Transformation Accelerator

In-Person Learning Session #1

Thursday, October 19, 2017

Center for Total Health | Washington, DC

Housekeeping

- Slides and Handouts can be found on the USBs on your team's table, or on KPAccelerator.org

- ***Optional*** Center for Total Health Tour after session ends

Team Connectedness

1. What do you find most meaningful about your work?
2. What is it about how I do my work that helps you do yours?
3. What could I do differently that would help you even more?

Today's Focus

Morning

- Value-based care
- Effective team based care
- Drivers to reach your goals

Afternoon

- Leverage team based care to identify changes
- Develop changes and PDSAs
- What's next for the program

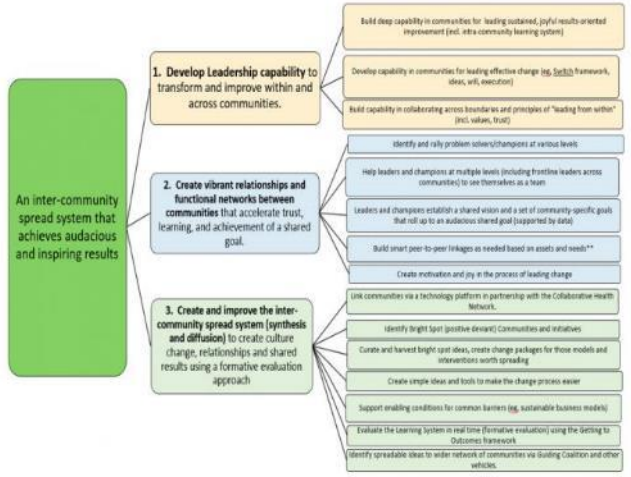
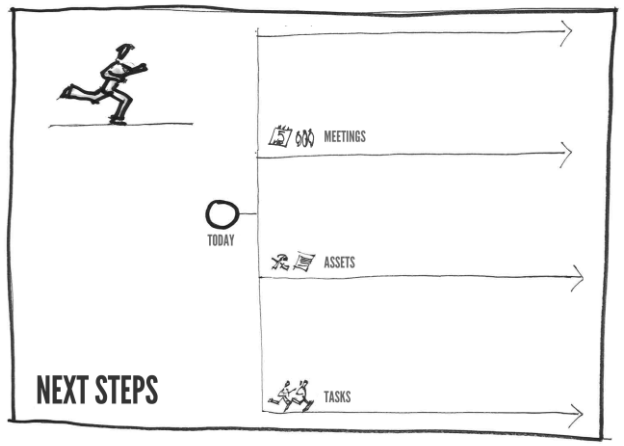


Figure 2: SCALE driver diagram. A driver diagram is a tool from Improvement Science (Langely, Moen, Nolan, Nolan, Norman et al., 2009) helps to organize thinking about what changes will lead to an improvement. The left-hand box represents the outcome of interest. The Primary Drivers (middle boxes) are the change that will lead to this outcome. The right-hand boxes are the secondary drivers that will lead to change in the primary drivers.



Transformation to Increase Value

Effective Team-based Care

October 19, 2017

Carolyn Shepherd, M.D.

KPTA Transformation Goals

Quadruple Aim

- Better Outcomes
- Better Experience
- Lower Costs
- Joy in Work

Value-Based Care

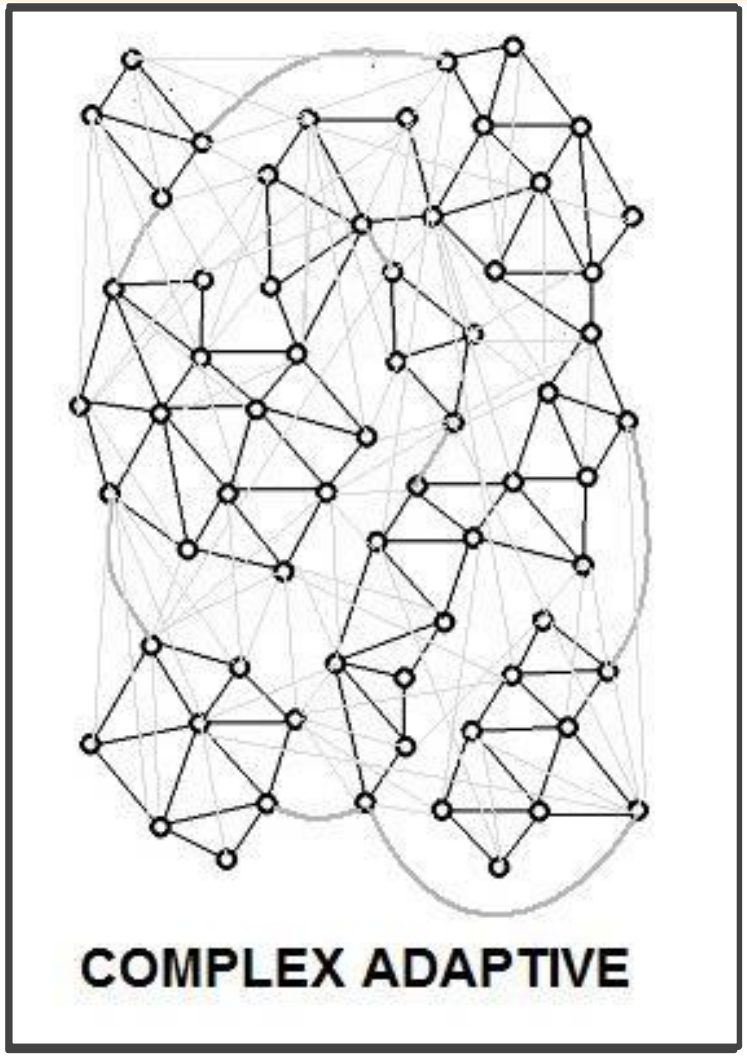
Value = $\frac{\text{patient outcomes + experience}}{\text{cost}}$

KPTA: Transformation Goals

Increasing Value Based Care:

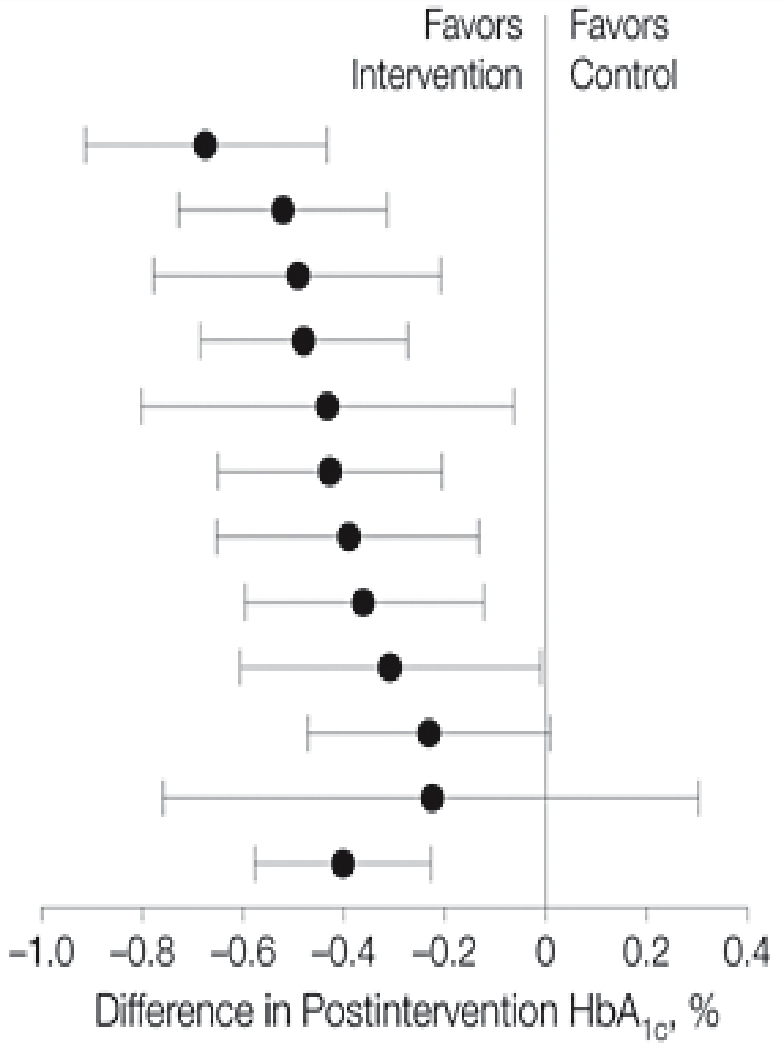
- Assuring delivery of comprehensive care
- Improving physical health prevention
- Improving oral health prevention
- Expanding delivery of primary care services
- Leveraging technology to increase access to care

Making Transformation Work



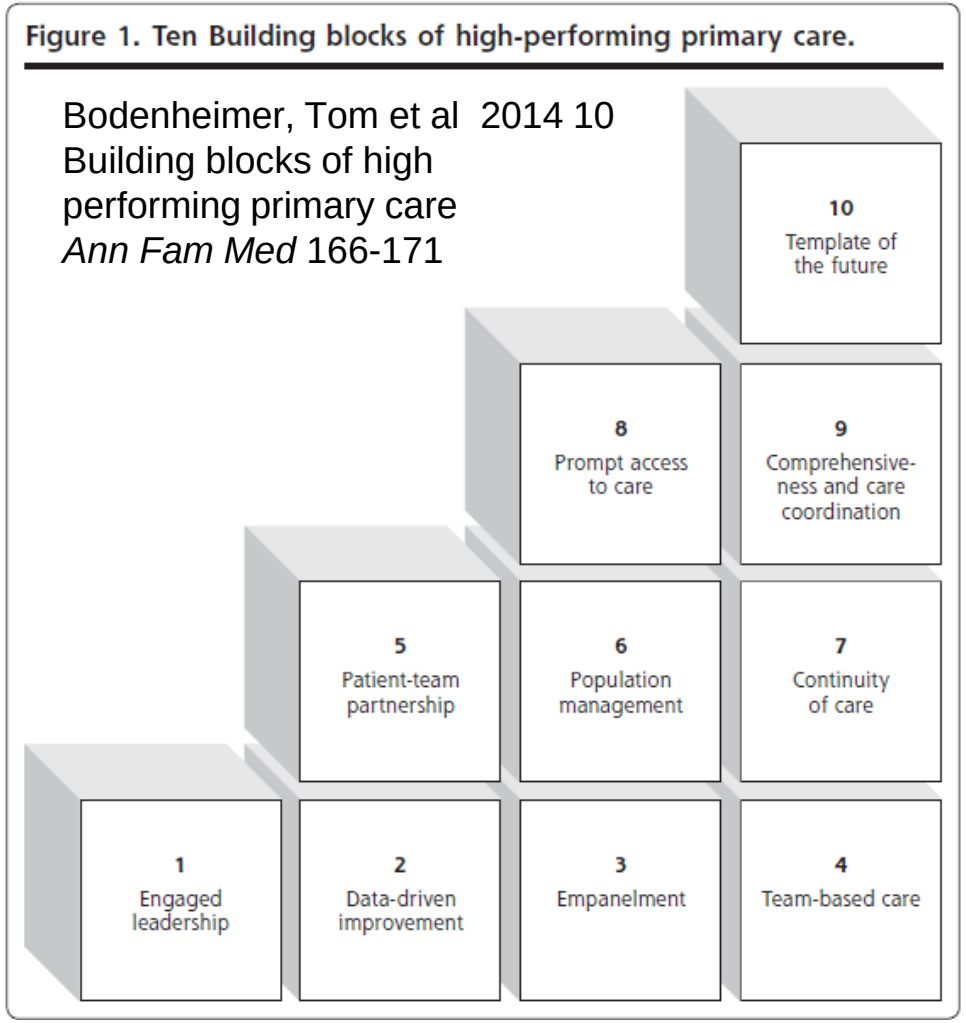
Value Based Care: Diabetes

Quality Improvement Strategy	No. of Trials
Team Changes	26
Case Management	26
Patient Reminders	14
Patient Education	38
Electronic Patient Registry	8
Clinician Education	20
Facilitated Relay of Clinical Information	15
Self-Management	20
Audit and Feedback	9
Clinician Reminders	18
Continuous Quality Improvement	3
All Interventions	66



Shojania, K. G. et al. JAMA 2006;296:427-440.

Build Systems that Work



System Wide changes:

Engaged leadership at all levels

Clear vision, and goals, adaptive leadership style extending population health beyond medical and into the community

Robust data systems, measurement and reporting

Financial/operational analytics, clinical informatics, performance monitoring, data for clinical decision making, data for addressing social determinants of health, data sharing and monitoring across sectors of the community

Training and knowledge management

Institutes, programs, training for using stories for building patient-clinician relationship, assessing vulnerabilities and resilience

Continuous improvement and innovation

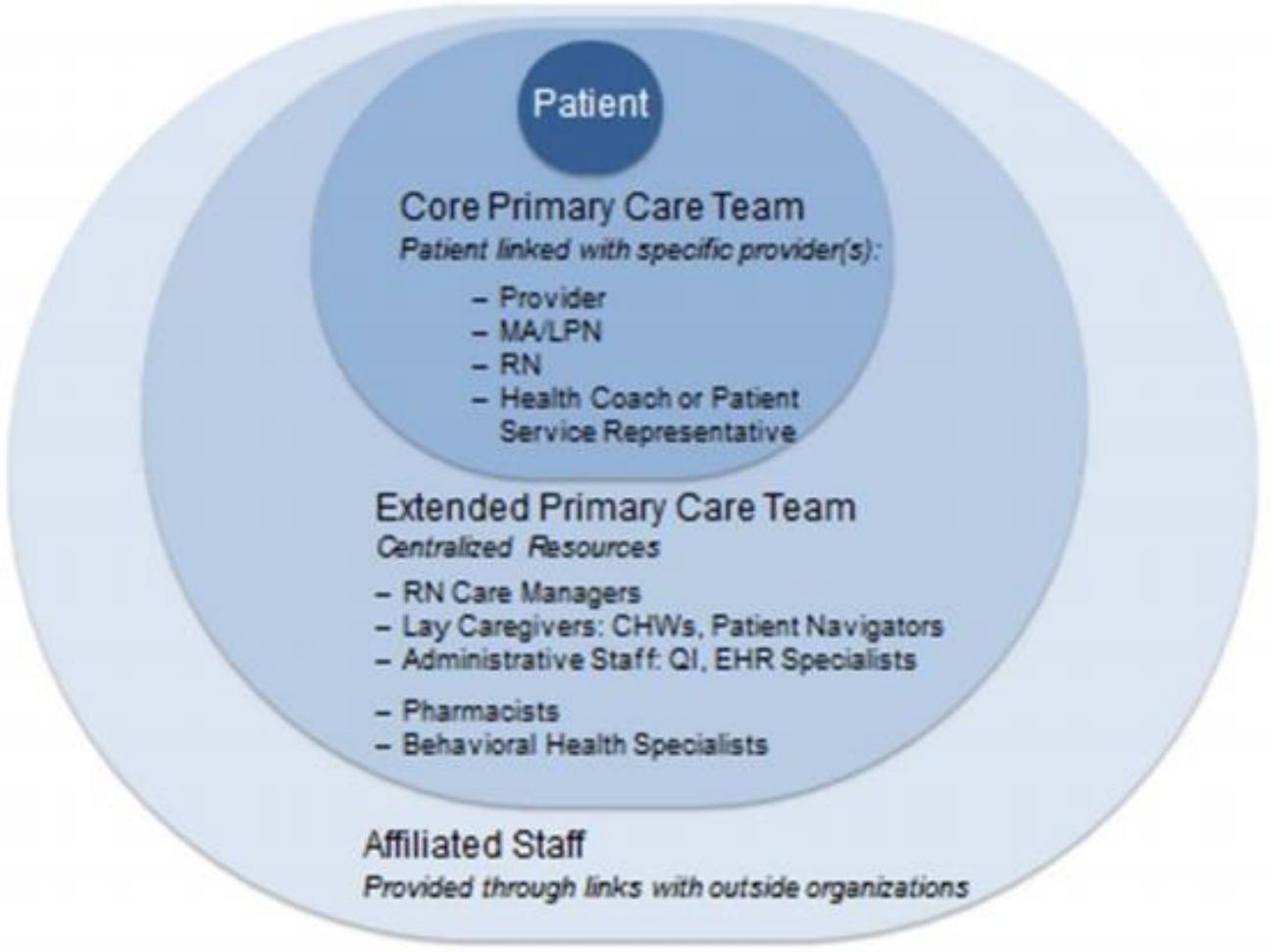
Improvement methodology, human centered design training, and clear plan for spread and scale

Community partnerships

Tools for building collaboration to identify and engage community partners

Build Systems That Work: LEAP

Build Systems that Work: LEAP



The Emerging Primary Care Workforce: Preliminary Observations From the Primary Care Team: Learning From Effective Ambulatory Practices Project Ladden, M D et al Academic Medicine: December 2013 - Volume 88 - Issue 12 - p 1830–1834

High Performing Primary Care Teams

RPCC Regional Primary Care Coalition

CCI CENTER FOR CARE INNOVATIONS

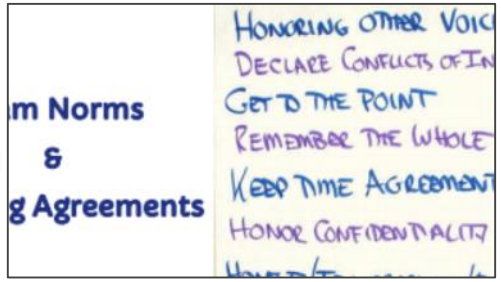
KAISER PERMANENTE

TEAM WORK

TASK WORK

Build the Team

Build Team Culture



Do the Work

Excellent Performance of Critical Functions

KPTA PGC Framework

Inter-professional Team Based Care at the Community Health Center Inc.

