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

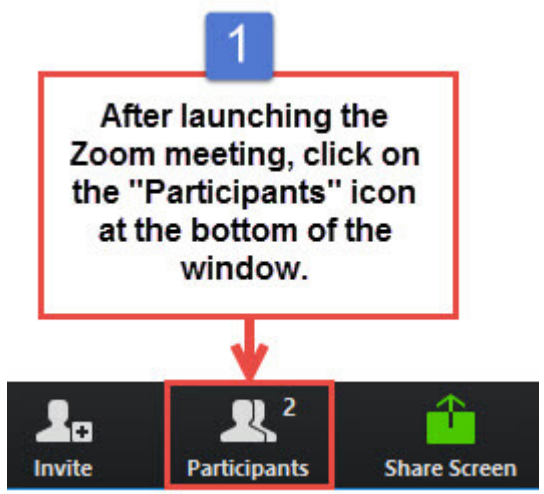
Comprehensive and Team-Based Care Community of Practice (CoP)

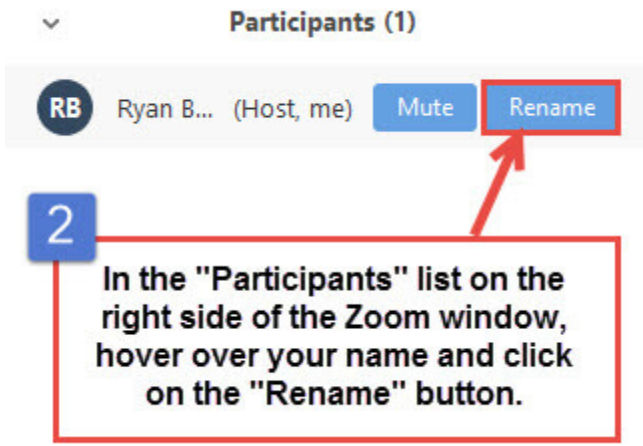
Session Four: February 4th, 2026

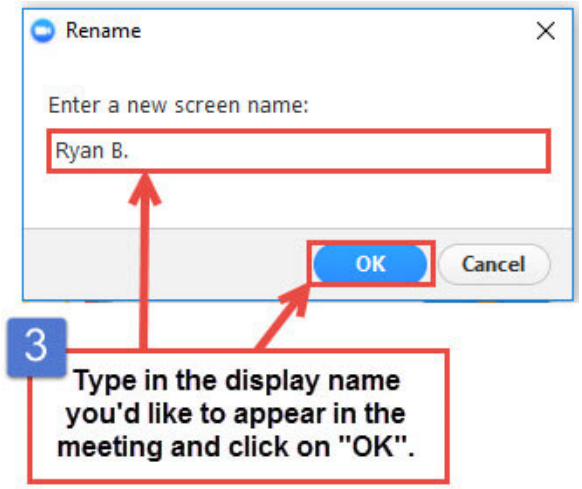
This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $550,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent 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”







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

Session Agenda

- 1:00-1:05pm Introduction
- 1:05-1:45pm Team-Based Care: Core and Interprofessional Teams
- 1:45-2:00pm Making Your Team Work: Team Development and Change Management
- 2:00-2:25pm Quality Improvement Refresh: Specific Aim Statements, Solution Storming, and PDSA Cycles
- 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

- Quality Improvement Consultant

Kathleen Thies, PhD, RN

- Consultant, Researcher

Margaret Flinter, APRN, PhD, FAAN

- Co-PI, NTTAP
- CHCI's Senior Vice President/Clinical Director

Amanda Schiessl, MPP

- Chief of Staff, MWHS
- Co-PI & Project Director, NTTAP

Meaghan Angers

- Senior Program Manager, NTTAP

Bianca Flowers

- Program Manager, NTTAP

MOSES/WEITZMAN Health System

Always groundbreaking. Always grounded.

Community Health Center, Inc.

A leading Federally Qualified Health Center based in Connecticut.

CeCN

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.

