CHCANYS

Community Health Care Association of New York State

The Companion Guide for Quality Improvement Leaders

EvidenceNOW

An AHRQ Initiative

HealthyHeartsNYC

CHCANYS
Community Health Care Association of New York State

Table of Contents

Speaking Your Narrative: Data as a Catalyst for Change and Storytelling

Telling Your Story as a High-Functioning Team: Embracing Teamwork and Team-Based Care

Sharing Highlights from Your Story: Tools, Best Practices, Case Studies, and Recommendations

About CHCANYS

Community Health Care Association of New York State (CHCANYS), New York's Primary Care Association (PCA) and the oldest PCA in the nation, represents over 65 Federally Qualified Health Centers (FQHCs) serving 2.2 million patients statewide. CHCANYS recognizes the importance of providing timely services and resources that address health centers' need to optimize a robust quality improvement (QI) strategy that will help them survive and thrive in an era of value-based payment, while providing optimal and holistic patient-centered care that achieves the **Quadruple Aim** of enhancing patient experience, improving population health, reducing costs, and increasing joy in work.

The breadth of CHCANYS' support to its member health centers includes:

- **Analysis** of state and federal health regulatory and policy issues affecting health centers;
- **Training** and education for health center administrative and clinical staff, and Board members;
- **Workforce development initiatives** to improve recruitment and retention of primary care providers, and to provide career training for health center employers; and
- **Quality and technology initiatives** that assist health centers with developing a data strategy focused on data analysis, hygiene, transparency, and governance to support quality improvement and holistic transformation through innovative approaches, most notably by shoring gaps in care for patients in need of chronic disease management, behavioral health services, and preventive care and life-saving screenings.

In 2016, CHCANYS implemented an innovative data-driven practice facilitation and coaching model of technical support to better activate and sustain change within health centers, advance population health, and position FQHCs for success in today's value-based health care and payment systems. Through leading on-site meetings with multi-disciplinary care teams, practice facilitators serve as catalysts for change by sharing resources and the latest evidence-based guidelines; guiding teams through QI activities, such as **workflow mapping** and performance improvement strategies; and pollinating health centers' best practices across the network.

EvidenceNOW: Advancing Heart Health in Primary Care and HealthyHearts NYC (HHNYC)

The Agency for Healthcare Research and Quality (AHRQ)'s EvidenceNOW: Advancing Heart Health in Primary Care initiative aimed to reduce the risk of cardiovascular disease in patients at small- to medium-sized primary care practices throughout the nation. More specifically, EvidenceNOW created seven regional cooperatives comprised of 12 states, with the intent of impacting more than 1,500 primary care practices and the eight million patients they serve. HealthyHearts NYC, led by NYU School of Medicine with partners Primary Care Information Project of the New York City Department of Health and Mental Hygiene and CHCANYS, was one of the seven cooperatives. Participating primary care practices sought to improve the ABCS quality metrics of heart health:

- **A**spirin use by high-risk individuals;
- **B**lood pressure control;
- **C**holesterol management; and
- **S**moking cessation.

The nearly 300 small primary care practices that participated in HealthyHearts NYC received a 12-month practice facilitation intervention that utilized a range of organizational development, project management, quality improvement, and practice improvement methods to build the practices' internal capacity for quality improvement. Lessons learned from CHCANYS practice facilitators' work with 19 health center sites in HealthyHearts NYC formed the basis for this toolkit.

CHCANYS TIP

If the project involves adult medicine quality metrics (e.g., cardiovascular disease risk reduction among patients over the age of 18), it is imperative that an adult medicine primary care provider who is familiar with evidence-based guidelines and patient care is the team's provider champion in order to drive the adoption of guidelines and inform best practices in the clinical care setting. More on project teams in Chapter 2.

Health center sites participating in HealthyHearts NYC (HHNYC) were connected to the Center for Primary Care Informatics (CPCI). This robust and comprehensive data warehouse, overseen by Azara Healthcare and utilized by more than 50 Federally Qualified Health Centers in New York, includes benchmarking and reporting capabilities, as well as clinical tools such as pre-visit planning reports and specialized registries. Project Leads made generous use of CPCI's reports and clinical tools throughout the HHNYC initiative. This made reviewing and validating data, along with setting SMART Aims for improved patient health outcomes, much easier than if access to such a multi-functional warehouse was not available. While not all health centers have access to a comparable warehouse or platform, the electronic health record (EHR) provides health center staff with an advantage in maintaining and overseeing data quality and accuracy.

FUNDING SOURCE
Agency for Healthcare Reseach and Quality (1R18HS023922). The content is solely the responsibility of the authors and does not necesarily represent the official views of the Agency for Healthcare Reseach and Quality.

GOALS OF THIS TOOLKIT

This toolkit assists with the successful completion of the following key elements that define a QI project:

- Develop and maintain organizational capacity for QI activities;
- Identify, sustain, and spread best practices among care teams/clinical sites; and
- Build a powerful data narrative that embraces governance, accuracy, and accountability to drive practice transformation and organizational change.

Achieving targets for a set of quality metrics requires a **top-down approach** *(see Chapter 2 & Chapter 3)* where leadership and decision-makers are instrumental in ensuring that changes inform optimal clinical practice, workflows, and excellent health outcomes for patients. However, how effective are good leaders and decision-makers if the unique role and set of skills that the Project Lead possesses are not included in the mix? This toolkit will further distinguish the Project Lead as an empowered **change agent** *(see Chapter 2 & Chapter 3)* and conduit of information sharing between leadership and front-line staff. The Project Lead is also a leader in his/her own right, through relationships with clinical and administrative team members and an understanding of the various clinical QI tools that the organization uses. The Project Lead is then uniquely positioned to bring all of the organization's human capital and technical strengths to the forefront in order to achieve substantial patient care improvements.

WHO SHOULD UTILIZE THIS TOOLKIT

This toolkit aids the Project Lead and leadership, as well as PCA colleagues and practice facilitators *(see Chapter 1)*. The Project Lead responsible for overseeing QI projects at health centers and primary care practices can be a clinical or administrative team member (e.g. provider champion, nurse manager, nurse practitioner, registered nurse, practice manager) with a passion for QI/practice transformation and who possesses effective leadership skills. Moreover, the Project Lead ensures that the project's QI activities are completed on schedule (e.g., Plan-Do-Study-Act pilots, data validation). He/She is the true driver of the project.

HOW THIS TOOLKIT CAN HELP YOU

This toolkit illustrates how a designated Project Lead can:

- Help practices meet targets on a set of key quality metrics;
- Address clinical inefficiencies in medical care and workflows that impact value-based care, operational efficiency, and financial viability; and
- Create a routinized and systematic QI culture to underpin practice transformation and value-based payment contractual arrangements characterized by high performing primary care teams and improved health outcomes.

Health centers and primary care practices aiming to achieve excellent, quality care can do so by applying the key concepts and drivers utilized by CHCANYS' practice facilitators to promote enhanced care practices, sustainability and spread, and greater understanding and applicability of evidence-based guidelines within the clinical care setting.

Please follow the link to the cardiovascular disease key driver model. Note that the **outcome measures** were pre-defined by AHRQ for this research study. Establishing key concepts and drivers at the outset may assist with enhancing care practices, and sustaining and spreading project goals and achievements. *(Also see Chapter 1.)*

Your organization's transformation and quality improvement journey is a unique narrative. For that story and its related gains to unfold and be optimized, we strongly encourage that you use this toolkit sequentially; however, we also welcome you to refer to individual chapters as needed.

This toolkit is divided into five chapters, with a glossary of terms and links to websites, resources, and templates highlighted throughout that can be utilized in the design and implementation of a successful QI project. Each chapter includes instructions, as well as tips and case studies showcasing challenges and best practices.

This journey toward becoming a transformed primary care practice necessitates the following person-powered and change management elements:

- Engaged and supportive leadership;
- Multidisciplinary project teams with protected administrative time and a willingness and commitment to do the work;
- A culture that embraces data as a catalyst for change and ongoing improvement for "broken processes," and not as a means to reprimand individuals;
- Standardized policies, procedures, and workflows;
- Defined jobs and scope of work that encapsulate patient-centered care and teamwork;
- Thriving team-based care and pre-visit planning capabilities that, at their core, involve a provider and medical assistant/nurse duo or teamlet *(see Chapter 4)*;
- Established mechanisms for population health management, where patients are grouped by risk and effectively recalled back into care;
- Sharing of best practices; and
- Sustained community resources and partnerships.

CHCANYS
Community Health Care Association of New York State

CHAPTER 1

Initiating a Quality Improvement Project

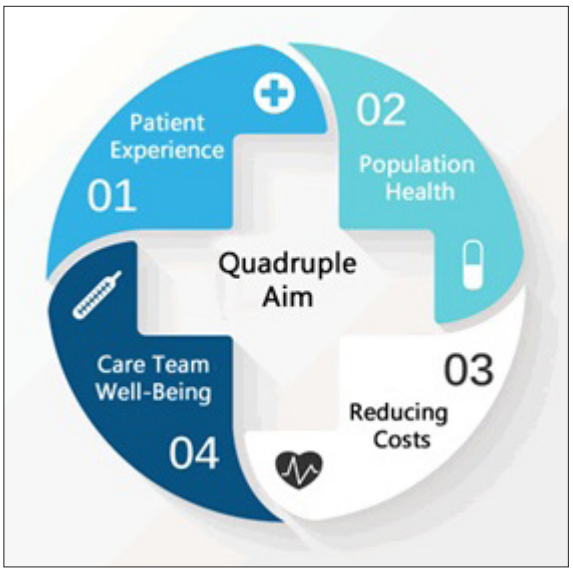
OBJECTIVE:

Describe the pre-work a Project Lead must do to set the stage for success

Improving patient care and outcomes is a key driver for health centers embarking upon quality improvement. Any health center staff member charged with leading a QI project, referred to throughout this toolkit as the **Project Lead**, must have a clear understanding of the value of practice transformation in a changing health care landscape to ensure the project's success. This chapter serves as a tool to help you, as the Project Lead, understand your role as a **change agent**, with support and direction from leadership.

THE VALUE OF PRACTICE TRANSFORMATION

In order to continue providing high quality care to patients in a value-based payment environment, practice transformation supports health centers as they adapt clinical and operational processes to anticipate the care patients require, manage the health of patients with chronic conditions, and maintain the holistic well-being of patients. These transformation efforts support the work that health centers do to promote the **Quadruple Aim** of enhancing patient experience, improving population health, reducing costs, and increasing joy in work.



Source: HITEQ – Health, Information, Technology, Evaluation and Quality Center

YOUR QUALITY IMPROVEMENT STRATEGY

Health centers must have a QI structure that aligns with the overall organizational goals and external environment, one which adopts a quality improvement model that regularly assesses, revamps, and builds efficiencies within existing workflows. Additionally, it is vital that a health center's QI strategy:

- Incorporates a quality management program that defines the health center's strategic direction;
- Serves as the blueprint for quality initiatives; and
- Includes a **quality management committee** that oversees and monitors ongoing quality improvement activities, reviews data, and makes recommendations.

Leadership Engagement and Communication

Your health center's QI strategy should incorporate frequent and transparent communication of the overall vision and performance data between health center **leadership** and all levels of health center staff. As the QI strategy is implemented, you, as the Project Lead, will serve as the liaison between leadership (where major decisions are made) and staff (who implement decisions which impact patient care and process). Throughout the project, you, with support from your health center's leadership, will maintain the influence and role as a change agent within the organization. You are critical for ensuring practice gains and true transformation.

As you collaborate with leadership to develop your plan at the outset of the QI project, consider frequency of communication and how to gain leadership support if there are roadblocks along the way.

Laying the Groundwork for QI Success

When initiating a QI project, your role as the Project Lead begins with understanding the purpose and value of focusing on a particular project, clinical workflows, measure or set of measures. It is important to emphasize that the Project Lead can be any individual within the health center who is charged with spearheading a quality improvement project. Both clinical staff (e.g., providers, nurses, nutritionists) and non-clinical staff (e.g., practice managers, QI directors) can be charged with the role of Project Lead.

CHCANYS TIP

Maintaining regular communication with leadership is vital for the success of your QI project.

It helps to schedule recurring check-in calls or meetings to keep leadership abreast of the project's progress and to secure the support needed to maintain momentum.

Frequent communication ensures that your project remains a priority of leadership.

As the Project Lead, it is imperative that you maintain regular communication with top leadership to ensure the QI project is aligned with the health center's overall strategy.

Consider these questions when engaging leadership at the onset of the project:

- Why have I been charged with leading this initiative?
- Is the focus on improving cardiovascular health, other chronic condition, or performance measure aligned with the health center's overall strategy?
- Is the focus related to a commitment to state, federal government, or other stakeholder goals, such as Healthy People 2020?
- What are the project's short- and long-term objectives?

Having this knowledge not only informs you, in your role as the Project Lead, on the specific priority areas that the project team should focus on, but also ensures alignment and reduces duplicative staff efforts.

THE ROLE OF THE PROJECT LEAD

Advocate for the Team

You are an advocate for the project team. This includes ensuring that team members are excited and motivated to participate in quality improvement activities, such as assessing current patient care practices, utilizing existing data infrastructure to monitor quality metrics over time, identifying areas for improvement, and testing and measuring ideas before implementation and routinization.

As the advocate, you also support the team by engaging with health center staff at all levels and within all departments to ensure necessary information, such as data, is available to the project team in a timely manner. You are also responsible for keeping health center leadership informed of the project's status.

Prioritize the Focus Area

Prior to launching your QI project, perform a needs and assets assessment by seeking input from various staff members. This will help you understand the gaps that exist within the health center's workflows and how they impact patients. It will also help you determine the resources available to address the identified gaps.

Based on CHCANYS practice facilitators' experience of implementing a cardiovascular disease (CVD) QI project (EvidenceNOW: Advancing Heart Health in Primary Care), below are a few questions you can modify to guide you in performing a needs and assets assessment:

- **What is the total population of patients with, or at risk for, CVD in my health center?** Having access to this population level data is necessary to build a good understanding of the disease prevalence in the health center, as well as which patients adhere to treatment and who needs further care. Careful review of the health center's Ischemic Vascular Disease aspirin and statin therapy measures could reveal differing prescribing practices of the health center's adult medicine providers, as well as any coding issues that may exist if the prevalence in your population is lower than expected.

- **How is patient information documented in the electronic health record?** Having a clear perception of current workflows is critical to understand where a process breakdown may exist, highlighting opportunities for staff education and, subsequently, improving clinical measures. Is documentation of blood pressure readings, for example, recorded in structured fields where data can be extracted from the EHR and presented in a report, or is this data documented freely in unstructured fields and, therefore, not able to be accurately captured in a report? Which blood pressure reading taken at a visit guides subsequent care?

- **Which factors influence the diagnosis of CVD and which staff member documents the diagnosis in the EHR?** Knowledge of the measure specifications for each related condition and whether patients are appropriately coded in the EHR is essential for ensuring that your project team understands and trusts the data you are working with. *(More information on data integrity and hygiene can be found in Chapter 3.)*

- **Is provider and clinical staff documentation standardized?** If not, what training opportunities exist? It is important to regularly review documentation processes and standardization with staff to ensure all of the great work they are doing is taken into account. For example, do all medical assistants document initial and repeat blood pressure readings the same way and in the same location within the EHR?

- **What internal resources does the health center have that support patients' CVD health?** For example, do case managers, nutritionists, pharmacists, and other ancillary staff support patients in the care of CVD?

- **What community resources are accessible to the health center in support of patients' CVD health?** Do resources exist that patients can tap into outside of the health center—such as nutritional programs, blood pressure self-monitoring programs, or tobacco cessation programs—in support of their journey to better cardiovascular health?

Establish Project Alignment

We encourage you to utilize a tool that demonstrates project alignment with other priority areas. This provides a snapshot view to help leadership and the project team understand the various levels within the health center at which the project supports transformation. The tool also encourages buy-in to preserve time and resources for the project.

Below you will find a sample CVD alignment grid that serves as a crosswalk between a current QI project and other larger initiatives. In this example, the project is aligned with the **Uniform Data System (UDS), Healthcare Effectiveness Data and Information Set (HEDIS)/Quality Assurance Reporting Requirements (QARR), Meaningful Use, Patient-Centered Medial Home (PCMH)**, and **New York State's Delivery System Reform Incentive Payment (DSRIP)** program, all of which propel health centers toward practice transformation.

