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Developing Quality Improvement Strategies in Team-Based Care Activity Session

Thursday, April 25th 2024

1:00-2:00pm Eastern / 10:00am-11:00am Pacific

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At the Weitzman Institute, we value a culture of equity, inclusiveness, diversity, and mutually respectful dialogue. We want to ensure that all feel welcome. If there is anything said in our program that makes you feel uncomfortable, please let us know via email at nca@chc1.com

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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

Speakers

- **Deborah Ward, RN,** Consultant, Community Health Center, Inc.,
- **Elise George, MPH,** Consultant, JSI Research & Training, Health Information Technology, Evaluation, and Quality Center (HITEQ)

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Objectives

- Understand QI principles
- Discuss the importance of actionable data
- Apply data analysis techniques to improve healthcare practices
- Enhance meeting facilitation skills for effective QI-focused meetings
- Review global aim statement using UDS data

What is Quality Improvement?

"Quality improvement (QI) consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups."[1] - HRSA

To do this, teams need actionable data.

"Every system is perfectly designed to get the results it gets."[2]

–Paul Batalden, MD

1. US Department of Health and Human Services, Health Resources and Services Administration. Quality improvement. 2011. https://www.hrsa.gov/sites/default/files/quality/toolbox/508pdfs/qualityimprovement.pdf. Accessed March 21, 2022.
2. Nelson, E. C., Batalden, P. B., & Godfrey, M. M. (Eds.). (2011). *Quality by design: a clinical microsystems approach*. John Wiley & Sons.

Common Models that Require Special Training

Six Sigma/DMAIC

Lean/Six Sigma

1. https://www.qualitymag.com/articles/94429-back-to-basics-six-sigma
2. https://www.greycampus.com/blog/quality-management/a-brief-introduction-to-lean-and-six-sigma-and-lean-six-sigma

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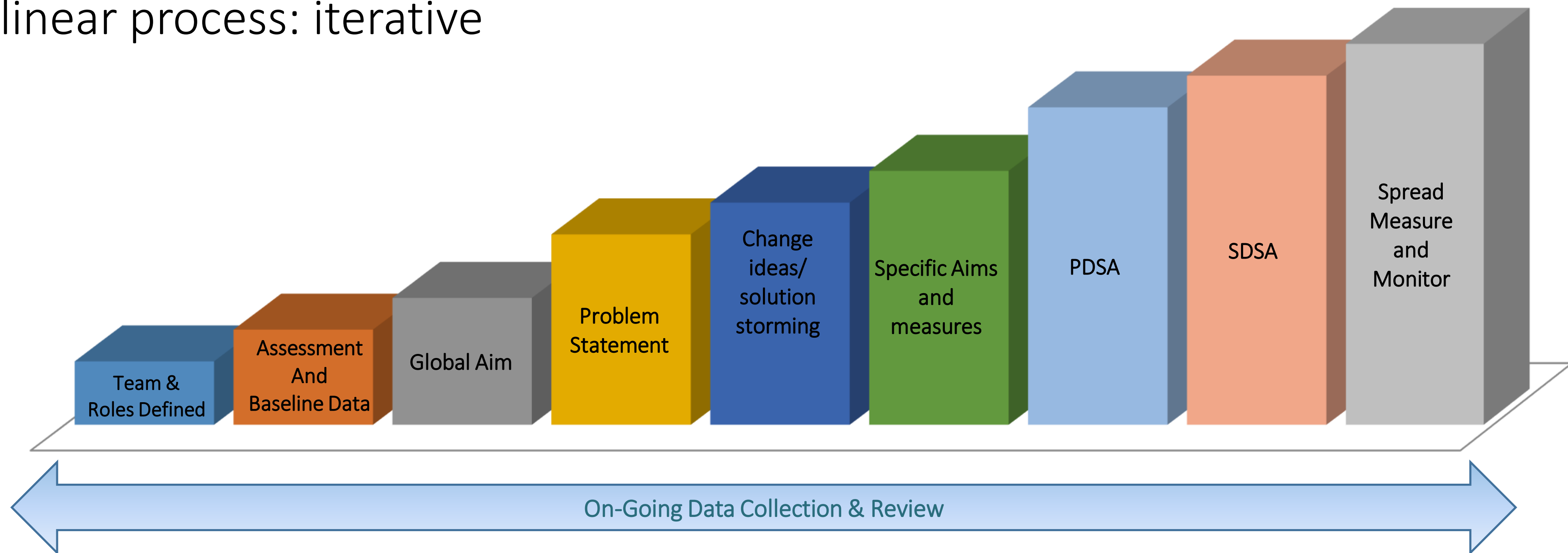
CHC's Stages of Improvement

These stages overlap with and are an adaptation of several models, e.g., the IHI model (PDSA) and DMAIC (Define/Measure/Analyze/Improve).

Not a linear process: iterative



Source: Thies, K., Schiessl, A., Khalid, N., Hess, A. M., Harding, K., & Ward, D. (2020). Evaluation of a learning collaborative to advance team-based care in Federally Qualified Health Centers. *BMJ Open Quality*, *9*(3), e000794.