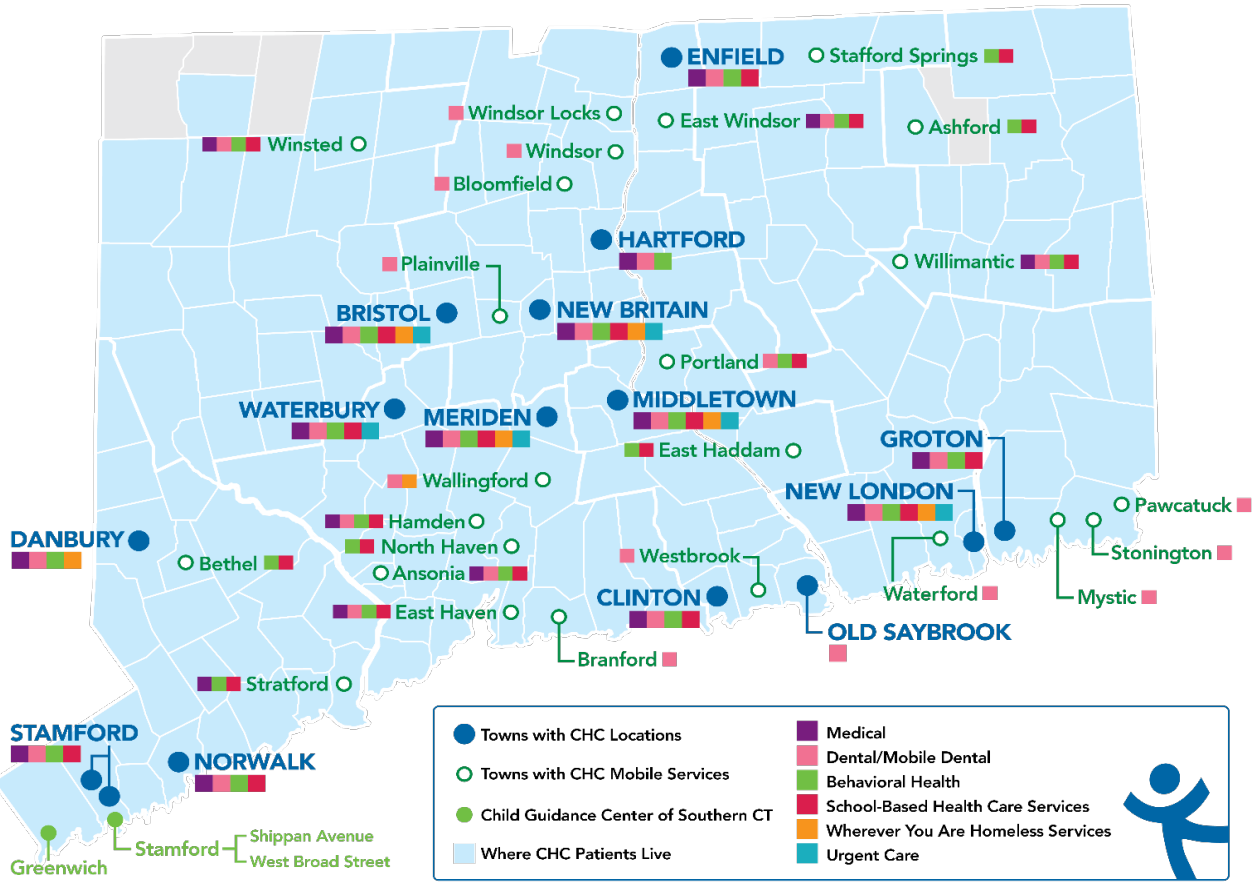
Center for Key Populations

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

MOSES/WEITZMAN
Health System
Always groundbreaking. Always grounded.

Community Health Center, Inc.

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.

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.

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

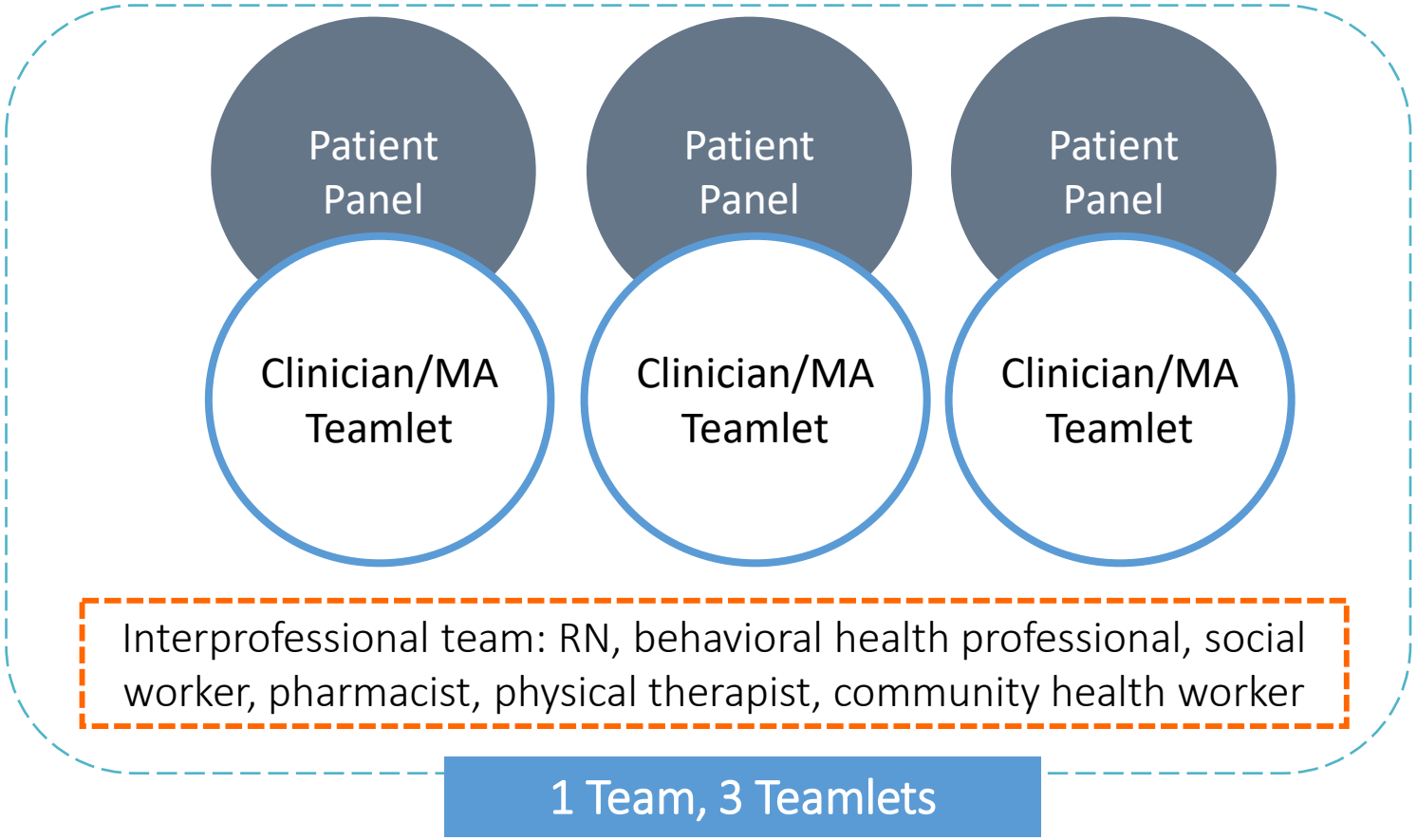
NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

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

Core and Interprofessional Teams

Tom Bodenheimer
Center for Excellence in Primary Care
University of California, San Francisco

Core Teams (Teamlets) and Interprofessional Teams



Agenda

- Review of core team
  - Functions that MAs can perform
  - Collaborative culture
- Interprofessional team

Some primary care functions that MAs can perform

- ✓ Panel management
- ✓ Medication reconciliation
  - ➢ MAs do the detective work: what meds is the patient actually taking compared with what they are prescribed to take
  - ➢ Clinicians make the decisions on how to reconcile the two lists: what the patient is taking vs. what they are prescribed
- ✓ Motivational interviewing
- ✓ In-room documentation/scribing

Poll from Learning Session 3

Do you provide time for MAs to do panel management?

32 responses	
They do panel management but we don't reserve extra time	31%
MAs don't do panel management	34%
They do panel management & we make sure they have time for it	9%
Unsure	25%

Clarifications on Panel Management

- Panel Management: Ensuring that all patients in our panel (the teamlet's panel) get recommended preventive and chronic care services.
- In other words, identifying and closing care gaps
  - Cancer screening metrics
  - Immunization metrics
  - Diabetes metrics
- Panel management involves many metrics. Few health centers do panel management for every metric. If you are doing panel management for several but not all metrics, you are well on your way.
- Once you have the workflow for some panel management metrics, like colon cancer screening or pneumococcal immunization, you can more easily apply those workflows to other metrics.