Additional resources for building a similar alignment grid that includes state-specific reporting requirements, which can demonstrate additional value of the project, can be found on federal and state government websites (e.g., Uniform Data System/Health Resources and Services Administration, Centers for Medicare & Medicaid Services, New York State). *(See sample)*

QI Leadership & Team Cardiovascular Disease Alignment Grid

MEASURE TITLE AND DESCRIPTION	MEASURE DEFINITION	SOURCE	ALIGNMENT MU MODIFIED STAGE 2 UDS HEDIS/QARR	CURRENT QI PROJECTS
Aspirin as Appropriate	Percentage of patients 18 years and older with CVD with documented aspirin use.	NQF 0068	**MU** - CDS; CPOE; e-Rx; Med Recon; Pt Edu; Health Info Exchange; Pt Access; Secure Messaging	Related PCIP Projects: Academic detailing – Smoking Cessation National Diabetes Prevention Program DOHMH Hypertension Project
			UDS – Table 6B, Section J: Ischemic Vascular Disease (IVD): Aspirin or Antithrombotic Therapy (Line 18)	
			HEDIS/QARR - Aspirin Discussion & Use	
Blood Pressure Control	Percentage of patients 18-85 years old who had a diagnosis of hypertension and whose blood pressure was adequately controlled.	NQF 0018	**MU** – CDS; CPOE; e-Rx; Med Recon; Pt Edu; Health Info Exchange; Pt Access; Secure Messaging	
			UDS – Table 7:Hypertension by Race and Hispanic/ Latino Ethnicity, Section B (columns 2a-2c)	
			HEDIS/QARR – Controlling High Blood Pressure	
Cholesterol Management (Statin Therapy)	Percentage of patients whose cholesterol is being appropriately managed with statins.	Based on 2013 AHA/ACC Guidelines	**MU** – CDS; CPOE; e-Rx; Med Recon; Pt Edu; Pt Access; Health Info Exchange	
			UDS – N/A	
			HEDIS/QARR – N/A	
Smoking Cessation	Percentage of patients 18 years and older who were screened for tobacco use and who received cessation counseling as necessary.	NQF 0028	**MU** - Pt Edu; CPOE; e-Rx; Med Recon; Pt Access; Secure Messaging; Health Info Exchange	
			UDS – Number of pts queried about tobacco use and received cessation counseling intervention, as appropriate, column C	
			HEDIS/QARR – Medical Assistance with Smoking Cessation	

QI Leadership & Team Cardiovascular Disease Alignment Grid

Site and Systems Level Transformation – Activities		
	PCMH 2014 STANDARDS	**DSRIP**
QI Capacity	-Standard 2: Team-Based Care -Standard 3: Population Health Management -Standard 6: Performance Measurement & QI	**Domain 3.b.i** ***(Cardiovascular Health, Million Hearts Campaign):*** Evidence-based strategies for disease management in high risk/affected populations (adult only) **Domain 4.b.i** ***(Prevent Chronic Diseases):*** Promote tobacco use cessation, especially among low SES populations and those with poor mental health
Population Health Management ***(Empowered Patients & SMS Integrated)***	-Standard 1: Patient-Centered Access -Standard 2: Team-Based Care -Standard 3: Population Health Management -Standard 4: Care Management and Support -Standard 5: Care Coordination & Care Transitions -Standard 6: Performance Measurement & QI	
Care Teams ***(Empowered Patients & SMS Integrated)***	-Standard 1: Patient-Centered Access -Standard 2: Team-Based Care -Standard 3: Population Health Management -Standard 4: Care Management & Support -Standard 5: Care Coordination & Care Transitions -Standard 6: Performance Measurement & QI	

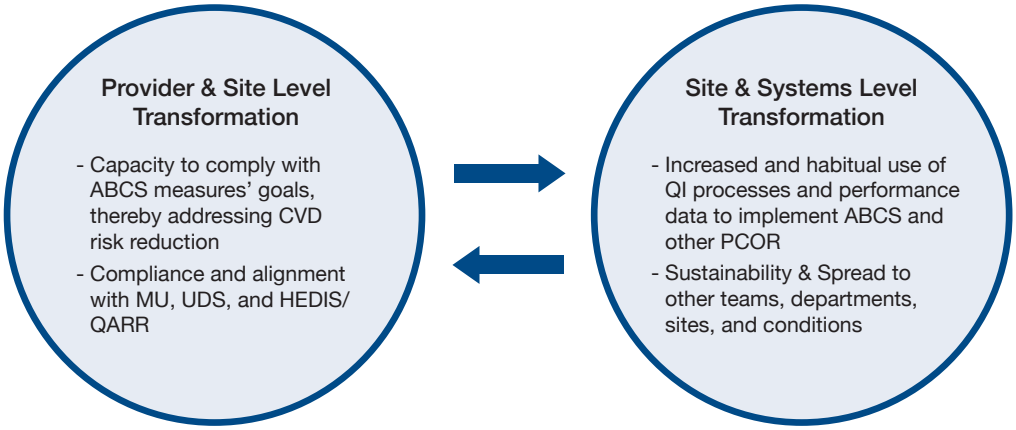
Resources:

1) UDS/HRSA: Reporting Instructions for Health Centers, 2015 - http://www.bphc.hrsa.gov/datareporting/reporting/2015udsmanual.pdf

2) CMS Medicare and Medicaid Electronic , Health Record (EHR) Incentive Programs, Final Rule Overview for Modified Stage 2 Measures (October 8, 2015) - https://www.cms.gov/eHealth/downloads/Webinar_eHealth_October8_FinalRule.pdf

3) NYS 2015 Quality Assurance Reporting Requirements - https://www.health.ny.gov/health_care/managed_care/qarrfull/qarr_2015/docs/qarr_specifications_manual.pdf

QI Leadership & Team Cardiovascular Disease Alignment Grid



The alignment diagram demonstrates for a health center how work on a cardiovascular disease QI project aligns with broader QI initiatives and overall ***practice transformation****. Provider and site level transformation activities such as building staff capacity to improve outcomes benefit larger programs such as Meaningful Use, UDS, and HEDIS/QARR. The QI activities also enable the health center to optimize processes, spread best practices, and create sustainable system level transformation.*

Review Baseline Data

You need to have a clear understanding of the project's focus measures. This requires knowledge of how to use the health center's data infrastructure to define the measures and establish the baseline data that will serve as a basis for measuring the project's progress. Take time to analyze the data to understand why it looks like it does and the story it tells about your health center's patient profile, patient population, and quality of care. We encourage you to further investigate the data, specifically a random sample of the numerator, denominator, and any exclusion of patients in the measure. We refer to this process as **data validation**, commonly known as chart review. *(A deeper dive into data validation is covered in Chapter 3.)*

Set SMART Aims

Working with the project team, you must set clear, well-defined goals that are **SMART** (Specific, Measurable, Achievable, Relevant, Time-bound).

Use your baseline data to establish what determine what the team is realistically able to accomplish during the project period. For example, is a 10%, 20%, or 30% increase in tobacco cessation rates realistic? *(See Tools and Templates for more information on establishing effective SMART Aim statements.)*

Utilizing the sample SMART Aim Statement Worksheet below can help your project team define its goals and remain focused throughout the course of the project.

SPECIFIC

MEASURABLE

ACHIEVABLE

RELEVANT

TIME-BOUND

SAMPLE SMART AIM STATEMENT WORKSHEET

SMART Aims help the project team stay focused. They are **S**pecific, **M**easureable, **A**ttainable, **R**ealistic/**R**elevant, and **T**imely).

Here's a guide to follow:

South End Clinic intends to: *(This is a general over-arching statement describing what you intend to accomplish during the time you work on this project – it answers the first question of the Model for Improvement. - "What are we trying to accomplish?" Use the Project AIM as a basis and individualize your AIM statement to reflect the unique needs and resources of your health center or system)*:

improve blood pressure control in adult patients _____

by *(time frame, i.e., month/year in which you intend to accomplish improvement)* **December 2017**

for *(what group are you doing this for – what is the target population)* **adults of ages 18 – 85 years**

because *(the rationale and reasons to work on this improvement project)* **as part of *HealthyHearts NYC EvidenceNOW: Advancing Heart Health in Primary Care quality improvement project.***

_____

Example SMART Aim: To improve hypertension control rate from 62% to 70% among the clinic's adult patient population by December 31, 2017.

Specific target goal for improvement for South End Clinic**:**

Measure of Focus	Baseline Data	Target Goal
Blood Pressure Control	**62%**	**70%**

Identify the Project Team

In addition to maintaining regular communication with leadership, you need to build a project team comprised of staff members who represent a variety of roles within your health center. Ideally, the project team should include a clinical champion (e.g., physician, nurse practitioner), member of operations (e.g., chief operations officer, practice manager), EHR or data analyst, and clinical support staff (e.g., medical assistant, licensed practical nurse, care coordinator). Also think about the value that a care manager, social worker, and data analyst can add to the project. These diverse team members are **sharing the care** of patients and will bring unique perspectives to the project. *(More information on the structure and dynamics of a project team is provided in Chapter 2.)*

The assembled project team will need the support of health center leadership in dedicating time for project team meetings and undertaking QI activities. Teams are highly invested in projects when they know they have **leadership buy-in** and support.

CHCANYS
Community Health Care Association of New York State

CHAPTER 2

Building Your Team and the Foundation for Success

OBJECTIVE:

Build the team and strategically align project goals with leadership's over-arching vision

Continuous **quality improvement (QI)** consists of ongoing, consistent actions that advance the delivery of primary care and health outcomes for patients. QI is a data-driven methodology that identifies areas for improvement. Organizational leaders should identify clinical, operational, and financial areas of focus that meet external and internal priorities related to care delivery. As the Project Lead *(see Chapter 1 for your role)*, we encourage you to guide the diverse project team in identifying issues and solutions for improved care and outcomes around a particular initiative, quality measure(s), or clinical process.

BUILDING YOUR DREAM TEAM

We encourage you to keep your team small. Teams of no more than six are easier to manage and can more efficiently explore, **pilot test**, and implement their performance improvement ideas to achieve success. Additional staff can be invited to future meetings for consultation on relevant subjects or to enrich discussions, as needed; however, the core project team remains accountable for the project's progress.

Include Diversity

When building your core team, consider the different roles, experiences, knowledge, and expertise that each team member will bring to the project. CHCANYS practice facilitators have learned that in order to successfully change clinical processes, an effective project team is likely to consist of diverse staff members, including:

- **Clinical champion:** A medical director, nurse practitioner, or physician's assistant, for example, with enough authority to develop clinical protocols supporting the project, approve transformation pilots or tests, and make decisions to implement new processes within the health center
- **Technical expert:** An EHR specialist or data analyst who knows the intimate workings of your health center's technical tools, data, documentation practices, and processes related to the project
- **Support or ancillary staff:** This is dependent on the focus of the project and could include a medical assistant, nurse, front desk staff member, nutritionist, social worker, behavioral health staff member, and/or billing specialist
- **Operations staff:** Someone who provides day-to-day **leadership**, such as the site director or practice manager
- **Executive sponsor:** Generally an executive leader and decision-maker, such as the chief medical officer or chief executive officer, who carries the ultimate responsibility for the project's success and ensuring the team has the time and resources necessary to successfully implement change; the executive sponsor will have an intermittent presence on the project team
- **Patients and/or caregivers:** They can bring a refreshing perspective to QI projects that focus on the patient experience and can be included in meetings as-needed

CHCANYS

TIP

Well-chosen project team members who represent the full diversity of health center roles will bring varying and unique perspectives and expertise to a project.

It will be necessary for team members to dedicate time to participate in meetings and performance improvement activities required by the project.

Similarly, it is important for you to recruit staff members who are motivated and willing to share responsibility for the success (and failure) of the project.

Note that the make-up of the core team is dependent on the project. For instance, a project that focuses on the implementation of a social determinants of health assessment tool, which assesses patients and collects social risk factors, would have a core team consisting of operations, clinical support (e.g., care manager), and a technical expert, with a clinical champion occasionally attending meetings related to the overlap of clinical co-morbidities and social determinants of health. This differs from broader projects that are centered on improving clinical **performance measures**, where a medical provider and clinical support staff member would play primary roles.

Keep in mind that staff roles directly impacted by the QI project at-hand should be represented on the team. For example, when establishing a referral management QI project team, it is critical to include a provider, referral specialist, and any other staff member who initiates, addresses, and/or follows up on referrals.

Individuals may think they can speak to the role of another staff member within the health center, but this is often not the case. For instance, a medical assistant may not be able to accurately speak to the services or education resources that a registered dietician provides to patients. Both of these staff roles bring unique expertise to the table when discussing workflow improvement around high blood pressure control. Therefore, it is important to obtain first-hand information from individuals who perform each role to ensure accuracy in understanding complex workflow processes in which multiple staff are involved.

Once team members are selected, create a project team grid that outlines the staff members who are committed to the project, their roles on the team, and the activities assigned to each role. This grid will serve as a resource for the team, and as a roster that leadership can reference for assuring staff members can dedicate time for QI activities. Keep in mind that the project team grid is a living document that you should update as additional staff join the team, new roles are assigned to project team members, and/or there is staff turnover. You are encouraged to review this tool regularly with the team to ensure individual accountability. *(See sample cardiovascular health QI Project Team Grid below.)*

CHCANYS
Community Health Care Association of New York State

Cardiovascular Health QI PROJECT TEAM GRID
Project Start Date: February 1, 2017 and End Date: January 31, 2018

Project Team Member Name	Role and Title	Contact Email	Contact Phone	Assigned Activities
	Provider Champion (Chief Medical Officer, Medical Director)	name@healthcenter.org		• Create leadership and staff buy-in to participate in QI projects and ensure that activities are performed to the best of the QI team's ability. • Provide clinical perspective to improve patient and population health • Assist with sustainability and spread of good workflow changes by communicating to leadership and staff.
	EHR Support/Data Analyst (IT Director)	name@healthcenter.org		• Discuss dashboards and reports in detail during structured team meetings. • Assist with chart reviews to ensure structured and uniform documentation in the EHR, which translates to accurate reports.
	QI Project Team Lead	name@healthcenter.org		• Coordinate team meeting and ensure attendance • Provide direction and focus to team activities • Advocate on behalf of QI team to leadership with the aim of driving lasting change, and spreading improved workflows to other teams and/or sites. • Lead workflow mapping activities in order to best address inefficiencies in current systems of care. • Communication- keep executive champion and organization apprised of the project
	Site Administrator (Practice Manager)	name@healthcenter.org		• Help to train staff on new workflows, policies and procedures • Assist with sustainability and spread of good workflow changes by incorporating into procedures and policies
	Clinical Support Staff (Ex. Medical Assistant, Registered Nurse, Clinical Pharmacist, Nutritionist)	name@healthcenter.org		• Help to train staff on new workflows, policies and procedures • Provide clinical perspective to improve patient and population health • Provide insight on the patient and family/care giver experience

DRIVERS OF SUCCESS

Aligning with Other Health Center Priorities

Chapter 1 of this toolkit discusses your critical role as the Project Lead in establishing a partnership with health center leadership (e.g. chief medical officer, chief executive officer). We encourage continuous, bi-directional communication with leadership, beginning at the outset of the project. This ensures project goals remain on target and aligned with the health center's priorities (which may shift), as outlined in the project alignment grid. We encourage you to attend health center meetings to provide project updates. Chapter 5 of this toolkit further explores opportunities for sharing best practices.

Project Alignment Case Study:

CHCANYS practice facilitators cultivated a meaningful partnership by working closely with the deputy chief medical officer of a large, multi-layered health center system and the Project Lead of a quality improvement project to ensure it aligned with existing U.S. Department of Health and Human Services, Health Resources and Services Administration, and Healthcare Effectiveness Data and Information Set goals that were part of the health center's larger clinical strategic plan.

Partnership with the deputy chief medical officer also empowered the Project Lead to maintain alignment with other center-wide initiatives led by the director of nursing and assistant vice president of operational integration on the health center's data strategy (see Chapter 3), team-based care (see Chapter 4), and patient empanelment.

Prior to launching the project, CHCANYS practice facilitators conducted bi-weekly calls with the deputy chief medical officer to determine which staff members would be assigned to the project, how often the team would meet, where, and for how long. As the project progressed, the bi-weekly calls transitioned to monthly calls and involved the Project Lead. These discussions continued to the end of the project and culminated in the creation of a sustainability plan for maintaining project achievements and alignment.

In the absence of a practice facilitator, the example above illustrates the partnership a Project Lead needs to form with the project's executive sponsor and other leadership staff to enable the project team to receive support necessary to engage in QI activities early in the project. The executive sponsor can guarantee staff assigned to the project dedicate time necessary to attend team meetings, focus on Plan-Do-Study-Act (PDSA) cycles, and sustain successful changes that, in turn, support larger health center initiatives.

CHCANYS TIP

Although the Project Lead contributes to the creation and modification of the project plan with specific project deliverables, the health center's QI leadership is ultimately responsible for this document.

Creating a Project Plan

A **project plan** is a roadmap that describes what the project team is planning to achieve, demonstrates the steps that the project team will take to reach its goal, and establishes a timeline for achieving each step. This plan should be developed with guidance from the health center's QI leadership and will serve as a reference for project team members and other health center staff.

Creating and following a project plan will help keep your team on track, and foster accountability and ownership. When implementing a project, challenges and roadblocks are inevitable. Having a project plan will help you and the team anticipate milestones that will be impacted by challenges and roadblocks, and help set the team back on course. *(See sample HHNYC Project Plan.)*

The project plan is a dynamic document you should reference regularly and modify as the project evolves to track the team's progress and reflect changes in the health center's priorities. The plan should provide details of the project, including:

- Project background;
- Description of project structure, including the QI methodology/model for improvement that will be used;
- Project team members;
- Meeting structure and frequency;
- SMART aim statement;
- Project timeline and relevant QI activities, including data review; and
- Project monitoring plan.

Running Effective Team Meetings

In working with multiple **project teams** over the years, CHCANYS practice facilitators have found that **team member engagement** dramatically increases when the Project Lead plans, in advance, an organized meeting and agenda. This preparation will help you facilitate a robust and interactive discussion. We also recommend distributing the agenda to project team members at least one day prior to the meeting and including homework or follow-up tasks, of which you will ask for a status update during the meeting. This ensures the project team comes prepared. *(See sample meeting agenda)*

Launching the Project

The first meeting or **project launch** sets the stage for the project and future meetings to come. CHCANYS practice facilitators have found that successful project launch meetings:

- **Provide information about the project's background:** Explain the reason for embarking on the project and demonstrate alignment to staff members' daily work and other health center initiatives. This provides the opportunity to cultivate buy-in, as our project team will see this as not "another project or thing to do;" but, rather, a chance to make a positive impact on what they are already doing.
- **Are attended by the executive sponsor or other leadership representative:** This gives you and the project legitimacy and demonstrates to the team that health center executive staff support the project.
- **Define each team member's role and communicate expectations:** This can be accomplished through a team-building exercise, which can strengthen team cooperation and collaboration. *(See sample Team Building Activity – 20 Questions video and customize questions to fit your team.)* You can also facilitate a *'ground-rules'* activity, which will help define acceptable and expected team behavior and etiquette. *(See Team Building Resources.)* Finally, discuss in detail the roles and responsibilities of each team member and how they impact the success of the project.
- **Present a Project Timeline:** Establishing a timeline enables the team to visualize what they can expect to unfold over the course of the QI project. The sample timeline below is based on an intensive 13-session Pre-Visit Planning QI Project. This timeline highlights the project curriculum and each session topic, clearly identifying which team members are required to attend each meeting and the anticipated duration of each meeting. This level of detail can be fine-tuned through discussion with leadership and as part of building the project plan, and can include the different concepts that will help achieve your project goals. Project team members should use this timeline as a guide when planning for each meeting. Referring to this timeline will help you anticipate when to invite guest attendees to meetings, as needed.

