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

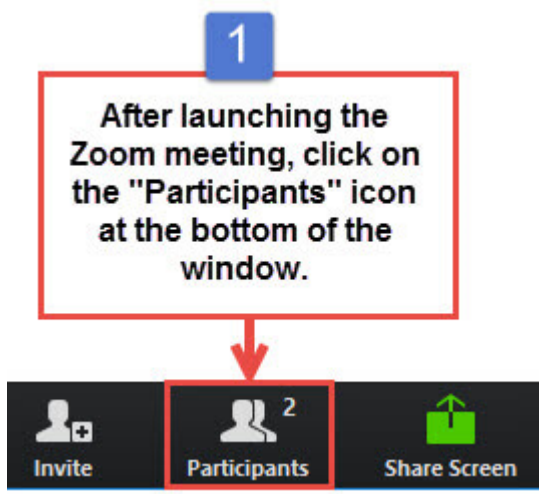
Comprehensive and Team-Based Care Community of Practice (CoP)

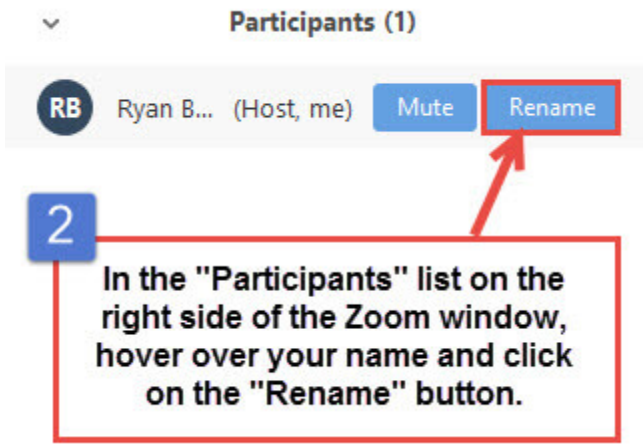
Session Two: December 3rd, 2025

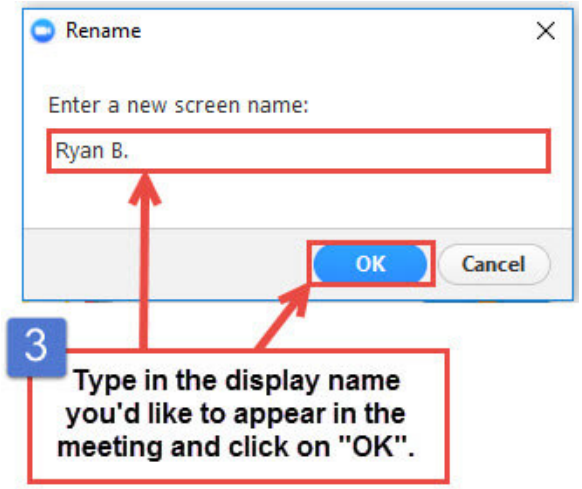
This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $550,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

Get the Most Out of Your Zoom Experience

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







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Session Agenda

- 1:00-1:05pm Introduction
- 1:05-1:40pm Fundamentals of Comprehensive Care & Primary Care Challenges
- 1:40-2:05pm Building a Team Culture: Sharing the Care
- 2:05-2:15pm Developing a Communication Plan & Stakeholder Analysis
- 2:15-2:25pm Quality Improvement Refresh: Global Aim Statement
- 2:25-2:30pm Q/A, Next Steps, and Evaluation

Community of Practice (CoP) Faculty

Tom Bodenheimer, MD

- Physician and Founding Director, Center for Excellence in Primary Care

Deborah Ward, RN

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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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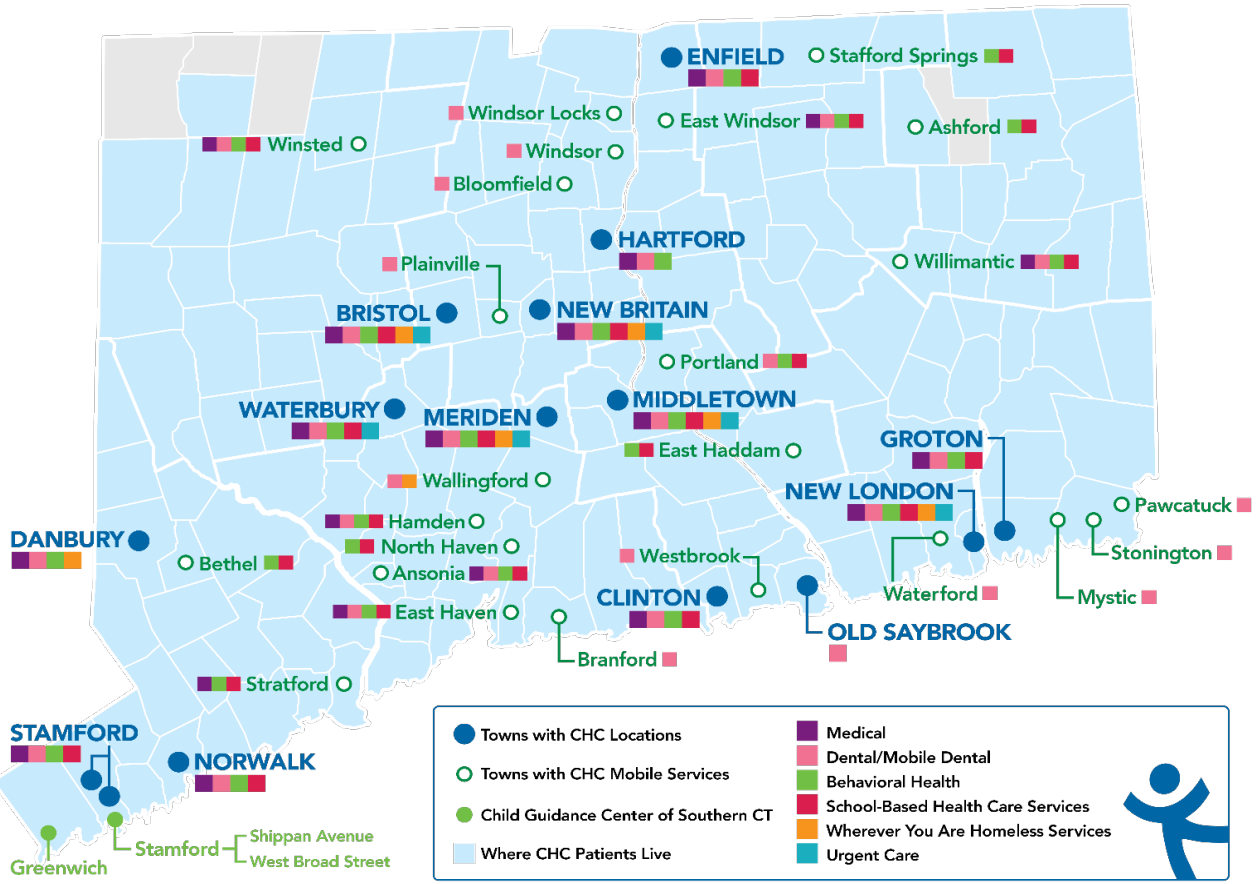
Locations & Service Sites



