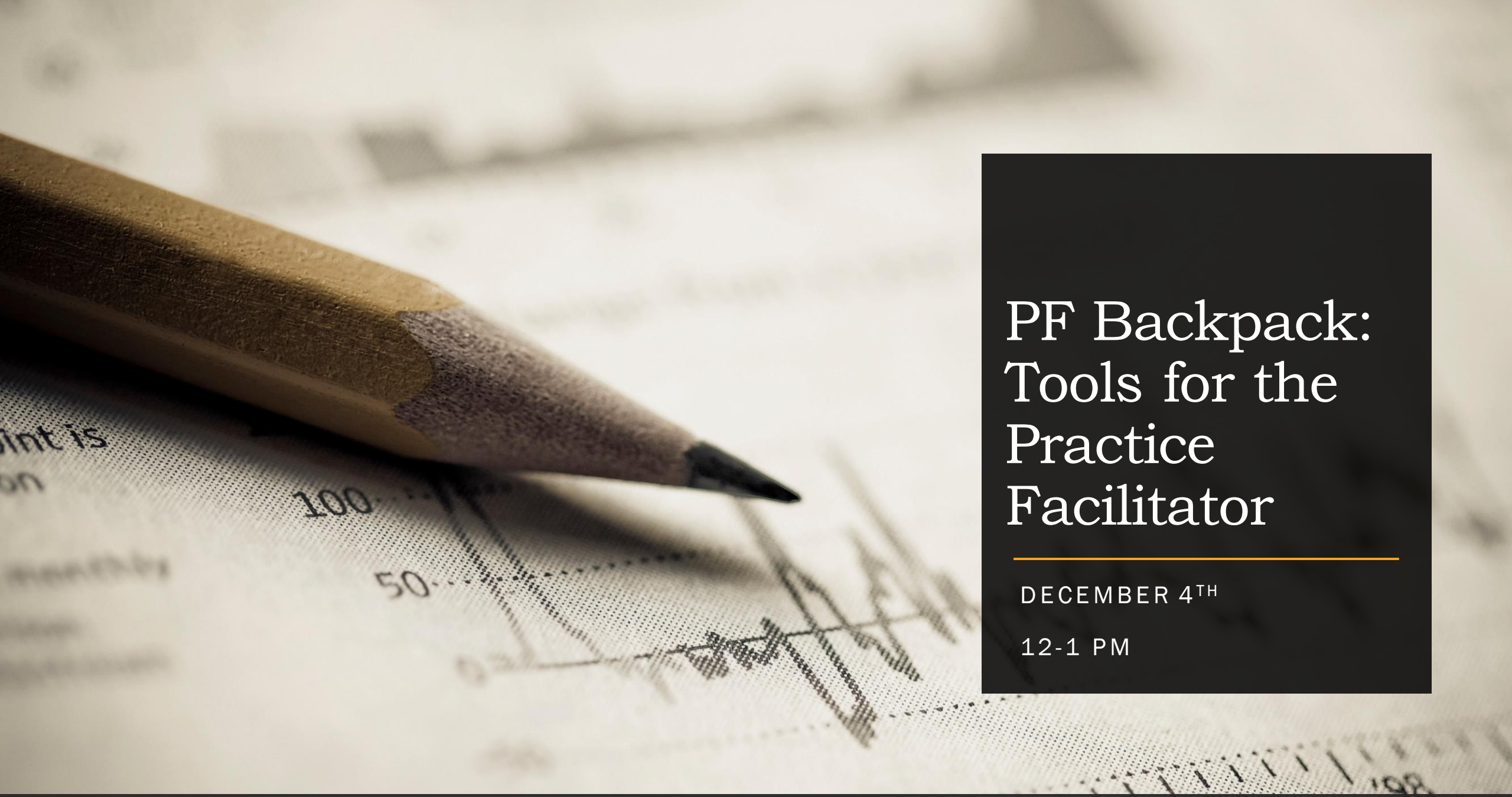


PF Backpack: Tools for the Practice Facilitator

DECEMBER 4TH

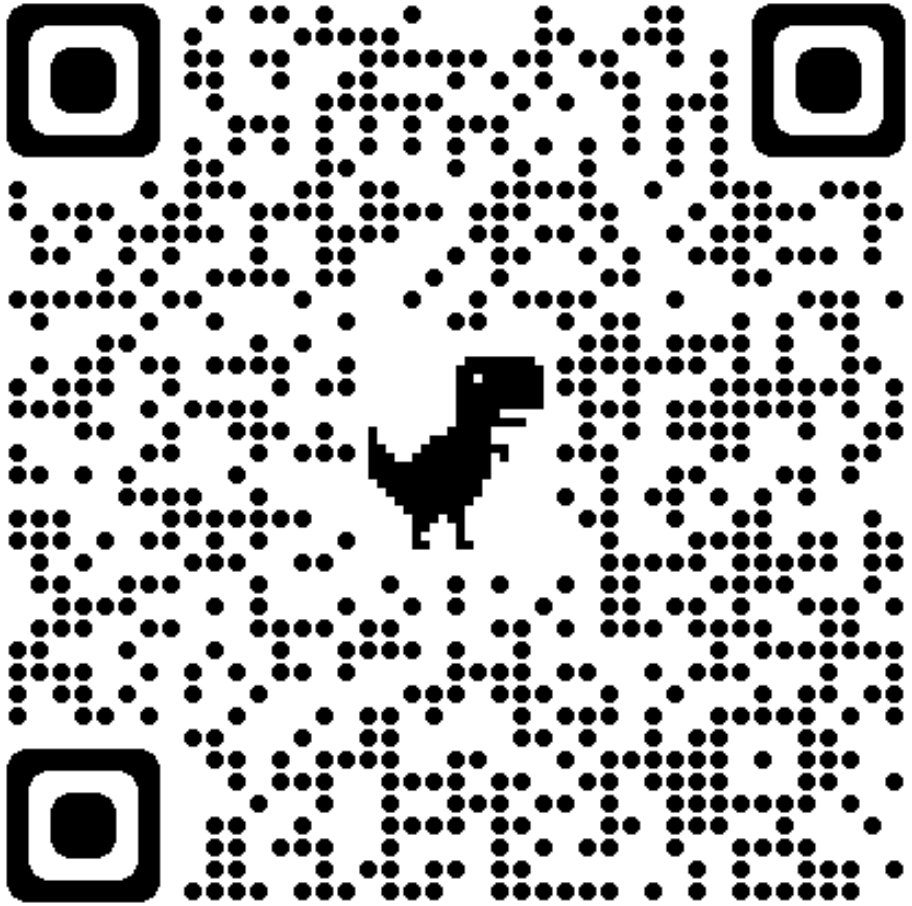
12-1 PM

Agenda

Model for Improvement

Bodenheimer Building Blocks

PF Backpack



Evaluation

https://practiceinnovationco.co1.qualtrics.com/jfe/form/SV_3vDd4sDYzpo0R9Q?Event=12042023BHITraining

