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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 Seven: May 6th, 2026

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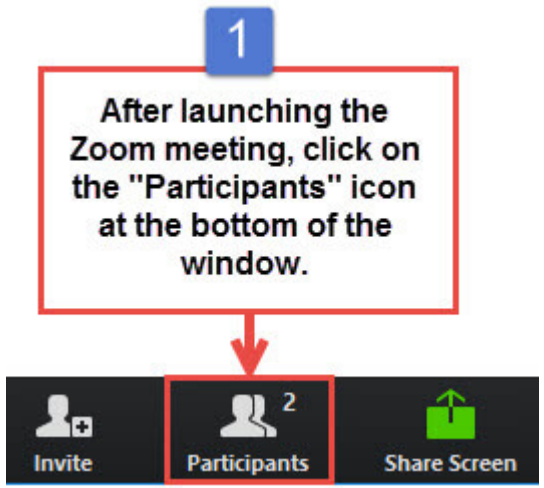
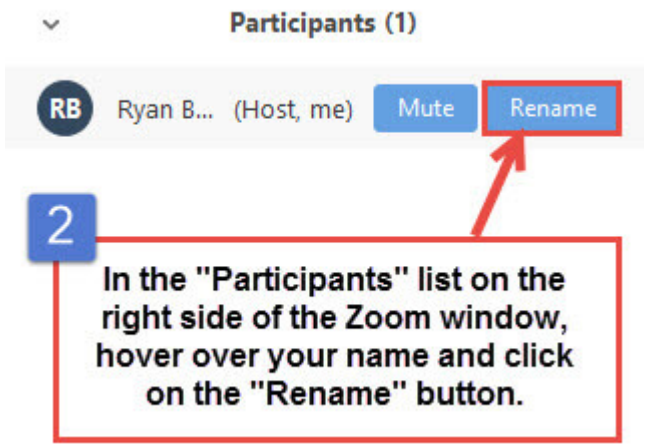
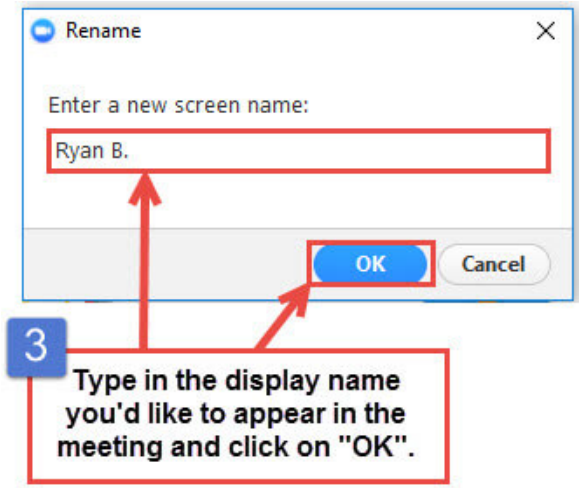
- Please keep yourself on MUTE to avoid background/distracting sounds
- Use the CHAT function or UNMUTE to ask questions or make comments
- Please change your participant name to your full name and organization
  - “Meaghan Angers CHCI”







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Session Agenda

- 1:00-1:05pm Welcome
- 1:05-1:20pm Artificial Intelligence and the Future of Primary Care
- 1:20-1:30pm Recruitment and Retention
- 1:30-1:50pm Quality Improvement: Standardization, Spread, and Playbooks
- 1:50-2:00pm Monitoring Progress
- 2:00-2:10pm Data Outcome and Displays
- 2:10-2:25pm Sustaining the Quality Improvement Model
- 2:25-2:30pm Wrap-Up

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
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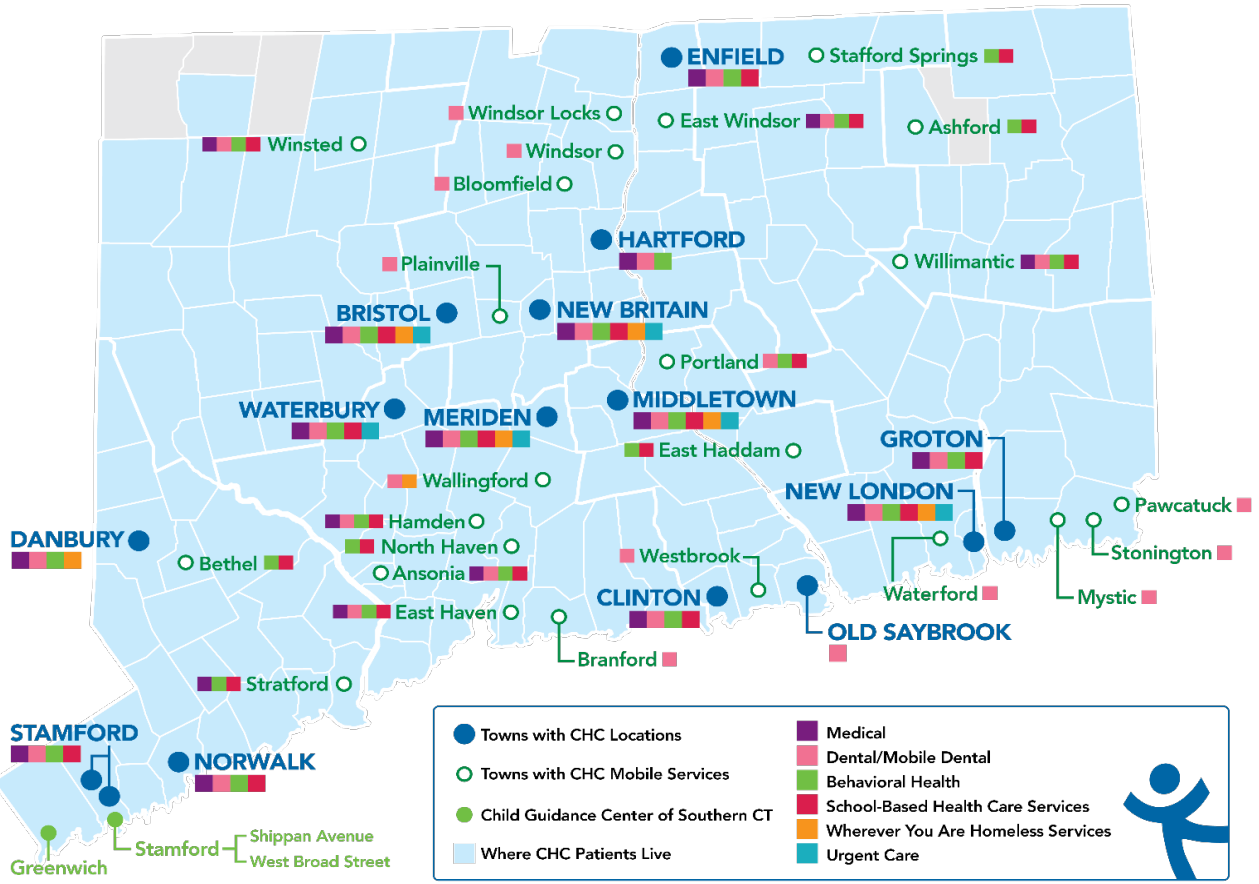
Locations & Service Sites



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

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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.

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

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CoP Structure

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

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

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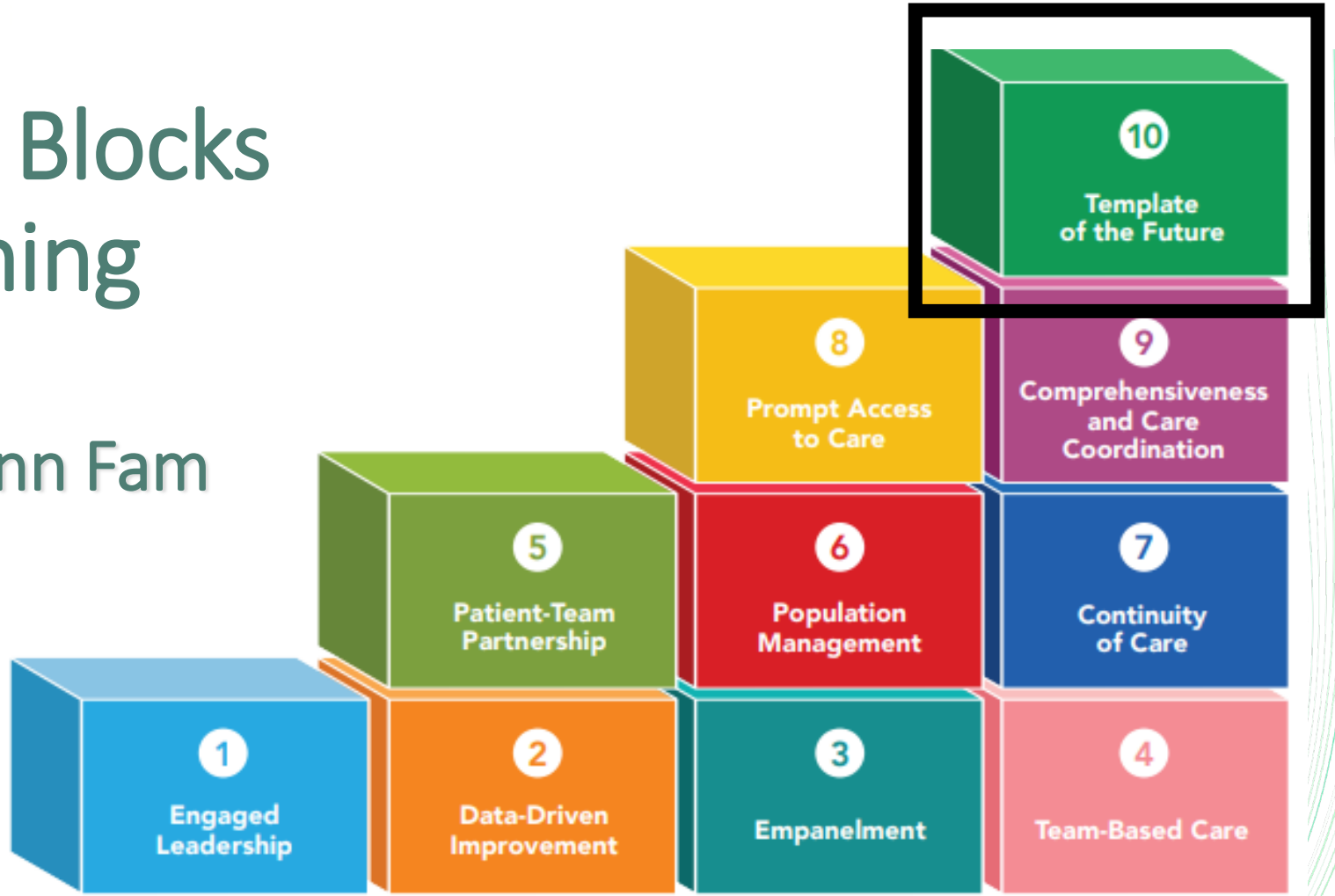
Artificial Intelligence (AI) and the Future of Primary Care

Eric Vaught, Chief Medical Officer

Community Health Center, Inc.

The 10 Building Blocks of High-Performing Primary Care

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



Polling Questions

- Have you implemented artificial intelligence (AI) at your health center?
  - Yes
  - No
  - Unsure
- In what areas:
  - Dictation
  - Chat bots and scheduling appointments
  - Coding and billing
  - Community health
  - Peer-review credentialing

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AI in Clinical Practice: What It Is and Is Not

IT IS:

- A clinical support tool that assists with documentation, data analysis, and decision support
- Designed to enhance efficiency, consistency, and access to evidence-based information

IS NOT:

- A replacement for clinician judgment, training, or accountability
- An autonomous decision-maker or diagnostic authority
- A substitute for patient-clinician relationships or ethical responsibility

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Sunoh AI Software
Phase II Pilot Project

Evolution of Scribe Technology

Document

Digitize

Speech to Text

AI

Sunoh Background

- Sunoh.AI™ is an innovative AI assistant that uses natural language processing to translate conversations between healthcare providers and patients into clinical documentation.
- These recordings are then transcribed using advance artificial intelligence algorithms to generate a summary. Providers can review and edit the information from the summary and merge into the Progress Notes.
- AI scribes document encounters in real-time, reducing the administrative burden on physicians and allowing them to focus more on patient care and personal well-being.
- AI scribes utilize machine learning to adapt to various speech patterns and medical terminologies, enhancing accuracy over time.

Sunoh Embedded in eCW Software

AI Consent:

- "Our electronic health record system, eCW, offers a tool that helps me focus more on your care by reducing the time I spend taking notes during our visit. The tool makes a temporary recording of our visit, creates a transcript and uses Artificial Intelligence to draft a summary of the visit for me to review. I will refer to the recording and transcript when reviewing the summary. Then, I will make changes to the summary, if necessary, to ensure that it is accurate. The completed summary will be available in the CHC portal.
- The recording and transcript are deleted automatically after seven days and are not used for any purpose other than to help me with documentation. While these files are not part of your medical record, they are maintained under the same strict confidentiality rules.
- Do I have your consent to use this tool for this visit and any future visits? You can change your mind at any time."