Panel Management: In-reach and Out-reach

- **In-reach:** panel management for patients who come to the clinic. Often done by the MA during the rooming process, for example
  - Identifying the care gap: has the diabetic patient had A1c in past 6 months? If not,
  - Closing the care gap: ordering an A1c
- **Out-reach:** panel management for patients who are not coming to the clinic
  - Requires a registry/list of patients with information on whether they have a care gap for each of the metrics you are working on
  - MA panel managers review the registry each month and contact patients with care gaps to come to the clinic (for cervical cancer screening or immunizations) or the lab (for diabetes labs) or radiology (for mammograms) in order to close the care gap
  - Outreach is harder but important; many patients with multiple care gaps are those patients who don't come to the clinic
- Some clinics work on in-reach first, and then move to out-reach

Team Culture

Share the Care

Ground Rules

Standing Orders/ Protocols

Defined roles with training and skills checks

Communication

Building Team Culture: A practical tool for teamlets

Getting to the Heart

- Each week, each teamlet (clinician and MA) has lunch together to get to know each other and to discuss how the teamlet is working
  - Week 1: introducing Getting to the Heart
  - Week 2: values, trust
  - Week 3: power, roles, agreements
  - Week 4: What have we learned, how do we move forward?
  - Total 8 weeks
- Evaluation
  - Improved patient access due to increased productivity
  - Improved patient and staff experience
- Resource: Getting to the Heart Strengthening Team Communication

Chat Question

Could you initiate Getting to the Heart in your clinic?

Agenda

- Review of core team
  - Functions that MAs can perform
  - Team Culture
- Interprofessional team

Now let's talk about interprofessional teams

- Primary care teams include core teams and interprofessional teams
- Interprofessional team members assist core teams for patients who need additional care
- Members of the interprofessional team vary from clinic to clinic. Most commonly:
  - RNs
  - Clinical pharmacists
  - Behaviorists including social workers
  - Physical therapists
- **These highly skilled professionals can add a great deal of capacity to see more patients using minimal clinician time and thereby reducing clinician burnout**

Polling Question

What do RNs in your clinic spend most of their time doing? (give your best estimate)

1. Telephone triage
2. Acute care: immunizations, wound care, explaining a treatment
3. Care management for chronic conditions (e.g. diabetes)
4. RN visits or co-visits with RN and clinician
5. We don't have RNs
6. Unsure

Polling Question

What do you think that RNs in your clinic would most like to do? (give your best guess)

1. Telephone triage
2. Acute care: immunizations, wound care, explaining a treatment
3. Care management for chronic conditions (e.g. diabetes)
4. RN visits or co-visits with RN and clinician
5. We don't have RNs
6. Unsure

Study of RNs in community health centers in California

- A study of RNs at 13 community health centers found that RNs confined to telephone triaging are often frustrated, but those doing co-visits and care management were able to fully utilize their professional skills.

Bodenheimer T et al.. RN Role Reimagined. California Healthcare Foundation. Published Aug 2015. Accessed January 4, 2023. https://education.weitzmaninstitute.org/sites/default/files/course/2025-10/CEPC%20RN%20Role%20Reimagined.pdf

Write in chat: If your RNs are mainly doing telephone triage, are they satisfied with that role?

RN Co-Visits

- Clinica Family Health in Colorado initiated RN co-visits in 2014, with nurses able to perform 8 co-visits per day.
- The RN takes the history, the clinician enters, and the RN becomes the scribe. The clinician leaves, the RN explains the care plan and arranges follow up services.
- Twenty- to 30-minute visits take 10 minutes of clinician time, the visit is billed as a clinician visit, and clinician documentation time is minimal.
- Capacity grew by 17% at one site and 12% at another. Patient access improved. Clinicians reported leaving work on time, with charting completed. RN and patient satisfaction were high.

Funk KA, Davis M. Enhancing the role of the nurse in primary care: the RN "co-visit" model. *J Gen Intern Med.* 2015;30(12):1871-1873.

RN Care Management For Diabetes

- Care management is a set of activities designed to assist patients and their support systems in managing their diabetes and related social problems. These activities include
  - identifying patients most likely to benefit;
  - assessing each patient's risks and needs;
  - developing a diabetes care plan with the patient and family;
  - reviewing labs and adjusting medications per protocol;
  - assisting patients in navigating appropriate services;
  - providing self-management support for healthy behavior change and medication adherence;
  - tracking patients' progress.
- Several studies demonstrate that RN care management is associated with significant improvements in diabetes outcomes.
- Care management requires planned visits in which diabetes is the only agenda item, so that enough time can be spent with the patients to make the visit effective.

Bodenheimer T and Willard-Grace R. Health Affairs 2022;41:947-954

Polling Question

What do pharmacists in your clinic spend most of their time doing? (give your best estimate)

1. Dispensing medications
2. Patient education on medications and med adherence
3. Care management for chronic conditions (e.g. diabetes)
4. We don't have pharmacists
5. Unsure

Pharmacists and Care Management

- Pharmacist care management of hypertension (including medication prescribing) achieved 72% blood pressure control compared with 57% with usual care
- Primary care clinicians report that pharmacists performing medication management decreased workload, reduced mental exhaustion, and increased patient access.
- At one practice, 27% of chronic disease patient appointments were converted to pharmacy appointments, opening access for other patients.
- Small clinic sites, unable to hire a pharmacist, can share pharmacist time with similar practices in their health system or network.

Bodenheimer T. Revitalizing primary care, Part 2. Ann Fam Med 2022;20:469-478

Polling Question

What are your major barriers to creating an interprofessional team? (for example – RN, pharmacist, behaviorist, physical therapist)

1. Can't recruit the personnel
2. No business case: the team members are expensive and there is little reimbursement
3. Team members are not trained to see patients independently so they cannot add capacity to improve access and reduce clinician burnout
4. State laws/regulations restrict what interprofessional team members can do
5. All of the above
6. Unsure

Barriers to building interprofessional teams

We can't recruit the personnel we need

Only practitioners are reimbursed

Who knows when the alternative payment model will actually arrive

No time to train and mentor staff in their enhanced roles

Scope of practice laws

Will patients accept their care?

