CCI
CENTER FOR CARE INNOVATIONS

Pre-Visit Planning: Using Data and Optimizing Care Team Roles

Today's Webinar Agenda

1. Welcome and Introductions
2. Pre-Visit Planning and Why it Matters
3. The CHC, Inc. Model of Pre-Visit Planning
4. CCI Health & Wellness: Improving Cervical Cancer Screening through Pre-Visit Planning
5. Q&A and Closing

Our Faculty

Carolyn Shepherd

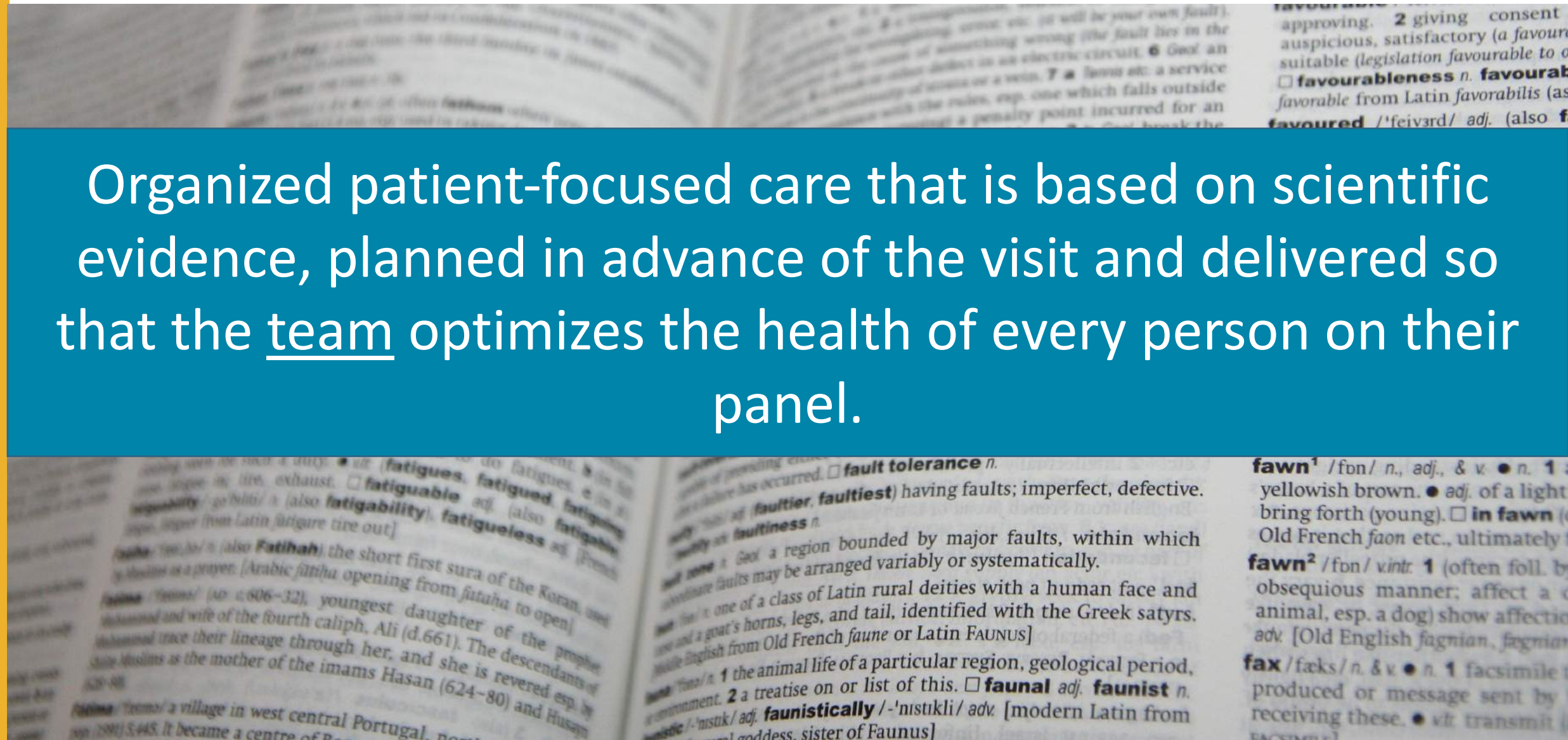
Tierney Giannotii

Mary Blankson

Kameela Clark

Marcela Cámpoli

Planned Care Definition



Organized patient-focused care that is based on scientific evidence, planned in advance of the visit and delivered so that the team optimizes the health of every person on their panel.

Planned Care-*KP Transformation Accelerator*

Primary Prevention

- Prevention of disease and promotion of wellness
  - Dental sealants
  - Cervical cancer prevention
  - Improving access

Secondary Prevention

- Prevention of complications caused by disease
  - HIV primary care

GREATER BADEN MEDICAL SERVICES
Primary and Preventive Health Care

CCI health & wellness services

Mary's Center

FAMILY AND MEDICAL COUNSELING SERVICE, INCORPORATED
FMCS
we care

LA CLÍNICA DEL PUEBLO

Why focus on Planned Care?

Exhibit 2. Health Care System Performance Rankings

1=best of eleven countries 11=worst of the eleven countries

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING	**2**	**9**	**10**	**8**	**3**	**4**	**4**	**6**	**6**	**1**	**11**
Care Process +	2	6	9	8	4	3	10	11	7	1	5
Access +	4	10	9	2	1	7	5	6	8	3	11
Administrative Efficiency +	1	6	11	6	9	2	4	5	8	3	10
Equity +	7	9	10	6	2	8	5	3	4	1	11
Health Care Outcomes +	1	9	5	8	6	7	3	2	4	10	11

Mirror, Mirror: How the US Health Care System Compares Internationally at a Time of Radical Change, The Commonwealth Fund, July 2017

Why Focus on Planned Care?

2016 UDS	US	Maryland	KPTA
Cervical Cancer Screening	54	50	62
First Molar Sealants	49	57	28
Asthma controller meds	87	90	91
CAD-Lipid lowering therapy	80	84	82
IVD-Anti-platelet therapy	78	82	80
Controlled HTN	64	62	60
HgbA1c>9	16*	28	35

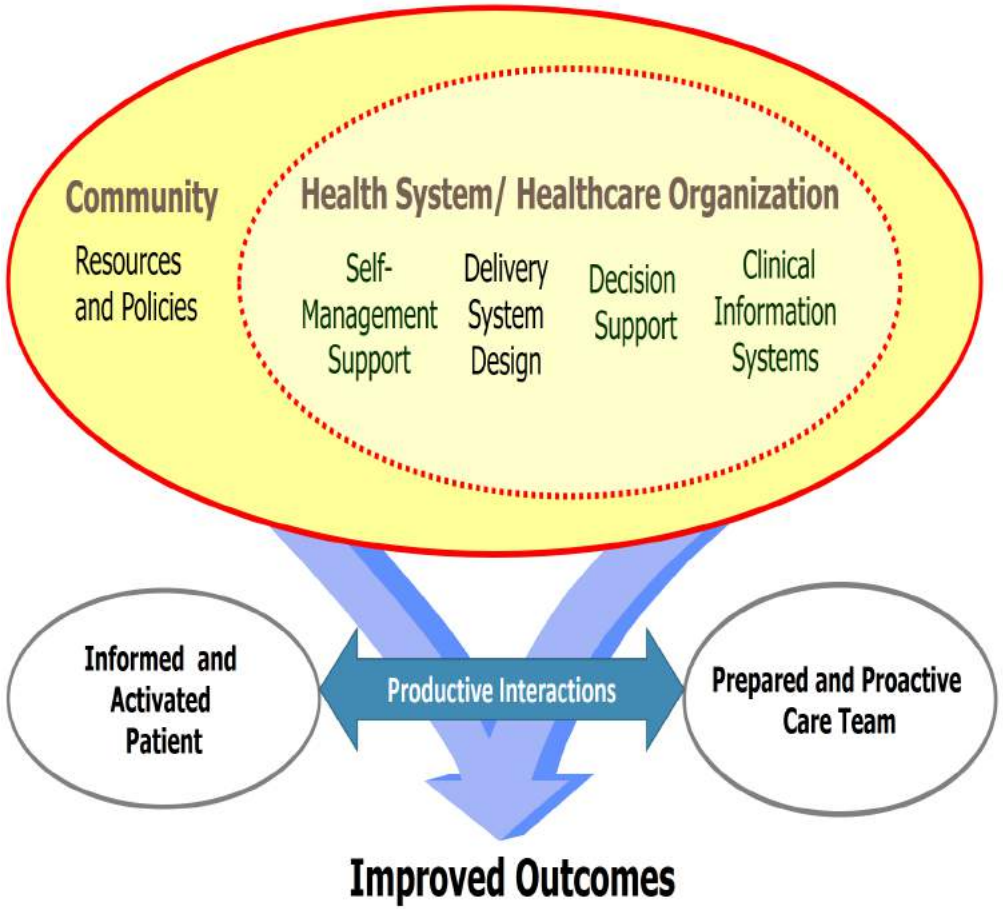
*National diabetes data from 2014

Why Focus on Planned Care?