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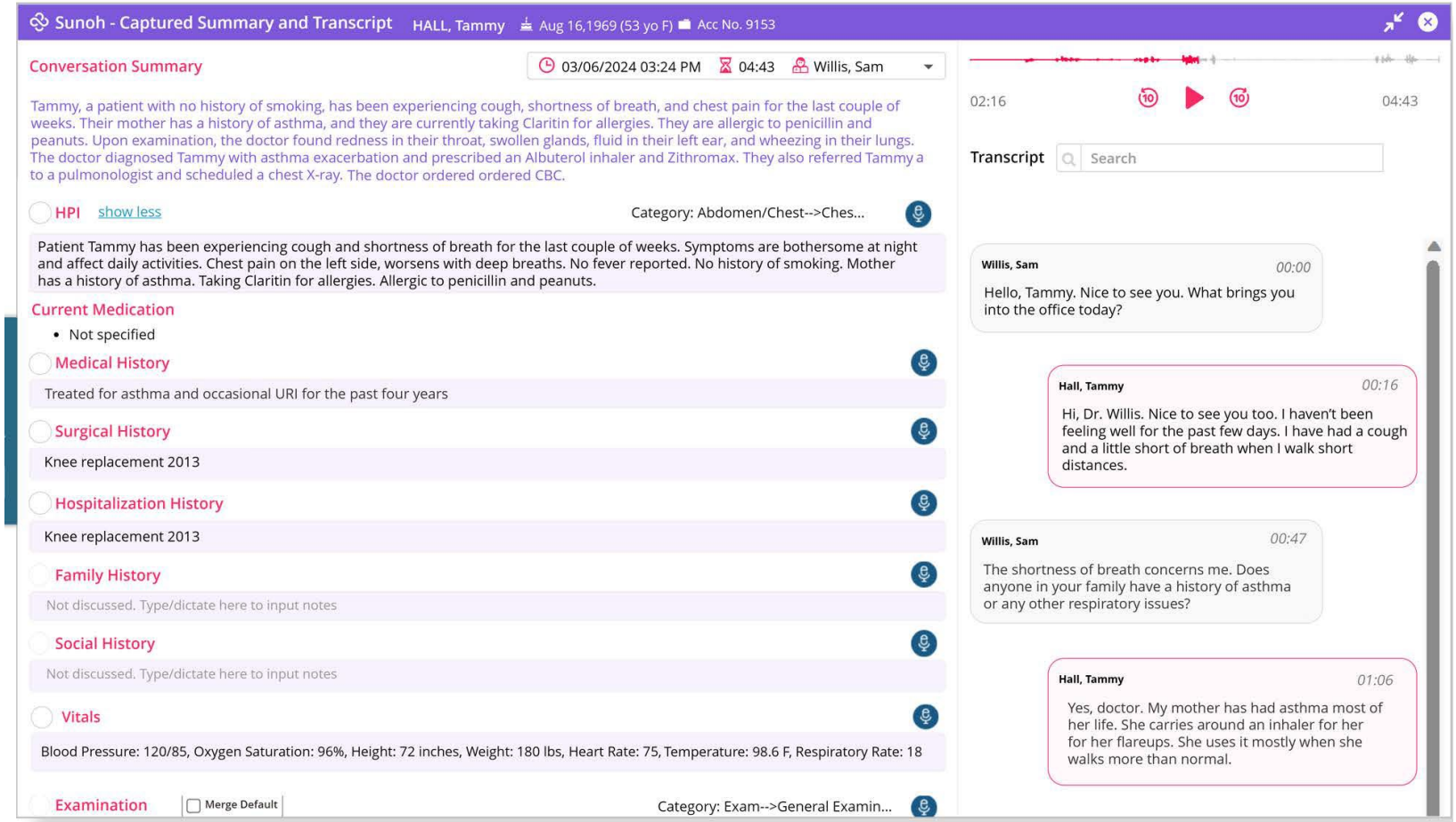
Test Patient

Patient data created by eCW for training environment



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Phase II Sunoh Usage Summary

Total Users: 30 users

Monthly Breakdown:

- September 2025: 1,194
- October 2025: 1,206
- November 2025: 1,167

Cost Per Encounter: $1.25

Total Cost of Sunoh (Sep – Nov 2025): $3,567

Avg. Cost per Provider: $45 / month

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Top Users by Provider Discipline

Discipline	Total # of Encounters	# of Sunoh Encounters	% of Encounters Using Sunoh
Psych	180	187	96.3%
Psych	131	137	95.6%
Psych	237	259	91.5%
Psych	279	315	88.6%
Psych	202	235	86.0%
Psych	246	288	85.4%
Psych	115	157	73.2%
Family Practice	577	925	62.4%
Psych	82	142	57.7%
Psych	98	175	56.0%
Family Practice	307	990	31.0%
Psych	33	150	22.0%
Family Practice	110	816	13.5%

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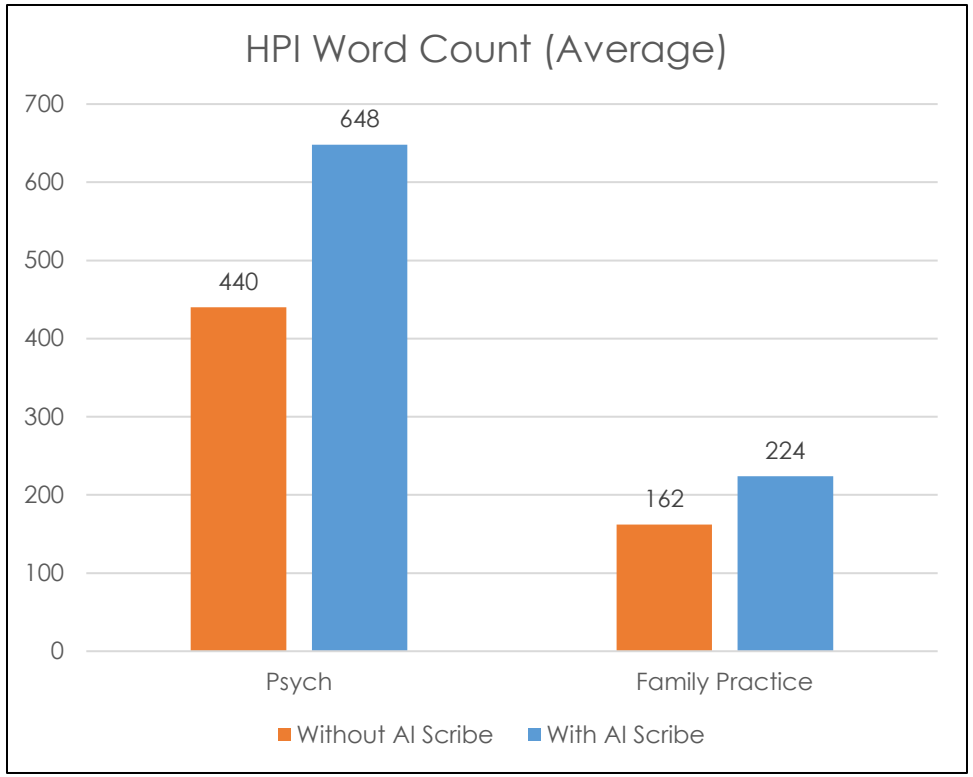
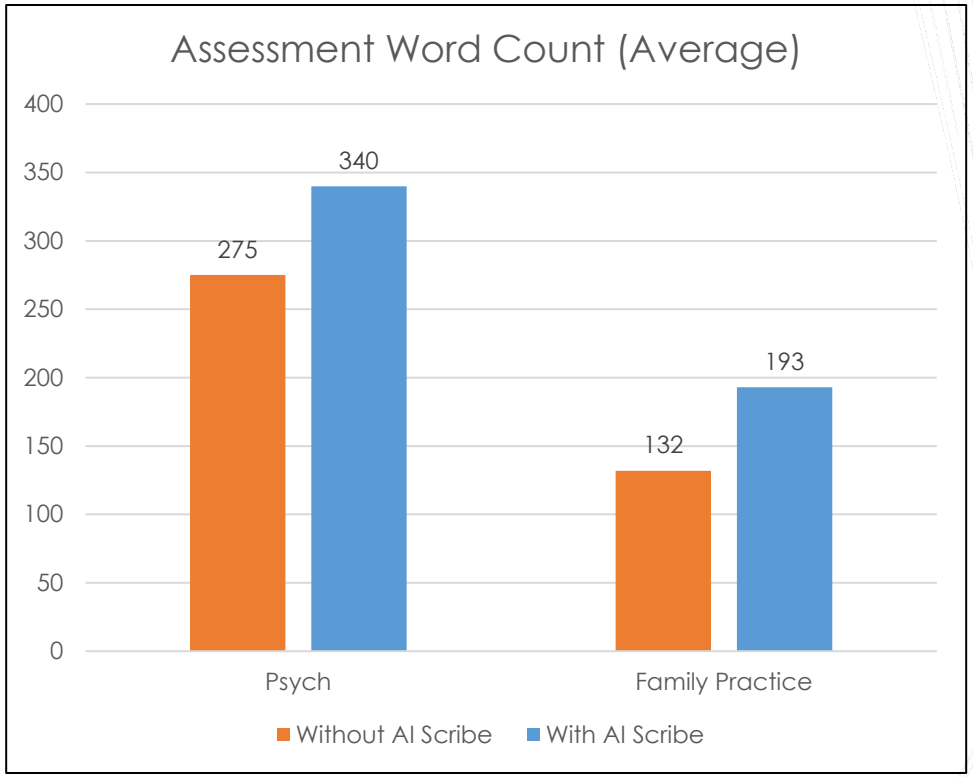
History of Present Illness (HPI) & Assessment Word Count





Survey Results (n=17 Providers)

- **75%** of respondents reported that Sunoh has either significantly or somewhat improved their documentation workflow.
- **82%** reported at least moderate time savings in their daily or weekly documentation efforts.
- **94%** said Sunoh allowed them to focus more on patients during visits, enhancing real-time engagement.
- **88%** rated Sunoh's documentation as either good quality or an improvement compared to their previous process.
- **63%** experienced significantly reduced after-hours charting.

Qualitative Feedback

Positive:

- “Sunoh has saved my brain.”
- “No longer dread locking notes.”
- “Huge improvement in note-lock rates.”
- “Dramatic improvement for psychiatry follow-ups.”

Constructive Criticism:

- Accuracy issues in complex notes and diagnoses.
- Limited usefulness for fast-typers or during short visits.
- Frustrations with HPI structure, order accuracy, and repeated patient consent prompts.
- Desire for deeper training and better Electronic Health Record (EHR) integration, especially for templates and lab ordering.

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2026 AI Driven Projects

XpertDox Medical Coding AI Features

- Clinical Documentation Support
  - Analyzes clinical notes to identify relevant diagnoses, procedures, and clinical indicators
  - Supports accurate, complete documentation aligned with the patient encounter
  - Highlights missing or unclear documentation that may impact coding or compliance
- Coding & Clinical Accuracy
  - AI-assisted identification of ICD-10-CM, CPT, and HCPCS code opportunities
  - Supports accurate capture of specificity and severity based on documented clinical facts
  - Reduces undercoding, overcoding, and documentation gaps
- Compliance & Risk Reduction
  - Designed to support compliant coding practices aligned with official guidelines
  - Provides defensible rationale tied directly to provider documentation
  - Helps reduce audit risk and denial exposure

XPC AI Peer Review Support

- Case Identification & Triage
  - Automated identification of cases for peer review based on configurable clinical and quality triggers
  - Supports routine, focused, and for-cause reviews
  - Risk-based prioritization to reduce manual chart screening
- Clinical Review Support
  - AI-assisted chart summarization highlighting relevant clinical events, timelines, and data points
  - Flags potential deviations from evidence-based guidelines or internal policies
- Consistency & Standardization
  - Promotes standardized peer review criteria across providers and sites
  - Reduces variability in case selection and documentation
  - Supports defensible, auditable peer review processes
- Reporting & Quality Improvement
  - Aggregated peer review data for trend analysis and quality improvement initiatives
  - Provider-level and system-level insights (non-punitive, improvement-focused)

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AI Organizational Governance

- Multidisciplinary AI governance committee (clinical, IT, compliance, legal, quality)
- Defined, approved use cases (e.g., documentation support, peer review, coding)
- Alignment with clinical standards, policies, and workflows
- HIPAA, privacy, and data security safeguards
- Ongoing monitoring for accuracy, drift, and reliability
- Clear expectations and education for clinical staff on appropriate AI use

AI augments clinical care — accountability remains human.

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Recruitment and Retention

Kathi Tourjee, Vice President of Human Resources

Moses/Weitzman Health System

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Retention is Not About One Job Category

- Provider satisfaction and retention is heavily impacted by having well-qualified and engaged staff in other positions:
  - Nursing
  - Medical/Dental Assistants
  - Front-office (reception/call center)
  - Back-office – those managing templates, incentives
- Scheduling flexibility has also become increasingly important as many providers are opting for shorter work weeks or other alternative scheduling.

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Areas of Focus

Compensation

- Base salary
- Meaningful/attainable incentives
- Retirement savings, emergency savings accounts
- Service milestone recognition

Staffing Model Flexibility

- Hiring part-time/temporary staff to off-set alternative schedules, Family and Medical Leave Act (FMLA) (continuous & intermittent)

Operational Logistics

- Patient reminders and other methods to reduce “no-shows”, which reduces the need for “over-books”

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Quality Improvement Refresh:

Standardization and Spread
Introduction to Playbooks

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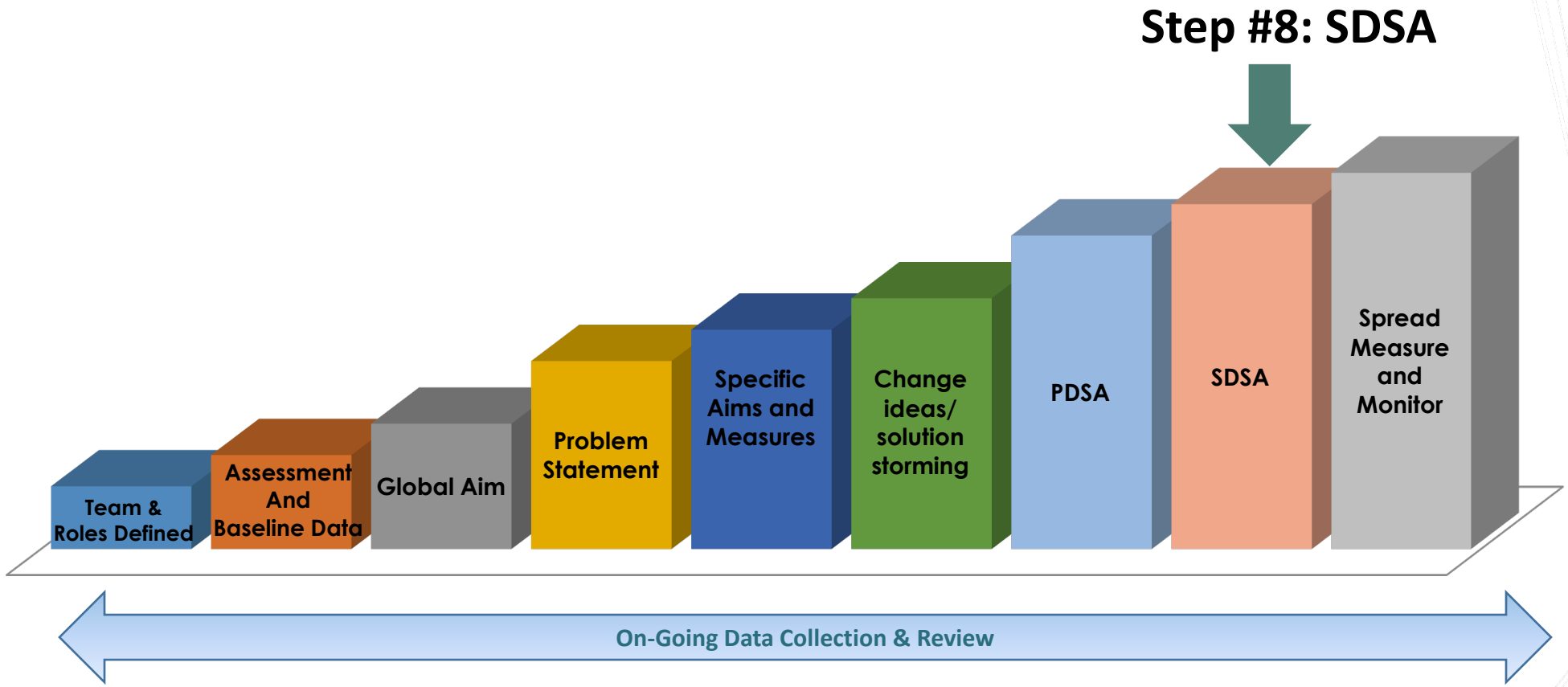
The Stages of Improvement



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Action Period

Global Aim

- We aim to improve…..

