TOOLKIT

FOR QUALITY IMPROVEMENT AND PRACTICE TRANSFORMATION FOR SERVING DIVERSE PATIENTS

FOR SOLO AND SMALL GROUP PRACTICES

Supporting the Implementation of the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care

*** EXCERPT PENDING CLEARANCE ***

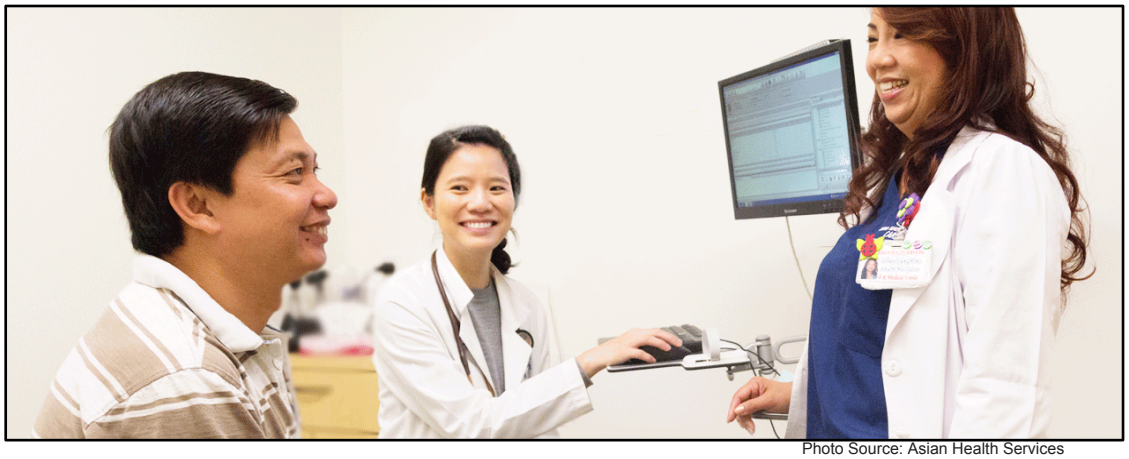

Photo Source: Asian Health Services

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➢ **These Tools Align with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care**

Given the increasing diversity of patients that health care providers are likely serving, this toolkit aligns its **tools** with the U.S. Department of Health and Human Services Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. Implementing the CLAS Standards reflects best practices to ensure that all patients receive the highest quality of care and achieve optimal health outcomes.

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TOPICS AND TOOLS

Topic 1: Organize Your Practice for Quality and Value

Tool 1A. Define Roles and Responsibilities for All Members of Health Care Team
Tool 1B. Use Standing Orders for Regular and Routine Tests
Tool 1C. Get Technical Assistance from Your Electronic Medical Record Vendor
Tool 1D. Develop and Implement a Continuing Education Plan

Topic 2: Understand the Needs of Your Diverse Patients
Tool 2A. Ask All Your Patients About Their Demographic Characteristics
Tool 2B. Provide Patient-Centered Care to Lesbian, Gay, Bisexual & Transgender Patients
Tool 2C. Conduct a Comprehensive Health Needs Assessment for Each Patient
Tool 2D. Use Community Level Data about Communities You Serve

Topic 3: Provide High-Quality Patient-Centered Care
Tool 3A. Follow the Most Recent Evidence-Based Guidelines
Tool 3B. Create Patient Registries
Tool 3C. Identify High Volume, High Opportunity Patients for Population Management
Tool 3D. Ensure Language Access for Patients Who Speak Languages Other than English
Tool 3E. Provide Multilingual Health Education Materials
Tool 3F. Improve Communications with Your Patients with Low Health Literacy

Topic 4: Engage Your Patients as Partners in Their Care
Tool 4A: Support Shared Decision-making with Your Patients and Their Families, Caregivers
Tool 4B. Ensure Effective Communications and Understanding by Your Patients
Tool 4C. Create a Care Plan for Every Patient
Tool 4D. Support Self-Management

Topic 5: Partner with Providers Outside of Your Practice
Tool 5A. Conduct Medication Reconciliations
Tool 5B. Follow-up with Your Patients After Hospitalizations
Tool 5C. Improve Care Coordination with Other Providers
Tool 5D. Leverage Community Resources

Topic 6: Continuously Improve Your Quality and Value
Tool 6A. Choose Quality Performance Measures for Improvement
Tool 6B. Get Credit for Identifying and Reducing Disparities
Tool 6C. Get Feedback from Your Diverse Patients/Families/Caregivers
Tool 6D. Share Quality Performance Data with Patients/Families/Caregivers/Public

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What Would I Gain from Using this Toolkit?

