The National Cooperative Agreement on Clinical Workforce Development

Building Interprofessional Teams

June 21, 2017
The NCA on Clinical Workforce Development provides education, information, and training to interested health centers in:

**Transforming Teams:** Increase the percentage of health centers utilizing team-based practice models.
- 8 National Webinars on the team based care model- 1730 attendees on live webinars, 1127 video views.
- Learning Collaboratives to implement team-based care practices- 13 health centers

**Training the Next Generation:** Increase percentage of health centers with a formal program to advance the education of health care professionals, either directly or via a formal agreement with an external organization.
- 12 National Webinars on developing Nurse Practitioner and Clinical Psychology residency programs and successfully hosting health professions students within health centers: 1162 attendees on live webinars, 712 video views
- Learning Collaboratives to implement these programs- 11 health centers
Implementing Post-Graduate Nurse Practitioner and Clinical Psychology Residencies
(Webinars were held January–May 2016)

1. Why Start a Postgraduate Residency Program? Building the Case for Your Organization
2. From Recruitment to Graduation: The Structure, Design, and Content of the 12-month Nurse Practitioner Residency Program
3. From Recruitment to Graduation: The Structure, Design, and Content of the 12-month Postdoctoral Clinical Psychology
4. What Your Board, Management, and Staff Need to Know about Starting a Postgraduate Residency Program in Your Federally Qualified Health Center Residency Program
5. Precepting, Supervision, Leadership, Logistics: What are the Staff Roles in a Postgraduate Residency Program?
6. Measuring the Outcomes: Research and Evaluation
7. Accreditation for Postgraduate Residency Programs (Nurse Practitioner and Clinical Psychology)
8. Case Presentations: Successful National Residency Programs

Advancing Team-Based Care
(Webinars were held February–June 2016)

1. Building Your Primary Care Team to Transform Your Practice
2. Enhancing the Role of the Medical Assistant
3. The Emerging Role of Nurses in Primary Care
4. Data Driven Dashboards to Support Team-Based Care
5. A Team Approach to Prevention and Chronic Illness Management
6. Complex Care Management in Primary Care
7. Achieving Full Integration of Behavioral Health and Primary Care
8. Dissolving the Walls: Clinic Community Connections

Health Professions Students in FQHCs
(Webinars were held March–April 2016)

1. Why Form a Health Professions Training Program at Your Federally Qualified Health Center?
2. Creating a Process that Works for You: Infrastructure for a Successful Student Training Program
3. How to Make it Work for the Students
4. Health Professions Students from HR to IT to the Pod
Teams Participating in a 9-month Learning Collaborative to Implement a Post-Graduate Residency Program, or Advance Team-Based Care

**POST-GRADUATE RESIDENCY:**
1. Avenal Community Health Center; Lemoore, CA
2. Central City Concern–Old Town Clinic; Portland, OR
3. CHAS Health; Spokane, WA
4. Health Right 360 (Lyon Martin Health Services); San Francisco, CA
5. Johnson City Community Health Center; Johnson City, TN
6. Lamprey Health Care; Newmarket, NH
7. Menominee Tribal Clinic; Keshena, WI
8. Montbello Health Center; Denver, CO
9. Petaluma Health Center, Inc.; Petaluma, CA
10. Rutgers Community Health Center; Newark, NJ
11. The Children’s Clinic; Long Beach, CA

**TEAM-BASED CARE:**
1. Avenal Community Health Center; Lemoore, CA
2. Carolina Family Health Centers, Inc.; Wilson, NC
3. Community Health Initiatives; Brooklyn, NY
4. Daughters of Charity; New Orleans, LA
5. Educational Health Center of Wyoming; Cheyenne, WY
6. El Rio Santa Cruz; Tucson, AZ
7. Healthcare for the Homeless; Houston, TX
8. Holyoke Health Center; Holyoke, MA
9. Johnson City Community Health Center; Johnson City, TN
10. Peach Tree Healthcare; Marysville, CA
11. Pecos Valley Medical Center; Pecos, NM
12. Sumter Family Health Center; Sumter, SC
13. Syracuse Community Health Center, Inc.; Syracuse, NY
14. The Children’s Clinic; Long Beach, CA
15. Tyler Family Circle of Care; Tyler, TX
16. Via Care Community Health Center; Los Angeles, CA

Presented by Community Health Center, Inc. and its Weitzman Institute and Inspiring primary care innovation and The Primary Care Team LEAP A program of GHH’s MacColl Center Supported by The Robert Wood Johnson Foundation
SPEAKERS

Anna Rogers, Director of the National Cooperative Agreement
Reema Mistry, MHS, Project Coordinator, National Cooperative Agreement
Mary Blankson, DNP, APRN, FNP-C, Chief Nursing Officer
Kasey Harding-Wheeler, MPH, Director for the Center of Key Populations
Melissa Aurora, Access to Care Coordinator
Bernie Delgado, RN, Staff Nurse
Diana Paris, APRN, FNP-BC W.Y.A Program
Who is in the Room?
- Organization size ranging from 26 – 200 employees
- Healthcare for the Homeless funding for 0, 2, 32, 37 years

Represented Roles and Organizations:
- Nurse Practitioner  ❖ Mercy Care Atlanta, GA
- Registered Nurse  ❖ Dept. of Health Services Los Angeles County, CA
- Nursing Care Manager  ❖ Unity Health Care, Washington, D.C.
- Director of Integration  ❖ Care Alliance Health Center, OH
- Health & Wellness Coordinator  ❖ Skid Row Housing Trust, CA
- Associate Medical Director  ❖ Tom Waddell Urban Health, CA
- CEO  ❖ St. Luke's Health Care Clinic, NM
- Community Health Worker  ❖ Duffy Health Center, MA
- Director of Social Work  ❖ Care for the Homeless, NY
1. One thing you are hoping to learn from this session
2. One particular challenge that you are hoping to address in this session
3. One thing that you do at your organization to promote a positive team environment
Hoping to learn from this session:

• How to work better/better **integrate with other departments** to better serve our patients
• Getting individuals working as a interdisciplinary team (**collaborating**)
• **Coordinating** care w/ SW, Pharmacy, specialists
• Improving **communication** amongst team members
• How staff from different departments or agencies can work together **collaboratively** to provide service to clients
• How to **inspire** supervisors and staff to work **efficiently** and with improved **communication**
• I'd like to learn how to be a better **team player** and how to rally **enthusiasm** to work together
• I would like to learn new ideas or strategies for how to bring **diverse** groups of professionals together to work on a shared goal or project
Particular challenge hoping to address today:

- How to move from a **multi discipline** to **inter discipline**
- Would appreciate knowing of any **forms/docs/excels** that are particularly helpful for other organizations when **coordinating care w/ interdisciplinary team mates**
- **Power dynamics** between team members
- Improving **communication** amongst team members
- The difficulty of staff that **resist change** even when its positive. How to better work through the loss (change) so that they can better embrace the new change (gain)
One thing that you do at your organization to promote a positive team environment:

- **Huddle** and prayer every morning.
- Positive **acknowledgement**
- Daily rounding
- **Respectful interaction** amongst providers
- Team Meetings
- At team meetings we take time to **recognize** recent successes and **thank** each other for specific instances of help
- **Humor**, and respecting and promoting work-life **balance**
- I **celebrate** the achievements of coworkers and clients
- One of the things we do to promote a positive team environment is to share client **success stories** of the team working together with the bigger team during all staff meetings. **Recognition** is very important and helps build morale and team connection
Learning Objectives:

1. Participants will be able to describe 2 ways in which team-based care models improve efficiency and patient outcomes
2. Participants will be able to name the ways in which nurses and medical assistants can be more fully utilized in improving health outcomes for key populations
3. Participants will be able to identify two potential impacts of using clinical dashboards on UDS outcomes
4. Participants will be able to describe ways that extended care, non-clinical team members can work with core clinical team members to provide seamless, non-fragmented care to patients
Community Health Center, Inc.