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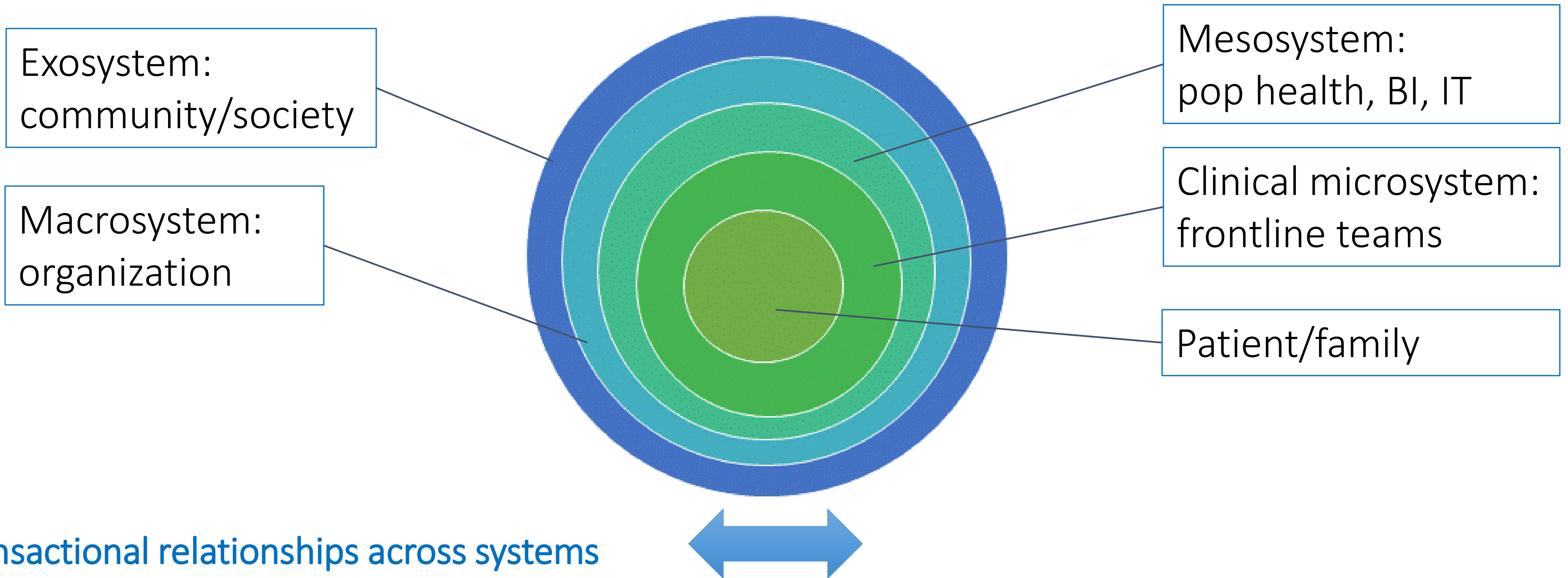
Systems Approach in Health Care



Based on Nelson, E. C., Batalden, P. B., & Godfrey, M. M. (Eds.) (2011). *Quality by design: a clinical microsystems approach*. John Wiley & Sons.

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Clinical Microsystems approach to QI

- A clinical microsystem in health care is "*a small group of people who work together on a regular basis to provide care to discrete subpopulations of patients. It has clinical and business aims, linked processes, and a shared information environment, and it produces performance outcomes*."
- Built on the premise that the people who do the work know how the work can be improved.
- QI is not a department.

Source: Nelson, E. C., Batalden, P. B., & Godfrey, M. M. (Eds.) (2011). Quality by design: a clinical microsystems approach. John Wiley & Sons.

Introduction to HITEQ

The HITEQ Center is a HRSA-funded National Training and Technical Assistance Partner (NTTAPs) that collaborates with HRSA partners including Health Center Controlled Networks, Primary Care Associations and other NTTAPs to engage health centers in the optimization of health IT to address key health center needs through:

- A **national website** with health center-focused resources, toolkits, training, and a calendar or related events.
- **Learning collaboratives**, **remote trainings**, and **on-demand technical assistance** on key content areas.

www.HITEQcenter.org | hiteqinfo@jsi.com | @HITEQcenter

HITEQ Topic Areas

Access to comprehensive care using health IT and telehealth

Privacy and security

Advancing interoperability

Electronic patient engagement

Readiness for value based care

Using health IT and telehealth to improve Clinical quality and Health equity

Using health IT or telehealth to address emerging issues: behavioral health, HIV prevention, and emergency preparedness

Assessing data alignment

Tying CQM specifications and EHR guidance to clinical practice through quality improvement efforts

Clinical Quality Measures

Quality measurement might be more accurately described as evaluating the ***documentation*** of patient care and whether ***that documentation*** aligns with measures that indicate high-value care.

Quality measures have **specifications**, which are the instructions on how to calculate a given measure. Specifications include the key elements of the measure - who falls into the numerator and denominator, and who may be excluded from a measure.

Clinical staff are providing care to patients and entering data related to those patients and their care into their EHR. Each EHR has guidance as to how and where data for quality measures should be **documented.**

Each health center has internal processes and mapping which need to align with both measure and EHR requirements**. Performance on clinical quality measures is determined by this alignment.**

To improve alignment, work is required across *many* levels: understanding quality reporting programs and requirements, understanding the elements of clinical quality measures, assessing data alignment, and addressing barriers by implementing QI approaches.

Why is data alignment important?

