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

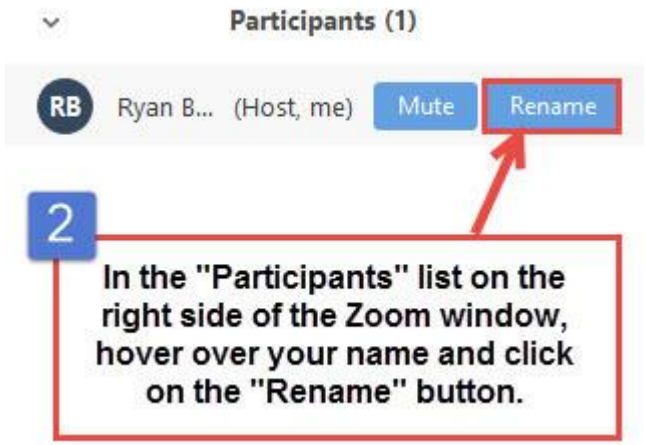
Comprehensive and Team-Based Care Community of Practice (CoP)

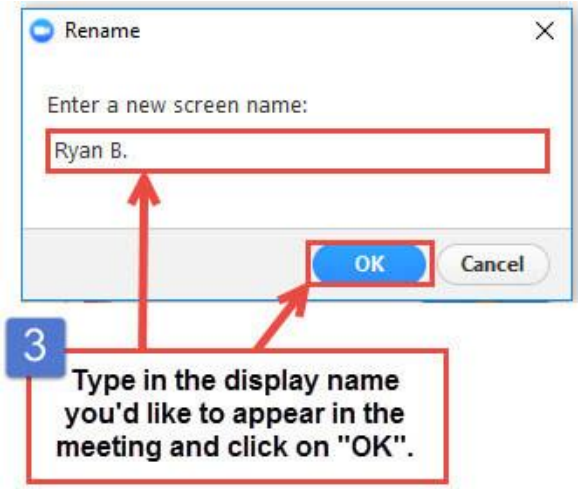
Session Six: April 1st, 2026

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”





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Session Agenda

- 1:00-1:05pm Welcome
- 1:05-1:35pm Meaningful Integration of Health Information Technology (HIT) for Team-Based Care
- 1:35-1:55pm Role of the Pharmacist in Team-Based Care
- 1:55-2:25pm Patient-Team Partnership and Communication
- 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
- 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

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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.

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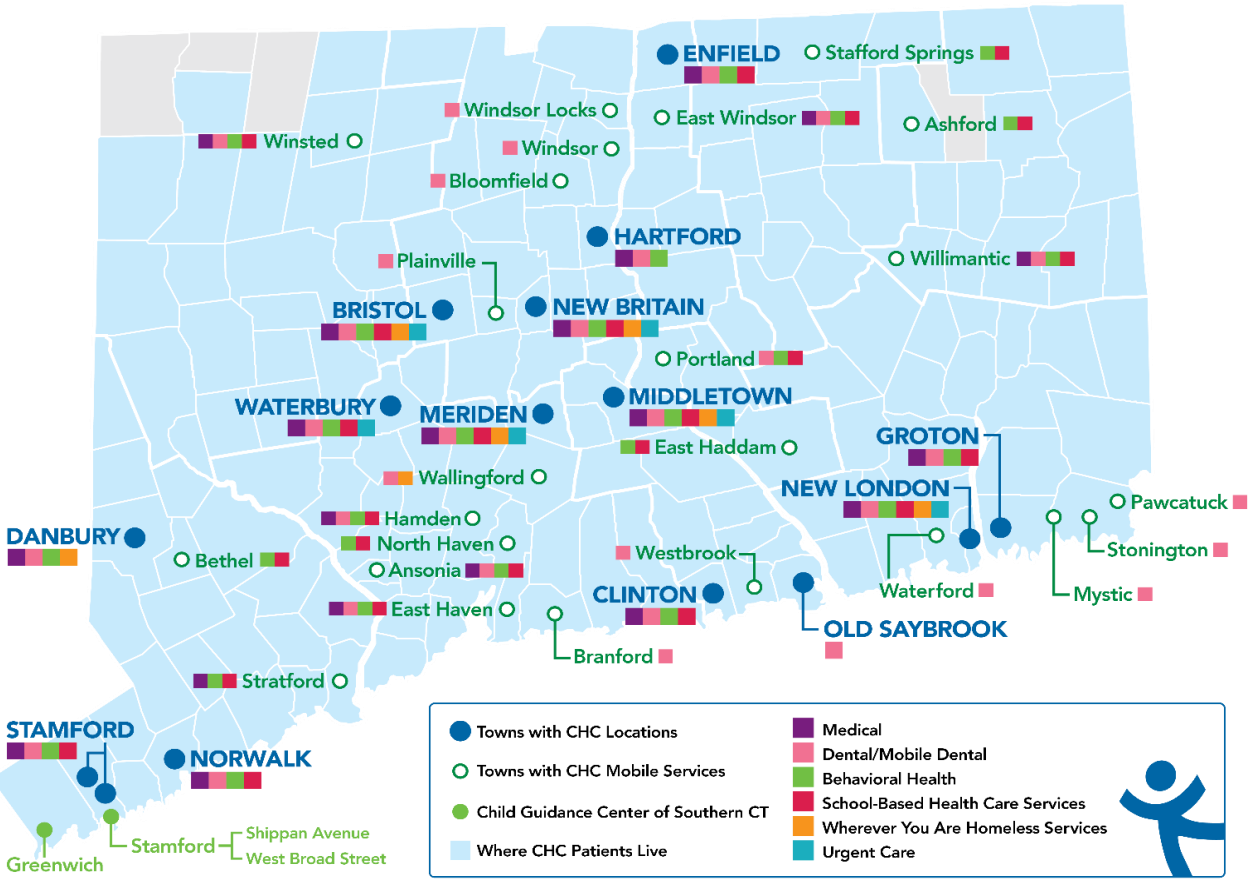
Locations & Service Sites



