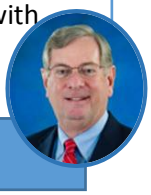
TCPi | Transforming Clinical Practices Initiative

Change Package in Action

This tool highlights how the TCPI National Faculty's transformation experiences relate to the TCPI Change Package. This document is categorized by Primary Drivers, Secondary Drivers, and Change Concepts. The TCPI Change Package describes the changes needed to transform clinical practices and meet TCPI goals. Each faculty has shared their experiences as they relate to the Change Package and how it relates to their performance story below. The faculty has only shared a few sentences about each change concept to provide an introduction into their expertise and as an invitation to follow-up with Faculty. Click on the Secondary Drivers below to view what the faculty has to offer. You may also search for a specific faculty member using CTRL + F or the Navigation Side Bar.

1.1 Patient and Family Engagement

1.1.1 Respect Values and Preferences. As a volunteer, and now CEO, of the National Blood Clot Alliance I have worked since 2004 to encourage clot survivors and their families to be actively engaged in their continuing medical care. I have made in-person presentations, participated in webinars, and written numerous articles on the importance of survivors and their families understanding of the nature of their medical condition and communicating effectively with their health care providers in order to achieve the best medical outcome possible. I have also worked with hospitals seeking to improve engagement with patients as part of PCORI contracts, where the National Blood Clot Alliance provides the patient perspective in the trial.



Randy Fenninger, JD, Vienna, VA

1.1.1 Respect Values and Preferences. My most powerful experience was working with patients and families around End of Life preferences to complete a Living Will, Medical Durable Power of Attorney or, in Colorado, the Medical Orders for Scope of Treatment form. The physicians, PAs, RN Care Manager and MAs all cherish working with patients and families at our office to get these documents to reflect their (the patients') preferences.

Mary Reeves, MD, Salida, CO

1.1.2 Listen to Patient and Family Voice. Getting feedback from patients has been very helpful. If any issue is identified by our patients, service recovery is done with 24-48 hours. Our patient satisfaction scores are at 4.7 to 4.8 out of 5.

Sabiha Raoof, MD, FCCP, Queens, NY

1.1.2 Listen to Patient and Family Voice. I help develop training videos for new staff at our hospital speaking on the pillars of family centered care and how that relates to the patients and families. By using patient testimonies in the video, staff can put a face and actual story with that concept and its importance.

Desiree Collins-Bradley, Houston, TX

1.1.2 Listen to Patient and Family Voice, 1.1.3 Collaborate with Patients and Families. Our clinic redesigned process improvement activities to include patients and families. In the outpatient setting each patient leaves with a set action plan as part of the After Visit Summary given at each visit. This plan might include reconciled medications/lab results/next visit scheduled or planned/high end imaging, or testing scheduled/specialty referrals.

Montgomery Elmer, MD, Appleton, WI

1.1.2 Listen to Patient and Family Voice, 1.1.3 Collaborate with Patients and Families. Patient partners have been embedded within our practice's quality improvement teams in all of our Patient Care Medical Homes and are critical to the development of office workflows.

Marijka Grey, MD, FACP, York, PA

1.1.3 Collaborate with Patients and Families. We started a PFAC and have been active for two years. Our patient members are eager to help us create solutions to challenges we face in the daily operations of the clinic. Our staff/ provider members come away from those meetings invigorated and refocused on our primary goal which is patient experience and care. Patient members leave the meetings with the pride knowing that their trusted healthcare team values their opinion.

Meggan Grant-Nierman, DO, Salida, CO

1.1.3 Collaborate with Patients and Families. In my practice really focused on the patient's goals and choices. In order to be able to do this we utilized pre-visit prep, team care & shared decision making.

Carol Greenlee, MD, Grand Junction, CO

1.1.3 Collaborate with Patients and Families. In collaboration with hospital leadership, I successfully recruited and built the PFAC for our Newborn Center. Today it is very active and has become a tool that our hospital uses not only in collaboration for our Newborn Center, but for hospital wide improvements as well.

