Practice Facilitation SKILLS WORKSHOP

in partnership with

nrhi
Network for Regional Healthcare Improvement

High-Value Care Support and Alignment Network

Accelerating Improvement Towards Targets - Part 1

Practice Transformation Initiative, a program of:

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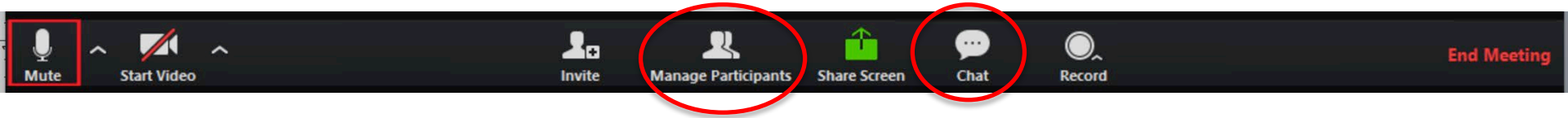
Breakthroughs for Better Healthcare

Integrated Healthcare Association

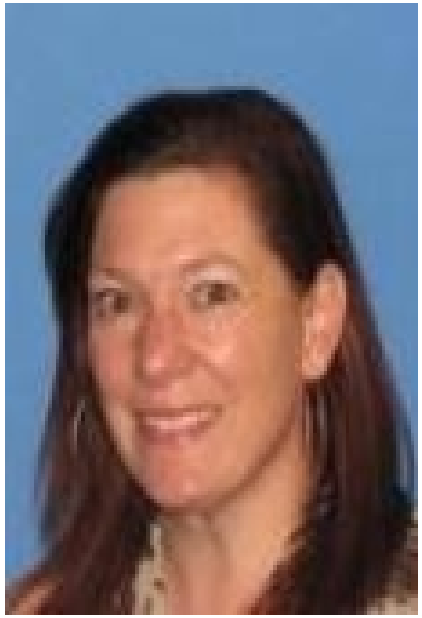
CCI Center for Care Innovations

Zoom Basics

- Click on the microphone icon in the lower left hand corner to ***mute*** or ***unmute*** yourself
- Click on the video icon in the lower left corner to **turn off/on your video- Please keep your video on**
- Click on the **chat** icon to send questions or comments to others- **Please chat to all so everyone can see your message**
- When you click on **manage participants,** you will see the option to **raise hand** - use this if you would like to contribute to the conversation
- Remember to *always* **disconnect from wifi** and **hardwire your internet connection** via an ethernet cable for the most secure and stable viewing experience



Crystal Eubanks



Aleece Caron

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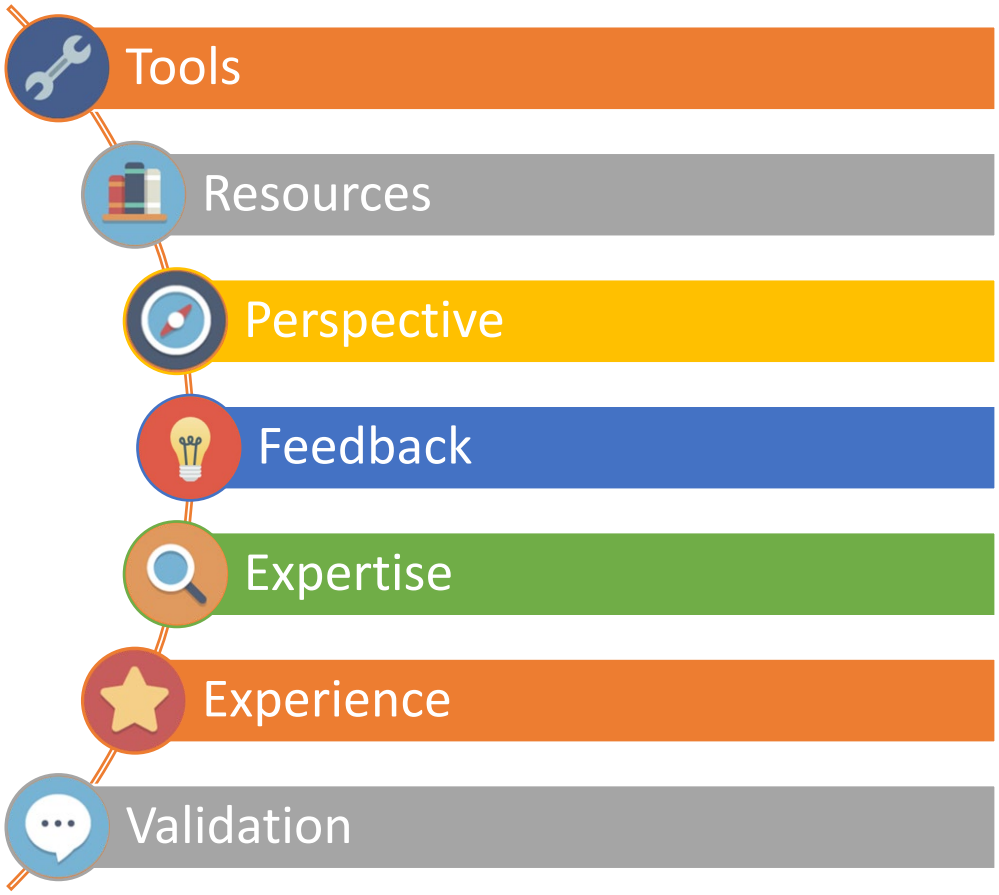
High-Value Care Support and Alignment Network

Hello and welcome!

Utilizing your coach support network



- Ask and offer another practice facilitator…
  - how to overcome a similar challenge.
  - perspective on a difficult situation.
  - a tool or resource used successfully.
  - expertise on a particular subject.
  - celebration!

Today's Agenda

1. Touch base from previous workshop
2. Review today's topic and objectives
3. Revisit Aims and Goals
4. Translate Outcomes into Action
5. Prepare to hit the ground running
6. Discussion & Wrap-up

6 Principles of Adult Learning

Safety	Respect	Inclusion
Relevance	Immediacy	Engagement

Practice Transformation Initiative

FACILITATING LEARNING FOR TRANSFORMATION

POLL:

What were you successful at transferring into your work?

