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| CTC/PCMH Kids Pilot Primary Care Telehealth Learning Collaborative  “Using Technology to Improve Care for Patients with Chronic Conditions” |
| **Telehealth Learning Collaborative (TLC) Project Plan** – v5 |
| *NOTE: Deliverables are indicated in the milestone document and in this TLC Project Plan; relevant information may be completed with your practice facilitator; and submitted to* *CTCtelehealth@ctc-ri.org* *(TLC project plans are due at the end of start-up and implementation phases).* ***Use as much space as needed to complete each section*** |
| **Practice Name:**  |
| **Practice Sites:**  |
| **Practice Facilitator Name:**  |
| **Check one: [ ] Cohort 1: February 2021 – January 2022; [ ] Cohort 2: May 2021 – April 2022** |
| **Chronic Condition(s) identified in application:**  |
| **Quality Improvement Team** Original QI team identified as part of application; team should consist of 3 to 4 staff in different roles and include a clinical champion, IT/EHR and behavioral health staff (if applicable); *Inform your practice facilitator of any changes in staff on QI team.*  |
| Name  | Title  | Role in Telehealth Project  |
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| **Start-Up Objectives** | **Start-Up Phase (months 1-4)**C1: February-May 2021C2: May – August 2021 | To identify needs/feasibility and plan for action |
| 1. **Define practice site (if multi-site practice) and practice telehealth needs**

