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
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
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 = patient outcomes + experience 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

<table>
<thead>
<tr>
<th>Quality Improvement Strategy</th>
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<td>Team Changes</td>
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<tr>
<td>All Interventions</td>
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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

High Performing Primary Care Teams

TEAM WORK

Build the Team

Build Team Culture

TASK WORK

Do the Work

Excellent Performance of Critical Functions
KPTA PGC Framework

Accelerate Sustained Transformation
Delivering High Value Care
Improving Systems of Care
Leveraging High Performing Teams
Optimizing Teamwork and Taskwork

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

**THREE FOUNDATIONAL PILLARS**

1. Clinical Excellence
2. Research and Development
3. Training the Next Generation
The Components of Integration

- Leadership Structure
- Facilities/Systems
- Workflow/Processes
- Training
- Evaluation
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

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<th>Last PCP Visit</th>
<th>Last Dental Visit</th>
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Self-Management Goal in EHR

Self-Management Goal Details
## Planned Care Dashboard

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<tr>
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<td></td>
</tr>
</tbody>
</table>

### Patient Details

- **Sex:** F
- **Age:** 12.0

- Last Medical Appointment: 9/8/2016 11:00:00 AM
- Last Dental Visit: 9/11/206
- Reason for Visit: initial/physical w/ twin brother

### Alerts

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<th>Due Date</th>
<th>Value</th>
<th>Notes</th>
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<td>Needs Flu Vaccine 2016-2017</td>
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<td>Depression Screening</td>
<td>Never</td>
<td>Done</td>
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### Patient Details

- **Sex:** F
- **Age:** 63.0

- Next Medical Appointment: 9/8/2016 1:20:00 PM
- Last Dental Visit: 5/5/2016
- Reason for Visit: pre-op

### Alerts

<table>
<thead>
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<th>DATES</th>
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<th>Due Date</th>
<th>Value</th>
<th>Notes</th>
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<td>DMP Foot Exam</td>
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<td>7/24/2016</td>
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</tbody>
</table>

### DATES

- **Bubblies**: TE, 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-lead 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

### Diabetes Analysis

<table>
<thead>
<tr>
<th>Last Visit Targets</th>
<th>Averages</th>
<th>A1C In Last Year</th>
<th>Avg Systolic</th>
<th>Avg Diastolic</th>
<th>Avg A1C</th>
<th>Last Encounter W/PCP</th>
<th>Last Retinal Screening</th>
<th>Last Foot Exam</th>
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<tr>
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<td>Diastolic BP</td>
<td>A1C</td>
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<td>130</td>
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<td>93</td>
<td>6.66</td>
<td>3/13/2015 10:00 AM</td>
<td>5/30/2014</td>
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</table>
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

- **Services:**
  - 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
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

**HIV Dashboard**

<table>
<thead>
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<th>Provider</th>
<th>Controlz.</th>
<th>First Diagnoses Date</th>
<th>Last Medical Encounter Date</th>
<th>Viral Load</th>
<th>HIV Medication</th>
<th>CD4 value</th>
<th>CD4 Prophylaxis</th>
<th>Last LDL Encounter</th>
<th>Last PPD Encounter</th>
<th>Last RPR Encounter</th>
<th>Last Chlamydia Encounter</th>
<th>Last Gonorrhea Encounter</th>
<th>PHQ Screen</th>
<th>Last Hiv Screen Date</th>
</tr>
</thead>
</table>

- **Total Patients:** 591
- **Selected Providers:** 111
CENTER FOR KEY POPULATIONS

Mission:
To ensure that every patient at CHC receives comprehensive care in a respectful manner within a safe environment.

Purpose:
To guarantee that key populations in the communities we serve have a central and cohesive focus within CHC.

https://www.chcl.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

Behavioral Health from the Beginning → Separate Buildings, Paper Charts → Integrating Facilities Integrated Care Record → Innovate Practices: Changing the Way We Operate → Next Steps
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
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

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<th>Intake</th>
<th>Last Therapist</th>
<th>Last Psychiatry Provider</th>
<th>Initial Care/Plan</th>
<th>Last Review</th>
<th>Last Discharge</th>
<th>Last PHQ</th>
<th>Controlled Substance</th>
<th>Auth/Boyd</th>
<th>Alerts</th>
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For New Britain Medical

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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
Processes

- Seamless Scheduling

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## Interdisciplinary Care Initiatives

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Thank you!