Objectives

1

Enhance PF skills

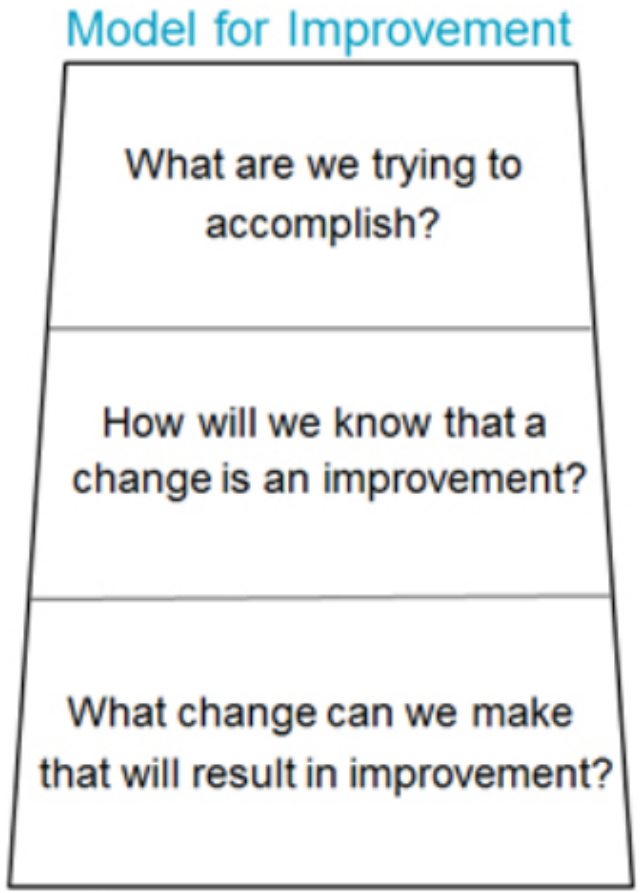
2

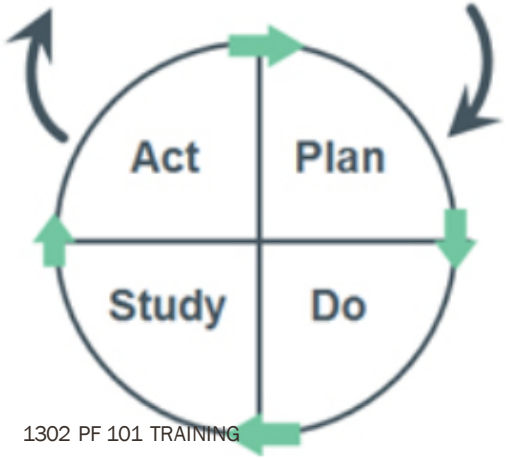
Gain increased understanding of the Model for Improvement and Bodenheimer Building Blocks.

3

Review PF Backpack resource

Institute for Healthcare Improvement





Setting Aims

The aim should be time-specific and measurable; it should also define the specific population of patients or other system that will be affected.

Establishing Measures

Teams use quantitative measures to determine if a specific change actually leads to an improvement.

Selecting Changes

Ideas for change may come from those who work in the system or from the experience of others who have successfully improved.

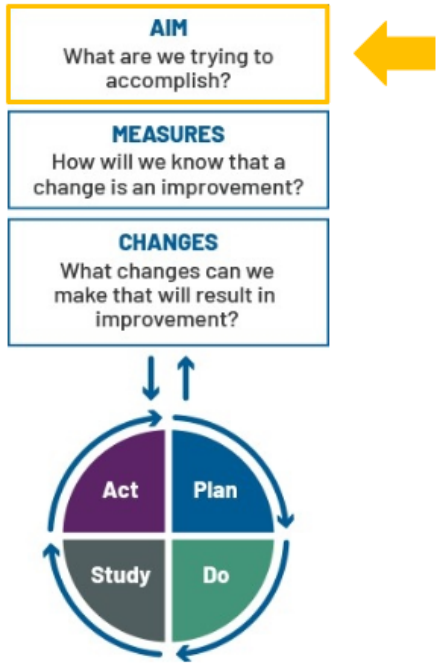
Testing Changes

The Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change in the real work setting — by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method adapted for action-oriented learning.

Step #1 – AIM

Step 1 - Create a 4-part aim statement

The Model for Improvement



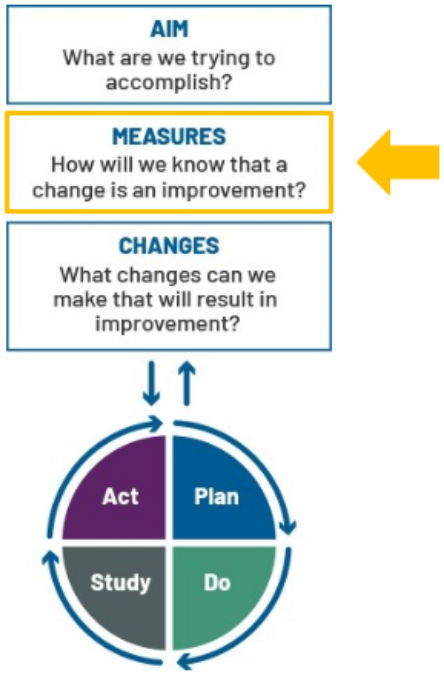
An aim statement should answer these four questions:

1. What do we want to improve?
2. Who is the improvement for?
3. How much improvement do we want to make?
4. By when?

Step #2 – MEASURES

Step 2 - Determine how to measure improvement

The Model for Improvement



Process measures

- Are the parts of the system functioning as planned?

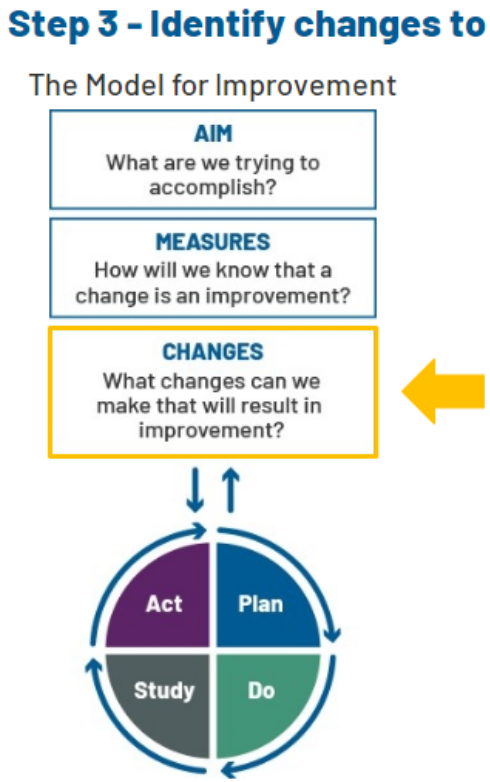
Outcomes measures

- What are the results of improved processes?

