 250
AC dinner mean 120

Plan
Medications:
HUMULIN INJ 70/30 20 u ac breakfast
PRINIVIL TABS 20 MG 1 qd
HYTRIN CAP 5MG 1 qd
PROZAC CAPS 10 MG 1 qd

Treatment: Will have annual foot exam at next visit.

Orders:
Ophthalmology consult
UA
HGBA1C
Metabolic Panel
Lipid Panel
Hemoccult

Education/Counseling (time): 10 minutes

Coordination of Care (time): 10 minutes

Follow-up/Return Visit: 3 months

Disposition: return to clinic

WeServeEveryone Clinic

1111 First Street California
111-111-11111 Fax: 111-111-1111

Adam Pie

Home: 888-888-8888
Male DOB: 08/08/1948 0000-88888 Ins: Commercial xxxx

12/19/2010 - Lab Report: Metabolic Panel Provider: Carl Savem MD
Location of Care: Millennium Health System

Tests:

(1) Metabolic Panel (ML-03CHEM)

ALK PHOS	72 U/L	35-100
BG RANDOM	125 mg/dl	70-125
BUN	16 mg/dl	7-25
CALCIUM	9.6 mg/dl	8.2-10.2
CHLORIDE	101 mmol/l	96-109
CO2	27 mmol/l	23-29
CREATININE	0.7 mg/dl	0.6-1.2
PO4	2.9 mg/dl	2.5-4.5
POTASSIUM	4.5 mmol/l	3.5-5.3
SGOT (AST)	31 U/L	0-40
BILI TOTAL	0.7 mg/dl	0.0-1.3
URIC ACID	4.8 mg/dl	3.4-7.0
LDH, TOTAL	136 IU/L	0-200
SODIUM	135 mmol/l	135-145

(2) HbA1c Test

HbA1c level	6.0%

(3) Lipid Profile

Cholesterol, Total	210 mg/dl
Triglycerides	236 mg/dl
HDL Cholesterol	36
LDL Cholesterol	127

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Adam Pie Home: 888-888-8888
Male DOB: 08/08/1948 0000-88888 Ins: Commercial xxxx

FLOWSHEET

Date	12/19/2010	12/18/2010
HEIGHT (in)		70
WEIGHT (lb)		190
TEMPERATURE (deg F)		98
TEMP SITE		oral
PULSE RATE (/min)		72
PULSE RHYTHM		
RESP RATE (/min)		16
BP SYSTOLIC (mm Hg)		158
BP DIASTOLIC (mm Hg)		90
CHOLESTEROL (mg/dL)		
HDL (mg/dL)		
LDL (mg/dL)		127
BG RANDOM (mg/dL)	125	
CXR		
EKG		
PAP SMEAR		
BREAST EXAM		
MAMMOGRAM		
HEMOCCULT		neg
FLU VAX		0.5 ml g
PNEUMOVAX		0.5 ml g
TD BOOSTER		0.5 ml g
Foot Exam		Complete
Eye Exam		**Complete**

Appendix 14B. Sample Medical Record: Tom Gelato

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Chart Summary

Tom Gelato Home: 666-666-6666
Male DOB: 06/06/1938 0000-66666 Ins: Commercial xxxxx

Patient Information

Name: Tom Gelato
Address: 5555 Flavor Ave
Ice Cream, California
Patient ID: 0000-66666
Birth Date: 06/06/1938
Gender: Male
Contact By: Phone
Soc Sec No: 666-666-6666
Resp Prov: Carl Savem
Referred by:
Email:
Home LOC: WeServeEveryone

Home Phone: 666-666-6666
Office Phone:
Fax:
Status: Active
Marital Status: Divorced
Race: White
Language: English
MRN: MR-111-1111
Emp. Status: Part-time
Sens Chart: No
External ID: MR-111-1111

Problems

DIABETES MELLITUS (ICD-250.)

Medications

HUMULIN INJ 70/30 (INSULIN REG & ISOPHANE (HUMAN)) 20 units
ac breakfast
Last Refill: #600 u x 0 : Carl Savem MD (04/17/2010)

Directives

DO NOT RESUSCITATE

Allergies and Adverse Reactions (! = critical)

! CODEINE

Services Due

FLU VAX, PNEUMOVAX, MICROALB URN

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Tom Gelato Home: 666-666-6666
Male DOB: 06/06/1938 0000-66666 Ins: Commercial xxxxx

11/13/2010 - Office Visit: F/u Diabetes
Provider: Carl Savem MD
Location of Care: WeServeEveryone Clinic

OFFICE VISIT

History of Present Illness
Reason for visit: Routine followup
Chief Complaint: No complaints

History

Diabetes Management
Hyperglycemic Symptoms
Polyuria: no
Polydipsia: no
Blurred vision: no

Sympathomimetic Symptoms
Diaphoresis: no
Agitation: no
Tremor: no
Palpitations: no
Insomnia: no

Neuroglycopenic Symptoms
Confusion: no
Lethargy: no
Somnolence: no
Amnesia: no
Stupor: no
Seizures: no

Review of Systems
General: denies fatigue, malaise, fever, weight loss
Eyes: denies blurring, diplopia, irritation, discharge
Ear/Nose/Throat: denies ear pain or discharge, nasal obstruction or discharge, sore throat
Cardiovascular: denies chest pain, palpitations, paroxysmal nocturnal dyspnea, orthopnea, edema
Respiratory: denies coughing, wheezing, dyspnea, hemoptysis
Gastrointestinal: denies abdominal pain, dysphagia, nausea, vomiting, diarrhea, constipation
Musculoskeletal: denies back pain, joint swelling, joint stiffness, joint pain
Skin: denies rashes, itching, lumps, sores, lesions, color change
Neurologic: denies syncope, seizures, transient paralysis, weakness, paresthesias
Psychiatric: denies depression, anxiety, mental disturbance, difficulty sleeping, suicidal ideation, hallucinations, paranoia
Endocrine: denies polyuria, polydipsia, polyphagia, weight change, heat or cold intolerance
Heme/Lymphatic: denies easy or excessive bruising, history of blood transfusions, anemia, bleeding disorders, adenopathy, chills, sweats
Allergic/Immunologic: denies urticaria, hay fever, frequent UTIs; denies HIV high risk behaviors

Vital Signs

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Male DOB: 06/06/1938
0000-66666
Ins: Commercial xxxxx

Tom Gelato

Home: 666-666-6666

Ht: **66** in. Wt: **195** lbs. T: **98.0** degF. T site: **oral** P: **72** Rhythm: **regular** R: **16** BP: **131/ 94**

Physical Exam

General Appearance: well developed, well nourished, no acute distress
Eyes: conjunctiva and lids normal, PERRLA, EOMI, fundi WNL
Ears, Nose, Mouth, Throat: TM clear, nares clear, oral exam WNL
Respiratory: clear to auscultation and percussion, respiratory effort normal
Cardiovascular: regular rate and rhythm, S1-S2, no murmur, rub or gallop, no bruits, peripheral pulses normal and symmetric, no cyanosis, clubbing, edema or varicosities
Skin: clear, good turgor, color WNL, no rashes, lesions, or ulcerations

Assessment

Problems (including changes): Blood pressure is lower. He is following his diet, by his account. He has not had any hypoglycemic episodes, no night sweats. Feet are inspected and there are no callouses, no compromised skin.
No vision complaints.

Impression: Sub optimal sugar, control with retinopathy and neuropathy, high glucometer readings.

Home Glucose Monitoring:
AC breakfast 110 to 220
AC breakfast mean 142
AC dinner 100 to 250
AC dinner mean 120

Plan

Medications:
HUMULIN INJ 70/30 20 u ac breakfast

Treatment: Will have annual foot exam at next visit.

Orders:
Ophthalmology consult
UA
HGBA1C
Metabolic Panel
Lipid Panel

Education/Counseling (time): 10 minutes

Coordination of Care (time): 10 minutes

Follow-up/Return Visit: 3 months

Disposition: return to clinic

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Chart Summary

Tom Gelato
Male DOB: 06/06/1938 0000-66666

Home: 111-111-111
Ins: Commercial xxxxx

Tests:

(1) Metabolic Panel (ML-03CHEM)

ALK PHOS	72 U/L
	35-100
BG RANDOM	125 mg/dl
	70-125
BUN	16 mg/dl
	7-25
CALCIUM	9.6 mg/dl
	8.2-10.2
CHLORIDE	101 mmol/l
	96-109
CO2	27 mmol/l
	23-29
CREATININE	0.7 mg/dl
	0.6-1.2
PO4	2.9 mg/dl
	2.5-4.5
POTASSIUM	4.5 mmol/l
	3.5-5.3
SGOT (AST)	31 U/L
	0-40
BILI TOTAL	0.7 mg/dl
	0.0-1.3
URIC ACID	4.8 mg/dl
	3.4-7.0
LDH, TOTAL	136 IU/L
	0-200
SODIUM	135 mmol/l
	135-145

(2) HbA1c Test

HbA1c level	11.0%

(3) Lipid Profile

Cholesterol, Total	210 mg/dl
Triglycerides	236 mg/dl
HDL Cholesterol	36
LDL Cholesterol	102

Tom Gelato

Home: 666-666-6666

Male DOB: 06/06/1938 0000-66666 Ins: Commercial xxxxx

Flowsheet

Enterprise/Medicine/Internal Medicine

Date	11/13/2010
HEIGHT (in)	66
WEIGHT (lb)	195
TEMPERATURE (deg F)	98
TEMP SITE	oral
PULSE RATE (/min)	72
PULSE RHYTHM	
RESP RATE (/min)	16
BP SYSTOLIC (mm Hg)	131
BP DIASTOLIC (mm Hg)	94
CHOLESTEROL (mg/dL)	
HDL (mg/dL)	
LDL (mg/dL)	102
BG RANDOM (mg/dL)	125
CXR	
EKG	
PAP SMEAR	
BREAST EXAM	
MAMMOGRAM	
HEMOCCULT	neg
FLU VAX	
PNEUMOVAX	
TD BOOSTER	0.5 ml g
Foot Exam	
Eye Exam	

Appendix 14B. Sample Medical Record: Steve Apple

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Steve Apple Home: 222-222-2222
Male DOB: 02/02/1945 0000-22222 Ins: Commercial xxxxx

Patient Information

Name: Steve Apple
Address: 2222 Computer Dr
Laptop, California
Patient ID: 0000-22222
Birth Date: 02/02/1945
Gender: Male
Contact By: Phone
Soc Sec No: 222-22-2222
Resp Prov: Carl Savem
Referred by:
Email:
Home LOC: WeServeEveryone

Home Phone: 222-222-2222
Office Phone:
Fax:
Status: Active
Marital Status: Married
Race: White
Language: English
MRN: MR-111-1111
Emp. Status: Full-time
Sens Chart: No
External ID: MR-111-1111

Problems

DIABETES MELLITUS (ICD-250.)

Medications

PRINIVIL TABS 20 MG (LISINOPRIL) 1 po qd
Last Refill: #30 x 2 : Carl Savem MD (11/27/2010)
HUMULIN INJ 70/30 (INSULIN REG & ISOPHANE (HUMAN)) 20 units ac breakfast
Last Refill: #600 u x 0 : Carl Savem MD (11/27/2010)

Directives

Allergies and Adverse Reactions (! = critical)

Services Due

CREATININE

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Steve Apple Home: 222-222-2222
Male DOB: 02/02/1945 0000-22222 Ins: Commercial xxxxx

2/1/2011 - Office Visit: F/u Diabetes
Provider: Carl Savem MD
Location of Care: WeServeEveryone Clinic

OFFICE VISIT

History of Present Illness
Reason for visit: Routine follow up to review medications
Chief Complaint: No complaints

History

Diabetes Management
Hyperglycemic Symptoms
Polyuria: no
Polydipsia: no
Blurred vision: no

Sympathomimetic Symptoms
Diaphoresis: no
Agitation: no
Tremor: no
Palpitations: no
Insomnia: no

Neuroglycopenic Symptoms

Confusion: no
Lethargy: no
Somnolence: no
Amnesia: no
Stupor: no
Seizures: no

Review of Systems
General: denies fatigue, malaise,
Eyes: denies blurring, diplopia, irritation, discharge
Ear/Nose/Throat: denies ear pain or discharge, nasal obstruction or discharge, sore throat
Cardiovascular: denies chest pain, palpitations, paroxysmal nocturnal dyspnea, orthopnea, edema
Respiratory: denies coughing, wheezing, dyspnea, hemoptysis
Gastrointestinal: denies abdominal pain
Musculoskeletal: denies back pain, joint swelling, joint stiffness, joint pain
Skin: denies rashes, itching, lumps, sores, lesions, color change
Neurologic: denies syncope, seizures
Psychiatric: denies depression, anxiety, mental disturbance, difficulty sleeping,hallucinations, paranoia
Endocrine: denies polyuria, polydipsia, polyphagia, weight change, heat or cold intolerance
Heme/Lymphatic: denies easy or excessive bruising, history of blood transfusions, anemia, bleeding disorders, adenopathy, chills, sweats
Allergic/Immunologic: denies urticaria, hay fever

Vital Signs

Steve Apple Home: 222-222-2222
Male DOB: 02/02/1945 0000-22222 Ins: Commercial xxxxx

Ht: **71** in. Wt: **191** lbs. T: **98.0** degF. T site: **oral** P: **72** Rhythm: **regular** R: **16** BP: **118/70**

Physical Exam

General Appearance: no acute distress
Eyes: conjunctiva and lids normal, PERRLA, EOMI, fundi WNL
Ears, Nose, Mouth, Throat: TM clear, nares clear, oral exam WNL
Respiratory: clear to auscultation and percussion, respiratory effort normal
Cardiovascular: regular rate and rhythm, S1-S2, no murmur, rub or gallop, no bruits, peripheral pulses normal and symmetric, no cyanosis, clubbing, edema or varicosities
Skin: clear, good turgor, color WNL, no rashes, lesions, or ulcerations

Assessment

Problems (including changes): Feet are inspected and there are no callouses, no compromised skin. No vision complaints.

Impression: Sub optimal sugar, control with retinopathy and neuropathy, high glucometer readings.

Plan

Medications:
HUMULIN INJ 70/30 20 u ac breakfast
PRINIVIL TABS 20 MG 1 qd

Treatment: Will have annual foot exam at next visit.

Orders:

Lipid Panel

Education/Counseling (time): 15minutes

Coordination of Care (time): 5 minutes

Follow-up/Return Visit: 3 months

Disposition: return to clinic

Steve Apple
Male DOB: 02/02/1945 0000-22222

Home: 222.222.2222
Ins: Commercial xxxxx

2/1/2011 - Lab Report: Metabolic Panel Provider: Carl Savem MD

Patient: Steve Apple
Note: All result statuses are Final unless otherwise noted.

Tests:

(1) Metabolic Panel (ML-03CHEM)

ALK PHOS	72 U/L
	35-100
BG RANDOM	125 mg/dl
	70-125
BUN	16 mg/dl
	7-25
CALCIUM	9.6 mg/dl
	8.2-10.2
CHLORIDE	101 mmol/l
	96-109
CO2	27 mmol/l
	23-29
CREATININE	0.7 mg/dl
	0.6-1.2
PO4	2.9 mg/dl
	2.5-4.5
POTASSIUM	4.5 mmol/l
	3.5-5.3
SGOT (AST)	31 U/L
	0-40
BILI TOTAL	0.7 mg/dl
	0.0-1.3
URIC ACID	4.8 mg/dl
	3.4-7.0
LDH, TOTAL	136 IU/L
	0-200
SODIUM	135 mmol/l
	135-145

(2) HbA1c Test

HbA1c level	5.0%

(3) Lipid Profile

Cholesterol, Total	210 mg/dl
Triglycerides	236 mg/dl
HDL Cholesterol	36
LDL Cholesterol	87

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Chart Summary

Steve Apple

Home: 222-222-2222

Male DOB: 02/02/1945 0000-22222 Ins: Commercial xxxxx

Flowsheet

Date	2/1/2011
HEIGHT (in)	71
WEIGHT (lb)	191
TEMPERATURE (deg F)	98
TEMP SITE	oral
PULSE RATE (/min)	72
PULSE RHYTHM	
RESP RATE (/min)	16
BP SYSTOLIC (mm Hg)	118
BP DIASTOLIC (mm Hg)	70
CHOLESTEROL (mg/dL)	
HDL (mg/dL)	
LDL (mg/dL)	87
BG RANDOM (mg/dL)	125
CXR	
EKG	
PAP SMEAR	
BREAST EXAM	
MAMMOGRAM	
HEMOCCULT	neg
FLU VAX	0.5 ml g
PNEUMOVAX	0.5 ml g
TD BOOSTER	0.5 ml g
Foot Exam	Complete
Eye Exam	**Complete**

Appendix 14 B. Sample Medical Record: Bill Windows

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Chart Summary

Bill Windows
Male DOB: 09/09/1953 0000-99999

Home: 999-999-9999
Ins: Commercial xxxxx

Patient Information

Name: Bill Windows
Address: 9999 Computer Dr
Operating System, California
Patient ID: 0000-99999
Birth Date: 09/09/1953
Gender: Male
Contact By: Phone
Soc Sec No: 999-99-9999
Resp Prov: Carl Savem
Referred by:
Email:
Home LOC: WeServeEveryone

Home Phone: 999-999-9999
Office Phone:
Fax:
Status: Active
Marital Status: Married
Race: White
Language: English
MRN: MR-111-1111
Emp. Status: Full-time
Sens Chart: No
External ID: MR-111-1111

Problems

DIABETES MELLITUS (ICD-250.)

Medications

HUMULIN INJ 70/30 (INSULIN REG & ISOPHANE (HUMAN)) 20 units ac breakfast
Last Refill: #600 u x 0: Carl Savem MD (09/27/2010)

Directives

DO NOT RESUSCITATE

Allergies and Adverse Reactions (! = critical)

Services Due

BP DIASTOLIC, BP SYSTOLIC, FLU VAX, PNEUMOVAX, MICROALB URN, FLU VAX, BP DIASTOLIC, BP SYSTOLIC, DIAB FOOT CK, ALBUMIN URIN, TSH, CHOLESTEROL, HGBA1C, CREATININE.

