MOSES/WEITZMAN
Health System

Advancing Team-Based Care Learning Collaborative

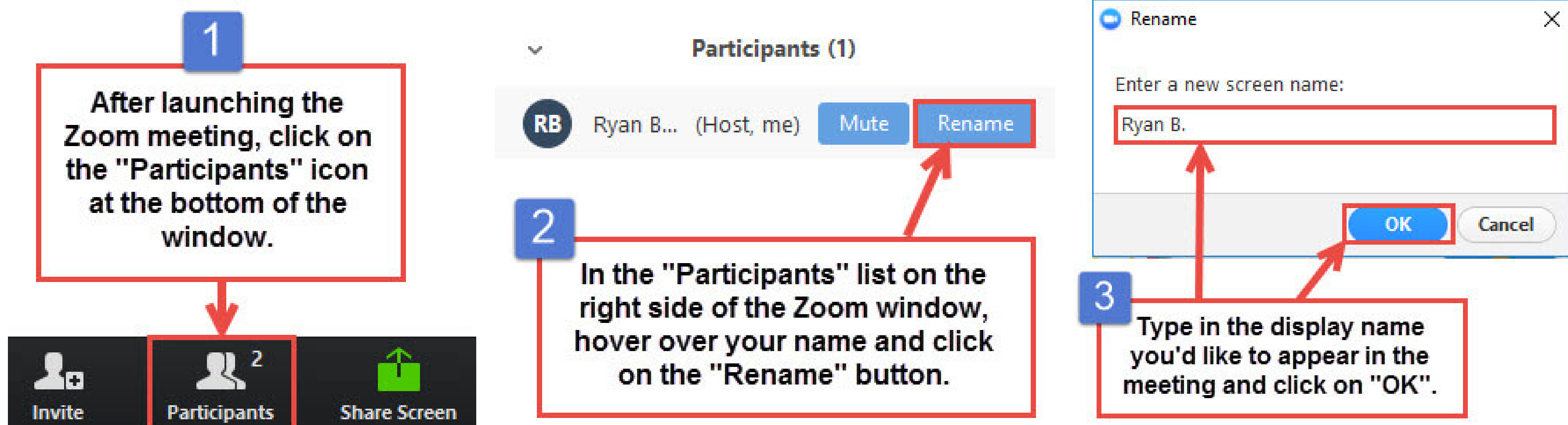
Learning Session 7: Wednesday May 29th, 2024

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A PROJECT OF
Community Health Center, Inc.
and the weitzman institute

MOSES/WEITZMAN
Health System

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”



NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A PROJECT OF
Community Health Center, Inc.
and the weitzman institute

MOSES/WEITZMAN
Health System

Session 7 Agenda

Time	Topic
1:00 – 1:05	Introduction
1:05 – 1:30	Role of Pharmacist in Primary Care
1:30 – 1:55	Virtual Patient Engagement and Support
1:55 – 2:10	Quality Improvement Refresh: Data Displays
2:10– 2:25	Making Your Team Work: Sustaining the Coaching Model
2:25– 2:30	Q/A, Next Steps, and Evaluation

Learning Collaborative Faculty

NTTAP Faculty, Collaborative Design, and Facilitation

Amanda Schiessl, MPP
- Project Director/Co-PI, NCA
- Amanda@mwhs1.com

Margaret Flinter, APRN, PhD, FAAN
- Co-PI, NCA & Senior Vice President/Clinical Director
- Margaret@mwhs1.com

Bianca Flowers
- Program Manager
- flowerb@mwhs1.com

Meaghan Angers
- Program Manager
- angersm@mwhs1.com

Mentors, Coaching Faculty

Deborah Ward, RN
- Quality Improvement Consultant
- WardD@mwhs1.com

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

Kathleen Thies, PhD, RN
- Consultant, Researcher
- ThiesK@mwhs1.com

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A PROJECT OF
Community Health Center, Inc.
and the weitzman institute

MOSES/WEITZMAN
Health System

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

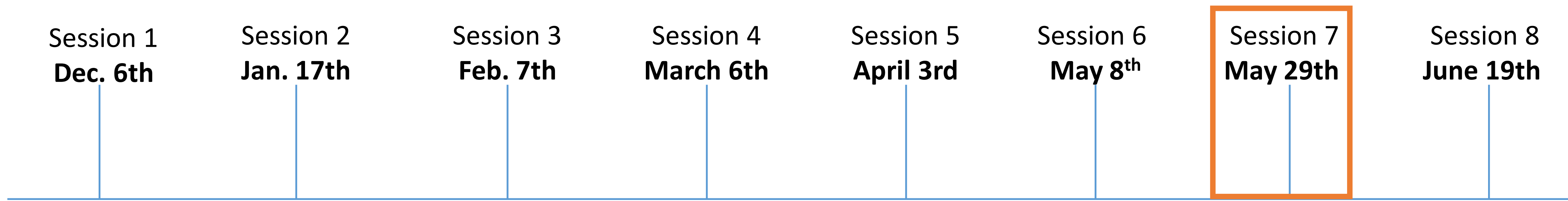
Preparedness for Emergencies and Environmental Impacts on Health

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A PROJECT OF
Community Health Center, Inc.
and the weitzman institute

MOSES/WEITZMAN Health System

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

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A PROJECT OF
Community Health Center, Inc.
and the weitzman institute

MOSES/WEITZMAN
Health System

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

NTTAP National Health Center Training & Technical Assistance Partners Clinical Workforce Development
A PROJECT OF Community Health Center, Inc. and the weitzman institute

MOSES/WEITZMAN Health System

Role of the Pharmacist

Kara Lewis, Director of Clinical Pharmacy Services

Community Health Center, Inc.

MOSES/WEITZMAN
Health System

Poll

1. Do you have a clinical pharmacist?
   Yes/No/Unsure

2. Do you have an in-house pharmacy?
   Yes/No/Unsure

MOSES/WEITZMAN
Health System

Value of Integrating a Pharmacist into the Primary Care Setting

1. Improve health outcomes and reduce health disparities through medication use optimization, chronic disease management, and other pharmacist-provided patient-care services
2. Decrease the workload of the primary care provider and decrease patient utilization of emergency care
3. Help to improve quality measures for value-based incentive payments

MOSES/WEITZMAN
Health System

Optimizing the Role of the Pharmacist in Team-Based Primary Care

- ✓ Direct consultation with clinical team
- ✓ Working with the population health team on outcomes
- ✓ Teaching
- ✓ Chair of Pharmacy and Therapeutics Committee
- ✓ Clinical management of 340B drug pricing program

MOSES/WEITZMAN
Health System

Consultation with Clinicians

- Real-time resource for individual clinicians, especially prescribers
- Offers feedback about medication management: de-prescribing and titrating medications, therapeutic interchange based on insurance coverage, and patient assistance programs.
- During interdisciplinary care team meetings: addresses a range of medication and pharmacy-related issues for the patients being discussed by reviewing lab results, response to treatment, insurance coverage, hospital notes and investigating possible barriers to care.

MOSES/WEITZMAN
Health System

Population Health

- Works with Senior Program Manager for CHCI's Population Health team regarding value-based contracts and informatics
  - Example: payer incentives related to medication adherence
  - Example: HTN, DM, hyperlipidemia, CGM project

MOSES/WEITZMAN
Health System

Teaching

- In-house resource for teaching our nurse practitioner residents
- Disseminates knowledge to clinical team
  - Provides information about new medications and searches the literature when a specific question comes up about possible side effects, long-term use, etc.
  - Stays up-to-date with recent clinical trials and guideline changes that impact medication management for chronic conditions
  - Built and maintain website with pharmacy information (links to discount med programs, Medicaid formularies and forms, drug disposal sites, 340B prescribing info)
- Participation as faculty in Project ECHO

MOSES/WEITZMAN
Health System

Pharmacy and Therapeutics Committee

Chair of Pharmacy and Therapeutics Committee:

- Ensures the safe and effective use of drug products across CHCI, including managing the formulary of clinic administered drugs
- Oversees policies and procedures related to all aspects of medication use (i.e. standing orders and delegated order sets, how samples of medications are stocked and distributed, new specialty medication workflows, etc.)
- Sub-Set: Controlled Medication Review Committee
    - Co-Chairs with the with CMO. Monitor prescribing trends in controlled medications across the organization, work with providers to ensure mitigation requirements met
- Drivers of other things based on data (i.e. pilot programs for specialty meds)

MOSES/WEITZMAN
Health System

340B Drug Pricing Program

- The 340B pricing program provides community health centers discounted drugs for patients and results in revenue for covered entities (HRSA oversees)
- At CHCI oversite and implementation of this program means support from several team members; clinical, finance, legal, medical records.
- Success and growth of program means looking at expanding access which leads to revenue increase for organization
- Pharmacy knowledge essential to coordinate with contract pharmacies

MOSES/WEITZMAN
Health System

Questions?