Balancing measures

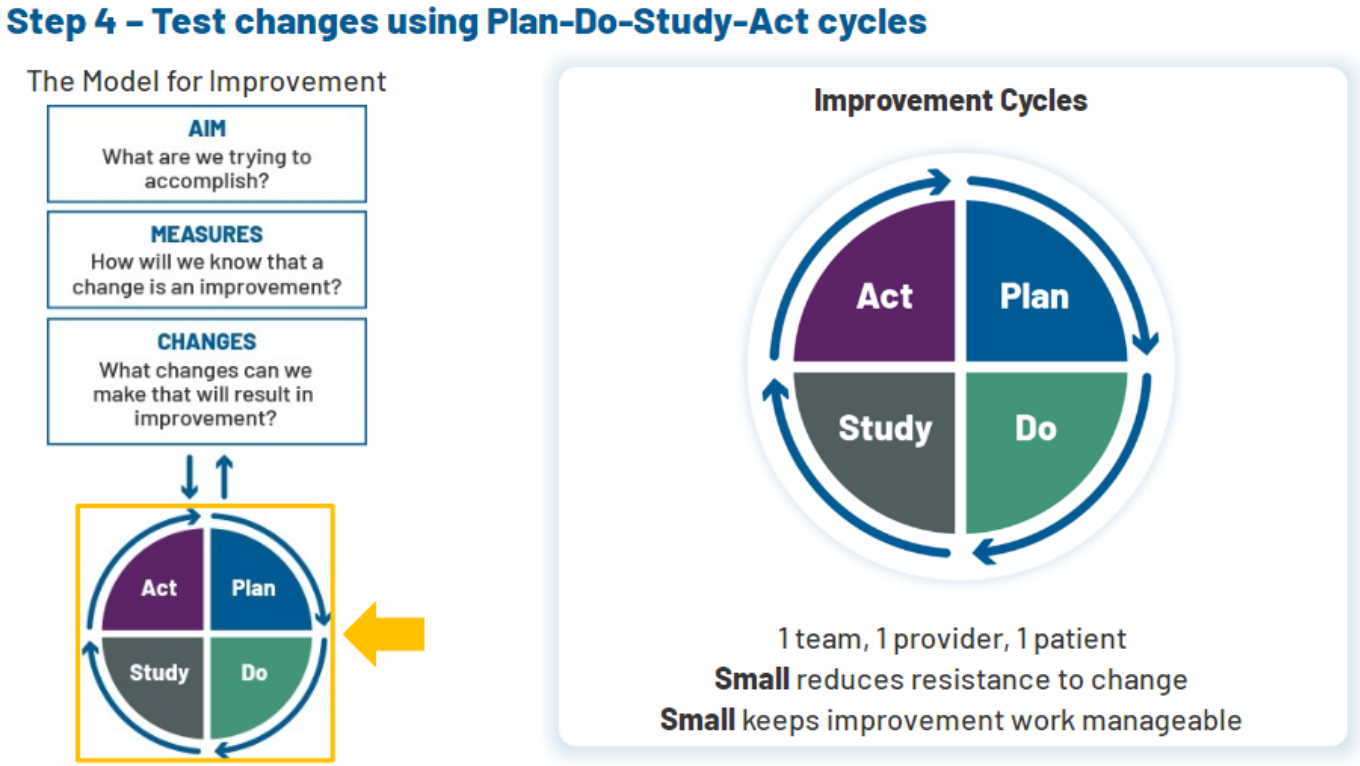
- Are there possible negative consequences of the change?

Step #3 – CHANGES



- Review strategies on a key driver diagram
- Brainstorm with staff and clinicians
- Conduct a "last 10 patients" chart audit
- Use the 5 Whys and create a fishbone diagram
- Steal shamelessly – Find exemplars!
- Consult evidence reviews, guidelines, evidence-based toolkits

Step #4 – PDSA


Step 4 – Test changes using Plan-Do-Study-Act cycles
The Model for Improvement
AIM
What are we trying to accomplish?
MEASURES
How will we know that a change is an improvement?
CHANGES
What changes can we make that will result in improvement?
Act
Plan
Study
Do
Improvement Cycles
Act
Plan
Study
Do
1 team, 1 provider, 1 patient
Small reduces resistance to change
Small keeps improvement work manageable

PDSA Form - AHRQ

PLAN DO STUDY ACT (PDSA) FORM

Cycle #:
Start Date: End Date:

Project Title: Project Lead:

State: ☐ Task-related; Task:

☐ Internal Process

Objective of this Cycle:

☐ Develop a Change ☐ Test a Change ☐ Implement a Change

Aim Statement (WHAT YOU ARE TRYING TO ACCOMPLISH):

- *Specific- targeted population:*
- *Measurable- what to measure and clearly stated goal:*
- *Achievable- brief plan to accomplish it:*
- *Relevant- why is it important to do now:*
- *Time Specific- anticipated length of cycle:*

PLAN

Test/Implementation Plan (THINK ABOUT WHAT CHANGES YOU CAN MAKE THAT WILL RESULT IN IMPROVEMENT):

What change will be tested or implemented? Include how change will be conducted, who will run it, where it will be run and when it will be run unless already noted in Aim Statement above. (If needed, include specifics on tasks, responsibilities and due dates.)

Prediction:

Data Collection Plan (THINK ABOUT HOW YOU WILL KNOW THE CHANGE IS AN IMPROVEMENT):

What data/measures will be collected?

Who will collect the data?

When will the collection of data take place?

How will the data (measures or observations) be collected and displayed?

What decisions will be made based on data?

DO

Activities/Observations:

Record activities/observations that were done in addition to those listed in plan (above):

STUDY

Questions: Copy and paste Prediction from Plan above and evaluate learning. Complete analysis of the data. Insert graphic analysis whenever possible.

Prediction:

Learning (Comparison of questions, predictions, and analysis of data):

Summary (Look at your data. Did the change lead to improvement? Why or why not?):

ACT

Describe next PDSA Cycle: Based on the learning in "Study," what is your next test?

https://www.ahrq.gov/sites/default/files/wysiwyg/evidencenow/tools-and-materials/pdsa-form.pdf

PLAN DO STUDY ACT (PDSA) FORM

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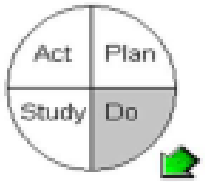

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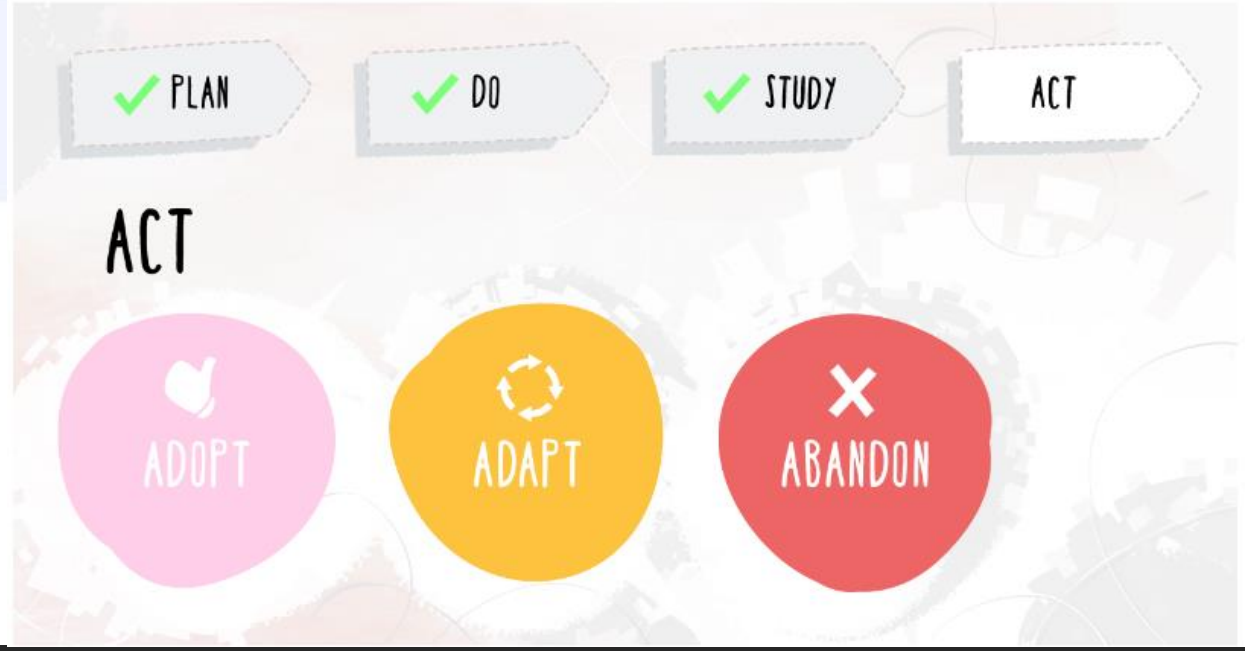


