## **GOAL** – Improve diabetes poor control HbA1c > 9%

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **ORG** | **CURRENT PERFORMANCE**  ***See HBACON spreadsheet*** | | | **2019** | | | **Commitment** | | **PRACTICES** | **PLAYS** |
| ***%*** | ***Num.*** | ***Denom.*** | ***Recommended Benchmark*** | ***Goal: %*** | ***Goal: Num.*** | ***Difference between 2018 and Goal num.*** | ***% of 2018 num.*** | ***# of practices contributing*** | ***PAT Milestones of Focus*** |
|  |  |  |  | 🞏 IHA Avg = 30.64%  🞏 IHA 75th percentile = 21.12%  🞏 IHA 90th percentile = 17.46%  🞏 Custom = |  |  |  |  |  |  |

## **FANTASY League** – practices contributing to the goal

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Number of people impacted** | **Number of Practices Contributing** | **Notes** |
| 🞏 **1st String**: Actively engaged practices |  |  |  |
| 🞏 **2nd String**: Large practices not actively engaged |  |  |  |
| 🞏 **3rd String**: Next engagement tier down |  |  |  |
| 🞏 **Custom**:  Definition: |  |  |  |

## **plays for improving performance** – pat milestones of focus

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| --- | --- | --- | --- | --- |
| **MILESTONE** | **CURRENT AVG.** | **GOAL AVG.** | **ACTIVITIES** | **DEPTS & STAFF TO BE INVOLVED** |
| 🞏 **4**: Practice can demonstrate that it encourages patients and families to collaborate in goal setting, decision making, and self-management. |  |  |  |  |
| 🞏 **10**: The practice and/or provider organization provides care management for patients at highest risk of hospitalizations and/or complications and has a standard approach to documentation. |  |  |  |  |
| 🞏 **19**: Practice uses an organized approach (e.g. use of PDSAs, Model for Improvement, Lean, FMEA, Six Sigma) to identify and act on improvement opportunities. |  |  |  |  |
| 🞏 **20**: Practice builds QI capability in the practice and empowers staff to innovate and improve. |  |  |  |  |
| 🞏 **21**: Practice regularly produces and/or receives provider organization reports and shares reports on performance at both the organization and provider/care team level, including progress over time and how performance compares to goals. Practice has a system in place to assure follow up action where appropriate. |  |  |  |  |
| 🞏 Other(s): |  |  |  |  |

## ROSTER

|  | **PRACTICE** | **ENGAGEMENT STATUS / TIER** | **COACH** | **CURRENT PERFORMANCE**  **December 2018** | | | **2019** | | | **COMMITMENT** | **PLAYS** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **%** | **Numer.** | **Denom.** | **Recommended Benchmark** | **Goal: %** | **Goal: Numer.** (=2018 Denom \* Goal %) | **Difference from 2018**  (=2018 Numer – Goal Numer) | **PAT Milestones** |
|  | *Example Rainbow Practice* | *High* | *CE* | *29.86%* | *292* | *978* | *IHA 75th* | *21.12%* | *207* | *85* | *21* |
| 1 |  |  |  |  |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |  |  |  |  |  |
| 9 |  |  |  |  |  |  |  |  |  |  |  |
| 10 |  |  |  |  |  |  |  |  |  |  |  |
| 11 |  |  |  |  |  |  |  |  |  |  |  |
| 12 |  |  |  |  |  |  |  |  |  |  |  |
| 13 |  |  |  |  |  |  |  |  |  |  |  |
| 14 |  |  |  |  |  |  |  |  |  |  |  |
| 15 |  |  |  |  |  |  |  |  |  |  |  |
| 16 |  |  |  |  |  |  |  |  |  |  |  |
| 17 |  |  |  |  |  |  |  |  |  |  |  |
| 18 |  |  |  |  |  |  |  |  |  |  |  |
| 19 |  |  |  |  |  |  |  |  |  |  |  |
| 20 |  |  |  |  |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- |
|  | **PAT Milestone** | **1** | **2** | **3** |
| **4** | Practice can demonstrate that it encourages patients and families to collaborate in goal setting, decision making, and self-management. | Practice is training practice staff in shared decision making approaches and developing ways to consistently document patient involvement in goal setting, decision making, and self-management. | Practice has developed approaches to encourage and document patient and family involvement in goal setting, decision making and self-management, but the process is not yet routine. | Practice can demonstrate that patients and families are collaborating in goal setting, decision making and self-management (e.g. shared care plans, documentation of self- management goals, compacts, etc.). |
| **10** | The practice and/or provider organization provides care management for patients at highest risk of hospitalizations and/or complications and has a standard approach to documentation. | Practice and/or provider organization identifies high risk patients but is not consistently able to provide care management to those at highest risk. | Practice and/or provider organization has assigned accountability for care management and is piloting a process for standardizing care management for patients determined to be at highest risk of hospitalizations and/or complications. | The care team and/or provider organization consistently provides care management for patients at highest risk of hospitalizations and/or complications, and care team has a standardized approach to documenting the care management plans. |
| **19** | Practice uses an organized approach (e.g. use of PDSAs, Model for Improvement, Lean, FMEA, Six Sigma) to identify and act on improvement opportunities. | The practice has decided on a standard QI methodology, has committed to partnering with a Practice Facilitator/Coach and is planning the implementation process. | The practice is beginning to incorporate regular improvement methodology to execute change ideas, which could include working with a Practice Facilitator/Coach on PDSAs. | The practice fully incorporates regular improvement methodology to execute change ideas in the practice setting and is doing so on its own, even when the Practice Facilitation Coach is not supporting the practice directly. |
| **20** | Practice builds QI capability in the practice and empowers staff to innovate and improve. | A limited number of practice staff/providers have QI skills and are involved in the practice’s QI initiatives, or have started working with a Practice Facilitator/Coach to identify areas for improvement and focus within the practice. | Practice is actively building QI capability such as consistently working with the Practice Facilitator/Coach and spreading QI training across all staff. | Practice has developed QI capability within the practice and empowers staff/ providers to participate in QI activities by allocating time for QI activities, including QI within defined job duties, recognizing and rewarding innovation and improvement. Or, practice has worked with a Practice Facilitation Coach for a period of time and the practice is now carrying out QI activities independent of the Practice Facilitator/Coach. |
| **21** | Practice regularly produces and/or receives provider organization reports and shares reports on performance at both the org. and provider/care team level, including progress over time and how performance compares to goals. Practice has a system in place to assure follow up action where appropriate. | Practice produces and/or receives provider organization reports on organizational or provider/ care team performance and how they are meeting quality goals but the reports are not shared in a fully transparent manner. | Practice produces and/or receives provider organization reports on how providers and/or care teams are performing and meeting quality goals but distribution of the reports is limited or there is inconsistent follow up on the reports. | Practice produces and/or receives provider organization reports on how providers and/or care teams are performing and meeting quality goals, transparently shares them within the organization, and has an effective system for follow up. |

### NOTES

### NOTES from pfe world cafe

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