Performance

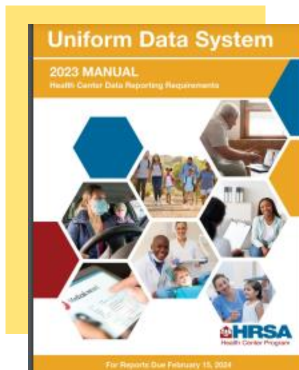
You won’t get “credit” for the measure, even if the particular service or care was provided, if the documentation doesn’t match the requirements.

Data exchange is changing

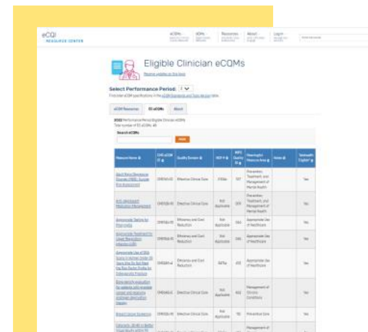
CQM data will be increasingly “automagically” being pulled from the back end of your system with the national trend towards reporting programs aligning with interoperability standards and reporting requirements (ex. dQMs and UDS+)

Your ability to interact with the data before it is reported, and catch any inconsistencies or errors, will be limited. This means that ensuring your workflows and care processes are aligned with measure specifications and EHR guidance is even more critical!

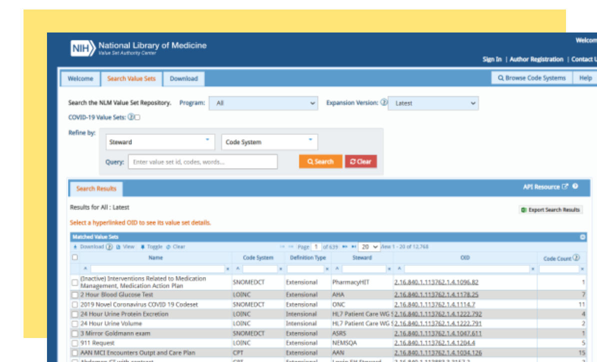
Measure Specifications



The UDS Manual published each year provides overview, UDS specific considerations, and links to measure specifications.



The manual links to the eCQI Resource Center, where measure information, specifications and data elements are found.



The eCQI Resource Specifications specify the data elements and their value sets. The codes that make up each value set are available from the Value Set Authority Center (VSAC) site.

Note: PCMH Standards & Guidelines, QRS Manual, and your MCO or ACO contract or HEDIS guidance would take the place of the UDS manual for those programs.

Clinical Quality Measures Specifications

What is Clinical Quality Language (CQL)?

CQL is a clinically focused, high-level query language that is used to define eCQMs. A significant feature of CQL are definitions or function statements that can be shared across and between measures and decision support rules. CQL is the guidance EHR vendors primarily use. This can be seen in the eCQI resource center.

What is a value set?

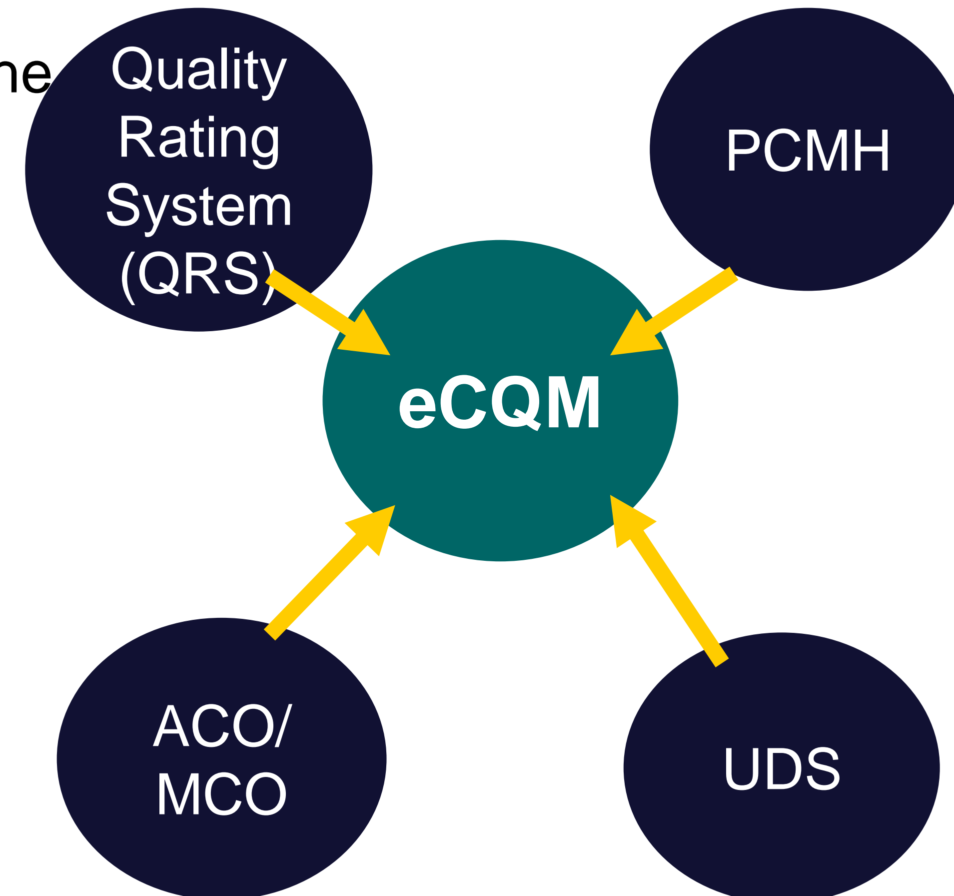
A value set is a list of specific values, terms, and their codes, such as ICD-10 and/or CPT codes, used to describe clinical and administrative concepts in eCQMs. The codes tied to each value set are accessed from the Value Set Authority Center (VSAC) site.