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

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

Community Health Center, Inc.
675 Main Street, Middletown, CT, 06457
www.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

Org-wide Aims

Aim Statement (outcome measures)

Primary Drivers

Secondary Drivers

Ideas to Test
Increase mammography screening rate from 50% to 70%

Increase mammography rate for PG site from 10% to 25%

Patient identification

Clinical protocol

Referrals and follow-up

Primary Drivers

Secondary Drivers

Planned care

Outreach

Guidelines for screening

Workflow from patient ID to referrals

Care team training

Document referral and outcome in EHR

Follow-up on positives

Workflow for making referrals

Ideas to Test

Test report to use in daily huddles

Call patients, educate, refer

Do training at staff meeting

Call positives and make appt with specialist
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
Improved outcomes for patients with Diabetes: 80% with good A1c control, 70% BP control, 80% with foot exam.

Outcomes

Primary Drivers

- Information Systems
- Planned Care
- Guideline-driven Care
- Patient Self Management

Secondary Drivers

- Identify DM patients at time of visit
- Recall patients for follow up
- Identify needed services for DM patients
- Team work dedicated to patient centered care
- Reliable care delivery processes
- DM protocol
- Care conforms to individual patient plan
- Patient is knowledgeable about DM & control
- Patient is able to participate in self management

Change Ideas

- Develop clinic team data report for diabetes management
- AM and PM huddle - to review diabetes data report and do pre-planning checklist
- Clinical workgroup develops guidelines and posts them in exam rooms and complete training
- Develop patient diabetes education pamphlet to review at visit

Org aim: Provide high-value, quality care

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
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

**Primary Drivers**
- Increase mammography screening rate from 50% to 70%
- Increase mammography rate for PG site from 10% to 25%
- Patient identification
- Clinical protocol
- Referrals and follow-up

**Secondary Drivers**
- Planned care
- Outreach
- Guidelines for screening
- Workflow from patient ID to referrals
- Care team training
- Document referral and outcome in EHR
- Follow-up on positives
- Workflow for making referrals

**Ideas to Test**
- Test report to use in daily huddles
- Call patients, educate, refer
- Do training at staff meeting
- Call positives and make appt with specialist
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

Act
- What changes are to be made?
- Next cycle?

Plan
- Questions & predictions (why?)
- Plan to carry out the cycle

Check/Study
- Complete data analysis
- Compare data to predictions
- Summarize what was learned

Do
- Carry out the plan
- Document problems and observations
- Begin data analysis

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

Fundamentals Matter

The standard work functions of primary care
High Performing Primary Care Teams

TEAM WORK

- Build the Team
- Build Team Culture

+ =

TASK WORK

- Do the Work

Excellent Performance of Critical Functions
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
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

How can your leadership and present team structure support your aim of providing Value Based Care? How are roles and responsibilities documented? (#1)
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
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
4. Enable staff to work independently
5. Engage patients as members of the care team

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)
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
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
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

Build the Team

Do the Work

Excellent Performance of Critical Functions
1. Assess performance.
   - Evaluate practice systems and ability to execute key functions with ambulatory guide assessments such as PCMH-A, BBPCA or PCTGA.
2. Build and maintain effective core teams.
   - Plan for reassessment of core team
   - Build relationship with the patient
   - Include resources and time.
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
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

Submit Participant Form & CFI
By Oct. 31, 2017

Receive $8,000
Oct./Nov. 2017

Submit Progress Report
December 15, 2017

Receive $12,000
January 2018
Resource Center Live Tour

KP Transformation Accelerator
Grantee Resource Center for Mid-Atlantic Region Grantees

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

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## 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?
CONTACT INFORMATION

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• Alexis Wielunski: alexis@careinnovations.org

THANK YOU!