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Chart Summary

Bill Windows Home: 999-999-9999
Male DOB: 09/09/1953 0000-99999 Ins: Commercial xxxxx

01/20/11- Office Visit: F/u Diabetes
Provider: Carl Savem MD
Location of Care: WeServeEveryone Clinic

OFFICE VISIT

History of Present Illness
Reason for visit: Routine follow up for Diabetes
Chief Complaint: No complaints

Diabetes Management
Hyperglycemic Symptoms
Polyuria: no
Polydipsia: no
Blurred vision: no

Sympathomimetic Symptoms
Diaphoresis: no
Agitation: no
Tremor: no
Palpitations: no
Insomnia: no

Neuroglycopenic Symptoms
Confusion: no
Lethargy: no
Somnolence: no
Amnesia: no
Stupor: no
Seizures: no

Review of Systems
General: denies fatigue, malaise, fever, weight loss
Eyes: denies blurring, diplopia, irritation, discharge
Ear/Nose/Throat: denies ear pain or discharge, nasal obstruction or discharge, sore throat
Cardiovascular: denies chest pain, palpitations, paroxysmal nocturnal dyspnea, orthopnea, edema
Respiratory: denies coughing, wheezing, dyspnea, hemoptysis
Gastrointestinal: denies abdominal pain, dysphagia, nausea, vomiting, diarrhea, constipation
Genitourinary: denies hematuria, frequency, urgency, dysuria, discharge, impotence, incontinence
Musculoskeletal: denies back pain, joint swelling, joint stiffness, joint pain
Skin: denies rashes, itching, lumps, sores, lesions, color change
Neurologic: denies syncope, seizures, transient paralysis, weakness, paresthesias
Psychiatric: denies depression, anxiety, mental disturbance, difficulty sleeping, suicidal ideation, hallucinations, paranoia
Endocrine: denies polyuria, polydipsia, polyphagia, weight change, heat or cold intolerance
Heme/Lymphatic: denies easy or excessive bruising, history of blood transfusions, anemia, bleeding disorders, adenopathy, chills, sweats
Allergic/Immunologic: denies urticaria, hay fever, frequent UTIs; denies HIV high risk behaviors

Vital Signs

Bill Windows

Home: 999-999-9999

Male DOB: 09/09/1953 0000-99999 Ins: Commercial xxxxx

Ht: **73** in. Wt: **200** lbs. T: **98.0** degF. T site: **oral** P: **74** Rhythm: **regular** R: **15** BP: **128/ 70**

Physical Exam

General Appearance: well developed, well nourished, no acute distress
Eyes: conjunctiva and lids normal
Ears, Nose, Mouth, Throat: TM clear, nares clear, oral exam WNL
Respiratory: respiratory effort normal
Cardiovascular: regular rate and rhythm
Skin: clear, good turgor, color WNL, no rashes, lesions, or ulcerations

Assessment

Problems (including changes): He is following his diet, by his account. He has not had any hypoglycemic episodes, no night sweats. Feet are inspected and there are no callouses, no compromised skin. No vision complaints.

Impression: Sub optimal sugar, high glucometer readings.
He will work harder on diet. Will increase insulin by 2 units. BP and symptoms are better.

Home Glucose Monitoring:
AC breakfast 110 to 220
AC breakfast mean 142
AC dinner 100 to 250
AC dinner mean 120

Plan

Medications:
HUMULIN INJ 70/30 20 u ac breakfast

Treatment: Will have annual foot exam at next visit.

Orders:
UA
HGBA1C
Metabolic Panel
Lipid Panel

Education/Counseling (time): 10 minutes

Coordination of Care (time): 10 minutes

Follow-up/Return Visit: 3 months

Disposition: return to clinic

Bill Windows
Male DOB: 09/09/1953 0000-99999

Home: 999-999-9999
Ins: Commercial xxxxx

01/20/2015 - Lab Report: Metabolic Panel Provider: Carl Savem MD
Location of Care: Millennium Health System

Patient: Bill Windows
Note: All result statuses are Final unless otherwise noted.

Tests:

(1) HbA1c Test

HbA1c level	6.0%

(2) Lipid Profile

Cholesterol, Total	210 mg/dl
Triglycerides	236 mg/dl
HDL Cholesterol	36
LDL Cholesterol	127

Bill Windows
Male DOB: 09/09/1953 0000-99999

Home: 999-999-9999
Ins: Commercial xxxxx

Flowsheet

Enterprise/Medicine/Internal Medicine

Date	01/20/2011	01/19/201
HEIGHT (in)		70
WEIGHT (lb)		190
TEMPERATURE (deg F)		98
TEMP SITE		oral
PULSE RATE (/min)		72
PULSE RHYTHM		
RESP RATE (/min)		16
BP SYSTOLIC (mm Hg)		128
BP DIASTOLIC (mm Hg)		70
CHOLESTEROL (mg/dL)		
HDL (mg/dL)		
LDL (mg/dL)	127	
BG RANDOM (mg/dL)	125	
CXR		
EKG		
PAP SMEAR		
BREAST EXAM		
MAMMOGRAM		
HEMOCCULT		neg
FLU VAX		0.5 ml g
PNEUMOVAX		0.5 ml g
TD BOOSTER		0.5 ml g
Foot Exam		Complete
Eye Exam		**Complete**

Appendix 14B. Sample Medical Record: Monica Latte

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Monica Latte Home: 444-44-4444
Female DOB: 04/04/1950 0000-44444 Ins: Commercial Orange Shield

Patient Information

Name: Monica Latte
Address: 4444 Coffee Ave
Chocolate, California
Patient ID: 0000-44444
Birth Date: 04/04/1950
Gender: Female
Contact By: Phone
Soc Sec No: 444-44-4444
Resp Prov: Carl Savem
Referred by:
Email:
Home LOC: WeServeEveryone

Home Phone: 444-444-4444
Office Phone:
Fax:
Status: Active
Marital Status: Divorced
Race: Black
Language: English
MRN: MR-111-1111
Emp. Status: Full-time
Sens Chart: No
External ID: MR-111-1111

Problems

DIABETES MELLITUS (ICD-250.)
HYPERTENSION, BENIGN ESSENTIAL (ICD-401.1)

Medications

PRINIVIL TABS 20 MG (LISINOPRIL) 1 po qd
Last Refill: #30 x 2 : Carl Savem MD (08/27/2010)
HUMULIN INJ 70/30 (INSULIN REG & ISOPHANE (HUMAN)) 20 units ac breakfast
Last Refill: #600 u x 0 : Carl Savem MD (08/27/2010)

Directives

Allergies and Adverse Reactions (! = critical)

Services Due

FLU VAX, PNEUMOVAX, MICROALB URN

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Monica Latte Home: 444-444-4444
Female DOB: 04/04/1950 0000-44444 Ins: Commercial xxxxx

3/18/2011 - Office Visit: F/u Diabetes
Provider: Carl Savem MD
Location of Care: WeServeEveryone Clinic

OFFICE VISIT

History of Present Illness
Reason for visit: Routine follow
Chief Complaint: No complaints

History

Diabetes Management
Hyperglycemic Symptoms
Polyuria: no
Polydipsia: no
Blurred vision: no

Sympathomimetic Symptoms
Diaphoresis: no
Agitation: no
Tremor: no
Palpitations: no
Insomnia: no

Neuroglycopenic Symptoms
Confusion: no
Lethargy: no
Somnolence: no
Amnesia: no
Stupor: no
Seizures: no

Review of Systems
General: denies fatigue, malaise, fever, weight loss
Eyes: denies blurring, diplopia, irritation, discharge
Ear/Nose/Throat: denies ear pain or discharge
Cardiovascular: denies chest pain
Respiratory: denies coughing, wheezing, dyspnea, hemoptysis
Gastrointestinal: denies abdominal pain, dysphagia, nausea, vomiting, diarrhea, constipation
Musculoskeletal: denies back pain, joint swelling, joint stiffness, joint pain
Skin: denies rashes, itching, lumps, sores, lesions, color change
Neurologic: denies syncope
Psychiatric: denies depression, anxiety, mental disturbance, difficulty sleeping, suicidal ideation, hallucinations, paranoia
Endocrine: denies polyuria, polydipsia, polyphagia, weight change, heat or cold intolerance
Heme/Lymphatic: denies easy or excessive bruising, history of blood transfusions, anemia, bleeding disorders, adenopathy, chills, sweats
Allergic/Immunologic: denies urticaria

Vital Signs

Monica Latte Home: 444-444-4444
Female DOB: 04/04/1950 0000-44444 Ins: Commercial xxxxx

Ht: **64** in. Wt: **140** lbs. T: **98.0** degF. T site: **oral** P: **72** Rhythm: **regular** R: **16** BP: **158/90**

Physical Exam

General Appearance: well developed, well nourished, no acute distress
Eyes: conjunctiva and lids normal, PERRLA, EOMI, fundi WNL
Ears, Nose, Mouth, Throat: TM clear, nares clear, oral exam WNL
Respiratory: clear to auscultation and percussion, respiratory effort normal
Cardiovascular: regular rate and rhythm, S1-S2, no murmur, rub or gallop, no bruits, peripheral pulses normal and symmetric, no cyanosis, clubbing, edema or varicosities
Skin: clear, good turgor, color WNL, no rashes, lesions, or ulcerations

Assessment

Problems (including changes): Blood pressure is lower. Feet are inspected and there are no callouses, no compromised skin. No vision complaints.

Impression: Sub optimal sugar, control with retinopathy and neuropathy, high glucometer readings. Will work harder on diet. Will increase insulin by 2 units.

Home Glucose Monitoring:
AC breakfast 110 to 220
AC breakfast mean 142
AC dinner 100 to 250
AC dinner mean 120

Plan

Medications:
HUMULIN INJ 70/30 20 u ac breakfast
PRINIVIL TABS 20 MG 1 qd

Treatment: Will have annual foot exam at next visit.

Orders:
UA
Metabolic Panel

Education/Counseling (time): 5 minutes

Coordination of Care (time): 20 minutes

Follow-up/Return Visit: 3 months

Disposition: return to clinic

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Monica Latte Home: 444-444-4444
Female DOB: 04/04/1950 0000-44444 Ins: Commercial xxxxx

03/18/2011 - Lab Report: Metabolic Panel Provider: Carl Savem MD

Tests:

(1) HbA1c Test

HbA1c level	6.0%

(2) Lipid Profile

Cholesterol, Total	210 mg/dl
Triglycerides	236 mg/dl
HDL Cholesterol	36
LDL Cholesterol	107

Monica Latte

Home: 444-444-4444

Female DOB: 04/04/1950 0000-44444 Ins: Commercial xxxxx

Flowsheet

Enterprise/Medicine/Internal Medicine

Date	03/18/2011
HEIGHT (in)	64
WEIGHT (lb)	140
TEMPERATURE (deg F)	98
TEMP SITE	oral
PULSE RATE (/min)	72
PULSE RHYTHM	
RESP RATE (/min)	16
BP SYSTOLIC (mm Hg)	158
BP DIASTOLIC (mm Hg)	90
CHOLESTEROL (mg/dL)	
HDL (mg/dL)	
LDL (mg/dL) 107	
BG RANDOM (mg/dL)	125
CXR	
EKG	
PAP SMEAR	
BREAST EXAM	
MAMMOGRAM	
HEMOCCULT	neg
FLU VAX	
PNEUMOVAX	
TD BOOSTER	0.5 ml g
Foot Exam	
Eye Exam	Complete

Appendix 14B. Sample Medical Record: Steve Apple

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Steve Apple Home: 222-222-2222
Male DOB: 02/02/1945 0000-22222 Ins: Commercial xxxxx

Patient Information

Name: Steve Apple
Address: 2222 Computer Dr
Laptop, California
Patient ID: 0000-22222
Birth Date: 02/02/1945
Gender: Male
Contact By: Phone
Soc Sec No: 222-22-2222
Resp Prov: Carl Savem
Referred by:
Email:
Home LOC: WeServeEveryone

Home Phone: 222-222-2222
Office Phone:
Fax:
Status: Active
Marital Status: Married
Race: White
Language: English
MRN: MR-111-1111
Emp. Status: Full-time
Sens Chart: No
External ID: MR-111-1111

Problems

DIABETES MELLITUS (ICD-250.)

Medications

PRINIVIL TABS 20 MG (LISINOPRIL) 1 po qd
Last Refill: #30 x 2 : Carl Savem MD (11/27/2010)
HUMULIN INJ 70/30 (INSULIN REG & ISOPHANE (HUMAN)) 20 units ac breakfast
Last Refill: #600 u x 0 : Carl Savem MD (11/27/2010)

Directives

Allergies and Adverse Reactions (! = critical)

Services Due

CREATININE

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Steve Apple Home: 222-222-2222
Male DOB: 02/02/1945 0000-22222 Ins: Commercial xxxxx

2/1/2011 - Office Visit: F/u Diabetes
Provider: Carl Savem MD
Location of Care: WeServeEveryone Clinic

OFFICE VISIT

History of Present Illness
Reason for visit: Routine follow up to review medications
Chief Complaint: No complaints

History

Diabetes Management
Hyperglycemic Symptoms
Polyuria: no
Polydipsia: no
Blurred vision: no

Sympathomimetic Symptoms
Diaphoresis: no
Agitation: no
Tremor: no
Palpitations: no
Insomnia: no

Neuroglycopenic Symptoms

Confusion: no
Lethargy: no
Somnolence: no
Amnesia: no
Stupor: no
Seizures: no

Review of Systems
General: denies fatigue, malaise,
Eyes: denies blurring, diplopia, irritation, discharge
Ear/Nose/Throat: denies ear pain or discharge, nasal obstruction or discharge, sore throat
Cardiovascular: denies chest pain, palpitations, paroxysmal nocturnal dyspnea, orthopnea, edema
Respiratory: denies coughing, wheezing, dyspnea, hemoptysis
Gastrointestinal: denies abdominal pain
Musculoskeletal: denies back pain, joint swelling, joint stiffness, joint pain
Skin: denies rashes, itching, lumps, sores, lesions, color change
Neurologic: denies syncope, seizures
Psychiatric: denies depression, anxiety, mental disturbance, difficulty sleeping,hallucinations, paranoia
Endocrine: denies polyuria, polydipsia, polyphagia, weight change, heat or cold intolerance
Heme/Lymphatic: denies easy or excessive bruising, history of blood transfusions, anemia, bleeding disorders, adenopathy, chills, sweats
Allergic/Immunologic: denies urticaria, hay fever

Vital Signs

Steve Apple Home: 222-222-2222
Male DOB: 02/02/1945 0000-22222 Ins: Commercial xxxxx

Ht: **71** in. Wt: **191** lbs. T: **98.0** degF. T site: **oral** P: **72** Rhythm: **regular** R: **16** BP: **118/70**

Physical Exam

General Appearance: no acute distress
Eyes: conjunctiva and lids normal, PERRLA, EOMI, fundi WNL
Ears, Nose, Mouth, Throat: TM clear, nares clear, oral exam WNL
Respiratory: clear to auscultation and percussion, respiratory effort normal
Cardiovascular: regular rate and rhythm, S1-S2, no murmur, rub or gallop, no bruits, peripheral pulses normal and symmetric, no cyanosis, clubbing, edema or varicosities
Skin: clear, good turgor, color WNL, no rashes, lesions, or ulcerations

Assessment

Problems (including changes): Feet are inspected and there are no callouses, no compromised skin. No vision complaints.

Impression: Sub optimal sugar, control with retinopathy and neuropathy, high glucometer readings.

Plan

Medications:
HUMULIN INJ 70/30 20 u ac breakfast
PRINIVIL TABS 20 MG 1 qd

Treatment: Will have annual foot exam at next visit.

Orders:

Lipid Panel

Education/Counseling (time): 15minutes

Coordination of Care (time): 5 minutes

Follow-up/Return Visit: 3 months

Disposition: return to clinic

Steve Apple
Male DOB: 02/02/1945 0000-22222

Home: 222.222.2222
Ins: Commercial xxxxx

2/1/2011 - Lab Report: Metabolic Panel Provider: Carl Savem MD

Patient: Steve Apple
Note: All result statuses are Final unless otherwise noted.

Tests:

(1) Metabolic Panel (ML-03CHEM)

ALK PHOS	72 U/L
	35-100
BG RANDOM	125 mg/dl
	70-125
BUN	16 mg/dl
	7-25
CALCIUM	9.6 mg/dl
	8.2-10.2
CHLORIDE	101 mmol/l
	96-109
CO2	27 mmol/l
	23-29
CREATININE	0.7 mg/dl
	0.6-1.2
PO4	2.9 mg/dl
	2.5-4.5
POTASSIUM	4.5 mmol/l
	3.5-5.3
SGOT (AST)	31 U/L
	0-40
BILI TOTAL	0.7 mg/dl
	0.0-1.3
URIC ACID	4.8 mg/dl
	3.4-7.0
LDH, TOTAL	136 IU/L
	0-200
SODIUM	135 mmol/l
	135-145

(2) HbA1c Test

HbA1c level	5.0%

(3) Lipid Profile

Cholesterol, Total	210 mg/dl
Triglycerides	236 mg/dl
HDL Cholesterol	36
LDL Cholesterol	87

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Chart Summary

Steve Apple

Home: 222-222-2222

Male DOB: 02/02/1945 0000-22222 Ins: Commercial xxxxx

Flowsheet

Date	2/1/2011
HEIGHT (in)	71
WEIGHT (lb)	191
TEMPERATURE (deg F)	98
TEMP SITE	oral
PULSE RATE (/min)	72
PULSE RHYTHM	
RESP RATE (/min)	16
BP SYSTOLIC (mm Hg)	118
BP DIASTOLIC (mm Hg)	70
CHOLESTEROL (mg/dL)	
HDL (mg/dL)	
LDL (mg/dL)	87
BG RANDOM (mg/dL)	125
CXR	
EKG	
PAP SMEAR	
BREAST EXAM	
MAMMOGRAM	
HEMOCCULT	neg
FLU VAX	0.5 ml g
PNEUMOVAX	0.5 ml g
TD BOOSTER	0.5 ml g
Foot Exam	Complete
Eye Exam	**Complete**

Appendix 14B. Sample Medical Record: Tom Gelato

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Chart Summary

Tom Gelato Home: 666-666-6666
Male DOB: 06/06/1938 0000-66666 Ins: Commercial xxxxx

Patient Information

Name: Tom Gelato
Address: 5555 Flavor Ave
Ice Cream, California
Patient ID: 0000-66666
Birth Date: 06/06/1938
Gender: Male
Contact By: Phone
Soc Sec No: 666-666-6666
Resp Prov: Carl Savem
Referred by:
Email:
Home LOC: WeServeEveryone

Home Phone: 666-666-6666
Office Phone:
Fax:
Status: Active
Marital Status: Divorced
Race: White
Language: English
MRN: MR-111-1111
Emp. Status: Part-time
Sens Chart: No
External ID: MR-111-1111

Problems

DIABETES MELLITUS (ICD-250.)

Medications

HUMULIN INJ 70/30 (INSULIN REG & ISOPHANE (HUMAN)) 20 units
ac breakfast
Last Refill: #600 u x 0 : Carl Savem MD (04/17/2010)

Directives

DO NOT RESUSCITATE

Allergies and Adverse Reactions (! = critical)

! CODEINE

Services Due

FLU VAX, PNEUMOVAX, MICROALB URN

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Tom Gelato Home: 666-666-6666
Male DOB: 06/06/1938 0000-66666 Ins: Commercial xxxxx

11/13/2010 - Office Visit: F/u Diabetes
Provider: Carl Savem MD
Location of Care: WeServeEveryone Clinic

OFFICE VISIT

History of Present Illness
Reason for visit: Routine followup
Chief Complaint: No complaints

History

Diabetes Management
Hyperglycemic Symptoms
Polyuria: no
Polydipsia: no
Blurred vision: no

Sympathomimetic Symptoms
Diaphoresis: no
Agitation: no
Tremor: no
Palpitations: no
Insomnia: no

Neuroglycopenic Symptoms
Confusion: no
Lethargy: no
Somnolence: no
Amnesia: no
Stupor: no
Seizures: no

Review of Systems
General: denies fatigue, malaise, fever, weight loss
Eyes: denies blurring, diplopia, irritation, discharge
Ear/Nose/Throat: denies ear pain or discharge, nasal obstruction or discharge, sore throat
Cardiovascular: denies chest pain, palpitations, paroxysmal nocturnal dyspnea, orthopnea, edema
Respiratory: denies coughing, wheezing, dyspnea, hemoptysis
Gastrointestinal: denies abdominal pain, dysphagia, nausea, vomiting, diarrhea, constipation
Musculoskeletal: denies back pain, joint swelling, joint stiffness, joint pain
Skin: denies rashes, itching, lumps, sores, lesions, color change
Neurologic: denies syncope, seizures, transient paralysis, weakness, paresthesias
Psychiatric: denies depression, anxiety, mental disturbance, difficulty sleeping, suicidal ideation, hallucinations, paranoia
Endocrine: denies polyuria, polydipsia, polyphagia, weight change, heat or cold intolerance
Heme/Lymphatic: denies easy or excessive bruising, history of blood transfusions, anemia, bleeding disorders, adenopathy, chills, sweats
Allergic/Immunologic: denies urticaria, hay fever, frequent UTIs; denies HIV high risk behaviors

Vital Signs

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Male DOB: 06/06/1938
0000-66666
Ins: Commercial xxxxx

Tom Gelato

Home: 666-666-6666

Ht: **66** in. Wt: **195** lbs. T: **98.0** degF. T site: **oral** P: **72** Rhythm: **regular** R: **16** BP: **131/ 94**

Physical Exam

General Appearance: well developed, well nourished, no acute distress
Eyes: conjunctiva and lids normal, PERRLA, EOMI, fundi WNL
Ears, Nose, Mouth, Throat: TM clear, nares clear, oral exam WNL
Respiratory: clear to auscultation and percussion, respiratory effort normal
Cardiovascular: regular rate and rhythm, S1-S2, no murmur, rub or gallop, no bruits, peripheral pulses normal and symmetric, no cyanosis, clubbing, edema or varicosities
Skin: clear, good turgor, color WNL, no rashes, lesions, or ulcerations

Assessment

Problems (including changes): Blood pressure is lower. He is following his diet, by his account. He has not had any hypoglycemic episodes, no night sweats. Feet are inspected and there are no callouses, no compromised skin.
No vision complaints.

