

AHRQ's Primary Care Practice Facilitation Forum

This email newsletter is the first step in building a learning network for individuals with an interest in practice facilitation. We will use this listserve to share questions and answers submitted by learning forum members, as well as resources, research articles and events of interest.

November 16, 2012

Perspectives from the Field

This week, we asked Connie Sixta, Senior Consultant, Sixta Consulting, Inc., about the **challenges facing practice facilitators serving different populations**. See her thoughts below, including an example of how a practice facilitator would help a practice to define and identify different populations.

How do you tailor practice facilitation efforts to practices serving different populations?

Connie Sixta: To adequately support practices with facilitation, the population/s within the practice must be defined and assessed. Characteristics that help define the practice population/s and the needs of the population include average age of the population, average number of visits per year, predominate health care needs (occasional acute illness versus preventative care versus chronic illness care), predominate risks, predominate conditions/illnesses, socioeconomic status, cultural needs, predominate language, and a myriad of other issues. Many times there are a number of subgroups within the practice population that need to be defined so that the practice can efficiently and effectively manage the total population. An example of this would be a pediatric practice that provides care to 1) a large number of newborns who require frequent visits for checks and immunizations and 2) a large number of adolescents who have annual sport physicals and occasional acute care visits. Both age-defined populations would need to be adequately defined to allow the practice to evaluate panel size, schedule, staffing needs and other programmatic needs.

As a practice facilitator assisting a practice in managing a particular population, you would help the practice complete the following steps:

- 1) Define the population specifically according to age, chronic illness, condition, or other characteristic. For example, if the practice wanted to manage an adult population with congestive heart failure (CHF), the facilitator would likely suggest the age range 18-75 since this is the age range for adults used in most meaningful use measures and would research CHF clinical guidelines to determine the definition of CHF the practice would apply (i.e. defined as patients with an echocardiogram and an ejection fraction of X);
- 2) Assist the practice in determining how to search their panels for the patients within the defined age ranges and who meet the criteria set forth in the CHF definition (this many times involves sorting for an ICD-9 code, sorting according to procedure, etc.)

3) Support the practice in selecting the CHF measures that define good CHF care by searching the literature for evidence-based clinical guidelines; and

4) Assist the practice in selecting evidence-based interventions/approaches used to improve the care of patients with CHF (i.e., create the change package or set of changes that improve CHF management).

At the end of the process the practice facilitator would have helped the practice define the population, identify measures that indicate good care for that population, and develop the set of changes to be tested/implemented to improve care.

When a practice designs new programs such as care management for “highest risk patients” (a previously undefined population), the practice may want to select a “pilot population” of patients they consider “for sure” to be highest risk. The characteristics of the pilot population and approaches related to the management of the population can thus be tested among the pilot group to see if they truly meet the needs of the group before implementing with the full population. This approach coincides with the performance improvement methodology of small cycle change within a small group of patients (to define the characteristics and needs of the population) and of testing changes to improve care before implementing more broadly. In this situation, the practice facilitator would support the practice in this process by suggesting the following steps:

1) Pull together a group of experienced providers and staff to begin to identify highest risk patients;

2) Convene the group of providers and staff to each identify the 5 patients that they are most concerned/worried about and would consider highest risk;

3) Search the medical record of the identified patients (5 patients per provider x the number of providers) to identify consistent characteristics of these highest risk patients (i.e. homeless, drug or alcohol abuse, mental health problems, ER utilization, etc.) and;

4) Populate the highest risk Care Manager registry and begin to follow-up with these patients to identify needs and interventions that improve care and outcomes.

This approach has been used effectively in Federally Qualified Community Health Centers where all of their patients are considered highest risk.

Resources

Check out the newly updated [PCPF Webinars page](#) and [PCPF Resources page](#) at the PCMH Resource Center (www.pcmh.ahrq.gov).

We've posted previous editions of the PCPF eNewsletter, slides and audio from the Practice Facilitation Webinar series, and information about upcoming learning opportunities. Please visit the PCMH Resource Center at www.pcmh.ahrq.gov to explore white papers, briefs, a searchable citations database, and other resources related to the Patient-Centered Medical Home and primary care improvement.

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