Desiree Collins-Bradley, Houston, TX

1.1.3 Collaborate with Patients and Families. The clinical pharmacy team within our primary care clinics play an active role in ongoing engagement with patients and their families. Motivational interviewing techniques are used when coaching and goal-setting with patients and family members with chronic health issues such as diabetes, hypertension, and cardiovascular disease. Care plans are created in a collaborative fashion using shared-decision making with patients. Patients and family members are then contacted in the interim by pharmacists to ensure care plan and medication adherence, to assess progress towards goals, and to address barriers to care.

Christine Rash-Foanio, PharmD, Chicago, IL

1.1.3 Collaborate with Patients and Families. In 20 years navigating the health care system as a primary caregiver for two special needs kids, I have never been asked directly by a clinic about our care experience or what could have been better. We are expected to fully adhere to a system that is not flexible or responsive – we come into the health care world vs. them coming into our world. I've had lots of simple ideas that would have improved compliance, reduced visit times, and even made the provider's job easier; but no one to share these ideas with and no one to listen. Please ask and start a conversation with patients and families – they are your best resource for transformational ideas!

Susan Brown, MPH, CPHIMS, West Des Moines, IA

1.1.4 Be Aware of Language and Culture. We have continuous interpreting of over 80 languages by video/ telephone and in-person interpretation in eight languages. Our staff is intentionally hired from our target communities and serves as cultural ambassadors in culturally sensitive care designs. Multiple care team members, including providers, are linguistically and culturally fluent in the multiple cultures that we serve.

Kirsten Meisinger, MD, Boston, MA

1.2 Team-Based Relationships

1.2 Team-Based Relationships. At WellSpan Medical Group we've redesigned care around the patient, providing consistent care teams within our patient centered medical homes, including social work, health coaches, and case management that all exist to support the patient.

Marijka Grey, MD, FACP, York, PA

1.2.1 Enhance Teams and 1.2.2 Clarify Team Roles. Team based care is, in my opinion, the cornerstone of practice transformation. We started our journey in transformation four years ago but it wasn't until our teams were full and robust that we started to see real growth. Having our medical assistants work as a team with the provider and with each other advances their duties and roles in the patient encounter and has given them a stronger sense of value and identity in the care team. Patients are recognizing them as an increasingly essential part of their care. The medical assistants have ownership of their role in the encounter and they now recognize the value of working at the top of the license and sharing the work load/administrative burden which allows the providers to work at the top of their license.

Meggan Grant-Nierman, DO, Salida, CO

1.2.1 Enhance Teams. At ARcare, we have reduced the level of effort and rework by utilizing an enhanced Change Management Team that includes a multi-disciplinary group that meet regularly to identify opportunities for improvement and manage the change process for the entire organization.

Greg Wolverton, Augusta, AR

1.2.1 Enhance Teams. We have created and organized teams within our clinics, we have created teams that care for certain populations of patients within our larger organization, and we have teams that care for patients in our satellite clinics. These teams involve core staff, certain care "teamlets"; NP/Pharmacist (co-visits), NP/dental therapist, NP/specialists, NP/patient/community.

Jane Anderson, DNP, APN, C-FNP, C-ANP, Minneapolis, MN

1.2.2 Clarify Team Roles. We have reviewed team roles to identify areas of responsibility that could be moved to other staff members. For example, depression screening was previously a clinician responsibility that was transferred to nursing staff. We created electronic reminders in the EHR that alerted nurses when this test was due. We went from 0% documented screens to greater than 90% of patients ages 12 and over in less than one year with the embedded alert and electronic documentation process.

Brenda Kennedy, DHA, MBA, BSN, RN, FAIHQ, Augusta, AR

1.2.2 Clarify Team Roles. We have implemented standard work with roles and responsibilities for all care team members that have resulted in our medical group achieving over 90th percentile on most HEDIS type measures.

Beth Averbeck, MD, Minneapolis, MN

1.2.2 Clarify Team Roles. I work as part of a collaborative care team in which we deliver mental health treatment in primary care settings. By working with a care manger that can support the assessment of patients, as a psychiatric consultant I can leverage my time to support more patients that I can when seeing all the patients directly. Clarifying team roles when you are sharing the care is critical for success.