Impression: Sub optimal sugar, control with retinopathy and neuropathy, high glucometer readings.

Home Glucose Monitoring:
AC breakfast 110 to 220
AC breakfast mean 142
AC dinner 100 to 250
AC dinner mean 120

Plan

Medications:
HUMULIN INJ 70/30 20 u ac breakfast

Treatment: Will have annual foot exam at next visit.

Orders:
Ophthalmology consult
UA
HGBA1C
Metabolic Panel
Lipid Panel

Education/Counseling (time): 10 minutes

Coordination of Care (time): 10 minutes

Follow-up/Return Visit: 3 months

Disposition: return to clinic

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Chart Summary

Tom Gelato
Male DOB: 06/06/1938 0000-66666

Home: 111-111-111
Ins: Commercial xxxxx

Tests:

(1) Metabolic Panel (ML-03CHEM)

ALK PHOS	72 U/L
	35-100
BG RANDOM	125 mg/dl
	70-125
BUN	16 mg/dl
	7-25
CALCIUM	9.6 mg/dl
	8.2-10.2
CHLORIDE	101 mmol/l
	96-109
CO2	27 mmol/l
	23-29
CREATININE	0.7 mg/dl
	0.6-1.2
PO4	2.9 mg/dl
	2.5-4.5
POTASSIUM	4.5 mmol/l
	3.5-5.3
SGOT (AST)	31 U/L
	0-40
BILI TOTAL	0.7 mg/dl
	0.0-1.3
URIC ACID	4.8 mg/dl
	3.4-7.0
LDH, TOTAL	136 IU/L
	0-200
SODIUM	135 mmol/l
	135-145

(2) HbA1c Test

HbA1c level	11.0%

(3) Lipid Profile

Cholesterol, Total	210 mg/dl
Triglycerides	236 mg/dl
HDL Cholesterol	36
LDL Cholesterol	102

Tom Gelato

Home: 666-666-6666

Male DOB: 06/06/1938 0000-66666 Ins: Commercial xxxxx

Flowsheet

Enterprise/Medicine/Internal Medicine

Date	11/13/2010
HEIGHT (in)	66
WEIGHT (lb)	195
TEMPERATURE (deg F)	98
TEMP SITE	oral
PULSE RATE (/min)	72
PULSE RHYTHM	
RESP RATE (/min)	16
BP SYSTOLIC (mm Hg)	131
BP DIASTOLIC (mm Hg)	94
CHOLESTEROL (mg/dL)	
HDL (mg/dL)	
LDL (mg/dL)	102
BG RANDOM (mg/dL)	125
CXR	
EKG	
PAP SMEAR	
BREAST EXAM	
MAMMOGRAM	
HEMOCCULT	neg
FLU VAX	
PNEUMOVAX	
TD BOOSTER	0.5 ml g
Foot Exam	
Eye Exam	

Appendix 14B. Sample Medical Record: Wendy See

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Wendy See

Home: 777-777-7777
Female DOB: 07/07/1943 0000-77777 Ins: Commercial Orange Shield

Patient Information

Name: Wendy See
Address: 7777 Candy Lane
Dessert, California
Patient ID: 0000-77777
Birth Date: 07/07/1943
Gender: Female
Contact By: Phone
Soc Sec No: 777-77-7777
Resp Prov: Carl Savem
Referred by:
Email:
Home LOC: WeServeEveryone

Home Phone: 777-777-7777
Office Phone:
Fax:
Status: Active
Marital Status: Single
Race: Asian
Language: English
MRN: MR-111-1111
Emp. Status: Full-time
Sens Chart: No
External ID: MR-111-1111

Problems

DIABETES MELLITUS (ICD-250.)
DEPRESSION (ICD-311)

Medications

HUMULIN INJ 70/30 (INSULIN REG & ISOPHANE (HUMAN)) 20 units ac breakfast
Last Refill: #600 u x 0 : Carl Savem MD (06/17/2010)
PROZAC CAPS 10 MG (FLUOXETINE HCL) 1 po qd
Last Refill: #30 x 2 : Carl Savem MD (06/17/2010)

Directives

Allergies and Adverse Reactions (! = critical)

! Benadryl

Services Due

FLU VAX

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Wendy See Home: 777-777-7777
Female DOB: 07/07/1943 0000-77777 Ins: Commercial xxxxx

9/22/2010 - Office Visit: F/u Diabetes
Provider: Carl Savem MD
Location of Care: WeServeEveryone Clinic

OFFICE VISIT

History of Present Illness
Reason for visit: Routine follow up
Chief Complaint: No complaints

History
Social History: Her husband died 2 years ago and she is more introspective.

Diabetes Management
Hyperglycemic Symptoms
Polyuria: no
Polydipsia: no
Blurred vision: no

Sympathomimetic Symptoms
Diaphoresis: no
Agitation: no
Tremor: no
Palpitations: no
Insomnia: no

Neuroglycopenic Symptoms
Confusion: no
Lethargy: no
Somnolence: no
Amnesia: no
Stupor: no
Seizures: no

Review of Systems
General: denies fatigue, malaise, fever, weight loss
Eyes: denies blurring, diplopia, irritation, discharge
Ear/Nose/Throat: denies ear pain or discharge, nasal obstruction or discharge, sore throat
Cardiovascular: denies chest pain, palpitations, paroxysmal nocturnal dyspnea, orthopnea, edema
Respiratory: denies coughing, wheezing, dyspnea, hemoptysis
Gastrointestinal: denies abdominal pain, dysphagia, nausea, vomiting, diarrhea, constipation
Musculoskeletal: denies back pain, joint swelling, joint stiffness, joint pain
Skin: denies rashes, itching, lumps, sores, lesions, color change
Neurologic: denies syncope, seizures, transient paralysis, weakness, paresthesias
Psychiatric: denies depression, anxiety, mental disturbance, difficulty sleeping, suicidal ideation, hallucinations, paranoia
Endocrine: denies polyuria, polydipsia, polyphagia, weight change, heat or cold intolerance
Heme/Lymphatic: denies easy or excessive bruising, history of blood transfusions, anemia, bleeding disorders, adenopathy, chills, sweats
Allergic/Immunologic: denies urticaria, hay fever

Wendy See

Home: 777-777-7777

Ht: **60** in. Wt: **120** lbs. T: **98.0** degF. T site: **oral** P: **72** Rhythm: **regular** R: **16** BP: **125/70**

Physical Exam

General Appearance: well developed, well nourished, no acute distress
Eyes: conjunctiva and lids normal, PERRLA, EOMI, fundi WNL
Ears, Nose, Mouth, Throat: TM clear, nares clear, oral exam WNL
Respiratory: clear to auscultation and percussion, respiratory effort normal
Cardiovascular: regular rate and rhythm, S1-S2, no murmur, rub or gallop, no bruits, peripheral pulses normal and symmetric, no cyanosis, clubbing, edema or varicosities
Skin: clear, good turgor, color WNL, no rashes, lesions, or ulcerations

Assessment

Problems (including changes): Blood pressure is lower.

Impression: Sub optimal sugar, control with retinopathy and neuropathy, high glucometer readings. He will work harder on diet. Will increase insulin by 2 units.

Medications:
HUMULIN INJ 70/30 20 u ac breakfast
PROZAC CAPS 10 MG 1 qd

Treatment: Will have annual foot exam at next visit.

Orders:

UA

Education/Counseling (time): 20 minutes

Coordination of Care (time): 5 minutes

Follow-up/Return Visit: 3 months

Disposition: return to clinic

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Wendy See
Male DOB: 07/07/1943 0000-77777
Home: 777-777-7777
Ins: Commercial xxxxx

Tests:

(1) HbA1c Test
HbA1c level 7.0%

(2) Lipid Profile

Cholesterol, Total	210 mg/dl
Triglycerides	236 mg/dl
HDL Cholesterol	36
LDL Cholesterol	90

WeServeEveryone Clinic
1111 First Street California
111-111-11111 Fax: 111-111-1111

Chart Summary

Wendy See

Home: 777-777-7777

DOB: 07/07/1943 0000-77777 Ins: Commercial xxxxx

Flowsheet

Date	9/22/2010
HEIGHT (in)	60
WEIGHT (lb)	120
TEMPERATURE (deg F)	98
TEMP SITE	oral
PULSE RATE (/min)	72
PULSE RHYTHM	
RESP RATE (/min)	16
BP SYSTOLIC (mm Hg)	125
BP DIASTOLIC (mm Hg)	70
CHOLESTEROL (mg/dL)	
HDL (mg/dL)	
LDL (mg/dL)	90
BG RANDOM (mg/dL)	125
CXR	
EKG	
PAP SMEAR	
BREAST EXAM	
MAMMOGRAM	
HEMOCCULT	neg
FLU VAX	0.5 ml g
PNEUMOVAX	0.5 ml g
TD BOOSTER	0.5 ml g
Foot Exam	Complete
Eye Exam	**Complete**

Appendix 14C. Sample Set of Electronic Pull Instructions for IT Staff

Diabetic Patient Identification
IT Instructions

Patient list generator

Step 1: Identify all patients that meet all of the following criteria:

- **Diabetic:** Select patients with any ICD9 = 250.xxx in the billing data.
- Among those, select patients with birth dates after 1/1/1927 and prior to 1/1/1962 [**Age > 50 years and <85 on 1/1/12**]

➢ Record number of patients seen at least twice in the 2-year period (3/30/2010-3/31/2012) ___

- Generate list seen at least once in both 12-month periods (3/30/2010-3/30/2011 AND 3/31/2011-3/31/2012).

➢ Record number of diabetics identified ___

- Of diabetic patients selected, select those with three hemoglobin A1c values dated from 3/31/2011 to 3/31/2012:
    - Record number of patients identified ___

Step 2: Identify all patients that meet all of the following criteria:

- **Hypertensive:** Select patients with any ICD9 = 401 or 402 or 403 or 404.
- Among those, select patients with birth dates after 1/1/1927 and prior to 1/1/1962 [**Age > 50 years and <85 on 1/1/12**]

➢ Record number of patients seen at least twice in the 2-year period (3/30/2010-3/31/2012) ___

- Generate list seen at least once in both 12-month periods (3/30/2010-3/30/2011 AND 3/31/2011-3/31/2012).

➢ Record number of hypertensives identified ___

Of diabetic patients identified in Step 1 (excluding criteria for hemoglobin A1c values, including those seen twice in both 12-month periods and only those within the range of birth dates listed), how many have any ICD9 = 401 or 402 or 403 or 404?

Appendix 14D. Performance Metric Calculator for Diabetes

Diabetes HEDIS Measure Outcomes

HEDIS Measure	Audit Result	Practice Goal	National or Local Benchmark
HbA1c screening rate = [Total(A)/30 (total # of charts audited)] × 100 =			
HbA1c less than 7.0 = [Total(B)/Total(A)] × 100 =			
Blood pressure documented = [Total(C)/30 (total # of charts audited)] × 100 =			
Blood pressure less than 130/80 = [Total(D)/Total(C)] × 100 =			
LDL-C screening rate = [Total(E)/30 (total # of charts audited)] × 100 =			
LDL-C less than 100 mg/dL = [Total(F)/Total(E)] × 100 =			
Eye Exams = [Total(G)/30 (total # of charts audited)] × 100 =			
Foot Exams = [Total(H)/30 (total # of charts audited)] × 100 =			

Appendix 14. WeServeEveryone Clinic Case Example

WeServeEveryone is a federally qualified health center (FQHC) in Long Beach, California. It served 35,000 patients and provided approximately 80,000 patient visits last year. Average cycle time for a visit at all three of its practice sites is 75 minutes. The organization wants to improve patient experience and is interested in reducing patient cycle time as one way to do this.

Approximately 50 percent of the patients who receive care from the clinic are Latino and about 20 percent are monolingual Spanish. About 3 percent of the patients speak Nahuatl. Thirty percent of patients receiving care from the clinic are Asian and Pacific Islanders, and the remaining 20 percent are Caucasian. Forty-five percent of patients are children, 50 percent of patients are adults, and 5 percent are geriatric. Fifty percent of patients are uninsured, and 98 percent are at or below 200 percent of poverty; 70 percent are at or below 100 percent of poverty. Twenty percent of patients are diagnosed with diabetes, 15 percent with hypertension, and 3 percent with asthma.

The chief medical officer (CMO) of WeServeEveryone was serving as a quality improvement (QI) committee of one for the clinic until recently when she attended a session at a conference about QI methods for FQHCs. After returning, she engaged your organization to assist her in forming a QI committee, updating the clinic's QI plan, and identifying some first improvement aims.

Because so many of their patients have diabetes, the CMO and the QI team decided to focus their initial QI work on improving their diabetes care. They are interested in seeing how they are performing on HEDIS* quality indicators for diabetes and comparing themselves to benchmarks from the local community clinic association and those contained in the *National Healthcare Quality Report*.

The clinic recently hired a care coordinator to help with the care of chronic disease patients. It also recently implemented an electronic health record. One of the clinicians recently realized that entries for foot exams had been mapped incorrectly and were not being captured as part of the comprehensive diabetes care record. This is the only data field that appears problematic at this point.

Dr. Sand thinks the clinic is doing "fine" with diabetes care and does not think it is necessary to look at the data. On the other hand, the CMO, Dr. Likes, is very interested in seeing what the data look like not only for diabetes but also for hypertension and asthma.
* HEDIS stands for Healthcare Effectiveness Data and Information Set.

Appendix 16. Introductory Guide to Academic Detailing ©

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This guide was developed by NaRCAD (National Resource Center for Academic Detailing) with support from a grant from the Agency for Healthcare Research and Quality to the Division of Pharmacoepidemiology and Pharmacoeconomics of Brigham and Women's Hospital.

This guide was authored by Steve Farrell, MBA, Michael Fischer, MD, MS, Jerry Avorn, MD, and Lindsay Ritz, MPH.Content based on materials developed by iDiS for the Alosa Foundation.

Academic Detailing Visits

Academic detailing is interactive educational outreach to physicians to provide unbiased, non-commercial, evidence-based information about medications and other therapeutic decisions, with the goal of improving patient care. It is usually provided to clinicians one-on-one in their own offices. The approach is based on the effective communication/behavior change/marketing approach that is used so powerfully by pharmaceutical industry sales reps ("detailers") to increase use of a company's products. However, academic detailing puts this approach solely in the service of providing practitioners with neutral, rigorous information to optimize their clinical decisionmaking.

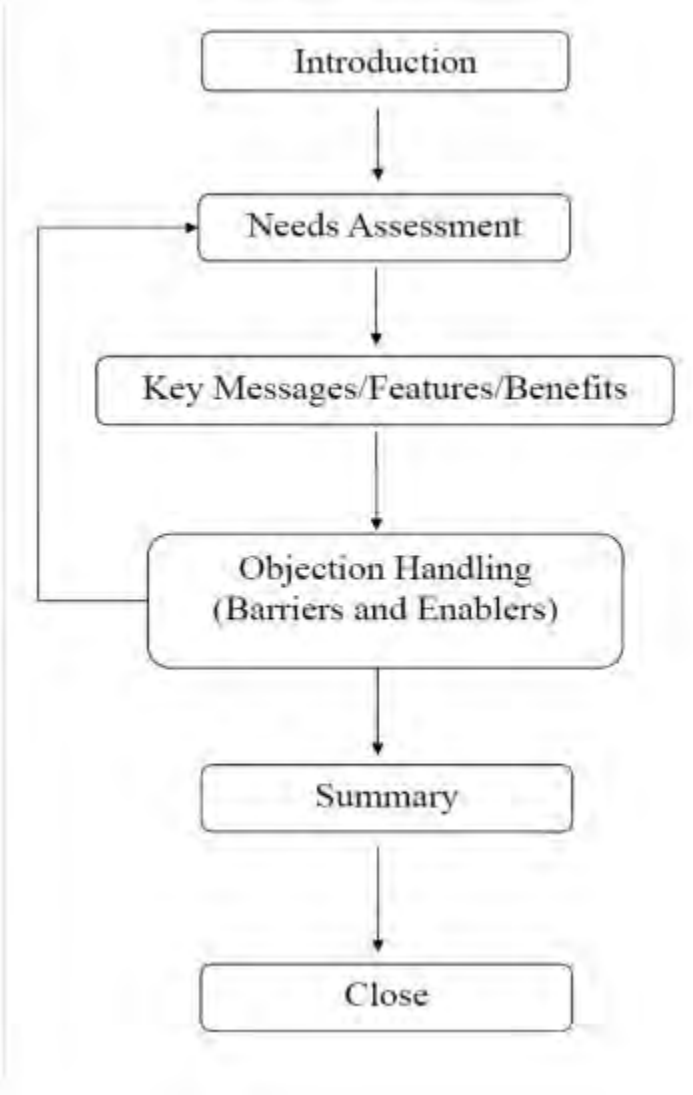
Like most human interactions, each academic detailing visit is a unique and potentially unpredictable encounter. This is especially true during the first meeting with a clinician. The flow and course of the discussion depends on the particular skills and personality of the detailer, as well as the clinician's specialty, practice patterns, attitudes, personality and mood. A series of common steps can help take an encounter successfully from the pleasantries of hellos to the communication and acceptance of specific evidence-based practice recommendations.

The steps include:

1. The Introduction
2. Needs Assessment
3. Key Messages/Features/Benefits
4. Understanding Barriers and Enablers
5. Identifying and Handling Objections
6. Summary
7. Close

The following pages will cover each of these key steps, and give a sense of how the elements fit together. It is important to understand that a successful academic detail is a conversation, not a checklist. The conversation should flow naturally from the subject matter itself, the focus of the clinician's medical practice, and the goal of successfully changing attitudes and behaviors in order to improve patient care.

Flow of an Academic Detailing Visit



The Introduction

The introduction is generally brief, but it forms one of the most important parts of an academic detailing visit. It sets the tone of the visit, conveys a sense of purpose, and can lay the foundation for future visits.

