

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

Session Five: March 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](https://www.hrsa.gov).

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 - “Meaghan Angers CHCI”

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Session Agenda

- 1:00-1:05pm Welcome
- 1:05-1:35pm Team-Based Care: Understanding Barriers
- 1:30-2:05pm Integrated Behavioral Health
- 2:05-2:25pm Data-Driven Improvements: Depression Remission Case Study
- 2:25-2:30pm Q/A, Wrap Up, 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
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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.

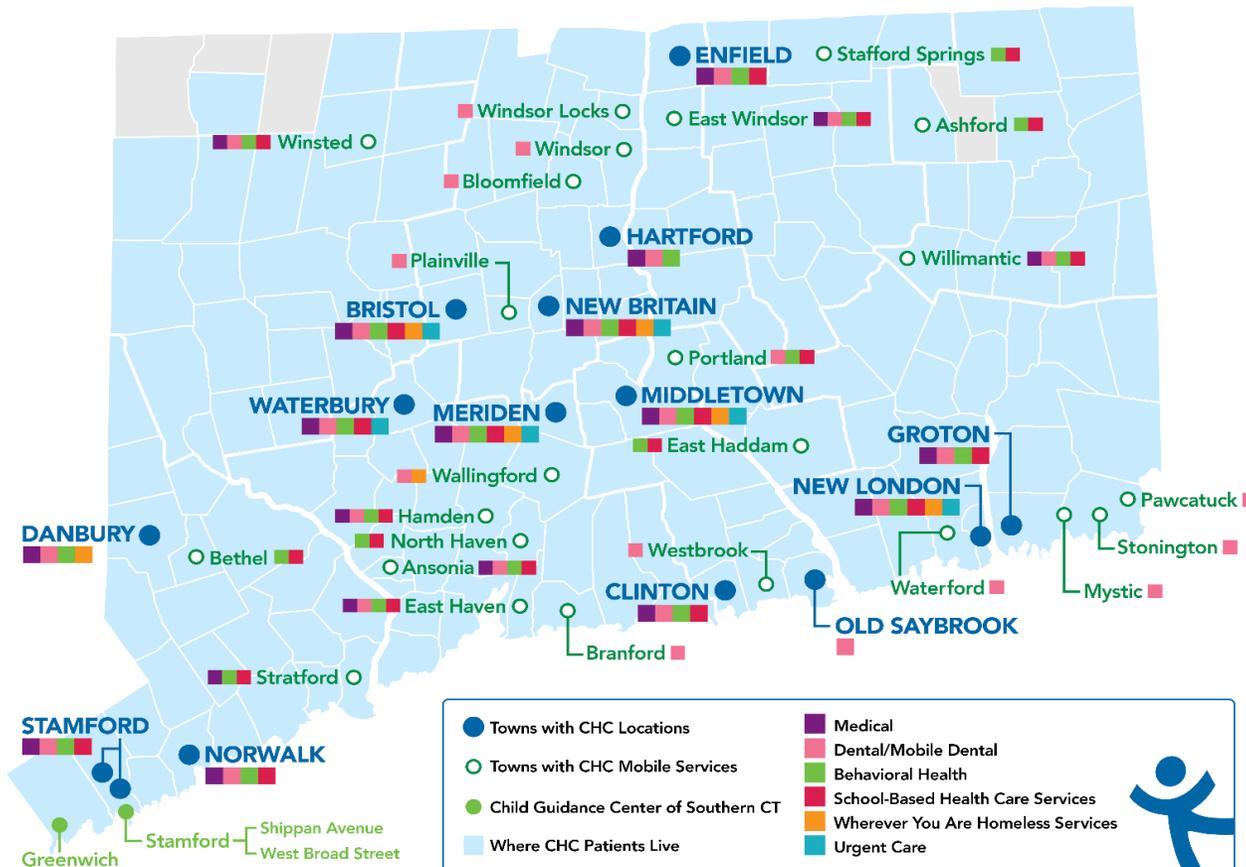
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Locations & Service Sites



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

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	Wilmington, North Carolina
Promise Healthcare	Champaign, Illinois
Total Health Care	Baltimore, Maryland
The Wright Center for Community Health	Scranton, Pennsylvania

Team-Based Care: Understanding Barriers

Tom Bodenheimer

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

What is a powerful team?