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.

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

Meaningful Integration of HIT for Team-Based Care

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

April 2025

IPHCA

About The HITEQ Center

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

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

The HITEQ Center is a HRSA-funded National Training and Technical Assistance Partner operated by JSI Research & Training, Inc. and Westat. This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of awards totaling $693,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

HITEQ Topic Areas

Virtual and digitally enabled care

Access to comprehensive care using health IT and telehealth

Privacy and security

Advancing interoperability and standards based exchange

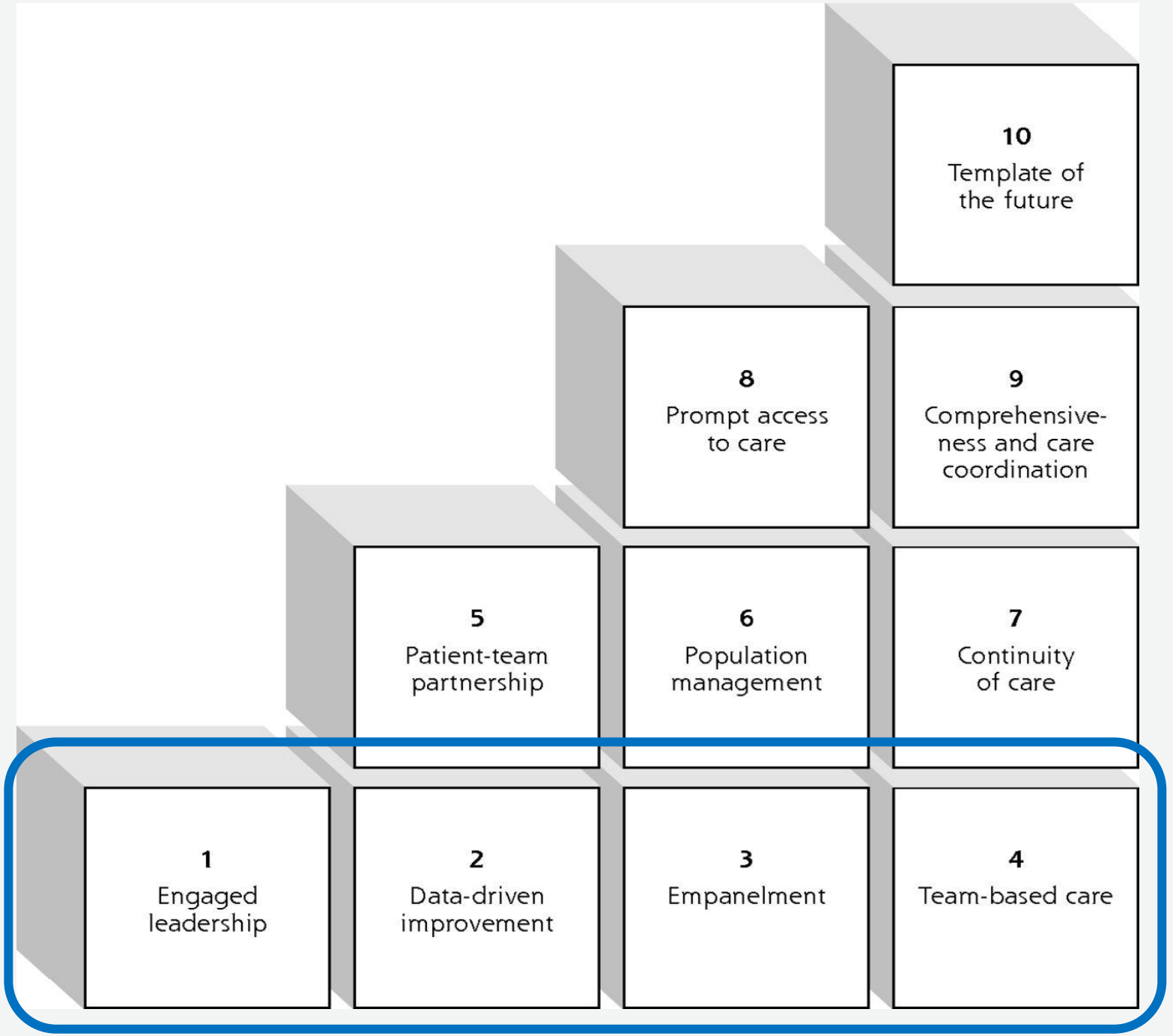
Electronic patient engagement and digital health

