

Practice Improvement Plan

The EvidenceNOW Southwest (ENSW) **Practice Improvement Plan** is the beginning of your work with your practice facilitator to improve outcomes related to cardiovascular health for your patients.

Review and Discuss

This planning document is a guide for a multidisciplinary practice team to review and discuss:

- ◆ **Strengths** to build on
- ◆ **Opportunities** for improvement
- ◆ **Priorities** that will help to improve the cardiovascular health of your patients

Rate Your Practice

As you review each building block as a team, you will be asked to rate your practice:

Red "We need focused support and improvement in this area."

Yellow "We have some experience in this area, but could still use some support to keep improving."

Green "We already excel in this area."

Create a Roadmap

The last page of this planning document will help your team create a roadmap for improvement by setting some concrete goals for your work with ENSW. A completed Practice Improvement Plan will help you and your facilitator find support and resources for your practice and patients.

Submit Online

Upon completing this planning document, please submit online here: bit.ly/ENSWPIPNotes

Practice Name: Kyle - test - small independent

Practice ID: 3004

Survey Date: 11/10/2015

Intervention Arm: ENHANCED

Questions?

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Engaged Leadership, Creating a Practice-wide Vision With Concrete Goals and Objectives

- Develop clear NSW communication plan and shared practice vision
- Form QI Team
- Lead bi-monthly QI meeting
- Develop project AIMS
- Complete PCMH monitor bi-annually
- Examine practice culture by completing survey instruments
- Engage with ongoing evaluation and technical assistance as defined by business agreements.
- Train staff to understand their role in supporting practice change
- Adoption of guidelines

	Not at All (0) to Completely (4)
Our practice has a QI team that meets regularly.	3
The QI team has a sustainable, reflective QI process that deals effectively with challenges and conflict.	3
	Strongly Disagree to Strongly Agree
Our practice's leaders provide information and skills-training to support professional growth.	AGREE
Our practice's leaders use opinion leaders, role modeling, or other vehicles to encourage support for changes.	AGREE
Our practice's leaders empower staff to authorize and make desired changes, providing to those who are charged with implementing improved care the power to authorize and make the desired changes.	NEITHER AGREE OR DISAGREE
Our practice uses rapid-cycling, or other vehicles for reducing the risk of negative results for introducing organization-wide change in care.	STRONGLY AGREE
Our practice uses clinical guidelines for cardiovascular disease prevention:	
CLINICIANS HAVE AGREED TO USE SPECIFIC GUIDELINES PRACTICE USES STANDING ORDERS	
Our practice uses clinical guidelines for management of patients at risk for cardiovascular disease (e.g., statin use among those at risk):	
CLINICIANS HAVE AGREED TO USE SPECIFIC GUIDELINES PRACTICE USES STANDING ORDERS	

How would you rate your practice overall on Engaged Leadership?

RED

YELLOW

GREEN

Notes

Data Driven Improvement Using Computer-Based Technology

- Complete baseline assessment to determine data capacity to report NSW measures.
- Create plan to address identified gaps in reporting capacity, including workflow redesign to systematically capture problematic data points and data validation.
- Provide quarterly reports on NSW clinical quality measures.
- Review data reports monthly with QI team.
- Use data to inform quality improvement activities.

During meetings our practice, **INFREQUENTLY** discusses data or reports about clinical quality from health plans or other external entities.

Our practice works with the following to support capture of EHR/Electronic Medical Record (EMR) data used to report clinical quality measures:

CLINICAL DATA WAREHOUSE

REGIONAL EXTENSION CENTER

HEALTH SYSTEM PRACTICE NETWORK

HEALTH INFORMATION EXCHANGE

PRIMARY CARE ASSOCIATION

HOSPITAL NETWORK

EXTERNAL CONSULTING GROUP

EHR System **Electronic**
 Year: **2012** Name: **Allscripts** Version: **I'm not sure about this**

Our practice's data resides in **DATA RESIDES IN A SERVER IN YOUR PRACTICE AND COPY IN THE *CLOUD***

Our practice's EHR vendor **CAN WITH RESTRICTIONS** help extract data and clinical quality measures.

The current EHR/EMR system **IS** certified to meet Meaningful Use as defined by Health and Human Services / Office of the National Coordinator for Health Information Technology (ONC).

The EHR currently **DO NOT KNOW** generate Continuity of Care Documents (CCDs).

Our practice **CANNOT** share any patient health information (e.g., lab results, imaging reports, problem lists, medication lists) electronically (not fax) with any other providers, including hospitals, ambulatory providers, or labs.

Our practice **CAN** incorporate clinical lab-test results into EHR/EMR as structured data (i.e., data recorded in discrete fields and not in text fields).

Our practice **DOES NOT** have someone who can configure or write quality reports from the EHR/EMR.

Data on the clinical quality of care provided by our practice or its clinicians **ARE** reported publicly by health plans or other external entities.

Data Driven Improvement Using Computer-Based Technology

Our practice has produced quality reports on the following clinical quality measures in the last 6 months¹.

PERCENTAGE OF PATIENTS AGED 18 YEARS AND OLDER WITH ISCHEMIC VASCULAR DISEASE (IVD) WITH DOCUMENTED USE OF ASPIRIN OR OTHER ANTITHROMBOTIC (NQF 0068).

PERCENTAGE OF PATIENTS AGED 18 THROUGH 85 YEARS OF AGE WHO HAD A DIAGNOSIS OF HYPERTENSION (HTN) AND WHOSE BLOOD PRESSURE (BP) WAS ADEQUATELY CONTROLLED (<140/90) DURING THE MEASUREMENT YEAR (NQF 0018).