Learning Session 2 Recap:

- ✓ 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 and reducing burnout
- Interprofessional team members add capacity by seeing patients independently, taking little or no clinician time
- Interprofessional team members help over paneled clinicians care for their panels, thereby reducing clinician burnout
- When interprofessional team members have standing orders to see patients independently, they often have greater work life satisfaction
- Medical assistants can also add capacity, saving clinician time by providing panel management functions

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.
- Health centers can organize RN co-visits with the RN doing most of the visit and the clinician coming in at the end to check the RN's work and complete the orders the RN entered into the EMR. RN co-visits can add substantial capacity.

Barriers to building powerful 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. In making goals and action plans, consider the barriers and which would be the most difficult to overcome. But don't let barriers paralyze you.

Chat Activity: 10 Minutes

Let's pretend that you have set an overall goal to build a powerful interprofessional team. One specific goal focuses on RNs.

You would like your RNs to become care managers for patients with diabetes who see patients independently and can change medication doses under standing orders. Your first action plan is to 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.

Write in the chat: What barriers you would need to overcome to move toward the goal of RNs becoming care managers?

RN care management for patients with diabetes: Barriers and who is causing the barrier

	Federal/ state government, professional associations, professional schools	Health system leaders	Physician reluctance	Team member reluctance	Patient reluctance
We can't recruit RNs	Nursing associations and nursing schools emphasize hospital nursing. Lack of RN faculty restricts number of slots in nursing schools	Leaders prioritize the number of hospital nursing jobs over ambulatory jobs. They pay clinic RNs 60% of what hospital RNs make.			
RNs are not trained in primary care functions	Nursing schools usually don't teach ambulatory care nursing	Not interested in developing in-house ambulatory training for RNs	Providers may want RNs to only do phone triage, which shields physicians from patients wanting same-day care	RNs may be satisfied with more traditional RN functions such as triage, wound care, and patient navigation	Patients may want to see their doctor rather than an RN care manager
RNs are not allowed to do care management (especially adjusting medication doses)	State nursing boards may not allow RNs to adjust medication doses	Even when the state allows medication adjustment under standing orders, health system leaders may say No	Providers may not trust RNs to adjust medications and may refuse to write standing orders	RNs may not feel comfortable adjusting medication doses	
Lack of a business case. Only clinicians (doctors, NPs, PAs) are reimbursed. RNs are an expense and don't generate revenue	Medicare and Medicaid generally set payment rules, which insurance companies follow	Health system leaders may take a narrow view of business case. They want revenues to equal expenses each month. Rather than getting revenue from P4P for better metrics, or greater patient satisfaction bringing new in more patients.			

Metrics to watch for team-based care

Don't just look at
 revenue vs. expense

Clinician and staff
 satisfaction leads to
 less turnover.
 Turnover is a huge
 expense to the clinic



Increase in visits or
 panel size

Billable services by
 RNs, PTs, Pharmacists

Redeployment of
 staff to higher value
 activities

Patient experience
 surveys; good
 performance can
 lead to P4P money
 and can attract
 new patients

Improvements
 screening rates or
 disease control

Reduced readmissions

Reduced ED use

Regulatory Barriers: Case Study

- California allows MAs to give injections for immunizations
- San Francisco General Hospital:
 - MAs give immunizations
 - Standing orders enable MAs to identify and administer immunizations without patient-specific clinician orders
- UCSF Health System:
 - MAs cannot give injections at all. RNs or LVNs give the injections.
- Many UCSF residents work at both SF General and UCSF hospitals; in one place they can rely on MAs to take care of immunizations by themselves while in another place the MAs cannot even give the shots
- Who is causing the barrier?



Empowering MAs to give childhood vaccinations independently: Barriers and who is causing the barrier

	Federal/ state government, professional associations, professional schools	Health system leaders	Physician reluctance	Team member reluctance	Patient reluctance
We can't recruit enough MAs	The economy is in a worker-shortage period	MAs are poorly paid and don't choose medical assistant careers			
MAs are not trained to identify which kids need which vaccines; how to administer the vaccines safely	Low-quality commercial MA training programs. Better community college MA programs may have limited curriculum.	Health system lawyers may be overly cautious	Providers feel only they can decide which vaccines to give, even though there is a standard vaccine schedule. MAs would consult if there were questions for particular patients	MAs may be reluctant, feeling uncomfortable with the responsibility, or because they are already working too hard	Less of an issue because patients are used to staff giving vaccines
MAs are not authorized to decide on which vaccines and to give the injection	State regulations may require that only clinicians and nurses can administer injections	Even when the state allows MAs to give injections, health system leaders may say No	Providers may not trust RNs to decide which vaccines to give to which patients, and refuse to create standing orders	MAs may not feel comfortable with this responsibility	
Lack of a business case.	Medicare, Medicaid and insurance may pay little for vaccine administration	Health system leaders may worry that they would need to hire more MAs. Even though the time it takes clinicians, or the expense of using RNs, would cost more. Taking a narrow view of business case. Rather than saving clinician time and thereby increasing access and market share.			