The toolkit can help solo and small group physician practices and other health care providers maximize their ability to meet expectations for quality improvement and practice transformation from the Centers for Medicare and Medicaid Services (CMS), health plans, accountable care organizations, and other payers, as well as professional licensing boards for renewal of certifications. It also can be used by community health centers, nurse practitioners, and physician assistants.

Physicians and other health care providers are expected to meet many requirements to stay competitive in today's rapidly changing health care policy and payment environments. While the toolkit is not a complete instruction manual or comprehensive compliance handbook for any specific standards or requirements, it provides practical and feasible **tools** to help meet several common standards.

➢ **These Tools Align with Requirements for Patient-Centered Medical Homes**
This toolkit also aligns its **tools** with the updated (2017) standards for recognition as a patient-centered medical home (PCMH) by NCQA.[1] Solo and small group physician practices and other practices who already are recognized as PCMHs by NCQA can get a jump-start on renewing their recognition under the updated standards by using these **tools**. Solo and small group physician practices and other practices who have not yet applied also can get a jump-start on meeting the updated standards.

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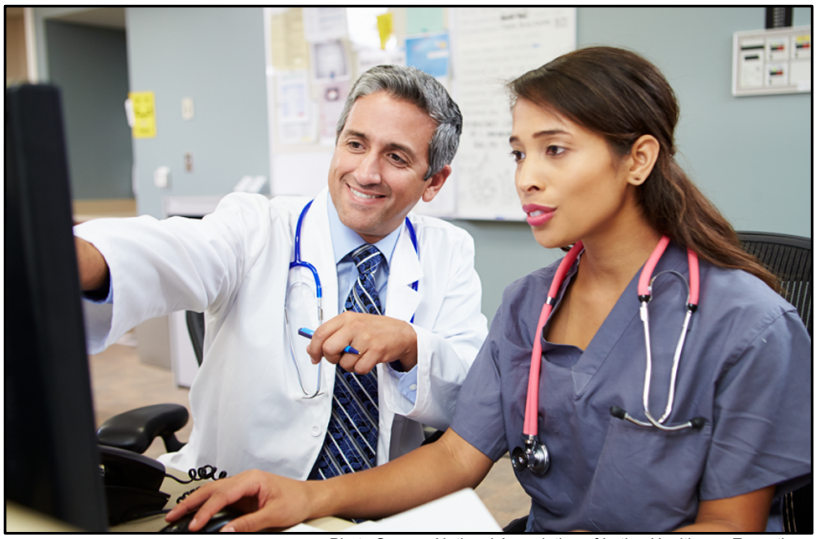

Photo Source: National Association of Latino Healthcare Executives

Topic 1: Organize Your Practice for Quality and Value

✓ Establish your practice's commitment to quality and value
✓ Organize and optimize your health care team
✓ Use your electronic medical record system to support quality and value
✓ Implement a plan for continuous learning and improvement

The first step in quality improvement and practice transformation is to organize your practice to maximize your quality performance and able to demonstrate the results that will be rewarded in the continuing shift away from fee-for-service towards value-based payments. It is vital for every physician or health care provider to assert leadership in organizing all members of your staff - your receptionist, office manager, medical assistant, nurse, billing clerk, etc. - as a "health care team". You may not have all these types of staff, but regardless of their number, background, education, and training, every member of your staff should be viewed as having roles and responsibilities for:

- improving your practice's quality performance,
- providing best possible "customer service", and
- optimizing practice's value-based payments.

[1] http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh/pcmh-2017

➢ How These Tools to Organize Your Practice for Quality and Value Align with CLAS Standards	➢ How These Tools to Organize Your Practice for Quality and Value Align with NCQA PCMH Standards
CLAS Standard 2: Advance and sustain governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources. **CLAS Standard 3**: Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area. **CLAS Standard 4**: Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis. **CLAS Standard 7**: Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided. **CLAS Standard 9**: Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.	**Team-Based Care 01 PCMH** Transformation Leads: Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities. **Team-Based Care 02** Structure and Staff Responsibility: Defines practice organizational structure and staff responsibilities/skills to support key PCMH functions. **Team-Based Care 06** Individual Patient Care Meetings/Communication: Has regular patient care team meetings or a structured communication process focused on individual patient care. **Team-Based Care 07** Staff Involvement in Quality Improvement: Involves care team staff in the practice's performance evaluation and quality improvement activities. **Team-Based Care 05** Certified EHR System: The practice uses an EHR system (or modules) that has been certified and issued an ONC Certification ID, conducts a security risk analysis, and implements security updates as necessary correcting identified security deficiencies. **Access & Continuity 07** Electronic Patient Requests: Has a secure electronic system for patient to request appointments, prescription refills, referrals, and test results. **Access & Continuity 08** Two-Way Electronic Communication: Has a secure electronic system for two-way communication to provide timely clinical advice.