The barriers are real and need to be addressed. First plan for building the team, one person at a time, and then tackle the barriers one by one. Don't let barriers paralyze you.

We will address these barriers in Learning Session 4.

Chat Discussion

Write in the chat an action plan for building an interprofessional team. Remember an action plan is a small step toward a larger goal. Examples:

Hold a meeting with the RNs in the clinic to discuss their work, whether they are satisfied with their roles, what they might think about RN care management or co-visits

If you don't have a pharmacist, make a plan for getting some pharmacist hours from other health centers or hospitals in the area

Start small.

What is a powerful team?

Remember from Learning Session 2:

- Primary care patient access is poor and getting worse
- Panel sizes are too large because few clinicians choose primary care careers
- Poor access and large panels are major contributors to burnout
- Powerful teams can help solve these challenges; poorly functioning teams cannot

What is a powerful team?

- A powerful team is a team that adds capacity to see more patients, thereby improving access
- Interprofessional team members add capacity by seeing patients independently, taking little or no clinician time
- Interprofessional team members help overpaneled clinicians care for their panels, thereby reducing clinician burnout
- When interprofessional team members have standing orders to see patients independently, they often have greater worklife satisfaction

What is a powerful team? Examples:

- In many states, pharmacists can independently care for patients with diabetes or hypertension – including ordering and interpreting labs and adjusting medications – under collaborative practice agreements.
- In some states, for example, California, RNs can be care managers for patients with diabetes, including adjusting medications under standing orders, thereby greatly helping clinicians care for their panels, reducing burnout, and improving quality.

If you have other examples of powerful interprofessional teams, please write them in the chat.

Take Home Points

- Primary care teams can be divided into the core team and the interprofessional team
- An important function for MAs on core teams is panel management
- Powerful interprofessional teams
  - Can add capacity to see more patients, improving access
  - Can reduce clinician burnout
  - Can increase interprofessional team member job satisfaction

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

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

A powerful team is a beautiful thing

Questions?

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

Making Your Team Work

Team Development and Change Management

Baseball Teams

- Know the roles of the pitcher, catcher, basemen, outfielders…and the umpire.
- They have a manager.
- They have a coach.
- Batters have studied how pitchers pitch; pitchers have studied how batters bat.
- They know their scores. And the scores of other teams.
- They know different ball parks and where the boundaries for a home run are.
- They know their fans.
- They practice….a lot.
- They stay in shape.

Normalizing Change: What We Know

Before you can change practice, you must change the individuals who work in the organization--that is, their values, attitudes, relationships, skills, and behavior. NOT a linear process!

- Start with changing their minds [values, attitudes] about the work ahead….*coherence*.
- Build relationships and ownership about how the work will be done….*cognitive participation.*
- Get into the weeds of the work together, develop new skills, try new ways of working….*collective action*.
- Track your progress and revise as needed….*reflexive appraisal*.

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

Team Development Refresh: Normalization Process Theory

Coherence

- Clarity of purpose, expectations & value
- Why are we here? How is the CoP different from other projects? Who is in charge? What is expected? Is this worth my time?
- Failure to build coherence from the start leads to conflict, and will make it impossible to move forward.

Cognitive Participation

- Relational work of team-work.
- Do we have the right people? How do I fit in?
- Ownership not "buy-in." Do we all want the same thing?
- Without ownership and a shared mental model for how to do the work, the team lacks direction and gets frustrated. The loudest voice wins.

Collective Action

- Operational work of teams: a shared mental model, a systematic approach— Improvement Ramp!
- Do we have the necessary resources? Data? Time?
- The team is delving into the work - "in the weeds" of change.
- Trust each other's expertise and commitment. Progress is being made.

Reflexive Monitoring

- Appraisal work that people do to assess and understand how change is working. It does not end.
- What fine-tuning do we need to do to make sure it is sustainable?
- Without reflexive monitoring, the work cannot spread, be sustained, or be revised/improved as needed.

Sources of Conflict

Lack of Coherence

- I don't know who is in charge. I don't know why we're meeting. I don't know what is expected. I don't know what team-based care is—aren't we doing it already? Is this a QI project?

Lack of Relational Work/Cognitive Participation

- No ownership as a team. Not using a shared mental model of how to do the work (meeting roles, improvement ramp). Jumping to solutions before clarifying the problem. Too many loud opinions. Work is top down from managers, core team not involved enough. I don't know where I fit in. Insecurity about being a team member.

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

Sources of Conflict

Lack of Collective Action

- Insufficient resources and administrative support, specifically data and time. Promises made are not kept. Failure to use shared mental model/systematic approach. Need different skills/won't develop new ones. Some people do all of the work while others slack off. Lack of engagement.

Lack of Reflexive Monitoring

- No tracking with data. Pilot is spread to other sites/teams without testing first. No sense of accomplishment —we wasted our time.