Anna Ratzliff, MD, PhD, Seattle, WA

1.2.2 Clarify Team Roles. Clinica Family Health utilizes an advanced care model and has been designing and redesigning care team roles for 15 years. Optimizing care team roles is at the heart of our success in driving quality outcomes as evidenced by multiple workflows we have developed in various areas of primary care.

Karen Funk, MD, MPP, Lafayette, CO

1.2.3 Optimize Continuity. Clinica Family Health has a 15 year history of prioritizing and continuity. We maintain 70% PCP continuity and 90% care team continuity.

Karen Funk, MD, MPP, Lafayette, CO

1.2.4 Define Specialty-Primary Care Roles. In our specialty practice, we utilized care compacts to help clarify what role was expected and I included delineation of my role in my referral response notes. I also chaired the National Medical Neighbor Project and the High Value Care Coordination project where we collaboratively defined the roles in Medical Neighborhood.

Carol Greenlee, MD, Grand Junction, CO

1.2.4 Define Specialty-Primary Care Roles. At CCWV, each provider has a morning huddle where the care coordinator, nurse, and patient navigator plan the day to anticipate if patients are candidates for health coaching, Medical Annual Wellness visits, care plans, or other quality initiatives.

Sarah Chouinard, MD, Central West, WV

1.2.4 Define Specialty-Primary Care Roles. We have project teams for low back/spine patients: NP/PT/ Spine surgeon- to provide evidenced-based appropriate conservative care to back patients. Appropriate specialty referrals, access to appropriate level of care within 2-3 days (not months for surgical consults- which is often inappropriate). We also have a project team with Pediatric Urology, using the same approach as the spinal care team.

Jane Anderson, DNP, APN, C-FNP, C-ANP, Minneapolis, MN

1.3 Population Management

1.3.1 Assign to Panels, 1.3.3 Stratify Risk. Each patient has an assigned provider (provider panels established) and through our EMR we are able to stratify risk and identify patients needing further intervention (hypertension or diabetic patients with conditions that are not under control). For patients with chronic diseases, we are able to identify if a patient is at their goal or not using our EMR.

Montgomery Elmer, MD, Appleton, WI

1.3.3 Stratify Risk. Our primary care clinics have adopted a standardized approach using reporting from our eHR to identify high-risk patients based on diagnosis and laboratory data. High-risk patients are then contacted and followed by care coordinators to assist in engaging the patients and help them to navigate the healthcare system.

Christine Rash-Foanio, PharmD, Chicago, IL

1.3.3 Stratify Risk. As part of my work delivering care, I use a registry to list all the patients that are enrolled in collaborative care. Each week, the care manager and I sort through this list of patients to identify the patients that are not improving. We then prioritize these patients for review and intensification of treatment. This helps our team focus on the patients that need it most!

Anna Ratzliff, MD, PhD, Seattle, WA

1.3.4 Develop Registries. Our registries are user-friendly and accessible to all team members with customization options. Our results are transparent across the organization and viewable by team, site and region. We can access any level of data to analyze our population.

Kirsten Meisinger, MD, Boston, MA

1.3.4 Develop Registries. We have been very successful at the identification and management of patients who meet multiple criteria. This has allowed us to develop patient-centered mechanisms to react to gaps in care and missed opportunities.

Greg Wolverton, Augusta, AR

1.3.4 Develop Registries. Clinica Family Health has experience in working with registries for population health for over 15 years and now utilizes a sophisticated patient-centered registry across all chronic conditions.

Karen Funk, MD, MPP, Lafayette, CO

1.3.5 Identify Care Gaps. We reviewed data and found that we had poor rates of obtaining at least one HbA1c test annually on our patients diagnosed with diabetes. We went from 16% to >80% by identifying this care gap and sharing results on this measure at a facility and provider level. Each facility team was required to discuss their own performance level for this measure and identify opportunities for improvement that would be deployed to help them improve.

Brenda Kennedy, DHA, MBA, BSN, RN, FAIHQ, Augusta, AR

1.3.5 Identify Care Gaps. As part of the "week-in-review" the Quality Team reviews lists of patients who have been identified by either quality programs through insurance incentive projects or through EHR monthly reports as needing services. Care Coordinators reach out the patients to encourage follow up care.

