Primary Care Practice Facilitation Curriculum

Module 23: Documenting Your Work With Practices

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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 facilitator practice record 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 sample facilitator practice record to enter data about a fictitious encounter with practice TheOnlyOneforMiles.

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 practice record 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 practice record to support and improve your work with a practice?
4. How can you use a practice record 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	Active		
Nominate as Exemplar on:			
Pneumococcal Vaccine delivery	80% of indicated vs. 20% in similar practices in area		

Improvement & Study Projects participating in:	Start date	End date	Description
1) Chronic Kidney Disease guideline implementation	9/1/12	10/2/13	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 0=no progress, 1=some progress, 2=solid progress	Notes
9/1/12	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	1	CKD: Met with registry 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	0	CKD: Dr. CKD not able to meet because practice busy treating patients with flu; registry manager out on vacation; Dr. Like Data not responding to
10/22/12	0	CKD: No progress with registry because manager out on vacation; Dr. CKD says can meet next week. Started first performance audit on patients with
11/8/12	2	CKD: Met with Dr. CKD and reviewed performance data. Dr. CKD indicates that information on medications is probably inaccurate due to out of date
11/18/12	2	CKD: Provided 15 minute training to CKD improvement team on Model for Improvement; provided training also on effective meeting facilitation.

PRACTICE PROGRESS DASHBOARD 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	CKD	NOTES/COMMENTS
OVERALL SCORE:	4	
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	
A4. Map workflow for performance reporting & use	3	
A5. Train Project team on Model for Improvement and PDSA cycles	6	
A6. Review performance report monthly and carry-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		
C. Use templates	CKD	NOTES/COMMENTS
OVERALL SCORE:		
C1. Select template tool from registry/EHR (or create)	1	Dr. CKD plans to meet with EHR 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		
D. Standardize care	CKD	NOTES/COMMENTS
OVERALL SCORE:		
D1. Select protocol/guideline for clinical care issue	3	Dr. CKD and team have adopted the CKD guidelines provided by the project. Are discussing modifying lab requirements since some of the labs are expensive and hard to obtain for uninsured patients. Will help schedule virtual conference with Academic Detailer for Dr. 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		
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 using ACIC		

Contacts | Encounter Notes | BASELINE Performance Data | Perf. Data Month1 | Perf. Data Month2 | Perf. Data RUN CHART | PDSA_1 | PDSA_2 | PDSA_3 | +

Figure 23.2. Sample facilitation practice record—PDSA sheet

PLAN DO STUDY ACT (PDSA) REPORT

Aim: (overall goal you wish to achieve):			
Describe your first (or next) 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 determine if prediction succeeds		
Do: Describe what actually happened when you ran the test			
Study: Describe the measured results and how they compared to the predictions			
Act: Describe what modifications will be made to the plan for the next cycle based on what you learned			

Contacts | Encounter Notes | BASELINE Performance Data | Perf. Data Month1 | Perf. Data Month2 | Perf. 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.

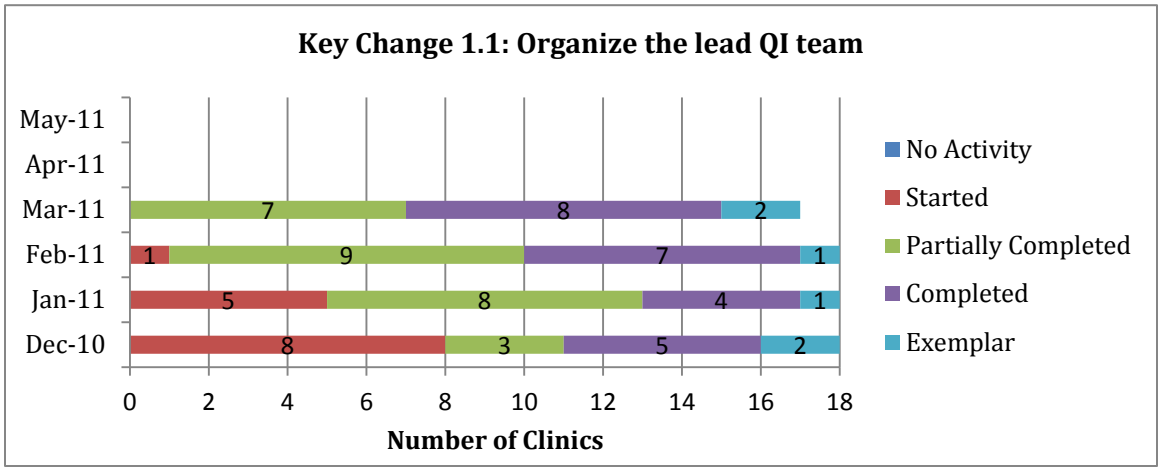
Transparency and the ability to collaborate and share information are essential to effective improvement work. At the same time, sharing too much information or the wrong type of information can derail the process. A good rule to use is: If you are in doubt about sharing a