MOSES/WEITZMAN
Health System

Virtual Patient Engagement and Support

Sydney Kennedy, Assistant Director of Telehealth

Community Health Center, Inc.

MOSES/WEITZMAN
Health System

How Patient Engagement Works at CHCI

- Find the balance that works best for your patient preferences, experiences and needs.
- CHC has a host of effective virtual strategies for patient engagement, education, and services:
  - Patient Satisfaction Surveys
  - Communicating scheduled appointments & with patients outside the appointment
  - Optimizing virtual appointments with team-based care

MOSES/WEITZMAN
Health System

Patient Satisfaction Surveys

- CHCI has chosen to contract with a national patient satisfaction vendor (The Crossroads Group, Inc.) used extensively by health centers in the U.S.
  - Each quarter, Crossroads staff calls and interviews a statistically significant number of patients, by discipline, on CHCI's behalf and conducts a thorough phone survey concerning the patient's most recent visit.
  - On average, a total of 800-1,000 surveys are completed monthly with a more than 90% success rate in reaching the targeted patients.
- Telehealth Video Visit Surveys
  - Twice a week someone from patient engagement team runs a report for patients that had a telehealth video the day before and sends a text message with the survey.

– Enhanced Video Visit post visit Survey
  - After a visit using a TytoCare device for enhanced diagnostics, the patients is presented a brief satisfaction survey.

MOSES/WEITZMAN
Health System

Communicating scheduled appointments & with patients outside the appointment

- Ability to effectively schedule is at the heart of a responsive, patient centered, efficient health center that can quickly identify and respond to patients needs in a complex care delivery environment
- Evolved from site-by-site front desk receptionists scheduling locally, to a centralized, multilingual statewide and flexible system.
- Self Schedule for rescheduling appointments as a bridge
- Waitlist scheduling, if an appointment is more than 2 weeks out we enroll patients in a waitlist, so that if an appropriate slot opens with their provider via cancellation they are notified and can take the slot.

Communicating Scheduled Appointments with Patients

- Significant portion of patient communication is focused on engaging with patients around their scheduled appointments.
- When a patient establishes care, they are automatically opted in (though of course may choose to opt out) to receive automated appointment reminders and other health related communications (i.e. flu shot reminders via text).
- Patients will then receive up to three reminders per scheduled appointment, including an initial reminder when the appointment is first scheduled. Additional reminders are sent 24 hours and 1 hour prior to the appointment time.
  - 24-hour and 1-hour reminders also include pre-visit instructions specific to the patient's appointment type and/or provider
- Patients receive text messages regarding cancelled appointments, and can cancel their appointment via text prior to the visit.

MOSES/WEITZMAN
Health System

Communicating with patients outside of their scheduled appointments

- CHCI engages with patients outside of their scheduled appointments in a variety of ways
- Patient Portal allows patients to access their medical records, visit notes, lab results, and ask questions and send messages back and forth with their providers/care team.
- Outside of the portal, text, email, and robo-call messages are regularly used to inform patients of important healthcare updates, including changes to their care team, the need to schedule a visit to resolve a gap in care, etc.

MOSES/WEITZMAN
Health System

Optimizing Virtual Appointments with Team-Based Care

- Waiting Room
- MA rooming patient
- Warm Hand Off to BH

MOSES/WEITZMAN
Health System

Virtual Tools for Emerging Issues

- Use of online surveys to gather additional patient and provider feedback
- Survey providers on their satisfaction with telehealth tools and the telehealth support teams to track any potential impact of virtual care on clinical quality or health outcomes.
- If a patient fails to show up for an appointment, they are automatically sent a missed appointment reminder and encourages the patient to reschedule the visit and links to a survey to provide details as to why the patient was unable to attend the appointment (ex. lack of transportation, did not receive an appointment reminder)
- Use cancellation reason/no show to tailor virtual visits for patients with poor transportation availability
- Automated feedback post visit to improve patient response rate.

MOSES/WEITZMAN
Health System

Future Innovations

- **MIRAH** – BH screening tools that allow patients to complete surveys outside of their appointments
  - Replacement for paper Ohio Scales completion
  - Will eventually be used with medical as well to integrate care
- Expanding existing patient engagement platform
  - Allows for AI powered customized appointment reminders, factor in SDOH
  - Expand Self Scheduling and improve texting routing
  - Outside patient appointments – enhanced campaign functionality

MOSES/WEITZMAN
Health System

Questions?

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A PROJECT OF
Community Health Center, Inc.
and the weitzman institute

