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# Advancing Team-Based Care Learning Collaborative

## Learning Session 5: Wednesday April 3rd, 2024

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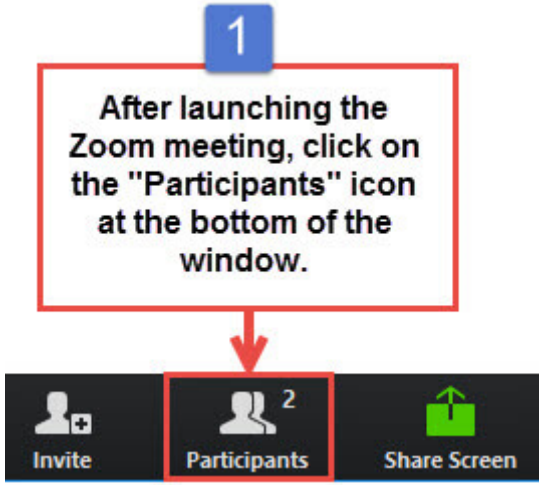
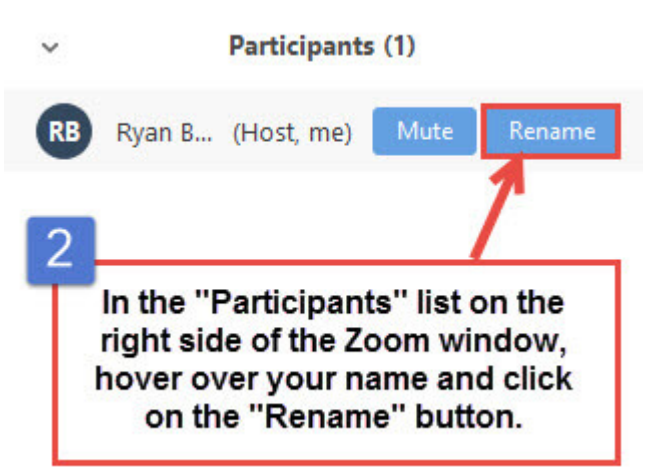
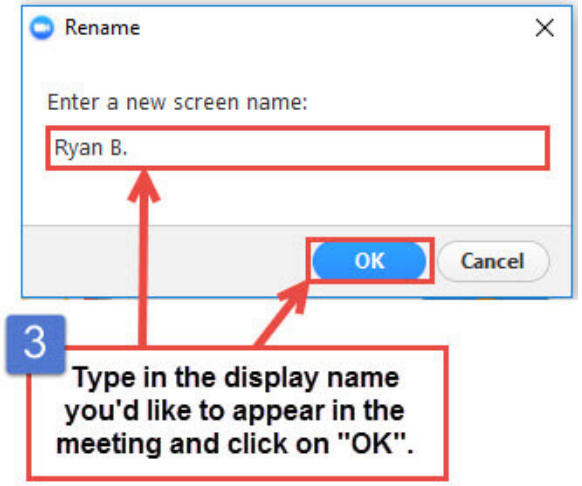
# Get the Most Out of Your Zoom Experience

- 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 5 Agenda

| | |
|---|---|
| 1:00 – 1:05 | Welcome |
| 1:05 – 1:15 | Role of Business Intelligence |
| 1:15 – 1:40 | Role of Population Health Management |
| 1:40 – 2:10 | Meaningful Integration of HIT for Team-Based Care |
| 2:10 – 2:25 | Quality Improvement Refresh: PDSA Cycles |
| 2:25– 2:30 | Q/A, Next Steps, and Evaluation |

# Learning Collaborative Faculty

## NTTAP Faculty, Collaborative Design, and Facilitation

Amanda Schiessl, MPP
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Tom Bodenheimer, MD
- Physician and Founding Director, Center for Excellence in Primary Care

Rachel Willard, MPH
- Director, Center for Excellence in Primary Care

## Evaluation Faculty

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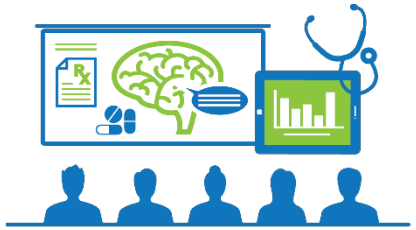
# National Training and Technical Assistance Partners
## Clinical Workforce Development

Provides free training and technical assistance to health centers across the nation through national webinars, learning collaboratives, activity sessions, trainings, research, publications, etc.

**Team-Based Care**

- Fundamentals of Comprehensive Care
- Advancing Team-Based Care

**Training the Next Generation**



- Postgraduate Residency and Fellowship Training
- Health Professions Training

**Emerging Issue**

- HIV Prevention

**Advancing Health Equity**

**Preparedness for Emergencies and Environmental Impacts on Health**

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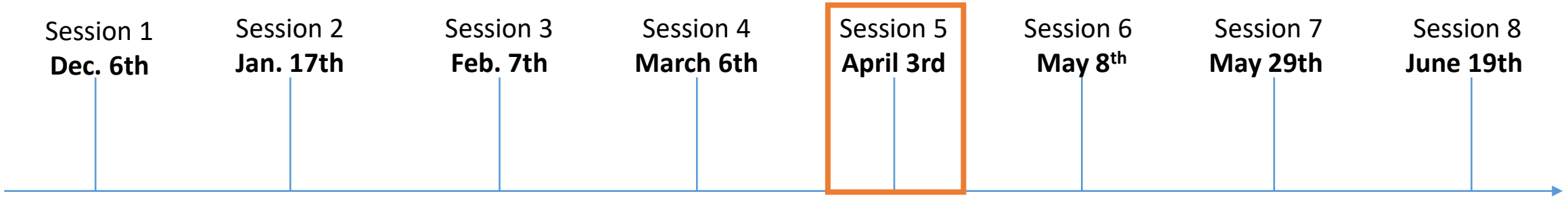
# Collaborative Structure and Expectations