Specific Aim Statements

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

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

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

SDSA

Playbook

Spread

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

Testing by Another POD Before a Broader Spread

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Clarifying Terms

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

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

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What is Spread?

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

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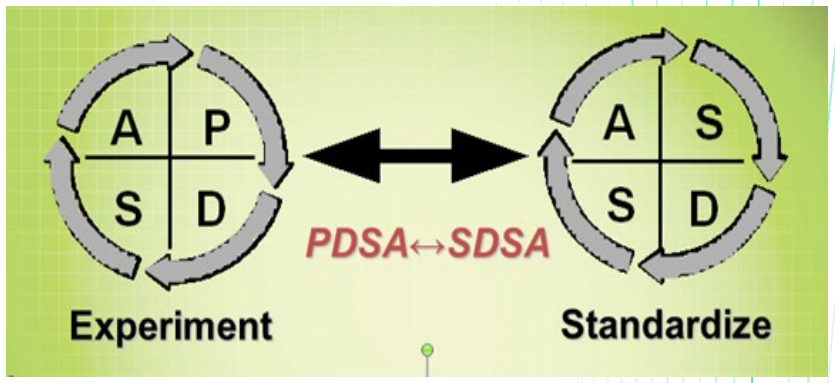
Ok, we've got this great process that is working well for our POD.

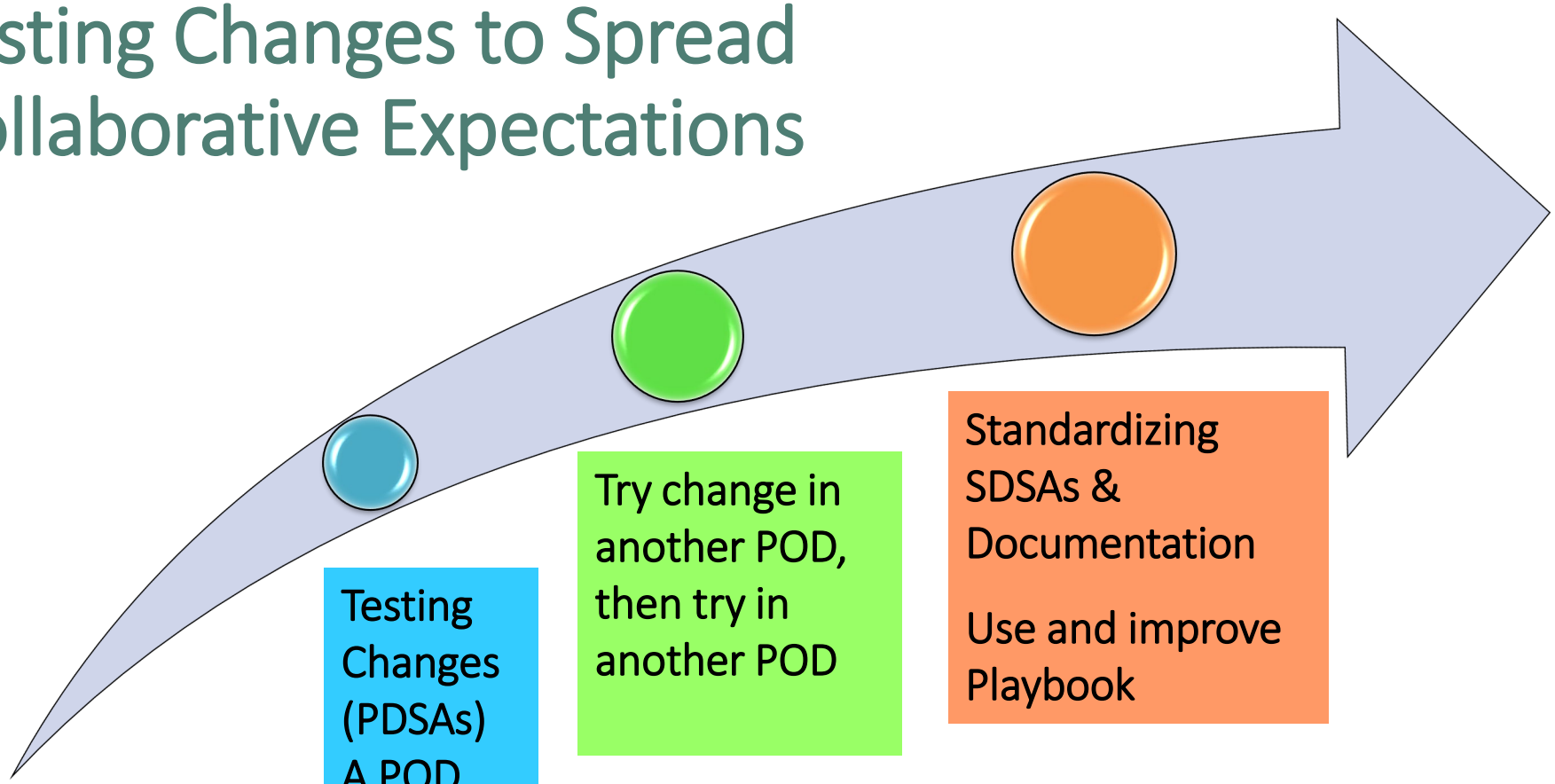
How do we know if we are ready to spread our work?

Is the Process Standardized?



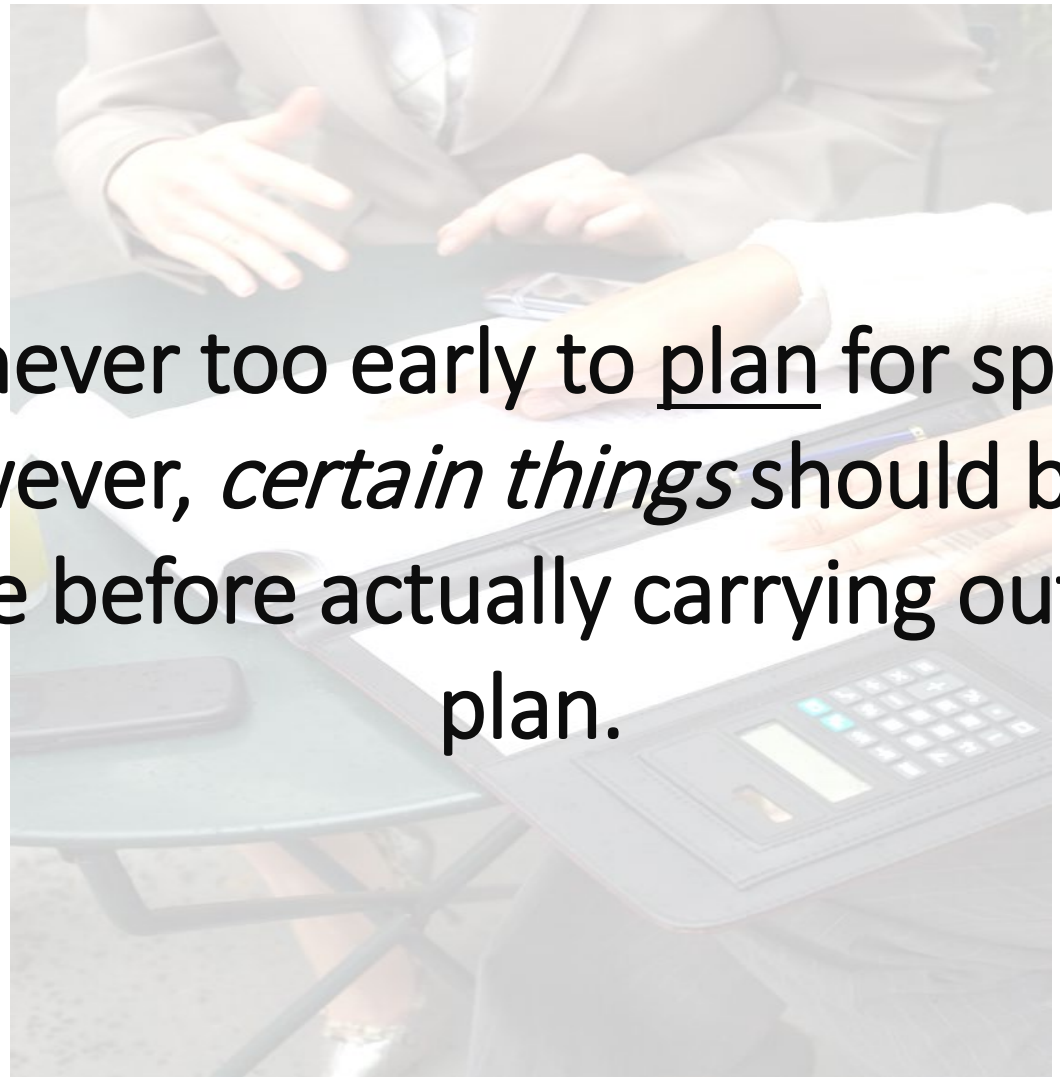
1. *Is the process failure free over time?*
   - Can your team count on it not to fail when everyone is following the process?
   - If one person overlooks it, will another catch it?
   - Are there clear specifications and communication?
   - Is the process supported by technology to reduce failure (EHR)?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

Testing Changes to Spread Collaborative Expectations



Broad Spread and Sustainability

A BIG Deal



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

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Communicating Spread

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

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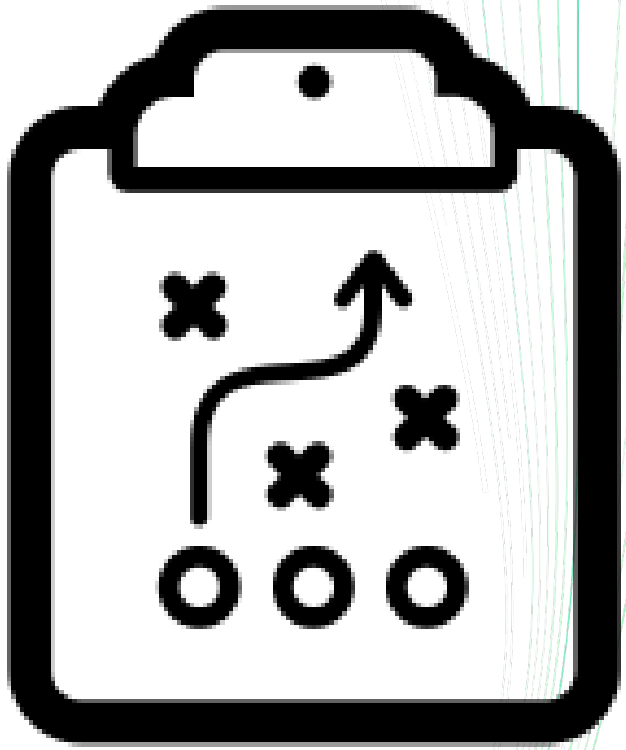
How Will You Know?

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

What is a Playbook?

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



Quality by Design, 2007

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Playbook Checklist

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

Quality by Design, 2007

PLAYBOOK CHECKLIST

Name of Process: _____
Contact Person:
Which of the following are included in this section?

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

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

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

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

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

DATE of last review: _____ (Date)

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Playbook Template Example

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

(Title)

Overview:

Key Steps

-

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

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

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

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Lessons Learned

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

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Questions?

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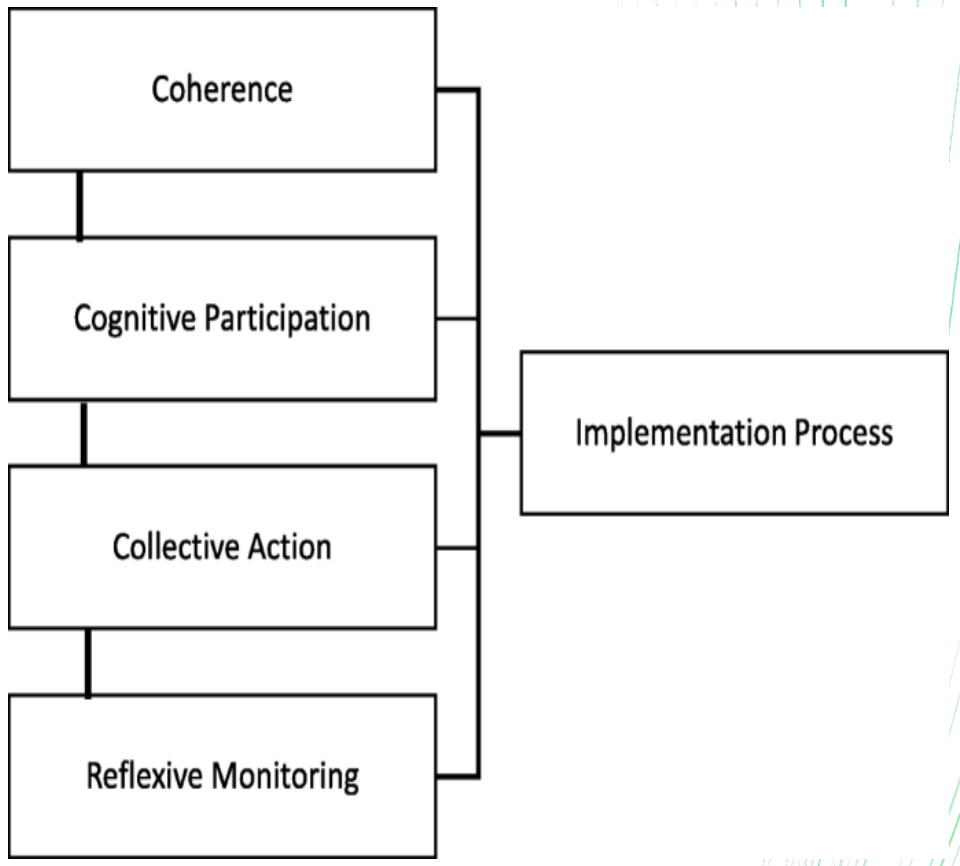
Making Your Team Work:
Monitoring Your Progress

Normalization Process Theory

- Normalization process theory is a sociological theory developed by Carl R. May, Tracy Finch, and colleagues between 2003 and 2009.
- Four stages
  1. **Coherence** – clarity of purpose, expectation, and value; why are we here?
  2. **Cognitive Participation** – relational work of the team; do we have the right people on the team?
  3. **Collective Action** – operational work of the team and a shared mental model among team members; do we have the necessary resources, data, and time?
  4. **Reflexive Monitoring**



https://implementationscience.biomedcentral.com/articles/10.1186/s13012-018-0758-1

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Reflexive Monitoring

- **Reflexive Monitoring** is the **appraisal work** that people do to assess and understand how change is working.
- The team **measures and tracks results**, talk about spread to other parts of the organization. *Is this working out after all? How do we spread this?*
- As they evaluate the work, they may **make changes to refine it**, or to **adapt it** to other settings for **sustainability**. *What fine-tuning do we need to do to make sure it is sustainable?*
- Appraisal is both personal as well as collective. Individuals may express **personal pride** in what they've learned, the team as a whole might feel good, and see growth in their ability to work as a team. Their efforts are seen as worthwhile. *We make a good team. I got a lot out of this.*

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Examples of Reflexive Monitoring

- "In 2 weeks they are going to re-run the report to see if the call back time has changed – to see if it's more efficient."
- "Physician on core team explained to other providers how this pre-visit planning would work as part of standing orders, training for MAs, etc."
- "This morning, we had a meeting regarding strategic planning. Others discussed the importance of communication at their sites, while we shared that we are already implementing many of the strategies they described. As a result, processes here are working more smoothly, and we were able to speak to what has been effective."
- "The team were trying to discuss what the team would like after the collaborative is over."
- "Were able to make improvements to what they presented last time. Their team was able to present some of their work to their CMO."