Readiness for value based care

Using health IT and telehealth to improve documentation integrity

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

Building Blocks of Team-Based Care



The foundations of team-based care are critical to effective integration of HIT.

~~Engaged Leadership~~	Data-Driven Improvement	Empanelment	Team-Based Care	=	Lack of clear vision
Engaged Leadership	~~Data-Driven Improvement~~	Empanelment	Team-Based Care	=	Lack of feedback
Engaged Leadership	Data-Driven Improvement	~~Empanelment~~	Team-Based Care	=	Lack of focus
Engaged Leadership	Data-Driven Improvement	Empanelment	~~Team-Based Care~~	=	Lack of structure

Integrating Health Information Technology (HIT)

Team-Based Roles & Responsibilities and HIT

- Who needs to access the data/ tools?
  - Consider internal and “external” access needed
- In what form?
  - Different reports or uses of reports for different roles/functions (e.g., Chronic Care Management vs. Pre-visit planning)
- Establish clear responsibilities by role and ensure end users are trained and comfortable

A Morning in the Life of a Primary Care Clinic

Time	What's Happening?
3:00 PM (day before)	Pre-visit planning: Review of registries or chart scrubbing tools to plan next day's huddle, obtain outstanding labs or referral notes
7:45 AM	Daily Huddle: Brief team check-in to review patients on the schedule, walk-in slots, anticipate equipment or staffing needs, obtain necessary records
8:15 AM	Medical Assistant (MA) - First patient roomed: Intake, select appropriate template, documentation of vital signs, screenings, pending "standing order" items
8:15 AM	Front Desk- Receives a call from a new patient that would like to schedule with a provider that is accepting new patients
8:35 AM	Care coordinator - Managing and placing referral to specialist
9:00 AM	Nurse - Reviewing lab report and calling patients with results; follow up protocols

A Morning in the Life of a Primary Care Clinic

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8:15 AM	MA - First patient roomed: Intake, select appropriate template, document vital signs, screenings and results, pending "standing order" items
8:15 AM	Front Desk- Receives a call from a new patient that would like to schedule with a provider that is accepting new patients (empanelment report/ understanding of open/closed panels)
8:35 AM	Care coordinator - Managing and placing referral to specialist
9:00 AM	Nurse - Reviewing lab report and calling patients with results; follow up protocols

Example Report: Using HIT to Drive Team-Based Care (TBC)

5:08 AM Thursday, November 17, 2022 — Visit Reason: **Injury Departure**

Keanu, Marvis
MRN: 7142415
DOB: 6/4/1969 (53)

Sex : M

Phone: 774-396-6711
Lang: Arabic
Risk: Low (29)

Portal Access: 12/26/2020
Cohorts: DM No A1c No LDL, November Diabetes

PCP: Doe, Jane
Payer:
CM: Tom Parace

DIAGNOSES (10)

ASCVD	Asthma	CAD
Cancer	COPD	Depression
DM	Hepatitis C	HIV
IVD		

RISK FACTORS (4)

ANTICOAG	Chronic Opioid Tx	IDD
SMI		

(8)

EMPLOYMENT	LANGUAGE	MATERIAL
MIGRANT	RACE	SAFETY
SECURITY	STRESS	

RAF GAPS DIAGNOSIS CATEGORIES (0)

ALERT	MESSAGE	MOST RECENT DATE	MOST RECENT RESULT
A1c	Missing		
LDL	Missing		
Tobacco Scr	Missing		
BP	Out of Range	5/16/2022	101/95
Foot	Missing		
I/P Encounter	Occurred	8/14/2022	