Take Home Points

- Powerful teams can make primary care more do-able: more trained people to care for overly large panels
- There are a number of barriers to building these teams. The big ones are:
 - Business case
 - Restrictive laws and regulations
 - Difficult to recruit team members
 - Training and mentoring is key and takes personnel and time
- It is necessary to analyze where is the barrier: government, health system leaders, physicians, staff, patients
- The business case is more complex than having revenues = expenses each month. Leaders should take a longer view and see improvements as an investment

Questions?

Integrated Behavioral Health

Tim Kearney, Chief Behavioral Health Officer
Community Health Center, Inc.

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Principles of Integrated Behavioral Health Care

- **Team care:** Primary care and behavioral health providers, whether co-located or not, share care.
- **Population-based:** The care team shares a defined group of patients tracked in a dashboard to ensure no one ‘falls through the cracks.’ Practices track and reach out to patients who are not improving.
- **Treat-to-Target:** Each patient’s treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured. Treatment continues and objectives are updated as patients improve until the clinical goals are achieved and the episode of behavioral health care ends.
- **Evidence-based care:** Patients are offered treatments for which there is credible research evidence to support their efficacy in treating the target.

Overview of the Behavioral Health Landscape

Clinical Providers:

- **Therapists**
 - Social worker, marriage and family therapist, counselor, psychologist, drug and alcohol counselor
- **Medication providers**
 - Psychiatrist, psychiatric nurse practitioner, prescribing psychologists
- **Level of licensure**
 - Licensed Independent Practitioners (LIP)
 - Licensed to Practice Under Supervision
 - Student or Resident Under supervision of appropriately credentialed LIP

Behavioral Integration & Primary Care Team

Screening for depression	Medical assistant, Medical Provider, Behavioral Health Provider
Care management	RN
Crisis management	Behavioral Health Provider
Brief and/or Extended Psychotherapy	Behavioral Health Provider
Referral for longer-term psychotherapy	BH Provider, Referral Coordinator
Psychotropic Medication	PCP or PMHNP, Psychiatrist
Psychiatric Consultation	Consulting Psychiatrist, PMHNP, Psychiatry
SBIRT	Trained staff to screen, refer, and treat.

Best Practices for Optimizing Integrated Behavioral Health

1. Shared Electronic Health Record (EHR) between all disciplines on the team to allow greater coordination of patient care.
2. Physical and virtual co-location with the other disciplines to provide patient-centered care and communicate seamlessly.
3. All patients are “CHCI patients”, not “medical patients” or “behavioral health patients” or “dental patients.”
4. Having the right people and orienting them to an integrated model of care.

Shared Electronic Health Record (EHR)

- Patient signs an informed consent for behavioral health care treatment where they are informed that the shared EHR is a standard practice.
- Behavioral Health Provider notes the type of session (individual, family, group) and whether the patient was seen in real life, via phone, or via video and gives a brief summary of the session.
- Screen for suicide at every session.
- All providers treating the patient have access to records from all disciplines.

Co-Location

- Physical and virtual co-location with other clinical disciplines.
- Move towards telehealth eliminated the greatest challenge – adequate physical space and introduced a new one – team based care when parts of the team are remote.
- Offer a wide-range of behavioral health services: brief assessments; individual, family and group therapy; short-term and long term behavioral health care; Medication Assisted Treatment (MAT) programs with relapse prevention support group; and psychiatry.