Build safety to allow for transformation.

Take next steps for Phase 2.

Create fun recognition/award for high performing practices.

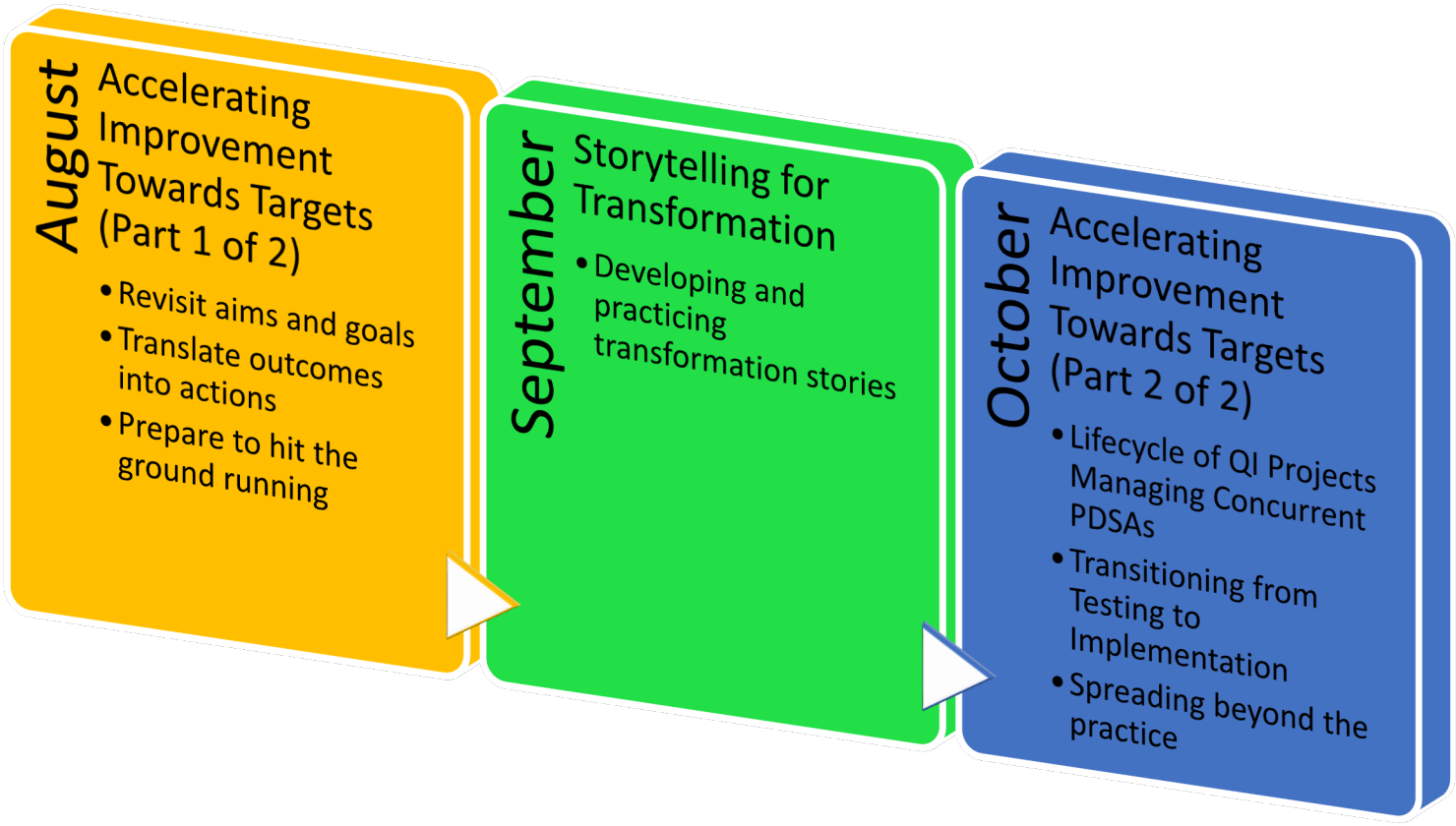
Take a step back and support the team.

Celebrate successes.

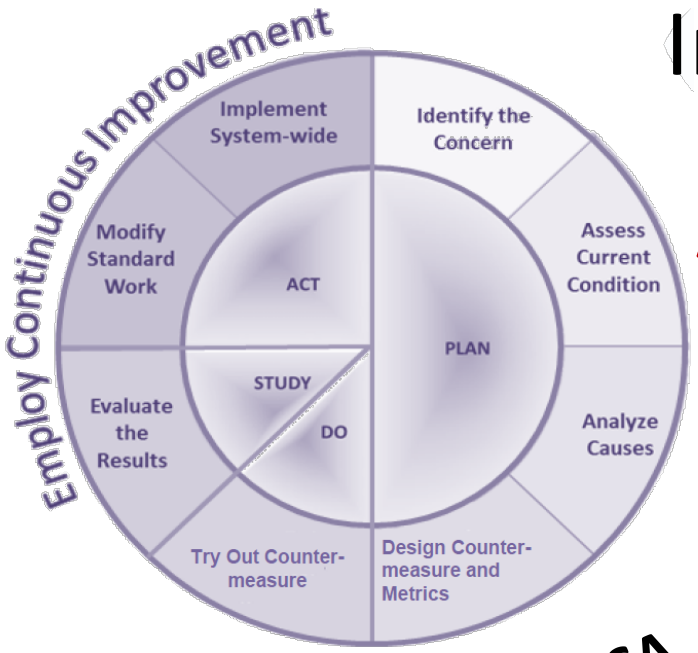
What were you successful at transferring into your work?

