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Comprehensive Care Learning Collaborative

Session Two: Wednesday January 17th, 2024

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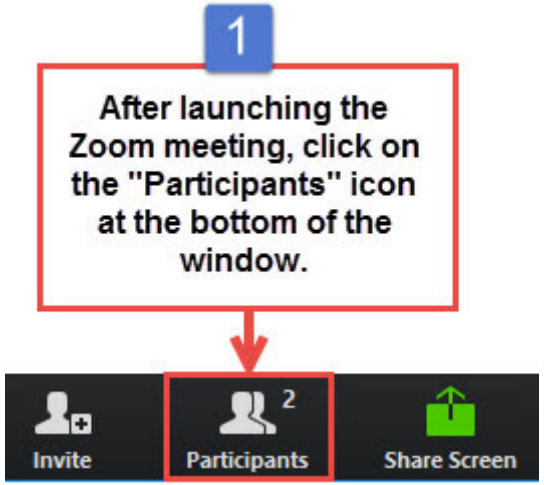
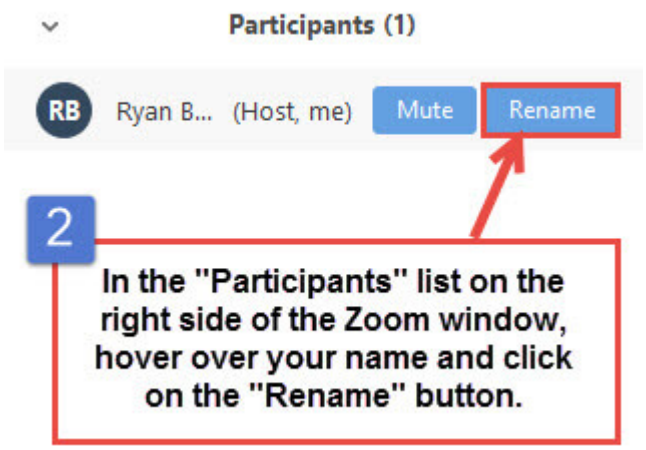
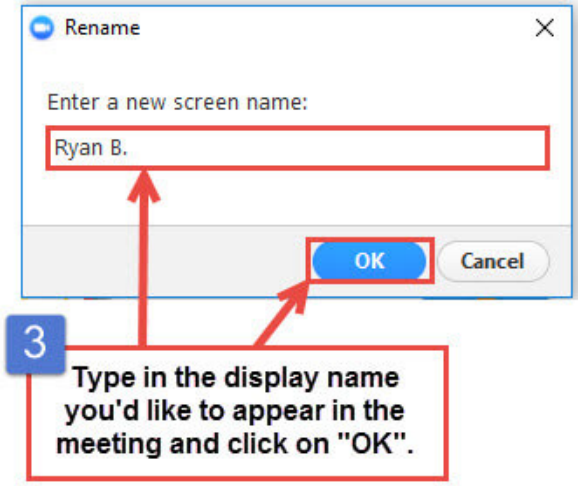
Get the Most Out of Your Zoom Experience

- Please keep yourself on MUTE to avoid background/distracting sounds
- Use the CHAT function or UNMUTE to ask questions or make comments
- Please change your participant name to your full name and organization
  - “Meaghan Angers CHCI”







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Session 2 Agenda

1:00 – 1:05	Introduction
1:05 – 1:15	TBC Spotlight: Catherine's Health Center
1:15 – 1:30	Teamlet Structure and Functions
1:30 – 1:45	Making Your Team Work: Team Development Communication Plan and Stakeholder Analysis
1:45 – 2:15	Building a Collaborative Team Culture
2:15 – 2:25	Quality Improvement Refresh: Global Aim Statement
2:25 – 2:30	Q/A, Next Steps, and Evaluation

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Learning Collaborative Faculty

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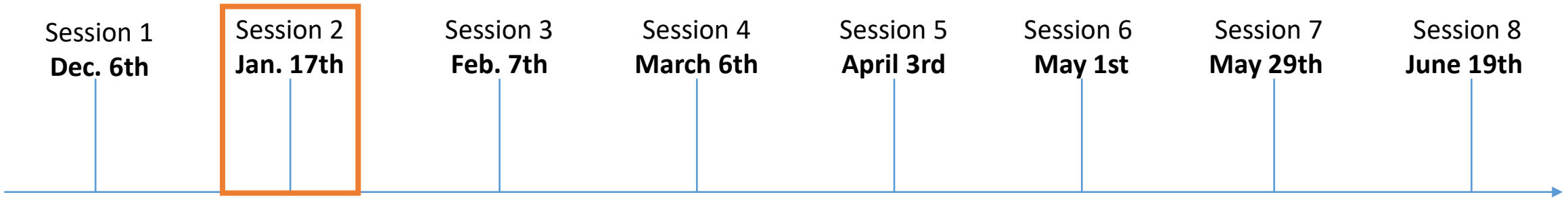
Collaborative Structure and Expectations

Eight 90-minute Zoom Learning Sessions



Between Session Action Periods

- Meet Weekly as a Team
- Conduct Daily Huddles
- Complete Assignments and upload to Moodle
- Use Online Moodle Learning Network (Share Your Work, Resources, etc.)

Between Sessions

- Coaches Meet with Mentors Weekly
- Faculty Support
- Discussion Board

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2023-2024 Cohort

Organization	Location
Brockton Neighborhood Health Center	Massachusetts
Brooklyn Plaza Medical Center	New York
Klamath Health Partnership	Oregon
Migrant Health Center, Western Region, Inc.	Puerto Rico
The Wright Center for Community Health	Pennsylvania

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Team-Based Care Spotlight:
Catherine's Health Center

Catherine's HEALTH CENTER

"We provide access to high quality, affordable and compassionate health care for the West Michigan community."

How It Started

Catherine's Health center started as a vaccine clinic in the basement of the St. Alphonsus Parish in Grand Rapids, Michigan on February 14, 1996.

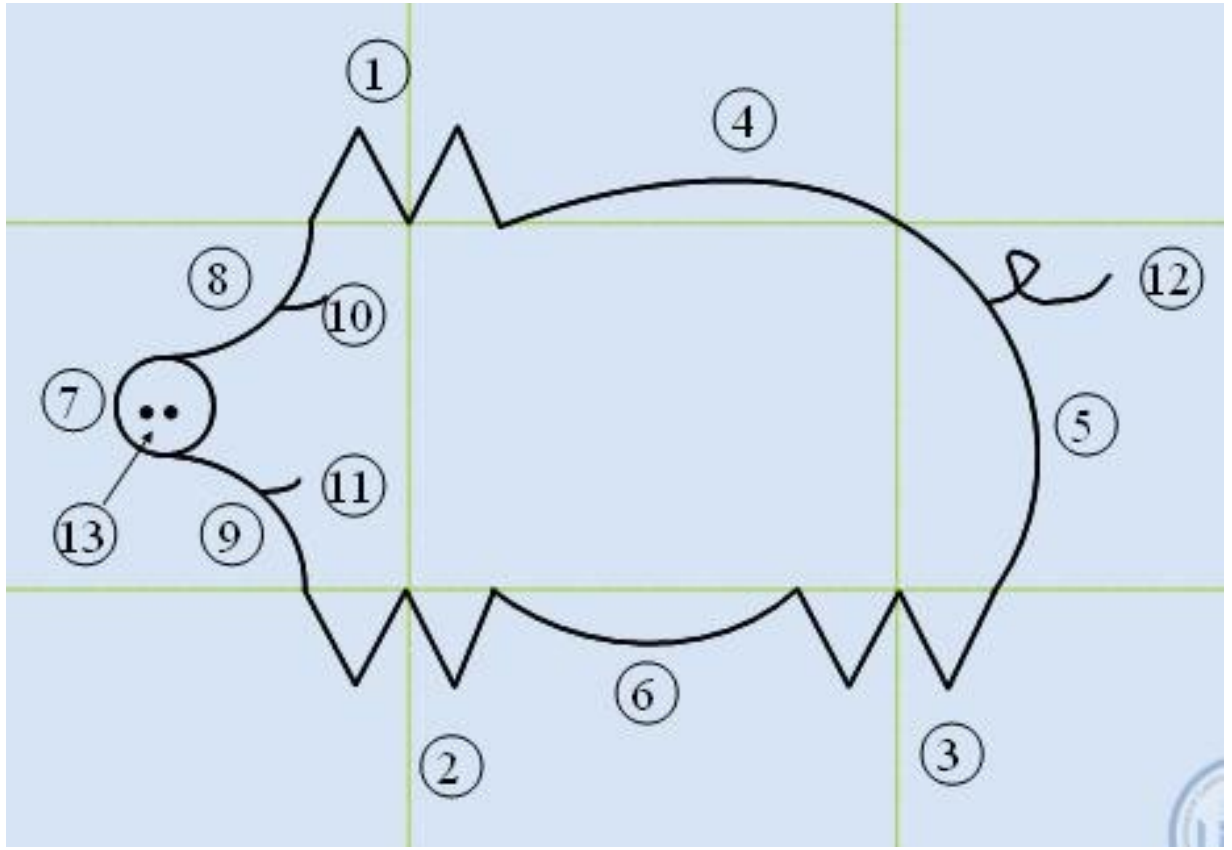
How It's Going

Catherine's Health Center became a Federally Qualified Health Center in 2020 with a single adult primary care office on the North side of Grand Rapids.