Warm Hand Off

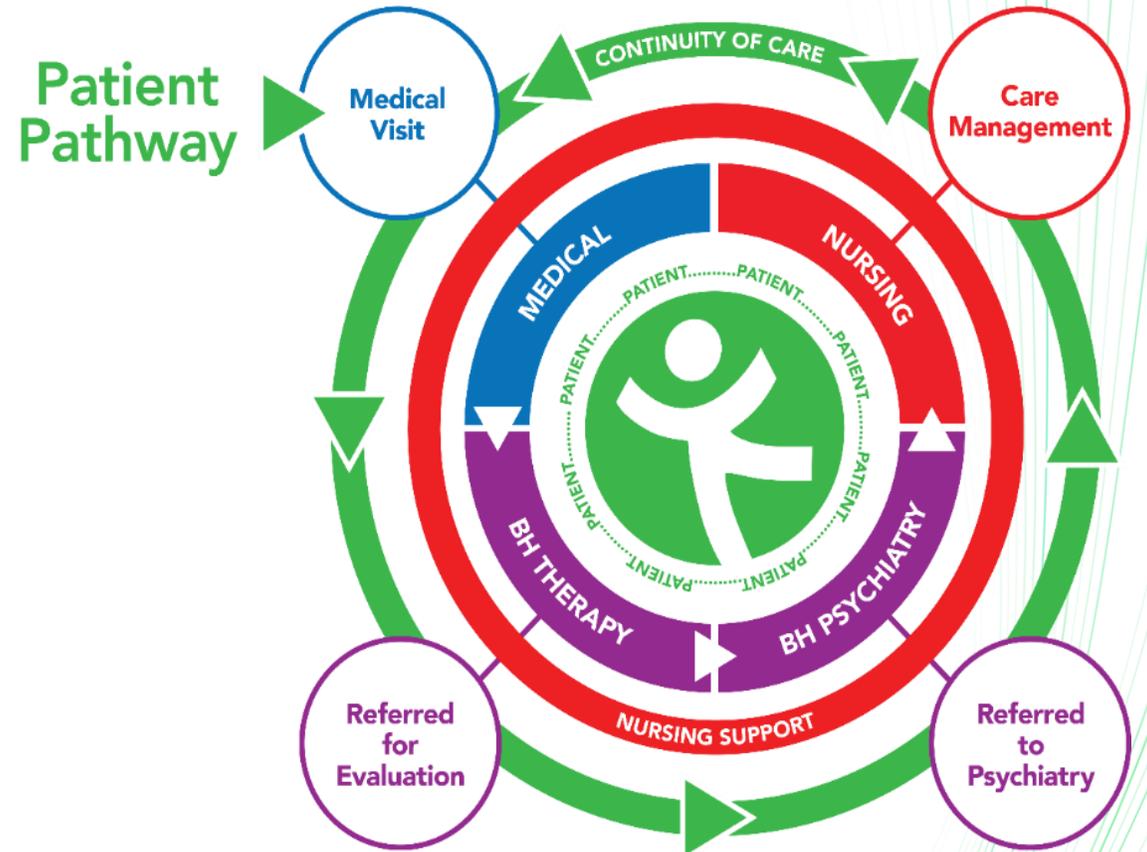
Warm Hand Off can be maintained in a hybrid team:

On Site:

- If a member of the team thinks a patient needs to see a behavioral health provider before leaving the appointment, it is flagged for the MA
- MA briefs the BH provider
- Every effort is made for patient to meet a BH provider before patient leaves

E-WHO (Electronic Warm Hand Off)

- Leverage EHR to do this virtually



All Patients are “CHCI Patients”

- In 2023, 12.0% of CHC Primary Care Patients were also CHC Behavioral Health Patients, and 65.3% of CHC Behavioral Health Patients were also CHC Primary Care Patients.
- All patients enter through the same doorway to be greeted by the same patient service associate, avoiding the stigma associated with seeing a therapist.
- Getting behavioral health care outside of our integrated team-based care system does not disqualify a patient from getting medical care at CHCI, though it makes coordination of services more difficult.
- Medical patients were more likely to keep initial appoints for behavioral health than those who had no previous connection to CHCI.

Having the Right People on the Team

- Behavioral health clinicians continue to focus on the interplay between a patient's inner world and social reality.
- The 45 minute session or weekly sessions that are often the norm in free standing behavioral health programs are often not needed, and the opportunity to have other team members provide parts of the care that the BH provider would need to do if they were a solo practitioner can lead to more effective and efficient care.
- Strong pod identify to build camaraderie.
- Inform candidates of unique opportunities, responsibilities, and obstacles of integrated care at time of hire.
- Training opportunities.