MOSES/WEITZMAN
Health System

Quality Improvement Refresh:
Data Displays

MOSES/WEITZMAN
Health System

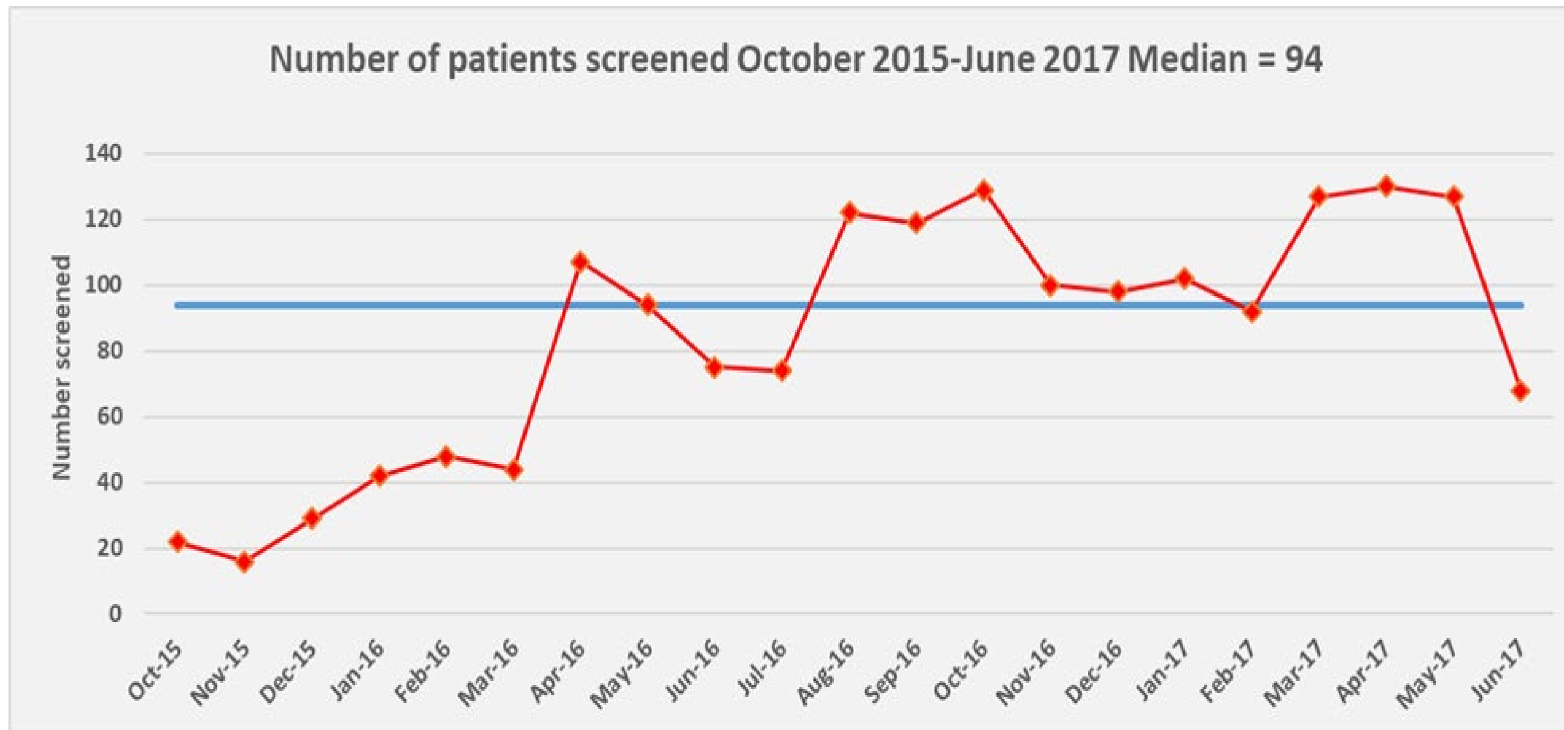
Good Data Displays

- **Good title**: Tells uninformed persons what they are looking at—what (% completed cervical cancer screening), when (Jan-March), where (Clinic A), female patients aged 23-64
- **Good labels**: time, numbers, percentages, locations
- **Line chart: X-axis** is usually *continuous* time/dates, Y-axis is numbers or percentages (never both)
- **Bar chart: X-axis** is entities/locations, e.g., Clinic A, or time/dates (e.g., quarterly data), Y-axis is numbers or percentages (never both)
- When comparing two graphs, make sure the Y-axes have the same intervals and range.

ALL GRAPHIC DISPLAYS REQUIRE CONTEXT TO BE INTERPRETED.

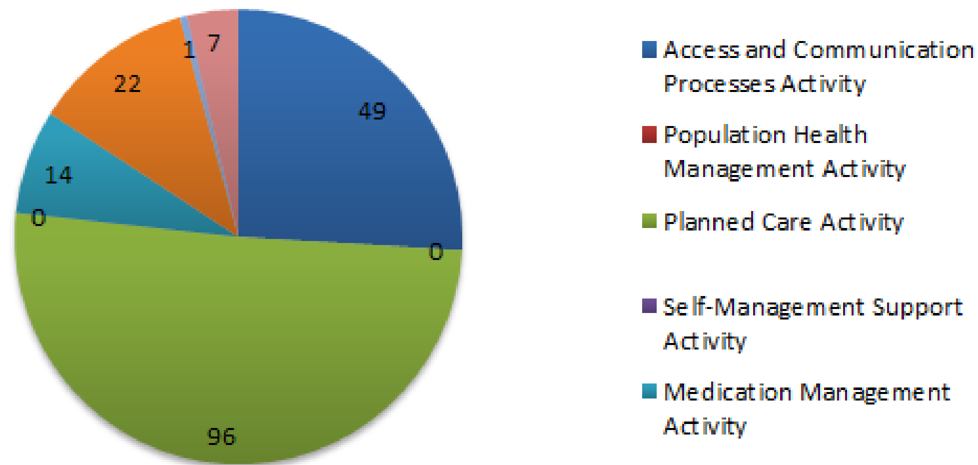
Run Chart is a type of Line Chart

A run chart displays data (Y axis) over a period of time (X axis). The time periods are uniform and sequential, that is month to month, or quarter to quarter. The Y axis label matches the title: number of patients. The Y axis can be percentages as well.

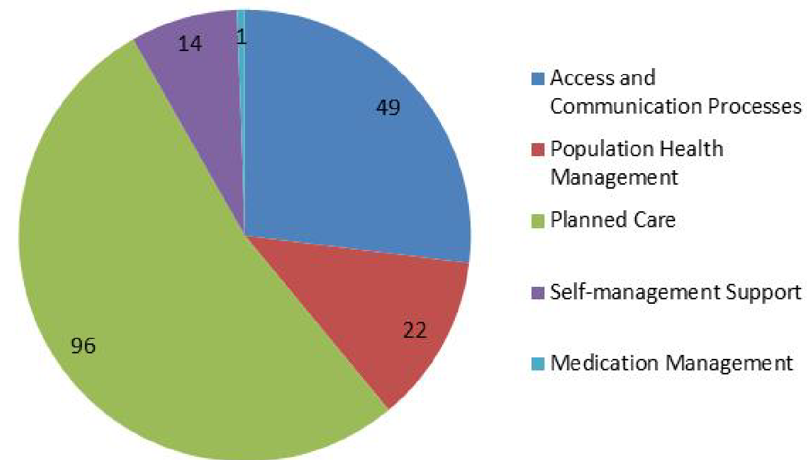


In this chart, the red line is the number of patients screened, each dot represents the number screened in that month, and the blue line is the median (excel will do that for you). That is, the data is ratio data (has a natural zero). Run charts use a median, not a mean. To use the mean, you need a control chart.

Pie Chart breaks a "whole" into its "parts"



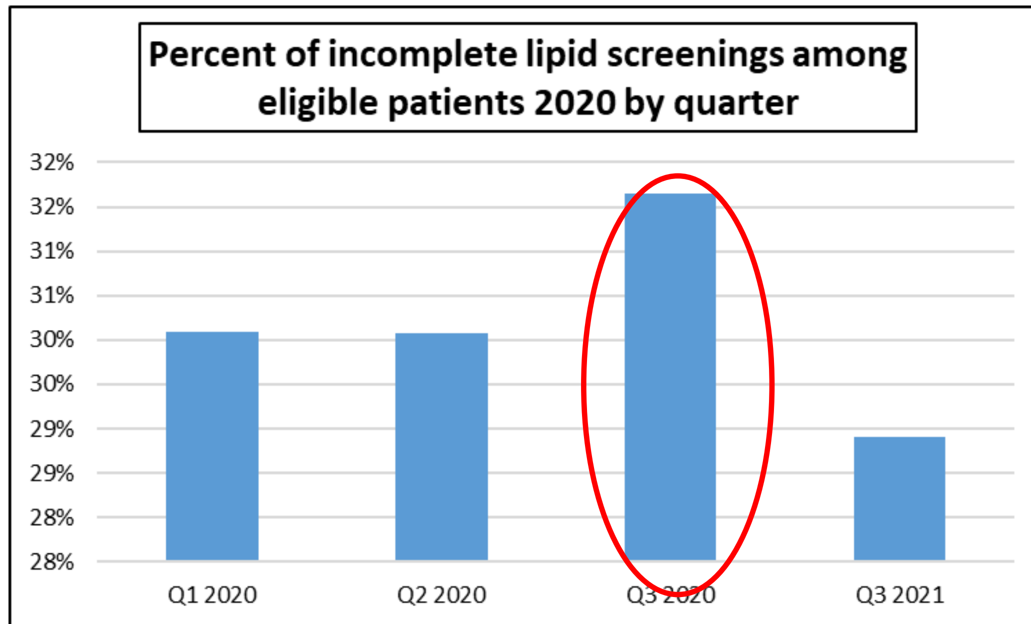
Confusing display: Min? %? 0? Five activities listed but six pieces of pie

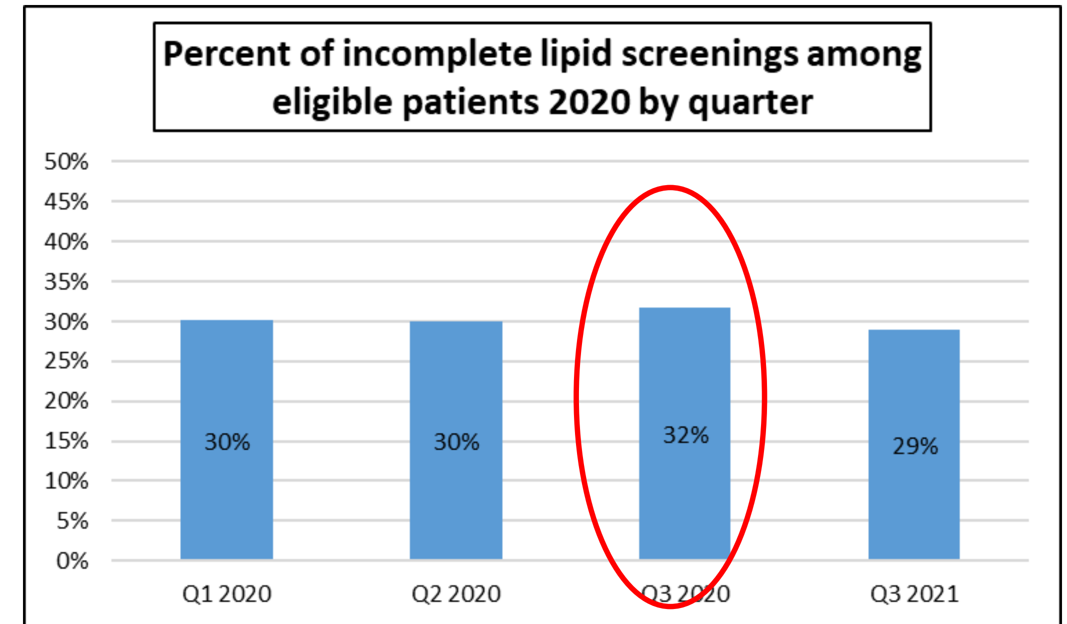


Better: Could also label as percentages as long as they add up to 100%.