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

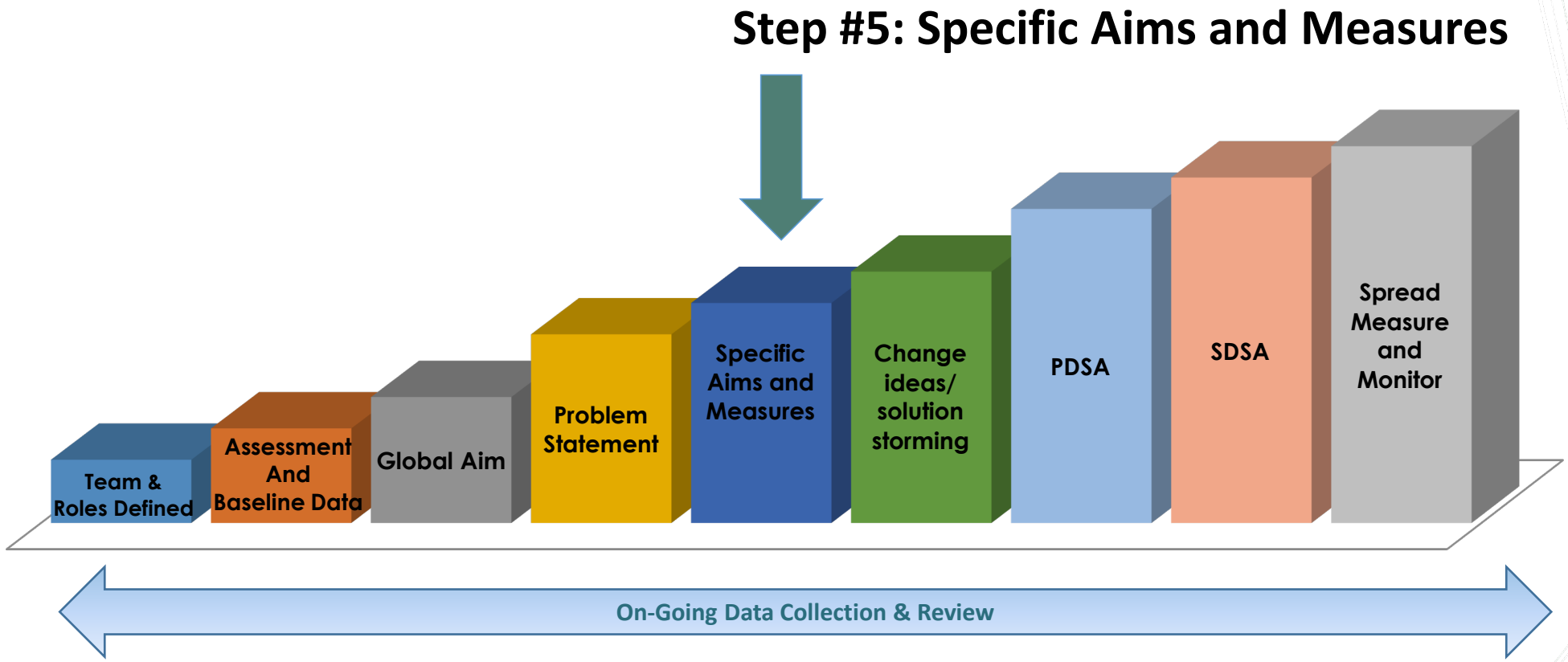
Questions?

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

Developing & Using a Specific Aim Statement

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

The Stages of Improvement



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

What is a Specific Aim Statement?

- A good specific aim states ***what*** you plan to accomplish and ***how you will know*** it when you do. Or don't.
- ***What*** you plan to accomplish should be something in your control, i.e., it does not require permission.

A good specific aim…

- …is based on baseline data;
- ….has measures that are clearly defined:
  - what is being measured,
  - how it will be measured (numbers, percentages, rates),
  - when it will be measured,
- ….is doable, that is, you can get the data and change the process that results in the data, and
- ….is the foundation for multiple PDSA(s) as you test changes in the multi-step process that you identified in your Global Aim.

Specific Aim Statement Template

We aim to _____ (*improve, increase, decrease*)
the _____ (*quality, number/amount, percentage*)
of_____ (*name the process*)
by _____ percent

OR

from _____ (*baseline data number/amount/percentage*)
to _____ (*number/amount/percentage*)

by _____ (*date*)

in _____ (*location*)

From the Workbook

Definition of UDS measure	Percentage of women 50 –74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period
Population (denominator)	Number of women 50 –74 years of age who were eligible for a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period (N=100)
Subsets	A: number of women whose mammogram is documented in EMR (n=42) B: number of women whose mammogram is NOT documented in EMR (n=58)
Measurement period	First quarter of 2025: January/February/March
Source of data/evidence	As documented in the EMR
Numerator	Subset A: Number of women 50 –74 years of age who were eligible for a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period whose mammogram is documented in EMR* (n=42)
Denominator	Population: Number of women 50 –74 years of age who were eligible for a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period (N=100)
Rate	Numerator/Denominator=42/100=42%

Example: Weak specific aim

We aim to increase screening rate for breast cancer in women patients by 15% from January to March.

Important? Yes.

Clear/Specific enough? In whom? 15% of what?

Doable? Not sure yet. Strategy? Staff? Time? Where does the data live? Can we get it out?

Example: Better and more specific

We aim to increase screening rate for breast cancer in female patients ages 50-74 from 22% as of December 31, 2024 to 37%* by March 31, 2025.*

- Who: eligible female patients ages 50-74
- Who: eligible patients enrolled in the clinic based on at least one visit the past year.
- When: December 31 to March 31
- Where is the data: electronic health record
- What dates will you ask BI to collect? December 31 – March 31
- Where: Clinic A
- How much: Does this reflect the current baseline and an achievable goal?

*KEY POINT: Percentage points are cleaner and easier to work with.

Percent vs. Percentage Points

- We aim to increase screening rate for cervical cancer in eligible female patients **by 15%** from January to February).
  - If baseline is 22%, then 15% increase is a new target: 25.3%.

- We aim to increase screening rate for cervical cancer in eligible female patients **by 15 percentage points from 22%** from January as of January 1 **to 37%** by February 28.
  - If baseline is 22%, then 22% = 15 points = new target 37%.

Big difference!

How many more patients do you need to screen to hit your target?

Month	# eligible patients:	# screened eligible patients: Subset A	15% Percent increase	15 Percentage points increase
December 31, 2024 Baseline	150	33	Baseline 22%	Baseline 22%
June 30, 2025 Target	150†	Target ???	22% * 1.15 =Target 25.3%	22% + 15 points = Target 37%
How many more patients need to be screened by March 31, 2025?			Target 38 patients which is 5 more patients	Target 56 patients, which is 23 more patients

†Challenge: The baseline of 150 patients is as of December 31, the end of the fourth quarter. But you don't know yet how many eligible patients will keep their appointments in the first quarter of 2025. What will you use for your denominator? You can use 150 or you can estimate the denominator based on previous quarters.

Data Plan

Name of data	Definition: Numerator	Definition: Denominator	Dates of interest	How to get the data
Breast cancer screening	Number of patients who were eligible for a mammogram and have the results documented in the chart	Number of patients who were eligible for a mammogram and DO NOT have the results documented in the chart	January 1, 2025-March 31, 2025	Where does the data live? Who has it? When to get it?