Resource: Optimizing the Role of Integrated Behavioral Health Providers in Health Centers

- **Description:** Join Behavioral Health experts from CHCI for an informative 60-minute webinar on the role of integrated behavioral health providers in health centers, featuring best practices for optimizing integration through tools like the electronic health record, co-location, and timely warm handoffs. Through a practical case study, Dr. Kearney will highlight the importance of screening tools such as the PHQ-9 in team-based care and share strategies to strengthen integrated behavioral health models.
- [Slides](#) | [Video](#)

Questions?

Data-Driven Improvements

Tierney Giannotti, MPA, Senior Program Manager for Population Health
Moses/Weitzman Health System

The 10 Building Blocks of High-Performing Primary Care

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



Data-Driven Improvements

- It is not a department or job description.
- It is the combined efforts and use of data, systems, and processes that occur across several levels of functioning within a health center
 - **Everyone** contributes to population health, beginning with individual patient encounters using a team-based approach to care, and extending out to value-based contracts with external agencies.
- Tools and Strategies: (1) Identifying gaps in care, (2) Documenting clear processes for closing care gaps, (3) Stratifying patients by risk, and (4) Ongoing feedback loops/reporting

Clinical Dashboard: Identifying Gaps in Care

Patient	PCP and Visit Info					
		ALERTS	Last Date	Due Date	Value	Notes
		*** PHQ-9	10/20/2025	TODAY		21 PHQ-9 due b/w 11/29/2025 and 3/29/2026
		*** Smoker Intervention				
		Needs Flu Vaccine 2025-2026				
		ACT				
		PEG				
		Health Literacy				
	Next Medical Appointment:					
	Last Dental Visit:					
Sex: M Age:						
	Reason for Visit: MED PCP Recall fu medslabs					

- Key piece of population health management are clinical dashboards, specifically the **Planned Care Dashboard** which is the engine driving all visits in primary care at CHC.
- MA does the pre-visit planning by reviewing the dashboard to identify what preventive services a patient is due to receive.

Job Tools to Support Care Gap Closure

- More than 40 care gaps on the Planned Care Dashboard
- Provides instructions on the process and who is responsible for each segment of the process
- Dashboards are not useful if there are no clear workflows in place for how to provide the care that the dashboard flags as needed.

PCD Item	Patient Population	How Often	What MA/LPN Does (or other clinical staff)
***PHQ-9	Patients <u>age</u> 12+ with a diagnosis of major depression or persistent depressive disorder on the problem list with PHQ-9 >5 at baseline period	Patients have <u>10-14 month</u> window after baseline period. Must complete PHQ-9 at today's visit if gap appears.	<ul style="list-style-type: none"> • Complete PHQ 9 Smart Form [MA] • Populate the value into the PHQ 9 section of the Vital Signs in the progress note [MA]

Psychiatry Dashboard: Gaps in Care

Moses/Weitzman Health System > CHC Data > Site Assets

Actions | Refresh | 1 of 1 | Find Next | 100%

[Email the BI team if you have an issue](#)



Community Health Center, Inc.

Show/Hide Preferred Language
 Show/Hide Guardian
 Hide Minor Informed Med Consent

Report Run Date 12/15/2025 11:31:45 AM

Psychiatry Dashboard

Patients seen in last 12 Months: 211

Visits in last 12 Months: 950

[Click Here for Data Definition of the Report](#)

patient info	ID	Primary Insurance	PCP Site	PCP	Age	Last Therapist	Last Psychiatry Provider	Last PsychVisitType	Telehealth Consent Date	BH R & R	Review DueDt	Intake	Depression Monitoring	Last InPerson BH [psych] or Med VisitDt	Las
													PHQ 9 Due By 3/29/2026		

Parameters

FilterCriteria
Next BH Visit

Specialty
Psychiatry

Provider

NextAppt
All

ControlNo
*

Beyond the Dashboards: Closing Care Gaps & Patient Outreach

- Community health extends beyond the primary health care teams.
- Three primary ways to close care gaps at CHCI
 1. Close care gaps in real time when the opportunity arises (i.e. when a patient is seen for an acute visit, order the HbA1c that is due)
 2. Identify patients for whom the care gap has been addressed, but for whom we do not have a record indicating it was addressed (i.e. receive care elsewhere, go to at outside lab or radiologist for screenings and tests)
 3. Reach out to patient by text or phone to schedule a visit or remind them of one so that they get the care they need to receive.

