Primary Care Practice Facilitation Curriculum

Module 23: Documenting Your Work With Practices





IMPROVING PRIMARY CARE

Primary Care Practice Facilitation Curriculum

Module 23. Documenting Your Work With Practices

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Module 23. Documenting Your Work With Practices

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

• Professional method of process for working with practices

Time

- Pre-session preparation for learners: 45 minutes
- Session: 40 minutes

Objectives

After completing this module, learners will be able to:

- 1. Use the <u>sample facilitation practice record</u> to document a practice encounter.
- 2. Understand the importance of documentation for internal quality improvement and performance monitoring.

Exercises and Activities To Complete Before and After the Session

Pre-session preparation. Ask the learners to review information in item 1 and complete the activity in item 2. (45 minutes)

- 1. The content of this module.
- 2. Ask learners to use the <u>sample facilitation practice record</u> to enter data about a fictitious encounter with practice <u>TheOnlyOneforMiles</u>.

During the Session. Presentation (20 minutes)

1. Present key concepts from the module.

Discussion. Ask questions and explore answers with learners. (20 minutes)

- 1. What experience did you have using the <u>sample facilitation practice record</u> in preparation for this session?
- 2. What experiences have you had in the past documenting improvement work with other organizations?
- 3. How can you use a <u>sample facilitation practice record</u> to support and improve your work with a practice?
- 4. How can you use a <u>sample facilitation practice record</u> to communicate with your supervisor and other facilitators within your facilitation program?

Module 23. Documenting Your Work With Practices

Practice facilitators work independently in the field much of the time and must manage improvement work across multiple practices and organizations at the same time. It is important to document the content and outcomes of your encounters with practices routinely to help:

- monitor the progress of practices through a particular improvement program or project and
- keep track of the different priorities and activities across multiple organizations.

This documentation will help your program director know which issues to focus on during training and supervision sessions. It can also help both of you identify practices that may be experiencing difficulty in a particular area and need additional help.

Good documentation supports team approaches to facilitation by providing a way for team members to stay up to date on developments at a practice and to communicate their progress at the practice with each other. In addition, it provides a historic record of your work with a practice that can support handoff of the practice to another facilitator if you leave the organization for any reason. Finally, it helps maintain continuity between the practice and the facilitation program.

Identifying Tools for Documenting Encounters and Progress

Facilitators use a variety of methods to document encounters and track progress with their practices. You can create paper-based forms or simple spreadsheets on a computer or you can use online spreadsheets and survey programs. Online solutions can be a good option because they are dynamic and can be accessed by both you and your program supervisor. Figures 23.1-23.3 provide an example of how to document encounters with and progress of a practice.

The process you use to track your own encounters with each of your practices in many ways will parallel the process used by your practices. Instead of documenting patient visits, however, you will document practice visits; and instead of managing a panel of patients, you will manage a "panel" of practices.

Figure 23.1. Sample facilitation practice record—summary sheet with encounter notes, exemplar practices, and key drivers