Veena Channamsetty, MD Chief Medical Officer
Mary L. Blankson, DNP, APRN, FNP-C Chief Nursing Officer

Community Health Center, Inc.

CHC Profile

- Founding year: 1972
- Primary care hubs: 14; 204 sites
- Annual budget: $105M
- Staff: 1,000
- Patients/year: 100,000 (est. 2017)
- Visits/year: 550,000
- Specialties: onsite psychiatry, podiatry, chiropractic
- Specialty access by e-Consult to 15 specialists

Elements of Model

- Fully Integrated teams and data
- Integration of key populations
- Data driven performance
- "Wherever You Are" approach

Weitzman Institute

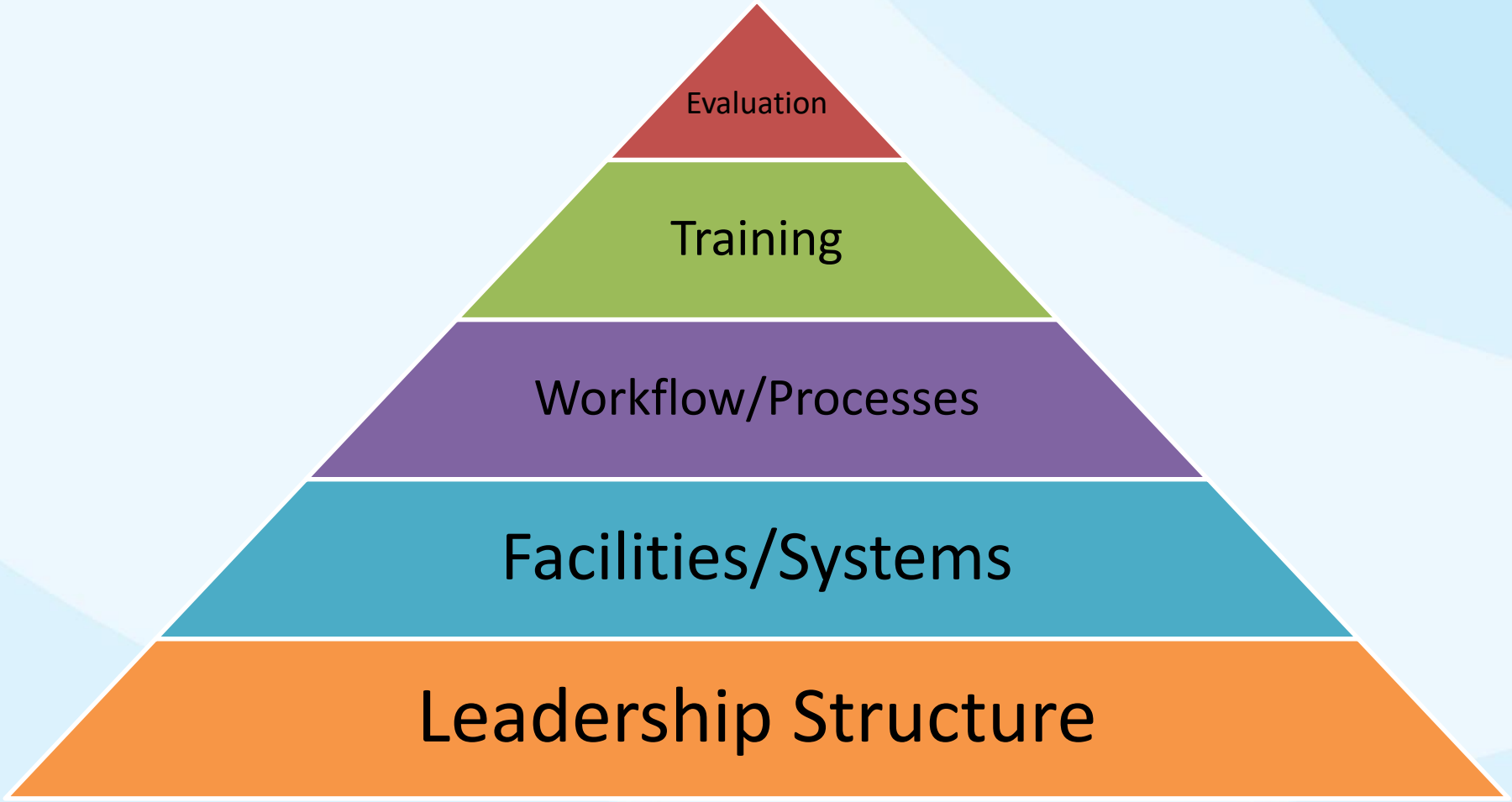
- QI experts; national coaches
- Project ECHO®— special populations
- Formal research and R&D
- Clinical workforce development

CHC Locations in Connecticut

THREE FOUNDATIONAL PILLARS

1	2	3
Clinical Excellence	Research and Development	Training the Next Generation

The Components of Integration



Interdisciplinary Leadership

4 Clinical Chief positions:

- Chief Medical Officer
- Chief Nursing Officer
- Chief of Behavioral Health
- Chief Dental Officer

Leadership Support

- Executive Mentoring
- Interdisciplinary Chief Meetings
- Leadership Meetings

Collaboration/Integration among departments

- QI Projects/Microsystem work
- Clinical Initiatives/Policies

PCMH/UDS/Clinical Quality

Interdisciplinary Leading

Onsite Clinical Directors

- OSMD
- Nursing Managers
- OSBHD
- OSDD

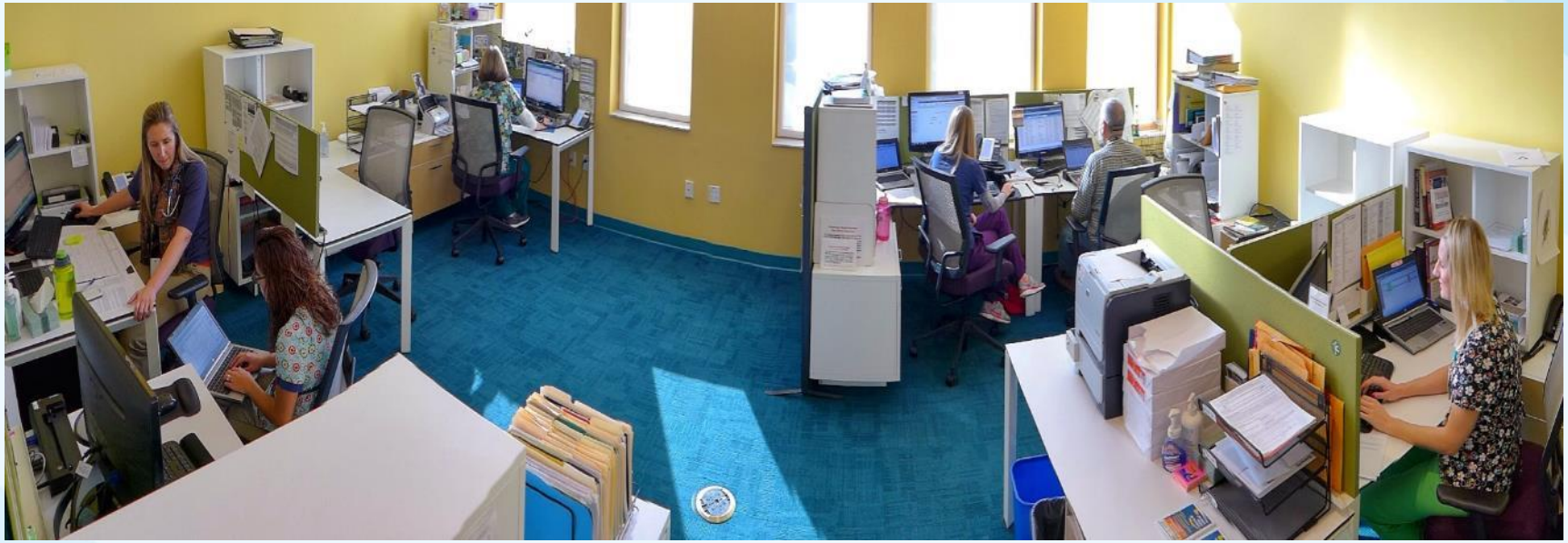
Collaboration/Integration among departments

- Integrated Microsystems
- Integrated Care Meetings
- Clinical/Pod "Huddles"

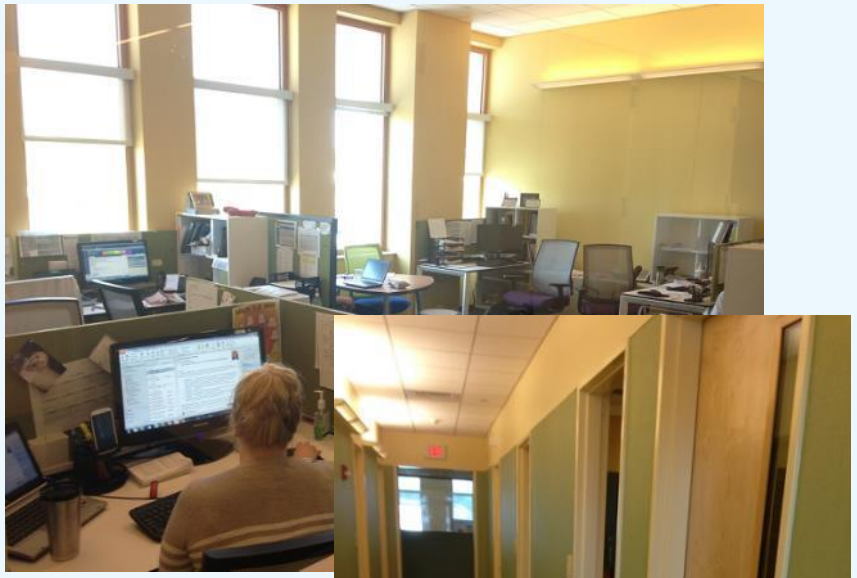
Leadership Support

- Leadership Skills Training
- Leadership Meetings

Interdisciplinary Pods that Promote Team-Based Care



Facilities: One Corridor Care

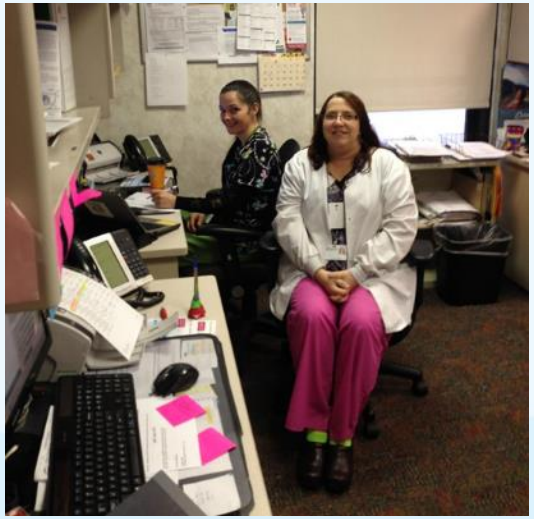


- Exam rooms and therapy rooms
- Reducing stigma of seeing behavioral health provider – no longer sent "over there"
- Seamless transition between medical and behavioral health

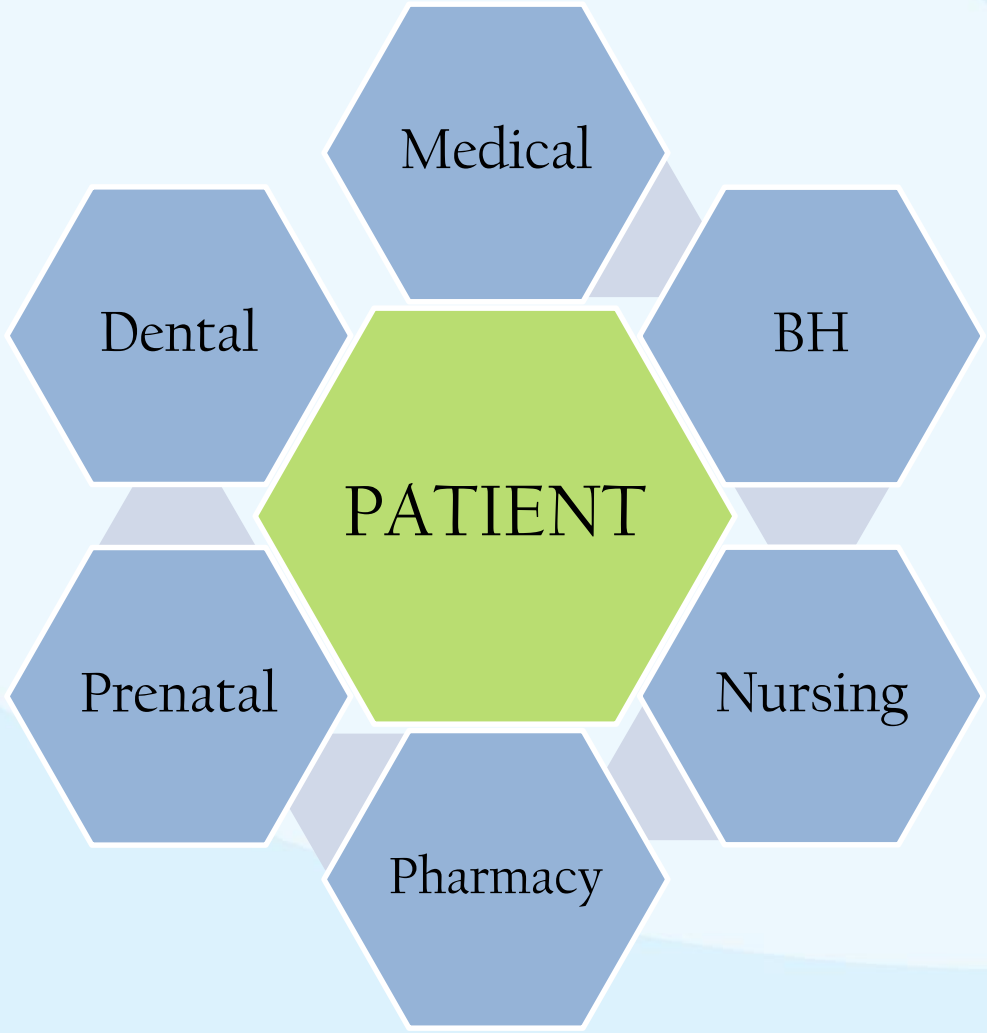
The Interdisciplinary Team

POD design

- 2 Medical Providers
- 1 Registered Nurse
- 2 Medical Assistants
- 1 Behavioral Health Clinician
- Additional members: podiatrist, dietician, Pharm-D, chiropractor, CDE
- Student/Trainees