OPEN REFERRAL W/O RESULT	SPECIALIST/LOCATION	ORDERED DATE	APPT. DATE
Open	Samantha Frost / Brighton	12/15/2022	
Gastroenterology	John Smith / Brookline	5/16/2022	5/17/2022
Gastroenterology	Ellen Bell / Boston	5/16/2022	6/12/2022
Gastroenterology	Samantha Frost / Brighton	5/16/2022	5/31/2022

Example: Pre-Visit Planning Process Using Azara DRVS Report

https://vimeo.com/227406460

Using HIT to Support Top of Scope Work

NOTE: “Top of scope” will likely differ by state based on scope of practice guidelines

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

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

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

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

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

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

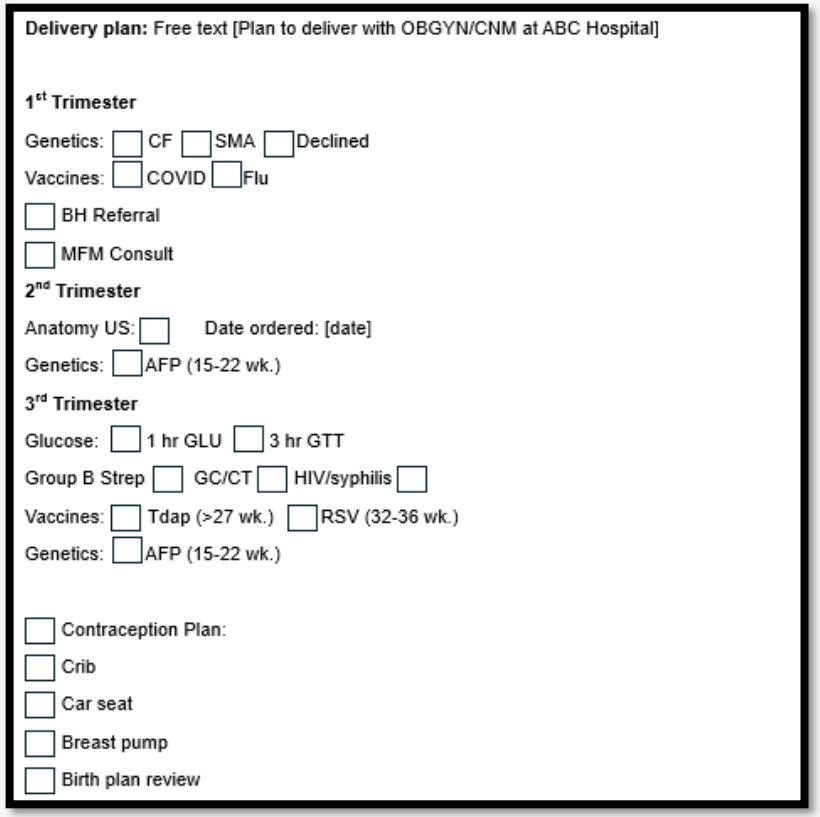
Using HIT to Support Top of Scope Work & Quality Outcomes

+ Embedding appropriate tools within Electronic Medical Record (EMR), community health tools to allow team members to share the care
  - Example: Pregnancy Overview & Plan customized templates or smart phrases in EMR

+ HIT tools that match clinical guidelines

+ Consider team-based care with specialists and community partners

+ Effective use of tools to improve quality outcomes



Delivery plan: Free text [Plan to deliver with OBGYN/CNM at ABC Hospital]

1st Trimester

Genetics: ☐ CF ☐ SMA ☐ Declined

Vaccines: ☐ COVID ☐ Flu

☐ BH Referral

☐ MFM Consult

2nd Trimester

Anatomy US: ☐ Date ordered: [date]

Genetics: ☐ AFP (15-22 wk.)

3rd Trimester

Glucose: ☐ 1 hr GLU ☐ 3 hr GTT

Group B Strep ☐ GC/CT ☐ HIV/syphilis ☐

Vaccines: ☐ Tdap (>27 wk.) ☐ RSV (32-36 wk.)

Genetics: ☐ AFP (15-22 wk.)

☐ Contraception Plan:

☐ Crib

☐ Car seat

☐ Breast pump

☐ Birth plan review

How to Get Started

+Choose one day on the calendar (could be tomorrow, next week) as a reflection day

+Consider the “bottlenecks” in your day

- What is one process you could improve?
- How does HIT support this process?
- What might need to change in order to improve it?
- Is it possible to test this change on a small scale?
- How would you know whether the test is successful?

IPHCA

Thank you!

Questions?

Taylor Thompson, MPH

tthompson@iphca.org

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Role of the Pharmacist in Team-Based Care

Kara Lewis, Director of Clinical Pharmacy Services

Community Health Center, Inc.