**–** Due: C1: by March 31, 2021; C2: by June 30, 2021; (*if multiple sites have different areas of focus, please consider a project plan for each site OR clearly define what is different for each site*)Considerations may include: * Feedback from staff to identify the biggest pain points and opportunities that exist in your organization
* Surveys, focus groups to help practices identify telehealth needs
* Services to be implemented
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| **NOTES:**  |
| **Action Items (due next meeting unless otherwise specified):** | Owner  | Completed (yes/no)  |
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| **2.a. Identify patients with chronic care need -** Due: C1: by April 15, 2021; C2: by June 30, 2021*(Practices may have identified multiple conditions to address [TLC application], however, the TLC & Quality Improvement Plan/ PDSA requires focus on one condition or closely related conditions – please review with your practice facilitator).* Considerations may include: * What patient chronic care needs may improve from better care management and telehealth technology?
* Which problems are most likely to be resolved by a telehealth solution?
* Who needs telehealth and why? You may want to conduct a clinical needs assessment or identify areas of opportunity from patients via satisfaction and/or experience survey response
* What services will be implemented?
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| **NOTES:**  |
| **Action Items (due next meeting unless otherwise specified):** | Owner  | Completed?  |
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| **2.b. Data plan: identify baseline data and outcome data and consider how and when data will be collected** **-** Due: C1: by April 15, 2021; C2: by June 30, 2021*(Note – Practices choose how they will measure success)*Considerations may include: * What impact are you looking to make?
* Who is you population of concern?
* What outcomes will indicate you have achieved your goal(s)? Consider measures related to the technology such as
	+ **Activity data, #** activities accomplished (number of patients using telehealth, for example), number of sessions
	+ **Performance data** – how well you accomplished them
	+ **Impact/outcome data** – what impact did you make
	+ **Patient input/surveys**
	+ **Case studies** – what has the practice experienced with existing telehealth?
* How will you capture data? Survey? Claims? Medical Records? Excel tracking for TLC project?
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| **NOTES:**  |
| **Action Items (due next meeting unless otherwise specified):** | Owner  | Completed?  |
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| **3. Identify technology option –** Due C1: by May 31, 2021; C2: by August 31, 2021Technology options may include use of telehealth, a phone app, RPM, etc. to support patients with selected chronic condition Considerations may include:* Practice needs (see resource guide for samples of practice needs assessment)
* Potential for reimbursement for the technology or telehealth modality
* Vendor selection (see resource guide for sample checklists)
* Technology available from community partner (i.e. periodically organizations may offer free devices)
* IT requirements; IT staff involvement throughout
* End users’ skills, capacity, training needed
* Firewalls, wifi, system requirements
* Tech availability or accessibility
* Simplicity
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| **NOTES:**  |
| **Action Items (due next meeting unless otherwise specified):** | Owner  | Completed?  |
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| **4. Estimate cost of program -** Due C1: by May 31, 2021; C2: by August 31, 2021Conservative estimate of added costs for program. (*Note: costs do not need to be shared with CTC-RI; the goal of this section is to ensure that cost of development and ongoing expenses are being considered)*Considerations may include:* Cost for technology vendor (start-up cost, monthly subscription, etc.)
* Expenses: short-term & long term; equipment (software, hardware)
* Additional staff hours: IT time, clinical provider and staff time spent developing business plan
* Revenue: short-term & long term
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| **NOTES:**  |
| **Action Items (due next meeting unless otherwise specified):** | Owner  | Completed?  |
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| **5. Performance Improvement and Patient Support Plan (Plan, Do, Study, Act - PDSA)** - initial plan due:C1: by May 31, 2021; C2: by August 31, 2021PDSA will include aim statement to define success, goals and metrics and plan; (NOTE: *Quality improvement plan/ PDSA only needs to focus on one condition* *or closely related conditions - See PDSA Template in Appendix A)*  |
| **NOTES:**  |
| **Action Items (due next meeting unless otherwise specified):** | Owner  | Completed?  |
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| **Implementation Objectives**  | **Implementation Phase****(months 5-12)**C1: June 2021 –Jan 2022C2: Sept 2021 – April 2022 | **Implement, measure and refine Performance Improvement and Patient Support Plan** |
| **1. Prepare to implement –** a. Develop and test staff/patient training materials b. Develop and test workflowsConsiderations may include:* Delineating clear roles and responsibilities
* Identifying all aspects of operations impacting (i.e. billing)
* Developing protocols to address problems
* Testing of system: All types of end users (patients & staff), across technology systems, (try to break system – and then fix weak points)
	+ Pilot before full-blown rollout; consider “super users”
* Developing training materials for end users – patients & staff
	+ Will vary by end user group
	+ Test training with pilot team first
	+ Update content on an ongoing basis
* Plan for evaluation (target for 1-2 months before end of collaborative)
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| **NOTES:**  |
| **Action Items (due next meeting unless otherwise specified):** | Owner  | Completed?  |
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| **1.a. Telehealth Staff Training Plan -**Describe who, what, where, when Considerations may include:* Who will train everyone involved – IT, providers, office staff, finance, etc.?
* Consider need/costs for periodic re-training & training of new personnel – ongoing expense
* Will you need someone to go to remote clinics or patient homes to install & train on equipment?
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| **NOTES:**  |
| **Action Items (due next meeting unless otherwise specified):** | Owner  | Completed?  |
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| **1.b. Telehealth Work Flow –** (description of workflow for patient encounter) - Due:C1: June 2021; C2: Sept 2021Considerations may include:* Include steps and staff role to perform each function
* Telehealth activities should be designed to complement your standard practices/working methods, not complicate or interrupt them
* see Resource Guide for samples
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| **NOTES:**  |
| **Action Items (due next meeting unless otherwise specified):** | Owner  | Completed?  |
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| 1. **Implementation –** “Go live” date: **-** C1: by July 31, 2021; C2: by Oct 31, 2021

Implement the Telehealth Performance Improvement Plan with selected patients; Considerations may include:* Implement with LOTS of support available
* Use data (timely as possible) to inform what’s working and what’s not (e.g. pop-up surveys)
* Communicate with staff
* Keep a running log of issues
* Aggregate into themes to identify root causes of issues
* Identify system issues vs. user errors
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| **NOTES:**  |
| **Action Items (due next meeting unless otherwise specified):** | Owner  | Completed?  |
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| 1. **Evaluation –** Due:C1: August 2021; C2: November 2021

