EDUCATIONAL DETAILING MODULE

Metric: BMI + Follow-up

For: (AGENCY NAME)

January 2020
LA Net

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Background on Enhancement Initiative

Agency-wide QI Interventions to Improve Performance on BMI

There are three primary interventions that are being used to improve performance on BMI at AGENCY. These are:

1) Training on enhanced clinical and documentation workflows based on the BMI Hotsheet
2) Centralized CHW calling to patients with service gaps (pts with high BMI without Intervention led by MEDICAL DIRECTOR)
3) Practice-level review of encounter notes for evidence of BMI counseling, and entry

Selecting an intervention level for your clinics or care teams

Levels of intervention and assignment criteria. There are 3 levels of coaching intervention for the BMI Improvement Intervention:

1. BMI Hotsheet + sample workflows only
2. Large group training on BMI Hotsheet + sample workflows, and
3. Educational detailing on BMI Hotsheet + sample workflows

Coaches will work with their primary care directors to determine the optimal mix of support, and criteria used to determine which providers receive which level of support. Additionally, care teams that fail to respond to level 1 survey, participate in level 2 training, or that demonstrated >20% missed-opportunity rate after 2 week run-in period automatically receive level level 3 educational detailing intervention.

Hotsheet handout alone (level 1)

is the least intense intervention, and can be used with all providers. It may produce improvement in well-organized, highly motivated providers but more will likely be required to produce sustained change for many other providers.

Large group training (level 2)

the second level of intervention, can be delivered in collaboration with the primary care director, or an opinion leader at the clinic. It is appropriate for all providers. Content for the session can be based on the same content delivered in an Academic Detailing session.

Educational detailing (level 3)

the most time intensive intervention approach, is the intervention of choice for high-volume providers who are receptive to coaching, and who have not yet attained the desired benchmark

for BMI performance. Improvement with these providers are likely to produce the greatest impact on the largest number of patients who make up the denominator of the BMI metric.

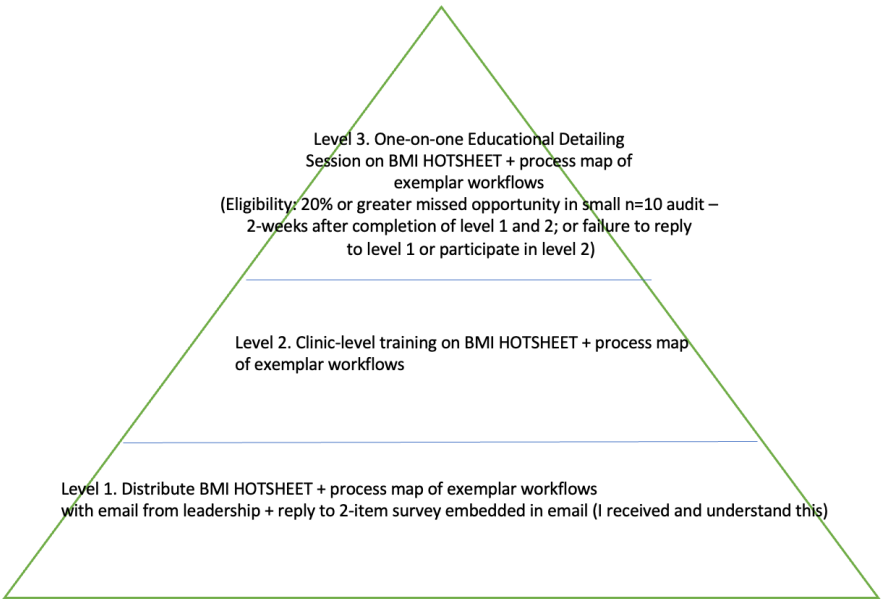


Figure 1. Levels of intervention: Level based on % of "missed opportunities" by care team & participation

Practice Facilitator Job Aid

Educational Detailing Process for BMI for (NAME OF INSTITUTION)

Step 1. Introduce

a) Introduction to Coach, Coaching & BMI AD process

Step 2. Review performance report

a) Review performance report (cluster, practice, provider relative to other providers)

Step 3. Share "Key Messages"

a) All care teams need to increase to **x%** by (date) for incentive dollars

b) Here is the "3 steps to BMI success" Hotsheet prepared by PC Directors, and high-level workflow map)

c) CMAs **CAN DO ALL** 3 steps, RNs can do **ALL** 3 steps (PROVIDE: Workflow map for CMA, Workflow map for RN)

Step 4. Engage & Act

a) What goals for improvement would you like to set after seeing this?

b) Audit & feedback previous 5-10 patients seen

c) Train individual on worksheet – review sheet, watch do one and coach (elbow support), reflect & repeat if needed

d) Set next visit date (next day or two) – conduct audit and feedback at each following session and do RCA with individual

e) Leave behind job aid

Objection Handling

1) I/my team doesn't have time.

   RESPONSE: ***It can take less than 30 seconds to close loop and provide handout-just print from Health Maintenance section (HM – show button) (weight/nutri)***

2) Data are inaccurate so I'm not going to engage till it is.

   RESPONSE: That's why we look at trends which are accurate -the error stays stable – your team trend is xxx

3) I/my team are already doing fine, so no need to change.

   RESPONSE: You/we all need to push to get improvement overall

4) CMAs are not allowed to do all the steps.

   RESPONSE: Actually, they are according to CMS and downtown. SHOW AGENCY JOB AID.

5) Doing this doesn't help the patient, so it doesn't matter.

   RESPONSE: Some patients really do appreciate it and it can create readiness in a way that is discrete and comfortable and not too in your face for the patient. One AGENCY patient shared this with her MA: "It was really helpful for me to know my BMI and know what that means. I thought I could coast but now realize I need to do some work. Thanks.

6) We will have to schedule another visit for the patient for follow-up.

   RESPONSE: "Follow-up" term is a misnomer in "BMI + Follow-up". It really means "follow-up the same day/e.g. do a same day **intervention"** – This can be a handout from ORCHID w/ title weight management (SHOW location on job aid), a notation in ORCHID of education/counseling delivered or referral made.

