



Beacon Change Package
Cohort #4

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Beacon Change Package

I. Performance Improvement Change Package

Steps for Performance Improvement

- 1) Choose a measure.
- 2) Determine a baseline.
- 3) Evaluate your performance.
- 4) If performance is not what you would like, develop a performance aim.
- 5) Make changes to improve performance.
- 6) Monitor performance over time.

High Leverage Changes Overview

Use Quality Improvement Tools, Models and Resources

- Review & use the Expanded Care Model (a.k.a Care Model)
- Review & use the Model for Improvement
- Team-based Care Delivery
- Monthly Measure and Narrative Reporting
- Community Learning Collaborative
- Quality Improvement Advisors

Step 1: Determine source of Registry Functionality

- a. Evaluate options for Population Health reporting
- b. Validate and test registry source information

Step 2: Implementing a Registry Functionality

- a. Select and install a registry tool or maximize EHR
- b. Determine total population based on measure set including numerators/denominators
- c. Determine staff workflow to support registry use
- d. Populate registry with patient data
- e. Routinely maintain registry data
- f. Use registry to manage patient care and support population management
 1. Pull measures from registry
 2. Review patients against evidence-based protocols for gaps in care
 3. Outreach to patients who are out of compliance on protocols
 4. Compare measures by individual provider and with other providers monthly

Step 3: Use Planned Care Template

- a. Select template tool from registry/EHR or create a flow sheet
- b. Determine staff workflow to support use of template
- c. Use template with all patients
- d. Ensure registry updated each time template used
- e. Monitor use of templates

Step 4: Use Protocols

- a. Select and customize evidence-based protocols to practice
- b. Determine staff workflow to support protocols, including standing orders
- c. Use protocols with all patients
- d. Monitor use of protocols

Step 5: Self Management Support

- a. Obtain patient education materials (e.g., asthma action plans)
- b. Determine staff workflow to support SMS
- c. Provide training to staff in SMS techniques
- d. Set patient goals collaboratively
- e. Document & monitor patient progress toward goals
- f. Link with community resources (schools, service organizations)
- g. Implement the patient activation measure

Step 6: Use HIE Protocols

- a. Implement community HIE
- b. Implement auto processing protocols
- c. Standardize staff work flow
- d. Maximize use of data points from HIE
- e. Monitor use of standard workflow
- f. Maximize functionality for Meaningful Use

ASTHMA-SPECIFIC PROTOCOL

- Assess and document asthma severity and control
- Prescribe appropriate asthma medications & monitor overuse of beta agonists
- Use asthma management plans
- Establish visit frequency protocol
- Assess and treat co-morbidities
- Assess, counsel, and prevent exposure to environmental triggers

DIABETES-SPECIFIC PROTOCOL

- Check and treat BP <140/90
- Check and treat cholesterol
- Check A1C and treat hyperglycemia
- Assess aspirin need and prescribe if not using
- Assess need for eye exam and make referral if needed
- Assess nephropathy risk
- Perform feet exams
- Provide appropriate vaccines
- Assess tobacco use and counsel to stop tobacco use
- Assess symptoms of Depression using PHQ2 and then PHQ9 as appropriate

CARDIOVASCULAR DISEASE PROTOCOL

- Check BP
- Assess BMI
- Check lipid and LDL levels
- Assess tobacco use and counsel to stop tobacco use
- Assess symptoms of Depression using PHQ2 and then PHQ9 as appropriate

DEPRESSION PROTOCOL

- Administer PHQ2
- If positive administer PHQ9
- Confirm diagnosis and establish baseline measure with PHQ9
- Determine method of treatment

PREVENTION PROTOCOL

- Alcohol misuse screening and brief counseling
- Cholesterol screening
- Colorectal cancer screening
- Immunizations
- Cervical cancer screening
- Tobacco screening and counseling
- Adult obesity screening and counseling
- Childhood obesity screening and counseling
- Breast cancer screening

II. Practice Transformation Change Package

* Indicates High Leverage Change Package Elements

Patient & Family Engagement and Proactive Care Team*

- Patient “linked” with Care Team for questions, scheduling and follow-up
- Patient & Family Experience Survey which informs process improvement
- Patient & Family as a member of the QI Team
- Implement shared care plan and develop understanding of preference sensitive care

Clinical Information System

- Registry-broaden to other patient populations
- E-Prescribing
- HIE implementation and use*
- Reporting to various national and local Incentive Models
- Computer Physician Order Entry (CPOE)
- QHN Clinical Summaries

Self Management Support

- Shared decision making
- Patient self-efficiency and individualized assessment
- Patient self management support
- Stages and processes of change
- Motivational interviewing
- Health coaching
- Patient satisfaction/experience

Decision Support

- Evidence-Based Guidelines
- Maximize technology clinical decision support
- Use of HP/Archimedes/QHN Data for Proactive Care Delivery

Delivery System Design

Team Based Care*

- Maximize staff to the “top of their license”
- Huddles

Care Coordination

- Test and referral tracking
- Establish medical neighborhood*
- Establish Care Coordinator role*
- Develop and implement Care Compact
- Transitions of Care
- Create referral network using HIE
- Utilizing CCD via QHN

Access and Scheduling

- Increase points of access
- Demand and supply capacity
- Open/Traditional access scheduling
- E-Visits

Service Enhancement

- Co-located Services

Community Resources

- Healthier Living Colorado*
- AHEC Support Services
- Public Health Department
- Health Plans and hospital systems
- Faith based organizations
- Academic centers
- Web Based and online resources
- Regional Extension Center Services*

Organization of Health Care - Organization of Practice

- Leadership/culture
- Peer mentoring and Learning Collaborative faculty
- Team-building
- Job Descriptions Reflecting QI roles and responsibilities*
- Culturally competent care delivery
- Financial practice health
- Lean principles