Be clear about the size of the whole (182 min) and how many parts it is divided into in your legend. Use either numbers or percentages depending on the story your data is telling.

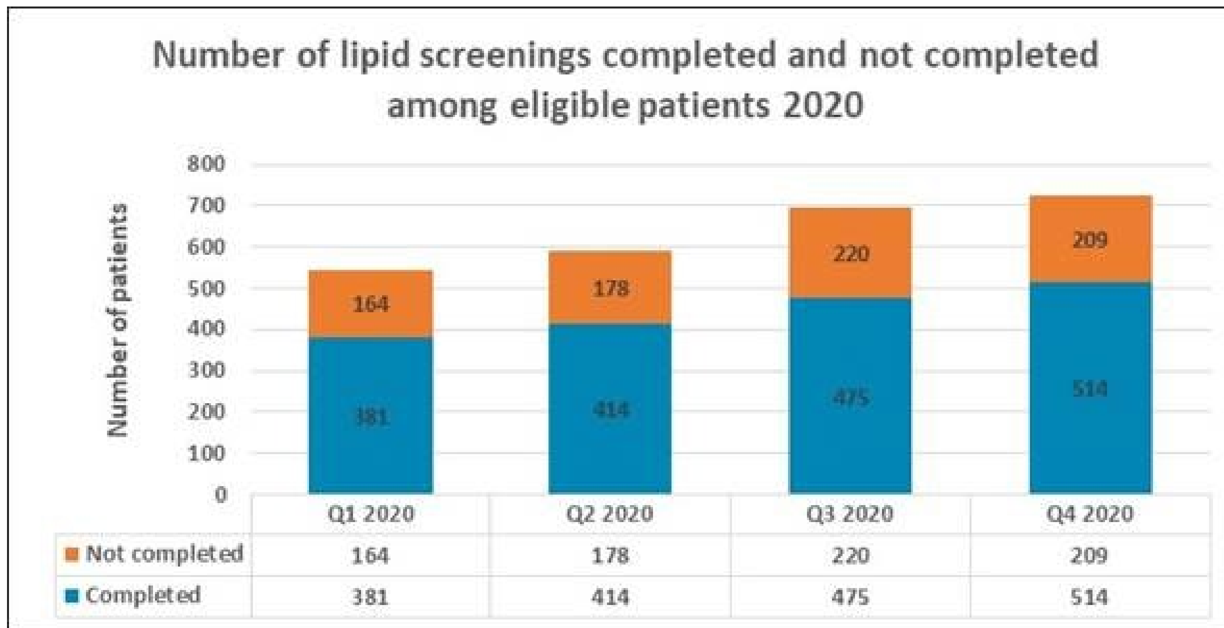
Single Bar Chart: Beware of intervals in Y-axis.





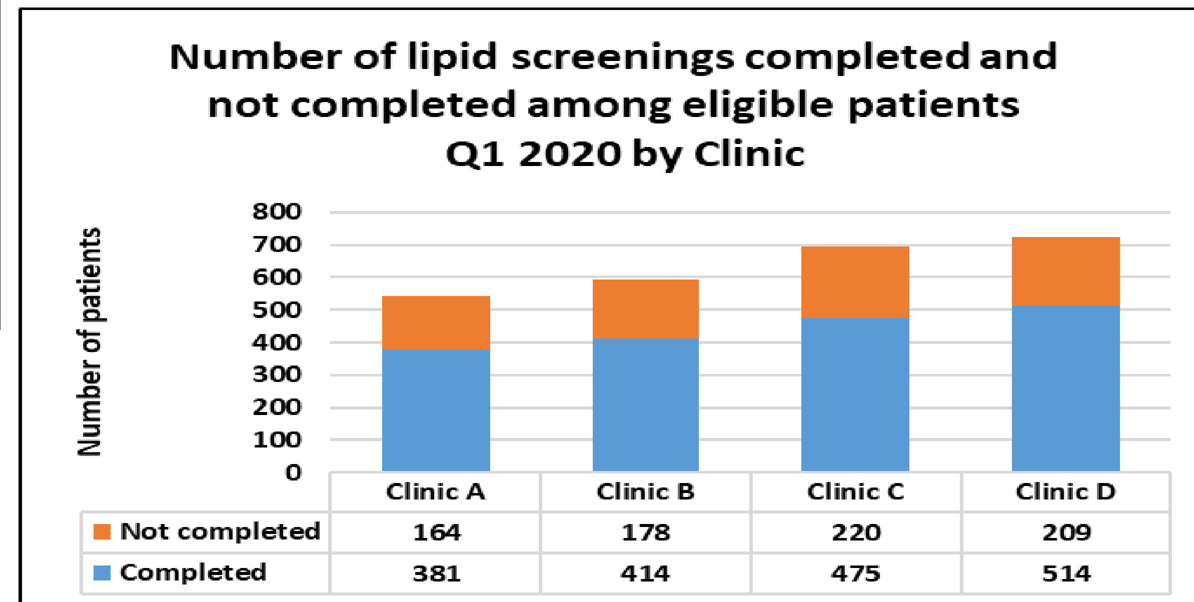
This is the same data. On the left, the Y axis ranges from 28-32%, with intervals of one unit (barely). On the right, the range is from 0 to 50% with five unit intervals. Be careful about the scales for data ranges and intervals (see excel). The one on the left suggests a problem in Q3. In fact, the % incomplete is about the same across all quarters. When comparing two graphs, make sure the ranges and intervals are the same.

Stacked Bar Chart: the whole and its parts comparing time or locations



	Q1 2020	Q2 2020	Q3 2020	Q4 2020
Not completed	164	178	220	209
Completed	381	414	475	514

Like a pie chart, a stacked bar graph gives you the whole and its parts. But unlike the pie chart, the X axis can be time, locations, names, etc.



	Clinic A	Clinic B	Clinic C	Clinic D
Not completed	164	178	220	209
Completed	381	414	475	514

This is the same data but the one on the left uses time (quarters) for the X axis, the one on the right uses location and the time is noted in the title.

