What the Heck is Practice Transformation?

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Qualis Health, Healthier Washington, Healthier Washington Practice Transformation Support Hub

The First 4 Change Concepts

- A brief overview the first 4 change concepts
- A quick view of the some of the resources you will need to have at your finger tips for each concept
- Shared understanding of how the foundational four change concepts make possible the level of system performance required of practice transformation

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Structure, Function & Procedures

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Engaged Leadership

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Engaged Leadership

- Establish and oversee specific system-level aims at the highest governance level
- Develop a data-driven executable strategy to achieve the system-level changes, and oversee their execution at the highest governance level
- Channel leadership attention to system-level improvement: personal leadership, leadership systems and transparency
- Engage physicians
- Build improvement capacity

Level A Leadership

- Executive leaders: support continuous learning, act on quality data, and have long term strategy to implement and spread quality improvement initiatives
- Clinical leaders: champion & engage care teams in improving patient experience and clinical outcomes
- Hiring and training processes: support & sustain improvement in care and incentives rewarding patient-centered care
- Responsibility for QI: is shared by all staff and made explicit through protected time to meet and resources for QI

Quality Improvement Strategy

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Quality Improvement Strategy

- Form a QI team sponsored by leadership
- Focus on organization's strategic priorities
- Choose a QI Strategy:
  - What are we trying to accomplish?
  - How will we know a change is an improvement?
  - What changes will result in improvement?
- QI and Health IT are two sides of same coin
- Test ideas on a small scale: PDSA cycles
- Spread by adapting as well as adopting
- Keep everyone on track with task lists

Task	Who	When

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Level A QI Methodology

- QI activities: based on proven improvement strategy & used continuously to meet goals
- Performance measures: comprehensive; with clinical, operational, & Pt experience measures fed back to providers
- QI activities conducted by: practice teams supported by QI structure with meaningful input from Pts & families
- An EHR: that can support population management and QI efforts

Empanelment

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Empanelment means..

- Assigning every patient assigned to a PCP/care team
- Definition of “population” for population management and care coordination
- Population health on a scale clinicians can handle
- Basis for data transparency
- A paradigm shift: it holds clinicians accountable for decisions that patients make

Empanelment requires

- First see where a practice is
- Set up a structure to support empanelment
  - Panel manager
  - Close alignment with QI Team
- Assign patients using an algorithm
- Identify practices where demand & capacity are not balanced
- Enact policies to “right-size” panels

Level A Empanelment

- Patients: assigned to specific practice panels that used for scheduling, and monitored for supply & demand
- Registries with Pt level data: used to manage target populations across a range of target conditions and risks
- Clinical Decision Support: used by practice teams for pre-visit planning and Pt outreach across a range of target conditions and risks
- Reports on care processes & clinical outcomes: routinely provided to care teams, and reported externally

Team-base Healing Relationships

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Team-based Healing Relationship

- Key to provider satisfaction, yet providers resist for many reasons
- Team culture is more important than team structure
- Team culture can be build by functioning as a team
  - Meetings to plan work
  - Working together to improve care

Key Changes for Continuous Team-based Health Relationships

- Establish organizational support for care teams accountable for their patient panel
- Link patients & providers/care team so each recognize each other as partners in care
- Ensure patients are able to see their provider/care team when ever possible
- Define roles & distribute tasks to reflect skills, abilities and credentials of team members

Structural Requirements of Teams

- A manageable panel of patients for which the team is responsible
- Team members: sharing responsibility for the health and well-being of the panel
- Co-location: a common place to work
- Meetings: time to plan the work
- A common set of goals and incentives

No single configuration

Teamlet

- Physician
- Medical Assistant

Complex Team

- Physician
- Midlevel: PA-C or NP
- Registered Nurse
- 2-3 Medical Assistants
- Social Worker, Chronic Disease educator Therapist, Pharmacist shared across teams
- Receptionist

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Level A Care Teams

- Pts are encouraged to see their paneled provider and care team: by the practice team, and are supported by scheduling – and actually do see care team
- Non-physician care team members: perform key clinical roles that match abilities and credentials
- The practice: routinely assesses training needs, assures staff are trained for their roles and responsibilities, and provides cross training to assure patients are consistently met