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	2022	2023	2024
Patients Seen	102,275	104,917	107,225

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

Provides **free** training and technical assistance to federally funded health centers and look-alikes across the nation through webinars, activity sessions, communities of practice, trainings, publications, and more!

To learn more, please visit https://www.weitzmaninstitute.org/nca.

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CoP Structure

- Eight 90-minute learning sessions
- Weekly 60-minute team leader check-in calls
- Internal health center team meetings
- Access resources via the Weitzman Education Platform
- Use Google Drive to share your work

Learning Session Dates	
Learning Session 1	Wednesday November 5th
Learning Session 2	Wednesday December 3rd
Learning Session 3	Wednesday January 14th
Learning Session 4	Wednesday February 4th
Learning Session 5	Wednesday March 4th
Learning Session 6	Wednesday April 1st
Learning Session 7	Wednesday May 6th
Learning Session 8	Wednesday June 3rd

2025-2026 Cohort	
Brooklyn Plaza Medical Center, Inc.	Brooklyn, New York
Community Access Network	Lynchburg, Virginia
Community Health and Dental Care (CHDC)	Pottstown, Pennsylvania
Excelth Inc.	New Orleans, Louisiana
Genesis Family Health DBA United Methodist Western	Garden City, Kansas
Ho-Chunk Health Care Center	Black River Falls, Wisconsin
Lyon-Martin Community Health Services	San Francisco, California
Morris Heights Health Center	Bronx, New York
New Hanover Community Health Center DBA MedNorth Health Center	Wimington, North Carolina
Promise Healthcare	Champaign, Illinois
Total Health Care	Baltimore, Maryland
The Wright Center for Community Health	Scranton, Pennsylvania

Community Access Network

Team Members:
DON – Jill Mabe
DOP – Dr. Jennifer Stirgwolt
MA – Terry McCoy
CHW – Towana Polk
DPH – Amy Bornhoft
CMO – Dr. Michael Judd

Community Access Network is a FQHC Look-Alike, located in Lynchburg, Virginia. We offer:

Primary medical care
Walk in care
Women's health
Behavioral health
Sexual health services
Dental care
Pharmacy
And more…

CAN's current Breast Cancer Screening rate is 32%. We look forward to applying the processes we learn here to improve our approach to quality as Teams and improve CAN's Breast Cancer Screening rate to 56%

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UCSF Department of Family & Community Medicine
Center for Excellence in Primary Care

Fundamentals of Primary Care: Primary Care's Challenges

Introduction to CEPC, History of LEAP, & Building Blocks of Primary Care

Polling Question #1

At my health center:

a. Most patients have prompt access to their personal primary care clinician
b. Most patients do not have prompt access to their personal primary care clinician
c. Most patients are not empaneled to a personal primary care clinician and see whichever clinician is most accessible
d. Unsure

At my health center:

a. On average, clinicians feel that they have the time and resources to care for their panel of patients
b. On average, clinicians feel that they don't have the time and resources to care for their panel of patients
c. Most clinicians do not have a panel of patients that they are responsible for
d. Unsure

At my health center:

a. We have teams and the same people are working on their team almost every day
b. We have teams but people often work on different teams because of scheduling problems
c. Unsure

At my health center:

a. Burnout is a problem for both clinicians and staff, but a manageable problem
b. Burnout is not a much of a problem
c. Burnout is severe. Many clinicians feel that primary care is not do-able — too many patients to see and not enough help from teams to provide good care for their patients
d. Unsure

Center for Excellence in Primary Care (CEPC)

Situated in the UCSF Department of Family and Community Medicine, CEPC identifies, develops, and disseminates promising innovations in primary care to improve the patient experience, enhance population health and health equity, and restore joy and satisfaction in the practice of primary care.

http://cepc.ucsf.edu/

Why do we need teams?

- A patient-care team is a group of diverse clinicians and practice staff who communicate with each other regularly about the care of a defined group of patients and participate in that care.
- Rather than a lone clinician being responsible for the care of a panel of patients, the team shares that responsibility.
- On an effective team, everyone on the team makes important contributions to the care of the team's panel of patients.
- Question: Why are teams necessary in primary care? Please answer this question either by speaking or writing in the chat.

Why do we need effective teams in primary care?

- Patient access is poor and getting worse
- Continuity of care is under stress
- Panel sizes are too large because not enough clinicians choose primary care careers (**clinicians are physicians, nurse practitioners (NPs), and physician assistants (PAs)**)
- Poor access and large panels are major contributors to burnout
- Effective teams can help solve these challenges; poorly functioning teams cannot
- Today we will focus on primary care's challenges. In the following two learning sessions we will focus on teams.