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

Key Takeaways

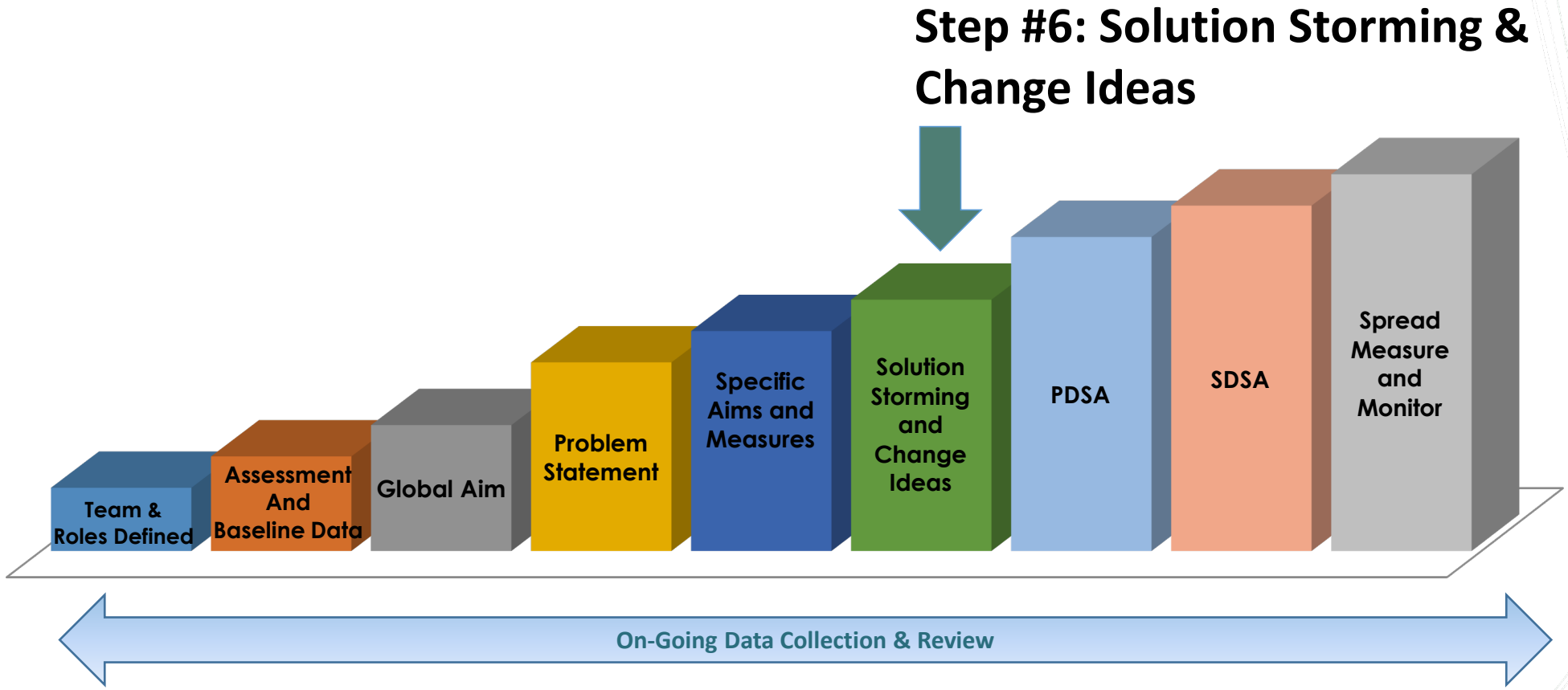
- ✓ Clear definitions of population (denominator) and subset of interest (numerator)
- ✓ Percentage points are cleaner: how many patients is that?
- ✓ Data plan
- ✓ There can be multiple specific aims and points for data collection in the screening process:
  - *How many eligible patients were identified?*
  - *How many who were identified received an order for a mammogram?*
  - *How many reports of patients who had a mammogram get back to us?*

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

Solution Storming & Change Ideas

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

The Stages of Improvement



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

What can YOU change?
Examples:

- **Workflow and Time**:
  - Who does what, when, how, and why?
  - How can we be proactive instead of reactive?
- **Eliminate Redundancies**:
  - Why are some tasks done twice and some are not done at all?
- **Data**: the right data at the right time in the right hands
  - What data do we need and when do we need it?
  - How do we get it?
- **Responsibilities and Roles**: clarify, retrain
  - Why are several people doing the same task?
  - Why are they all doing it differently?

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

What can YOU change?
Examples for Breast Cancer Screening:

- Who identifies the patients who are due for a mammogram, and how do they do that?
- Can you create standing orders for mammograms? Can you allow Medical Assistants to place the order for the mammogram?
- Is the mammogram off-site? Who makes the referral for an appointment for the mammogram?
- Do you have a system for follow-up to see if the patient made and/or attended the appointment for their mammogram?
- How do you receive the report and get the results recorded into the electronic health record?
- Who communicates the results to the patient?

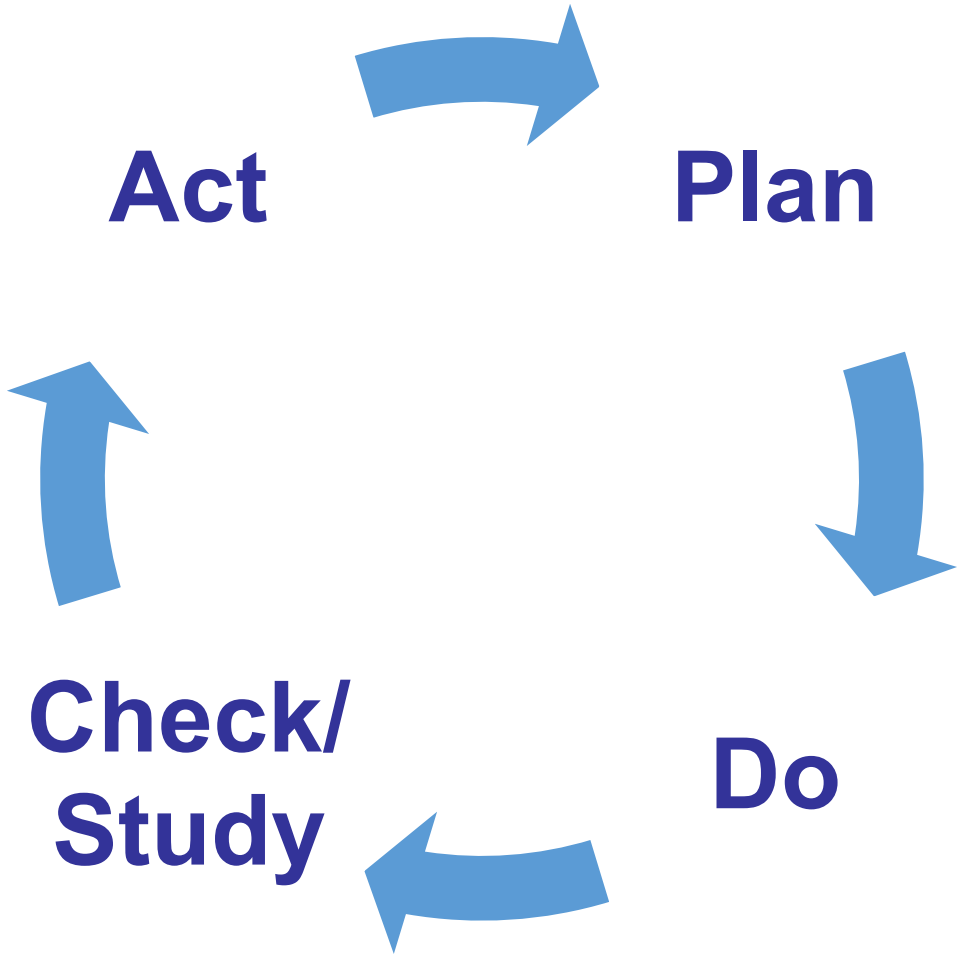
NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Change Ideas