The 4 Higher Level Change Concepts Objective

- A brief introduction to the 4 higher level change concepts
- A quick view of the some resources you will need to have for each change concept
- An understanding of how the upper level change concepts function together to allow care teams to achieve the goal
- The goal is the quadruple aim; the upper level change concepts are interwoven strategies

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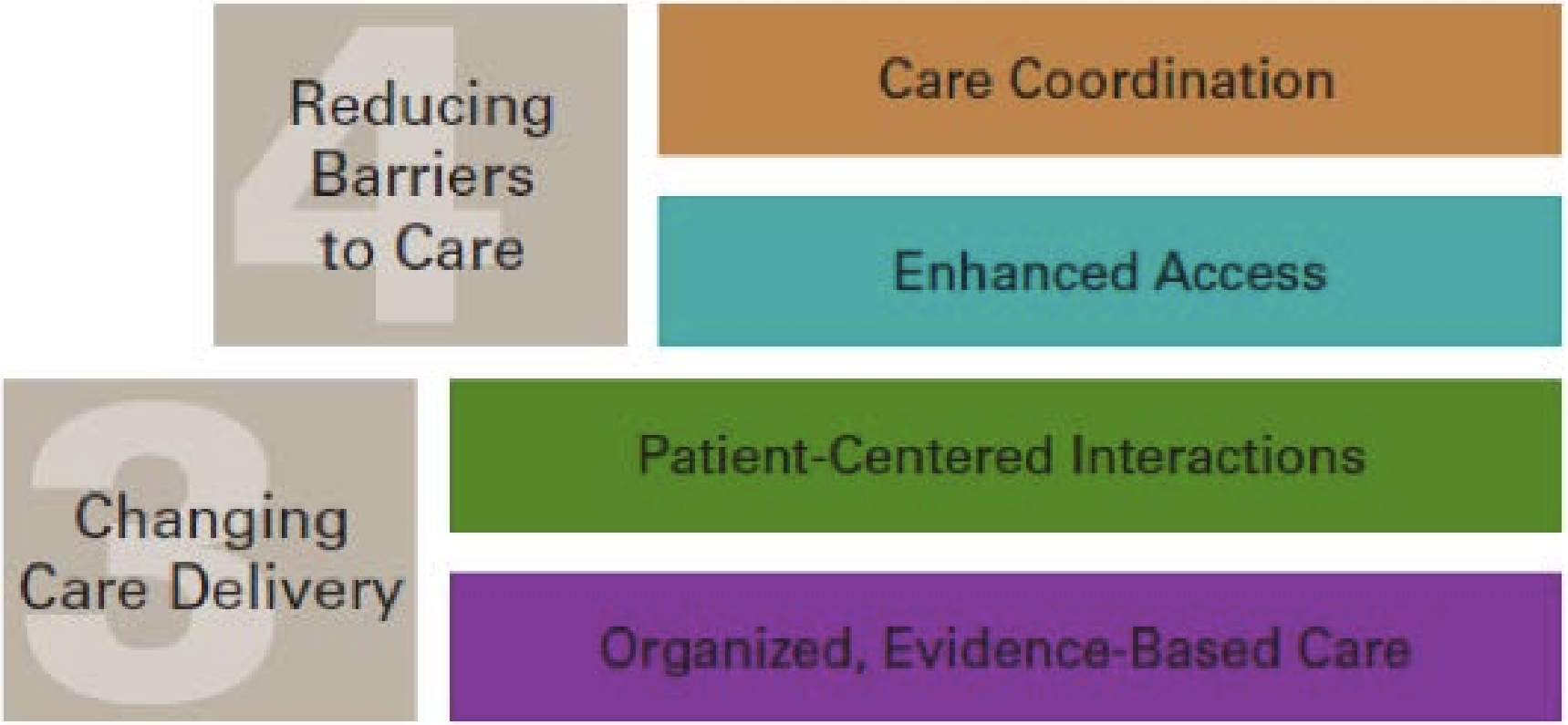
Upper-Level Concepts are Strategies



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Organized Evidence-Based Care