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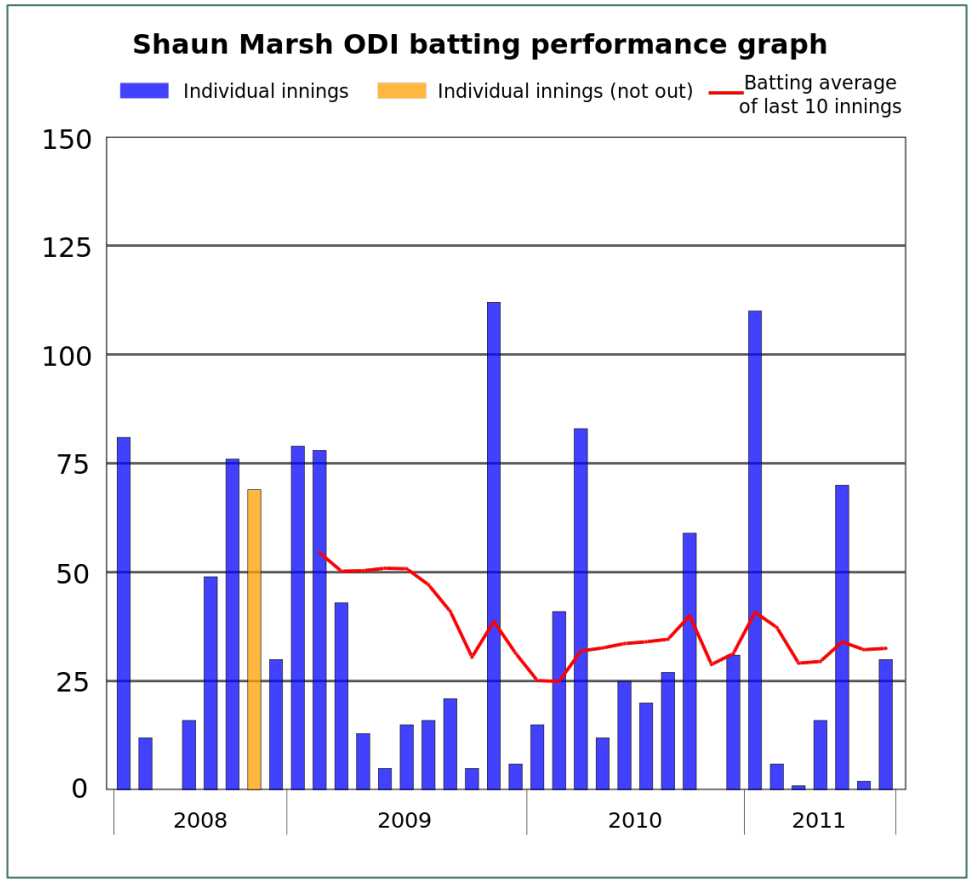
Making Your Team Work: Reflexive Monitoring



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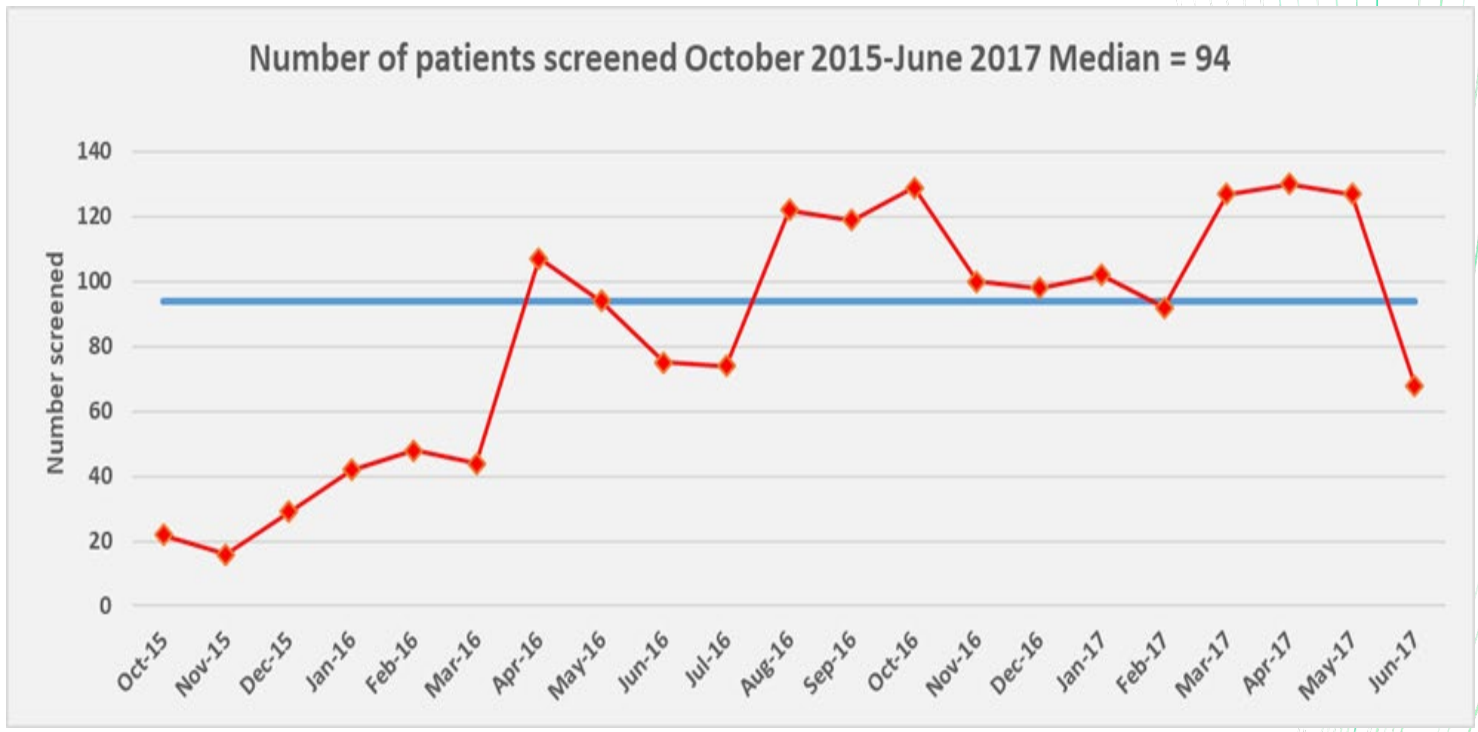
Without reflexive monitoring, the work cannot spread, be sustained, or be revised/improved as needed.



Sources of Conflict & Failure to Normalize Change

Lack of Reflexive Monitoring:

- Team stops meeting. Resources disappear. "All done. Next project."
- No plan to track data to demonstrate improvement—or not—over time.
- Aims were too broad to be achievable, measurable, trackable.
- Spread without testing minor adaptations to suit new setting.
- Failure to spread shared mental models of improvement and Team-Based Care (TBC), failure to be systematic (i.e., Pilot becomes policy without testing spread. No sense of accomplishment—I wasted my time. Team doesn't get credit for their work.).
- No playbook to sufficiently detail the work and guide spread and standardization.

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Data Outcomes and Displays

Four types of outcome metrics for interventions

Interventions can be educational/training programs or new clinical processes/models. Which outcomes apply? Which ones can be measured?

- *Implementation/process outcomes*
  - Evidence for how an intervention (new program or process) was implemented: numbers of participants trained in intervention, their satisfaction with the intervention, was intervention implemented as intended, sustainability of intervention.
- *Learner outcomes*
  - Evidence for what participants learned, how they changed their behavior or intend to change their behavior as a result of the intervention; knowledge, skills, attitudes (KSAs).

Outcomes con't.

- *Service outcomes*
  - Evidence for improved quality in health services: efficiency, safety, effectiveness, patient-centeredness, and timeliness as outlined in Crossing the Quality Chasm.
  - A service outcome is something that you do.
- *Patient outcomes*
  - Evidence for improved health status of a population of patients, such as improved blood pressure control (UDS).
  - A patient outcome is something that the patient does.

You need a minimum of 14 consecutive data points (days, weeks, months, quarters) for evidence to be statistically valid.

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Service v. Patient Outcomes

Service outcome	Patient outcome
Increased A1c screening rate	Improved A1c in population of patients screened
Increased colorectal cancer screening rate	Decrease in colorectal cancer in population of patients screened
Increased number of nurse visits for blood pressure checks	Improved blood pressure control of population of patients who attend visits
Increased number of annual wellness visits → Improved screening rates	Improved medication compliance

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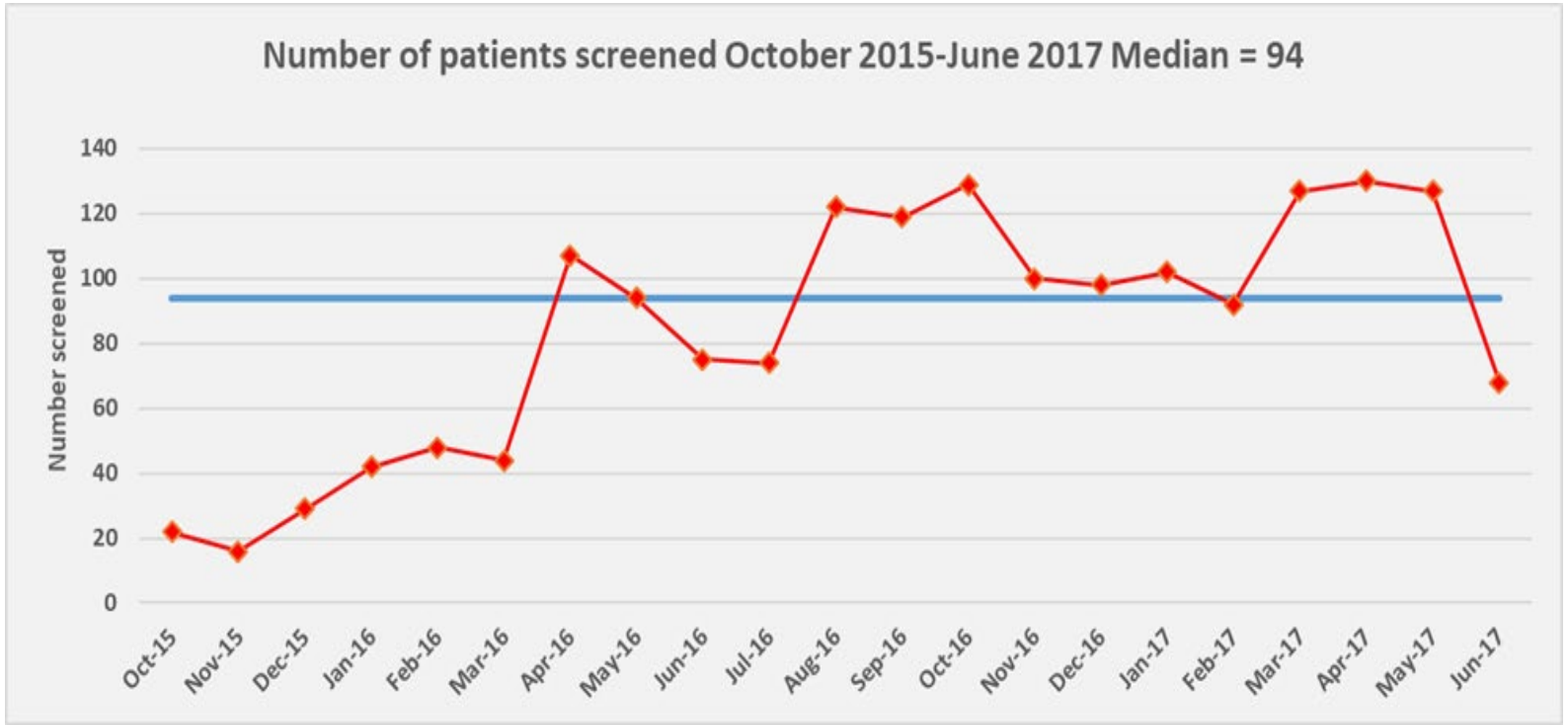
Good Data Displays

- **Good title**: Tells uninformed persons what they are looking at—what (% completed cervical cancer screening), when (Jan-March), where (Clinic A), female patients aged 23-64
- **Good labels**: time, numbers, percentages, locations
- **Line chart: X-axis** is usually *continuous* time/dates, Y-axis is numbers or percentages (never both)
- **Bar chart: X-axis** is entities/locations, e.g., Clinic A, or time/dates (e.g., quarterly data), Y-axis is numbers or percentages (never both)
- When comparing two graphs, make sure the Y-axes have the same intervals and range.

