NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Comprehensive and Team-Based Care Learning Collaborative

Session 6: Wednesday April 9th, 2025

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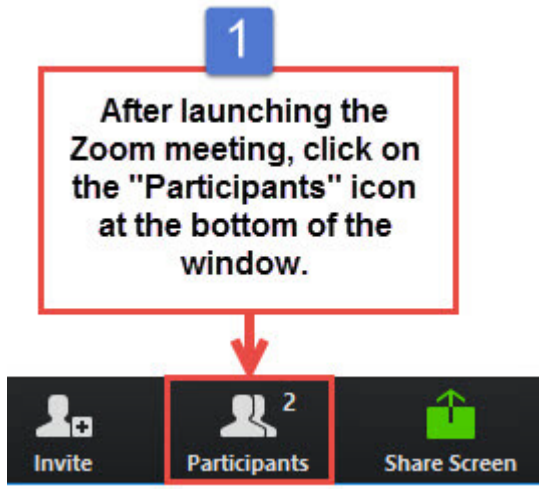
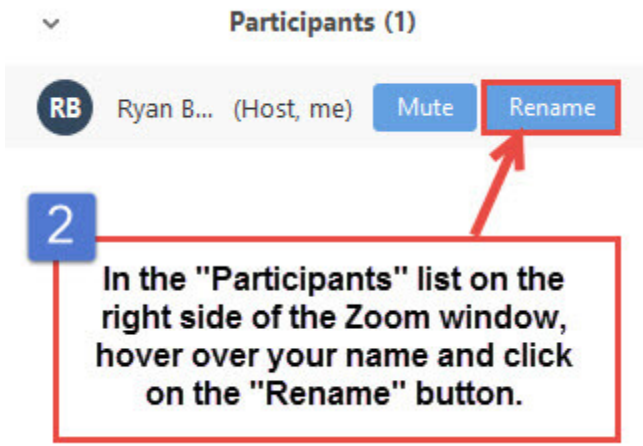
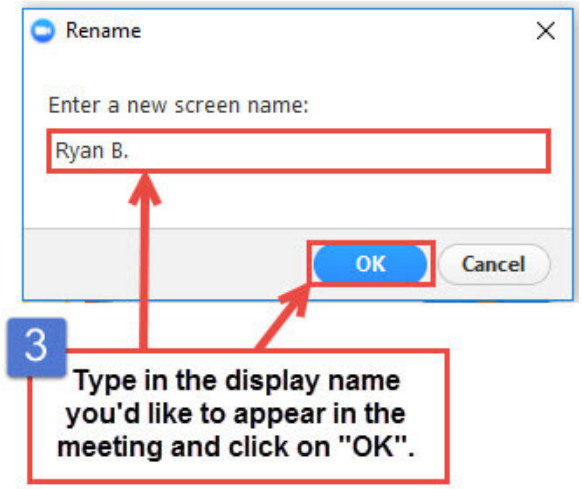
Get the Most Out of Your Zoom Experience

- 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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Agenda

- 1:00-1:05pm Welcome
- 1:05-1:40pm Meaningful Integration of HIT for Team-Based Care
- 1:40-2:00pm Role of the Pharmacist in Team-Based Care
- 2:00-2:25pm Quality Improvement: Standardization, Spread, and Playbooks
- 2:25-2:30pm Q/A, Wrap Up, and Evaluation

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Learning Collaborative Faculty

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- Co-PI & Project Director, NTTAP

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MOSES/WEITZMAN Health System

Always groundbreaking. Always grounded.

Community Health Center, Inc.

A leading Federally Qualified Health Center based in Connecticut.

ConferMED

A national eConsult platform improving patient access to specialty care.

The Consortium for Advanced Practice Providers

A membership, education, advocacy, and accreditation organization for APP postgraduate training.

National Institute for Medical Assistant Advancement

An accredited educational institution that trains medical assistants for a career in team-based care environments.

The Weitzman Institute

A center for innovative research, education, and policy.

Center for Key Populations

A health program with international reach, focused on the most vulnerable among us.