Act

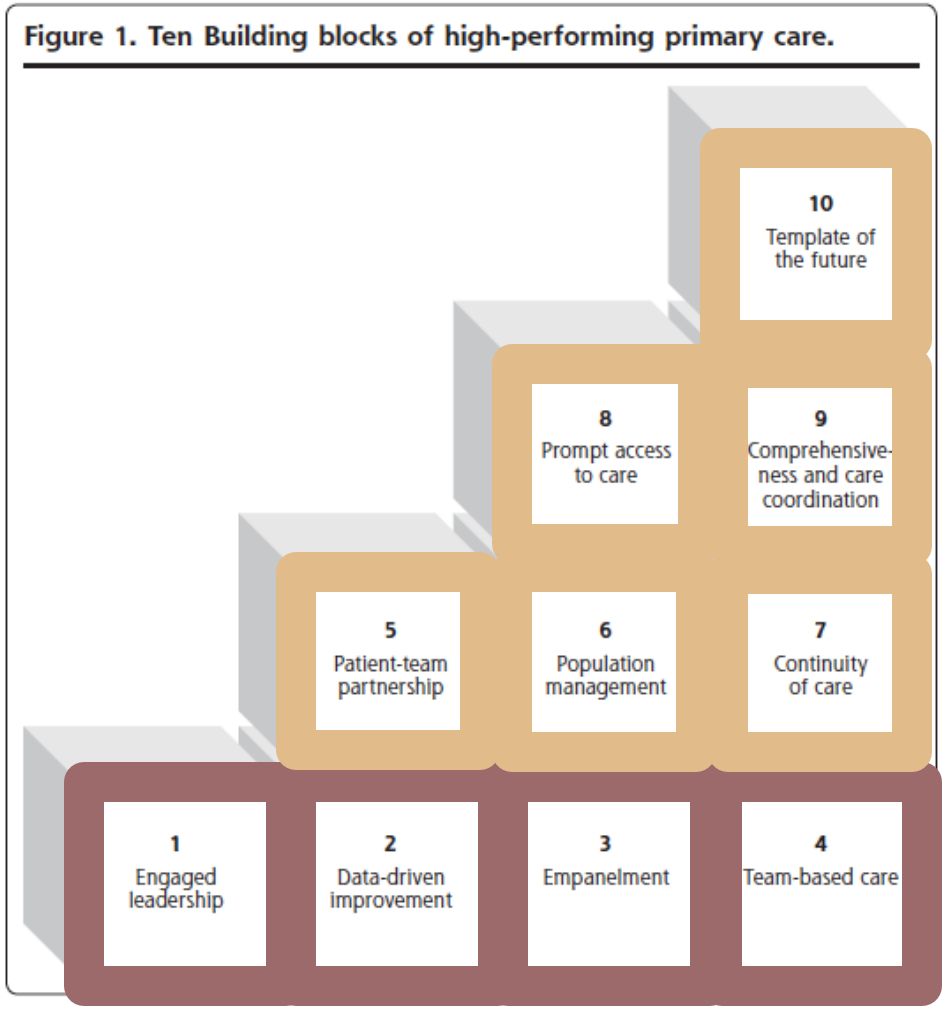
1. Adopt – results are what you planned and what you want – ADOPT!
2. Adapt – result are almost what you wanted – ADAPT!
3. Abandon – results are not what you wanted after several tries – ABANDON!

Bodenheimer Building Blocks

10 Building Blocks of high functioning and performing practices

Maroon = foundational elements

Tan = advanced elements



Bodenheimer, et al. Annals of Family Medicine. 2014

BB 1 – Engaged Leadership

Importance of Change Leadership

1. Effective leadership is the foundation for practice transformation
2. Lack of leadership alignment and support undermines the change process
3. Empowering effective formal and informal leaders creates a shared leadership culture
4. “It takes two”
   - Provider Champion
   - Staff member
5. It is a big culture change to empower teams and allow team roles to expand

Effective Leaders for Change

Actively engage in the process & respond to people in a timely manner

Facilitate the development of a shared vision

Help everyone figure out how they can contribute

Are transparent with information & data

Identify and empower other leaders in the practice

Provide protected time for the team and themselves to meet to address changes

Empower people to work at highest level: facilitative leadership/shared leadership

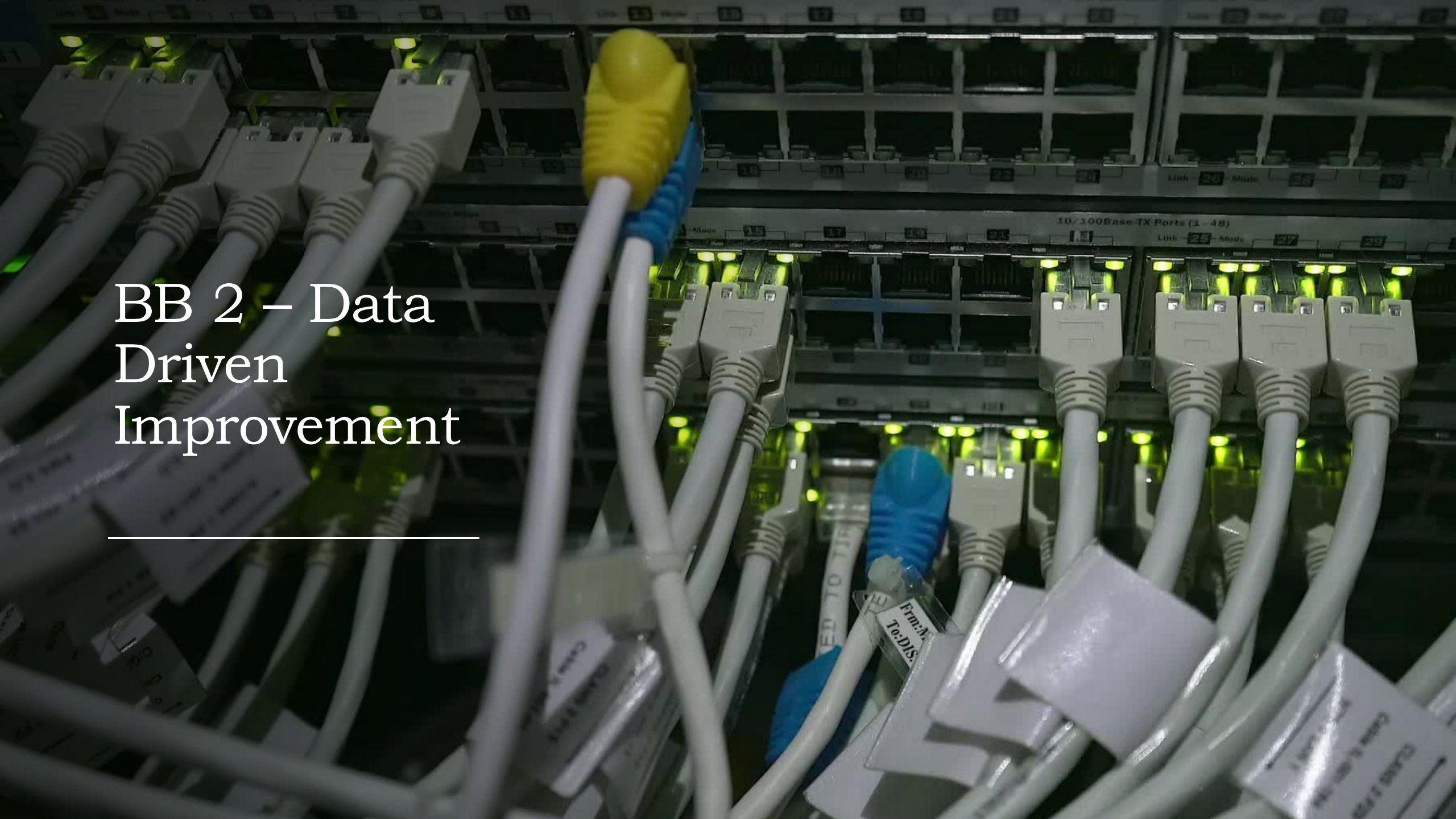
Hold people (and self) accountable

Encourage innovation

Are not afraid of failures

Buy into a team approach to improvement and problem-solving

Effective Leaders (continued)

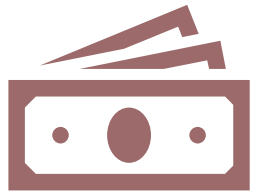


BB 2 – Data Driven Improvement

Why is data so important?

