Practice Facilitation

SKILLS WORKSHOP

Creating QI Plans with Practices

CQC California Quality Collaborative
Breakthroughs for Better Healthcare
Integrated Healthcare Association
CCI Center for Care Innovations

Crystal Eubanks

Senior Manager of
Practice Transformation

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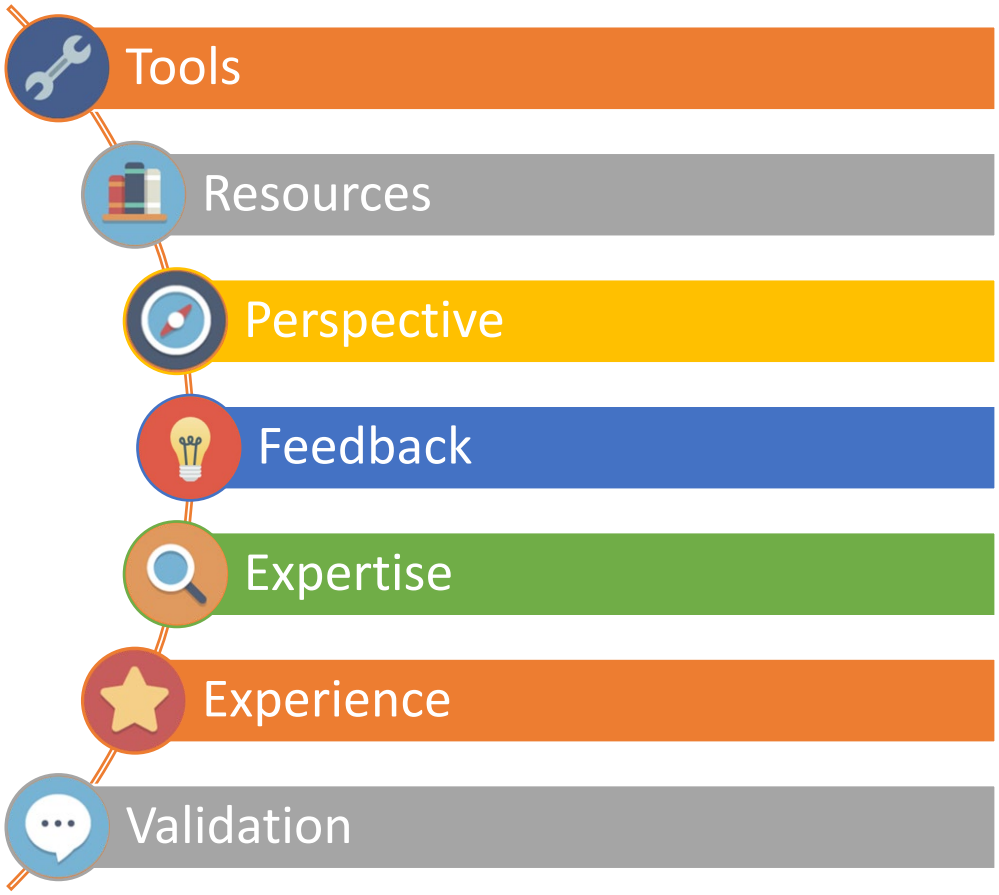
California Quality Collaborative
Breakthroughs for Better Healthcare

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. Review the Phases of Transformation.
2. What is a QI (Transformation) Plan?
3. What are some transformation plan examples and templates I can use?
4. How can I work with a practice to develop a plan?

POLL: What experience do you have in developing micro-aims or QI plans with PTI practices?

- What is a micro-aim or QI plan?!?!
- I know what they are, but haven't yet developed any with my practices.
- I've developed a few, though I could use some help making them better.
- I've developed several and feel confident doing it.

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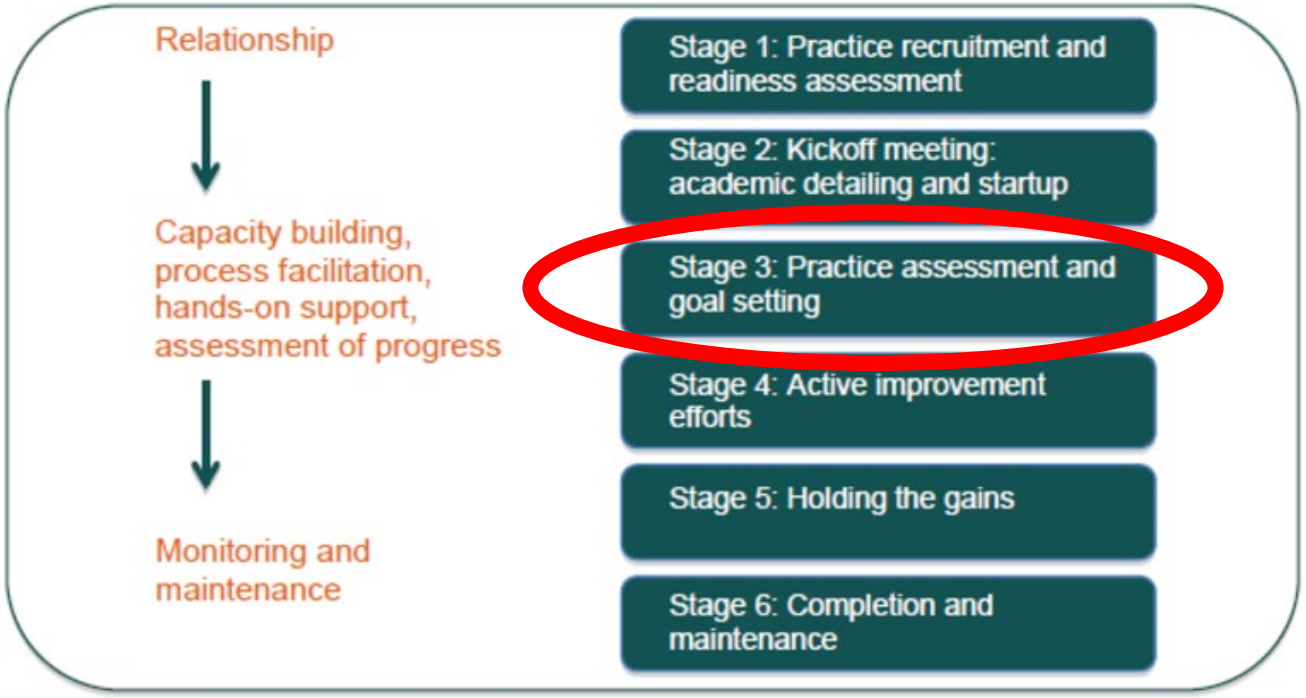
Moving from Transformation Phase 1 to Phase 2

