The Practice Facilitation Handbook

Training Modules for New Facilitators
and Their Trainers

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AHRQ is the lead Federal agency charged with supporting research designed to improve the quality of health care, reduce its cost, address patient safety and medical errors, and broaden access to essential services. AHRQ sponsors and conducts research that provides evidence-based information on health care outcomes; quality; and cost, use, and access. This information helps health care decisionmakers—patients and clinicians, health system leaders, and policymakers— make more informed decisions and improve the quality of health care services.

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About This Handbook

The Practice Facilitation Handbook is designed to assist in the training of new practice facilitators as they begin to develop the knowledge and skills needed to support meaningful improvement in primary care practices. It evolved from the Agency for Healthcare Research and Quality's *Integrating Chronic Care and Business Strategies in the Safety Net* toolkit. That toolkit was developed to aid safety net practices in implementing the Chronic Care Model, now commonly referred to as the Care Model, in their practices.

The handbook consists of 20 training modules, each 30 to 90 minutes long with varying requirements for presession preparation for learners. Each module contains a Trainer's Guide, which includes a checklist of materials, the learning objectives for the session, and a list of readings and activities designed to develop basic knowledge and skills. The modules are organized into four parts:

- Part 1 is a basic introduction to practice facilitation and work with safety net practices and includes an overview of a typical facilitation process.
- Part 2 presents core competencies for practice facilitators. It aims to build expertise that is valuable for facilitators regardless of the topic. Core competencies include quality improvement and measurement skills.
- Part 3 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, and tracking progress with practices.
- Part 4 includes modules specifically targeting facilitators working with practices that are implementing the Care Model or transforming into patient-centered medical homes (PCMHs). Both the Care Model and PCMH promote changing delivery systems to encourage responsiveness to patients' needs and preferences.

This handbook is not a comprehensive facilitator training curriculum. The content of the training materials is based on the core and specialized competencies that a practice facilitator needs to support a practice in implementing the change package contained in the *Integrating Chronic Care and Business Strategies in the Safety Net* toolkit. Other excellent facilitation resources are available, many of which we have referenced and did not want to duplicate. These resources, however, are diffuse. We have assembled a compendium to make it easy for trainers to introduce new facilitators to information and skills they must master to successfully improve quality, particularly in safety net practices working on Care Model or PCMH implementation.

How To Use This Handbook

This handbook is designed to be used by a trainer as a resource when preparing new facilitators to work with primary care practices. A new facilitator may use it directly as a resource for self-study. The use and sequence of the modules should be tailored to learners' needs. Not all facilitators will benefit from all modules.

The training materials follow 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 training. The trainer is encouraged to incorporate the activities suggested in each module into their trainings as well as others they may have used in

the past. Whenever possible, the trainer is encouraged to invite experienced practice facilitators from each group to co-teach specific modules and to include discussion of their "real world" experiences in the practice.

The training sessions should be tailored to meet the needs of the learner and 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 virtually, the trainer will need to modify the interactive elements of each module to fit the virtual environment.

Training a group of learners allows for interactive learning methods such as group discussions and role plays. The modules can, however, be adapted for individualized self-study. In these cases, the learner may complete the professional development plan contained in Module 1 and craft a learning agenda tailored to this plan. Interactive sections that require group participation can be eliminated or modified. For example, the learner may record responses to discussion questions in a journal.

Part 1. Introduction to Practice Facilitation

Module 1 Trainer's Guide: Practice Facilitation as a Resource for Practice Improvement

Time

- Presession preparation for learners: 30 minutes
- Session: 85 minutes
- Followup by trainer: 30-60 minutes

Materials Checklist

❑ Internet access and video display.
❑ Online access or paper copy for each learner of:

- 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.
- Practice Facilitator Professional Development and Training Plan. See Appendix.

Objectives

Learners will:

- Be able to describe the function and key activities of a practice facilitator.
- Be able to describe the core competencies of practice facilitators.
- Create a Practice Facilitator Professional Development Plan based on information from this module.

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

Presession Preparation

Read (30 minutes)

1. Module 1.
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

Present/review (25 minutes)

3. Module 1.

Read and discuss (15 minutes)

1. Discuss content of the module:

   - What is the purpose and goal of practice facilitation?
   - What skills do facilitators need?

2. Discuss the Baskerville article and the evidence supporting practice facilitation.

Act (45 minutes)

1. Introduce the Practice Facilitator Professional Development and Training Plan form to the learners.

   - Explain that the form will be used to design training, both didactic and experiential, tailored to their specific learning needs.
   - 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.

2. 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.

After the Session (For Trainer 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 1.
2. Use 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 1. Practice Facilitation as a Resource for Practice Improvement

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 a more indepth 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:

> *Practice facilitators work with primary care practices "to make meaningful changes designed to improve patients' outcomes."*
>
> *—DeWalt, et al., 2010*

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; and
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 1.1. 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 and is also used in the most cost-effective manner.

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 this training.

You will also:

- Map workflows and assist practices in redesigning them to support desired 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 your practices need 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.
- 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 16). The scope and complexity of the desired changes will dictate the type and intensity of support you will need to provide to the practice.

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 in the intervention and the existing 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 therefore 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 provide support to your 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 them as needed 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 help 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 1.1 lists some of the key activities practice facilitators undertake when working with their practices.

Table 1.1. 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 develop performance monitoring systems - Help teams use performance data to set improvement goals 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, benchmarking, chart reviews, audit and feedback) - 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

Topic	Activities
Assessing organizations	• 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
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 practice in new service models such as PCMH or the Care Model, processes, treatments, and best practices and their benefits. For example, provide training on: o Team-based care o Empanelment and panel management o Planned care o Action plans with patients o Self-management support o Care coordination o 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
Identifying and spreading exemplar practices	• Document exemplars and best practices and share with program and facilitation community
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

Evidence on Practice Facilitation

While some believe practice facilitation is a relatively new approach to supporting practice improvement, its origins can be traced back at least 20 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 also 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 begun using 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 providers, assisted clinicians with chronic disease management, provided professional education, and facilitated system-level improvements. However, the part directly attributable to practice facilitation could not be determined, as most of the studies included practice facilitation as one part of a multicomponent intervention.

More recently, 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.

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 also associated with larger effects.

Sustainability of Change

Studies have 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 have found that the effects of practice facilitation were sustained for as long as 12 months postintervention (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 followup, there were significant increases in asthma consultations, new diagnoses of asthma, and reaffirmation of past diagnoses in intervention versus control practices.

Cost Benefit

Others have 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 have 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 were selected for the study that were deemed ready and highly motivated to adopt the NDP model of the PCMH. 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 and ready to change and the practice facilitation intervention was primarily virtual, so of relatively low intensity.

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.

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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.

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.

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.

Module 2 Trainer's Guide: Working With Safety Net Practices

Time

- Presession preparation for learners: 80 minutes
- Session: 65 minutes

Materials Checklist

- ❑ Computer with Internet access, projector, speakers.
- ❑ Web-based tutorials and presentations on America's health care safety net, produced by Kaiser Permanente. Available at: http://www.kaiseredu.org/Tutorials-and-Presentations/Americas-Health-Care-Safety-Net.aspx.
- ❑ Redlener I, Grant R. America's safety net and health care reform — what lies ahead? N Engl J Med 2009 Dec 3;361(23):2201-4. Available at: http://www.nejm.org/doi/full/10.1056/NEJMp0910597 (online access or one copy for each learner).
- ❑ 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 (online access or one copy for each learner).
- ❑ Bodenheimer T. Clinica Family Health Services (formerly Clinica Campesina). Notes from April 18, 2011, visit. UCSF Center for Excellence in Primary Care (one paper or electronic copy for each learner). See Appendix.

Objectives

Learners will be able to:

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

Exercises and Activities To Complete Before and During the Session

Presession Preparation

View (20 minutes)

1. America's health care safety net, produced by Kaiser Permanente. Available at: http://www.kaiseredu.org/Tutorials-and-Presentations/Americas-Health-Care-Safety-Net.aspx.

Read (60 minutes)

1. Module 2.

2. Redlener I, Grant R. America's safety net and health care reform — what lies ahead? N Engl J Med 2009 Dec 3;361:2201-4. Available at: http://www.nejm.org/doi/full/10.1056/NEJMp0910597.
3. 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.
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During the Session

Present/review (20 minutes)

1. Module 2.

Discuss (45 minutes)

Ask the learners:

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 2. Working With Safety Net Practices

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,
- Federal, State, and locally supported community health centers and Federally Qualified Health Centers (FHQCs),
- Local health departments, and
- Special service providers such as:

    o Family planning clinics.
    o School-based health programs.
    o Ryan White AIDS programs.
    o Some communities' teaching and community hospitals.
    o Private physicians who care for predominantly uninsured or Medicaid patients.
    o 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 That 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 also lack the resources to hire more staff to meet demand for services. In addition, many patients who are cared for in the safety net are dealing with more complex health issues, which need more clinical time to adequately address. Therefore, demand for service can often exceed supply, resulting 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 underresourced. 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 opt to 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 practice. 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 16) 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 providers 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. Nonphysician members of the care team can handle routine tasks through standing orders and other means. This frees the physician 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 the patient's insurer may not cover or that the patient 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 are struggling 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 are supporting 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. 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 with them to exchange ideas.

For example, group visits can be a way to increase access in cases where 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 be a clear improvement to 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 tapped as a resource for practices that are interested in adopting but have not yet done so.

Administrative Challenges

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 their interventions so they are the most 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 also has downsides.

Clinicians in safety net settings are typically paid less than those working 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 to fill workforce gaps. 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 these 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 essential administrative, leadership, and change management skills. You will need to be aware of this and not assume that an individual's title implies skills in management or leadership. In some cases, you may need to provide executive coaching support to practice 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 to implement, do not cause staff burnout, and can be sustained long term.

Suboptimal Health Information Technology

Health information technology (IT) resources present yet another challenge. Improving quality of care requires robust, well-organized, and intuitive health IT systems that enable providers to manage panels of patients, easily 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 are changed.

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 are designed to 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 purchase of expensive software to enable EHRs and the registry product to exchange data. As a facilitator, you will need to become familiar with the different EHR and registry systems your practices use. You will also need to be aware of the technical support available to them through their IT product vendors 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, will involve 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 large 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 with the product.

As you continue your training as a facilitator, 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 can be found at: http://www.healthit.gov/providers-professionals/regional-extension-centers-recs. Also see Module 17.

Patient Challenges

Many of the patients who receive care through the safety net have low income, 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 followup 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.

You may also want to work with your practices to include patients on their QI teams. This can take the work of a QI team to an entirely different level of effectiveness and ensures that the work that takes place results in more patient-centered improvements. An introduction to methods for engaging patients and families as members of QI teams can be accessed at: http://www.safetynetmedicalhome.org/sites/default/files/Webinar-Patient-Family-Advisory-Councils.pdf.

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, available at http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15 (HHS, 2013) and build them into your work.

Challenges Accessing Specialty Care

Safety net patients can experience great difficulty accessing specialty care depending on their insurer. 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 real barriers to implementing targeted improvements in your practices and can have a significant impact on patient outcomes and experience.

You can play a role in helping a practice develop productive relationships with specialty providers 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 also help practices improve their referral processes and followup by evaluating the effectiveness of the current processes and helping the practice redesign workflow in this area. Collecting data on wait times and unmet requests for specialty care services can provide valuable information to your practices that they 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.

Assets in Safety Net Practices

At the same time you grapple with these challenges, you will also benefit from the many assets safety net organizations offer. Most staff and clinicians in FQHCs, look-alikes, and other community health centers are mission driven and work in these settings because they have a commitment 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 the range of resources provided through HRSA, the Centers for Medicare & Medicaid Services, and others. These have included opportunities to participate in learning collaboratives and early access to patient registries as a way 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 already in place to use for QI and practice transformation work.

FQHCs and larger community health centers often provide a wider range and more comprehensive care than many traditional, non-safety net practices. For example, FQHCs often have full dispensaries and some may even have licensed pharmacies onsite. Many have health education programs and social services to help link patients to outside resources. Still others have implemented telemedicine and e-consultation programs to facilitate specialty care access for their patients. They may also serve as training sites for residents from local medical schools and residency programs, which can help keep them abreast of the latest 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 for for-profit practices in the safety net, clinicians and staff in these private 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 very 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 many strengths these organizations have that can be leveraged to support continuous QI and

implementation of new models of patient care (Kretzmann and McKnight, 1993). This is important not only in providing resources, but also in building your practices' confidence and hope in their ability to improve.

In later modules, you will learn about asset-based approaches to assessment and development. It is important to keep this in mind at all times, or you may not see and engage important resources available in your practices.

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Module 3 Trainer's Guide: An Overview of the Facilitation Process

Time

- Presession preparation for learners: 15 minutes
- Session: 60 minutes

Materials Checklist

- ❑ Computer with Internet access, projector, or other video capacity
- ❑ Online access to:

  - Hindmarsh M. Using self-management support in your coaching approach. QIIP Practice Facilitator Training; 2008 May 12-13; Toronto, ON. See Appendix.