7) *We missed it this time around. We'll have to remember to do it next time.*

   RESPONSE: YOU CAN CLOSE MISSED OPPORTUNITIES for BMI FOLLOW-UP (Aka referral and education) with an outreach call where the CMA provides "information" on weight loss/management. Add when appropriate: This can be built into your practice workflow. Would you like to incorporate this? (+ assist)

Educational Detailing Scripts

Introduction

My name is _____. I am working with MEDICAL DIRECTOR and _____ to help meet the AGENCY's PRIME Metric goals for this June.

Today I'm working with care teams on BMI + Follow-up.

I'd like to share data with you on your clinic's performance on this metric, and then walk through some ideas about how your care team can improve its performance on this metric.

Do you have a few minutes to go over this with me? It will take about 10 minutes.

First, though, have you done any recent work on this metric, BMI? (if yes, ask them to describe)

Key Messages

Key message 1. Obesity is a very common problem at AGENCY. 70% or more of AGENCY adult patients have BMIs of 25 and over. From these data, x % of your patients have BMIs 25 or higher.

Key message 2. (Agency) must improve performance on the BMI + Follow-up PRIME metric by XXX% by June to XXXX% in order to receive millions in performance incentives

Key message 3. Your care team can improve your performance score on BMI by doing 3 things:

1) making sure that every adult patient 18-74 has a BMI in the chart in the last 6 months;

2) making sure every one of your patients with a BMI equal to or over 25 (or below 18.5) receives one of three types of interventions during the visit:

a) either an educational handout from ORCHID
b) verbal counseling or a referral to a weight or
c) nutrition program during their visit

3) your care team documents this in the right place!

Key message 4. Most providers scores are low because they are not doing the intervention/follow-up and documenting it. You can improve your performance dramatically by doing this.

Key message 5. Follow-up does not mean another visit. The term is confusing. It is actually an "intervention" that ideally happens during the same visit. It can be giving the patient a hand out from ORCHID, giving a verbal instruction or counseling and documenting it, or making referral to an internal or external resource for weight or nutrition and documenting it in the right place.

Key message 6. There is a new optional also for referrals –this is referrals 1) to free Weight Watchers for HEALTH PLAN members; 2) referrals to L.A. Care Family Resource Centers for ANY patient for nutrition, exercise, weight loss (video: https://www.youtube.com/watch?v=Woa7bG2IU7w&feature=youtu.be)

Key message 7. CMAs and RNS can do all 3 steps -obtain BMI, provide the 3 types of intervention, and document it in the record. It does not have to be done by the MD
At Olive View, the nurse does all steps
At Rancho, the CMA does all steps

Key message 8. MEDICAL DIRECTOR's office is using CHWs to make calls to patients with high BMIs who do not have an intervention documented during their visit. They are only calling English speaking patients. They are doing this for all patients across AGENCY as a last minute push.

Performance Data Review

I'd like to review your performance data with you for the month of April. Your team is at ____.

This is based on a denominator of ____.

The numerator is _____.

The denominator is based on all patients with an MRN ever in ORCHID (so both active and inactive patients). The numerator is from ORCHID and comes from the vital signs section (BMI), and for ONL from the various methods of intervention: the health maintenance recommendation section, from the health education materials, from eConsult, from the General Medicine Tab for referral orders.

To dig a bit deeper

___% of your patients are outside normal limits/have BMI equal or over 25

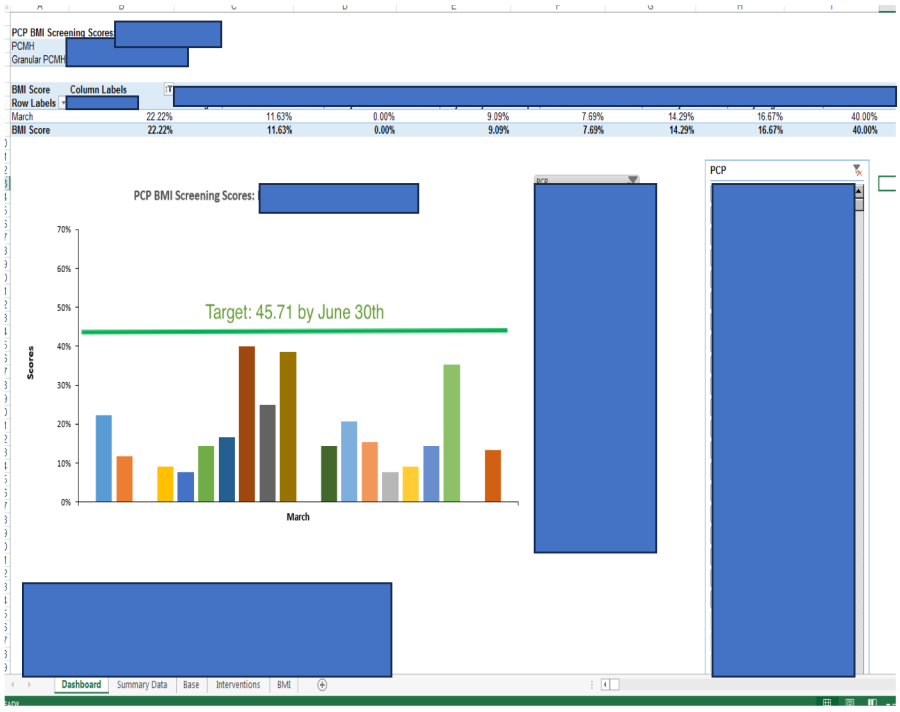
___% of your normal weight patients have a BMI within 6 months and meet the metric for a score of ___%