Access is Getting Worse

- 2015 household survey: 48% of people in US who were sick could not obtain same/next-day appointment. [Commonwealth Fund, 2015 International Profiles of Health Care Systems]
- In 2017, secret shopper calls were conducted to 2,000 practices in 30 cities. New patient wait times for primary care appointments:
  - 2014: 20 days
  - 2017: 30 days

Source: Merritt Hawkins 2017 Survey of Physician Appointment Wait Times

Challenges to Continuity of Care

- Continuity of care means patients seeing the same primary care clinician or team whenever they need care, whether in person, by phone/video visit, or through the electronic patient portal
- US primary care acute visits per capita decreased by 30%, 2002 – 2015
- At the same time, more and more patients are seeking primary care in urgent care, retail clinic, and emergency departments
- As a result, many patients are seeing different primary care clinicians in different sites with little communication among the clinicians

Continuity of care is associated with:

- ✓ Better preventive care
- ✓ Better chronic care
- ✓ Greater patient satisfaction
- ✓ Lower healthcare costs

Primary Care Panels are Too Large

- 7500 primary care physicians enter the workforce each year; 8,500 retire each year
- Major increase in NPs/PAs helps relieve the shortage
- Clinician-population ratio going down (physicians, NPs, PAs)
- As a result, panel sizes are too large. U.S. average 2194. Norway: 1100
- With a panel of 2500, it takes a primary care physician without a team 26.7 hours per day to provide excellent care; **with an effective team it takes 9.3 hours per day**
- Panel size in FQHCs is smaller because FQHC patients have more chronic conditions, more severe chronic conditions, more problems with health-related needs
- Write in the chat if you know the average panel size in your health center

Source: Bodenheimer T. Revitalizing primary care, Parts 1 and 2. Ann Fam Med 2022;20:464-468, 469-478; Porter et al. J Gen Intern Med 2022, July 1

Polling Question #2

In your health center, nurse practitioners and physician assistants:

a. Have their own panels

b. Some have their own panels; others help physicians care for their panels

c. None have their own panels

d. We do not employ nurse practitioners or physician assistants.

e. Unsure

Primary Care Clinicians in Health Centers

- NPs and PAs are critical components of the primary care system in low-income communities around the U.S.
- HRSA's 2024 UDS report: In FQHCs,
  - NP/PA FTEs (17,658.41)
    - Nurse Practitioners: 13,434.71
    - Physician Assistants: 4,223.70
  - Physician FTEs: 15,755.73

Burnout

- National survey, % of physicians reporting burnout in 2020:
  - All physicians: 38%
  - Primary care physicians: Over 50%[1]
- Survey of 740 primary care clinicians and staff in 2 local health systems:
  - 53% of clinicians and staff reported burnout
  - Higher rates of burnout were associated with leaving practice[2]
- Burnout is strongly associated with reductions in work hours[3]
- More burnout means more physicians leaving or cutting their hours, leading to more work for everyone else
- Effective teams can greatly mitigate burnout

1. Shanafelt TD et al. Mayo Clinic Proceedings 2022;97:491-506
2. Willard-Grace R et al. Burnout and health care workforce turnover. Ann Fam Med 2019;17:36-41.
3. Shanafelt TD et al. Mayo Clin Proc 2016;91:422-431)

Burnout

- The Maslach Burnout Inventory measures 3 components of burnout
- Two of these are:
  - Emotional exhaustion
  - Cynicism
- Emotional exhaustion: “I have too much work.” Seeing too many patients too fast for too many days
- Cynicism: feeling alienated from the work: “I don’t like my work” – EMR documentation
- In one study:
  - 27% of the average physician’s day was face time with patients.
  - 49% was spent on EMR and administrative work[4]

Even with burnout, many primary care clinicians feel great joy in our work

4. Sinsky et al.. Ann Intern Med 2016;165:753-760

Burnout

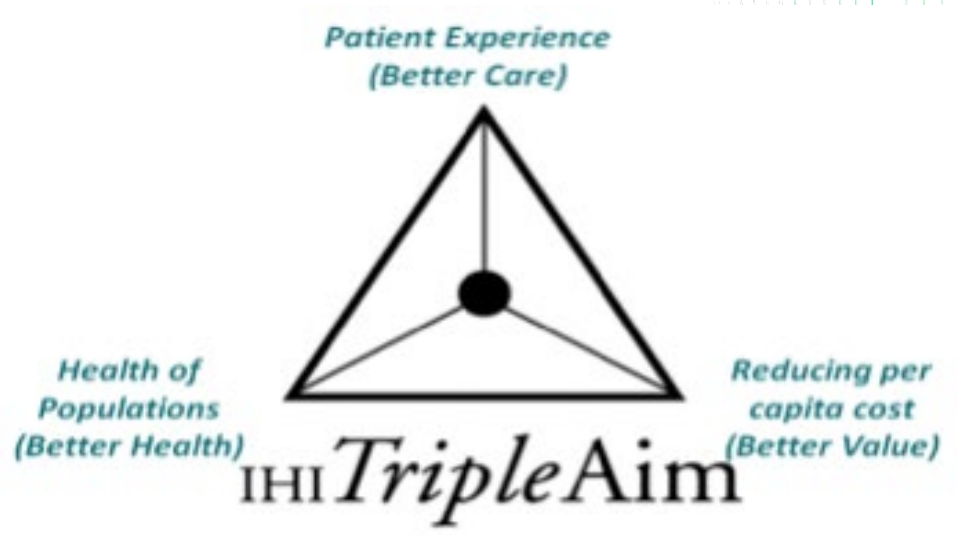
- As access gets worse, burnout increases.
- Patients are calling to get into the clinic or dropping in, creating chaos in the daily schedule.
- As panel size increases, burnout increases.
- Almost all burnout studies are about physicians; most nursing burnout studies focus on hospital nursing.
- In a recent letter to the New York Times, a California family physician suggested that **burnout** is not the best term. It should be **overwork**.