Though we have made progress, we are not where we need to be:

- The patients come with their own agenda
- Lack of time in the visit
  - Rushed practitioners can't follow guidelines
  - Teams lack time & data to prepare for the visit
  - Lack of time to build relationships
- Patients not-yet-engaged
- Lack of care coordination and planned care
  - Lack of active follow-up

Planned Care and the Chronic Care Model



- Titer to the patient need
- Identify high-risk patients
- Use point-of-care reminders
- Enable planned interactions
- Clinicians stay focused on patient's agenda

Evidence on the Chronic Care Model in the new millennium. Health Aff. 2009;28(1):75-85
Coleman K, et al

Useful Data to Facilitate Planned Care

Clinica Family Health Services
Lafayette, Colorado

CarePlanner

		PCP: Farrell, Edward **Status**: Active **Payer**: Medicare Clinica FQHC **Group Visits**: DM EF		57 Year(s)	M	04/04/2014 Farrell, E **CarePlan Rvw**: 4/12/13

Alerts	Appts	Active Problem List
Past Due - Diabetes Eye Exam Past Due - Yearly Substance Risk Screening (SBIRT) Past Due - Self Management Goal (Diabetes, Hypertension, Anticoagulation,) Past Due - CRC Screen (colonoscopy, sig or FOBT) Due Now - INR - Last INR 2.30 on 4/4/14 Target 3.00 - 4.00 2 Wks - Last A1c 7 - 9 on 02/07/2014 Abnormal Body Mass Index - was 48.81 on 02/07/2014	Appt on 04/25/2014 at 08:20AM for BRF-Follow Up And INR with Farrell, Edward Appt on 04/25/2014 at 08:20AM for BRF-Follow Up And INR with Thornton Charlotte Ricchetti PharmD	08/23/2013 - S/P CABG x 1, in 1999 and 2001-V45.81 08/20/2013 - Hx of PE x 2 and DVT x 3 - 415.19 01/09/2013 - Hyperlipidemia LDL goal <70 - 272.4 03/15/2012 - Obesity - 278.00 03/15/2012 - Unspecified essential hypertension - 401.9 06/01/2010 - DM w/renal manifest, type II - 250.40 10/02/2009 - Emphysema - 492.8 Anticoagulant therapy - V58.61 Chronic ischemic heart disease - 414.9

Active Medications

Start Date	Stop Date	Brand Name	Generic Name	Dose	Instructions
01/08/2014	01/08/2015	HUMULIN R	INSULIN REGULAR, HUMAN	100 unit/mL	30 units SQ TID before meals and sliding scale
01/08/2014	01/08/2015	METOPROLOL TARTRATE	METOPROLOL TARTRATE	100 mg	take 1 tablet by oral route 2 times every day with meals
10/22/2013	10/21/2014	WARFARIN SODIUM	WARFARIN SODIUM	5 mg	take 2 Tablet by oral route every day
08/30/2013	08/29/2014	HUMULIN N	NPH, HUMAN INSULIN ISOPHANE	100 unit/mL	inject 120 units by Subcutaneous route every morning and 100 units every evening
08/23/2013	08/23/2014	ALBUTEROL SULFATE HFA	ALBUTEROL SULFATE	90 mcg	inhale 1 - 2 Puff(s) by INHALATION route every 4 - 6 hours as needed
08/16/2013	08/17/2014	GLUCOPHAGE	METFORMIN HCL	1,000 mg	1 tablet twice daily
08/16/2013	08/16/2014	AMLODIPINE BESYLATE	AMLODIPINE BESYLATE	10 mg	take 1 tablet (10MG) by ORAL route every day
07/02/2013	07/02/2014	CRESTOR	ROSUVASTATIN CALCIUM	40 mg	take 1 tablet by oral route every day (stop lipitor)
05/13/2013	05/12/2014	FUROSEMIDE	FUROSEMIDE	80 mg	take 1 tablet by oral route 2 times every day
05/07/2013	05/08/2014	METOLAZONE	METOLAZONE	5 mg	take 1 tablet (5MG) by oral route every day

Diabetes - High Risk

Systolic	Diastolic	Eye Exam	Foot Exam	A1c (Last 3)
120	66	06/23/11	8/23/13	02/07/2014 - 8.0 01/17/2014 - 8.0 11/15/2013 - 8.4

Group Visit: DM EF

Anticoagulation

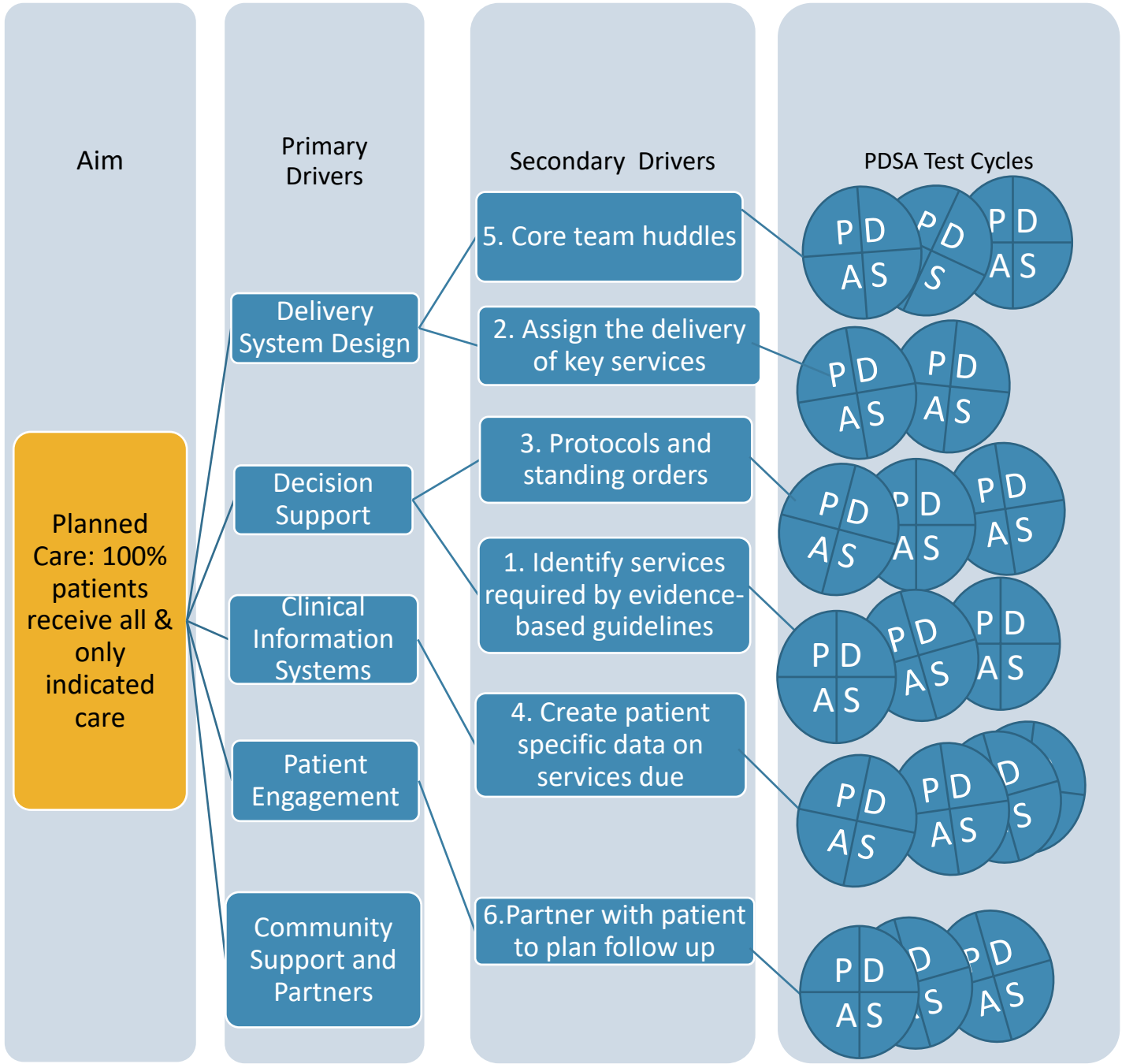
Indication(s)	Therapy Start	Therapy Durtion	INR	Goal Range	Risk
7111-OTH PULMONARY EMBOLISM&INFARCTION	01/01/1997	lifelong	4/4/2014 - 2.30 3/21/2014 - 3.90 3/7/2014 - 2.20	3.00 - 4.00	Low

Open Referrals	Future Labs	Diagnostics
11/15/2013 - Referral: Orthopedics. Evaluate and treat.		06/20/2013 - scheduled - MRI, cervical spine, w/o contrast -

Six Steps to Providing Planned Care

1. Identify the common services required by evidence-based guidelines
2. Assign the delivery of key services to specific staff and ensure that they are trained
3. Use protocols and standing orders to allow staff to act independently
4. Efficiently generate patient-specific data on services that are due
5. Huddle with the core practice team and review patient before clinic sessions
6. Patient engagement

Planned Care: a key component of high quality care



Want to learn more?

- McGlynn EA, Asch SM, Adams J, Keesey J, Hicks J, DeCristofaro A, Kerr EA. The quality of health care delivered to adults in the United States. N Engl J Med. 2003 Jun 26;348(26):2635-45. PubMed PMID: 12826639.
- Bodenheimer T, Grumbach K. Improving Primary Care: Strategies and Tools for a Better Practice. New York, NY: McGraw Hill Medical (Lange); 2007.
- E. C. Schneider, D. O. Karnak, D. Squires, A. Shah and M. M. Doty, *Mirror, Mirror: How the US Health Care System Compares Internationally at a Time of Radical Change,* The Commonwealth Fund, July 2017
- Coleman K, Austin BT, Brach C, Wagner EH. Evidence on the Chronic Care Model in the new millennium. Health Aff. 2009;28(1):75-85
- Coleman K, Wagner E, Schaefer J, Reid R, LeRoy L. Redefining Primary Care for the 21st Century. White Paper. (Prepared by Abt Associates, in partnership with the MacColl Center for Health Care Innovation and Bailit Health Purchasing, Cambridge, MA under Contract No.290-2010-00004-I/ 290-32009-T.) AHRQ Publication No. 16(17)-0022-EF. Rockville, MD: Agency for Healthcare Research and Quality; October 2016.
- Safety Net Medical Home Initiative Planned Care Organized, evidence-based care
- Improvingprimarycare.org Do the Work Planned Care Module

POLL: What are your greatest challenges with pre-visit planning?

- Hard to get data from current systems
- Roles not clearly defined
- Lack of agreement on evidence-based guidelines and protocols
- Unclear workflows
- Not trusting that others can get the work done
- Other (please chat this in to the chat box)

Planned Care at Community Health Center, Inc.