eCQMs as Common Denominator

Electronic Clinical Quality Measures (eCQMs)

Uses data electronically extracted from electronic EHRs and/or health information technology systems to measure the quality of healthcare provided by eligible clinicians and/or eligible professionals. eCQMs measure many aspects of patient care, including:

- Patient and Family Engagement
- Patient Safety
- Care Coordination
- Population/Public Health
- Efficient Use of Healthcare Resources
- Clinical Process/Effectiveness



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Resource:

Clinical Quality Measures for Eligible Professionals Crosswalk

The first column links to the measure specifications; and the row shows the quality programs that the measure is used in.

2023 Eligible Professional / Eligible Clinician eCQMs Program / Reporting Crosswalk

Measure Name	CMS ID	NQF ID (No Applicable = no longer endorsed)	CMS Quality ID (MIPS ID)	Telehealth Eligible	HRSA BPHC Uniform Data System (UDS) CY2023	Million Hearts	CMS Quality Payment Program (QPP) - APM Performance Pathway (APP) Measures	Medicare Shared Savings Program (MSSP)/ CMS ACO Shared Savings Program	CMS Core Set (Set Medicaid *HEDIS Spe
Electronic Clinical Quality Improvement (eCQI) Resource Center https://ecqi.healthit.gov/				https://ecqi.healthit.gov/sites/default/files/2023-EC-Telehealth-Guidance-v2.pdf	https://bphc.hrsa.gov/data-reporting/uds-training-and-technical-assistance	https://millionhearts.hhs.gov/files/MH_CQM.pdf	https://www.cms.gov/medicare/medicare-fee-for-service-payment/sharedsavingsprogram/program-guidance-and-specifications	https://www.cms.gov/medicare/medicare-fee-for-service-payment/sharedsavingsprogram/downloads/aco-shared-savings-program-quality-measures.pdf	https://www.medi dicaid/quali care/downloads/ core-set.
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	CMS2v12	Not Applicable	134	Yes	Yes		134	ACO-8	CDF-CI
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	CMS22v11	Not Applicable	317	No		A		ACO-21	
Closing the Referral Loop: Receipt of Specialist Report	CMS50v11	Not Applicable	374	Yes					

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Key Takeaway: Most measures are aligned with eCQMs, so understanding those is key to success with all clinical measures.

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How to Access Measure Specifications

eCQI resource center is a centralized location for news, information, tools, standards related to eCQMs. This is also where you can access measure specifications for all eCQMs. Access video instructions: https://vimeo.com/635520357

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Question: What can be done with these codes once you have downloaded them?

- Use for provider training
- Update or create favorites in the EHR
- For reviewing results/validating

EHR Requirements

- Each particular EHR has its own requirements as to where data needs to be captured to ‘count’.
- Always needs to be structured data, but also needs to be of the right *type* and in the right *place*.

EHR Requirements

Annual Changes

1. Each EHR generally puts out user guide or quality measure guidance annually (e.g., updated with updated eCM specifications and UDS manual). Each vendor makes this available on their intranet or community site.

Structured Data

2. All measure components require structured data. Most eCQMs look at orders (labs, diagnostic imaging, procedures, etc.) and/ or CPT codes. Need to have completed data (such as complete results, closed encounters with appropriate CPT codes, etc.)

Type and Location of Data

3. Each EHR has report mapping that pulls data from specific codes, types of data, and location of that data (such as in HPI, social history, etc.). Knowing the details of this is essential to ensuring accurate reports.

Optimizing EHR to align with CQM

Optimization is the process of refining EHR processes and programming to maximize the effectiveness of the tool in achieving optimal outcomes.

Internal Workflow + Mapping

- Assess what information is being captured, where, and how in the EHR.
- Assess consistency across providers, care team, and sites.

Assessing Data Alignment

Several approaches:

- Compare **results from the EHR, to whether all the component parts were found during the chart review.**
  - Are there cases where the EHR says the patient doesn't meet the measure, but the information was found in the chart review? **Dig in!**
- Compare **location, type, and codes associated with each component** to identify inconsistency. **Dig in to those inconsistencies!**

CQM Alignment Issues

NUMERATOR ISSUES

- Report not finding evidence of compliance in chart
- *Examples: Scanned lab results or results documented in text not ‘counting’, documentation of medication or screening not aligned with specs*

INITIAL POPULATION/ DENOMINATOR ISSUES

- Report not looking at the correct population of patients.
- *Examples: wrong time frame, missing exclusions, only including established patients, not documenting exclusions in the patient's chart*

CLINICAL SERVICE ISSUES

- Indicated service not being provided or outcome not being achieved
- *Examples: HbA1c is in fact 9.5%, patient has not received the required screening, etc.*

Why does type of issue matter?

Resources

Resources are limited, so targeting specific gaps is key for efficiency and best care.

Right Approach

Gaps in data vs. gaps in services or outcome issues require different approaches to address.