Can’t improve what you can’t measure

How do you know that what you are doing is working?



Often tied to payment

Data Planning

Where will you get the data from?

- EHR – are there specific reports?
- Do you have a dashboard that providers have access to?

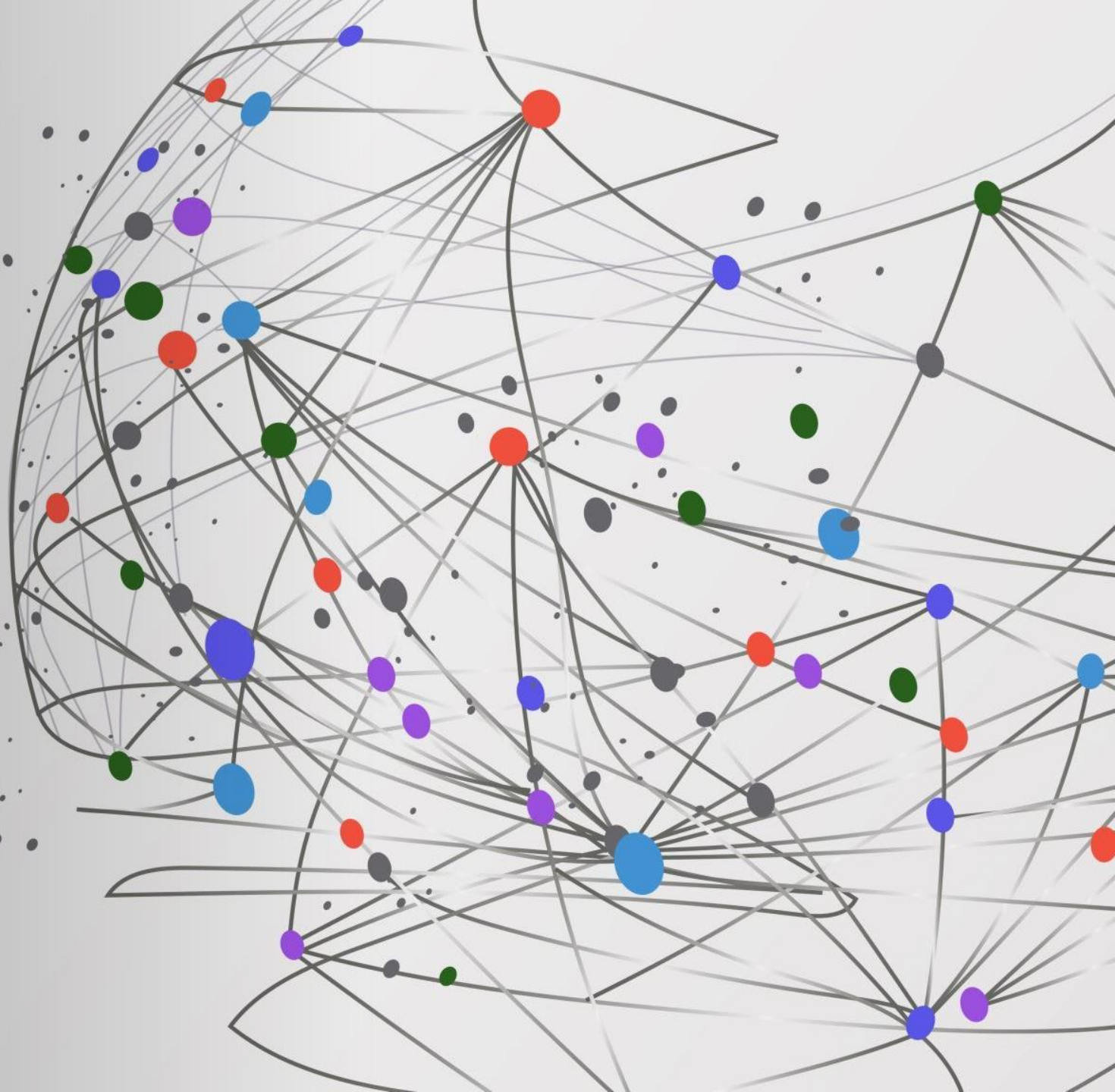
Who will pull the data?

When will they pull the data?

Where will you review the data?

Who will validate the data?

BB 3 – Empanelment



Empanelment

Who are your patients?

Who do your patients say their doctor is?

Identify your denominator – key to population management

To know how many patients have an A1C > 9, first need to know who your patients are with diabetes.

The 4-Cut Method for Panel Assignment

CUT	PATIENT DESCRIPTION	ASSIGNMENT
1	Patients who have seen only one provider	To that sole provider
2	Patients who have seen multiple providers, but one provider the majority of the time	To the majority provider
3	Patients who have seen two or more providers equally (no majority can be determined)	To the provider who performed the last physical
4	Patients without a physical or health check who have seen multiple providers	To provider seen most recently

Source: Murray et .al,. "Panel Size: How Many Patients Can One Doctor Manage?" Family Practice Management, April 2007

BB 4 – Team Based Care

Everything is cool when you're part of a team!

The Institute for Healthcare Improvement defines a care team as, **“the right mix of people coming together with the right tools to deliver the right care for a defined population of patients.”**

Team-based Care

Evidence for TBC

Many care and care-coordination activities are better provided by non-physician members of a care team (Coleman & Reid, 2010).

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).

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).

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

Attributes of Highly Functional Care Teams:

Clear expectations and available tools

Easy to understand and discuss processes of care

Information is available when needed

Everyone on the staff is valued; there's a culture of respect and caring

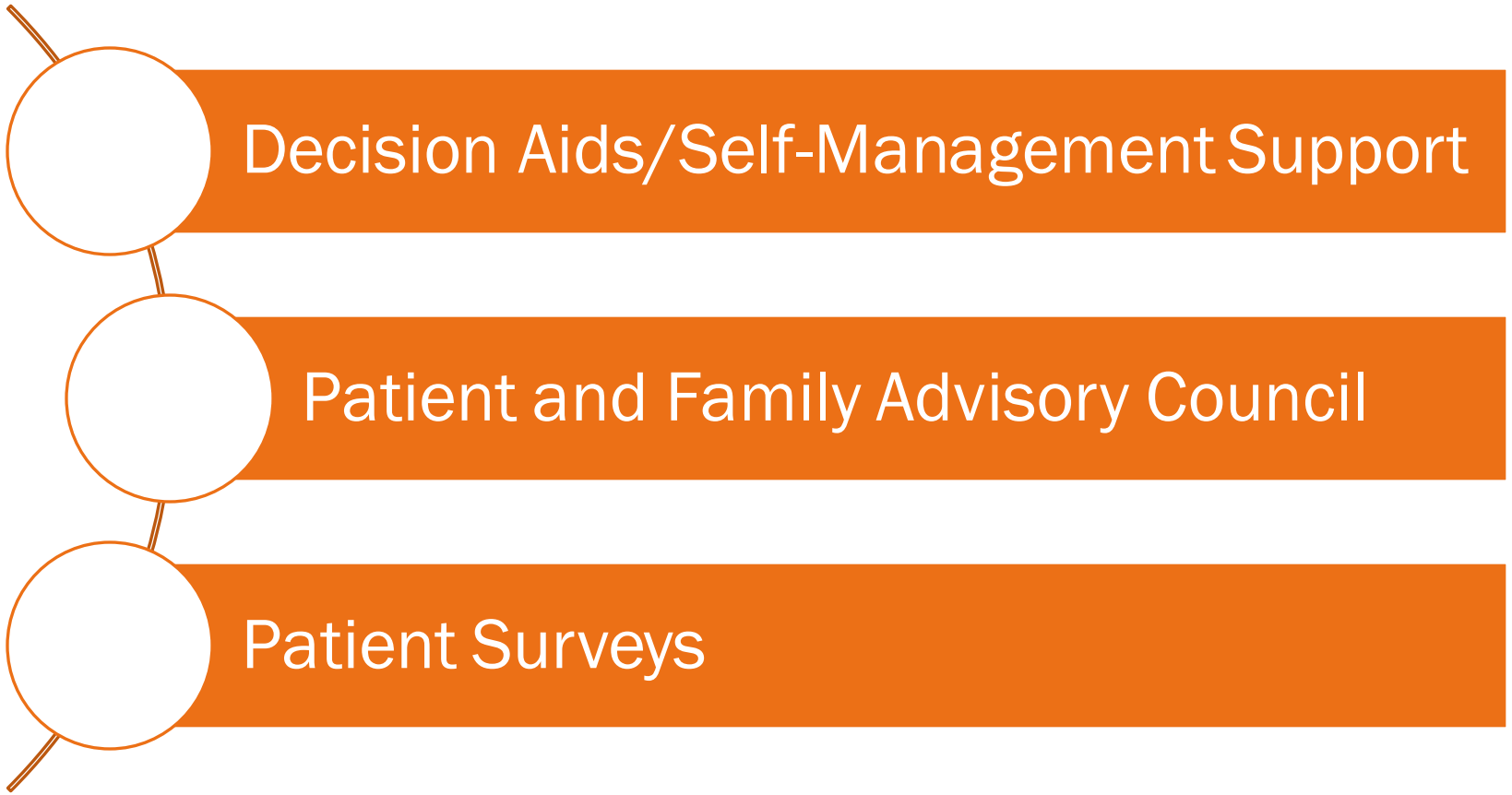
Feedback of performance and opportunities to grow

Positive attitudes of co-workers

Working at the top of your license

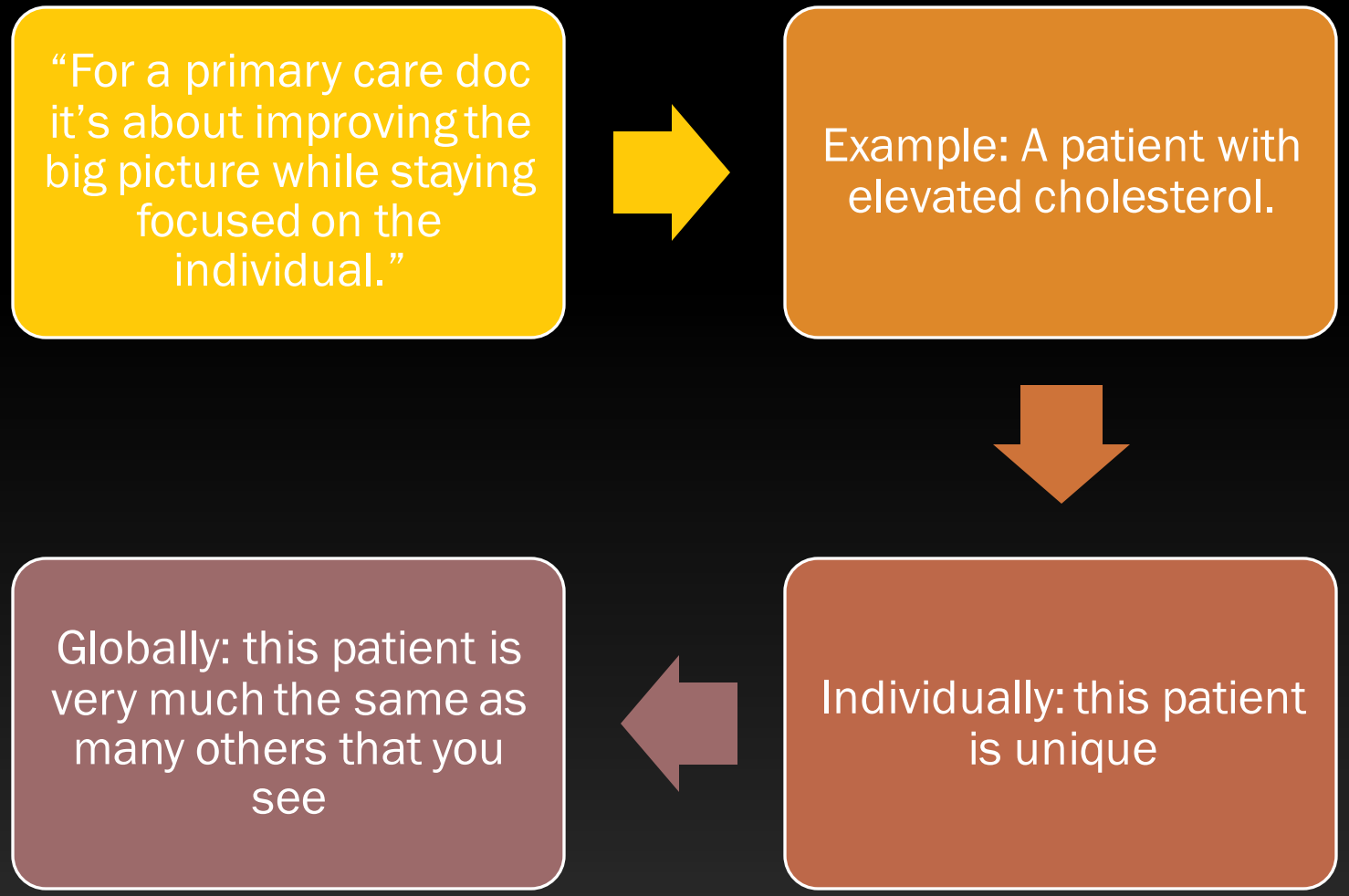
BB 5 – Patient team partnership

How do you plan to partner with your patients?