If you have previously called on the clinician, your introduction will be a brief reacquainting, since you have laid the groundwork during your previous visits and have already established a relationship. In many cases, you will be calling on someone for the first time and will need to build the relationship from scratch. An important challenge is that while nearly all prescribers know about pharmaceutical company sales reps, most may never have heard of academic detailing—public-service health educators whose job is to communicate unbiased summaries of evidence, rather than to promote sales of particular products. Thus, most initial visits require explaining the nature of the program and making it clear that it is not just another industry-sponsored promotional program, nor an intervention to cut costs without regard for clinical quality.

The introduction needs to effectively communicate:

Who you are:

Name, title, brief occupational background as relevant.

Where you are from:

The agency or group that you represent, or are funded by, a brief background on your organization if it might be unknown to the clinician.

What the academic detailing service is:

Why the sponsoring group has established the program.

Why you are there and what benefit will you deliver:

What is your purpose for calling on this clinician? How will your visit benefit the clinician?

Example:

“Hi my name is Sally Markinson. I am an academic detailer and a nurse practitioner by training. I’m here as part of a new service supported by the State Department of Health to provide practitioners with summaries of the most current evidence about medications you are currently prescribing

[modify as needed for other interventions]. Our goal is to provide you with up-to-date and useful information to help you in managing your patients."

Check for acceptance: Time is precious for a clinician. You want to make sure that you ask for the time you need in a respectful fashion and that the clinician agrees that it will be worthwhile to talk with you. Emphasize that this is a *service* being offered to the physician, and convey the idea that it can actually be a highly *efficient* use of his/her time to receive a condensed overview of the most recent literature on a given topic.

Example:

"I was hoping to discuss the care of patients with Type 2 diabetes. It should take about 15-20 minutes of your time, in which we can discuss this overview of the most recent clinical literature about the risks and benefits of common approaches to treatment; I believe you'll find it very informative. Would now be a good time for us to talk?"

"Is this still a good time for us to talk? When would you like me to finish by?"

Note: You need to use your judgment. Does it seem like there is a big backlog of patients? Might another time be better? Is it office policy that visits must be scheduled in advance? Can you get by with just 5 or 10 minutes? If you don't meet now will you get another chance?

Needs Assessment

To be effective as an academic detailer you need to understand the clinician, his/her practice, beliefs, attitudes, issues, and concerns. This way, you will be able to tailor your visit to address that practitioner's specific situation and needs. This *interactivity makes* it possible for you to adjust your presentation to each of the above elements, rather than delivering a canned one-size-fits-all lecture.

After the introduction, you will need to *bridge to* your intended topic and ask probing questions to assess the perceptions and needs of the clinician.

Note: Needs assessment begins as soon as you walk in the door of the office. How busy is it? What types of patients are in the waiting room? Are patient guides on display? What topics do these guides cover?

Bridge

The bridge is a straightforward way to move smoothly from the introduction to the

conversation.

Example:

"As you know, undiagnosed or uncontrolled diabetes is becoming a major public health problem. I want to talk with you about the care of your Type 2 diabetes patients…"

"Many of the doctors I speak with say that the care of their diabetes patients is a real challenge; I would like to talk with you about your care of Type 2 diabetes patients."

Open-Ended Questions

The goal of the needs assessment is two-fold. You want to understand more about the clinician's practice and attitudes regarding your chosen topic and you want to get thoughtful participation by the doctor in the conversation.

Questions like "Do you see many diabetics?" "How many of your patients are on insulin?" are considered *closed-ended*. While they might be useful in gaining some information, questions that can be answered with yes or no or simple replies do not lead into deeper conversation. These questions might be used to gather specific, relevant information, but you need to rely on more thoughtful questions to really learn about the clinician's practice and to establish an engaging interaction.

To establish a productive conversation, primarily use questions that are *open-ended and* give the clinician an opportunity to say what is on his or her mind. These are typically "how" or "why" questions.

Example:

"I hear from a lot of doctors that compliance is a big challenge. How do you deal with compliance problems among your diabetic patients?"

"Why do you start most of your patients on long-acting insulin?"

"What typically is the trigger that makes you decide to add insulin to the regimen for a particular patient? Why is that?"

Key Messages

In an academic detailing visit your goal is to bring about behavioral change in keeping with the best evidence to improve patient outcomes. You have a limited

amount of time to achieve this goal, so it is important to know what the key messages that you need to deliver are. These messages need to be planned and thoroughly understood well in advance of your visit.

Key messages are a limited number of important points that are relevant, compelling, and succinct, and are generally specific practice recommendations. Your clinician must understand and accept these messages before any action can be expected. If at the end of your conversation your clinician will remember only a few points, what would you like them to be? Those few things are your key messages.

Key messages are linked to the materials you share with the clinician. Depending on the topics and the clinician, some messages may be more impactful and better accepted than others. In some discussions you may choose to stress specific messages more than others, as the circumstances dictate. Your ultimate goal is to help the practitioner accept as many of the messages as possible. If multiple visits are planned with the same clinician, you might limit the key messages you focus on during each visit.

Examples:

Good key messages:

- Target HbA1c levels to below 7% for most patients with diabetes.
- Initiate insulin therapy as promptly as possible when oral agents are not effective.
- Use metformin in most cases as the preferred oral antidiabetic starting treatment.
- Ineffective key messages:
- HbA1c levels are indirect measures of glucose levels.
- There are over 63 different oral antidiabetic agents to choose from.
- Sulfonylureas work to increase cellular sensitivity to insulin.
- A meta-analysis of all oral agents showed that they were all equally effective.

Note: Just because something is not a key message does not mean it should not be mentioned or shared. It just means that the delivery of that message is not the ultimate goal. Such information may help to support the delivery and the acceptance of your key message, but delivering that information alone does not guarantee that you successfully deliver your key messages.

Features and Benefits

Any product, service or proposed action can be presented as a series of features. *Features* are facts or details that describe a product. A drug may be designed to be taken once a day, or a guideline can consist of 7 easy-to-follow steps. While it is important to identify the features, the discussion cannot be left there. *Benefits* must also be discussed.

A *benefit* is how a feature meets the needs of the clinician; it has a clear and direct impact. It provides the "what's in it for me?"

> *Example:*
>
> "A once-a-day drug will be easier for your patients to take and will increase their compliance. That means you don't have to worry as much about the risk of noncompliance."
>
> "Following this 7-step guideline will enable you to deliver improved care and save you a lot of time."

If you are not sure if something is a feature or a benefit, just ask yourself the question, *"So what?"* If you still need further explanation to answer the "So what?" question, then you are still describing a feature and haven't yet gotten to the benefit.

> *Example:*
>
> "X has no known harmful drug interactions." *(feature)* **So what?**
>
> "…so that when you initiate therapy with X you won't have to make changes to any of the other medications your patients are already taking." *(benefit)*

In an academic detailing visit, you should always connect a feature with a benefit. The benefit motivates people to change their opinions or behaviors.

Features and benefits are often linked by words such as "therefore," "because," "so that," "which means," etc.

> *Examples:*
>
> "Metformin and sulfonylureas work by different mechanisms; therefore, you gain additional HbA1c control by adding a sulfonylurea to a patient inadequately controlled with metformin."

"The ADA recommends that if the HbA1c level is still above 8% after the use of two oral antidiabetic agents, insulin therapy should be initiated, which means you do not need to worry about the cost, risks, and complexity of adding another oral agent and can get adequate control sooner."

Barriers and Enablers

When examining your features, benefits and key messages, it is important to plan ahead and anticipate potential challenges you may encounter, as well as potential responses to these challenges. We call these *barriers and enablers*.

Barriers are potential obstacles to acceptance of key messages that clinicians may perceive. These most often appear in the form of an *objection*(see next section). *Enablers are* parts of your key messages; they are benefits and features that might address the concern.

For each key message you should be ready to identify the potential barriers and what enablers might be useful in addressing those barriers.

Examples:

Key Message: "If two oral agents do not control glucose levels, insulin therapy should be added to the regimen."

Possible Barrier: "My patients don't want to be on insulin. So I think it is best to add a third oral agent."

Possible Enabler: "It is common for patients not to want to be on insulin. That is why the ADA recommends waiting until two agents don't work. But after that, the data shows that the delay can have a negative impact on the patient's long term health outcomes, and that is why it is so important to start insulin early."

Key Message: "If two oral agents do not control glucose levels, insulin therapy should be added to the regimen."

Possible Barrier: "I actually prefer to replace the oral agents with insulin alone. It is cheaper and requires less work for the patient to only take one medicine."

Possible Enabler: "Data shows that combining oral agents with insulin actually works better. It provides better glucose control and weight control, and can reduce the likelihood and severity of side effects. Since your patient is already familiar with their routine in taking their oral medicine, the addition of insulin will also create the least disruption."

Handling Objections

As acknowledged in the review of barriers and enablers, clinicians will not always accept the messages you are delivering or agree with the information you share. These *objections* may be direct ("I don't agree that I should be monitoring my patients that often") or they may be indirect ("I don't see that as a problem in my practice"). It is therefore very important to use your communication skills to understand what the true *barrier is* behind the stated objection.

Encountering objections should not be considered a sign of failure or a negative reflection of your skills as an academic detailer. In fact, an objection presented by a physician is a sign of participation and opens an opportunity for addressing an issue he or she sees as an important concern. Objections can also signal the need to better understand your clinician's situation and to provide more information. Objections could signal: a lack of understanding of the issue, a fear that change means more work, a lack of recognition of the need for change, a misunderstanding of what you communicated, or a genuine disagreement with the content of your message.

Overcome objections by having a positive attitude and avoiding an argument. Use the objection as an opportunity to further your understanding of your clinician and the barriers presented and to move the discussion forward. It may not be necessary to immediately respond to the objection with a counterargument. There are specific steps you should take to effectively manage objections.

Steps for handling objections:

1. **Probe** (ask questions) to clarify your understanding of the objection.
    - This is an opportunity to better understand your clinician's needs and attitudes.
2. **Restate** the objection to signal that you are being attentive to the clinician's concerns, and to confirm that you understand them and have identified the true barrier.
3. **Consider** whether you are prepared to address the objection then and there, or if you need more information and time to do so.
4. **Respond** to the objection, utilizing probing skills and relevant key messages, features/benefits, and enablers.
5. **Gain confirmation** that you addressed the objection successfully.

Objections will generally fall into one of four categories:

1. **Stops:** A disagreement with your key messages and rejection of your call to action."I don't think approach A is better than approach B because it is

more time consuming."

2. **Stalls:** A deferral of decision on your call to action."We have a staff meeting next week and we will discuss the situation and make a decision."
3. **On the fence:** An indication that the clinician is open to your position, but just not completely convinced."I understand how your approach could be useful, but I am worried we won't be able to implement it."
4. **Indifference:** A general lack of interest.

Stops

Stops are effectively no's. They can be based on:

- misunderstandings
- skepticism of clinical content
- valid concerns regarding drawbacks

For stops you need to get a better understanding of the concern by asking clarifying questions.

Misunderstandings or skepticism are the easiest to address. They require tactful provision of the correct information. For skepticism you may have to provide the source data or credible third party support for your position.

Valid concerns are sometimes the most challenging to address, since the objections are not over the facts themselves, but rather over the weighting of the facts and the identification of a drawback. For such concerns you should acknowledge the concern and then reframe the issue so that it fits into the bigger picture, where the benefits outweigh the drawbacks.

> *Example:*
>
> "You are correct, Doctor Smith. Patients are often resistant to initiation of insulin therapy. But most patients with difficult-to-control diabetes will end up on insulin at some point, and data shows that late initiation can have negative long term consequences, including preventable progression of end-organ damage."

Stalls

A stall is usually a polite "no" or sometimes an avoidance of making a decision. The challenge with a stall is that it keeps you from knowing the clinician's true thinking. Use the opportunity to discover if a barrier exists behind the stall by asking direct questions.

Example:

Doctor: “Thanks for the information. We have a staff meeting next Friday and we will discuss it then.”

AD: “Great! I will follow up on Monday.” (accepted stall)

vs.

AD: “Based on the information we discussed today, what will your recommendation be at the meeting?” (probed for better understanding)

Depending upon what you discover, you may have to re-engage the stalling physician and handle the true barrier.

On the Fence

For those who are still on the fence, you need to better understand what benefit is missing for the clinician. What would be convincing? Were the benefits that you shared not significant enough? What needs are unfulfilled? Through open-ended probing questions you should be able to uncover what it would take to change their stance.

- Use open-ended probing to understand the nature of the remaining concern or hesitation or to discover what would be convincing.
- Offer information, features, and benefits related to your key messages to address the concern.
- Check to ensure resolution.
- “What would convince you to choose another form of insulin for your patients?”“What do you think is the most compelling clinical data for a product?”

Indifference

In addressing indifference, you need to ask questions to help the clinician see a bigger need.

- Acknowledge the clinician’s point of view.
- Request permission to probe.
- Use closed-ended probes to create awareness of a need.
- Confirm the recognition of the need.
- Show how the need can be met.

Example:

"Have you had patients for whom it took unusually long to get their diabetes under control?"

"Did any of them have their cardiovascular or renal status deteriorate during this period?"

"Would it be beneficial to be able to avoid the problems associated with this disease progression?"

(Indifference is one of the times when using closed-ended questions can be very helpful.)

Note: Successful objection handling should ultimately conclude with the acceptance of a relevant key message through its features/benefits. This will enable you to successfully bring the objection to closure.

Summary and Close

The *summary of* an academic detailing visit should not take long. It is not a catalog of everything that was discussed. It is an overview of the key messages that the clinician agreed to and a general sense of where the conversation concluded. It includes checking to make sure that all key concerns have been covered. The role of the summary is to have the clinician acknowledge the key messages "bought into" during the discussion.

During a summary:

- Provide a brief review of the key messages, emphasizing those the clinician seems to have accepted.
- Ask if the clinician has any questions regarding what was covered.
- If further questions exist, use the opportunity to answer them.
- Do not repeat messages that were not well received.

Example:

"Dr. Jones, we discussed the comparative effectiveness data on oral antidiabetic medications and the ADA recommendations based on that data to initiate therapy first with metformin. In addition, we noted the evidence that when oral agents are inadequate to reach target A1c levels, moving to insulin therapy is too often postponed. The recommendations are that if greater control is needed after two oral agents are used, then insulin should

be started. Do those guidelines seem applicable in your practice? Was there anything important you feel I haven't answered or addressed about managing your patients with diabetes?"

After the summary comes the *close*, when you ask the clinician to implement some of the key messages/practice recommendations. From the flow of the conversation with the clinician and the acceptance or rejection of your key messages, you should have a good understanding of what changes he or she may be ready to accept. It is important, however, to get the clinician to own that change. Further, it is helpful to get them to visualize how the changes will be implemented.

Examples:

"I hope this information was helpful to you and that you find these suggestions easy to implement…."

"Will you be able to transition to this new guideline soon?"

"Do you already have patients in mind who might fit those criteria?"

"It's great that you are willing to try these recommendations. Can I check in with you next month to see if you've been successfully implementing the changes and answer any additional questions you may have?"

Note: The close is when you should take the opportunity to see if the clinician would be willing for you to meet with him or her again in the future to share more information.

Appendix 18. Informal Practice Readiness Assessment

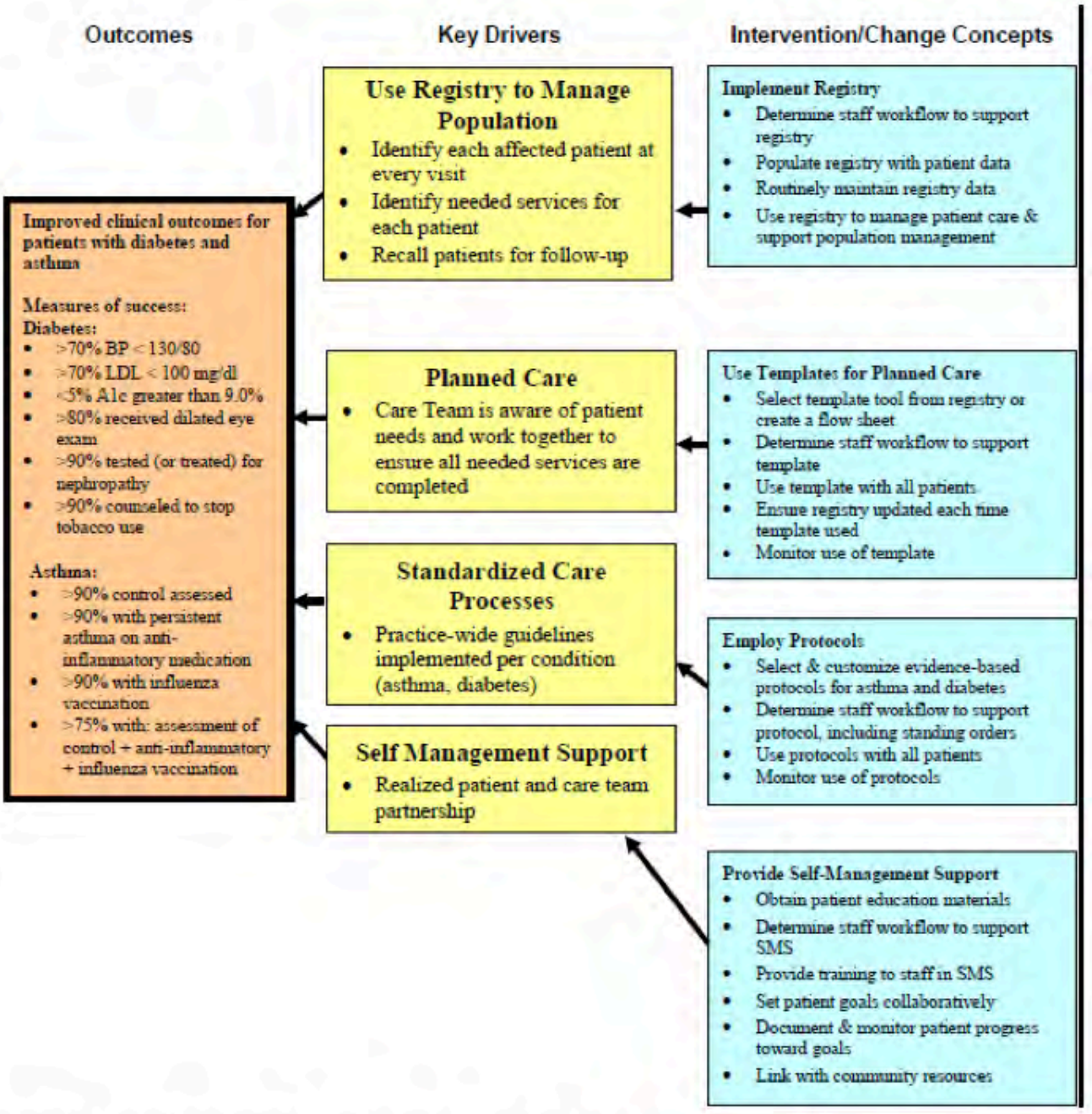
Informal Assessment of Practice Readiness for Improvement

- ❑ Practice or organizational leadership is interested in specific or general improvement as evidenced by request for assistance or receptivity to receiving facilitation to support improvement.
- ❑ Practice or organizational leadership is willing to participate in ongoing communication with the practice facilitator and the improvement team.
- ❑ Practice or organization is willing and able to identify an "improvement" champion who will be the practice facilitator's point person.
- ❑ Leadership is willing to provide protected time for key staff to engage in improvement work.
- ❑ Team members are willing to meet regularly as an improvement team, and members follow through with this.
- ❑ Team members are willing to gather and report data on practice performance with key metrics.
- ❑ Practice has sufficient organizational and financial stability to avoid becoming too distracted or overwhelmed by competing demands or financial concerns.
- ❑ Practice is not engaged in other large-scale improvement projects and does not have other demanding competing priorities.