**CHC Profile:**
- Founding Year - 1972
- 200+ delivery sites
- 140k patients

**Foundational Pillars**

1. **Clinical Excellence** - fully integrated teams, fully integrated EMR, PCMH Level 3

2. **Research & Development** - CHC’s Weitzman Institute is the home of formal research, quality improvement, and R&D

3. **Training the Next Generation** - Postgraduate training programs for nurse practitioners and postdoctoral clinical psychologists as well as training for all health professions students
Center for Key Populations: Mission

- To ensure that key populations in the communities we serve have a central and cohesive focus.
- To ensure that the integration of their care is fully realized through the integral collaboration and utilization of the vast and rich resources available at CHC, including
  - World-class clinical care
  - Quality improvement
  - Training and education of the next generation to care for these populations, and
  - Research and publication to help study, improve and transform the care they receive.
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
Community Health Center, Inc. Where health care is a right, not a privilege, since 1972.

**Organizational Chart**

**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 Microsystems)**

**Project ECHO**

**Research**

**Teaching**
Contact Information

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Why Primary Care Teams?

- Improved clinical outcomes
- Better patient access and experience
- Improved support for complex patients
- Reduced burnout

Become a recognized PCMH
Team Structure:
Major Findings From Site Visits

- Providers and their panels supported by Core teams consisting of MAs, front desk, and others.
- All core teams supported by RN care managers, behavioral health specialists, pharmacists, etc.
- Medical assistants, receptionists, and lay-persons play key patient care roles.
- Roles are expanded. All staff work at the top of their license and skillsets.
Primary Care Team

Core Team

- Provider -MA Teamlet
- Provider -MA Teamlet
- Provider -MA Teamlet

Extended Care Team

- Receptionist
- Team RN
- Health Coach
- Panel Manager

- RN Care Managers
- Lay Caregivers
- Pharmacists
- Behavioral Health Specialists
- Administrative Staff

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The Primary Care Team

A program of CHRF's MacColl Center supported by The Robert Wood Johnson Foundation
How do effective practices create effective teams?

• Hire bright, energetic folks with good interpersonal skills.
• Define key roles and tasks and distribute them among the team members (everybody at top of their license).
• Train staff to perform tasks.
• Use protocols and standing orders to enable staff to operate independently.
• Establish job ladders.
• Give teams time to meet.
Primary Care Team Guide

Improving Primary Care: A guide to better care through teamwork.

GET STARTED
Find out how to get the most from this guide.

BUILD THE TEAM
Learn how to create effective teams by redesigning staff and clinician roles.

DO THE WORK
Learn how effective teams work together to provide better, more efficient care.

*Primary care is changing.* All across the U.S., practices are trying to transform themselves to improve the quality of their care, become patient-centered medical homes, and qualify for new payment opportunities. The Primary Care Team Guide, developed by staff at the MacColl Center for Health Care Innovation, offers practical advice, resources, and models to help leaders and staff engaged in or considering practice transformation build more effective care teams and deploy them to optimize patient care.
Facilities and Physical Model

• Interdisciplinary Pods that Promote Team-Based Care
• Open office structure
• Collaboration throughout the workday
Care that is Comprehensive: IPCP Team

Additional on-site specialties
- Nutrition
- Diabetes education
- Chiropractic
- Podiatry
- Retinal screening
Interdisciplinary Care
“Every CHC Patient has Team!”
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
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
Independent Nursing Visits 2015/2016
Total Visits: 20,717, Total Services Delivered: 28,418

- Immunization and Screening: 12,870
- Chronic Illness Care & Management: 4,228
- Chronic Pain Support: follow up & assessment: 5,444
- Recurring Medication Administration: (ie. progesterone administration and monitoring for prevention of pre-term birth): 736
- Anticoagulation Management: 1,422
- Nursing visits for Standing or Delegated Orders: 2,952
- Smoking Cessation visits: 766

Total Visits: 20,717, Total Services Delivered: 28,418
Chronic Illness Care

- Hypertension, 41.9%
- Diabetes Management, 25.3%
- BH, 10.6%
- Asthma/COPD, 7.9%
- Hyperlipidemia, 0.7%
- Other, 8.8%
- CAD, 1.0%
- Obesity, 1.6%
- HCV/HIV, 2.2%
- Other, 8.8%

Community Health Center, Inc. Where health care is a right, not a privilege, since 1972.
Role of the Medical Assistant

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

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Clinical Addiction Services

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Kasey Harding – Wheeler, MPH
Director of the Center for Key Populations
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hardink@chc1.com
Objectives: Primary Care at the Shelter

- Reducing health barriers while expanding access to treatment
- Positively creating a trusted relationship with our Team Based Healthcare team
  - Nursing Care Coordination Visits: HTN, Diabetes, Suboxone
  - MAs – 1st line in alerting PCP for any potential health concerns
  - BH: identifying clients that can benefit BH Services
- Services: Screen, Screen, Screen !!!
  - PHQ-2, PHQ-9; SBIRT (Screening, Brief Intervention, & Referral to Treatment) – identify clients with alcohol abuse & substance abuse & referring clients for of additional treatment services
  - Bridging Care by Offering "light touch" by helping managing their chronic medical conditions such as cardiovascular disorders, diabetes, psychiatric disorders etc
  - Annual labs including based on risk factors HCV screening, STI screening, TB screening
  - Offering PAPs, Mammograms, Colonoscopy
ADDICTION INVOLVES MULTIPLE FACTORS

Biology/Genes → Environment

Brain Mechanisms → Addiction

DRUG

Why do people use drugs? It Feels Great !!!

Pleasure Seeking Principle chasing “Endorphin Rush”

Drugs
Alcohol
Gambling
Sex
Food
Exercise
Nurturing
DEFINITIONS

TOLERANCE

• The person's body is less responsive to alcohol or drugs because of repeated exposure.
• Therefore it requires more substance to produce an effect (e.g. euphoria, anxiety reduction).
• Long-term users consume large quantities.