Mary Blankson, DNP, APRN, FNP-C
Chief Nursing Officer
Tierney Giannotti, MPA
Senior QI Manager of Population Health

Background: Planned Care at CHC

- **Why was change needed?**
  - Cumbersome process
  - Involved searching in multiple different locations of the EHR
  - Time spent prepping for no-shows
  - Lack of prep patients booked same day or as walk ins
  - Focus only on 8-10 planned care items

Planned Care Dashboard (PCD) Purpose

- 2014: CHCI implemented the PCD to:
  - Improve overall efficiency of patient visits by:
    - Anticipating the needs of patients
    - Supporting the work of MAs

- PCD lists:
  - Preventive care services /screenings
  - Evidence based care for chronic illnesses
  - unaddressed or open items in the health record

Currently: there are 40 measures on the PCD

Aims	Primary Drivers	Secondary Drivers	PDSA Test Cycles
Improve Screening Mammogram rates by 10% in a 12 month period	Delivery System Design	E-huddle vs. Morning huddle	
	Decision Support	Assign Responsibility/ Measure Success	
	Clinical Information System	Standing Orders/ Templates	
	Patient Engagement	SDOH/Barriers Assessment	
	Partner Radiology Centers	Care Coordination / Community Linkages to care	
	Resources for the Uninsured	Pathway for Access to Care	

Breast Cancer Screening: Area for Improvement

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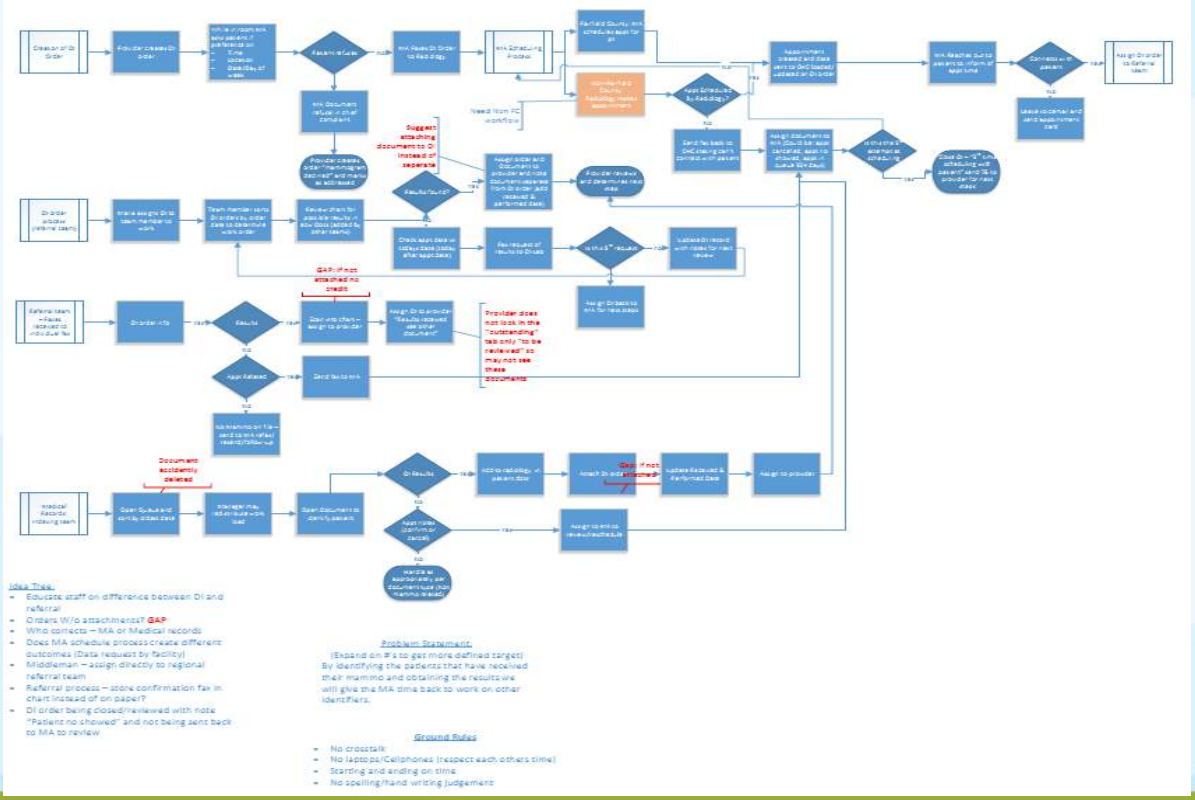

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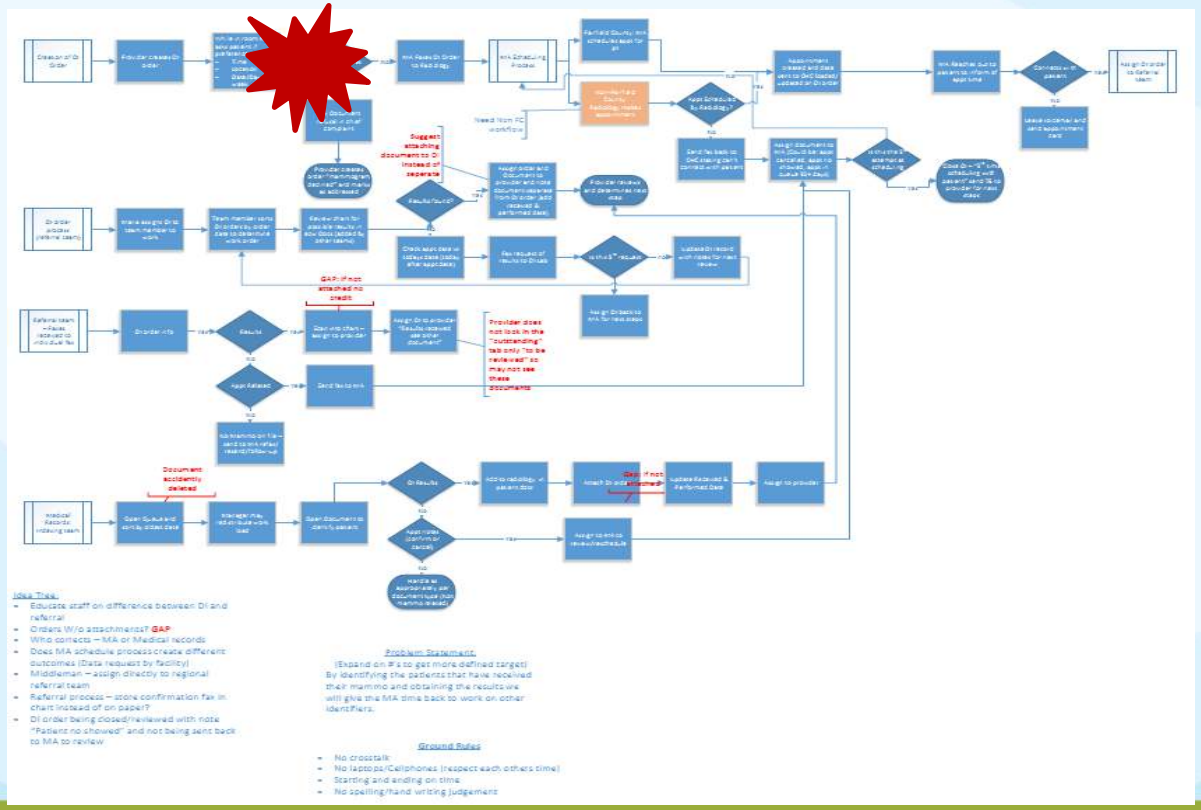