The devastation and the beauty of California

Emblematic of the 2 sides – burnout and joy – of primary care

Don Berwick and the Triple Aim

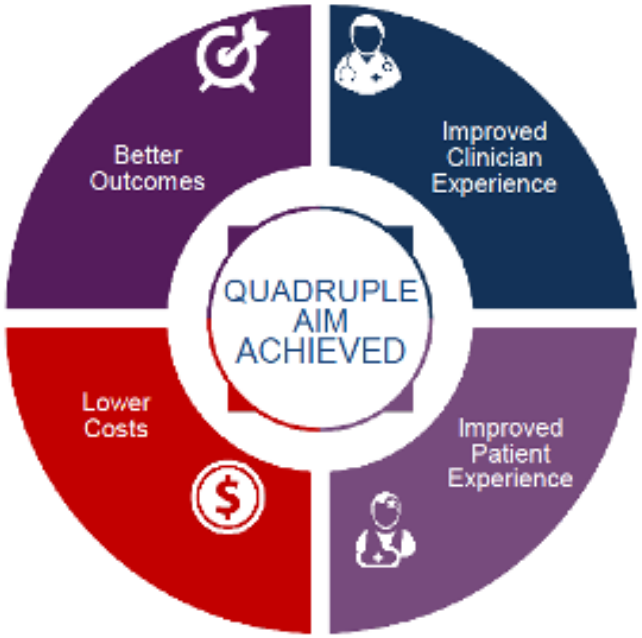
- In 2008, Don Berwick, a pediatrician and the nation's foremost leader on improving health care, unveiled the doctrine of the triple aim.
- The triple aim:
  1. Improving the patient experience of care
  2. Improving the health of populations
  3. Reducing the cost of health care
- The triple aim was widely accepted as health care's overarching goals.



5. Berwick DM et al. The triple aim: care, health, and cost. Health Affairs 2008;27:759-769.

The Quadruple Aim

- As evidence of clinician and health worker burnout grew, the idea was introduced that the three aims were not achievable without a satisfied health workforce.
- This led to the addition of a fourth aim:
  4. Improving the worklife of clinicians and staff
- The fourth aim helps to achieve the other 3 aims because health worker dissatisfaction is associated with: poor patient experience, reduced patient adherence to treatment plans thereby worsening community health, and higher costs of care.



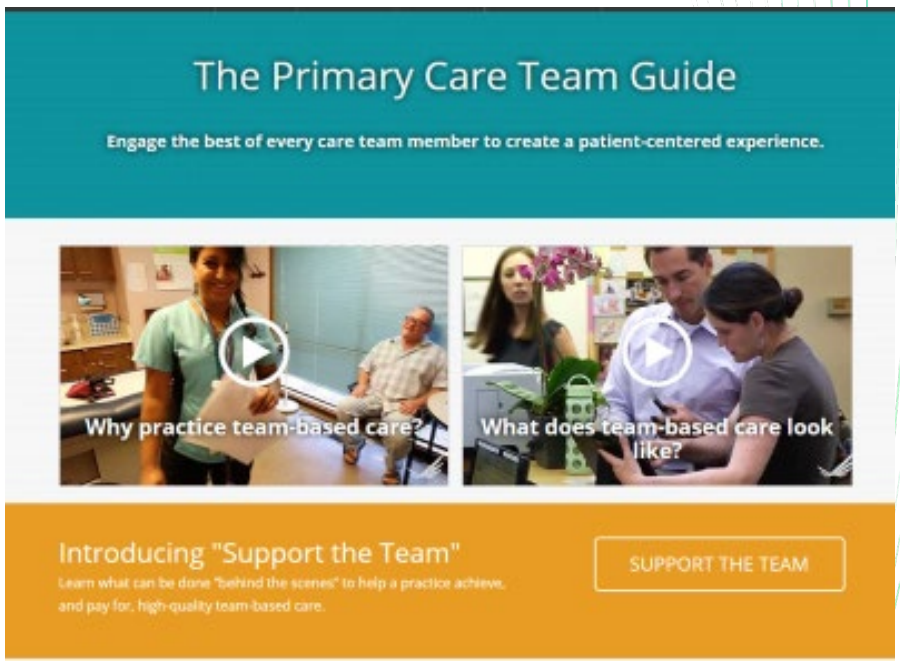
6. Bodenheimer and Sinsky. From triple to quadruple aim: care of the patient requires care of the provider. Ann Fam Med 2014;12:573-576.

The LEAP Project
Learning from Effective Ambulatory Practices

- Funded by the Robert Wood Johnson Foundation, chaired by Ed Wagner and Margaret Flinter.
- 2012-2013: LEAP project teams performed detailed 3-day site visits to 31 primary care practices.
- The practices had been selected through a careful process of identifying the highest-performing primary care practices in the country.
- Extensive site visit notes were taken and the 31 practices participated in a learning community to identify and interpret themes from the site visits.

LEAP's Primary Care Team Guide

- LEAP has produced a terrific web-based primary care team guide
- The team guide offers learning modules, materials on the different team members, and practice assessment tools on team-based care
- It is worth spending time with this website: http://www.improvingprimarycare.org



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10 Building Blocks of High-Performing Primary Care

10 Building Blocks:
How were they developed?

Case Study Methodology

- Site visits to 23 highly-regarded practices
- Our experience as practice coaches at 25 additional practices
- Review of existing models and research

→ 8 hospital-based clinics

7 integrated delivery system sites

6 FQHCs

2 independent private practices

7 of 23 had 5 or fewer physicians

What do we mean by "high-performing"?

- Practices known as innovators
- Reputation for high-performance in one or more of the quadruple aims

23 High-Performing Practices

These 23 are only a small sample of the many high-performing primary care practices in the U.S.