ABUSE

• The person neglecting responsibilities (working, taking medications, caring for children, or attending school).
• Difficulties with family, friends, and coworkers.
• Consuming even when it is dangerous (e.g. driving, liver inflamed).
• Legal problems.
• Abuse may lead to dependence.
Opioid Use Disorder (DSM-V)
(2 or more within a 12 month period)

- **Tolerance**
  - Need for increased amounts to achieve desired effect, or
  - Diminished effect with continued use of same amount

- **Withdrawal**
  - The characteristic opioid withdrawal syndrome, or
  - The same or closely related substances are taken to relieve or avoid withdrawal symptoms

- **Opioids taken in larger amounts/longer period than intended**

- **Inability to/persistent desire to cut down or control opioid use**

- **Great deal of time spent in activities necessary to obtain, use or recover from opioids**

- **Craving/strong desire to use opioids**
Opioid Use Disorder (DSM-V) 
(2 or more within a 12 month period)

- Recurrent use results in failure to fulfill obligations at work, school, or home
- Social, occupational and recreational activities given up or reduced because of opioid use
- Recurrent opioid use in situations in which it is physically hazardous
- Continued use despite knowledge of having persistent/recurrent physical/psychological problem that is likely caused/exacerbated by opioids

Severity: Mild = 2-3; Moderate = 4-5; Severe = 6 or more
# Opioid Withdrawal

<table>
<thead>
<tr>
<th>SYMPTOMS</th>
<th>OBJECTIVE FINDINGS</th>
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</thead>
<tbody>
<tr>
<td>• Stomach pain/ Abdominal Cramps</td>
<td>• Withdrawal symptoms peak between 48 – 72 hours and then subside after a week</td>
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<tr>
<td>• Bone/ Muscle Aches</td>
<td>• Tachycardia</td>
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<tr>
<td>• Chills and/or cold sweats</td>
<td>• Diaphoresis</td>
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<tr>
<td>• Diarrhea</td>
<td>• Restlessness</td>
</tr>
<tr>
<td>• Goose bumps</td>
<td>• Tremor</td>
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<tr>
<td>• Nausea, Vomiting</td>
<td>• Pupil dilatation</td>
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<tr>
<td>• Rhinnorhea</td>
<td>• Runny nose</td>
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<tr>
<td>• Restlessness</td>
<td>• Lacrimation</td>
</tr>
<tr>
<td>• Sweating, Shaking</td>
<td>• Yawning</td>
</tr>
<tr>
<td></td>
<td>• Piloerection</td>
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<tr>
<td></td>
<td>• Flushing</td>
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</tbody>
</table>

- Withdrawal symptoms peak between 48 – 72 hours and then subside after a week.
Opioid Excess

1. Miosis (pinpoint pupils)
2. Sedation / lethargy
3. Bradycardia
4. Respiratory depression
5. Hypothermia
6. Stupor
7. Coma
8. Death
~4.8 million Americans aged 12+ illicitly used opioid pain relievers or heroin in 2014.
~2.5 million have an opioid use disorder.
# received opioid substitution therapy (2013):
  – 330,308 (methadone)
  – 48,148 (buprenorphine)
Opioid overdose death rates: 9.0 per 100,000

Medication Assisted Therapy

Best evidence-based treatment for opioid use disorder

Biological rationale

✓ Prevents withdrawal
✓ Relieves craving for opioids
✓ Blocks or attenuates euphoric effect of exogenous opioids

Methadone (full agonist), Buprenorphine (partial agonist), Naltrexone (full antagonist)
Methadone

• Methadone can ONLY be prescribed for opioid use disorders in Opioid Treatment Programs (OTP).

• An OTP is any treatment program certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) in conformance with 42 Code of Federal Regulations (CFR), Part 8, to provide supervised assessment and medication-assisted treatment for patients who are opioid addicted.

• An OTP can exist in a number of settings, including, but not limited to, intensive outpatient, residential, and hospital settings.

• Types of treatment can include medical maintenance, medically supervised withdrawal, and detoxification, either with or without various levels of medical, psychosocial, and other types of care.
Naltrexone (Narcan)

- Effective in specialized populations; e.g. impaired professionals
- Low attraction, in general, in traditional OTPs
- Early drop out is common: Hx. with po tabs
- I.M. Naltrexone Depot—30 day duration, less overall exposure to NTX, no black box LFTs
- Off opioids for 7—10 days; naloxone challenge
- Strategies to shorten “off opioid interval”*
- Loss of Tolerance: OD Concerns
- Can be prescribed in non-OTP settings, e.g. CHC

Naltrexone

• CVS offers Naltrexone without a Prescription due to “the rapid rise of opioid overdoses....This helps caregivers, concerned loved ones, first responders and patients get naloxone more easily.”

• Available in 41 states: AL, AK, AR, AZ, CA, CO, CT, FL, GA, IA, ID, IL, IN, KY, LA, MA, MD, MN, MO, MS, MT, NC, NH, ND, NJ, NM, NV, NY, OH, OR, PA, RI, SC, TN, TX, UT, VA, VT, WA, WI & WV

Save a life with naloxone. Retrieved from https://www.cvs.com/content/prescription-drug-abuse/save-a-life
Buprenorphine

- Partial opioid agonist at the mu receptor
- It has a ceiling effect at moderate doses
- It has a high affinity for the opioid receptor
- It has a slow dissociation rate from the opioid receptor
- Must be taken sublingually
- Is usually co-administered with naloxone as Suboxone
Medical Team Collaboration

• Provider Training via CHC “Project ECHO”
  • Multidisciplinary Faculty providing weekly didactics to support primary care providers to effectively manage Suboxone Hepatitis C, HIV, Pain Management to help improving health care outcomes & developing evidence based care plans

• Mental health specialists - E.g. Psychiatrists, psychologists, substance abuse counselors (e.g. CHC shelter, we’ve LADC : license addiction drug counselor). Clinician coordinating therapy Groups & Suboxone Groups
  • Provider is key in leading core team
  • May consist of medical assistant and nurse .
  • Exploring personal experiences/attitudes toward addiction.
  • Frequent listening/acknowledging/educating imperative!
Medical Team Collaboration with Behavioral Health

• Common Diagnoses at the Shelter:
  • PTSD (sexual abuse, physical abuse), Substance Abuse, (Common Drugs Heroin, Cocaine, THC, Alcohol), Depression, Generalized Anxiety, Bipolar Disorder

• Providers screening clients MH Disorders:
  • + PHQ-9, + SBIRT, Risk Factors (Recent Incarceration, Trauma)
    Refer for “WHO – Warm Hand Off” 30 min appt then schedule Intake Appt (45 mins – 1 hour)

• Medical Providers can bridge clients until patients are established with psychiatrist, IOP, Residential Treatment programs

• BH Therapy
  • Motivational Interviewing, Cognitive Behavioral Therapy, Dialectical Behavior Therapy
    • Weekly Suboxone Groups
CHC Buprenorphine Program

Both in office and home inductions done.

– No buprenorphine stored on site.

– Patient Agreement: Reviewed and signed with MA/RN/MD At initial or soon after initial visit

– In-office: patient picks up bup from pharmacy, brings back for first dose in office with RN/MD. Waits about 2 hours at or near clinic to ensure no adverse affects. Seen again in 2-3 days. Then weekly.