3-Month Followup

- ❑ Practice members respond to emails and calls.
- ❑ Practice members attend meetings.
- ❑ Practice members follow through on most assignments.
- ❑ At least one meaningful PDSA cycle is complete.

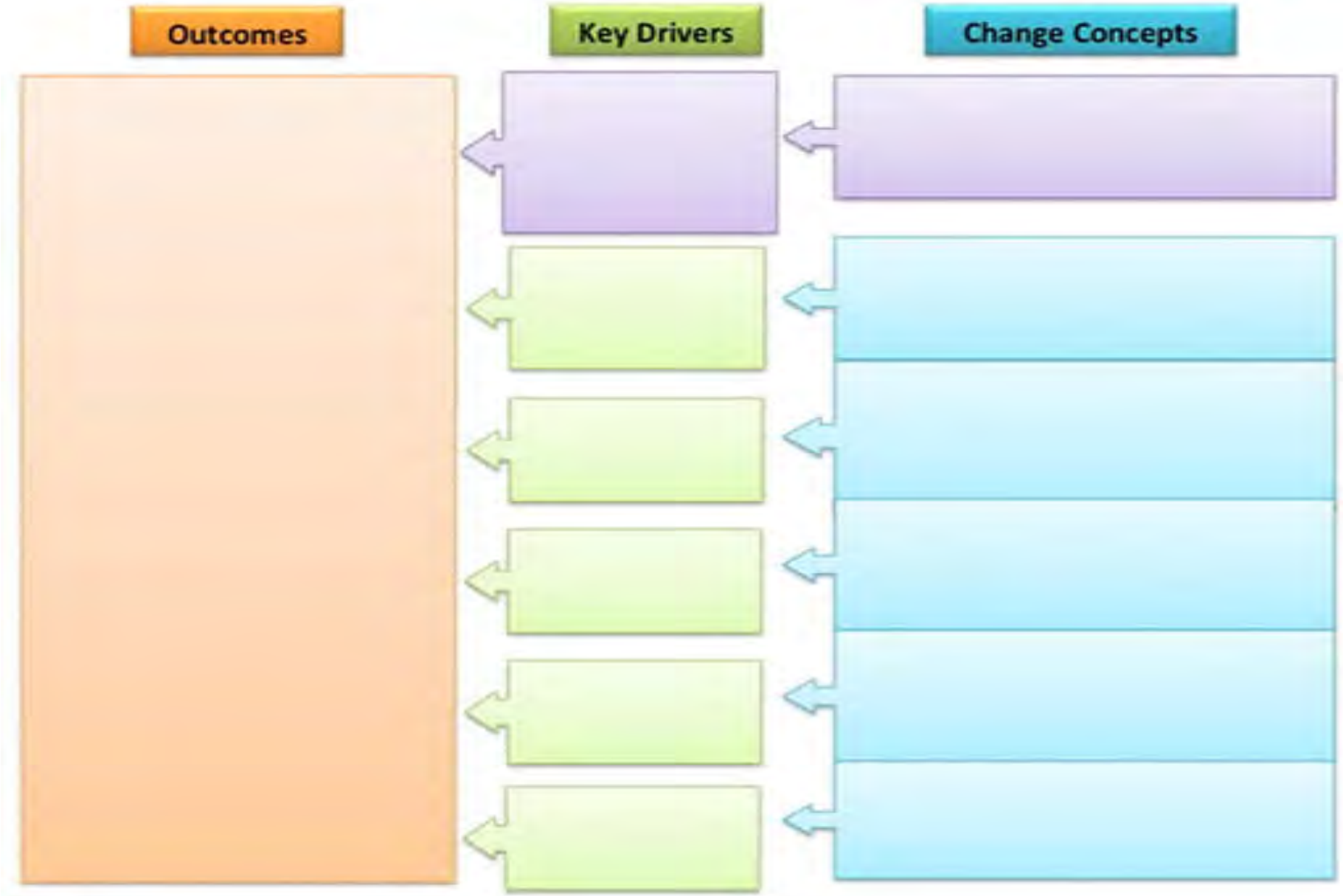
Appendix 20 A. IPIP Key Driver Model



Source: Margolis PA, DeWalt DA, Simon JE, et al. Designing a large-scale multilevel improvement initiative: the improving performance in practice program. J Contin Educ Health Prof 2010 Summer;30(3):187-96.

Appendix 20 B. Blank Key Driver Template

Practice: _____ Date: _____



Appendix 20C. QI Plan Generator

You can use the template below to generate a draft QI plan for your practice or organization. It is a starting place. You will want to add to the document over time. The most effective way to use this tool is as a team. Work together with others in your practice who are likely to participate in forming and running your QI program to create a draft plan. You can then use this draft plan as a tool to get your team up and running and as a starting point for a more comprehensive plan you will develop over time.

1. What are your organization's priorities and core values? You can identify these by generating a list of statements that represent your organization's mission and overall values. Example: We strive to put the patient first in all our work.

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2. Describe your quality vision for your practice or organization and how it aligns with these values. This is the end to which all quality improvement efforts at your practice are working.

OUR QUALITY VISION IS:

Describe your quality improvement infrastructure. How will the quality improvement program be staffed and structured?

3. Who will lead your organization's quality improvement efforts? This is usually a Quality Improvement Committee or Team that oversees and monitors QI projects and activities. This committee may report to the board of directors or the head of the organization.

Who will lead your quality efforts and who will they report to? (Example: Our QI Committee will report to the CEO and will be chaired by...)

4. Who will serve on the Quality Improvement Committee? The most effective committees include representatives from all areas of the practice (physicians, PAs, nurses, health educators, *promotores*, clerks, and patient representatives)

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5. What are the duties and responsibilities of the Quality Improvement Committee?

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6. What meeting structure will you use? Most committees meet monthly to bimonthly to set priorities, review progress and assure progress towards improvement goals.

How often will you meet? Where will you meet? When will you meet? Will you have a special retreat each year for setting priorities or reviewing progress?

7. What quality improvement approach(es) will you use? Most healthcare organizations use the Institute for Healthcare Improvement's Model for Improvement (MFI) and Plan Do Study Act (PDSA) cycles to structure their improvement work.

8. What will you use to generate performance data? Who will be responsible for this? And how will they be supported in carrying out this function?

9. What are your annual quality goals? These are specific aims and outcomes that your QI committee and organization will work towards and direct resources towards in the coming year. It can help to use SMART when identifying improvement goals: Specific, Measureable, Attainable, Relevant, Time-bound.

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10. What goal will you work on first?

QI Plan Generator

11. QI teams are smaller groups that will work on each of the goals above. Who will be on each project team? Some teams can have dozens of staff members and patient representatives that are impacted by or involved with the process being improved.

Team 1

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12. Performance measurement. What indicators will you use to assess your current performance and progress over time for your first quality goal? Example: All staff will receive the PACT training module on patient-centered care and pass the knowledge assessment with a score of at least 90%.

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4	
5	
6	

Communicating about your quality activities. What means will you use to communicate with your staff, leadership and patients about the quality activities being undertaken by the committee and improvement teams? Example: You might share meeting minutes, a QI committee report to the Board of Directors, an article in your newsletter or on your website.

13. Communicating with staff.

14. Communicating with leadership.

15. Communicating with patients.

Education. How will you provide staff and other with training and learning opportunities in the area of quality and process improvement? What skills and knowledge do you want them to develop?

16. Plan for educating your Quality Improvement Committee and Project team members

17. Plan for educating general staff and clinicians.

Evaluation. How will you track and evaluate your progress? You will want to evaluate both: 1. The effectiveness of the Quality Improvement Plan (this document) and how well it was implemented, and 2. The quality improvement projects the practice and committee undertook over the year. Some committees and teams use dashboards and datawalls as a way to visually present and display progress. These can be updated on a monthly or quarterly basis and can be a very helpful way to monitor progress over time.

18. Evaluation of Quality Improvement Plan effectiveness.

19. Evaluation of Quality Improvement Plan effectiveness. Example of metrics: adherence to meeting schedule; number of successful improvement projects; use of systematic improvement process; diversity of improvement team. Metrics for assessing the effectiveness of your Quality Improvement Plan:

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20. Evaluation of Quality Improvement Project #1.

21. Evaluation of Quality Improvement Project #1. Metrics:

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Appendix 21. Relational Delegation: Introduction to Making Effective Delegations and Holding Team Members Accountable

Developed by Anthony Suchman and Penelope R. Williamson

Effective delegation and accountability are core tasks of successful leadership and management. When done well, those with newly delegated responsibilities build their capacity, unleash their creativity, and enhance their self-efficacy. Effective delegation also gives leaders more time to mentor those in their charge and focus on larger system issues. Too often, however, leaders do not effectively delegate tasks or assure accountability for their implementation. The delegation may be too vague or there might be micromanaging instead of true delegation. Feedback may be impromptu and impressionistic—if it is given at all. It may be focused more on the person than on the behavior, and it does not lead to performance improvement. Ultimately, if performance levels are unacceptable, delegations are often withdrawn in a manner that is unnecessarily hurtful to the individual and harmful to the organizational culture. Worse yet, the unfulfilled delegation may not be withdrawn and the poor performance would be allowed to continue, to the detriment of customers, coworkers, and the whole organization.

Fortunately, there are some straightforward principles and practices that can help you make effective delegations and maintain accountability, thus maximizing the performance of your team or organization. We offer these below, along with illustrative conversations showing what these principles might look like in action. We divide this information into three sections that correspond to three obligations you have to those to whom you make delegations:

- A well-conceived delegation (made to the right person, with clear expectations and adequate support)
- An honest assessment of progress, with feedback and coaching as needed
- Withdrawal of a delegation, role, or position that is not working

Making a well-conceived delegation. In making an effective delegation, your first and most important task is to choose the right person—to seek the best alignment between the task and the individual. While the selected individual must have sufficient skills and experience to take on the new role, he or she does not necessarily have to be the most skilled or experienced person. Other factors are equally important in assessing best fit. People are most creative, committed, and effective when their work holds personal interest and meaning. Perhaps the delegation represents a step up in responsibility, a chance to gain new knowledge and skills, or a chance to develop important new working relationships. Perhaps the work is in a domain for which an individual has a longstanding interest or passion. Or maybe the work will enhance the individual's visibility within the organization. It is helpful to exchange perspectives about fit with the person you have chosen. It reinforces a pattern of partnership from the outset, and it can reveal important considerations of which you might not have been aware. Avoiding an unwise delegation is far more efficient than having to clean up afterwards.

Once you have chosen the right person, it is important that you **establish clear expectations for**

the work you are delegating. This means not only naming the overall task or role to be delegated but also providing enough details to ensure that you and your employee share an accurate understanding of what is being asked: What is the desired outcome? What is the deadline? What resources are available (or must not be used)? Who else should or should not be involved? Are there any other parameters within which the delegation must be carried out? The amount of detail provided will depend on the nature of the work and the experience of the appointee.

The simplest way to ascertain the level of detailed information an employee needs is to ask. It is often helpful for the boss to start this inquiry, as it may be difficult for an employee to do so.

Negotiating clear, mutually understood expectations strengthens partnership by letting the employee know he or she is not in this alone and has a supportive, thinking partner. It also is the basis for reviewing performance and providing feedback along the way. Unambiguous expectations are the starting point for maintaining accountability.

It is also essential to **ensure adequate preparation and resources for the person to do the job**. As above, an open, transparent conversation can help you learn what an employee needs to perform the task well. Does he or she have (or can acquire) the resources, knowledge, and skills needed? These might include financial, educational, or other resources; emotional support; and a constructive environment. Taking on a new role or task might necessitate prioritizing or giving up some current responsibilities. What help will you provide at the start and over time? Clear negotiation of these important variables will help pave the way for a successful delegation.

Finally, it is crucial to **arrange for a feedback session at the time of the initial delegation**. Delegation requires supervision; it is not a hand-off but rather a reapportioning of responsibilities. It is far more efficient and beneficial to all involved to have timely assessments of successes and needs along the way, making course corrections as appropriate, than to discover at some end point that expectations have not been met. It is helpful to arrive at an understanding ahead of time about when performance will be assessed and what criteria will be used. Here again, expectations can be established mutually. Involving the employee in each step of the delegation reinforces and models partnership and sets the stage for trust and mutual accountability.

To summarize, the four steps in making a well-conceived delegation are:

1. Choose the right person. Find alignment between the needs of the organization and the personal goals and interests of the person receiving the delegation.
2. Establish clear expectations. Be sure expectations are shared by both the person in charge and the employee.
3. Ensure adequate preparation. Make sure people have or can acquire the resources and knowledge and skills to do the job, including training, financial or other resources, emotional support, and a constructive environment.
4. Plan the assessment prospectively. Arrive at an understanding ahead of time of how and when performance will be assessed—preferably mutually decided upon.

Example of a Delegation Meeting Conversation

Boss: Hi Rob. Is this a good time to meet? (Yes? Good.) I'm very pleased to be talking with you today. I have heard you express an interest in taking on larger scale projects and have observed your excellent way of relating with people, and we have a need that just might fit. I'd like you to coordinate our annual community outreach meeting, which is set for June 7th, four months from now. I think you would do an outstanding job with this. I hope you'll agree to take this on.

Rob: I'm delighted you thought of me, and would like to consider it. What is involved?

Boss: We already have a venue and a date, which is a good thing but also creates the need for efficient planning, as it is only four months away. I'd expect you to coordinate the work of everyone who will be involved and to keep on top of the planning and implementation along the way. Let me ask you, have you done something like this before?

Rob: I've headed up some projects of a smaller scale.

Boss: The basics are likely familiar. Let's explore how you might take your experience to a larger scale. What would be helpful?

Rob: I'd appreciate knowing how you would approach this task.

Boss: I'd suggest that you begin by creating a timeline with all the major tasks so that you can pace yourself accordingly. Also, you'll probably want to gather a planning team to help you think of all the necessary steps and carry out all that will need to happen to plan and bring about this important gathering. I'm available to meet with you weekly or at least bi-weekly over this time to be of help and to provide supervision since this is your first time with a project of this scope. How does that sound? What are your thoughts?

Rob: That all sounds good. I like the idea of a planning team and also that you'll be available for consultation and supervision. Will I have any other support (time freed up from my other roles, secretarial help)?

Boss: You bet. (Gives details of what will happen and support.) Is there any other help you need to get started?

Rob: I have to admit, I've never created a timeline before.

Boss: Thanks for being forthright. I can show you how I approach this. I'd start by drawing a line across a sheet of paper. The end point is the event. The beginning point is today. We've already agreed that you will form a planning team. If you can do that by next week, put an X there to mark the spot. Then think of all the tasks that will be involved (such as marketing, creating a schedule, lining up speakers or workshops, arranging for food and lodging, etc.) and in what order they need to be done, and list them on the line. Sometimes it's helpful to work backwards from the date of the event. You might take a first stab at this and then invite your planning team

to help fill in and refine your draft. Does that help?

Rob: That is great. I have a good sense of what I need to do now and am pleased you thought of me for this project. I'm glad to accept.

Boss: Good. I'm delighted, and I feel confident you'll do well. Time is of the essence, and everything that happens will depend on the timeline and the planning team. I'd like to meet again as soon as you have created a draft of the timeline and gathered the planning team. Is a week enough time for those two steps?

Rob: Yes; I think so.

Boss: Good. Then let's meet next Friday at 2:00 PM, and I'd like to see the timeline and know who's on the team by then.

Assessing progress and giving feedback. Having made a well-conceived delegation with clear descriptions of expected outcomes and the parameters within which they must be achieved, the next step is to follow through with planned progress assessment. This step is much simpler if you have defined the assessment criteria in advance: you both know what data to gather and there is less potential for misaligned expectations. The crucial success factors here are honest feedback, effective coaching, and a good partnership process.

- Use direct observations whenever possible.
- Celebrate and reinforce successes; reinforce positive expectations.
- Show genuine belief in the capacity of the other to grow and perform.
- Offer mentoring and guidance as appropriate; invite the other person to make their own thinking process explicit.
- Point out errors and omissions, using them as learning opportunities for presenting and alternative approaches.
- Use partnership and dialogue skills (Partnership, Empathy, Acknowledgment, Respect, Legitimation and Support (PEARLS – see Table A21.1), skilled inner listening, inquiry, and advocacy).
- Make a plan for the next timely cycle of performance review and evaluation—when it will take place, what specific performance expectations will be assessed, and what data and criteria will be used.

Table A21.1 Types of relationship-building statements with illustrative examples.

Partnership	We'll see this through together. I really want to work on this with you.
Empathy	It sounds like that was frightening for you. I can feel your sadness as you talk.

Acknowledgement	You put a lot of work into that project. You researched this proposal very thoroughly.
Respect	I so respect your commitment. I've always appreciated your creativity.
Legitimation	This would be hard for anyone. Who wouldn't be worried about something like this?
Support	I'd like to help you with this. I want to see you succeed.

Adapted from Clark W. Hewson M, Fry M, Shorey J. *Communication Skills Reference Card.* St. Louis, MO: American Academy on Communication in Healthcare; 1998.

Example of a Feedback Meeting Conversation

Boss: Hi Rob, it's good to see you. How have you been doing since we met last week?

Rob: Very well. I have pulled together a six-person planning team and we had our first meeting, yesterday. I think it is a very good group, representing the spectrum of activities in our organization that will be needed for bringing about this community outreach gathering. I emailed you the names yesterday.

Boss: Yes, I got them.

Rob: They are eager to be helpful and had some great ideas already; I felt good about our first meeting and about planning the event.

Boss: Terrific. I have already heard a buzz of excitement and have observed that you have gone about pulling together your planning team in a relational and inclusive manner. I'm glad you included people with a broad range of responsibility and capabilities. It looks to be a great team. Now, what about the timeline?

Rob: I have started on it, but didn't get as far as I'd hoped. (Perhaps shows sketchy timeline with only several points on it.)

Boss: I'm a little surprised that you have not done more on this, as we talked last week about how important the timeline is to all that follows, and that time is of the essence. Tell me, what has gotten in the way?

Rob: After our team met yesterday, I got slammed with two urgent deadlines from my regular "day job" and didn't want to let my colleagues down. I was up until midnight finishing that work, and just haven't had the time to sit down and put all the points on the timeline, from our conversation in the planning team and from my own thinking. I didn't want to present you with a

half-baked product. I'll do it in the next few days.

Boss: I can see how that could happen. I can also see that this is an important learning opportunity for you. The annual meeting is very important to the whole organization and to our community. Your leadership will determine its success. Taking this on presents a chance for you to prioritize and to set limits on what you can and cannot do while you are coordinating this effort. How will you approach this now?

Rob: I think I just have to say no to some other "urgent" things that keep appearing on my plate until this is done.

Boss: Yes, I agree. As you know, I arranged for you to be able to cut back on your regular work for these few months, so I have your back on this. We absolutely need this timeline in the next few days. I believe in your capacity to do both things. Let your immediate supervisor know what you can and can't do in the short run and put this timeline together by Tuesday. You've made a great start with the team. Now we need this organizational piece in order to assure we can pull off the meeting. Can I count on you for that?

Rob: Yes, I'll get it done.