MOSES/WEITZMAN
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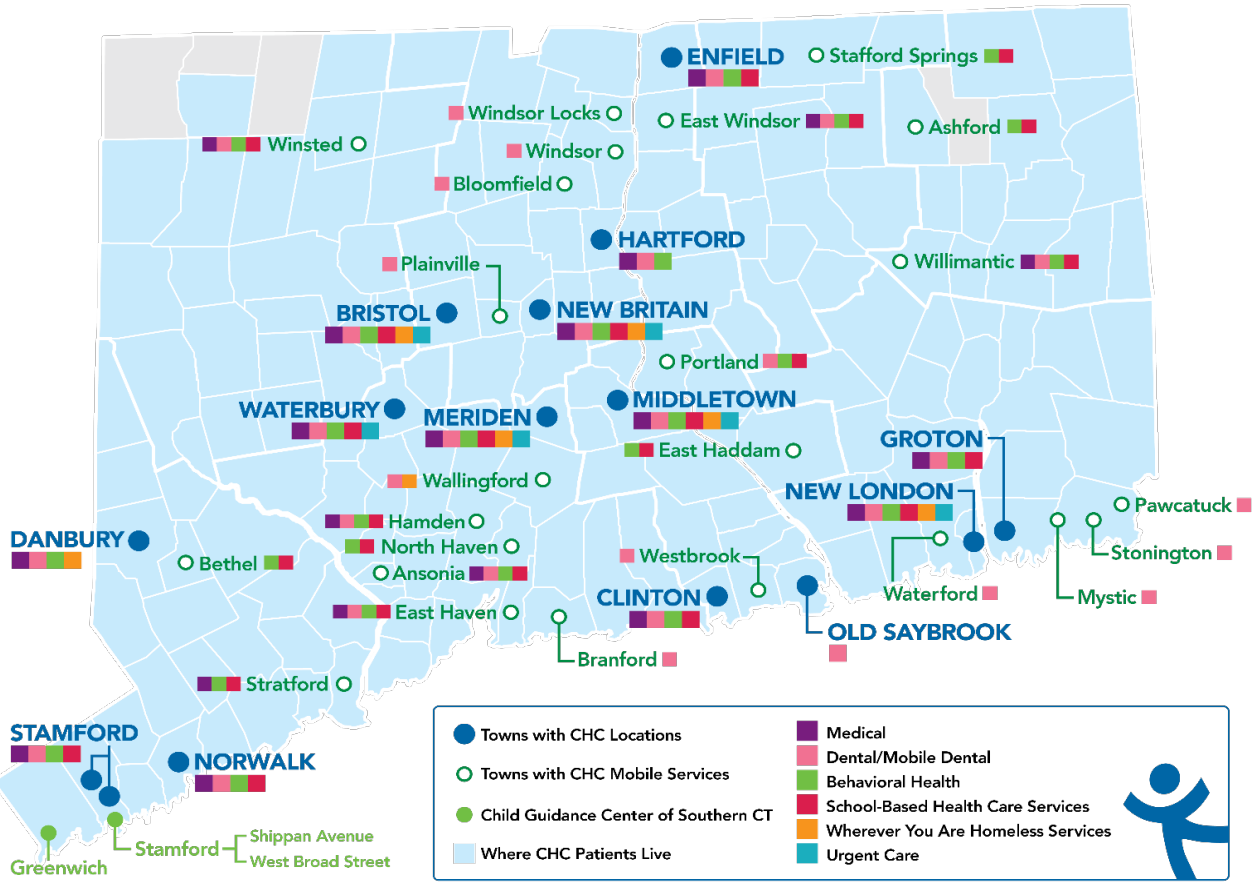
Locations & Service Sites



THREE FOUNDATIONAL PILLARS

1	2	3
Clinical Excellence	Research and Development	Training the Next Generation

Overview

- Founded: May 1, 1972
- Staff: 1,400
- Active Patients: 150,000
- Patients CY: 107,225
- SBHCs across CT: 152

Year	2021	2022	2023
Patients Seen	99,598	102,275	107,225

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National Training and Technical Assistance Partners (NTTAP)
Clinical Workforce Development

Provides **free** training and technical assistance to health centers across the nation through national webinars, activity sessions, learning collaboratives, trainings, publications, and more!

To learn more, visit weitzmaninstitute.org/nca

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Learning Collaborative Structure

- Eight 90-minute Learning Collaborative video conference sessions
- Weekly 60-minute calls between mentors and team lead
- Internal team workgroup meetings
- Access resources via the Weitzman Education Platform
- Use Google Drive to share your work

Learning Session Dates	
Learning Session 1	Wednesday November 13th
Learning Session 2	Wednesday December 11th
Learning Session 3	Wednesday January 8th
Learning Session 4	Wednesday February 12th
Learning Session 5	Wednesday March 12th
Learning Session 6	Wednesday April 9th
Learning Session 7	Wednesday May 14th
Learning Session 8	Wednesday June 11th

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2024-2025 Cohort	
Cherry Health	Grand Rapids, Michigan
Chestnut Family Health Center	Bloomington, Illinois
Community Health & Wellness Center of Greater Torrington	Torrington, Connecticut
Community Health Service Inc.	Moorhead, Minnesota
Complete Health DBA Community Health Center of Black Hills, Inc.	Rapid City, South Dakota
Excelth Inc.	New Orleans, Louisiana
HCCH Medical Clinics (Harrison County Community Hospital)	Bethany, Missouri
North Shore Community Health Inc.	Salem, Massachusetts
Primary Health Network	Sharon, Pennsylvania

Meaningful Integration of HIT for Team-Based Care

Taylor Miranda Thompson, MPH
Associate Director of Community Health Initiatives
Illinois Primary Health Care Association

April 2025

IPHCA

About The HITEQ Center

The HITEQ Center is a HRSA-funded National Training and Technical Assistance Partner (NTTAPs) that supports health centers to become data-driven by providing training, technical assistance, and resources for effective use of data, health IT, and EHRs. This support aims to enhance the quality, security, and documentation of care while addressing barriers and maximizing value.

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

The HITEQ Center is a HRSA-funded National Training and Technical Assistance Partner operated by JSI Research & Training, Inc. and Westat. 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 awards totaling $693,000 with 0% 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.