– Home: patient receives 3-7 day prescription. Then weekly.
Buprenorphine Program
Workflow

Initial Visit
- Eligibility, Hx, Px, Labs, Tox screen, Agreements

Home

Weekly visits

MD/RN

Sub Abuse groups

Stabilization

Internal or external

Maintenance

Every 2-4 weeks

BH and Medical assessments and treatment

Relapse

Weekly visits

Induction

Reengagement

Death

Overdose

Program Failure/Out of Care

Partial Abstinence

Complete Abstinence

(Revised) Treatment Plan

Buprenorphine Program Workflow
Toxicology Screening

And Diversion
Toxicology Screening

- Lab screening and/or point of care testing.
- MAs collect toxicology screens when patient seeing provider.
- RNs collect screens if nursing visit.
- BH groups send patients to on-site lab for screens.
- Toxicology screens sent out to Quest lab.
  - Extensive drug screening; all GC/MS confirmed.
Medication Voucher System

- Designed to reduce diversion and improve attendance and retention.
- Empowers clinical team to continue buprenorphine (contingency management). Coordinate with one (or more) pharmacy(ies).
  - Voucher is **not** a prescription.
  - Embossed by clinician.
  - Signed by clinician and patient.
  - Valid for 2 days.

Prescriptions are sent to pharmacy by prescriber directly.
  - E.g. One week prescription with 3 refills; patient in weekly groups and monthly provider visits.
Summary

• Screen, Screen, Screen !!!

• Using Medical Team Collaboration and Nurse Care Coordination are key to Reducing Health Barriers & Fostering trusted relationship with our medical healthcare team

• Coordinating Primary Care Services between Shelter in conjunction with Interdisciplinary Care with Behavioral Health, Dentistry, Nursing, Nutrition, and Podiatry.

• Lastly, “Take a Breath .... Just Breathe! “
Contact Information

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WHO ELSE IS ON THE TEAM?  
Building a Comprehensive Team
Center for Key Populations:
Team Based Care

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CHC Model
Primary Care Services - Shelter

- **Team Members**
  - Medical Assistant
  - Nurse
  - Access to Care Coordinator
  - Behavioral Health Clinician
  - Collaborating Partnerships with Shelter Staff
    - Director of Health Services, VNA, Case Managers

- **Important Reminders as PCP:**
  - Constantly identifying high risk patients for psychiatric disorders, drug use, STI Screening, HCV screening/treatment
  - Being Mindful very Transient Population with Trauma, PTSD therefore offering Non-Judgmental Demeanor is key!
  - Limited Services: Sometimes must act in Multiple Different Roles
    - Case Manager, Psychiatrist, Public Health Educator, Comedian
Primary Care Services - Shelter

- **Important Lessons**
  - Recognizing the Signs of
    - Alcohol Withdrawal
    - Benzodiazepines Withdrawal
    - Opioid Withdrawal & Excess
    - Patients engaged in active Domestic Violence Relationships
  - Securing alternative method to contact client in case they leave the shelter and their number changes or out of service
  - Staying in Constant Communication with the Shelter Safe
  - Adding ICD “Homeless” to the Problem List other providers are aware because patients are sometimes lost to follow-up & may reappear at another shelter or clinic site
  - During the Medical Appointment, if possible scheduling clients for their routine screening (PAPs, mammograms, colonoscopies) & Initial Appointments with Dentistry, BH, Nutrition, Podiatry
Nursing Role

“The role of the nurse in the shelters is integral to the highest level of functioning as a team for the patient. At times it is similar to the role of the site nurse but more often than not it involves significant additional functions and the ability to be flexible and crisis manage. The nurse is indispensable as far as I am concerned.”

~ CHC provider

“The nursing role in the shelter is one that requires specific qualities in order to be successful. There is a real balance between clinical nursing skills and competencies and the more innate skills of identifying resources and providing extensive patient education that is tailored to the individual.”

~ CHC provider
Access To Care Role

Register and Screen Patients
Medical Insurance Eligibility
Medical and BH Billing
Medical and BH Coding
Schedule Appointments
Provide recall
Follow/track patients
Assist patient with paperwork
Make/track referrals
Care Coordination with Partner Agencies
Schedule main site appointments
Schedule specialty appointments

Transportation
Translation
Coordinate free dental care
Patient assistance with financial information
Patient assistance with clerical information
Coordination with insurance companies
Case Management

“The Access to Care role is important to the program for the “glue” it provides to patients. It is the person who is the face of the program for staff, external sources and patients alike. This role ensures that patients are being tracked and monitored closely and that they receive every service and entitlement available to them. This is a huge boost for our program and something that everyone should have.”

~ CHC Provider
Behavioral Health Role

Individual BH sessions
Group BH Sessions
Substance Abuse Treatment
Substance Abuse Groups
Support for MAT
Crisis Management
Integrated Care Management
Patient Education
Support for Medical Team

Particular Challenges
- Dual Diagnosis
- Complex BH Needs
- Lack of Referral sources for IOP etc.
- Lack of awareness
- Fear and Stigma
- Perception of problem
Medical Assistant

Vitals
Medical History
Care Management
Screenings
Enrollment into Programs
Care Coordination
Scheduling Appointments
Order Supplies
Keep Equipment up to date
Keep Safety logs up to date
Joint Commission Readiness
DPH Readiness

“The role of the MA is difficult to quantify because it is so diverse and challenging in this setting. The MA must work to the top of their license in order to perform at the level needed but also must take on the role of scheduling patients and making sure they have their entitlements up to date. It is a real balance. I don’t know where I would be without the MA to keep things moving along.”

~ CHC provider
Other Roles

Community Health Workers: trusted, knowledgeable frontline health personnel who typically come from the communities they serve. CHWs bridge cultural and linguistic barriers, expand access to coverage and care, and improve health outcomes.

Patient Navigators: guides patients with complex healthcare needs through and around barriers in the complex health delivery care system to help ensure timely screenings, diagnosis, treatment and education as needed.

Care Coordinators: responsible for ensuring that a patient gets needed health and social services by providing detailed tracking of all clinical and psychosocial needs and services.

Complex Care Managers: Identify the most complex patients and use care coordination and case management to ensure appropriate delivery of healthcare services.

Community Outreach Workers: utilize community outreach to identify those patients in most need of healthcare services and link them to it in a timely manner.
Role of Shelter Staff and Partner Agencies

- Coordinate care for shelter patients
  - Appointments
  - Transportation
  - Childcare
- Provide continuity between healthcare and housing
  - Case Management
  - Paperwork
- Provide psychosocial support for patients
  - ADL
  - Community Integration
  - Support Groups, recreation
Role of Technology and Innovation in bringing Comprehensive Care to Shelters

**Project ECHO HIV/HCV, Buprenorphine**
Weekly video learning network that connects providers working in shelters and their teams with a faculty of experts for the care and treatment of HIV/HCV and Medication Assisted Treatment. Increases access to services for patients and trains the next generations of providers.

**EConsults**
Utilizes technology to acquire specialty consultation for patients in orthopedics, cardiology, dermatology and other services, often avoiding having to send a patient to an office visit, which can be a barrier to care.
Project ECHO

- Builds communities of practice
- Connects primary care providers with a panel of expert multidisciplinary faculty
  - Improves retention of primary care providers
- Provides brief didactic and case-based learning and management
- Improves health care outcomes with evidence based care plans
  - Improves access to specialty care
  - Creates a force multiplier
Effective Communication – CHC model

**Regional Monthly Meetings** – community partners and collaborators are invited to CHC for meetings to discuss services and patients.

**Community Care Team Meetings** – CHC participates in meetings held by the Emergency Departments in most towns where we have services. Discussion of high risk patients and decreasing utilization of ED and hospital admission reductions.