Boss: Good. Let's meet on Tuesday at 3:00 PM with the timeline. Please send me a draft in advance of the meeting so I can review it. See you then.

Ending a delegation, role or position that is not working. Most of the time, when you have delegated a job or task thoughtfully, set clear expectations, given actionable feedback and offered timely coaching, things work out well. The delegation and feedback sessions provide opportunities for celebrations, course corrections, and learning along the way. Occasionally, however, in spite of these steps and good intentions, things do not work out. In service to patients or customers, co-workers, the organization (and its mission), and even to the underperforming employee, it falls to you to end a delegation or even a job. It is important to learn the skills of ending a delegation well. Paradoxical as it may seem, it is possible to do this in a relational manner, preserving an employee's self-worth and a relational organization culture:

- Set the stage: "As we had planned, we're meeting to compare your actual progress with the goals and expectations we discussed previously."
- Forecast the bad news: "I'm afraid the news isn't good."
- Give the news, stating it clearly and unambiguously: "Your efforts haven't fulfilled our needs; I can't keep you in this role."
- Characterize the problem as mismatch between the individual's strengths and what the role requires: "I've seen that you are good at x, y and z. This role requires a, b, and c. It's just not the right match and it's not good for you or for the organization for you to stay in this role."
- Keep the focus on the behavior and not the person: "You're work is not sufficiently organized and it's not completed on time" rather than "You're no good."
- Use empathy and other PEARLS (see Table A21.1): "I imagine that this is pretty hard to hear…"

It is essential to emphasize that ending a delegation represents a mismatch between the strengths of the person and the role requirements of the job. This is not a bad person; rather, their behavior didn't meet agreed upon expectations. Even if this is not the right task for this person at this time, it is important to indicate that you still have belief in the capacity of the person. And it is helpful to be empathic to how hard it is to hear bad news (as well as to give it).

We come back to our scenario with the Boss and Rob. Rob has not sent a timeline in advance of the meeting as requested, and an email prompt has led to an incomplete timeline that does not meet the needs for the project. Rob has not been able to let go of the "urgent" tasks that are always present in order to attend to what is most important.

Example of a Meeting to End a Delegation Conversation

Boss: Hello, Rob. Our meeting today is to compare your actual progress with the goals and expectations we have discussed. I'm afraid the news isn't good. In spite of your best efforts, your work on the timeline has not been sufficiently organized or timely enough to meet the needs of this project. I have decided I cannot keep you in this role.

Rob: (Hangs his head.) I'm very disappointed. I know I can do it. I've been trying so hard and I'm getting better.

Boss: I can empathize. This must be hard to hear.

Rob: It is—I feel like I've failed.

Boss: I don't see it that way. I see it as more of a mismatch between your strengths at this time and what the role requires. You have great strengths with part of this role (gathering the right people and getting them involved), but the organizational aspects and efficiency are also vital to a time-sensitive initiative like the annual community outreach meeting. You have not been able to manage your time efficiently and get the detailed timeline completed even with several extensions. I have to balance the needs of the organization with your learning needs.
I see this is my error, in part. I pushed you too fast into this role. You are on a learning curve regarding learning effective time management. I believe you can become good at this. But it will take more time than we have available right now. I'd like to help you continue to learn, but can't do it at the cost of this program's success.

Rob: You still believe I can learn this?

Boss: I do—if you're interested in making this a part of your repertoire.

Rob: I really am.

Boss: I'm glad to hear it. I'd like you to work closely with Dr. X for the remainder of this project. I have asked her to take the lead on the meeting. You'll be her second in charge. She has great strengths in time management, and you'll learn a lot from working with her. And you'll

continue to bring your gifts in working with the team. How does that sound?

Rob: [Silence] . . . It feels like a demotion, but I'm also glad I'm not off the project all together and that you believe I am not a lost cause. I want to lead projects like this in the future. I think it will be good to work with Dr. X.

Boss: I admire your graciousness in handling this shift of responsibilities. I think this will be an important turning point for you, and I look forward to our continued work together.

Unclear delegations and inadequate processes of accountability are arguably the leading cause of productivity loss in organizations—and the most easily correctible. Using the principles described above, you can improve the practice of delegation and accountability, which will improve organizational performance and at the same time foster a workplace culture of respect and partnership.

Source: Appendix 3: A Relationship-centered Approach to Delegation and Accountability. Adapted from Suchman A, Sluyter D, Williamson P. *Leading Change in Healthcare: Transforming Organizations With Complexity, Positive Psychology and Relationship-centered Care.* London: Radcliffe Publishing; 2011.

Appendix 22 A. Relationship-centered Meetings as a Tool for Changing Practice Culture

Reproduced with permission from: Anthony L. Suchman and Penelope R. Williamson. Principles and Practices of Relationship-Centered Meetings

Facilitating relationship-centered meetings
The quality of relationships within a work team or committee has a profound effect on the group's results. It determines the participants' willingness to bring forward their diversity and differences as a resource for creativity, their openness to change, their motivation and initiative, and their commitment to the group and its work. Many, if not most meetings are conducted in a way that actually inhibits relationships and engaged conversation, resulting in meetings that feel dull and unproductive. Fortunately, there are some straightforward principles and simple meeting formats that can make meetings more relational and elicit high-quality participation. These methods require no additional time, only a little bit of courage to try something new. You can provide the leadership needed to suggest or implement these methods regardless of whether you are a team leader or a team member.

Principle #1: Invest Time in Relationship Building; It Will Pay Large Dividends in Efficiency and Performance. When members of a team know and trust each other, people can say what they think and explore each other's positions. Differences of opinion and perspective are a stimulus for creativity, not conflict. Meetings are enjoyable and the group makes rapid progress. Conversely, when people don't know each other, they get hung up on stereotypes ("What do you expect from an immunologist, or a social worker?"). They misinterpret each other's meaning and intentions and get mired in unnecessary conflict. They hold their ideas back for fear of ridicule and they waste a lot of time defending themselves and protecting their turf - time that could be better devoted to the work at hand. Often the urgency of the work makes it tempting to short-cut relationship building ("We don't have time for this 'soft stuff;' there's real work to do.") but it is always a false economy. The more urgent the work, the greater the likelihood of inadvertent relational breaches that amplify over time, the more urgently good relationships are needed, and the poorer the efficiency and outcomes will be if they are lacking.

Methods

Initial meeting: There are many ways to help people get to know each other at the first meeting of a group. Participants can take turns introducing themselves, saying a bit about what they had to do or give up to attend the meeting and why it was important to do so. Or they can tell a brief story about how they have come to be where they are at this point in their careers and lives. If the group numbers between 8 and 16, you might invite people to divide into pairs. People take turns interviewing each other for a few minutes using the questions above, and then when the whole group reconvenes each person introduces her/his partner. If the group numbers 8 or fewer, you might still use the paired interview approach or you can invite people to tell their stories directly to the whole group. In the latter case, it helps establish trust in the group to give people the option of passing if they'd rather not address the whole group. People rarely avail themselves of

that option but it makes them comfortable to know they have it.

Subsequent meetings: At the start of each meeting, it's helpful to begin with a round of "checking-in," offering an invitation to each person, always with the option to pass, of reflecting on how they're doing at the moment or what might be going on for them outside of the meeting that might be diverting their attention. Often simply naming the distraction helps to ameliorate it, and if it is something truly difficult, a child's or parent's illness or a major home repair in progress, for instance, the team members can offer support and will know not to take it personally if that person is observed during the meeting to be staring off into space and scowling. Another approach to check-in is to offer each person an opportunity to describe something that has gone well since the previous meeting.

Principle #2: Foster High-Quality Conversation (Level 2). The "free for all" conversational format at most meetings wastes time and potential. People have to fight to get the floor only to be interrupted before they can complete their thoughts; some people are not heard from at all. This leads to poor listening, ineffective articulation of ideas, a poor sense of teamwork and low commitment to any decisions that result. So instead of a free-for-all, use a little light structure in the service of better conversation.

Methods

Nominal group process: This is just a fancy term for giving each person in turn a specified amount of time without interruption to say what they think. You can allow a brief period of questioning before proceeding to the next person, or you can wait to hear from everyone before proceeding to questions and/or freeform dialog. In one variation, people suggest one idea at a time and keep going around the circle until there are no further ideas. Recording ideas on a board or flip chart can ensure that ideas are not lost. It's often useful to engage in another round of nominal group process after a discussion has been in progress for a while to see what level of consensus exists and what issues still need more attention.

Talking stick: This method involves using an object (traditionally a stick, but any object will do) to signify who has the floor. After finishing, a speaker passes the object to someone else, who then has the floor. This method brings a little order to the conversation and helps people finish their thoughts without interruption.

Principle #3: Explore Differences with Openness and Curiosity. When faced with a difference of opinion, people are all too easily hooked into a struggle over who's right and who's wrong. They fight as if their lives are at stake, and it's no wonder given all the humiliation associated with being wrong in traditional medical learning environments. The challenge here is to recognize that most situations are more complex than any one person can grasp, that everyone has a unique piece of the puzzle, and if anyone's piece is lost everybody loses. When people see things differently, most of the time they are both right.

Methods

The cone in the box: Figure A1.1 is a simple and effective graphic for helping people recognize that different perspectives are not mutually exclusive.[1] It shows a cone inside a box. People looking through a peephole at point A will see a circle, and through point B, a triangle. Their observations may seem mutually incompatible and they will argue forever unless they can get past the belief that someone else's different perception invalidates their own and accept that reality is more complex than what they are seeing on their own.

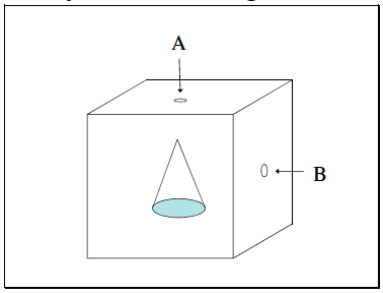

FIGURE A1.1: The Cone in the Box.

Listen for Internal Reactions: A failsafe indicator that you have a difference of opinion is your internal reaction. The most useful thing you can do when you suddenly experience a strong feeling (e.g., anger, defensiveness, humiliation) in response to what someone else says or does is to pause for a moment and "turn to wonder." "I wonder why I'm feeling this way." "I wonder what led him or her to that stance." The discipline of shifting from "knowing that you are right" to curiosity about your response allows you to move to inquiry.

Inquiry and advocacy: When encountering a difference of opinion, presume that the other person is competent and conscientious. Resist the initial temptation to argue and instead use inquiry – exploratory questions – to better understand the other person's views and reasoning. If you can show that you understand his/her view by accurately reflecting it back, so much the better. Only then is it time to advocate for your own perspective, clearly explaining your reasoning. And by then, you may have discovered there is in fact no difference, or that the heart of the difference is something other than what you thought at first, so you can respond more effectively. As a facilitator, you can help your group recognize when they are getting stuck in a right-wrong conversation and invite them to use more inquiry and less advocacy to find their way through.

Principle #4: In Pursuing Change, Learn from Successes. Most groups working on organizational change focus on problems, trying to identify and fix the root causes. The major problem with this time-honored approach is that the problems are too often equated with people. No one likes to be a problem, so people divert a lot of energy into defending themselves to avoid shame; the conversation makes little headway. An effective and
Zen-like alternative is to seek out and learn from instances in which the desired change is already present. They're almost always around if you look for them.

Method

[1] Brown J. *A Leader's Guide to Reflective Practice.* Victoria, BC: Trafford Publishing; 2007.

Appreciative Inquiry: This philosophy and methodology for organizational change is based on discovering and building upon the existing capacity within an organization. For example, if we want to foster better interdisciplinary collaboration, we'll make more progress by learning from successful instances – what went right, what factors made it possible, and how do we do more of that – rather than discussing where things went wrong and why. Curiously, we'll end up talking about exactly the same issues, attitudes and behaviors in either conversation, but with very different emotional tones that profoundly influence people's openness to change. A typical AI process begins with people pairing up and taking turns telling each other stories of successful collaboration. The interviewer can explore the partners' experiences in more detail using questions such as:

- What did you do or bring to the situation that contributed to the success?
- Who else was involved and what did they do that helped?
- What aspects of the setting or situation made a difference?
- What useful lessons can we take from this story?

Partners can then present each other's stories and lessons learned back to the whole group. This method is, in fact, a powerful form of participative inquiry. It invites people to step forward from a place of capacity rather than defensiveness, and helps people feel more hopeful and welcoming of change. Please see Module 11 on Appreciative Inquiry, for more information and resources on this process.

Appreciative debriefing: A similar approach can be applied in miniature at the close of each meeting. You can invite (with the option of passing, as always) each participant to reflect on moments during the meeting that they found particularly useful, important or engaging. This encourages people to become more aware of the process of their meetings and to discover how they can be helpful to each other. Positively reinforcing these helpful behaviors increases the likelihood of their use in future meetings and builds the sense of connection in the group, thus serving Principle #1.

Principle #5: When Meetings Get Stuck, Interrupt the Pattern. Sometimes meetings get stuck. You may find yourselves going around the same arguments again and again. Or one person may be dominating the conversation or holding fast to a point when the rest of the group is ready to move on. There may be emotions that are not being acknowledged. In such situations, the group can find itself caught in a pattern from which it is unable to extricate itself.

Method

Reflective time out: An effective way to help the group share responsibility for managing itself and changing the pattern is to take a time out from the conversation to reflect together on the conversation itself. Questions like "How is the conversation going so far?" or "What are you experiencing at this moment?" invite people to notice what's happening and to learn from others' observations. Other questions can help the group think about how to move forward include "What would help us right now?" or "What might we try to do differently?" The conversation can sometimes be stuck because an important issue has not yet been explicitly named (there's an "elephant in the room"). A question like "What important topics are we not yet talking about?"

can open the door. The meeting leader or a facilitative group member can offer answers to these questions and make suggestions about how to change the conversation (and may need to if the other group members are not forthcoming), but the group learns more and partnership is enhanced if the group can find its own solutions.

In a reflective time out, you can offer people a quiet moment for reflection and then hear from each person. This is a variation on the method of nominal group process described above. If there is not sufficient trust and safety for people to speak their concerns to each other directly, another variation is to ask people to write their comments down and pass them in to be read anonymously.

Principle #6: Trust the Process; Don't Try to Control the Outcome. Good group process draws forth the best capacity of the group. You will no doubt find yourself heading into some meetings convinced that you already know what decision the group should make, and trying (subtly, or so you think) to steer the group towards your predetermined outcome. There are two major problems with this approach: (1) People don't like feeling manipulated; they will fight you and will be unmotivated to follow through. (2) The group is smarter than you are, so your solution is unlikely to be as good as what the group would come up with. Rather than focusing on the desired outcome, focus on maximizing the quality of the process, on the quality of relationships and trust, and on the quality of listening, exploring, advocating and understanding. If the process is as good as possible, the best possible outcome will result.

Methods

All of the above. The relationship-centered principles outlined above rest on a strong body of evidence. Relationship quality is well associated with a wide variety of organizational outcomes in healthcare, including quality and safety of care, cost, patient and staff satisfaction, and the capacity to learn new procedures. The principles and methods are also easy to apply. They may be unfamiliar and may feel a bit awkward at first. But if you share your awkwardness with the group and let them know what you're trying to do and why, they will support you. Just remember what you are trying to accomplish – creating a more relational environment in which to work and get care. Bold change is accomplished by people who are willing to risk something new. Using these simple principles and methods, you can help your teams reach a new level of performance and engagement.

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Appendix 22B. Effective Meeting Role Cards

Timekeeper

Keeps the team on time through tracking time remaining for each agenda item and when necessary requesting the team to re-negotiate time to complete discussions and actions.

- Announce 1/2 way through the time
- Give a one minute warning
- Time is up

CHKD

Cystic Fibrosis Foundation

Facilitator

- Manage the group process and ensure balanced participation by all members of the group.
- Alert the group when the discussion is not focused on the agenda.

CHKD

Cystic Fibrosis Foundation

Leader

Prepares the Agenda,

and helps move the team through the agenda by eliciting participation from all

CHKD

Cystic Fibrosis Foundation

Participant

- Follow Ground Rules!
- Keep an open mind to new ideas
- Arrive early to start on time
- Communicate with all staff to share progress and gain their interest and ideas
- Have Fun!

CHKD

Cystic Fibrosis Foundation

Source: Dartmouth Institute Microsystem Academy, Cystic Fibrosis Foundation, Children's Hospital of the King's Daughters, Norfolk, Virginia (2014). Used with permission.

Appendix 23. *Sample Practice Record*

Encounter Notes

Clinic ALLOVERTHEPLACE			
Practice Facilitator (PF)	Lisa Helps A lot	Cell:	Email:
PF Standing Visit (day/time):	Mondays 1-4		
Practice status	Active		
Nominate as Exemplar on:			
Pneumococcal Vaccine delivery	80% of indicated vs. 20% in similar practices in area		

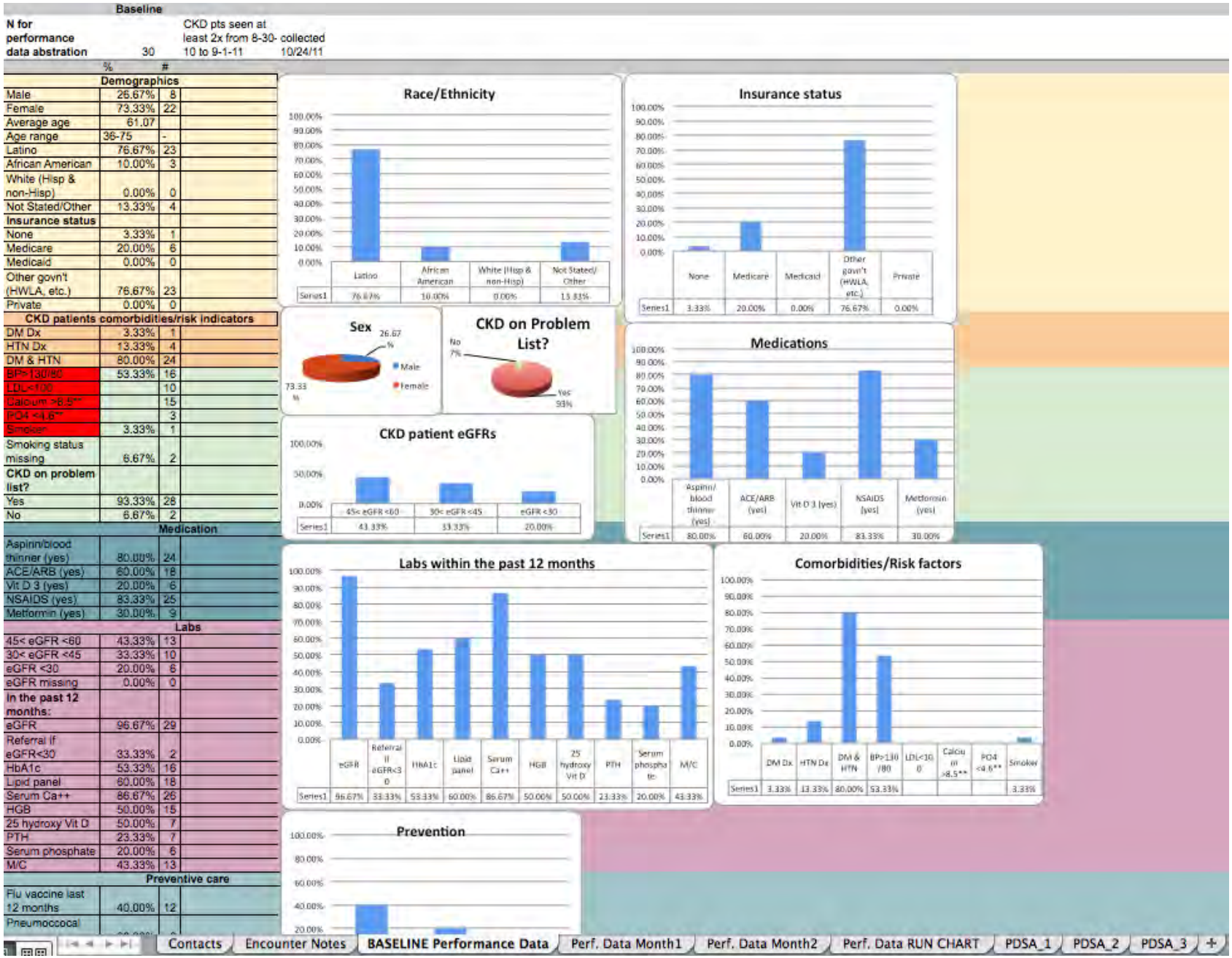
Improvement & Study Projects participating in:	Start date	End date	Description
1) Chronic Kidney Disease guideline implementation	9/1/12	10/2/13	Improve quality and outcomes for patients with CKD
2) Implement Care Teams	11/21/12	11/21/12	Implement care teams to support transformation to patient-centered medical home and to improve access and quality

Encounter Notes - Overview (date)	Practice Status 0=no progress, 1=some progress, 2=solid progress	Notes
9/1/12	2	CKD: Met with CKD champion for practice and his team; held project kick-off meeting; academic detailing on CKD guidelines and their use in primary care
9/8/12	1	CKD: Met with registry manager at request of Dr. Like Data. There are problems pulling eGFR data into the registry. Also, clinicians are coding CKD as
10/12/12	0	CKD: Dr. CKD not able to meet because practice busy treating patients with flu; registry manager out on vacation; Dr. Like Data not responding to
10/22/12	1	CKD: No progress with registry because manager out on vacation; Dr. CKD says can meet next week. Started first performance audit on patients with
11/8/12	2	CKD: Met with Dr. CKD and reviewed performance data. Dr. CKD indicates that information on medications is probably inaccurate due to out of date
11/16/12	2	CKD: Provided 15 minute training to CKD improvement team on Model for Improvement; provided training also on effective meeting facilitation.