Obtain input from patient/parent/caregiver based on test of change, outcomes and evaluation results; make adjustments based on data/feedback from patients, staff and community partner (as applicable);Considerations may include:* Conduct patient satisfaction surveys as part of PDSA
* Re-measure baseline data (what key indicators /clinical outcomes were selected to measure as part of Startup phase?)
* Consider whether targets set in your PDSA been met? (This is the “Study/Act” part of the PDSA)
* Refer to Resource Guide for sample patient satisfaction surveys, etc.
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| **NOTES:**  |
| **Action Items (due next meeting unless otherwise specified):** | Owner  | Completed?  |
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| **4. New tests of change for PDSA: -** Due: C1: Sept 2021; C2: December 2021New test of change in PDSA to improve engagement after selecting underserved, vulnerable, high risk patients who may need additional assistance to utilize the technology option to improve chronic illness outcomes*(if vulnerable patients were included in PDSA in start-up phase, then this new test of change may not be needed )* |
| **4 a. Identify High risk patients** Considerations may include:* Vulnerable populations where data shows evidence of disparities in access to care
* Patients with low digital literacy
* Patients who may need access to language interpreter
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| **NOTES:**  |
| **Action Items (due next meeting unless otherwise specified):** | Owner  | Completed?  |
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| **4 b. Identify community partnerships** *(May have begun in Start-up phase)* Identify potential strategies/partnerships that could be used to assist patients/parents/ caregivers who need assistance using telehealth technology *(if applicable: aligning with a community partner for telehealth may not be relevant for all practice needs)*Considerations may include:* Use community health teams if applicable for your practice
* Use community resources to help patients secure or understand technology for visits (i.e. URI Cyber Seniors)
* Use RI Parent Information Network (RIPIN), home visiting network, etc.
* Refer to resource guide for list of available community resources
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| **NOTES:**  |
| **Action Items (due next meeting unless otherwise specified):** | Owner  | Completed?  |
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| **5. Update and submit a PDSA/QI Plan Storyboard** – Due:C1: January 2022; C2: April 2022 PDSA Storyboard to include data, patient evaluation results, sustainability plan and potential for spread to other practices. (*Storyboard format TBD*) |
| **NOTES:**  |
| **Action Items (due next meeting unless otherwise specified):** | Owner  | Completed?  |
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Appendix A – PDSA Template

PDSA (Plan-Do-Study-Act) Worksheet for Testing Change

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| *(Initial plan due: C1: by May 31, 2021; C2: by August 31, 2021)* |
| **Title**:  |
| **Background/Goal of Project:** (briefly describe the problem you are having or area that needs improvement, note background information and target population) |
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| **Aim:** (overall goal you wish to achieve) (**S**pecific, **M**easurable, **A**ttainable, **R**elevant, **T**ime-bound) |
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| **Baseline Data:**  |
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| **Outline your patient engagement strategy:** |
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| *Every goal will require multiple smaller tests of change* |
| **Describe your first (or next) test of change:** | **Person responsible** | **When to be done** | **Where to be done** |
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| **Plan:**  |
| **List the tasks needed to set up this test of change** | **Person responsible** | **When to be done** | **Where to be done** |
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| **Predict what will happen when the test is carried out** |
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| *(Plan first round of measurement ~ 30 days after start of test– suggested due:C1: by July 31,2021; C2: by Oct 31,2021)* |
| **Measures to determine if prediction succeeds** |
|  |
| **Do:**  |
| Describe what actually happened when you ran the test |
|  |
| **Study:**  |
| Describe the measured results and how they compared to the predictions |
|  |
| **Act:**  |
| Describe what modifications to the plan will be made for the next cycle from what you learned  |
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| *(New Test of Change due: C1: Sept 2021; C2: December 2021)* |
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| **New Test of Change** (during Implementation Phase) New test of change in PDSA to improve engagement with selected underserved, vulnerable, high risk patients – who may need additional assistance to utilize the technology option to improve chronic illness outcomes |
| **Plan for Vulnerable population** |
| **Describe your next test of change:** | **Person responsible** | **When to be done** | **Where to be done** |
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| **List the tasks needed to set up this test of change** | **Person responsible** | **When to be done** | **Where to be done** |
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| **Predict what will happen when the test is carried out** |
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| *(Plan 2nd round of measurement ~ 30 days after start of test– suggested due:C1:by Dec 31,2021; C2:by Feb 28 ,2022)* |
| **Measures to determine if prediction succeeds** |
|  |
| **Do:**  |
| Describe what actually happened when you ran the test |
|  |
| **Study:**  |
| Describe the measured results and how they compared to the predictions |
|  |
| **Act:**  |
| Describe what modifications to the plan will be made for the next cycle from what you learned  |
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| Describe your sustainability plan: |
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| *Final PDSA – Due: C1: January 2022; C2: April 2022* |