Objectives

Learners will be able to:

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

Exercises and Activities To Complete Before and During the Session

Presession Preparation

Read (15 minutes)

1. Module 3.

During the Session

Present/review (30 minutes)

1. Module 3.
2. Hindmarsh M. Using self-management support in your coaching approach. QIIP Practice Facilitator Training; 2008 May 12-13; Toronto, ON. See Appendix.

Discuss (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:

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

Module 3. An Overview of the Facilitation Process

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 3.1 shows the six stages of most practice facilitation interventions.

Figure 3.1. Common stages in a practice facilitation intervention
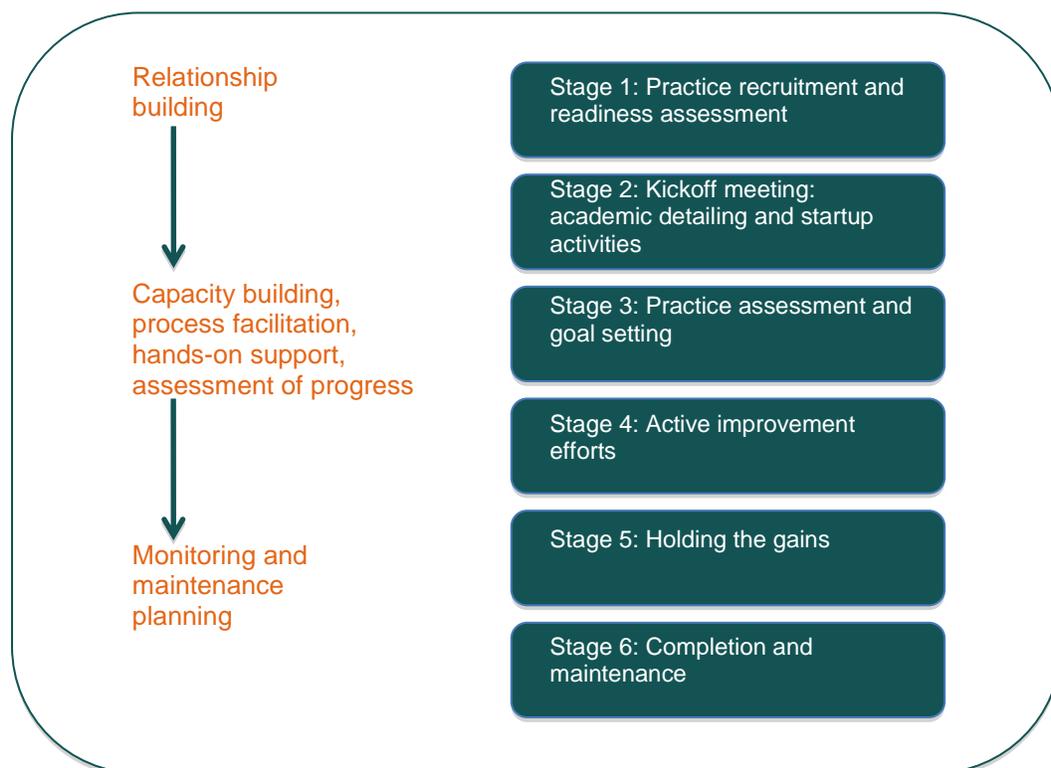
Source: Adapted from Knox, 2010.

Stage 1: Recruitment and Assessing Readiness

The first stage involves recruiting practices to participate in improvement and evaluation of 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,
- Conducting an assessment of the practice's ability to undertake the proposed improvement effort,
- Completing preliminary paperwork such as executing business associate agreements that will allow you to access clinical data for measuring and monitoring practice performance,
- Setting goals with the practice early, and
- Identifying the champion for the improvement effort at the practice and beginning to build a working relationship with him or her.

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 play a role in implementing 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 sales people use to develop and maintain customers can be useful as you get to know a new practice.

> *Effective facilitation is based on effective relationships.*

Keeping a card deck with information about each clinician and staff person in the practice can be helpful in remembering 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 14) 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.

Choose "high yield" changes that are the most likely to improve outcomes for patients and 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 very legitimate concerns about the accuracy of the data that are used in performance reports.

Practices often need an "early win" to build confidence and positive expectations about their ability to change.

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 4.) 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.

Finally, you will help keep the QI team and 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.

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 first need to help identify someone who can serve as an internal facilitator for the practice and provide extra training and support to this individual. You will work with this person 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.

You will next want to 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.

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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.

Part 2. Core Competencies for Practice Facilitators

Module 4 Trainer's Guide: Approaches to Quality Improvement

Time

- Presession preparation for learners: 40 minutes
- Session: 95 minutes

Materials Checklist

- ❑ Computer, Internet access, projector, and speakers.
- ❑ Online access to:

  - Video introduction of the Model for Improvement. Available at: http://www.aafp.org/online/en/home/practicemgt/quality/qitools/modelvideo.html.

- ❑ Online access to or paper copies of:

  - 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 (one per learner).

- ❑ Paper copies of or online access to:

  - Plan Do Study Act (PDSA) planning template (one per learner). See Appendix.

- ❑ Access to Institute for Healthcare Improvement's (IHI) Open University for training on key quality improvement (QI) tools and methods at: http://app.ihi.org/lms/onlinelearning.aspx.

Objectives

Learners will be able to:

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

Exercises and Activities To Complete Before and During the Session

Presession Preparation

Read (20 minutes)

1. Module 4.
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.

Explore (20 minutes)

1. Visit Institute for Healthcare Improvement's Open University on QI. Available at: http://app.ihi.org/lms/onlinelearning.aspx.
2. Select modules to complete based on gaps identified in your learning assessment from Module 1 and list these to report to the group. (Complete modules as you are able over the next few sessions.)

During the Session

Present (10 minutes)

1. Module 4.

View (15 minutes)

1. Video introduction of the Model for Improvement. Available at: http://www.aafp.org/online/en/home/practicemgt/quality/qitools/modelvideo.html.

Discuss (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?

Act (20 minutes). Ask learners to:

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.

Discuss (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 (10 minutes)

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

Discuss (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?

Discuss (5 minutes)

1. Discuss any modules you identified that you plan to complete or have completed from the IHI Open University. Discuss what you learned or why you made these selections.

The Practice Facilitation Handbook

Module 4. Approaches to Quality Improvement

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 4.1 contrasts these two frameworks.

Table 4.1. 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 began in earnest with the publication of two landmark Institute of Medicine (IOM) studies:

- *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 studies, 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 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 4.2, still resonate today. Although written for

manufacturing, they have become part of health care thinking and are inherent in all QI methodologies.

Table 4.2. 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 them, and ultimately spread the effective changes through the practice or organization (see Figure 4.1). 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 4.1.

Figure 4.1. The Model for Improvement

THE MODEL FOR IMPROVEMENT*

What are we trying to accomplish?

AIM. *Determine which specific outcomes you are trying to change.*

How will we know that a change is an improvement?

MEASURES. *Identify appropriate measures to track your success.*

What change can we make that will result in an improvement?

CHANGES. *Identify key changes that you will actually test.*

Act — Plan — Study — Do

Multiple PDSA Cycles:

Hunches, theories and ideas for changes that result in improvement.

Source: Langley GL, Nolan KM, Nolan TW, et al. The improvement guide: a practical approach to enhancing organizational performance. San Francisco: Jossey-Bass; 1996.
* 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 then 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 then 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 of using 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.

Use of 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 simplify the discussion for the practice. Large and lofty goals are excellent for inspiration and rallying troops, but the actual work of improvement can be mundane and tedious and involve small changes, tested, and then spread, in sequence until the goal is attained.

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 very 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 then studying individuals or practices that are "exemplars" in the process or part of the process under question. It can be used to identify the best process for activities such as managing lab test results, managing prescription refills, delivering adult immunizations, managing walk-ins, and caring for diabetic patients.

The first step in best practices research is to clearly define the process you are seeking to improve and break it down into discrete elements or subprocesses. The second step is to define what constitutes a best practice for each element or subprocess. The third step is to identify exemplars in the overall process or for each element or subprocess through peer nomination and

confirmation through performance audit, or through chart audit reviews. The next step is to combine the methods used by exemplars into a best approach.

The final step in the process is to 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 & Peterson, 2005; Mold & Gregory, 2003). Best practices research is an approach that can help you identify exemplar practices appropriate to spread.

References

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.

Module 5 Trainer's Guide: Mapping and Redesigning Workflow

Time

- Presession preparation for learners: 45 minutes
- Session: 85 minutes

Materials Checklist

- ❑ Computer, access to Internet, projector or video capacity.
- ❑ Online access to or paper copies of:

  - Guide on Workflow Mapping. LA Net Community Health Resource Network; 2013. See Appendix.
- ❑ Copy of Redesign Reflection Questions.
- ❑ Large paper, sticky notes, and pens to use in group mapping exercise.

Objectives

Learners will be able to:

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

Exercises and Activities To Complete Before and During the Session

Presession Preparation

Read (15 minutes)

1. Module 5.

Access (30 minutes)

1. 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

Present/review (30 minutes)

1. Module 5.
2. Guide on Workflow Mapping. LA Net Community Health Resource Network; 2013. See Appendix.

Act (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.
   - Map the same workflow a second time while the Practice Facilitator observes the process and corrects the map.

4. Exercise 2. Create a "Swim Lane" 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).

   - Create a workflow map of handling patient calls to clinicians (or another multistage, multi-individual process with which the learners are familiar).

Discuss (10 minutes)

1. What did you learn from the mapping exercise?

   - Highlight lessons such as:

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

Act (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 5.1 in module to redesign workflow.

Discuss (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 5. Mapping and Redesigning Workflow

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.

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 5.1 shows an example of a 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. 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 5.1. Sample workflow map: lab result followup
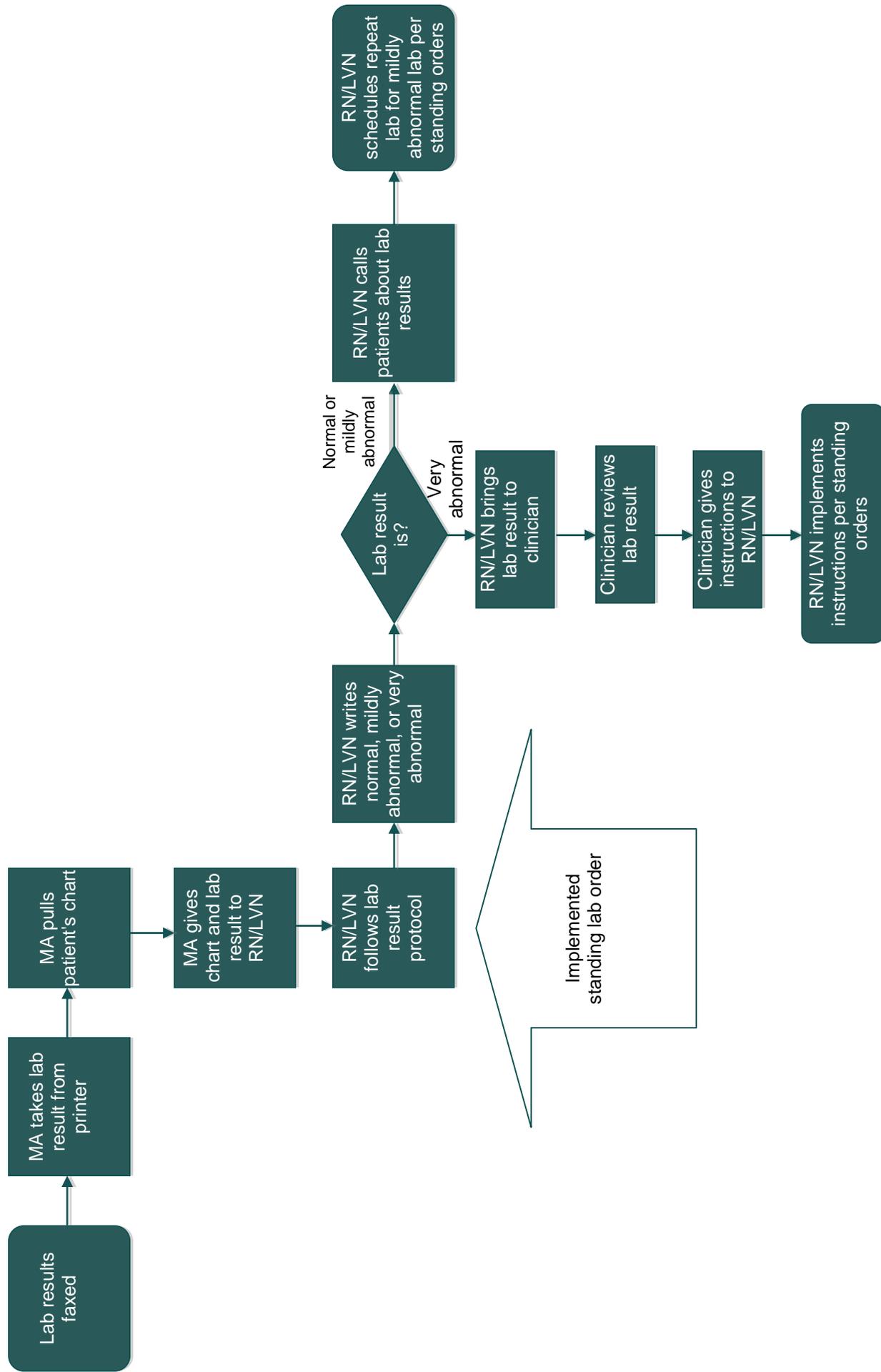
The workflow begins: Lab results faxed → MA takes lab result from printer → MA pulls patient's chart → MA gives chart and lab result to RN/LVN → RN/LVN follows lab result protocol (Implemented standing lab order) → RN/LVN writes normal, mildly abnormal, or very abnormal → Lab result is?

