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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 DOCUMENTCohort 1: February 2021 – January 2022Cohort 2: May 2021 – April 2023 |
| Deliverable | **Timeframe Due Dates** | **Notes** |
| Kick-off Learning Session: Practice QI team attendance/participation  | February 10, 20217:30 – 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, 2021C2: May 14, 2021 | Identified as part of application Completed with the Practice Facilitator – details to be submitted to CTC-RI@ctc-ri.org |
| QI team participation in monthly meetings  | C1: February 2021 – January 2022C2: 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 2021C2: 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 |
| 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 outcomes2.b Identify baseline data needed and plan for obtaining  | C1: FebruaryC2: 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 2021C2: 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 2021C2: 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 2021C2: 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 2022C2: Sept 2021 – April 2023 | Completed with the Practice Facilitator – details to be submitted to CTC-RI@ctc-ri.org |
| 1. Prepare to implement: Develop and test workflows; Develop and test staff/patient training materials  | C1: June 2021C2: 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 2021C2: 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 2022C2: 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 2022C2: 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 2022C2: April 2023 | Completed with the Practice Facilitator – details to be submitted to CTC-RI@ctc-ri.org |