Facilitator
Identify the Goal – What are you trying to SOLVE?
Time Limit
Brain-Write
Quantity vs. Quality
Write EVERYTHING
Don't Judge
Embrace the Ridiculous
Start general & basic – end specific
Look for themes
Avoid Group Think
Fresh Eyes – Someone Outside of the Group

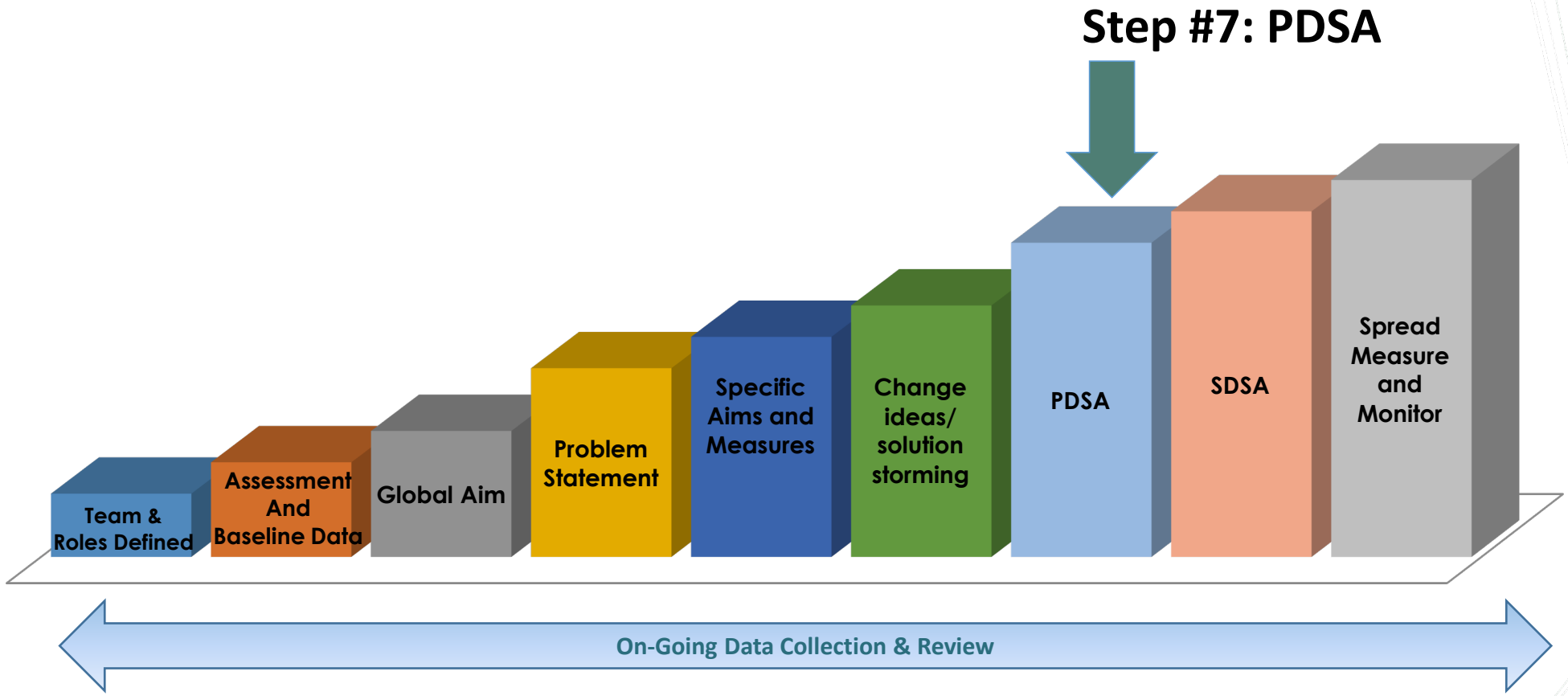
NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Developing & Using PDSAs



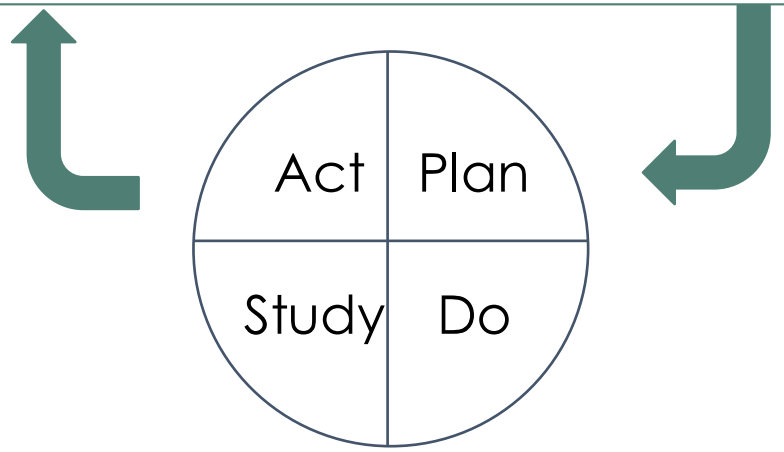
NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

The Stages of Improvement



Model for Improvement

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



Three questions…

…coupled with an approach for testing change.