- Normal or mildly abnormal → RN/LVN calls patients about lab results → RN/LVN schedules repeat lab for mildly abnormal lab per standing orders
- Very abnormal → RN/LVN brings lab result to clinician → Clinician reviews lab result → Clinician gives instructions to RN/LVN → RN/LVN implements instructions per standing orders

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
- Dispensing phone advice
- Assigning patients to panels
- Completing new patient workups
- Educating patients/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
- MA role (previsit, 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:

- Healthy/preventive care
- Acute problems (major/minor)
- Chronic conditions (diabetes, hypertension, congestive heart failure)
- 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 5.1 contains some questions that can be useful in starting a team on the redesign process. Review the following questions with the practice:

Table 5.1. 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/.

Module 6 Trainer's Guide: Assessing Practices

Time

- Presession preparation for learners: 60 minutes
- Session: 70 minutes

Materials Checklist

- ❑ Case example. TheOnlyOneforMiles. See Appendix.
- ❑ Access to AHRQ CAHPS® survey website: https://www.cahps.ahrq.gov/clinician_group/
- ❑ Access to Clinical Microsystem Assessment Tool. Adapted from Assessing, Diagnosing and Treating Your Outpatient Primary Care Practice. Available at: http://dms.dartmouth.edu/cms/materials/workbooks/.
- ❑ Access to sample assessment tools:
  - **Status of Care Model implementation**
    - o Implementation of the Care Model-Practice Systems. Assessing Chronic Illness Care (ACIC): http://improvingchroniccare.org/index.php?p=Survey_Instruments&s=165.
    - o Patient Assessment of Care for Chronic Conditions (PACIC): http://www.improvingchroniccare.org/index.php?p=PACIC_Survey&s=36.
  - **Patient satisfaction and experience:**
    - o CAHPS® (Consumer Assessment of Healthcare Providers and Systems): https://www.cahps.ahrq.gov/clinician_group/.
  - **Provider and staff satisfaction:**
    - o Primary Care Staff Satisfaction Survey: http://www.improvingchroniccare.org/downloads/2.1_primary_care_staff_satisfaction_survey.doc
  - **Organizational capacity for improvement:**
    - o Change Process Capability Questionnaire (CPCQ) developed by Leif Solberg. See Appendix.
  - **Patient-centered medical home status:**
    - o Medical Home Index: http://www.medicalhomeimprovement.org/knowledge/practices.html.
    - o National Committee for Quality Assurance: http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH/PCMH2.aspx.
  - **Other resources for practice data**
    - o Health Resources and Services Administration (HRSA) Uniform Data System (UDS) report on safety net practices in your area: http://bphc.hrsa.gov/healthcenterdatastatistics/.
- ❑ Sample data inventory form. See Appendix.

Objectives

Learners will be able to:

- Describe the key principles of data-driven improvement and why this is a central concept in improvement work and facilitation.
- List the different aspects of a practice that might be assessed as part of a practice improvement intervention.
- Identify some common tools for assessing practices.
- Access HRSA's UDS reports for Federally Qualified Health Centers.

Exercises and Activities To Complete Before and During the Session

Presession Preparation

Read/Scan (60 minutes)

1. Read Module 6.
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.

During the Session

Present (25 minutes)

1. Module 6.

Exercise (30 minutes)

1. Complete the CPCQ for one of your practices (or the TheOnlyOneforMiles case example).
2. Complete the ACIC for one of your practices (or for TheOnlyOneforMiles case example).

Discuss (15 minutes)

1. What lessons did you learn from completing these surveys and also 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 6. Assessing Practices

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 6.1 contains some important metrics you will need to talk to your practices about assessing.

Table 6.1. Assessment metrics

Assessment Topic	Metrics
Access and continuity	- Same day access - Nontraditional visits to traditional 3rd next available appointment - Patients seeing own provider or care team - Other
Clinical information systems and progress toward Meaningful Use	- Registries - Problem lists - Medication lists - Flow sheets - Checklists of tests and interventions - Decision support tools - Other
Clinical performance	- Key performance and outcome metrics for: - Coronary artery disease (CAD) - Heart failure (HF) - Diabetes mellitus (DM) - Preventive care (PC) - Hypertension (HTN) - Other clinical performance metrics relevant to the particular practice
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 - Other

Assessment Topic	Metrics
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 • Other
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 Assessing 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 16 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 with the work environment, skills staff members have, and ways staff members spend their time. You can identify sources of stress and underutilized staff and collect 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 be used to examine how the practice does on specific metrics for clinical performance and patient outcomes. Different groups have defined sets of quality metrics available that you can use 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" is conducted to identify the reasons for the failure and make suggestions for improvement. For example, in a practice interested in improving its lab reporting process, you can use observation and document review to 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 best fit the goals for the facilitation intervention and those of the practice and 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 are routinely used to assess practices. You may also choose to augment those with additional assessments individual practices you are supporting would like you to conduct. Describe the options to the practice, but be careful or you'll wind up drowning in assessment data.

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 information. Part of your job will be to help the practice focus the assessment on those items that are directly relevant to the improvement goals at hand.

Identifying Assets as Well as Challenges

It is important to approach the assessment from an asset-based rather than deficit-based perspective. More than likely you are 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 very 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 trap, 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.

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 beyond them 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/healthcenterdatastatistics) 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 designed an assessment tool, the ACIC, that you can use to stimulate productive discussions about the needs and improvement goals of the practice. Table 6.2 summarizes the elements of the ACIC.

Table 6.2. Elements of the 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 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 • Followup 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 followup • 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 piggyback off of 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 to work on the answers to these and other relevant questions aimed at building internal capacity in the practice to do the things with data that you are doing now and to sustain this work over time.

References

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.

Module 7 Trainer's Guide: Measuring and Benchmarking Clinical Performance

Time

- Presession preparation for learners: 55 minutes
- Session: 75 minutes

Materials Checklist

- ❑ Computer and Internet access, projector, or video display.
- ❑ Online access to or paper copies of:

    - 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 (one per learner).
    - 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 (one per learner).
    - Benchmarking. Available at: https://en.wikipedia.org/wiki/Benchmarking.

Objectives

Learners will be able to:

- Identify sources for selecting performance measures for primary care.
- Describe the importance of the numerator and denominator in defining performance measures.
- Describe benchmarking and its use by facilitators to support improvement work.

Exercises and Activities To Complete Before and During the Session

Presession Preparation

Read (55 minutes)

1. Module 7.
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. See Appendix.
4. Benchmarking. Available at: https://en.wikipedia.org/wiki/Benchmarking.

During the Session

Present (15 minutes)

1. Module 7.

Discuss (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?

Act (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 assess their clinical performance on for primary care for diabetes mellitus and chronic kidney disease.
3. Use online resources to identify national or local external benchmarks for performance for these metrics.

Discuss (15 minutes)

1. What did you learn from the exercise?
2. How will you use this in your work with your practices?

Module 7. Measuring and Benchmarking Clinical Performance

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 their 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.

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 data. Data collection timelines should allow sufficient time for change. They 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 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 diabetic patients.

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 diabetic patients 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 diabetic patients in a provider'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 record. If you use any

diabetic patients regardless of whether they have an HbA1c value available, the percentage of patients who have elevated HbA1cs 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 diabetic patients receiving care in the previous month as the denominator and the number of these 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 diabetic patients with low-density lipoprotein (LDL) below 100, you would specify the denominator as the number of diabetic patients with an LDL test, not just the number of diabetic patients. 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 6 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 to help members of a practice understand where their 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 7.1 for an example of a benchmarked practice report card.

Pay attention to numerators and denominators when benchmarking. It is important to ensure that you are making "apples to apples" comparisons.

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 can compare among themselves. Community clinic associations often host this type of local effort, often through managing multiorganization 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 might be 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 on Quality Assurance are other potential resources for benchmarking, as well as State and local health and public health agencies.

Health information technology vendors are also 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.

Figure 7.1. 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

Continuity PCP%

21 Day Contact Postdischarge Ratio

Ratio of PC Telephone Encounters/All PC Encounters

Same Day Appts PC Provider Ratio
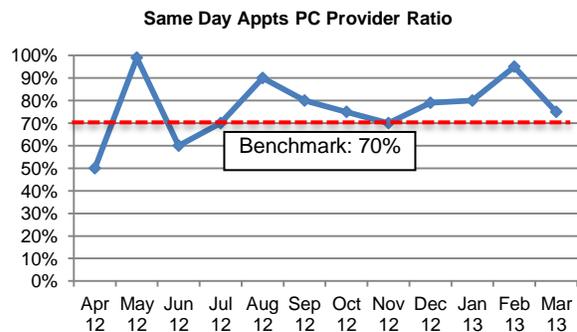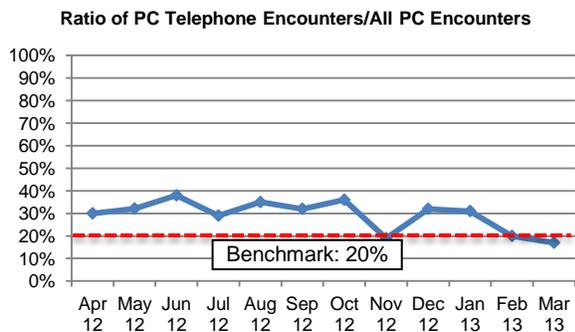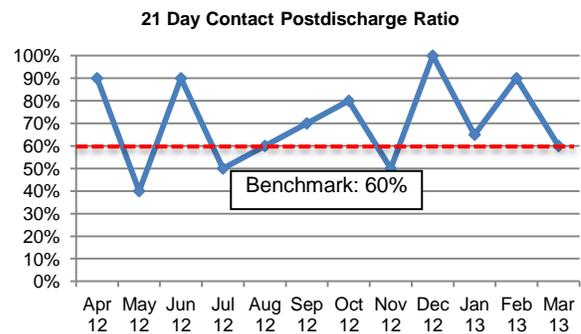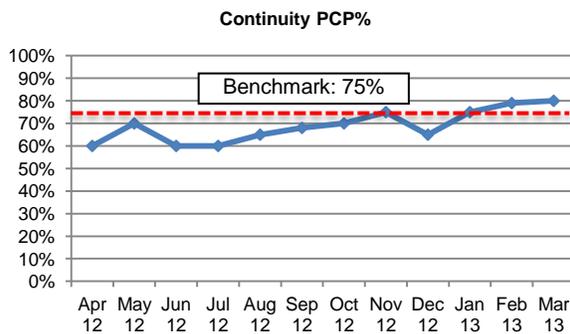
Module 8. Trainer's Guide: Collecting Data With Chart Audits

Time

- Presession preparation for learners: 60 minutes
- Session: 60 minutes

Materials Checklist

- ❑ Sample abstraction form. Three copies per learner. See Appendix.
- ❑ Mock patient records from three time periods (online access or one copy for every two participants). See Appendix.
- ❑ Sample set of electronic data pull instructions for Information Technology (IT) staff for a performance audit. See Appendix.
- ❑ Access to: 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#fpm20080700pa3-bt1.

Objectives

Learners will be able to:

- Conduct a paper chart audit using a data abstraction form.
- 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

Presession Preparation

Read (10 minutes)

1. Module 8.
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#fpm20080700pa3-bt1

Act (50 minutes)

1. Have learners conduct chart abstractions of Diabetes HEDIS indicators for three different time periods for the clinic WeServeEveryone. Have them use the mock patient records and data abstraction form contained in the Appendix.

   - The date of abstraction for the following patients is October 27, 2010:

     o Billy Gato
     o Cherie Amore
     o Wendy See

- The date of abstraction for the following patients is January 10, 2011:

  - John Donut
  - Adam Pie
  - Tom Gellato

- The date of abstraction for the following patients is April 14, 2011:

  - Steve Apple
  - Bill Windows
  - Monica Latte

During the Session

Present (10 minutes)

1. Module 8.

Discuss (15 minutes)

1. What experience have you had conducting chart audits or working with performance data?
2. What did you learn?
3. What were your experiences conducting the chart audits for today's session? What aspect was easiest for you? What was the most challenging? What did you learn from this presession assignment that you would apply to your work with practices?

Act (25 minutes)

1. Divide into pairs or small groups.
2. Have learners work together to create instructions for IT for an electronic data pull that parallels that of the paper audit they conducted during presession work. Have them use the sample Data Pull Instructions template to create the request.

Discuss (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 8. Collecting Performance Data Using Chart Audits

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 a laborious task. Facilitators frequently spend most of their time with a practice creating systems to access reliable data and building capacity in the practice to use these data in their 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, providers, and leadership. The use of data and feedback systems allows practices to see improvements during an intervention, make adjustments, and stay engaged.