In 2021 we added a dental office and this year we have opened 2 new sites on the south side of Grand Rapids with full life primary care, dental, SUD, and behavior health services.

We have big growth goals for the future as we go from 4,000 annual patients in 2021 to a goal of 19,000 annual patients in the coming years.

Team Builders



UDS Review

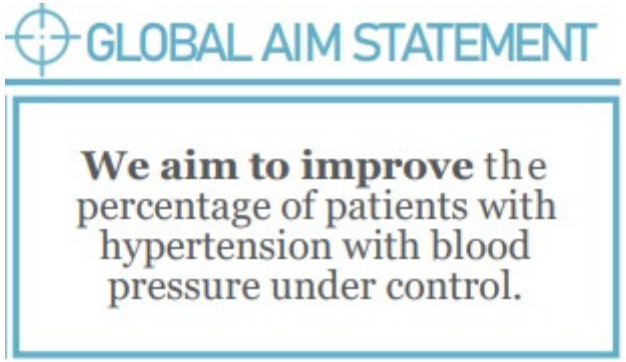
Breast Cancer Screening:

- Percentage of women 51 to 74 who had a screening mammogram performed for breast cancer in the 27 months prior to the end of the measurement period.
- The screening mammogram can be documented Athena by one of the following methods:
  - Documenting the date for "Most recent mammogram date" or the "Date of the last mammogram" in the GYN history of the patient's health history section
  - Documenting a mammography screening in the surgical history section
  - Documenting a mammography screening result in the results section
  - Manually entering a date for the measure in the quality tab

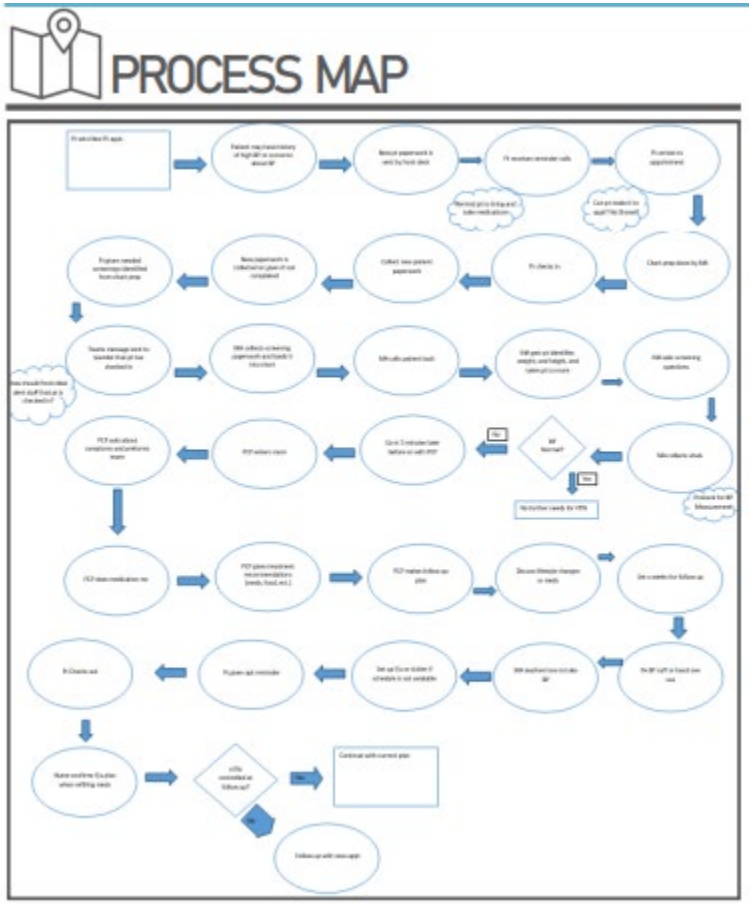
Cervical Cancer Screening:

- Percentage of women 21 to 64 years of age who were screened for cervical cancer using either of the following criteria:
  - Women age 21 to 64 who had cervical cytology (pap) performed every 3 years.
  - Women age 30 to 64 who had a human papillomavirus (HPV) test performed within the past 5 years including the measurement year.

Global Aim Statement



Process Map



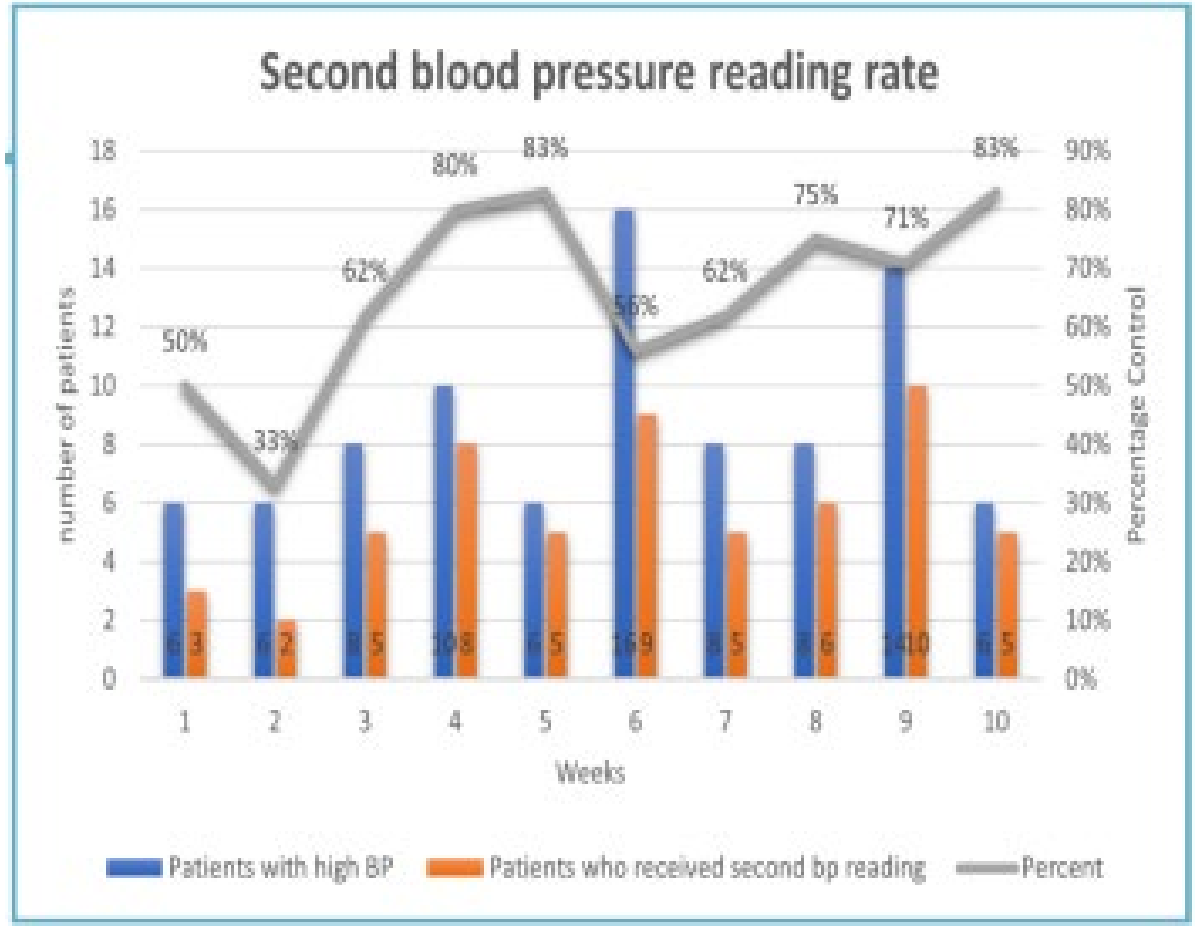
Catherine's HEALTH CENTER

Specific Aim

SPECIFIC AIM STATEMENT

85% of patients with a BP reading >140/90 will receive a second BP and it will be recorded in the chart.