PRACTICE PROGRESS DASHBOARD PROJECT	CKD	
Overall Assessment Scales:		0 = No activity; 1 = Planning; 2 = Activity, no change; 3 = Testing; 4 = Implementation; 5 = Spread; 6 = Complete
A. Create Quality improvement team/cmt and performance monitoring system	CKD	NOTES/COMMENTS
OVERALL SCORE:	4	
A1. Designate Project team leader	6	Dr. CKD is the champion.
A2. Identify performance metrics	6	
A3. Develop performance report generator using EHR and registry data	3	
A4. Map workflow for performance reporting & use	3	
A5. Train Project team on Model for Improvement and PDSA cycles	6	
A6. Review performance report monthly and carry-out PDSAs	0	
B. Use registry to manage target population	CKD	NOTES/COMMENTS
OVERALL SCORE:	3	
B1. Create registry	3	Underway, waiting for registry manager to return from vacation
B2. Populate registry		
B3. Assess & leverage existing population management resources		
B4. Train staff in population management		
B5. Map workflow for population management		
B6. Create reports templates/alerts to allow population management & planned care		
B7. Monitor use of registry to manage patient care and support population management		
C. Use templates	CKD	NOTES/COMMENTS
OVERALL SCORE:		
C1. Select template tool from registry/EHR (or create)	1	Dr. CKD plans to meet with EHR manager to create template.
C2. Map workflows to use template		
C3. Use template at every patient visit		
C4. Ensure registry/EHR updated after every patient visit		
C5. Monitor use of templates		
D. Standardize care	CKD	NOTES/COMMENTS
OVERALL SCORE:		
D1. Select protocol/guideline for clinical care issue	3	Dr. CKD and team have adopted the CKD guidelines provided by the project. Are discussing modifying lab requirements since some of the labs are expensive and hard to obtain for uninsured patients. Will help schedule virtual conference with Academic Detailer for Dr. CKD and his team to discuss this issue with him.
D2. Modify for use in safety net environment		
D3. Map workflow to implement/use protocol		
D4. Use protocol at every patient visit		
D5. Monitor use of protocol		
E. Self Management support	CKD	NOTES/COMMENTS
OVERALL SCORE:		
E1. Assess existing SMS resources at practice		

Contacts | Encounter Notes | BASELINE Performance Data | Perf. Data Month1 | Perf. Data Month2 | Perf. Data RUN CHART | PDSA_1 | PDSA_2 | PDSA_3 | +

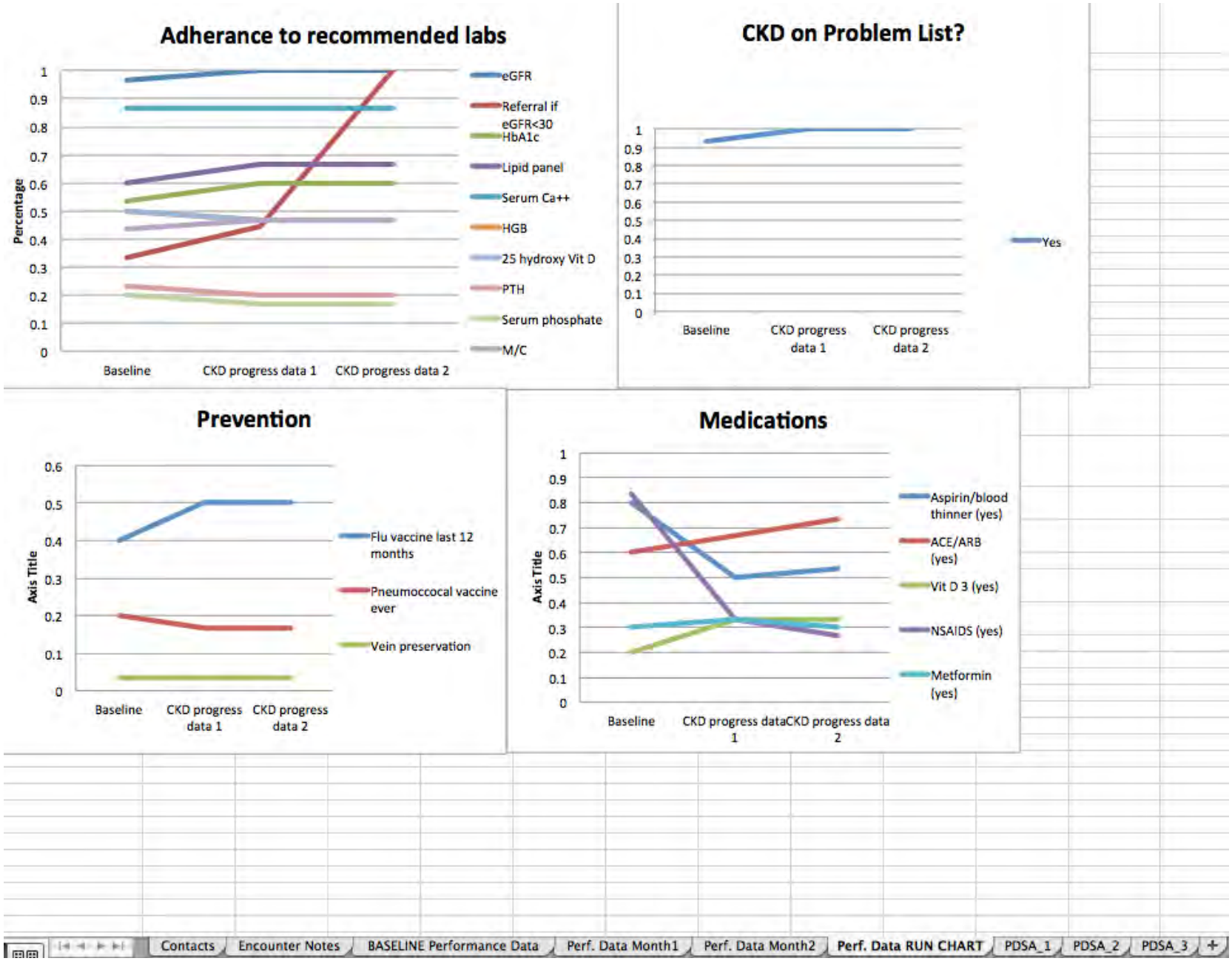
Baseline Performance Data



Baseline		
N for performance data abstration	30	CKD pts seen at least 2x from 8-30- collected 10 to 9-1-11 10/24/11

	%	#
Demographics		
Male	26.67%	8
Female	73.33%	22
Average age	61.07	
Age range	36-75	-
Latino	76.67%	23
African American	10.00%	3
White (Hisp & non-Hisp)	0.00%	0
Not Stated/Other	13.33%	4
Insurance status		
None	3.33%	1
Medicare	20.00%	6
Medicaid	0.00%	0
Other govn't (HWLA, etc.)	76.67%	23
Private	0.00%	0
CKD patients comorbidities/risk indicators		
DM Dx	3.33%	1
HTN Dx	13.33%	4
DM & HTN	80.00%	24
BP>130/80	53.33%	16
LDL<100		10
Calcium >8.5**		15
PO4 <4.6**		3
Smoker	3.33%	1
Smoking status missing	6.67%	2
CKD on problem list?		
Yes	93.33%	28
No	6.67%	2
Medication		
Aspirin/blood thinner (yes)	80.00%	24
ACE/ARB (yes)	60.00%	18
Vit D 3 (yes)	20.00%	6
NSAIDS (yes)	83.33%	25
Metformin (yes)	30.00%	9
Labs		
45< eGFR <60	43.33%	13
30< eGFR <45	33.33%	10
eGFR <30	20.00%	6
eGFR missing	0.00%	0
In the past 12 months:		
eGFR	96.67%	29
Referral if eGFR<30	33.33%	2
HbA1c	53.33%	16
Lipid panel	60.00%	18
Serum Ca++	86.67%	26
HGB	50.00%	15
25 hydroxy Vit D	50.00%	7
PTH	23.33%	7
Serum phosphate	20.00%	6
M/C	43.33%	13
Preventive care		
Flu vaccine last 12 months	40.00%	12
Pneumoccocal		

Performance Data Run Chart



Plan Do Study Act Reporting Template

PLAN DO STUDY ACT (PDSA) REPORT			
Aim: (overall goal you wish to achieve):			
Describe your first (or next) test of change:	**Person responsible**	**When to be done**	**Where to be done**
Plan			
List the tasks needed to set up this test of	**Person responsible**	**When to be done**	**Where to be done**
Predict what will happen when the test is	**Measures to determine if prediction succeeds**		
Do: Describe what actually happened when you ran the test			
Study: Describe the measured results and how they compared to the predictions			
Act: Describe what modifications will be made to the plan for the next cycle based on what you learned			

Contacts | Encounter Notes | BASELINE Performance Data | Perf. Data Month1 | Perf. Data Month2 | Perf. Data RUN CHART | PDSA_1 | PDSA_2 | PDSA_3 | +

Appendix 29 A. Team Visualization Exercise[i]

The goal of this exercise is to illustrate how the current models in most primary care practices do not function as team-based care. When working with your practice, be sure to get all care team members to participate. Each staff member will be given 60 jelly beans and a short, clear plastic cup. Also have a cup in the middle labeled "No one."

- Ask the group which staff member performs each of 10 tasks (listed below).
- Instruct all staff members to drop a jelly bean into **each** staff member's cup who they think **currently performs** that task.
- Instruct staff members to drop a jelly bean into the "No one" cup if they don't think anyone currently performs that task. For example, if a staff member thinks a task is currently performed by two physicians, a nurse practitioner, and a physician's assistant, that staff member would put a jelly bean in each of the cups of those four providers.

Ask which staff member:

1. SETS the intervals for blood monitoring for patients on warfarin?
2. DECIDES when to call a patient with diabetes to come in for a visit?
3. SELECTS the vaccines to be given to an 18-month-old baby?
4. DECIDES to arrange a diabetes retinal screening referral?
5. ORDERS the mammogram for a 55-year-old woman with severe hypertension and heart disease?
6. INITIATES diabetes microfilament foot testing to prevent amputations?
7. FINDS patients with severe persistent asthma who are not on controller medications and brings them in for an appointment?
8. DECIDES which children with ADHD should come for a visit?
9. DECIDES when a patient with major depression (PHQ 17) should come back for a visit?
10. ADMINISTERS Screening, Brief Intervention, and Referral to Treatment (SBIRT) screening to patients in your practice?

At the end of the exercise, the group will probably discover that most of the jelly beans end up in the primary care providers' cups. Facilitate a discussion using the following prompts:

- What did you observe about this exercise? What did you learn from it?
- What implications do you think this has for you all as a care team?
- Why are there jelly beans in the "No one" cup? What can you do about that?
- What should the distribution of jelly beans look like to be real team-based care?
- What changes would you need to make to how you are currently practicing to do this?
- How would this affect your workflow?
- Are there goals you want to include in your quality improvement plan based on this exercise?

Module 29: Implementing Care Teams

Appendix 29B. In a Perfect World: Task Reassignment Exercise[i]

Date:

Practice:

Facilitator:

Participants:

Task	Who Does It Now?	In a Perfect World, Who Would Do It?
Book appointments		
Take incoming calls		
Chart preparations		
Triage		
Medication refill requests		
Check in		
Suture removal		
Dressing change		
Flu shots		

[i] Adapted with permission from Institute for Healthcare Improvement, Cambridge, MA.

Appendix 31A. Empanelment Exercise

Name:

Date:

Information on patient visits to clinic in past year:

Patient	Provider 1	Provider 2	Provider 3
John	1*	3	1
Lisa	1	1*	1
Nancy	2*	0	0
Lucy	1*	4	5
Samantha	1	4*	5
Timothy	2	2*	4
George	1	3	2
Michael	1	1	1*
Bianca	0	0	2*
Carl	1*	1	2
* Last provider seen			

Where would you obtain these data for a practice?

Assign patients to a panel based on data above.

Patient	Provider 1	Provider 2	Provider 3
John			
Lisa			
Nancy			
Lucy			
Samantha			
Timothy			
George			
Michael			
Bianca			
Carl			

Appendix 31B.1. Panel Management Training

By Dr. Thomas Bodenheimer, M.D., M.P.H., and Amireh Ghorob, M.P.H.

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Note: This document has been formatted for the Web. It has not been edited, except to correct typographical or grammatical errors.

Part 1: Introduction to Panel Management

What is panel management and population-based care?

Population-based care is a proactive approach to healthcare. By population we mean the panel of patients associated with a provider or clinic. Population-based care means that the provider or clinic is concerned with the entire population of its patients, rather than only those patients who happen to come in for appointments. The population might be only some of a provider's or clinic's patients; for example, the patients with diabetes or the patients with Hepatitis B.

Panel management is the way in which we do population-based care. Panel management uses the patient registry to monitor patient care.

What is a registry?

Effective panel management relies on the availability of accurate and complete information in a patient registry. The registry is a database that stores patient health care information. The registry is a list of the names of all the patients of a provider or a clinic, with medical information about each patient. The registry can be searched to give feedback to a clinic and a clinician on performance measures; identify patients overdue for mammos, paps, HbA1c or LDL blood tests, eye exams, etc. The registry can also identify patients not in control of HbA1c, LDL, or blood pressure, patients who need more coaching or more extensive planned visits with a RN or nutritionist.

Some information in a registry is entered electronically from a laboratory or from the electronic medical record of a clinic, for example, patient demographic information, diagnoses, and lab values such as HbA1c and LDL cholesterol. Other information may need to be input by someone in the clinic, for example, blood pressure, weight, and BMI.

Although many clinics have a registry available, often the registry is not used to its full capacity. That is why panel managers with protected time are needed to work the registry.

Who is a Panel Manager?

Ideally, a clinic team member (for example, a medical assistant) is trained to be a Panel Manager. The Panel Manager reviews the registry on a regular basis to makes sure that patients complete their preventive and chronic care tasks on time (pap smears, mammograms, HbA1c levels, etc), receive lifestyle counseling, and are prescribed and are taking medications. Panel Managers call and send letters and lab slips to patients who need lab work done and make appointments for eye exams, mammograms, pap smears, etc. In some cases, the panel manager works with clinicians to review patients' medications and contact patients to intensify medications based on the clinician's orders. The Panel Manager may also have the job to enter data into the registry (like blood pressures) and to keep the registry up to date.

A Panel Manager can enormously help clinicians and patients by doing this work, which makes the Panel Manager a key person on the health care team.

In order for primary care clinics to use health coaching and panel management, they need to train coaches and Panel Managers. More importantly, they need to guarantee coaches and Panel Managers protected time. Ideally, the same people serve as both panel managers and coaches. All Panel Managers need health coach training since they perform outreach to patients.

Panel Management and Chronic Care

Sample Chronic Care Registry

Look at the example of a chronic care registry report. Any search criteria can be used to create a registry report based on a particular panel of patients with particular characteristics (clinic, clinician, last blood pressure, LDL or HbA1c value). In this sample report, patients in Column 1 represent the panel. The columns 2-12 represent the information that was selected by the person doing the search.

Group Activity

Use the chronic care registry sample and routine chronic care measures table to answer the questions below.

1. How many patients are in this panel?
2. What information is available on each patient?
3. What are some reasons that some fields are blank?
4. Which patients have HbA1c > 7?
5. What does this mean?

6. How often should HbA1c be measured if the patient is at goal? And if not at goal?
7. Which patients have BP > 130/80?
8. What does this mean?
9. How often should BP be measured if the patient is at goal? And if not at goal?
10. Which patients have LDL>100 and are diabetic?
11. What does this mean?
12. How often should LDL be measured if a diabetic patient is at LDL goal? And if not at LDL goal?
13. Which patients have LDL>130 and are not diabetic?
14. What does this mean?
15. How often should LDL be measured if the patient not diabetic and is at LDL goal? And if not at LDL goal?

Team Activity

With your team, answer the questions below. Use the chronic care sample registry and routine chronic care measures table.

1. Review the values for patients A, B, C, and D.
    a. Which of these patients would you call to schedule a group blood pressure clinic appointment?
    b. Which of these patients need to get labs done now?
    c. Which of these patients are you most concerned about?
2. Review the values for patients H and K: Which of these patients are you most concerned about?

Role Play

Do a role-play with a partner. One will play the role of panel manager/health coach; the other will be the Patient D from the Chronic Care Registry. The coach will make a mock phone call to the patient and try to arrange lab slip pick up and an appointment.

After doing the mock call, both participants will provide feedback about the coach's role using the Panel Management Checklist.

Switch roles and repeat the mock phone call.

Panel Management and Preventive Care

Sample Preventive Medicine Registry

Panel management is an important way to help deliver preventive medicine. Registries can be set up to look at dates of most recent cancer screenings and other preventive measures. Information in this sample registry is organized to allow panel managers to contact patients who are overdue for colorectal cancer screening, mammograms, and the pneumococcal vaccine.

Group Activity

Use the preventive medicine registry sample and the routine preventive measures table to answer the questions below.

1. Why are some of the fields blank?
2. Which patients are overdue for colorectal cancer screening?
3. Which patients are overdue for a mammogram?
4. Which patients should receive a pneumococcal vaccine?