CHCANYS TIP

Project team meetings create a space where each team member can step away from his/her daily routine, reflect on the project goals, and contribute to the team's improvement efforts.

Utilize existing technology, such as email or the health center's EHR system, to schedule regularly recurring meetings at a date and time that works for all project team members.

Set up reminders to be distributed to the project team in advance of each meeting, and remind team members who were assigned tasks to have a status update ready to present at the meeting.

If possible, hold the meeting off-site, as this will infuse new energy, avoid disruptions, and ensure total focus of your team.

VISIT PLANNING IMPLEMENTATION PROJECT: Curriculum and Timeline

PHASE I
Planning

	1	2	3	4	5
Session # / Agenda	Project Introduction (1 hr.)	Configure Alerts & Data Validation (1.5 hrs)	Standing Actions (1.5 hrs)	Workflow Mapping (2 hrs)	Review Data Validation (1 hr)
Project Lead					
Leadership Team					
Clinical Team					
QI/Data Team					

PHASE II
Pilot Roll-out

	6	7
Session # / Agenda	Project Team Pre-Work Presentation to Leadership Team (1 hr.)	Huddle Coaching (3 hrs)
Project Lead		
Leadership Team		
Clinical Team		
QI/Data Team		

PHASE III
Ongoing Support

	8	9	10
Session # / Agenda	Pilot Team Huddle Support (30 min)	MA Huddle Support (30 min)	Pilot Team Huddle Support (30 min)
Project Lead			
Leadership Team			
Clinical Team			
QI/Data Team			

PHASE IV
Expansion

	11	12	13
Session # / Agenda	Pilot Teams Outcomes Presentation Leadership Team (1 hr)	Develop Expansion Plan (1.5 hrs)	Project Wrap-Up (1.5 hrs)
Project Lead			
Leadership Team			
Clinical Team			
QI/Data Team			

Leadership Team:
Includes CMO/Medical Director and at least two other individuals. Ideally will include at least one **C-Suite** Executive, CMO/Medical Director, MA Supervisor, Director of HIT, Director of QI, and any other leadership role(s) instrumental in implementing team based care practices at your health center. Leadership Team should understand the project, agree to its scope and requirements, and empower staff to work on it. Are decision-makers who will help integrate PVP into health center culture.

Clinical Team:
Includes CMO/Medical Director, MA Supervisor, Provider Champion and MA Champion. Are "early adapters", open to change, and accepting of new or modified care team roles. Are involved in the project's Planning Phase leading up to implementation of the PVP report and huddling.

QI/Data Team:
Includes EHR/IT Manager and QI Manager. Responsible for conducting data validation to ensure accuracy of the PVP report.

View sample timeline

CHCANYS
Community Health Care Association of New York State

CHAPTER 3

Nurturing a Culture of Accurate and Trusted Data

PART 1: Contributing to the Data Culture: Maintaining Data Hygiene/Cleanliness through Validation

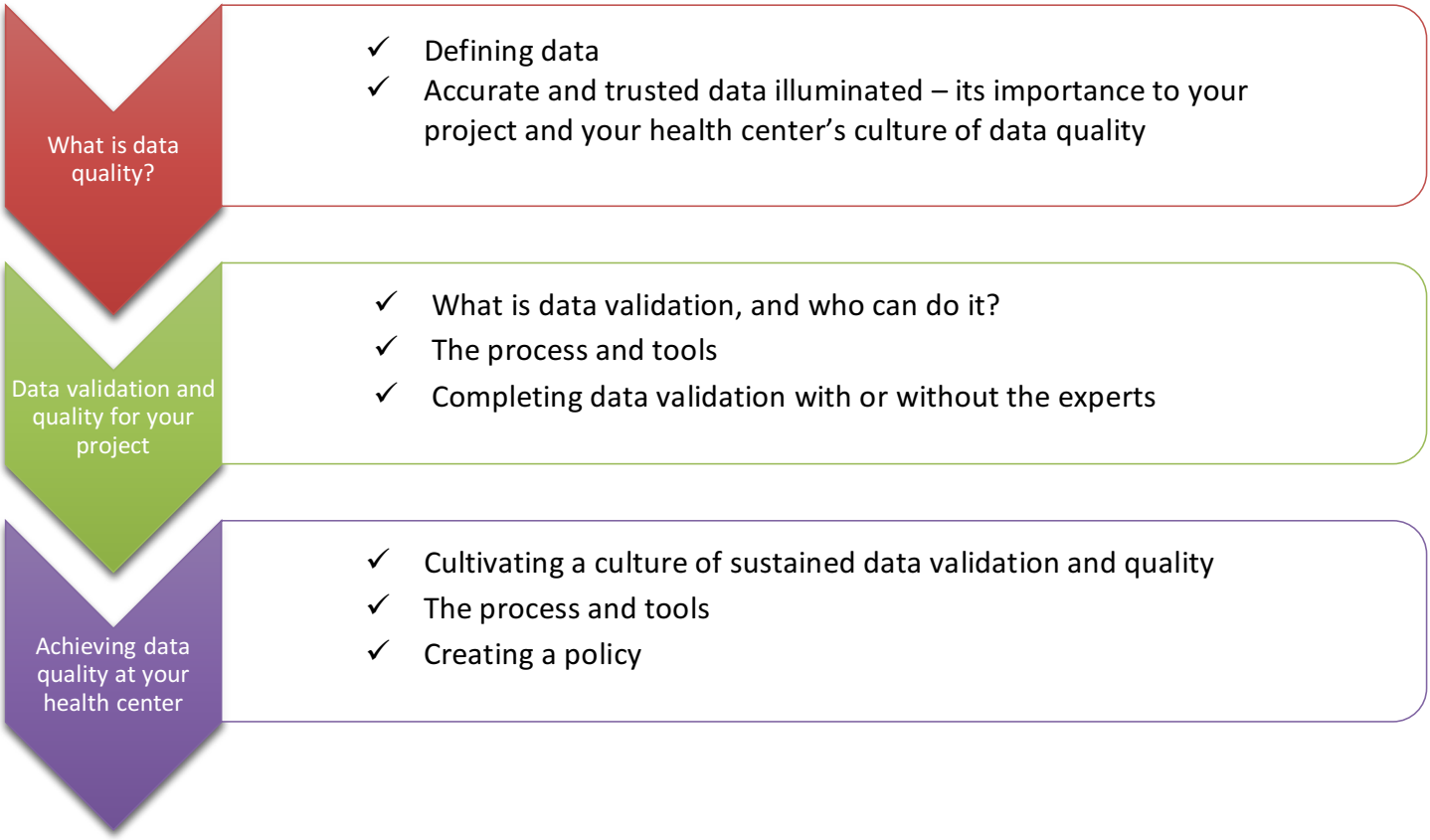
OBJECTIVE:

Highlight the value of clean, accurate data, ensuring data quality and its use in decision-making and improving patient health outcomes

This chapter is designed to guide you in validating data, using whatever tools and staff members are available. Part 1 focuses on defining data and its vital role in dictating quality improvement and enhancing patient care and experience at your health center. Most importantly, you will be given concrete steps and guidance on how to validate data and who should do it. Part 2 will help you develop, in collaboration with health center leadership, a data strategy and plan.

Your health center's electronic health record (EHR) features prominently in your quest to ensure data accuracy, as it is a repository of all patient level data that your clinical care teams have amassed. This data tells two compelling stories—one of the individual patient's clinical care and social needs, and how health center staff can best address them; and one of the needs and care gaps that exist among the health center's larger patient population.

The trajectory of this chapter is best summarized in the graphic below.



DATA DEFINED

Data for the purposes of this project is patient information that is produced and stored by your health center, or by another organization and shared with your health center. Data includes, but is not limited to:

- Patient clinical records;
- Patient demographic information;
- Health plan claims and cost information;
- Financial records;
- Number of visits;
- Wait times;
- Patient hospitalizations; and
- Emergency department visits.

This patient information is also a collective narrative to which all staff who document in the EHR contribute. It tells a story about health outcomes and improvements that can be made in the care that patients receive.

The word "data" can also represent:

- Performance improvement via provider dashboards, scorecards, and storyboards
- Status of reporting requirements for federal, state, and specialized initiatives (e.g., Uniform Data System, Quality Payment Program/Merit-based Incentive Payment System, Delivery System Reform Incentive Payment Program, Healthcare Effectiveness Data and Information Set/Quality Assurance Reporting Requirements, Meaningful Use)
- Tracking your health center's priority metrics (e.g., preventive screenings, such as breast and colorectal cancer; uncontrolled hypertension)
- Tracking of state and federal priority metrics (e.g. *Healthy People 2020*)

Data Quality and the Role it Plays in Nurturing a Culture of Accurate and Trusted Data

Part of building a strong foundation for your QI project's success is contributing to your health center's **data strategy and quality**, and the story that it tells about patients' health outcomes. With accurate and trusted data, QI efforts around team-based care and population health management are continuously refined and serve as the medical home your health center strives to create for its patients.

The bricks and mortar that constitute your medical home include team-based care (which supports teamlet huddles and pre-visit planning for targeted, individualized point-of-care) and population health management (which supports the use of registries in order to effectively group patients by risk for care management, outreach, and recall). Of course, in order to make bricks and mortar withstand the pressures and hurdles of the daily elements (e.g., treating complex patients with multiple co-morbidities safely and efficiently, no matter the perceived lack of staffing or resources), you need a strong foundation comprised of a stalwart data strategy, effective team, and dedication to quality improvement.

Your **medical home**, as demonstrated within the confines of this toolkit, is comprised of the following:

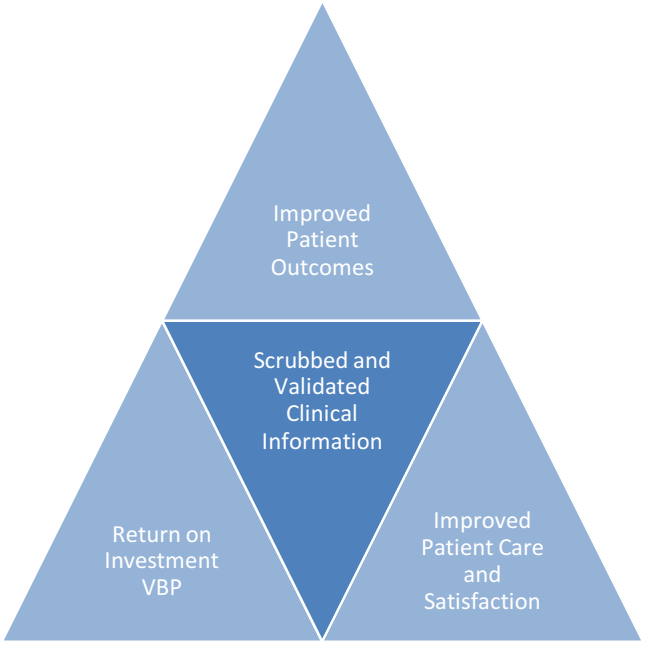
Initiating a Quality Improvement Project (Chapter 1), Creating your Team and Foundation for Success (Chapter 2), and Nurturing a Culture of Accurate and Trusted Data (Chapter 3). Once your foundation is strong, the gains of Team-Based Care and Population Health Management (Chapter 4), which serve as your home's bricks and mortar, can then be successfully implemented and serve as the impenetrable walls of your home, which are tantamount to excellent patient care.

Why Accurate and Trusted Data Matters

Accurate and trusted data is comprised of the following elements:

- Improved patient outcomes;
- Improved patient care and satisfaction;
- Return on investment of value-based payment; and
- Scrubbed and validated clinical information.

Components of Accurate and Trusted Data



The intersection of these positive outcomes are best depicted in the graphic below.
Accurate and trusted data also matters to you, as the Project Lead, and the health center in these various ways:

To the Project Lead

- ☐ Allows the project team to get right to work with setting **SMART Aims** and implementing **plan-do-study-act rapid cycles of change**
- ☐ Avoids the dreaded "this data doesn't look right" from being uttered at the onset of the project and derailing momentum and progress
- ☐ Enables the project team to track improvements over time with confidence
- ☐ Emboldens the project team to present improvements to various stakeholders (e.g. leadership, staff, patients, and the Board) with confidence

To your Health Center

- ☐ Informs patient care and decision-making on how to improve it
- ☐ Allows for the proactive use of clinical tools by care teams, such as **registries** for targeted recall and outreach (e.g. **population health management**) and **pre-visit planning** to proactively address individual patients' gaps in care before the visit, such as missing labs, tests, and screenings (**team-based care)**

CHCANYS

TIP

EHR documentation trainings and refreshers are a must to ensure standardization, even among experienced and seasoned staff. Do not assume that a written policy is up-to-date, or that everyone abides by it. Changes and updates in coding, workflows, and bi-directional interfaces with lab companies and health information exchange are constant.

Internal staffing and leadership changes also impact standardized documentation. Free text and documentation in multiple places within the EHR has a ripple effect, directly undermining billing, reporting, and the ability to quantify, via dashboards and reports, the quality care that clinical teams are providing to patients.

Optimized clinical care is also undermined when patient information, including diagnosis codes, medications, and treatment protocols, is inaccurately documented or not updated. This impedes the actionability of pre-visit planning reports and registries.

ACCURATE AND TRUSTED DATA 101—IT'S TIME TO VALIDATE

Accurate data is documented in a standardized manner within the patient note in the EHR. **Data validation** is the process of ensuring data is accurate and trusted. From structured fields within the EHR, reports, dashboards, and clinical tools can be reliably generated.

The three main causes of inaccurate data are:

- **Documentation:** Is free text used instead of structured fields? Do health center guidelines dictate the use of specific fields to document specific pieces of information?
- **Workflows:** Do staff document the same information in different fields? Is re-training warranted if the variation is widespread enough?
- **Mapping:** Do your data tools generated from other complementary tools, warehouses, or platforms accurately reflect what is entered into the EHR? In other words, is this information correctly mapped?

Data validation requires that a team of select individuals within the health center take responsibility for **scrubbing data** and overseeing the quality of data documented in the EHR. These individuals should review the accuracy of data as recorded in structured fields. They must also ensure that the data is correctly mapped to the complementary warehouses, registries, and additional platforms your health center is using.

You will need these selected individuals to validate your project's metrics using protected administrative time to do the work. Ideally, your health center's data team should consist of:

- **EHR specialist or director of information technology:** Understands the ins and outs of the EHR and where to best document in structured fields and templates; this individual ideally understands the physical hardware and software capabilities of the actual computer system and, more importantly, data input or documentation practices and the reasoning behind them
- **Data analyst, informatics specialist, or director of information technology:** Oversees reporting needs and submission requirements of federal and state funders from the EHR, as well as other complementary tools and sources
- **QI lead (e.g., manager or director):** Has a grasp on reporting requirements for all of the health center's performance metrics so that project deliverables from different state and federal stakeholders are met
- **Additional specialist:** Oversees other tools being used at your health center, such as a referral management platform, data warehouse, or other clinical tool
- **Clinical lead (e.g., chief medical officer, medical director, registered nurse manager):** Is familiar with patient care workflows from check-in to check-out, and can speak to the reasoning for preferred documentation practices among clinical care teams

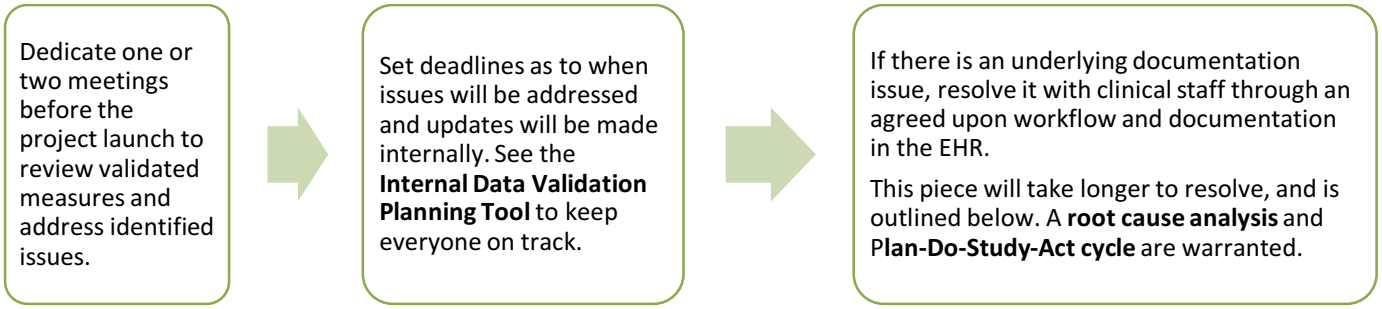
Data validation is a time-consuming but critical component of ensuring data quality. Your health center's data team has the capacity and expertise to validate data contained in the reports pulled from your EHR and other data aggregation tools. Utilizing the data team to ensure the accuracy of project data will enable you to focus on enhancing overall performance on project metrics.

When pulling reports from the EHR and other tools, the data team should consider:

- Where, specifically, the data is being pulled from
- How data is mapped from the EHR to additional tools, such as a data warehouse
- Why mapping might be inaccurate or out-of-date (e.g., changes or updates were not reported to the vendor; staff turn-over)
- Trending data or provider dashboards looks odd (e.g., an unexplained dip or improvement) and what this might mean if technical issues are ruled out (e.g., a provider is on medical leave; staff turn-over at a particular site; holiday season or other special occasion that significantly contributes to low patient volume in a particular week)

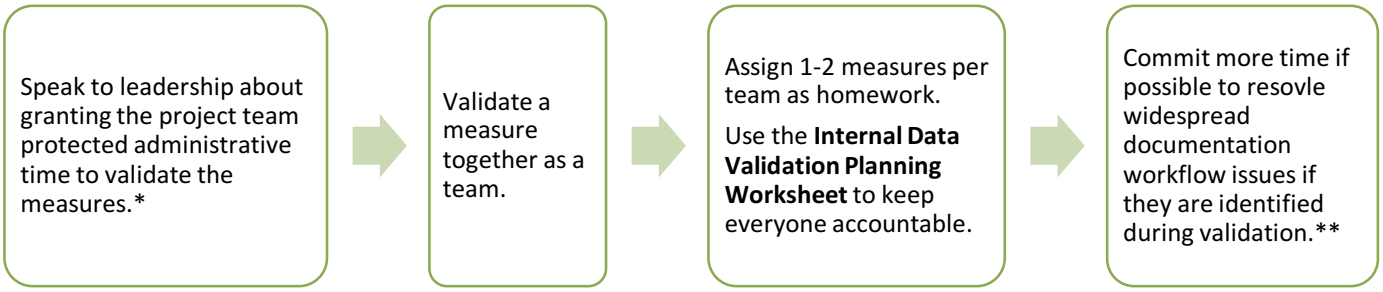
Validating your project's metrics need not be a daunting task, if you and the project team work together to consider corresponding workflows and staff training needs.