2nd BPs



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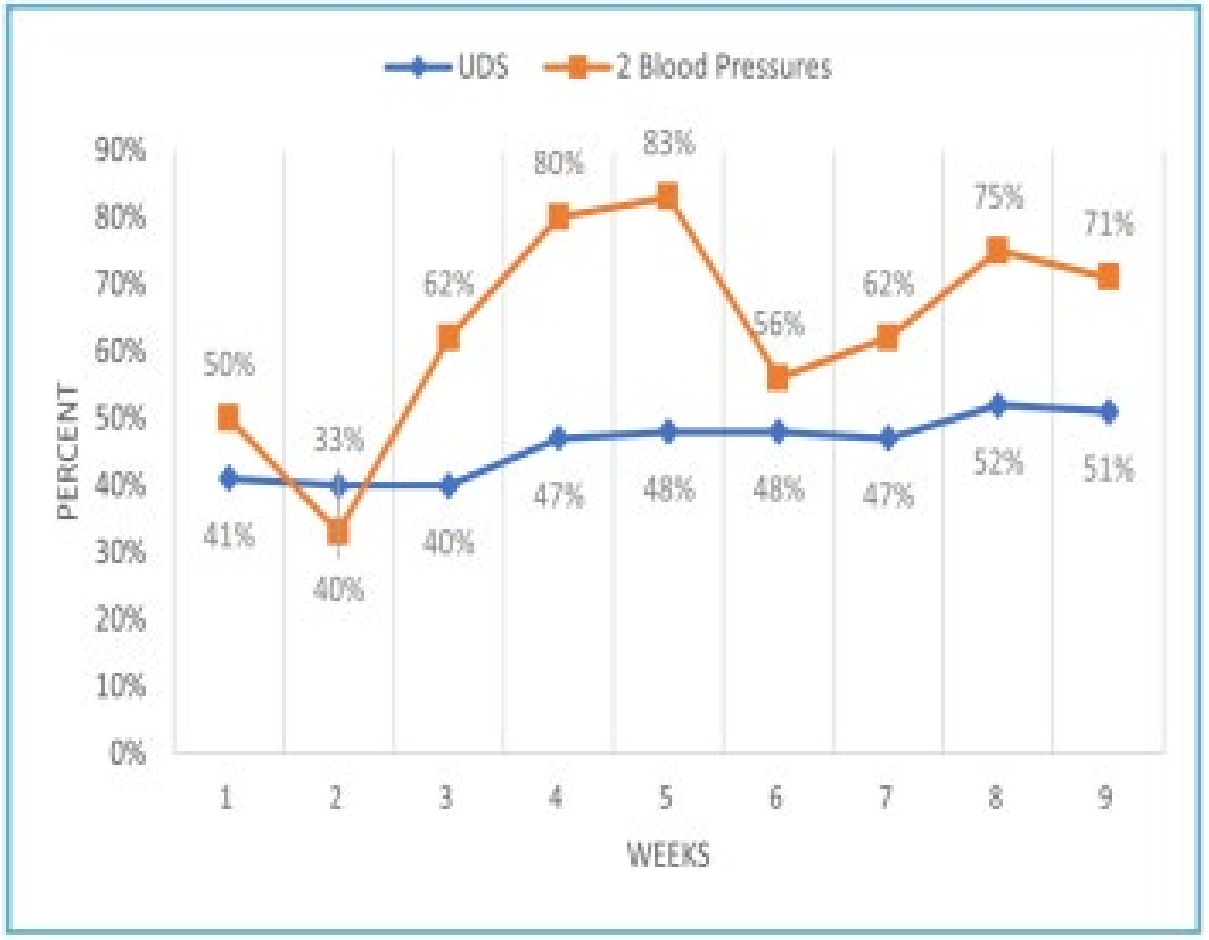
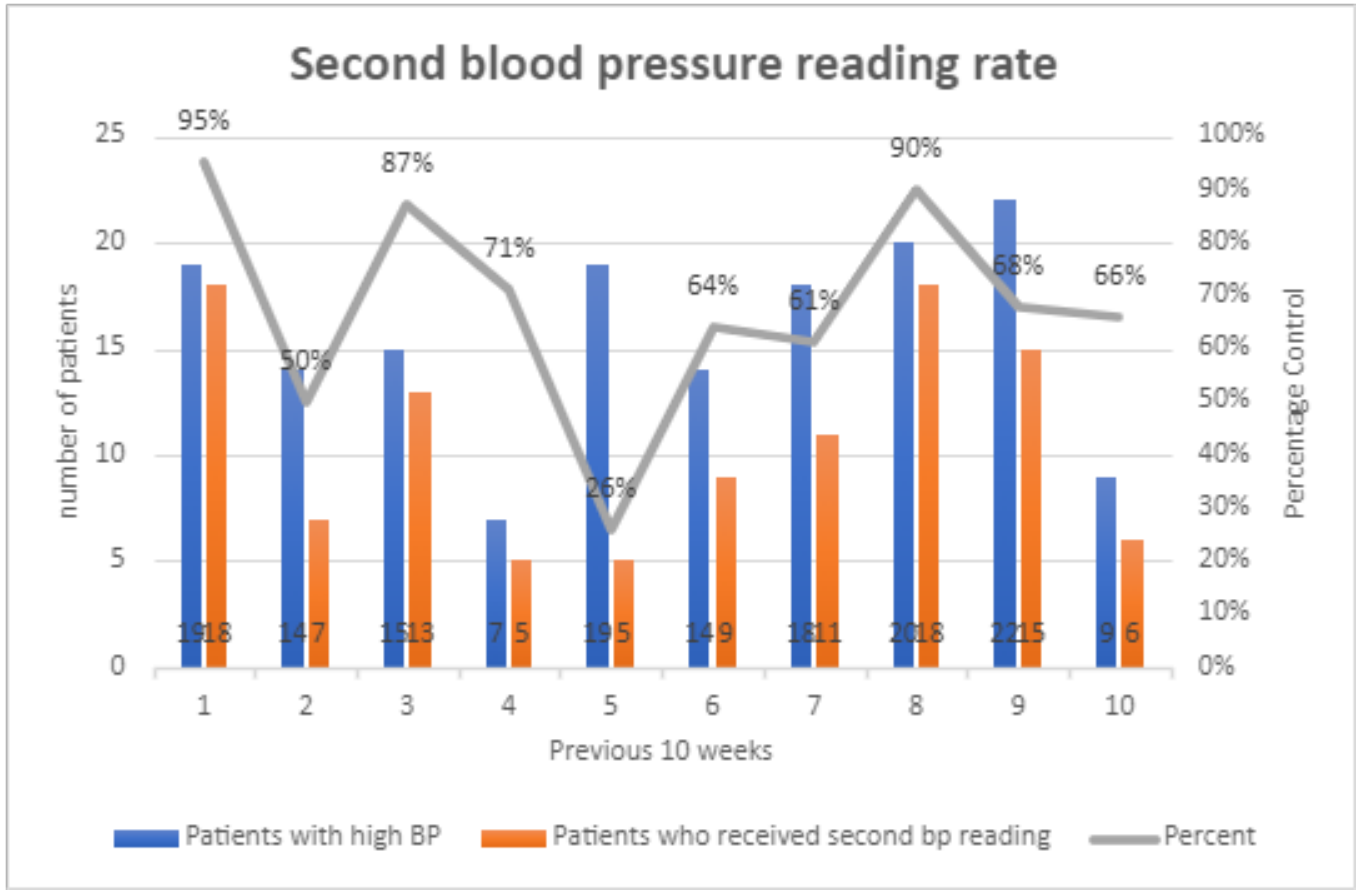
HTN Control



Catherine's HEALTH CENTER

2nd BPs Now



Catherine's HEALTH CENTER

Take Aways

- ⇒ Meet consistently, start small, and celebrate the wins. This will help build confidence to keep doing more.
- ⇒ Build up the team with lots of team building exercises, establishing rules to make a space for open and honest communication.
- ⇒ Make sure everyone on the team is there and check in on each other.

Next Steps

- Continue our work at the Wyoming Clinic
- Spread the process to the rest of the system
- Keep up the changes we have already made

Thank you!