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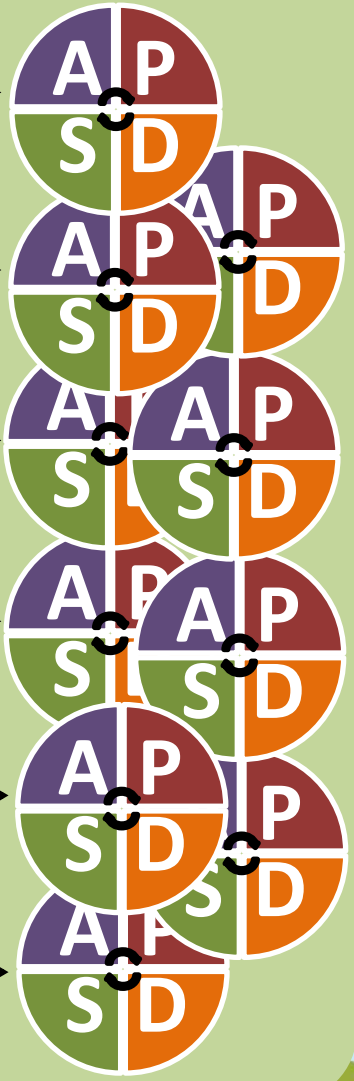
Improve Screening Mammogram Ordering by 10% in a 12 month period	Delivery System Design	E-huddle vs. Morning huddle	
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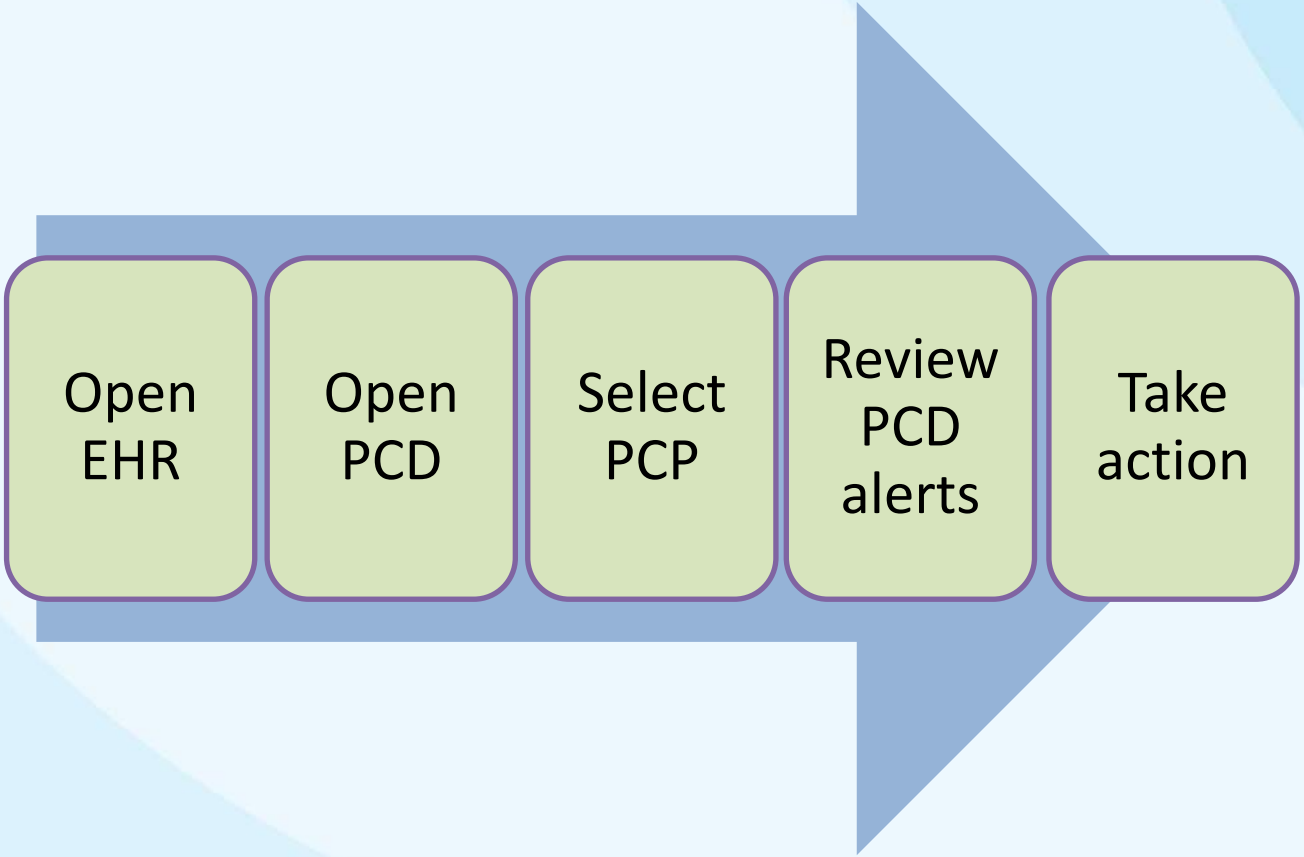
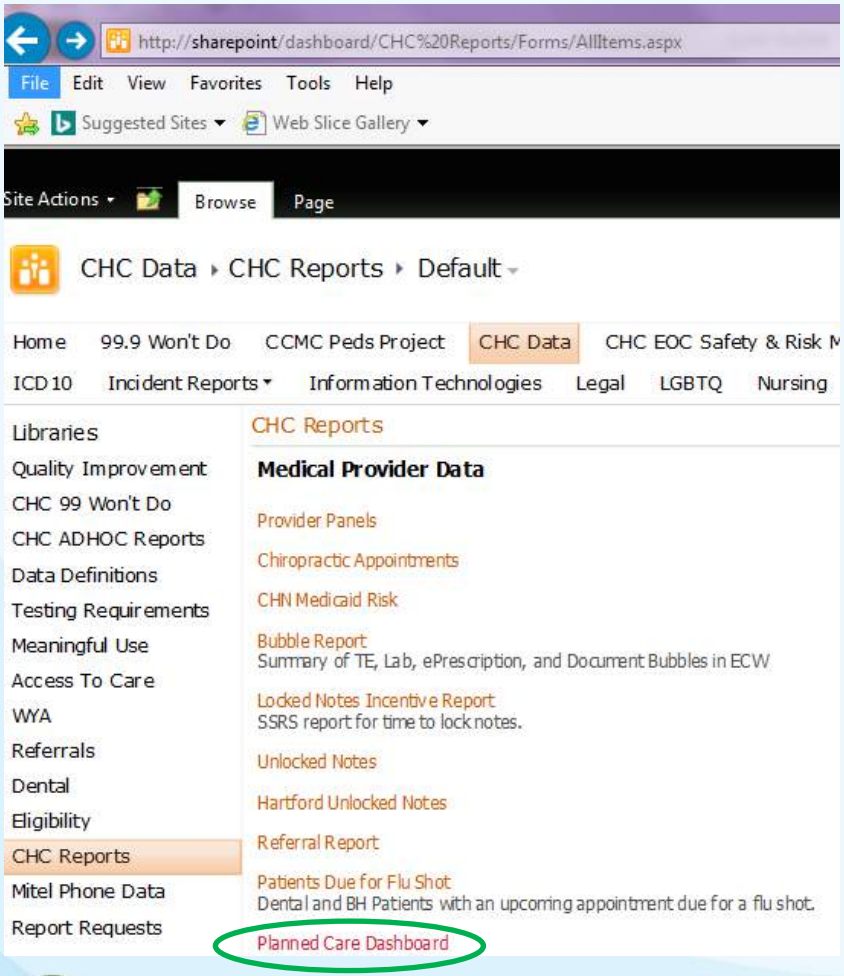
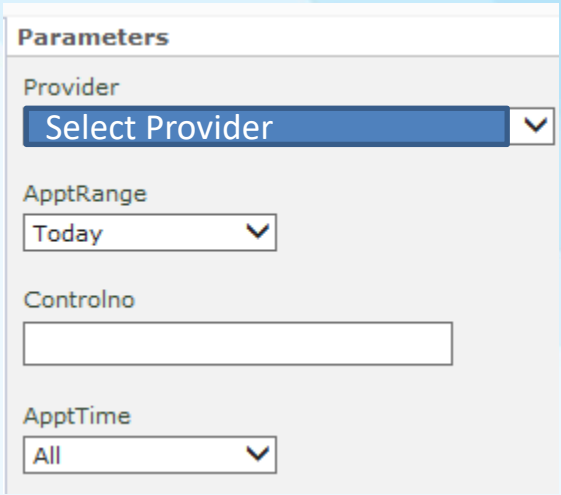
	~~tie~~	~~H/B~~ ~~s~~	
	Partne ology	Care ation / Co nity Link care	
	~~Re he~~ ~~nsu~~	~~w r~~ ~~ss t e~~	

Steps in Planned Care for MAs



Open Planned Care Dashboard & Select Provider





Planned Care Dashboard Display

Provider Name

Data as of : 1/23/2018

Contact Us!

Appointment Range	Data Legend	
Display only patients with an upcoming appointment within the selected range.	In Compliance Out of Compliance Order in Progress Not in Denominator	3/15/2015 A date indicates that a Due Date is upcoming or has past.

Patient	PCP and Visit Info
ID Sex: F Age: 19.0	Provider Name Next Medical Appointment: 1/24/2018 9:00:00 AM Last Dental Visit: 8/28/2017 Reason for Visit: ED F/U Pregnancy

ALERTS	Last Date	Due Date	Value	Notes
DM Retinopathy	Never Done	Never Done		Ordered in last 30 days.
ACT	5/30/2017	Every Visit	25	>19 is good control
HPV	Done of	Never Done		
Chlamydia Screen	Never Done	Never Done		
Depression Screening	11/15/2016	11/15/2017		

Bubbles	#
TE	
RX	
Doc	2
Lab	

Split Screen: PCD and EHR

Patient	PCP and Visit Info
ID Sex: M Age: 44.0	Provider Name Next Medical Appointment: 1/24/2018 10:00:00 AM Last Dental Visit: Never Done Reason for Visit: f/u meds

ALERTS	Last Date	Due Date	Value	Notes
WHO CANDIDATE				
Needs Flu Vaccine 2017-2018				
Body Mass Index	10/20/2017		29.93	Needs Education
SBIRT	Never Done			Yearly, 18+ yrs old

Bubbles	#
TE	
RX	1
Doc	
Lab	

Office Visits

P R | Provider Name | Appt. Time All Day | View All

Facility | CHC of Meriden Medical | sel | < 01/24/2018 > | Sort by Appt Time

	Visit Type	Appt Time	Patient Name	P/R	Reason	Sex	Age	Visit St	Arr Time
	Physicalc	09:40 AM	Patient Name	DP	*MED PCP Recall - HP. WCC	F	6M 5D	ARR	09:50 AM
	Est MD 20/	10:00 AM		DP	suboxone JS	M	23 Y	ARR	10:01 AM
	Est MD 20/	10:00 AM		DP	*MED PCP Recall - HP. HCV End of Tx f/u; Inhaler effi	M	52 Y	ARR	09:47 AM
	Est MD 20/	10:40 AM		DP	f/u appt	M	25 Y	ARR	10:41 AM
	Est MD 20/	11:00 AM		DP	f/u catre--cdd	M	47 Y	ARR	10:56 AM
	Est MD 20(	11:20 AM		DP	f/u	F	8Y 7M	ARR	11:01 AM
	Est MD 20/	11:40 AM		DP	suboxone JS	M	50 Y	ARR	11:48 AM
	24 Hour Ap	02:00 PM		DP	f/u on diabetic regimen s/p d/c from YNHH 1/19/2018	M	59 Y	ARR	01:52 PM
	Est MD 20(	02:40 PM		DP	excessive coughing, s/p ER d/c for uti	F	2M 27D	ARR	02:03 PM

Tool for PCD: Mammograms

PCD Item	Patient Population	How Often	What MA/LPN Does (or other clinical staff)

Breast Cancer Screening (turns red 3 months prior to due date)
 	
(yellow for 30 days once the mammogram has been ordered or declined)
	Women age 50 to 74	Every 24 months	• Ask the patient if she has had a mammogram in past 24 months. If yes, complete Non ROI ROI and send to the facility where she got it done and order a "Mammogram Outside" (via Manage Orders) **[MA]**
			
			• If she had not had one, order a mammogram using DI.
			