Next Steps When You Have the Experts



Next Steps When You Don't Have the Experts

If your health center does not consistently conduct data validation, or if a dedicated team does not exist, do not fret! Include in your data validation process whomever oversees the EHR and reporting needs, along with your QI project team. Remember that you and the project team cannot set QI targets and work toward them with confidence until the project metrics are accurate and trusted.



*This is particularly important if validation and documentation, workflow, and mapping issues are not consistently reviewed organizationally.

If you do not have the luxury of resolving issues with workflows and documentation before the project launch, then spend time conducting **root cause analysis and **Plan-Do-Study-Act cycles** during the project itself. Do not allow this to delay your project start date. You will need to wait until your metrics have been validated to then re-engage your project team around setting appropriate performance targets.

Data Validation Case Study

Re-training staff on standardized EHR documentation and workflow is required for the accuracy of a measure if an issue is pervasive enough. For example, medical assistants and providers who document blood pressure in both free text and structured fields impact the accuracy of the hypertension control measure. If the health center were to then run reports or registries to gauge the number of uncontrolled hypertensives that require immediate follow-up and care, they would not get an accurate report.

One such HHNYC site decided to address a similar broken process at the conclusion of a project, as it was decided that documentation re-training and refreshers would be beneficial for seamless workflows, patient care, and the use of clinical tools. At the project's wrap-up meeting, the EHR trainer announced that she would visit each health center site every month to provide training during an assigned lunch hour. The trainer had become empowered and emboldened as she saw, directly through first-hand project participation, how variations in documentation inversely impact patient care and create frustrations among the project team. As an impassioned proponent of standardized documentation, the EHR trainer took the lead in assisting care teams in adopting effective documentation practices.

Getting to Work—The How-to of Data Validation

Validating your project's metrics is as easy as 1-2-3-4-5:

1. **Understand the measure definitions:** Explain numerators, denominators, exclusions, and what constitutes a false positive and a false negative.

		EHR Says	
		Positive	Negative
Data Source Says	Positive	PASS	Fail- false positive
	Negative	Fail- false negative	PASS

2. **Select a sample of patient records to validate:** Start with at least five patient records per measure to determine if documentation inaccuracies or trends exist; you may need to validate more charts depending on the complexity of the issue(s) you encounter
3. **Use an Excel workbook to keep all information together:** If mapping issues or other inaccuracies are found when documentation problems are ruled out, your team can easily provide detailed information to the vendor's support team; particularly helpful is recording whether a patient's record has "passed" or "failed" the review, and why
4. **Review data validation results and categorize issues:** Examples include measure specifications, documentation, mapping, and connectivity/technical issues; determine an action plan and next steps
5. **Follow your organization's HIPAA policy and confidentiality rules**

PART 2: Focusing on Data Validation Policy at Your Health Center

OBJECTIVE:

Ensure that efforts to nurture a culture embracing data strategy and hygiene are part of a larger, organization-wide policy

DATA QUALITY FOR YOUR ORGANIZATION—WHAT IT TAKES

Like any good habit, data quality needs to be maintained in the long term so that data is consistently accurate, rather than continuously double-checked and "fixed."

At the organizational level, ongoing data checks must be accomplished in three distinct ways:

- **Routine maintenance:** The data team is responsible for communicating changes (e.g., lab and code changes) to staff and vendors that oversee related complementary tools, to ensure data quality and accuracy, and that generated tools and reports are maintained for actionable use by care teams.
- **"Spot" checking data:** When the clinical care team spot checks data in clinical reports and tools, it can help ensure accuracy and actionability. For example, a medical assistant or licensed practical nurse who is part of the clinical care teamlet doing pre-visit planning reviews the related report to ensure alerts and diagnoses codes are correct, and provides timely feedback to the data team regarding missing or "fuzzy" patient information.
- **Performance improvement feedback:** Continuously sharing performance feedback with providers and care teams via dashboards/scorecards during staff meetings and one-on-one performance reviews, for example, are excellent methods of communicating improvements to enhance patient care and experience.

CHCANYS

TIP

When validating data, always keep the measure specifications/definition in mind to determine whether a patient chart has "passed" or "failed."

For instance, with an uncontrolled hypertension measure, is the patient in the denominator due to eligibility criteria, such as age and diagnosis of the condition? Is the patient erroneously in the denominator if it is noted that she had preeclampsia while pregnant? What if a patient is in the numerator, even if her eligibility exceeds the time defined in the specifications? Perhaps she should then be grouped in the exclusion of the measure.

When validating data, review a sample of patients in the numerator and the denominator, and those who fit exclusion criteria. (*See sample Data Validation Workbook.*)

When organizations do not have a defined data team, it is necessary to assign these routinized activities to select individuals who will take ownership of scrubbing and validating data. This will help establish a robust data culture that underpins ongoing QI activities.

Utilizing the Data Integrity Roles worksheet can help your health center identify and assure accountability when issues are identified in the validation process.

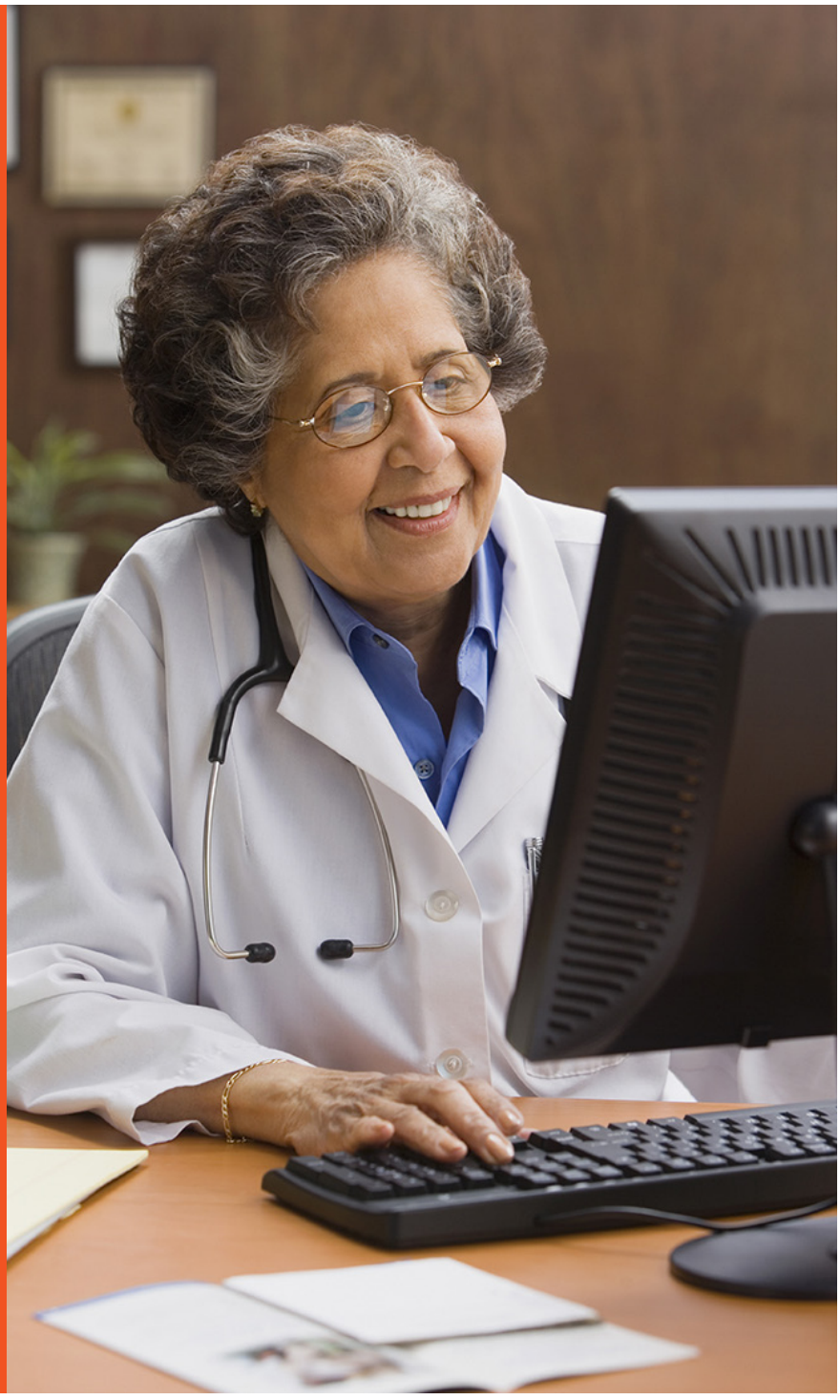
CHCANYS

TIP

Spot checking involves reviewing a patient chart, clinical tool, or report to ensure accurate documentation. It is an effective exercise for getting all staff on board with data validation and quality.

For example, a medical assistant or other support staff member who is leading a teamlet in using a pre-visit planning report generated from the EHR or other tool can spot check the report to ensure care gaps and related alerts are correct.

Any troubling trends found on the report, such as missing alerts for preventive mammogram screenings for eligible women, are red flags for the health center's assigned data expert to further investigate the data source and potential documentation and mapping problems.



Assembling a Policy and Plan

To create a robust data culture, collaborate with health center leadership to create a policy (or refine one if it already exists), keeping the following considerations and key discussion points in mind:

Policy Considerations	Key Discussion Points
Which staff members are responsible for ongoing data validation?	- How often does the health center review performance data? - Who currently runs reports? - How is data communicated to staff? - How frequently does the health center conduct data validation? - What actions are taken regarding data discrepancies? -Who is responsible for resolving these actions?
How often should data be validated?	
What corrective actions will be taken by designated staff to resolve data discrepancies?	

Your organization's data strategy should include a Data Dissemination Plan and Data Integrity Roles, which can assist in your health center's efforts to standardize the data validation process and create a more robust, seamless data culture. Set the expectation and cultivate a culture where data is constantly reviewed and presented to all levels of staff.

As part of your data strategy and quality standardization process, also consider creating a guide that explains the steps a staff member should take to validate their data and instructs them on how to gain access to the resources and tools discussed in this chapter. *(See sample Data Governance Policy.)*

CHCANYS TIP

Clinical staff can contribute to your organization's culture of data quality by documenting their clinical visits on time.

Methods for assisting with this include using an organized, efficient, and logical visit template in the EHR; having medical assistants or other support staff serve as scribes during the patient visit; and exploring ways in which busy schedules can be maximized while avoiding burn-out. Is there a way to ensure that providers see all of their patients, including walk-ins, have adequate protected administrative time, eat lunch, and leave clinic on time?

Explore resources related to joy in work and how this balance can be achieved for the health center's busy and dedicated primary care workforce.

CHCANYS
Community Health Care Association of New York State

CHAPTER 4

Introduction to Team-Based Care

OBJECTIVE:

Identify and define the quality improvement activities that will lead to improved and cohesive team-based care, and opportunities to sustain and spread gains

The importance of having the right team members at the helm of your project cannot be overstated. Whether **initiating your quality improvement project**, **creating a project team**, or mastering a better understanding of your data and its accuracy for the benefit of your project and organization, you have taken great strides as the Project Lead to form partnerships with individuals who have the know-how and expertise to bring your project goals and objectives to fruition. It is, after all, person-power coupled with accurate data that emboldens organizational change and improvement.

In this chapter, we will define team-based care and, more specifically, teamlet huddles and how to ensure they are impactful. Team-based care, when implemented well, enhances collegiality among care providers in their shared responsibility of caring for the patient, while also establishing the foundation for efficient operations that benefit the health center, and improve patient outcomes as well as patient and staff satisfaction. Sustaining and spreading the gains you have made through the implementation of teamlet huddles will also be explored.

DEFINING TEAM-BASED CARE

Team-based care, also known as team-based healing relationships, is an extension of all that you have been doing to actualize practice transformation and collaboration at your health center to improve patient care and bring the joy back to work. Team-based care is essential to the existence of a thriving and dynamic **medical home**.

Team-based care is also required for organizations seeking to become a recognized Patient-Centered Medical Home (PCMH). The National Academy of Medicine defines team-based care as "...the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high-quality care."

No primary care provider can do it alone. A growing body of literature suggests that the complex clinical and social needs of patients, in parallel with growing patient panels and shorter visit times, make it impossible for the primary care provider to diagnose, treat, and educate patients all on their own. Rather, it is a team of dedicated health care professionals (e.g., nurses, medical assistants, pharmacists), along with lay staff (e.g., patient navigators, coordinators, educators, coaches) that best provides patients with holistic and comprehensive care.

Health Centers are uniquely primed to adopt team-based care, as their staff is already comprised of this diverse and talented workforce. Armed with compelling patient data that is organized by a provider's panel, and which coalesces demographic data with clinical and social gaps, allows the care team to proactively address the patient's needs during the actual clinical visit. This makes teamlet huddles ever the more impactful.

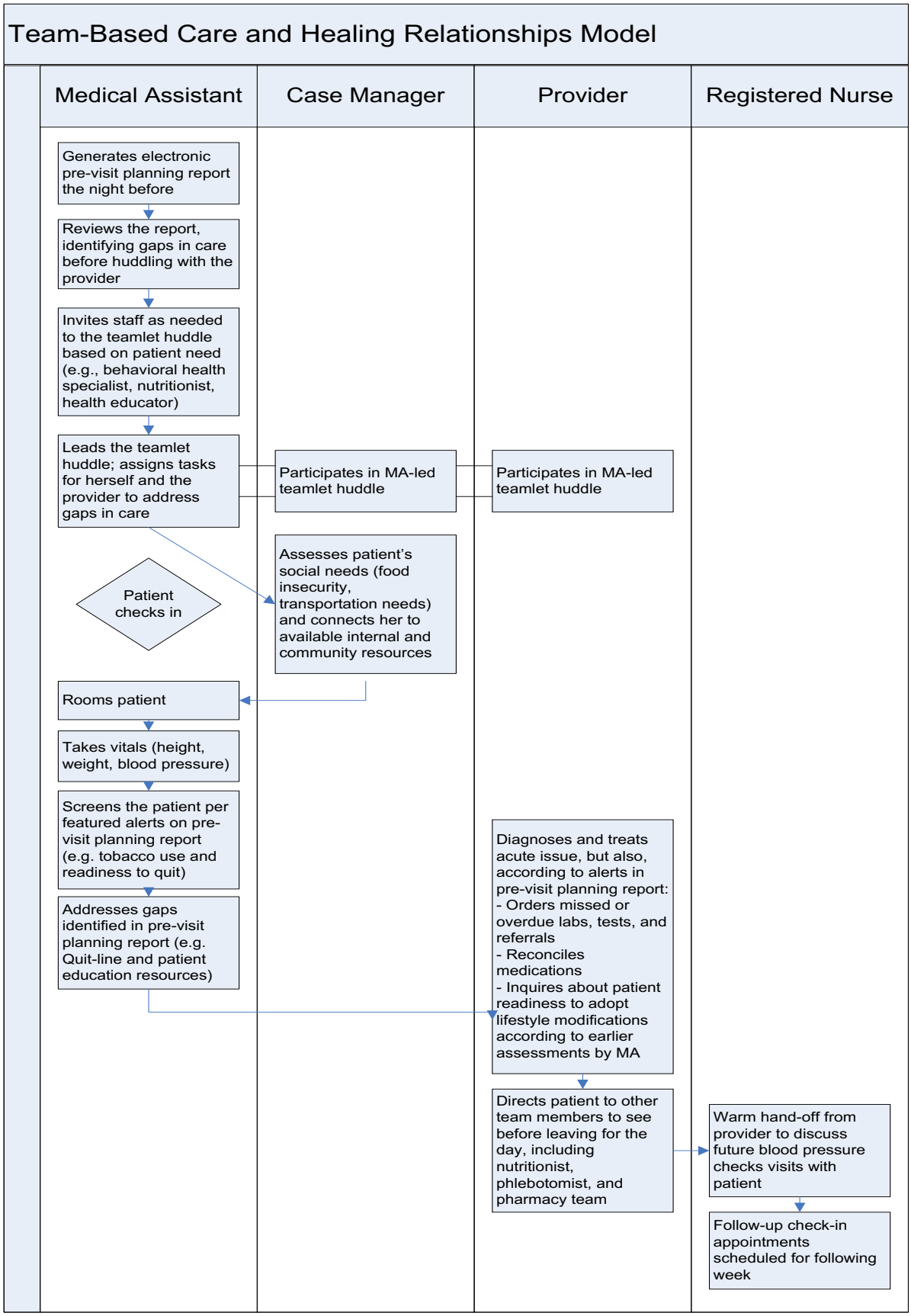
The following table differentiates provider-centered care from that which is patient-focused and based on team-based healing relationships and ongoing communication.