Team Activity

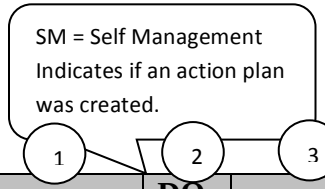
Colorectal cancer screening usually means having a fecal occult blood test (FOBT) every year or a colonoscopy every 10 years.

1. How does the panel manager know that a patient needs a FOBT test?
2. As a team, write a colorectal cancer screening guideline to increase the colorectal cancer screening rate in this panel.

Appendix 31 B.2

Chronic Care Routine Measures Table

Sample Chronic Care Registry Report



1	2	3	4	5	6	7	8	9	1	1	1
Name	**DOC SM**	**BP DATE**	**BP/s**	**BP/d**	**LDL Date**	**LDL**	**A1c DATE**	**A1c**	**DIABETIC**	**SMOKER**	**DATE ASKED IF SMOKES**
Patient A	NO	2/21/2011	127	70	11/30/2010	93			NO	NO	11/20/2010
Patient B	YES	2/15/2011	110	55	2/15/2011	145	9/25/2010	11.3	YES	YES	2/15/2011
Patient C	NO	4/7/2010	158	87	4/11/2010	81	4/11/2010	6.7	YES	NO	3/15/2008
Patient D	YES	1/20/2011	148	95	12/14/2010	170	12/14/2010	8.9	YES	YES	12/12/2009
Patient E	NO	10/28/2010	129	72	12/10/2010	54	12/10/2010	9.6	YES	YES	3/30/2010
Patient F	NO	8/21/2010	125	88	4/20/2010	125			NO		
Patient G	YES	6/24/2010	149	85	4/16/2009	102			NO	NO	12/2/2008
Patient H	NO	3/5/2011	147	90	3/5/2011	81	3/5/2011	12.1	YES	NO	3/5/2011
Patient I	NO	1/29/2010	120	64	2/3/2010	65			NO	NO	12/22/2004

Chronic Care Routine Measures		
Routine Measure	Frequency	Goal
HbA1c	Every 3 months if not at goal	HbA1c < 7% Frail patients: HbA1c < 8%
	Every 6 months if at goal	
Blood Pressure	Every 3 months if not at goal	Systolic < 130 Diastolic < 80 (BP <130/80)
	Every 6 months if at goal	
LDL	Every 3 months if not at goal	Diabetics and/or CHD: LDL < 100 All other: LDL < 130
	Every year if at goal	
Smoking	Every year	"No"

Sample Preventive Medicine Registry Report

Preventive Care Routine Measures

1 Name	2 Phone Number	3 Age	4 Sex	5 Date of Pneumovax	6 Date of FOBT	7 Date of Colonoscopy	8 Date of Mammogram
Patient A	(415) 555-0179	76	F	12/22/2007	5/11/2008	10/24/1995	12/15/2005
Patient B	(415) 555-0134	55	M		7/21/2009		
Patient C	(415) 555-0110	65	M				
Patient D	(650) 555-0189	52	F		8/14/2010		9/30/2008
Patient E	(415) 555-0143	53	F		12/6/2010		12/18/2010
Patient F	(415) 555-0123	58	F				5/28/2009
Patient G	(650) 555-0112	55	M				
Patient H	(650) 555-0150	42	F	6/10/2009			10/21/2010
Patient I	(415) 555-0175	68	M	2/3/2008	7/28/2010		
Patient J	(415) 555-0120	62	M			3/27/2007	
Patient K	(415) 555-0130	75	F	7/14/2010		1/17/2002	8/22/2004

Preventive Care Routine Measures Table
Preventive Medicine Routine Measures Table

Routine Measure	Who should get it?	Frequency
Pneumococcal vaccine	Adults > 65 years old	Once*
Colorectal Cancer Screening	Adults 50-75 years old	FOBT once a year or Colonoscopy every 10 years
Mammograms	Women 50-74 years old	Every 2 years

*Patients with diabetes and some other conditions need the vaccine once before age 65 and once after age

Appendix 31B.3. Panel Management Training

Part 2: Creating clinical practice guidelines

How are clinical practice guidelines (standing orders) created that inform the panel manager when a care gap exists?

A care gap exists when a patient is overdue for a service that should be done periodically. F instance, a care gap exists when a patient with poorly controlled diabetes has not had a HbA test in over 3 months.

A care gap exists when a patient is above goal for a particular disease. For example, if a patient's goal for diabetes control is a HbA1c of 7 or below, a care gap exists if the most re HbA1c is greater than 7.

How does the panel manager know the guidelines that determine whether pa is overdue for a service or whether the patient's disease is in poor control?

The national guidelines, created by the American Diabetes Association, indicate that patient with diabetes in poor control should have an A1c test every 3 months, and patients with dia in good control should have an A1c test every 6 months. Each clinic needs to decide whethe they will use those national guidelines or create different guidelines. The guidelines (also c standing orders) need to be established and put into writing by the medical director or by the agreement of all the clinicians. Panel managers need to be trained to understand those standi orders.

Team Activity

Read the example standing order below. With your team, answer the questions that follow

Panel managers should check the registry every month and identify all patients with diabet with HbA1c above 7 who have not had a HbA1c in 3 months. Send a HbA1c requisition to t lab for those patients, and send the standard HbA1c lab letter to those patients with a follow phone call in 2 weeks for those patients who have not yet gone to the lab.

1. You are the panel manager. How would you fill out the lab requisition and how woul you get it to the lab?

2. How would the panel manager know which patients have a HbA1c goal of 8 rather t 7?

Group Discussion

Discuss reasons behind exceptions to routine follow-up.

Team Activity

Activity 1: Create a standing order to increase the percentage of patients completing colorectal cancer screening at your clinic.

Activity 2: Create a standing order to improve health outcomes for diabetes patients at your clinic.

Key messages

1. Some patients are exceptions to standing orders.
2. Each clinic must figure out a way to identify patients who should not receive the routine follow-up.
3. **Decisions on which patients are exceptions should be made by clinicians, not by panel managers**.

Part 3: Outreach

What is out-reach and how is it provided?

After the panel manager has identified care gaps, outreach is done by mailings and phone calls to close the gap. Out-reach is the best option for patients who do not have appointments in the near future.

Outreach Letter

Below are two example letters. We will read each letter and discuss.

Example 1

Dear Mr. Rojas,

We need you to come to the lab for an A1c blood test. Our records show you are overdue for this lab. Please come in or call me as soon as possible.

Sincerely, Diana

Group Discussion

Is this a good letter? Why or why not?

Example 2

Dear Mr. Rojas,

Dr. Alvarez asked me to write you because it is time for you to have another lab test for your diabetes. This test is called A1c. This measures your average blood sugar for the past 3 months. The last time we checked your A1c, it was too high, meaning that your diabetes was not in good control. We repeat this test every 3 months if your A1c is high.

An up-to-date A1c can guide our work together to help you take care of your diabetes.

You can go directly to the lab. I have sent the lab a slip with your information. Should you need help or have questions about the test, please call me.

Best wishes, Diana from Dr. Alvarez' team

Group Discussion

Is this a good letter? Why or why not?

Outreach Phone-Call Script

Below are two example phone-call scripts. We will read each script and discuss.

Example #1

Hello Mr. Rojas, this is Diana. [Hello, who is this?]

Oh, I sent you a letter 2 weeks ago about getting new labs, but it looks like you didn't go. We need you to go to the lab because it is really important for your health. [I haven't gone because I haven't had a chance yet.]

Could you go to the lab tomorrow to get your A1c test? [No, I work tomorrow]

But it is very important for your health that you go. Don't you want to take care of your diabetes? [No.]

Group Discussion

Is this a good phone call? Why or why not?

Example #2

Hello Mr. Rojas. This is Diana, calling from Dr. Alvarez' office.

[Oh, hello]

Is this a good time to talk? [Yes]

How are you today? [I am doing OK.]

Dr. Alvarez asked me to call you because it is time for you to have lab test for your diabetes. The test is called A1c. Do you know what the A1c test is? [No]

It is a measure of your average blood sugar for the past 3 months. [Oh yeah, my sugar test]

Do you remember what your last test showed us? [It was too high?]

That's right, the last time we checked your A1c, it was too high, meaning that your diabetes was not in good control. If it is okay with you, we'd like you to come in to get a new A1c test so we have a guide to help you take care of your diabetes. Would that be OK? [Yes, I can come in. Where do I go?]

Just go to the lab. I have sent a lab slip to the lab so they know that you will be coming. When do you think you could come? [Next Wednesday, when I don't have work]

Great. Do you have an appointment with Dr. Alvarez anytime soon? [No]

It would be good to have an appointment a week or two after the lab test. Let's help you set up an appointment now.

Group Discussion

Is this a good phone call? Why or why not?

Role play

Do a role-play with a partner. One will play the role of panel manager/health coach; the other will be a patient. Use the scenarios below to do outreach. Do scenario 1 and then switch roles and do scenario 2.

Scenario 1: Ms. Gonzalez is a patient who has diabetes, A1c of 9.5, and has not had an A1c test for 6 months. Ms. Gonzales is motivated to improve her diabetes but does not understand her disease very well. Make a phone call to ask the patient to come to the lab for an A1c test.

Switch roles.

Scenario 2: Mr. Rojas has diabetes, A1c done 1 year ago of 10.2. He has not had an appointment for 5 months. He appears resistant about caring for his diabetes. Make a phone call to ask the patient to come to the lab for an A1c test.

Part 4: In-reach

What is in-reach and how is it provided?

In-reach is for patients who do have an appointment soon and for patients who drop in for care. In-reach takes advantage of the patient being in the clinic to try to close the care gap.

In-reach can be done regardless of what the patient has come to the clinic for. During an eye appointment, a podiatry appointment or a social work visit (or any other visit), the optometrist, podiatrist, or social worker would look at the screen and see what can be done to close the care gap.

In-reach works best if the electronic medical record has a panel management screen that indicates whether a patient has a care gap (for example a woman 60 years old who has not had a mammogram for 3 years) or is in poor control of a chronic condition (for example a patient with high LDL cholesterol who has not had a cholesterol blood test in 2 years). With this electronic panel management tool, in-reach can be done by the medical assistant during the rooming process. For example, if the patient is overdue for a mammogram, the medical assistant writes a mammogram order and makes an appointment for the patient to get a mammogram.

If there is no electronic medical record with a panel management screen, medical assistants can review the chart during the rooming process to determine if the patient has a care gap (preventive or chronic care) and try to close the care gap.

Do panel managers always implement standing orders exactly as the orders are written?

For effective panel management to take place, panel managers need to exercise some clinical judgment. For example, you can have a standing order that says every patient with diabetes needs a LDL-cholesterol test every year, but what does this really mean? If a patient comes in for an appointment in September 2010 and the last LDL was in November of 2009, does the panel manager wait until November 2010 to order an LDL or should he/she order one now even though the patient received an LDL test 10 months ago?

Group Discussion

Should panel managers have some disgression or should they only implement the standing orders exactly as written?

Role play

Do a role-play with a partner. One will play the role of panel manager/health coach; the other will be the patient. Use the scenarios below to do outreach. Do scenario 1 and then switch roles and do scenario 2.

Role play #1: Ms. Phillips is 60 years old and has not had a FOBT test in 2 years and has never had a colonoscopy. The medical assistant discusses having Ms. Phillips get a FOBT.

Switch roles

Role play #2: Mr. Johnson comes in for a podiatry appointment. Mr. Johnson has diabetes with A1c done 3 weeks ago that is 9.6. Clinical practice guidelines agreed upon by the clinic leadership says that patients with A1c levels above 8 should get a one-hour appointment with a health coach. The medical assistant in the podiatry clinic has seen the panel management screen and knows that Mr. Johnson has a care gap about his diabetes control.

Part 5: Implementing panel management

How do panel managers get the training and the time to meet their responsibilities to their patients?

Each clinic's leadership after consulting with clinicians and staff needs to decide its panel management priorities. This partly depends on which conditions are entered in the registry. Some registries only include patients with diabetes; it would be difficult for a clinic with only a diabetes registry to do panel management for preventive care.

If the registry includes patients with diabetes, hypertension, hepatitis B, cervical cancer screening (PAP smears), breast cancer screening (mammograms), and colorectal cancer screening, then the clinic would need to decide its priorities based on how many patients are at risk for these different conditions and how much panel management time is available.

Panel managers need training for those conditions the clinic has decided are its priorities. The clinic leadership, or a quality improvement committee, may change priorities from month to month and make sure that the panel managers are trained to carry out each new priority.

Team Discussion

What types of patients can your clinic focus on? Based on this focus, create your clinic's priorities.

Models of Panel Management

There are two models of panel management that can be implemented to provide time for panel managers to do their work. One is the **specialized panel manager model.** In this model, one or two people (usually medical assistants) are trained to be full or half-time panel managers. During their panel manager time, they do *not* do medical assisting. The panel managers are responsible for the panel management of all patients in the clinic who need panel management.

The other model is the teamlet model. In this model every medical assistant in the clinic is trained to be a panel manager, and every medical assistant spends part of their time doing panel management. Each clinician is paired up with a medical assistant – who is also a panel manager -- in a two person team, called a teamlet. The teamlet, not just the clinician, is responsible for a panel of patients. The responsibility of the medical assistant/panel manager is to provide the panel management only for that panel of patients.

Team Discussion

1. Which of these models do you prefer for your clinic?
2. What are some barriers to implementation?
3. What are the solutions to these barriers?

Appendix 31 C. Sample Policies and Procedures

Community Clinic	**Policy File Name:**
	Page 1 of 4
Policy Title: Panel Assessment and Maintenance	Original Date: Revision Date(s):
	Approval Date:
Manual: Clinical	Effective Date:
	Policy Created/Revised By:

Purpose

To link each primary care patient with a Primary Care Provider (PCP).

Goal

To increase patient and provider satisfaction, improve continuity of care, and improve delivery of care.

Procedural Steps:

1. PCP Assignment Roles and Responsibilities

Clinic Manager:

- Reviews PCP assignments for team providers monthly.
- Addresses discrepancies in PCP assignment and unassigned patients seen by team provider.
- Tracks visits with PCP versus other providers ("Continuity Report").
- Determines whether panel is open/closed based on ideal panel size provided by the IT Panel Support.
- Follows up on patient requests to change providers.

IT/Data Analyst:

- Provides Clinic Managers an Ideal Panel Size report on a quarterly basis.
- Provides Clinic Managers an Actual Panel Size report on a monthly basis.
- Provides Clinic Managers with a monthly report of unassigned patients.
- Provides a PCP Discrepancy report that tracks visits with PCP versus other providers ("Continuity Report").
- Informs the Call Center, AMD, DOO, Clinic/Nurse Managers, and CMO of closed panels.

Nurse Manager:

- Whenever a provider leaves, the NM will coordinate a Transition Team Meeting consisting of the following staff: Billing Manager, Clinic Manager, Data Analyst, AMD/CMO, and Call Center lead to: evaluate patient needs in collaboration with team; reassign patients to other clinic providers according to panel capacity; and notify affected patients.

2. Assigning Patients

New Patients

Call Center:

- Schedules patient visit for next available/open provider panel.
- Call all new IPA enrollees with a followup letter if there is no response to schedule initial assessment visit with their assigned PCP.

Front Desk Specialist:

Registration-related duties:

- Assigns PCP in practice management system when new patient checks in during first appointment.
- Registration/Discharge places PCP label on medical chart with Provider/Team name.
- Provides the Patient Handbook to new patients.

Discharge-related duties:

- Confirms assignment with patient. If patient requests different provider or if provider requests change, facilitates change of assignment only to an open panel. (Please refer to PCP Assignment Change.)

Unassigned Patients Previously Seen

Front Desk Specialists:

Registration-related duties:

- Based on the four-cut method, determines who their PCP is and makes the assignment in the practice management system.
- Assigns to PCP using the "four-cut" method unless patient requests different assignment.
- Confirms PCP assignment at check-in.
- If patient requests PCP change, staff will immediately contact the Clinic Manager.

Discharge-related duties

- Reviews PCP assignment and confirms with patient and provider, and changes assignment as indicated.

- If request is made to change to a Panel that is already full, immediately contact the Clinic Manager.
- Confirms PCP assignment when making appointments.
- Confirms PCP assignment with new patients.
- Resolves discrepancies with provider assignment for established patients, contacts Clinic Manager.
- Changes PCP assignment upon request by provider or management team.

3. PCP Assignment Change

Patient who wants to change PCP assignment within the same clinic:

- Discharge and/or Registration staff: Facilitates the PCP change (in practice management system), unless the panel of the provider the patient is requesting is full. If the patient or provider does not agree with the request for change, defer to Clinic Manager and AMD as needed.
- Inform the patient and providers of the change through email.
- Clinic Manager: If patient has a provider preference regarding gender, then change can be made; otherwise, consults with current PCP. If transfer is approved, confirms acceptance by new PCP (should include PCP-PCP communication).

Patient requests transfer to PCP at different clinic:

- Discharge: Will make change to an open PCP panel at patient's desired location.
- Clinic Manager: Consults with current PCP. Reviews patient's history (# of PCP changes, no-shows, number of clinic transfers).
- Provider: Notes request to change on the discharge form and will consult with the referring provider, if available or known.
- Discharge staff: Informs patient of new PCP and ensures PCP reassignment in practice management system.

PCP requests transfer to a different clinic:

- Discharge: Will make change to an open PCP panel at patient's desired location.
- Clinic Manager: Consults with current PCP. Reviews patient's history (# of PCP changes, no-shows, number of clinic transfers).

4. Patient Notification of Provider Transfer or Termination

In the event of a provider transfer or termination, each clinic site will take responsibility for notifying patients.

CMO and AMD:

- Notifies Clinic Manager, Nurse Manager, IT, Billing Manager, and Call Center Manager of the provider leaving within 2 weeks of receiving notice.

Information Technology Panel Support Staff:

- Provides the Clinic Manager a list of patients assigned to the provider, patient letters, and optional mailing labels, if needed.
- Upon request, provides PCP/team with panel list.

Call Center:

- Eligibility will provide the IPA Disenrollment list to Clinic Managers on a monthly basis. (Note: The list produced will be from the month prior.)

Clinic Manager:

- The manager will ensure that the computer is updated with the revised PCP information. Standard personalized letters will be sent from the provider to notify patients of the transfer or termination. Patients should be told that the clinic will notify them when their PCP has been replaced. Until reassignment occurs, patients will be seen by the appropriate provider as determined by the clinic manager in coordination with the other providers at the site.
- Will inactivate account of disenrolled IPA patient in practice management system.

Billing Manager:

- Assigns PCP a new provider number in practice management system when a new PCP is hired or when caseload needs to be reassigned to new provider. Clinics will be responsible for reassigning the patient to a new PCP within the clinic site.

Appendix 32. Self-Management Support Tasks and Assignments: Role Visualization Exercise for Self-Management Support

Complete the chart by describing what each team member will do for each of the listed tasks for self-management support. Not all team members will be involved in each activity, nor is the list of tasks exhaustive.

Role	PCP	Nurse	MA	Clinical Care Manager	Dietitian/PT/OT	Administrative Staff/Patient Navigator	Other
Introduce SMS, describe roles.							
Set visit agenda.							
Collaborate on patient goal setting.							
Provide information and skills training to patients.							
Create an action plan.							
Connect patients with resources in community and elsewhere in health system.							
Oversee disease registry/ proactive followup.							
Conduct previsit chart reviews.							

Adapted with permission from Institute for Healthcare Improvement, Cambridge, MA.