PERCENTAGE OF PATIENTS AGED 18 YEARS OR OLDER WHO WERE SCREENED ABOUT TOBACCO USE ONE OR MORE TIMES WITHIN 24 MONTHS AND WHO RECEIVED CESSATION COUNSELING INTERVENTION IF IDENTIFIED AS A TOBACCO USER (NQF 0028).

Our practice **CAN** report the above quality measures at the practice level.

Our practice **CAN** report the above quality measures by clinician (MD, DO, NP, PA).

Strongly Disagree to
Strongly Agree

Our practice can report measurements of practice performance on cardiovascular disease prevention measures (such as aspirin for patients at risk for ischemic vascular disease) for comparison with our peers.

AGREE

Our practice sets goals and benchmarks rates of performance quality on cardiovascular disease prevention measures at least yearly.

AGREE

How would you rate your practice overall on data driven improvements using computer technology?

RED

YELLOW

GREEN

Notes

1. If this section is blank it means this question was not answered on the practice survey.

Empanelment

- Achieve and maintain at least 95% empanelment to provider and care teams.

Our practice's clinicians **DO** have their own panel of patients for whom they are responsible.

Not at All (0) to
Completely (4)

Our practice has an ongoing, reliable system for empanelment and panel management within our data systems and practice processes.

2

How would you rate your practice overall on empanelment?

RED

YELLOW

GREEN

Notes

SAMPLE

Team-Based Care

- Practice periodically reviews assessment of distribution of patient care tasks by role.
- Process redesign to reflect changing staff roles on the care team.
- Team training to define staff roles and responsibilities.
- Practice better distributes workload throughout the team in ways that makes optimal use of team members' training and skill sets.
- Practice creates standardized protocols and standing orders to describe workflow and staff roles.
- Practice participates in bi-annual NSW Collaborative Learning Sessions.

Strongly Disagree to
Strongly Agree

Our practice uses teams to focus on accomplishing the change process for improved care.

DISAGREE

Our practice delegates to non-clinician staff the responsibility to carry out aspects of care that are normally the responsibility of physicians processes.

DISAGREE

Our practice deliberately designs care improvements so as to make clinician participation less work than before.

AGREE

How would you rate your practice overall on team-based care?

RED

YELLOW

GREEN

Notes

Patient-team partnership

All practices:

- Assess patient satisfaction
- Provide self-management support
- Promote patient activation
- Engage in shared decision-making

Enhanced intervention practices:

- Include patients as advisors
- Convene Patient and Family Advisory Councils
- Convene focus Groups
- Include patients on QI team

	Strongly Disagree to Strongly Agree
In our practice a system has been implemented for including patients and family input in ongoing improvement activities.	2
In our practice a patient experience survey is used regularly to monitor practice performance.	3
Patients and families are actively linked with community resources to assist with their self-management goals.	3
Our practice has the capacity to link patients to community resources to address social determinants of health.	2
Patients and families are provided with resources to help them engage in the management of their health between office visits.	2

How would you rate your practice overall on patient-team partnership?

RED

YELLOW

GREEN

Notes

Population management

- Develop and maintain CVD registry
- Identify gaps in care
- Establish protocols for patient outreach

Our practice has a registry for the following conditions:

ISCHEMIC VASCULAR DISEASE (IVD)

DIABETES

HYPERTENSION

PREVENTION SERVICES

HIGH CHOLESTEROL

HIGH RISK (HIGH UTILIZATION) PATIENTS

Our registry **CAN** be configured to add new conditions.

Not at All (0) to
Completely (4)

Our practice can identify patients with care or outcomes that fall outside of guidelines that may require more intensive care.

2

How would you rate your practice overall on population management?

RED

YELLOW

GREEN

Notes

Practice Improvement Plan

The Practice Improvement Plan will give your practice a roadmap using what you've reported on your Practice Survey to guide your work with EvidenceNow Southwest.

From the previous pages of the Practice Feedback Report, transcribe here how your practice rated itself in the following building block domains. Then rank your top three priority areas for focused improvement.

ENGAGED LEADERSHIP	<input type="checkbox"/> RED	<input type="checkbox"/> YELLOW	<input type="checkbox"/> GREEN	RANK
DATA DRIVEN IMPROVEMENT USING COMPUTER BASED TECHNOLOGY	<input type="checkbox"/> RED	<input type="checkbox"/> YELLOW	<input type="checkbox"/> GREEN	
EMPANELMENT	<input type="checkbox"/> RED	<input type="checkbox"/> YELLOW	<input type="checkbox"/> GREEN	
TEAM-BASED CARE	<input type="checkbox"/> RED	<input type="checkbox"/> YELLOW	<input type="checkbox"/> GREEN	
PATIENT-TEAM PARTNERSHIP	<input type="checkbox"/> RED	<input type="checkbox"/> YELLOW	<input type="checkbox"/> GREEN	
POPULATION MANAGEMENT	<input type="checkbox"/> RED	<input type="checkbox"/> YELLOW	<input type="checkbox"/> GREEN	

As a team, what is your nine-month goal as a participant in Evidence Now Southwest?
Think big about what you would like to accomplish.

SAMPLE

Practice Improvement Plan

To move towards this goal and considering the building blocks that your practice identified as priorities, write three SMART (Specific, Measurable, Attainable, Realistic, Timely) goals that will help you narrow down a place to begin your work with a focus on clinical interventions to improve cardiovascular risk.

Your practice is in the enhanced intervention arm of EvidenceNow Southwest. One goal should describe your plan for including patient engagement in your quality improvement efforts.

GOAL 1:

GOAL 2:

GOAL 3:

Which of these will your team begin working on this week? Consider how and who on your team is going to lead this effort.

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