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Team Structure and Functions

Tom Bodenheimer
Center for Excellence in Primary Care
University of California, San Francisco

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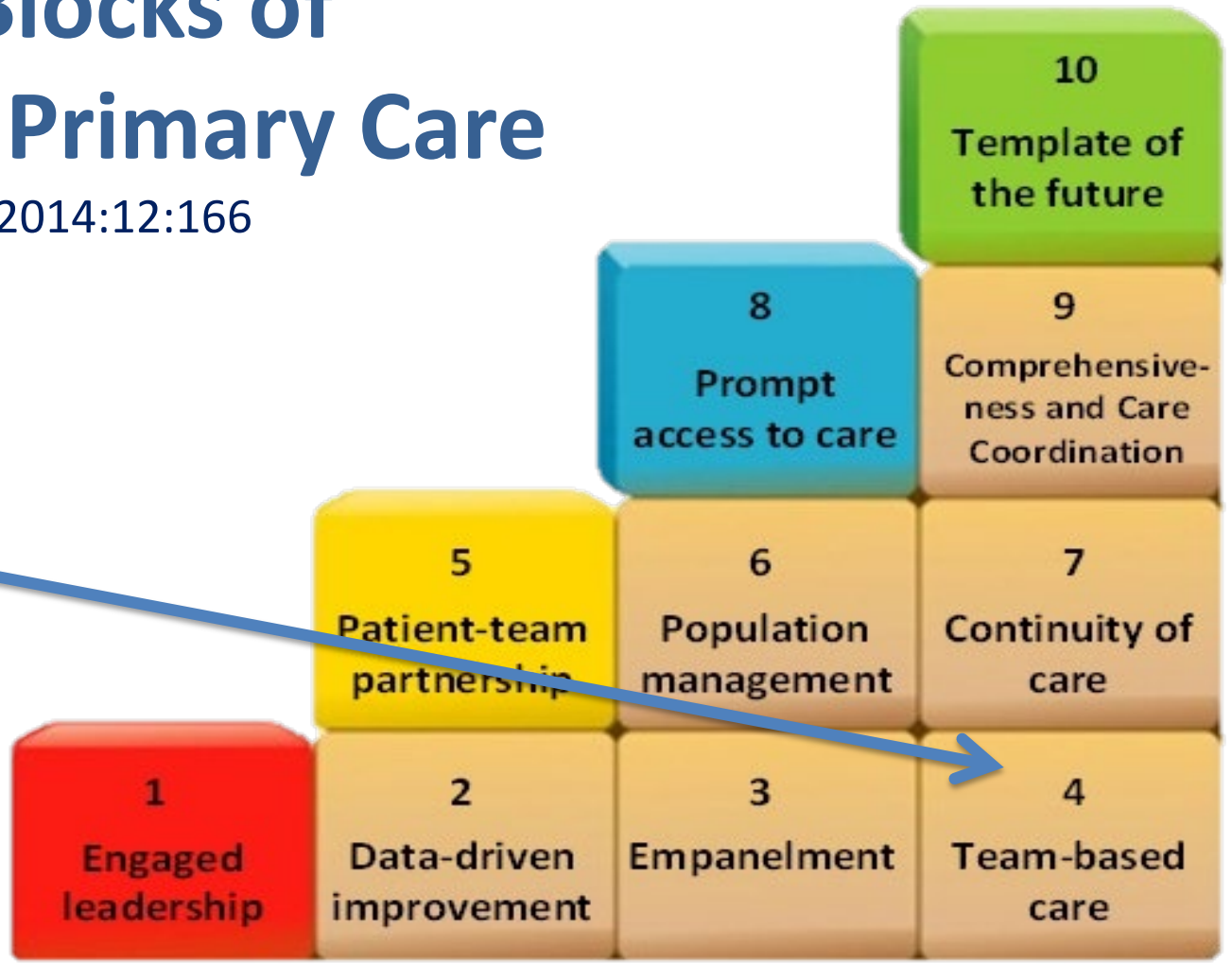
The 10 Building Blocks of High-Performing Primary Care

Bodenheimer et al, Ann Fam Med 2014:12:166



Teams

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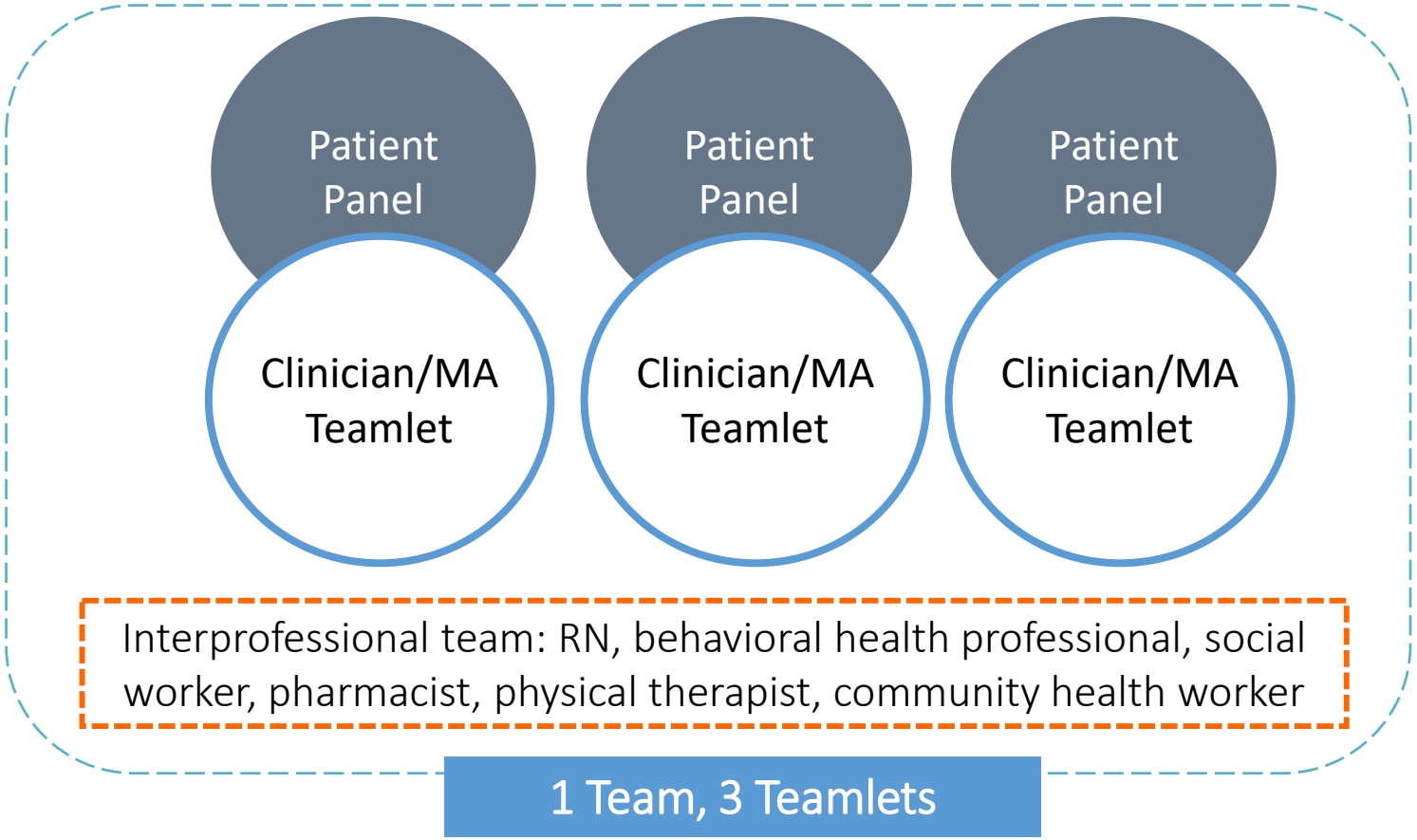
Core teams (teamlets) and interprofessional teams



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Let's talk about the core team, also called the clinician/MA teamlet

In our visits to bright-spot practices, many had implemented the teamlet model

The same clinician and MA almost always work together

Patients empaneled to a teamlet are almost always cared for by that teamlet

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Advantages of the teamlet structure

Through the patient's eyes

- Patients prefer small practices over large practices [Rubin et al, JAMA 1993;270:835].
- Teamlets convert large, often impersonal practices into small units comfortable for patients.
- Familiarity: patients know their teamlet members and teamlets know their patients.

For clinicians

- Working in stable teamlets is associated with lower burnout rates than working in teams with shifting personnel or no teams [Willard- Grace et al, J Am Board Fam Med 2014;27:229].