- Build safety to allow for transformation 1/16 6%
- Celebrate successes 7/16 44%
- Create fun recognition/awards for high performing practices 4/16 25%
- Take a step back and support the team 3/16 19%
- Take next steps for Phase 2 1/16 6%

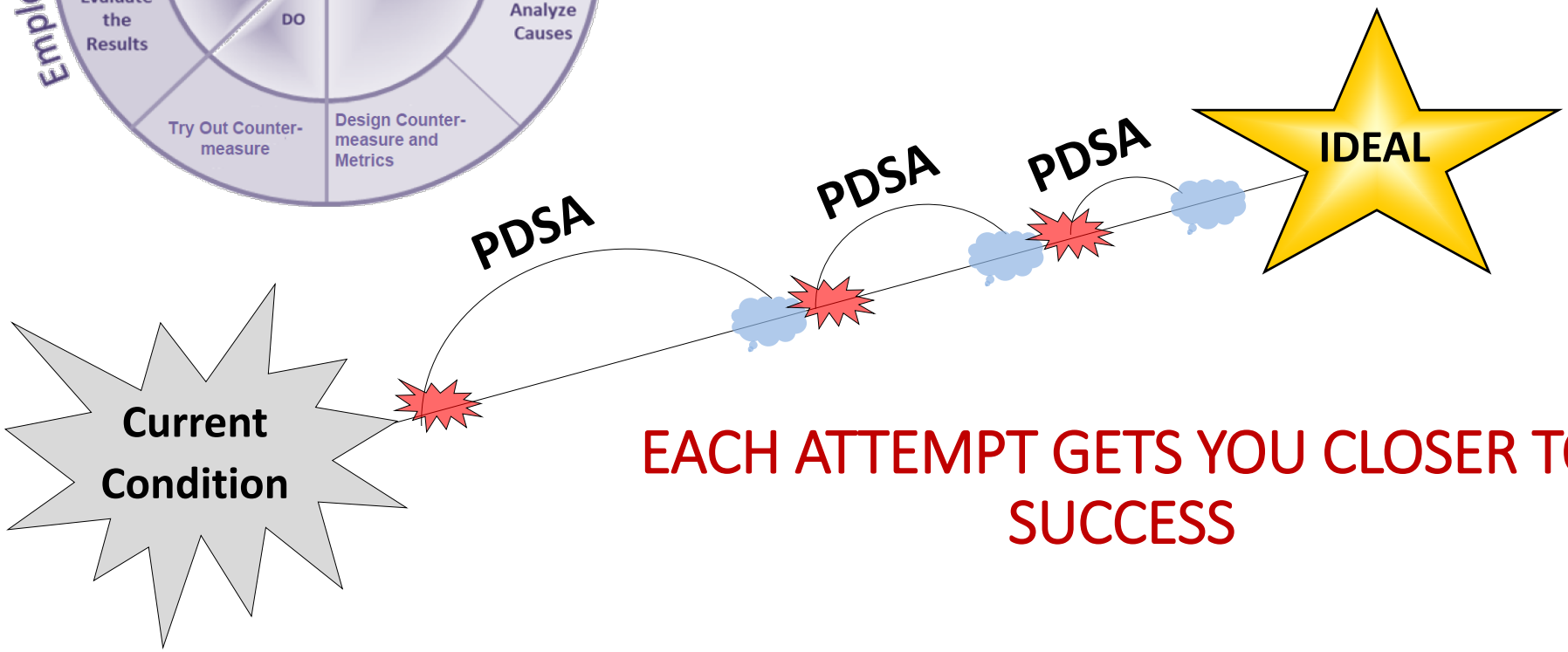
Upcoming Workshop Topics



Improvement Strategy



Problems are solved one step at a time



EACH ATTEMPT GETS YOU CLOSER TO SUCCESS

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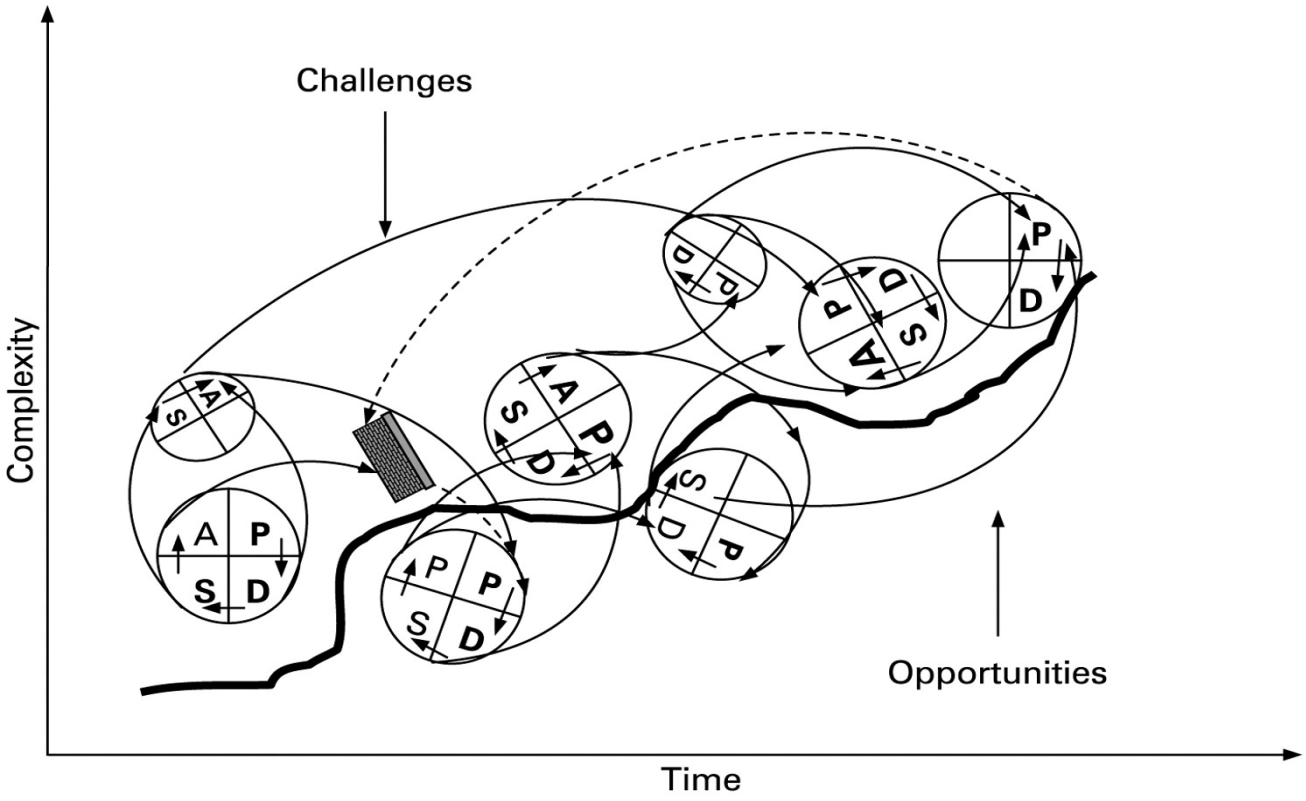
Model of Improvement



