Transforming Clinical Practice
Continuing Professional Development Opportunities

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Disclosures

- None
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Objectives

1. Explore the learning opportunities for physicians to improve their knowledge and skills for transforming clinical practice

2. Discuss the role of integrating the practice team as part of completing professional development activities

3. Describe access to the learning opportunities to receive Performance Improvement Activity and MOC Part IV credits
ABFM and CU-DFM Pilot Project

• Pilot Objectives:
  • How can we improve the continuing certification process so that it is more meaningful for physicians?
  • How can we help physicians to complete their requirements for continuing certification and also help them meet milestones/criteria for initiatives they are participating in (i.e. Transforming Clinical Practice Initiative - TCPi, State Innovation Model - SIM, Comprehensive Primary Care - CPC+)?
Pilot Project

• Developed 3 Performance Improvement (PI) Activity/MOC Part IV modules based on key drivers for TCPi
  • These modules are currently available for all TCPi physicians to complete

• Pilot the training of practice facilitators to implement the PI Activity/MOC IV module with physicians participating in TCPi:
  • Complete one of the e-Learning modules; emphasis on Cost and Value of Care
  • Assist physicians with meeting continuing certification and TCPi requirements
  • Facilitate making this activity meaningful, team-based, and sustainable

• 7 practices in Colorado enrolled (1 FM, 1 IM, 2 physiatrists, 1 pediatrician, 1 OBGYN; 1 FM residency program); 1 FM residency program in MA
Data Collection

Practice Facilitators
Pre-and-Post pilot project qualitative interviews to determine:

• Successes & challenges
• Best practices
• Methods for sustainability
• Methods for wider dissemination
• Review and feedback on:
  • Cost and Value of Care Resource Guide
  • Practice Facilitator PI Activity/MOC IV training module

Physicians
Post-Pilot qualitative interviews to determine:

• Successes & challenges
• Best practices
• Methods for sustainability
• Methods for wider dissemination
Tour of the ABFM e-Learning Modules
A Step-wise Guide to Performance Improvement Activities (PIA)

- Get credit for the work you are doing!
- Link activities and resources
- Align with practice transformation work, i.e. TCPI change tactics
- Structured approach to QI
- Applicability with QPP & other performance related agendas
- Patient Family Advisors
- Patient Surveys
  - Patient Motivation & Engagement
  - AAFP My Health Confidence
- Choosing Wisely
- Cost campaigns
  - Patient Empowerment
  - Take Control Guide for Patients
- Specialty referral
- Care Compacts
  - Referral Response Checklist
  - Subspecialist Response
Access to the Modules via ABFM

Transforming Clinical Practice Initiative/Bodenheimer’s 10 Building Blocks

The ABFM’s PRIME Support and Alignment Network, in collaboration with the University of Colorado-Denver, Department of Family Medicine’s e-Learning team have leveraged the power of Bodenheimer’s 10 Building Blocks of Primary Care and best practices from the landmark, federal Transforming Clinical Practice Initiative to help you improve in three areas:

- Person- and Family-Centered Care
- Cost and Value of Care
- Care Across the Medical Neighborhood

Create your own PDSA cycle intervention using PRIME Registry or other data for tracking your improvement.

Complete one of these three activities—hosted on the University of Colorado’s e-Learning platform—for 20 ABFM PI activity credit points. Use the code ABFM.

Click Here to get started.

See the TCPi section on this webpage.
CUelearning.org or https://cuelearning.org/focus_areas/tcpi/

Register with code **ABFM** if you are an ABFM Diplomate.

If you are a Diplomate from another specialty, enter the code **TCPi**.
## Performance Improvement Activities (MOC IV)

<table>
<thead>
<tr>
<th>Module Title</th>
<th>% Complete</th>
<th>Completion</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>TCpi Person- and Family-Centered Care Design</td>
<td>100 %</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>TCpi Cost and Value of Care</td>
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<tr>
<td>TCpi Care Coordination Across the Medical Neighborhood</td>
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Module Tips

• Ideally completed as a team-based Performance Improvement Activity.

• Each physician on the team seeking credit will need to access and complete the module.

• Use your own tools (run charts, reports, etc.)

• If you do not have tools, the module will provide what you need.
Applying the 10 Building Blocks

Data-Driven Improvement
A cornerstone of TCPI and practice transformation is using data systems that track clinical, operational, and patient experience metrics; and these data are used for improving practice operations and patient outcomes. For example, throughout this activity, you will use data, first at baseline and again after you’ve chosen and implemented your intervention, to determine if your intervention has been effective.
The TCPI Change Package primary driver, Sustainable Business Operations, encompasses the main concepts of improving the cost and value of care. The specific change tactics are:

- 3.1 Strategic use of practice revenue
- 3.2 Staff vitality and joy in work
- 3.3 Capability to analyze and document value
- 3.4 Efficiency of operation
1. Data Collection

During this exercise there are two data collection points: one before your intervention and one afterwards. The data you collect will focus on a clinical measure you wish to improve. You need data from at least 10 patients, preferably more. Your EHR may be able to produce whole-panel measures for you, or you may have access to a registry that will also provide measures.

2. Create an Intervention Plan

You will select a clinical measure and one or more interventions to improve patient outcomes. As part of your intervention plan, you’ll 1) create an Aim statement; 2) map your current process (if one exists) and identify areas for improvement; 3) identify SMART (specific, measurable, attainable, realistic, timely) goals.

3. Implementation

The implementation time frame should be at least one week, but preferably a minimum of a month, to establish a new process.

4. Analyze

In this activity, you will compare your pre- and post-intervention data to gauge the success of your intervention.