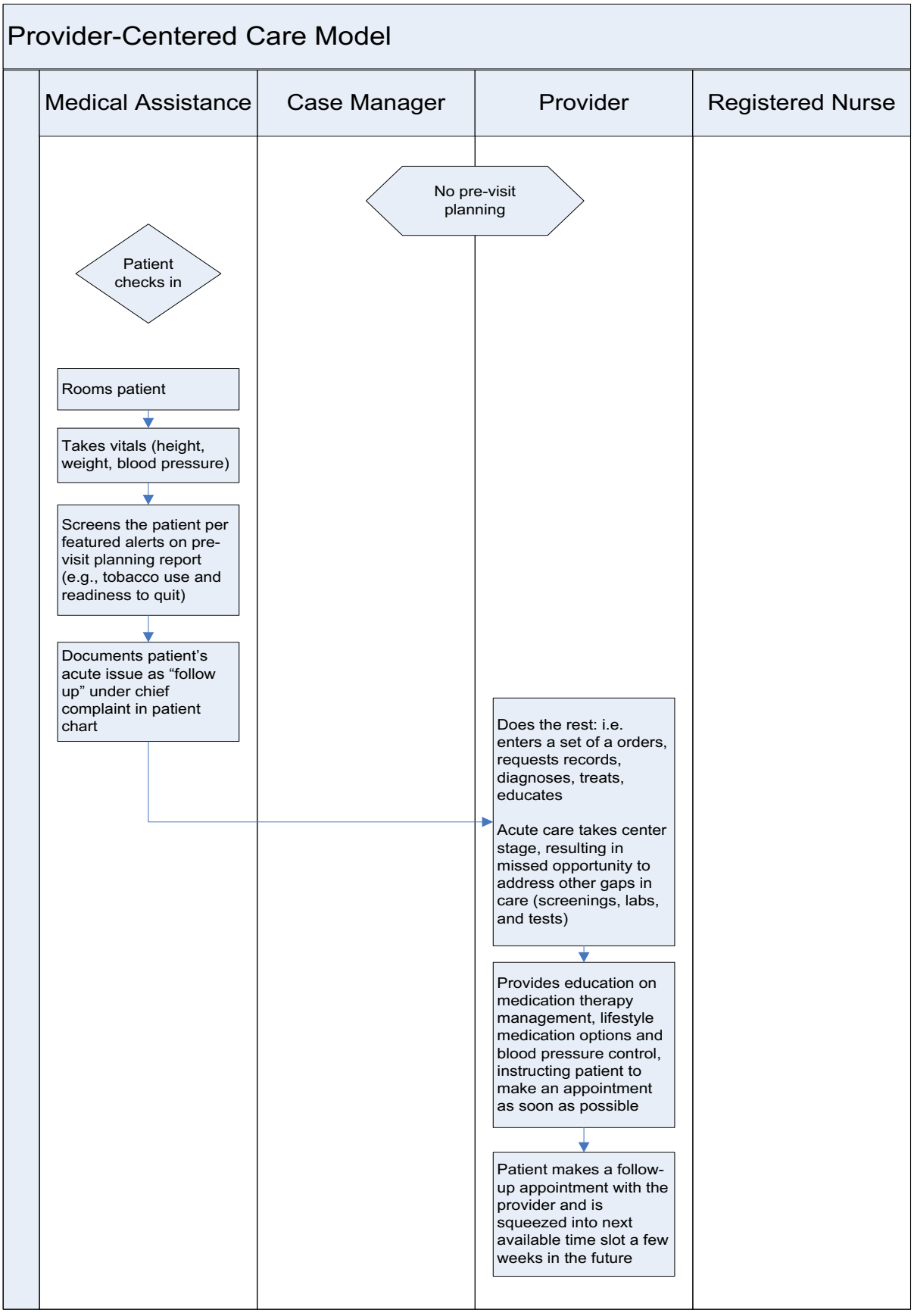
Benefits of Provider-Centered Care vs.Team-Based Care and Healing Relationships

Provider-Centered Care Model	Team-Based Care and Healing Relationships Model
The clinician in charge does it all and the perspective is provider-driven only	Patient-centered and collaborative; revolves around a team of clinical and non-clinical staff members with the patient at the center of their care; patient is consistently made aware of who his/her medical team is and each member's roles and expectations
Patient visit is focused on acute/urgent care issues and is episodic	Patient visit is focused on identifying and addressing the patient's complex clinical and social needs, with opportunities for follow-up and referrals related to the treatment of chronic conditions and preventive screenings (e.g., weekly blood pressure checks with an assigned nurse; referral for cancer screening)
No time or staff for population health management (e.g., outreach and recall for high-risk patients and no-shows)	Teamlet huddles are dedicated to consistent use of a population health registry to identify and recall high-risk patients with multiple co-morbidities; assigned support staff pull data and generate reports featuring high-risk patients and no-shows; assigned staff are given the protected time to contact patients and bring them back into care; team case conferencing that focuses on how to best tailor interventions with individual, complex patients is the norm
Little communication between provider and support team	Provider and support team continuously communicate, plan for the day, and make tweaks as needed through morning and afternoon teamlet huddles
Support team tasks are rudimentary; skillsets are underutilized	Staff members work at the top of their licensure and skillsets; training is on-going; taking the initiative is highly encouraged; the cultivation of leadership skills is celebrated

Sample model of care for patient with uncontrolled hypertension (>140/90) and social needs	
Provider-Centered Care Model	**Team-Based Care and Healing Relationships Model**
No pre-visit planning	Pre-visit planning and teamlet huddling: Medical assistant generates electronic pre-visit planning (PVP) report the night before the teamlet huddle - Medical assistant reviews the report before huddling with the provider to identify gaps in care - Medical assistant leads the teamlet huddle, assigning tasks for self and the provider to address gaps in care

	- Medical assistant invites other staff to the teamlet huddle, based on patient needs (e.g., behavioral health specialist, nutritionist, health educator)
Patient checks in and waits to be seen (30-45 minutes)	Patient checks in and waits to be seen (30-45 minutes) while case manager assesses patient's social needs (e.g., food insecurity, transportation needs); case manager connects patient to appropriate internal or community-based resources
Medical assistant rooms the patient: **- Takes patient into exam room** **- Takes vitals (e.g., height, weight, blood pressure)** **- Screens patient as per featured alerts on PVP report (e.g., tobacco use and readiness to quit)** **- Documents patient's acute issue as "follow up" under chief complaint in the patient chart**	Medical assistant rooms the patient: - Takes the patient into exam room - Takes vitals (e.g., height, weight, blood pressure) - Screens patient as per featured alerts on PVP report (e.g., tobacco use and readiness to quit) - Addresses gaps identified in the PVP report (e.g., quit-line and patient education resources)
Provider performs clinical visit: **- Enters a set of orders, request records, diagnose, treat, and educate** **- Acute care needs take center stage, resulting in missed opportunity to address other gaps in care (e.g., missed screenings, labs, tests)** **- Educates patient on medication therapy management, lifestyle options, and blood pressure control** **- Instructs patient to make a follow-up appointment as soon as possible**	Provider engages other team members in clinical visit: - Provider diagnoses and treats acute issue - According to alerts in the PVP report, provider orders missed or overdue labs, tests, and referrals; reconciles medications; inquiries about patient's readiness to adopt lifestyle modification changes (e.g., diet, smoking cessation) according to medical assistant's earlier assessments using **motivational interviewing** techniques - At end of their time together, provider clearly directs patient to other team members he/she should see before leaving the health center for the day, including: • Nutritionist to discuss lifestyle modification options and classes provided at the health center or by community-based partners • Phlebotomist to do labs • Pharmacy team to fill/re-fill prescription(s) and provide education At conclusion of visit, warm hand-off with: • Registered nurse to discuss future blood pressure check visits until blood pressure is controlled
Patient checks out: **-Makes follow-up appointment with provider, and is squeezed into next available time slot a few weeks away**	Patient checks out: - Makes follow-up appointment with registered nurse for blood pressure check in one week and follow-up visit with provider


Team-Based Care and Healing Relationships Model
Medical Assistant
Case Manager
Provider
Registered Nurse
Generates electronic pre-visit planning report the night before
Reviews the report, identifying gaps in care before huddling with the provider
Invites staff as needed to the teamlet huddle based on patient need (e.g., behavioral health specialist, nutritionist, health educator)
Leads the teamlet huddle; assigns tasks for herself and the provider to address gaps in care
Participates in MA-led teamlet huddle
Participates in MA-led teamlet huddle
Patient checks in
Assesses patient's social needs (food insecurity, transportation needs) and connects her to available internal and community resources
Rooms patient
Takes vitals (height, weight, blood pressure)
Screens the patient per featured alerts on pre-visit planning report (e.g. tobacco use and readiness to quit)
Addresses gaps identified in pre-visit planning report (e.g. Quit-line and patient education resources)
Diagnoses and treats acute issue, but also, according to alerts in pre-visit planning report:
- Orders missed or overdue labs, tests, and referrals
- Reconciles medications
- Inquires about patient readiness to adopt lifestyle modifications according to earlier assessments by MA
Directs patient to other team members to see before leaving for the day, including nutritionist, phlebotomist, and pharmacy team
Warm hand-off from provider to discuss future blood pressure checks visits with patient
Follow-up check-in appointments scheduled for following week


Provider-Centered Care Model
Medical Assistance
Case Manager
Provider
Registered Nurse
No pre-visit planning
Patient checks in
Rooms patient
Takes vitals (height, weight, blood pressure)
Screens the patient per featured alerts on pre-visit planning report (e.g., tobacco use and readiness to quit)
Documents patient's acute issue as "follow up" under chief complaint in patient chart
Does the rest: i.e. enters a set of a orders, requests records, diagnoses, treats, educates
Acute care takes center stage, resulting in missed opportunity to address other gaps in care (screenings, labs, and tests)
Provides education on medication therapy management, lifestyle medication options and blood pressure control, instructing patient to make an appointment as soon as possible
Patient makes a follow-up appointment with the provider and is squeezed into next available time slot a few weeks in the future

Additional Benefits of Team-Based Care

Benefits to the Patient	Benefits to the Care Team and Health Center
Improved medication adherence	Reduction in medication errors
Fewer in-hospital admissions and readmissions	Reduced cost of care
Increased satisfaction	Increased joy at work
Patient and his/her family/caregiver are at the center of care and make decisions in partnership with the care team about the treatment plan and course of action	Sharing the care is embraced
Value-based payment contracts, which rely on improved patient health outcomes, are more easily achieved when everyone's roles and responsibilities are clearly delineated and communicated.	

CHCANYS

TIP

A registered nurse's unique skillset and expertise can be underutilized if relegated to administering vaccinations, collecting vitals, and triaging walk-in visits and phone calls.

A registered nurse can do so much more, such as overseeing a panel of patients with multiple co-morbidities and providing education on managing medications and chronic conditions. Such patients featured on the pre-visit planning report for the day could be considered for a co-visit between the registered nurse and provider.

A registered nurse can also play a key role in teaching and training other staff members on chronic disease management best practices. More about the role of a registered nurse in team-based care can be found in the California Healthcare Foundation's compelling report, "RN Role Reimagined: How Empowering Registered Nurses Can Improve Primary Care."

HOW TEAM-BASED CARE IMPACTS TRANSFORMATION

When team-based care is implemented consistently, and staff roles and responsibilities are defined and embedded in streamlined workflows, the potential to enhance service delivery and the patient experience is achieved, ensuring:

- **Access to care:** More hours of service and fewer wait times
- **Continuity of care:** Successful utilization of clinical and non-clinical support staff (e.g., medical assistant, nurse, care coordinator, health coach, patient navigator) to ensure timely patient education, self-management support of acute and chronic conditions, and referrals for preventive care services
- **Care coordination facilitates referrals to:**
  - Internal specialty care (e.g., behavioral health, nutrition)—warm hand-offs are always recommended when possible;
  - External specialty care for preventive care services (e.g., mammography cancer screenings at diagnostic imaging centers or hospitals); and
  - Other enabling services that are available through partnerships with community-based organizations (e.g., a pre-diabetes support group held at a local YMCA).

Instituting the team-based model of care also has notable benefits for staff, including:

- **Increased job satisfaction** and **joy in work**: Reduces provider burn-out and staff turn-over;
- Staff working to their fullest potential **and at the top of their licensure and expertise**: Reduces boredom and under-utilization of a talented and committed workforce.

CHCANYS TIP

When striving to make care conducive to the patient's preferences and needs, as well as acclimating to the team-based care framework, consider putting a contract in place. What better way to set the stage and tone of this model than having the roles of the care team and patient concretely delineated in writing?

This creates the expectation for not only the care team to be involved in the patient's care, but also for the patient to feel accountable for his/her care and to maintain communication with his/her team. *(See Patient Contract Sample.)*

CHCANYS

TIP

One effective and fun way to elaborate on staff members' roles and responsibilities within the team-based care model is to complete the Roles Matrix Worksheet and Jelly Bean exercise. This exercise visually shows how individual staff members may have much more on their plates (or in their cups!) in terms of responsibilities at the health center compared to their colleagues.

Can roles and responsibilities be shifted so that everyone is truly "sharing the care"? The exercise brings the QI project team and care team members together, during which the responsibilities as listed on the Roles Matrix worksheet are read out loud.

Each staff member is given a cup labelled with his/her title. After every statement, whoever is responsible for that particular task places a jelly bean in his/her cup. At the end of the exercise, the group compares the cups. For those that are filled to capacity or overflowing, the group tries to reassign tasks in an "ideal" reality. The "ideal" is a great place to start in terms of exploring PDSA cycles.

THE POWER OF TEAMLET HUDDLES

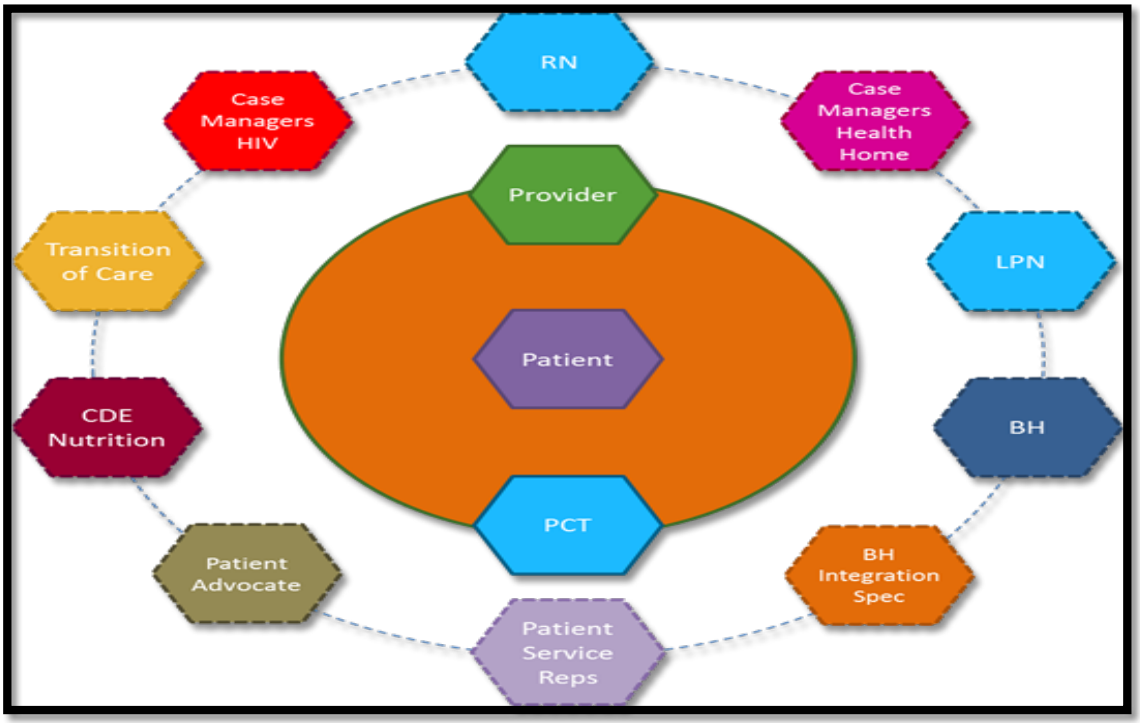
Teamlet huddles provide ample opportunities for care teams to address gaps in care during the patient visit through enhanced use of inter-communication and planning.

The power of the teamlet huddle lies in the fact that it creates a space for:

- Showcasing all team members' worth and importance in patient care;
- Promoting teamwork through communication;
- Ensuring team members plan tasks and understand each other's interdependent roles; and
- Deriving value from the huddle's consistency and ability of the support staff lead (e.g., medical assistant/licensed practical nurse) to identify patient care gaps and assign responsibilities and follow-up in a timely manner.

The teamlet is comprised of a provider (e.g., physician, nurse practitioner, physician assistant) and empowered support staff members (e.g., medical assistant, licensed practical nurse). Within the larger team-based care framework, the provider and support staff are central to identifying and addressing gaps in patient care. Other staff members are invited to participate in the teamlet's morning huddle, as needed, so it is clearly communicated that timely internal referrals or warm hand-offs will be implemented according to patients' needs.