Credibility

Standardized measurement allows for an objective way to quantify strengths and identify opportunities for improvement.

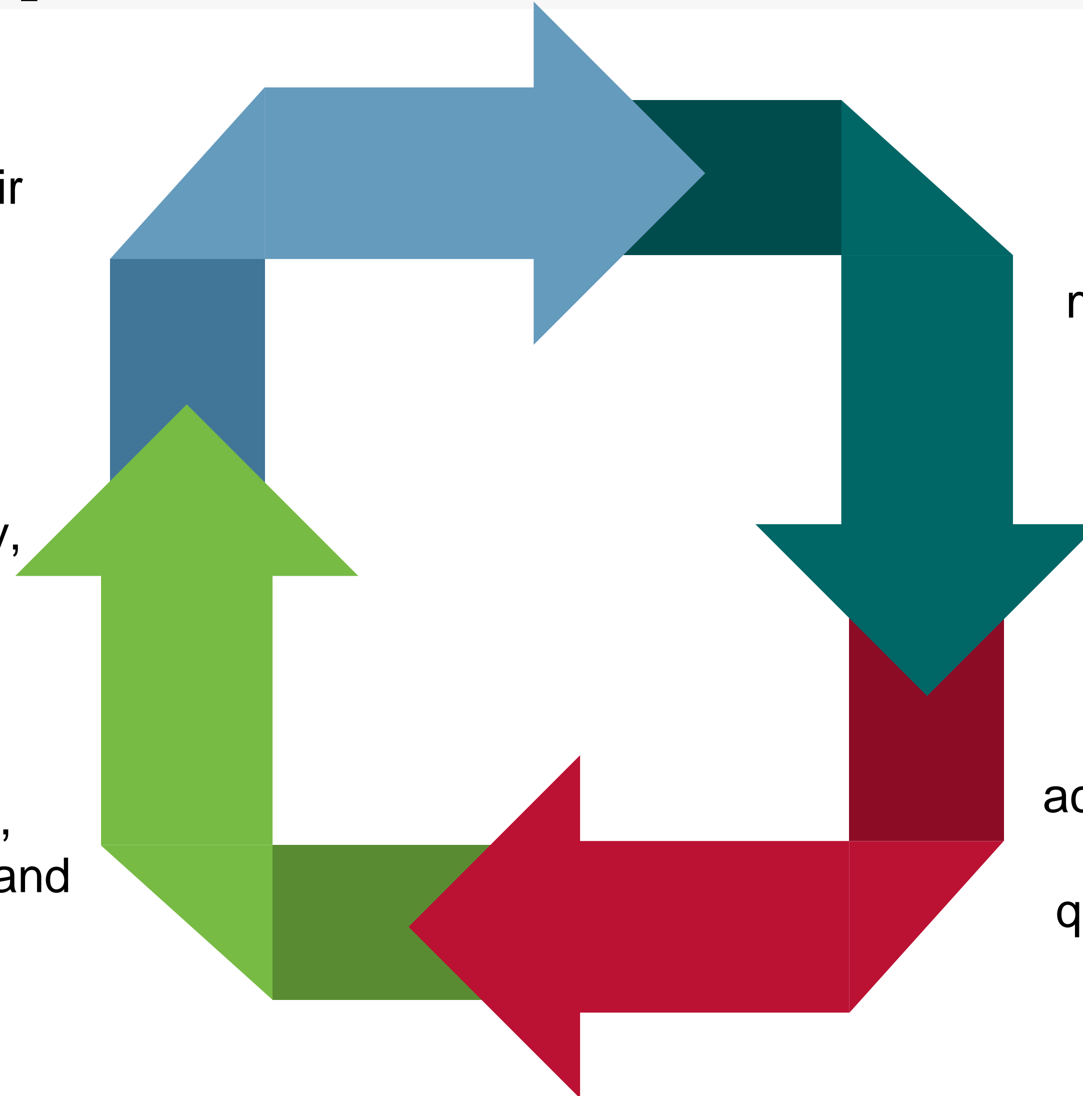
Change Fatigue

Change fatigue is real, particularly right now. Narrowing in on the nature of the issue ensures that efforts achieve desired results rather than just pile on more change.

What goes into optimizing alignment?

DATA

Generated by visits and their related services (labs, diagnostic imaging, procedures, medications, etc.); as well as data collection about patients (demographic, social history, screenings, etc.)



EHR

A *tool* to record and report health data in a structured manner; a digital record that stores comprehensive health information your patients.

REPORTING

Quickly and systematically access and review population-level outcomes across of quality, operational, and other metrics, by querying *data* in the *EHR,* based on standardized specifications.

OPTIMIZATION

Using *reporting* to identify issues with *data* in the EHR, and improving consistency and alignment to address those issues, to achieve optimal outcomes.

TOOL: Data Definition Worksheet

PERFORMANCE MEASURE DATA DEFINITION WORKSHEET

WHAT IS IT AND HOW CAN IT HELP ME?

ONC EHR Certification criteria means that vendors use eCQMs' (electronic Clinical Quality Measures') specifications to define measures. Therefore, reported data for a measure should be consistent regardless of vendor. In practice, however, it is important to confirm the vendor's logic is consistent with the health center's definition and workflows. This tool supports alignment of the health center's data definition with the vendor's reporting logic.