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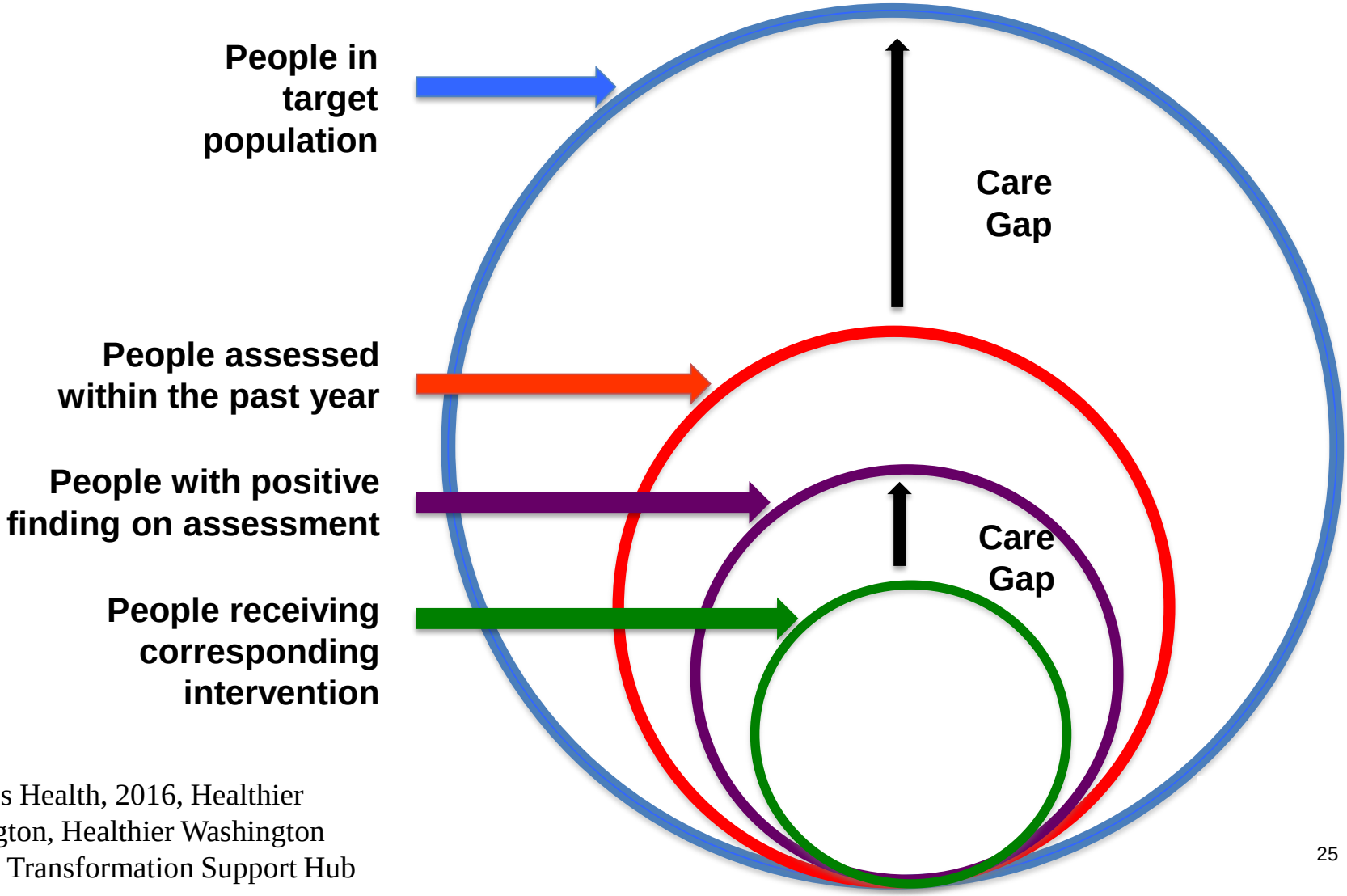
Organized Evidence-based Care

- Define high priority target populations
- Adopt a standard of care based on medical evidence
- Assure all members of the target population receive the standard of care
  - Population reporting
  - Optimal use of health information technology
  - QI methodology
  - Lean process engineering