Considerations When Collecting Clinical Performance Data

Depending on the practice, you may gather data through hand abstraction or by downloading data from an electronic health record (EHR) or registry. In general, an audit of 10 to 30 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 most effective to conduct an audit of the previous 12 months and organize these data by quarter to show fluctuations in performance over the time period. Fluctuations 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 time 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 PDSA (Plan-Do-Study-Act) 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 for wider spread in the practice or organization. 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.

To conduct the actual audit, you will need to create a paper or electronic extraction form, or a performance data request for staff in charge of the practice's EHR. Figure 8.1 contains an example of an abstraction spreadsheet. If you use paper records, you can enter the data directly into the spreadsheet. If you request the data from the practice information technology (IT) staff or the individual in charge of access to the EHR, ask for the data to be output to the spreadsheet. Spreadsheet data can be exported into statistical software for further analysis.

Figure 8.1. Sample abstraction spreadsheet

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.									
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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(i)=

Procedures for Electronic Health Record Audits

While in the past most audits were conducted using paper abstraction forms and paper medical charts, with the increased use of EHRs, many audits are now conducted by accessing electronic health data. If your practice uses EHRs, you may be able to get the system to generate a report with the data you need. This function, however, might require new programming; 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 and can reconfigure reports to meet your needs will also have a high payoff.

With electronic patient data, you and the practice staff can 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. Equally important is to train staff to develop their own reports and modify existing reports so they can easily add new performance metrics 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 criteria for the patient records that will be queried, and time period for the data, you will also need to specify the format for receiving the data. 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 10 to 30 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 are provided in the Appendix.

Procedures for Paper Chart Audits

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 too 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 inclusion criteria. 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 to obtain 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. The patient record numbers then need to be given 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 whose medical records will be needed.

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. A number of measures can be taken to protect confidential information. As a rule, never take identified patient data offsite from a practice.

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 descriptions.

*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.***

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 reidentify 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 make sure you comply with all regulations of the Health Insurance Portability and Accountability Act 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 performance data and best practices across practices is a critical part of the facilitation process, 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.

Module 9 Trainer's Guide: Preparing and Presenting Performance Data

Time

- Presession preparation for learners: 60 minutes
- Session: 120 minutes

Materials Checklist

- ❑ Computer, Internet access, and a projector or video display.
- ❑ Copy of Performance Metric Calculator (diabetes). See Appendix.
- ❑ Copy of the Performance Report Generator. Available at: http://www.lanetpbrn.net/wp-content/uploads/Performance-Report-Generator_1.xlsb.
- ❑ Copy of the WeServeEveryone Clinic case example. See Appendix.
- ❑ Computer access for learners to generate graphic displays of practice data.

Objectives

Learners will be able to:

- Manipulate performance data to check for out-of-range values and missing values.
- Produce simple frequencies from data.
- Prepare a graphic display of performance data.
- Benchmark the data against an external standard.

Exercises and Activities To Complete Before and During the Session

Presession Preparation

Read (10 minutes)

1. Module 9.

Act (50 minutes)

1. Using data abstracted from earlier module, have learners calculate HEDIS performance metrics for the clinic WeServeEveryone, for each of the three time periods using the Performance Metric Calculator contained in the Appendix. 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.
2. Have learners prepare a presentation of the chart audit findings across the three time periods or 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

Present (15 minutes)

1. Module 9.

Discuss (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 prework assignment?

Act (60 minutes)

1. Have learners break into pairs or small groups. Designate a Practice Facilitator for each group. Have the 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 that should 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?

Discuss (in pair or small group) (20 minutes)

1. Have learners provide feedback to their facilitator using the Stop, Start, Keep format.
    a. Start doing—Something you might start doing in your presentation 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?
3. What did you learn from this exercise and how will you use this in your work with your practices?

Module 9. Preparing and Presenting Performance Data

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. In preparing to do this, 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 of 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 BP of 1125). 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 team can make the data difficult to interpret and validate. Providing too much detail, on the other hand, can bury the team in data 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 when 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 these reporting processes into the EHR and practice management systems.

A picture is worth a thousand words.

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 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 trendlines. 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.

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.

Table 9.1. Sample performance report to QI Team on a chronic kidney disease guide implementation project

Baseline		
N for performance data abstraction	30	CKD pts seen at least 2x from 8-30-10 to 9-1-11 collected 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
Pneumococcal		

Charts (BASELINE Performance Data): Race/Ethnicity — Latino 76.67%, African American 10.00%, White (Hisp & non-Hisp) 0.00%, Not Stated/Other 13.33%. Insurance status — None 3.33%, Medicare 20.00%, Medicaid 0.00%, Other govn't (HWLA, etc.) 76.67%, Private 0.00%. Sex — Male 26.67%, Female 73.33%. CKD on Problem List? — No 7%, Yes 93%. CKD patient eGFRs — 45< eGFR <60 43.33%, 30< eGFR <45 33.33%, eGFR <30 20.00%. Medications — Aspirin/blood thinner (yes) 80.00%, ACE/ARB (yes) 60.00%, Vit D 3 (yes) 20.00%, NSAIDS (yes) 83.33%, Metformin (yes) 30.00%. Labs within the past 12 months — eGFR 96.67%, Referral if eGFR<30 33.33%, HbA1c 53.33%, Lipid panel 60.00%, Serum Ca++ 86.67%, HGB 50.00%, 25 hydroxy Vit D 50.00%, PTH 23.33%, Serum phosphate 20.00%, M/C 43.33%. Comorbidities/Risk factors — DM Dx 3.33%, HTN Dx 13.33%, DM & HTN 80.00%, BP>130/80 53.33%, LDL<100, Calcium >8.5**, PO4 <4.6**, Smoker 3.33%. Prevention.

Sheet tabs: Contacts | Encounter Notes | BASELINE Performance Data | Perf. Data Month1 | Perf. Data Month2 | Perf. Data RUN CHART | PDSA_1 | PDSA_2 | PDSA_3 | +

Run charts (Perf. Data RUN CHART): "Adherence to recommended labs" (eGFR, Referral if eGFR<30, HbA1c, Lipid panel, Serum Ca++, HGB, 25 hydroxy Vit D, PTH, Serum phosphate, M/C) across Baseline, CKD progress data 1, CKD progress data 2. "CKD on Problem List?" (Yes). "Prevention" (Flu vaccine last 12 months, Pneumococcal vaccine ever, Vein preservation). "Medications" (Aspirin/blood thinner (yes), ACE/ARB (yes), Vit D 3 (yes), NSAIDS (yes), Metformin (yes)).

Helping Practices Reflect and Act on Data

Many if not most times, the information systems in practices 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 upon, and then 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?

References

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.

Module 10 Trainer's Guide: Academic Detailing as a Quality Improvement Tool

Time

- Presession preparation for learners: 40 minutes
- Session: 50 minutes

Materials Checklist

❑ Farrell S, Fischer M, Avorn J, et al. Introduction guide to academic detailing. Boston, MA: National Resource Center for Academic Detailing and Alosa Foundation; 2011. See Appendix.

Objectives

Learners will:

- Be able to define academic detailing and its purpose in a quality improvement intervention.
- 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 a resource to consult during their work with practices.

Exercises and Activities To Complete Before and During the Session

Presession Preparation

Read (40 minutes)

1. Module 10.
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. See Appendix.

During the Session

Present (20 minutes)

1. Module 10.
2. *Introductory Guide to Academic Detailing*.

Discuss (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 in these cases?
3. What were the three most important "takeaways" for you from the reading?

Module 10. Academic Detailing as a Quality Improvement Tool

Academic detailing is peer-to-peer educational outreach. Academic detailing has its roots in pharmaceutical detailing and was designed to improve prescribing practices by physicians. The peer-to-peer format of these commercially oriented encounters has now been adapted for use in improving 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?

These peer-to-peer visits help build leadership's buy-in to the proposed practice changes and help them understand the role of practice facilitators, what they can and cannot do, and how they can help practices implement these changes. Practice staff are more likely to accept a message if it comes from someone with their same background.

At the beginning of a facilitation intervention, an academic detailer can legitimize the practice facilitator and 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 his or her practice. This shows the practice that it can be done, that barriers can be overcome.

When Should You Use Academic Detailing?

You can't start too early. As noted in Module 13, 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 an encore performance.

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 whom they work with.
- 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 particularly skilled speakers for future reference.

Before they meet the practice, brief your detailers to 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 few, or even a single member, of the 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. But practice change is a team sport; practice members will generally learn something from a detailer even if the subject is not their own.

What Is the Facilitator's Role?

Once you identify the 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 buy-in and increase knowledge.
3. Decide who should participate in an academic detailing visit.
4. Remain the point person/primary point of contact with the practice.
5. Listen to the encounters with the detailer and support translation of learning/ideas generated into practice by the quality improvement team.

Part 3. In the Practice

Module 11 Trainer's Guide: Introducing a Practice to Facilitation

Time:

- Presession preparation for learners: 75 minutes
- Session**:** 60 minutes

Materials Checklist

- ❑ Computer, Internet, and a projector or video display.
- ❑ Paper and pens, or computers and a printer.

Objectives

Learners will:

- Be able to give a succinct description or "elevator speech" that explains practice facilitation.
- Tell two stories that illustrate the activities of facilitators in practices.

Exercises and Activities To Complete Before and During the Session

Presession Preparation

Read (15 minutes)

1. Module 11.

Act (60 minutes)

1. Have learners draft two short stories illustrating facilitator activities in practices that are appropriate for use in explaining facilitation to practices to share during the session.

During the Session

Present (15 minutes)

1. Module 11.

Act (30 minutes)

1. Ask learners to develop a 2- to 4-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.

Discuss (15 minutes)

1. What did you learn from this exercise?
2. How will you use this information with your practices?

Module 11. Introducing a Practice to Facilitation

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. 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 practice facilitation.
- 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, telephonic, 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. The 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 can be made 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 very important 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.

Module 12 Trainer's Guide: Assessing Practice Readiness for Change

Time:

- Presession preparation for learners: 10 minutes
- Session: 40 minutes

Materials Checklist

☐ Case example: TheOnlyOneforMiles. See Appendix.

☐ Informal Practice Readiness Assessment. See Appendix.

Objectives

Learners will:

- Identify four factors experts believe are associated with practice readiness to engage in facilitated improvement.
- Practice using the readiness assessment with a fictional or real practice.

Exercises and Activities To Complete Before and During the Session

Presession Preparation

Read (10 minutes)

1. Module 12.

During the Session

Present (15 minutes)

1. Module 12.

Read (5 minutes)

1. Have learners read fictional case example or description of real practice.

Discuss (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 12. Assessing Practice Readiness for Change

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).

Resources should focus on practices that are most likely to benefit from facilitation.

Figure 12.1 presents a model that can be used to triage facilitation resources. It reflects the view of some experts in practice facilitation 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 practices that are already functioning very effectively and 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 12.1. Model for triaging allocation of practice facilitation resources
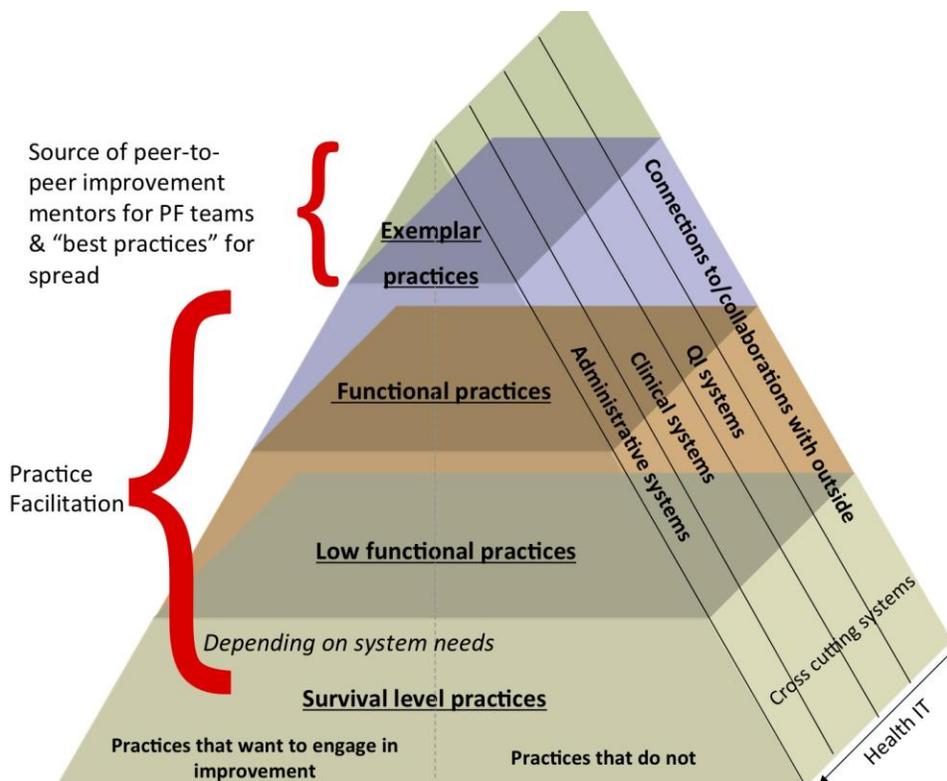
Source: Knox L, ed. Report. on the AHRQ 2010 consensus meeting on practice facilitation for primary care improvement. (Prepared by LA Net through a subcontract with the University of Minnesota under Contract No. HHSA290200710010 TO 3.) Rockville, MD: Agency for Healthcare Research and Quality; 2010.