Discussion Question

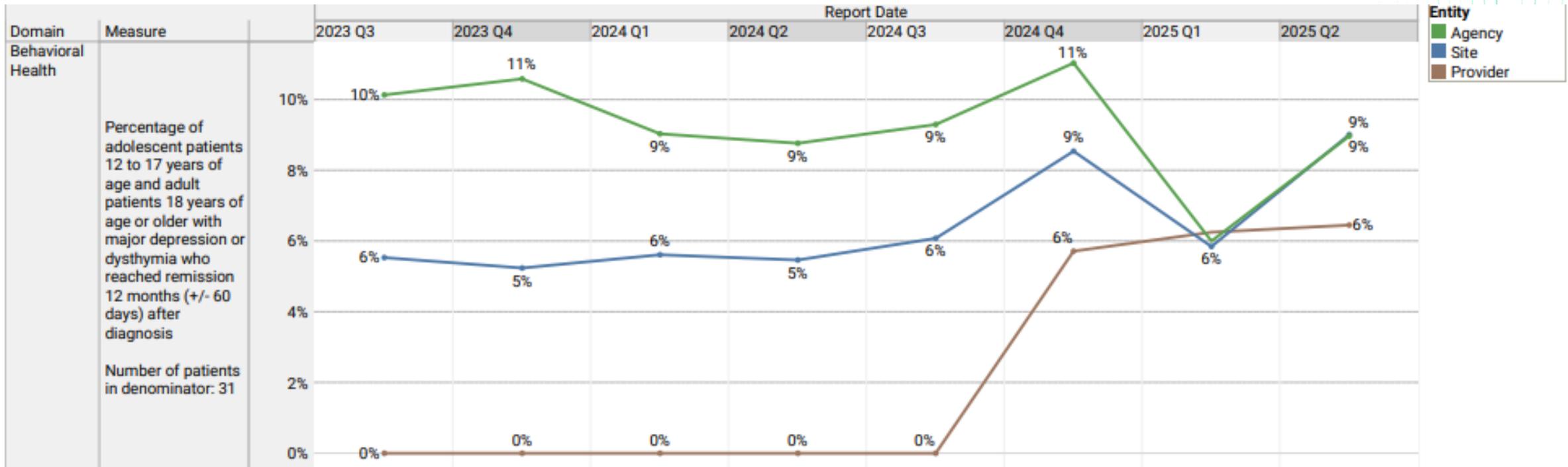
How do you close your care gaps at your health center?
Who does it?

Please type your answer in the chat or unmute.

Lessons Learned for Clinical Dashboards

- Conduct chart reviews and site visits to learn from the clinical team what is and what is not working.
- Consider all of the various ways staff learn:
 - Email written instructions
 - Screenshots of the process
 - Video of the rationale for addressing the care gap and the process for completing it

Quarterly Chronic Disease Management Report



Depression Remission Case Study

DEPRESSION REMISSION PI PROJECT CHARTER

Date:	June 2025
Team Members	<ul style="list-style-type: none"> Anita Kasdan – QI Coach Dan Bryant –Co- Coach, Eric Vaught - CMO Garett Matlick – Clinician Champion Tichianaa Armah – Psychiatry Tierney Giannotti – Pop Health Nick Ciaburri – BI Jennifer Corridon – PMHNP
Problem Statement	<p>Historically :</p> <ol style="list-style-type: none"> Low rates of PHQ9s are completed when due (data collection) 2024 Rate: Only 11% of those in the denominator are meeting the measure (completed PHQ9 in time frame and demonstrate depression remission)
Why Now	This is a UDS measure. Historically only about 11% of our patients meet this measure. Without Mirah anymore (automation), we anticipate additional challenges in collecting PHQ9s.
Measures	<p>The percent of patients age 12 and older with major depression or dysthymia who reached remission within 12 months (+/- 60 days) (10-14 months) after index event.</p> <p>Currently 1664 pts in denominator</p>
Goal Statement	<p>Two phases:</p> <ol style="list-style-type: none"> Improve collection of PHQ9s within the required timeframe (CY24 was 49%) Improve % of clients who meet the measure (depression remission) to 25% (CY24 was 11%)
Milestones / Dates	<ul style="list-style-type: none"> Start Initial PDSA June 30

CY 2024 Data

2024 CHC Rate for Depression Remission : **11%**

Denominator: 1,853
Numerator: 205

There were **1,648 (89%)** patients who did NOT meet the measure.

They either didn't have a follow up PHQ-9 (**n=1,013**) OR it was > 9 (**n=635**)

Patients who did NOT meet Numerator because they did not have PHQ-9 in follow up period (n=1,013)

Patients who did NOT meet Numerator but did have PHQ-9 in window period (n=635)

KEY POINT: CHC is not meeting this measure...because the PHQ-9 is NOT being done in the required timeframe.

