First Things First: Getting Started

Introduction: What You Will Find in This Module

Now that you have decided to tackle changes to enable you to thrive in a value-based payment environment, where will you start? This module distills the lessons and experiences of over 120,000 primary care and specialty clinicians enrolled in TCPI practices, and describes the foundational work needed to achieve and report great outcomes in both primary and specialty care. Throughout the text, links lead to resources that TCPI practices found useful, including the full TCPI Change Package.

The First Things

Leading Change

From the TCPI Change Package:
2.1.1 Provide dedicated, visible, and sustained leadership for the practice's transformation strategy.
The most important factor in any change initiative's success is leadership. A clinician or senior administrative leader must provide ongoing direction to the entire staff. This is not something you can delegate. Undertaking and leading change remains a personal decision that leaders make. If you need support in deciding whether to begin transformation, talk with a peer who can discuss the benefits and challenges of beginning the work and answer your questions.

You can take the following first steps to begin implementing change:

1. ***Identify a clinical champion for the work***. A physician usually fills that role and actively implements and encourages change. Clinical champions also serve as a respected voice among physicians and other staff. Choose someone excited to participate and support them through designated time for transformation work.
2. ***Allocate time for clinical and administrative leadership to practice improvement efforts.*** This includes participation in regular team meetings. Once you have developed a roadmap for change (see below), ensure that you schedule and attend regular meetings to share the plan with all staff and guide the work.

From the TCPI Change Package:
2.1.2 Develop a roadmap, ensuring that there is compelling vision and strategy for change.
Once you have decided to lead change, you need a plan. Your plan should include a vision for your practice, goals, and what you will work to achieve. Initial goals may be a single item like, "We are going to improve access and scheduling to the benefit of our

patients and staff." Or they may be more far-reaching, describing improvement in several clinical areas, utilization, and/or achieving value-based payment thresholds. You should choose your initial goals based on your organization's experience with improvement and resources. Regardless of where you start, all plans need three elements: a vision, measurable goals, and the resources committed.

- This two-page tool presents a useful format for developing an initial quality improvement (QI) plan. Compass Practice Transformation Network, which provided technical assistance to TCPI practices in six states, developed the tool.
- You can also find detailed guidance on developing a roadmap in this HRSA document, Developing and Implementing a QI Plan.

Creating a Shared Vision

From the TCPI Change Package:

2.1.3 Create a Shared Vision: Share the Vision and Goals Across the organization to ensure that all staff members understand their role in achieving them.

If your practice already has a culture of transparent sharing and strong communication, you are a step ahead. If you don't routinely discuss organizational priorities, quality, and patient care in regular meetings (e.g. staff meetings, huddles, other), then devote time to implementing steps to increase communication. The experience of thousands of TCPI practices is clear – all staff in the practice, regardless of how big or small it is, must coordinate their work to succeed.

- Begin with jointly developing or updating your practice vision statement. Involve all staff in this activity.
- Next, choose priorities and discuss with all staff their role in achieving what you set out to do. If you are just beginning the work, you might set priorities in the three topics discussed in this module: first steps in team-based care, data management, and patient/family engagement. However, if these areas are already well-developed, you may choose to work on other priorities such as improving patient access, chronic disease management, referral management, or something else. The choice is up to you. By choosing to focus on an area that is meaningful to you, practice staff, and your patients it will be easier to maintain momentum and achieve your goals.
- See the section below on data management for guidance on setting priorities.

Team Based Care: First Steps

From the TCPI Change Package:

1.2.1 Enhance the care team to include individuals who interact with the patient and family members both directly and indirectly.

Once you establish leadership support and priorities for improvement, implement team-based care. Thriving in a value-based environment requires the coordinated activities of all staff. Team-based care enables care coordination, population management, and other requirements of value-based payment. If your practice already has care teams in

place, with multidisciplinary daily huddles and strong cross-team communication, you may choose to skip this section. Or, you may take the opportunity to consider expanding your team to include additional members (e.g. a pharmacist, a behavioral health provider). If you are just starting to develop care teams, begin with the following steps:

1. ***Identify initial team members***. In a primary care practice, this may include a physician, a nurse, and a medical assistant (MA). Consider including the clinic manager and staff responsible for scheduling where applicable. In a specialty practice, the team may be different. The key in deciding who participates on the team: try to include all individuals who interact with the patient/client and family members in the delivery of care.
2. ***Clarify and change current roles***. The goal is to ensure that all staff work to the top of their licensure, thereby reducing the burden on physicians while maintaining or improving high-quality care delivery. One approach to this work is to use process mapping and "swim lane" diagrams to plan all the work involved in a clinical visit and clarify who does the work and how hand-offs occur. The following tools and tips will help:
    - A list of activities* to include in your swim lane diagram. This list provides a useful reminder of the many activities to complete. You will need to revise it depending on your practice type and preferences.
    - A Word template* to create a swim lane document.
    - You may also search YouTube for "process mapping" and "swim lane diagram" to view how-to videos.
    - Once you have clarified who completes activities now, consider ways to shift existing work to other staff. For example, MAs, with the proper training, play a central role in pre-visit planning, diabetes self-management, care coordination, and referral tracking in some practices.
    - Developing your care team is a group activity. Involve everyone in the conversation and remember to define quality improvement terms in all conversations. The terms and concepts are unfamiliar to most health care professionals and building a shared understanding of them is important. You may find this NQF glossary helpful.

    *Thank you to the Delmarva PTN for developing and sharing these resources.
3. ***Implement pre-visit prep***. Managing hectic clinic schedules is more difficult when unexpected requirements come up during the patient/client visit. Missing information from referrals, ensuring that indicated preventive screenings are scheduled, or unique patient requirements such as wheelchair use are examples of many issues that may disrupt your work flow if not planned for. Pre-visit prep requires reviewing the clinic schedule 1-2 days in advance, identifying patient and staff needs that can be prepared in advance, and bringing this information to the daily practice team huddle. Both nurses and MAs (with the proper training) can do this work. Pre-visit prep allows the care team to plan in advance to mitigate workflow disruptions.
4. ***Implement Daily Huddles***. Daily practice team huddles are more than "the next big thing." Health care professionals that implemented huddles typically say, "I

don't know how we did without them." You can find wealth of information online, including toolkits for huddle implementation (https://edhub.ama-assn.org/steps-forward/module/2702506 and https://cepc.ucsf.edu/healthy-huddles)and YouTube videos. Here are two tips:

- With experience, the daily huddle will take 5-10 minutes, but it takes time and experience before your team hones its skills and achieves that level of efficiency. Stick with it and continue to refine how you structure and moderate the huddle until you get to your ideal format.
- Some find handing control of patients/client facing activities to others on the team the most challenging aspect of implementing huddles. "But I am responsible," you may say. "How will I be sure it's getting done correctly?" To address this concern, start small. Rather than redesigning *everything,* try shifting one or two tasks from a physicians to a nurse or MA. Check in to see how it's going before moving on. It may also be helpful to focus on the likely benefits of team-based care:
  - Reduced burden on physicians and other over-stretched staff.
  - Increased reliability, ensuring your patients/clients receive all the care you want them to receive.
  - Increased staff morale – dramatic leaps in job satisfaction are reported within practices that have provided the proper training and expanded the roles of non-physician staff.

Developing an effective care team that reduces burden for all staff and provides excellent care is takes time and commitment. The guidance here suggests first steps. For additional information, visit the Team Based Care Module.

Get a Handle on Data

In addition to documenting patient notes and reporting, data provide information on practice performance and opportunities for improvement. Over the longer term, data confirms sustained improvements. Data also give you information for comparison of your performance across sites or states. However, as TCPI practices have learned, getting a handle on data poses real challenges for many practices. As you get started, you need to:

- Decide what data are meaningful to you, your staff, and your organization;
- Address challenges in data collection and getting the right data to the right place;
- Use data to analyze care delivery and practice performance; and
- Share data transparently with staff, engaging everyone in improvement.

The TCPI Change Package highlights the importance of data in several of its drivers and change concepts. To explore additional resources, visit Drivers 2.3 and 2.4 (links)

Decide what data are meaningful

If you decide to participate in value-based care, organizational leadership will need to choose priorities and identify important to meet organizational goals. Meaningful data is "actionable" and something you can DO something about. The data needs to align with something that matters – ask yourself, "WHY do we need these data?" For example, "Smoking cessation improves surgical outcomes, reduces CVD events, and impacts many cancers and other conditions, so let's get data on our smoking cessation and get to work on it." If that's not your focus, choose different data.

Tips for deciding what data to focus on:

- Start small. It is better to identify measures that are useful and might provide an early "win" rather trying a shotgun approach and address too many items.
- Are clinical outcome measures (improvement in patient outcomes) most important to your organization or do you need to focus on clinical process measures that reflect the consistency of staff in following established workflows or standing orders? In many cases, a meaningful set of data balances both outcome and process measures.
- Many will choose to focus on data important to payers. This may be essential to support the viability of organization. Ideally, those measures will also have meaning for staff. Try to make sure you choose at least one measure that staff feel strongly about, be it patient waiting times, staff experience, health literacy, improving diabetes outcomes, or something else.