P = Plan D = Do = Barrier —— = Direct flow of impact

S = Study A = Act ----- = Lingering background impact Arrowhead = Feedback or feedforward

Different sizes of letters and cycles and bold letters = denotes differences in importance/impact

POLL:

How confident are you that you can work with clinicians to implement QI concepts, such as PDSAs?

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How confident are you that you can work with clinicians to implement QI concepts, such as PDSAs?

- Confident: 6/16 37.5%
- Mildly confident: 4/16 25%
- Moderately confident: 3/16 19%
- Undecided: 1/16 6%
- Very unconfident: 2/16 12.5%

Revisit Aims and Goals

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Seeing the Peak:
Our focus for the next 6 months

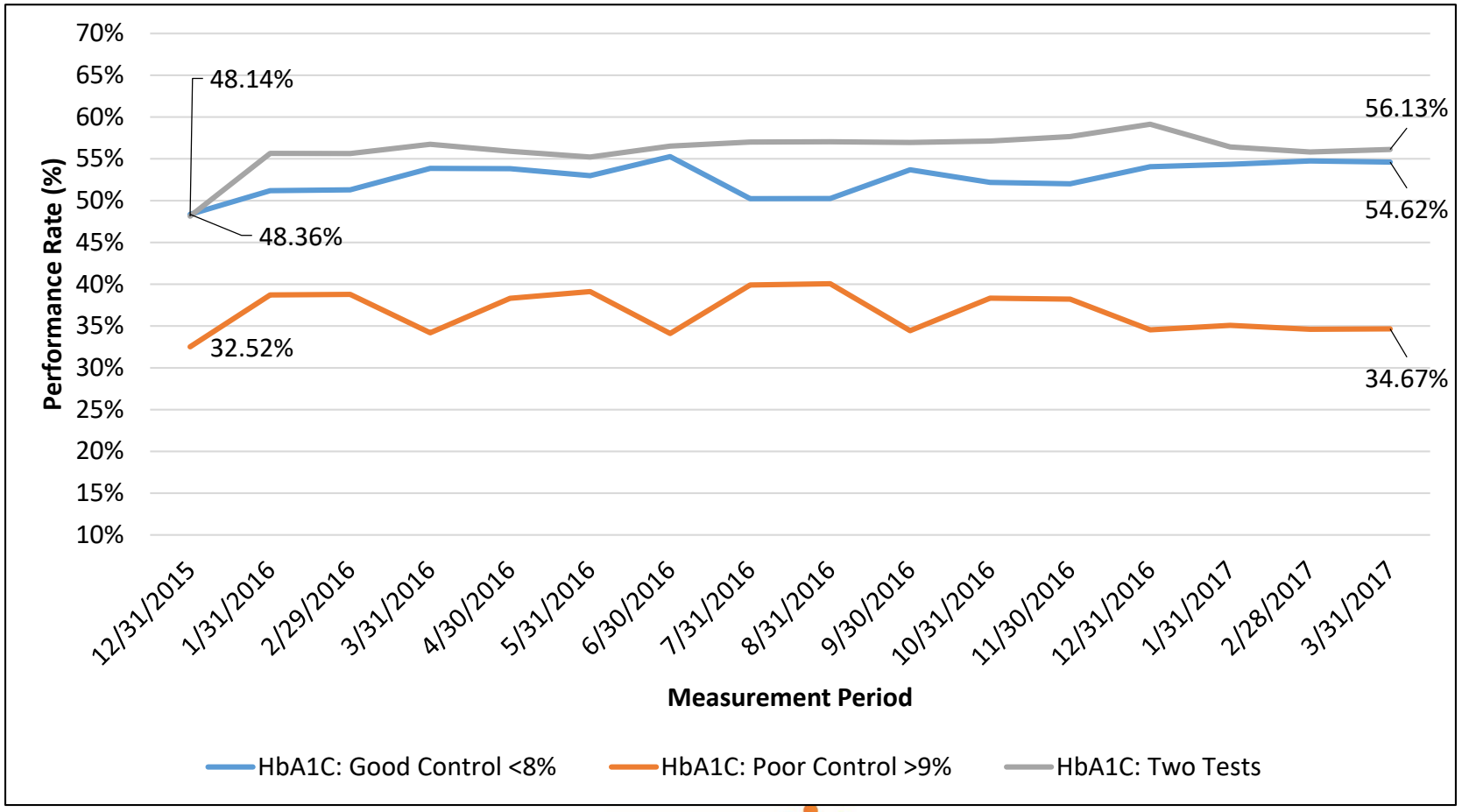
Our program's commitment to CMS by December:

- Improve diabetes control **by 5% from current performance** (increase HbA1c <8%, decrease HbA1c >9%)
  - ✓1,500 primary care practices
  - ✓3,000 clinicians
  - ✓**<u>100,000 patients</u>**

Seeing the Peak:
Our focus for the next 6 months

- Expand practice engagement
- Moving through phase 2:
  - Risk stratification and management of higher risk patients
  - QI capability within the practices
  - Data use at organization and practice levels
  - Patient and family engagement at organization and practice levels
  - Team-Based Care