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Poll

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

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Value of Integrating a Pharmacist into the Primary Care Setting

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

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

- Direct consultation with clinical team
- Working with the community health team on outcomes
- Teaching/education and training for organization
- Chair of Pharmacy and Therapeutics Committee
- Clinical management of 340B drug pricing program

Consultation with Clinicians

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

Community Health

- Works with Director of Population Health for CHCI's Community Health team regarding value-based contracts and informatics
  - *Example*: Payer incentives related to medication adherence
  - *Example*: Uniform Data System (UDS) medication related measures
  - *Example*: Hypertension (HTN), Diabetes Mellitus (DM), hyperlipidemia, CGM project
- **Continuous Glucose Monitoring (CGM) Project:** Successfully obtained for over 1000 patients by creating centralized ordering workflow managed by pharmacy team

Teaching

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

Pharmacy and Therapeutics Committee

Chair of Pharmacy and Therapeutics Committee:

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

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340B Drug Pricing Program

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

Pharmacy Opportunities

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

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Questions?

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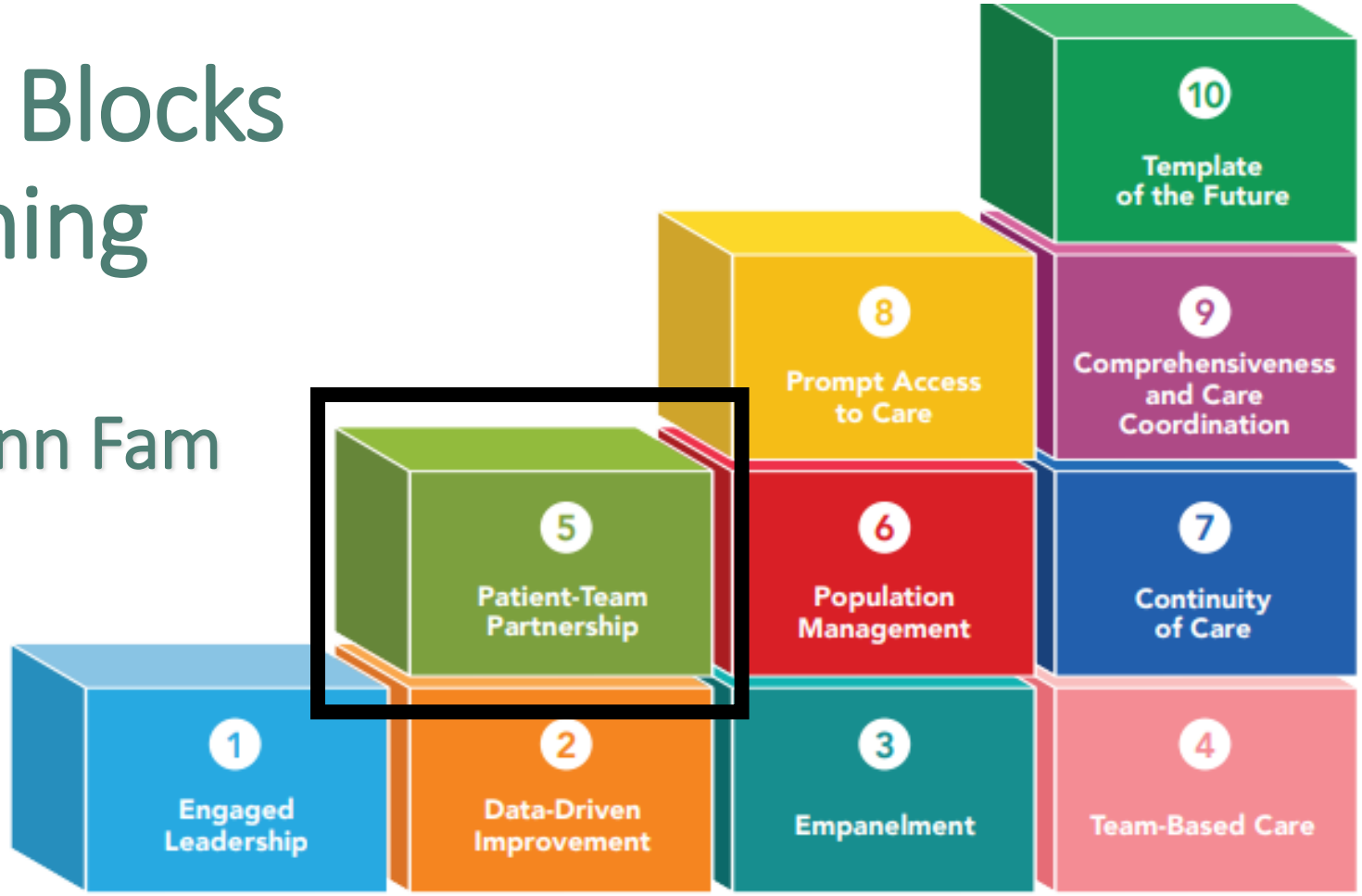
Patient-Team Partnership and Communication

