CPCPracticeSpotlight58

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Setting Your Improvement Project in Motion: Get a Quick Start with Pre-Planning, Guidelines, Communication and Tools

Family Physicians of Greeley, Greeley, Colorado; 24 physicians, 3 PAs; 33,000 patients

Nov. 6, 2015

CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.2: Planned Care for Chronic Conditions and Preventive Care

CPC Change Driver 3: Continuous Improvement Driven by Data

- 3.1: Internal Measurement and Review

For more information about the CPC initiative, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/.

Situation: A few weeks ago, RN care managers at **Family Physicians of Greeley** (FPG) proposed to their CPC committee that the care management team undertake a short-term improvement project focused on early identification and preventive treatment for COPD. The care managers prepared a brief proposal package that clearly articulated the project, identified resources and laid out a plan for improvement including measures. The pre-work and clear communication about the data-driven need and the expectations helped elicit key physician support to get the project quickly underway.

Strategy: FPG care managers **Kristy Munch, RN,** and **Maria Sanchez, RN,** prepped a two-page proposal that zoomed in on key components. The first page described the current situation, the background and their goal in fewer than 100 words, and the second page delineated the proposed work through a series of lists: a screening process, a workflow and a timeline. The result is a concise yet thorough presentation of the project.

The set up (page one):

The situation – In addition to identifying patients eligible for pulmonary function tests due to their risk factors, the care managers shared data that showed an opportunity for improvement among patients with a COPD diagnosis: "In May 2015, 1,507 FPG patients were identified as having COPD/emphysema/chronic bronchitis/asthma. Only 56% of these patients had a pulmonary function test."

The background – A driver (or effect) was described here. This proposal cited COPD as the diagnosis accounting for 23% of hospital readmissions.

The goal (aim) – Goal setting for an improvement project must be ***realistic*** for the proposed timeframe. This three-month project simply sought to make an improvement on the 56% rate cited earlier as well as to provide patients identified as at risk with preventive interventions. These are attainable, measurable goals for this time period. They also construct a basic framework that could be expanded upon later.

FPG's Process Measures

1. Total number of assessment screening tools completed by patients
2. Total number of PFT screenings complete as the result of positive results on the assessment screening tool and provider assessment

FPG's Outcome Measure

Numerator:

Total number of patients diagnosed with COPD as a result of positive results on the assessment screening tool and PFT screening

Denominator:

Total number of patients who have been diagnosed and received treatment for COPD as the result of a positive assessment screening tool and PFT screening

FPG helped focus its teams' efforts by clearly defining how they would know the process is working (the process measure) and how they would evaluate its effectiveness (the outcome measure).

The proposal (page two): This page described the "how" and "who" of making the improvement by listing roles and their responsibilities. This eliminated process gaps and established accountability.

The screening tool – Medical assistants (MAs) would provide a one-page, seven-question screening tool to all patients 18 or older, and/or those with specific risk factors. If the patients' responses to the tool indicate a risk for COPD and the physician's assessment concurs a pulmonary function test (PFT) is appropriate, the patient is scheduled for a PFT and referred to care managers.

The care managers' role – Care managers would complete the follow-up on setting the screening appointment, recording results, referring the patient for follow-up with the PCP as needed and meeting with the patient to create a care plan with self-management support resources.

The timeframe – For the purposes of the CPC rapid cycle action group, FPG set the improvement period as three months. Currently, they expect to evaluate the outcomes in late December 2015.

Progress to date: FPG is a few weeks into their improvement work, and a few issues have emerged. While one MA whose physician is on the CPC committee has become an enthusiastic champion of screening, others have resisted adding the screening to their workflows, citing lack of time. To help them with time management, a care manager sketched out the MA's workflow as an example for others; care managers continue to work with MAs to blend the screening into their workflows. Another issue is calibrating the demand for PFTs and filling appointments in a timely manner. Screening slots are filling quickly, but patients whose appointments are few weeks out are cancelling their appointments. A key epiphany of this work is that the focused nature of the project permits tweaks and adjustments for improvement rather than overhauling a large, permanent change in office workflow. These limited-focus projects can also be used to test and create lasting change.

TMF Health Quality Institute

This material was prepared by TMF Health Quality Institute under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Any statements expressed by the individual and resources cited in this publication are not an opinion of, nor endorsement by, TMF or CMS.