	Change Concept Ref	Milestone	0	1	2	3
Driver 2.1 Engaged and Committed Leadership						
18	**2.1.2**	Practice has developed a vision and plan for transformation that includes specific clinical outcomes and utilization aims that are aligned with national TCPI aims and that are shared broadly within the practice.	Practice has not yet begun developing its transformation vision and detailed plan.	Practice is beginning to develop a vision and plan that addresses goals of transformation but aims are not yet set.	Practice has developed a plan that addresses goals of transformation with specific aims but has not yet detailed how the aims will be addressed.	**Practice has developed and shared a vision and detailed plan that addresses goals of transformation with specific clinical outcomes and utilization aims along with the detail on how each of the aims will be addressed.**

Figure 3.1. Common stages in a practice facilitation intervention



Source: Adapted from Knox, 2010.

AHRQ Practice Facilitation Handbook: https://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod3.html

What is a QI plan?

Practice Transformation Initiative, a program of:

QI Plan Components

https://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod14.html

Who

- QI Team members with diverse representation
- Roles and commitments

When

- Meeting Schedule: dates/times and frequency

What

- Statement of the quality vision
- SMART Goals [Micro-Aim Statement] and key activities [Driver Diagram]
- Description of the program structure

How

- Process to drive improvement (example = MFI, PDSA)
- Documentation of PDSAs and improvement efforts
- Monitoring of current and ongoing status and evaluation
- Acquisition and reporting of data

	Change Concept Ref	Milestone	0	1	2	3
Driver 2.1 Engaged and Committed Leadership						
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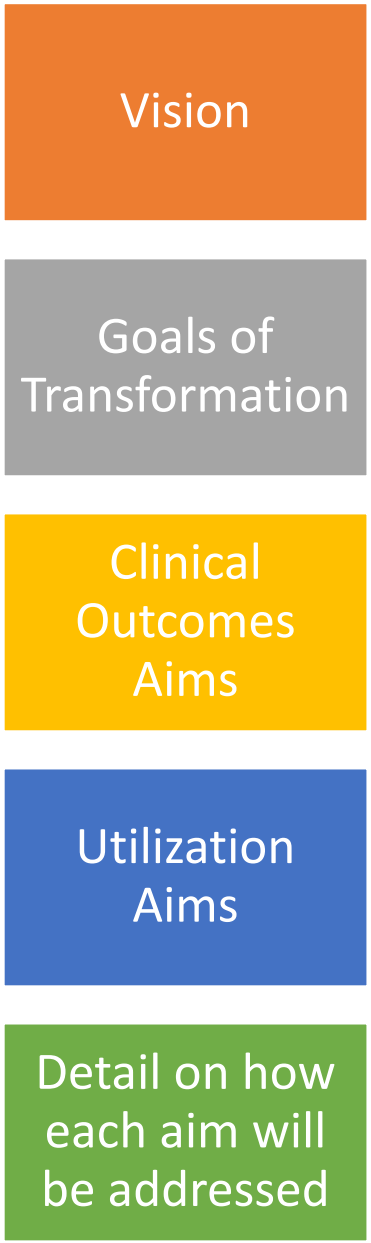
CMS' 5 Key Elements of an Aim

Practice has developed and shared a **vision**

and detailed plan that addresses

goals of transformation with **specific clinical outcomes** and **utilization aims** along with the **detail on how each of the aims will be addressed**.



Practice Transformation Initiative

QI Plan Components

CMS Requirements

Who

- QI Team members with diverse representation
- Roles and commitments

When

- Meeting Schedule: dates/times and frequency

What

- **Statement of the Quality Vision**
- **SMART Goals [Micro-Aim Statement] and key activities [Driver Diagram]**
  - **CLINICAL OUTCOMES**
  - **UTILIZATION AIMS**
- Description of the program structure

How

- Process to drive improvement (example = MFI, PDSA)
- Documentation of PDSAs and improvement efforts
- Monitoring of current and ongoing status and evaluation
- Acquisition and reporting of data

Think about a practice that has changed / transformed.

POLL: Which of these components were the MOST SIGNIFICANT to their change?

Vision	Goals of Transformation	Clinical Outcomes Aims	Utilization Aims	Detail on how each aim will be addressed

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Think about a practice that has changed / transformed.

POLL: Which of these components were the LEAST SIGNIFICANT to their change?

- Vision
- Goals of Transformation
- Clinical Outcomes Aims
- Utilization Aims
- Detail on how each aim will be addressed

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What are some great examples and templates?