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Patient—Team Partnership

Population Management

Data-Driven Improvement

Template of the Future

Empanelment

Prompt Access to Care

Team-Based Care

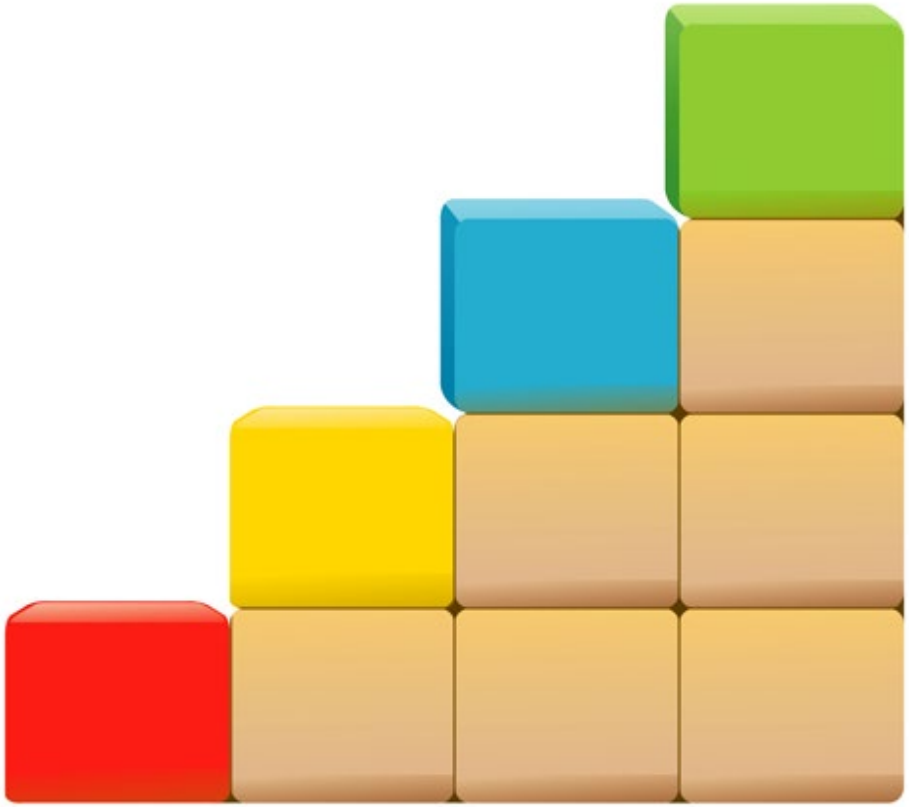
Comprehensiveness and Care Coordination

Engaged Leadership

Continuity of Care

What are the foundational building blocks (1,2,3,4)?
Write in the chat which BBs need to be addressed first

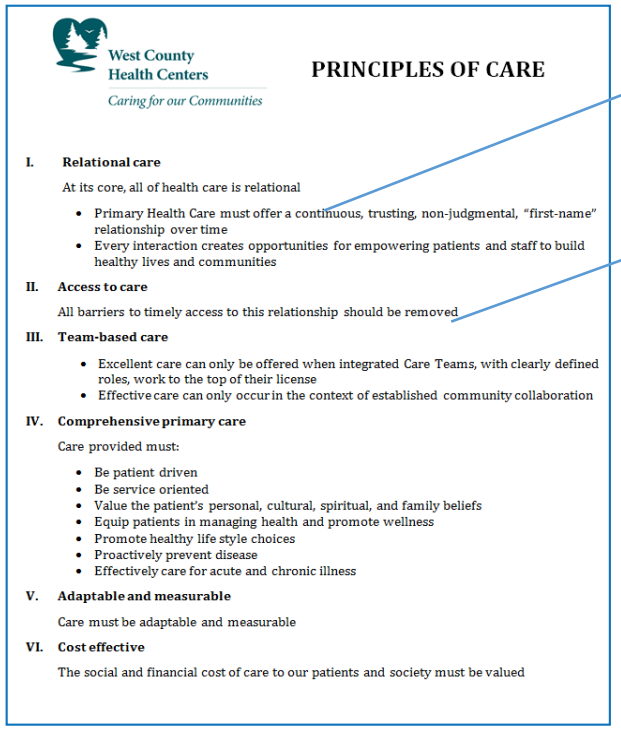
- Prompt Access to Care
- Data-Driven Improvement
- Template of the Future
- Patient-Team Partnership
- Engaged Leadership
- Continuity of Care
- Population Management
- Team-Based Care
- Comprehensiveness and Care Coordination
- Empanelment



The 10 Building Blocks of High-Performing Primary Care[7]

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

BB1 | Creating Practice-Wide Vision with Concrete Goals and Objectives



West County Health Centers
Caring for our Communities

PRINCIPLES OF CARE

I. Relational care

At its core, all of health care is relational

- Primary Health Care must offer a continuous, trusting, non-judgmental, "first-name" relationship over time
- Every interaction creates opportunities for empowering patients and staff to build healthy lives and communities

II. Access to care

All barriers to timely access to this relationship should be removed

III. Team-based care

- Excellent care can only be offered when integrated Care Teams, with clearly defined roles, work to the top of their license
- Effective care can only occur in the context of established community collaboration

IV. Comprehensive primary care

Care provided must:

- Be patient driven
- Be service oriented
- Value the patient's personal, cultural, spiritual, and family beliefs
- Equip patients in managing health and promote wellness
- Promote healthy life style choices
- Proactively prevent disease
- Effectively care for acute and chronic illness

V. Adaptable and measurable

Care must be adaptable and measurable

VI. Cost effective

The social and financial cost of care to our patients and society must be valued

Primary Health Care must offer a continuous, trusting, non-judgmental, "first-name" relationship over time

All barriers to timely access to this relationship should be removed.