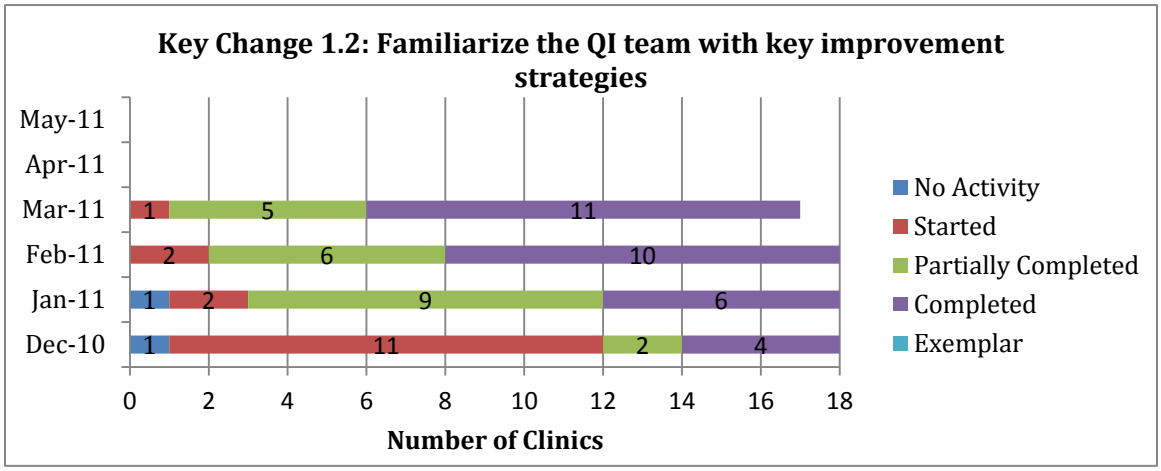
piece of information, don't. You can always make it available later, but you cannot retract it once it has been shared.

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 http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/

Appendix 23. *Sample Practice Record*

Encounter Notes

Clinic ALLOVERTHEPLACE			
Practice Facilitator (PF)	Lisa Helps A lot	Cell:	Email:
PF Standing Visit (day/time):	Mondays 1-4		
Practice status	Active		
Nominate as Exemplar on:			
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10/12/12	0	CKD: Dr. CKD not able to meet because practice busy treating patients with flu; registry manager out on vacation; Dr. Like Data not responding to
10/22/12	0	CKD: No progress with registry because manager out on vacation; Dr. CKD says can meet next week. Started first performance audit on patients with
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OVERALL SCORE:	4	
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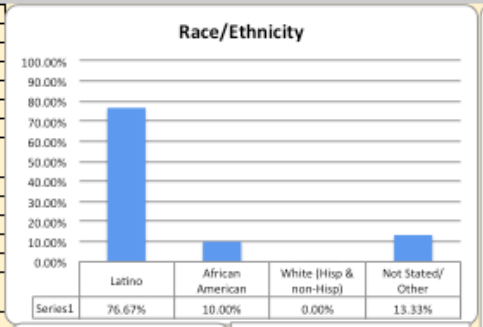
A2. Identify performance metrics	6	
A3. Develop performance report generator using EHR and registry data	3	
A4. Map workflow for performance reporting & use	3	
A5. Train Project team on Model for Improvement and PDSA cycles	6	
A6. Review performance report monthly and carry-out PDSAs	0	
B. Use registry 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		
C. Use templates	CKD	NOTES/COMMENTS
OVERALL SCORE:		
C1. Select template tool from registry/EHR (or create)	1	Dr. CKD plans to meet with EHR 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		
D. Standardize care	CKD	NOTES/COMMENTS
OVERALL SCORE:		
D1. Select protocol/guideline for clinical care issue	3	Dr. CKD and team have adopted the CKD guidelines provided by the project. Are discussing modifying lab requirements since some of the labs are expensive and hard to obtain for uninsured patients. Will help schedule virtual conference with Academic Detailer for Dr. 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		
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		