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Adult Family Practice Vision: Providing the highest quality care to our patients and families that is accessible, affordable and patient- centered.

AIM Statement: By September 2019, our clinicians and practice staff will work as a team to complete all 5 stages of transformation and be prepared to thrive in a value-based healthcare environment. We will provide patients the care they want and need that is safe, appropriate, and effective at reasonable cost.

Our Clinicians will: 1) achieve sustained improvement in practice efficiency and quality of care, and
2) demonstrate savings through reduction of unnecessary testing and avoidable hospital use.

Our Patients will: 1) use more preventive services,
2) engage in better management of chronic conditions,
3) experience better health outcomes, and
4) report greater satisfaction with care received.

We will accomplish this by:

- Training our clinicians/staff on the MFI QI methodology through resources provided by our PTN coach
- Implementing evidence based protocols specific to our identified clinical outcomes
- Educating clinicians & implementing select Choosing Wisely guidelines to decrease unnecessary testing/procedures
- Using a web based patient satisfaction survey to capture patient feedback and identify areas of focus
- Capturing a combination of claims and EHR data to drive improvement, monitor trends and evaluate progress toward our goals
- Completing a Pharmacy Medication Management Needs Assessment to identify top areas of focus to work on with our Network Pharmacist
- Defining our medical neighborhood and formalizing lines of communication to ensure flow of information and clear transitions in care
- Reaching out to community partners and identifying community and referral resources

CCNC

Measure	Domain	Baseline	YR 3 Target Improvement
Breast Cancer Screening	Preventive Care/Clinical	X	HEDIS 90th percentile
Tobacco use: screening and cessation intervention (adults) (NQF 0028)	Preventive Care/Clinical	X	HEDIS 90th percentile
Controlling High BP for (NQF 018)	Disease Management/Clinical	X	HEDIS 90th percentile
Diabetes A1c control (NQF 59)	Disease Management/Clinical	X	HEDIS 90th percentile
Adherence to Chronic Medications for Patients with Multiple Conditions	Disease Management/Claims	X	5% over baseline
Total Risk-Adjusted Medicaid Costs (PBPM)	Cost & Utilization/Claims	X	Reduce Spending to >5% below expected
Medicaid ED Visit Rate, Risk-Adjusted	Cost & Utilization/Claims	X	Reduce ED visits to >5% below expected
Risk Standardized All Condition Readmissions	Cost & Utilization/Claims	X	Reduce all cause readmissions by 5% of baseline
Use of Imaging Studies for Low Back Pain	Cost & Utilization/Claims	X	5% improvement over baseline
Patient Satisfaction: Quality of Providers' Communicate with Patients (Composite Score)	Patient Experience/Pt Report	X	Reach CAHPS 75th percentile
Patient Satisfaction: Attention to Your Child's Growth and Development (Composite Score)	Patient Experience/Parent Report	X	Reach CAHPS 75th percentile
Patient Satisfaction: Urgent care appointments scheduled as soon as needed	Patient Experience/Parent Report	X	Reach CAHPS 75th percentile

WADOH

P-TCPI Clinic Aim Statement

Purpose
This Aim Statement encompasses what the clinic/clinician will achieve upon the completion of the Pediatric Transforming Clinical Practice Initiative. Participating clinics/clinicians will have many, many aims throughout the initiative—all leading to this Aim.

Instructions
The draft Aim below serves as a guide as you develop your own statement and improvement measures. You are welcome to change the statement to align with your own quality and business goals or copy this one as yours. Yellow highlights indicate areas you may want to focus on for individualizing your own Aim.

NW Spokane Pediatrics **1/25/17**

Aim: By the end of September 2019, **we aim to** transform our system of care to one that demonstrates value for payment through improved performance measures of well-child visit and immunization rates and asthma medication management; and decreased avoidable ER visits.

Our measures of success in achieving the aim include:

- Avoidable ER visits will decrease by 10% by 2019
- 100 % of our clinicians/practice teams will achieve level 5 of the Five Phases of Transformation by June 2019
- Obtain EMR system; that is simplistic, meet requirements of CMS, Technical assistance, Meaningful use, pediatric focused, efficient training for staff, By May 2017

We will achieve this by:
Using the P-TCPI resources to guide us. This includes completing the Practice Assessment Tool every six months and developing work plans and tests of change with our regional transformation team's help and ongoing support. We will use Molina claims data and our own EHR data to track our improvement. We will include our patients/families and staff in co-creating the changes for how we deliver care to achieve the measures of success.

Think about a practice plan you are working on.

POLL: Which of these components needs the most focus?

Vision	Goals of Transformation	Clinical Outcomes Aims	Utilization Aims	Detail on how each aim will be addressed

Practice Transformation Initiative, a program of:

Guiding a Practice

Guidelines

Template - Optional

Examples

Template - Required

Practice Transformation Initiative

GUIDELINES FOR QI AIMS & PLAN

VISION

A one-sentence statement describing the clear and inspirational long-term change, resulting from your work.

Questions to consider:

- What is your dream end-state?
- In a perfect world, what would this look like?
- What would success look like?

MEASURES

Select several measures including at least 1 in each of the following areas:

-Clinical Outcomes

-Unnecessary Testing

-Unnecessary Hospital Utilization

-Patient and Family Engagement

Identify current performance and data source.

GOALS

Reference current performance, benchmarks, and organizational goals.

Define long-term (~3 years) performance goals and/or relative improvement goals.

PLAN

For each measure:

☑ Identify a time period for focus.

☑ Identify change interventions utilizing primary and secondary drivers of transformation.