Concrete Goals (examples)

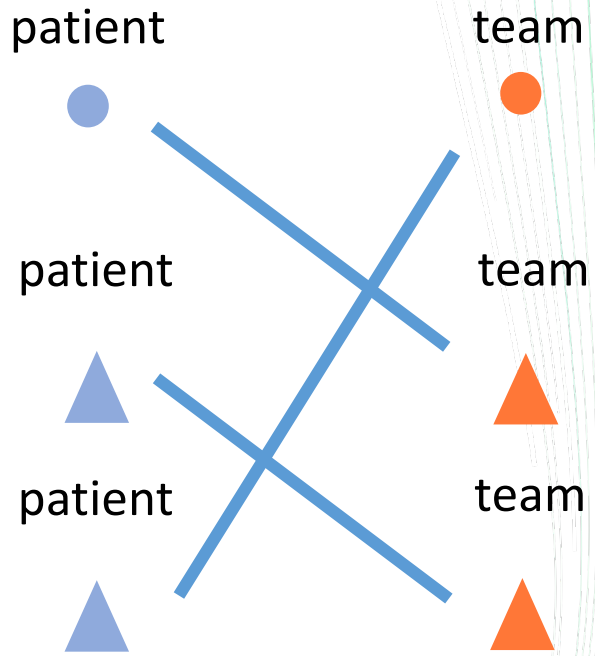
- By December 31, 2024, the % of diabetic patients with A1c > 9 will be reduced from 20% to 12%
- By July 1, 2025, all patients will be able to obtain an appointment with their own primary care clinician within 5 days of making the request

BB2 | Data-Driven Improvement

- Relevant data
- Accurate data
- Shared and discussed with everyone
- Data drilled down to clinician/team level
- Data analyzed by demographics to uncover poor health outcomes

BB3 | Empanelment

- **Empanelment**: Linking patients with a primary care clinician/team
- **Advantages**:
  - Patient and clinician/team know each other
  - Allows clinic to offer and to measure continuity of care
  - Allows calculation of panel size
  - Provides denominator for quality measures



Empanelment Guide: https://education.weitzmaninstitute.org/sites/default/files/course/2025-10/Implementation-Guide-Empanelment.pdf

BB4 | Team-Based Care

Anatomy

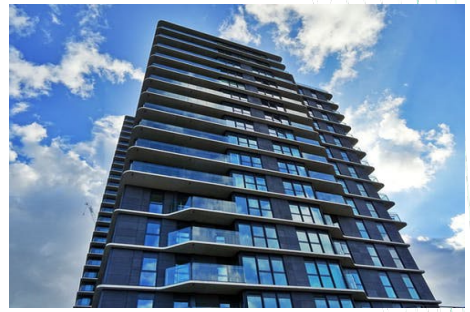
1. A stable team structure
2. Co-location
3. Defined roles
4. Standing orders or protocols
5. Defined workflows
6. Staffing ratios adequate to facilitate new roles
7. Ground rules

Physiology

1. Culture shift: Share the Care
2. Training and skills checks
3. Communication

Patients and Teams

- Primary care practices are getting larger
- But patients prefer small practices
  - Study of 367 practices of different sizes
  - Patients were asked | How was your visit?
  - Small practices | 64% excellent
  - Large practices |48% excellent
- Patients want to know their team members
  - “Physicians and staff knowing me is very important”
  - In small practices, patients report: “I know the people in the practice and the people in the practice know me”
- Teams can divide a large practice into smaller units that are more comfortable for patients



There will be extensive discussion of teams in the next 2 learning sessions.

Questions?

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Building a Team Culture: Sharing the Care

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

Building Team Culture

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

Culture Shift: Share the Care

Share the care is a culture shift

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

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

Tasks ⟷ Responsibilities

Task or Responsibility?

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

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

Sharing the Care Has Positive Effects

- Medical assistants taking responsibility to ensure that all patients have received appropriate cancer screening improved screening rates.[8]
- Teams with a strong team climate were associated with better diabetes management, patient satisfaction, and patient activation.[9]
- An observational study of 27 practices found that moving toward a "share the care" culture increases physician and staff satisfaction.[10]

8. Baker. Qual Saf Health Care.2009;18(5):355-359; Kanter, Perm J. 2010;14(3):38-43
9. Becker and Roblin. Medical Care 2008;46:795-805; Bower, Campbell, Bojke, & Sibbald. Qual Saf Health Care 2003;12:273-279
10. O'Malley et al. JGIM 2015;30;183-192

Ground Rules

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

Polling Question

At our health center:

a. We have written ground rules that everyone has agreed on for how meetings are conducted

b. We have written ground rules that everyone has agreed on for how teams work together during patient care times

c. We don't have any written ground rules

d. Unsure

Questions?

We will continue Building Team Culture: Sharing the Care in Session 3!

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Developing a Communication Plan & Stakeholder Analysis

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

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

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Step 1. Identify Stakeholders

