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| CTC/PCMH Kids Pilot Primary Care Telehealth Learning Collaborative “Using Technology to Improve Care for Patients with Chronic Conditions” MILESTONE SUMMARY DOCUMENT  Cohort 1: February 2021 – January 2022  Cohort 2: May 2021 – April 2023 | | |
| Deliverable | **Timeframe Due Dates** | **Notes** |
| Kick-off Learning Session: Practice QI team attendance/participation | February 10, 2021  7:30 – 9AM | Cohort 1 (C1) and Cohort 2 (C2) to attend February kick off |
| Practice Quality Improvement (QI) team identified: Team should consist of 3 to 4 staff in different roles and include a practice clinical champion and an IT/EHR staff member | C1: February 19, 2021  C2: May 14, 2021 | Identified as part of application  Completed with the Practice Facilitator – details to be submitted to [CTC-RI@ctc-ri.org](mailto:CTC-RI@ctc-ri.org) |
| QI team participation in monthly meetings | C1: February 2021 – January 2022  C2: May 2021 – April 2023 | Meet monthly with the Practice Facilitator |
| Ongoing webinars/Learning: Participate in webinars/other learning opportunities to identify telehealth applications / approaches | CTC-RI webinars run February 2021 – May 2021 | Priority for webinars that are relevant to selected chronic condition/technology |
| Quarterly peer Learning Collaborative meetings: QI team attendance/participation | Quarterly schedule and  Exact dates TBD  TBD if Learning Collaborative is held in smaller groups based on similar chronic condition | Practice to present on their population of focus, technology chosen, QI work plan, patient engagement strategy, barriers/challenges and data results |
| Start-Up Objectives: To identify needs/ feasibility and plan for action | **Start-Up (1-4 months)**  C1: February-May 2021  C2: May – August 2021 | Do we need a “project form” for these start up objectives in addition to QI/PDSA form?  Completed with the Practice Facilitator – details to be submitted to [CTC-RI@ctc-ri.org](mailto:CTC-RI@ctc-ri.org) |
| 1. Define the practice site and patient needs the team hopes to address via a telehealth program | C1: February  C2: May | Consider practice data and clinical experience |
| 2.a. Identify patients with chronic care needs who could benefit from better care management using team approach and telehealth technology to improve outcomes  2.b Identify baseline data needed and plan for obtaining | C1: February  C2: May |  |
| 3. Identify technology option that could be used to support patients with selected chronic condition and potential clinical-community partnership opportunity | C1: by May 2021  C2: by August 2021 |  |
| 4. Cost of program: Identify an initial conservative estimate of added costs for program (beyond clinical provider time and tie creating an initial business plan) | C1: by May 2021  C2: by August 2021 |  |
| Complete AIM statement to define success, goals and metrics and plan; |  | Isn’t the AIM statement part of the PDSA form? Or is this different, more general AIM statement for the project? |
| 5. Performance Improvement and Patient Support Plan (P-D-S-A)\*: submit PDSA which includes baseline data, technology, and training plan for staff and patients; | C1: by May 2021  C2: by August 2021 |  |
| *\*Considerations for PDSA that may begin during Start-up OR Implementation Phase – a) & b)* |  |  |
| a) High risk patients: Identify vulnerable/high risk patients who may need additional assistance to utilize the technology option based on risk | C1: February-May 2021 *OR* in Implementation Phase  C2: May – August 2021 *OR* in Implementation Phase |  |
| b) Community partnerships: Identify potential strategies/partnerships that could be used to assist patients/parents/caregivers that need assistance with using telehealth technology to improve management of chronic conditions | C1: February-May 2021 *OR* in Implementation Phase  C2: May – August 2021 *OR* in Implementation Phase |  |
| Implementation Objectives: Implement, measure and refine Performance Improvement and Patient Support Plan | **Implementation Phase**  **(5-12 months)**  C1: June 2021 –February 2022  C2: Sept 2021 – April 2023 | Completed with the Practice Facilitator – details to be submitted to [CTC-RI@ctc-ri.org](mailto:CTC-RI@ctc-ri.org) |
| 1. Prepare to implement:  Develop and test workflows; Develop and test staff/patient training materials | C1: June 2021  C2: Sept 2021 | Does practice need to submit work flow?  Does practice need to submit training plan? |
| 2. Implement the Telehealth Performance Improvement Plan with selected patients; | C1: July 2021  C2: Oct 2021 |  |
| 3. Evaluation: Obtain input from patient/parent/caregiver based on test of change and outcomes and evaluation results; Implement adjustments based on data and feedback from patients, staff and community partner (as applicable); | C1: June 2021 –February 2022\*  C2: Sept 2021 – April 2023\* | \*Determine plan for obtaining patient /family/ caregiver input, evaluation frequency with Practice Facilitator |
| 4. High risk patients:  If not considered in Start-up phase, include a new test of change in your PDSA to improve engagement with selected undeserved, vulnerable, high risk patients – those experiencing barriers to care and health disparities with respect to using technology to improve chronic illness outcomes; | C1: June 2021 –February 2022  C2: Sept 2021 – April 2023 |  |
| 5. Update and submit a P-D-S-A storyboard including data and patient evaluation results, sustainability plan and potential for spread to other practices. | C1: February 2022  C2: April 2023 |  |
| 6. Wrap Up Session: Practice QI team attendance and participation | C1: February 2022 |  |
| Practice earns incentive payment ($5,000.00) with verification of practice meeting service delivery requirements | C1: February 2022  C2: April 2023 | Completed with the Practice Facilitator – details to be submitted to [CTC-RI@ctc-ri.org](mailto:CTC-RI@ctc-ri.org) |