The 10 Building Blocks of High-Performing Primary Care

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



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Agenda

- Workflow Evolution: 2018-Present
- Automation of Reminders and Recalls
- Self-Scheduling
- Waitlist
- Digital Forms
- Engaging Patients
- Workload Reduction

Patient Engagement: A 7-Year Journey

- **Reminders:** Automated notifications
- **Actionable Reminders:** Cancellations & confirmations
- **Expanded Automation:** Outreach tied to provider-created recalls
- **Self-Scheduling:** Outreach campaigns & recalls
- **Advanced Automation:** Automated recalls allowing custom messaging
- **Digital Forms:** E-consents, Release of Information (ROI), medical history, etc.
- **Additional Features:**
  - Waitlist management
  - Patient feedback
  - Texting categories for tailored communication
  - Website scheduling

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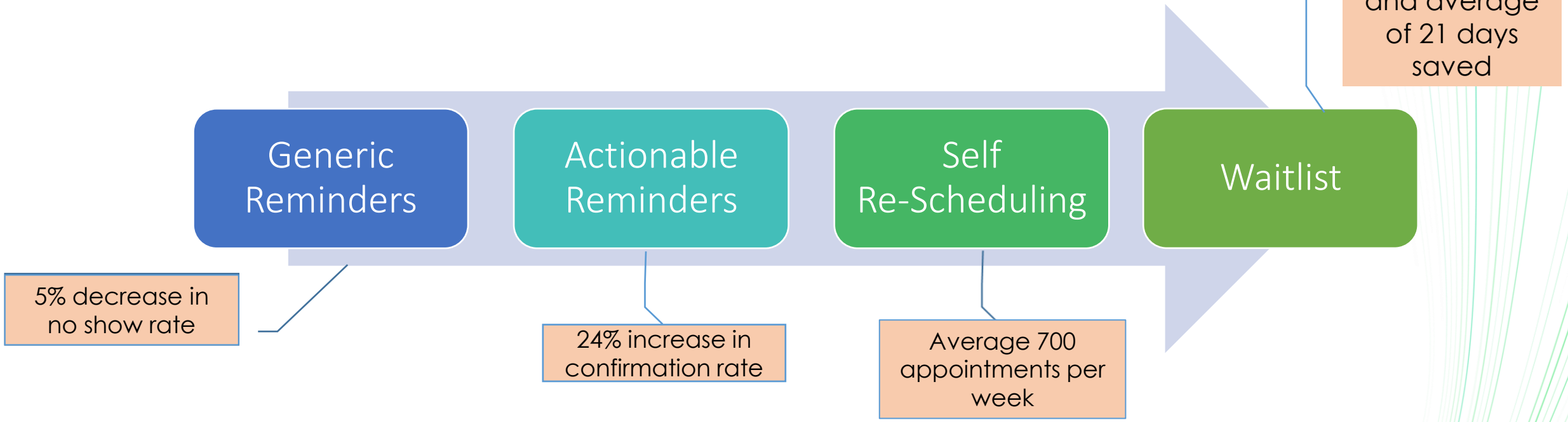
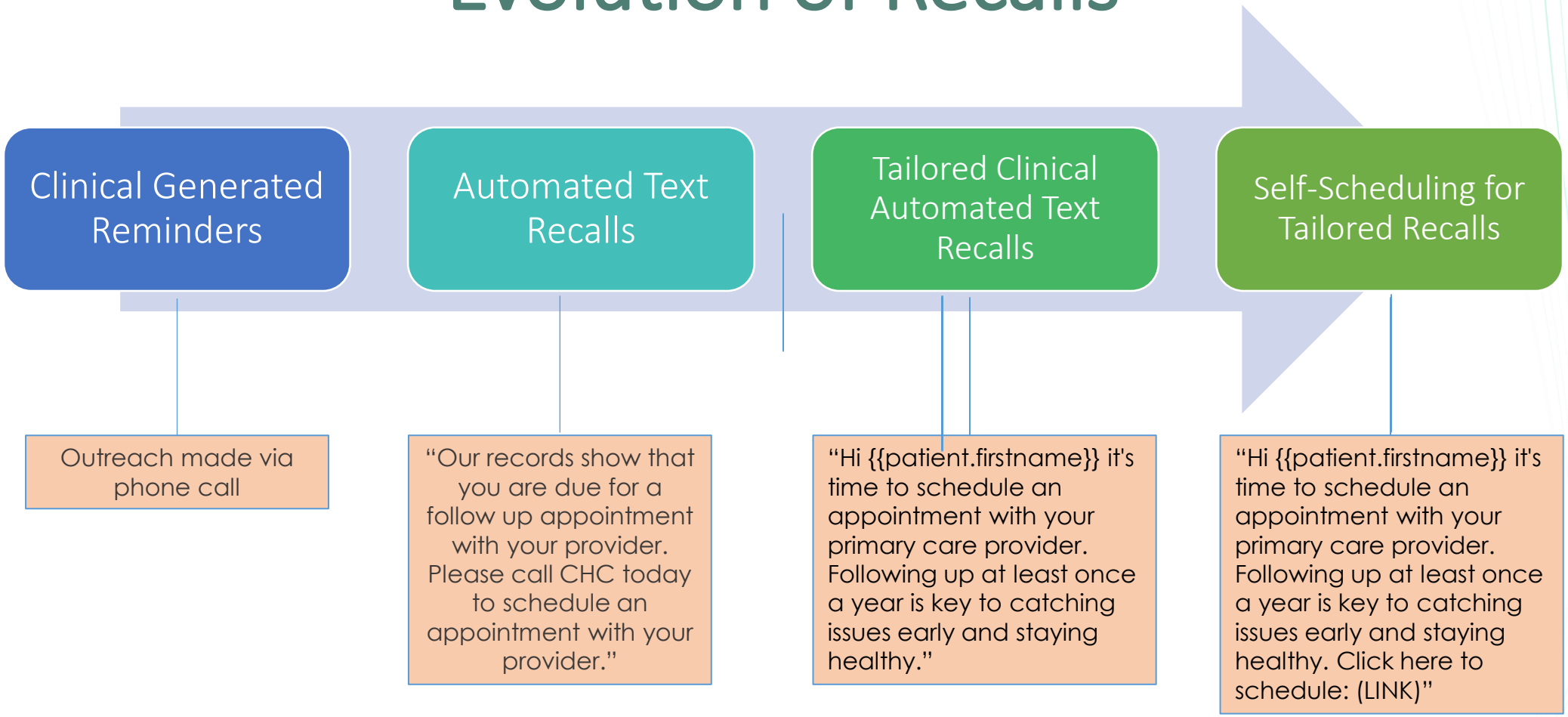
Evolution of Reminders