HITEQ Topic Areas

Virtual and digitally enabled care

Access to comprehensive care using health IT and telehealth

Privacy and security

Advancing interoperability and standards based exchange

Electronic patient engagement and digital health

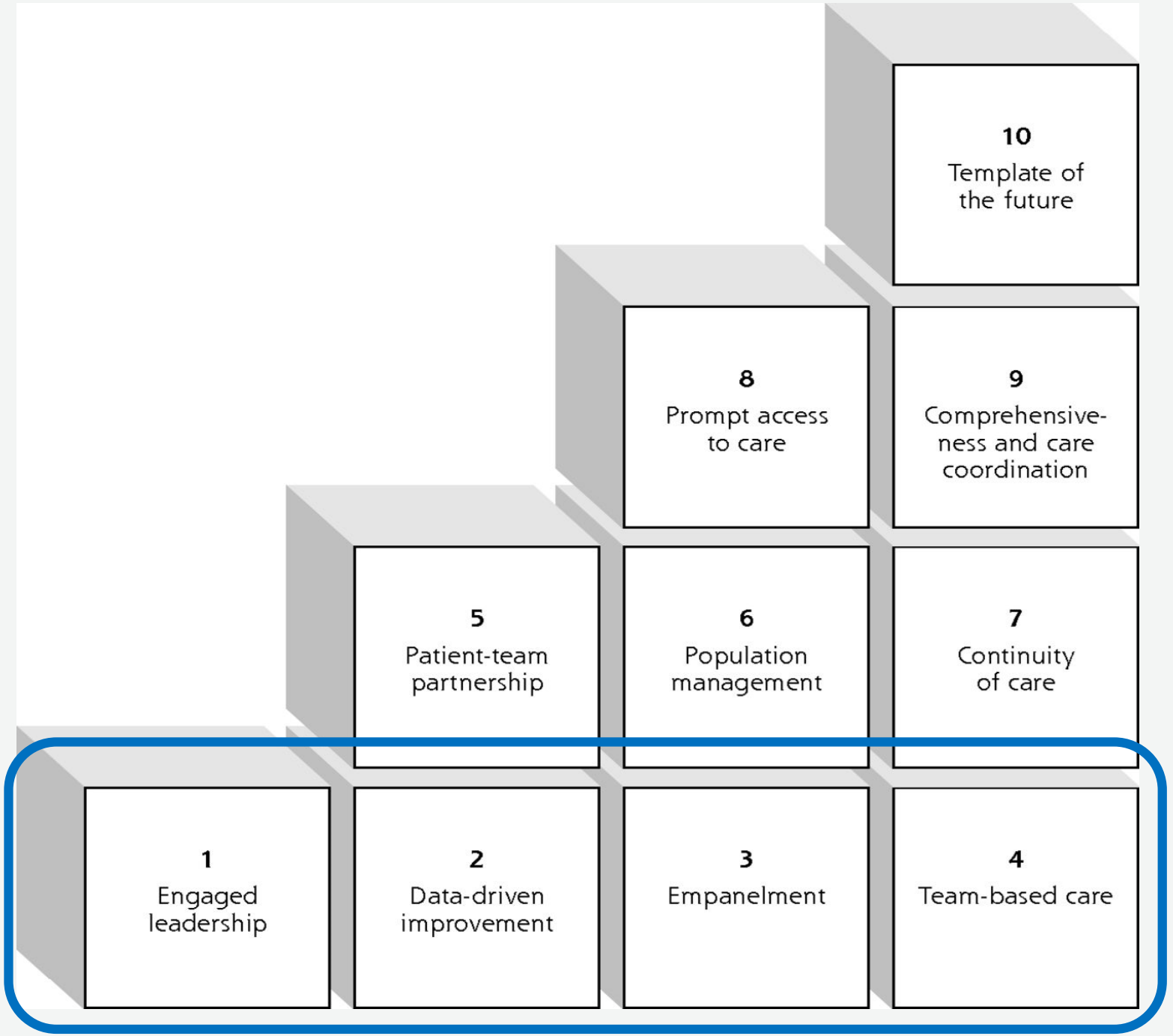
Readiness for value based care

Using health IT and telehealth to improve documentation integrity

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

Foundations of Team-Based Care

Building Blocks of Team-Based Care

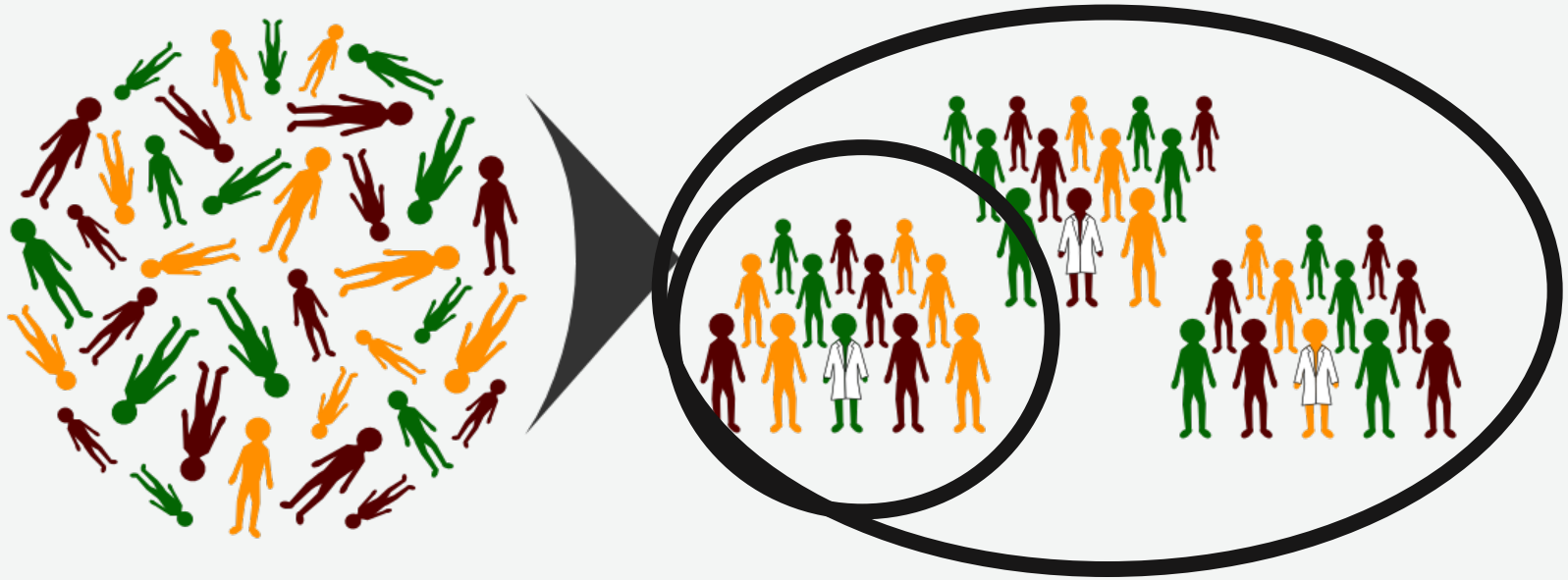


Empanelment

+ The process of assigning all patients in a practice to a designated provider/ care team

+ Patient panel:

+ Care team assumes responsibility for coordinating and providing all primary care services for their panel of patients



Team-Based Roles & Responsibilities

+ Use of HIT/ Business Intelligence (BI) tools is not just an IT function

+ Establish clear responsibilities by role and ensure end users are trained and comfortable

Role	Action
Front Desk	Each Monday, run outreach registries for patients • If patient has alerts due next week: Outreach to schedule • 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 • If patient needs information about prep for visit (e.g. fasting for labs), contact patient with instructions • Document all contact attempts within the TE template in NextGen with your initials

Integrating Health Information Technology (HIT)

Team-Based Roles & Responsibilities and HIT

+ Who needs to access the data/ tools?

+In what form?

- Different reports or uses of reports for different roles/functions (e.g., Chronic Care Management 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

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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

Phone: [redacted]
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

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" will likely differ by state based on scope of practice guidelines

+ Consider how infrastructure supports team members being able to work at the top of their scope/ skill set

+Huddles – Access to reports; time within schedule for nursing, MAs or team members to review reports and prepare

+ Standing orders – Facilitates trust and confidence that non-licensed staff are working according to guidelines, taking guesswork out of when an action is appropriate

- Simple – A1c, FIT test, urine pregnancy test
- Complex – Nursing labs and review with protocols/ provider review in place
    - UTI, STI, Strep culture

+ Sharing the care – What constraints are placed that could be opened up to share division of work among team members?