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Medical Assistants

- 750,000 in US, projected to add 120,000 new jobs by 2031
- Average pay 2021: $18/hour
- Most in physician offices – 58%
- Many unfilled MA job openings
- 90% women, 24% Latina, 10% African-American, 8% Asian

Sources: Bureau of Labor Statistics. Occupational Outlook Handbook 2022 Chapman et al, Research Brief: The Increasing Role of Medical Assistants in Small Primary Care Physician Practice: Key Issues and Policy Implications (Feb. 2010) (http://futurehealth.ucsf.edu/)

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Polling Question

Do MAs at your health center work with one primary care clinician?

1. Almost always
2. As much as possible given schedules
3. We don’t link MAs to a particular clinician
4. Unsure

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Some primary care functions that MAs can perform

- ✓ Panel management
- ✓ Medication reconciliation
- ✓ Health coaching
- ✓ In-room documentation

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Panel Management

Panel Management:

Ensuring that ALL of the patients in our panel get recommended preventive and chronic care services

- Estimated 50% of preventive care activities could be shared with MAs
- Evidence shows that it improves…
  - Cancer screening rates
  - Diabetes lab tests
  - Diabetes retinal screening rates
  - Smoking cessation counseling
  - Depression screening
  - Control of blood pressure

Source: Altschuler, Ann FamMed 2012;10. Kantor, Perm J 2010;14(3). Baker, Qual Saf Heath Care 2009;18(5). Blash, UC Davis Family Practice Center, www.futurehealth.ucsf.edu. Jean-Jacques, Ann Fam Med, 2012;10. Chen & Bodenheimer, Arch Intern Med 2011;171.

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Panel Management

Panel Management:

Ensuring that ALL of the patients in our panel get recommended preventive and chronic care services

- In the pre-visit, MAs use an EMR screen that tells whether a patient has care gaps: not up to date on immunizations, cancer screenings, diabetes care
- After identifying the care gaps, MAs close the gaps (give immunization, do A1c test, give patient stool occult blood test kit, make appointment for mammo or PAP) using standing orders
- MAs can also consult patient registries that provide lists of patients with care gaps and contact those patients to close those gaps

Source: Altschuler, Ann FamMed 2012;10. Kantor, Perm J 2010;14(3). Baker, Qual Saf Heath Care 2009;18(5). Blash, UC Davis Family Practice Center, www.futurehealth.ucsf.edu. Jean-Jacques, Ann Fam Med, 2012;10. Chen & Bodenheimer, Arch Intern Med 2011;171.

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Polling Question

Do you provide time for MAs to do panel management?

1. MAs don’t do panel management
2. They do panel management but we don’t reserve extra time
3. They do panel management & we make sure they have time for it
4. Unsure

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Medication Reconciliation

Med rec has 2 parts:

1. Detective work: What is the patient actually taking?

- MA function

2. What should the patient actually take?

- Clinician function

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Health Coaching

Health Coaching: MAs helping patients with chronic conditions to improve their self-management.

- Health coaching means collaborating with patients on medication adherence and healthy lifestyles
- MAs, nurses, pharmacists, social workers, community health workers can be trained to do health coaching
- Evidence shows that it improves…
  - Improve medication adherence
  - Type 2 diabetes control
  - Depression improvement
  - High blood pressure control
  - Patient engagement and satisfaction

Source: Altschuler, Annals of Family Medicine 2012;10. Margolius Annals of Family Medicine 2012;10. Nelson, Health Aff 2010;29. Ivey, Diabetes Spectrum 2012;25. Geinsichen, Annals of Internal Medicine 2009;151.

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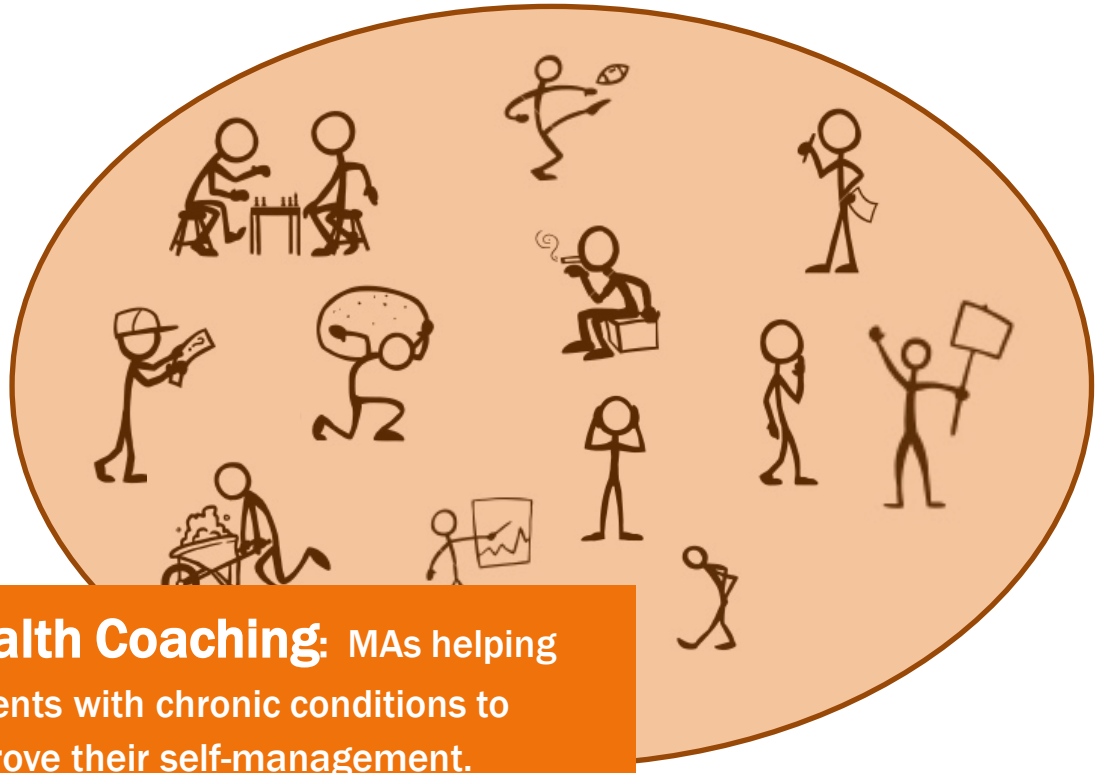
Health Coaching



Health Coaching: MAs helping patients with chronic conditions to improve their self-management.

- The problem with health coaching is that it takes time and takes focus
- Can't be done as part of pre-visit (rooming) tasks
- For terrific overview on health coaching, read Ghorob A. Health Coaching: Teaching Patients to Fish. Family Practice Management May/June, 2013
- CEPC Health Coaching Curriculum https://cepc.ucsf.edu/content/health-coaching-curriculum

Source: Altschuler, Annals of Family Medicine 2012;10. Margolius Annals of Family Medicine 2012;10. Nelson, Health Aff 2010;29. Ivey, Diabetes Spectrum 2012;25. Geinsichen, Annals of Internal Medicine 2009;151.

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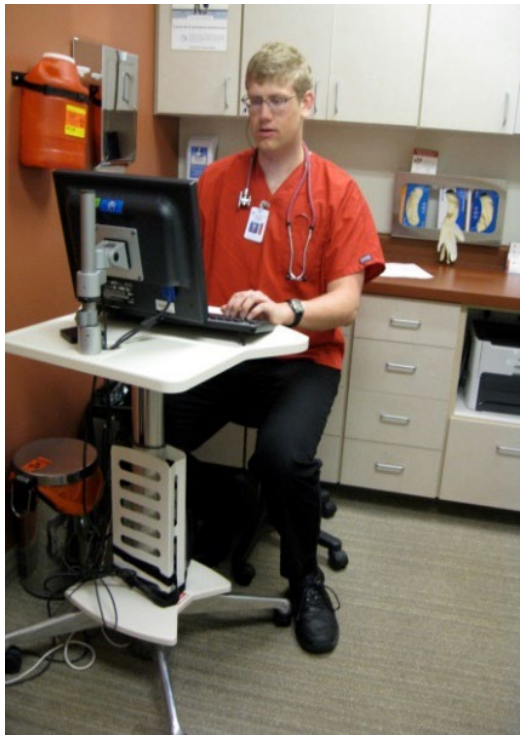
In-room documentation (scribing)

Scribe model (Shasta Community Health Center)

- Average productivity rate markedly increased for clinicians with scribes
- Clinician burnout greatly reduced

There is evidence that it improves…

- Clinician & patient experience
- Improved clinical outcomes
- Increased productivity



Source: Ammann Howard K, et al . Adapting EHR Scribe Model to Community Health Centers: The Experience of Shasta Community Health Center's Pilot. Blue Shield of California Foundation Report. 2012 Feb; Bodenheimer T, Ann Fam Med 2022:20:469-478.