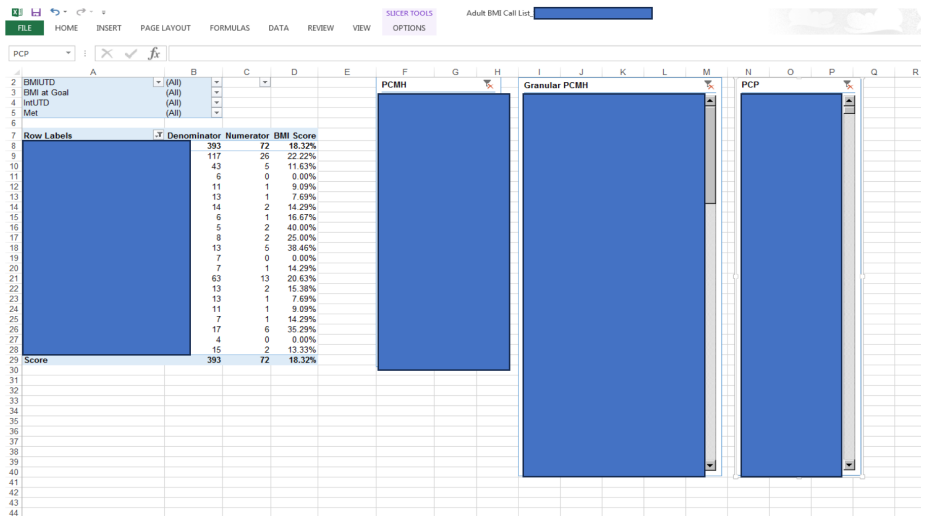
___% of your patients with ONL BMI have a BMI within 6 months and ___ % also have intervention within 6 months.

___% of your patients that should have a BMI don't have one at all

Is any of this a surprise? Any of it expected?

To reach the target of 45.71% your team will need to get ____ patients in the numerator





BMI + Follow-up Job Aid/Hotsheet

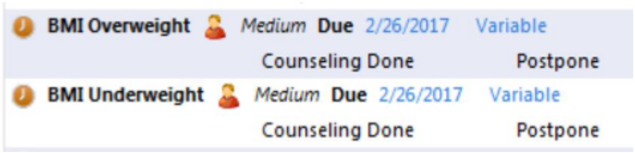
Target measure	BMI Screening and Follow-up (1.7.1)
Expectation	All patients 18 years of age or older with an outpatient encounter in the last year must have a BMI measured in the previous 6 months. A follow-up plan must be documented if the BMI is abnormal (<18.5 or >=25).

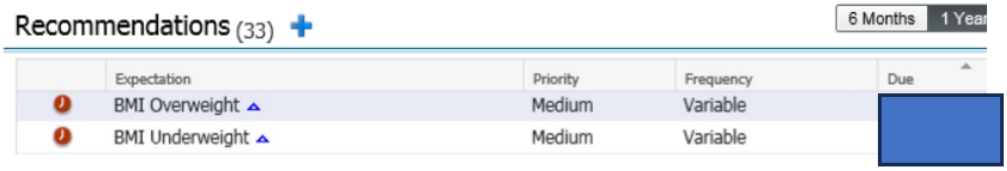
Hot Sheet Initiation Date:
Last Revision Date:
Implementation Date:

Participating Areas:

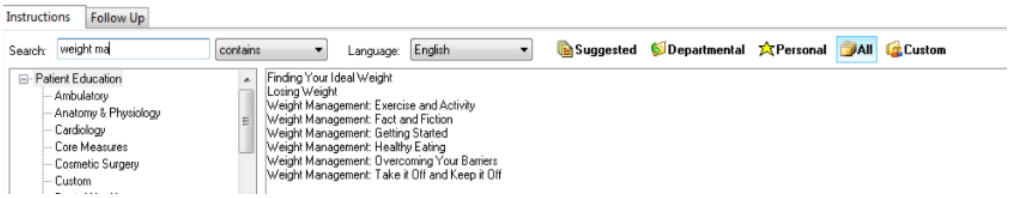
Suggested Improvement Plan:

- Ensure that adult patients are screened for height and weight at every outpatient primary care visit on intake
- Document follow-up plan whenever BMI is <18.5 or >=25. Providers have three ways to do this:
  1) Use the rules in the Health Maintenance or Recommendations section to document counseling was done:

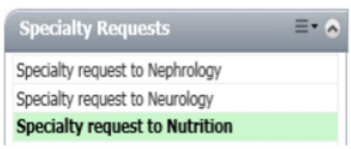


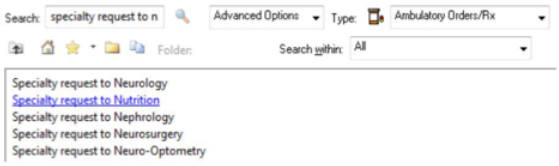


  2) Use Patient Education to give patient handouts (this will satisfy the HM/Recs rule):
     a. Make sure you click the "All" button, as shown below (custom-created documents don't count)
     b. Search for either "Losing Weight" or "Weight Management" and select a document
     c. Make sure to sign the document once selected (you might also print it, depending on local workflows)
     d. Remember nurses can also insert patient education when generating the discharge paperwork



  3) Where locally used, refer the patient to nutrition from the General Medicine tab or with an order:
     a. Some locations require the provider also place an in addition to placing the ORCHID order