You might not want to follow the triage model for several reasons. 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. Figure 12.2 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 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.

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.

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 courses of action to consider with practices that do not meet readiness criteria at 3 months:

- Continue the intervention. You may believe that 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 later time when they are better prepared to engage.
- Ramp up the intensity of the intervention, often 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.

References

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/portal/server.pt/community/pcmh__home/1483/pcmh_implementing_the_pcmh___practice_facilitation_v2. Accessed April 4, 2013.

Module 13 Trainer's Guide: Conducting a Kickoff Meeting

Time:

- Presession preparation for learners: 10 minutes
- Session**:** 60 minutes

Materials Checklist

☐ Program materials. Specific to the practice facilitation intervention (provided by the program).

☐ Sample copies of the facilitation program's Business Associate Agreement, Memorandum of Understanding, project summary sheet. (Provided by the particular facilitation program).

Objectives

Learners will:

1. Understand the purpose of a kickoff meeting.
2. Be able to facilitate an effective kickoff meeting.

Exercises and Activities To Complete Before and During the Session

Presession Preparation

Read (10 minutes)

1. Module 13.

During the Session

Present (15 minutes)

1. Module 13.

Discuss (15 minutes)

1. What is the purpose of a kickoff meeting?
2. What is the role of the facilitator?

Act (30 minutes)

1. Divide into groups of three and conduct a "mock kickoff" session. Designate one person as the facilitator, one as the practice staff, and one as the observer.
2. Report to the group about "lessons learned" from the mock kickoff session.

Module 13. Conducting a Kickoff Meeting

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 14), and gives you an additional opportunity to educate staff and clinicians about your role as a facilitator.

The goal of the first meeting is to introduce the QI team and practice leadership to the requirements of the improvement project, decide about their participation in the effort, and identify their initial priorities and goals for their participation.

The first meeting also provides an opportunity to conduct an initial training with the QI team on the content. When appropriate, you should incorporate informal academic detailing into the first session. 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 his or her experiences with the others. This individual can serve as a copresenter with you at the meeting as well as a member of the facilitation team for the practice.

In an ideal world, you will have already conducted the initial assessment of the practice and can report these data to those at the meeting and engage them in using the data to set early improvement goals. This said, in most cases this will not be possible because obtaining these data is typically time consuming and requires a considerable amount of relationship building before a practice will give a facilitator access to this information. In addition, administrative paperwork will need to have been executed that enables you to view certain types of patient data. Often this paperwork is still in process at the time of the kickoff.

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 prework 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, the practice leadership, and the QI team members. A number of online scheduling resources can help you set up the meeting.

Meeting Agenda

Do not 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 16). If you are bringing an academic detailer, provide enough time for him or her time to share his or her experiences with facilitation and its impact on his or her practice and patients.

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 should give an overview of the goals of the facilitation intervention and your role and function as facilitator. 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 13.1.

Table 13.1. Sample agenda for kickoff meeting

12:00-12:10	Welcome and introductions Goals for meeting
12:10-12:30	Review of key elements of the facilitation intervention Academic detailer presents experiences with facilitation and/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)

Module 14 Trainer's Guide: Creating Quality Improvement Teams and QI Plans

Time

- Presession preparation for learners: 90 minutes
- Session: 120 minutes (30 minutes optional)

Materials Checklist

- ❑ Access to Health Resources and Services Administration's Developing and Implementing a QI Plan. Available at: http://www.hrsa.gov/quality/toolbox/methodology/developingandimplementingaqiplan/index.html.
- ❑ Copies or online access to:

  - Improving Performance in Practice (IPIP) key driver model. See Appendix.
  - Blank key driver model templates. See Appendix.
  - Assessing Chronic Illness Care (ACIC) tool (Version 3.5) Available at: http://improvingchroniccare.org/index.php?p=Survey_Instruments&s=165 (one per learner).
  - QI plan generator. See Appendix.
  - WeServeEveryone Clinic case example. See Module 9 Appendix B.

Objectives

Learners will be able to:

- Identify the main elements of a QI plan for a primary care practice.
- Create a practice-level key driver model.
- 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

Presession Preparation

Read (90 minutes)

1. Module 14.
2. Developing and Implementing a QI Plan. HRSA. April 2011. Available at: http://www.hrsa.gov/quality/toolbox/methodology/developingandimplementingaqiplan/index.html.

During the Session

Present (30 minutes)

1. Module 14.
2. Developing and Implementing a QI Plan. HRSA. April 2011.

Discuss (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 the HRSA document and Module 14 about developing a QI plan and program that you can use with your practices?
3. What is a key driver model and why can they be helpful to you in your work with practices?

Act (30 minutes)

1. Divide into pairs or small groups. Identify roles: Practice Facilitator and Participant (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.

Act (30 minutes) (optional)

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.

Discuss (15 minutes)

1. What did you learn from the previous exercise(s)?

Module 14. Creating Quality Improvement Teams and QI Plans

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 (QIC) is the group of individuals within a practice charged with carrying out improvement efforts. The team may report to the organization's chief executive officer. 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.

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 team should have a clearly identified "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 voices and perspectives of individuals involved in all aspects of the process/activity under scrutiny. The role of the QI team champion is to ensure that the team functions effectively and fulfills its charter for the organization.

Who Should Be on a Quality Improvement Team?

The Institute for Healthcare Improvement (IHI) recommends that every team include at least one member who has the following roles[i]:

- **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 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, analysis, and change

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[i] Adapted from the Institute for Healthcare Improvement. Science of Improvement: Forming the Team. Available at: http://www.ihi.org/knowledge/Pages/HowtoImprove/ScienceofImprovementFormingtheTeam.aspx.

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 on a daily basis with the team, he or she may join periodically and stays apprised of its progress. When needed, this member can assist the team in obtaining resources and overcoming barriers encountered when 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. It is important that the team include 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/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 to complete with the QI team is to identify goals for the improvement work and associated performance metrics. It is useful to have preliminary performance data available to use in setting improvement goals whenever possible. Goals are fluid and will likely change

during your work with the practice 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.

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, as well as the work of individual facilitators and facilitation teams at the practice level. 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 action items** that must occur to produce the desired big changes.

Example of a Key Driver Model

Figure 14.1 shows a program-level key driver model for improving diabetic and asthmatic patient outcomes based on the Care Model (see Module 16). This key driver model was developed for the Improving Performance in Practice Initiative funded by the Robert Wood Johnson Foundation and provided by Dr. Darren DeWalt.

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 the approaches they will use to achieve their goals. The far right column contains the "change concepts" or action items/steps to implement a particular key driver.

Figure 14.1. Key driver model for Care Model implementation (sample based on Improving Performance in Practice Initiative)

Outcomes	Key Drivers	Intervention/Change Concepts

Improved clinical outcomes for patients with diabetes and asthma

Measures of success:
Diabetes:
- >70% BP < 130/80
- >70% LDL < 100 mg/dl
- <5% A1c greater than 9.0%
- >80% received dilated eye exam
- >90% tested (or treated) for nephropathy
- >90% counseled to stop tobacco use

Asthma:
- >90% control assessed
- >90% with persistent asthma on anti-inflammatory medication
- >90% with influenza vaccination
- >75% with: assessment of control + anti-inflammatory + influenza vaccination

Use Registry to Manage Population
- Identify each affected patient at every visit
- Identify needed services for each patient
- Recall patients for follow-up

Implement Registry
- Determine staff workflow to support registry
- Populate registry with patient data
- Routinely maintain registry data
- Use registry to manage patient care & support population management

Planned Care
- Care Team is aware of patient needs and work together to ensure all needed services are completed

Use Templates for Planned Care
- Select template tool from registry or create a flow sheet
- Determine staff workflow to support template
- Use template with all patients
- Ensure registry updated each time template used
- Monitor use of template

Standardized Care Processes
- Practice-wide guidelines implemented per condition (asthma, diabetes)

Employ Protocols
- Select & customize evidence-based protocols for asthma and diabetes
- Determine staff workflow to support protocol, including standing orders
- Use protocols with all patients
- Monitor use of protocols

Self Management Support
- Realized patient and care team partnership

Provide Self-Management Support
- Obtain patient education materials
- Determine staff workflow to support SMS
- Provide training to staff in SMS
- Set patient goals collaboratively
- Document & monitor patient progress toward goals
- Link with community resources

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.

Designing a Key Driver Model With a Practice

You should work with the practice to develop a practice-level key driver model that links to the outcomes identified by the practice and targeted by the facilitation intervention. The practice's QI plan should be based on the practice-level key driver model to reflect the change concepts included in the model. If your program has a predefined key driver model for the intervention, you should review the prescribed model with the practice's QI team and work with them to identify the drivers and change concepts they want to implement first, second, and third. You should also ask the practice to identify what other items not currently represented on the key driver model 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/Achievable,
- Relevant, and
- Time bound (IOM).

When defining its change goals, the practice should include numeric targets. Distinguish between goals that will be accomplished during the period you are facilitating (if it's 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 QI plan should provide guidance to the practice on who is to participate on the QI team, how often it is to meet, and what its goals and key activities are. 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. A good QI plan includes among other things:

- A statement of the quality vision.
- A description of the program structure.
- A membership for the QI team or committee that is diverse.
- 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 will be to assist practices in developing a plan or to review the plan they already have.

Monitoring Progress on the Quality Improvement Plan

With new 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 so that the burden on staff is minimized 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 assist them in identifying the staff needed to prepare the reports and the time they will need to accomplish this task. In addition, you will need to work with the team to revise staff job descriptions to include this task, as well as their performance evaluation. 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 one 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 report will create a written record of the team's progress and help increase ownership and accountability in the QI team and 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.

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.

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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. Available at: http://pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/pcmh_implementing_the_pcmh__practice_facilitation_v2. Accessed April 4, 2013.

SMART Objectives. The Smart Bites Toolkit. Institute of Medicine. Available at: http://www.iom.edu/About-IOM/Making-a-Difference/Community-Outreach/~/media/Files/About%20the%20IOM/SmartBites/Planning/P1%20SMART%20Objectives.ashx. Accessed April 26, 2013.

Module 15 Trainer's Guide: Documenting Your Work With Practices

Time

- Presession preparation for learners: 45 minutes
- Session: 40 minutes

Materials Checklist

- ❑ Computer, Internet access, and a projector or video display.
- ❑ Practice record or your particular program's method for documenting facilitation encounters and practice progress. See Appendix. Sample practice record also available at: http://www.lanetpbrn.net/wp-content/uploads/ClinicAllOverThePlaceprogress.xlsx.
- ❑ Copy of practice TheOnlyOneforMiles case study. See Module 6 Appendix B.

Objectives

Learners will:

- Be able to use the facilitator practice record to document a practice encounter.
- Understand the importance of documentation for internal quality improvement and performance monitoring.

Exercises and Activities To Complete Before and During the Session

Presession Preparation

Read (15 minutes)

1. Module 15.

Act (30 minutes)

1. Ask learners to use the sample facilitator practice record to enter data about a fictitious encounter with practice TheOnlyOneforMiles.