## Eight 90-minute Zoom Learning Sessions




### Between Session Action Periods

- Meet weekly as a team
- Conduct daily huddles
- Complete deliverables and upload to the Google Drive
- Use the Weitzman Education Platform to access resources and receive CME credit for learning sessions

### Between Sessions

- Coaches meet with coach-mentors weekly
- Faculty support
- Complete deliverables

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# 2023-2024 Cohort

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

# Center for Family Health & Education

# Who are we:

- FQHC dedicated to serving underserved and low-income populations by providing affordable and Accessible Healthcare services
- Our team is made up of
  - A-CMO
  - Director of Operations
  - Quality Assurance Coordinator
  - Staff Educator
  - Dental Provider
  - Clinic Manager
  - Dental Assistant
  - Receptionist

# Our Goal:

- Our Goal is to enhance our Quality Assurance process to create a more effective workflow
- We hope to accomplish this by
  - Gathering tools that help strengthen our team dynamic
  - Following the PDSA cycle with guidance from the Collaborative to ensure we are following the right steps

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# Role of Business Intelligence


## Nick Ciaburri, Director of Business Intelligence

Community Health Center, Inc.

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# What is Business Intelligence?

"BI systems combine data gathering, data storage, and knowledge management with analytical tools to present complex internal and competitive information to planners and decision makers. Implicit in this definition is the idea (perhaps the ideal) that business intelligence systems provide actionable information delivered at the right time, at the right location, and in the right form to assist decision makers"

(Negash, 2004, p. 178).

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# Dashboards and Reports

- The end-users (executives to MAs) see customized reports and dashboards produced by BI.
- These dashboards and reports are built in collaboration with the end-users, and there are many iterations tested until all parties are satisfied that these products are usable and the data is actionable.
- To get this end product: BI team had to build the data warehouse which transforms and cleans the data from the EHR to make it more usable for reporting.

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# Best Practices for Actionable Data

- You can collect all the data you want, but if it is not structured in a way that is useful and meaningful, staff will not be able to use it in a timely manner to provide or to improve patient care.
- BI Team works closely with the clinical chiefs, senior administrators and the population health team to identify what data are most important to them and their staff, what they are trying to improve, and when/how often they need to see the information.
- For data validity – conduct chart reviews.

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# Challenges to Data Accessibility and Validity

- Biggest challenge to **data validity**: ensuring that the denominator in a measure is correct.
  - It is one thing to count how many patients were screened/not screened for cancer (numerator); it is another to count how many were supposed to be screened based on eligibility criteria (denominator).
- Biggest challenge to **data integrity**: invalid and/or inaccurate data entry by end-users
  - For our BI team, end-users include every staff person who enters any kind of data into the electronic health record and other HIT systems, such as billing and coding. That is, data integrity involves everyone with access to these records.

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# Questions?

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# Role of Population Health Management


## Tierney Giannotti, MPA, Senior Program Manager for Population Health

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# Defining Population Health

- Kindig and Stoddart's definition (2003) **"the health outcomes of a group of individuals, including the distribution of such outcomes within the group."**[1]
  - Focuses on populations **"within specific geopolitical area"** and goes beyond their clinical health to include **"social, economic, environmental, and individual behavioral and genetic traits."**
- CDC: Population health brings significant health concerns into focus and addresses ways that resources can be allocated to overcome the problems that drive poor health conditions in the population[2]


Sources:

1. Kindig D, Stoddart G. What is population health? American Journal of Public Health 2003 Mar;93(3):380-3.
2. Center for Disease Control and Prevention. What is Population Health? https://www.cdc.gov/pophealthtraining/whatis.html

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# Population Health Management

- It is not a department or job description.
- It is the combined efforts and use of data, systems, and processes that occur across several levels of functioning within a health center
  - ***Everyone*** contributes to population health, beginning with individual patient encounters using a team-based approach to care, and extending out to value-based contracts with external agencies.
- Tools and Strategies: (1) Identifying Gaps in Care, (2) Closing Care Gaps & Patient Outreach, (3) Risk Stratification, and (4) Feedback loops/reporting

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# Clinical Dashboard: Identifying Gaps in Care

| Patient | PCP and Visit Info |
|---|---|
| Sex: F<br>Age: | Next Medical Appointment:<br>Last Dental Visit:<br>Location<br>SiteName:<br>Reason for Visit:<br>*MED PCP Recall. routine- LO |

| ALERTS | Last Date | Due Date | Value | Notes |
|---|---|---|---|---|
| *** DM HbA1C - Needs in person Visit | 4/20/2022 | 7/20/2022 | 10.1 | |
| *** Body Mass Index | 9/16/2022 | | 36.54 | Needs Diet and Exercise Education regardless of BMI |
| *** Depression Screening | | | | |
| Needs Flu Vaccine 2022-2023 | | | | |
| DM Foot Exam | 10/4/20 | | | |
| Micro Albumin | 3/24/202 | | | |
| SBIRT | 4/27/202 | | | |
| Annual Chronic Pain Screening | 3/10/202 | | | |
| Covid Vaccine, Booster | 6/18/202 | | | |
| ACES Screening | Never Done | | | |
| Needs SMG | Never Done | | | |
| HARK | Never Done | | | |

| Bubbles | # |
|---|---|
| TE | |
| RX | |
| Doc | |
| Lab | 1 |

- Key piece of population health management are clinical dashboards, specifically the **Planned Care Dashboard** which is the engine driving all visits in primary care at CHC.
- MA does the pre-visit planning by reviewing the dashboard to identify what preventive services a patient is due to receive.