**Quarterly Shelter Staff Meeting** – CHC attends shelter meetings to communicate changes in services with shelter staff on a regular basis.

**CHC Monthly Staff Meetings** – Designed to ensure that all staff working in various shelters across the agency are communicating effectively and have the support they need.

**Printed Materials** – Printed materials are updated and disseminated by the communications and outreach department.
Using Clinical Dashboards and other Electronic Tools to Support Team-Based Care

Mary Blankson, APRN, DNP, FNP-C
Bernie Delgado, RN
Disclosure

We have no financial or commercial conflicts of interest to report regarding this educational presentation.
Learner Objectives

1. The learner will be able to describe how electronic dashboards were developed to support team-based care.

2. The learner will understand how an electronic dashboard provides decision support for nurse care managers and other clinical team members in primary care.

3. The learner will understand how electronic dashboards can aid in reducing missed opportunities and enhance panel management activities for the clinical team using them.
Challenges of Using Existing EHR fields

- EHRs initially were designed to document care of individual patients and for billing insurers for reimbursement of services, and not for measuring population data or clinical processes.
- Existing EHR fields may not suit a data model for measuring complex care.
- Some fields are redundant or use different wording to measure the same thing.
- Limitations in linking data
- Altering fields has consequences for how related fields are populated and accessed, and may interrupt data collection already under way.
- Building new fields requires re-training nurses.
Data Driven: the *Right* Data at the *Right* Time

- **EHR**
- **ETL Process**
- **Data Warehouse**
- **Structured Data Pulls**
- **Dashboards**
- **Scorecards**
Care that is Comprehensive: IPCP Team

Additional on-site specialties
- Nutrition
- Diabetes education
- Chiropractic
- Podiatry
- Retinal screening
**Novo – Managing the Patient Relationship**

*Internal Rules engine takes into account:*
- No Shows
- Panel Size Management
- Age Restrictions
- Appoint type restrictions
- Specialties
- PCMH+ Risk Scores
- ED Visits
- Load balances Longer appt. types i.e. Physicals & Initials

- Medicaid Verification
- In Clinic

- Patients
  - Incoming Phone Calls
  - Providers / 3rd Parties

- Patient Support Services (All CHC Sites)

- Novo
  - Patient Validation
    - Patient Profile
    - Recalls / Appts / Alerts
    - Rules Engine*
      - Nurse Triage
      - Appt Scheduling
      - Other Administrative Support

- Update Patient & Scheduling Information (Centrcity)

- EHR Data (eCW)
- 3rd Party Data
  - ED Data
  - Health Risk Patient Cost

- Care Team Data
- Appointment Data (Centrcity)
- Preventative Care Reminders
NOVO

WYA (Wherever You Are) Healthcare for the Homeless Program

CHC has medical sites at homeless shelter sites across Connecticut. Appointments can be scheduled on site at the shelters or through NOVO. If patients have questions they may contact the following people:

New London – New London Main Site
Danbury – Danbury Main Site
Middletown, Meriden, New Britain, Wallingford – Melissa Aurora (860) 622-1517

Early Detection Program (EDP)

Pre-Exposure Prophylaxis (PreP)

Medication provided to patients who are HIV NEGATIVE but at high risk for contracting HIV. This medication is 99% effective in eliminating risk for HIV if taken every day. Primary Care Providers are able to provide this medication and CHC has a full time PreP navigator responsible for tracking and coordination of all PreP patients agency wide. Contact information for PreP Navigator – Idiana Velez CHC Extension 3908

CHC Ryan White – HIV Program

CHC is funded by the Ryan White Care Act to provide comprehensive medical and HIV Specialty care to people living with HIV. Appointments can be scheduled in NOVO but for any questions please use the following contact information.

Omar Perez – CHC Extension 6098
Maria Lorenzo – CHC Extension 6062
# Planned Care Dashboard

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<thead>
<tr>
<th>Patient</th>
<th>PCP and Visit Info</th>
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<tr>
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<tr>
<td></td>
<td>Sex: F Age: 12.0 Last Dental Visit: 9/11/2006 Reason for Visit: initial/physical...w/ twin brother</td>
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<tr>
<td></td>
<td>Next Medical Appointment: 9/8/2016 1:20:00 PM</td>
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<tr>
<td></td>
<td>Sex: F Age: 63.0 Last Dental Visit: 5/5/2016 Reason for Visit: pre-op</td>
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## ALERTS

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<td>Depression Screening</td>
<td>Never Done</td>
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<tr>
<td>WHO CANDIDATE</td>
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## Bubbles

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### Planned Care Dashboard

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#### ALERTS

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<td>DM Foot Exam</td>
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**Next Medical Appointment:** 6/14/2017 9:20:00 AM

- **Sex:** M
- **Age:** 45.0
- **Last Dental Visit:** Never Done
- **Reason for Visit:** 

**Bubbles**

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<tr>
<td>Doc</td>
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<td>Lab</td>
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Planned Care in Behavioral Health and Delivery of Integrated Services

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<th>ID</th>
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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 Req'd</th>
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<tr>
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<td>9</td>
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For New Britain Medical

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<th>Appt Start</th>
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<tr>
<td>9:20:00 AM</td>
<td>9:40:00 AM</td>
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<td>BH Diagnosis</td>
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<tr>
<td>9:40:00 AM</td>
<td>10:00:00 AM</td>
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<td>Scheduled</td>
<td>Opioid Patient</td>
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<tr>
<td>9:40:00 AM</td>
<td>10:00:00 AM</td>
<td></td>
<td>Scheduled</td>
<td>Opioid Patient, Last PHQ &gt;= 15</td>
</tr>
</tbody>
</table>
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
Making Geography Irrelevant Through eConsults

• Provider requests a specialty consult, submits to referral coordinator

• Referral Coordinator generates eConsults based on standard process/protocol (default eConsult)

• eConsults sent using technology best suited for each site;

• eConsult recommendations:
  – Primary care management: eConsult returned to PCP/referral coordinator at the primary care site
  – “Bricks and mortar” Face to Face: CeCN hands off patient data and information to PCP organization referral team to schedule traditional face to face visit with specialist
eConsults

Resolved without a F2F: 83 (69%)

Required a F2F: 34 (31%)
<table>
<thead>
<tr>
<th>Current Specialties</th>
<th>Coming Soon</th>
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<tr>
<td>Cardiology</td>
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<tr>
<td>Dermatology</td>
<td>Addiction Medicine</td>
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<tr>
<td>Endocrinology</td>
<td>Complex Primary Care</td>
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<tr>
<td>Gastroenterology</td>
<td>Developmental Pediatrics</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>Pediatric Cardiology</td>
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<tr>
<td>Nephrology</td>
<td>Pediatric Endocrine</td>
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<td>Pediatric Behavioral Health</td>
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<td>Pediatric Pulmonary</td>
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<tr>
<td>Orthopedics</td>
<td>Retinal Screening</td>
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<tr>
<td>Pain Management/Medicine</td>
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<tr>
<td>Psychiatry</td>
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<tr>
<td>Rheumatology</td>
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<tr>
<td>Urology</td>
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Development of a Dashboard to Provide Decision Support for Complex Care Management in Primary Care
Global Alert for Enrollment in Complex Care Management