PTI Year 2 Progress: Focusing on Diabetes



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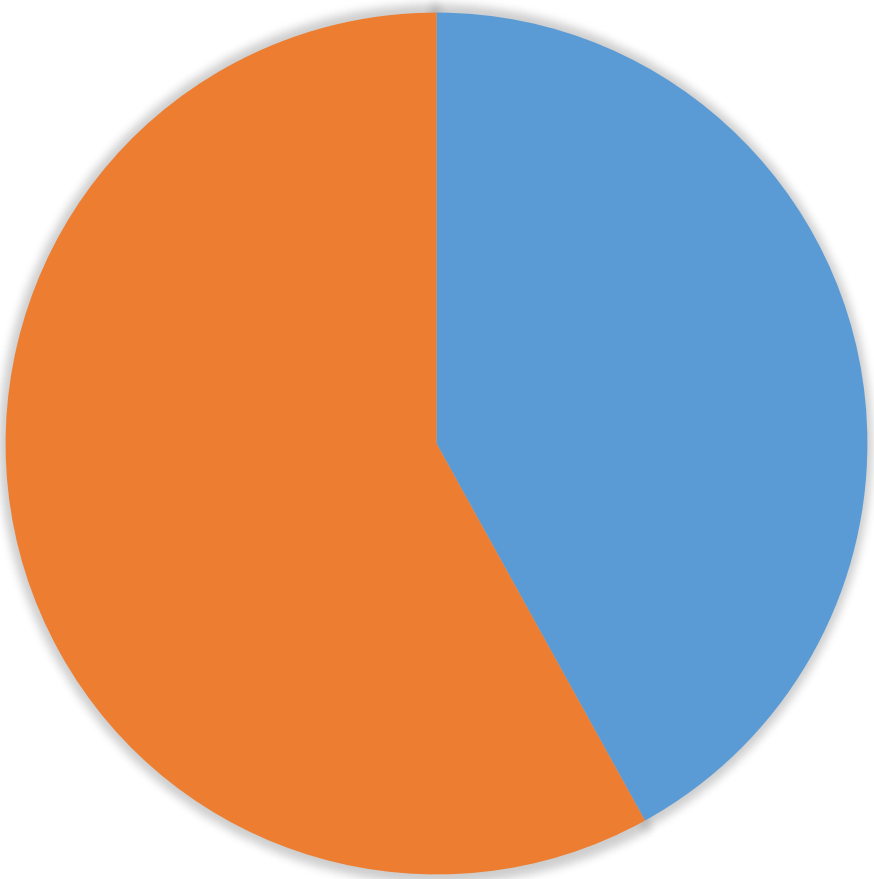
By December 31, 2017, we will improve Diabetes outcomes by 5%, impacting 15,000 people.

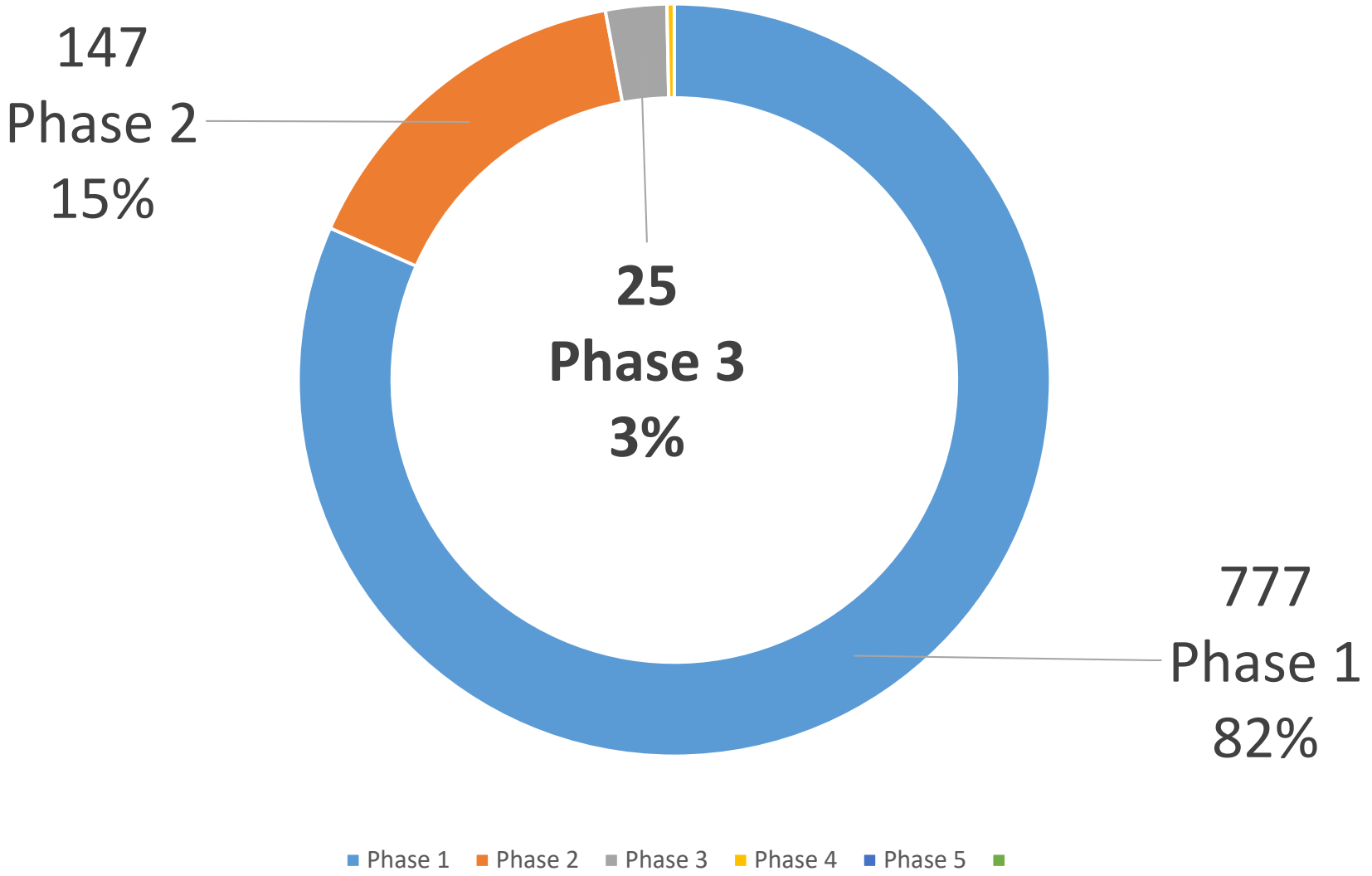
Measure	June 2017	Goal: Dec. 2017	# of practices needed to reach goal	# of practices within 5% of the goal	# of patients to receive a test
HbA1c: Two Tests	56%	**61%**	567	106 (19%)	
HbA1c: Good Control <8%	55%	**60%**	630	249 (40%)	
HbA1c: Poor Control >9%	35%	**30%**	920	175 (19%)	

PTI PRACTICES
AS OF JULY 2017



Practice Transformation Initiative

PTI Goal Progress: By 12/31/17, 90% of practices will have achieved Phase 3.