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# Job Tools to Support Care Gap Closure

- More than 40 care gaps on the Planned Care Dashboard
- Provides instructions on the process and who is responsible for each segment of the process
- Dashboards are not useful if there are no clear workflows in place for how to provide the care that the dashboard flags as needed.

| PCD Item | Patient Population | How Often | What MA/LPN Does (or other clinical staff) |
|---|---|---|---|
| ***DM HbA1c<br><br>(turns orange when it has been ordered >30 days ago) | Patients with diabetes age 18 or older | Varies based on last result:<br>1) Last A1c >=7.1% visit every 3 months<br>2) Last A1c <=7.0% every 6 months | • Order a lab called "Hemoglobin A1c" or "Hemoglobin A1c In House" or "Hemoglobin A1c with calculation" [MA]<br>• Quest results: automatically attached and checked as received<br>• Identify A1c results from outside providers (e.g., endocrinology) and create an "A1c Outside" order and attach results. Click "Received" and send to provider to review. [MA]<br>• In House results: will appear in "L" bubble (Labs) and need to be checked "Received" as well as to have a number in the value tab and a collection date noted [MA]<br>• Click "Reviewed" [Prov] |

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# Beyond the Dashboards: Closing Care Gaps & Patient Outreach

- Population health extends beyond the primary health care teams.
- Three primary ways to close care gaps at CHCI
  1. **Close care gaps in real time** when the opportunity arises (i.e. when a patient is seen for an acute visit, order the HbA1c that is due)
  2. **Identify patients** for whom the care gap has been addressed, but for whom we do not have a record indicating it was addressed (i.e. receive care elsewhere, go to at outside lab or radiologist for screenings and tests)
  3. **Reach out to patient** by text or phone to schedule a visit or remind them of one so that they get the care they need to receive.

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# Discussion Question

## How do you close your care gaps at your health center?

## Who does it?

*Please type your answer in the chat or unmute.*

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# Lessons Learned for Clinical Dashboards

- Conduct chart reviews and site visits to learn from the clinical team what is and what is not working.
- Consider all of the various ways staff learn:
  - Email written instructions
  - Screenshots of the process
  - Video of the rationale for addressing the care gap and the process for completing it

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# Risk Stratification and Strategies to Mitigate Risk

- In Connecticut, the HUSKY Medicaid PCMH+ program uses the Johns Hopkins Adjusted Clinical Groups (ACG) System to assign risk scores to patients, which are in turn available to providers who care for those patients
  - Use risk score for integrated care meetings
  - Provide that information to call center staff

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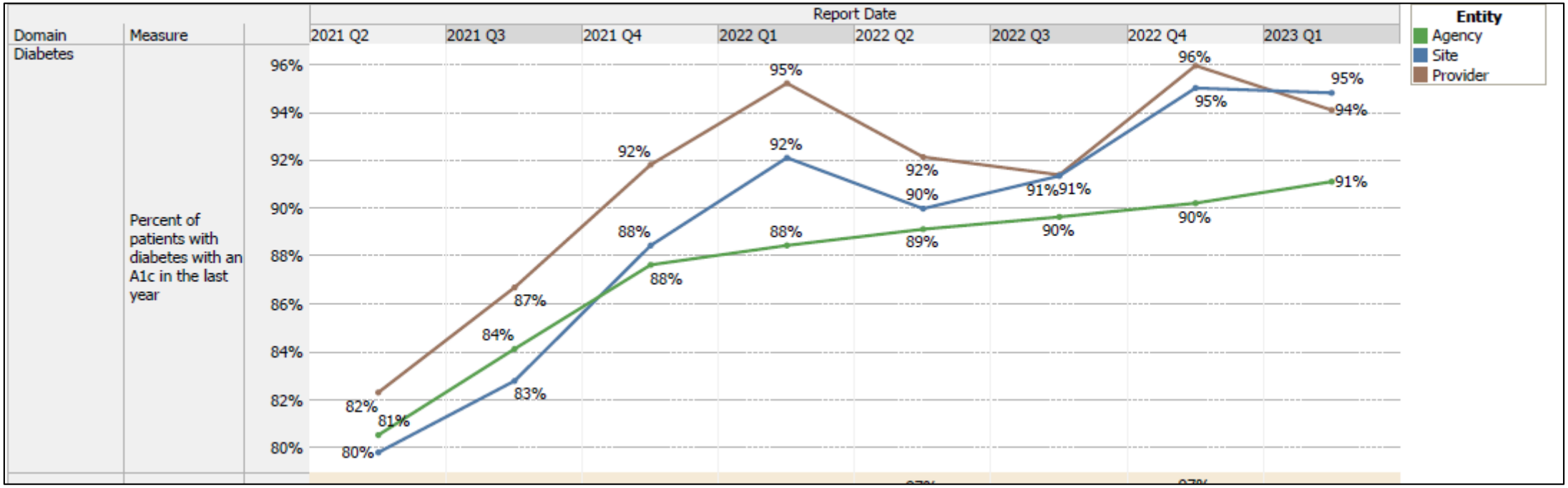
# Quarterly Chronic Disease Management Report

- Reports sent to care team (MA, Nurse and Provider) quarterly and compares rates of key measures to their own site and agency-wide.



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# Polling Question

## Is your health center engaged with value-based contracts?

(Yes/No/Unsure)

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# Defining Value-Based Care

- Value-based care is a healthcare **delivery model** in which providers, including physicians and hospitals, are **paid based on patient care outcomes.**
- Under **value-based care agreements**, providers are **rewarded** for helping patients **improve their health**, **reduce the effects** and **incidence of chronic disease**, and **live healthier lives** in an evidence-based way.
- The **"value"** in value-based care is **derived from measuring health outcomes against the cost of delivering the outcomes.** The **value extends to all—patients, providers, payers, suppliers, and society** as a whole.
- https://catalyst.nejm.org/what-is-value-based-care

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# Value-Based Contracts

- Give careful consideration to the requirements of the payor
  - Quality Measures; Hierarchical Condition Categories
  - Timelines
  - Portals; Data Accuracy
- Philosophy for your agency that is well articulated and understood:
  - Crosswalk metrics so that internal clinical expectations are understood in the context of value based metrics
- Benefits: Additional data about your patients you may not have – can enhance quantitative knowledge about patients; Supports targeted investments to achieve optimal health outcomes
- Pitfalls: Takes considerable work and dedicated staff to make it effective and worth time and effort

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# Examples of Elements of Value-Based Contracts

- Incentive to implement certain visit types (i.e. Annual Wellness Visits, Transition Care Management)
- Per member per month payment
- Lump sum for financial savings
- Bonus payment for each care gap you close

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# Questions?