PDSA #1 Results

PDSA #1

Time limited pilot: 6/30/25-7/5/25

Two Components:

- For patients who had upcoming visit who are “in the window” to have the PHQ-9 follow-up completed, the Chief Complaint indicates: “PHQ-9 due”.
- A SnapComms pop-up message broadcasted at 1:00 p.m. and sent to:
 - Behavioral Health providers
 - Medical providers (excluding Podiatry, Chiro and Nutrition)
 - Nursing
 - Medical Assistants

Subjective:
Chief Complaints:
 1. PHQ-9 Due.

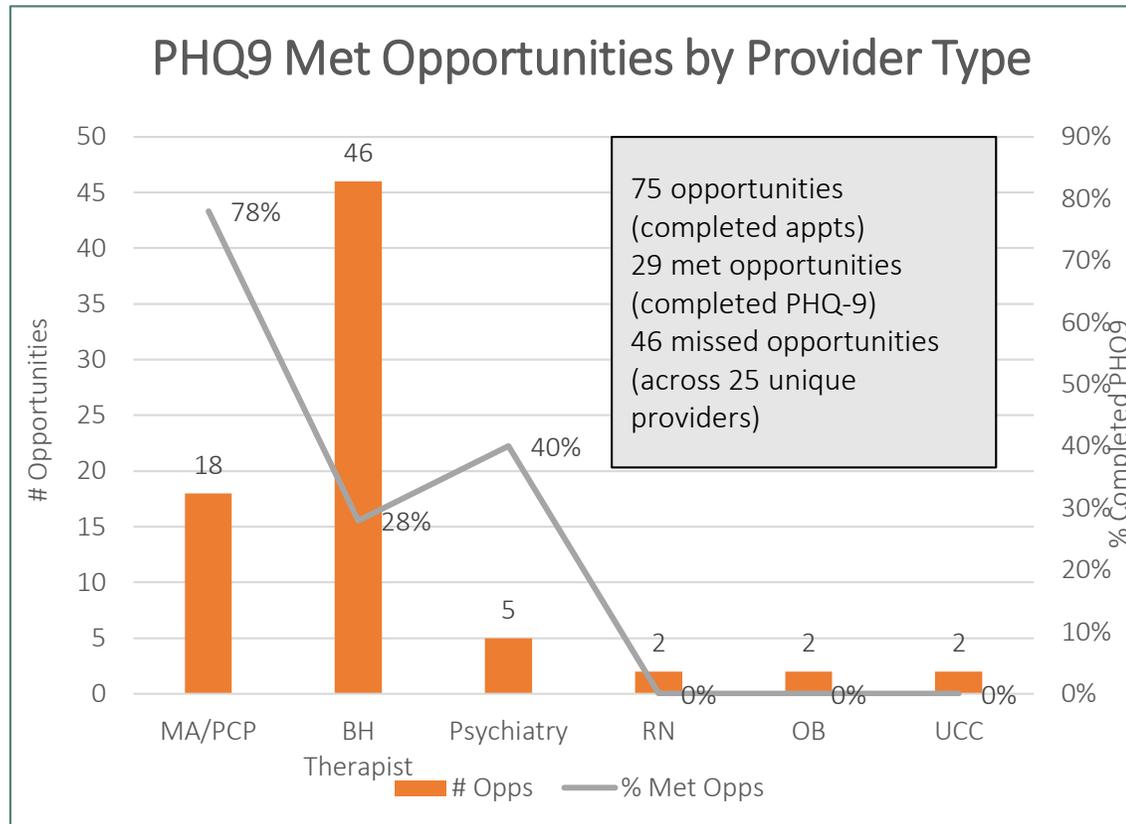
“If you see a PHQ-9 reminder in the Chief Complaint today, please complete the Smart Form during today's visit.”

We Anticipated 60% Compliance....

PDSA #1 Results

Date of Visit	CC Updated and Snap Comms		Visit Completed		If visit completed – was PHQ-9 completed	If visit completed – was PHQ-9 completed
	n	%	n	%	n	%
6/30/2025	20	55%	11	55%	1	9%
7/1/2025	42	62%	26	62%	12	46%
7/2/2025	25	64%	16	64%	8	50%
7/3/2025	34	59%	20	59%	8	40%
7/5/2025	3	67%	2	67%	0	0%
Total	124	60%	75	60%	29	39%

PDSA #1 Results



Results show greatest opportunity for improvement lies among pts engaged with BH.