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Making Your Team Work

Team Development Refresh

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Baseball Teams

- Know the roles of the pitcher, catcher, basemen, outfielders…and the umpire.
- They have a manager.
- They have a coach.
- Batters have studied how pitchers pitch; pitchers have studied how batters bat.
- They know their scores. And the scores of other teams.
- They know different ball parks and where the boundaries for a home run are.
- They know their fans.
- They practice….a lot.
- They stay in shape.

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Normalizing Change: What We Know

Before you can change practice, you must change the individuals who work in the organization--that is, their values, attitudes, relationships, skills, and behavior. NOT a linear process!

- Start with changing their minds [values, attitudes] about the work ahead….*coherence*.
- Build relationships and ownership about how the work will be done….*cognitive participation.*
- Get into the weeds of the work together, develop new skills, try new ways of working….*collective action*.
- Track your progress and revise as needed….*reflexive appraisal*.

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Team Development Refresh: Normalization Process Theory

Coherence

- Clarity of purpose, expectations & value
- Why are we here? How is the learning collaborative different from other projects? Who is in charge? What is expected? Is this worth my time?
- Failure to build coherence from the start leads to conflict, and will make it impossible to move forward.

Cognitive Participation

- Relational work of team-work.
- Do we have the right people? How do I fit in?
- Ownership not "buy-in." Do we all want the same thing?
- Without ownership and a shared mental model for how to do the work, the team lacks direction and gets frustrated. The loudest voice wins.

Collective Action

- Operational work of teams: a shared mental model, a systematic approach— Improvement Ramp!
- Do we have the necessary resources? Data? Time?
- The team is delving into the work - "in the weeds" of change
- Trust each other's expertise and commitment. Progress is being made.

Reflexive Monitoring

- Appraisal work that people do to assess and understand how change is working. It does not end.
- What fine-tuning do we need to do to make sure it is sustainable?
- Without reflexive monitoring, the work cannot spread, be sustained, or be revised/improved as needed.

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Sources of Conflict

Lack of Coherence

- I don't know who is in charge. I don't understand the purpose. I don't know what is expected. I don't value this.

Lack of Relational Work/Cognitive Participation

- No ownership. Not on the same page. No shared mental model of how to do the work. Jumping to solutions before determining what the issue is. No direction. Too many loud voices. I don't know where I fit in. Insecurity about being a team member. Bullying

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Sources of Conflict

Lack of Collective Action

- Insufficient resources and administrative support. Failure to use shared mental model/systematic approach. Wrong set of skills/won't develop new ones. Slackers and the overworked. Lack of engagement.

Lack of Reflexive Monitoring

- No tracking. Pilot becomes policy without testing spread. No sense of accomplishment —I wasted my time.

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Developing a Communication Plan & Stakeholder Analysis

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Why do you need a plan to engage and communicate with stakeholders?

- Control the narrative: drive the story of the work you are doing by being proactive; don't leave it to others to guess.
- Communicate on a regular basis with stakeholders in different parts of your organization
- Make sure that the group implementing the innovation shares a consistent message
- Anticipate/address concerns, questions and challenges.

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Step 1. Identify stakeholders

A stakeholder is someone/some department who has something to gain or lose when change is introduced.

- Who is currently involved in the work that will change?
- Who currently oversees this work? Who currently is accountable for the outcomes of the work?
- Who will be affected by changing how this work is done and how? New roles? New workflows? New responsibilities?
- What departments or sites need to be involved? Who are their leaders and how to you get to them? (Site Directors, HR, IT, etc.)
- What is the opinion of the stakeholders regarding the planned change: Against? Supportive? Doesn't matter one way or the other.

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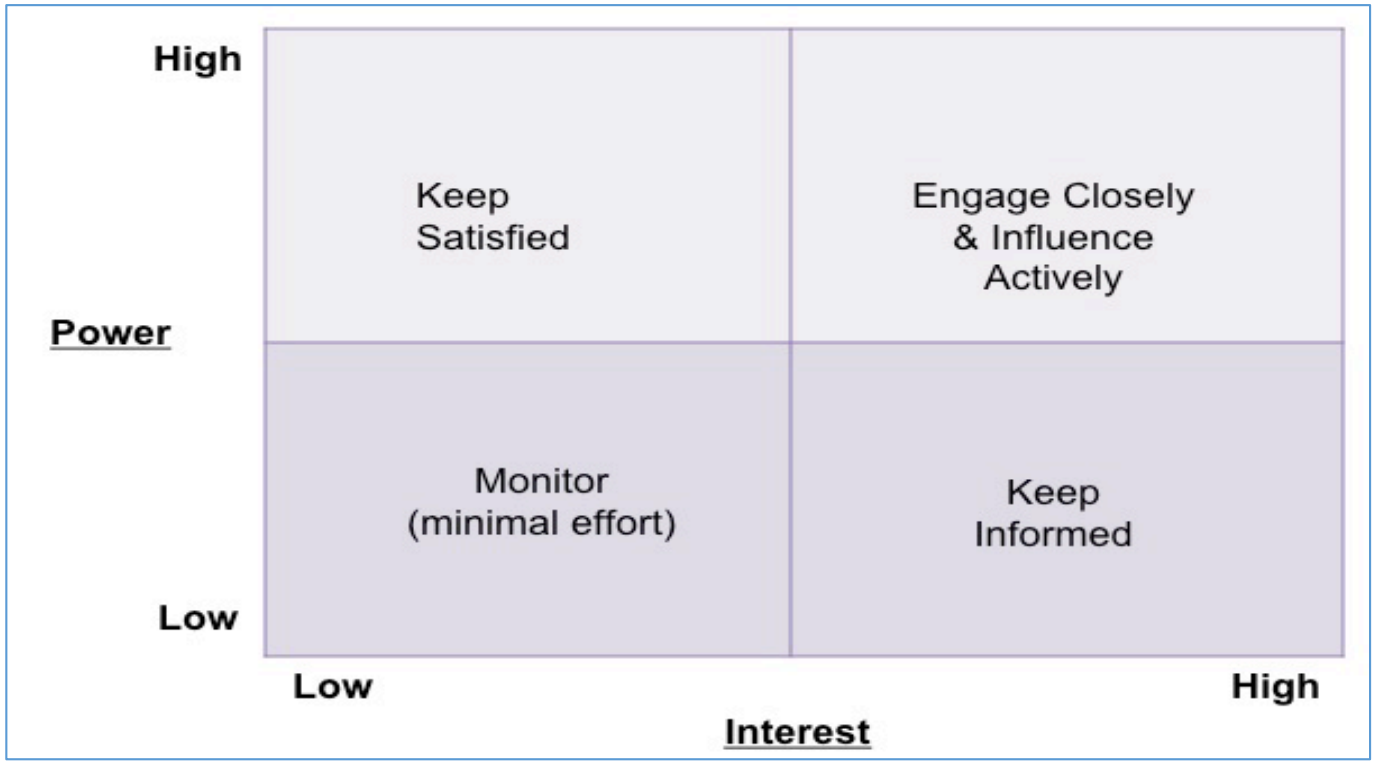
Table 1. Example of identifying stakeholders

Stakeholder	Strongly against	Moderately against	Neutral	Moderately supportive	Strongly supportive
Providers				C	D
IT		C		D	
HR			C D		
Nursing			C		D
Reception	C			D	
Other stakeholder					

C= current position D= desired position Who do you need to influence in what direction?

Step 2. Analyze the position of stakeholders relative to their power and interest.



What are the formal channels through which each stakeholder gets important information? The informal channels?

Step 3. Communication plan: Who, what, when, where, why, how

COMMUNICATION PLAN FOR IMPORTANT PROJECT DATE: November 2023 PROJECT LEAD: Mrs. Peacock					
Who: Stakeholder	Why communicate with this person?	What: Message(s) for this person	Who: Who in your project group is in the best position to communicate with this person?	When and how often?	How: What venues or media will be used?
Mr. Green, CEO	Has invested in time for us to meet. Will need his/her support to implement the innovation.	Assure him/her that we are using time well. Update on progress of group, lessons learned from other groups, ideas for implementation and application. Keep good energy.	Colonel Mustard, Director of Big Department and Project Lead	Monthly meeting of directors. One-on-one meetings as appropriate to request resources as needed or ask advice.	Oral report monthly but written report added to meeting minutes.