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Access for All Colorado

# Meaningful Integration of HIT for Team-Based Care

Taylor Miranda Thompson
Senior Quality Initiatives Manager
Colorado Community Health Network
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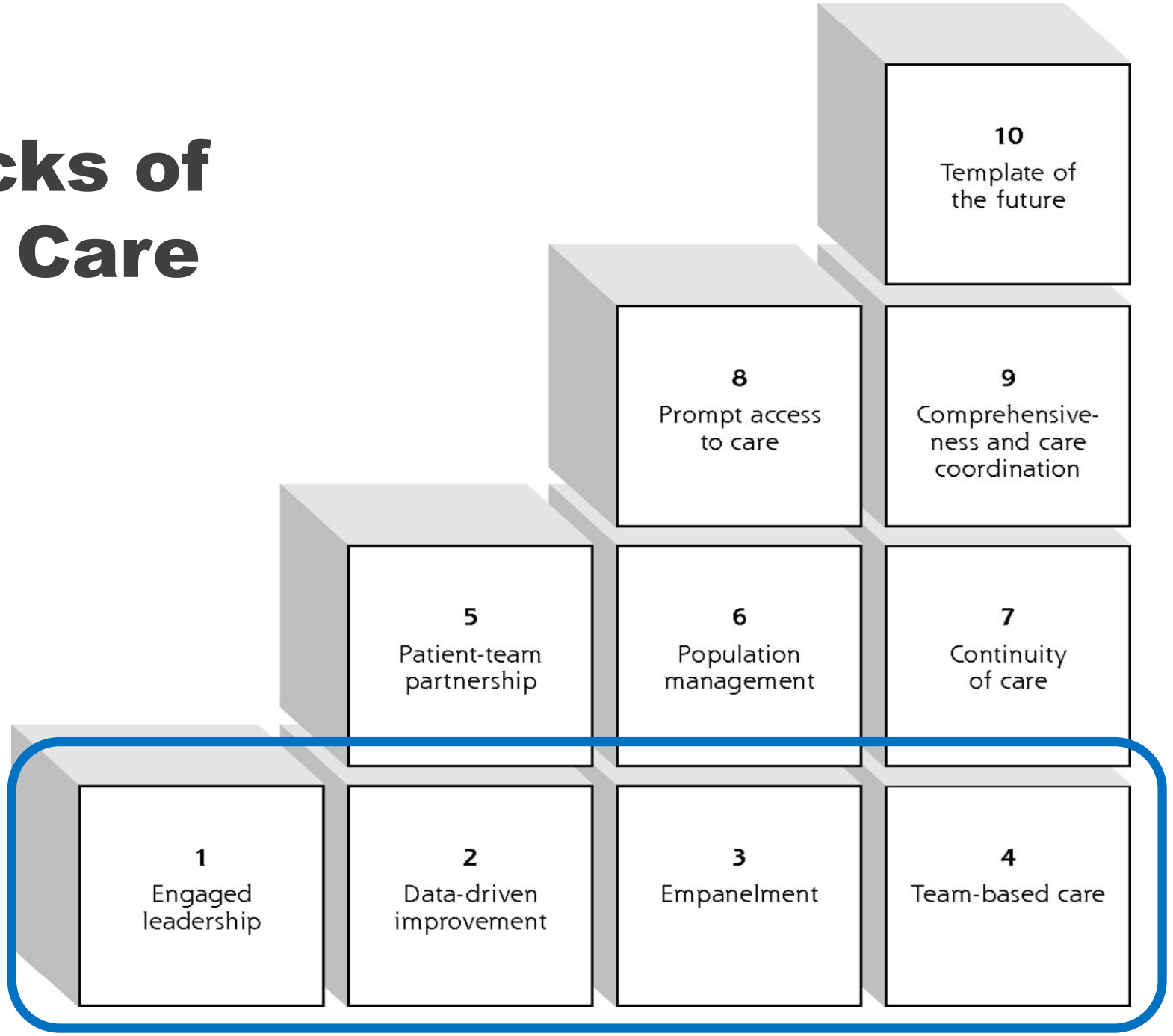
# Building Blocks of Team-Based Care



# Empanelment

- Process of assigning a portion of the practice's patients to a provider/care team
- Care team assumes responsibility for coordinating and providing all primary care services for their panel of patients

# Team-based Roles & Responsibilities

- Use of BI/HIT is not just an IT function
- Establish clear responsibilities by role and ensure training

| Role | Action |
| --- | --- |
| Front Desk | Each Monday, run outreach registries for patients<br>• If patient has alerts due next week: Outreach to schedule<br>• If patient has appt scheduled: Do not contact, indicate in “Reason for Appt” that patient has chronic disease, preventive care, and/or OB alerts due<br>• If patient needs information about prep for visit (e.g. fasting for labs), contact patient with instructions<br>• Document all contact attempts within the TE template in NextGen with your initials |

# Team-Based Roles & Responsibilities and HIT

- Who needs to access the data?
- In what form?
  - Different reports or uses of reports for different roles/functions (e.g., CCM vs. Pre-visit planning)