ALL GRAPHIC DISPLAYS REQUIRE CONTEXT TO BE INTERPRETED.

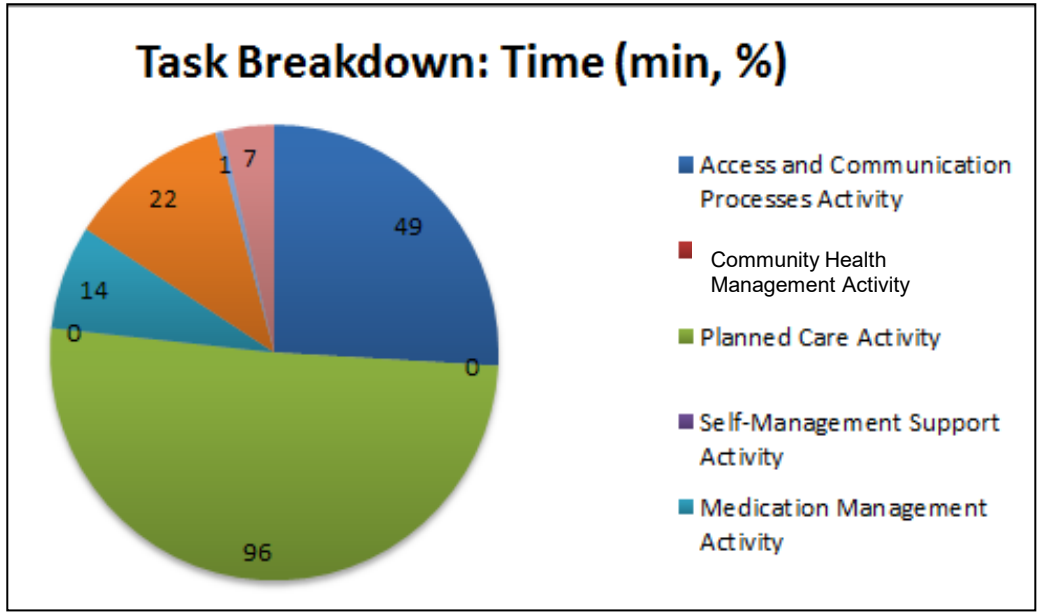
Run Chart is a Type of Line Chart

A run chart displays data (Y-axis) over a period of time (X-axis). The time periods are uniform and sequential, that is month to month, or quarter to quarter. The Y-axis label matches the title: number of patients. The Y-axis can be percentages as well.

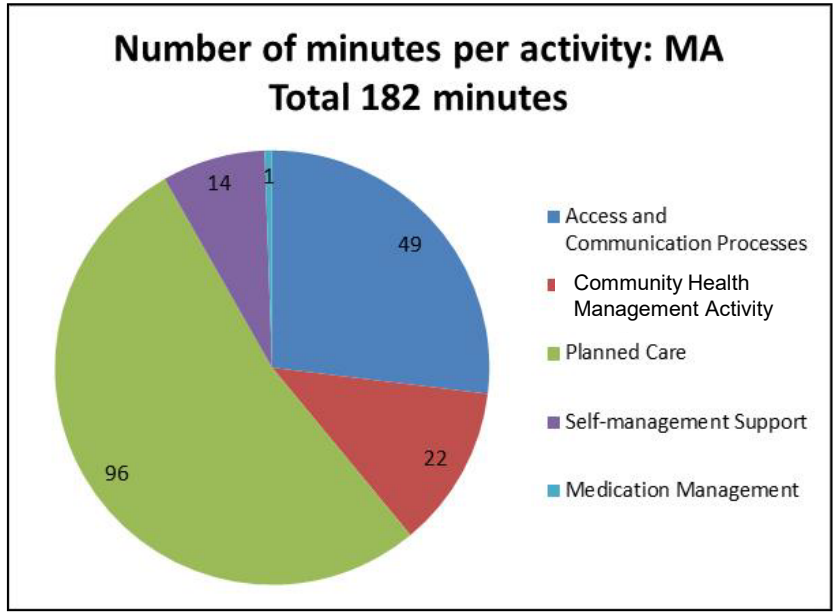


In this chart, the red line is the number of patients screened, each dot represents the number screened in that month, and the blue line is the median (excel will do that for you). Because this is ratio data with a natural zero, a run chart uses the median rather than the mean.

Pie Chart breaks a “whole” into its “parts”



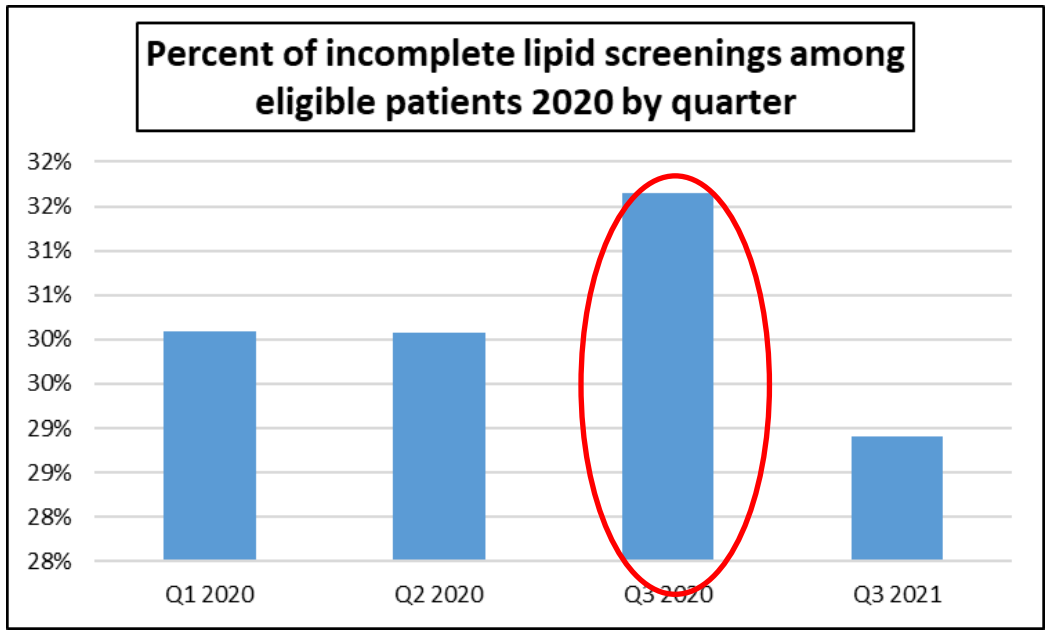
Confusing display: Min? %? 0? Five activities listed but six pieces of pie

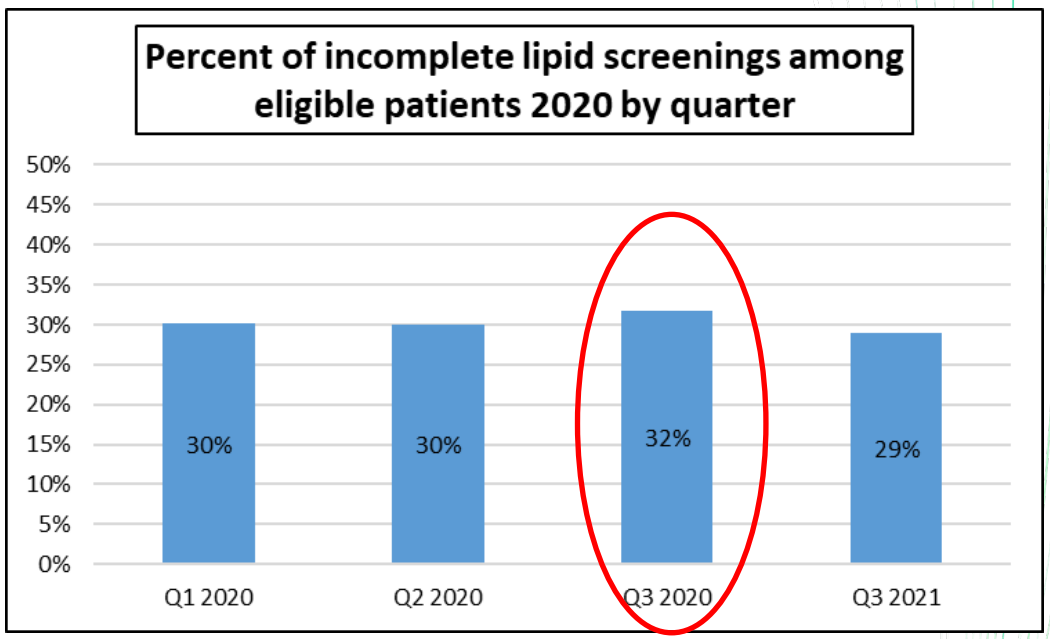


Better: Could also label as percentages as long as they add up to 100%.

Be clear about the size of the whole (182 min) and how many parts it is divided into in your legend. Use either numbers or percentages depending on the story your data is telling.

Single Bar Chart: Beware of intervals in Y-axis.





This is the same data. On the left, the Y axis ranges from 28-32%, with intervals of one unit (barely). On the right, the range is from 0 to 50% with five unit intervals. Be careful about the scales for data ranges and intervals (see excel). The one on the left suggests a problem in Q3. In fact, the percent incomplete is about the same across all quarters. When comparing two graphs, make sure the ranges and intervals are the same.

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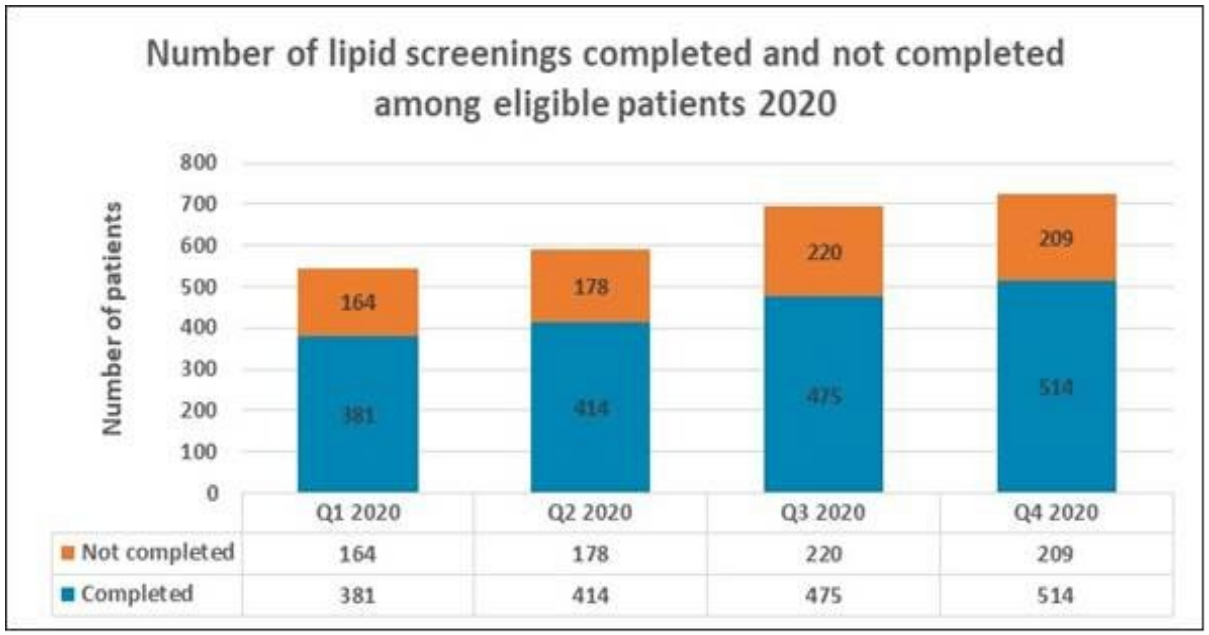
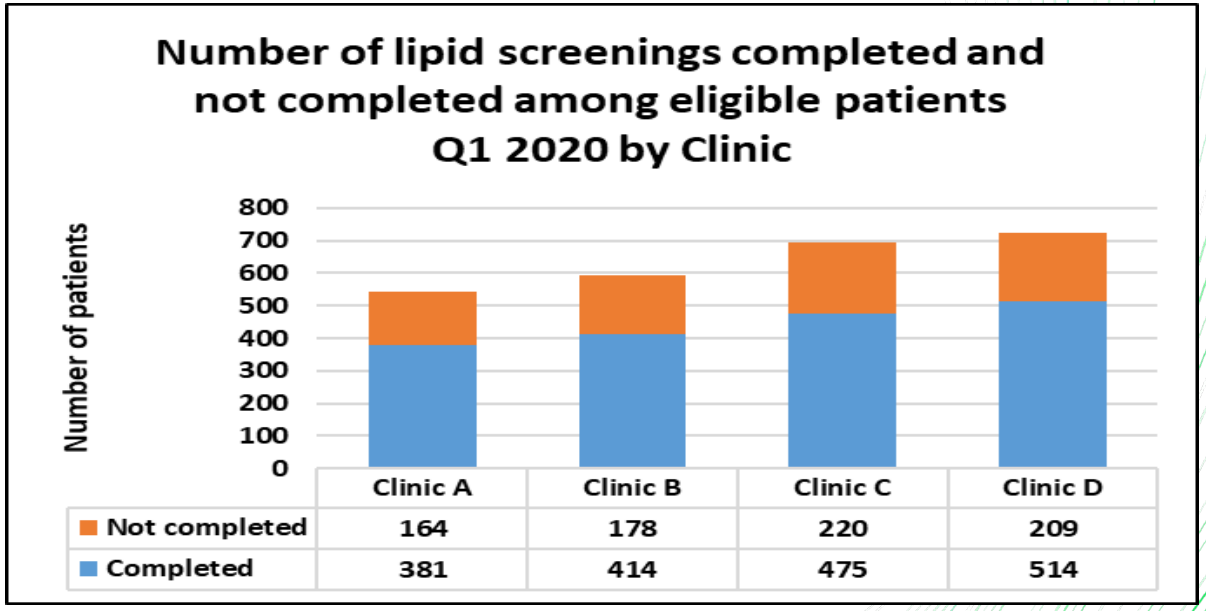
Stacked Bar Chart: the whole and its parts comparing time or locations