• Allows for more population-based views of complex care processes and outcomes.
• Provides more complete and more timely access to population health trends and analytics based on the rich data set.
• Helps reduce variations in complex care management
• Minimizes the data collection burden – structured data may be automatically extracted for complex care measurement
Global Alert for Enrollment in Complex Care Management

RN CCM Global Alert
Global Alert for Enrollment in Complex Care Management

Global Alert on Patient’s Home Page
Reason for Complex Care Management

<table>
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<tr>
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Consider Possible Data Sources

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<tr>
<th>Patient ID</th>
<th>Uncontrolled DM</th>
<th>Uncontrolled HTN</th>
<th>Uncontrolled Asthma</th>
<th>&amp; Chronic Cond.</th>
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*From hospitalization document*

*From CHN Claims data*
**Customizing the Sort**

![Graphical representation of a data table with columns for Patient ID, 2 ER Visits in Last 12 Mths, Hosp. in Last 12 Mths, Uncontrolled DM, Uncontrolled HTN, Uncontrolled Asthma, 4 Chronic Cond., Smoking Status, A1C, Blood Pressure, LDL, Gender Age.](image)
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<th>A1C :</th>
<th>Blood Pressure</th>
<th>LDL :</th>
<th>Gender</th>
<th>Age</th>
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<th>Action Item</th>
<th>Action Item Due Date</th>
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<th>Last Dental Visit</th>
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</table>
Revised CCM Dashboard

New filter option
## Self-Management Goal in EHR

### Self-Management Goal Details

#### 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 FBS be, recording your results, testing action plan, verbalized understanding. Hypoglycemia Patient explains that he has not had an episode in the last few months, but when he does get dizzy and his BG reading would be lower than 100 but it's never been below 70. He treats hypoglycemia with half a cup of orange juice and a piece of sweet bread. Symptoms — Polyphagia after dinner, desire for any other symptoms of hypoglycemia. Foot problems — Denies. Note — 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: None 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 returns excellent adherence.

---

#### Care Coordination Drill

**Patient ID**

**2 ER Visits in Last 12 Mths.**

**Hosp. Last 12 Mths.**

**DM HTN Asthma A1C Chronic Cond.**

**Smoking Status**

**A1C BP Age - Sex CC Start Date CC End Date**

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<th>Hosp. Last 12 Mths.</th>
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<th>HTN</th>
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<td>5/25/2016</td>
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Training Primary Care RNs to a New Model

Project ECHO: RN complex care Management: 24 RNs participate bi-weekly for two hours of didactic, Plus case presentation and feedback
Project ECHO Complex Care Management: Training Primary Care RNs to a New Model

- First session on 9/24/15
- Duration: 2 hours; 1 didactic and ~2 cases
- All 12 sites involved – Approx. 35 nurses
- Faculty consists of:
  - Chief Nursing Officer
  - Medical Provider
  - Pharmacist
  - Behavioral Health Provider
  - Homecare Nurse
  - Complex Care Management Specialist and Certified Diabetes Educator
  - Registered Dietician and Certified Diabetes Educator
  - Access to Care Coordinators
Equipping RNs for Complex Care Management

Didactic Topics Covered:

1. Complex Care Management
2. Care Transitions
3. Homecare Nursing
4. Health IT for Complex Care Management
5. Complex Pain Care
6. Substance Abuse
7. Self-Management Goal Setting
8. Medical Nutrition Therapy
9. Diabetes Management
10. Diabetes Medication Management
11. Personality Disorders
12. CT Medicaid: Intensive Case Management Program
13. Medication Reconciliation
14. HIV PrEP and PEP
15. LGBT Cultural Competency
16. Asthma (Tx, Meds, Spirometry)
17. Wound Care
18. COPD
19. Congestive Heart Failure
20. Obesity and Weight Management

Future Topics:

1. HIV
2. Hepatitis C
3. Role of the Complex Care Management Nurse
4. Anxiety Disorders
5. Triage for Behavioral Health Concerns and the Suicidal Patient
6. Psychiatry Medications
7. Buprenorphine Treatment
Transition Care Template
Transition Care Template

**HPI:**

Hospital Transition

- Hospital Discharge
  - From: ---

- ED Discharge
  - Admission Date: ---
  - Admission Reason: ---
  - Discharge Date: ---

- Medication
  - Medications Reconciled? ---
  - Medications Filled? ---
  - Medication adherence ---
  - Reasons for poor med adherence ---
  - System for taking medications? ---

**Follow-up/Discharge Plan**

- Other agencies providing services? ---
- If yes, has patient been contacted by agency? ---
- Reviewed discharge instructions ---
- Follow up appointment with PCP? ---
- Specialist follow up ---
- Transportation ---

**Red Flags**

- Alarm symptoms present ---
- Alarm symptom/zone sheet reviewed? ---

**Self-Care**

- Patient needs assistance with: ---
- Support System ---
- Community Services ---

**Patient’s Concerns**

- Patient is concerned about: ---

**VNA Referral:** ---

**Falls**

- Patient fell in hospital ---
- Patient fell at home ---
- Patient at risk for falls at home ---
- Home safety evaluation ---
Percent of fields completed

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<tr>
<td>Admission Reason:</td>
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<tr>
<td>Follow-up/Discharge Plan</td>
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<td>Medication</td>
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<td>Self-Care</td>
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<td>VNA Referral:</td>
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<td>Falls</td>
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Self Management Goal Template

Nursing Care Coordination

Self Management
Self Management Goal Template

Ready to Set New Goal
Self Management Goal Template

Confidence Interval

Motivational Interviewing
Self Management Goal Template

Select or type the self-management goal:

New goal: reduce soda intake from 3 cans per day to 1
Self Management Goal Template

Follow-up on a current self-management goal
Self Management Goal Template

Progress Toward Goal
Why a Scorecard?

- “Live” data
- Reinforces a “measurement culture”
- A framework for decision-making
- Linkage of strategy and resource allocation
- Learning and continuous improvement
- Greater management accountability
- Support staff in understanding the value of their work
Development of Care Coordination Scorecard

- Designed in coordination with CC Dashboard
- Define potential CC patients
- Discipline-specific measures
- Include both Clinical and Operational measures
- Track core program objectives over time
- Link data with desired responses
- Ensure usability
- Dedicated time for use

Design & Implementation
Care Coordination Scorecard: County Summary
Care Coordination Scorecard

Fairfield County: Current Enrollment by Date

- Nurse Name
- Patients Currently Enrolled

<table>
<thead>
<tr>
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<th>Nurse</th>
<th>Name</th>
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<tbody>
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<td>24</td>
<td>26</td>
</tr>
<tr>
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<td>3/31/2015</td>
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<td>14</td>
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<td>62</td>
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<tr>
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## Complex Care Management Scorecard

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<th>Nurse</th>
<th>PCP</th>
<th>Panel Size</th>
<th>Total CC Patients</th>
<th>Potential CC Patients</th>
<th>CC TE's</th>
<th>HTN Controlled</th>
<th>HTN Patients</th>
<th>Controlled HTN</th>
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<td>120</td>
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<tr>
<td>20</td>
<td>102</td>
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Lessons Learned

• Focus on Design & Implementation
• Include the Frontline team members in every step
• Ongoing improvement
  • Design
  • Measures
  • Data
• Ongoing training/Support
• Evaluate usability
• Celebrate success
Thank you
EHR References


Dashboard References


Scorecard References


Key Populations
Quality Improvement Model

Kasey Harding – Wheeler, MPH
Director of the Center for Key Populations
Community Health Center, Inc.
hardink@chc1.com
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
“Wherever You Are”
Healthcare for Homeless
## Who do we serve?

