Primary Care Practice Facilitation Curriculum

Module 12: An Introduction to Assessing Practices: Issues to Consider

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Primary Care Practice Facilitation Curriculum

Module 12. An Introduction to Assessing Practices: Issues to Consider

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Module 12. An Introduction to Assessing Practices: Issues to Consider

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Foundational knowledge for data-driven improvement and use of performance reports
- Application of practice assessment to determine practice readiness

Time

- Pre-session preparation for learners: 60 minutes
- Session: 70 minutes

Objectives

After completing this module, learners will be able to:

1. Describe the key principles of data-driven improvement and why this is a central concept in improvement work and facilitation.
2. List the different aspects of a practice that might be assessed as part of a practice improvement intervention.
3. Identify some common tools for assessing practices.
4. Access Health Resources and Services Administration (HRSA) Uniform Data System (UDS) reports for Federally Qualified Health Centers.

Exercises and Activities To Complete Before and During the Session

Pre-session preparation. Ask the learners to review information in items 1-3 and explore items 4-5 (60 minutes)

1. The content of the module.
2. Review and explore online resources for assessing practice systems and sample assessment tools listed above.
3. Download and review a copy of a UDS report on a safety net practice in your area.
4. Access to Clinical Microsystem Assessment Tool. https://clinicalmicrosystem.org/uploads/documents/microsystem_assessment.pdf. Improving Chronic Care has rebranded itself as the Accelerating Care Transformation Center.
5. Access sample assessment tools:

    - Status of Care Model implementation
        - Implementation of the Care Model-Practice Systems. Assessment of Chronic Illness Care (ACIC): https://www.act-center.org/application/files/2016/3111/2004/Assessment_Assessment_of_Chronic_Illness_Care_version_3.5.pdf

- Patient Assessment of Care for Chronic Conditions (PACIC): https://www.act-center.org/application/files/1016/3111/2006/Assessment_Patient_Assessment_of_Care_for_Chronic_Conditions.pdf

- Patient satisfaction and experience:
  - CAHPS® (Consumer Assessment of Healthcare Providers and Systems): https://cahps.ahrq.gov/surveys-guidance/cg/about/index.html

- Provider and staff satisfaction:
  - Primary Care Staff Satisfaction Survey located in Assessing, Diagnosing and Treating Your Outpatient Primary Care Practice: https://clinicalmicrosystem.org/uploads/documents/2.5.21_PDF_outpatient-primary-care_-workbook.pdf

- Organizational capacity for improvement:
  - Change Process Capability Questionnaire (CPCQ) developed by Leif Solberg. See Appendix 12A.

- Patient-centered medical home measures and recognition:
  - Medical Home Index: https://www.aucd.org/docs/lend/medhome/medhome_index_cmhi.pdf
  - National Committee for Quality Assurance: https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/
  - PCMH-A Assessment at http://www.safetynetmedicalhome.org/sites/default/files/PCMH-A.pdf

- Other resources for practice data
  - HRSA Uniform Data System report on safety net practices in your area: http://bphc.hrsa.gov/datareporting/index.html

During the session. Presentation (25 minutes)

1. Present key concepts from the module.

Exercise for learners (30 minutes)

1. Complete the CPCQ for one of your practices (or the TheOnlyOneforMiles case example). See Appendix 12C.
2. Complete the ACIC for one of your practices (or for TheOnlyOneforMiles case example). Available at https://www.act-center.org/application/files/2016/3111/2004/Assessment_Assessment_of_Chronic_Illness_Care_version_3.5.pdf.

Discussion. Ask questions and explore answers with learners (15 minutes)

1. What lessons did you learn from completing these surveys and reviewing the UDS data reports?
2. What have been your experiences and lessons learned assessing systems in practices (or other organizations)?
3. How might you use these tools with practices you are working with?

Module 12

Effective improvement work is data driven. Information on the practice and its performance on key measures is used to:

- create buy-in for improvement work.
- identify areas in need of improvement and strengths that can be leveraged to support improvement work.
- compare the practice's performance to that of others (benchmarking). Prioritize improvement efforts and activities.
- set improvement goals.
- track progress toward improvement goals.
- monitor maintenance of improvements once achieved.