Sarah Chouinard, MD, Central West, WV

1.3.5 Identify Care Gaps. Our primary care sites identified diabetes mellitus (DM) as a high-prevalence condition among our practices. A registry of all patients with a DM diagnosis was created and reports were generated to identify patients who were uncontrolled or who had gaps in their DM care. An outreach plan was created for clinical pharmacists to contact and begin disease co-management of patients with uncontrolled DM. Success rates of achievement of DM control are then assessed on a monthly basis to ensure continuous improvement in clinical quality.

Christine Rash-Foanio, PharmD, Chicago, IL

1.3.5 Identify Care Gaps. Clinica Family Health developed a sophisticated Care Planner tool that works in conjunction with Nextgen to identify care gaps at the point of care about five years ago. This is a critical component of our care team huddles and is integrally related to our patient-centered registry or Outreach Tool.

Karen Funk, MD, MPP, Lafayette, CO

1.3.5 Identify Care Gaps. Care gaps are defined through our electronic health record with reports that can be pulled and acted upon. Currently we have diabetes, hypertension, screenings, immunizations, readmission rates, and depression screening (to name a few). Information is gathered and action plans created to identify who needs to help work the care gaps. In addition, we work with payers who have their own care gaps and receive patient specific reports to help reduce those as well. For one payer in particular that we meet with on a quarterly basis, our pediatrics department closed hundreds of care gaps for well child checks which improved on our timely immunization rates.

Misty Parris, RCEP, Bellingham, WA

1.4 Practice as a Community Partner

1.4.1 Community Health Needs. We have 3 types of satellite clinics.

1) One within an independent and memory care senior living community. This prevents the over-use of specialists, provides and educates in primary care services, provides access and family support within their community, and delivers health topic education on-site

2) Two mental health care facilities which provide access to care and assist in avoiding the ER or receiving no care

3) A treatment facility which assists in avoiding ER, access to care, continuity of care after discharge, and preventing relapse.

Jane Anderson, DNP, APN, C-FNP, C-ANP, Minneapolis, MN

1.4.2 Community Collaboration. I coordinate and participate in the non-profit Project Delivery of Chronic Care Houston (Project DOCC). It promotes community collaboration by getting the medical resident physicians out of the office and into the home of a chronically ill or disabled child or adult. It gives them a snapshot of a day in a life for the families and how it affects them. Baylor College of Medicine and University of Texas' medical residents conduct pre and post surveys and have seen great data-supported outcomes. They complete the post-survey after they have the home visit and parent interview. All of the evaluations are analyzed and they have consistently shown positive outcomes after each rotation. Baylor is in the process of completing a 10-year analysis of the program.

Desiree Collins-Bradley, Houston, TX

1.4.2 Community Collaboration. In my work with the National Blood Clot Alliance, I have been directly involved with medical specialty societies, like the American College of Emergency Physicians and the American College of Physicians, on programs related to improved care transitions, coordination of care, and medication management. At the National Blood Clot Alliance I oversee a physician referral network designed to connect patients with specialists who can help them overcome complex medical problems following a blood clot.

Randy Fenninger, JD, Vienna, VA

1.4.2 Community Collaboration. We spend very little of our lives in the healthcare system. What has really helped me manage my kids with special needs is our community resources such as our church, the Y, and case management services. Health care providers should ask and learn over time about the best resources in their particular community (since it varies), so that they are up to speed and share that helpful information with other patients and families. It "takes a village" and may keep patients from repeatedly bringing all their problems back to the healthcare system to solve!

Susan Brown, MPH, CPHIMS, West Des Moines, IA

1.4.4 Use Community Resources. We practice in a rural county that has a Health Coalition. Our RN-care manager serves on the coalition and has worked with the coalition to publish a web-based resource guide to community resources that can be used by anyone.

Mary Reeves, MD, Salida, CO

1.4.5 Be Transparent. Minnesota has over 10 years of public reporting, now on quality, experience and cost. We share those results transparently by clinic in some areas on the web and by clinician within the organization. This has been key to our medical group being one of the highest performing medical groups within Minnesota Community Measurement.

Beth Averbeck, MD, Minneapolis, MN

1.5 Coordinate Care Delivery

1.5.1 Manage Care Transitions. Through the state Health Information Exchange, we are notified when our patients have been to the ER. Each morning our care coordinators reach out to anyone who was seen in an ER to see if we need to follow up quickly and/or to see if we can encourage the treatment of non-emergent care in our offices next time.