### Number of patients served since January 1, 2016

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<th>Patients/Sessions</th>
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<td>Unduplicated WYA Patients</td>
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<tr>
<td>Behavioral Health Visits</td>
<td>750</td>
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<tr>
<td>Dental Visits</td>
<td>438</td>
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<tr>
<td>Substance Abuse</td>
<td>560</td>
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### Top Five Diagnosis Since January 1, 2016

- Primary Hypertension
- Type 2 Diabetes Mellitus
- Hyperlipidemia
- Behavioral Health Needs
- Immunization Visit
### Where do our patients come from?

<table>
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<th>Patient reported living situation</th>
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<td>Patients who report living in the shelter or site where we see them</td>
<td>45%</td>
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<tr>
<td>Patients who report living outside or in their car</td>
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<tr>
<td>Patients who report living in transition with a relative or friend (usually for less than a week at a time)</td>
<td>11%</td>
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<tr>
<td>Patients who report not knowing where they will stay the night of their medical visit</td>
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<table>
<thead>
<tr>
<th>Patient Reported Risks</th>
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<td>Domestic Violence History</td>
<td>36%</td>
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<tr>
<td>Substance Abuse History</td>
<td>51%</td>
</tr>
<tr>
<td>Serious Mental Health History</td>
<td>62%</td>
</tr>
<tr>
<td>Emergency Department Visit within last 30 days</td>
<td>26%</td>
</tr>
<tr>
<td>Hospital Admission within last 6 months</td>
<td>21%</td>
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<tr>
<td>Previous suicide attempt</td>
<td>33%</td>
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<tr>
<td>Incarcerated within the last 2 years</td>
<td>19%</td>
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</table>
What services do we offer?

- Primary Care Services
- Dental Treatment and Dental Hygiene
- Individual and Group Substance Abuse Services
- Individual and Group Behavioral Health Services
- HIV Treatment and Services
- Hepatitis C Treatment and Services
- Diabetes and Nutrition Education
- Podiatry Services
- Group Nutrition Visits
- Team Based Care Coordination
- Opiate Replacement Therapy
- Narcan Education
- Early Detection Program for Breast and Cervical Cancer
- Wise Woman Cardiovascular Early Detection Program
- Bi-Annual Mobile Mammogram
- Annual Flu Clinics
- High Impact HIV Prevention – PrEP, PEP
The future of Healthcare for the Homeless

Community Based Care

Preventive Healthcare

Technology Enhanced Care

Medical Respite Care
Why is Quality Management Important?

✓ Measures performance at the agency, team and individual level
✓ Maximizes patient health outcomes and safety
  ~ Process outcomes
  ~ Health outcomes
✓ Improves efficiencies and reduces waste
✓ Decreases cost associated with process failure and poor outcomes
✓ Provides proactive process that recognizes and solves problems before they occur
✓ Improves Communication
✓ Involves teams, including consumers, in QM decision making
✓ Provides another method of program accountability
Specific Quality Management Challenges and Limitations in Non-Traditional Sites

Processes for non-traditional sites may differ from main sites

- Budget limitations
- Equipment, supplies and hours may not be conducive to all initiatives
- Staffing is often limited
- Not all staff roles are represented
- Staff coverage can be limited
- Training and education constraints
- Geography, location, proximity limitations
- Leadership Buy–In

Productivity/Capacity Limitations
“Quality is not an act, it is a habit.”

- Aristotle
Improvement Ramp for Implementing Quality Improvement

Step 1
Team Structure
Define TBC Structure (Core, Extended), Schedule Meetings

Step 2
Assessment
What is our current practice?

Step 3
Global Aim
What is our overall goal for advancing team based care model?

Step 4
Define Problem
Let’s define the problem. (Fishbone Diagram and Process Mapping)

Step 5
Specific Aims
What do we want to accomplish in the short term?

Step 6
Measures
How will we know that we accomplished it?

Step 7
Change Ideas
Let’s brainstorm what can we try to do differently? Strategies?

Step 8
PDSA
Repeat PDSA as needed, start new

Step 9
Standardize
Make it standard practice.

Step 10
Spread and Monitor
Spread, track how it’s working.
Building a Team – Optimizing Roles

Make conscious choices about who is on the team.

Decide ahead of time how many people will be on the team

Have diversity in your team make-up

Have as many roles as possible represented

Ensure availability and enthusiasm of participants

Get leadership approval for all participants – don’t forget to include all supervisors on communication

Create a positive opportunity that promotes participation

Remember that your team will be your “word on the street”
Effective Meeting Skills: Keep It Simple

Ground Rules

Meeting Roles

Timed Agenda

WORK
PURPOSE STATEMENT

Why Are We Here?

PURPOSE

WE THE RN TEAM AT CHC

STRIVE TO ACCOMPLISH 3 GOALS WITH THE WORK WE DO.

1. TO PROVIDE THE BEST QUALITY CARE AND SUPPORT TO THE MARGINALIZED POPULATIONS WHILE WORKING TO REDUCE STIGMA AND HELP PATIENTS REACH THEIR FULL POTENTIAL.

2. TO USE INNOVATION AND KNOWLEDGE TO FURTHER CHC’S MISSION OF ACHIEVING A WORLD CLASS, INTEGRATED PRIMARY HEALTHCARE SYSTEM.

3. TO PROVIDE A WORK ENVIRONMENT THAT SUPPORTS PERSONAL AND PROFESSIONAL GROWTH AND FULFILLMENT.
What drives the **Patients** Nuts

1. NOVO
2. ACCESS TO TEAM
3. WAIT TIME DURING APPT. (DOUBLE BOOKS)
4. PRIOR AUTH WAIT TIME
5. EXPECTATIONS
6. ACCESS TO BH/DENTAL
7. RESPONSE TIME
8. COMMUNICATION (APPT/REFERRALS/RECALLS)
9. TRANSPORTATION
10. GROUPS & EDUCATION
11. BH
12. BILLING
13. FORMS/LETTERS
14. LAB ACCESS
15. ACCESS TO PROVIDER - APPTS & F/U

What drives the **Team** Nuts

1. CAMARADERIE
2. DEDICATION
3. THE CAUSE
4. TEAMWORK
5. FLEXIBLE
6. COMFORT LEVEL W/ EACH OTHER
7. SUPPORT TO PTS
8. EXCELLENT CARE
9. TEAMWORK
10. COMPLEMENTARY SKILL SETS
11. PATIENCE
12. SUPPORT TO EACH OTHER
13. INDIVIDUALIZED CARE
14. COMMUNITY ACTION
15. MEDICAL HOME
16. COMMUNITY AGENCY COLLABORATION
17. STAFFING
18. BILLING/COLLECTION BAL.
19. REFERRALS/NO SHOWS
Common themes