Clinic ALLOVERTHEPLACE								
Practice Facilitator (PF)	Lisa Helps A lot	Cell:	Email:					
PF Standing Visit (day/time):	Mondays 1-4							
Practice status Nominate as Exemplar on:	Active							
Nominate as Exemplar on:	80% of indicated					-		
Pneumococcal Vaccine delivery	vs. 20% in similar							
	practices in area							
Improvement 8 Study Designs participation								
Improvement & Study Projects participating in:	Start date	End date	Description					
1) Chronic Kidney Disease guideline								
implementation	9/1/12		Improve quality and outcomes for patients with CKD					
2) Implement Care Teams	11/21/12	11/21/12	Implement care teams to support transformation to patient-centered medical home and to improve access and quality					
Encounter Notes - Overview (date)	Practice Status		Notes					
	0=no progress,							
	1=some							
	progress, 2=solid							
9/1/12	progress 2	CKD: Met with CKD	champion for practice and his team; held project kick-off meeting; academic detailing on CKD guidelines and their use in primary care					
9/8/12			try manager at request of Dr. Like Data. There are problems pulling eGFR data into the registry. Also, clinicians are coding CKD as					
10/12/12			ble to meet because practice busy treating patients with flu; registry manager out on vacation; Dr. Like Data not responding to					
10/22/12			with registry because manager out on vacation; Dr. CKD says can meet next week. Started first performance audit on patients with					
11/8/12			XD and reviewed performance data. Dr. CKD indicates that information on medications is probably inaccurate due to out of date stude being to CKD improvement home on Model for Improvement are ided training due on directive medice facilitations that the stude being to CKD improvement home on Model for Improvement are ided to being an official medice facilitations of the stude to be and the stude to be a					
11/18/12	2	CKD: Provided 15 n	ninute training to CKD improvement team on Model for Improvement; provided training also on effective meeting facilitation.					
PRACTICE PROGRESS DASHBOARD						(in the second s		
PROJECT	CKD							
Overall Assessment Scales:		0 =	No activity; 1 = Planning; 2 = Activity, no change; 3 = Testing; 4 = Implementation; 5 = Spread; 6 = Complete					
A. Create Quality Improvement team/cmt and performance monitoring system	СКО		NOTES/COMMENTS					
OVERALL SCORE:	4		NOTESICONINENTS			-		
A1. Designate Project team leader	6		Dr. CKD is the champion.					
A2. Identify performance metrics	6							
A3. Develop performance report generator using EHR and registry data	3	k						
A4. Map workflow for performance reporting & use	3	 						
A5. Train Project team on Model for Improvement	6							
and PDSA cycles A6. Review performance report monthly and carry-				b				
out PDSAs	0							
B. Use registry to manage target population	CKD		NOTES/COMMENTS					
OVERALL SCORE:	3							
B1. Create registry	3		Underway, waiting for registry manager to return from vacation					
B2. Populate registry B3. Assess & leverage existing population								
management resources								
B4. Train staff in population management								
B5. Map workflow for population management								
B6. Create reports templates/alerts to allow population management & planned care								
B7. Monitor use of registry to manage patient care								
and support population management	CKD							
C. Use templates OVERALL SCORE:	CKD		NOTES/COMMENTS					
C1. Select template tool from registry/EHR (or			Dr. CKD plans to meet with EHR manager to create template.					
create)	1		Dr. CKD plans to meet with Enry manager to create template.					
C2. Map workflows to use template								
C3. Use template at every patient visit C4. Ensure registry/EHR updated after every								
patient visit								
C5. Monitor use of templates	01/10							
D. Standardize care OVERALL SCORE:	CKD		NOTES/COMMENTS					
OVERALE BOORE.			Dr. CKD and team have adopted the CKD guidelines provided by the project. Are discussing modifying lab requirements since some of					
			In other and examinate applied the obtain for uninsured patients. Will help schedule virtual conference with Academic Detailer for Dr.					
D1. Select protocol/guideline for clinical care issue 3			CKD and his team to discuss this issue with him.					
D2. Modify for use in safety net environment D3. Map workflow to implement/use protocol								
D3. Map workflow to implement/use protocol D4. Use protocol at every patient visit								
D5. Monitor use of protocol								
E. Self Management support	CKD		NOTES/COMMENTS					
OVERALL SCORE:								
E1. Assess existing SMS resources at practice								
Contact:	S Encounter	Notes BASEL	.INE Performance Data 🦼 Perf. Data Month1 🦼 Perf. Data Month2 🦼 Perf. Data RUN CHART 🦼 PDSA	_1 PDSA_2	PDSA_3	1+1		

Figure 23.2. Sample facilitation practi	ce record—PDSA s	heet					
		DEDODT					
PLAN DU 3	STUDY ACT (PDSA)	REPORT					
Aim: (overall goal you wish to achieve):							
/ (oronan goal you mon to aomoro).							
Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done				
Describe your first (or flext) test of change:	Person responsible	when to be done	where to be done				
Plan							
List the tasks needed to set up this test of	Person responsible	When to be done	Where to be done				
Predict what will happen when the test is	Measures to determ	ine if prediction succ	shoo				
Fredict what will happen when the test is	measures to determ	ine in prediction succ	6643				
Do: Describe what actually happened when y	ou ran the test						
Study: Describe the measured results and ho	w they compared to the	nredictions					
otady: pesende die measurea results and no	in they compared to the	productions					
Act: Describe what modifications will be mad	e to the plan for the nex	t cycle based on what	it you learned				
Contacts Encounter Notes	BASELINE Performance Dat	a / Perf. Data Month1 /	Perf. Data Month2 / Pe	rf. Data RUN CHART 🖌	PDSA_1 PDSA_	2 PDSA_3	+

Knowing Which Encounters To Document

It is important to document all "meaningful" encounters with a practice. This means any substantive work that supports the practice's improvement goals. This work includes onsite visits, virtual support, email exchanges, and independent research or information gathering you may do for the practice in support of its quality improvement (QI) goals. The key words are *substantive* and *meaningful*.