STRATEGIES

Describe strategies to improve staff experience and joy in work.

Some strategies will be directly related to change interventions identified in the plan.

Practice Transformation Initiative

PTN Examples

Alabama Physician Alliance Practice Transformation Network (BHSALA)
Phase 1 Practice Transformation Plan

Practice Name _____ **Process Improvement Specialist** _____ **Date** _____

Practice has developed a vision and plan for transformation that includes specific clinical outcomes and utilization aims that are aligned with national TCPI aims and that are shared broadly within the practice.

Shared Vision (check one)

- ☐ Deliver quality care that is effective, efficient, and accessible at a lower cost and higher value to the patients, providers, and payers.
- ☐ Utilize process improvement, education, data analytics, and gap analysis to improve health outcomes, increase patient satisfaction, provide better care at a lower cost, and enhance efficiencies to create joy in the workplace.
- ☐ Foster a patient-centered culture to improve patient outcomes and reduce the overall cost of healthcare by reducing duplication of efforts and unnecessary testing and procedures.
- ☐ Other:_____

Goals for Transformation (check all that apply)

- ☐ 1.1 Focus on patient & family engagement:
  - ☐ Respect values & preferences
  - ☐ Listen to patient & family voice
  - ☐ Collaborate with patients
  - ☐ Be aware of language & culture
- ☐ 1.2 Build team-based relationships
  - ☐ Enhance teams
  - ☐ Clarify team roles
  - ☐ Optimize continuity
  - ☐ Define specialty-primary care roles
- ☐ 1.3 Population management
  - ☐ Assign to panels
  - ☐ Assign accountability
  - ☐ Stratify risk
  - ☐ Develop registries
  - ☐ Identify care gaps
- ☐ 1.4 Establish practice as a community partner
  - ☐ Discover community health needs
  - ☐ Involve practice in community collaboration
  - ☐ Identify social determinants
  - ☐ Use and share community resources
  - ☐ Be transparent
- ☐ 1.5 Coordinated care delivery
  - ☐ Manage care transitions
  - ☐ Establish medical neighborhood roles
  - ☐ Cultivate coordinated care
  - ☐ Ensure quality referrals
  - ☐ Manage medication reconciliation
- ☐ 1.6 Organized, evidence-based care
  - ☐ Consider the whole person
  - ☐ Implement evidence-based protocols
  - ☐ Decrease care gaps
  - ☐ Reduce unnecessary tests
- ☐ 1.7 Provide enhanced access to patients
  - ☐ Provide 24/7 access
  - ☐ Meet patient scheduling needs
  - ☐ Create patient-centered space
  - ☐ Mitigate access barriers

Alabama Physician Alliance Practice Transformation Network (BHSALA)
Phase 1 Practice Transformation Plan

PTN Clinical Outcome Aims (check all that apply)

- ☐ PQRS1: Diabetes: HbgA1c Poor Control: 5% improvement
- ☐ PQRS128: Preventive Care & Screening: BMI screening *and* follow-up plan: 2% improvement
- ☐ PQRS134: Preventive Care & Screening: Clinical depression screening *and* follow-up plan: 5% improvement
- ☐ PQRS226: Preventive Care & Screening: Tobacco use screening and cessation intervention: 5% improvement
- ☐ PQRS236: Controlling High Blood Pressure: 2% improvement
- ☐ PQRS53: Asthma: Pharmacologic Therapy for Persistent Asthma – Ambulatory Care Setting: 5% improvement
- ☐ PQRS204: Ischemic Vascular Disease (IVD): Use of aspirin or another antithrombotic: 5% improvement

Practice-specific Aims (check all that apply)

- ☐ Improve Transition of Care protocols to reduce hospital readmissions
- ☐ Increase Patient Portal usage to enhance access
- ☐ Accurately capture and report data to close care gaps
- ☐ Implement Care Guidelines
- ☐ Prioritize team huddles
- ☐ Foster team-based care
- ☐ Develop community resource list for patients
- ☐ Optimize EHR capabilities
- ☐ Become more efficient and organized
- ☐
- ☐
- ☐
- ☐
- ☐ Other:_____

Plan of Action (check all that apply)

	PTN Resources	Due Date
☐ PDSA/5S/Lean/Six Sigma		
☐ Implement tracking system		
☐ Begin utilizing Care Guidelines		
☐		
☐		

The specific utilization of service aims (and savings targets):

The costly treatment of progressing diseases makes it imperative that we set preventive maintenance goals, which will translate to cost savings down the line.

PTN Examples

Sample Practice's Practice Plan Summary

Based on Assessment Completed On: **7/26/2016**

Target Date of Next Assessment: **1/22/2017**

Our Vision

Our practice will support TCPi's goal of improving health outcomes for millions of Medicare, Medicaid, and CHIP beneficiaries and other patients by decreasing our hypertension (bp140/90) by percent. We aim to complete this by January 2018.