During the Session

Present (20 minutes)

1. Module 15.

Discuss (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 15. 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 also help your program director to 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 also 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 can use a variety of different methods to document encounters and track progress with their practices. You can use paper-based forms you create to record encounter data, simple spreadsheets on a computer, or online spreadsheets and survey programs designed to collect and manage information. Online solutions can be a good option because they are dynamic and can be accessed by both you and your program supervisor. Figures 15.1-15.3 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 those being 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 15.1. 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

Date	Status	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

OVERALL SCORE: 4 — NOTES/COMMENTS

	Score	
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

OVERALL SCORE: 3 — NOTES/COMMENTS

	Score	
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

OVERALL SCORE: — NOTES/COMMENTS

	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

OVERALL SCORE: — NOTES/COMMENTS

	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

OVERALL SCORE: — NOTES/COMMENTS

E1. Assess existing SMS resources at practice	

Tabs: Contacts | Encounter Notes | BASELINE Performance Data | Perf. Data Month1 | Perf. Data Month2 | Perf. Data RUN CHART | PDSA_1 | PDSA_2 | PDSA_3 | +

Figure 15.2. 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 | +

Figure 15.3. Sample facilitation practice record – data and graphics
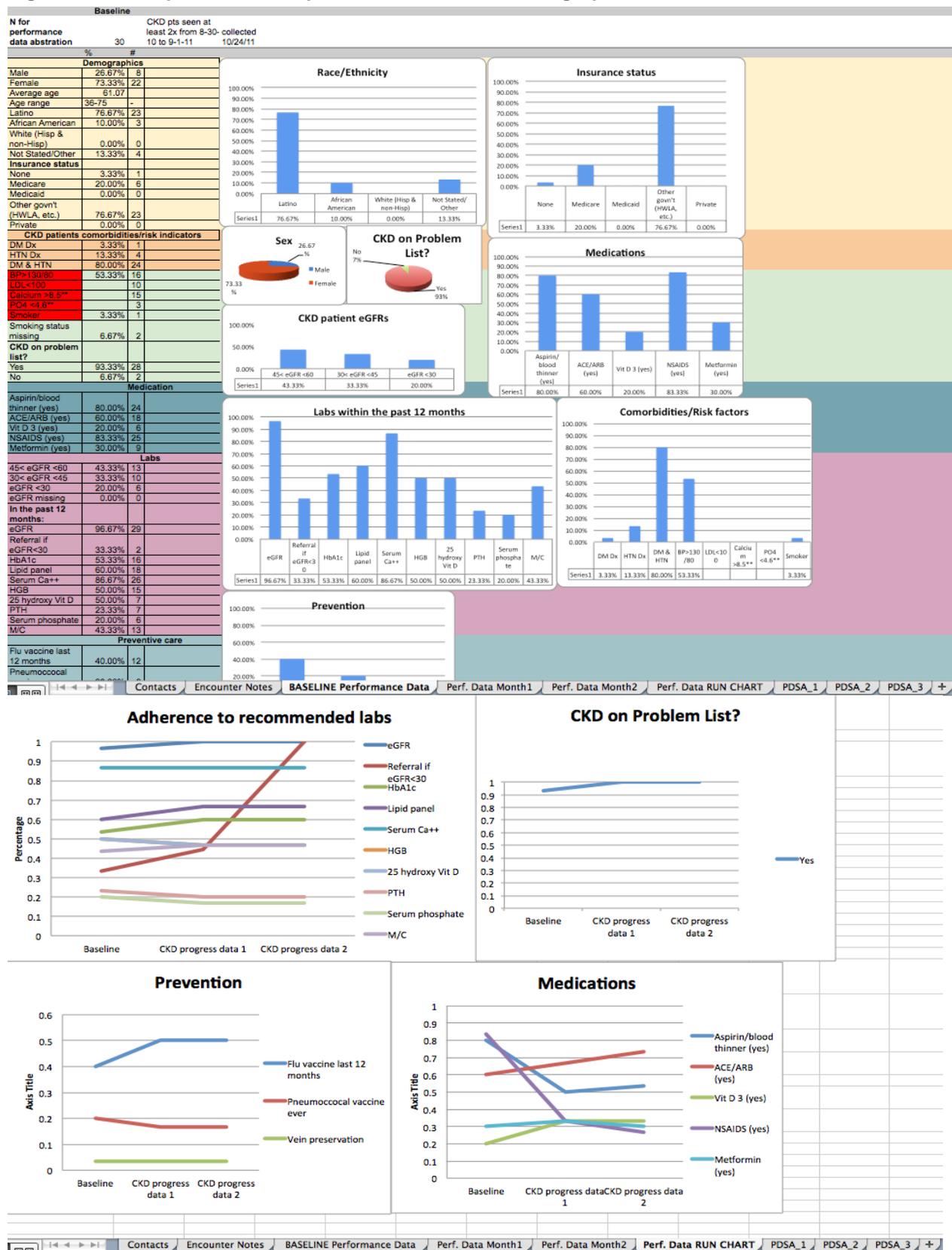
Knowing Which Encounters To Document

It is important to document all "meaningful" encounters with a practice. This means any substantive work that occurs in support of 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. It also helps the practice track its own progress with its improvement work. Finally, it can 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 15.4 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 15.4. Sample graphic showing progress across a panel of practices

Key Change 1.1: Organize the lead QI team

| Month	No Activity	Started	Partially Completed	Completed	Exemplar
Dec-10		8	3	5	2
Jan-11		5	8	4	1
Feb-11		1	9	7	1
Mar-11			7	8	2
Apr-11					
May-11					

Key Change 1.2: Familiarize the QI team with key improvement strategies

Month	No Activity	Started	Partially Completed	Completed	Exemplar
Dec-10	1	11	2	4	
Jan-11	1	2	9	6	
Feb-11		2	6	10	
Mar-11		1	5	11	
Apr-11					
May-11					

Key Change 2.1: Use data to set priorities

A horizontal stacked bar chart showing the Number of Clinics by month for the categories: No Activity, Started, Partially Completed, Completed, and Exemplar.

- May-11: (no data)
- Apr-11: (no data)
- Mar-11: Completed 17
- Feb-11: Completed 18
- Jan-11: Started 1, Partially Completed 2, Completed 15
- Dec-10: Started 5, Partially Completed 3, Completed 9

X-axis: Number of Clinics (0 to 18)

Part 4. Implementing the Care Model and Patient-Centered Medical Home

Module 16 Trainer's Guide: Introduction to the Care Model

Time

- Presession preparation for learners: 115 minutes
- Session: 60 minutes

Materials Checklist

❑ Access to computer, speakers, and Internet.

Objectives

Learners will be able to describe:

1. Key elements of the Care Model.
2. Key elements of a patient-centered medical home (PCMH).
3. How the Care Model and PCMH relate.

Exercises and Activities To complete Before and During the Session

Presession Preparation

Read (15 minutes)

1. Module 16.

Watch (100 minutes)

1. Ed Wagner's *Improving Chronic Illness Care Across the Population* online video. Available at: http://www.youtube.com/watch?v=jJe7Y9-cRgw.
2. National Committee on Quality Assurance (NCQA)'s video on the PCMH. Available at: http://www.youtube.com/watch?v=ZC4YCLG4h5k&feature=player_embedded.

During the Session

Present (15 minutes)

1. Module 16.

Discuss (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 PCMH in safety net practices on patient outcomes? Patient experience? Costs of care for the practice? Costs of care for the payer?

Module 16. Introduction to the Care Model

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 16.1, 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 16.1. The Care Model
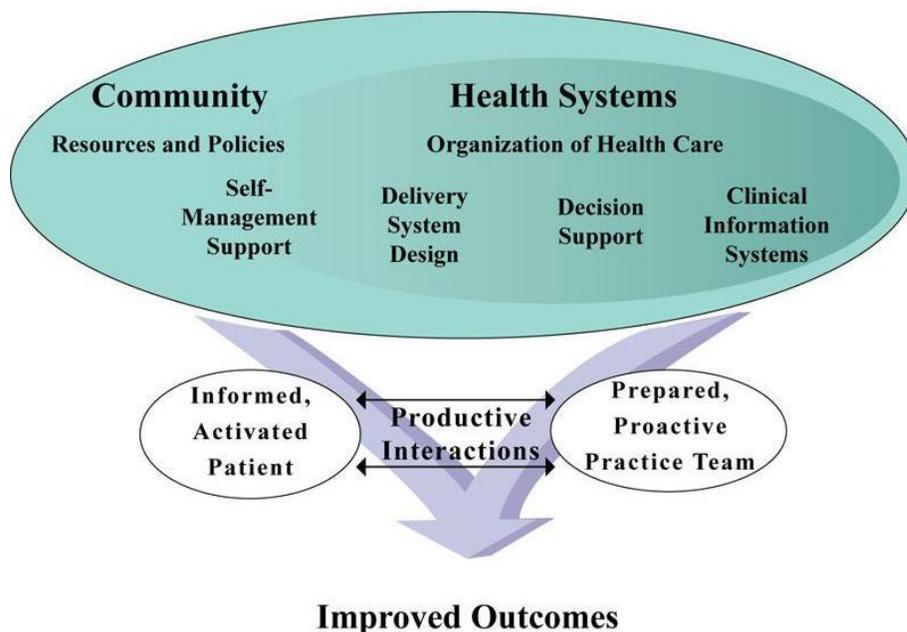
Developed by the MacColl Center for Health Care Innovation. ® ACP-ASIM Journals and Books. Used with permission.

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 16.2).

Figure 16.2. Expanded Care Model
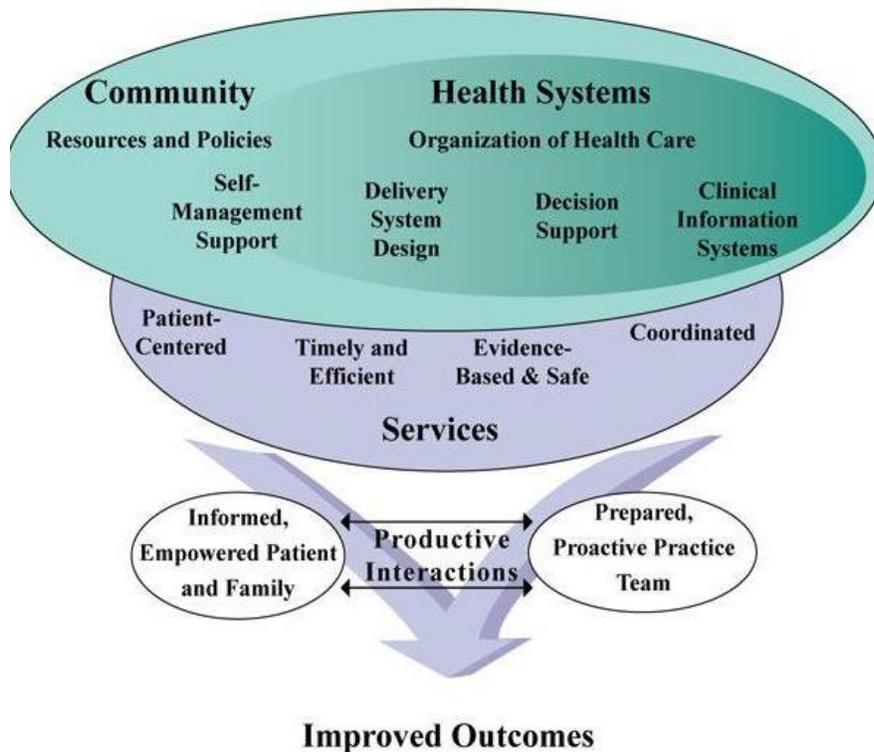
Source: 1996-2011 The MacColl Center for Health Care Innovation. The Improving Chronic Illness Care program is supported by The Robert Wood Johnson Foundation, with direction and technical assistance provided by Group Health's MacColl Center for Health Care Innovation. Used with permission.

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.

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Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness. JAMA2002 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 April 8, 2013.

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.

Module 17 Trainer's Guide: Electronic Health Records and Meaningful Use

Time

- Presession preparation for learners: 45 minutes
- Session: 50 minutes

Materials Checklist

- ❑ Computer, Internet access, and a projector or video display.
- ❑ Access to the following Web sites:

  - New York eHealth Collaborative: http://nyehealth.org/.
  - Massachusetts eHealth Institute: http://mehi.masstech.org/.
  - Health IT.gov, Meaningful Use: http://www.healthit.gov/policy-researchers-implementers/meaningful-use.
  - Official Web Site for the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/ehrincentiveprograms/.
  - Workflow Assessment for Health IT Toolkit: http://healthit.ahrq.gov/portal/server.pt/community/health_it_tools_and_resources/919/workflow_assessment_for_health_it_toolkit/27865.
- ❑ 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. See Appendix.

Objectives

Learners will be able to:

- Identify the origins of meaningful use.
- Describe the three stages of meaningful use and timeframes for implementation.
- Advise an organization on how to apply for incentive payments and reporting requirements.

Presession Preparation

Read (15 minutes)

1. Module 17.

Review (30 minutes)

Web sites with information on meaningful use.

During the Session

Present (30 minutes)

1. Module 17.
2. 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. See Appendix.

Discuss (20 minutes)

1. What are the three levels of meaningful use and why are they important?
2. What implications does meaningful use have for your work with practices?
3. What are some key workflows that you can help practices redesign to meet meaningful use requirements?
4. How do you think meaningful use might help or impede in quality improvement work at a practice?

Module 17. Electronic Health Records and Meaningful Use

The need for skills in health information technology (IT) 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 registries and how to use them most effectively.

It is important to understand that in an outpatient setting, as opposed to inpatient, a medical record covers the lifetime of a patient, not one episode of care (an inpatient stay). Thus, you need a longitudinal record from which you can generate reports over time.

If you work with a practice that is still paper based, the longitudinal record is an important concept for the practice to keep in mind when choosing an ambulatory care EHR. In addition, not all ambulatory practices are the same. Depending on specialties provided, (e.g., oncology, HIV services), there may be specific documentation or scheduling needs that a particular vendor has not considered before.

EHR Implementation

Regardless of which EHR a practice uses, the practice facilitator should immediately determine how hardware and software are supported and by whom. If all or a portion of the EHR is resident (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.

Module 2 in this handbook discusses some of the challenges that safety net practices face in implementing and optimizing health IT. For example, EHRs only help practices manage population health if they have the features and capabilities that let them analyze data across groups of patients. 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.

Fortunately, resources are available for both you and your practices. One is the Health Resources and Services Administration's Health IT Adoption Toolbox, available at http://www.hrsa.gov/healthit/toolbox/HealthITAdoptiontoolbox/index.html. It is 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 in their facilities.