			  ◦ Order DI = Mammogram – Bilateral Screening [MA}
			  ◦ Mammogram – Bilateral Diagnostic [Prov]
			  ◦ Mammography screening with U/S –Hospital specific [MA/Prov]
			
			• If she declines, order a "Mammogram Declined" (via Manage Orders) **[MA] with provider permission** or **[Prov]**
			
			• Once results come in: Results checked as "Received" , "Collection Date" entered and "Attached" **[MA]** or Medical Records
			
			• DI Result "Reviewed" **[Prov]**

Missed Opportunities

- (notes -Patient agenda and planned care agenda)

Missed Opportunity Report

Week of 1/7/2018

Completed / Opportunities (%Completed)

Provider	Cervical Cancer	Breast Cancer	Colon Cancer	Diabetes A1c	Diabetes Retinopathy	Diabetes Foot Exam	Asthma Control Med	Asthma ACT	CAD Lipid Med	IVD Aspirin
Agency Average	44/678 (6.5%)	92/400 (23.0%)	47/461 (10.2%)	74/113 (65.5%)	0/80 (0.0%)	5/55 (9.1%)	1/8 (12.5%)	194/448 (43.3%)	2/8 (25.0%)	2/9 (22.2%)
Provider Names	0/0	0/0	0/0	0/0	0/0	0/0	0/0	5/10 (50.0%)	0/0	0/0
	0/16 (0.0%)	2/6 (33.3%)	3/8 (37.5%)	0/0	0/0	0/0	0/1 (0.0%)	11/11 (100.0%)	0/0	0/0
	4/21 (19.0%)	4/10 (40.0%)	8/15 (53.3%)	1/2 (50.0%)	0/1 (0.0%)	0/1 (0.0%)	0/0	7/8 (87.5%)	0/0	0/0
	0/9 (0.0%)	0/10 (0.0%)	0/5 (0.0%)	0/2 (0.0%)	0/1 (0.0%)	0/1 (0.0%)	0/0	0/5 (0.0%)	0/0	0/0
	1/8 (12.5%)	3/7 (42.9%)	0/10 (0.0%)	2/2 (100.0%)	0/2 (0.0%)	0/2 (0.0%)	0/0	3/12 (25.0%)	0/0	0/0
	0/4 (0.0%)	0/1 (0.0%)	1/1 (100.0%)	0/0	0/0	0/0	0/0	1/2 (50.0%)	0/0	0/0
	0/22 (0.0%)	1/14 (7.1%)	1/13 (7.7%)	1/5 (20.0%)	0/4 (0.0%)	0/4 (0.0%)	0/0	1/9 (11.1%)	0/0	0/0

Medical Assistant Performance Appraisal

MA Performance Appraisal Data: Agency and Site Average and Your Rate

Time Period: 7/1/2016-6/30/2017

MA Name: _____

Measure	Agency Average	Meriden Average	Your Rate
Depression Screening	81.4%	87.9%	
Smoking Assessment	100.0%	100.0%	
Colon Cancer Screening	61.2%	63.7%	
A1C	83.0%	80.3%	
Literacy in Social History	51.1%	56.0%	
Initial appointments documented	32.7%	39.5%	
Chaperone for all well women visits	60.8%	81.4%	
SOGI	90%	96%	
PEDS Screening	58.7%	71.2%	
HIV	78.7%	83.7%	
Child BMI Percentile	99.7%	99.3%	
Child Weight Education	85.6%	91.9%	
Asthma -ACT	78.9%	72.1%	
Adult BMI	98.6%	98.3%	
Adult Weight Education	73.4%	70.5%	
Chlamydia	33.3%	30.8%	
Planned Care Dashboard	630		
SBIRT	45%	77%	

Key:

Red box indicates the site average is statistically significantly lower than the agency average.

Green box indicates the site average is statistically significantly higher than the agency average.

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Literacy in Social History	51.1%	49.6%	
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Chaperone for all well women visits	60.8%	41.8%	
SOGI	90%	92%	
PEDS Screening	58.7%	70.3%	
HIV	78.7%	83.0%	
Child BMI Percentile	99.7%	99.7%	
Child Weight Education	85.6%	87.8%	
Asthma -ACT	78.9%	89.2%	
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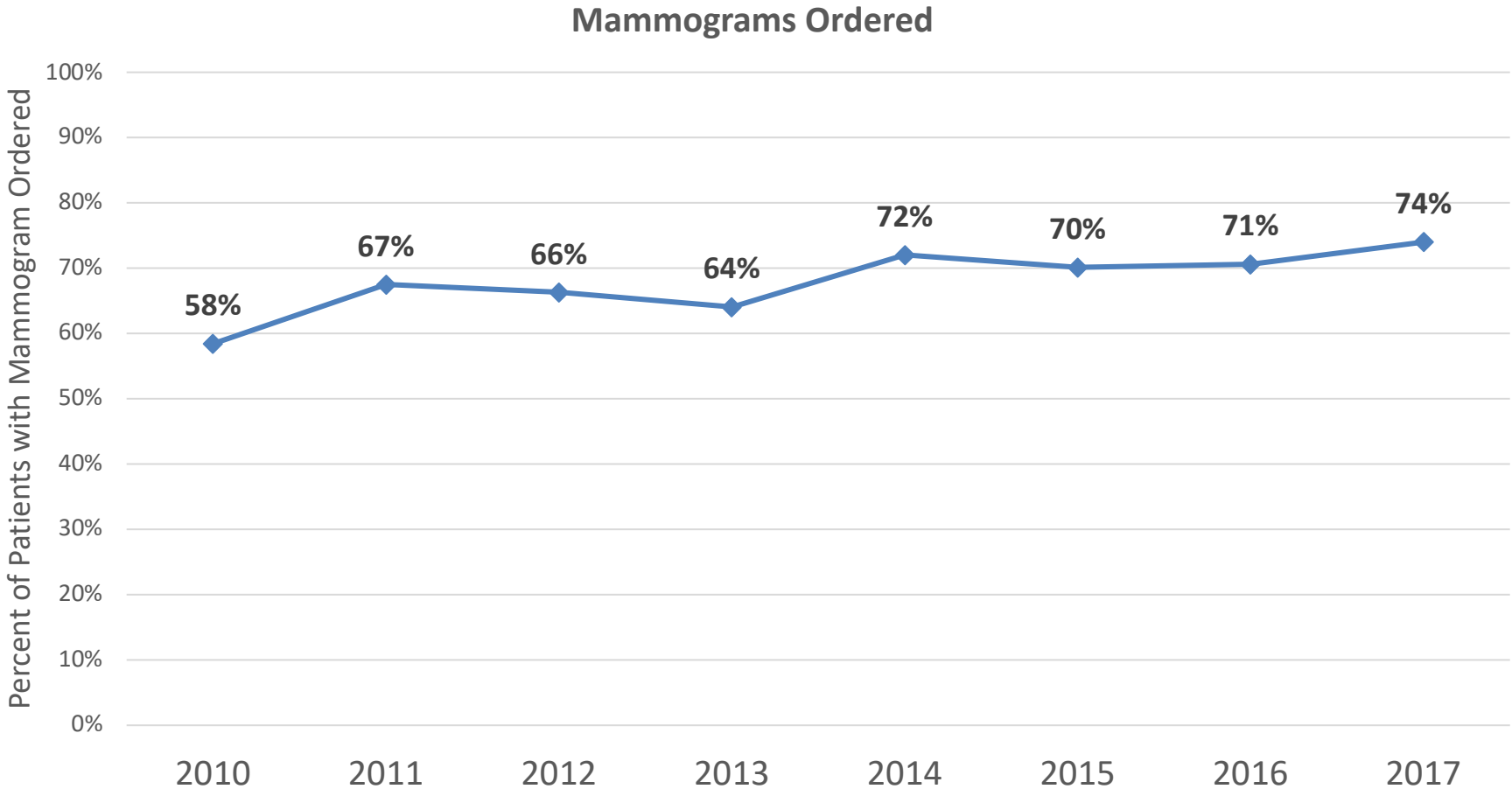
Orders for Mammograms 2010-2017