# A Morning in the Life of a Primary Care Clinic

| Time | What's Happening? |
|---|---|
| 3:00 PM (day before) | Pre-visit planning: Review of registries or chart scrubbing tools to plan next day's huddle, obtain outstanding labs or referral notes |
| 7:45 AM | Daily Huddle: Brief team check-in to review patients on the schedule, walk-in slots, anticipate equipment or staffing needs, obtain necessary records |
| 8:15 AM | MA - First patient roomed: Intake, select appropriate template, documentation of vital signs, screenings, pending "standing order" items |
| 8:15 AM | Front Desk- Receives a call from a new patient that would like to schedule with a provider that is accepting new patients |
| 8:35 AM | Care coordinator - Managing and placing referral to specialist |
| 9:00 AM | Nurse - Reviewing lab report and calling patients with results; follow up protocols |

# A Morning in the Life of a Primary Care Clinic

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| 8:15 AM | Front Desk- Receives a call from a new patient that would like to schedule with a provider that is accepting new patients (empanelment report/ understanding of open/closed panels) |
| 8:35 AM | Care coordinator - Managing and placing referral to specialist |
| 9:00 AM | Nurse - Reviewing lab report and calling patients with results; follow up protocols |

# Example Report: Using HIT to Drive TBC

**5:08 AM** Thursday, November 17, 2022 — Visit Reason: **Injury Departure**

**Keanu, Marvis**
**MRN:** 7142415
**DOB:** 6/4/1969 (53)

**Sex at Birth:** M
**GI:** Transgender Female/ Male-to-Female
**SO:** Lesbian or gay

**Phone:** 774-396-6711
**Lang:** Arabic
**Risk:** Low (29)

**Portal Access:** 12/26/2020
**Cohorts:** DM No A1c No LDL, November Diabetes

**PCP:** Doe, Jane
**Payer:**
**CM:** Tom Parace

**DIAGNOSES (10)**

| | | |
|---|---|---|
| ASCVD | Asthma | CAD |
| Cancer | COPD | Depression |
| DM | Hepatitis C | HIV |
| IVD | | |

**RISK FACTORS (4)**

| | | |
|---|---|---|
| ANTICOAG | Chronic Opioid Tx | IDD |
| SMI | | |

**SDOH (8)**

| | | |
|---|---|---|
| EMPLOYMENT | LANGUAGE | MATERIAL |
| MIGRANT | RACE | SAFETY |
| SECURITY | STRESS | |

**RAF GAPS DIAGNOSIS CATEGORIES (0)**

| ALERT | MESSAGE | MOST RECENT DATE | MOST RECENT RESULT |
|---|---|---|---|
| A1c | Missing | | |
| LDL | Missing | | |
| Tobacco Scr | Missing | | |
| BP | Out of Range | 5/16/2022 | 101/95 |
| Foot | Missing | | |
| I/P Encounter | Occurred | 8/14/2022 | |

| OPEN REFERRAL W/O RESULT | SPECIALIST/LOCATION | ORDERED DATE | APPT. DATE |
|---|---|---|---|
| Open | Samantha Frost / Brighton | 12/15/2022 | |
| Gastroenterology | John Smith / Brookline | 5/16/2022 | 5/17/2022 |
| Gastroenterology | Ellen Bell / Boston | 5/16/2022 | 6/12/2022 |
| Gastroenterology | Samantha Frost / Brighton | 5/16/2022 | 5/31/2022 |

Source: Fictional patient from
https://www.azarahealthcare.com/blog/the-azara-effect

# Example: Pre-Visit Planning Process using Azara DRVS Report

- https://vimeo.com/227406460

# Using HIT to Support Top of Scope Work

- Note: “Top of Scope” might differ by scope of practice guidelines in your state
- Consider how **infrastructure** supports top of scope

- Huddles – Access to reports; time within schedule for nursing staff and other team members to review reports, prepare

- Standing orders – Facilitates trust and confidence that non-licensed staff are working according to guidelines, not having to guess when an action is appropriate
  - Simple – A1c, FIT test
  - Complex – Nursing labs and review with protocols and provider review in place
    - UTI, STI, Strep Culture

- Sharing the care – What constraints are placed that could be opened up to share the division of work among team members?
  - E.g., Telephone Encounters

# How to get started

- Choose one day on the calendar (could be tomorrow, next week) as a reflection day
- Consider the “bottlenecks” in your day
- What is one process you could improve?
  - How does HIT support this process?
  - What might need to change in order to improve it?
  - Is it possible to test this change on a small scale?
  - How would you know whether the test is successful?

# Questions?

Thank you!