Core and Revolving Team Members



Source: Azara Healthcare

The teamlet model of care and pre-visit planning encompasses the following overarching steps:

Planning for the day

1. **Pre-visit plans**: Medical assistantruns and reviews the pre-visit planning report or reviews patient charts in the EHR to anticipate clinical care needs to be addressed that day

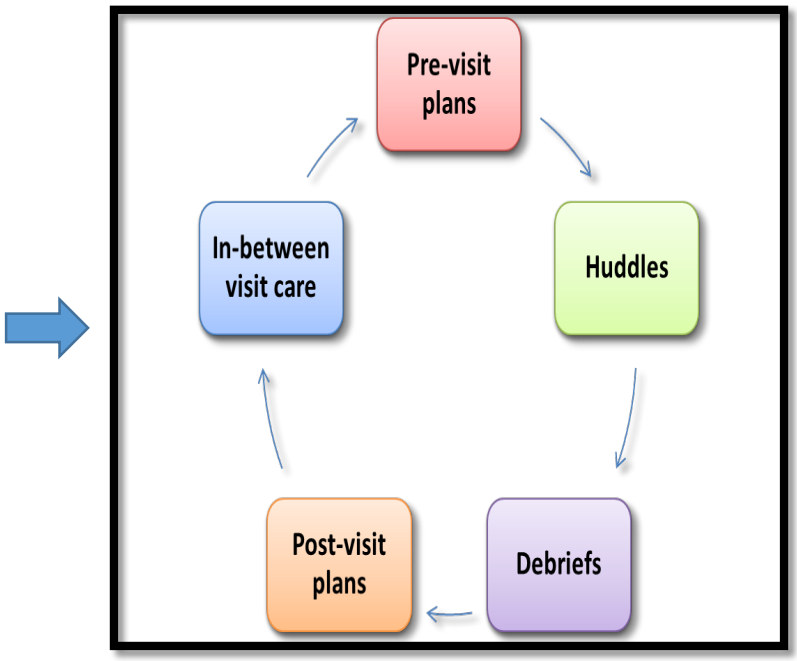
2. **Huddles**: Provider and medical assistantmeet to discuss patients' care gaps and confirm assigned tasks and responsibilities

3. **Debriefs**: Provider and medical assistant meet at mid-day to discuss outstanding items and emergencies encountered during the day, and any tweaks that need to be made in the schedule (e.g., patient needed an ambulance, making an appointment with an internal specialist pending)

After visit proactive next steps

4. **Post-visit plans**: Medical assistant or overseeing registered nurse reviews team responsibilities and communicates who will ensure closing the loop (e.g., medical case manager assigned to conduct outreach to no-shows, registered nurse makes follow-up calls to patients on a new medication regimen)

5. **In-between visit care**: Completion of actions to pre-visit via follow-up calls or visits (e.g., ensure lab and diagnostic imaging results are updated in the patient chart and communicated to the patient, new medication regimens are being adhered to; follow-up care regarding a blood pressure check reading and education from a nurse)



Source: Azara Healthcare

Elements of the Teamlet Huddle

- Lasts a maximum of 10 minutes
- Has a sense of urgency, like a football team about to undertake an important play—you're in it to win it on behalf of your patients
- Has a consistent time and place to meet
- Initiated by the Medical Assistant who is in charge of reviewing patients' needs and care gaps
- Discussion centers on patients with special intervention needs, patients with risk factors, anticipated scheduling bottlenecks due to increased number of walk-ins during a particular time of day or patients with special needs expected, for example, and work-around plans

- Organize for extra services, if needed, such as behavioral healthcare; care coordination; diabetes, asthma, nutrition education; translation; ambulette services for patients with mobility impairment
- Distinction between the morning (AM) teamlet huddle and the afternoon (PM) or mid-day teamlet huddle, as displayed in the comparison chart below

CHCANYS TIP

An **administrative huddle** can include all staff meeting before the health center opens its doors and is meant to focus on operations and "housekeeping" issues for the day, such as staffing updates (who is in and who is out), IT/EHR issues, whether an auditor or external visitor is expected and preparations that need to be done, and updates on the availability of supplies and stocking needs in exam rooms.

During a **clinical huddle**, the core teamlet reviews a checklist of the important tasks that need to be completed on behalf of every patient on the report. Is the patient overdue for a preventive mammography? Are a patient's A1c lab results missing or overdue? What about screening for depression? Gaps on your report are opportune moments to enhance patient care and wellness during the patient visit.

AM Huddle vs. PM or Mid-day Huddle

AM Huddle
Review the previous day, including any unfinished follow-ups
Review scheduled patients with chronic conditions
Review patients who have been recently hospitalized or in the emergency room
Review patients who are common no-shows or frequently late
Review cancelled appointments
Review patients who need special assistance (e.g., ramp for entrance)

PM or Mid-Day Huddle
Debrief about day's events, starting with unfinished issues to be handled before everyone leaves
Debrief about any emergency-related issues (e.g., EMS was called)
Preview what is in store for tomorrow
Share thank you's, recognitions, and announcements
Review call backs you are waiting on (e.g., from specialists' offices, labs)

USING PRE-VISIT PLANNING TO CREATE STANDARDIZATION

Of utmost importance within a team-based care and teamlet huddle framework is support staff feeling comfortable in initiating a treatment or assessment on behalf of the patient without having to ask the provider beforehand or being fearful of repercussions for taking initiative. Check with your State Education Department to ascertain the responsibilities that support staff can legally undertake.

Also consider having the teamlet, along with the project team, complete a Standing Actions Worksheet to determine which tasks the support staff can comfortably undertake when addressing alerts and gaps in care identified in the pre-visit planning (PVP) report.

Tools and Reports that Assist with Pre-visit Planning

Using an electronic PVP report that can be simply generated from the EHR or other comparable system the night before or the same day as a teamlet huddle is advantageous because it:

- Does the work medical assistants/licensed practical nurses already do manually, using EHR data and electronic calculation of alerts;
- Displays only relevant and actionable items to help teams prepare for visits, such as opportunities for preventive screenings, vaccinations, or blood work; assessments; and to proactively address social needs (e.g., housing, food insecurity); and
- Displays active diagnoses and relevant risk factors (e.g., obesity, uncontrolled hypertension, use of illicit substances).

Paper tools can also be used for recording important details (but not minutes) about patient gaps in care as discussed during the huddle. An electronic pre-visit planning report does the tedious work for you of including the patient's latest chief complaint as documented in the chart and deciphering follow-up. Paper and electronic reports can be submitted as proof of your huddling practices when seeking PCMH recognition.

CHCANYS TIP

The teamlet huddle is a prime opportunity to let support staff (e.g., medical assistant, licensed practical nurse, patient care technician) shine. But what if you experience push back? What if staff does not want "one more thing" put on their plate?

Leadership engagement and internal messaging around staff development and professional growth, and the opportunity for all staff to work to the top of their skillset, are key. Leadership and human resources should also consider promoting upward mobility within the organization, which shows that staff who demonstrate leadership skills and an enthusiasm in their work can look forward to promotions and increased pay.

If this is not an option, consider other incentives to ignite joy in work, staff retention, and mobility, such as reimbursement for continuing education credits or certifications; attendance at trainings or conferences; or the opportunity to participate in the improvement and development of evaluations, procedures, policies, curriculum, or other internal processes.

Check with your EHR vendor, or other aggregation tools and platforms that your health center uses, to assess opportunities for using an electronic report. To avoid confusion, select only one report to use. Compare data in the report against that found in your EHR—the true repository of all of your health center patients' health-related information—and not to other reports. Also remember to spot check data within the report to ensure it is accurate and timely.

Sustaining & Spreading Your Gains

- Meet periodically to assess the effectiveness of your teamlet huddles and identify successes and weakness; feedback from the pilot teamlet is critical
- Be comfortable with making tweaks as needed, especially if there is staff turn-over or certain days in the week/times in the day with increased no-shows or walk-ins
- Revisit the Roles Matrix and Standing Actions worksheets. Perhaps you would like to focus on patients with uncontrolled hypertension with a blood pressure reading of >140/90. What are the roles of the medical assistant and provider in terms of medication reconciliation and medication adherence education? Can you involve your pharmacy team or registered nurse?

With regards to the roles matrix and changing job descriptions, consider:

- How will roles and responsibilities be communicated?
- Will job descriptions be modified and by whom? Should this be a joint effort between a supervisor and human resources?
- What trainings are needed if this is a new task for someone (i.e. screening by a medical assistant)?
- Who will conduct staff training?
- How often will staff training occur? Should training be included in new staff on-boarding and then periodically offered as a refresher?
- Will the new assigned task or responsibility become part of the staff member's annual evaluation?

(See a sample Standing Actions Policy Template.)

With regards to teamlet huddles and spreading best practices, think about:

- Tailoring standing actions and alerts for a specific department's teamlet (e.g., pediatrics, obstetrics/gynecology, internal medicine)
- The feasibility of front desk staff pulling the report
- How to handle a high volume of walk-ins or no shows
- Identifying certain hours in the day/days in the week when no-shows and/or walk-ins are more prevalent
- Taking advantage of no-shows as opportunities to assess patients through a population health management lens (e.g., are more staff and time needed for outreach and recall?) and to determine the cause (e.g., do patients have transportation issues?); assessing patients' social determinants of health could help your organization put a plan in place to address clinical and social needs more effectively

CHCANYS TIP

When engaging a new teamlet within a department or site to pilot a huddle, always choose staff members who are eager to participate and not resistant to change.

Show the teamlet instant results in metric improvements by focusing on low hanging fruit (e.g., medical assistant recording body mass index and informing the provider during the huddle when it is out of range for a particular patient).

Illustrate the strength of the medical assistant's role when given responsibility for a health care measure that could be entirely within his/her control (e.g., depression screening), and focus on measures that are of a priority for your health center.

CHCANYS

TIP

If not everyone has truly bought into team-based care or teamlet huddling, put a hesitant team/teamlet at ease by doing the "What's In It For Me" (WIIFM) exercise.

This entails going around the room and asking, "Why is team-based care or teamlet huddling important to you?"

You may be surprised by the range of answers that you hear, which may include anything from "improving patient care" to "improving camaraderie in the health center."

CHCANYS
Community Health Care Association of New York State

CHAPTER 5

Sharing Best Practices

OBJECTIVE:

Explore opportunities for peer learning and sharing project progress and learned patient care best practices with stakeholders, both internal and external to the organization

Sustaining successful **Plan-Do-Study-Act** cycles and lessons learned during the course of the project, while implementing some of the great ideas that emerge from team discussions, is dependent upon the buy-in of all levels of staff at your health center. As your project gains traction and the team begins experiencing improvements, it is important for the project team to share these achievements with health center colleagues.

Chapter 1 and Chapter 2 discussed the importance of keeping leadership, particularly the executive sponsor (e.g., chief medical officer, chief executive officer), updated on the project's progress through regular meetings and check-in calls. During these discussions, you should provide a status report of milestones met and deliverables, as well as any obstacles the team has encountered. Utilization of a simple Project Management Tracker to track your team's deliverables can help ensure you have this information ready for meetings with leadership.

CONVEYING PERFORMANCE DATA

As illustrated in Chapter 2, health centers that involve all levels of staff, including those occupying front-line roles, in QI projects, discussions, and pilots tend to experience greater staff engagement and satisfaction. Providing regular performance reports to such staff enhances a sense of accountability and ownership for patient health outcomes. Sharing data helps staff recognize the significance of their roles and potential impact on clinical services and patient health-seeking behaviors.

At some health centers, it is common practice for leadership to disseminate data at regular intervals, usually via email, to clinical leaders and other staff whose responsibilities impact performance on identified metrics. However, we encourage you, as the Project Lead, to regularly share project and measure outcome data with all staff. As described in Chapter 3, it is imperative that staff have confidence in the data that is shared.

Below is a sample report card that a Project Lead shared with leadership to convey measure improvement (or decline) of two pilot physician/medical assistant teamlets. The report depicts the measures from baseline, when the project began, and progress achievements using monthly data. Comparison of teamlets A and B enables providers and leadership to see the differences within teamlets, and among provider practices and patient panels. Similar reports highlight providers who are performing well, giving them the opportunity to share their practice with colleagues to impact better patient outcomes.

Pilot Team A: MD/MA Teamlet A

Measure	Baseline Jan 2017 Trailing Year	Feb 2017 Monthly	Mar 2017 Monthly	Apr 2017 Monthly	May 2017 Monthly	Jun 2017 Monthly	Jul 2017 Monthly	Aug 2017 Monthly	Project Target
Hypertension Control (UDS, HEDIS, **NQF 0018**)	74% (299/402)	76% (307/405)	76% (308/406)	76% (298/392)	80% (309/386)	80% (306/382)	81% (315/387)	82% (312/382)	80%
IVD Aspirin Use (UDS, **NQF 0068**)	87% (33/38)	89% (33/37)	92% (33/36)	91% (32/35)	89% (31/35)	91% (29/32)	91% (29/32)	88% (28/32)	90%

Pilot Team B: MD/MA Teamlet B

Measure	Baseline Jan 2017 Trailing Year	Feb 2017 Monthly	Mar 2017 Monthly	Apr 2017 Monthly	May 2017 Monthly	Jun 2017 Monthly	Jul 2017 Monthly	Aug 2017 Monthly	Project Target
Hypertension Control (UDS, HEDIS, **NQF 0018**)	75% (158/212)	75% (162/216)	71% (154/218)	69% (157/226)	73% (168/229)	69% (155/225)	68% (155/227)	71% (155/217)	80%
IVD Aspirin Use (UDS, **NQF 0068**)	90% (28/31)	90% (28/31)	91% (30/33)	91% (32/35)	97% (36/37)	97% (36/37)	94% (33/35)	94% (34/36)	90%

Importance of Provider Report Cards through Audit and Performance Feedback

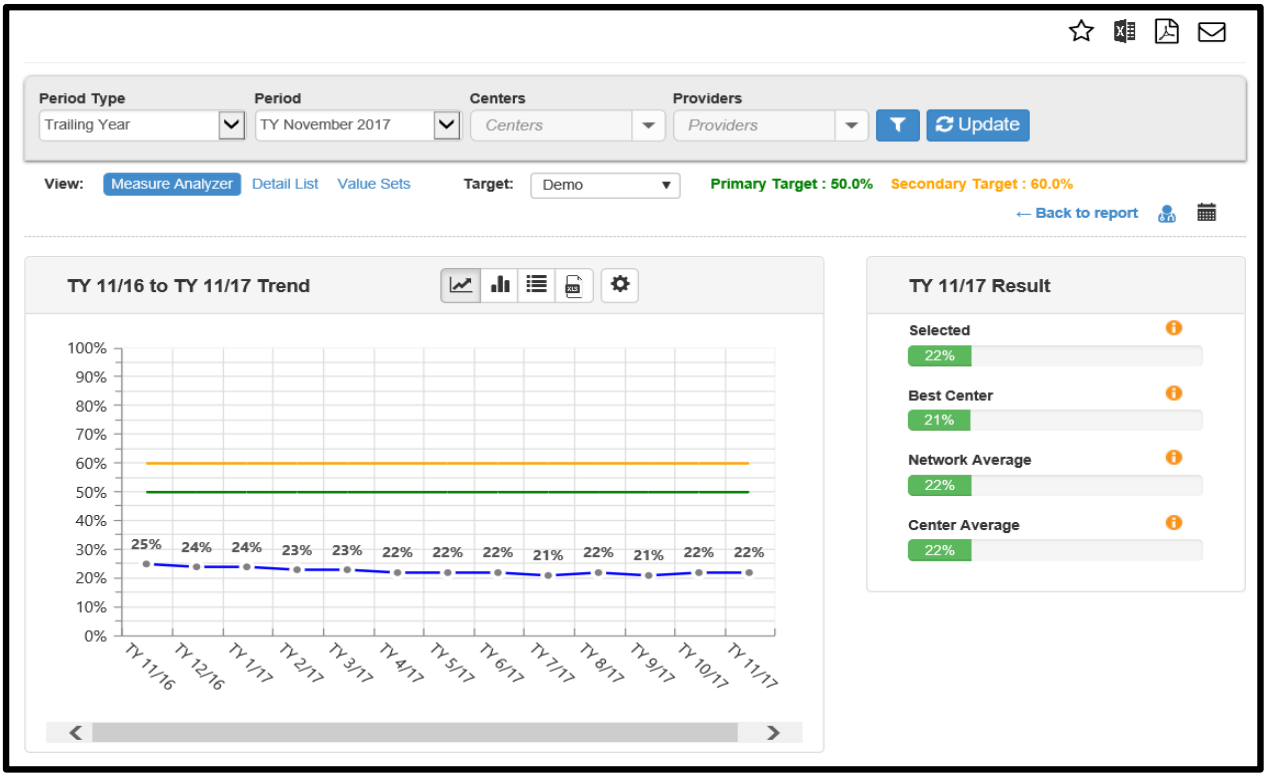
Adopting a culture where openly displaying performance data is encouraged. This creates a level of transparency that allows staff to recognize where performance needs improvement or has excelled in meeting or surpassing clinical targets.

When improvement opportunities are identified, the message should be that these are due to broken processes and not people, and that display of this data is not meant to be punitive toward a person or set of individuals, but is rather an opportunity to engage all staff in exploring avenues to improve patient care and experience.

Additionally, provider comparison provides a window for leadership to see if variations in patient outcomes result from providers following different guidelines, which would warrant standardization and re-training. Sharing data can also ignite healthy competition, which could result in improved performance, patient care, health outcomes, and staff satisfaction. As seen in the graphic below, data can be displayed using visually appealing tables, graphs, charts, or pictographs.

The following sample reports are taken from the **Center for Primary Care Informatics (CPCI)**, a web-based data reporting and analytics warehouse licensed by Azara Healthcare that provides New York State FQHCs with the information they need to maximize QI efforts.

Diabetes A1c>9 (NQF 0059 modified)



Source: Azara Healthcare

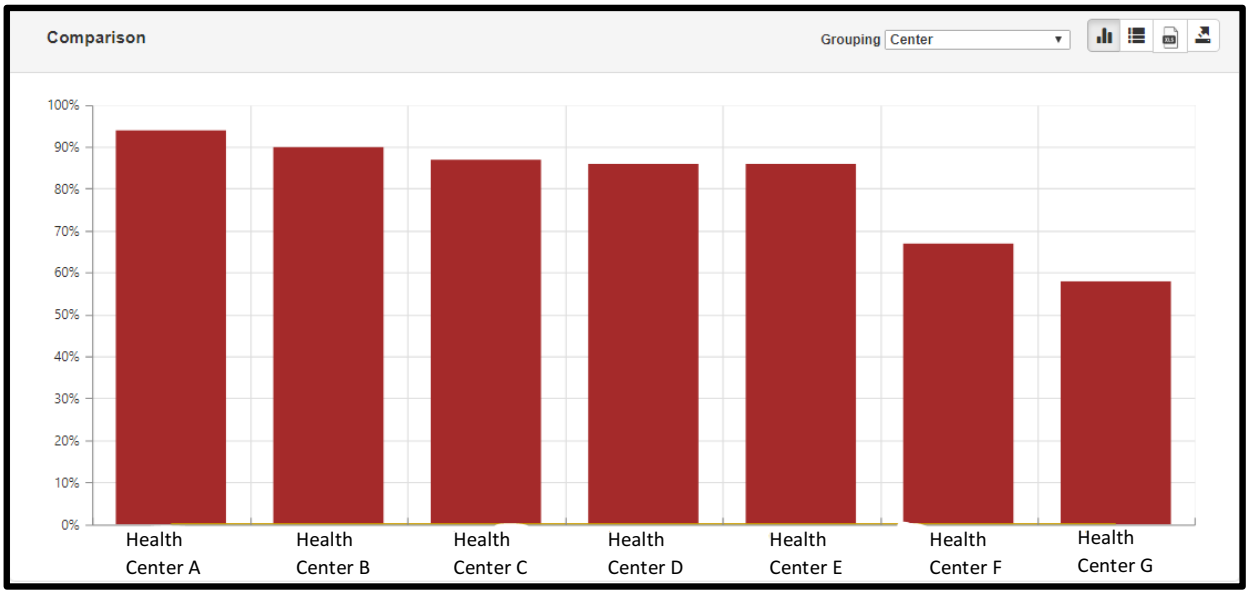
This sample diabetes A1c >9 measure report shows a health center's set targets and progress over 12 months, in comparison to other health centers in the network. Sharing similar reports on any measure(s) with project teams and leadership on a regular basis, such as monthly and quarterly respectively, provides stakeholders with ongoing progress reports.