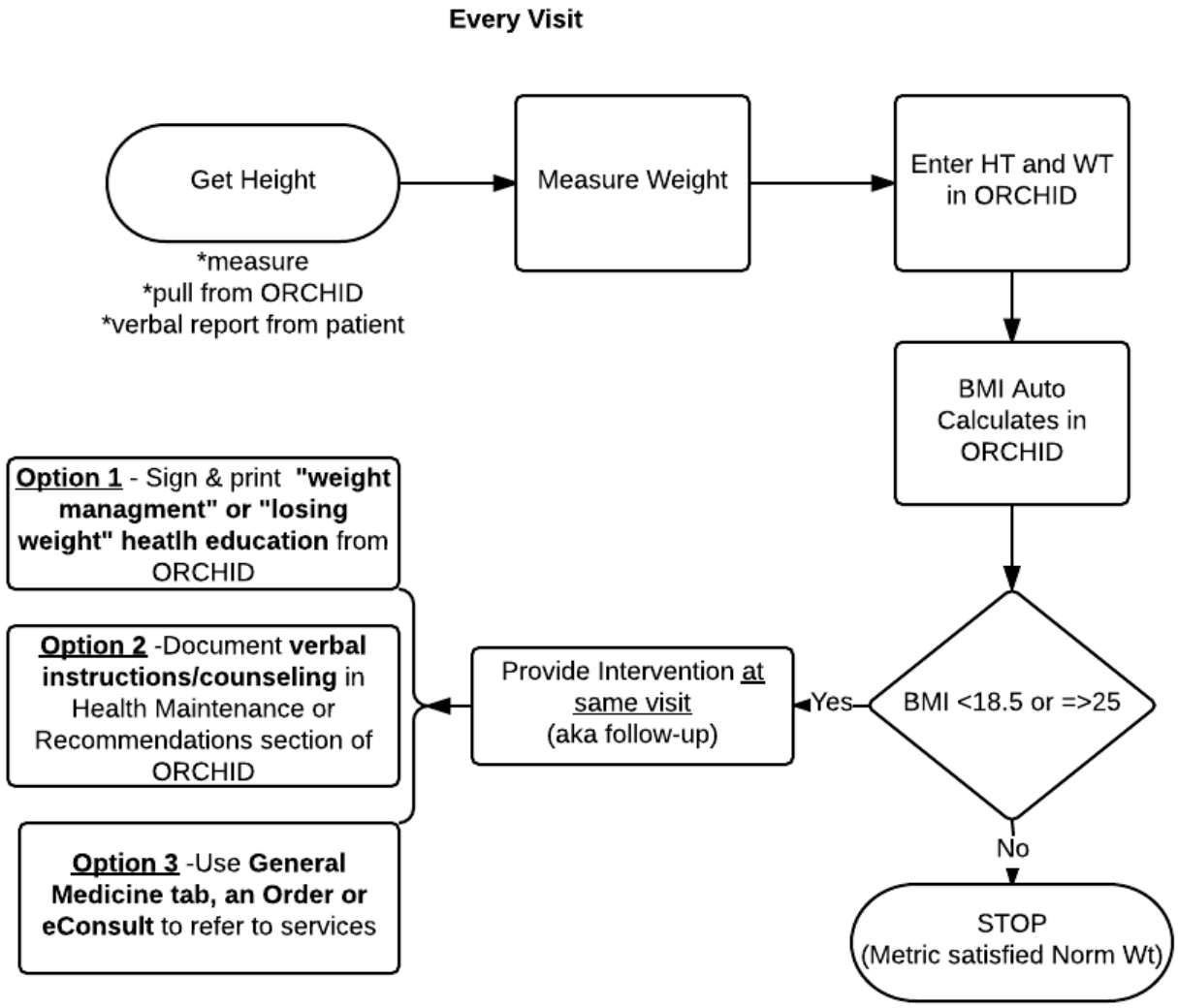


Approved: (Date)

High-level Workflow Map for Meeting BMI Metric

Here is a high-level workflow for meeting the BMI metric. It is based on the Hot Sheet. How do you currently do this on your team? CMA all, RN all, Combo MD and other?

High-Level Workflow to Accompany BMI Hot Sheet
Two Steps to BMI Success: BMI every Visit & Intervention w/ ONL



Detailed Workflows for Improving BMI + Follow-up Performance

Key message: There are 3 parts to the BMI workflow:
1) measuring BMI every 6 months (this could be done routinely at every visit if it is easier);
2) providing an intervention to patients who fall outside normal limits (<18.5 or =>25 BMI);
3) documenting #1 and #2 in the right place and the right time.

Key message: Being specific about workflows and "who does what" will improve performance

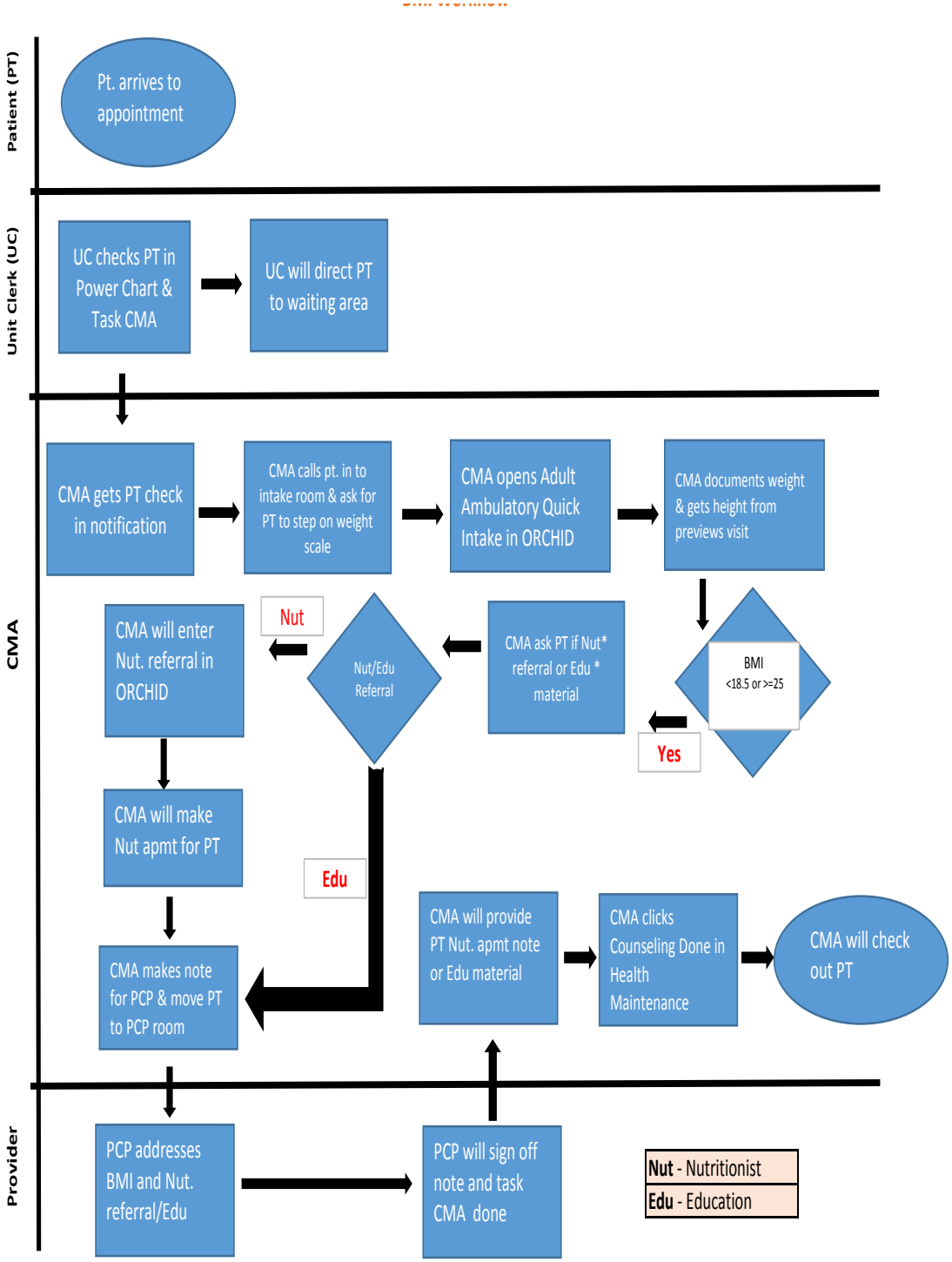
Key message: There are 3 workflows that a care team can use to accomplish these tasks and improve performance – e.g. reduce errors or "missed opportunities" and improve their performance on the BMI metric:

1) CMA completes all 3 steps (Sites using this approach: Name)
2) RN completes all 3 steps (Sites using this approach: Name)
3) Share the Care – Team work between the physician and the CMA/RN (Sites using this approach: Name)

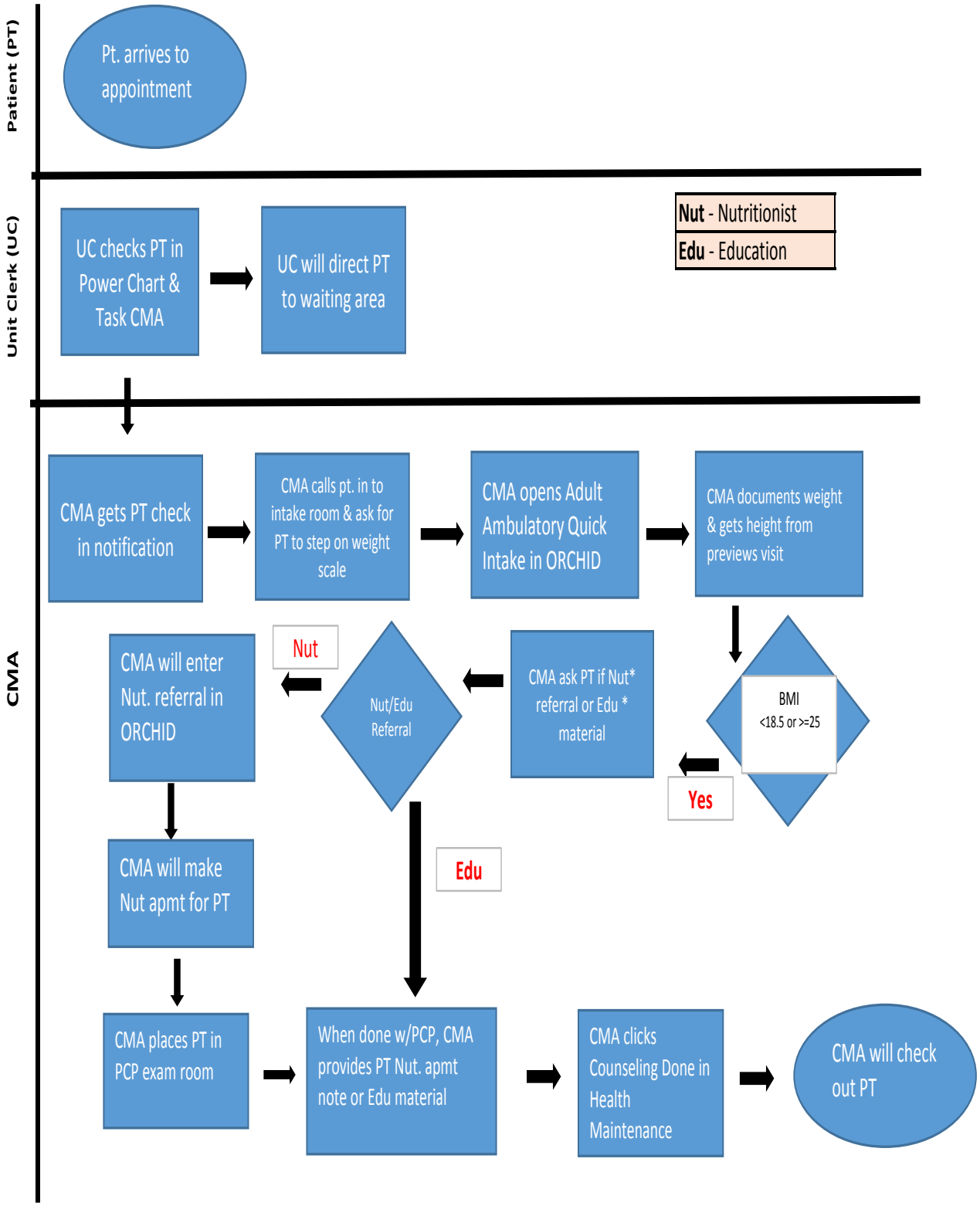
Key message: Three principles to remember when developing or refining your workflow/s:
1) simple is better;
2) any system that requires you to remember to do the right thing is a bad system;
3) reducing variation in process improves performance and reduces errors (missed opportunities)