Identifying What To Assess

What you assess should be determined by the scope and goals of the facilitation intervention. You will need to work closely with your practices to prioritize areas for assessment as you begin to work with them. Table 12.1 contains some important metrics you will need to talk to your practices about assessing.

Table 12.1. Assessment metrics

Assessment Topic	Metrics
Access and continuity	• Same day access • Nontraditional visits to traditional • Third next available appointment • Patients seeing own provider or care team
Clinical information systems and progress toward meaningful use	• Registries • Problem lists • Medication lists • Flow sheets • Checklists of tests and interventions • Decision support tools
Clinical performance	• Key performance and outcome metrics for: o Coronary artery disease (CAD) o Heart failure (HF) o Diabetes mellitus (DM) o Preventive care (PC) o Hypertension (HTN) o Other clinical performance metrics relevant to the particular practice
Implementation of key elements of	• Elements of the Care Model

Assessment Topic	Metrics
aspirational care models	• Elements of the patient-centered medical home
Finance	• Monthly expenditures • Expenditures per visit • Debt ratio • Working capital
Patient experience	• Patient satisfaction • Patient engagement with care team • Visit cycle time • Patient support and empowerment as owners of their own health
Quality improvement systems	• Quality improvement plan content • Implementation of plan • Presence of performance reporting systems and their use
Safety and reliability	• Medication error monitoring and prevention • Adverse event monitoring and prevention
Staff morale and satisfaction	• Staff satisfaction • Staff burnout

Identifying Assessment Tools

A variety of tools exist to assess a practice. They fall into four categories:

- Surveys and rating scales (patient, provider, staff, whole practice)
- Chart/medical record audits
- Direct observation and interviews
- Document review

Assessments can look at practice processes. For example, the Clinical Microsystems Assessment is a comprehensive assessment package for assessing multiple domains of a practice from clinical systems and performance to patient satisfaction and experience to financial issues.

Specialized tools exist for assessing particular aspects of practice performance and functioning. For example, the Assessment of Chronic Illness Care (ACIC) tool evaluates the degree to which a practice's processes and methods are consistent with the different elements of the Care Model. (See Module 24 on Care Model.) Similarly, the Medical Home Index evaluates the degree to which a practice reflects aspects of the patient-centered medical home.

Surveys let you gather information in a systematic fashion. You may want to survey staff satisfaction about the work environment, skills staff members have, and time management. You can identify sources of stress, ways staff may be underutilized, and ideas for improvement.

Surveys of patient satisfaction or experiences with care are another important source of information. Patient surveys can be broad (e.g., clinician/group CAHPS®) or specific to certain types of transformations (e.g., Patient Assessment of Chronic Illness Care, CAHPS® Patient-Centered Medical Home Survey). Qualitative methods, such as focus groups, can also be useful in gauging patient opinions.

Chart or electronic health record audits can examine how the practice performs on specific metrics for clinical performance and patient outcomes. Different groups have defined sets of quality metrics available to guide your assessments in these areas. Your practices will most likely be familiar with them and may already be tracking their performance on some of these metrics. A few examples are listed below:

- National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS) indicators (https://www.ncqa.org/hedis/measures/).
- Measures endorsed by the National Quality Forum (https://www.qualityforum.org/QPS/QPSTool.aspx).

Direct observation will be one of the most powerful assessment tools available to you as a facilitator and something that can make you very valuable to your practices. Direct observation can be used to gather information about patient experience at the practice. For example, you might use a "secret shopper" approach to better understand what a patient experiences in a practice if this is an area of focus for a practice. You may spend time in the waiting room or observe the interaction of a care team to better understand and assess how they work together. You may use observation to assess factors affecting staff workflow or satisfaction or to evaluate the implementation of new policies or procedures by staff in the practice environment. Observations of specific elements of the practice can be captured using field notes or checklists and then provided to the quality improvement (QI) team to use in designing improvements.

Document review is another important tool for assessing a practice. Examining documents and archival information produced as part of clinical care or various aspects of care can provide valuable insight into what is working and not working with a practice's systems. You can use document review and observation as tools to conduct "fall-out" assessments, where a forensic analysis of system "failures" identifies the reasons for the failure and suggests improvements. For example, in a practice interested in improving its lab reporting process, observation and document reviews can help track patients who failed to receive their lab results within the specified time period and identify failures in the system. The practice can use these data to correct and improve the process and reduce failures in the future.