Care that is Comprehensive: IPCP Team



Additional on-site specialties

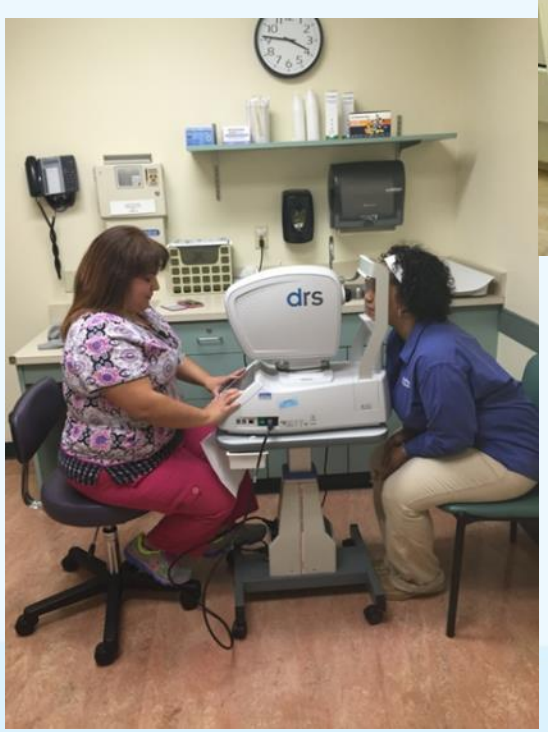
- Nutrition
- Diabetes education
- Chiropractic
- Podiatry
- Retinal screening

Role of the Provider

- Clinical Leader/Responsible
- Clinical Management
  - Support planned care
  - Evidence based care delivery
  - Care coordinate with team
- Empower the Team
- Leverage the Team
- Engage in the Team

Role of the Medical Assistant

- Planned Care
- Delegated Ordering
- Panel Management
- Scanning/Faxing/handling of incoming faxes
- Retinal Camera Operation
- QI/Microsystem Participants



Domains of RN Nursing Practice at CHC, Inc.

Essential member of the primary care team and interprofessional activities

(1) RN supports (2) primary care providers/panels

Key functional activities:

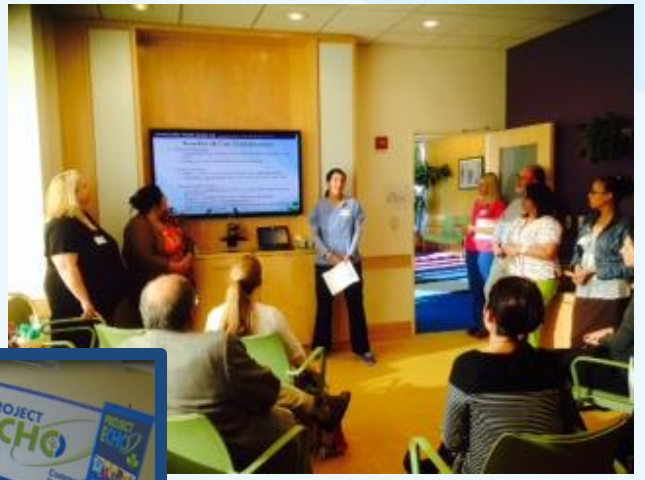
- Patient education and treatment within provider visits
- Independent Nurse Visits under standing orders
- Delegated provider follow up visits using order sets
- Self management goal setting and care management
- Complex Care Management; coordination and planning
- Telephonic Advice and Triage via dedicated triage line
- Quality improvement leaders, coaches, and participants
- Leaders and participants in research
- Clinical mentoring of RN students; Supervision and mentoring of Medical Assistants

Nursing Standing Orders

- Uncomplicated UTI
- Vulvovaginal candidiasis
- Comprehensive diabetes visit with retinal screening
- Pupil dilation
- Titration of basal insulin
- Pedi & adult vaccines
- TB DOT
- Bronchodilator testing in spirometry
- Tobacco cessation
- Emergency contraception
- Pregnancy testing
- Orders for emergency situations

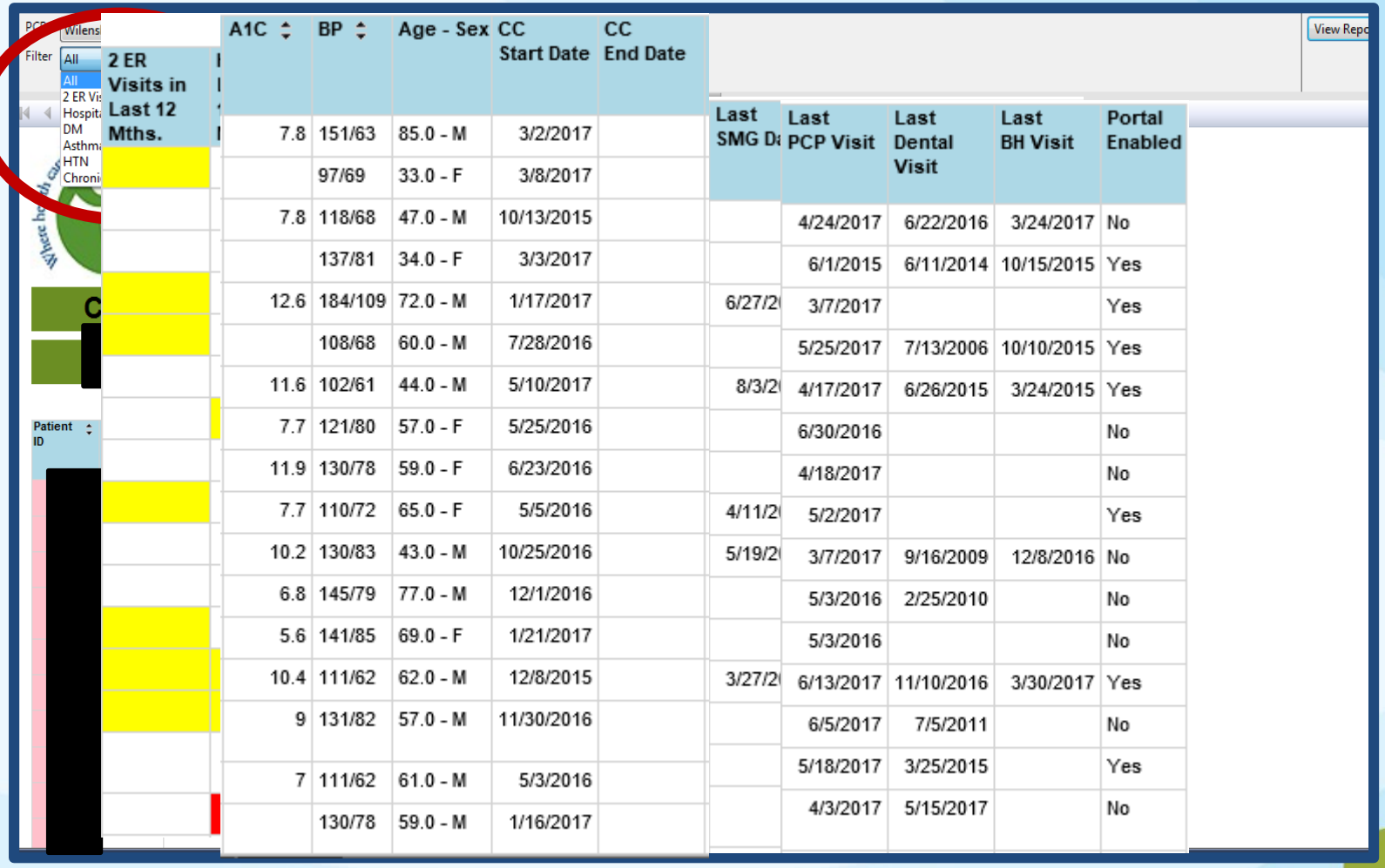
RN Complex Care Management

- Comprehensive didactics for Complex Care Management
  - Transition Care, Medication Reconciliation, CHF, DM, Pediatric Asthma, COPD, Psych, Motivational Interviewing, Chronic Pain, Addiction, HIV/HCV, Self Management Goal Setting
  - Care Plan/Zone Sheet development & Self-Management
- EHR Templates
  - Structured Intakes/Follow up
  - Nursing Informatics/Outcome Measures
  - Dashboards (Population Management)
- Community Engagement
  - Data Sharing
  - ICMs



CCM Dashboard

New filter option



History of Present Illness

Diabetes:

Home glucose testing ------Checks QID. Glucose control ------Fair per last A1c of 7.6. Topics discussed Using your glucometer, When to test, What should my FSBS be, Recording your results, Testing Action Plan , Pt verbalized understanding. Hypoglycemia Patient explains that he has not had an episodes in tha last few months, but when he does he gets dizzy and his BG reading would be lower than 105 but it has never been below 70. He treats hypoglycemia with half a cup of orange juice and a piece of sweet bread. Symptoms ------ Polyphagia after dinner, denies any other symptoms of hyperglycemia. Foot Problems ------Denies. Diet ------ Patient reports that he consumes too many snacks after dinner and many of these are sweets that he shares with his five year old son. Exercise ------Patient reports that although he does not have a set exercise routine, he does feel that he is very active working as a barber long hours and engaging in active play with his five year old son.

Medications:

Medication review Name of each med, How pt keeps track of meds, Purpose of each med, Why it is important to take meds , Refills needed, Tips for better adherence, pt verbalized understanding. Adherence rate ------Patient reports excellent adherence

Self Management:

Ready to set a new goal? Ready to set a new goal? Yes. SM Goal: Healthy Eating Will substitute evening sweet snacks with sugar free products. SM Goal:Being Active/Exercise N/A at this time. SM Goal: Medication Use N/A at this time. SM goal: Glucose Monitoring N/A at this time. SM Goal:Self Care/Risk Reduction N/A at this time. Confidence Score: ------7.

Care process review:

Foot exam in past year? Foot exam? ------. Eye exam past year? Eye exam past year? ------Patient reports that [redacted] to his eye doctor within the past year, but unsure if retinopathy screening wa[redacted] Patient agrees to bring us the contact information for his eye doctor and to s[redacted]lease for us to get those records at his next visit. Hemoglobin A1C in past 6 m[redacted] A1C Yes Within the last three months.

A1c education provided. Patient ve[redacted]d understanding.

Community Health Center, Inc.

Care Coordination Drill

[redacted]

Patient ID	2 ER Visits in Last 12 Mths.	Hosp. Last 12 Mths.	DM	HTN	Asthma	4 Chronic Cond.	Smoking Status	A1C	BP	Age - Sex	CC Start Date	CC End Date
[redacted]		6/2/2016						7.8	151/63	85.0 - M	3/2/2017	
									97/69	33.0 - F	3/8/2017	
								7.8	118/68	47.0 - M	10/13/2015	
									137/81	34.0 - F	3/3/2017	
								12.6	184/109	72.0 - M	1/17/2017	
									108/68	60.0 - M	7/28/2016	
								11.6	102/61	44.0 - M	5/10/2017	
								7.7	121/80	57.0 - F	5/25/2016	
								11.9	130/78	59.0 - F	6/23/2016	
		8/17/2016						7.7	110/72	65.0 - F	5/5/2016	
								10.2	130/83	43.0 - M	10/25/2016	
								6.8	145/79	77.0 - M	12/1/2016	

SM goal: Glucose Monitoring, SM Goal: Healthy Eating, SM Goal: Being Active/Exercise, SM Goal:Self Care/Risk Reduction, SM Goal: Medication Use, Confidence Score:------7

Self-Management Goal in EHR

Self-Management Goal Details

Planned Care Dashboard

Patient	PCP and Visit Info
[redacted] Sex: F Age: 12.0	[redacted] Next Medical Appointment: 9/8/2016 11:00:00 AM Last Dental Visit: 9/11/2006 Reason for Visit: initial/physical...w/ twin brother

ALERTS	Last Date	Due Date	Value	Notes
VARNISH CANDIDATE				Fluoride
Needs Flu Vaccine 2016-2017				
Depression Screening	Never Done	Never Done		

Patient	PCP and Visit Info
[redacted] Sex: F Age: 63.0	[redacted] Next Medical Appointment: 9/8/2016 1:20:00 PM Last Dental Visit: 5/5/2016 Reason for Visit: pre-op

ALERTS	Last Date	Due Date	Value	Notes
WHO CANDIDATE				
Needs Flu Vaccine 2016-2017				
DM Foot Exam	7/24/2015	7/24/2016		

Bubbles	#
TE	1
RX	
Doc	
Lab	

What is MA Panel Management?

- Recurring biweekly (40 min) dedicated time will be scheduled for Panel Management activities
  - Medical Assistant Reviews
    - Diabetes Dashboard
    - HTN Dashboard
    - Opioid Dashboard
    - Missed Opportunities Dashboard
  - Nurse-led Complex Care Management Panel Review
    - Provider & Nurse
    - Care Coordination Dashboard

Goals & Outcomes of MA Panel Management

- The goal of MA Panel Management is to:
  - Re-connect patients who are overdue for f/u back to the clinical team
  - Ensure that uncontrolled patients are adhering to defined treatment plans
  - Ensure all planned care associated with HTN, DM and chronic Opioid treatment have been completed
- The expected outcome of MA Panel Management is to:
  - Improved rates of HTN & DM control
  - Improved rates of Planned Care completion
  - Improved adherence to defined treatment plans

Figure 1. Diabetes Dashboard by Provider

Community Health Center, Inc.

Diabetes Analysis

Last Visit Targets				Averages					
Systolic BP	Diastolic BP	A1C	A1C in Last Year	Avg Systolic	Avg Diastolic	Avg A1C	Last Encounter W/PCP	Last Retinal Screening	Last Foot Exam
109	70	7	Y	111	75	7	4/22/2015 3:20:00 PM	4/24/2015	1/23/2015
114	57	7.7	Y	115	66	7.7	6/3/2015 2:20:00 PM		
117	73	6.3	Y	118	69	6.05	1/23/2015 11:00:00 AM	6/6/2014	6/5/2014
131	80	6	Y	118	78	6.03	11/7/2014 1:00:00 PM	7/22/2013	1/17/2014
120	75	7.6	Y	119	78	7.77	4/3/2015 9:20:00 AM	2/3/2015	1/28/2015
118	80	10.1	Y	121	82	8.45	5/6/2015 10:00:00 AM	10/29/2014	2/4/2015
124	74	6.7	Y	122	78	8.32	7/1/2015 3:40:00 PM	4/3/2015	8/22/2014
138	86	12.2	Y	123	80	9.45	6/3/2015 9:20:00 AM		6/3/2015
115	74	8.5	Y	126	82	8.4		6/5/2015	4/6/2015
127	86		N	127	86				5/23/2014
132	85	9.5	Y	130	83	9.5	2/25/2015 3:00:00 PM		
135	59	5.2	Y	131	65	5.2	5/29/2015 11:00:00 AM		4/17/2015
130	84	5.8	Y	133	79	6.15	5/8/2015 1:00:00 PM		5/8/2015
126	77	8	Y	134	80	8	1/28/2015 1:00:00 PM		
128	88	7.8	Y	142	88	7.8	6/5/2015 2:20:00 PM		
126	89	7	Y	142	101	6.8	5/1/2015 2:40:00 PM		
144	94	6	Y	147	99	6.55	3/13/2015 10:00:00 AM		5/30/2014

Dental Integration

- Patient Centered Home (Dental Patients are Medical Patients)
- Fluoride Varnish (Hygienists in Pods)
- Provide Oral Health Education and try to establish Dental Home
- Prenatal Packages (Part of our Dental team)
- Referring patients for Smoking Cessation

Center for Key Populations

- Ensures access to integrated, quality specialty care for 5 key groups with highest burden of, and risk for, HIV who experience barriers to comprehensive, respectful and safe care.
  - Men who have sex with men
  - Transgender people
  - People who inject drugs
  - (Recently) incarcerated
  - Sex workers
- <u>Services:</u>
  - HIV screening, prevention, and treatment
  - HCV screening, prevention and treatment
  - STI screening, prevention and treatment
  - Buprenorphine maintenance therapy for opioid use disorder
  - Homeless care services
  - LGBTQ health

Organizational Chart

CHC Senior Leadership
CHC Board of Directors
Mark Masselli, CEO
Margaret Flinter, VP
Veena Channamsetty, CMO
Mary Blankson, CNO
Tim Kearney, CBHO
Gary Reid, BOD Chair

Center for Key Populations
Kasey Harding – Wheeler MPH
Marwan Haddad MD, MPH, AAHIVS

Key Populations Team
Patricia Mik, RN
Lizbeth Vazquez, MA
Omar Perez, MA
Maria Lorenzo, MCM
Stephanie Moses, Data
Douglas Janssen, Outreach
Idiana Velez, PrEP
Grace Capreol. IT

- Wherever You Are (Homeless) Program
- HIV Program (Ryan White Part C)
- HCV Program
- Sub Use Program (TEACH-BMT/HRSA)
- LGBT Program
- Oasis Wellness Center (Ryan White A and B)

- Consumer Advisory Board
- Quality Improvement (Clinical Microsystem)
- Project ECHO
- Research
- Teaching

What are we doing at CHC?