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

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

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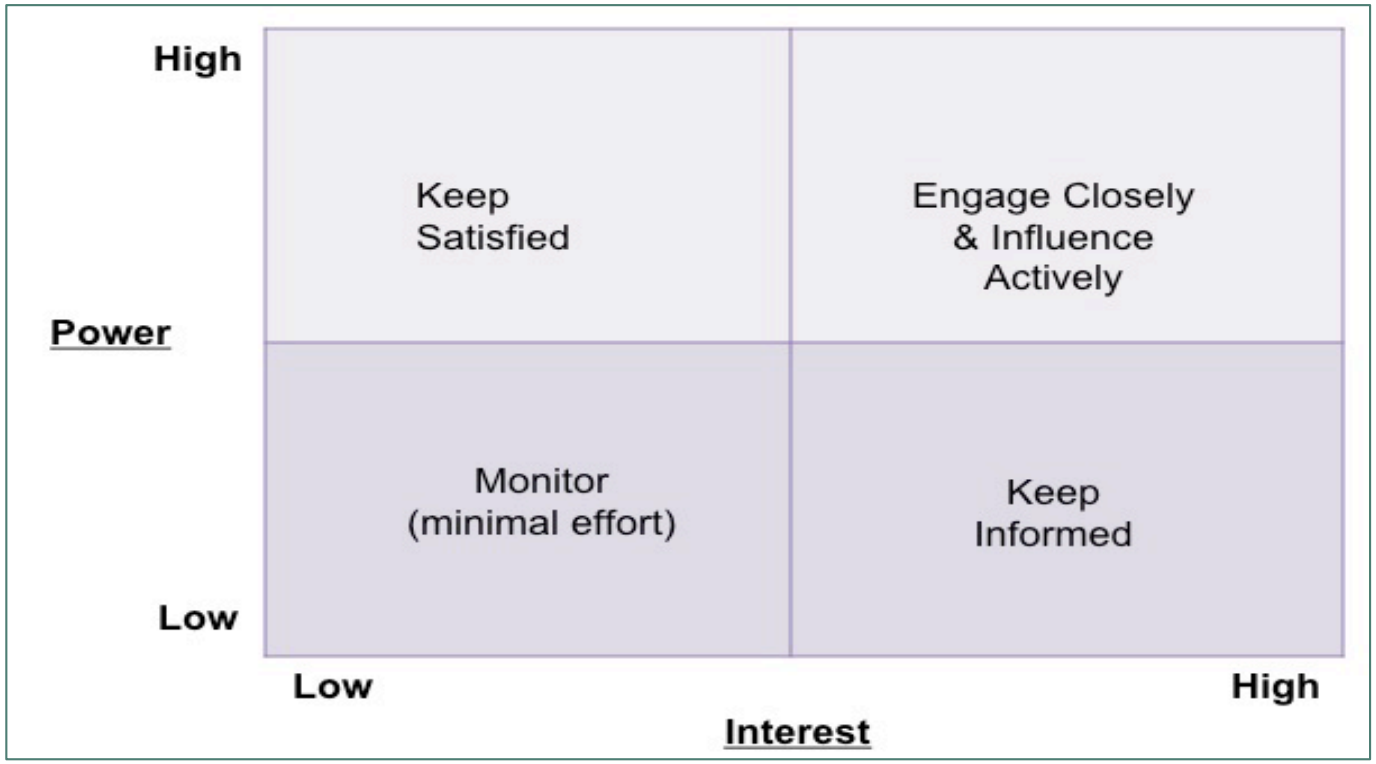
Table 1. Example of identifying stakeholders

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

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

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



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

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

COMMUNICATION PLAN FOR IMPORTANT PROJECT
DATE: November 2023
PROJECT LEAD: Mrs. Peacock

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

Final Advice

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

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Developing & Using a Global Aim Statement

Quality Improvement Refresh

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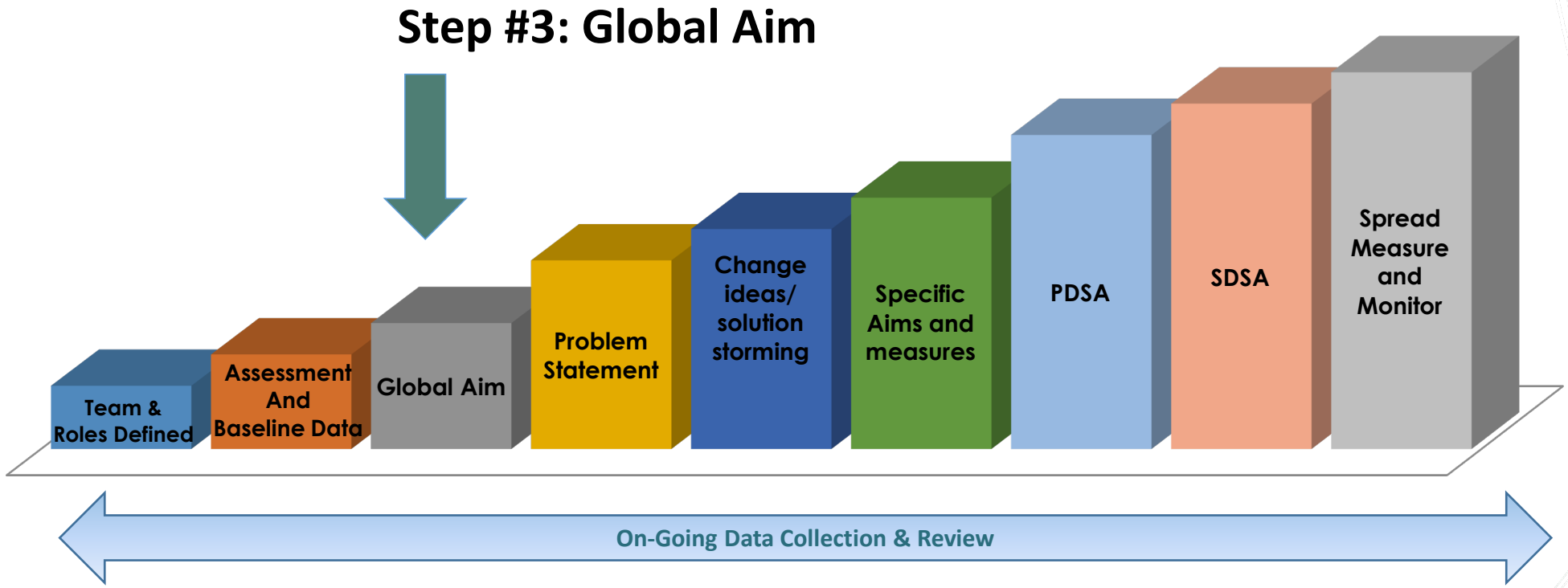
The Stages of Improvement



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

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

Writing a Structured Global Aim

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

Example of a Global Aim Statement

- Theme for improvement: UDS measure for breast cancer screening.
- We aim to improve: the process for breast cancer screening.
- In: Dr. Smith's panel at the Main St. Clinic.
- The process begins with: identifying patients who are eligible for screening.
- The process ends with: documenting in the patient's health record that screening has occurred.
- By working on the process, we expect: to improve the UDS measure for breast cancer screening rate.
- It's important to work on this now because: our current rate for breast cancer screening is in the 3rd quartile so we can't take advantage of value-based reimbursements. Our rate has declined, but we have a lot of new staff and so have an opportunity to get a standardized workflow in place. We need to be better about making sure that our patients are being screened as the incidence of breast cancer in our population is higher than average. We're pretty good about ordering the mammograms, but we don't do mammograms at our clinic so we need to get better at having them documented in our records.