Sharing the Practice Record With Your Practices

Depending on the system your facilitation program uses for documenting and tracking progress at the practice level, you may be able to involve individual practices in updating and maintaining their practice record. This is most feasible when you use Web-based or cloud-based information systems that allow multiple people to access and collaborate on the same document. For example, a quality improvement group in Los Angeles uses a combination of Smartsheets and Google Docs to create a dynamic practice record that both the facilitator and each practice can access and contribute to.

Inviting practices to contribute to their practice record increases the transparency of the process and helps the practice track its own progress with its improvement work. The practice record can also serve as a shared space and project management and collaboration platform between the facilitator and the practice.

Protecting Confidentiality and Privacy

When you opt to share and jointly maintain the practice record with an individual practice, remember that much of the information you work with as a facilitator at a practice is sensitive in nature. You need to be careful about the type and level of detail of the information you enter into the practice record. For example, you should not include detailed notes about personal conversations with a staff person about a conflict with another staff person at the practice.

In this case, you will need to find another way to capture and convey sensitive information of this type to your supervisor and address the issue in the shared practice record in a manner that preserves the privacy of the persons involved. For example, you can include a comment in your notes that the QI team may want to consider training on conflict resolution. But leave out any specific information about the staff persons involved or the content of the conflict that might make it possible to identify the parties involved.

Similarly, do not post any identifiable patient data on the practice record or information about other practices you are working with that has not been cleared for sharing. You will need to remind your practices and their QI teams about these limits as well.

Transparency and the ability to collaborate and share information are essential to effective improvement work. At the same time, sharing too much information or the wrong type of information can derail the process. A good rule to use is: If you are in doubt about sharing a

piece of information, don't. You can always make it available later, but you cannot retract it once it has been shared.

Reporting Progress Across Your Practices

You will need to report to your supervisor how your practices are faring as a group. Figure 23.4 shows one way of conveying the big picture by charting practices' progress in implementing key changes. Note that progress is not linear. Practices that completed a key change in one month may backslide the following month.



Figure 23.3. Sample graphic showing progress across a panel of practices



Note: this module is based on Module 15 of the Practice Facilitation Handbook. Available at <u>https://www.ahrq.gov/ncepcr/tools/pf-handbook/index.html</u>