Tool 1A: *Define Roles and Responsibilities for All Members of Your Health Care Team*

Whether you are a solo practitioner, in a small physician group practice, part of a larger multi-specialty group, or practicing in a community health center, a key to success in organizing your practice for quality and value is to clearly define your health care team members' roles and responsibilities.

There should be ➢ **a standardized procedure for each day's schedule of patients**, with clear assignments for each member of your health care team to complete the following tasks before YOU see the patient:

□ review patient charts the day before, ensuring latest lab and test results are available (your team should reschedule a patient if a needed lab or test result is not ready or can't be located)

□ confirm every appointment the day before by phone, email, and/or text message (your team should communicate in the primary language of the patient or family member/caregiver; your team may want to send multiple reminders through different communications channels, e.g. a phone call to the patient and a text message to a family member)

□ check-in each patient upon arrival for their appointments, confirming (and updating) contact information and medication lists

□ take and record vital signs
□ document any presenting or new problems or conditions
□ check the medical record and remind patients about needed or overdue preventive and chronic care services such as cancer screenings; offer to assist in scheduling such screenings, etc. that are needed

After YOU see the patient, there should be clear responsibilities for your health care team to complete the follow-up steps for each patient (using electronic summary of care/visit if available from your electronic medical record system):

□ confirm any new or changed prescriptions (confirm the current pharmacy that will be receiving any prescriptions electronically; for patients who read languages other than English, your team should check to make sure that the pharmacy can print translated medication instructions and provide medication counseling in your patient's language)
□ confirm scheduling for any follow-up tests and for any referrals to specialists or social services
□ provide any needed health education (in your patient's primary language)
□ schedule a next appointment (confirm how best to send reminders)

While you are the prescriber, orderer, and referrer, your health care team can assist in ensuring that all preparation and follow-up steps are understood and completed by your patient (and your patient's family and caregivers, when appropriate). Every member of your health care team should be trained and prepared to assist you in doing these important tasks so that YOU can spend the most time with your patients, focused on clinical care.

Cambridge Health Alliance, Model of Team-Based Care Implementation Guide and Toolkit
http://www.safetynetmedicalhome.org/sites/default/files/CHA-Teams-Guide.pdf

Qualis Health, Team-Based Planning Worksheet (2012)
http://www.safetynetmedicalhome.org/change-concepts/continuous-team-based-healing-relationships

Safety Net Medical Home Initiative, Patient-Centered Interactions Implementation Guide (2013)
http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Patient-Centered-Interactions.pdf

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Tool 1D: *Develop and Implement a Continuing Education Plan for Yourself and Your Health Care Team*

Since all health professionals have continuing education requirements, you should develop a formal annual continuing education plan for yourself and each member of your health care team, aligning all your learning experiences individually and as a team to optimize your practice's quality performance. There may be some training and continuing education activities that you could attend together as a team that will help reinforce your learning and working together more effectively as a team.

Association of American Medical Colleges, American Association of Colleges of Nursing, and Josiah Macy Foundation, Lifelong Learning in Medicine and Nursing (2010)
http://www.aacn.nche.edu/education-resources/MacyReport.pdf

You might identify continuing education activities sponsored by local medical societies, specialty physician associations, minority physician organizations, and other health professional associations, or continuing education opportunities provided by your local hospital, health plan, or medical or nursing school.

➢ **Here is a sample continuing education plan for yourself and all the members of your health care team:**

Health Care Team	Continuing Education Objectives	Continuing Education Activities to be Completed This Year
Physician	Learn about requirements for Medicare Quality Payment Program (QPP) under MACRA	Listen to CMS webinars about QPP; attend local medical society CE workshop on MACRA and QPP
Receptionist	Learn more about improving customer service, especially for patients with limited English proficiency and lower health literacy	Attend CE activities about improving CAHPS scores for patients with limited English proficiency and lower health literacy
Medical Assistant	Become trained as a phlebotomist	Attend training on phlebotomy
Office Manager	Learn about requirements for Medicare Quality Payment Program (QPP) under MACRA	Listen to CMS webinars about QPP
Nurse Manager	Gain additional training and skills as a care manager for complex patients	Attend Continuing Nursing Education on care management for complex patients

Bringing such activities on-site at your practice during extended lunch hours is an efficient way to allow your staff participation with minimum of time away from scheduled patient care. You might want to "host" and invite some of your colleagues to participate and share any costs of the activities (i.e., staff from other practices in your medical building).

➢ **Here are training programs sponsored by the Centers for Medicare & Medicaid Services (CMS):**
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/CCSQGrandRoundsContinuingEducationSeries.html

https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/

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Additional information and resources about this project:
http://www.ncapip.org/resources/page71/

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