Global Aim Template

Theme for improvement: _____

(Based on your practice assessment)

We aim to improve: _____

(Name the process)

In: _____

(Clinical location in which process is embedded)

The process begins with: _____

(Name where the process begins)

The process ends with: _____

(Name the ending point of the process)

By working on the process, we expect: _____

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

Statement is broad, but clear

- What: breast cancer screening.
- Who: eligible women ages 50-74.
- Where: at the Main St. Clinic.
- Start: with identifying patients who are eligible for screening.
- End: with documenting in the patient's health record that screening has occurred.
- Why: better patient care, improved performance.

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Common Mistakes

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

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Questions?

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Wrap-Up

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Deliverables

- ✓Conduct your internal health center team meetings
- ✓Team leaders attend weekly 60-minute team leader check-in calls
- ✓Complete Step 3 in the Quality Improvement Workbook

Access the Google Drive to upload deliverables:

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Next Steps

- **Team Leader Check-In Calls:**
  - Wednesday December 10th 1:00pm Eastern / 10:00am Pacific
  - Wednesday December 17th 1:00pm Eastern / 10:00am Pacific
  - Wednesday January 7th 1:00pm Eastern / 10:00am Pacific
- **Session 3**: Wednesday January 14th 1:00pm Eastern / 10:00am Pacific

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

Weitzman Education Platform

Weitzman Education Platform – this will serve as the platform to receive CE credits for each learning session and access recordings/slide decks/resources:

- Register for the course here: https://education.weitzmaninstitute.org/content/nttap-comprehensive-and-team-based-care-community-practice-cop-2025-2026
  - Access Code: TBC2025
- If you do not have an account, follow these instructions: https://education.weitzmaninstitute.org/user/register
  - Choose a username, password (save it somewhere safe so you can continue to use it!), and fill out some basic user information.
  - Click Create New Account.
  - If you encounter any technical difficulties, please reach out to myself or submit a ticket.

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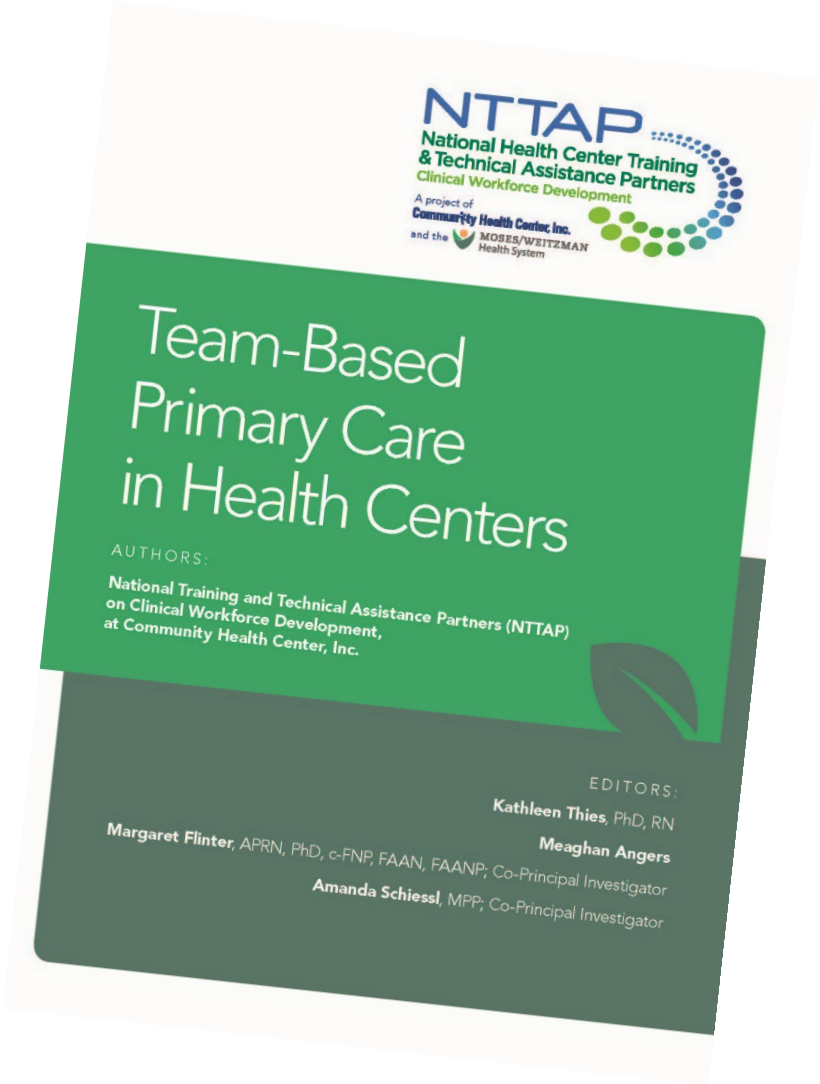
Download our book, *Team-Based Primary Care in Health Centers*!

https://www.weitzmaninstitute.org/wp-content/uploads/2024/09/Team-BasedPrimaryCareinHealthCenters.pdf



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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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REMINDER: Complete evaluation in the poll!

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

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