Three sample workflow maps:

Shared Care/Teamwork BMI Workflow

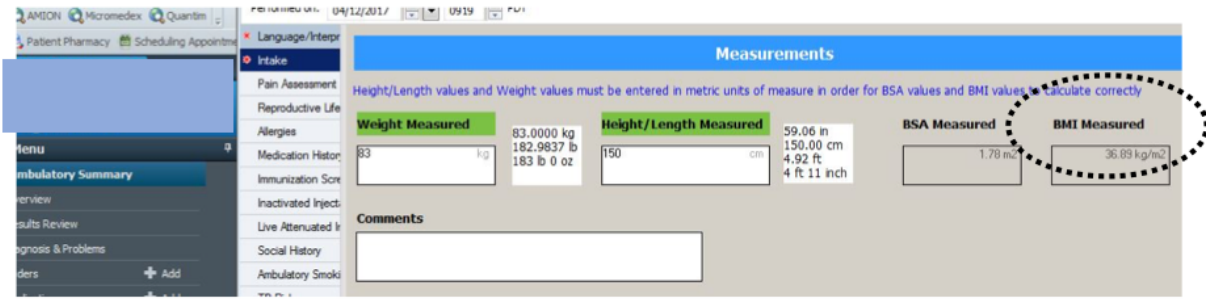


CMA Only


Patient (PT)
Pt. arrives to appointment
Unit Clerk (UC)
UC checks PT in Power Chart & Task CMA
UC will direct PT to waiting area
Nut - Nutritionist
Edu - Education
CMA
CMA gets PT check in notification
CMA calls pt. in to intake room & ask for PT to step on weight scale
CMA opens Adult Ambulatory Quick Intake in ORCHID
CMA documents weight & gets height from previews visit
BMI <18.5 or >=25
Yes
CMA ask PT if Nut* referral or Edu * material
Nut/Edu Referral
Nut
Edu
CMA will enter Nut. referral in ORCHID
CMA will make Nut apmt for PT
CMA places PT in PCP exam room
When done w/PCP, CMA provides PT Nut. apmt note or Edu material
CMA clicks Counseling Done in Health Maintenance
CMA will check out PT

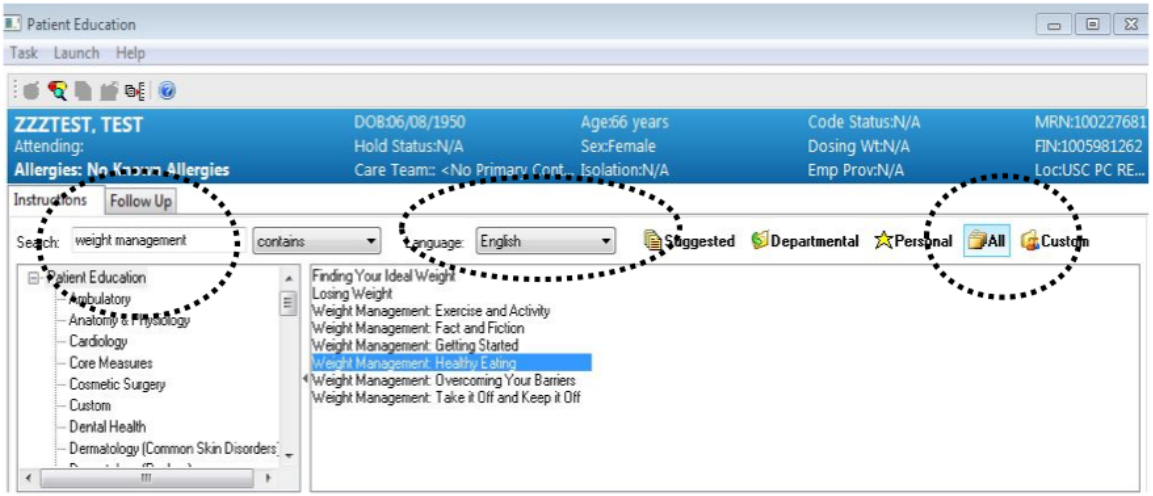
Outpatient nursing job aid: PRIME BMI and follow up

Step 1: Ask patient height or measure height. Obtain weight. **Note BMI (≥ 25, or ≤ 18):**

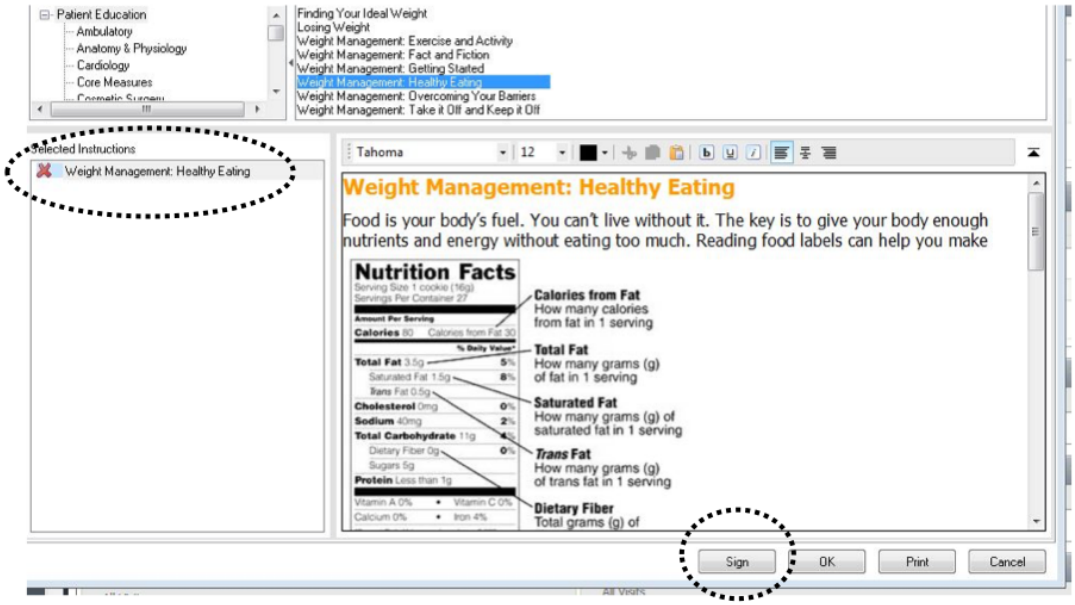


Step 2: If **BMI is ≥ 25, or ≤ 18,** Go to VISIT SUMMARY and click "INSTRUCTIONS +":