Sarah Chouinard, MD, Central West, WV

1.5.1 Manage Care Transitions. Primary care has a care management program with RNs, LPNs and patient navigators. Through this process, patients that are discharged from the hospital, ED and nursing care facilities are risk stratified and followed up with the appropriate care management member and/or clinician. We have recently started collaborating with hospital care management teams for better hand off. We will be following hospital readmissions very closely through this process. To date, we call 100% of our high risk patients identified on a daily report. Also all of those patients called are all offered an appointment to be seen by the appropriate clinician within 7-14 days depending on their risk. We have collaborated with the hospital system to identify where readmissions are happening to drill down on where we need to focus our efforts.

Misty Parris, RCEP, Bellingham, WA

1.5.1 Manage Care Transitions. Patients who experience severe clotting episodes often need support from a variety of community services. The National Blood Clot Alliance has worked with patients and families to help them find sources for the services they need. We have experience helping patients and families expand their network to ensure that their medical, social and behavioral health needs can be met in order to achieve the best possible medical outcome.

Randy Fenninger, JD, Vienna, VA

1.5.1 Manage Care Transitions. We actively manage hospital discharges and ER visits. We have established work flows, designated staff to do the work, and we collect and review the data for effectiveness. Even with Medicaid expansion, ER visits have decreased by 7%.

Mary Reeves, MD, Salida, CO

1.5.3 Coordinate Care. As a Tier 3 Patient Centered Specialty Practice we focused on optimizing care coordination with use of team approach within our practice. We utilized patient and family partnership and engagement as well as improved communication and collaboration between practices or services.

Carol Greenlee, MD, Grand Junction, CO

1.5.3 Coordinate Care. My special needs son sees seven providers and I recently found a new primary provider for him closer to where we live. I really appreciated it when she picked up the phone (on her own) and had a conversation with several others, without me asking, to better understand his situation from day one. It has always felt like no one in healthcare talks to each other – that I am the walking medical record and without me there would be no coordination at all. I always wanted to be part of a patient centered medical home as a centralized point of coordination – maybe I have found that now! Coordinating care will result in improved patient/caregiver satisfaction, better health outcomes, increased efficiencies and hopefully provider joy in their work!

Susan Brown, MPH, CPHIMS, West Des Moines, IA

1.5.4 Ensure Quality Referrals. Improving the referral process and care coordination was a big part of our specialty practice transformation and included care coordination agreements, pre-visit review and pre-consultation. I also chaired the High Value Care Coordination workgroup (collaboration of primary care, specialists and patient & family advocate groups) where we created checklist of what makes up a good referral request and a good referral response and also helped create "pertinent data sets" (what to send with a referral) from several specialty societies for specific disorders.

Carol Greenlee, MD, Grand Junction, CO

1.5.5 Manage Medication Reconciliation. Clinical pharmacists are included on each care team within the hospital and within each primary and specialty care clinic to ensure the accurate, effective, and safe use of medications within our institution. Medication reconciliation that involves the patient and family is performed at all visits and points of care transitions. If medication issues are identified, patients are referred to clinical pharmacist clinic visits for co-management. Patients are seen by pharmacists at frequent intervals, if necessary, to ensure safe and effective use of mediations. All changes are documented and communicated within the medical record.

Christine Rash-Foanio, PharmD, Chicago, IL

1.6 Organized, Evidence-Based Care

1.6.1 Consider the Whole Person. As a caregiver for my special needs son, I voiced an idea to "cluster" services together during a single visit to maximize outcomes and efficiency for all involved (medical, dental, lab, and hygiene). Expecting to be told "no", the office instead worked with me to coordinate seven visits into one. The impact was outstanding patient/caregiver satisfaction, improved patient compliance, provider satisfaction/joy in work and positive patient health outcomes.

Susan Brown, MPH, CPHIMS, West Des Moines, IA

1.6.2 Plan Care. I heard of a clinic that co-created agendas with the patients and caregivers prior to a visit, sometimes in a more secluded section of a waiting room. The agenda addressed: Why are you here today? What is the desired outcome/result? How long are you expecting this visit to take? Any parking lot items for next time? I would be thrilled to do this prior to my kids' visits, since it would impact the efficiency of the visit, I would feel that my voice was heard and I would feel part of the care team.