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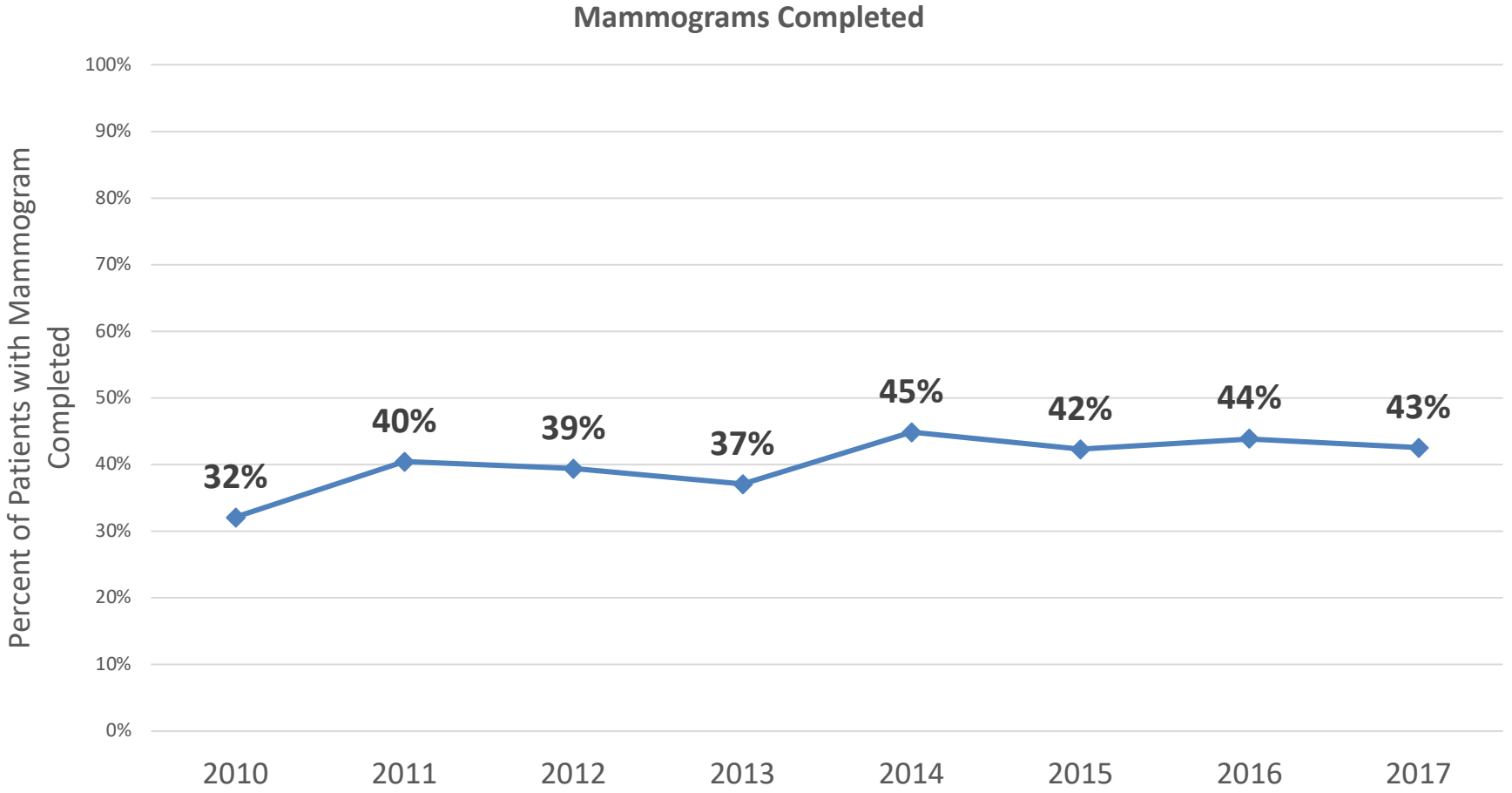
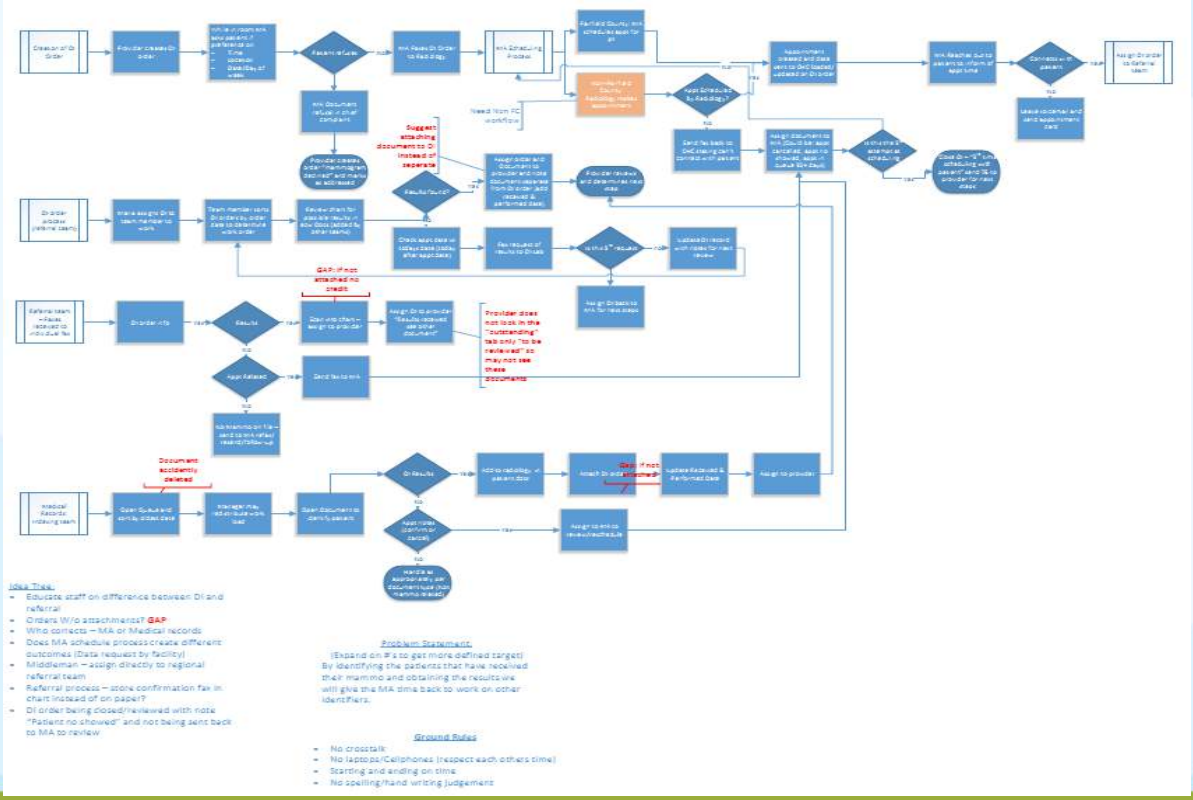
Breast Cancer Screening Completed



Breast Cancer Screening: Area for Improvement

- Result is an Operations Team was initiated including Medical Records and Referral Department staff to understand why the rates are not higher
  - Team flow mapped current process



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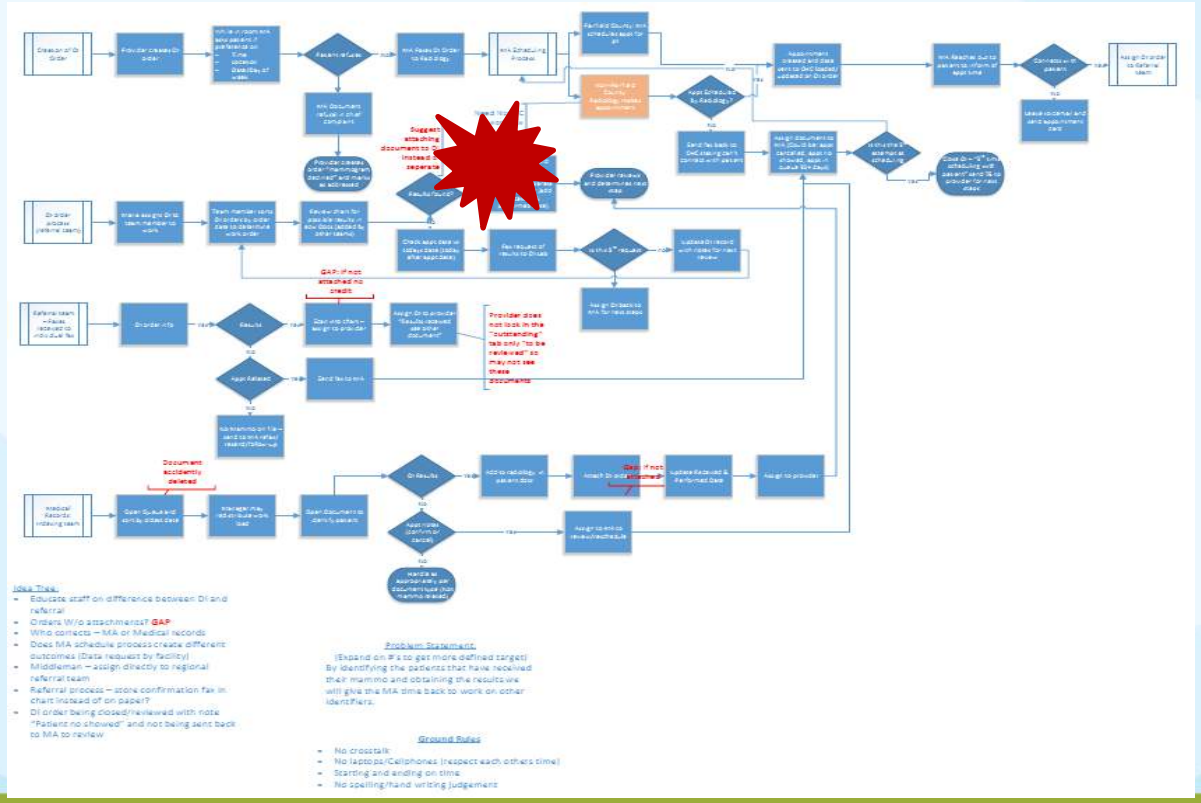


PDSA

Our team is conducting this PDSA to see if this small change will affect the number of mammogram results that are properly attached to the order and "count".

PLANNING THE PDSA

Task	By Whom	Week of	Where (Site, Pod, Town,
Obtain buy-in from Chief Nursing Officer	Jen B	2/16/2018	Meriden - Aislinn's providers Danbury - Maribel's providers
Inform Referrals and Indexing Team of the PDSA	Hayley H	after Jen talks with Mary 2/19/18	
Implement PDSA	Aislinn and Maribel	2/26/2018	Meriden - Aislinn's providers Danbury - Maribel's

DO - POST PDSA

Task	Challenges	Successes
Hayley sends all mammogram DIs for providers A, B, C and D to Aislinn and Maribel		

Baseline Data

Describe the data you have	Numerator	Denominator
What is the source of the data? Data from CHN lists patients who had a mammo but for whom CHC does not have the result.	818 (patients with a mammo completed that are not "counting" in CHC's system). A record review of 100 of these 818 revealed that 28% are in the EHR but not counting because they are not attached/documented correctly.	1661 (patients with a mammo completed according to CHN)
What is the timeframe for the data? Last 12 months		
What is the data measuring? Patients with a mammo completed for whom the test is in the record but not attached and documented correctly.		

Future Work

- Consider interventions involving patient navigation
- Identify reasons patients are not going for mammograms, once the data are clean
- Analyze data to identify high performing sites and/or providers to uncover any best practices
- Analyze data to identify areas of lower performance and provide supports as needed

Summary: There are dozens of PDSAs that can be performed on this one measure!

Pre-Visit Planning

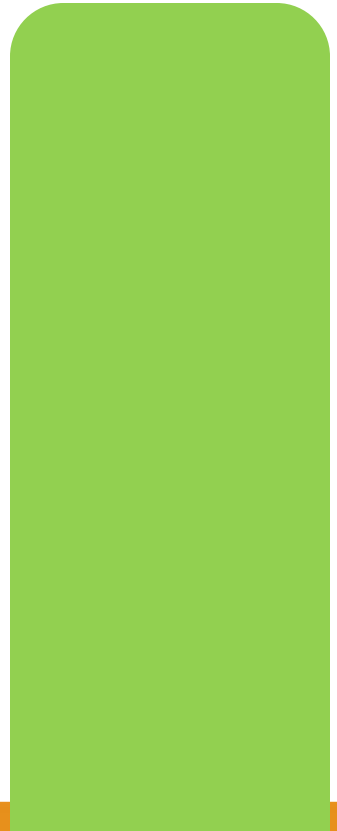
CCI Health & Wellness Services
Greenbelt


10,000
economically disadvantaged/homeless/disabled
state medical assistance coverage or uninsured