- E.g., Telephone encounters/ In-basket access

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?

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Thank you!

Questions?

Taylor Thompson, MPH

tthompson@iphca.org

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Role of the Pharmacist in Team-Based Care

Kara Lewis, Director of Clinical Pharmacy Services

Community Health Center, Inc.

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Poll

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

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

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Value of Integrating a Pharmacist into the Primary Care Setting

1. Improve health outcomes 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

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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/education and training for organization
- Chair of Pharmacy and Therapeutics Committee
- Clinical management of 340B drug pricing program

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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 or at request of prescriber consult 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

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*: Uniform Data System (UDS) med related measures
  - *Example*: HTN, DM, hyperlipidemia, CGM project
- **Continuous Glucose Monitoring (CGM) Project:** Successfully obtained for over 1000 patients by creating centralized ordering workflow managed by pharmacy team

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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 maintains website with pharmacy information (links to discount med programs, Medicaid formularies and forms, drug disposal sites, 340B prescribing info)
- Participation as faculty in Project ECHOs

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 CMO. Monitor prescribing trends in controlled medications across the organization, work with providers to ensure mitigation requirements met

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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, IT
- 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

Pharmacy Opportunities

- Drivers of other things based on data (i.e. pilot programs for specialty meds) and needs of the organization
- Fill primary care gaps (i.e. provider panel transition support)
- Cultivate pharmacy relationships with organization (external and internal)

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Questions?