Final Advice

- Managing up: communicating with someone above you in leadership
- Be clear about expectations
- Manage their expectations about your work
- Manage the relationship between this leader and your work group
- Leaders often move on to the next BIG Thing and suddenly promised resources disappear
- Leaders want things to move more quickly and are convinced they have the solutions—you need to explain how your group works and why
- Your boss has a boss: don't leave your boss out on a limb
- Speak with one voice and stay on message
- Don't gossip or complain about your work group: it erodes trust
- Ask for advice, suggest solutions

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Building a Collaborative Team Culture

Tom Bodenheimer and Rachel Willard-Grace
Center for Excellence in Primary Care
University of California, San Francisco

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Collaborative Team Culture

- Share the care
- Ground rules
- Standing orders/protocols
- Defined roles with training and skills checks
- Communication

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Culture Shift: Share the Care

Share the care is a culture shift

- From "I" – clinician makes all decisions
- to
- "We" – the team takes responsibility for their panel

Sharing the care is not only delegating tasks to non-clinician team members; it is re-allocating responsibilities so that all team members contribute meaningfully to the health of the panel

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Task or Responsibility?

- Doing an electrocardiogram on a patient
- Checking the registry to see which patients in your panel are overdue for colorectal cancer screening and arranging for screening to be done
- Calling a patient to give normal lab results
- Weighing a patient
- Conducting a 4 session health coaching class for patients with diabetes
- Teaching newly hired MA how to perform med-rec
- Doing med-rec with a patient
- Scribing for your teamlet clinician

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Please write in the chat examples of how you have shared the care in your clinic by delegating responsibilities to non-clinician team members.

Share The Care

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Sharing the care has positive effects

- Medical assistants taking responsibility to ensure that all patients have received appropriate cancer screening improved screening rates (Baker. Qual Saf Health Care.2009;18(5):355-359; Kanter, Perm J. 2010;14(3):38-43).

- Teams with a collaborative team climate were associated with better diabetes management, patient satisfaction, and patient activation (Becker and Roblin. Medical Care 2008;46:795-805; Bower, Campbell, Bojke, & Sibbald. Qual Saf Health Care 2003;12:273-279).

- An observational study of 27 practices found that moving toward a "share the care" culture increases physician and staff satisfaction (O'Malley et al. JGIM 2015;30;183-192).

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Ground Rules

- Ground rules are expected behaviors for everyone on a team
- Should be agreed on by everyone on the team; that allows the team to hold a team member accountable if he/she violates the ground rule
- Two situations needing ground rules
  - **Meetings:** who runs the meeting, who sets agenda, step forward/step back
  - **Team behavior during patient care times:** being on time, being respectful of patients and team members, giving feedback to team members (including clinicians) who are not empathetic, what to do if someone violates a ground rule he/she agreed to

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Collaborative Team Culture

- Share the care
- Ground rules
- Standing orders/protocols
- Defined roles with training and skills checks
- Communication

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Sharing the care is done using standing orders

What is a standing order?

A protocol approved by the medical and administrative leadership of a health care facility that empowers RN, medical assistants, or other team members to provide a specific service to appropriate patients.

- Sharing the care cannot be done without standing orders
- Standing orders must conform to state laws and regulations
- Standing orders must be approved by the medical director of the clinic or health system within which the clinic resides

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Some primary care functions that can be re-allocated among the team with standing orders

- **Panel management:** making sure patients receive all the routine chronic and preventive care services on a timely basis
- **Health coaching:** Helping patients set goals and make action plans to improve health-related behaviors, for example healthy eating, physical activity, and taking medications
- **Chronic medication refills:** Taking this important but time-consuming function away from clinicians and having RNs responsible for chronic medication refills
- **RN care management for patients with diabetes:** RNs can titrate medication doses using a standing order (not allowed in all states)

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Example of Standing Order for MAs

West County Health Centers CARE TEAM DIABETES PROTOCOL

MAs may, without consulting the medical provider, perform the following tasks:

Order **Hemoglobin A1C** if not done in the last *6 months*

Order fasting **LIPID PROFILE** if not done in the last *1 year*

Order urine **Microalbumin/Creatinine ratio** if not done in the last *1 year*

Order a **DIABETIC EYE EXAM** if not done in the last *1 year*, and assign the case to the referral coordinator to track

Perform a PHQ2 if not done in the last *1 year* and refer for clinical follow up if answered yes to either of the questions.

Schedule an Office Visit for the following:

A **DIABETIC FOOT EXAM** if not done in the last *1 year*

An **Office Visit** if patient has not been seen in the last *6 months*

Influenza vaccination if not received in the last 1 year and within the months of November and April

Approved by Medical Director, West County Health Centers _____

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Defined roles with training and skills checks

Example

- To share the care at Ocean Park Health Center in San Francisco, MAs were delegated the responsibility to do foot exams on each patient with diabetes every 6 months.
- MAs must:
  1) Take a test on how to do a diabetic foot exam,
  2) Observe 10 foot exams, and
  3) Perform 10 foot exams under observation by the nursing director before being cleared to do foot exams on their own.
- Every year the nursing director observes each MA doing foot exams to make sure they are being done with high quality

If you have an example of how a team member was trained and authorized to perform a new function, please write it in the chat.

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Communication

- ✓ Minute to minute communication through co-location
- ✓ Huddles
- ✓ Team meetings

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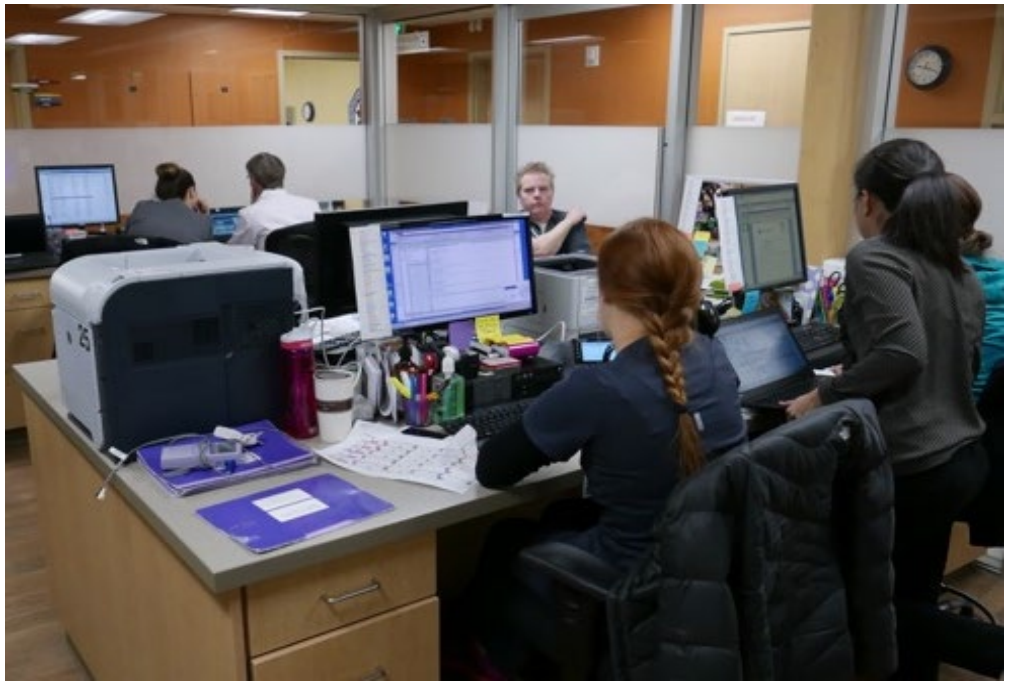
Co-location

- Minute-to-minute communication is most easily done when the team works together in one shared space
- Ideally, the clinic architecture is changed to create pods
- Yet it isn't necessary to re-model the clinic to achieve co-location
- For example, at Univ of North Carolina Family Medicine Center, 2 stand-up work stations were created along hallways and the clinician and MA work right next to each other for easy communication



Central Washington Family Medicine Residency at Yakima

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Polling Question

Are your teams co-located (work together in a shared space)?

1. Yes for all teams
2. Yes for some teams
3. No and there are plans to co-locate
4. No and there are no plans to co-locate
5. Unsure

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Co-location

- Co-located practices report that some physicians initially resist colocation but embrace it when they find that it saves them time.
- Teams with many face-to-face interactions among all team members deliver higher quality cardiovascular disease care at a lower cost [Mundt et al, Ann Fam Med 2015;13:139-148]
- In three studies, co-location was associated with improved team collaboration and coordination [MacNaughton K et al, BMC Health Services Research 2013;13:486; Sims S. et al. J Interprof Care 2015;29:20; O'Malley AS et al, JGIM 2015;30:183].

