

## Practice Facilitation Plan

### Ultimate Goals for Facilitated Practices

OVERALL GOAL: PRACTICE DEMONSTRATES CONSISTENT IMPROVEMENT IN THE MANAGEMENT OF PATIENTS/MEMBERS SUFFERING FROM CHRONIC DISEASES.

- ❖ GOAL #1: PRACTICE HAS AN IDENTIFIABLE SYSTEM FOR CARE DELIVERY TO CHRONICALLY ILL PATIENTS/MEMBERS (improve what happens during a visit)
  - Practice demonstrates familiarity with chronic disease treatment guidelines as evidenced by post-facilitation assessment.
  - Practice has in place an identifiable system for continuous quality improvement including the ability to assess current practices, identify interventions and measure progress.
  - Practice will begin to evaluate the methods and tools for patient education and make necessary improvements.
  - Practice utilizes CareMeasures or other approved registry tool to identify gaps in care, assist provider in effectively addressing gaps, provide basic education to patient, report findings and measure outcomes.
  
- ❖ GOAL #2: PRACTICE HAS AN IDENTIFIABLE SYSTEM FOR CARE MANAGEMENT OF CHRONICALLY ILL PATIENTS/MEMBERS (improve what happens between visits)
  - Practice has an organized and thorough system for patient/member education.
  - Practice has an established system to encourage self-management, including self-management tools (medication logs, blood sugar logs, etc.) and community resources access.
  - Practice has an established method to identify patients/members with chronic illnesses and do outreach in order to increase self-management and compliance (either using CareMeasures or an approved tracking system).

### STAGE 1: Basic Practice Facilitation schedule

**Pre-Visit/Pitch:** By OHCA personnel and/or PF manager to “sell” this concept

**Pre-Visit/Introductory (optional):** By PF to introduce themselves and establish tentative dates of visit (this may occur with number 1, or it may occur by phone or in person by PF)

**Initial intensive intervention visit:** 20-24 working days within the practice. Practice meets basic criteria for completion of initial intervention:

## Week 1

### Completed assessment phase

- Practice self assessment
- Objective assessment by PF (assessment tool, org. chart with job descriptions, job assignments/analysis and performance reviews)
- Process mapping
- Policy and procedure identification if available
- Meet w/staff to ID work flow processes, pain points, tools in use (e.g. flow sheets, med. lists, problem lists), follow-up visit plan, and behavioral health assessment plan.
- Identify prevalence of Chronic Disease and associated cost drivers (e.g. claims data, chart reviews, MEDai)

## Week 1 - 2

### Data Findings Presentation: Processes needing improvement identified

- Identify measures for focused attention
- Identify processes for PDSA cycles
- Strategy for practice redesign
- Strategy for prepared proactive practice team

## Week 2 - 3

### Basic use of CareMeasures registry (or approved substitute): Including data entry and metabolic profile summary (outstanding care opportunities) utilization

- Processes for identifying patients, gaps and methods to close gaps
- Process for Metabolic Profile Summary use/standing orders
- Functionality
- Identify processes for data entry, summary printing and report follow up (PF will assist in initial data entry)

## Week 3

### Focus on specific strategies to improve provider/patient interactions:

- Standing orders
- Further develop team roles
- Utilization of patient education resource library
- Schedule appropriate follow-up visit
- No show/no call reduction strategies

Establish and begin distribution of written educational materials including disease Specific materials

Week 4

“Team Care Delivery” system established

- Education for Disease Specific best practices (electronic file offered to practices and sent, in-services provided for staff and PCP)
- Staff education including:
  - Practice process mapping, Practice redesign principles, QA vs. QI principles, Quality improvement training, QI techniques including PDSA, LEAN, CCM, etc. and Performance monitoring
  - Establish and begin distribution of written educational materials including disease specific materials
  - Assist with policies and procedures if appropriate

Week 4

Begin assessment of Care Management processes (educational plan, self-management tools, community resources, tracking) and provide some introductory tools for Care Management

Weeks 1 - 4

Maintain weekly one-to-one meetings with PCP including monitoring of:

- Satisfaction
- Support
- Provider input regarding PI processes

**Post-initial intervention follow-up:** Weekly times one month, then monthly thereafter

## STAGE 2: **Extended Practice Facilitation schedule**

**Secondary Extensive Intervention visit(s):** For practices identified as candidates for extensive intervention; PF will return to practices. Criteria for practice to receive secondary extensive intervention visits include (but are not limited to):

- a. Size
- b. Investment
- c. Impactability
- d. Risk score
- e. Number of providers
- f. Lack of progress toward graduation criteria (see Basic Practice Facilitation Stage 1 schedule )
- g. Other factors may need to be considered on a case by case basis

## **Agenda for Stage 2:**

Continued assessment of patient educational plan/resources, patient self-management tools, access to community resources and patient tracking tools

Data findings: identify areas for improvement and utilize/reinforce PDSA and other Process Improvement cycles to remediate areas with opportunity for improvement

Identify tools for use: CareMeasures, letters, call backs, medication lists, community classes, etc.

Further develop a team-care delivery approach utilizing these tools

Reinforcement of all processes implemented during Stage 1

**Post-Secondary Intervention follow-up:** Weekly for 1 month, then monthly for up to 6 months or until such time as the practice no longer needs assistance, as evidenced by attainment of the overall goals of “Improved Care Delivery” and “Improved Care Management”

- a. Note: For those practices who “qualified” for secondary extensive intervention sessions, PF will continue to assess need for further intervention and collaborate with OHCA regarding possibility of additional sessions.
- b. OHCA and IFMC staff to collaborate on decision to offer secondary extensive intervention session to given practice