Another set of resources is the 62 Regional Extension Centers (RECs) funded to help primary care providers adopt and use EHRs. RECs represent a range of organizations that serve local communities throughout the country. REC services include outreach and education, EHR support (such as working with vendors or helping providers choose a certified EHR system), and technical assistance in implementing health IT and using it in a meaningful way to improve care. You can locate an REC near your practices by going to http://www.healthit.gov/providers-professionals/regional-extension-centers-recs.

Impact of EHRs on Workflow

As a facilitator, you will need to help your practices integrate their EHRs into their workflows. Module 5 on mapping workflows will guide you in mapping the workflow regarding entry of documentation into the EHR and use of EHR data to identify patients whose conditions are not under control or who have not received appropriate preventive services.

EHRs can also improve care when, for example, standing orders are entered to authorize nurses and other staff to carry out medical orders per practice-approved protocol. For instance, one study showed that EHR reminder tools combined with standing orders for screening, immunizations, and diabetes measures helped staff adopt new roles (Nemeth, et al., 2012).

You can also help your practices use their EHRs to identify patient education materials suitable for each patient. For example, EHRs can be linked to libraries of easy-to-understand print and audiovisual materials. Data stored in the EHR, such as the patient's preferred language, can be used to select appropriate materials. You can also help your practices learn to use the EHR to produce visual displays (e.g., lab results over time) that can be used for patient education, shared decisionmaking, and action planning.

If your practices have selected EHRs that do not have the full functionality needed to support the Care Model or 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 at a health care center, a registry is a subset of the patients in the EHR. A registry is generally easier to use for tracking patient 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.

EHR Reports

The types of reports an EHR generates is key to helping a practice actively manage patients, track operational indicators, and meet meaningful use, regulatory, and accreditation requirements. Depending on the type of report, it can be at the practice or provider level, but starting with the practice level is a good way to identify red flags that require drilling down to the provider level. 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 center, the next step should be provider-specific compliance.

> *Conducting a comprehensive workflow analysis is a critical step to health IT implementation.*
>
> *—Health Resources and Services Administration*

These data can be powerful motivators for provider change, as providers see how they're performing against the practice as a whole and other providers, as well as positive reinforcement for those exceeding expectations. Other reports can be used the same way:

1. Number of open/closed encounters (day/week/month).
2. Productivity (number of patients seen per hour).

3. Referral patterns, both internal, for supportive services (e.g., social work, nutrition) and specialists, and external, for specialists and community-based organizations.
4. Patient flow, as measured through wait time and cycle time.
5. Health/functional status, by patient and population.
6. Educational materials provided.
7. Adherence to recommended treatment guidelines, decision support use, and literature searches.

When you review data, your first question should always be, "Does this pass the sniff test?" Often, you can spot data glitches by thinking logically about what you are looking at. For example, suppose a report shows that a lab value for a glomerular filtration rate, used for measuring kidney failure, is not being documented in the EHR, but the physicians are adamant that they are documenting the lab results. That's a red flag. So you ask a physician to show you where it is in the record, and you discover it is in a text field that the report is not searching.

For data to be useful, they must be accurate and therefore credible. The old adage garbage in = garbage out has never been more applicable than with an EHR, so instilling a sense of ownership of what is put into the EHR by documenters is very important. Practice facilitators must always stress the importance of timely and accurate documentation. They should share ways quality documentation can benefit providers (e.g., helping them meet meaningful use requirements, creating a solid legal defense [if it isn't documented, it didn't happen], communicating with the rest of the care team, and most importantly, giving the patient an up-to-date medical record). If the data are suspect and subject to second guessing, the important task of using data to measure and improve performance and health outcomes cannot happen.

Relationship of Meaningful Use to EHRs

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. Within ARRA, the Health Information Technology for Economic and Clinical Health (HITECH) Act specifically targeted health care by providing the means to structure a paperless national health information network. To do so, 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. For primary care providers, 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 this key driver of reimbursement for primary care at the local site level, since EHR funding is tied to meeting meaningful use criteria. Leveraging meaningful use is a powerful way to achieve quality documentation in the EHR (for specific improvement projects as well as better patient care) and is always something to keep in mind.

Stages of Meaningful Use

In primary care, meaningful use consists of three stages:

1. Stage 1: transferring data to EHRs and being able to share information.
2. Stage 2: includes new standards such as online access for patients to their health information and electronic health information exchange between providers.
3. Stage 3: implementation.

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 the visit summary for patients at the end of their visit. The focus is on data gathering and sharing. Stage 1 has the following 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 Clinical 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 17.1 shows examples of the minimum thresholds for meeting meaningful use established in stage 1.

Table 17.1. Examples of stage 1 measures

Meaningful Use Objective	Measure
Use CPOE for medication orders.	CPOE is used for at least 30% of all medication orders.
Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM* or SNOMED CT®**.	At least 80% of all unique patients seen by the EP have at least one entry or an indication of none recorded as structured data.
Generate and transmit permissible prescriptions electronically (eRX).	At least 75% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.
Maintain active medication list.	At least 80% of all patients seen by the EP have at least one entry (or an indication of none if the patient is not currently prescribed any medication) recorded as structured data.
Record smoking status for patients age 15 years or older.	More than 50% of all unique patients age 15 years or older have smoking status recorded as structured data.

* ICD-9-CM = International Classification of Diseases, 9th Revision, Clinical Modification
** SNOMED CT = Systematized Nomenclature of Medicine—Clinical Terms.

Stage 2

Stage 2 (to be 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. Table 16.2 includes examples of stage 2 measures.

Table 17.2. Examples of stage 2 measures

Meaningful Use Objective	Measure
Use CPOE for medication, radiology, and laboratory orders.	More than 60% of medication, 30% of laboratory, and 30% of radiology orders during the EHR reporting period are recorded using CPOE.
Use clinically relevant information to identify patients who should receive reminders for preventive/followup care and send these patients the reminder, per patient preference.	More than 10% of all unique patients who have had two or more office visits within the 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference when available.
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.	Generate at least one report listing patients with a specific condition.
Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR).	More than 10% of medication orders during the EHR reporting period are tracked using eMAR.
Record smoking status for patients age 13 years or older.	More than 80% of all unique patients age 13 years or older have smoking status recorded as structured data.

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.

The HITECH Act has also funded States and communities to support and accelerate meaningful use through health IT infrastructure and exchange capabilities such as HIEs and RECs. As a practice facilitator, you are in the unique role of being able to help primary care practices optimize health IT. Enhancing EHR capabilities at the local level and exploring linkages between a local EHR and its larger community through an HIE, a mandate that States must comply with starting in 2014, helps foster population-focused improvement efforts and furthers the core mission of the community health center.

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 (eHealth) Collaborative 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. Consider a pregnant patient who receives her primary care in her hometown of Buffalo and travels to the Bronx to visit relatives. While there she goes into labor prematurely. Thanks to the eHealth network, her prenatal records from her patient care team at the community health center she visits in Buffalo are available online to the Bronx hospital where she is being treated.

2. The Massachusetts eHealth Institute (MeHI) 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 doctors' 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 by 2015.

Meaningful Use Funding

Funding for meaningful use is the key to succeeding. EHR incentive programs are available for Medicare and Medicaid providers. Facilitators can help their practices qualify for and draw down incentive payments by being knowledgeable about how to apply for funding and the processes needed for accountability.

CMS has defined the minimum requirements that providers must meet to qualify for payments for stages 1 and 2 of meaningful use. Providers apply online by going to the CMS Registration Guide for Eligible Providers, which walks the provider through all the steps to enroll. Providers must have a National Provider Identifier and a National Plan and Provider Enumeration System (NPPES) number and be enrolled in the Provider Enrollment, Chain, and Ownership System (PECOS). There are instructions on how to enroll for providers who do not have accounts. The registration process outlines how the incentive payments will be made and to whom, based on the provider's NPPES/PECOS accounts.

Eligible providers who demonstrate meaningful use of certified EHR technology can receive up to $44,000 from Medicare over 5 consecutive years. Medicare incentive payments are made approximately 4 to 8 weeks after the provider attests that they have successfully demonstrated meaningful use of certified EHR technology for the stage that they have applied for. Medicaid incentives, which are greater, are paid by the States, and timeframes vary by State. The steps for applying and reporting through the three stages are clearly outlined at http://www.echoman.com/meaningful-use-step-by-step.

Deciding whether to apply for Medicare or Medicaid funding is the first step (see Table 17.3). Once a provider is enrolled in stage 1, the timeline is set for proceeding through stage 2 and stage 3 reporting. As of 2013, all providers are reporting on stage 1 measures, as stage 2 does not become effective until 2014. However, providers in stage 1 are already planning for stage 2 and looking ahead to stage 3 in 2016.

Table 17.3. 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.
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.

Demonstrating meaningful use every year happens through an attestation process. Attestation is a legal statement that the EP has met the thresholds and all requirements of the EHR Incentive Program and is done electronically through the CMS link: https://ehrincentives.cms.gov. For stage 1, attestation pertains to:

- 15 core objectives.
- 5 out of 10 menu objectives.
- 3 core (or 3 alternate core) clinical quality measures.
- 3 out of 38 additional clinical quality measures.

More information on EHR incentives and certification and how to attain meaningful use is available at http://www.healthit.gov/providers-professionals/how-attain-meaningful-use.

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* (IOM, 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 17.4 displays how various meaningful use criteria and health IT capabilities relate to Care Model and PCMH features.

Table 17.4. 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

Meaningful Use and Health IT Capability*	Care Model Domains	PCMH Standards
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.

As a facilitator, you can help your practices attain meaningful use. One way you can assist them is in helping them to map and then redesign key workflows. Some of the workflows that may need to be redesigned are shown in the box below.

Workflows That May Require Redesign

- 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.
- 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.

- 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.

Adapted from Bodenheimer T. Personal communication, January 2011.

References

Institute of Medicine. Crossing the quality chasm: a new system for the 21st century. Washington, DC: National Academy Press; 2001:
Nemeth LS, Ornstein SM, Jenkins RG, et al. Implementing and evaluating electronic standing orders in primary care practice: a PPRNet study. J Am Board Fam Med 2012 Sept-Oct; 25(5):594-604.

Module 18 Trainer's Guide: Using the AHRQ Care Model Toolkit With Practices

Time

- Presession preparation for learners: 75 minutes
- Session: 60 minutes

Materials Checklist

- ❑ Computer, Internet access, projector, and link to *Integrating Chronic Care and Business Strategies in the Safety Net* toolkit. Available at: http://www.ahrq.gov/populations/businessstrategies/. (Note: This document is best used online as it relies heavily on Web links for its content.)
- ❑ Copies of Table of Contents of the toolkit (one per learner).

- ❑ Individual computer stations with access to the Internet.

Objectives

Learners will be able to:

- Provide a summary of the content and chapters in *Integrating Chronic Care and Business Strategies in the Safety Net* toolkit.
- Identify where the toolkit supports key drivers of improvement contained in the Improving Performance in Practice Initiative (IPIP).
- Use the toolkit to support improvement work with practices.

Exercises and Activities To Complete Before and During the Session

Presession Preparation

Read (15 minutes)

1. Module 18.

Review (60 minutes)

1. Access and review *Integrating Chronic Care and Business Strategies in the Safety Net* toolkit. Available at: http://www.ahrq.gov/populations/businessstrategies/.
2. Document the elements in the toolkit you have had experience using in the past and what you learned using them.

Present (20 minutes)

1. Module 18.

Act (20 minutes)

1. Have learners map contents of toolkit to the Assessing Chronic Illness Care assessment tool (available at: http://improvingchroniccare.org/index.php?p=Survey_Instruments&s=165) and to the IPIP key driver model contained in Module 14 on quality improvement approaches.

Discuss (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 18. Using the AHRQ Care Model Toolkit With Practices

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

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 each of four phases of Care Model implementation. Within each phase the 12 key changes do not need to be implemented in any particular order but should be pursued based on the needs of each practice. Table 18.1 lists the phases and key changes recommended in the toolkit.

Table 18.1. Toolkit phases and key changes contained in the Care Model toolkit

Phase 1: Getting Started
1.1   Organize your quality improvement team
1.2   Familiarize your entire team with key improvement strategies
Phase 2: Assess Data and Set Priorities for Improvement
2.1   Use data to set priorities
2.2   Select performance measures based on your needs assessment
2.3   Build performance measurement capacity
Phase 3: Redesign Care and Business Systems
3.1   Organize your care team
3.2   Clearly define patient panels
3.3   Create infrastructure to support patients at every visit
3.4   Plan care
3.5   Ensure support for self-management
Phase 4: Continuously Improve Performance and Sustain Changes
4.1   Reexamine your outcomes and make adjustments for continued improvement
4.2   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:

- Give you 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 substeps outlined by the toolkit.

References

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 April 10, 2013.

Module 19 Trainer's Guide: Implementing Care Teams

Time

- Presession preparation for learners: 90 minutes
- Session: 50 minutes

Materials Checklist

- ❑ Computer, Internet access, projector or video display, speakers.
- ❑ Copies (one per learner) of:

  - 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.
  - 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.
  - Access to video: Active Care Teams (ACT): Embracing Daily Team Huddles. Oakland: California Health Care Safety Net Institute; 2012. Available at: http://safetynetinstitute.org/content/team_huddles.htm.