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Communication: Huddles

- Huddles are brief (5 – 10 minute) stand-up discussions about patients coming in that day
- Every morning, or also huddle after lunch
- MAs may review ("scrub") the charts of patients coming in that day and lead huddles:
  - Ms. G is overdue for PAP smear and mammogram
  - Mr. K needs an A1c, cholesterol, creatinine, foot exam and referral for eye exam
  - Mr. T's dog died yesterday and he is very upset
- Deciding who will handle the different patient needs speeds clinic time and improves quality
- Many clinics use teamlet huddles – only the clinician and MA.

For a good huddle video, Google: Planned care huddle Youtube, Michael Zimmerman, 2008

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Communication: Team Meetings

- Some practices have siloed meetings
  - Clinicians meet with clinicians
  - Nurses meet with nurses
  - MAs meet with MAs
- Those have value, but cannot take the place of all-team meetings
- Monthly all-team meetings, with everyone suggesting agenda items in advance, can
  - Solidify team cohesion, starting with brief bonding exercises or going around the room to see how each person is doing
  - Discuss challenges and get ideas on how to improve services and clinic operations (e.g., what to do when patients are late or how the team will implement COVID vaccination)
  - Share data on clinic projects and celebrate accomplishments
  - Discuss team ground rules

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Take Home Points

- Teams that share the care and build a collaborative culture are better for patients, clinicians and staff
- Ground rules, agreed upon by all team members, define accepted behaviors and help create team cohesion
- Standing orders, allowed by state regulators and approved by health system leaders, are needed to authorize the functions of team members
- Teams need a clear division of tasks with training and skills checks to make sure team members are functioning with high quality
- Team communication is improved by co-location, brief daily huddles, and regular team meetings.

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Sharing the care is a beautiful thing

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Quality Improvement Refresh: Global Aim Statement

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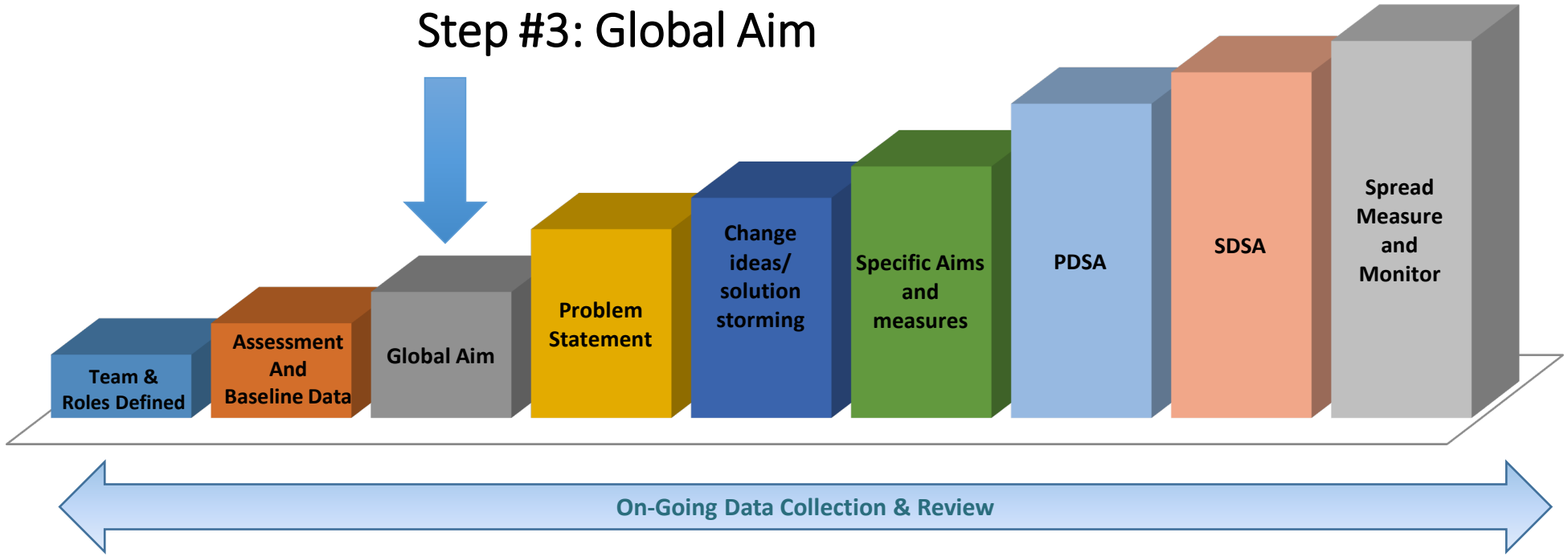
The Stages of Improvement



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The Global Aim is a documented statement of what you propose to improve in your focus area.

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Global Aim Statement

- Based on what you found in your data: what's the problem or general theme?
- States clearly where you want to start your work
- Identifies where you want to focus the work
- Identifies why it is important to work on the identified process
- Creates an opportunity to build consensus for the team

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Writing a Structured Global Aim

1. The aim is to improve the quality and value of…*(name the process).*
2. The process starts with…*(name start point)* and the process ends when…*(name end point).*
3. By working on this we expect to:
    a. *(Name better, hoped for results).*
4. It is important to work on this now because….*(list reasons)*

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Example of Structure Global Aim

1. We aim to improve..._*the process of colon cancer screening at the Middletown clinic site*
2. The process starts with..._*identifying patients who are due for colon cancer screening* and the process ends when..._*screening results are documented in the patient record*
   .
3. By working on this we expect to:
   a. _*improve the rate of colon cancer screening in adults (UDS measure)*
4. It is important to work on this now because….
   a. *we need to improve our UDS measures for reimbursement purposes*

   b. We want to improve patients' health through early intervention

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Global Aim Template

Theme for improvement: _____

(Based on your practice assessment)

We aim to improve: _____

(Name the process)

In: _____

(Clinical location in which process is embedded)

The process begins with: _____

(Name where the process begins)

The process ends with: _____

(Name the ending point of the process)

By working on the process, we expect: _____

It's important to work on this now because: _____

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Example of Structured Global Aim

*We aim to improve the **rate** of **cervical cancer screening** for **Dr. Smith's panel in Pod A at the Main St. Clinic**. The **process begins** during pre-visit planning by identifying the patients who are due for/eligible for screening based on UDS definition of eligibility. The **process ends** with documentation in the EMR that screening has been completed. By working on this, we **expect** to improve our UDS measure for cervical cancer screening, clarify the process for how documentation of screening by providers outside of our clinic gets into the EMR, and reduce gaps in care. **It's important** to work on this now because our screening rate has declined, and we have new staff we can train to a new workflow.*

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Statement is broad, but clear

- What: colon cancer screening
- Who: adult patients [see UDS definition for specifics]
- Where: at the Middletown site
- Why: better patient care, improved performance
- Start: with identifying patients who are due for screening when they come in for a visit
- End: documentation in the record is the end because that is how the UDS measure is counted

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Common Mistakes

- ✓ The theme is too broad and/or is not based on an assessment of your practice, e.g., "communication"
- ✓ The global aim will be difficult to measure, e.g., "improve the efficiency of ….."
- ✓ The global aim includes a strategy, e.g., "we will improve the UDS measure by doing [this or that]." Save strategies for the PDSA.
- ✓ The location—which will identify the team and/or population of patients—is not clear
- ✓ The process does not have a clear beginning, that is, what does someone do to get the process started?
- ✓ The end of the process gets mixed up with the outcome measure. For example, the end is not "increased screening rate," the end is that someone "documented in the record."
- ✓ Expectations are too high!

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Questions?

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Action Period 2 Deliverables

- Conduct your weekly team meetings
- Narrow down topic you would like to work on (i.e. UDS measure, workflow, etc.).
- **Deliverable**: Complete communication plan to share/discuss during coach calls
- **Deliverable**: Develop Problem Statement based on UDS data Assignment: Develop Global Aim

Google Drive

https://drive.google.com/drive/folders/1VFv0Ar6VbdVDS_fkY6fPXQw36Tq0A1Wg?usp=drive_link

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Reminders

Coach Calls:

- Wednesday January 24th 1:00pm ET / 10:00am PT
- Wednesday January 31st 1:00pm ET / 10:00am PT

Session 3: Wednesday February 7th 1:00pm ET / 10:00am PT

CME and Resource Page Access Code: TBC2023

https://education.weitzmaninstitute.org/content/nttap-comprehensive-and-team-based-care-learning-collaborative-2023-2024

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REMINDER: Complete evaluation in the poll!

Next Learning Session is **Wednesday February 7th!**

Explore more resources!

National Learning Library:
Resources for Clinical Workforce Development

https://www.weitzmaninstitute.org/ncaresources

Health Center Resource Clearinghouse

https://www.healthcenterinfo.org/