BB 6 – Population Management

Population Management

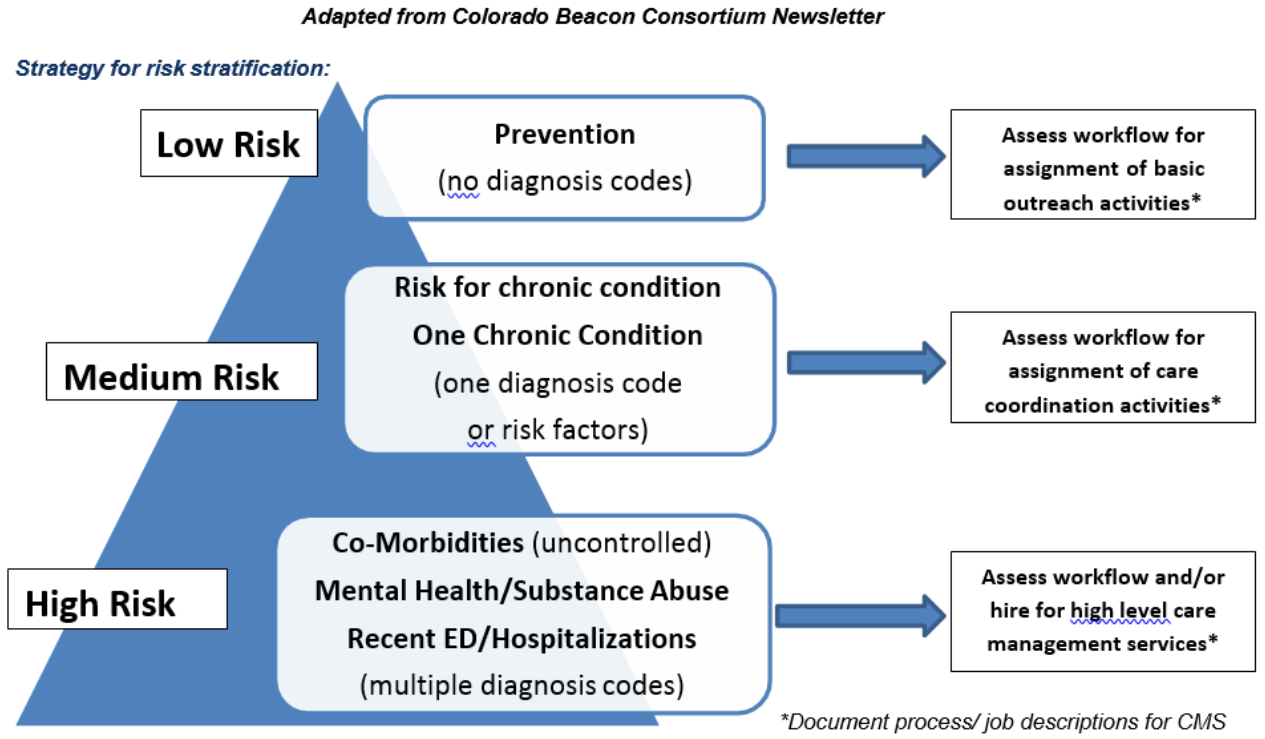


Ways to manage patients

Registries

- Used at point of care to identify what is needed at visit
- ID gaps in care for populations
- Tracking trends over time
- Comparisons between providers, practices, systems
- Outreach and care management

Risk Stratification



BB 7 - Continuity of Care

Continuity of Care – Building Off Empanelment

Once you have your empanelment report, you can start to look at continuity of care between providers or teams of providers.

Continuity is important because patients have higher satisfaction and better outcomes and receive more cost-effective care.

Discuss continuity of care at provider, staff and/or QI meetings so staff are familiar with the process and concept.

BB 8 – Prompt access to care

Access Strategies

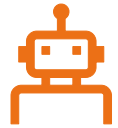
See your own patients.

Make it easy to schedule an appointment.

Offer to see patients the day they call.

Manage patient demand.

Use e-mail with patients.

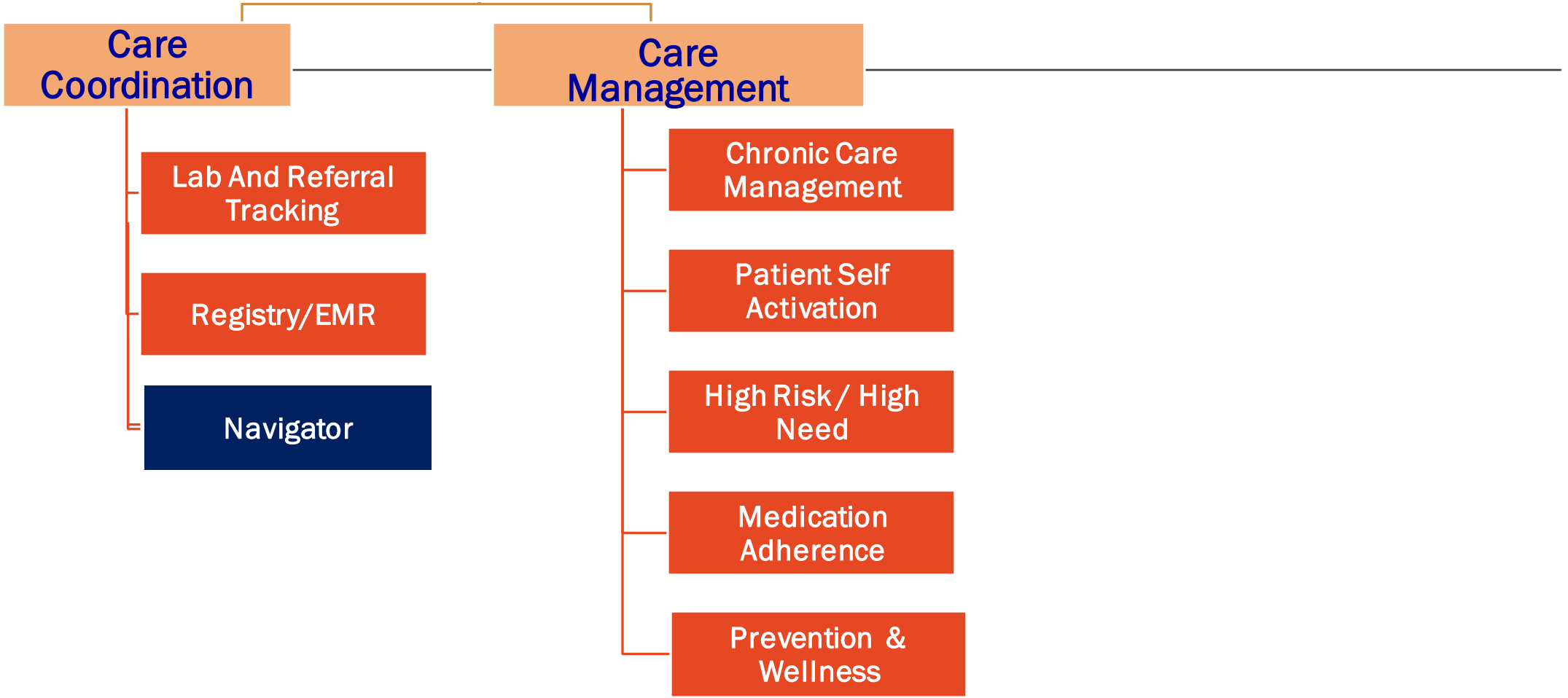


Removing barriers

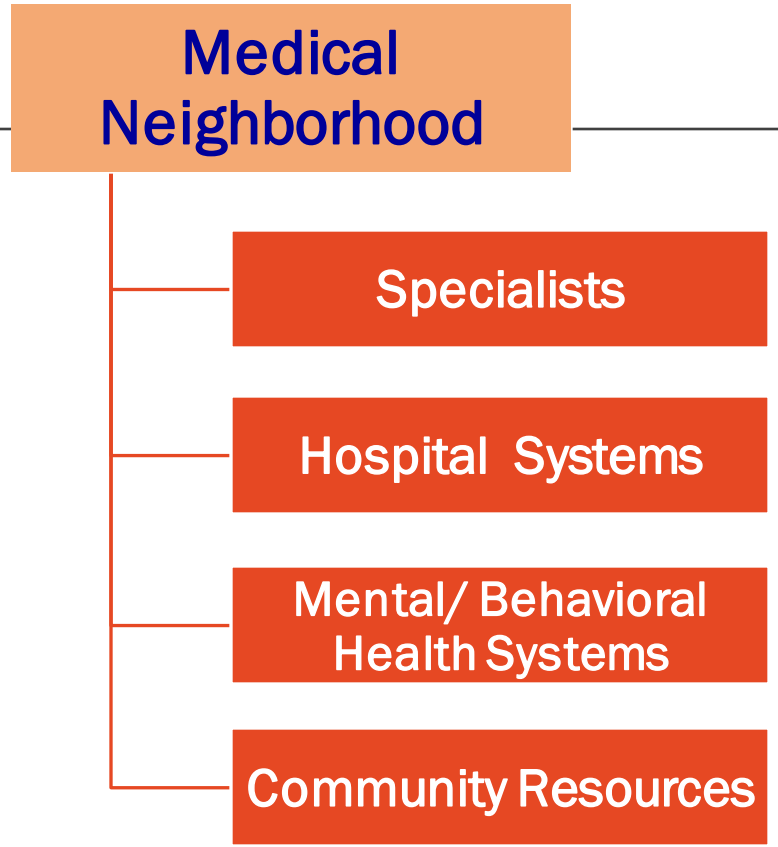
https://www.aafp.org/fpm/2010/0900/p48.html