Action Items - Core Aims/Measures:

Aim / Measure	Baseline Measurement	Target	
		Year 1	Year 4
Hypertension (BP140/90)	50.0%	55.0%	80.0%
Tobacco Use: Screening and Cessation Intervention	80.0%	82.0%	90.0%
Adult Body Mass Index (BMI) Assessment	90.0%	92.0%	95.0%
Screening for Clinical Depression and Follow-Up Plan	40.0%	60.0%	90.0%
Ambulatory Care-Sensitive Conditions: Acute Conditions (In Cases per 1,000)	40.0	35.0	20.0
30 day all-cause Hospital Readmissions	100.0	80.0	50.0
ED Utilization For Ambulatory Care-Sensitive Cond's	6.0%	4.0%	2.0%
Utilization of Imaging for lower back pain	10.0%	8.0%	6.0%
Imaging for lower back pain	$15,000	$12,000	$9,000
Total Cost of Care (TCoC), with Resource Use Index (RUI)	$1,000,000	$800,000	$700,000
CAHPS	10.0%	15.0%	25.0%

Action Items - Additional/Optional Aims/Measures:

Aim / Measure	Baseline Measurement	Target	
		Year 1	Year 4
Community and Social Risk	50.0%	40.0%	30.0%

Phase	PAT Question Number	Current Score	Milestone	Current Score - Description	Actions	Target Completion Date	Driver
1	13	0	Practice has developed a vision and plan for transformation that includes specific clinical outcomes and utilization aims that are aligned with national TCPI aims and that are shared broadly within the practice.	Practice has not yet begun developing its transformation vision and detailed plan.	Develop vision and plan for transformation.		2.1.2
2	1	0	Practice has met its targets and has sustained improvements in practice-identified metrics for at least one year.	Practice has identified the metrics it will track that are related to TCPI aims and has collected baseline information on these metrics.	Develop a regular monitoring program for the metrics defined.		None
2	7	0	Practice has a reliable process in place for identifying risk level of each patient and providing care appropriate to the level of risk. This may include risk includes developing a health condition not already present, exacerbation of a condition or complications, need for a higher intensity of care, including hospitalization	Practice does not have a defined process for identifying patient risk level.	Define process for identifying high risk patients		1.3.3
2	8	1	Practice facilitates referrals to appropriate community resources, including community organizations and agencies as well as direct care providers.	Practice is compiling an inventory of resources and establishing communication with them to link patients with appropriate community resources.	Establish a referral process and implement it using the knowledge base.		1.4.4

TEMPLATE: Practice QI Aim & Plan

PRACTICE QUALITY IMPROVEMENT AIMS & PLAN							
PRACTICE NAME:		**DATE:**		**PRACTICE FACILITATOR:**			
PRACTICE VISION							
PERFORMANCE CATEGORY *[Select at least 1 measure in each category.]*	**MEASURE SET**	**MEASURE** ***Bolded = QPP High Priority Measure***	**CURRENT PERFORMANCE**	**DATA SOURCE**	**GOAL**	**PLAN** **Year / Quarter**	**Change Interventions (Primary & Secondary Drivers)**
CLINICAL OUTCOMES	Asthma	☐ **Medication Ratio: Ages 5-64**					
	Diabetes Care	☐ Blood Pressure Control ☐ Eye Exam ☐ HbA1c Control ☐ **HbA1c Poor Control** ☐ HbA1c Testing ☐ Nephropathy Monitoring					
	Hypertension	☐ **Controlling Blood Pressure: Ages 18-85**					
	Other	☐					
UTILIZATION: Unnecessary Testing	Cervical Cancer Screening	☐ Overscreening ☐ Underscreening					
	Overuse of Imaging Studies for Low Back Pain	☐ Overuse of Imaging Studies for Low Back Pain					
	Other	☐					
UTILIZATION: Unnecessary Hospital Visits	Inpatient	☐ Average Length of Stay ☐ Bed Days ☐ Discharges					
	ED Visits	☐ PMPY					
	Other	☐					
PATIENT & FAMILY ENGAGEMENT		☐					
STRATEGIES FOR IMPROVING STAFF EXPERIENCE & JOY IN WORK							

POLL:
Which of these would most help your practices develop a QI Plan to score a 3 on PAT Question 18?

- Examples
- Guidelines
- Organizational Template
- No help needed
- Something else?

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How can I work with a practice to develop a QI plan?

Practice Transformation Initiative, a program of:

POLL:
Think of a recent challenge you had in developing a QI plan with a practice.

Practice Transformation Initiative, a program of:

Common Challenges

Practice Transformation Initiative

"Coaches offer a **structure**, **time**, and **place** for practices to **solve their own problems**."

—Humboldt Del Norte Foundation, a Robert Wood Johnson Aligning Forces for Quality participant

Tools to Use When Developing a Plan

- Aim Statement
  - Purpose and Components
  - Organizational Aim Statement
- Driver Diagram
  - Purpose and Components
  - PTI Driver Diagram
- PAT Baseline Data
- PTI Portal Data
- Performance Benchmarks

Practice Transformation

DRIVER DIAGRAM

AIM:
[Insert organizational Aim here.]

Measurements:
[Insert organizational measures and goals here in areas of:

- *Clinical outcomes*
- *Utilization*
- *Patient and family engagement*
- *Phases of Transformation*
- *Joy in Work*

1. Leadership & Vision	• Leaders at all levels • Org/practice-wide vision • Measurable goals and objectives
2. Data	• Data systems that collect information related to measures • Actionable data displays, regularly updated data • Data shared widely
3. Empanelment	• Each patient linked to PCP/care team • Panel size standards and measurement
4. Team-Based Care	• Other health care professionals part of team • Standing orders for uncomplicated patients • Dyads/teamlets within practices • Co-location • Daily huddles
Clinical Guidelines	• Clinician training/education on evidence-based clinical guidelines for specific chronic illnesses • Standard work flows by patient diagnosis
5. Patient Engagement	• Shared decision-making • Agenda-setting • Patient satisfaction data
6. Population Health	• Health coaching for subset of patients • Panel stratification • Panel management • Complex care management
7. Continuity	• Tracking of continuity measures • Support of practice staff for continuity
8. Access	• Collecting and tracking data for 3NA • Accommodating patient preference for seeing own provider vs same day access
9. Coordination	• Automatic notification of hospital discharge or ED visit • Care/referral coordinator • Maximization of specialist referrals; diagnostics secured in advance