Routine HIV testing – 86% compliance rate across the agency

PrEP (Pre-Exposure Prophylaxis) – daily medication assistance to reduce the transmission risk of HIV

PEP (Post Exposure Prophylaxis) – medication assistance to reduce risk of HIV transmission after exposure

Risk Reduction Counseling - Reduce patient risk for HIV or transmitting HIV through education of risk

HIV Treatment and Care - HIV Treatment from your primary care provider at your healthcare home

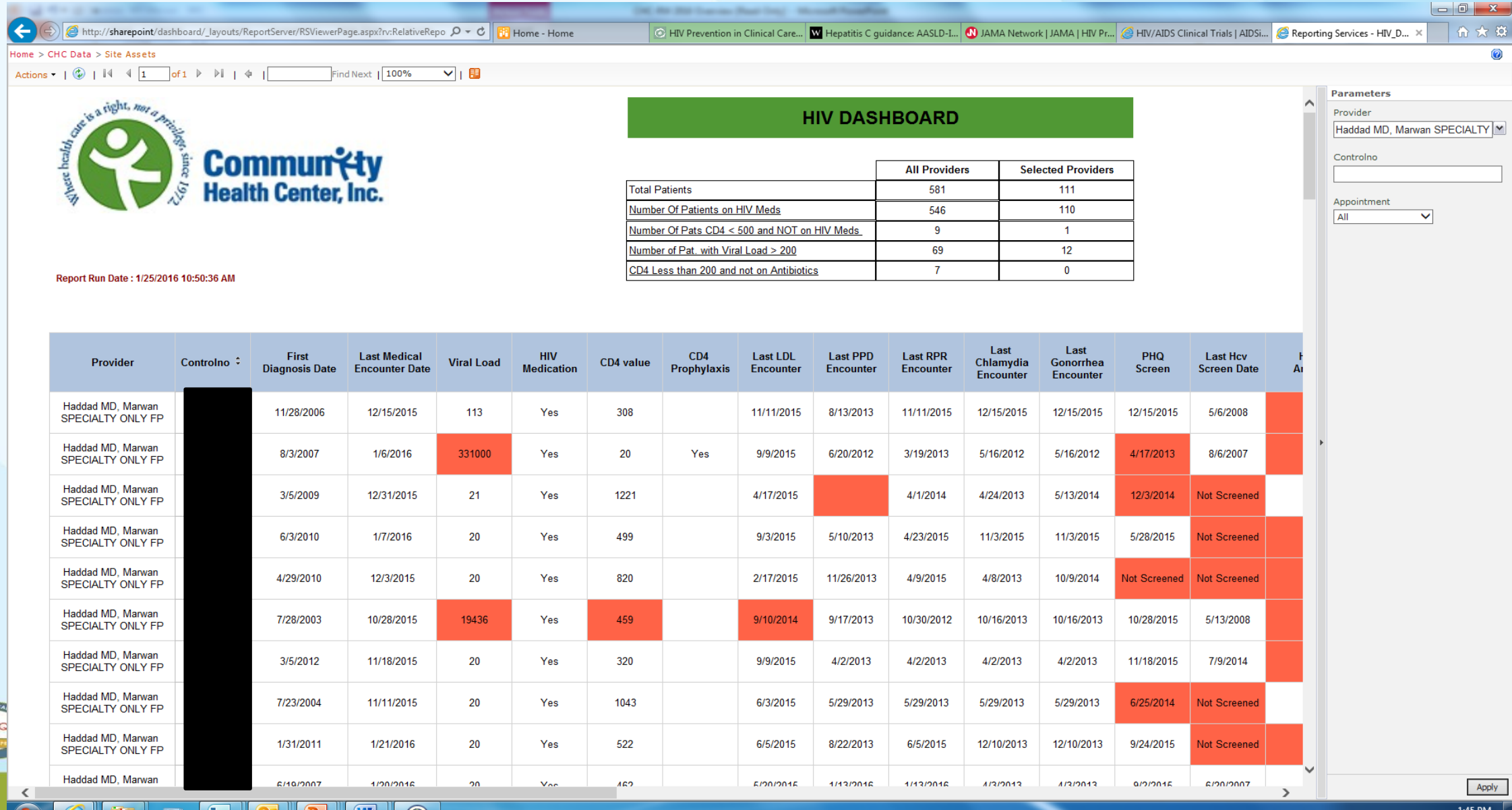
What are we doing at CHC?

Routine Hep C Testing for Baby Boomers - 64% compliance rate for patients born between 1945-1965

Hepatitis C Treatment and Care – Care and treatment for patients by their PCP in their medical home

- Participant in HIV/HCV 1.5 million HRSA grant to increase cure rate for co-infected patients.
- Lead Contributor to the Statewide Hepatitis C Task Force
- Lead Contributor of the National Hepatitis C Roundtable

CHC HIV Dashboard



http://sharepoint/dashboard/_layouts/ReportServer/RSViewerPage.aspx?rv:RelativeRepo

Home - Home | HIV Prevention in Clinical Care... | Hepatitis C guidance: AASLD-I... | JAMA Network | JAMA | HIV Pr... | HIV/AIDS Clinical Trials | AIDSi... | Reporting Services - HIV_D...

Home > CHC Data > Site Assets

Actions | 1 of 1 | Find Next | 100%

Where health care is a right, not a privilege, since 1972. Community Health Center, Inc.

HIV DASHBOARD

	All Providers	Selected Providers
Total Patients	581	111
Number Of Patients on HIV Meds	546	110
Number Of Pats CD4 < 500 and NOT on HIV Meds	9	1
Number of Pat. with Viral Load > 200	69	12
CD4 Less than 200 and not on Antibiotics	7	0

Report Run Date : 1/25/2016 10:50:36 AM

Parameters

Provider: Haddad MD, Marwan SPECIALTY

ControlNo:

Appointment: All

Apply

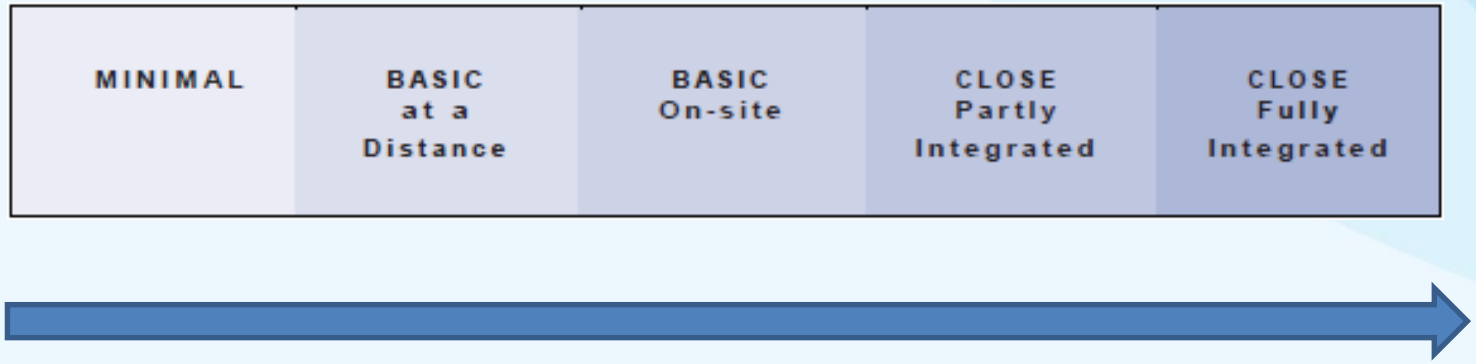
Provider	ControlNo	First Diagnosis Date	Last Medical Encounter Date	Viral Load	HIV Medication	CD4 value	CD4 Prophylaxis	Last LDL Encounter	Last PPD Encounter	Last RPR Encounter	Last Chlamydia Encounter	Last Gonorrhea Encounter	PHQ Screen	Last Hcv Screen Date	H A
Haddad MD, Marwan SPECIALTY ONLY FP	[redacted]	11/28/2006	12/15/2015	113	Yes	308		11/11/2015	8/13/2013	11/11/2015	12/15/2015	12/15/2015	12/15/2015	5/6/2008	
Haddad MD, Marwan SPECIALTY ONLY FP		8/3/2007	1/6/2016	331000	Yes	20	Yes	9/9/2015	6/20/2012	3/19/2013	5/16/2012	5/16/2012	4/17/2013	8/6/2007	
Haddad MD, Marwan SPECIALTY ONLY FP		3/5/2009	12/31/2015	21	Yes	1221		4/17/2015		4/1/2014	4/24/2013	5/13/2014	12/3/2014	Not Screened	
Haddad MD, Marwan SPECIALTY ONLY FP		6/3/2010	1/7/2016	20	Yes	499		9/3/2015	5/10/2013	4/23/2015	11/3/2015	11/3/2015	5/28/2015	Not Screened	
Haddad MD, Marwan SPECIALTY ONLY FP		4/29/2010	12/3/2015	20	Yes	820		2/17/2015	11/26/2013	4/9/2015	4/8/2013	10/9/2014	Not Screened	Not Screened	
Haddad MD, Marwan SPECIALTY ONLY FP		7/28/2003	10/28/2015	19436	Yes	459		9/10/2014	9/17/2013	10/30/2012	10/16/2013	10/16/2013	10/28/2015	5/13/2008	
Haddad MD, Marwan SPECIALTY ONLY FP		3/5/2012	11/18/2015	20	Yes	320		9/9/2015	4/2/2013	4/2/2013	4/2/2013	4/2/2013	11/18/2015	7/9/2014	
Haddad MD, Marwan SPECIALTY ONLY FP		7/23/2004	11/11/2015	20	Yes	1043		6/3/2015	5/29/2013	5/29/2013	5/29/2013	5/29/2013	6/25/2014	Not Screened	
Haddad MD, Marwan SPECIALTY ONLY FP		1/31/2011	1/21/2016	20	Yes	522		6/5/2015	8/22/2013	6/5/2015	12/10/2013	12/10/2013	9/24/2015	Not Screened	
Haddad MD, Marwan		6/19/2007	1/20/2016	20	Yes	462		5/20/2015	1/13/2016	1/13/2016	4/3/2013	4/3/2013	9/2/2015	6/20/2007	

https://www.chc1.com/Our-Model-Of-Care/Clinical-Excellence/Center-for-Key-Populations

What does Team Based Care look like?
Case Example in Integration

Behavioral Health Integration

Collaboration Continuum

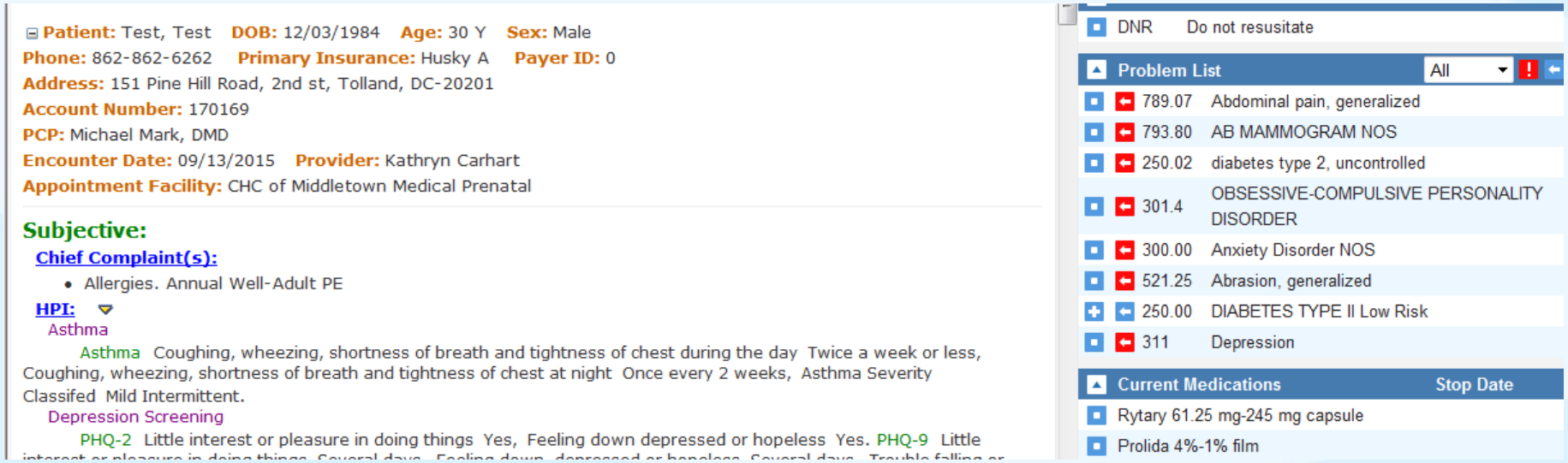


CHC's Journey

Systems and Technology

Integrated EHR

- Up-to-date patient medical and behavioral health information available.
- Pain scores and access to other data – bi-directional information sharing
- Shared Care Plans
- Electronic referral and recall process
- Collaborative Care Dashboard



Patient: Test, Test **DOB:** 12/03/1984 **Age:** 30 Y **Sex:** Male
Phone: 862-862-6262 **Primary Insurance:** Husky A **Payer ID:** 0
Address: 151 Pine Hill Road, 2nd st, Tolland, DC-20201
Account Number: 170169
PCP: Michael Mark, DMD
Encounter Date: 09/13/2015 **Provider:** Kathryn Carhart
Appointment Facility: CHC of Middletown Medical Prenatal

Subjective:

Chief Complaint(s):

- Allergies. Annual Well-Adult PE

HPI:

Asthma

Asthma Coughing, wheezing, shortness of breath and tightness of chest during the day Twice a week or less, Coughing, wheezing, shortness of breath and tightness of chest at night Once every 2 weeks, Asthma Severity Classifed Mild Intermittent.