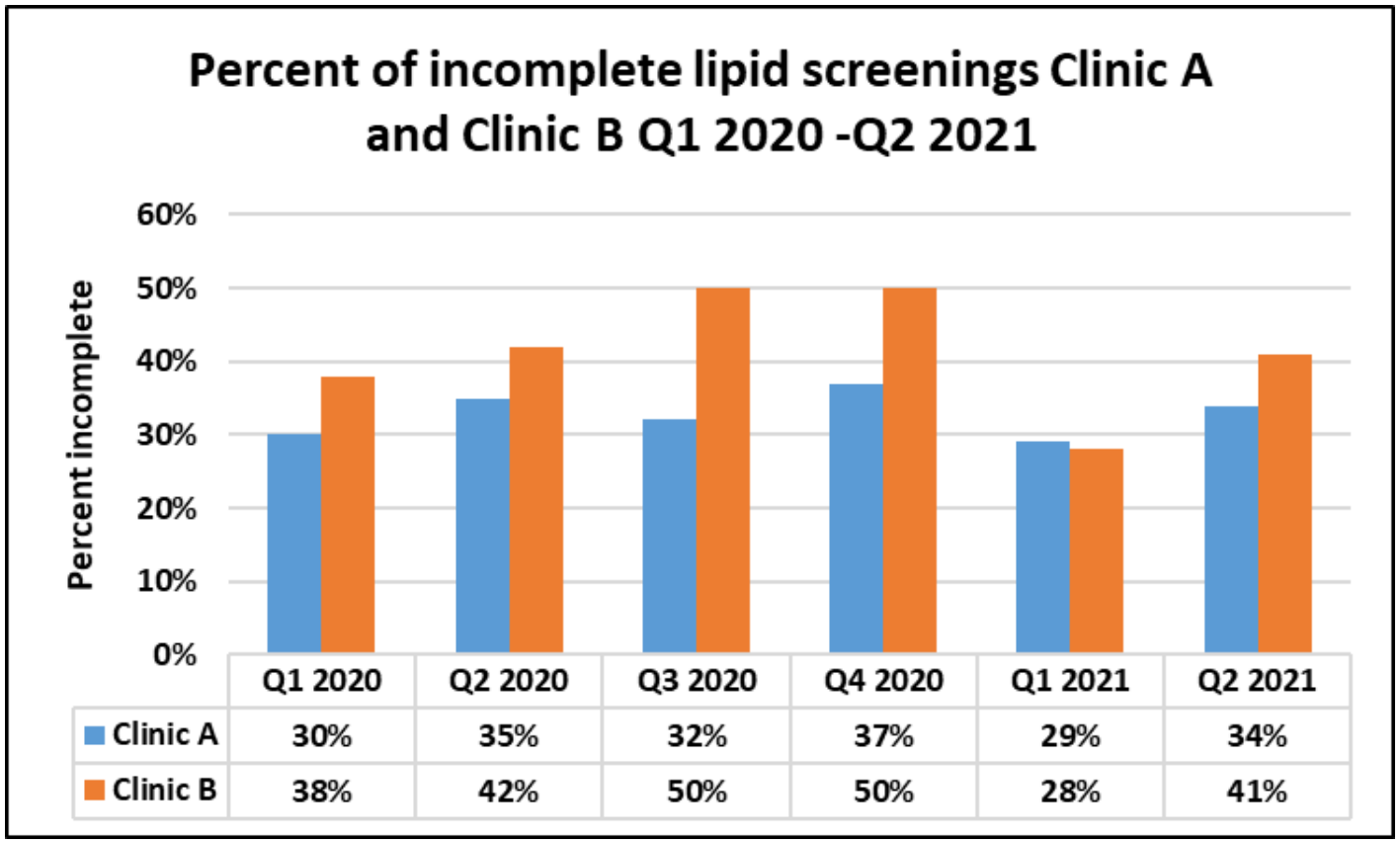


Like a pie chart, a stacked bar graph gives you the whole and its parts. But unlike the pie chart, the X-axis can be time, locations, names, etc.



This is the same data but the one on the left uses time (quarters) for the X-axis, the one on the right uses location and the time is noted in the title.

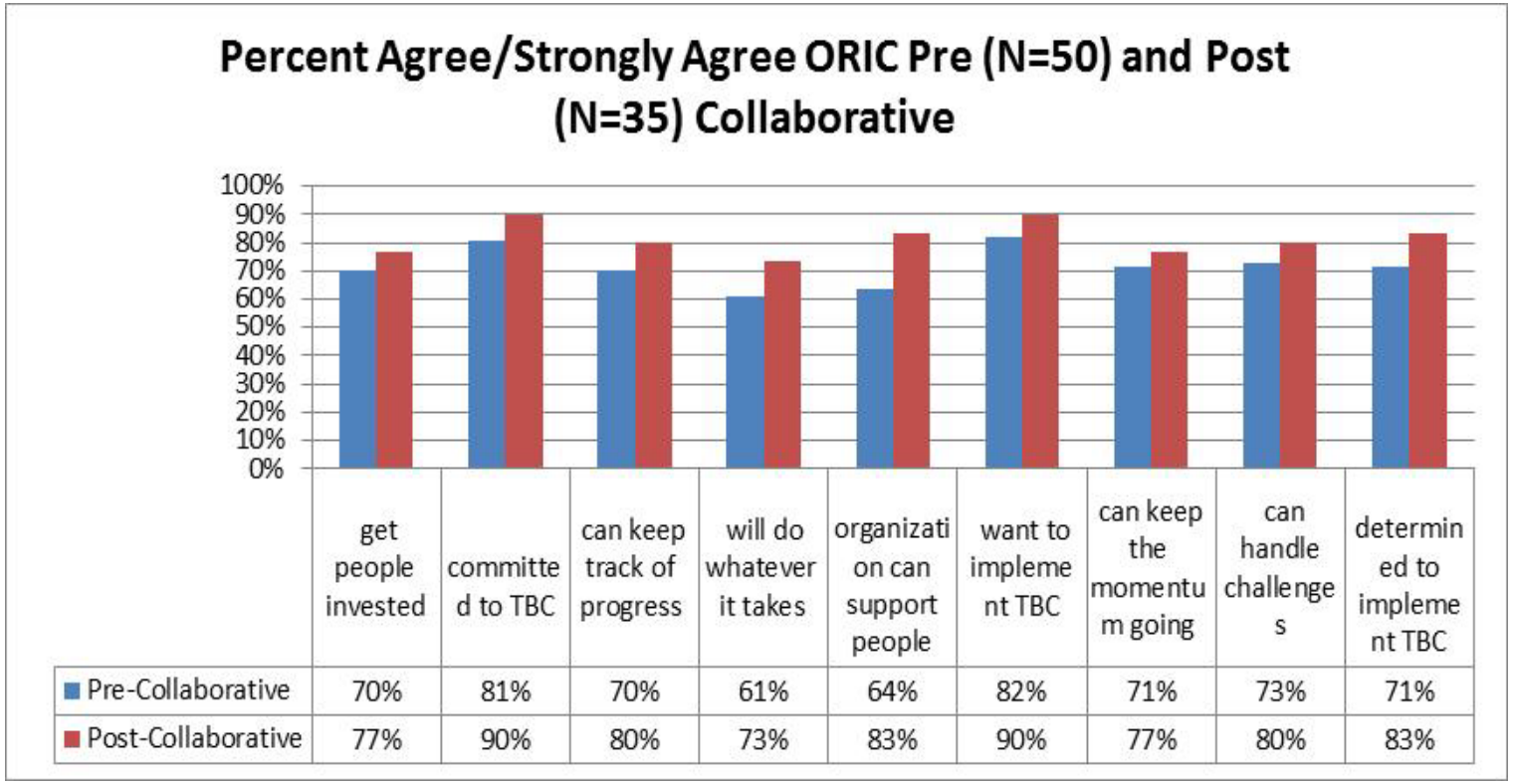
Side by side bar chart comparing two clinics



	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021
Clinic A	30%	35%	32%	37%	29%	34%
Clinic B	38%	42%	50%	50%	28%	41%

This is a side-by-side bar chart comparing incomplete screening rates between two clinics over time. Beware of interpretation without context. Using numbers here may not be helpful, as clinics vary in size of the population in the denominator.

Side by side bar chart comparing pre and post scores



	get people invested	committed to TBC	can keep track of progress	will do whatever it takes	organization can support people	want to implement TBC	can keep the momentum going	can handle challenges	determined to implement TBC
Pre-Collaborative	70%	81%	70%	61%	64%	82%	71%	73%	71%
Post-Collaborative	77%	90%	80%	73%	83%	90%	77%	80%	83%

Side-by-side bar charts are a good way to compare pre- and post-scores. Note that the title includes the sample size (N) for both pre and post, indicating that the denominators are different.

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Sustaining Practice Change

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How Quality Improvement Works at CHC

- Performance Improvement Committee
- Frontline Teams

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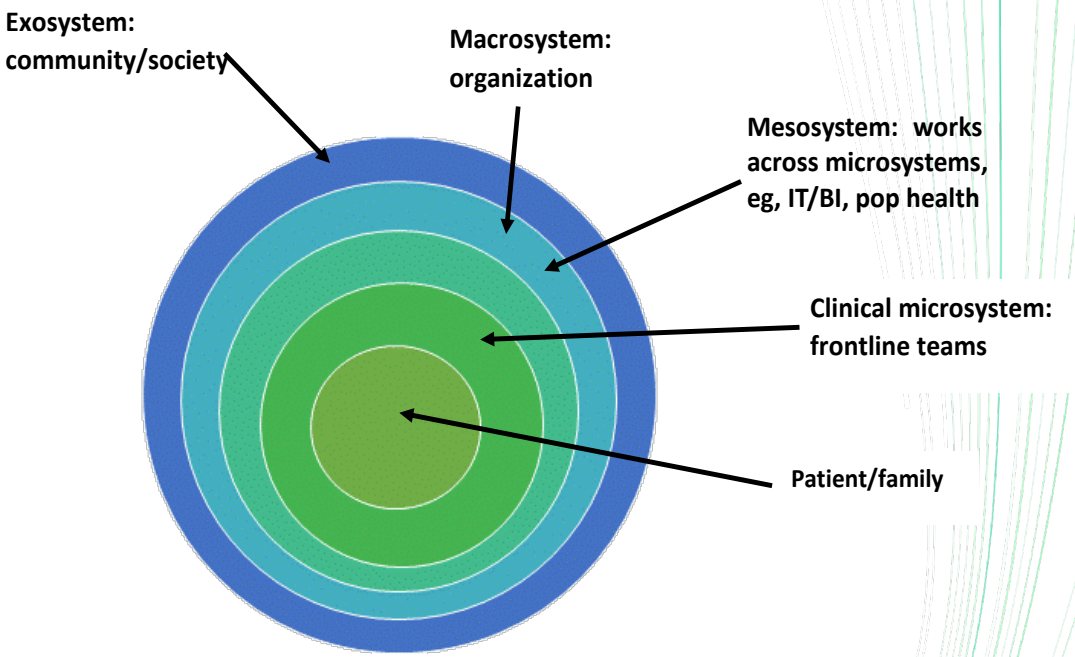
We use Clinical Microsystems approach to QI:

- Data-driven, team-based, and systems oriented
- Begins with assessment of current practice, not PDSA cycles
- Provides a data-based systematic approach to changing practice—the improvement ramp
- Improvement ramp provides a shared mental model of improvement for the team
- Uses many of the same tools as Lean/Six Sigma
- Utilizes team leaders to guide frontline teams through the improvement process

Clinical Microsystems Approach

A clinical *microsystem* in health care is "a small group of people who work together on a *regular basis* to provide care to discrete subpopulations of patients. It has clinical and business aims, linked processes, and a *shared information environment*, and it produces performance outcomes" (Nelson, et al., 2002, p. 474). The *mesosystem* consists of teams/departments that work across and support other systems, for example, Information Technology/Business Intelligence, Community Health, as well as Quality Improvement.



CHC's Performance Improvement Structure

PERFORMANCE IMPROVEMENT PLAN
FY 2021-2022

COMMUNITY HEALTH CENTER
PERFORMANCE IMPROVEMENT PLAN

I.PURPOSE

The purpose of this plan is to describe Community Health Center Inc.'s (CHCI) comprehensive performance improvement process and to define our approach to quality improvement and integration with all clinical departments. Specific goals are established and approved by the performance improvement committee followed by CHCI Board of Directors. This program addresses the following: (1) the quality and utilization of health center services; (2) patient satisfaction and patient grievance processes; and (3) patient safety and adverse events. The PI plan is prepared and overseen by the Performance Improvement Committee (PIC) in conjunction with the Dental, Medical, and Behavioral Health Quality Improvement Committees of CHCI. CHC's Performance Improvement Plan (PIP) was first written in 1999 and is updated annually by the PIC.

II. OBJECTIVES

The Objectives of the PI Process are:

- To assess and monitor quality across all domains of performance at CHCI
- To ensure that all clinical services, whether delivered in person or virtually, meet the highest standards of quality, effectiveness, and efficiency
- To ensure that CHCI's staff, services, and facilities reflect the highest level of respect for all patients and communities. This includes but is not limited to the provision of programs, staff, and materials to all CHC patients. To engage staff at all levels and across all disciplines in continuous quality improvement
- To implement and ensure adherence to CHCI's Safety and Risk Management Plan including Reviewing and tracking of all patient feedback and incident reports and other problems in

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Performance Improvement Goals

Category	Goal topic	Specific Goal	Source
Chronic disease care	Diabetes control	Increase the number of patients with an A1c (HbA1c) less than 9.0 percent	UDS
	A1C testing	Reduce the number of patients with diabetes who have not had an A1c completed in the last 12 months.	CHC
	Hypertension (HTN) control	Increase the number of patients with hypertension whose BP is controlled (less than 140/90)	UDS
	Blood Pressure (BP) documentation	Reduce the number of patients with hypertension who have **NOT** had a BP documented in the last 12 months	CHC
	Home BP cuff use	Increase the number of patients with HTN who have a home BP cuff	CHC

1. Category
2. Goal topic
3. Define Specific goal
4. Source
5. 2020 Rate
6. Current rate
7. Current Goal (2021)
8. Recommended Goal

- Community Health
- Chronic Disease
- Screening
- Behavioral Health
- Preventative Care
- Dental
- Medical and Dental
- Prenatal

Next Steps

1. Existing Teams:
   i. Is the team on track to achieve goal(s) for the year?
   ii. Any modifications needed?
2. New Teams:
   i. What type of team (micro/meso)?
   ii. Team composition?
   iii. Team lead?
3. Process in Place:
   i. Is the existing process sufficient and likely to achieve the goal(s)?
   ii. Any modification(s) needed for the process?
   iii. Catchball back to a Microsystem for testing/refinement needed?