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Quality Improvement Refresh:

Standardization and Spread
Introduction to Playbooks

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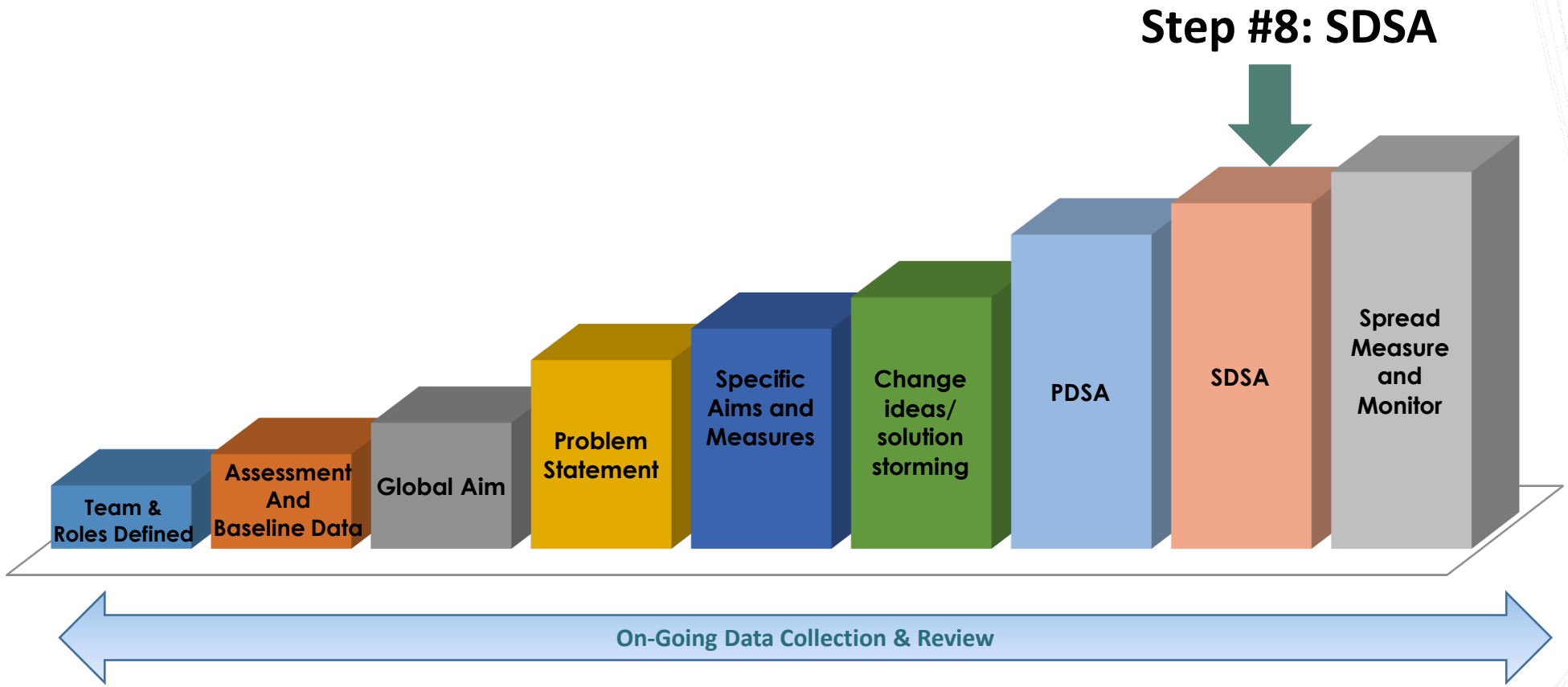
The Stages of Improvement



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Action Period

Global Aim

- We aim to improve…..

Specific Aim Statements

Specific Aim Statement
- PDSA#1-Measurement-Results
- PDSA #2-Meaurement-Results

Specific Aim Statement
- PDSA#1-Measurment-Results
- PDSA #2-Meaurement-Results

Specific Aim Statement
- PDSA#1-Measurement-Results
- PDSA#2-Measurement-Results

SDSA

Playbook

Spread

Testing Changes (PDSAs) to …..
Standardizing (SDSAs) to….

Testing by Another POD Before a Broader Spread

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Clarifying Terms

- **Plan-Do-Study-Act (PDSA) Cycle** – an approach to testing a change and learning from the experience
- **Standardize** – the effort to make something reliable and defect-free
- **Standardize-Do-Study-Act (SDSA) Cycle** – an approach to standardizing a process and learning from the experience
- **Spread** – the movement of an idea or process from one setting to another setting
- **Sustain** – the ability to maintain an effort (process) without or with minimal vulnerability over time

- You can spread a successful PDSA process to another POD
- You can create a playbook describing the new standardized steps and process
- You can create sustainable change that positively impacts patients

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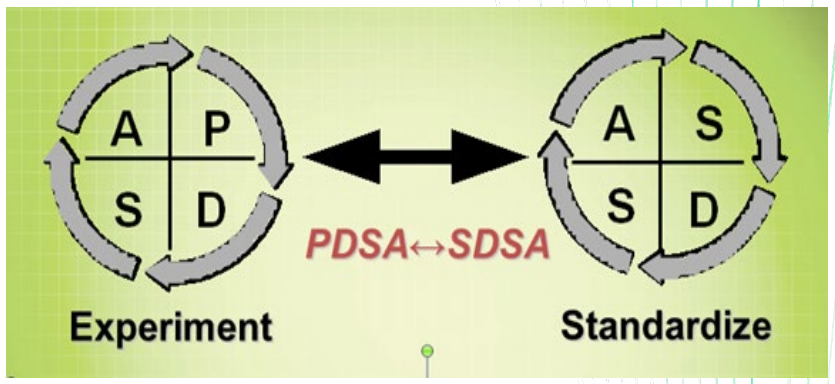
What is Spread?