Taylor Miranda Thompson, CCHN

tmiranda@cchn.org

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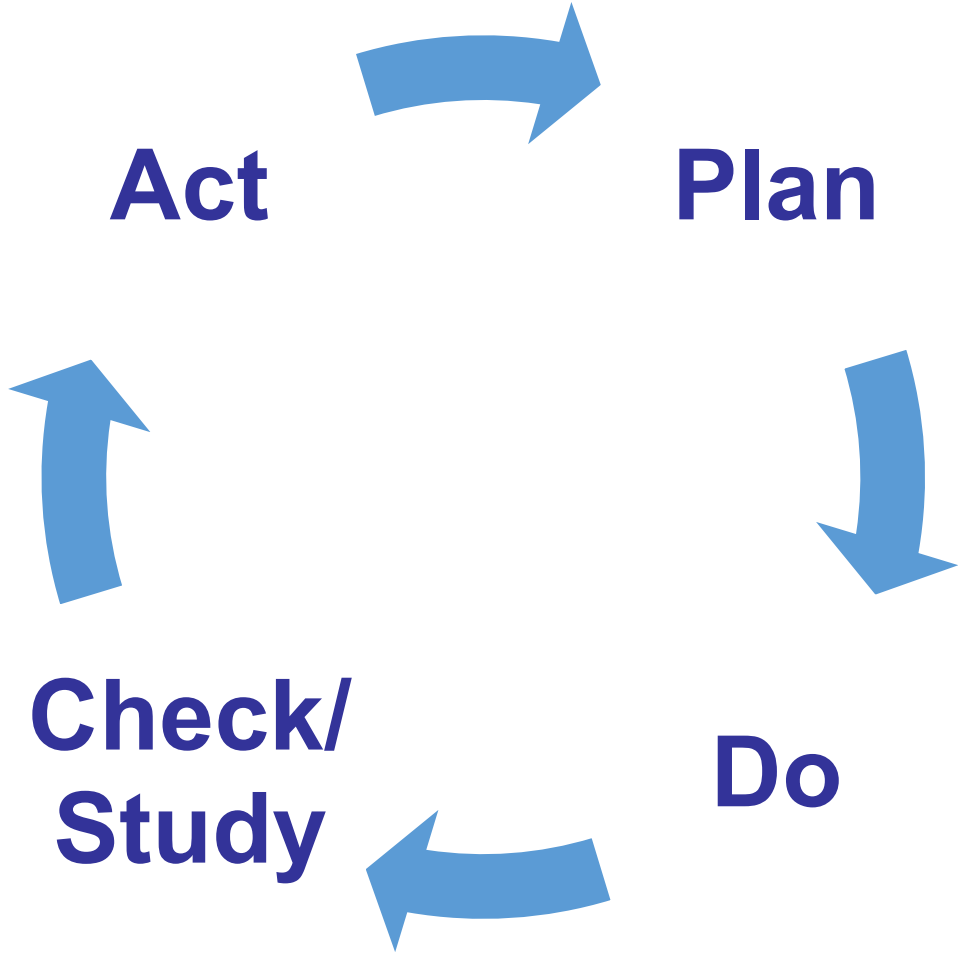
# Quality Improvement Refresh:

## Developing & Using PDSAs



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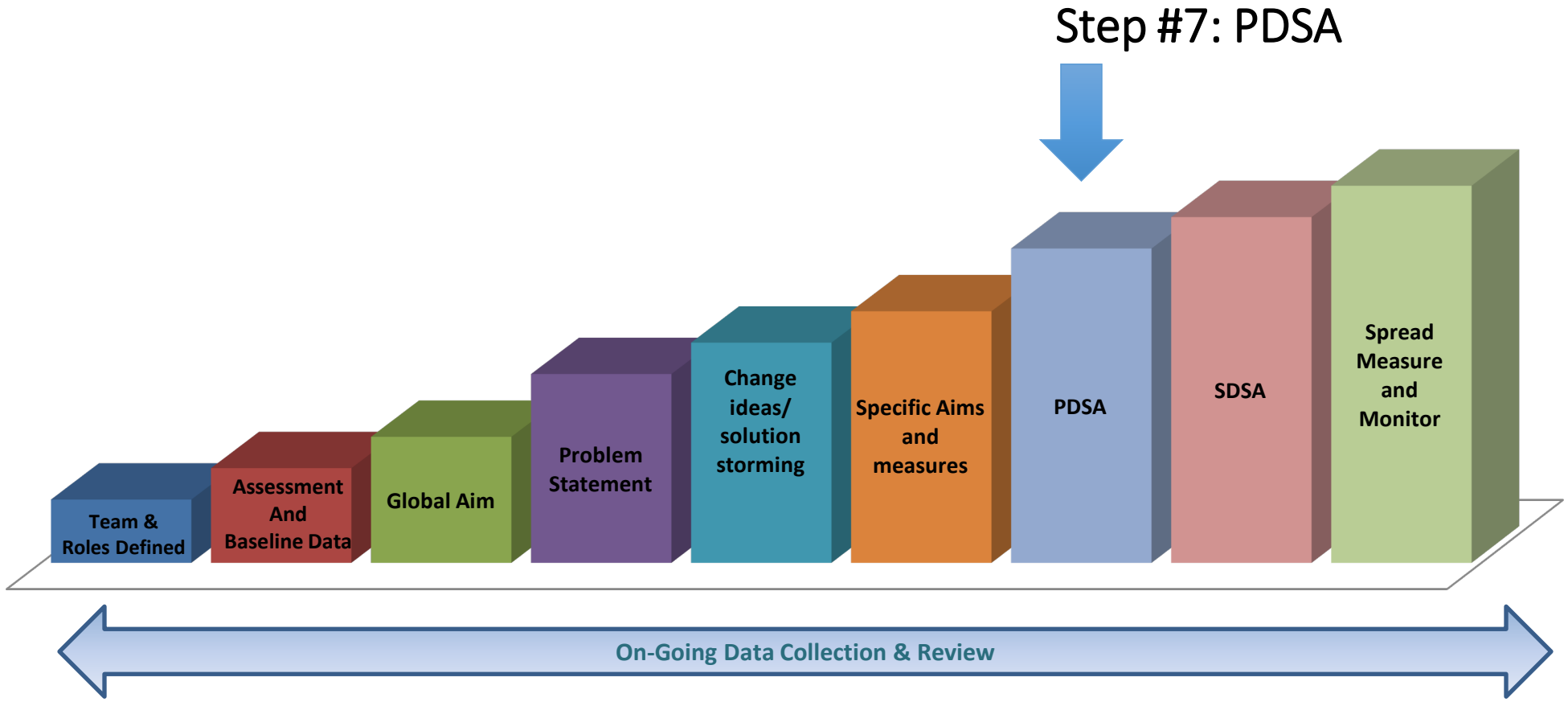
# The Stages of Improvement