Susan Brown, MPH, CPHIMS, West Des Moines, IA

1.6.3 Implement Evidence-Based Protocols. Electronic reminders were developed in the EHR to align with evidence-based protocols. For example, reminders for pharmacological therapy for persistent asthma increased from 21% to 69% and appropriate cholesterol treatment from 23% to 68%.

Brenda Kennedy, DHA, MBA, BSN, RN, FAIHQ, Augusta, AR

1.6.3 Implement Evidence-Based Protocols, 1.6.4 Decrease Care Gaps. We have changed the way we establish evidenced based protocols by using quantitative results from various discreet sources of data to drive care and have begun utilizing a two-source metric; Process (Qualitative) metrics and Outcomes metrics (Quantitative) in our informed data. This informed data is used to drive passive notices and gaps in care notifications and in some cases, automatically drive orders.

Greg Wolverton, Augusta, AR

1.7 Enhanced Access

1.7.1 Provide 24/7 Access, 1.7.2 Meet Patient Scheduling Needs, 1.7.3 Create Patient-Centered Spaces. We have always had 24-hour access to an on-call physician, long before it was a requirement of practice transformation. We had always had continuity of care because we are a rural practice and we see patients across the medical neighborhood (clinic, hospital, community sports physicals, nursing home, home visits, hospice house calls, etc.). This is one of the many milestones that our rural practitioners may already be meeting. We advanced in this driver by expanding to digital means of access with our teams as we now allow MAs and RNs to do protocol-driven nurse visits for things such as UTI appointments, Strep swabs, immunization visits, or wound care visits. This dramatically improved our access to care and also frees up providers to see appointments that absolutely require physician time. There were 308 Nurse visits in 2014, 697 Nurse visits in 2015 and 738 Nurse visits for 2016 which shows that in the first year of team based care, our nurse checks (which included RN wound care visits and MA protocol visits like suture removal, strep swab, UA checks, etc.) MORE THAN doubled in one year and further increased in the next year. This massively improves access as that is 738 visits that would have been on a physician schedule limiting other more critical patients from being seen.

Meggan Grant-Nierman, DO, Salida, CO

1.7.2 Meet Patient Scheduling Needs. We have made enormous strides in patient access by using MD/mid-level pairs to co-manage a panel of patients. We have improved continuity to over 90% with this pairing and patient satisfaction has improved due to improved choice and relationship building across the team.

Kirsten Meisinger, MD, Boston, MA

1.7.3 Create Patient-Centered Spaces, 1.7.4 Mitigate Access Barriers. Working as part of an integrated behavioral health care team in primary care, I can support the care of patients in a setting with less stigma. Most of my work is delivered over the telephone providing case reviews with a care manager. Because I work with a team, I have been able to support delivery of evidence-based treatment in a setting without access to a psychiatrist previously.

Anna Ratzliff, MD, PhD, Seattle, WA

1.7.3 Create Patient-Centered Spaces. My special needs kids have major sensory issues, which means the bright lights, noises and unknowns of the healthcare system are very difficult for them. I assume this applies across many patient types such as the elderly and mentally ill. A "sensory" exam room with lamp lighting (not fluorescent), an iPod playing soft music, and a rocking chair with a blanket is a wonderful example of a simple, inexpensive way to create an inviting atmosphere to increase patient compliance, improve patient satisfaction, shorten exam times, and allow providers to accomplish things with less resistance!

I heard of a clinic that gave iPads to a random sample of patients in the waiting room and asked them, while they waited, to take pictures of what they liked or didn't like about the office. Then to continue that process while waiting in the exam room and throughout the remainder of the visit. Then the staff quickly scrolled through the pictures with them at the end of the visit to capture their thoughts and took these notes to staff meetings. What a great idea!!

Susan Brown, MPH, CPHIMS, West Des Moines, IA

2.1 Engaged and Committed Leadership

2.1.1 Commit Leadership. Our small practice has committed leadership because the physicians are the practice owners and the leaders of the organization. We succeed because we all recognize that our community, our staff, our patients and our own livelihood depends on this practice staying in business. We commit as physician leaders to the process of transformation out of respect for each other as business partners and medical colleagues.