Many different tools are available to examine different domains of practice functioning, from clinical care processes to administrative systems and financial stability. You will need to work

with each practice to pick the tools and approaches that not only fit the goals for the facilitation intervention and those of the practice, but are most likely to yield information that can be acted on to make improvements.

Choosing Assessment Tools

Your facilitation program may have a set of basic assessment tools and measures that it expects you to use to assess the practices you will be working with. You may choose to augment the tools your program has selected with additional assessments that you find helpful or the practices you are working with would like you to use.

The goal is to select a set of measures that will yield information that is "actionable" for the practice, but not to overwhelm them with data. Many variables might be interesting to assess but are not essential. Part of your job will be to help the practice focus the assessment on those items that are relevant to the improvement goals.

Identifying Assets as Well as Challenges

It is important to approach the assessment from an asset-based rather than deficit-based perspective. You are probably working with a practice because it is having difficulty implementing desired changes on its own. Thus, the tendency can be to focus only or mainly on the practice's problems and weaknesses. This can result in a negative dynamic in which the practice facilitator feels as though he or she must "rescue" the practice. This approach is debilitating to the practice and inhibits the sustained improvement and increased practice capacity that are goals of facilitation.

To avoid this scenario, try to develop an "asset" map of the practice that includes a list of the skills and talents of staff and clinicians as well as the resources the practice may already have that are relevant to practice improvement. The book *Building Communities from the Inside Out: A Path Toward Identifying and Mobilizing a Community's Assets* (1993) can assist you in shifting the paradigm from one that is deficit driven to one that is asset based. Incorporating an Appreciative Inquiry (AI) approach into your work can also help with this. Module 9 provides an introduction to AI concepts that you may want to incorporate into your work with practices.

Leveraging Existing Data Resources

Practices, especially those in the safety net, already collect a considerable amount of performance and patient data for the Federal Government and third-party payers. In addition, practices may collect information for other QI work going on at the practice. Therefore, practices may be resentful if you try to impose new data collection on them that is seen as duplicative.

Leverage the data the practice is already collecting whenever possible. Sources of assessment and monitoring data include:

- Disease registries: patient characteristics, quality of care metrics, possible use as population management tool
- Electronic health records: patient characteristics, quality of care metrics, possible use as population management tool, utilization
- Patient surveys: patient experience
- Health Resources and Services Administration (HRSA) Uniform Data System (UDS): quality of care and clinical outcome metrics
- Reports required by health plans: quality of care and clinical outcome metrics, utilization, other process indicators specific to plan
- Existing QI reporting: various metrics
- Data collected for prior research or QI efforts: various metrics
- Workflow maps
- Staff surveys: various metrics

Be sure to take an informal inventory of data sources before recommending any new data collection. This inventory should include the resources listed above and extend to data collection required by their different payers and projects they may be participating in with local researchers. For example, HRSA's UDS (http://bphc.hrsa.gov/datareporting/index.html) is a requirement for grantees of HRSA Primary Care Programs. A variety of data elements are included, such as patient demographics, services provided, staffing, clinical indicators, utilization rates, costs, and revenues. See Appendix 12B for a sample data inventory form.

Using Assessment Tools To Stimulate Reflection and Discussion

The MacColl Center for Health Care Innovation's assessment tool, the ACIC, can help stimulate productive discussions about the needs and improvement goals of the practice. Table 12.2 summarizes the elements of the ACIC.