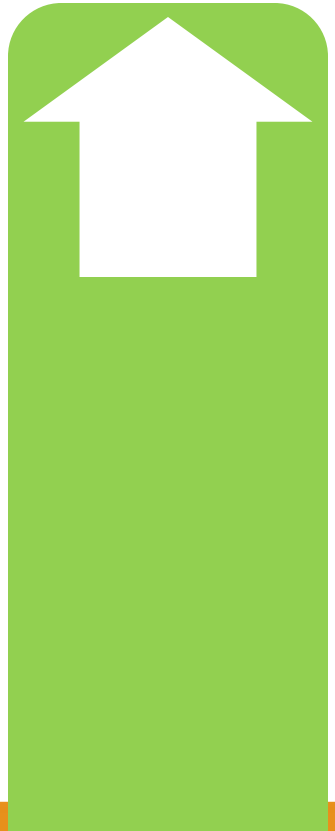
Services

Prenatal, Reproductive Health, Family Planning,
(Preventive Cancer Screenings, Nutrition Counseling, Centering)

Transformation Goals



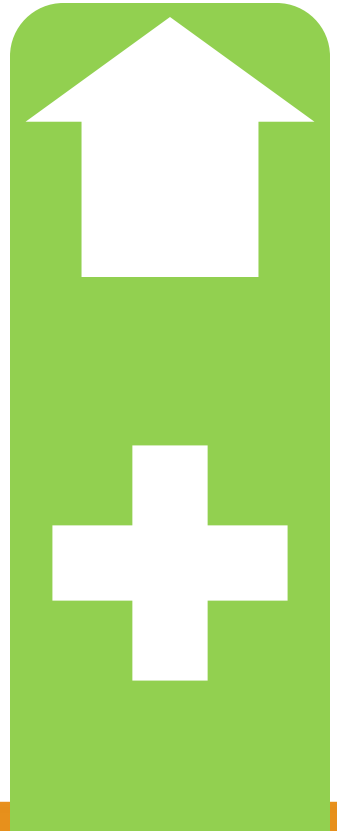
Transformation Goals



from 78% to 85%

preventive cervical cancer screenings
Patients (21-29 yrs) by July 2018

Transformation Goals



from 78% to 85%

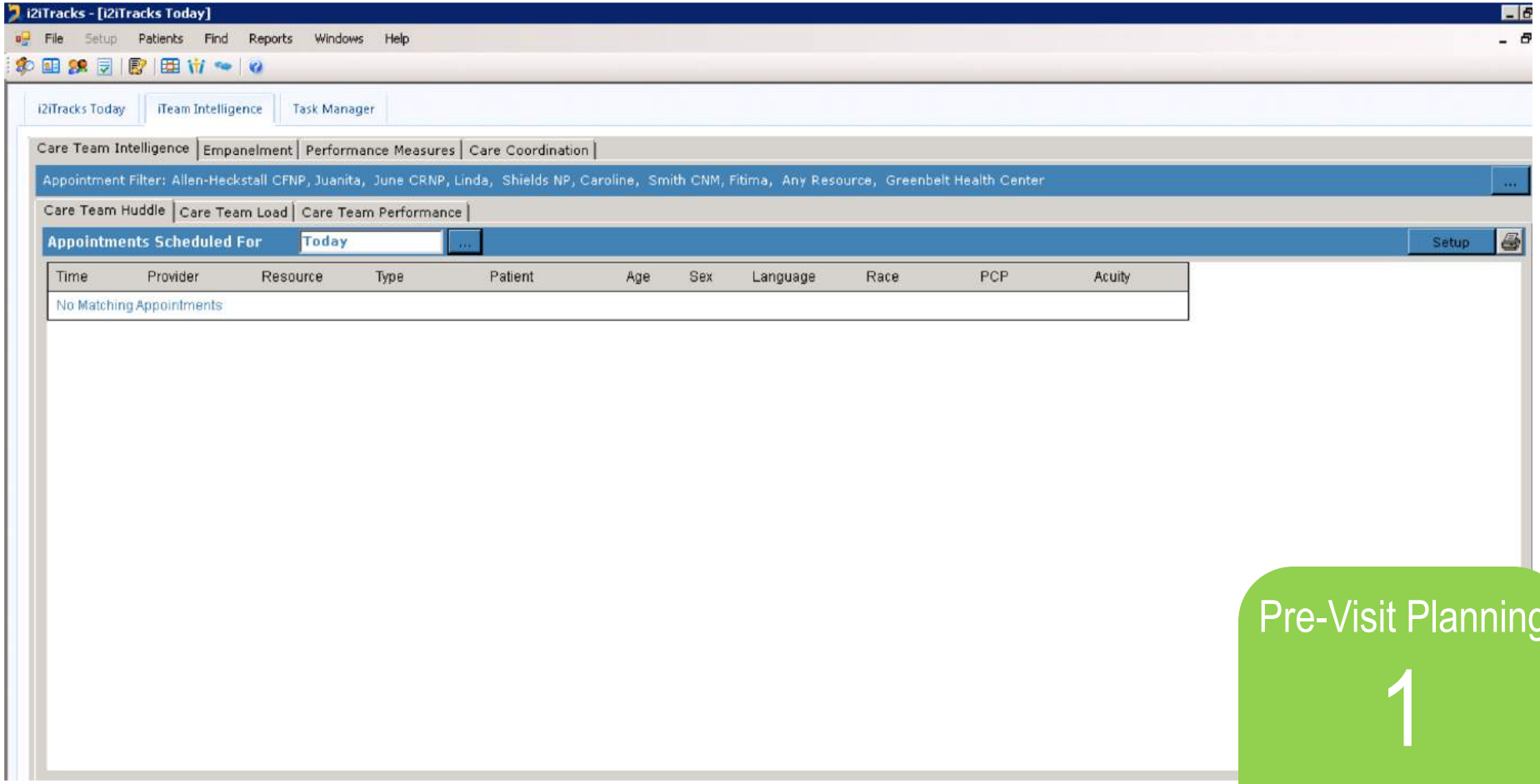
preventive cervical cancer screenings
Patients (21-29 yrs) by July 2018

Screening Guidelines

Approved July 2017

Pre-Visit Planning

1

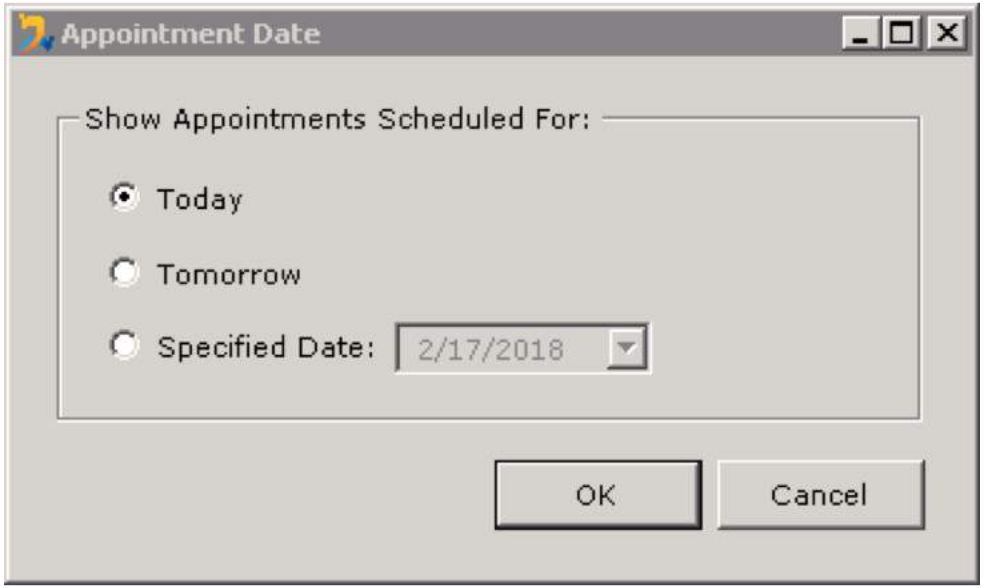


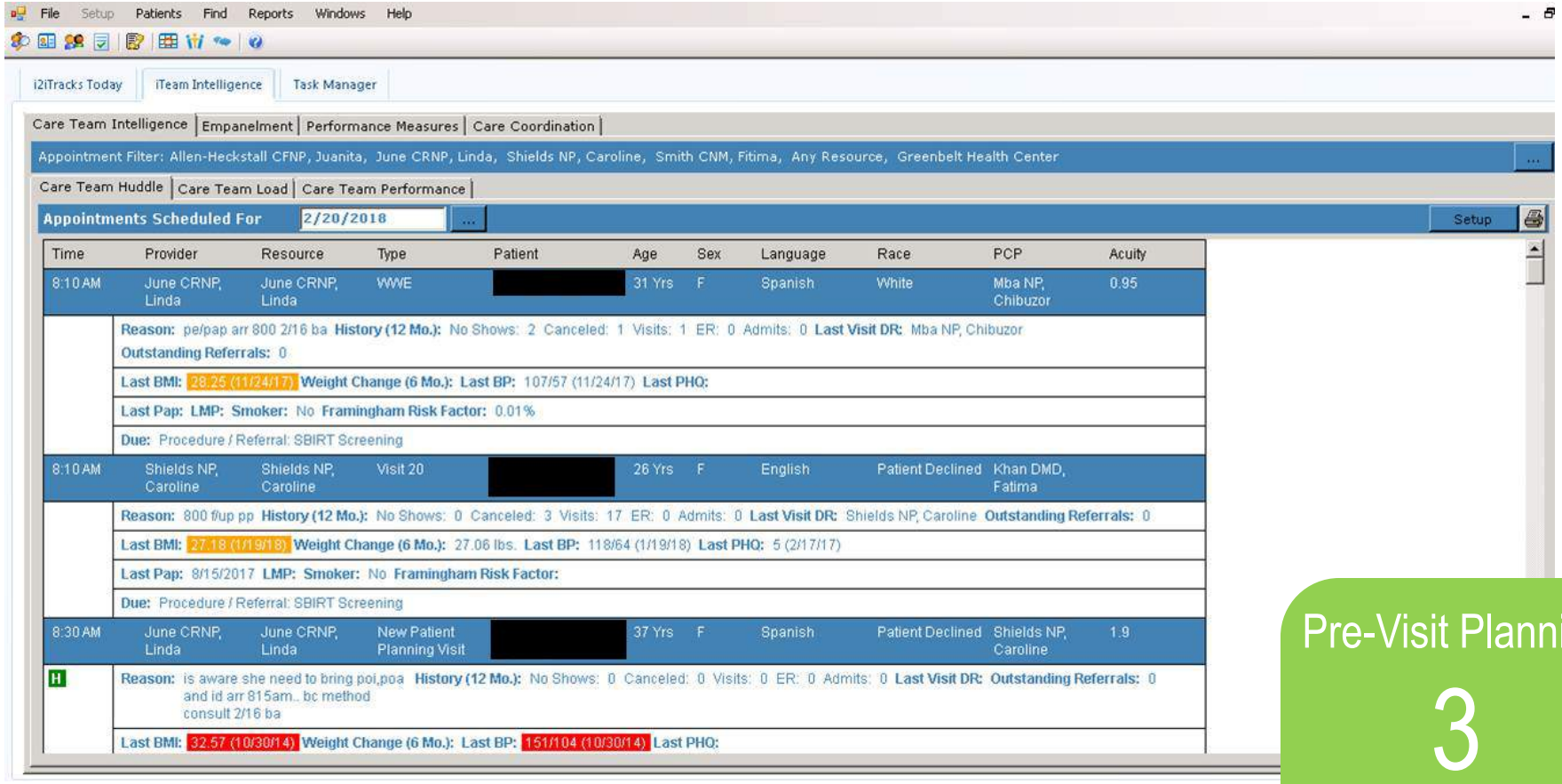
Pre-Visit Planning

1

Pre-Visit Planning

2


Appointment Date
Show Appointments Scheduled For:
Today
Tomorrow
Specified Date:
2/17/2018
OK
Cancel