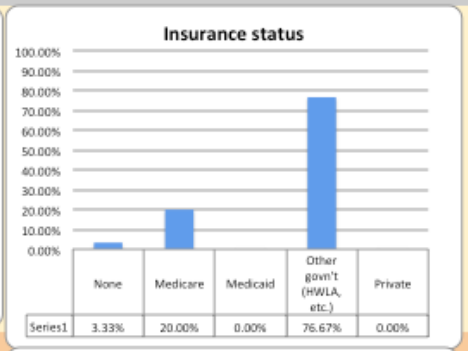
Contacts | Encounter Notes | BASELINE Performance Data | Perf. Data Month1 | Perf. Data Month2 | Perf. Data RUN CHART | PDSA_1 | PDSA_2 | PDSA_3 | +

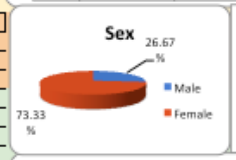
Baseline Performance Data

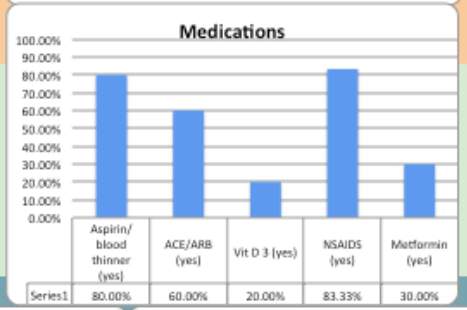
	Baseline		
N for performance data abstration	30	CKD pts seen at least 2x from 8-30- collected 10 to 9-1-11	10/24/11

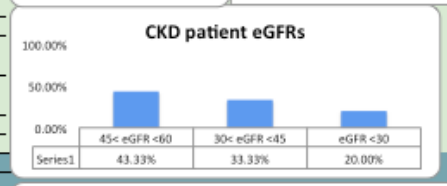
	%	#
Demographics		
Male	26.67%	8
Female	73.33%	22
Average age	61.07	
Age range	36-75	-
Latino	76.67%	23
African American	10.00%	3
White (Hisp & non-Hisp)	0.00%	0
Not Stated/Other	13.33%	4
Insurance status		
None	3.33%	1
Medicare	20.00%	6
Medicaid	0.00%	0
Other govn't (HWLA, etc.)	76.67%	23
Private	0.00%	0
CKD patients comorbidities/risk indicators		
DM Dx	3.33%	1
HTN Dx	13.33%	4
DM & HTN	80.00%	24
BP>130/80	53.33%	16
LDL<100		10
Calcium >8.5**		15
PO4 <4.6**		3
Smoker	3.33%	1
Smoking status missing	6.67%	2
CKD on problem list?		
Yes	93.33%	28
No	6.67%	2
Medication		
Aspirin/blood thinner (yes)	80.00%	24
ACE/ARB (yes)	60.00%	18
Vit D 3 (yes)	20.00%	6
NSAIDS (yes)	83.33%	25
Metformin (yes)	30.00%	9
Labs		
45< eGFR <60	43.33%	13
30< eGFR <45	33.33%	10
eGFR <30	20.00%	6
eGFR missing	0.00%	0
In the past 12 months:		
eGFR	96.67%	29
Referral if eGFR<30	33.33%	2
HbA1c	53.33%	16
Lipid panel	60.00%	18
Serum Ca++	86.67%	26
HGB	50.00%	15
25 hydroxy Vit D	50.00%	7
PTH	23.33%	7
Serum phosphate	20.00%	6
M/C	43.33%	13
Preventive care		
Flu vaccine last 12 months	40.00%	12
Pneumoccocal		

