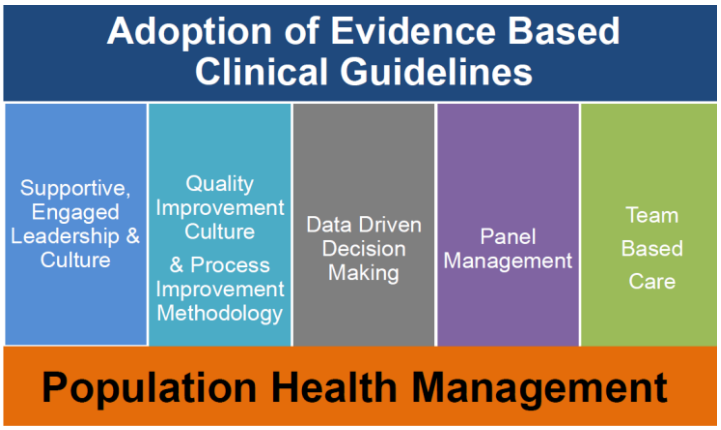
PHASE BUILDING BLOCKS SUMMARY

You may be familiar with the Building Blocks of High Performing Primary Care, which are the shared characteristics of primary care practices that provide high quality, accessible, and patient-centered health care. The Building Blocks of PHASE are the core elements needed to successfully implement PHASE in a community setting. This is the framework for our transformation work and the basis for the training and technical assistance that is provided to participating organizations.

As part of the evaluation process, CCHE administers a Building Blocks of PHASE Assessment several times throughout the grant cycle. The purposes of the assessment are:

- Assess your organization's capacity for population management
- Use assessment results for planning and to inform technical assistance
- Advance your organization's work by deepening understanding of strengths and opportunities for improvement

The assessment tool can be downloaded by clicking this link: Download Resource.



Building Block 1: Foster a supportive and engaged leadership culture and process improvement methodology

- Executive leaders support continuous learning throughout the organization, review and act upon quality data, and have a long-term strategy and funding commitment to explore, implement and spread quality improvement initiatives.
- Clinic leaders consistently champion and engage clinical teams in improving patient experience of care and clinical outcomes.
- Senior leaders have at least three years in current position and more than ten years total clinic leadership experience.
- Board members participate on Board QI committee that meets at least three times a year.
- Senior leaders interact with front line staff around issues of strategy, quality and patient satisfaction. Leaders have a strong sense of both what's working well at the clinic, as well as recent challenges or issues.
- In major organizational initiatives, planning and execution processes are participatory, include all departments and are team-oriented. Teams work together to align both clinical and administrative interests.
- Senior leadership has systematic ways of communicating and engaging with managers, providers, staff, and the community in an ongoing way.
- Clinic staff have regular structured communication across care teams, sites, departments, and senior leaders. Staff has a good rapport with each other, feels open to voicing concerns, and sharing concerns and improvement ideas upward ot managers and senior leaders.

Building Block 2: Ensure a quality improvement culture and process improvement methodology

- The responsibility for conducting quality improvement activities is shared by all staff, from leadership to team members and is made explicit through protected time to meet and specific resources to engage in QI.
- Quality improvement activities are based on a proven improvement strategy and used continuously in meeting organizational goals.
- Quality improvement activities are conducted by practice teams supported by a QI infrastructure (e.g., dedicated QI staff) with meaningful involvement of patients and families.
- Goals and objectives for quality improvement are the centerpiece of multidisciplinary meetings aimed at developing strategies to meet objectives.
- The clinic has worked on more than five quality and process improvement initiatives over the last three years, has demonstrated improvements across multiple clinical outcomes, and has standardized many of these improvements across the organization. Staff working on current quality improvement efforts meet weekly, and a committee that oversees these efforts meets at least monthly.

Building Block 3: Employ data-driven decision making

- Performance measures are comprehensive including clinical, operational, and patient experience measures -- and fed back to individual providers.
- Reports on care processes or outcomes are routinely provided as feedback to practice teams, and transparently reported externally to patients, other teams and external agencies.
- Registry or panel level data are available to practice teams and routinely used for pre-visit planning and patient outreach, across a comprehensive set of diseases and risk states.
- Registries on individual patients are available to practice teams and routinely used for pre-visit planning and patient outreach, across a comprehensive set of diseases and risk states.
- An electronic health record that is meaningful use certified is also used routinely to support population management and quality improvement efforts
- Data and information are used to drive decisions at all levels in the organization. Line staff knows how their day-to-day actions affect performance metrics and achievement of goals. Data literacy is a hallmark of the organization.
- Data quality measures (e.g. % accuracy0 prioritize and inform ongoing data quality efforts and trace errors to individuals for training. Data collection and aggregation is highly automated with built -in data quality checks and exception reports.
- IT support and data services include dedicated IT staff ahat are deployed to maintain and support optimization of analytics systems. Analytics systems interface with and leverage existing IT platforms, fully support organization data needs and to build a data-driven culture with self-service analytics. Data governance processes are fully formed to guide the provision of data analytic services.

Building Block 4: Promote team-based care

- Non-physician practice team members perform key clinical service roles that match their abilities and credentials.
- Providers and clinical support staff consistently work with the same provider/clinical support staff person almost every day.
- Workflows for clinical teams have been documented, are utilized to standardize workflows, and are evaluated and modified on a regular basis.
- The practice routinely assesses training needs, assures that staff are appropriately trained for their roles and responsibilities, and provides cross-training to assure that patient needs are consistently met.
- Standing orders that can be acted on by non-physicians under protocole have been developed for many conditions and are used extensively.
- The organization’s hiring and training processes support and sustain improvements in care through training and incentives focused on rewarding patient -centered care.

Building Block 5: Ensure the capacity for population/panel management

- Patients are assigned to specific practice panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand.
- A patient who comes in for an appointment and is overdue for preventing care (e.g., cancer screenings) will be identified as being overdue for care through a health maintenance screen or system of alerts that is used consistently, and clinical assistants may act on these overdue care items (e.g. administer immunizations or distribute colorectal cancer screening kits) based on standing orders.
- A patent who comes in for an appointment and is overdue for chronic care (e.g. diabetes lab work) will be identified as being overdue for care through a health maintenance screen or system of alerts that is used consistently, and clinical assistants may act on these overdue care items (e.g., complete lab work) based on standing orders.
- When patients are overdue for preventive (e.g., cancer screenings) but do not come in for an appointment, they would be contacted and asked to come in for care, and clinical assistants may act on these overdue care items (e.g., distribute colorectal cancer screening kits) based on standing orders.
- When patients are overdue for chronic care (e.g., diabetes lab work) but do not come in for an appointment, they would be contacted and asked to come in for care, and clinical assistants may act on these overdue care items (e.g., complete lab work) based on standing orders.
- Self-management support is provided by members of the practice team trained in patient empowerment and problem-solving methodologies.
- Clinical care management services for high risk patients are systematically provided by the care manager functioning as a member of the practice team, regardless of location.
- Visits are organized to address both acute and planed care needs. Tailored guideline-based information is used in team huddles to ensure all outstanding patient needs are met at each encounter.