Depression Screening

PHQ-2 Little interest or pleasure in doing things Yes, Feeling down depressed or hopeless Yes. PHQ-9 Little

DNR Do not resusitate

Problem List All

789.07	Abdominal pain, generalized
793.80	AB MAMMOGRAM NOS
250.02	diabetes type 2, uncontrolled
301.4	OBSESSIVE-COMPULSIVE PERSONALITY DISORDER
300.00	Anxiety Disorder NOS
521.25	Abrasion, generalized
250.00	DIABETES TYPE II Low Risk
311	Depression

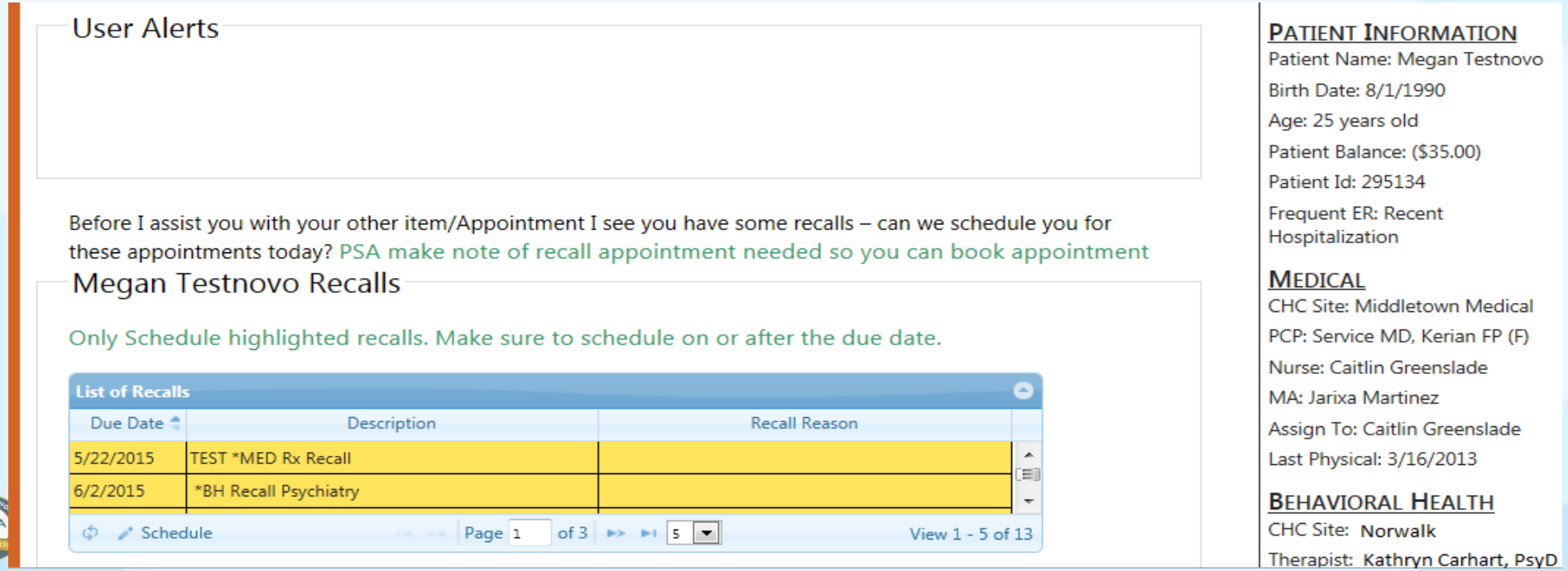
Current Medications **Stop Date**

Rytary 61.25 mg-245 mg capsule
Prolida 4%-1% film

Systems and Technology

Integrated Scheduling System

- Call any CHC number and connected to same scheduling agent
- Medical, dental, therapy and psychiatry services all scheduled through one system
- All Recalls visible at all points of contact



Systems and Technology and Process

Collaborative Care Dashboard

- Planned Care in Behavioral Health
- Delivery of Integrated Services

ID	Total Therapy Visits	Intake	Last Therapist	Last Psychiatry Provider	Initial CarePlan	Last Review	Last Discharge	Last PHQ	Controlled Substance	Auth Reqd	Alerts	Flu Shot Due	Fluoride Varnish due
[redacted]	3	8/27/2015	Stephens, Jenna		N/A	N/A	N/A	8/27/2015	N/A				
	107	6/29/2012	Stephens, Jenna	Stevens, B. Jamie	N/A	9/7/2015	N/A	12/4/2013	4/4/2013				
	79	10/8/2012	Stephens, Jenna	Stevens, B. Jamie	N/A	9/7/2015	N/A	4/2/2015	11/26/2013	Yes			
	10	4/2/2015	Stephens, Jenna	Stevens, B. Jamie	4/29/2015	7/29/2015	N/A	3/31/2015	N/A				
	9	10/13/2012	Stephens, Jenna	Stevens, B. Jamie	N/A	7/29/2015	3/10/2015	7/15/2014	8/14/2015				
	9	8/18/2015	Stephens, Jenna		N/A	N/A	1/24/2013	1/6/2015	N/A				
	55	11/26/2013	Stephens, Jenna	Stevens, B. Jamie	10/29/2014	6/24/2015	11/19/2014	8/25/2015	N/A				

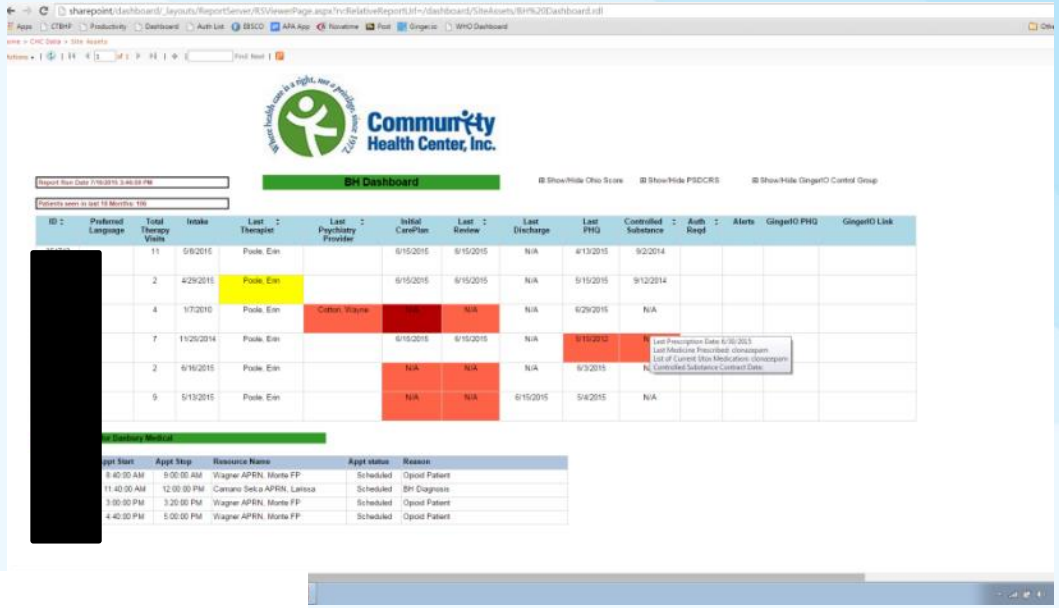
s for New Britain Medical

Appt Start	Appt Stop	Resource Name	Appt status	Reason
9:20:00 AM	9:40:00 AM	Silva MD, Mauricio IM	Scheduled	BH Diagnosis
9:40:00 AM	10:00:00 AM	Borgonos MD, Ovanes-FP	Scheduled	Opioid Patient
9:40:00 AM	10:00:00 AM	Oggenfuss APRN, Jurg ADULTS ONLY	Scheduled	Opioid Patient, Last PHQ >= 15

Processes

Rethinking the warm hand-off process: Proactive vs Reactive

- Medical initiated warm hand-off *and* behavioral health initiated warm hand-off
- Staggered vs. consecutive visits – make our presence known
- Criteria:
  - No BH services and PHQ above 15
  - No BH services and BH Diagnosis
  - No BH services and chronic pain patient

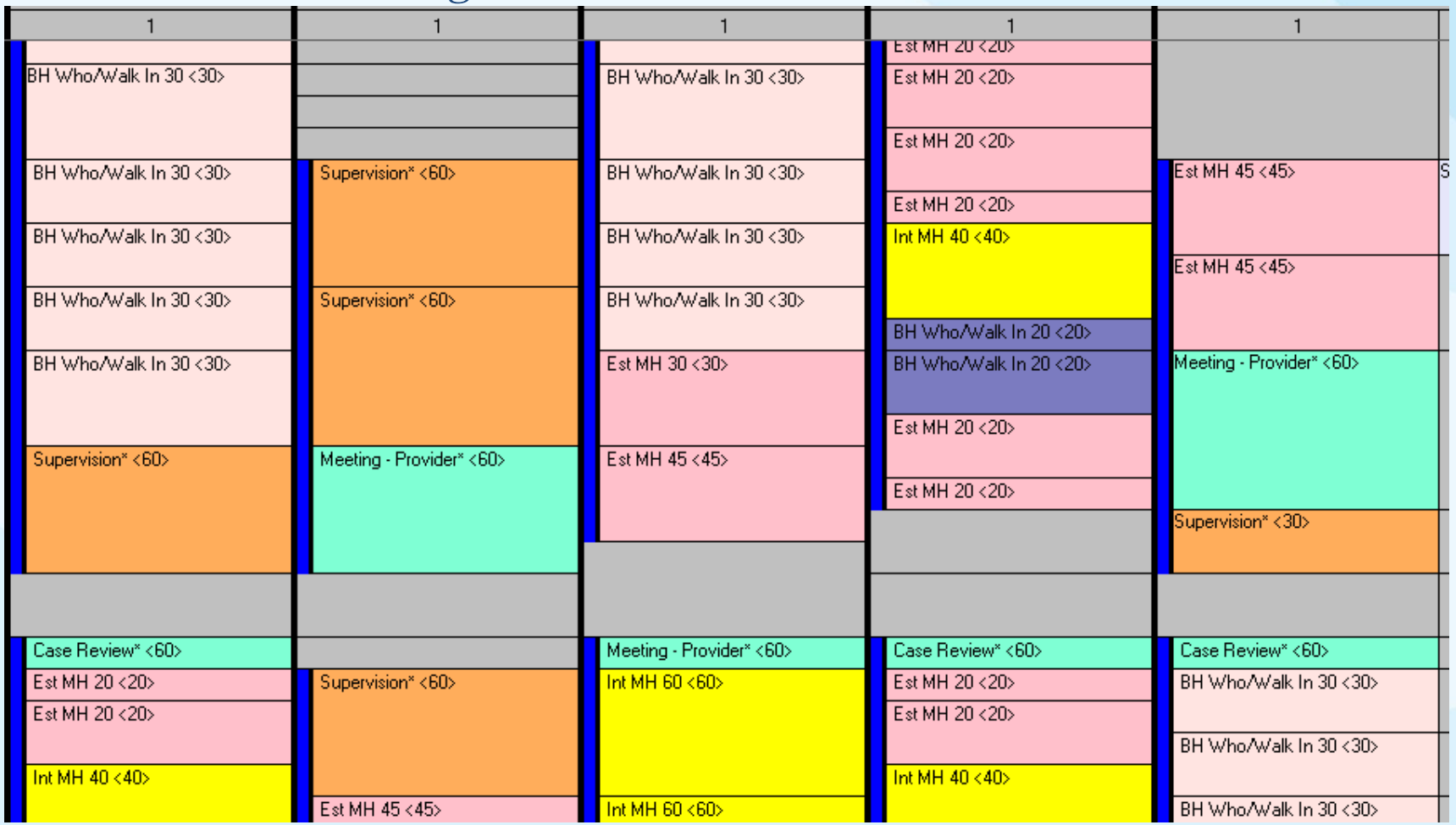


WHO Candidates for Middletown Medical

ControlNo	Appt Start	Appt Stop	Resource Name	Appt status	Reason
[redacted]	10:00:00 AM	10:20:00 AM	Huddleston MD, Matthew-FP	Scheduled	Last PHQ >= 15, BH Diagnosis
	10:20:00 AM	10:40:00 AM	Fine APRN, Ashley Resident	Scheduled	Last PHQ >= 15
	10:40:00 AM	11:00:00 AM	Huddleston MD, Matthew-FP	Scheduled	Last PHQ >= 15
	11:00:00 AM	11:20:00 AM	Crandall MD, Laura- FP	Scheduled	BH Diagnosis
	1:20:00 PM	1:40:00 PM	Fine APRN, Ashley Resident	Scheduled	Last PHQ >= 15
	1:40:00 PM	2:00:00 PM	Crandall MD, Laura- FP	Scheduled	BH Diagnosis
	2:20:00 PM	2:40:00 PM	Crandall MD, Laura- FP	Scheduled	Last PHQ >= 15
	2:20:00 PM	2:40:00 PM	Mitchell APRN, Nichole Resident FP	Scheduled	BH Diagnosis
	2:40:00 PM	3:00:00 PM	Crandall MD, Laura- FP	Scheduled	BH Diagnosis
	3:00:00 PM	3:20:00 PM	Crandall MD, Laura- FP	Scheduled	Opioid Patient, BH Diagnosis
	3:20:00 PM	3:40:00 PM	Adams APRN, Kaitlin FP	Scheduled	BH Diagnosis
	3:20:00 PM	3:40:00 PM	Crandall MD, Laura- FP	Scheduled	Last PHQ >= 15

Processes

- Seamless Scheduling



Interdisciplinary Care Initiatives

Initiative	BH	Medical	Nursing	Dental
Integrated Care Meetings	X	X	X	
Recalls	X	X	X	X
BH Groups	X	X		
Shared Medical Visits	X	X	X	
Warm Hand-Offs	X	X	X	X
Prenatal-Dental Project		X	X	X
Shared Care Plans	X	X	X	
Complex Care Management	X	X	X	
Trauma Screening & TFCBT	X		X	
Standing Orders	X	X	X	
Fluoride Varnish		X	X	X
SBIRT	X	X	X	
BH Dashboard	X	X	X	X
Appointment Allocation	X	X	X	X

Thank you!