- O = Administrative Responsibilities
- O = PT/Team Dynamics
- O = Data
- O = Access
- O = Agency Issues
- O = Community Collaboration
- O = Integration
TOOLS

Fishbone Diagram

Parking Lot
Map Current Process

<table>
<thead>
<tr>
<th>Write a Theme for Improvement: Access</th>
</tr>
</thead>
</table>

**Global Aim Statement**

Create an aim statement that will help keep your focus clear and your work productive. We aim to improve: **The execution & documentation of ICSP clinical performance measures**

(Name the process)

In: **New Britain**

(Clinical location in which process is embedded)

The process begins with: **An ICSP patient being scheduled for a visit with a provider**

(Name where the process begins)

The process ends with: **The successful completion & documentation of the clinical performance measures**

(Name the ending point of the process)

By working on the process, we expect: **To improve the quality of patient care, improve reporting, and improve efficiency of the team.**

(List benefits)

It is important to work on this now because: **The RSR is due in December, reporting/data benefits the patient, the patients feel more connected in times where access is limited, team needs to be more efficient in light of schedule changes.**

(List imperatives)
Map New Process

**Specific Aim Statement**

We will: □ improve  □ increase  □ decrease

The: □ quality of  □ number/amount of  □ percentage of
ICSP Patients Attending an Annual Exam  
(process)

From: **0 patients**  
(baseline state/number/amount/percentage)

To: **25 patients**  
(describe the change in quality or state the number/amount/percentage)

By: **September 1, 2014**  
(date)
PDSA Cycle: Example Annual Exam

Plan: Test the use of a pre-visit checklist that identifies patients in need of annual screenings. MA completes pre-visit checklist and hands to provider after rooming the patient. Provider completes necessary screenings, orders labs, and documents in the EHR.

Do: Measure the number of patients that received an annual exam. Measure the time it takes to complete the annual exam.

Study: Time needed to complete the pre-visit huddle, checklist, and screenings in visit proved too burdensome on the team.

Act: Place the idea of an annual exam on hold due to the time burden. Choose a new global aim for focus based on a piece of the annual exam.
Themes, Processes, Patterns, and PDSA Cycles

Global Aims

Coverage
- PDSA
- Spec. Aim
- PDSA
- Spec. Aim
- PDSA
- Spec. Aim

PAPS
- PDSA
- Spec. Aim
- PDSA
- Spec. Aim
- PDSA
- Spec. Aim

Referrals
- PDSA
- Spec. Aim
- PDSA
- Spec. Aim
- PDSA
- Spec. Aim
- PDSA
- Spec. Aim
Timeline for Rollout

PDSA 1:
- Pod
- Evaluate & Create Action Plan
- Data Review
- Data Review
- Training for Microsystem Team

Dec. ‘15

PDSA 2:
- Time Study
- Survey Monkey Qualitative review
- Training
- Newsletter Article to Agency

Jan ‘16

PDSA 3:
- Expand to other clinical teams
- EHR Change
- Playbook
- Decision on Agency Roll-Out

Feb ‘16

PDSA 4:
- SOGI for Peds
- RN/LPN Training
- Report out to Performance Improvement (PI) Committee
- Data Review
- Data Review

Mar ‘16

June ‘16

July ‘16
Timeline for Rollout

Aug '16
- System Change
- PSA, MA, Provider Training

Sept '16
- Agency Go-Live
- Data review PI Committee Meeting

Oct '16
- Site Meetings & Retraining

Nov '16

Dec '16

Jan '17
- Data Review PI Committee Meeting
- Internal Resource Page Published
### Use data to drive communication and momentum
Agency-wide 6-Month SO/GI Collection Rates

<table>
<thead>
<tr>
<th>Patient Age Group</th>
<th>18 years+</th>
<th>13-17 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Profile Complete</td>
<td>30359</td>
<td>4356</td>
</tr>
<tr>
<td>Profile Started, Not Complete</td>
<td>971</td>
<td>197</td>
</tr>
<tr>
<td>Total Patients with at least Partial SOGI Profile</td>
<td>31330</td>
<td>4553</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>SOGI Status</th>
<th>Count</th>
<th>Percent</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Profile Complete</td>
<td>30359</td>
<td>78.6%</td>
<td>4356</td>
<td>54.2%</td>
</tr>
<tr>
<td>Profile Started, Not Complete</td>
<td>971</td>
<td>2.5%</td>
<td>197</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

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Use data to drive communication and momentum.
Use positive patient feedback to sustain momentum!

First place I seen do this. Anything I want to be. Good job!
Improving Team Communication

- Give teams time to meet - huddles
  - Use Effective Meeting Skills
    - Establish Ground Rules
    - Meeting Roles
    - Agenda
  - Tools: Idea Tree and Parking Lot
- Understand your purpose as a team
Improving Team Communication

The 13 Rules of Team Engagement:

1. Celebration: describe wins at every meeting.
2. Transparency: declare yourself. Hidden agendas are unacceptable.
3. Exploration: add to ideas.
5. Honor: difference is strength not weakness.
7. Candor: point out what isn’t working.
8. Accountability: deliver on commitments.
10. Clarity: ask questions before drawing conclusions.
11. Flexibility: be willing to change your mind.
12. Results: who does what by when?
Improving Team Communication

Enhancing dynamics:
4 questions individuals can ask the team:

- What strengths do I bring to the team? (name three)
- When am I most useful to the team? (identify a situation or interaction)
- How could I better contribute to the team? (describe an observable behavior)
- What are your hopes for me in relation to the team? (meaningful contribution)
Effective Communication – CHC model

Regional Monthly Meetings – community partners and collaborators are invited to CHC for meetings to discuss services and patients.

Community Care Team Meetings – CHC participates in meetings held by the Emergency Departments in most towns where we have services. Discussion of high risk patients and decreasing utilization of ED and hospital admission reductions.

Quarterly Shelter Staff Meeting – CHC attends shelter meetings to communicate changes in services with shelter staff on a regular basis.

CHC Monthly Staff Meetings – Designed to ensure that all staff working in various shelters across the agency are communicating effectively and have the support they need.

Printed Materials – Printed materials are updated and disseminated by the communications and outreach department.
Lessons Learned

• Quality Improvement is on-going and the process requires continuous attention.
• Prioritize a true change in agency culture not just process.
• Find and lead with your team – make them your champions.
• Facilitate collaborations with internal departments early in the process (i.e.: data, business intelligence).
• Be prepared for the “hoops” you need to jump through to get to an agency wide initiative – committee presentations, BOD approval.
• Patient feedback can invigorate enthusiasm in staff.
• Communicate results
Thank You!

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Wrap-Up
Final Questions
Building an Action Plan
Survey
Where to start?
Build Your Action Plan and Team!

Meet together

Redesign Care Team Roles

- What’s the work?
- Address staff concerns
- Understand scope of practice
- Evaluate how things are going
- Patient input
- Plan for spread

Facilitate teamwork

- Trust
- Training
- Titles
- Data needs
- Think hard about part-time providers
- Standing orders
- Co-location

• Daily Huddles
• Weekly/biweekly QI meetings
• Start with Core team 1st, then expanded care team

Meet together

- What’s the work?
- Address staff concerns
- Understand scope of practice
- Evaluate how things are going
- Patient input
- Plan for spread