Staff Vitality & Joy in Work

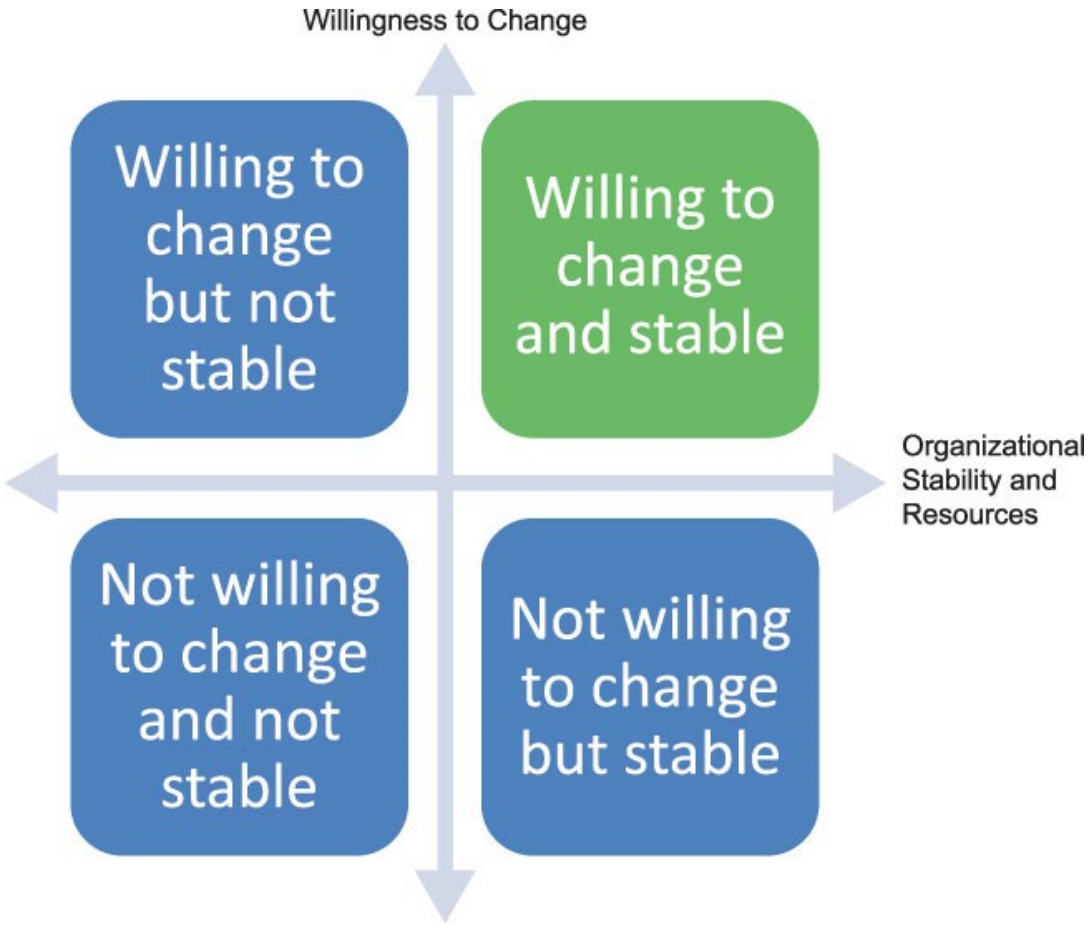
Aligning Financial Incentives for Improvement / Sustainable Business Operations

#s 1-9: CMS Change Package drivers that align with 10 Building Blocks

Checklist: Developing a QI Plan

- ✓Is the practice willing to change? Ready to change?
- ✓Has the PAT Baseline been completed?
- ✓When in the relationship will I introduce and develop the QI plan?
- ✓Have I reviewed the purpose of the Aims and Plan?
- ✓Have I shared the organizational aim statement?
- ✓Have I offered examples, guidelines, and/or template?
- ✓Have we as a team discussed the practice perspective and priorities?
- ✓Have we balanced organizational and practice priorities?
- ✓Who will create the 1st draft – coach or team member?
- ✓How will we make revisions and finalize?

Practice Readiness to Engage



https://pcmh.ahrq.gov/page/engaging-primary-care-practices-quality-improvement-strategies-practice-facilitators

Practice Transformation Initiative

IDEA: Practice Readiness Checklist

Figure 12.2. 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 with this plan.
- ❑ 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.

Create your own readiness criteria and checklist for the organization and project.