Veena Channamsetty, MD
Chief Medical Officer
veena@chc1.com

Mary L. Blankson, DNP, APRN, FNP-C
Chief Nursing Officer
mary@chc1.com

Refresh & Stretch

Driver Diagrams

Tammy Fisher, MPH

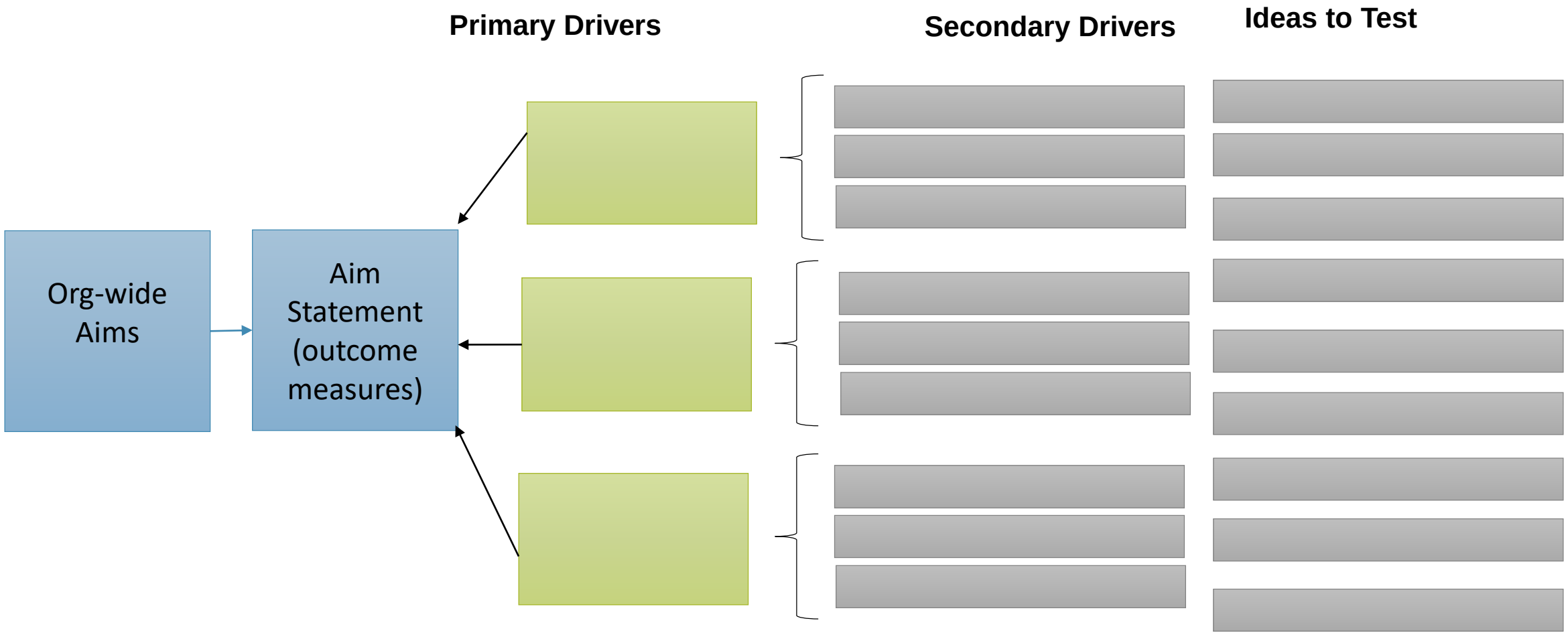
Sr. Director, CCI

KPTA Coach

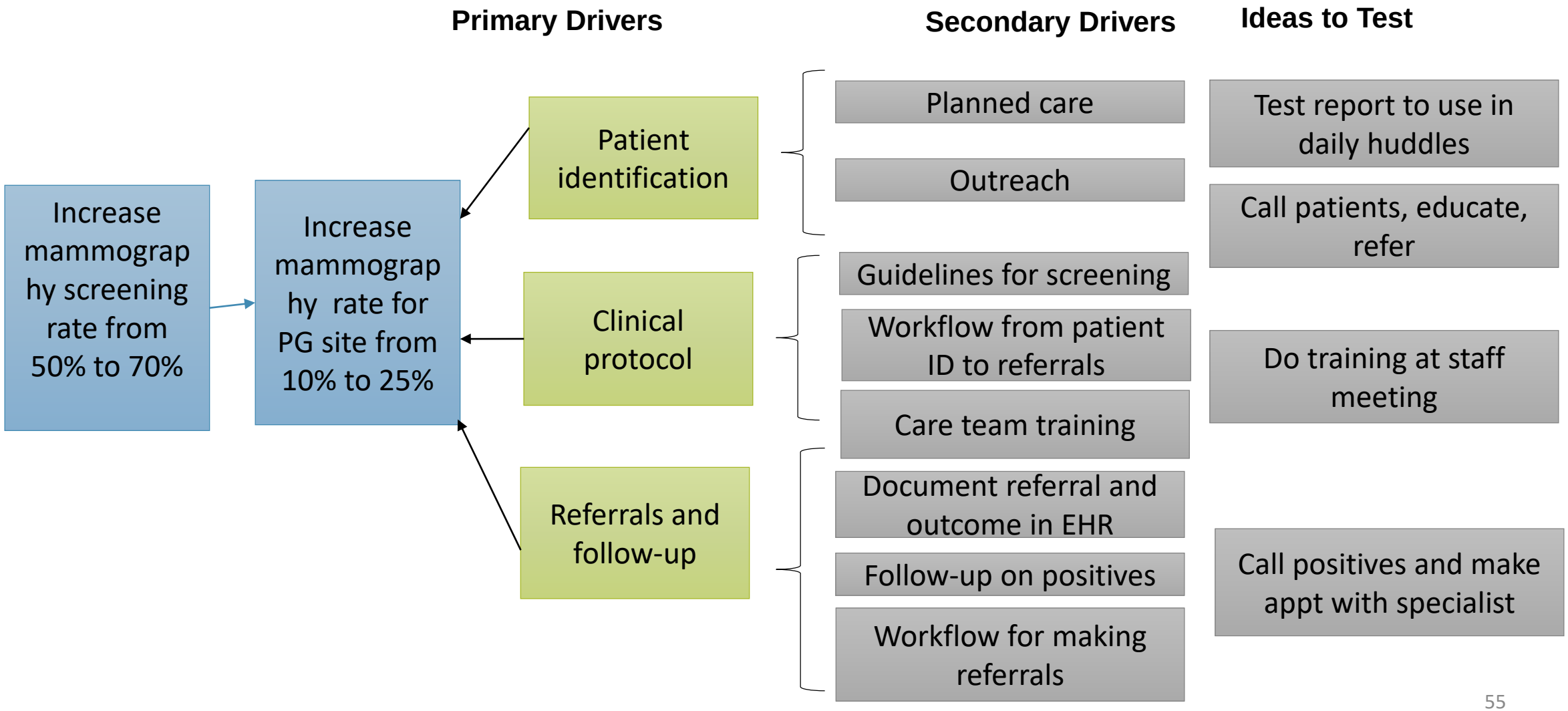
Why use them?

- To visualize your theory of what drives the achievement of your aim
- Shows the relationship between the overall **aim**, the **primary drivers** that contribute directly to achieving the aim, the **secondary drivers** that are components of the primary drivers, and **specific change ideas to test**

Anatomy of driver diagrams



Example – mammography screening



About drivers

Primary Drivers

- Primary influencers
- Groups of secondary drivers with common resources, manager, equipment, patients, etc…
- Could be assigned to a team to improve

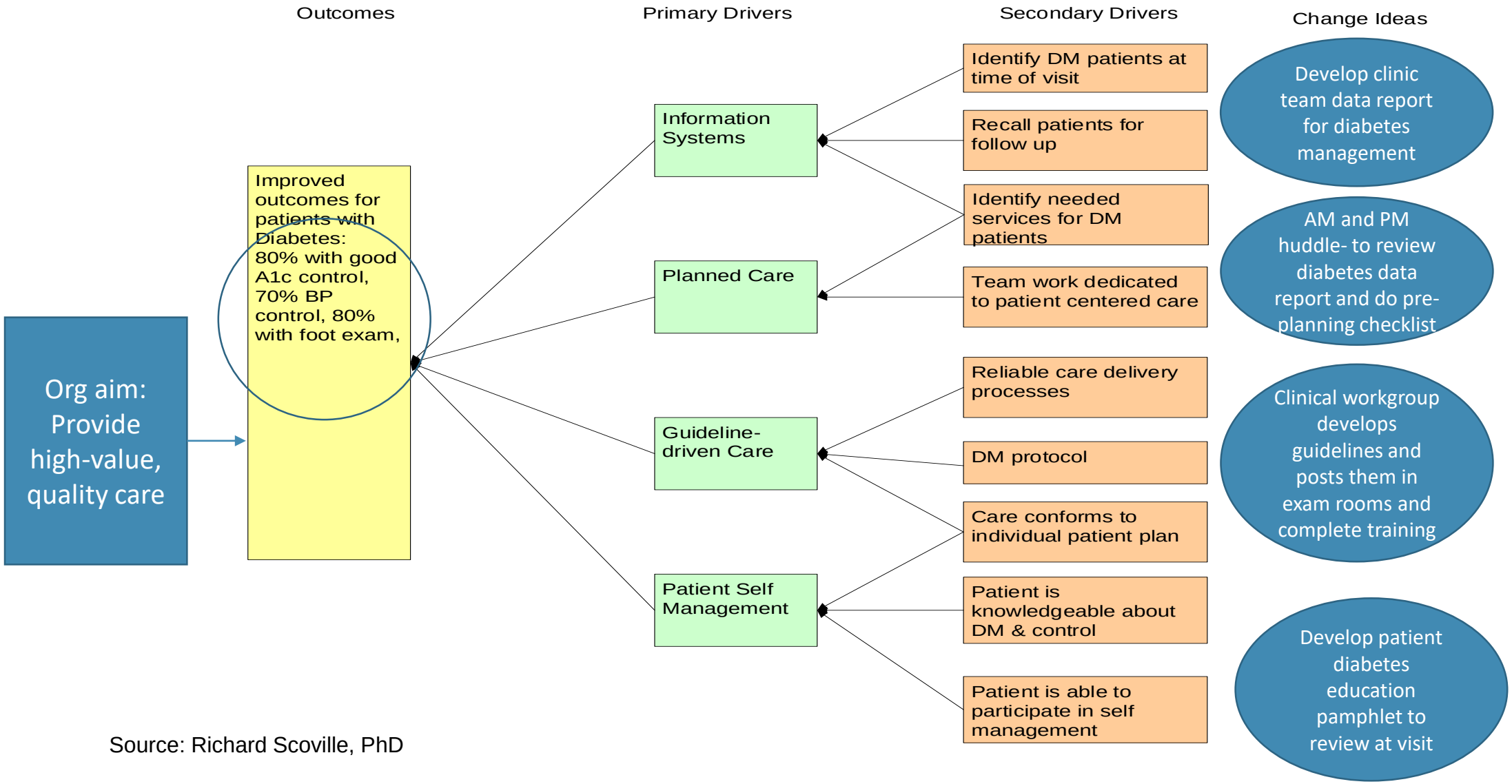
Secondary Drivers

- Structures, processes, or aspects of culture that contribute to desired outcomes
- Evidence based: from the clinical or improvement literature
- Necessary and sufficient for improvement

Aims and Measures

- Your aim contains your outcome measure (s)
  - 1-3 outcomes are best
- Outcome measures are typically longer indicators of progress/success
- Three types of measures
  - Outcome – “the voice of your project”
  - Process – relates to your secondary drivers or changes
  - Balancing – evaluates unintended consequences
- Process measures are earlier indicators of success

Diabetes driver diagram



Source: Richard Scoville, PhD

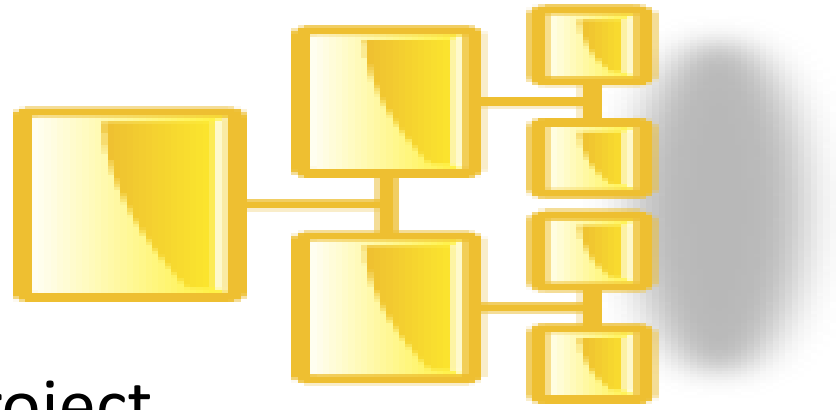
Table exercise – 5 minutes

- Identify 3 process measures for the diabetes diagram
- Identify 1 balancing measure

Tips

- Include those who know the work, front line staff
- If primary drivers aren’t known, start with secondary drivers
  - Cluster common ideas together to identify primary drivers
  - No more than 6 drivers
- Include patients to validate drivers and to develop changes to test
- It’s iterative

Team time and share out



- 20 minutes: start a driver diagram for your project
  - Begin identifying primary and secondary drivers for your project
  - Complete at least one primary driver and one secondary driver
- 10 minutes: pair up with another team, present your diagram
  - Can you consolidate the primary drivers?
  - Ideas for secondary drivers?
- 10 minutes: who wants to share?
  - What are your drivers?
  - What surprised you about this experience?

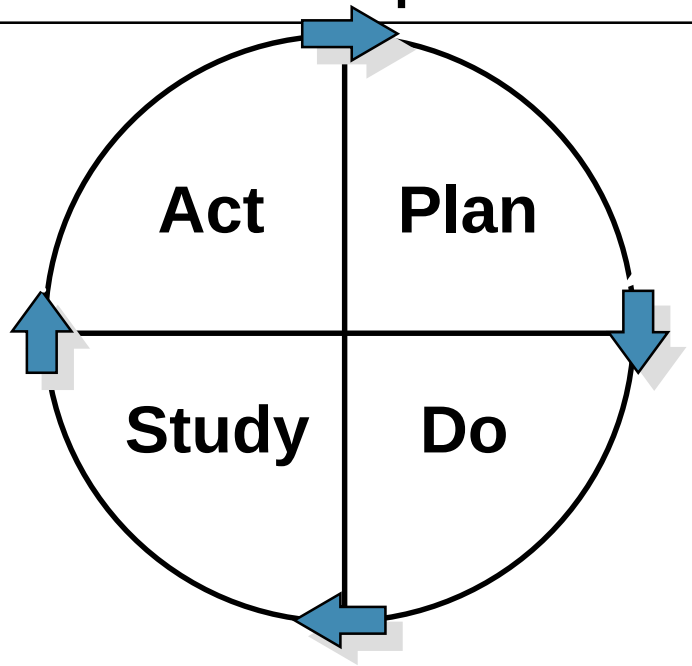
Develop and test changes

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What changes can we make that will result in improvement?



From Associates in Process Improvement.

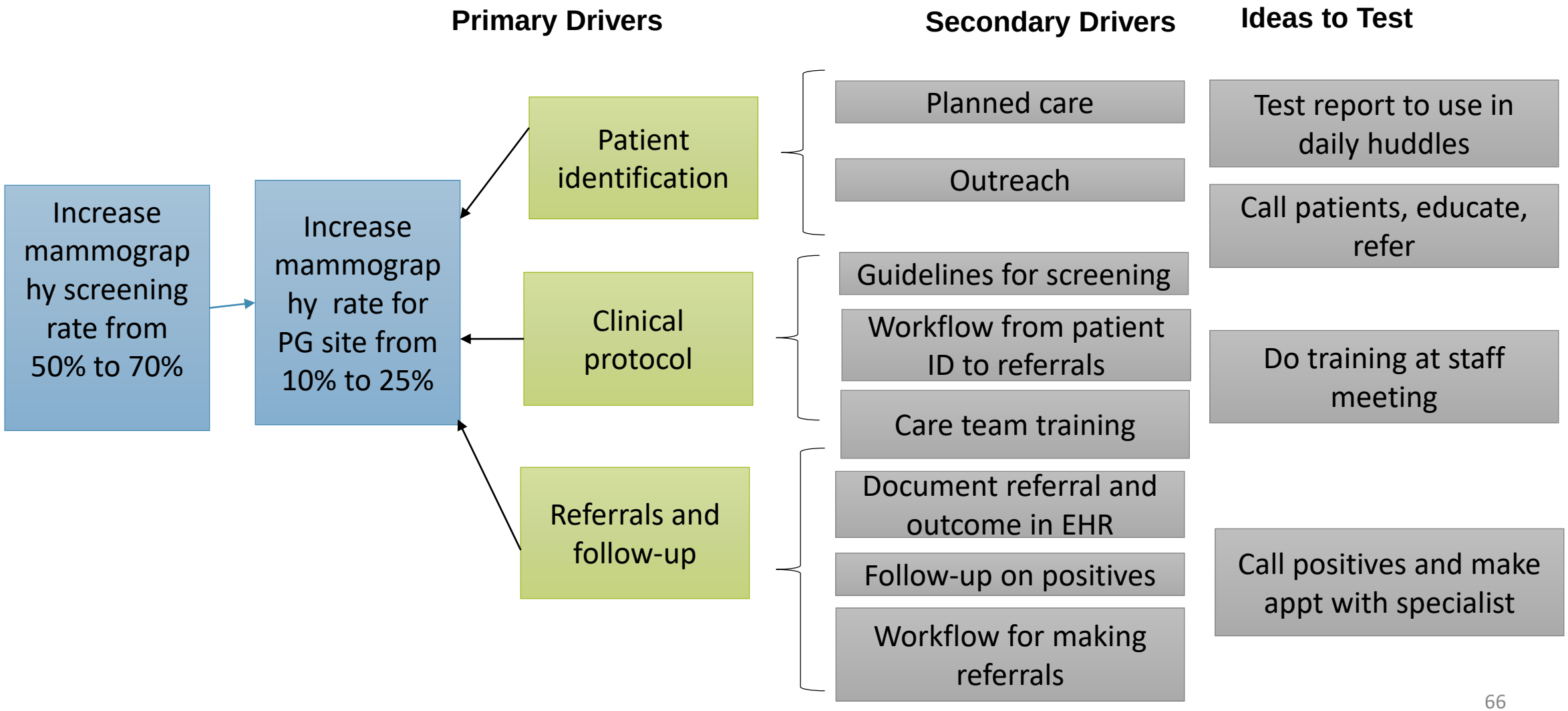
Identify changes

- Process mapping
- Driver diagrams
- Change packages
- Great ideas from site visits, conferences, etc.