5. Revise Your Intervention Plan
**Intervention Planning Steps**

### 10 Building Blocks of High Performing Primary Care

- **Introduction**
- **PI Module Overview**
- **Pre-Intervention**
  - Data Reporting
  - Develop an Intervention Plan
  - Example
  - Intervention Plan
- **Intervention Implementation**
- **Post-Intervention**
- **Summary**
- **Conclusion**
Clinical Measure to Improve *

Select the documented clinical measure you want to improve with your intervention plan. Numbers in parentheses after measure names are PRIME IDs.

Patient with improving clinical indicators for BP control, diabetes, that may increase quality payments (80%)

Data Source *

Select where your numerator and denominator or percentage values came from.

Other Registry

Percentage *

The percentage of patients from your data that are meeting your goal for the target measure.

Select a Measure

Select a Data Source

Enter a percentage or numerator and denominator

Submit

Please enter a value between 0 and 100.
Questions to Consider for Key Building Blocks

Data-Driven Improvement- Does the data you’ve collected inform you about the quality of the **cost and value** of the care you provide? If not, what other data do you need?

Empanelment- are your patients **empaneled** so that you and your **team** can accurately manage your registries and other tools?

Engaged Leadership— Have you set a practice-wide vision for this activity? Do others on your team know you are doing this PI module?

Team-Based Care— How can your team help you with this PI activity? And how will this PI activity help your team to provide better patient care?

Template of the Future- Are you and your team looking at ways to decrease patient costs and increase the value of your services?
Select resources to assist your plan.

2. From the categories below, select at least one intervention you want to try. You may select more than one intervention. Note: interventions and resources listed are suggestions; you may use other interventions and resources of your choosing.

**Choosing Wisely Interventions**

- **Choosing Wisely Support**
  - Patient Empowerment
  - Patient Education

Note: The Choosing Wisely Toolkit contains many resources that you may want to review and use for your intervention. Click this link to access the toolkit: [Choosing Wisely Toolkit, an initiative of the ABF Foundation](#)

**Decision Support Interventions**

- **Decision Support**
  - Personal Decisions
  - Shared Decisions

**Patient Self-Management Support Interventions**

- **Patient Motivation and Engagement**
  - Patient Readiness Survey
  - Patient Confidence

**Resources**

- Choosing Wisely Process Flow and Other Tools
- Take Control Guide for Patients
- Facts about Control Guide for Patients
- Top Things to Share with your Patients

- Ottawa Personal Decision Guide
- Mayo Clinic Shared Decision Making Aids

- Patient Activation Measure (PAM) *Note: there may be a cost.
- AAFP My Health Confidence Worksheet

**Pre-Intervention**

- Data Reporting
- Develop an Intervention Plan
- Example

- Intervention Plan
5. Now try to nail down your intervention in the format of a SMART goal. SMART goals are specific, measurable, attainable, realistic, and timely. The end of your statement should resemble an Aim statement for the intervention you’ve chosen.

Example: I will increase the % of patients with one or more chronic diseases engaging in shared decision-making (measurable) by 50% (specific and realistic) over the next six months (timely) through the use of the Personal Care Guide shared-decision tool.*

0 of 500 max characters

The steps above were adapted from Institute for Healthcare Improvement.

7. Start the Plan step of your P-D-S-A cycle by completing the following information.

What you’ve just done is: 1) mapped your current work flow to anticipated areas for process change and 2) written an Aim statement for your intervention using a SMART goal format. Now you can start the Plan part of your P-D-S-A cycle.

Complete the following fields for each task needed to set up your intervention (note: these tasks may overlap steps in #5, above).

Enter Details for Task 1
Incorporate your Plan into your Practice

Now that you've completed the pre-intervention steps and developed an intervention, it is time to implement your plan. Implementation takes place outside the module context. You and your team should spend a minimum of one week (we recommend at least a month) following your plan and providing patients with your intervention. You’ll need enough time to provide the intervention to at least 10 patients, preferably more, so that you have sufficient post-intervention data to compare against your pre-intervention data.

Once you have completed your intervention, return to this page and click Next to mark your intervention complete and to start the post-intervention portion of this activity.
Following the same steps for the **Post-Intervention Plan**, you can modify your approach to meeting the goal based on what you learned in the Pre-Intervention.
Obtaining Credit for PIA/MOC IV

Approved by ABFM for PIA/MOC IV. Certificates of Completion can be printed via CUeLearning, My Account.

ABFM Diplomate completion will be reported by CU e-Learning.

Diplomates to other boards submit to appropriate board.

Modules are free to use with the provided registration codes. PIA/MOC IV cost is determined by your respective board.
Resource Guide for Cost and Value of Care Module

Online tool for Practice Facilitators to share and use Cost and Value of Care resources with practice teams.

Link to Resource Guide
An eLearning module is being developed and designed to reach Practice Facilitators nationally with steps and tips for working with physicians and practice teams on projects that meet criteria for PI and MOC IV activity and credit.
In partnership with the American Board of Family Medicine’s TCPi SAN, the PIA CU e-Learning modules were created by a team at the University of Colorado Department of Family Medicine.
Resource Guide and Practice Facilitator PI Activity/MOC IV Training Module
Results from the Pilot Project:

Qualitative Interviews

**Practice Facilitators**
- Like the structure of modules
  - =
  - =
  - 

**Physicians**
- Team tie
- Building Block
- Structure
Results from the Pilot Project:

- 3 External Practice Facilitators
- 20+ Physicians
  - 12 Residency Faculty
  - 6 Residents
  - 6 Independent
Next Steps

Expand pilot to MA and ME

Offer training to all Colorado PFs

Continue to refine Resource Guide and Practice Facilitator Training Module
Questions
What’s on your mind?

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