https://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod12.html#fig12.2

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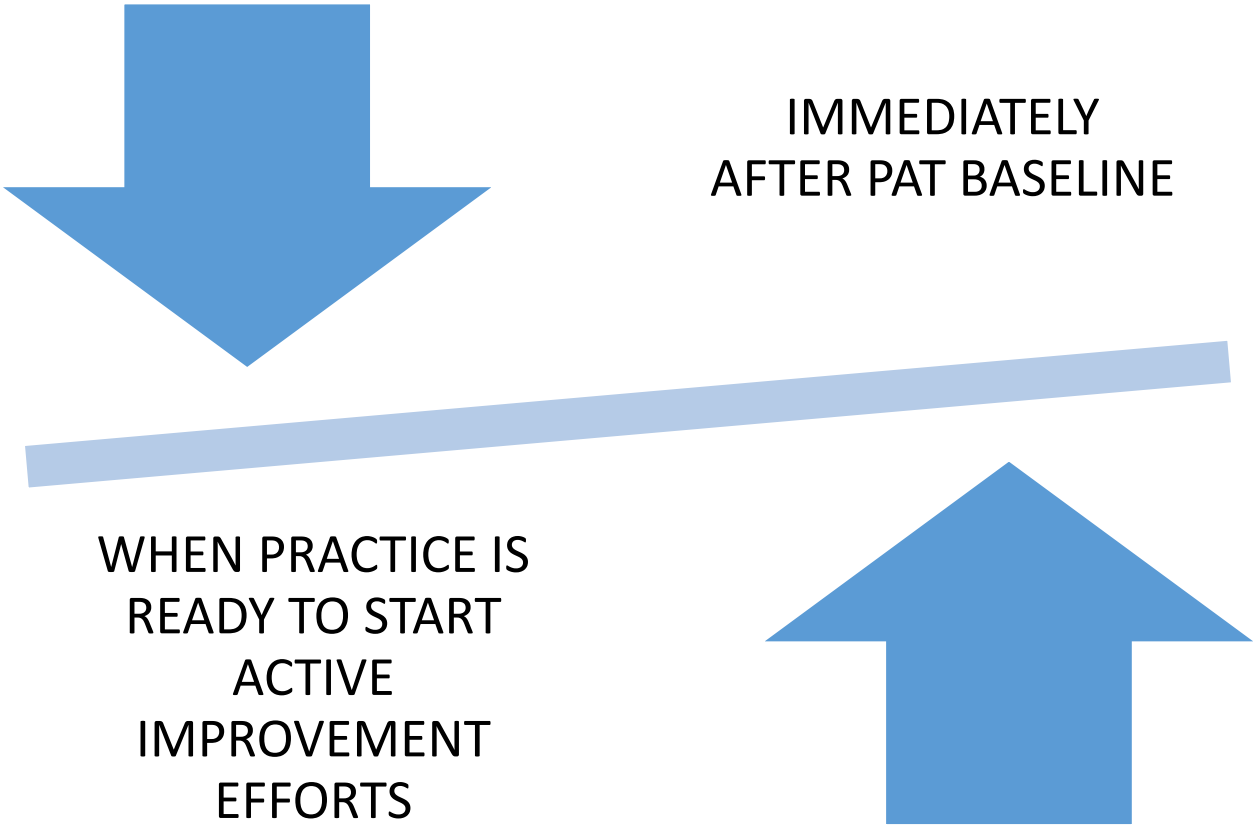
When should I create a QI plan with a practice?



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Follow-up Considerations

- How will the PF team document QI Plans? Electronic? For individual practices and in aggregate (all practices)?
- How will you answer the question – what are the practices working on? What are the practices achieving?
- How will you monitor progress – with a practice? Across practices?

What would you use?

What else do you need?

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POLL:
What will you transfer into your work from this workshop today? And how you will know the transfer has been successful?