Evolution of Recalls



Automated Recall Examples

- Well-Child Checks (WCCs) (1-30 months)
- Annual WCC (3-17 years)
- Follow up care (No visits or physical <12 months)
- AIC-Diabetes in control (if <7 = 6 months)
- AIC-Diabetes NOT in control (if >7.1 = 3 months)
- Psych – appointment and medication follow up
- Blood pressure in control (6 months)
- Blood pressure NOT in control (3 months)
- Blood pressure severe (1 month)
- Dental hygiene/exams (Child) – every 6 months (Exams due annually)
- Dental hygiene/exams (Adults) – every 12 months

Self-Scheduling

- Began with inserting self-scheduling forms in established medical and dental hygiene campaigns
- Expanded into Specialty, Urgent Care, Dental, Primary Care Provider (PCP) and finally Behavioral Health/Psych
- Website self-scheduling live 2025

Waitlist

- Appointments scheduled between 7 days and 60 days in the future will be offered to join the waitlist for a sooner appointment.
- Cancellations between 100 minutes and 7 days will trigger an offer to patients who joined the waitlist
- Coming Soon:
  - Auto-add to waitlist
  - Manually pushed offers by Patient Service Associate (PSA) (capture open slots outside of cancellations)

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Consent Forms and Documentation

- Started with manual pushes of General and Telehealth consents only
- Created logic to auto send based on form expiration and appointment type
- Now have over 15 digital forms set up for both automation and manual
- Custom Checklists
  - Sends each patient a link with a list of multiple documents needed based on the form requirements and appointment type (School-Based Health Center (SBHC) Intakes, Fixed Site Intakes, New Patient Packets etc.)

Engaging Patients: Campaigns

- A campaign calendar is used to track and manage recurring outreach campaigns based on frequency, ensuring consistent patient engagement and operational follow-through.
- **Daily:** Emergency Room (ER) discharges & non–Transitional Care Management (NON-TCM) discharges
- **Weekly:** Missing Insurance & Text to Pay
- **Monthly:** Retinal Screenings, Medicaid patients not seen in 18 months & overdue balance
- **Overdue Recalls:** A1c/BP checks, Dental Hygiene & Patient-Centered Medical Home (PCMH)+ WCC
- **Quarterly:** Overdue Pap's and Colorectal Screenings
- **Ad Hoc:** Provider Changes, SBHC, Medicaid Redetermination, Marketing (Email)

Engaging Patients: Surveys & Feedback

Feedback messages are randomized, and responses are based by score:

- Promoter (8–10): Directs patients to leave a Google review.
- Neutral (6–7): No review request is sent.
- Detractor (0–5): Directs patients to an anonymous internal survey