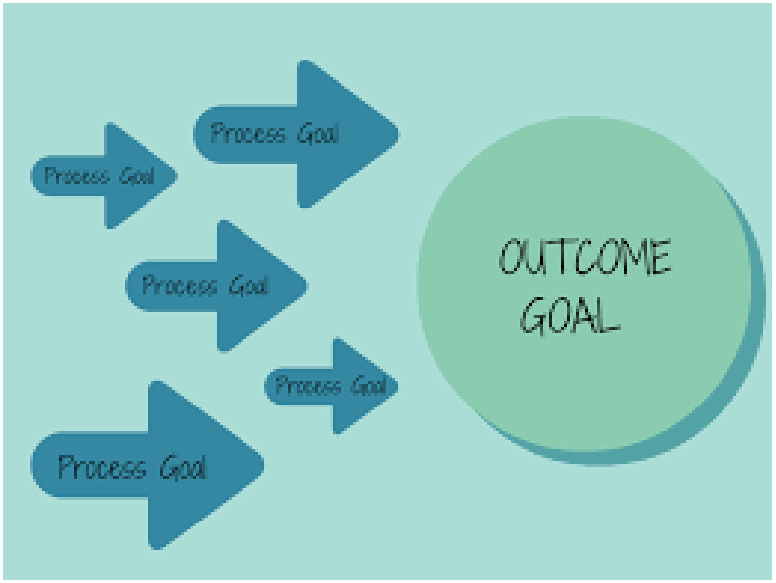
POLL:
Which goal(s) do you think you can impact personally by the end of the year?

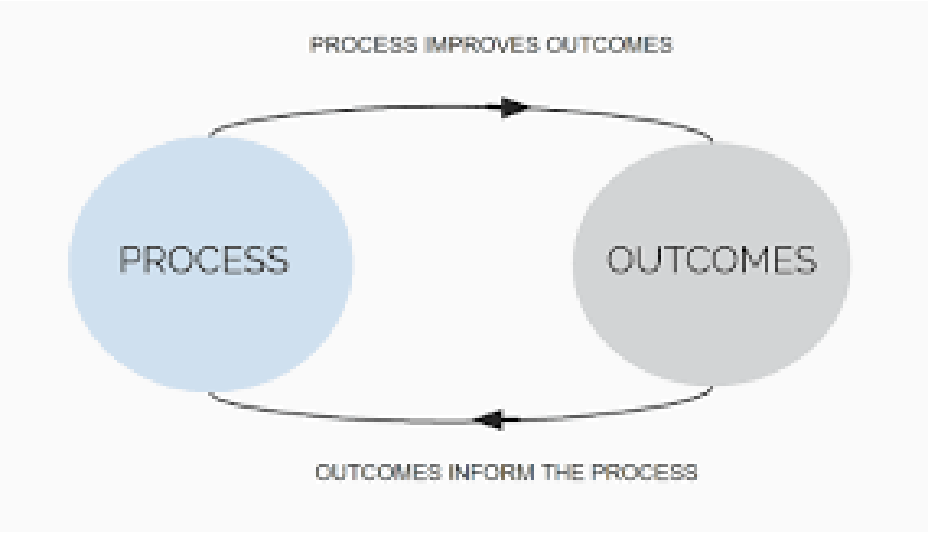
- Expand practice engagement
- Improve HbA1c: Two Tests
- Improve HbA1c Good Control <8%
- Improve HbA1c Poor Control >9%
- Move practices through Phase 2

Which goal(s) do you think you can impact personally by the end of the year?

- Expand practice engagement 8/28 28%
- Improve HbA1c: Two Tests 6/28 21%
- Improve HbA1c Good Control <8% 1/28 4%
- Improve HbA1c Poor Control >9% 1/28 4%
- Move practices through Phase 2 12/28 43%

Translate outcome measures into ACTION!





Donabedian's Quality Framework

What do we want to achieve?

What changes will drive our progress?

How will we measure our progress?

How should we modify our latest changes?

modified from: ***The Foundation of Improvement*** by Thomas W. Nolan *et. al*

Listen to this improvement story to identify important components.

OUTCOME MEASURE =	**Aim**	**Intervention**	**Measure**
PROCESS MEASURE #1			
PROCESS MEASURE #2			
PROCESS MEASURE #3			

A successful strategy for implementing elements of a hypertension best practice in safety net clinics

- To improve blood pressure processes and control in safety net clinics.
  - In April 2015, we conducted a 1.5 hour meeting describing Kaiser's hypertension best practice with a quality improvement (QI) team from 13 primary care clinics in a large safety net health system.
  - QI teams at each clinic developed a QI plan for BP improvement