MOSES/WEITZMAN
Health System

Side by side bar chart comparing two clinics

Percent of incomplete lipid screenings Clinic A and Clinic B Q1 2020 -Q2 2021

Percent incomplete

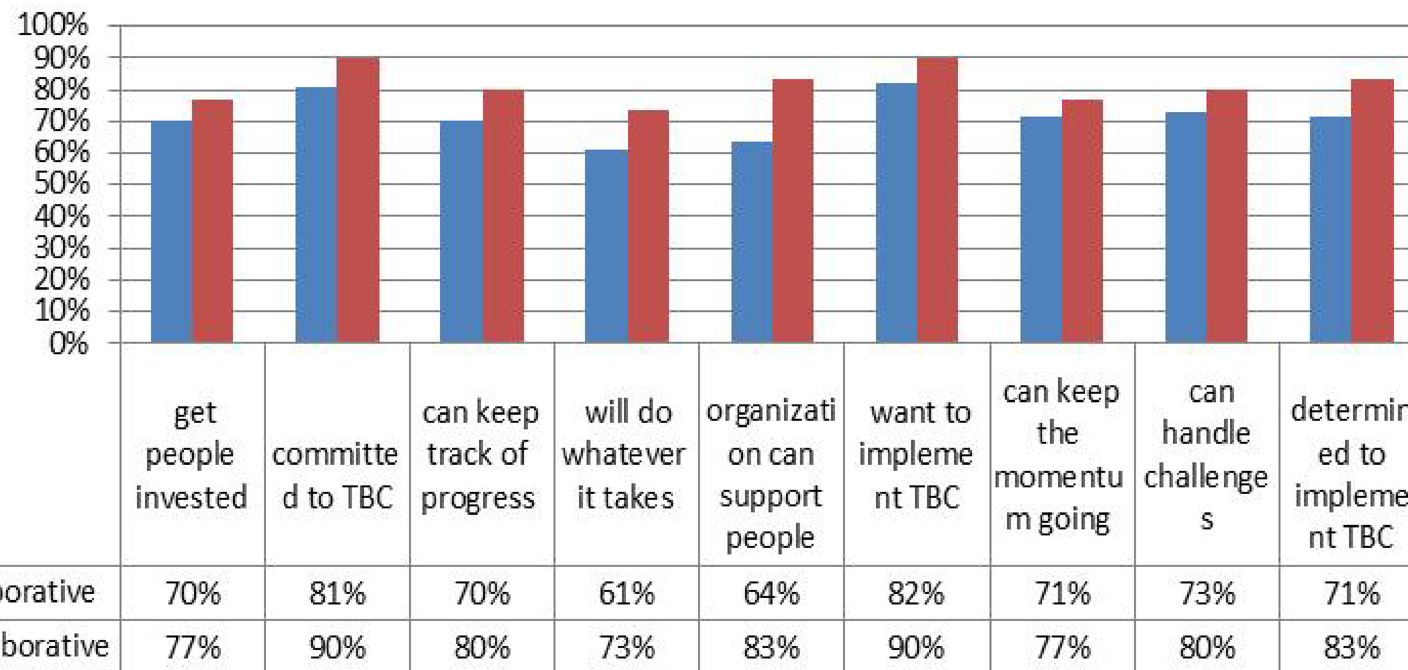
60%
50%
40%
30%
20%
10%
0%

	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021
Clinic A	30%	35%	32%	37%	29%	34%
Clinic B	38%	42%	50%	50%	28%	41%

This is a side by side bar chart comparing incomplete screenings rates between two clinics over time. Beware of interpretation without context. Using numbers here may not be helpful, as clinics vary in size of the population in the denominator.

MOSES/WEITZMAN
Health System

Side by side bar chart comparing pre and post scores



	get people invested	committed to TBC	can keep track of progress	will do whatever it takes	organization can support people	want to implement TBC	can keep the momentum going	can handle challenges	determined to implement TBC
Pre-Collaborative	70%	81%	70%	61%	64%	82%	71%	73%	71%
Post-Collaborative	77%	90%	80%	73%	83%	90%	77%	80%	83%

Side by side bar charts are a good way to compare Pre and Post scores. Note that the title gives the N for both Pre and Post. That is, the denominator is different.

MOSES/WEITZMAN
Health System

Questions?

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A PROJECT OF
Community Health Center, Inc.
and the weitzman institute

MOSES/WEITZMAN
Health System

Making Your Team Work: Sustaining the Coaching Model

MOSES/WEITZMAN
Health System

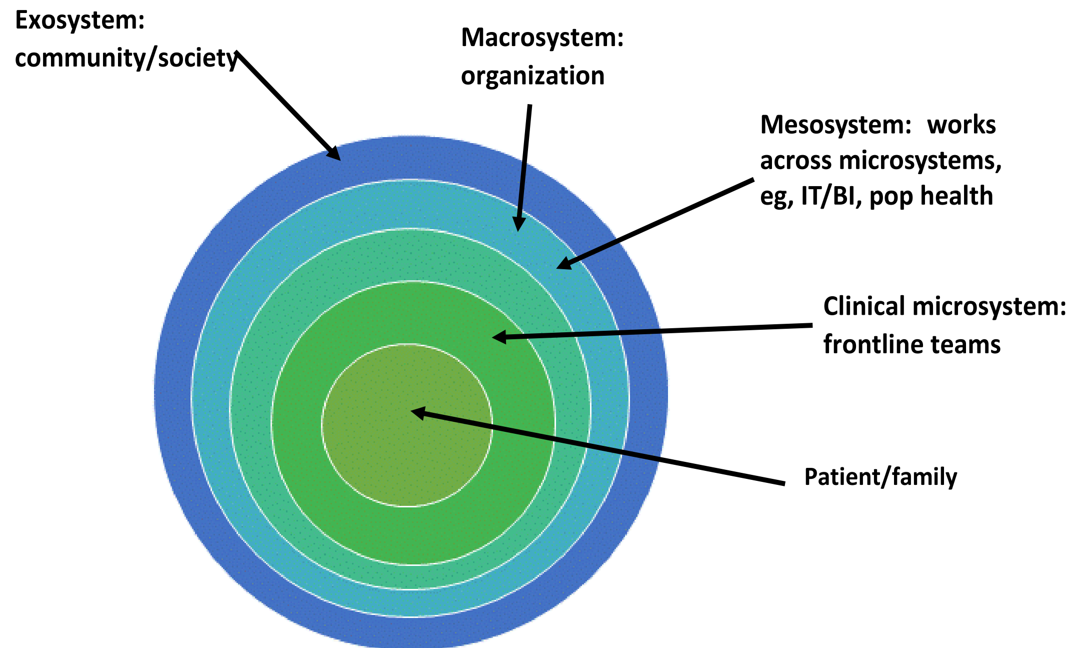
How Quality Improvement Works at CHC

- ✓ Performance Improvement Committee
- ✓ Teams and Coaching

We use Clinical Microsystems approach to QI:

- Data-driven, team-based, systems oriented
- Begins with assessment of current practice, not PDSA cycles
- Provides a data-based systematic approach to changing practice—the improvement ramp
- Improvement ramp provides a shared mental model of improvement for the team
- Uses many of the same tools as Lean/Six Sigma
- Utilizes coaches to guide frontline teams through the improvement process

Clinical Microsystems approach



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” (Nelson, et al., 2002, p. 474). The *mesosystem* consists of teams/departments that work across and support other systems, for example, Information Technology/Business Intelligence, Population Health, as well as Quality Improvement.

CHC's Performance Improvement Structure

PERFORMANCE IMPROVEMENT PLAN
FY 2021-2022

COMMUNITY HEALTH CENTER
PERFORMANCE IMPROVEMENT PLAN

I.PURPOSE

The purpose of this plan is to describe Community Health Center Inc.'s (CHCI) comprehensive performance improvement process and to define our approach to quality improvement and integration with all clinical departments. Specific goals are established and approved by the performance improvement committee followed by CHCI Board of Directors. This program addresses the following: (1) the quality and utilization of health center services; (2) patient satisfaction and patient grievance processes; and (3) patient safety and adverse events. The PI plan is prepared and overseen by the Performance Improvement Committee (PIC) in conjunction with the Dental, Medical, and Behavioral Health Quality Improvement Committees of CHCI. CHC's Performance Improvement Plan (PIP) was first written in 1999 and is updated annually by the PIC.

II. OBJECTIVES

The Objectives of the PI Process are:

- To assess and monitor quality across all domains of performance at CHCI
- To ensure that all clinical services, whether delivered in person or virtually, meet the highest standards of quality, effectiveness, and efficiency
- To ensure that CHCI's staff, services, and facilities reflect the highest level of respect for all patients and communities. This includes but is not limited to the provision of linguistically, culturally, and socially appropriate services, programs, staff, and materials to all CHC patients. To engage staff at all levels and across all disciplines in continuous quality improvement
- To implement and ensure adherence to CHCI's Safety and Risk Management Plan including Reviewing and tracking of all patient feedback and incident reports and other problems in

MOSES/WEITZMAN
Health System

Performance Improvement Goals

Category	Goal topic	Specific Goal	Source
Chronic disease care	Diabetes control	Increase the number of patients with an A1c (HbA1c) less than 9.0 percent	UDS
	A1C testing	Reduce the number of patients with diabetes who have not had an A1c completed in the last 12 mo.	CHC
	HTN control	Increase the number of patients with hypertension whose BP is controlled (less than 140/90)	UDS
	BP documentation	Reduce the number of patients with hypertension who have **NOT** had a BP documented in the last 12 months	CHC
	Home BP cuff use	Increase the number of patients with HTN who have a home BP cuff	CHC

1. Category
2. Goal topic
3. Define Specific goal
4. Source
5. 2020 Rate
6. Current rate
7. Current Goal (2021)
8. Recommended Goal

- Population Health
- Chronic Disease
- Screening
- Behavioral Health
- Preventative Care
- Dental
- Medical and Dental
- Prenatal

MOSES/WEITZMAN
Health System

Next Steps

1. Existing Teams:
   i. Is the team on track to achieve goal(s) for the year?
   ii. Any modifications needed?
2. New Teams:
   i. What type of team (micro/meso)?
   ii. Team composition?
   iii. Coach?
3. Process in Place:
   i. Is the existing process sufficient and likely to achieve the goal(s)?
   ii. Any modification(s) needed for the process?
   iii. Catchball back to a Microsystem for testing/refinement needed?