Brainstorming

- 1-2-4 All
- Pick a primary or secondary driver
  - 1 minute: what ideas do you have?
  - 2 minutes: pair up, and share
  - 4 minutes: pair up with a team (now your four)
  - All: share two great ideas

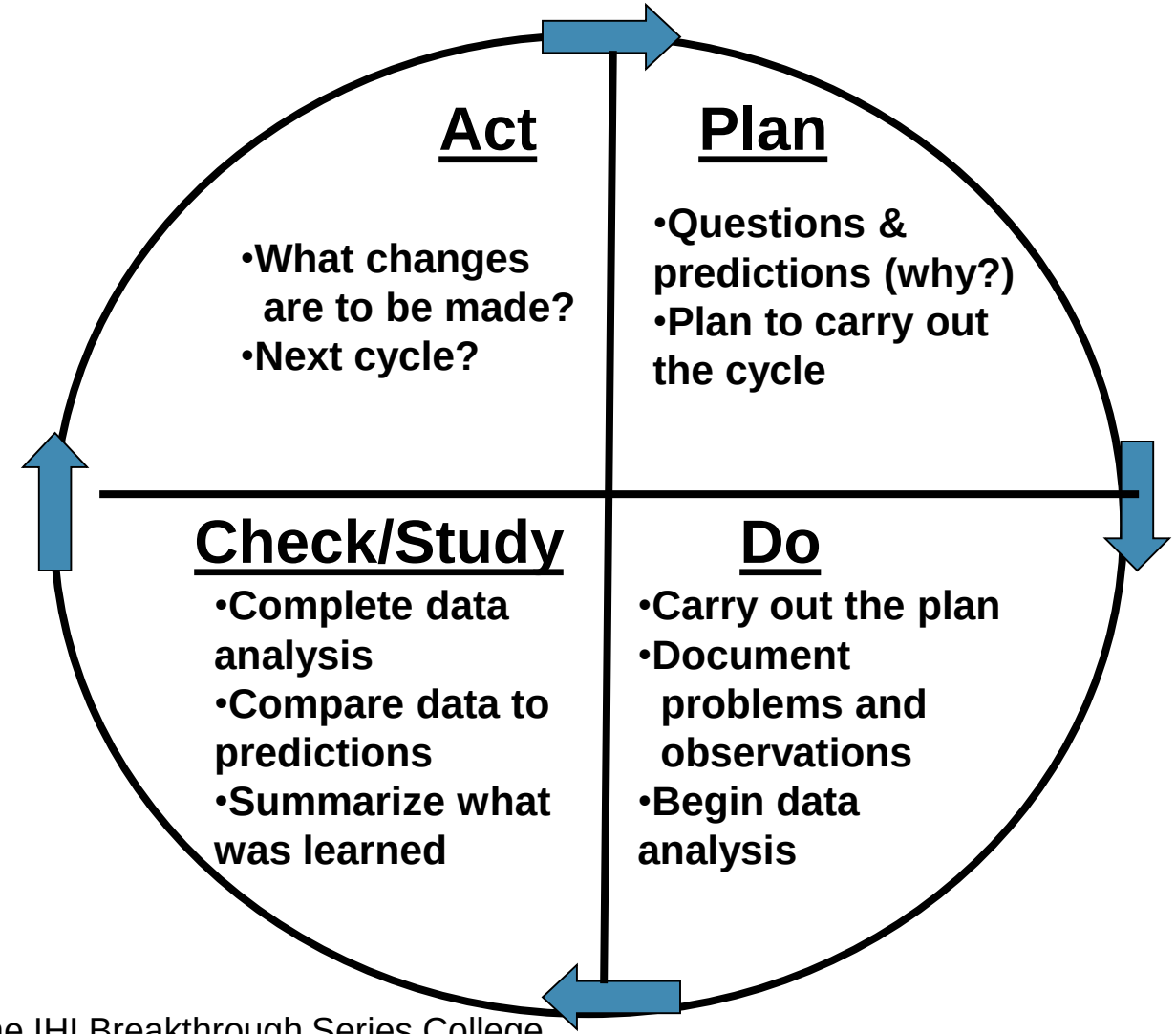
Example – mammography screening



Charter elements

1) Define your problem – what is the case for change?
2) What are your goals? – what are the outcomes you are hoping to achieve?
3) How do your goals fit in with your larger org-wide goals? – within which focus area or larger org wide goal does this project fit into?
4) What changes will help you reach your goals? – secondary drivers and changes to try
5) How will you know a change is an improvement? – measures, record your outcome, process and balancing measures

Rapid Cycle Improvement - PDSA



Adapted from the IHI Breakthrough Series College

Why Do Small Tests of Change?

- Understand the likelihood that change will result in improvement
- Understand the extent and limitations of the change
- Learn to adapt the change to local environment
  - **Evaluate cost**
  - **Address unexpected consequences**
- Gain buy-in and minimize resistance if change is implemented and spread

Adapted from the IHI Breakthrough Series College

Action Plan Worksheet

- PLAN: Activities and timelines, including person responsible
- DO: Describe what actually happened during test
- STUDY: Review data collected during plan phase and compare to predictions
- ACT: Determine what to change and what to keep based on previous plan cycle (this is a new PLAN)

Next steps

- Draft your first PDSA
- Does your charter line up with your driver diagram?
  - What works?
  - What doesn’t?

Worksheets

- Driver diagram template
- Tracking multiple PDSAs worksheet
- Charter for Improvement worksheet

Time for Lunch

Faculty are available if you have questions!

Leveraging Effective Team-based Care

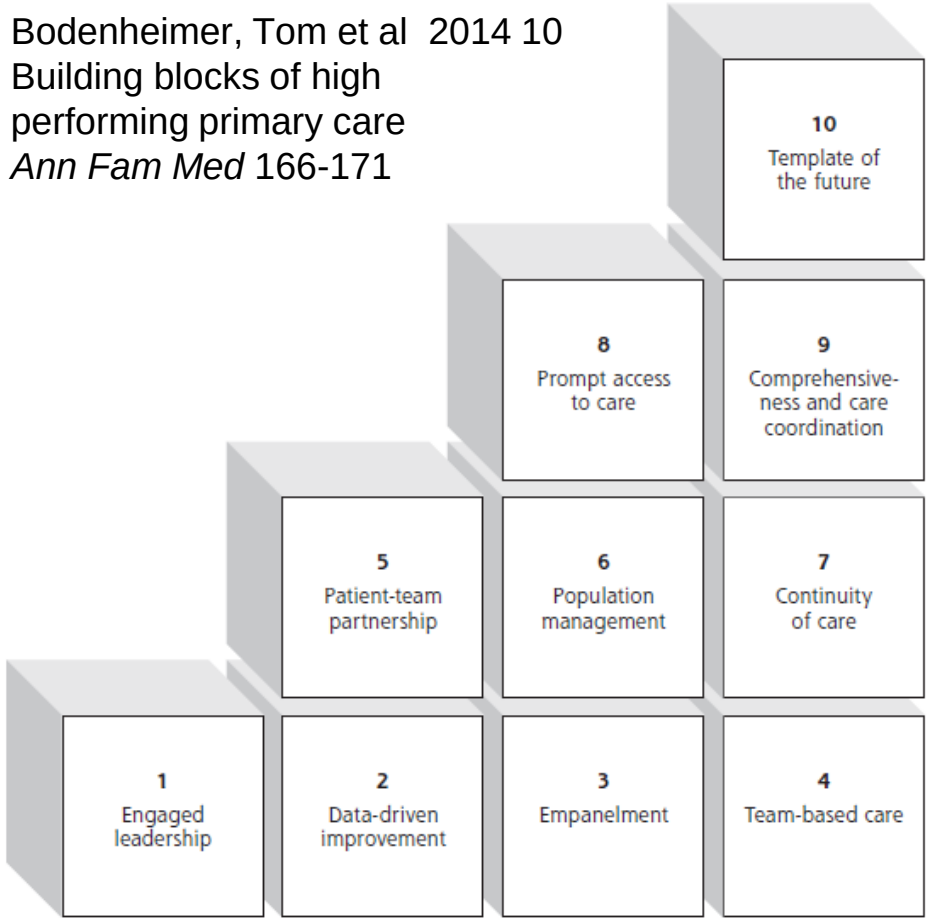
October 19, 2017

Carolyn Shepherd
Veena Channamsetty
Mary Blankson

Build Systems that Work

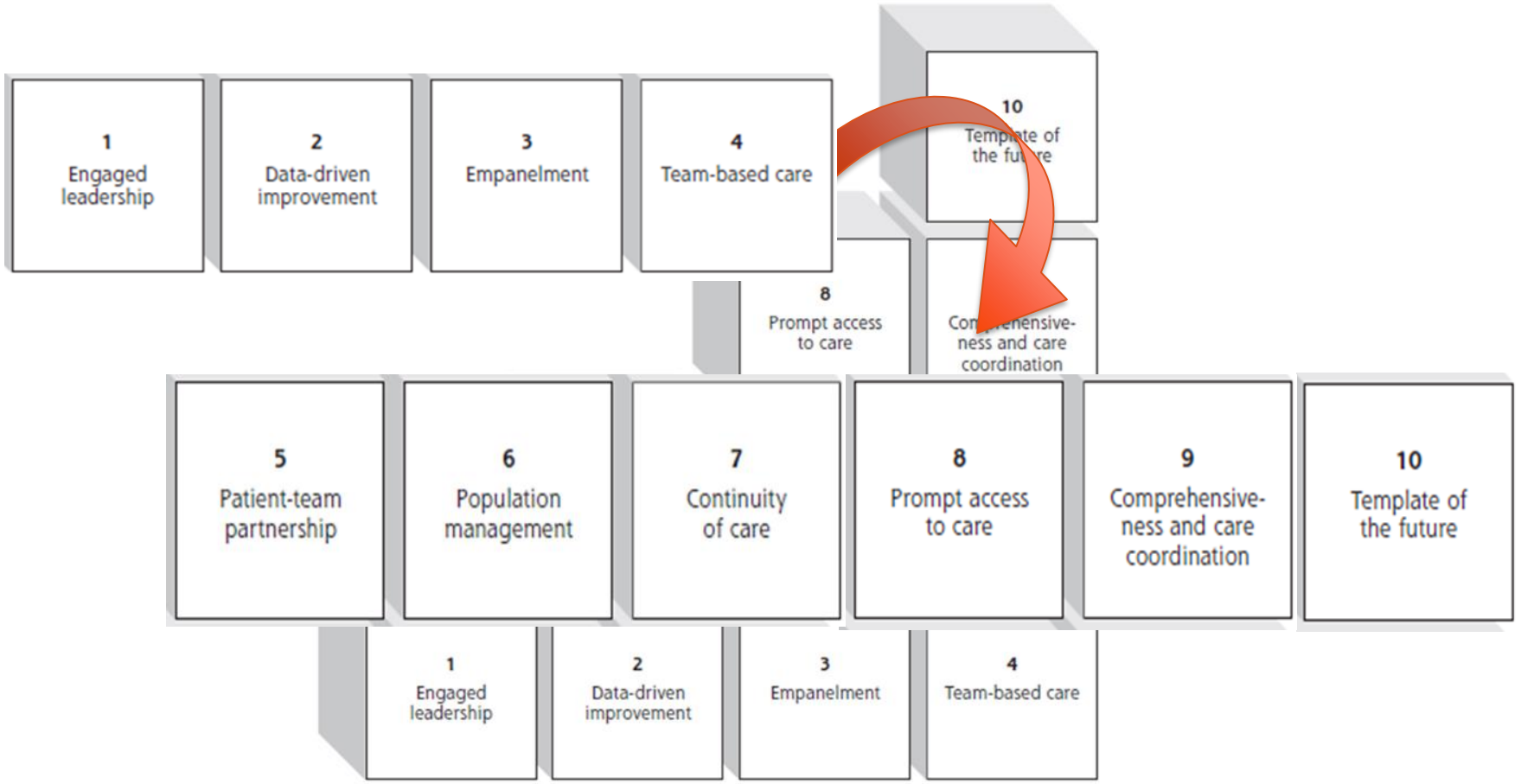
Figure 1. Ten Building blocks of high-performing primary care.

Bodenheimer, Tom et al 2014 10 Building blocks of high performing primary care *Ann Fam Med* 166-171



Fundamentals Matter

The standard work functions of primary care



High Performing Primary Care Teams

RPCC Regional Primary Care Coalition

CCI CENTER FOR CARE INNOVATIONS

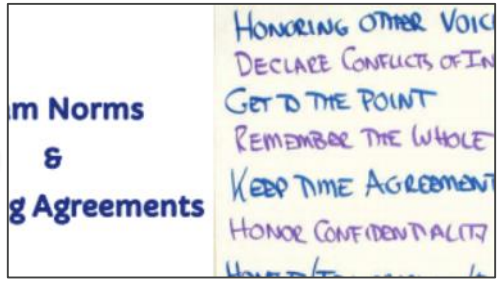
KAISER PERMANENTE

TEAM WORK

Build the Team

+

Build Team Culture



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TASK WORK

Do the Work

=

Excellent Performance of Critical Functions

Team Work-Build the Team

1. **Identify organizational leadership for teams and start building a team culture**

2. **Develop a core care team structure or structures**
   - Centralized vs core team
   - What are the needs of our patients now?
   - Start with what you have
   - Consider what you can add
   - TEST IT
   - Reduce variation

Team Work-Build the Team

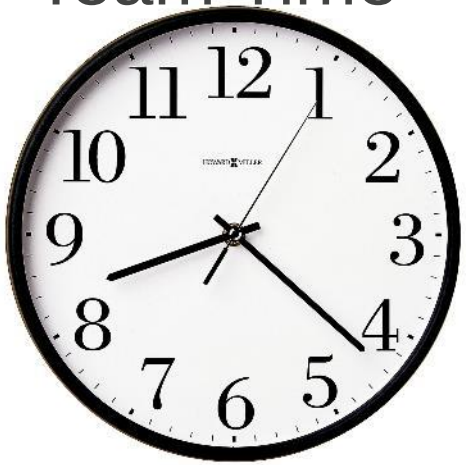
3. Develop clear roles and responsibilities for every member of the team

- Work at the top of the skillset and credentials
- Expand the roles of additional staff members
- Research state policies regarding licensure and scope of practice
- Partner with union personnel.

Team Work-Build the Team

1. **Identify organizational leadership**
2. **Develop a core team structure**
3. **Develop clear roles and responsibilities**

Team Time



How can your leadership and present team structure support your aim of providing Value Based Care? How are roles and responsibilities documented? (#1)

Team Work-Build the Team

4. Encourage and enable staff to work independently.

- Culture of independence of the team
- Develop standard work processes for the delivery of common services
- Maximize the use of standing orders

Team Work-Build the Team

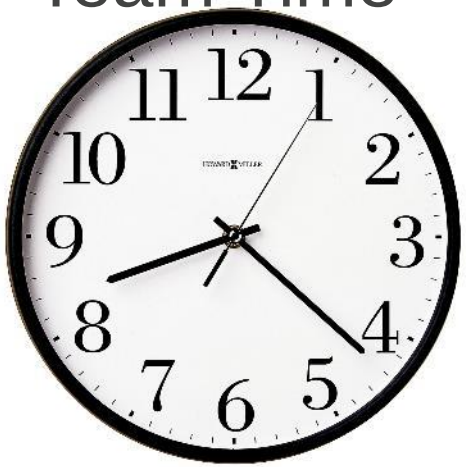
5. Engage patients as a member of the care team and help them understand what they can expect in a team-based model of care.