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

Weitzman Institute
inspiring primary care innovation

PDSA Worksheet for Testing Change

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

Aim: (overall goal you wish to achieve)

Every goal will require multiple smaller tests of change

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

Plan

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

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

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

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

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

PLAN: Comes from Specific Aim Statement

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

DO

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

STUDY

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

ACT

Take action:

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

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

PDSA Example

PDSA Example

Aim: We aim to increase screening rate for breast cancer in female patients ages 50-74 from 22% as of as of December 31, 2024 to 37% by March 31, 2025.

Describe your first (or next) test of change:	Person Responsible	When to be Done (Date and Timeframe)	Where to be Done (Site Location, Where are the site, Pod, etc.)
Audit patients who have no recorded mammogram or no recorded mammogram in the past 28 months to determine current participation rate amongst eligible patients	John and Jane	4/1/2025 – 5/1/2025	Site A, Pod X

Plan:

List the tasks needed to set up this test of change	Person Responsible	When to be Done (Date and Timeframe)	Where to be Done (Site Location, Where are the site, Pod, etc.)
1. Designated staff member/s to host a practice meeting and plan Cycle 1. 2. Designated staff member/s to audit patient records to determine the proportion of eligible patients who have no recorded mammogram or no recorded mammogram in the past 28 months.	John and Jane	4/1/2025 – 5/1/2025	Site A, Pod X

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds	Person (s) Responsible for Collection of Data
Increase in eligible female patients getting screened for breast cancer	Breast cancer screening measure	Sally

Do: Designated staff members audit patient records to determine the proportion of patients aged who have no recorded mammogram or no recorded mammogram in the past 28 months.

Study: Designated staff members meet to review and discuss findings (proportion of patients with no mammogram recorded or no mammogram recorded in the past 28 months).

Act: Provide reminders to patients via letters, SMS, and/or audio messages to help encourage participation in breast cancer screening.

SUSTAIN

Once you've adopted:

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

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

Wrap-Up

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

Deliverables

- ✓Conduct your internal health center team meetings
- ✓Team leaders attend weekly 60-minute team leader check-in calls
- ✓Complete Step 5 in the Quality Improvement Workbook
- ✓Complete Step 6 in the Quality Improvement Workbook

Access the Google Drive to upload deliverables:

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

Next Steps

- **Team Leader Check-In Calls:**
  - Wednesday February 11th 1:00pm Eastern / 10:00am Pacific
  - Wednesday February 18th 1:00pm Eastern / 10:00am Pacific
  - Wednesday February 25th 1:00pm Eastern / 10:00am Pacific
- **Session 5**: Wednesday March 4th 1:00pm Eastern / 10:00am Pacific

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

Weitzman Education Platform

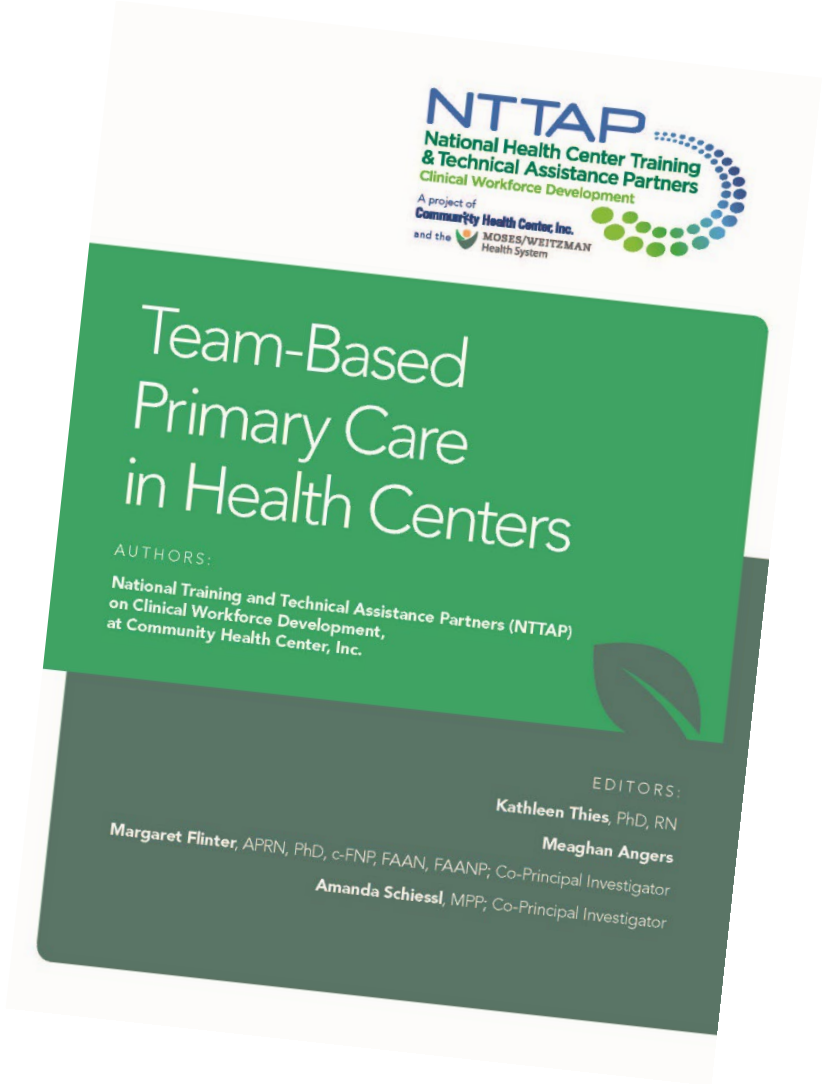
Weitzman Education Platform – this will serve as the platform to receive CE credits for each learning session and access recordings/slide decks/resources:

- 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.

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

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

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



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

Explore more resources!

National Learning Library:
Resources for Clinical Workforce Development

https://www.weitzmaninstitute.org/ncaresources

Health Center Resource Clearinghouse

https://www.healthcenterinfo.org/

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

Contact Us!

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

Meaghan Angers
Senior Program Manager
angersm@mwhs1.com

Bianca Flowers
Program Manager
flowerb@mwhs1.com

REMINDER: Complete evaluation in the poll!

Next Learning Session is **Wednesday March 4th!**

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.