

# Planned Care

Using data and the team to organize visits in order to address care gaps and provide all the services needed for the highest quality of care.

#### **Key Changes**

- Assign delivery of key services to specific staff positions and ensure they are trained.
- Use protocols and standing orders to allow staff to act independently.
- Efficiently generate patient-specific data on services that are due.
- Huddle with the core team and review patient information before clinic session.
- Plan and ensure care plan follow up.

### **Examples**

- Review delivery system design, decision support, IT systems and patient engagement strategies for opportunities of improvement.
- Develop strategy for sharing the care plan with patient and family at appropriate intervals.
  Include patient in the design process.
- Flow map current in-clinic process for populations of focus.
- Look for opportunities in flow map to improve process through PDSAs.
- Evaluate who is doing the work now and who could do the work.

- Develop and test template for workflows which define expectations.
- Design and test workflow for gathering important patient clinical information for the huddle.
- Develop and test workflow for staff to run the daily huddle.
- Design and test workflow for assuring patients have indicated work up before visit.
- Use missed opportunities to learn how to improve in-clinic process design as a team.
- PDSA the process for sharing care plan with patient.

#### **Primary Care Team Guide Assessment-Related Questions**

8	Standing orders that can be acted on by non- independent providers under	do not exist for the practice	have been developed for some conditions but are not regularly used.	have been developed for some conditions and are regularly used.	have been developed for many conditions and are used extensively.
	protocol	1 2 3	4 5 6	7 8 9	10 11 12
Planned Care					
	Components	Level D	Level C	Level B	Level A
16	Visits	largely focus on acute problems of patient.	are organized around acute problems but with attention to ongoing illness and prevention needs if time permits.	are organized around acute problems but with attention to ongoing illness and prevention needs if time permits. The practice also uses subpopulation reports to proactively call groups of patients in for planned care visits.	are organized to address both acute and planned care needs. Tailored guideline- based information is used in team huddles to ensure all outstanding patient needs are met at each encounter.
		1 2 3	4 5 6	7 8 9	10 11 12
17	A patient who comes in for an appointment and is overdue for preventive care (e.g., cancer screenings)	will only get that care if they request it or their provider notices it.	might be identified as being overdue for needed care through a health maintenance screen or system of alerts, but these tools are inconsistently used.	will be identified as being overdue for care through a health maintenance screen or system of alerts that is used consistently, but clinical assistants may not act on these overdue care items without patient-specific orders from the provider.	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.
		1 2 3	4 5 6	7 8 9	10 11 12

## **How Primary Care Teams Achieve the Quadruple Aim**



- Engaged Leadership
- QI Strategy
- Teamwork
- Empanelment/Continuity
- Enhanced Access