MOSES/WEITZMAN
Health System

New Teams

Discussion at PI/Steering Committee meeting

- Change idea solution storming
- Is it a micro/meso system?
- Does this need a coach?
- Where to test?

	New QI team	Topic	Detail
1	Diabetes Control	Diabetes control	Increase the number of patients with an A1c (HbA1c) less than 9.0 percent
		A1C testing	Reduce the number of patients with diabetes who have not had an A1c completed in the last 12 mo.
	HTN control	HTN control	Increase the number of patients with hypertension whose BP is controlled (less than 140/90)
		BP documentation	Reduce the number of patients with hypertension who have **NOT** had a BP documented in the last 12 months
2	Cancer screening	Breast Cancer Screening	Increase the % of women with appropriate mamographic breast cancer screening
		Cervical Cancer Screening	Increase the number of patients who have appropriate cervical cancer screening
3	CRC	Colorectal Cancer Screening	Increase the number of patients who have appropraite colorectal cancer screening
4	Antipsychotics	Metabolic monitoring for antipsychotics	Increase the number of children and adolescents (ages 1-17) on Antipsychotics who have metabolic monitoring
5	Pedi Well-care/recall	Well care 12-21	Increase the number of children and adolescents ages 12-21 with at least one annual well care visit
6	Population health	Equity	Develop and implementat a process to accurately capture patient Race and Ethnicity
			Update the quarterly chronic disease dashboard to report outcomes for African American and Hispanic/Latinx populations separately
			Reduce the rate of uncontrolled hypertension in African American patients

Community Health Center, Inc.
Performance Improvement Team Update

PI Goal(s) aligned with the project	To optimize the process for obtaining required screenings
Name of Project	Automated Forms Group
Project Manager/Coach	Deb Ward
Team Members	Dan Bryant, Veena Channamsetty, Mary Blankson, Tim Kearney, Nicole Seagriff, Ho Chang, Sheela Tummala, Tichianaa Armah, Operation team members: Meredith Johnson, Lisa Avellino, Mette Smith
Start Date	Operations team: Feb 22, 2024, Medical team: May 17, 2024
Meeting Frequency	Frequency not yet established: Next step schedule one hour meetings

Community Health Center, Inc.
Performance Improvement Team Update

Project Goal(s) (Include Project Charter and/or Aim Statements if appropriate)

DRAFT: Electronic Forms

Problem Statement
- Staff are required to collect many screening forms from our patients. Patients and staff are sometimes not able to gather this information at the required interval during a patient visit due to the number of screening that are simultaneous due. Patients may not answer accurately due to the number of questions.

Team Members
- Dan Bryant, Veena Channamsetty, Mary Blankson, Tim Kearney, Nicole Seagriff, Ho Chang, Sheela Tummala, Tichianaa Armah, Operation team members: Meredith Johnson, Lisa Avellino, Mette Smith

Research Question/ Why work on this now?
- CHC has invested in several different modalities of data collection from patients such as Mirah, the patient portal, luma, tablets, kiosk

Measures
- Reduction of at least 5 top identified forms to become electronically collected
- Maintain or improve the number of response to collection of forms

Goal Statement
- **We aim** to optimize the process for collection of required screenings.
- **The process begins** with identification of required screening tools
- **The process ends with** electronic documentation in the health record.
- **It is important to work on this now because :**
  - staff are often multitasking and unable to secure this information at the time of rooming a patient because of the number of required screenings.
  - **Technology will enable us to gather the information during non value added time of the patient visit or before the scheduled visit. Several screenings can also be done in the waiting room.**
  - Reduce screening burden

Milestones/ Dates
- Identify the top 5 tools for testing: June 2024
- Screening tool to be automatically entered into structured data:TBD

Scope
- ? Is purchasing ECW upgrade in scope, Increase staff FTE in scope?

Screening tools

PCD Item	Patient Population	How Often	What MA/LPN Does (or other clinical staff)
ACES (Adverse Childhood Experiences) Live 9/13/21	All patients 18 and older	Once ever	• Merge the ACES screening template [MA] • Provide the patient with ACES handout to complete [MA] • Score patient's completed ACES form and enter the responses in the template [MA]
ACT (Asthma Control Test)	Patients with asthma age 5-40	Every visit regardless of last ACT date or result *(Note >19 indicates good control)*	• Complete the Asthma Control Test at every visit, found in the Vitals [MA] • Document the score in Vitals [MA] • If patient declines, enter in Vitals [MA]
Annual Chronic Pain Screening	All medical patients age 18 and older in medical (except in Hartford)	Every 12 months Annual screening, alert on PCD 30 days before due date	• Open the Smart Form, "Chronic Pain" with the patient [MA] • If the patient says "most days" or "every day" open the Smart Form, "PEG" [MA]
***Asthma Controller Med (alert is in orange b/c action is for PCP)	Patients with a diagnosis of persistent asthma on the problem list age 5-64	Patients who were dispensed at least one prescription for a preferred therapy (inhaled corticosteroid) during the last 12 months	• Note in Chief Complaint that patient needs an Asthma controller med [MA] • If patient does not have persistent asthma, change the diagnosis code in the problem list to reflect the correct diagnosis [Prov] • If patient has persistent asthma but is not on a medication, consider seeing the patient and reevaluate whether patient should start appropriate medication [Prov]
Baby-PSC	Patients 2 months - 12 months of age	Complete at each WCC visit 2, 4, 6, 9, 12 and 15 months of age	• MA hands parent/guardian the Baby PSC to complete (English/Spanish available) and then, based on local workflow: • MA or PCP clicks on the BPSC link in the HPI section of the WCC template and enters the score for each of the three questions

MOSES/WEITZMAN
Health System

Coach Training within Health Centers

- Identification of the new coach
- Communication with leaders
- Commitment from the coach in training and supervisor
- Training (six to seven didactic sessions)
- Mentor program
- Monthly Coach meeting
- Reports to Performance Improvement/Steering committee

MOSES/WEITZMAN
Health System

Why CHC uses it

- Data-driven, team oriented
- QI happens where the work happens
- QI is done by the people who do the work
- Builds on unique context of individual staff in specific clinical units in a larger organization
- Elevates skill level of staff, ownership of improvement and practice, team-ness
- Uses trained coaches to guide staff
- Structured, systematic "mental model" for how to improve

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 CHANGE IDEA

What could we try?
Realistic ideas, Manager|Leader involvement.