- Spread is the process of taking a successful implementation process from a pilot, and replicating that change or package of changes (playbook) in other teams within a practice or other practices.
- During implementation, teams learn valuable lessons necessary for successful spread including key resource issues, best sequence of tasks, and how to help team members adopt and adapt a change.
- **Spread efforts benefit from the use of the SDSA cycle.** Teams adopting the change have the skills to test the standard and work toward achieving the results of other teams.

Ok, we've got this great process that is working well for our POD.

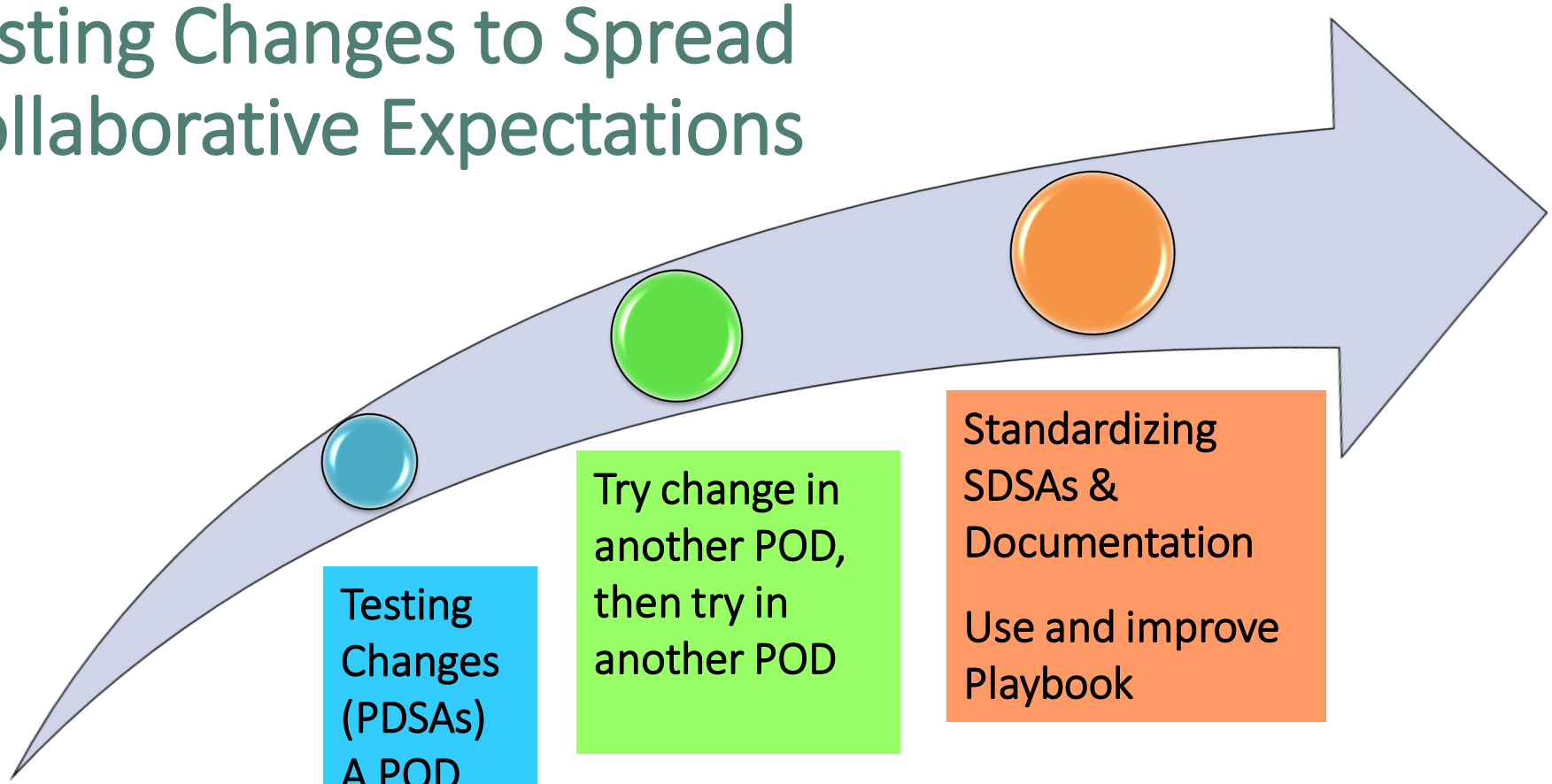
How do we know if we are ready to spread our work?