CHCANYS TIP

The presentation of data should be fun, colorful, and appealing to your audience. Utilizing charts and graphs may provoke interest and discussion from various audiences. Interactive tables are more enticing than static ones.

Benchmarking data that compares providers and health centers with one another, and against national standards, can generate robust discussion that can lead to opportunities for peer-to-peer learning and improved patient care.

Sample Benchmark Data Comparing a Network of Health Centers



Source: Azara Healthcare

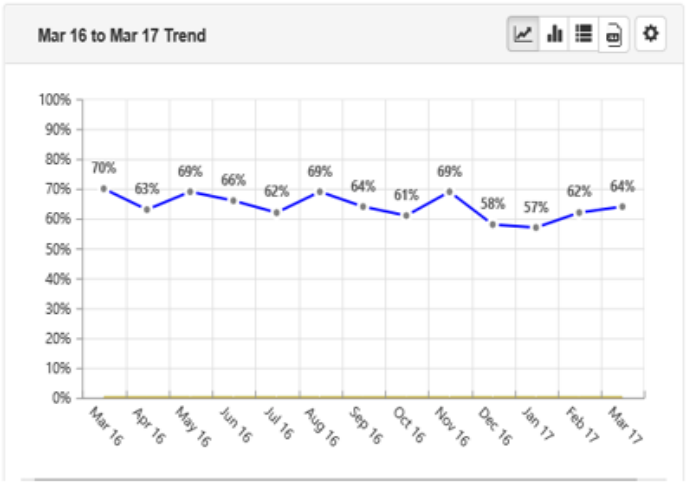
This sample benchmarking report depicts performance of seven health centers in the tobacco screening and cessation measure of the *HealthyHearts NYC* project. **Benchmark data** provides health centers with information on how they stack up against their peers which could lead to exploration of best practices between health center colleagues.

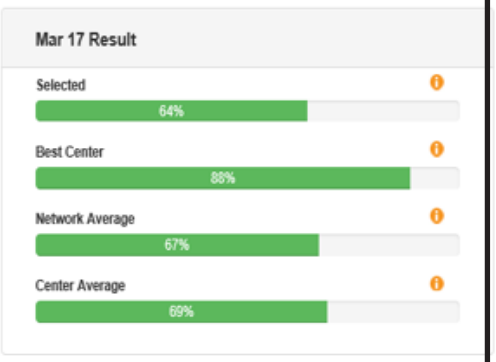
When working with your project team to improve performance metrics, it is particularly helpful to have **baseline** and **trending data** available to demonstrate the progress of those measures over time. This information helps the team understand in which direction they are heading and whether implemented changes have resulted in improvement.

As seen in the report below, specific details, such as numerator and denominator data, can help the team further understand the size of the population. Trending data, on the other hand, can help the team reflect on what caused a rise or fall in the measure. It is important to remember that improvement changes can take time, and teams should not get frustrated if there aren't immediate increases in the measures.

You should work with the team's data specialist to share a summary of the measures during team meetings and generate discussions on specific areas of focus. The data can be displayed as a snapshot of current data, trending data, benchmark data comparing you to other health centers in your network, where available, as well as data drilled down to the population level, drawing focus on the numerator and denominator, as shown below.

HTN: Controlling High Blood Preseeure (NQF 0018)





Grouping	% Htn Pts With Bp <140/90	Pts W/ Bp <140/90	Pts W/ Htn	Excluded Pts
Mar 16	70%	152	220	2
Apr 16	63%	128	204	1
May 16	69%	129	188	2
Jun 16	66%	131	199	2
Jul 16	62%	116	187	1
Aug 16	69%	140	205	3
Sep 16	64%	119	188	2
Oct 16	61%	117	194	1
Nov 16	69%	128	187	1
Dec 16	58%	108	186	1
Jan 17	57%	110	192	0
Feb 17	62%	115	186	0
Mar 17	64%	130	205	2

Source: Azara Healthcare

Using Measure Dashboards

Health centers can utilize **measure dashboards** to display measure performance, benchmarks, and performance comparisons of different providers and sites. In instances where data from other organizations is available, you can compare your health center performance with your peers. As shown below, dashboards consolidate critical performance measures in one place, making it easier for leadership and providers to stay continually up-to-date on the information that is most important.

Dashboards - Cancer Screening

Source: Azara Healthcare

Using Storyboards to Tell Your Story

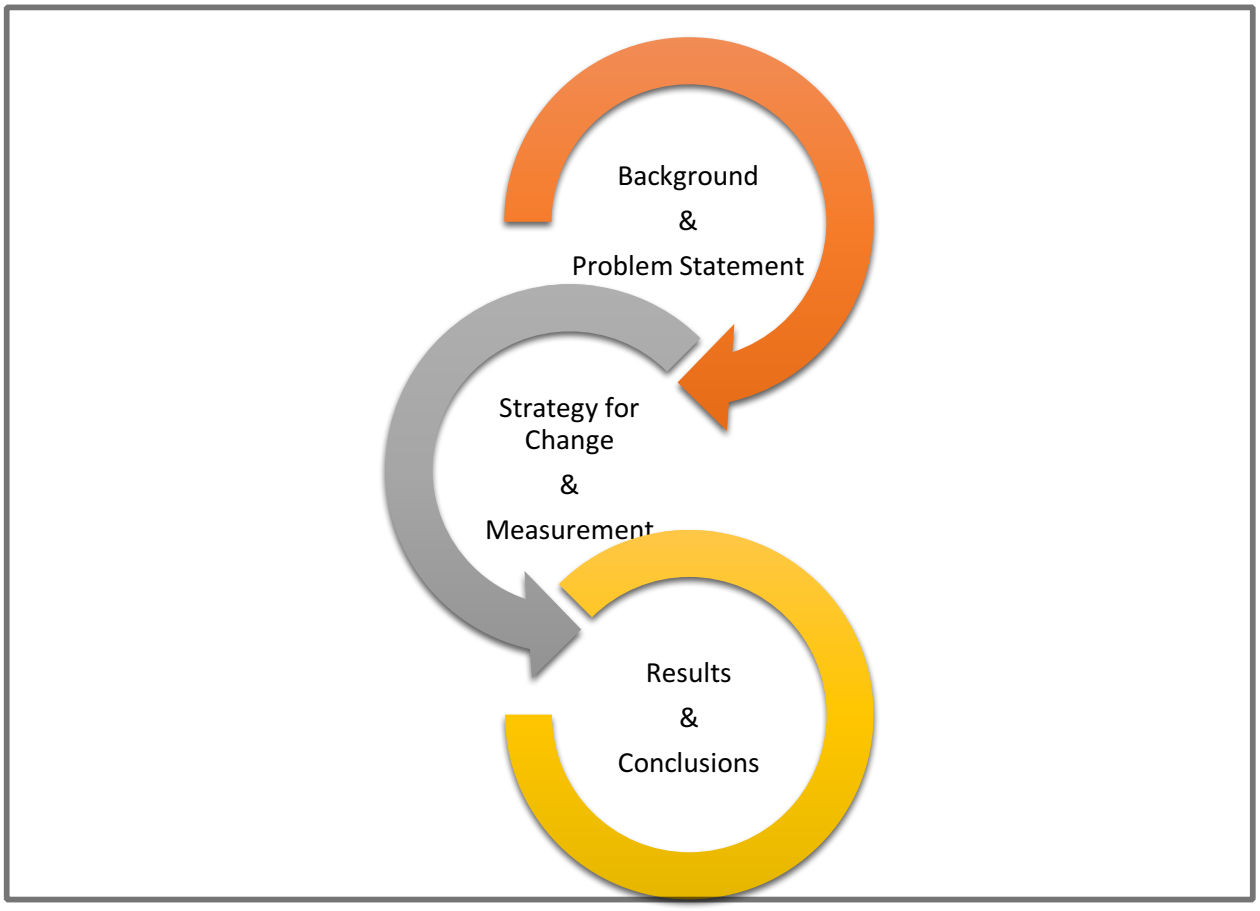
Every Project Lead comes to realize that any QI project provides an opportunity to positively impact the health center by improving processes that support quality patient care and health outcomes. Documenting your team's baseline data, activities, pilots, and progress, and subsequently translating this information into a storyboard that tells your QI journey, will empower your team to communicate the value of your work and showcase your success to different audiences.

A **storyboard** is a graphical outline or display of sequential events that demonstrate your team's project achievements. Every small improvement is an opportunity to celebrate—not only with your project team, but also with health center leadership and staff.

Display your storyboard in a common location for all staff to see, and be sure to include a brief project background, your problem statement, measures that were impacted, your strategy for change, how you measured change, pilot/project results, and the conclusions or next steps.

We also encourage you to disseminate your storyboard externally, such as at clinical conferences, where you can showcase your work to a wider audience.

Elements of a Storyboard



LEARNING OPPORTUNITIES ENHANCE CLINICAL PRACTICE
PEER-TO-PEER LEARNING

Through years of experience, CHCANYS practice facilitators have found that one of the most sought after opportunities for sharing best practices is between peers. Providers and other clinicians find great value in hearing how their peers, within and outside of their organization, are addressing challenges similar to those they face. Health center staff have a great deal of knowledge to share, and as the Project Lead, you should advocate for exploring ways in which your health center can learn from other health centers.

Suggested **peer-to-peer learning** opportunities include:

- Participating in performance improvement projects with other health centers where you can showcase your successes and challenges
- Ad hoc conference calls with colleagues working on similar projects or measures
- Facilitation of a webinar with a health center peer that has seen improvements as the result of a new workflow, measure, or process change
- Engagement in a committee of peers on a specific subject matter (e.g., behavioral health, oral health, sexual health, reproductive health), which facilitates brainstorming solutions to challenges and sharing best practices with a broad audience through conference calls, webinars, and/or emails or other shared online communication platform

Case Study: Health Center Peer-to-Peer Learning

A HHNYC practice facilitator convened two project teams from different health centers to provide an opportunity for peer-to-peer learning. Staff from the health center that had been 'doing it well' for years shared their experience of introducing team-based care practices and teamlet structure, using CPCI's pre-visit planning tool to address gaps in care at point-of-care and improve patient flow from check-in to check-out.

The partnership offered a platform for sharing solutions to addressing common challenges, and it allowed both health centers to borrow and customize ideas to fit the workflows and cultures of their respective organizations.

The facilitator coordinated the peer-to-peer learning opportunity in collaboration with the assistant director of nursing at the hosting health center. This key contact ensured that clinicians and administrators committed to her center's population health and team-based care efforts would attend the three-hour in-person meeting. Front-line staff of the visiting health center who were participating in HHNYC were eager to learn and incorporate best practices of team-based care and, more specifically, how to promote standardized communication and messaging among all departments and leadership at their health center.

The visiting team compiled a list of guiding questions, which they shared with the hosting team prior to the meeting. The questions greatly helped to facilitate the conversation that ensued. As the result of this peer-to-peer meeting, the visiting team was more inclined to pilot teamlet huddles and use CPCI's pre-visit planning report; lead a project wrap-up meeting with their health center leadership, including the chief executive officer, where improvements in the outcome metrics featured prominently; and create more opportunities for staff members to participate in longer term QI projects beyond the life of the HHNYC initiative.

Academic Detailing

Academic detailing, also known as educational outreach, is education provided by a trained health care professional for the purpose of improving clinical practice and patient care. This face-to-face or virtual training led by an expert in the field is as an opportunity for providers to learn new information (e.g., the latest research in a particular field, recently released evidence-based guidelines, recommended prescribing methods and screening practices). Experts are commonly from a university-based academic detailing program, a hospital with which a health center is affiliated, or a state-level organization such as **New York State's Delivery System Reform Incentive Payment (DSRIP)** program. *(See sample CVD academic detailing recordings used during the HHNYC initiative for provider education.)*

WHERE TO SHOWCASE RESULTS

There are several forums where you can showcase your team's successes and challenges for leadership, other staff, and various stakeholders within and outside your organization to see. It is highly advisable for you to be aware of and maintain a schedule of opportunities at your health center for disseminating information to relevant audiences on a regular basis. One way to identify and target these opportunities is to outline the various meetings that your health center hosts, including when, where, and how often they take place.

Examples of dissemination forums targeting a variety of audiences include:

- All-staff meeting
- Provider meeting
- Leadership meeting
- Patient advisory board
- Board of directors meeting

Utilizing a simple tool, such as a QI Site Engagement Grid, will help you identify appropriate forums for sharing a progress report of your QI team's work, facilitate staff training on a new workflow, and impart lessons learned.

When embarking upon system-wide improvements, it is vital that you involve relevant health center staff in these discussions to ensure everyone impacted by the process change adopts the modifications. For example, when a team working on a project to improve blood pressure control identified, during a hypertension PDSA, a widespread EHR documentation issue, they used a nursing staff meeting to urgently retrain nurses, medical assistants, and licensed practical nurses on how to accurately document repeat blood pressure readings.

CHCANYS TIP

Consider these questions when planning to communicate your project to health center colleagues:

What levels of staff will your project impact?

Could utilizing a few minutes of an all-staff meeting to highlight the project help disseminate critical information?

Are you embarking upon a project that will change a specific workflow or process?

Has the project team stumbled upon an inconsistency in provider documentation that warrants provider retraining?

Are providers consistently utilizing updated guidelines that align with the measures under review?

Do the latest evidence-based guidelines need to be integrated into practice?

What is the best method to disseminate this information to your colleagues?

Case Study: Dissemination of a Tobacco Screening PDSA Results and Workflow Redesign

CHCANYS' experience facilitating a HHNYC tobacco screening and performance improvement project assessment with one particular health center provides an example of the need to share significant lessons learned during QI projects.

The project team was involved in a PDSA of patients utilizing kiosks in the waiting room to complete a tobacco self-assessment form. The PDSA revealed that data entered by patients at the kiosk upon check-in was not integrated into the patient chart. This revelation came from carefully scrutinizing health center metrics, mapping the specific workflow, and testing theories discussed during project team meetings. During the study phase of the PDSA cycle, the team discovered that medical assistants unknowingly repeated the tobacco assessment with patients because data was not recorded in the patient medical history within the EHR.

In response to this barrier to progress, project team members, namely the medical assistant and EHR specialist, worked closely to identify the broken process and develop a solution. In this case, it was determined that by the medical assistant clicking a button in the EHR, the patient-entered data via the kiosk would be imported into the medical record and ready for review during the patient intake process.

In addition to identifying and resolving the issue, the project team ensured that all medical assistants were trained on this process redesign in the patient rooming workflow. During a nurse meeting, the team shared with the medical assistants an overview of the QI project and results of the PDSA, and provided step-by-step instructions on how to import into the EHR the tobacco assessments that patients completed at the kiosk.

Showcasing this lesson with peers and providing an opportunity to learn from the project team assured standardization of a new process across the health center, built efficiencies into the patient workflow, improved the health center's overall tobacco screening rate and, most importantly, ensured that medical assistants had the information they needed to assess patients' readiness to quit smoking and provide patients with the necessary resources for improving their health.

All of the information, tools, and resources in this toolkit are provided to help you, the Project Lead, and QI support staff develop the story behind clinical actions and workflows implemented by the countless health center staff who engage with patients on a daily basis, to improve quality of care and health outcomes. Since you may not be aware of the vast array of resources available to aid in simplifying the process of implementing a project, and you may have little time to research materials that can be pieced together to create a formal clinical QI plan, this toolkit serves as a concise guide to the steps for improving clinical performance at the team, site, or organizational level. The toolkit focuses heavily on CHCANYS' unique approach to practice facilitation, which places critical importance on routinized data validation and the ability to illustrate patient health outcomes by fluctuations in performance data on the quality metrics that reflect the health center's strategic clinical plan.