New Teams

Discussion at Performance Improvement (PI)/Steering Committee meeting

- Change idea solution storming
- Is it a micro/meso system?
- Does this need a team lead?
- Where to test?

	New QI team	Topic	Detail
1	Diabetes Control	Diabetes control	Increase the number of patients with an A1c (HbA1c) less than 9.0 percent
		A1C testing	Reduce the number of patients with diabetes who have not had an A1c completed in the last 12 mo.
	HTN control	HTN control	Increase the number of patients with hypertension whose BP is controlled (less than 140/90)
		BP documentation	Reduce the number of patients with hypertension who have **NOT** had a BP documented in the last 12 months
2	Cancer screening	Breast Cancer Screening	Increase the % of women with appropriate mamographic breast cancer screening
		Cervical Cancer Screening	Increase the number of patients who have appropriate cervical cancer screening
3	Colorectal Cancer (CRC)	Colorectal Cancer Screening	Increase the number of patients who have appropraite colorectal cancer screening
4	Antipsychotics	Metabolic monitoring for antipsychotics	Increase the number of children and adolescents (ages 1-17) on Antipsychotics who have metabolic monitoring
5	Pedi Well-care/recall	Well care 12-21	Increase the number of children and adolescents ages 12-21 with at least one annual well care visit

Community Health Center, Inc.
Performance Improvement Team Update

PI Goal(s) aligned with the project	To optimize the process for obtaining required screenings
Name of Project	Automated Forms Group
Project Manager/Coach	Deb Ward
Team Members	Dan Bryant, Veena Channamsetty, Mary Blankson, Tim Kearney, Nicole Seagriff, Ho Chang, Sheela Tummala, Tichianaa Armah, Operation team members: Meredith Johnson, Lisa Avellino, Mette Smith
Start Date	Operations team: Feb 22, 2024, Medical team: May 17, 2024
Meeting Frequency	Frequency not yet established: Next step schedule one hour meetings

Community Health Center, Inc.
Performance Improvement Team Update

Project Goal(s) (Include Project Charter and/or Aim Statements if appropriate)

DRAFT: Electronic Forms **Problem Statement**	• Staff are required to collect many screening forms from our patients. Patients and staff are sometimes not able to gather this information at the required interval during a patient visit due to the number of screening that are simultaneous due. Patients may not answer accurately due to the number of questions.
Team Members	• Dan Bryant, Veena Channamsetty, Mary Blankson, Tim Kearney, Nicole Seagriff, Ho Chang, Sheela Tummala, Tichianaa Armah, Operation team members: Meredith Johnson, Lisa Avellino, Mette Smith
Research Question/ Why work on this now?	• CHC has invested in several different modalities of data collection from patients such as Mirah, the patient portal, Iuma, tablets, kiosk
Measures	• Reduction of at least 5 top identified forms to become electronically collected • Maintain or improve the number of response to collection of forms

Goal Statement	• **We aim** to optimize the process for collection of required screenings.
	• **The process begins** with identification of required screening tools
	• **The process ends with** electronic documentation in the health record.
	• **It is important to work on this now because :**
	  • staff are often multitasking and unable to secure this information at the time of rooming a patient because of the number of required screenings.
	  • **Technology will enable us to gather the information during non value added time of the patient visit or before the scheduled visit. Several screenings can also be done in the waiting room.**
	  • Reduce screening burden

Milestones/ Dates	• Identify the top 5 tools for testing: June 2024 • Screening tool to be automatically entered into structured data:TBD
Scope	• ? Is purchasing ECW upgrade in scope. Increase staff FTE in scope?

Screening tools

PCD Item	Patient Population	How Often	What MA/LPN Does (or other clinical staff)
ACES (Adverse Childhood Experiences) Live 9/13/21	All patients 18 and older	Once ever	• Merge the ACES screening template [MA] • Provide the patient with ACES handout to complete [MA] • Score patient's completed ACES form and enter the responses in the template [MA]
ACT (Asthma Control Test)	Patients with asthma age 5-40	Every visit regardless of last ACT date or result *[Note >19 indicates good control]*	• Complete the Asthma Control Test at every visit, found in the Vitals [MA] • Document the score in Vitals [MA] • If patient declines, enter in Vitals [MA]
Annual Chronic Pain Screening	All medical patients age 18 and older in medical (except in Hartford)	Every 12 months Annual screening, alert on PCD 30 days before due date	• Open the Smart Form, "Chronic Pain" with the patient [MA] • If the patient says "most days" or "every day" open the Smart Form, "PEG" [MA]
***Asthma Controller Med (alert is in orange b/c action is for PCP)	Patients with a diagnosis of persistent asthma on the problem list age 5-64	Patients who were dispensed at least one prescription for a preferred therapy (inhaled corticosteroid) during the last 12 months	• Note in Chief Complaint that patient needs an Asthma controller med [MA] • If patient does not have persistent asthma, change the diagnosis code in the problem list to reflect the correct diagnosis [Prov] • If patient has persistent asthma but is not on a medication, consider seeing the patient and reevaluate whether patient should start appropriate medication [Prov]
Baby-PSC	Patients 2 months - 12 months of age	Complete at each WCC visit 2, 4, 6, 9, 12 and 15 months of age	• MA hands parent/guardian the Baby PSC to complete (English/Spanish available) and then, based on local workflow: • MA or PCP clicks on the BPSC link in the HPI section of the WCC template and enters the score for each of the three questions

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Team Leader Training within Health Centers

- Identification of the new team lead
- Communication with leadership
- Commitment from the team lead in training and supervisor
- Training (six to seven didactic sessions)
- Mentor program
- Monthly team leads meeting
- Reports to Performance Improvement/Steering Committee

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Why CHCI Uses It

- Data-driven, team oriented
- QI happens where the work happens
- QI is done by the people who do the work
- Builds on unique context of individual staff in specific clinical units in a larger organization
- Elevates skill level of staff, ownership of improvement and practice, team-ness
- Uses trained team leads to guide staff
- Structured, systematic “mental model” for how to improve

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Continuous Monitoring for Success

1. TEAM AND ROLES DEFINED

Team Lead Assigned, Identify Core and Extended Team Members, Define Roles, Schedule Team Meetings, Communication Plan

TOOLS/SKILLS/PROCESS:

Effective Meeting Tools
Forming/Storming/Norming/ Performing

2. ASSESSMENT AND BASELINE DATA

What is our current state? Describe population of interest, Identify data sources, Drill down to specific areas of focus. Related to other projects?

TOOLS/SKILLS/PROCESS:

Tick & Tally & other data collection
Process Mapping
Role Assessment
Team Practice Assessment

3. GLOBAL AIM

What is our overall goal for advancing TBC Model? Theme, Name process, location, Start/End of Process, Benefits/Imperatives

TOOLS/SKILLS/PROCESS:

Build Consensus
Fishbone Diagram (cause & effect diagram)

4. PROBLEM STATEMENT/THEME

Problem Statement, Importance, Goals/ Objectives, Deliverables, KPIs

TOOLS/SKILLS/PROCESS:

QI Charters as agenda items
Brainstorming/ Brain writing
Multi-Voting
Impact/ Effort Grid
Fishbone Diagram
Five Whys
Process Map
Build consensus

5. SPECIFIC AIMs and MEASURES

What do we want to accomplish in days and weeks? What will change, by how much & when , How will we know that we accomplished it?

TOOLS/SKILLS/PROCESS:

Specific Aim Tool
Build Consensus
Fishbone Diagram (cause & effect)
Tick & Tally & other data collection

6. SOLUTION STORMING for CHANGE IDEA

What could we try?
Realistic ideas, Manager | Leader involvement.

TOOLS/SKILLS/PROCESS:

Idea Tree
Parking Lot
Force Field Analysis
Impact Effort
Multi-Voting

7. PDSA

Aim, test, who, when, where.
PLAN Tasks: How will we do it? What, Who, When, Where. Predictions, Measures
DO: Lets try it out. Results
STUDY: How is it working out? **ACT:** Lets try it again with modifications?

TOOLS/SKILLS/PROCESS:

PDSA Template
Keep test SMALL
Only one PDSA at a time
Measures

8. SDSA

Standardize the test that was successful. *Will it work the same in every day routine?* Document.

TOOLS/SKILLS/PROCESS:

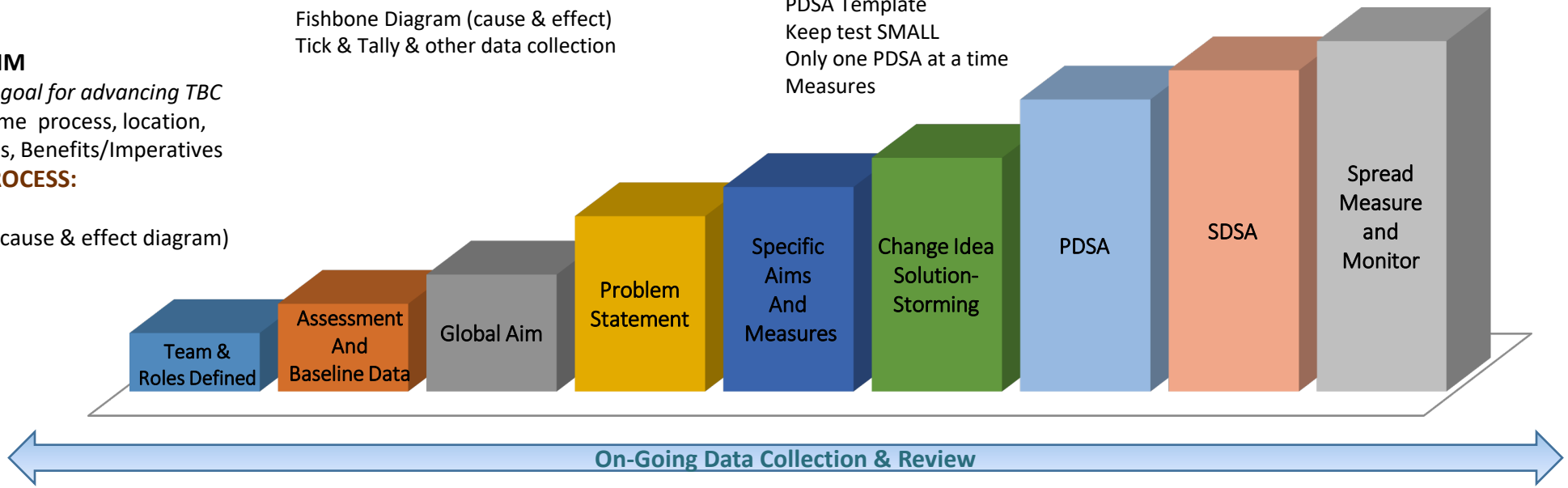
Involve all team members
Communication Plan
Playbook – Influence Spread

9. SPREAD, MEASURE & MONITOR

Implement spread strategy and track how it is working.

TOOLS/SKILLS/PROCESS:

- Communication Skills
- Spread Strategy
- Big Picture View
- Connecting the dots
- QI Process



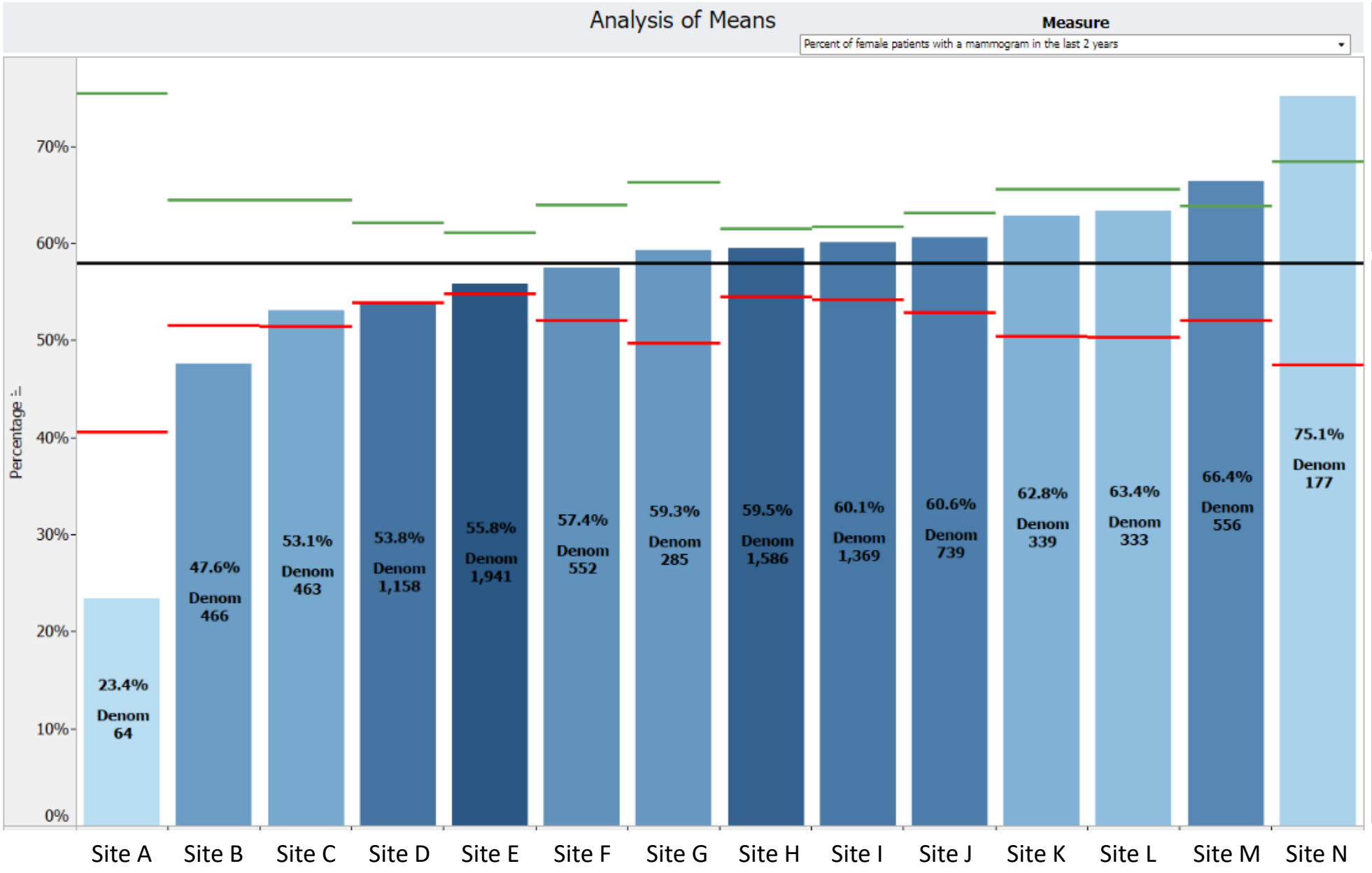
MOSES/WEITZMAN

Community Health Center, Inc.