HOW TO USE THIS TOOL:

1. Review performance on all health center measures to prioritize measure(s) for further investigation. Consider measures for which health center performance is not consistent with provider expectation suggesting inconsistencies between where health center is documenting information and where vendor is pulling information for reporting.
2. In the ***Measure:*** box, write the measure that you intend to evaluate (i.e. hypertension control, diabetes control, colorectal cancer screening, etc.). Reference the eCQI Resource Center address for the eCQM in ***ecQI Reference:*** box.
3. Go to ecQI Resource Center at: https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms/2018-performance-period-epec-ecqms.
4. Select measure from list in eCQI Resource Center. NOTE: If you want to see how the measure has changed from prior year, click on last column "Version Compare".
5. Transfer information to Data Definition Worksheet (column a).
   a. ***Measure Description:*** Brief statement describing the measure.
   b. ***Numerator:*** Criteria for inclusion in the standard.
   c. ***Denominator (Initial Patient Population):*** Criteria for inclusion in the universe.
   d. ***Exclusions:*** Criteria for patients to be excluded from the denominator (or universe).
6. Scroll to **Specifications** and click on html link to identify additional criteria for the measure. Takes you to new specifications detail page. Scroll to "Data Criteria" and identify any terms requiring further clarification.
7. Select term from "Data Criteria" and cut and paste the Value Set code in parenthesis in a google browser. Your google browser will bring up a USHIK link. Click on the link. Scroll down the list to the data criteria you are interested in and click on the link. NOTE: You will need to sign up for a user ID and password to use USHIK but the process is quick and only required once.

The *HITEQ Center, for Health Information Technology, Evaluation, and Quality Improvement* is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under cooperative agreement number U30CS29366, National Training and Technical Assistance Cooperative Agreement

- This tool will lead you through assessing alignment between your data and the EHR's logic
- It provides step by step instructions and a place to document your findings.

Download worksheet here

Worksheet to Work through the Process

Measure:				
ecQI Reference:				
Description	**A.** **Definition from specifications in eCQI Resource Center**	**B.** **Where and how is data documented in EHR?**	**C.** **Where is vendor pulling data for reporting?**	**D.** **Reconciliation and Follow-up Action Required?**
Numerator				
Denominator (Initial Patient Pop)				
Exclusions (Denominator)				
Value Set (USHIK)				

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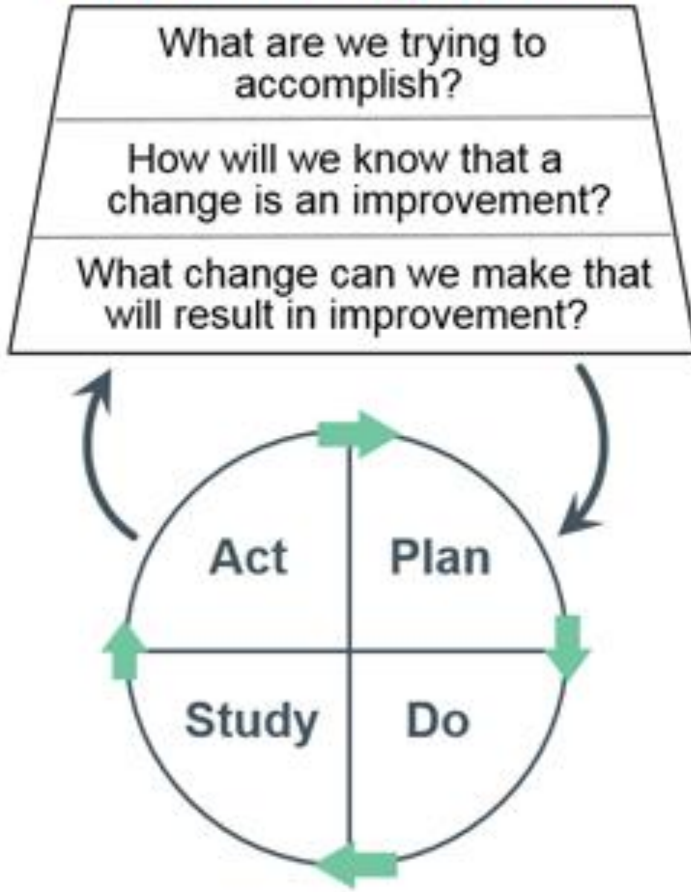
Addressing Where Alignment is Needed

- All data needs to be structured data in the correct form (code, type, and location)
- Lab orders often require LOINC codes.
- Measures with medications (e.g., statin) often require updating rx information.
- Correct CPT codes often need to be included in addition to orders and results.
- Update mapping between your providers, your system, and your vendor.



Moving towards QI

You have identified:

an area where EHR or report is not appropriately identifying patients/compliance based on specifications

and/or

where your care team processes are not aligned with data capture requirements or report mapping

Now you can implement and test change!

Questions?

WEBSITE

www.HITEQcenter.org

EMAIL ADDRESS

HITEQinfo@jsi.com

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $693,000 with 0 percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

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Effective Meeting Skills for Effective Meetings

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Discussion Question

What works well in your meetings?