Empanelment: the basis of data integrity



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QI Methodology: roadmap to improvement

- What are we trying to accomplish?
  - All our patients with hypertension have a most recent BP in chart within 6 months < 140/90
- How will we know a change is an improvement?
  - Run chart: percent of HTN patients meeting goal
- What changes will result in improvement?
  - HTN Registry; outreach to patients not at goal
  - Office visit workflow to assure elevated BP addressed
  - Standard protocol for addressing elevated BP including follow up
- PDSA cycles to test changes

Levels A Population Health

- Comprehensive guideline-based info on chronic illness & prevention: guides tailored individual data available at time of visit
- Visits: organized to address acute & planned care needs
- Care Plans: developed collaboratively with self-mgmt & clinical mgmt goals recorded routinely and guide care at every point of service
- Behavioral Health outcomes: measured and tracked on population health level & review regularly for QI
- Behavioral Health services: readily available, onsite or through community organization with referral protocol

Patient-Centered Care

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Key Changes for Patient-Centered Interactions

- Respect pts and families' values & expressed needs
- Encourage pts to expand their role in decision-making, health-related behaviors, & self-management
- Communicate with pts in a culturally appropriate manner, in language & at a level the pt understands
- Provide self-management support at every visit with goal-setting and action planning
- Obtain & use feedback from pts/family about their healthcare experience for QI

A Quality Improvement Approach

- Assessing how we're doing as a PCMH
- Gathering information about the needs of the patients in the panel
- Based on the needs measure our success in meeting those needs.
- Make a plan for improvement, and identify tools required to meet those needs
- Implement and test better ways to engage patients

Measuring Satisfaction

Patient Surveys publicly available for free

- CAHPS: Consumer Assessment of Healthcare Providers and Systems – AHRQ
- PCAT: Primary care assessment tool - Starfield
- ACESI: Ambulatory Care Experience Survey – Tufts University
- PEQ: Patient Experience Questionnaire University of Stirling, Scotland

Patient-Centered Communication

- Start every visit by establishing an agenda
- Elicit patient's perspective
- Be aware of the cultural beliefs that may be different than allopathic medicine
- Find out how much the patient wants to know
- Every diagnosis and treatment plan involves choices and priorities

Making Patients Partners in Care

- Patients as advisor on care teams
  - Patients receive training
  - Attend team meetings
- Patient participation on systems level
  - Participation in QI work
  - Feedback for all care processes that affect patients.

Level A Patient-Centered Interactions

- Assessing Pt & Family values & preferences: systematically done regularly & used for planning care
- Pt involvement in care decisions: supported by care teams trained in shared decision-making
- Communication with Pts: Supported by translation services, multi-lingual staff, training in health literacy & closing loop to assure Pts can manage at home
- Self Management Support: to assist Pt self-efficacy
- Principles of Pt Centered Care: used to guide change
- Pt-centered interactions: measured frequently and incorporated into quality improvement activity

Expanded Access

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Key Changes of Expanded Access

- Provide 24/7 Pt/Family friendly scheduling
- Reduce barriers to care
- Balance supply and demand
- Increase capacity
- Shift supply to cover gaps
- Decrease unnecessary demand