TOOLS AND TEMPLATES

Introduction	_	
1	CHCANYS Tool_Cardiovascular Disease Key Driver Model	https://www.dropbox.com/s/oid545swhxc-8g6o/CHCANYS%20Tool_Cardiovascular%20Disease%20Key%20Driver%20Model.pdf?dl=0
Chapter 1		
2	CHCANYS Tool_Quality Metrics Crosswalk	https://www.dropbox.com/s/zeyjdm5dnnff5em/CHCANYS%20Tool_%20Quality%20Metrics%20Crosswalk.xlsx?dl=0
3	CHCANYS Tool_Project Lead Meeting Dos	https://www.dropbox.com/s/hqpv1q2g8qatdqk/CHCANYS%20Tool_Project%20Lead%20Meeting%20Dos.docx?dl=0
4	CHCANYS Tool_QI Leadership and Team CVD Alignment Grid	https://www.dropbox.com/s/2w23tdzp5qugdhb/CHCANYS%20Alignment%20Grid.pdf?dl=0
5	CHCANYS Tool_SMART Aim worksheet sample	https://www.dropbox.com/s/ngws78abjwjl1jq/CHCANYS%20Tool_SMART%20Aim%20Statement%20Worksheet%20Sample.docx?dl=0
6	CHCANYS Tool_SMART Aim worksheet	https://www.dropbox.com/s/48f9f4tvgay6een/CHCANYS%20Tool_SMART%20Aim%20Statement%20Worksheet.docx?dl=0
Chapter 2		
7	CHCANYS Tool_CVD Health QI Project Team Grid Sample	https://www.dropbox.com/s/17kj51d17qohu04/CHCANYS%20Tool_%20Cardiovascular%20Health%20QI%20Project%20Team%20Grid%20Sample.doc?dl=0
8	CHCANYS Tool_HHNYC Project Plan Sample	https://www.dropbox.com/s/gwalcf8ohjoovr9/CHCANYS%20Tool_HHNYC%20Project%20Plan%20Sample.docx?dl=0
9	CHCANYS Tool_Meeting Agenda Sample	https://www.dropbox.com/s/8bv9u1eqtnrq9q3/CHCANYS%20Tool_Meeting%20Agenda%20Sample.docx?dl=0
10	CHCANYS Tool_Team Ground Rules Sample	https://www.dropbox.com/s/9uvbc00wu5fpc6d/CHCANYS%20Tool_Team%20Ground%20Rules%20Sample.doc?dl=0
11	CHCANYS Tool_Timeline Curriculum Sample	https://www.dropbox.com/s/5553jjix50u1v6d/CHCANYS%20Tool_Timeline%20Curriculum%20Sample.xlsx?dl=0

Chapter 3		
12	CHCANYS Tool_Data Validation Sample Guide	https://www.dropbox.com/s/yunn1i04zc2ccsr/CHCANYS%20Tool_%20Data%20Validation%20Sample%20Guide.PDF?dl=0
13	CHCANYS Tool_ABCS Data Validation Workbook	https://www.dropbox.com/s/cesrgrjpgbomw43/CHCANYS%20Tool_ABCS%20Data%20Validation%20Workbook.xlsx?dl=0
14	CHCANYS Tool_ABCS Trailing Year Data Sample	https://www.dropbox.com/s/yzlpmjrhpxbkg4p/CHCANYS%20Tool_ABCS%20Trailing%20Year%20Data%20Sample.docx?dl=0
15	CHCANYS Tool_Data Dissemination Plan	https://www.dropbox.com/s/z26635t1x3fpmn6/CHCANYS%20Tool_Data%20Dissemination%20Plan.docx?dl=0
16	CHCANYS Tool_Data Integrity Roles Worksheet	https://www.dropbox.com/s/qiqpbmfqcj2fhlt/CHCANYS%20Tool_Data%20Integrity%20Roles%20Worksheet.docx?dl=0
Chapter 4		
17	CHCANYS Tool_ Roles Matrix Worksheet Sample	https://www.dropbox.com/s/gwmj6uhq2bt0wcn/CHCANYS%20Tool%20_Roles%20Matrix%20Worksheet%20SAMPLE.doc?dl=0
18	CHCANYS Tool_Clinical Registries Planning Tool	https://www.dropbox.com/s/a1utarnv3oorz5i/CHCANYS%20Tool_Clinical%20Registries%20Planning%20Tool.docx?dl=0
19	CHCANYS Tool_Patient Contract Sample	https://www.dropbox.com/s/s480t60m6vo2lvc/CHCANYS%20Tool_Patient%20Contract%20Sample.docx?dl=0
20	CHCANYS Tool_PDSA_HTN Pt check out and follow up Sample	https://www.dropbox.com/s/jj9q2wzo1dhbm7o/CHEBB6~1.DOC?dl=0
21	CHCANYS Tool_Plan-Do-Study-Act Template	https://www.dropbox.com/s/yximk3h8eesykd6/CHCANYS%20Tool_PlanDoStudyAct%20Template.docx?dl=0
22	CHCANYS Tool_Standing Actions Policy Template	https://www.dropbox.com/s/lyzyy4cvon5m5hb/CHCANYS%20Tool_Standing%20Actions%20Policy%20Template.docx?dl=0

23	CHCANYS Tool_Standing Actions Worksheet _Sample	https://www.dropbox.com/s/dbziinqb9pn3ifq/CHCANYS%20Tool_Standing%20Actions%20Worksheet%20Sample.xlsx?dl=0
24	CHCANYS Tool_Tobacco Cessation Workflow Sample	https://www.dropbox.com/s/in9q4l0kpagmsjp/CHCANYS%20Tool_Tobacco%20Cessation%20Workflow%20Sample.pdf?dl=0
25	CHCANYS Tool_Guiding Questions on Team-Based Care and Population Health Management Best Practices	https://www.dropbox.com/s/d2lhkx4vgiukpmj/CHCANY~1.DOC?dl=0
26	CHCANYS Tool_Project Management Tool	https://www.dropbox.com/s/09d3ailxj4ss7bu/CHCANYS%20Tool_Project%20Management%20Tool.docx?dl=0
27	CHCANYS Tool_QI Site Engagement Grid Sample	https://www.dropbox.com/s/hcwnnxh9x1k0evb/CHCANYS%20Tool_QI%20Site%20Engagement%20Grid%20Sample.docx?dl=0
28	CHCANYS Tool_QI Site Engagement Grid	https://www.dropbox.com/s/6gyaspg98o15gh4/CHCANYS%20Tool_QI%20Site%20Engagement%20Grid.docx?dl=0

Click on arrow to return to text

GLOSSARY OF TERMS

Academic Detailing – face-to-face or remote education by a trained health care professional for the purpose of improving clinical practice and patient care

Baseline Data – preliminary data that is reviewed at the onset of the project; informs SMART aims/targets to be achieved at the conclusion of the project, or at any time throughout the life of the project as dictated by the project team (e.g., quarterly, at the half-way mark)

Benchmark Data – the opportunity to compare providers', site's, or organizations' performance measures against each other

Center for Primary Care Informatics (CPCI) – a data warehouse that serves as a comprehensive repository of aggregated primary care data for Primary Care Associations and their member health centers in New York and other states nationwide. The warehouse provides its users with extensive reporting capabilities that draw clinical, operational, and financial data nightly from health center electronic health records (EHRs) and practice management systems. CHCANYS practice facilitators utilized the benchmarking data and clinical tools featured in the CPCI during the HealthyHearts NYC initiative to drive progress in quality improvement initiatives among participating health centers

Change Agent – staff member or Project Lead, not necessarily at the C-suite/leadership level, who assists with organizational change by forging strong connections and partnerships with project team members and staff that, over time, activates colleagues' engagement and "buying in" to the transformation taking place (e.g., nurse manager who believes strongly in the power of teamlet huddles, and provides detailed updates and reports during nursing staff and other team meetings to convey the importance of the practice and impact on process and outcomes measures)

CMS – Centers for Medicare & Medicaid Services. CMS oversees many federal healthcare programs, including those that involve health information technology such as the meaningful use incentive program for electronic health records (EHR)

C-Suite – typically includes Chief Executive Officer (CEO), Chief Operations Officer (COO), Chief Financial Officer (CFO), Chief Informatics Officer (CIO), and Chief Medical Officer/Medical Director (CMO)--who make decisions in alignment with the organization's strategic vision and priorities

Data Scrubbing – consistently reviewing data to ensure it is complete and not duplicative or mapped incorrectly against complementary tools and/or aggregated patient level data housed in a warehouse so an organization can confidently use data to promote better performance measures, quality improvement initiatives, and reporting requirement needs; the means by which data accuracy is maintained, typically by an assigned group of individuals or data team

Data Strategy and Quality – health center leaders develop a strategic plan for using data to inform patient care and reporting needs, and to assign pertinent roles and responsibilities to staff in order to ensure that data cleanliness and accuracy are prioritized

Click on arrow to return to text

Data Validation – review and analysis of a random sample of data for accuracy

DSRIP – Delivery System Reform Incentive Payment, designed to restructure the health care delivery system by reinvesting the Medicaid program

Executive Sponsor – a member of the health center leadership team who is responsible for the success of the quality improvement project and ensuring that the project team has time and resources needed to successfully implement change

HEDIS – Healthcare Effectiveness Data and Information Set is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service

HRSA – Health Resources and Services Administration, is the primary Federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable

Joy in Work – in response to evidence that burn-out has become increasingly pervasive among primary care providers, often due to administrative tasks and patient care needs, leadership can promote a culture of joy by adopting team-based care, where staff members work at the top of their licensure and skill sets, and implementing seamless workflows; the provider and support staff then reap the reward of "touching" the patient at opportune times during the patient visit, resulting in greater collaboration and relationship building with each other and the patient

Leadership – an organization's C-suite which typically includes Chief Executive Officer (CEO), Chief Operations Officer (COO), Chief Financial Officer (CFO), Chief Informatics Officer (CIO), and Chief Medical Officer/Medical Director (CMO)--that makes decisions in alignment with the organization's strategic vision and priorities; regarding quality improvement initiatives, leadership plays an important role in designating key staff to participate and allocating protected administrative time to do the work and share sustainability of gains made within the larger organization

Leadership Buy-in – the C-suite's resolute support, which enhances project progress

Measure Dashboard – data visualization tool that displays performance measures and key indicators

Medical Home – a care delivery model that is conceptually similar to the National Committee for Quality Assurance's Patient-Centered Medical Home (PCMH), where the tenets of team-based care and population health management are routinely used in the promotion of optimal patient care; the medical home is patient-centric and includes all levels of staff (clinical as well as non-clinical), where the patient and his/her family's/caregivers' needs and preferences in care are also prominently featured

Motivational Interviewing – a technique that clinicians use to motivate and inspire patients to make healthy lifestyle changes and manage chronic conditions

Outcome Measures – track the impact of healthcare services on a patient's health. For example, measuring the percentage of hypertensive patients whose last blood pressure reading was under 140/90 mmHg is an outcome measure for controlled hypertension

Click on arrow to return to text

Peer-to-Peer Learning – educational opportunities where peers or colleagues share and learn current and best practices

Performance Measures – tracking progress in patient health outcomes according to a provider's or group of providers' clinical data

Pilot Test – testing and measuring an idea in small scale; this term is used interchangeably with plan-do-study-act

Plan-Do-Study-Act (PDSA) – a four-step plan that helps facilitate the process of change, which includes: 1) Plan: Identify an opportunity for making a change; 2) Do: Implement the pilot/test on a small scale (e.g., one teamlet, a small group of patients); 3) Study: Review the data after a certain period of time to determine if improvements in outcome measures (e.g., number of patients who last blood pressure reading was under 140/90 mmHg), or if process measures have improved (e.g., increase in the number of tobacco use assessments, increase in the number of counseling sessions over a set period of time for patients who smoke); 4) Act: Use positive results to further plan for sustainable change and spread among different teams, departments, or sites

Practice Coach – external consultant who provides quality improvement and transformation support

Practice Transformation – the strategic modification of organizational practices to better support patient care in a changing healthcare environment

Process Measures – track what healthcare providers do or not do for patients in order to maintain their health, screen for or treat disease. These measures reflect the latest evidence-based guidelines. For example, measuring the percentage of patients who have their blood pressure recorded at least annually is a process measure used to screen for hypertension

Project Launch – initial project team meeting that kick-starts an initiative, providing background for team members and includes a presence from health center leadership

Project Lead – an individual within the health center who is charged with spearheading a quality improvement project

Project Plan – a dynamic document that describes the project goals, steps to achieve the goals, and includes background, structure, quality improvement methodology, team members, project timeline, and monitoring plan

Project Team – a diverse team of staff roles with a common goal of engaging in a performance improvement venture

Provider Report Cards – comprehensive reports on the quality of care provided by physicians

QARR – Quality Assurance Reporting Requirements, a set of indicators used by the New York State Department of Health to monitor health plan performance and award quality incentives

Click on arrow to return to text

Quadruple Aim – expansion of the widely accepted concept of Triple Aim (enhancing patient experience, improving population health, reducing health care costs) in optimization of health system performance, to include care team satisfaction

Quality Improvement (QI) – when related to health care, the changes applied to systems within an organization in order to ensure optimal patient care, as measured using performance metrics; quality improvement tools used in the promotion of sustainable changes include root cause analyses, workflow mapping, and Plan-Do-Study-Act rapid cycles of change

Quality Management Committee – Health center staff tasked with providing oversight & monitoring for ongoing quality improvement projects and activities, as well as maintaining and communicating an overall vision for the practice

Root Cause Analysis (RCA) – used to identify the root cause of a problem or broken process/workflow within an organization, which can be addressed (See Appendix for sample)

Sharing the Care – when all staff, clinical and non-clinical, equally share responsibilities in relation to care for the patient; no one staff member is burdened with all facets of care (e.g., coordination, referrals, education, management of medication regimen)

Storyboard – a graphical outline or display of sequential events that tells a story, such as in a quality improvement project; the outline/display contains a background, problem statement, strategy for change, measurement, results, and conclusions

Team Engagement – commitment and motivation of team members that results in contribution and advancement of the team's goals and objectives

Top-down Approach – approach to organizational problem-solving in which leadership is engaged and bought into the prospect of change that a quality improvement process can promote, so that such processes are then embraced and undertaken by staff at the front lines of patient care

Trending Data – the opportunity to reflect on quantitative improvements, dips, and plateaus in performance measures, as displayed visually on provider dashboards and reports, and what they impart about gaps in patient care delivery

UDS – Uniform Data System, a standardized reporting system that provides HRSA consistent information about health centers and look-alikes

Workflow Mapping – an exciting process to engage all levels of staff in documenting the patient experience, and encounters with staff during the clinical visit. Informs plan-do-study-act cycles of change

REFERENCES

Azara Healthcare and the Center for Primary Care Informatics (CPCI)
http://www.azarahealthcare.com/
http://www.chcanys.org/index.php?src=gendocs&ref=Statewide%20Primary%20Care%20Informatics%20Data%20Warehouse&category=HIT

Community Healthcare Association of New York State (CHCANYS)
http://www.chcanys.org/

Center for Excellence in Primary Care
http://cepc.ucsf.edu/

UDS/HRSA: Reporting Instructions for Health Centers, 2015
http://www.bphc.hrsa.gov/datareporting/reporting/2015udsmanual.pdf

CMS Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, Final Rule Overview for Modified Stage 2 Measures (October 8, 2015)
https://www.cms.gov/eHealth/downloads/Webinar_eHealth_October8_FinalRule.pdf

NYS 2015 Quality Assurance Reporting Requirements
https://www.health.ny.gov/health_care/managed_care/qarrfull/qarr_2015/docs/qarr_specifications_manual.pdf

Institute for Healthcare Improvement (IHI)
http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementSettingAims.aspx

HealthyPeople2020
https://www.healthypeople.gov/2020/topics-objectives

EvidenceNOW
EvidenceNOW: Advancing Heart Health in Primary Care
https://www.ahrq.gov/evidencenow/summary.html

Safety Net Medical Home Initiative
http://www.safetynetmedicalhome.org/

Agency for Healthcare Research and Quality (AHRQ)
https://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod14.html

Institute for Healthcare Improvement (IHI)
http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementFormingtheTeam.aspx

American Academy of Family Physicians
http://www.aafp.org/fpm/1999/0400/p25.html

Heart Health Resources

NYC Treats Tobacco
https://med.nyu.edu/pophealth/divisions/new-york-city-treats-tobacco

NYS Smokers' Quitline
https://www.nysmokefree.com/

National Diabetes Prevention Program
https://www.cdc.gov/diabetes/prevention/index.html

AHA/AMA High Blood Pressure Initiative
https://targetbp.org/

CDC and CMS Cardiovascular Disease Prevention Initiative
https://millionhearts.hhs.gov/about-million-hearts/index.html

NYC DOHMH High Blood Pressure Resources
http://www1.nyc.gov/site/doh/health/health-topics/heart-disease-blood-pressure.page

PDSA Resources

IHI PDSA Worksheet
http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx

IHI PDSA video
http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Whiteboard5.aspx

Team Building Resources

Azara Healthcare and PVP tutorials
https://vimeo.com/227407105 - Huddle only
https://vimeo.com/227406460 - PVP report and huddle

YouTube Team Building Activity
https://www.youtube.com/watch?v=oZjKGRz969s

Huddle.com
https://www.huddle.com/blog/team-building-activities/

Venture Team Building
http://www.ventureteambuilding.co.uk/team-building-activities/

Center for Care Innovations
https://www.careinnovations.org/

Health Information Technology, Evaluation, and Quality Center (HITEQ) Resources
https://hiteqcenter.org/Resources

American Medical Association/Steps Forward - Technology and Finance
https://www.stepsforward.org/modules?category=technologyandfinance&sort=recent

Joy in Work
Sinsky et al. In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practices (2012)
http://www.ihi.org/Topics/Joy-In-Work/Pages/default.aspx
http://www.annfammed.org/content/11/3/272.full

Safety Net Medical Home Initiative; Change Concepts - Continuous & Team-Based Healing Relationships
http://www.safetynetmedicalhome.org/change-concepts/continuous-team-based-healing-relationships

The Primary Care Team Guide; product of The Primary Care Team/LEAP program
http://www.improvingprimarycare.org/start/about

Cambridge Health Alliance Model of Team-Based Care Implementation Guide and Toolkit
https://www.integration.samhsa.gov/workforce/team-members/Cambridge_Health_Alliance_Team-Based_Care_Toolkit.pdf

Steps Forward - Workflow Process (TBC); Professional Well-Being (Joy in practice)
https://www.stepsforward.org/modules?category=workflow&sort=recent

UCSF: Center for Excellence in Primary Care
http://cepc.ucsf.edu/setting-agenda-video

Institute for Healthcare Improvement (IHI)
http://app.ihi.org/events/viewposterboard.aspx?EventId=2248

Data Resources

Azara Healthcare Tutorial: Data Validation Secrets
https://vimeo.com/246377414

Azara Healthcare Tutorial: Anatomy of a Measure Part 1: Defining the Measure
https://vimeo.com/221528403/c15e00311f

Azara Healthcare Tutorial: Anatomy of a Measure Part 2: Mapping and Validation
https://vimeo.com/221529298/ccd6f2bd76

Azara Healthcare Tutorial: Anatomy of a Measure Part 3: Processing and Attribution
https://vimeo.com/221531869/4ed49ec791

HITEQ Center – Health Information Technology, Evaluation, and Quality Center
http://hiteqcenter.org/

Center for Care Innovations (CCI) - Website
https://www.careinnovations.org/data-analytics/

Center for Care Innovations (CCI) – Data Governance Handbook
https://www.careinnovations.org/wp-content/uploads/2017/11/CCI-Data-Governance-Handbook.pdf