Insert answer in the chat or unmute yourself

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Best Practices

- Holding regularly scheduled team meetings to maintain communication and progress
- Creating and following a standardized meeting agenda template to keep discussion on track and ensure all relevant topics are covered
  - The agenda should include items like objectives, updates, issues to resolve action items, etc.
- Starting meetings by discussing best practices and strategies for effective teamwork

Meeting Roles

- Facilitator/Coach
- Time Keeper
- Recorder
- Leader

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Meeting Norms Ground Rules

- Assume good intent
- Phones on mute
- Keep laptops closed
- Use specific examples
- Be kind/ Respectful
- Equal airtime

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Questions to ask yourself

BEFORE every meeting:

1. What do I need from this meeting?
   a) Is there anything that needs to be accomplished before the end of the meeting?
2. What do I already know about this topic?
3. What do I expect I/we can do/have after the meeting that I cannot do/have now?
4. What do I need from other members from this team?
5. What can I personally contribute to this team/project?

AFTER every meeting:

1. My expectations were met by…
2. These are the things I can improve for the next meeting…
3. I was surprised to discover…
4. I commit to improving these skills…
5. My personal action items to improve future meetings…

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Agenda

Department:
Time of Meeting:
Meeting Location:
Participants:

Aim of Team or Project:		
Time	**Item**	**Aim/Action**
	Clarify objectives	Leader reviews objectives
	Confirm meeting roles	Use meeting role cards to assist each member on expectation of that role
	Review agenda	Leader quickly reviews agenda items. Time keeper tracks time for each item. Recorder tracks action items.
	Work through each agenda item	Track action steps for each item to be completed (use action planning template)
	Review meeting record and action plan	Recorder reviews with team
	Plan next agenda	Leader and/or facilitator helps group create agenda items based on action plan and next steps
	Team assigns meeting roles for next meeting	Team members decide on which roles they will take on for next meeting

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Other Helpful Tools

Parking Lot
process of ordering new forms
Editing of form - Dental insurance.
Excel spreadsheet - edit issues
"Employer" (school name) - if
school not on drop down - No process.
Medical Record # added.
Enfield scanning issue!

1. TEAM AND ROLES DEFINED

Coach Assigned, Identify Core and Extended Team Members, Define Roles, Schedule Team Meetings, Communication Plan

TOOLS/SKILLS/PROCESS:

Effective Meeting Tools
Forming/Storming/Norming/Performing

2. ASSESSMENT AND BASELINE DATA

What is our current state? Describe population of interest, Identify data sources, Drill down to specific areas of focus. Related to other projects?

TOOLS/SKILLS/PROCESS:

Tick & Tally & other data collection
Process Mapping
Role Assessment
Team Practice Assessment

3. GLOBAL AIM

What is our overall goal for advancing TBC Model? Theme, Name process, location, Start/End of Process, Benefits/Imperatives

TOOLS/SKILLS/PROCESS:

Build Consensus
Fishbone Diagram (cause & effect diagram)

4. PROBLEM STATEMENT/THEME

Problem Statement, Importance, Goals/Objectives, Deliverables, KPIs

TOOLS/SKILLS/PROCESS:

QI Charters as agenda items
Brainstorming/ Brain writing
Multi-Voting
Impact/ Effort Grid
Fishbone Diagram
Five Whys
Process Map
Build consensus

5. SPECIFIC AIMs and MEASURES

What do we want to accomplish in days and weeks ? What will change, by how much & when , How will we know that we accomplished it?

TOOLS/SKILLS/PROCESS:

Specific Aim Tool
Build Consensus
Fishbone Diagram (cause & effect)
Tick & Tally & other data collection

6. SOLUTION STORMING for IDEA

What could we try?
Realistic ideas, Manager|Leader inv

TOOLS/SKILLS/PROCESS:

Idea Tree
Parking Lot
Force Field Analysis
Impact Effort
Multi-Voting

7. PDSA

Aim, test, who, when, where.
PLAN Tasks: How will we do it? What, Who, When, Where. Predictions, Measures
DO: Lets try it out. Results
STUDY: How is it working out? **ACT:** Lets try it again with modifications?

TOOLS/SKILLS/PROCESS:

PDSA Template
Keep test SMALL
Only one PDSA at a time
Measures

8. SDSA

Standardize the test that was successful. *Will it work the same in every day routine?* Document.

TOOLS/SKILLS/PROCESS:

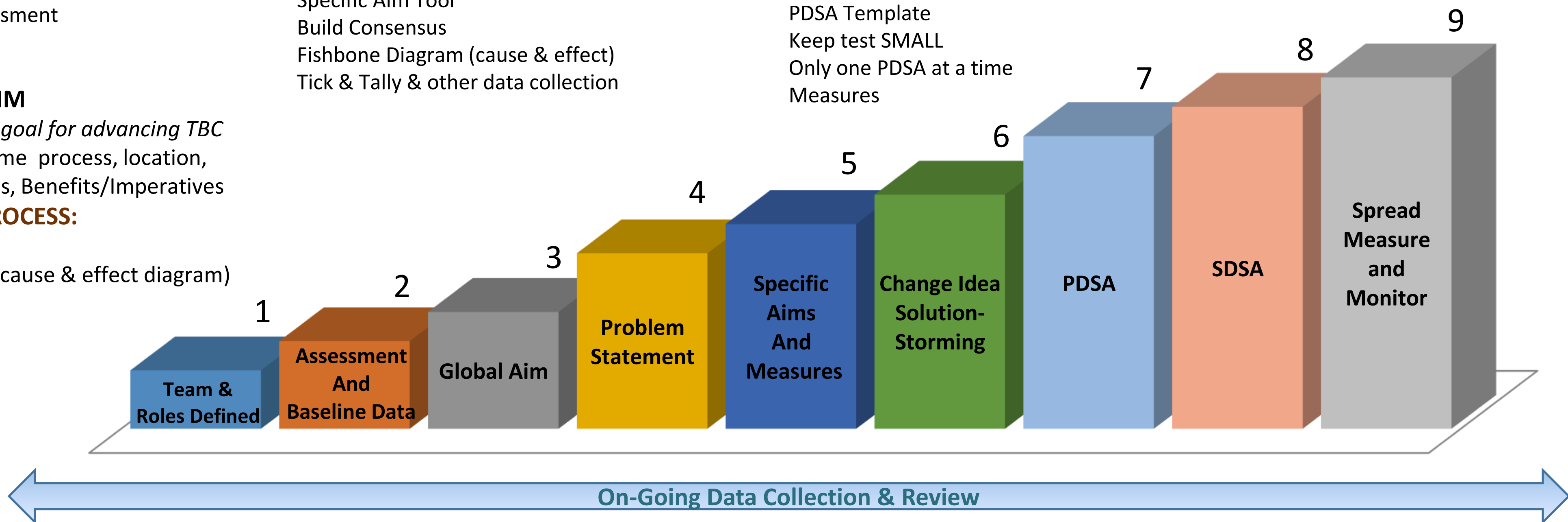
Involve all team members
Communication Plan
Playbook – Influence Spread

9. SPREAD, MEASURE & MONITOR

Implement spread strategy and track how it is working.

TOOLS/SKILLS/PROCESS:

- Communication Skills
- Spread Strategy
- Big Picture View
- Connecting the dots
- QI Process



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Developing & Using a Global Aim Statement

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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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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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Questions?

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Wrap-Up

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Comprehensive and Team-Based Care Learning Collaborative

- Free eight-month participatory experience designed to provide knowledge, tools, and coaching support to help health centers and look-alikes implement advanced models of team-based care.
- In this Collaborative, teams will learn how to:
  - Use quality improvement concepts and skills to facilitate their implementation of a model of high-performing team-based care
  - Conduct self-assessments of their current team-based care model to identify areas for process improvement and role optimization
- Outcomes of the learning collaborative:
  - Identified a clinical team to work on a quality improvement project
  - Implemented pre-visit planning and morning huddles
  - Integrated behavioral health with warm welcomes/handoffs
  - Increase UDS measures, such as hyptertension, cancer screenings, etc.
- The Collaborative will begin Fall 2024 – to express interest or request more information, please reach out to Meaghan Angers (angersm@mwhs1.com)

Team-Based Care

- **Fundamentals of Comprehensive Care**
- **Advancing Team-Based Care**

Our NTTAP also offers learning collaborative opportunities in Postgraduate NP Residency Programs, Health Professions Student Training, and HIV Prevention!

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Next Session:

Advancing Quality Improvement in Team-Based Care

Thursday, May 2, 2024 2:00pm-3:00pm ET / 11:00am-12:00pm PT

Join us as we explore the development of process maps and fishbone diagrams to enhance quality improvement strategies within team-based care. Using best practices as a framework, our expert speaker will provide participants with step-by-step examples to guide them through a process map and fishbone diagram activity.

Register Today!

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Explore more resources!

National Learning Library:
Resources for Clinical Workforce Development

National Learning Library

CHC has curated a series of resources, including webinars to support your health center through education, assistance and training.

Learn More

The National Training and Technical Assistance Cooperative Agreements (NCAs) provide free training and technical assistance that is data driven, cutting edge and focused on quality and operational improvement to support health centers and look-alikes. Community Health Center, Inc. (CHC, Inc.) and its Weitzman Institute specialize in providing education and training to interested health centers in Transforming Teams and Training the Next Generation through;

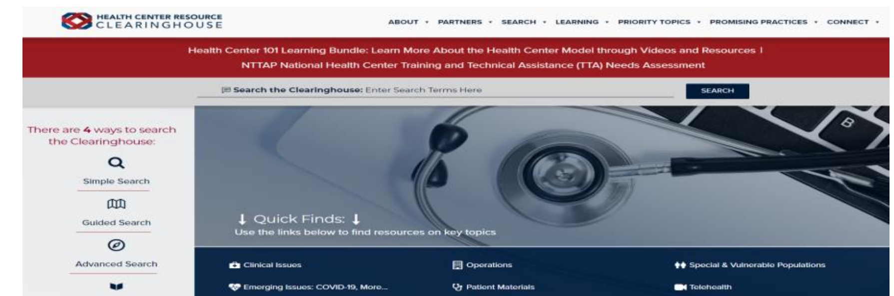
National Webinars on advancing team based care, implementing post-graduate residency training programs, and health professions student training in FQHCs.

Invited participation in Learning Collaboratives to advance team based care or implement a post-graduate residency training program at your health center.

Please keep watching this space for information on future sessions. To request technical assistance from our NCA, please email NCA@chc1.com for more information.

https://www.weitzmaninstitute.org/ncaresources

Health Center Resource Clearinghouse



https://www.healthcenterinfo.org/

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Contact Information

For information on future webinars, activity sessions, and learning collaboratives: please reach out to nca@chc1.com or visit https://www.chc1.com/nca