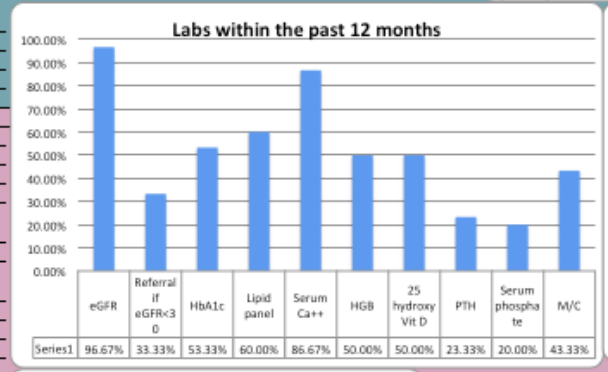


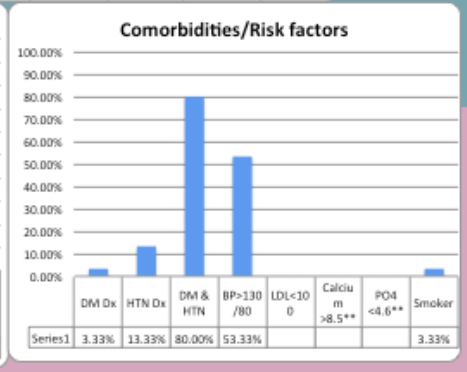


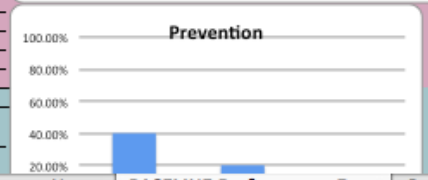






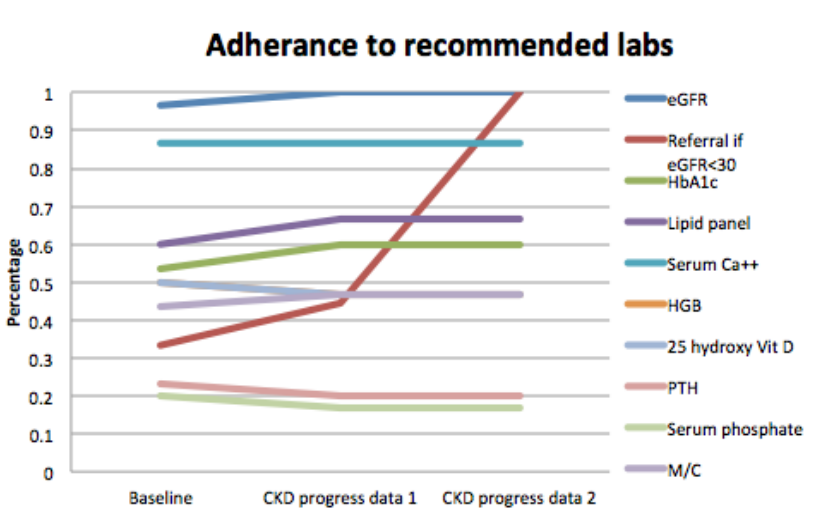


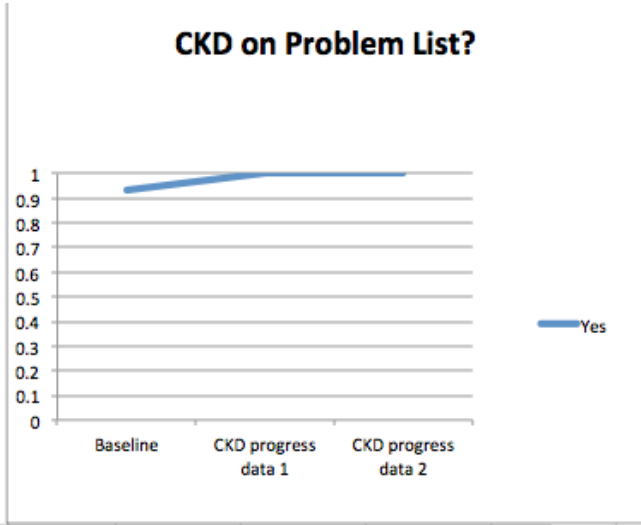


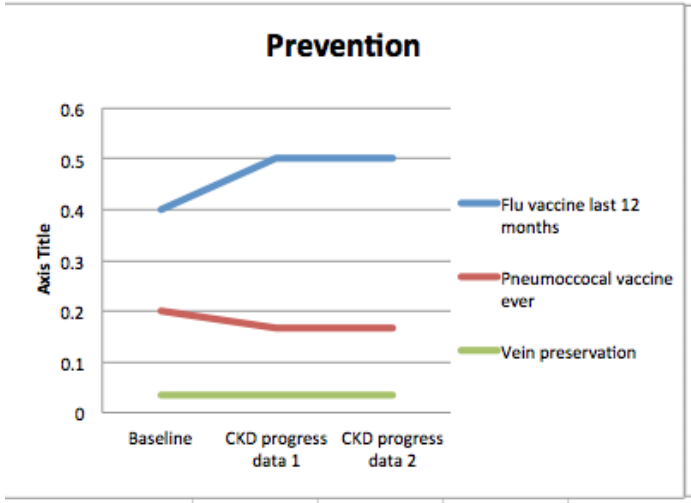


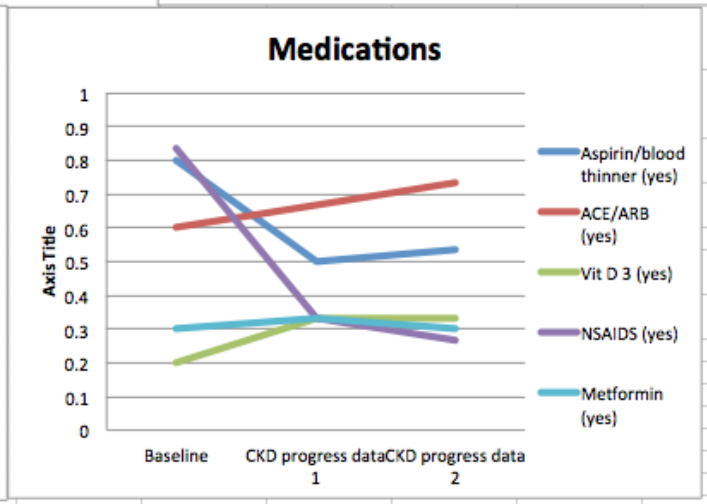
Contacts | Encounter Notes | BASELINE Performance Data | Perf. Data Month1 | Perf. Data Month2 | Perf. Data RUN CHART | PDSA_1 | PDSA_2 | PDSA_3 | +

Performance Data Run Chart









Contacts | Encounter Notes | BASELINE Performance Data | Perf. Data Month1 | Perf. Data Month2 | **Perf. Data RUN CHART** | PDSA_1 | PDSA_2 | PDSA_3 | +

Plan Do Study Act Reporting Template

PLAN DO STUDY ACT (PDSA) REPORT

Aim: (overall goal you wish to achieve):

Describe your first (or next) 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 determine if prediction succeeds

Do: Describe what actually happened when you ran the test

Study: Describe the measured results and how they compared to the predictions

Act: Describe what modifications will be made to the plan for the next cycle based on what you learned

Contacts | Encounter Notes | BASELINE Performance Data | Perf. Data Month1 | Perf. Data Month2 | Perf. Data RUN CHART | PDSA_1 | PDSA_2 | PDSA_3 | +

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"

LA Net Data Inventory Form, 2010; revised 2015