Data collection

The experience of the TCPI practices is clear; the data available from the electronic health record (EHR) is often of poor quality. You may often say, "the data is wrong, so I won't spend time with it." To fully participate in value-based care, however, you need to get useful, accurate data from your systems. Frequently, problems arise because there are multiple locations where a specific type of data can be entered. If you and your staff have experienced problems with the data coming out of your EHR, do this:

- Run a common report (e.g. the percent of patient visits for which a BMI was completed). If possible, choose a measure that you know just doesn't feel right.
- If the data look wrong, process map the work flows involved in obtaining a BMI, including the field(s) where the data are entered and extracted for reports. Engage staff in creating process maps so that you can develop a clear understanding as to how staff actually performs the work.
- If you learn that staff do not have a standard approach to entering or extracting the data, create a standard process and train staff. A network of six TCPI primary care practices "improved" three preventive screening measures by over 30% in one week by standardizing data entry in this way!
- Repeat for other measures as needed.

Data analysis
Meaningful data must provide leadership and staff information they can act on. Link to data guidance. The ability to "drill down" to compare performances between locations or groups provides additional opportunities to test multiple changes concurrently and determine which changes are the most effective. To do this, you will want to look at data over time, using run charts or control charts. Training in use of this data approach is widely available. Initially, you may want to view the videos available from the Institute for Healthcare Improvement. Registration is required and available for no cost.

Share data transparently
From the TCPI Change Package:
2.3.1 Use data transparently: Use data to continuously and transparently monitor and improve performance, quality, and service.
Providing wider access to data seems to make sense as you empower more people to make better, faster decisions. However, *capturing* data and *sharing* it are two different things. Without reliable data, it can be difficult to introduce a needed change or to know if a change is even needed. Data transparency is key component of implementing and sustaining improvement efforts. The notion behind transparency proves straightforward; greater availability of data on performance helps staff make better choices and motivates them to improve. Choose one or more ways to share data at least monthly on the organization's priorities. Options include an all-staff email of reports and updates, sharing data at weekly or monthly staff meetings, and printouts displaying current results posted in staff areas.

Patient/Client and Family Engagement

From the TCPI Change Package:
1.1.2 Listen to patient and family voice: Implement formal systems for hearing the patient and family voice and using this input for strategic, quality, and business planning and performance success.
Health care professional in all areas of practice strive to meet patient and client needs. Increasingly, however, focus is placed on providing care in collaboration with those served and demonstrating specific patient/client/family engagement strategies. Engagement has many forms, but a useful distinction can be made between engaging patients/clients *in their own care* and engaging patients/clients in the design and delivery of *the care delivery system.* TCPI practices, and the practice coaches who supported them, learned that it is best to begin with engaging patients, clients, and families in their own care. Suggested first steps include:

1. **Implement Teach Back.** At the end of appointments, you often ask, "Do you have any questions?" Frequently the response will be 'no'. Patients, clients and family members may be overwhelmed with the amount of information shared and the medical terminology used. Teach Back is a profound but simple approach to more effective conversations. By using Teach-back, you can:

- Prevent safety issues by ensuring clear understanding of instructions.
- Learn when the patient/client or family member needs more explanation.
- Improve loss to follow-up or failure to adhere to instructions and recommendations.

  The AHRQ Teach Back resource include several one-page resources that can get you started implementing Teach Back.

  YouTube has several videos on Teach Back. Sharing these with your staff is one way to begin staff training.
  - https://www.youtube.com/watch?v=bzpJJYF_tKY (less than two minutes long)
  - https://www.youtube.com/watch?v=cllXBnHBiD4&t=105s ((less than five minutes long)

2. **Implement Care Plans and Visit Summaries.** Care Plans and Visit Summaries enhance the ability of patient/clients and family members to remember the content on their interactions with providers, support patient engagement by providing concrete information to react to and improves the quality of information by enabling patient/client corrections.
   - Care Plans: this AHRQ site has concise guidance on creating Care Plans.
   - Visit Summaries: see page 3 of this 24-page document, Providing Clinical Summaries to Patients after Each Office Visit: A Technical Guide, prepared by Qualis Health to find a comprehensive list of items to include in a visit summary.

Next Steps

We hope you find this guidance to practice transformation useful. Once you have fully implemented the steps suggested in this module, consider reviewing the other modules in the series.