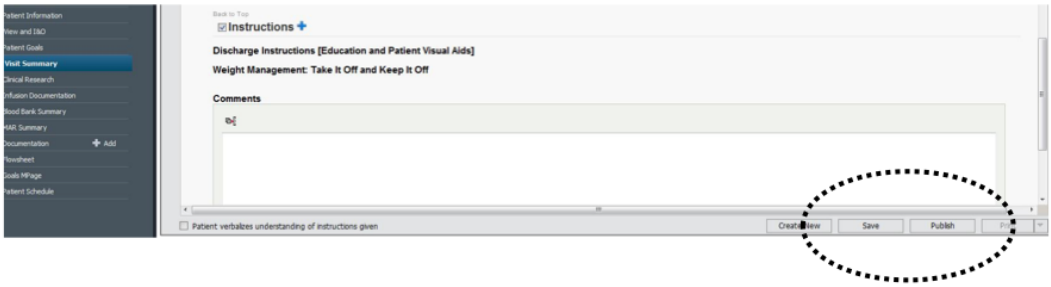
Step 3: Patient education will load. Type "WEIGHT MANAGEMENT" in the search box, choose the patient's language, and select "ALL".



Step 4: Double click on relevant topic that appears under "WEIGHT MANAGEMENT" and then "SIGN":



Step 5: Make sure to "SAVE" and "PUBLISH" the Patient Summary!



Thank you for helping our patients manage their weight, and helping us achieve success on our Quality Measure: PRIME BMI and follow up!

Modifying Workflows

Here is a useful tool for care teams/providers who want to review/modify their workflows to improve performance.

First you review your current state, then you define your future or desired state -either from the ones I just shared, or one that you all develop de novo to fit your needs.

Would you like to set a time to complete these activities? I can facilitate if that would be useful.

We will want to include anyone who is involved in: a) the patient care process involving weighing, calculating BMI, documenting BMI, b) providing counseling, patient education and referrals for nutrition, weight and exercise, c) QI metrics you are responsible for related to BMI, d) EHR superuser/whisperer with knowledge or skills related to BMI entry and health education materials available, e) coding and/or billing related to BMI, f) any staff/clinician with passion in this area, g) practice leadership w/ interest or oversight of this area.

Let's create a list of these people.

What is a good date to hold this meeting? Do you have a QI team meeting upcoming that we might add this to or should it be separate?

Looking at the high- level flow chart – who currently does these different tasks?

CURRENT STATE

Task	Who does this on your team? MD, RN, CMA, CHW
Get height (3 methods)	
Measure weight	
Enter height & weight in ORCHID	
Provide intervention – Option 1 Sign and print education materials from ORCHID	
Provide intervention – Option 2 Verbal instructions/counsel & document in ORCHID	
Provide intervention –Option 3 – refer to services using General Tab, Order, eConsult	

Are there areas that can introduce areas that you could redesign or remove?
What changes might you make to these roles to improve performance?

FUTURE or DESIRED STATE

Task	Who does this on your team? MD, RN, CMA, CHW
Get height (3 methods)	

Measure weight	
Enter height & weight in ORCHID	
Provide intervention – Option 1 Sign and print education materials from ORCHID	
Provide intervention – Option 2 Verbal instructions/counsel & document in ORCHID	
Provide intervention –Option 3 – refer to services using General Tab, Order, eConsult	

Create a "current state" and "desired state" workflow map with team.

Key message: Map what you do, not your memory of what you do (e.g. map real-time)

Key message: The person that owns the process holds the mapping pen

PDSA Cycle with Changed Workflow (Optional)

We can test out new workflows to fill these gaps and help you get more of your patients into the numerator.

I can help you project manage your PDSA cycles to test your "future/desired" state workflow and refine it. Would that be helpful?

I recommend we use the Plan Do Study Act process. It is very easy but also systematic and let's us do small tests of change before we roll-out larger ones.

Key message: PDSAs are rapid (1 hour, 1 day) and small (1 patient, 1 provider) tests of a change. Multiple ones are done until you perfect the process.

PDSA Elements, Sample and Worksheet

Sample PDSA Worksheet to use as example for team/provider

PDSA (plan-do-study-act) worksheet

Tool: Patient Feedback
Step: Dissemination of surveys
Cycle: 1st Try

Plan

I plan to: test a process of giving out satisfaction surveys and getting them filled out and back to us.

I hope this produces: at least 25 completed surveys per week during this campaign.

Steps to execute:

1. We will display the surveys at the checkout desk.
2. The checkout attendant will encourage the patient to fill out a survey and put it in the box next to the surveys.
3. We will try this for 1 week.

Do

What did you observe?

- We noticed that patients often had other things to attend to at this time, like making an appointment or paying for services and did not feel they could take on another task at this time.
- The checkout area can get busy and backed up at times.
- The checkout attendant often remembered to ask the patient if they would like to fill out a survey.

Study

What did you learn? Did you meet your measurement goal?

We only had 8 surveys returned at the end of the week. This process did not work well.