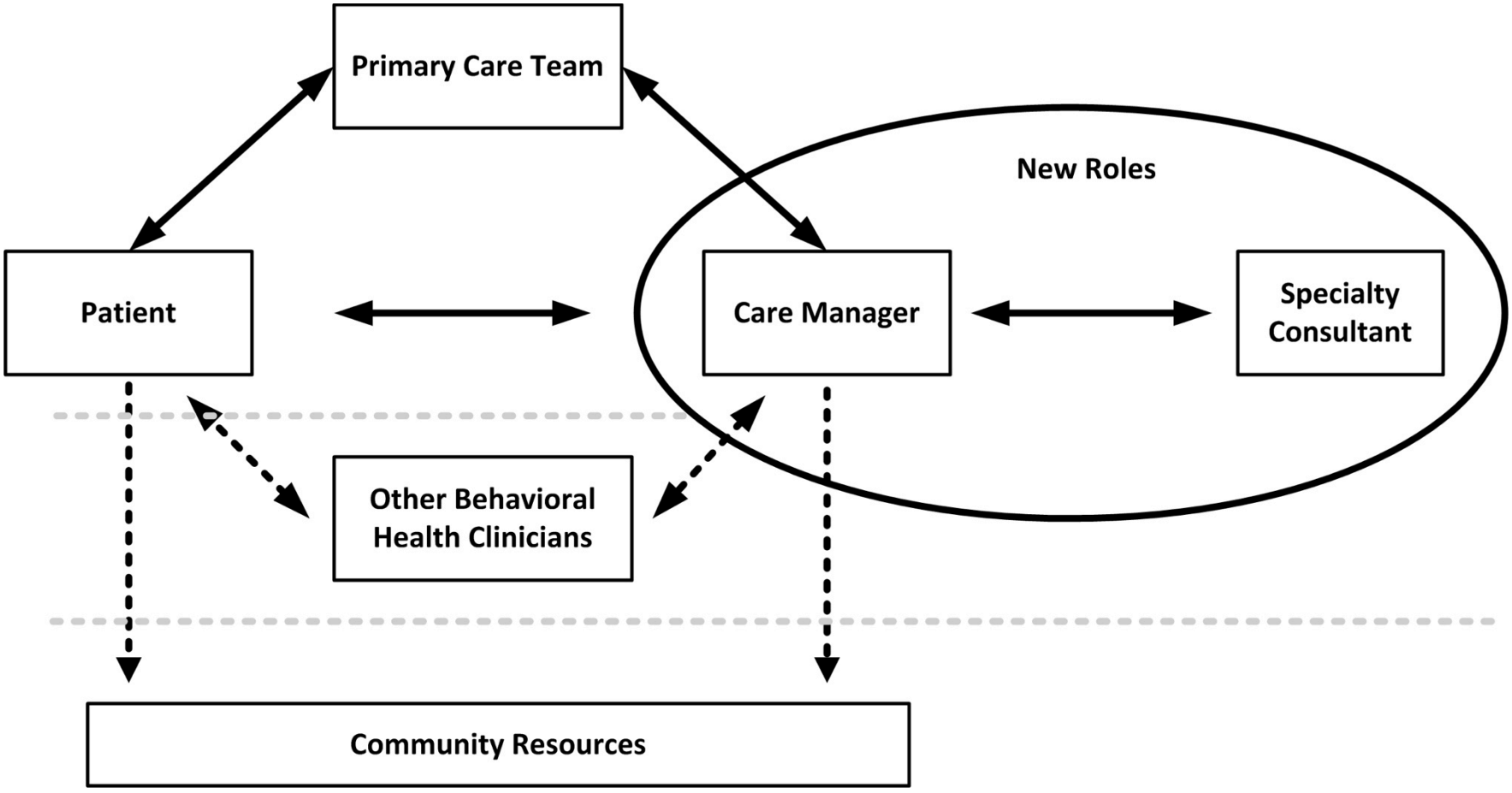
Level A Expanded Access

- Appointment systems are: Flexible, customizable, SDA, scheduled f/u & multiple provider visits
- Contacting practice time during business hours: done with email, phone using systems monitored for timeliness
- After hours access: available via choice of e-mail, phone or in-person by care team or provider in close contact with PCP
- Patients' insurance coverage issues: viewed as shared responsibility of patient and assigned member of the care team

Care Coordination Key Changes

- Link patients with community resources to facilitate referrals and respond to social service needs.
- Integrate behavioral health and specialty care into care delivery through co-location or referral protocols.
- Track and support patients when they obtain services outside the practice.
- Follow-up with patients within a few days of an emergency room visit or hospital discharge.
- Communicate test results and care plans to patients/families.

Collaborative Care Model



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Level A Care Coordination

- Specialty services: available from care team specialists, or providers in organization with referral protocols
- Behavioral Health: on-site care team members, or community organizations with referral protocol agreements
- Information for referrals: is communicated in advance and occurs with timely follow up after visit
- Hospital/ED follow up: is structured to assure primary care contact in a few days
- Linking Pts to community resources: via active coordination between systems by designated staff person
- Test results/care plans: consistently communicated conveniently to Pts

Questions?
Thank you

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