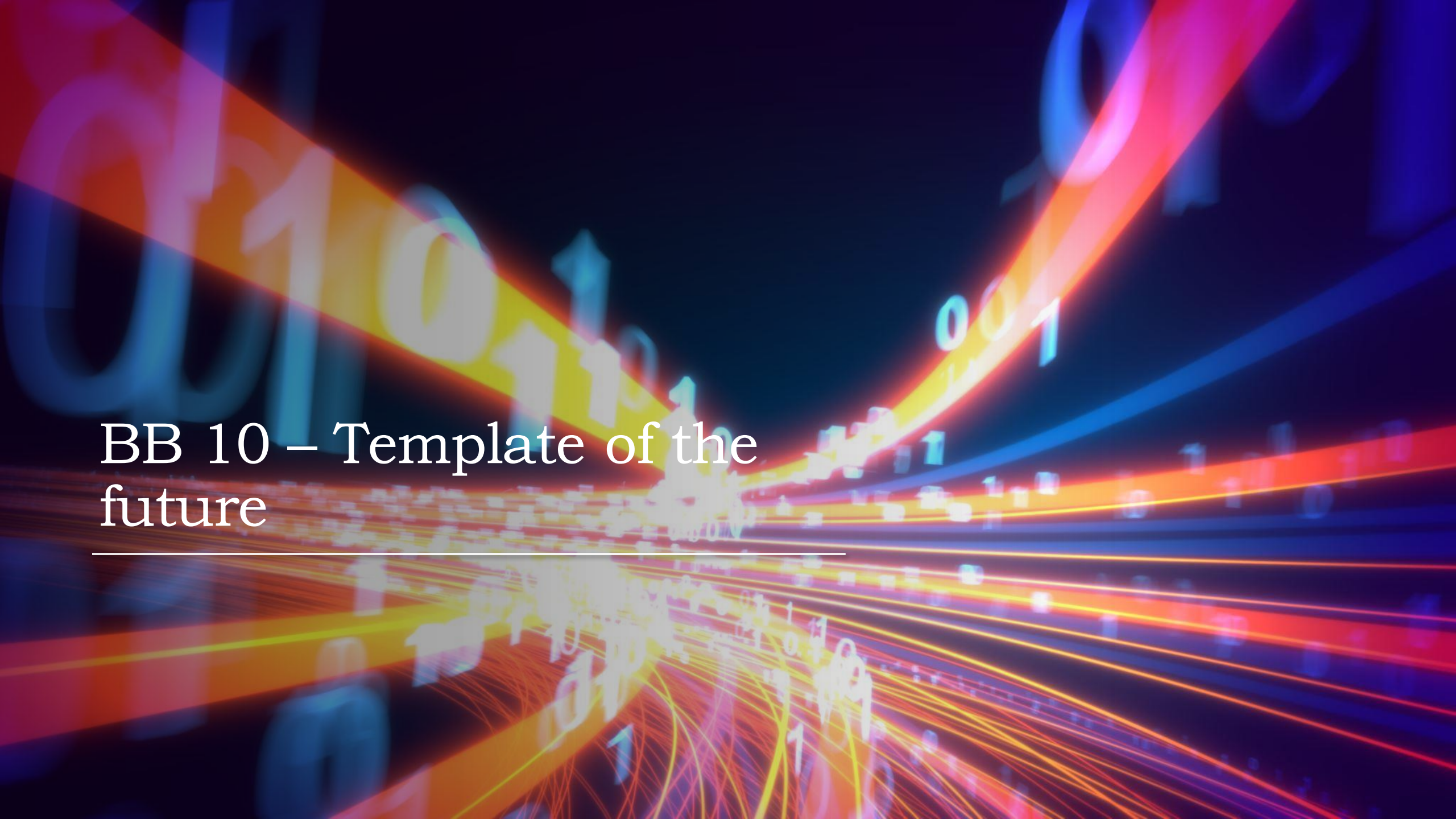
BB 9 – Comprehensive and care coordination

Internal Coordination and Management



External Coordination





BB 10 – Template of the future

PF Backpack

WE WILL CONTINUE TO UPDATE AND ADD RESOURCES

1302 E-learning Modules

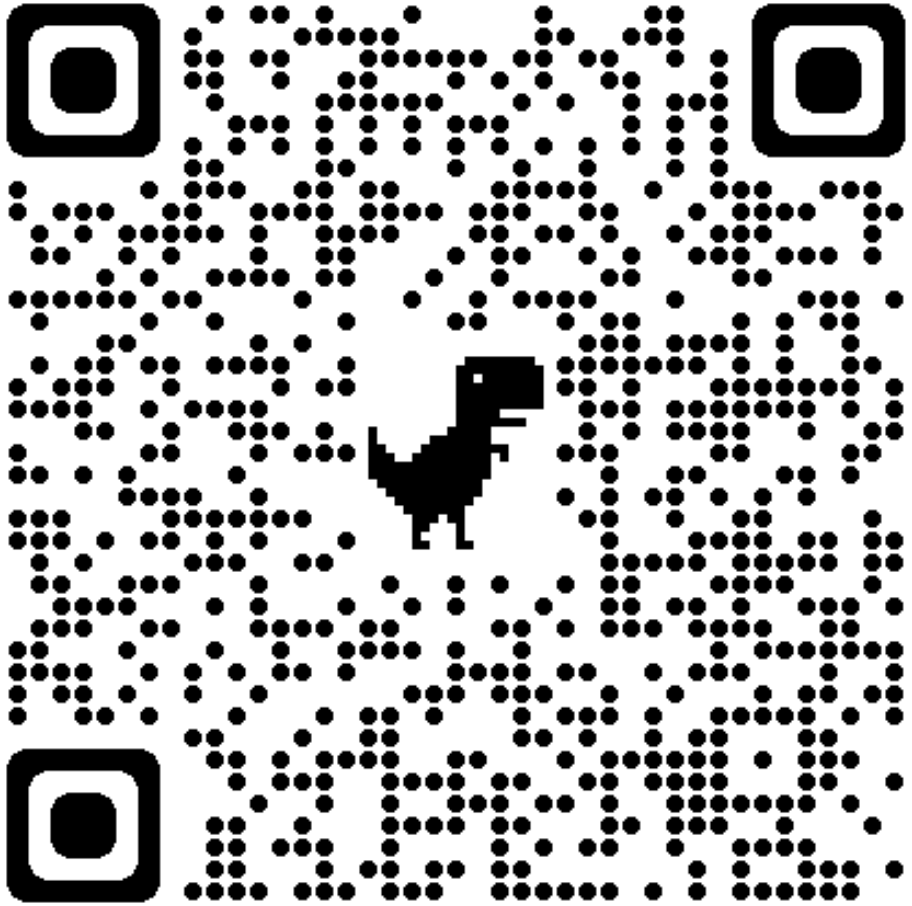
- Introduction to Behavioral Health Integration
- Integrated Care Workflow
- Substance Use Disorders Part 1: Introduction
- Substance Use Disorders Part 3: SBIRT
- Depression, Distress, and Anxiety
- Behavioral Health Providers and the Care Team
- Behavioral Health in Pediatrics: Adverse Childhood Experiences
- Patient Engagement and Behavioral Health
- Obesity and Depression
- Men and Depression
- Whole-Person Care for the Aging and Senior Patient
- Psychological Trauma & the Integrated Care Team

To access 1302 E-learning Modules:

Go to CUeLearning.org

Register with the code: 1302

If you already have an account with CUeLearning, please email Support@CUeLearning.org and they will update your account.



Evaluation

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