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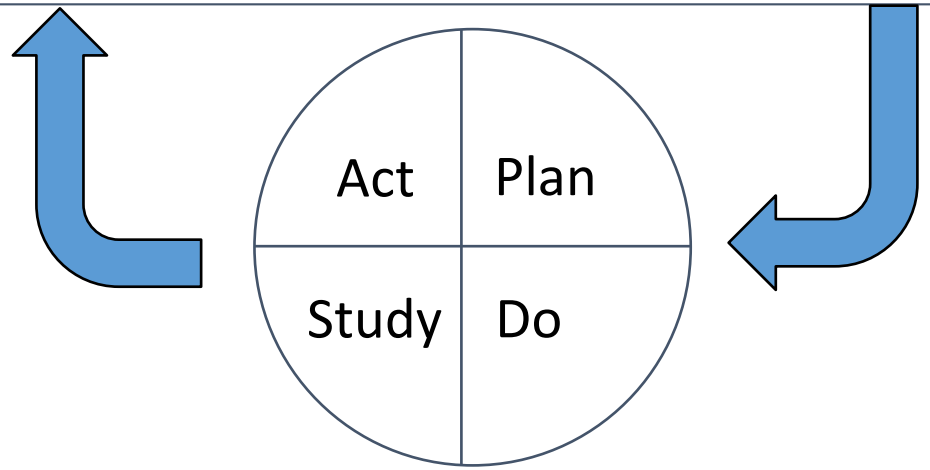
# Model for Improvement

- What are we trying to accomplish? (Aim)
- How will we know that a change is an improvement? (Measures)
- What change can we make that will result in improvement? (Solution/Change)




*Three questions...*

*...coupled with an approach for testing change.*

*Langley GJ, et. al. The Improvement Guide (2nd Edition), 2009.*

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# PDSA Worksheet for Testing Change

| | |
|---|---|
| **Date:** | |
| **Team Members:** | |
| **Pre-Planning Tools To Consider: (circle)** | Stakeholder Analysis, Communication Plan, Communication Matrix, Influencing Strategy, Facilitated Site/Dept. Meeting |

**Aim:** (overall goal you wish to achieve)

*Every goal will require multiple smaller tests of change*

| Describe your first (or next) test of change: | Person Responsible | When to be Done | Where to be Done |
|---|---|---|---|
| | | | |

## *Plan*

| List the tasks needed to set up this test of change | Person Responsible | When to be Done (Dates & Timeframe) | Where to be Done (Site Location, Where at the site, Pod, etc.) |
|---|---|---|---|
| | | | |

| Predict what will happen when the test is carried out | Measures to determine if prediction succeeds | Person (s) Responsible for Collection of Data |
|---|---|---|
| | | |

***Do*** **Describe what actually happened when you ran the test**

***Study*** **Describe the measured results and how they compared to the predictions**

***Act*** **Describe what modifications to the plan will be made for the next cycle from what you learned**

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# PLAN: Comes from Specific Aim Statement

- **WHAT** are we striving to accomplish?
- **WHAT** will we do?
- **WHEN** will this occur (what is the timeline)?
- **HOW MUCH?** What is the specific, numeric improvement we wish to achieve?
- **FOR WHOM?** Who is the target population?

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# DO

- Implement the improvement
- Collect and document the data
- Document the problems, unexpected observations, lessons learned, and knowledge gained

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# STUDY

- Analyze the results:
  Was an improvement achieved?
- Document lessons learned, knowledge gained, and any surprising results that emerged.

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# ACT

**Take action:**

- ✓ *Adopt* - standardize
- ✓ *Adapt* – change and repeat
- ✓ *Abandon* – start over

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inspiring primary care innovation

## PDSA Worksheet for Testing Change

| | |
|---|---|
| **Date:** | March 22, 2020 |
| **Team Members:** | Raneda, husband, and children |

### Aim:

Global: We aim to improve the process of sorting and discarding of various forms of paper in the house. The process begins with any form of paper brought into the house and ends with the disposal or filing of papers. By working on the process, we expect to reduce the amount of paper clutter, make essential papers more accessible, and create more organization throughout the house.
Specific: We will decrease the amount of mail left on the counters from 15 pieces of mail a week to less than three pieces of mail a week.

*Every goal will require multiple smaller tests of change*

| **Describe your first (or next) test of change: 1B** | **Person Responsible** | **When to be Done** | **Where to be Done** |
|---|---|---|---|
| All mail will be addressed through sorting, disposal, and filing on a daily basis by:<br>1. Throwing out all enveloped mail addressed to "current resident" and<br>2. Sorting, disposal, and filing of remaining junk mail and bills. | <br><br>Children<br><br>Raneda | <br><br>Daily<br><br>Daily | <br><br>Kitchen<br><br>Kitchen counter |

### ***Plan***

| **List the tasks needed to set up this test of change** | **Person Responsible** | **When to be Done** (Dates & Timeframe) | **Where to be Done** (Site Location, Where at the site, Pod, etc.) |
|---|---|---|---|
| 1. Educate children on what mail they can throw away is and looks like as well as where to place sorted mail. | Raneda | 3/23/20 | Kitchen |
| 2. Prioritize what remaining mail will be addressed and shredded, addressed and filed, and just thrown away. | Raneda and Husband | 3/23/20 | Kitchen |
| 3. Identify where any sorted mail that is not opened or addressed is placed. | Raneda and Husband | 3/23/20 | Kitchen |

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| Predict what will happen when the test is carried out | Measures to determine if prediction succeeds | Person (s) Responsible for Collection of Data |
|---|---|---|
| As junk mail is discarded immediately and other mail is sorted and addressed more frequently, less clutter will exist. | Tally of amount of mail left on counters daily. | Raneda |


***Do*** **Describe what actually happened when you ran the test**

On 3/23/20, I educated the kids to identify enveloped mail by looking for whether it says "current resident" or says one of parent's name with "or current resident." I also educated the kids to leave only parents sorted mail on counters. Sister's mail is to be placed on her desk in her room daily. The kids were asked to get mail from mailbox and have it sorted by 3pm daily. I used the current mail for the day to demonstrate for the kids. When I finished sorting the mail, I opened all of remaining junk mail, my mail, and household bills at kitchen counter. I made a pile of those to be shred, file, and follow-up such as medical/tax bills. I also made a pile of all of my husband's personal bills (ie, credit card) and placed them on his office desk unopened. I then shredded the shred pile, filed away the file pile in storage file bins and placed follow-up mail on my nightstand. The process ran smoothly every day with the children completing the initial pick up of mail, discarding catalogs, advertisements, and "current resident" enveloped and un-enveloped mail.