Current PDSA: Dedicated person outreaching to patients engaged with BH by phone prior to due date. Results to date show 15/25 (60%).

Questions?

Wrap-Up

Deliverables

- ✓ Conduct your internal health center team meetings
- ✓ Team leaders attend weekly 60-minute team leader check-in calls
- ✓ Complete Step 7 in the Quality Improvement Workbook

**Access the Google Drive
to upload deliverables:**



Next Steps

- **Team Leader Check-In Calls:**
 - Wednesday March 11th 1:00pm Eastern / 10:00am Pacific
 - Wednesday March 18th 1:00pm Eastern / 10:00am Pacific
 - Wednesday March 25th 1:00pm Eastern / 10:00am Pacific
- **Session 6:** Wednesday April 1st 1:00pm Eastern / 10:00am Pacific
- Register for the [Weitzman Education Platform](#) to receive CME, resources, and more!



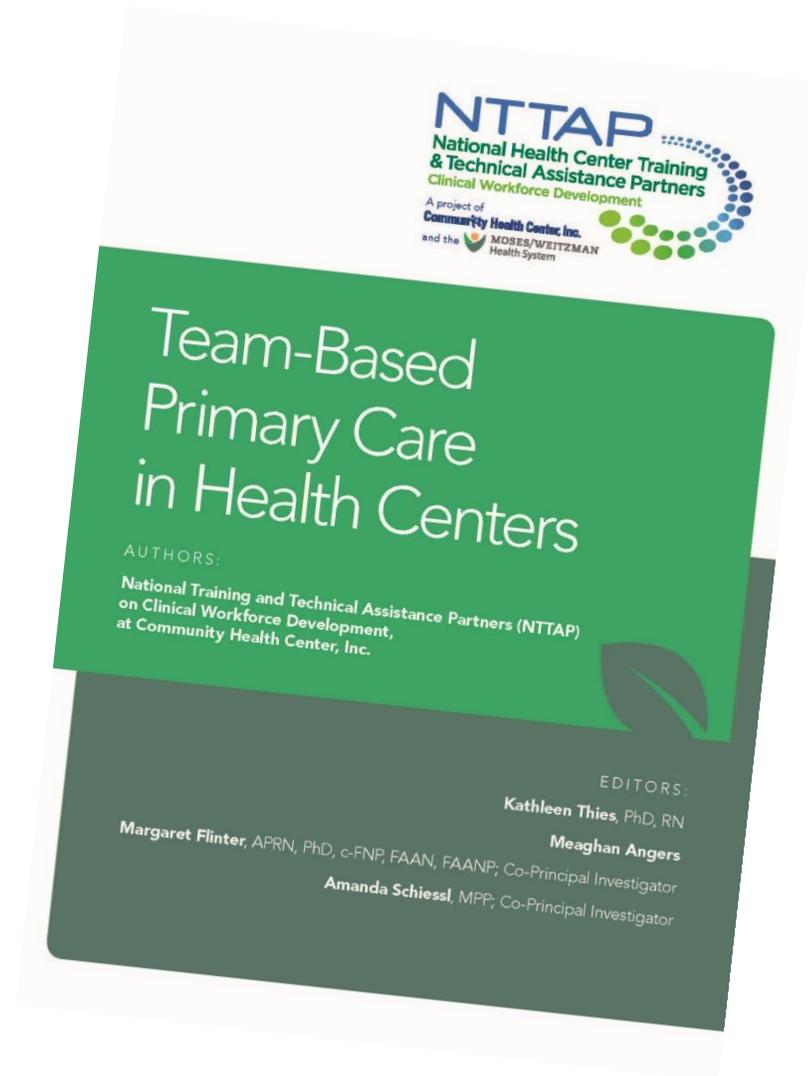
Weitzman Education Platform

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](#).

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

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



Explore more resources!

National Learning Library: Resources for Clinical Workforce Development

National Learning Library



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

[Learn More](#)

<https://www.weitzmaninstitute.org/ncaresources>



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

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

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

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

Health Center Resource Clearinghouse



<https://www.healthcenterinfo.org/>

Contact Us!

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REMINDER: Complete evaluation in the poll!
Next Learning Session is **Wednesday April 1st**!

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