Methods

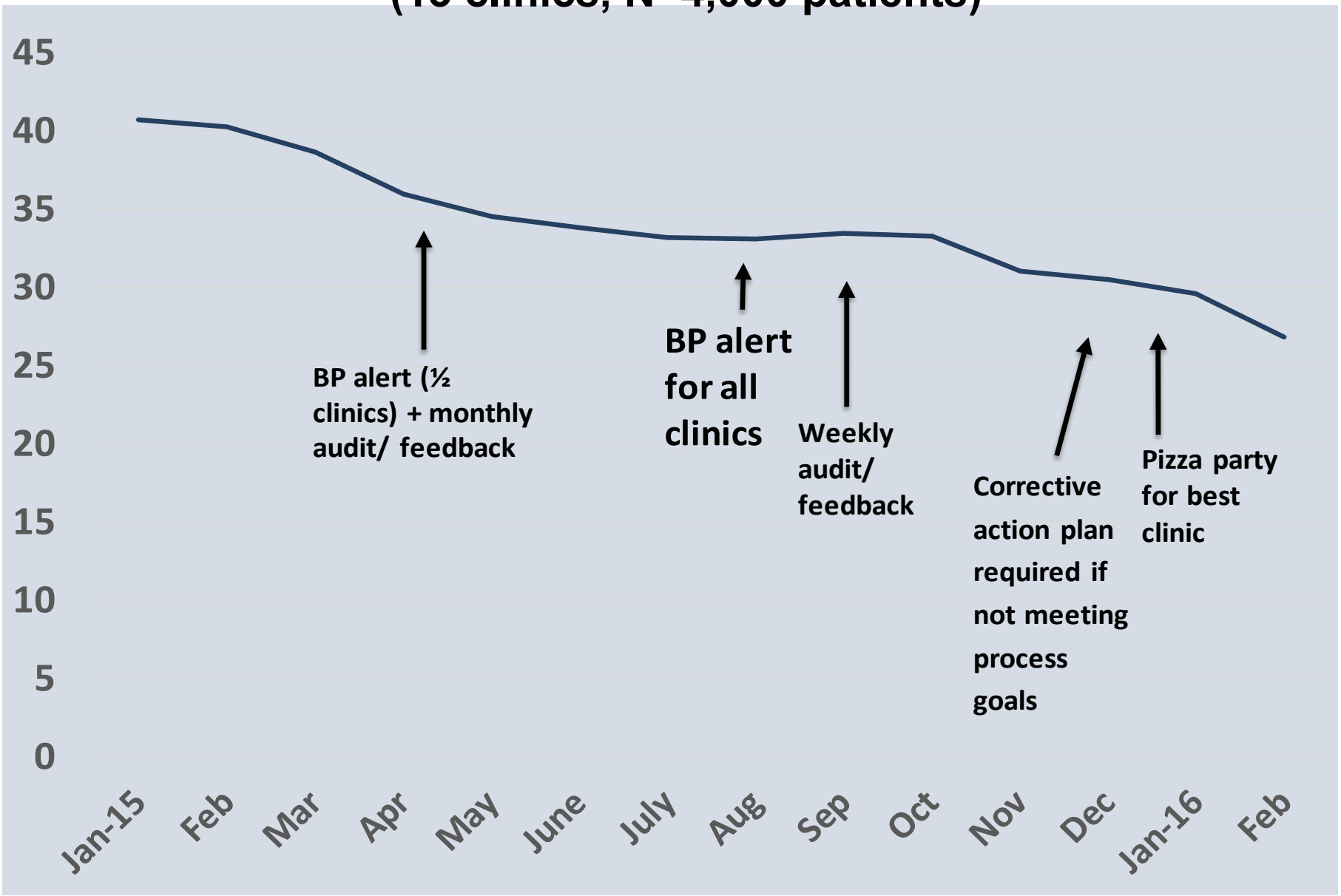
The Kaiser best practice included the following:

- Repeat BP measurement if the first BP measurement was elevated
- A treatment algorithm prioritizing once daily low cost medications
- Timely follow-up in monthly Nurse or Medical Assistant-led HTN visits until BP is controlled
- Outreach to adults with elevated BP

Implementation across sites included:

- An electronic alert reminder to recheck the BP if the first BP reading was elevated
- Audit/feedback of data on % eligible patients with repeat BP measurement
- Practice coaching monthly for several months

10 point absolute improvement in BP control (13 clinics, N~4,000 patients)