Workload Reduction: Saving Time for MAs and Front Desk Staff

- Access to Pre-Approved Messaging Library:
  - Links to digital forms
  - Lab reminders
  - Normal Lab notification
- Telephone encounters can be assigned to texting bins to bulk sent via Luma:
  - Appointment needed, recall screening
  - Appointment needed, Rx refill
  - Appointment needed, test results
  - PCP, site transfer
  - LetterForm, ready for pick up

Workload Reduction:
Saving Time for Billing and Access to Care (ATC) Staff

- Staff can also use pre-approved text templates to engage patients regarding financial matters, such as:
  - Sliding Fee Discount Application
  - Proof of Income documentation
  - Insurance Capture (Upload Picture of Insurance Card)

- Coming Soon:
  - **E-Check In-** Patients will soon be able to pay any outstanding bills when completing their pre-appointment paperwork

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Wrap-Up

Deliverables

- ✓Conduct your internal health center team meetings
- ✓Team leaders attend weekly 60-minute team leader check-in calls
- ✓Complete Step 8 in the Quality Improvement Workbook
- ✓Complete Step 9 in the Quality Improvement Workbook

Access the Google Drive to upload deliverables:

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Next Steps

- **Team Leader Check-In Calls:**
  - Wednesday April 8th 1:00pm Eastern / 10:00am Pacific
  - Wednesday April 15th 1:00pm Eastern / 10:00am Pacific
  - Wednesday April 22nd 1:00pm Eastern / 10:00am Pacific
  - Wednesday April 29th 1:00pm Eastern / 10:00am Pacific
- **Session 7**: Wednesday May 6th 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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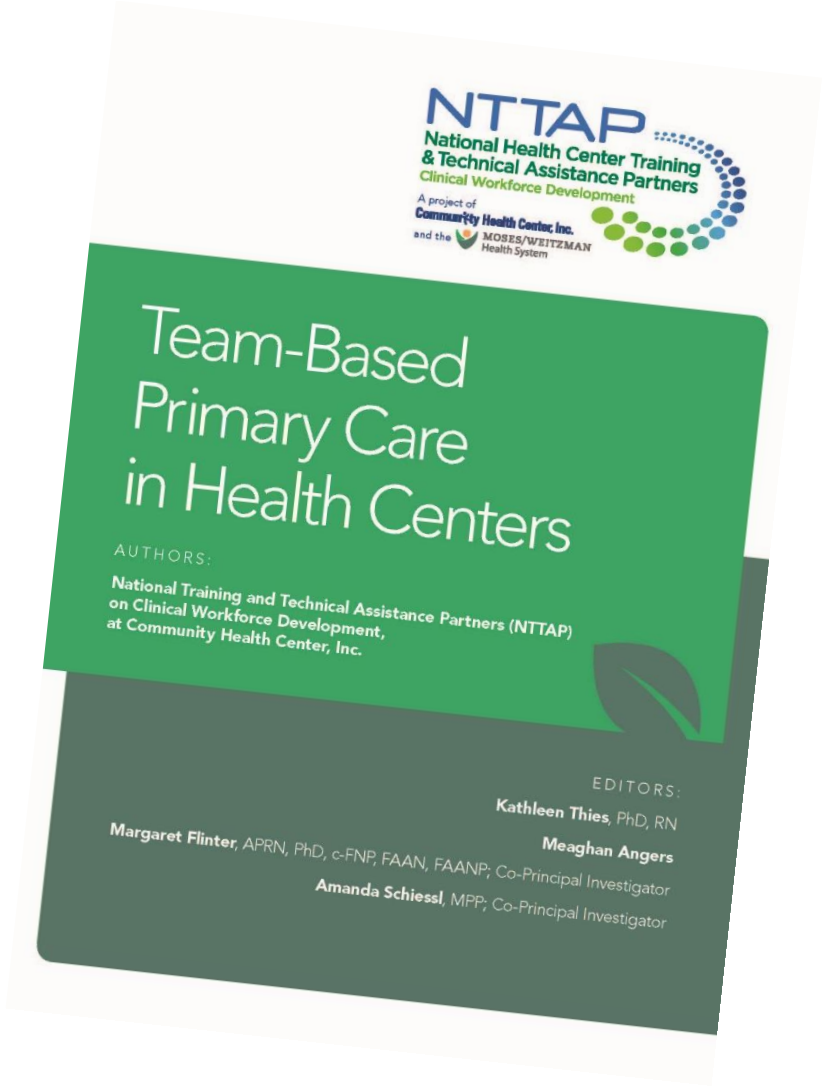
Download our book, *Team-Based Primary Care in Health Centers*!

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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Contact Us!

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REMINDER: Complete evaluation in the poll!

Next Learning Session is **Wednesday May 6th!**