[redacted] Patient ID & Name

Pre-Visit Planning

3

Lessons Learned

Lessons Learned

- ✓ Data Management

Lessons Learned

- ✓ Data Management
- ✓ Patient recall process

Lessons Learned

- ✓Data Management
- ✓Patient recall process
- ✓Lab results

Lessons Learned

- ✓ Data Management
- ✓ Patient recall process
- ✓ Lab results
- ✓ Abnormal results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CENTER FOR CARE
INNOVATIONS
Questions?

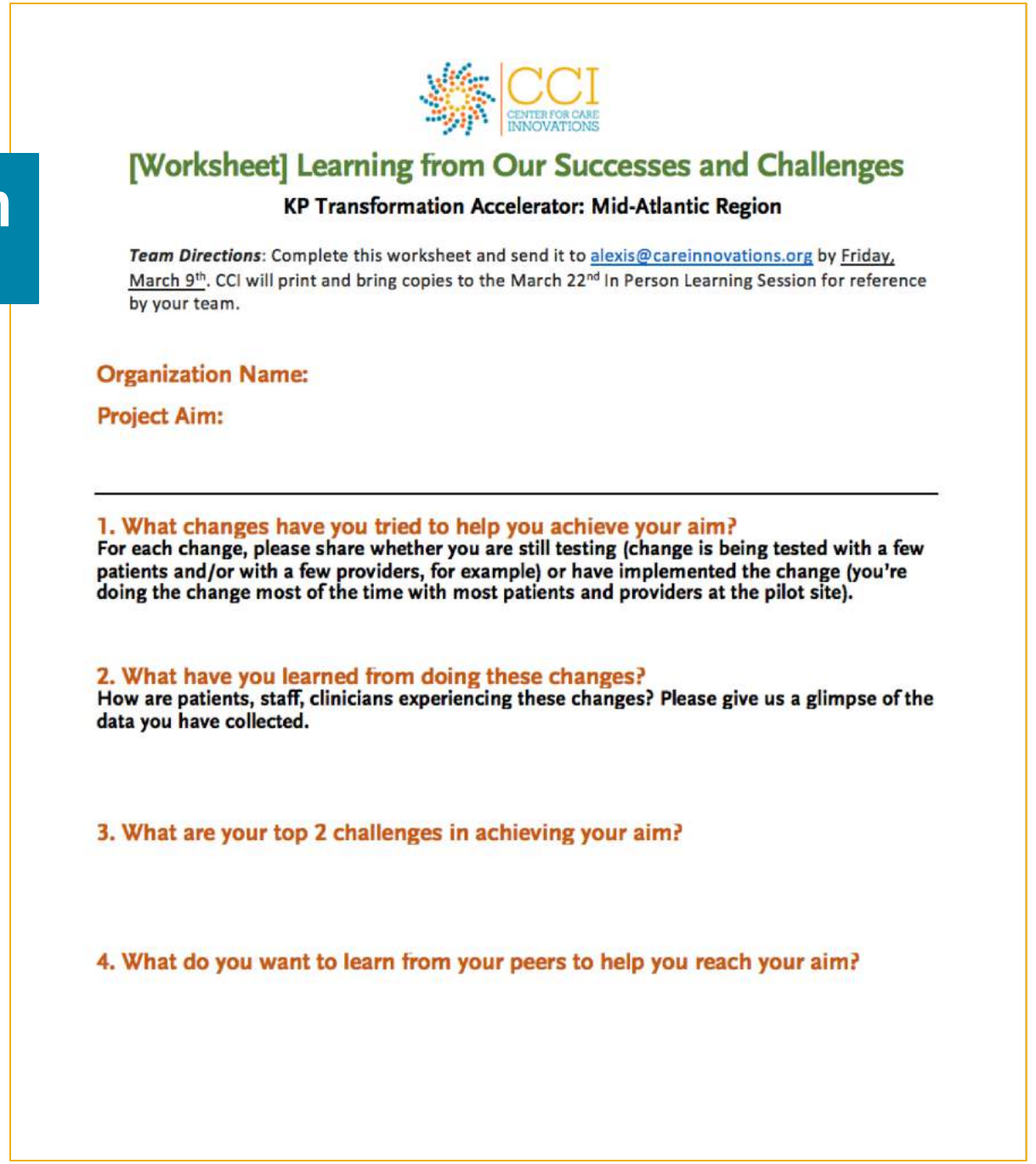
KPTA In-Person Session: Planned Care

Thursday, March 22nd | 8:45am – 4:00pm
Center for Total Health | Washington, DC

Register Now

Pre-Work – Due March 9th

- Complete the worksheet and sent to alexis@careninnovations.org
- Reach out to Alexis, Tammy, or Carolyn if you have questions
- CCI will print copies for you to reference during the learning session



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[Worksheet] Learning from Our Successes and Challenges

KP Transformation Accelerator: Mid-Atlantic Region

Team Directions: Complete this worksheet and send it to alexis@careinnovations.org by Friday, March 9th. CCI will print and bring copies to the March 22nd In Person Learning Session for reference by your team.

Organization Name:

Project Aim:

---

1. What changes have you tried to help you achieve your aim?
For each change, please share whether you are still testing (change is being tested with a few patients and/or with a few providers, for example) or have implemented the change (you're doing the change most of the time with most patients and providers at the pilot site).

2. What have you learned from doing these changes?
How are patients, staff, clinicians experiencing these changes? Please give us a glimpse of the data you have collected.

3. What are your top 2 challenges in achieving your aim?

4. What do you want to learn from your peers to help you reach your aim?

STAY UP-TO-DATE!

Transformation Accelerator Support Portal

Got to:
www.careinnovations.org/accelerator-team/

OVERVIEW | UPDATES & CALENDAR | PROGRAM RESOURCES | RESOURCE LIBRARY | TEAMS & PARTNERS

CCI CENTER FOR CARE INNOVATIONS
RPCC Regional Primary Care Coalition
KAISER PERMANENTE®

Transformation Accelerator Support Center

HELLO, TEAM MEMBERS!

This is the support center for participants of the **KP Transformation Accelerator** program. Program updates, report due dates, resources and more will be posted to this website. This website is managed by Center for Care Innovations.

For more information about KP Transformation Accelerator, please visit the program page.

- Current Updates
- Calendar

KEY DATES

2nd Installment Release	January – February 2018
Webinar: Planned Care	February 28, 2018
In-Person Convening	March 22, 2018
Progress Report #2 Due	May 15, 2018
In-Person Convening	July 24, 2018
In-Person Convening	October 10, 2018
Final Financial & Narrative Report Due	December 31, 2018

Current Updates

Read below for all the most current program announcements, reminders, and newly posted resources. Be sure to bookmark this page and check back regularly so that you don't miss a thing!

WEBINARS & EVENTS

Webinar: Planned Care. February 28, 2-3pm ET	Pre-Visit Planning: Using Data and Optimizing Care Team Roles. Register here.
Optional: Team-Based Care Webinar Series. March 1, 8	Optional team-based care webinars delivered by CHC, Inc. and the Weitzman Institute's Clinical Workforce Development. More information here.
In-Person Learning Session: Planned Care. March 22, Center for Total Health	**Pre-work due March 9th**. Complete this worksheet and email to Alexis. Use this example as a template. Register by March 9th. More details on registration page.
In-Person Learning Sessions. Save the Dates! July 24 and October 10	The 2nd and 3rd in-person learning sessions will be held at the Center for Total Health in Washington, D.C.

NEW RESOURCES

Program Resources

Program Resources

Webinars

POPULATION HEALTH

Transformation Accelerator: Informational Webinar

AUG 9, 2017 • CENTER FOR CARE INNOVATIONS

This webinar detailed the program structure, expectations, and timelines in the Accelerator program.

Documents & Templates

PROGRAM OVERVIEW

- Program and Funding Overview

REPORTING

- Progress Report Form – December 2017
- Charter for Improvement (CFI) Template
- Budget template

Program Resources

Webinars

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Learning Sessions & Site Visits

Learning Session #1: Learning, Reflecting, and Applying

CLICK FOR MORE DETAILS.

Serve the People Site Visit

CLICK FOR MORE DETAILS.

Community Health Center, Inc.

CLICK FOR MORE DETAILS.

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HANDOUTS

- Agenda
- Faculty Biographies
- Team-Based Care Reflection Worksheet
- Driver Diagram Toolkit

PRESENTATIONS

- Full Slidedeck
- Introduction & Closing Slides
- Driver Diagrams
- Team-Based Care Framework
- Leveraging Team-Based Care

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Resource Library

Learning About Improvement

Innovation & Capacity Building

Population Health Management

Team-Based Care

THANK YOU!

Carolyn Shepherd

Tierney Giannotii

Mary Blankson

Kameela Clark

Marcela Cámpoli