Diabetes Analysis

				Last Visit Targets				Averages									
Age	Last Panel Mgmnt Date	Sex	Race/Ethnicity	Systolic BP	Diastolic BP	A1C	A1C in Last Year	Avg Systolic	Avg Diastolic	Avg A1C	Next Appt	Last BMI	Last Microalbumin date	Appt Place Of Last Encounter With Any PCP	Last Encounter W/PCP	Last Diagnosis	Last Retinal Screening
72	6/25/2013	M	Black or African American	96	63		N	100	59			24.48	03/04/2022	In Person	3/4/2022 10:00:00 AM	12/17/2020	1/17/2019
56		F	Undetermined H	107	67	6.40	Y	103	66	6.40		25.74	05/29/2020	In Person	2/14/2022 9:20:00 AM	5/27/2020	12/3/2019
62		F	Undetermined H	104	76	6.90	Y	104	76	6.90		23.77	06/17/2021	In Person	8/12/2021 11:00:00 AM	6/30/2020	1/21/2019
79		M	Undetermined H	116	79	8.30	Y	105	70	7.45		27.66	01/14/2021	In Person	11/22/2021 11:20:00 AM	6/7/2021	2/18/2022
85		M	Undetermined H	100	56	6.50	Y	106	60	6.50		26.79	02/18/2021	In Person	2/14/2022 10:20:00 AM	10/1/2020	6/6/2019
76		F	Undetermined H	108	66	10.50	Y	106	64	10.50		34.67	02/06/2020	In Person	2/11/2022 11:00:00 AM	11/14/2020	9/13/2018
44		F	Undetermined H	107	53		N	107	53		3/14/2022 3:20:00 PM	36.80	01/18/2021	In Person	3/29/2021 3:20:00 PM	10/23/2020	4/16/2021
64	10/28/2014	F	Undetermined H	107	67	7.20	Y	107	67	7.60		20.77	03/16/2021	Phone	1/12/2022 10:00:00 AM	5/12/2020	12/6/2016
62		F	Undetermined H	116	73		N	108	72		3/14/2022 9:00:00 AM	27.47	01/06/2021	In Person	12/2/2021 2:40:00 PM	10/3/2020	5/12/2021
70		M	American Indian or Alaska Native	119	74	6.50	Y	109	70	6.65		28.73	07/12/2021	In Person	11/18/2021 3:40:00 PM	10/3/2020	7/19/2019
54	8/9/2012	F	Black or African American	109	72	10.90	Y	110	73	10.90		37.97		In Person	11/5/2021 11:00:00 AM	11/5/2021	
66		F	Undetermined H	100	61	9.70	Y	111	67	9.70		29.32	12/10/2021	In Person	2/7/2022 10:00:00 AM	12/12/2020	11/22/2021
65		M	Asian	118	73	5.70	Y	111	67	5.70		22.11	12/13/2021	In Person	12/13/2021 11:20:00 AM	10/9/2020	12/24/2018
57		F	Undetermined H	108	64	4.90	Y	111	70	4.90		32.03	10/06/2020	In Person	2/8/2022 10:00:00 AM	10/1/2020	8/11/2020
31		F	White	111	71		N	111	71			47.35	01/25/2008	In Person	10/28/2021 3:40:00 PM	5/14/2021	
53		F	Undetermined H	112	63	5.30	Y	112	63	5.30		39.13	09/25/2020	In Person	2/3/2022 12:20:00 PM	11/20/2020	10/5/2021
49	5/28/2013	F	Undetermined H	103	57	11.10	Y	112	67	10.40		37.76	06/23/2021	In Person	9/16/2021 2:40:00 PM	8/28/2021	1/9/2020
74		M	Undetermined H	110	67	6.80	Y	112	73	6.73		37.01	09/07/2021	In Person	2/14/2022 2:00:00 PM	10/29/2021	6/10/2021
66		M	Undetermined H	116	57	7.40	Y	113	57	7.40		22.50	07/08/2021	In Person	1/24/2022 2:08:00 PM	11/17/2020	2/8/2022

81



The green reference line for an organization is its upper limit for this measure. Red is the lower limit. The grey line between the green and red is the overall site average for this measure. Sometimes certain low denominator sites are excluded from the calculations. If there are low denominator site exclusions they are listed below. Darker blue bar indicate a higher denominator and lighter blue a lower denominator.

Excluded Low Denominator Sites

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Questions?

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Wrap-Up

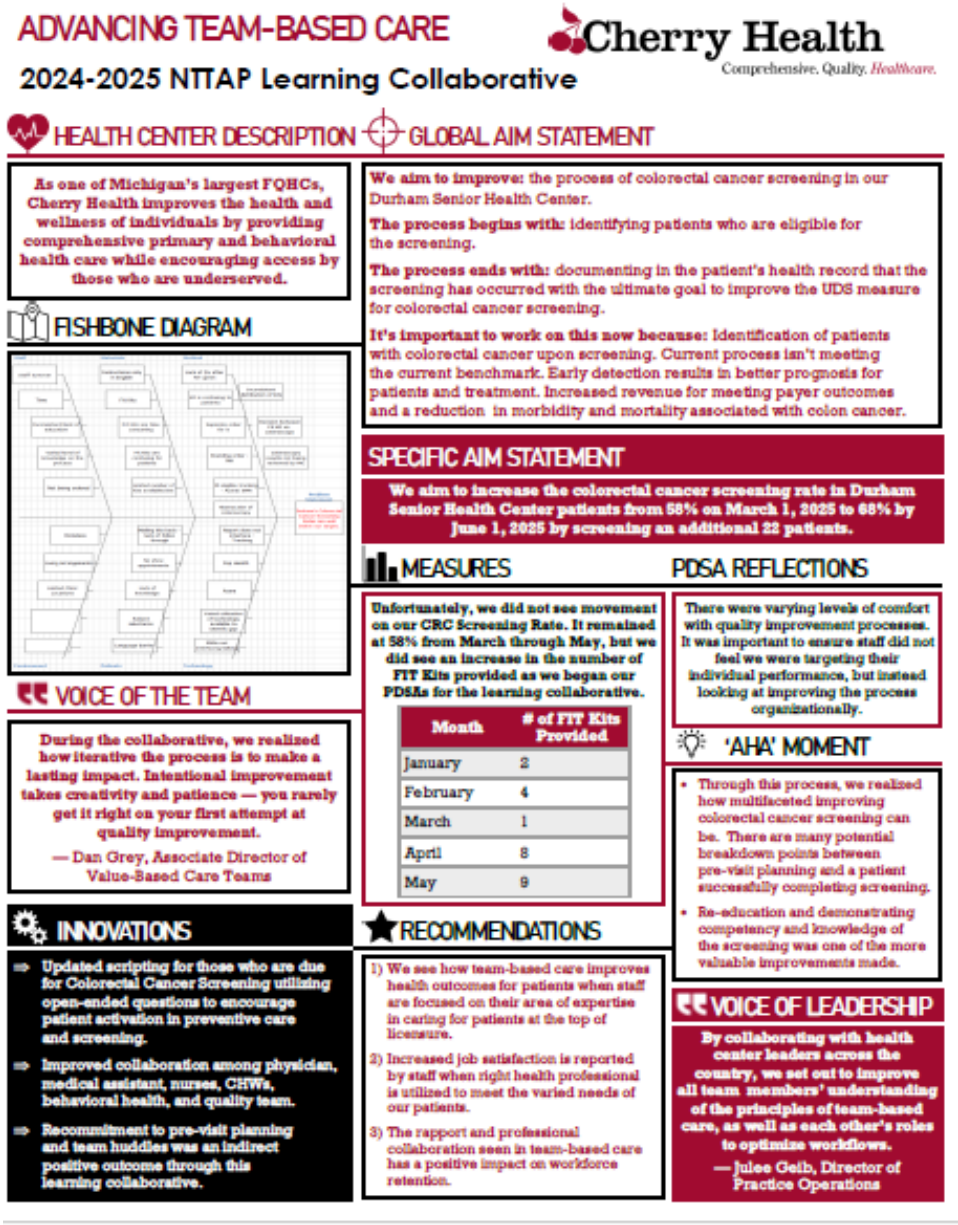
Deliverables

- ✓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
- ✓Complete showcase template

Access the Google Drive to upload deliverables:

Showcase Overview

- **Showcase Template Due Date**: Monday May 11th
  Please let me know if you need an extension.
- **Showcase Presentation Date**: Wednesday June 3rd
- **Showcase Purpose**
  1. Tell the story of your health center's work during this CoP in a clean, crisp, visual format
  2. Generate reflection among you and the other team members about your involvement in this CoP
  3. Share your work in future meetings with other health center staff including leadership and external stakeholders such as the health center board, community partners, and funders



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Next Steps

- **Team Leader Check-In Calls:**
  - Wednesday May 13th 1:00pm Eastern / 10:00am Pacific
  - Wednesday May 20th 1:00pm Eastern / 10:00am Pacific
  - Wednesday May 27th 1:00pm Eastern / 10:00am Pacific
- **Session 8**: Wednesday June 3rd 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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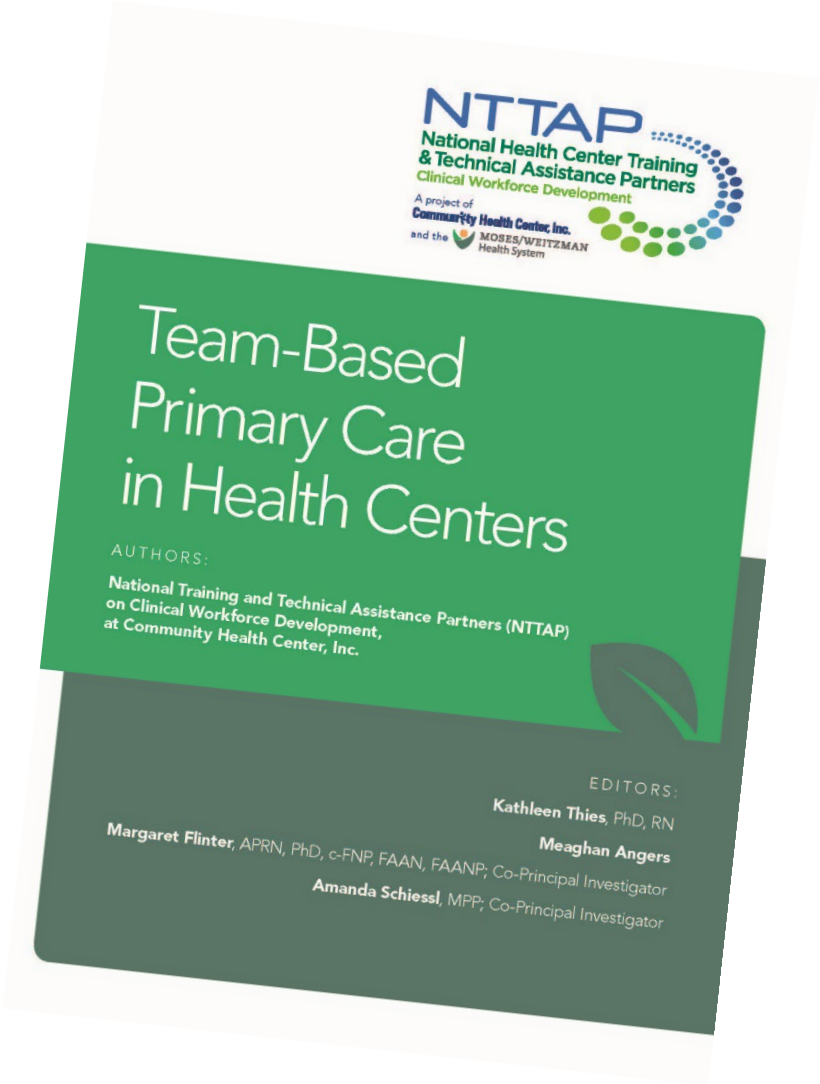
Download our new book, *Team-Based Primary Care in Health Centers*!

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



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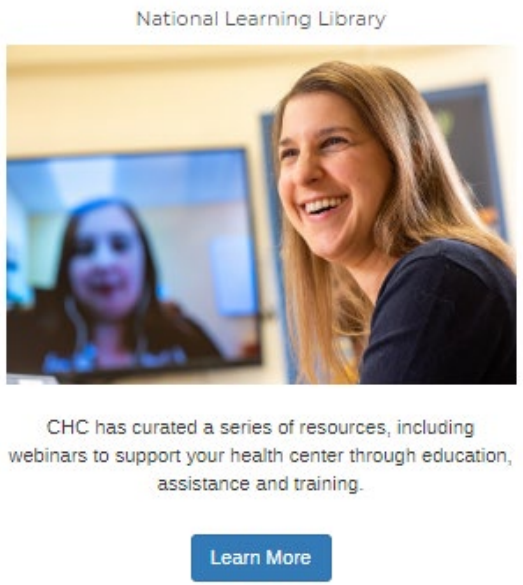
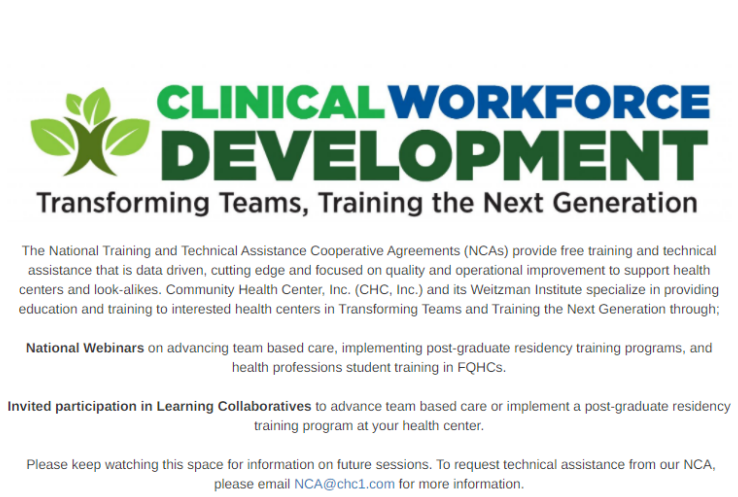
Explore more resources!

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 June 3rd!**

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