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:

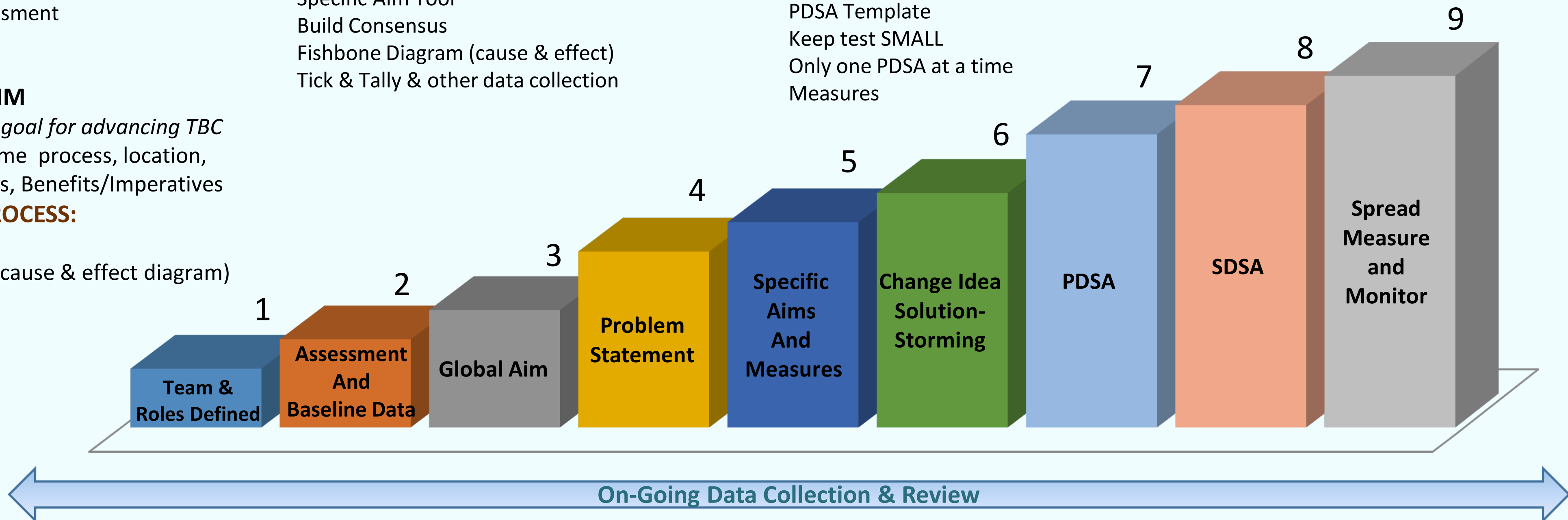
Involve all team members
Communication Plan
Playbook – Influence Spread

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



MOSES/WEITZMAN
Health System

Continuous Monitoring for Success

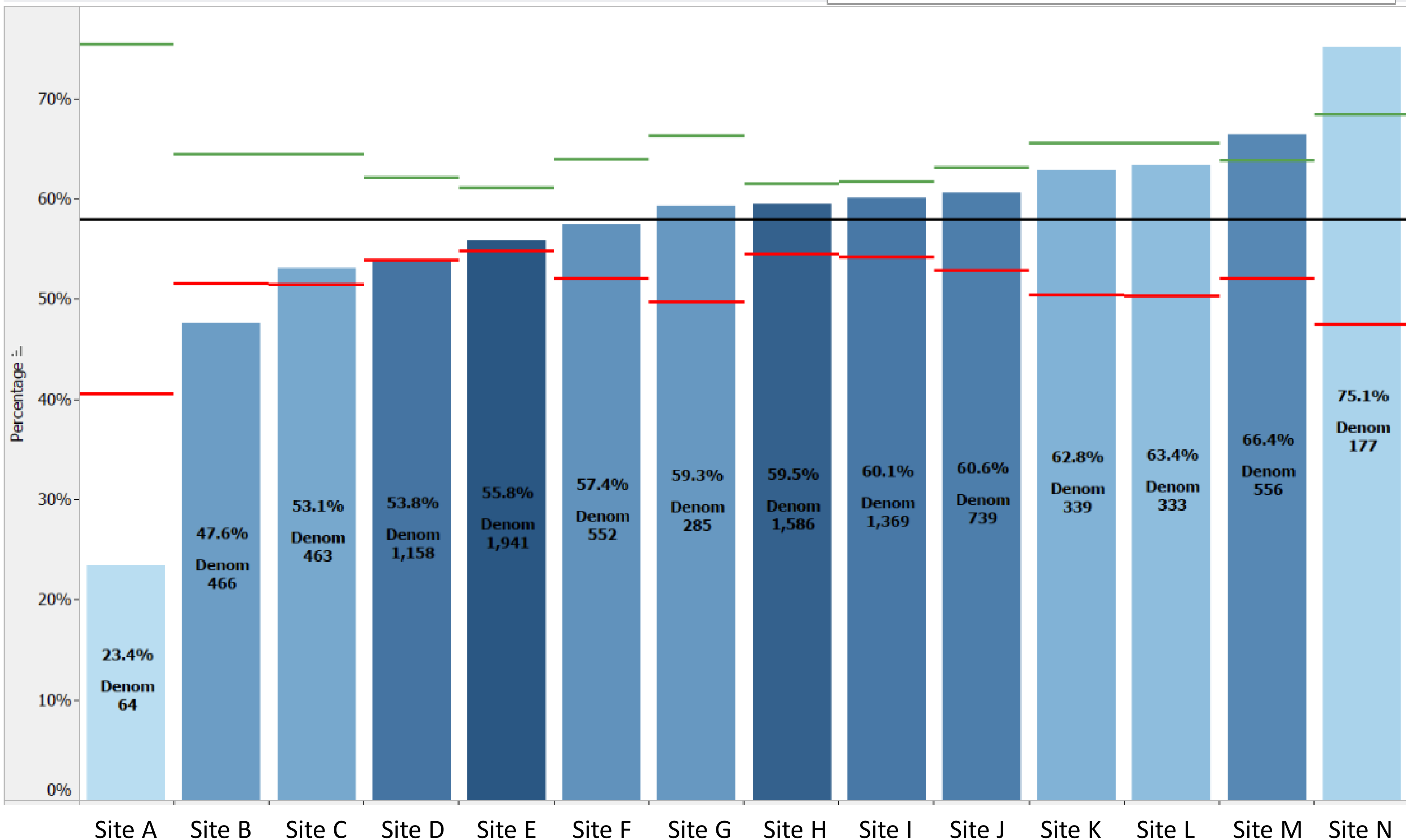
Diabetes Analysis

age	Last Panel Mgmnt Date	Gender	Race/Ethnicity	Last Visit Targets			A1C in Last Year	Averages			Next Appt	Last BMI	Last Microalbumin date	Appt Place Of Last Encounter With Any PCP	Last Encounter W/PCP	Last Diagnosis	Last Retinal Screening
				Systolic BP	Diastolic BP	A1C		Avg Systolic	Avg Diastolic	Avg A1C							
72	6/25/2013	M	Black or African American	96	63		N	100	59			24.48	03/04/2022	In Person	3/4/2022 10:00:00 AM	12/17/2020	1/17/2019
56		F	Undetermined H	107	67	6.40	Y	103	66	6.40		25.74	05/29/2020	In Person	2/14/2022 9:20:00 AM	5/27/2020	12/3/2019
62		F	Undetermined H	104	76	6.90	Y	104	76	6.90		23.77	06/17/2021	In Person	8/12/2021 11:00:00 AM	6/30/2020	1/21/2019
79		M	Undetermined H	116	79	8.30	Y	105	70	7.45		27.66	01/14/2021	In Person	11/22/2021 11:20:00 AM	6/7/2021	2/18/2022
85		M	Undetermined H	100	56	6.50	Y	106	60	6.50		26.79	02/18/2021	In Person	2/14/2022 10:20:00 AM	10/1/2020	6/6/2019
76		F	Undetermined H	108	66	10.50	Y	106	64	10.50		34.67	02/06/2020	In Person	2/11/2022 11:00:00 AM	11/14/2020	9/13/2018
44		F	Undetermined H	107	53		N	107	53		3/14/2022 3:20:00 PM	36.80	01/18/2021	In Person	3/29/2021 3:20:00 PM	10/23/2020	4/16/2021
64	10/28/2014	F	Undetermined H	107	67	7.20	Y	107	67	7.60		20.77	03/16/2021	Phone	1/12/2022 10:00:00 AM	5/12/2020	12/6/2016
62		F	Undetermined H	116	73		N	108	72		3/14/2022 9:00:00 AM	27.47	01/06/2021	In Person	12/2/2021 2:40:00 PM	10/3/2020	5/12/2021
70		M	American Indian or Alaska Native	119	74	6.50	Y	109	70	6.65		28.73	07/12/2021	In Person	11/18/2021 3:40:00 PM	10/3/2020	7/19/2019
54	8/9/2012	F	Black or African American	109	72	10.90	Y	110	73	10.90		37.97		In Person	11/5/2021 11:00:00 AM	11/5/2021	
66		F	Undetermined H	100	61	9.70	Y	111	67	9.70		29.32	12/10/2021	In Person	2/7/2022 10:00:00 AM	12/12/2020	11/22/2021
65		M	Asian	118	73	5.70	Y	111	67	5.70		22.11	12/13/2021	In Person	12/13/2021 11:20:00 AM	10/9/2020	12/24/2018
57		F	Undetermined H	108	64	4.90	Y	111	70	4.90		32.03	10/06/2020	In Person	2/8/2022 10:00:00 AM	10/1/2020	8/11/2020
31		F	White	111	71		N	111	71			47.35	01/25/2008	In Person	10/28/2021 3:40:00 PM	5/14/2021	
53		F	Undetermined H	112	63	5.30	Y	112	63	5.30		39.13	09/25/2020	In Person	2/3/2022 12:20:00 PM	11/20/2020	10/5/2021
49	5/28/2013	F	Undetermined H	103	57	11.10	Y	112	67	10.40		37.76	06/23/2021	In Person	9/16/2021 2:40:00 PM	8/28/2021	1/9/2020
74		M	Undetermined H	110	67	6.80	Y	112	73	6.73		37.01	09/07/2021	In Person	2/14/2022 2:00:00 PM	10/29/2021	6/10/2021
66		M	Undetermined H	116	57	7.40	Y	113	57	7.40		22.50	07/08/2021	In Person	1/24/2022 2:08:00 PM	11/17/2020	2/8/2022