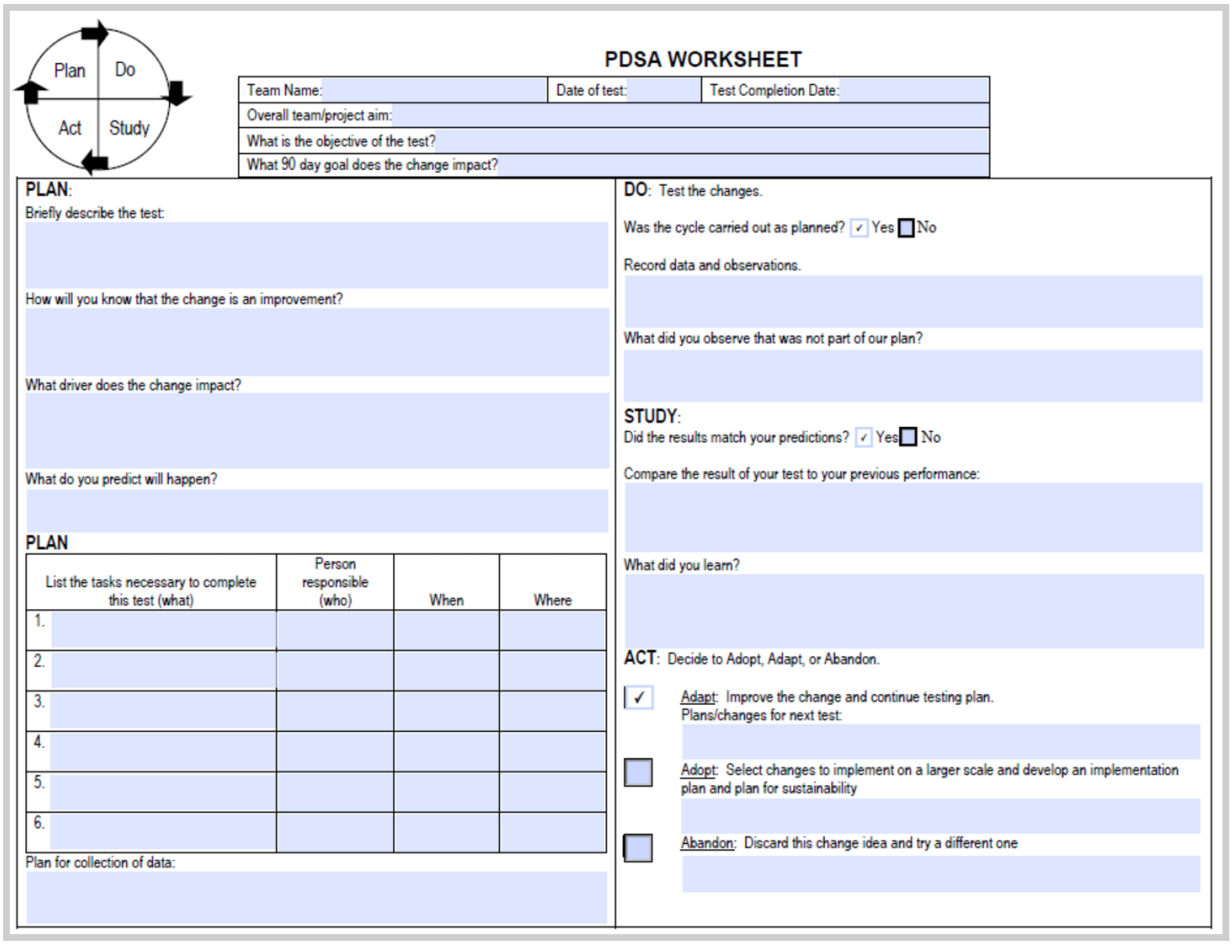
Act

What did you conclude from this cycle?

Patients did not want to stay to fill out the survey once their visit was over. We need to give patients a way to fill out the survey when they have time.

We will encourage them to fill it out when they get home and offer a stamped envelope to mail the survey back to us.

Sample Worksheet



PDSA WORKSHEET

Team Name:	Date of test:	Test Completion Date:
Overall team/project aim:		
What is the objective of the test?		
What 90 day goal does the change impact?		

PLAN:

Briefly describe the test:

How will you know that the change is an improvement?

What driver does the change impact?

What do you predict will happen?

PLAN

List the tasks necessary to complete this test (what)	Person responsible (who)	When	Where
1.			
2.			
3.			
4.			
5.			
6.			

Plan for collection of data:

DO: Test the changes.

Was the cycle carried out as planned? ☑ Yes ☐ No

Record data and observations.

What did you observe that was not part of our plan?

STUDY:

Did the results match your predictions? ☑ Yes ☐ No

Compare the result of your test to your previous performance:

What did you learn?

ACT: Decide to Adopt, Adapt, or Abandon.

☑ Adapt: Improve the change and continue testing plan.
Plans/changes for next test:

☐ Adopt: Select changes to implement on a larger scale and develop an implementation plan and plan for sustainability

☐ Abandon: Discard this change idea and try a different one

Summarizing & Ending Session

Dr./Ms/Mr. _____, thank you so much for meeting with me.

Review what was accomplished during the visit:

We've reviewed the "two steps" for BMI success –"BMI at every visit, and intervention with ONL."

We reviewed your current and desired workflows for BMI.

You are working on a ____ PDSA

Describe next steps

I will:

- ☐ Follow-up with you on the future state meeting
- ☐ PDSA cycle
- ☐ Training
- ☐ Check progress/success (tomorrow/next week/?) by reviewing patients from the day before for presence of a BMI or BMI + Intervention

- ☐ And will follow-up on the following for you_____

- ☐ Do you have any additional questions? Thoughts? Requests?

- ☐ I'll leave my information if you need to reach me.

Documenting your Coaching Encounter w/ the practice

Step 1. Search for practice name
Step 2. Select goal "BMI+Follow-up" under practice improvement goals
Step 3. Document encounter under "notes" – use edit date function to modify date if needed
Step 4. Update status of goal if indicated
Step 5. Document work on other goals if appropriate
Step 6. Select "team" or "urgent" if you would like team assistance/input
Step 7. Select "sign-off" to send report to your supervisor