Is the Process Standardized?



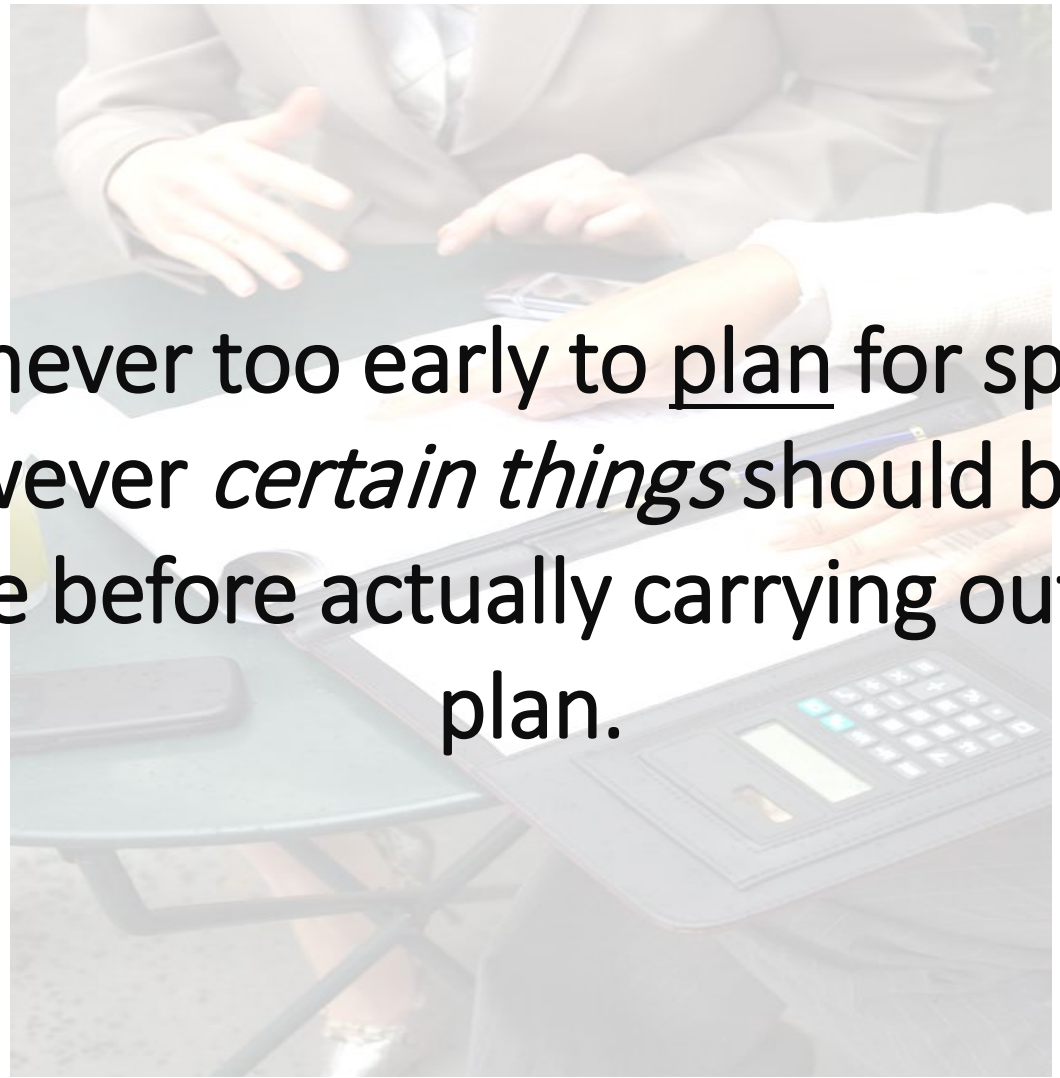
1. *Is the process failure free over time?*
   - Can your team count on it not to fail when everyone is following the process?
   - If one person overlooks it, will another catch it?
   - Are there clear specifications and communication?
   - Is the process supported by technology to reduce failure (EHR)?
   - A process recognizable by your team as "the way we do things" here
2. *Is there an expectation that that the evidence based process will be followed?*
3. *Is the process LEAN with minimal steps in the process?*

Testing Changes to Spread Collaborative Expectations



Broad Spread and Sustainability

A BIG Deal



It is never too early to plan for spread however *certain things* should be in place before actually carrying out the plan.