Analysis of Means

Measure

Percent of female patients with a mammogram in the last 2 years



The green reference line for an organization is its upper limit for this measure. Red is the lower limit. The grey line between the green and red is the overall site average for this measure. Sometimes certain low denominator sites are excluded from the calculations. If there are low denominator site exclusions they are listed below. Darker blue bar indicate a higher denominator and lighter blue a lower denominator.

Excluded Low Denominator Sites

MOSES/WEITZMAN
Health System

Questions?

NTTAP National Health Center Training & Technical Assistance Partners Clinical Workforce Development
A PROJECT OF Community Health Center, Inc. and the weitzman institute

MOSES/WEITZMAN Health System

Action Period 7 Deliverables

- Conduct your weekly team meetings
- **Assignment**: Showcase Presentation

Google Drive

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

NTTAP
National Health Center Training
& Technical Assistance Partners
Clinical Workforce Development
A PROJECT OF
Community Health Center, Inc.
and the weitzman institute

MOSES/WEITZMAN
Health System

Showcase Overview

- Due Date: Wednesday June 5th
- Date: Wednesday June 19th
- Template Overview:
  - Innovations*
  - ‘Aha’ Moments*
  - Recommendations to others*
  - Global Aim Statement
  - Process Map or other visuals
  - Specific Aim Statement
  - Measures/Impacts
  - Key Partners
  - Quote from leadership
  - Quote from team member

*Required

ADVANCING TEAM-BASED CARE

2021-2022 NTTAP Learning Collaborative

MHEDS
Multi-Cultural Health Evaluation Delivery System

HEALTH CENTER DESCRIPTION

MHEDS is a FQHC Look-Alike located in Erie, PA. We have 2 clinic sites and offer primary care, women’s health, internal medicine, health education and medical case management.

Our patient population consists primarily of refugees and immigrants from more than 15 countries, with about 80% better served in a language other than English. Many of our staff come from the communities we serve.

KEY PARTNERS

Internal stakeholders:
- ⇒ Clinical team
- ⇒ QI Staff
- ⇒ IT Staff
- ⇒ MHEDS’ Management and Board of Directors

External stakeholders:
- ⇒ Patients
- ⇒ Insurers

GLOBAL AIM STATEMENT

We aim to improve the cervical cancer screening process at our JFK Center office

The process starts with pre-visit planning and CDSS alert review and **ends with** proper documentation of Pap test results in the Electronic Health Record such that the results are pulled in our UDS report.

PROCESS MAP

VOICE OF THE TEAM

“This project has been helpful because we are teaching our patients about screening exams and the importance of finding problems early. We have also learned the value of tracking down results and looking at our numbers so we can make sure all of our patients benefit from screenings.”

- Rolonda Johnson, RN

SPECIFIC AIM STATEMENT

We will increase the percentage of eligible women who have cervical cancer screening done and documented in the chart from 19% to 50% by December 31, 2022.

INNOVATIONS

- Implemented daily 10 minute morning huddles.
- Clarified team communication through the electronic health record using telephone encounters and internal messaging.
- Developed streamlined workflow by creating detailed and process maps to identify areas for improvement.
- Created a detailed playbook of cervical cancer screening for future staff training.

VOICE OF LEADERSHIP

Prior to starting this collaborative, MHEDS realized “we need to decrease variation in many areas, both clinical and administrative, and communication throughout the organization needs to be consistent and effective.”

One outcome from participating in this collaborative is learning the value of scheduling time for staff to talk as a group, insuring that every member feels comfortable voicing their ideas and opinions.

- Sue Chute, COO

RECOMMENDATIONS

- Commit and plan time for team meetings. Don’t expect staff to always meet during lunch. Block a consistent day and time weekly or monthly.
- Really focus on understanding every aspect of the current process before making a change. Process mapping is a great exercise that we have not previously used, but will definitely use again for future projects.

PDSA REFLECTIONS

- The changes we selected were simple for staff and effective.
- Looking at the data in detail uncovered a problem we didn’t even know we had, which led to another change idea.

MEASURES

After just one month of implementing the changes in our PDSA cycles, we saw an organization level increase in compliance with **cervical cancer screening from 19% in 2021 to 22%** organization-wide.

When each site was run separately, **the JFK office increased to 25% compared to the Peach St. office at 21%.**

MHEDS Cervical Cancer Screening

	Percent compliance with Cervical Cancer Screening
2021 UDS report - whole organization	19%
UDS report May 2022 - whole organization	22%
Peach St. May 2022	21%
JKF May 2022	25%

‘AHA’ MOMENT

Communication matters!

- ⇒ Making time to meet with the team to discuss problems and share ideas regularly is key.
- ⇒ When staff realize that their time, ideas and opinions are valued, they contribute in ways that management and administration can’t.
- ⇒ Many times our meetings about the improvement project resulted in discussions about other important problems that we were able to solve together as a group.

NTTAP National Health Center Training & Technical Assistance Partners Clinical Workforce Development
A PROJECT OF Community Health Center, Inc. and the weitzman institute

MOSES/WEITZMAN Health System

Reminders

Coach Calls:

- Wednesday June 5th 1:00pm ET / 10:00am PT
- Wednesday June 12th 1:00pm ET / 10:00am PT

Session 8: Wednesday June 19th 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

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A PROJECT OF
Community Health Center, Inc.
and the weitzman institute

MOSES/WEITZMAN
Health System

NTTAP Contact Information

Amanda Schiessl
Project Director/Co-PI
Amanda@mwhs1.com

Bianca Flowers
Project Manager
flowerb@mwhs1.com

Meaghan Angers
Project Manager
angersm@mwhs1.com

REMINDER: Complete evaluation in the poll!

Next Learning Session is **Wednesday June 19th**!

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A PROJECT OF Community Health Center, Inc. and the weitzman institute

MOSES/WEITZMAN Health System

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;

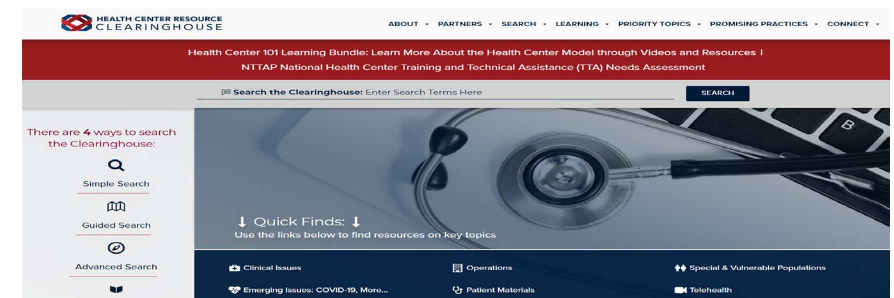
National Webinars on advancing team based care, implementing post-graduate residency training programs, and health professions student training in FQHCs.

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/