***Study*** **Describe the measured results and how they compared to the predictions**

By Sunday, there was no paper clutter in the kitchen. There was a stack of mail (8) in my husband's office and 5 pieces of mail for follow up on my nightstand. In addition, I had to file documents away every day. These results align with the predictions in that all mail was addressed creating no clutter in kitchen, but this could result in just a movement of where clutter exists if the mail on nightstand and in my husband's office is not addressed appropriately. In addition, a better way of maintaining files (ie, electronically) may also be beneficial to prevent so many papers being filed in storage file bins.

***Act*** **Describe what modifications to the plan will be made for the next cycle from what you learned**

For the next cycle, a clear systematic way to address the follow up pile with time frames for how long before follow up pile needs to be addressed, how will be addressed, and then how discarded, stored, or disposed of. In addition, the data collection form is too broad in determining types of paper/received. In the future, the data should also include break down of type of mail received daily (ie, junk mail, school papers, mom mail, dad mail, sister mail, and household bills).

# PDSA Example

## PDSA Worksheet for Testing Change

| | |
|---|---|
| **Date:** | 10.16.18 |
| **Team Members:** | Jeremiah Walsh, Kim Tozzi, Julie Yoskowitz, Kellie Vansaghi, Veronica Smith |
| **Pre-Planning Tools To Consider: (circle)** | Stakeholder Analysis, Communication Plan, Communication Matrix, Influencing Strategy, Facilitated Site/Dept. Meeting |

**Aim:** Increase the number of emergency department discharge summaries available to the provider at the time of the patient's visit

***Every goal will require multiple smaller tests of change***

| Describe your first (or next) test of change: | Person Responsible | When to be Done | Where to be Done |
|---|---|---|---|
| Obtain data on the percentage of ER discharge summaries in the chart to determine how good/bad the current process is | Veronica, PSC and Kellie, LPN | Daily | OHI Stafford |

### Plan

| List the tasks needed to set up this test of change | Person Responsible | When to be Done (Dates & Timeframe) | Where to be Done (Site Location, Where at the site, Pod, etc.) |
|---|---|---|---|
| Keep paper log of patients with appointments for ER follow up visits and whether their chart was prepped or not | Kellie, LPN | Daily log and report in weekly to obtain baseline data | OHI Stafford, Family Medicine Department Provider |

| Predict what will happen when the test is carried out | Measures to determine if prediction succeeds | Person (s) Responsible for Collection of Data |
|---|---|---|
| Depending on how busy the day is, we do not think a completed log will be turned in daily. The data provided will be more than we have now, but not comprehensive. | Tracking the number of logs turned in to determine an accurate baseline rate | Jeremiah and Kim to obtain data from the site |

**DO** **The PSC was moved to a different site and the log was not completed every day. Upon requesting the logs on 10/30/18, we were advised that daily flow was being documented in the site notes and based off those notes, no charts were prepped with any ER documentation.**

**STUDY** **The outcome of this PDSA gave us the same information that we had going in. We were given verbal confirmations based on observation that charts are not being prepped with ER discharge summaries, but no data is available with: the number of charts that should have been prepped, which hospitals the patient was discharged from, did the patient tell us before they came in that they were following up from the hospital, etc.**

**ACT** **We need to follow up with the LPN on a daily basis to ensure the log is being completed. We will request that this be discussed during the morning huddle so everyone can participate in completing the log.**

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# SUSTAIN

Once you've adopted:

- **Monitor** – reports, dashboards, quarterly meetings
- **Maintain** – who is the owner, process for looking into measures when they fall below?
- **Check-In** – conversations, connections, accountability, transparency, trust
- **Develop a playbook** – a recipe to perform the new process, training tool

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
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# Questions?

# Action Period 5 Deliverables

- Conduct your weekly team meetings
- **Assignment:** Develop PDSA

Google Drive

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

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# Reminders

## Coach Calls:

- Wednesday April 10th 1:00pm ET / 10:00am PT
- Wednesday April 17th 1:00pm ET / 10:00am PT
- Wednesday April 24th 1:00pm ET / 10:00am PT
- Wednesday May 1st 1:00pm ET / 10:00am PT

**Session 6:** Wednesday May 8th 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!

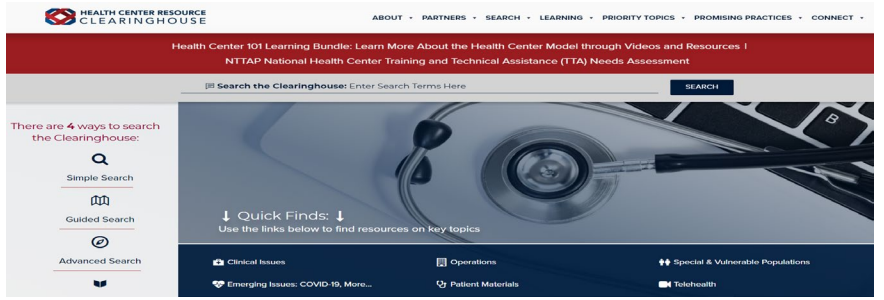
Next Learning Session is **Wednesday May 8th!**

# Explore more resources!

## National Learning Library:
### Resources for Clinical Workforce Development


https://www.weitzmaninstitute.org/ncaresources

## Health Center Resource Clearinghouse




https://www.healthcenterinfo.org/