Table 12.2. Elements of the Assessment of Chronic Illness Care (ACIC)

Component	Content
Health delivery system	• Organizational leadership is in place for Care Model • Organizational goals exist for Care Model • Improvement strategies exist for Care Model • Incentives and regulations are in place for Care Model • Senior leadership supports quality improvement in Care Model • Benefit structure supports patient engagement in Care Model
Community linkages	• Patients are linked to outside resources • Practice partners with community organizations • Health plans coordinate guidelines, measures, and resources at

Component	Content
	practice level
Self-management support	• Needs are assessed and documented • Self-management support is provided to patients • Concerns of patients and their families are addressed • Behavioral interventions and peer support are provided
Decision support	• Evidence-based guidelines are available through reminders and other methods • Specialists provide guidance to enhance primary care clinician capacity • Provider education is provided for Care Model on issues such as population management and self-management support • Patients are informed about guidelines
Delivery system design	• Effective practice teams deliver team-based care • Team leadership is clearly defined and empowered • Appointment systems support effective care • Follow-up is tailored and guideline driven • Planned visits are used for regular assessments, preventive care, and self-management support • Continuity of care is a priority and includes coordination of care across providers
Clinical information systems	• Registry is used and tied to guidelines and provides prompts and reminders about services • Reminders to providers include information to team about guideline adherence at time of visit • Feedback is timely, specific to team, and aimed at improving team performance • Information about patient subgroups is given to providers to support planned care • Treatment plans are established collaboratively with patients
Integration of Care Model components	• Patients are informed about guidelines • Registries include results of patient assessment and self-management goals developed with patient • Community programs provide feedback about patients' progress • Practice uses data and feedback from teams to plan population care and self-management support programs and monitors success over time • Specific staff are charged with supporting routine follow-up • Team reviews guidelines with patient to guide self-management and behavior modification appropriate to patient goals and readiness

Adapted from Assessment of Chronic Illness Care (ACIC). Copyright 2000, The MacColl Center for Health Care

Innovation, Group Health Cooperative.

Building Practice Capacity for Data Collection and Use in a Practice

While you will most likely collect and analyze data early in an improvement intervention, from the very beginning you will need to plan how you will build capacity in the practice to continue producing performance measures over the long term. Consider the following questions:

- What information systems do they have or need to support this effort?
- How can you help them develop the systems they lack and learn to mine data from those they have?
- Who in the practice will do this?
- What data will they collect? How often?
- What skills will they need and how can you help them develop these skills?
- What systems and software will they need to analyze and interpret the data for use in QI work? What will the workflow be for staff who will collect and analyze these data? How long will it take to complete this task each reporting period?
- Can this activity be incorporated into other required reporting activities, such as reports to health plans?
- Will leadership provide protected time to staff for these activities?
- What factors are likely to interfere with or prevent staff from completing this key activity?
- How can this get written into their job descriptions?
- How will new staff filling this role in the future be trained?
- What systems will be put in place to hold them accountable for completing these tasks?
- What schedule will they follow for collecting the data and reporting them to the QI team?
- How will the data be displayed so they are meaningful and actionable to the QI team?
- Can they "automate" parts of this process to make it easier for staff to obtain data and produce periodic reports?

As you work with the data, you will need to begin working on the answers to these and other relevant questions. Your objective is to build internal capacity in the practice to do the things with data that you are doing now and to sustain this work over time.

Note: this module is based on Module 6 of the Practice Facilitation Handbook. Available at: https://www.ahrq.gov/ncepcr/tools/pf-handbook/index.html.

Reference

Kretzmann J, McKnight J. Building communities from the inside out: a path toward finding and mobilizing a community's assets. Evanston, IL: Asset-Based Community Development Institute, Northwestern University; 1993.

Appendix 12A. Change Process Capability Questionnaire (CPCQ)

How would you describe the approach to quality improvement in your medical group or clinic?

	strongly disagree	somewhat disagree	neither agree or disagree	somewhat agree	strongly agree	NA
1. Clinicians in our medical group/clinic believe that high quality care is very important	1	2	3	4	5	8
2. We have greatly improved the quality of care in the past year	1	2	3	4	5	8
3. We choose new processes of care that are more advantageous than the old to everyone involved (patients, clinicians, and our entire medical group/clinic)	1	2	3	4	5	8
4. Our resources (personnel, time, financial) are too tightly limited to improve care quality now	1	2	3	4	5	8
5. Our medical group/clinic operations rely heavily on organized systems	1	2	3	4	5	8
6. The thinking of our leadership is strongly oriented toward systems	1	2	3	4	5	8
7. Our medical group/clinic attaches more priority to quality of care than to finances	1	2	3	4	5	8
8. The clinicians in our medical group/clinic espouse a shared mission and policies	1	2	3	4	5	8
9. The clinicians in our medical group/clinic adhere to medical group/clinic policies	1	2	3	4	5	8
10. Our medical group/clinic leadership is strongly committed to the need for quality improvement and for leading that change	1	2	3	4	5	8
11. Our medical group/clinic has well-developed administrative structures and processes in place to create change	1	2	3	4	5	8
12. Our medical group/clinic is undergoing considerable stress as the result of internal changes	1	2	3	4	5	8