- Introduction to practice for new patients
- Help established patients understand what to expect in a team-based care model
- Develop simple scripting that reinforces the model

Team Work-Build the Team

4. **Enable staff to work independently**
5. **Engage patients as members of the care team**

Team Time



Do you have the right people on your team, including patients to reach your aim? Can they initiate the work of your aim independently? (#2)

Team Work-Build the Team

6. Provide team members with regular, dedicated time and support

- Meet about patient care and quality improvement
- Facilitate strong team relationships
- Provide USEFUL timely information for improvement
- Provide tools and resources

Team Work-Build the Team

7. Provide training so that staff members learn new tasks and learn how to coordinate with team members.

- Staff members learn new tasks
- Team members learn how to coordinate care delivery

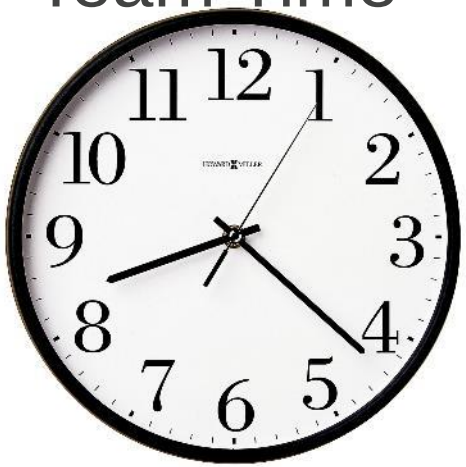
Team Work-Build the Team

8. Develop career ladders for staff

- Recruitment
- Retention
- Justice

Team Work-Build the Team

Team Time



6. **Provide team members with time and support**
7. **Provide training on tasks and how to coordinate to get the work done**
8. **Develop career ladders for staff**

Do you have the necessary support structures (time, information, training, opportunity) to ensure your Team Work is effective in addressing your aim? (#3)

Team Work-Build the Culture

- **Shared Goals**
- **Clear Roles**
- **Mutual Trust**
- **Effective Communication**
- **Measurable Processes and Outcomes**

Mitchell, Pamela et al October 2012 IOM Roundtable on Value and Science-Driven Health Care. Core Principles and Values of Effective Team-Based Health Care

High Performing Primary Care Teams

RPCC Regional Primary Care Coalition

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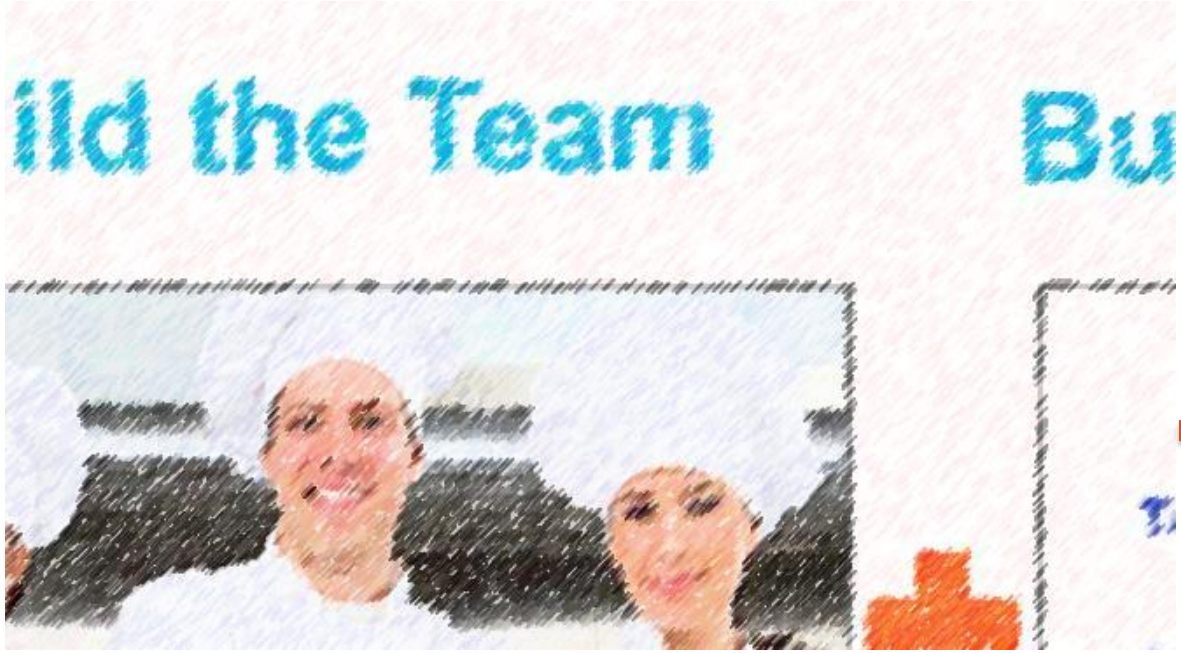


TASK WORK

Do the Work

Excellent Performance of Critical Functions

Task Work

1. Assess performance.

- Evaluate practice systems and ability to execute key functions with ambulatory guide assessments such as PCMH-A, BBPCA or PCTGA.

Block 6: Population management

Components	Level D	Level C	Level B	Level A
27. A patient who comes in for an appointment and is overdue for preventive care (e.g., cancer screenings)	...will only get that care if they request it or their provider notices it.	...might be identified as being overdue for needed care through a health maintenance screen or system of alerts, but this is inconsistently used.	...will be identified as being overdue for care through a health maintenance screen or system of alerts that is used consistently, but clinical assistants may not act on these overdue care items without patient-specific orders from the provider.	...will be identified as being overdue for care through a health maintenance screen or system of alerts that is used consistently, and clinical assistants may act on these overdue care items (e.g., administer immunizations or distribute colorectal cancer screening kits) based on standing orders.
Score	1 2 3	4 5 6	7 8 9	10 11 12
28. A patient who comes in for an appointment and is overdue for chronic care (e.g., diabetes lab work)	...will only get that care if they request it or their provider notices it.	...might be identified as being overdue for needed care through a health maintenance screen or system of alerts, but this is inconsistently used.	...will be identified as being overdue for care through a health maintenance screen or system of alerts that is used consistently, but clinical assistants may not act on these overdue care items without patient-specific orders from the provider.	...will be identified as being overdue for care through a health maintenance screen or system of alerts that is used consistently, and clinical assistants may act on these overdue care items (e.g., complete lab work) based on standing orders.
Score	1 2 3	4 5 6	7 8 9	10 11 12
29. When patients are overdue for preventive (e.g., cancer screenings) but do not come in for an appointment	...there is no effort on the part of the practice to contact them to ask them to come in for care.	...they might be contacted as part of special events or using volunteers but outreach is not part of regular practice.	...they would be contacted and asked to come in for care, but clinical assistants may not act on these overdue care items without patient-specific orders from the provider.	...they would be contacted and asked to come in for care, and clinical assistants may act on these overdue care items (e.g., distribute colorectal cancer screening kits) based on standing orders.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Task Work

2. Build and maintain effective core teams.

- **Plan for reassessment of core team**
- Build relationship with the patient
- Include resources and time.

Task Work

3. Use rapid cycle tests of change to evaluate process changes

- Improving key functions is complex disruptive change management
- Be rigorous about applying improvement science

Task Work

4. Make new or improved functions standard work and sustainable.

- Leadership critical
- Dismantle old systems
- Incorporate change in training, HR (pay structure, promotions, recruitment…)

Be a Learning Organization…

- Make the fundamentals solid- leadership, data-driven improvement, empanelment and team-based care
- Study and understand what worked and what didn't work
- Apply this knowledge to the next challenge
- Develop a standardized process that centers on the patient and works for your clinic

Break

Team Time: CFI Updates

Tammy Fisher

Wrap Up – What's Next?

In Summary

Effective team-based care

- 10 Building Blocks for High Performing Primary Care
- CHC's journey toward high performing team-based care

Driving change and improvement in your goals

- Using driver diagrams to visualize your project's goals, measures, and key drivers

Leveraging team-based care to achieve your project goals

- 3-part framework: build the team, do the task work, create the team culture
- CHC's team-based care approach

Strengthening charters & developing changes

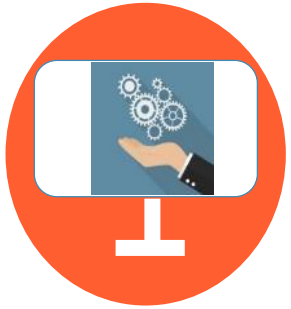
- Change ideas for your projects
- Rework charters

What's Next?

CFI & Progress Reports

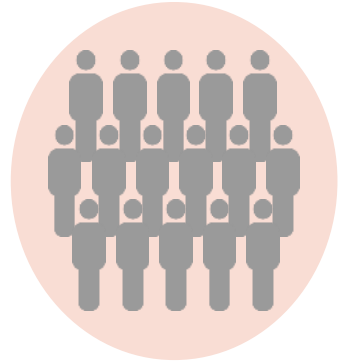
Site visits

Coaching with Tammy & Carolyn



Resource Center

Quarterly Webinars



Learning Sessions

Site Visits

Santa Ana, CA

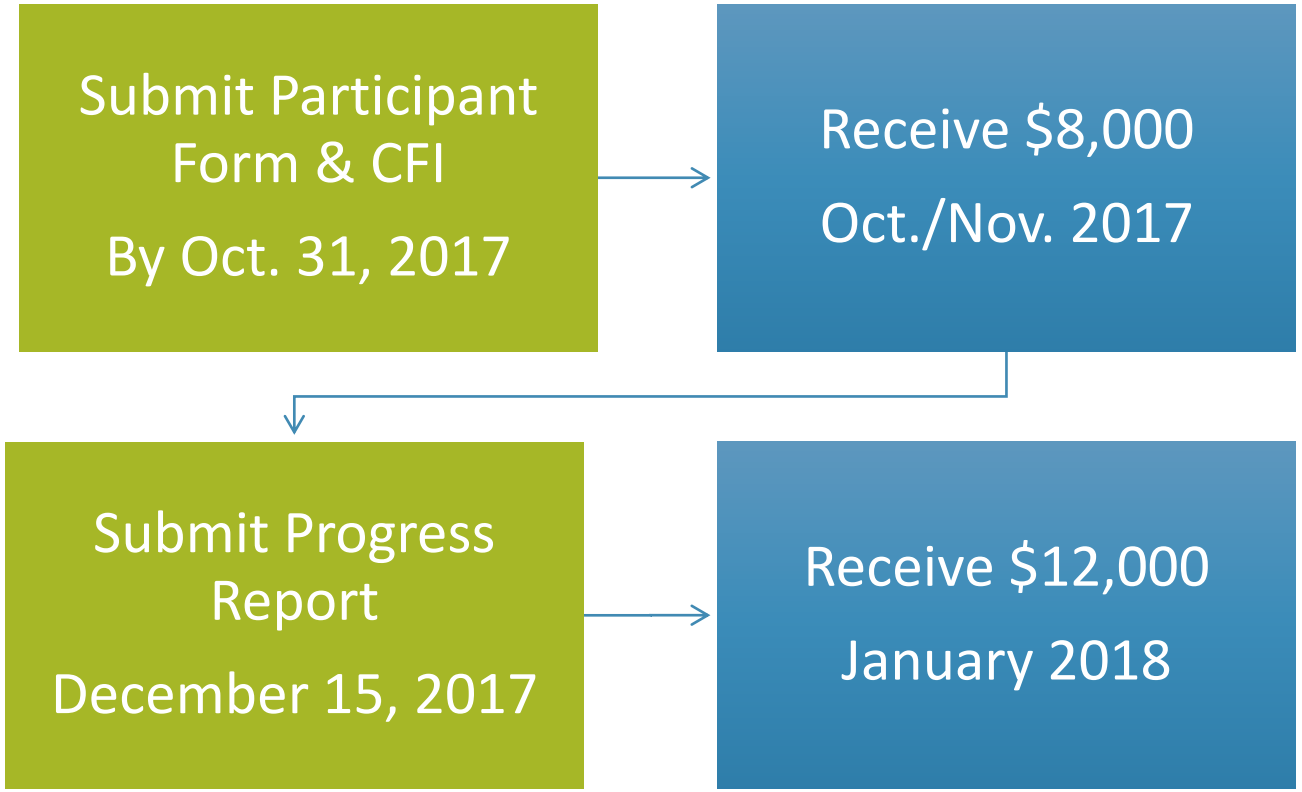
Wednesday, December 13, 2017

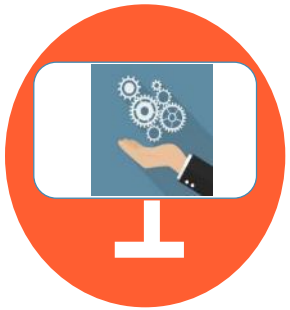
Middletown, CT

Wednesday, January 17, 2018

Register your team by October 30th

Charter for Improvement & Progress Reports





Resource Center Live Tour

KP Transformation Accelerator

Grantee Resource Center for Mid-Atlantic Region Grantees

Home | Program Resources | Technical Assistance Hub | About | Contact

Program Updates

We will share program information and resources related to the Transformation Accelerator program on this site. Program updates are below and will be updated on a regular basis. For other questions, contact us.

Announcements & Reminders

- **In-Person Learning Session #1:** Click here for details and registration.
- **Site Visits:** Click here for details and registration.
- **October 31 – Final day to submit Participant Form and CFI:** Please submit this form to confirm your participation in the Accelerator program and to receive the first installment of grant funding.
- **August 8 – Informational Webinar:** Slides and recording can be found here.

Quick Links

» Program Calendar

» Technical Assistance Hub

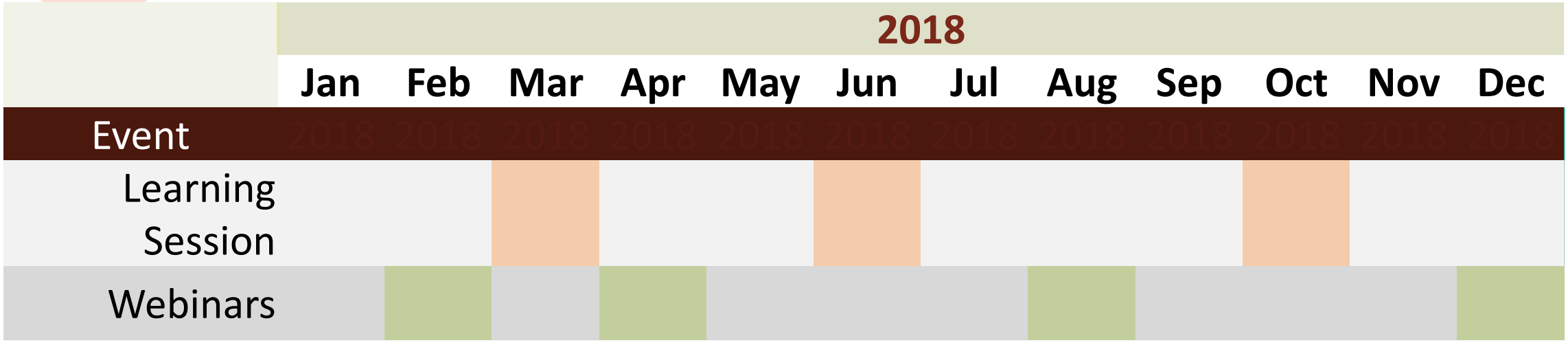
» All TA Opportunities

» Contact

Don't see the resources you're looking for?

Request other training »

Learning Sessions & Webinars



Learning Session Dates and Topics

1. March 22, 2018 | Planned Care
2. June 28, 2018 | Data Analytics
3. October 2018 | Population Health Management

What is your biggest take away?

What did you appreciate today?

Closing

CONTACT INFORMATION

- Tammy Fisher: tammy@careinnovations.org
- Alexis Wielunski: alexis@careinnovations.org

THANK YOU!