- ❑ Copies (one) of:
  - Team Visualization Exercise.
  - In A Perfect World: Task Reassignment Exercise.

Objectives

Learners will be:

- Able to describe characteristics of care teams in small and medium practices and their advantages and challenges.
- Able to describe "exemplar" care team models.
- Familiar with two "care team" building exercises—jelly bean exercise and role visualization and definition exercise—with practice quality improvement teams.

Exercises and Activities To Complete Before and During the Session

Presession Preparation

Read (90 minutes)

1. Module 19.
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.

During the Session

Present (30 minutes)

1. Module 19.
2. View: Active Care Teams (ACT): Embracing Daily Team Huddles by the California Safety Net Institute. Available at: http://safetynetinstitute.org/content/team_huddles.htm.

Discuss (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 19. Implementing Care Teams

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).

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.

> *"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

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).
- Providers 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 19.1 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 (those with Level A or Level B evidence) (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 doesn't count time for phone calls, charting, and other administrative tasks.

Figure 19.1. Time demands in primary care

2500 Patients

Chronic Care Management (6.7 hrs/day)

Level A & B Recommended Preventive Care Services (7.4 hrs/day)

Acute Care (4.6 hrs/day)

And that doesn't count phone call, charting, and other paperwork or other administrative tasks.

18.7 hours per day

Cutting panel size to 1250 = 9.35 hours per day
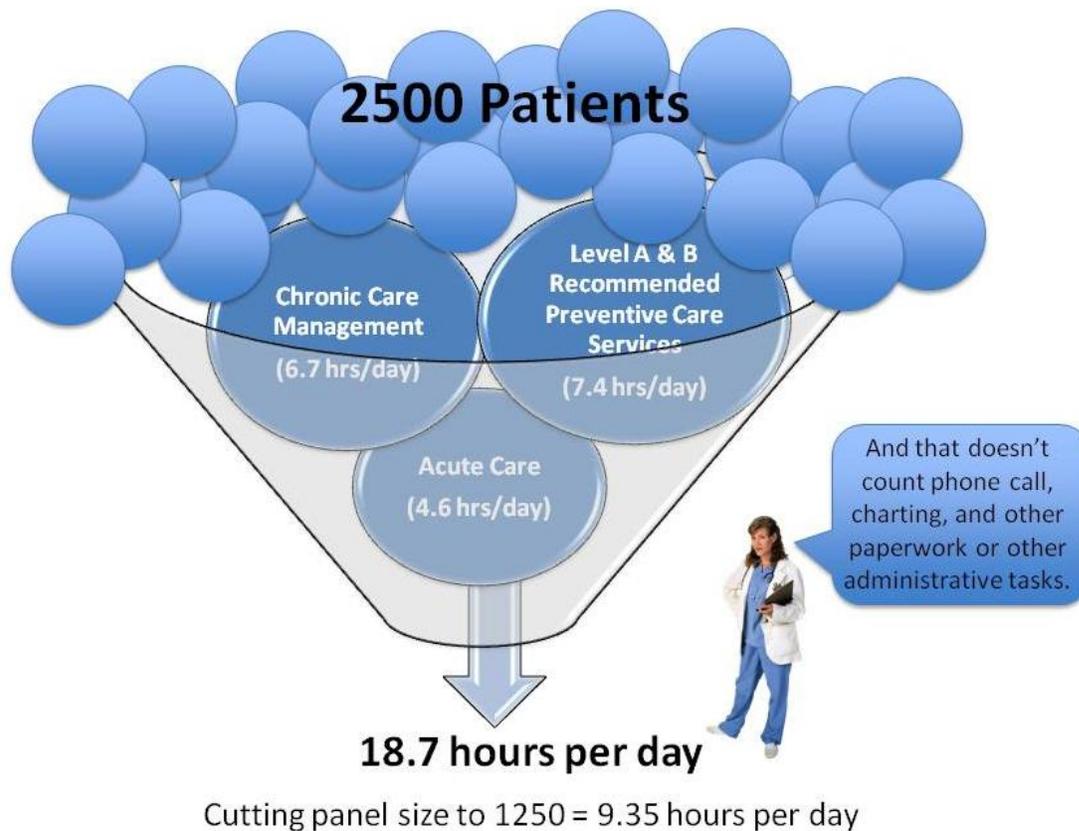
Based on data from: Yarnall KSH, Pollak KI, Østbye T, et al. Primary care: is there enough time for prevention? Am J Public Health. 2003 Apr;93:635-64; and Østbye T, Yarnall KSH, Krause KM, et al. Is there time for management of patients with chronic diseases in primary care? Ann Fam Med 2005 May;3:209-14.

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, and
- Pharmacists can conduct medication reconciliation and management.

Team-based care decreases costs and increases revenue (Coleman & Reid, 2010).

Team-based care requires all team members to make adjustments. Primary care providers 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 providers

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 providers 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 their 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:

        - Previsit planning.
        - While patient is in the office.
        - Postvisit.
        - 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 7 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.

Activity 1: 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 (QI) plan based on this exercise?

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[i] Provided by Carolyn Shepherd, M.D.

Activity 2: In a Perfect World - Task Reassignment Exercise

This is a good followup 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 19.1). 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, followup). (See the example in Table 19.2.) 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 them 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 19.1. Task reassignment table

Task	Who does it now?	In a perfect world, who would do it?

Adapted from IHI.

Table 19.2. 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		

References

Agency for Healthcare Research and Quality. Patient Centered Medical Home Resource Center. Defining the PCMH. Available at: http://pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/PCMH_Defining%20the%20PCMH_v2. Accessed April 10, 2013.

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.

Module 20 Trainer's Guide: Facilitating Panel Management

Trainer's Guide

Time

- Presession preparation for learners: 75 minutes
- Session: 90 minutes

Materials Checklist

- ❑ Access to computer, speakers, and Internet.
- ❑ Copy (one per learner) or online access to:

  - Empanelment Part 1: Establishing patient-provider relationships. Implementation guide. Seattle, WA: Safety Net Medical Home Initiative; March 2010. Available at: http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Empanelment-1.pdf.
  - Empanelment Part 2: Assigning and managing panels in a patient-centered medical home. Implementation guide. Seattle, WA: Safety Net Medical Home Initiative; June 2011. Available at: http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Empanelment-2.pdf.
  - Empanelment Exercise. See Appendix.
  - Bodenheimer T, Gohreb A. Panel management training. See Appendix.
  - Sample Policies and Procedures. See Appendix.

Objectives

Learners will be able to:

- Identify steps involved in training a practice on key concepts of panel management.
- Use panel management training by Bodenheimer and Gohreb to train key practice staff on panel management.

Exercises and Activities To Complete Before and During the Session

Presession Preparation

Read (15 minutes)

1. Module 20.

Watch (30 minutes)

1. Video on outcomes of panel management: http://www.youtube.com/watch?v=qKiD-4deFPQ.

   Note to trainer: 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.

2. Video on registry product as a tool to enable panel management. Available at: http://www.i2isys.com/i2i_video.htm?_kk=UDS%20reports&_kt=64254862-76fd-4c95-ae6e-7a721a0a5736&gclid=CM_vzYiR7a0CFQ5_hwodHlyZ6w.

Read (30 minutes)

1. Empanelment Part 1: Establishing patient-provider relationships. Implementation guide. Seattle, WA: Safety Net Medical Home Initiative; March 2010. Available at: http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Team-Based-Care.pdf.
2. Empanelment Part 2: Assigning and managing panels in a patient-centered medical home. Seattle, WA: Safety Net Medical Home Initiative; June 2011. Available at: http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Empanelment-2.pdf.

During the Session

Present (15 minutes)

1. Module 20.

Conduct (50 minutes)

1. Present Bodenheimer T, Ghoreb A. Panel management. University of California San Francisco, Department of Family and Community Medicine; 2012. See Appendix.

Act (10 minutes)

1. Conduct Empanelment Exercise.

Discuss (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 20. Facilitating Panel Management

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 as population management, is a proactive approach to health care. "Population" means the panel of patients associated with a provider 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). In most community health care centers, patients are scheduled with whichever physician is available as opposed to an assigned provider. This is the old reactive model of care and one that does not help build relationships with patients.

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 provider.

> *Empanelment must be an early change on the journey to becoming a PCMH, because other key changes such as continuous, team-based health relationships, enhanced access, population-based care, and care coordination depend on the presence of such linkages.*
>
> *—Katie Coleman and Kathryn Philips*

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 19, 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 Family Practice Management Toolbox: Patient Panel Size Worksheet, available at: http://www.aafp.org/online/en/home/publications/journals/fpm/fpmtoolbox.html#Parsys6841.

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?

Here are some steps for assigning patients to clinicians' panels:

1. Begin by reviewing patient visit records to determine if there are patients who have seen only one provider. 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 providers, assigning new patients to providers, and staffing models to support providers based on the number of patients assigned to the panel. A sample of Policies and Procedures is contained in the Appendix.

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—a more sensitive measure of true appointment availability).
- Patient satisfaction survey with specific questions on access and satisfaction.
- Staff satisfaction with the empanelment process, including clinicians, other clinical staff, and office staff.

Module 21 Trainer's Guide: Improving Self-Management Support

Time

- Presession preparation for learners: 110 minutes
- Session: 90 minutes

Materials Checklist

- ❑ Access to computer, Internet, projector, or video display.
- ❑ Copies (one per learner) or online access to:

    - Bodenheimer T, Abramowitz S. Helping patients help themselves: how to implement self-management support. Oakland: California HealthCare Foundation; 2010. Available at:
      http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/H/PDF%20Helping PtsHelpThemselvesImplementSelfMgtSupport.pdf.
    - Partnering in Self-Management Support: A Toolkit for Clinicians. Institute for Healthcare Improvement. Available at:
      http://www.ihi.org/knowledge/Pages/Tools/SelfManagementToolkitforClinicians.aspx.
    - 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 (EHR) and case examples of health coach implementation. Available at:
      http://www.safetynetmedicalhome.org/sites/default/files/Webinar-Patient-Centered-Interactions-2.pdf.

- ❑ Copy of the Self-Management Support Tasks and Assignments. See Appendix.
- ❑ Access to What, Why, and How of Self-Management 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.

Objectives

Learners will be able to:

- 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.
- List the actions facilitators can take to assist practices to improve self-management support for their patients.
- Identify online resources that facilitators can use to increase practice member knowledge of self-management support.

Exercises and Activities To Complete Before and During the Session

Presession Preparation

Read (15 minutes)

1. Module 21.

View (20 minutes)

1. What, Why and How of Self Management 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

Explore (15 minutes)

1. AHRQ Resource Site on Self-Management Support available at:
    http://www.orau.gov/ahrq/sms_home.html.

Read and Review (60 minutes)

1. Helping patients help themselves: how to implement self-management support. Oakland:
    California HealthCare Foundation; 2010. Available at:
    http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/H/PDF%20HelpingPtsH
    elpThemselvesImplementSelfMgtSupport.pdf.
2. Partnering in Self-Management Support: A Toolkit for Clinicians. Institute for Healthcare
    Improvement. Available at:
    http://www.ihi.org/knowledge/Pages/Tools/SelfManagementToolkitforClinicians.aspx.

During the Session

Present (30 minutes)

1. Module 21.
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 EHR and case examples of health coach implementation. Available
    at: http://www.safetynetmedicalhome.org/sites/default/files/Webinar-Patient-Centered-
    Interactions-2.pdf.

Act (30 minutes)

1. Have learners divide into pairs or small groups. Designate Practice Facilitator and participant(s).
2. Review ACIC section on Self-Management Support. Complete section on PracticeOnlyOneforMiles or practice with which learner is already working. Have practice facilitator "facilitate."
3. Use Self-Management Support Roles and Assignments to model an enhanced self-management support program for the practice.

Discuss (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 PCMH?
4. What were the results of your ACIC assessment? What did you learn from using the tool?

Module 21. Improving Self-Management Support

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.

Self-management is the patient's ability to deal with everything that having a chronic condition entails, including symptoms, treatment, emotional impact, physical and social consequences, and lifestyle changes. It also includes patients' beliefs in their ability to overcome or 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.

> *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*

What Self-Management Challenges Do Safety Net Patients Face?

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 stories and myths in the patient community about treatments such as insulin, resulting 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 e-mail, phone, text messages, and mailings to support their efforts to maintain healthy behaviors.

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. At a minimum, a self-management program should be evidence based, linguistically competent (meaning they are 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 4, 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 (see, DeWalt, et al., 2010, Health Literacy Universal Precautions Toolkit, Tool 20, Use Health and Literacy Resources in the Community).
- 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 19, you can help your practice think through the various tasks involved in self-management support (SMS) and which staff members could perform those tasks. Table 21.1, adapted from the Institute for Healthcare Improvement, gives you a template to work from. You and your practices will need to customize the list of tasks and staff.

Table 21.1. Self-management support tasks and assignments

Task	Primary Care Clinician	Nurse/Pharm acist	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 IHI.

The Practice Facilitation Handbook

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