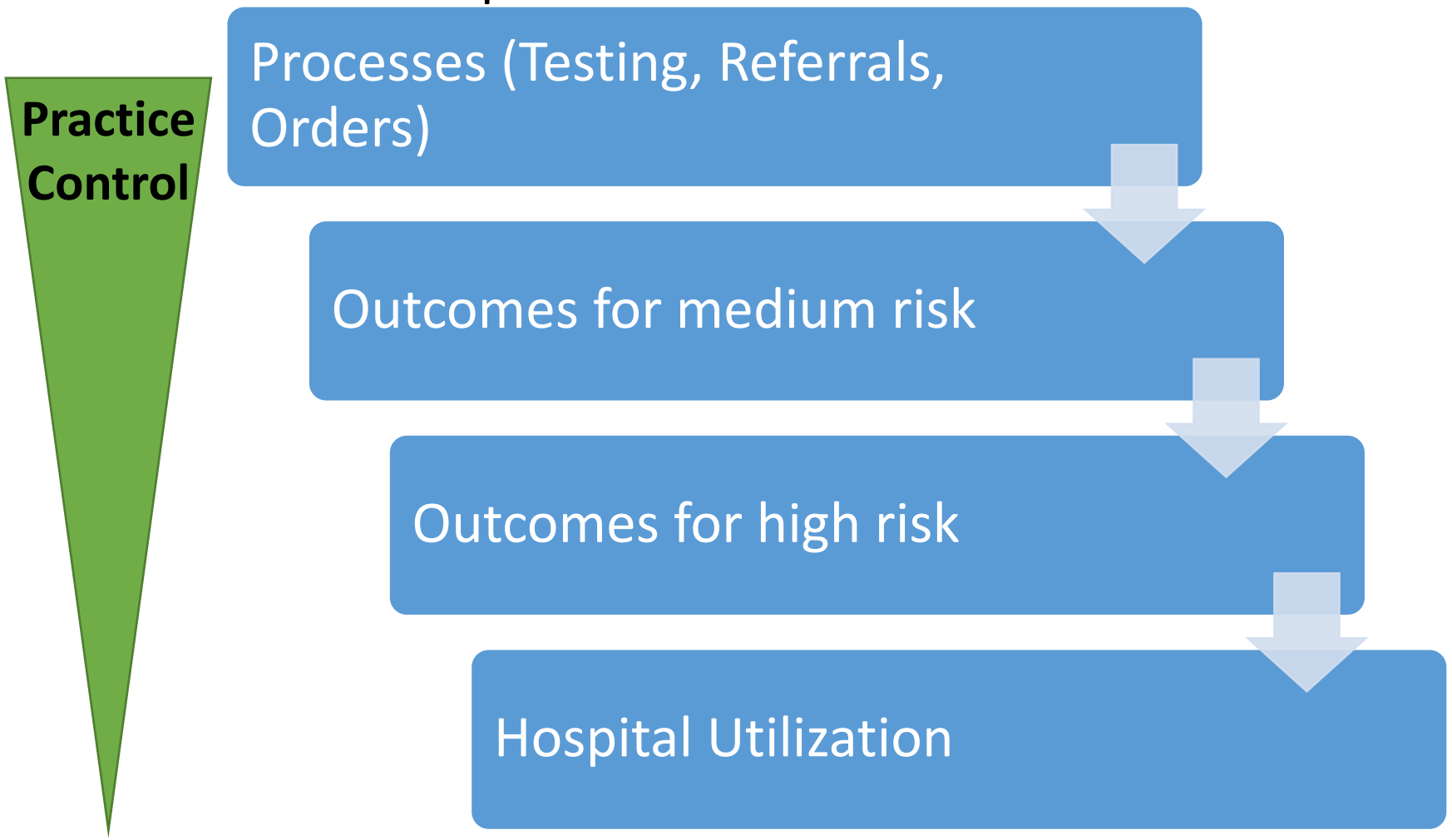


Examples of data sharing: Better Health Partnership

LOCATION	Total Patients	No. with High BP	% with High BP	No. with Follow-up	Follow-up (%)
ALL SITES	11709	3092	26.41	1867	60.38
[redacted]	728	187	25.69	145	77.54
[redacted]	82	31	37.80	21	67.74
[redacted]	763	147	19.27	87	59.18
[redacted]	175	46	26.29	29	63.04
[redacted]	901	256	28.41	155	60.55
[redacted]	716	209	29.19	129	61.72
[redacted]	847	257	30.34	193	75.10
[redacted]	259	50	19.31	30	60.00
[redacted]	461	141	30.59	116	82.27
[redacted]	572	130	22.73	99	76.15
[redacted]	1252	350	27.96	199	56.86
[redacted]	385	88	22.86	51	57.95
[redacted]	299	63	21.07	41	65.08
[redacted]	709	156	22.00	92	58.97
[redacted]	745	194	26.04	116	59.79
[redacted]	695	231	33.24	120	51.95
[redacted]	1004	298	29.68	115	38.59
[redacted]	328	55	16.77	39	70.91
[redacted]	162	30	18.52	13	43.33
[redacted]	335	99	29.55	31	31.31
[redacted]	284	72	25.35	45	62.50

OUTCOME MEASURE = BP Control	**Aim**	**Intervention**	**Measure**
PROCESS MEASURE #1		Showing data and tracking improvement	Was it shared weekly at the practices
PROCESS MEASURE #2		Timely follow-up using support staff / monthly f/u ma visit	Scheduled? Show rates By MA? Impact on patients involved
PROCESS MEASURE #3		Implemeting re-check	Feedback tool, measuring, built into EHR

Sequence improvement focus for effective impact.



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What do you anticipate that your practice team needs NOW to hit the ground running?

Please unmute or chat in to share your thoughts.

IDEA: Next Steps

Schedule and confirm next meeting.

Revisit aim statement and goals.

Review data and current state.

Is the team still willing and ready? Any changes in data or priorities?

'Meet then where they are' - adjust aim statement and goals as necessary.

Decide focus improvement measure through the end of the year.

Detail related process measures, change tactics, and first PDSA in the QI plan.

IDEA: Easy Wins for Diabetes and Phase 2 Milestones

Patient & Family Engagement	• Document self-management goals in the chart.
Population Management	• Ensure all DM patients are empaneled and active with the practice. • Connect DM patients with HbA1c >9% to IPA/centralized case management services.
Practice as Community Partner	• Create a 1 page list of community resources related to healthy lifestyle – eating, physical activity, stress management, and smoking cessation.
Coordinated Care Delivery	• Determine if IPA or health plans have hospital follow-up for patients. If so, ask for list of patients.

IDEA: Easy Wins for Diabetes and Phase 2 Milestones

Organized, Evidence-based Care	• For patients with HbA1c <9%, automate referrals to health education services. • For patients with HbA1c >9%, automate referrals to a behavioral health clinician (LCSW).
QI Strategy	• Pick a process goal easily impacted by the non-clinician care team staff like HbA1c testing or referrals to specialists.
Transparent Measurement & Monitoring	• Post run charts for DM measures in the break room. • Review run charts as a standing QI team agenda item.
Staff Vitality & Joy in Work	• Team-Based Care components where non-clinicians can step up – huddles, standing orders.

What more do you want to know?

What else do you need?

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What will you transfer into your work from this workshop today?

Please unmute or chat in to share your thoughts.

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UPCOMING EVENTS

- **August 16 - 17:**

Practice Facilitation Basics Training

@ DoubleTree Anaheim Convention Center

- **September 7th** @ 10am:

Practice Facilitation Skills Workshop – Storytelling for Transformation

2017 Practice Facilitation Skills Workshops

February 2
BUILDING RELATIONSHIPS WITH PRACTICES

March 2
MANAGING PRACTICE FACILITATION WORK

April 13
CREATING QI PLANS

May 4
BUILDING CAPACITY & MOTIVATTION FOR CHANGE

June 1
ACHIEVING PHASE 2 MILESTONES

July 6
FACILITATING LEARNING FOR TRANSFORMATION

August 3
ACCELERATING IMPROVEMENT TOWARDS TARGETS - PART 1

September 7
STORYTELLING FOR TRANSFORMATION

October 12
ACCELERATING IMPROVEMENT TOWARDS TARGETS - PART 2

November 2
ACHIEVING PHASE 3 MILESTONES

December 7
YEAR-END REFLECTION & PLANNING

Practice Transformation Initiative

SOCIALCAST
Virtual Learning Community

BOX
Virtual Library

PTI DATA PORTAL

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Help us improve our offerings!

Share your feedback here:

https://www.surveymonkey.com/r/pfsw_170803

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