	strongly disagree	somewhat disagree	neither agree or disagree	somewhat agree	strongly agree	NA
13. The working environment in our medical group/clinic is collaborative and cohesive, with shared sense of purpose, cooperation, and willingness to contribute to the common good	1	2	3	4	5	8
14. The clinicians in our medical group/clinic are very interested in improving care quality	1	2	3	4	5	8
15. We have many clinician champions interested in leading the improvement of care quality	1	2	3	4	5	8
16. Our medical group/clinic understands and uses quality improvement skills effectively	1	2	3	4	5	8
17. The leaders of our efforts to improve care quality are enthusiastic about their task	1	2	3	4	5	8
18. Our medical group/clinic has a well-defined quality improvement process for designing and introducing changes in the quality of care	1	2	3	4	5	8

Our medical group/clinic has used the following strategies to implement improved care quality…

	strongly disagree	somewhat disagree	neither agree or disagree	somewhat agree	strongly agree	NA
19. Providing information and skills-training	1	2	3	4	5	8
20. Use of opinion leaders, role modeling, or other vehicles to encourage support for changes	1	2	3	4	5	8
21. Changing or creating systems in the medical group/clinic that make it easier to provide high quality care	1	2	3	4	5	8
22. Removal or reduction of barriers to better quality of care	1	2	3	4	5	8
23. Organizing people into teams focused on accomplishing the change process for improved care	1	2	3	4	5	8
24. Delegating to non-physician staff the responsibility to carry out aspects of care that are normally the responsibility of physicians	1	2	3	4	5	8

	strongly disagree	somewhat disagree	neither agree or disagree	somewhat agree	strongly agree	NA
25. Providing to those who are charged with implementing improved care the power to authorize and make the desired changes	1	2	3	4	5	8
26. Using periodic measurement of care quality for the purpose of assessing compliance with any new approach to care	1	2	3	4	5	8
27. Reporting measurements of individual or care unit performance for comparison with their peers	1	2	3	4	5	8
28. Setting goals and benchmarking rates of performance quality at least yearly	1	2	3	4	5	8
29. Customizing the implementation of any care changes to each site of care	1	2	3	4	5	8
30. Use of rapid cycling, piloting, pre-testing, or other vehicles for reducing the risk of negative results from introducing organization-wide change in care	1	2	3	4	5	8
31. Deliberately designing care improvements so as to make physician participation less work than before	1	2	3	4	5	8
32. Deliberately designing care improvements to make the care process more beneficial to the patient	1	2	3	4	5	8

Appendix 12B. Sample data inventory form

Department:	
Date:	

Information being collected (Summary – Optional: attach copy of variables collected to this form)	**Source for data**	**For what patients or activities?**	**For what purpose?** (Fed govt., payer, practice internal QI, other) provide details	**Data source/ Method?** (Electronic registry (name), paper survey, etc.) Provide name and details	**When?** (Daily, monthly, quarterly)	**Being used in QI or clinical care at practice?** Y/N	**Location of data and person in charge of data collection?**	**What information on race/ ethnicity is being collected?** (Be specific – list variables)	**HOW is race/ ethnicity info being collected?** (Patient completes form, verbal question by receptionist, etc.)
EXAMPLE: Diabetes lab data, PHQ 9 data, visit data	Manual entry from PHQ 9 forms; auto input from billing system; auto input from lab feed	All diabetic patients at practice	Report to County PPP program; BPC disparities collaborative	I2I registry, Excel Spreadsheet	Daily as able	Partial: Patients with elevated PHQ 9s are flagged on a monthly basis and names are given to director of behavioral health	Computer in main office; Mary Gonzales	Ethnicity: Hispanic/ non-Hispanic Race: White African American Asian American Indian	Entered from information provided by patient on "first visit form"

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.