Module 23: Documenting Your Work With Practices

Appendix 23. Sample Facilitation Practice Record

Encounter Notes

Clinic ALLOVERTHEPLACE Practice Facilitator (PF)	Lisa Helps A lot	Cell:	Email:			
Standing Visit (day/time):	Mondays 1-4				1	+
actice status	Active					-
ominate as Exemplar on:						
	80% of indicated					
eumococcal Vaccine delivery	vs. 20% in similar					
	practices in area					_
						_
provement & Study Projects participating						
Observice Kideney, Disconse, svideline	Start date	End date	Description			4
Chronic Kidney Disease guideline plementation	9/1/12	10/2/13	Improve quality and outcomes for patients with CKD			
Implementation	11/21/12	11/01/10	Implement care teams to support transformation to patient-centered medical home and to improve access and quality			+
Implement Gale Teams	102012		implement care teams to support transformation to patient-centered medicar forme and to improve access and quarky			+
ncounter Notes - Overview (date)	Practice Status		Notes			
	0=no progress,					
	1=some					
	progress, 2=solid	1				
	progress					L
9/1/12) champion for practice and his team; held project kick-off meeting; academic detailing on CKD guidelines and their use in primary care			_
9/8/12			stry manager at request of Dr. Like Data. There are problems pulling eGFR data into the registry. Also, clinicians are coding CKD as			_
10/12/12			able to meet because practice busy treating patients with flu; registry manager out on vacation; Dr. Like Data not responding to			\rightarrow
10/22/12			with registry because manager out on vacation; Dr. CKD says can meet next week. Started first performance audit on patients with NCD and benefacian or date. Dr. CKD informatic information and the start and the start of the st		-	
11/8/12			CKD and reviewed performance data. Dr. CKD indicates that information on medications is probably inaccurate due to out of date			
11/16/12	Z	CKD: Provided 15 h	minute training to CKD improvement team on Model for Improvement; provided training also on effective meeting facilitation.			
PRACTICE PROGRESS DASHBOARD					·	ai a
ROJECT	CKD					
verall Assessment Scales:	U.S.	0-	No activity; 1 = Planning; 2 = Activity, no change; 3 = Testing; 4 = Implementation; 5 = Spread; 6 = Complete			٩
Create Quality Improvement team/cmt and		0 =	No activity, 1 = Planning; 2 = Activity, no change; 3 = Testing; 4 = Implementation; 5 = Spread; 6 = Complete			
rformance monitoring system	CKD		NOTES/COMMENTS			
/ERALL SCORE:	4	1				
. Designate Project team leader	6	1	Dr. CKD is the champion.			
. Identify performance metrics	6	5				
. Develop performance report generator using	3	1				
IR and registry data						
. Map workflow for performance reporting & use	3	5				
 Train Project team on Model for Improvement of PDSA cycles 	6	1				
 Review performance report monthly and carry- 				-		
t PDSAs	. 0					
Use registry to manage target population	CKD		NOTES/COMMENTS			
VERALL SCORE:	3	5				
1. Create registry			Underway, waiting for registry manager to return from vacation			Т
. where i the buy	3					
2. Populate registry	3					
2. Populate registry 3. Assess & leverage existing population	3					
 Populate registry Assess & leverage existing population anagement resources 	3	5 				-
Populate registry Assess & leverage existing population anagement resources Train staff in population management	3					+
2. Populate registry 5. Assess & leverage existing population anagement resources 5. Train staff in population management 5. Map workflow for population management	3		- - - - - - - - - -			
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Baseline Performance Data



Performance Data Run Chart



Plan Do Study Act Reporting Template

			PLAN DO S	TUDY ACT (PDSA)	REPORT						
Aim	(overall goa	l vou wieh	to achieve):								
~	(overall goa	i you wish	to achieve).								
Desc	cribe your fire	st (or next)	test of change:	Person responsible	When to be done	Where to be done					
Plan											
List	the tasks nee	eded to set	up this test of	Person responsible	When to be done	Where to be done					
Pred	lict what will	nappen wn	en the test is	Measures to determ	ine if prediction succ	eeds					
Do:	Describe what	t actually I	happened when yo	ou ran the test							
-											
Stud	ly: Describe t	ne measur	red results and not	w they compared to the	predictions						
Act:	Describe wh	at modifica	tions will be made	e to the plan for the nex	t cycle based on what	at vou learned					
mm		Contacts	Encounter Notes	BASELINE Performance Dat	a 🔪 Perf. Data Month1	Perf. Data Month2	Perf. Data RUN CHART	PDSA	_1_PDSA_2	PDSA_3	$\left(+\right)$

Module 12: An Introduction to Assessing Practice Systems: Issues to Consider Appendix 12C. Case Example: OnlyOneforMiles

The practice OnlyOneforMiles is interested in working with you to implement panel management and to improve their diabetes care. The Chief Medical Officer is excited about the project and responds to your emails to them about the project within a day. You schedule a meeting with him. You ask him to identify key individuals who might participate on the Care Model project team for the intervention period. He says okay. When the day of the meeting comes, Dr. Enthusiasm shows up for the meeting. But no one else is with him. You ask where the others are and he says that everyone was too busy that day to join.

As the two of you visit about project expectations, he mentions that the CEO is not interested in participating and is concerned the project and changes will make the practice lose money. The practice is also implementing its EHR in the next two months and so staff and clinicians are stretched thin. Despite the challenges, the practice is financially fairly stable, and has a low rate of clinician and staff turnover. The practice recently began to transition to care teams from traditional physician-centric models, which has been causing some conflict, but so far things are going okay with that change.

Dr. Enthusiasm is excited about working with you as he thinks it complements the change to care teams and might help improve them. He also thinks that the practice should try to implement panel managers and wants a practice facilitator to help. He wants to know next steps to starting work with you. Dr. Enthusiasm's practice is located in a semi-rural community and is one of the only sources of primary care for low-income patients in the region.