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Communicating Spread

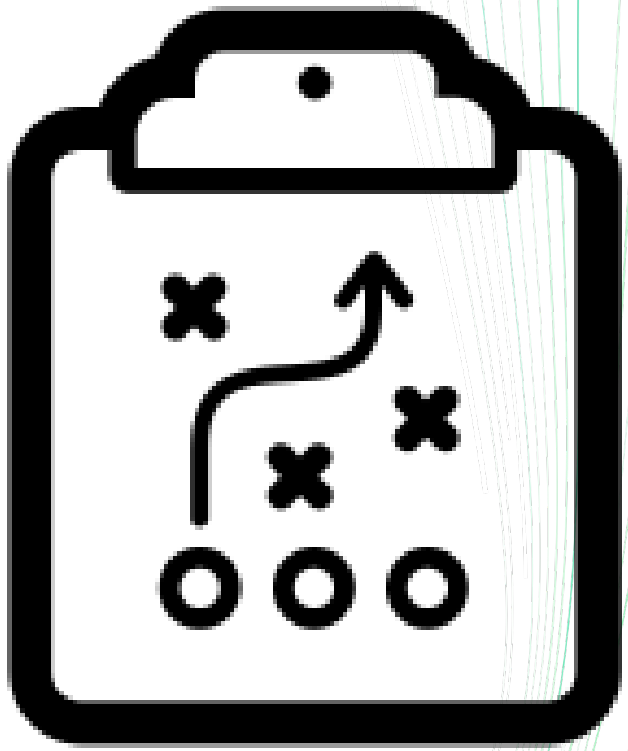
- Does leadership have all of the information they need to confidently speak with staff about the standardization?
- Have you gotten the approval of any committee or group internally that is required for standardization?
- Do you have a strategy to train the necessary staff on the standardization before it is implemented?
- Do you have (at the very least) the framework for a playbook that agency staff can use a reference?
- Have you developed a plan for evaluation with timelines and individuals responsible for measurement?

How Will You Know?

- A process recognizable by all in the workplace as **“the way we do things” here**
- **Five staff member**s can regularly articulate the process steps when asked individually to describe
- A “miss” (defect) in the process flow can be **immediately identified** so that it can corrected
  - There is a process in place to identify a failed step in process
  - There is a communication plan to support correcting a process defect to all areas
- **Measures** clearly indicate that the process is working

What is a Playbook?

- **Collection of processes and tools** that have been tested using improvement science and resulted in a 'way we want process done'.
- Playbook serve as **repository for standard processes** (SDSAs), ensuring improvement does not 'slip'.
- The purpose is to provide a common and **easy to access** place to post and search all standardized processes and tools – using technology.



Quality by Design, 2007

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Playbook Checklist

- Process Maps
- Role Responsibilities
- Protocols
- Standing Orders
- Data Collection Tools
- Pictures or Visuals

Quality by Design, 2007

PLAYBOOK CHECKLIST

Name of Process: _____
Contact Person:

Which of the following are included in this section?

☐ Process Maps and Role Responsibilities
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

☐ Protocols | Standing Orders | Forms
- ☐ _____
- ☐ _____
- ☐ _____

☐ Data Collection Tools for Measuring and Monitoring Standards Implementation
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

☐ Visuals and Pictures
- ☐ _____
- ☐ _____
- ☐ _____

WHO will observe, review and update? _____ (Name)
_____ (Frequency of Review)

DATE of last review: _____ (Date)

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Playbook Template Example

Play #1 – (Who is Involved in this step)

(Title)

Overview:

Key Steps

-

Process flow instructions and flow map:
(Copy/paste process flow below)

Strategy
This play begins the eight-stage process of creating major change in an organization.
Change Management Component: Play #1 helps to establish the sense of urgency with the identified organization, brings the team together to examine data and realities of the current process, potential crises and major opportunities and how these can be enhanced by implementation of CECN eConsult model.

Ownership and Involvement
The Implementation Manager will coordinate all meetings and communications with initial team. Primary contacts in this play will include XXXXX.

Lessons Learned

- Standardization is on-going and the process requires continuous attention.
- Prioritize a true change in agency culture not just process.
- Facilitate collaborations with internal departments early in the process (i.e.: data, business intelligence)
- Be prepared for the “hoops” you need to jump through to get to an agency wide initiative – committee presentations, BOD approval
- Patient feedback can invigorate enthusiasm in staff
- Training to all levels of staff is arduous but necessary in standardization – remember to include administration, IT, billing, finance.
- Communication to the correct individuals is a key to success.
- Recognition for key staff (especially those with increased work load) is essential
- Leadership buy-in can make or break an initiative.
- Assign a key point of contact for questions, concerns and suggestions.
- Highlight successes often!

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Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Questions?

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Wrap-Up

Action Period 6 Deliverables

- Conduct your weekly team meetings
- Team leads attend weekly 60-minute team leader check-in calls
- Complete Step 8 and 9 in the Quality Improvement Workbook

Access the Google Drive to upload deliverables:

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Next Steps

- **Team Leader Check-In Calls**
  - Wednesday April 16th 1:00pm Eastern / 10:00am Pacific
  - Wednesday April 23rd 1:00pm Eastern / 10:00am Pacific
  - Wednesday April 30th 1:00pm Eastern / 10:00am Pacific
  - Wednesday May 7th 1:00pm Eastern / 10:00am Pacific
- **Session 7**: Wednesday May 14th 1:00pm Eastern / 10:00am Pacific

- Register for the Weitzman Education Platform to receive CME, resources, and more!

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Explore more resources!

National Learning Library:
Resources for Clinical Workforce Development

https://www.weitzmaninstitute.org/ncaresources

Health Center Resource Clearinghouse

https://www.healthcenterinfo.org/

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Contact Us!

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REMINDER: Complete evaluation in the poll!

Next Learning Session is **Wednesday May 14th!**