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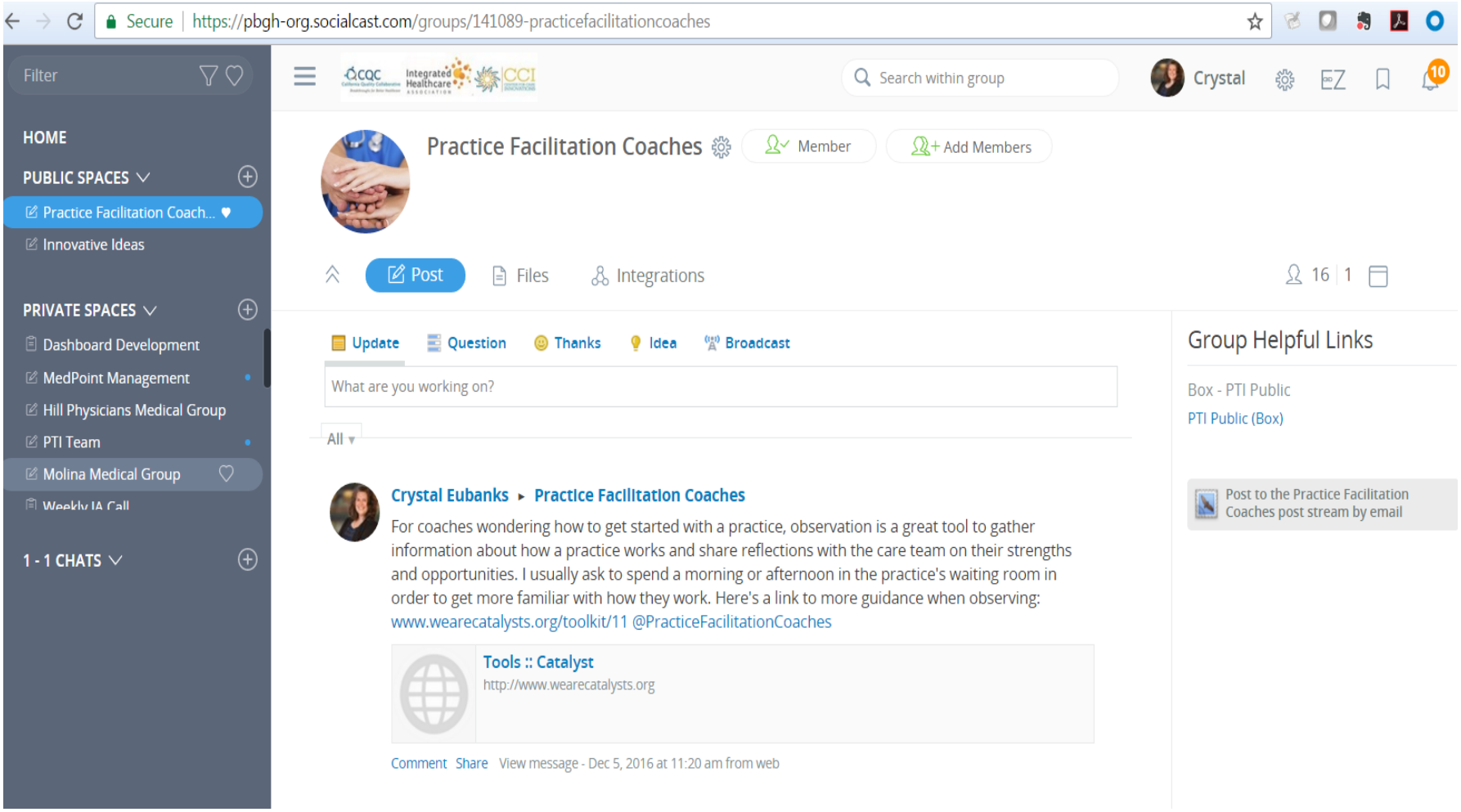
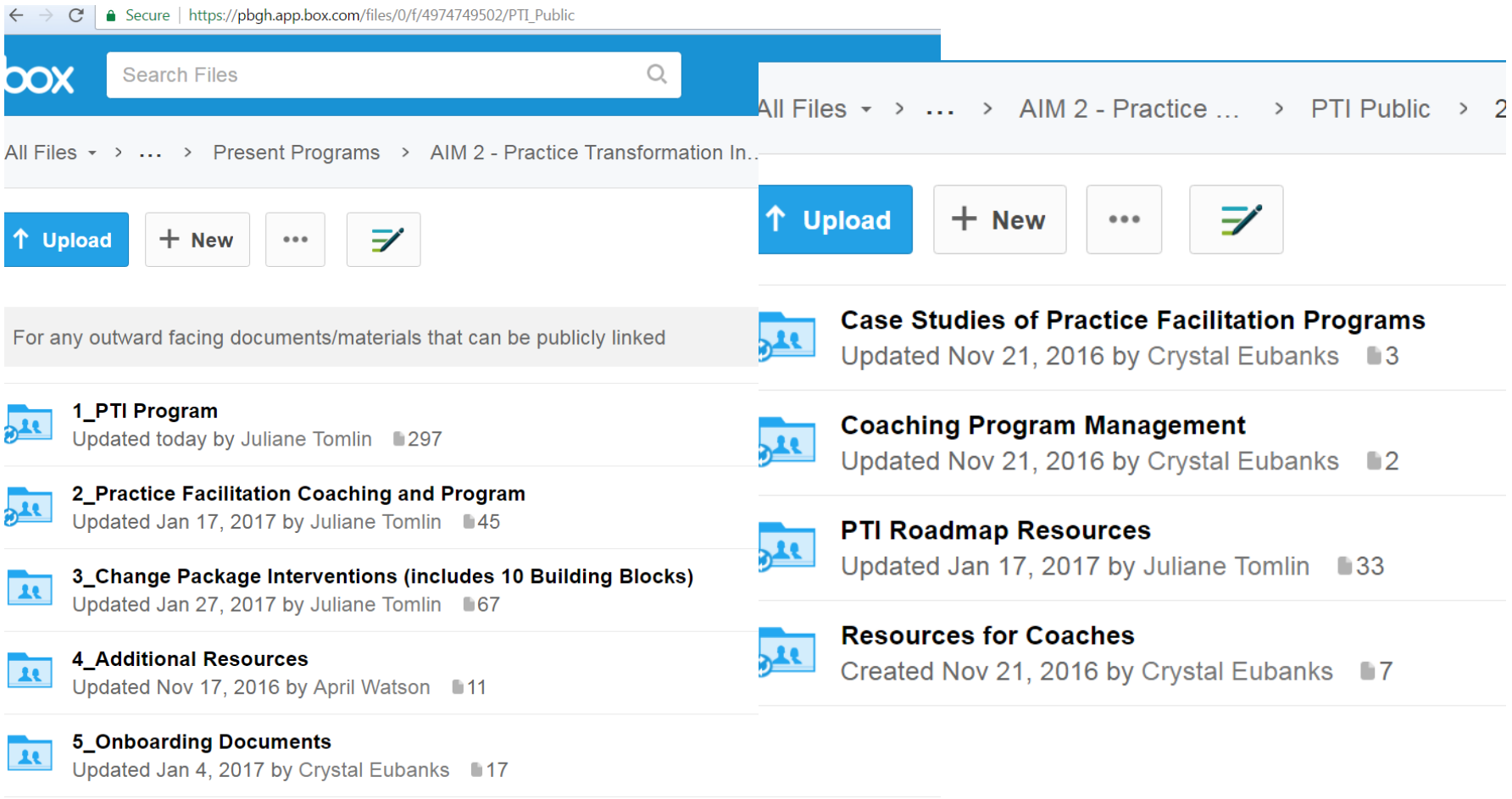
Connect with coaches on Socialcast



Practice Transformation Initiative

Digital Resource Library



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UPCOMING EVENTS

- **April 19th** @ 1pm: Share & Learn Webinar – Patient & Family Engagement
- **May 4th** @ 10am: Practice Facilitation Skills Workshop

Crystal Eubanks, Senior Manager - Practice Transformation – ceubanks@calquality.org

Jen Burstedt Correa, Project Manager – jburstedt@calquality.org

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Help us improve our offerings!

Share your feedback here:

https://www.surveymonkey.com/r/pti-pfsw-04-17

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