Meggan Grant-Nierman, DO, Salida, CO

2.1.1 Commit Leadership. We have developed a toolkit for leader standard work that was co-designed with leaders and our organizational leadership staff. This has helped sites identify areas of opportunity resulting in improved results. In one case, a site went from hypertension control in the low 70% to mid-80%.

Beth Averbeck, MD, Minneapolis, MN

2.1.1 Commit Leadership, 2.1.2 Develop a Roadmap, and 2.1.3 Create a Shared Vision. We shared our vision at department meetings, hospital-wide performance improvement meetings, and at Board of Trustees meetings. Our administration is fully supportive of our departmental goals.

Sabiha Raoof, MD, FCCP, Queens, NY

2.1.1 Commit Leadership, 2.1.2 Develop A Roadmap, 2.1.3 Create a Shared Vision. Through all our work and success on transformation, we have developed a leadership commitment to the work output. This commitment grew organically due to the measured success of previous transformation efforts and focus on short term wins. With these wins, we have been able to develop an automatic shared vision and roadmaps for the future.

Greg Wolverton, Augusta, AR

2.1.1 Commit Leadership. As the director of the clinic, I lead from within, we have no "leveling." Our team is the strength, I am committed to ideas and innovation. Our organizational leadership is committed to our mission and vision; there is on-going support both financially and through dissemination of what we are doing. We have daily verbal leadership commitment and support locally and organizationally.

Jane Anderson, DNP, APN, C-FNP, C-ANP, Minneapolis, MN

2.1.1 Commit leadership, 2.1.2 Develop a roadmap, 2.1.3 Create a shared vision. Community Board and CEO along with senior leadership team create a shared roadmap/vision for the organization. True North —a lean concept—helps synthesize goals for the organization. This is an ongoing process of vision development and adjustments with input from across the organization.

Montgomery Elmer, MD, Appleton, WI

2.1.1 Commit leadership. I have worked hand-in-hand with our hospital nursing leadership to help develop a rounding tool that would be used in our units. I have also been included in shared governance and nursing congress meetings to ensure the patient voice is included at the executive level.

Desiree Collins-Bradley, Houston, TX

2.1.2 Develop A Roadmap. The beauty of the TCPI Change Package is that it is the roadmap. Our senior leadership and care coordinators have gone through a four-part series regarding TCPI and are committed to using the change package as our guide in making workflow changes, hiring, and QI initiatives.

Sarah Chouinard, MD, Central West, WV

2.1.2 Develop a Roadmap. Clinica Family Health utilizes a deliberate structure of clinical and operational co-leadership at each of our health centers to help drive and standardize our care team model**.**

Karen Funk, MD, MPP, Lafayette, CO

2.1.2 Develop a Roadmap. Our transformation journey began with the Comprehensive Primary Care initiative and the roadmap we used were the nine milestones of the initiative. Don't re-invent the wheel. Find one and make it your own by discussion throughout your organization.

Mary Reeves, MD, Salida, CO

2.1.3 Create a Shared Vision. Union Square and Cambridge Health Alliance share a vision of equitable healthcare for everyone – regardless of age, gender, legal status in the US or any other distinguishing features. We have teams whose members all have their own panel of patients and we feel responsible for our patients in a highly professional manner. Our focus on making everyone feel special each day is what unites all of our work.

Kirsten Meisinger, MD, Boston, MA

2.1.3 Create a Shared Vision. We operate from our mission and vision statements, our culture is developed around this. I make hiring decisions with our mission and vision in mind, I make our culture very clear. I encourage those interested in working in our environment to spend time in the culture to know it fits for them.

Jane Anderson, DNP, APN, C-FNP, C-ANP, Minneapolis, MN

2.1.3 Create a Shared Vision. I helped our team come up with a strategy to display our infection and fall risk data transparently within the unit for all to see including patients and families.

Desiree Collins-Bradley, Houston, TX

2.1.3 Create a Shared Vision. Leadership talked about our vision and goals internally, but then as QI teams were formed, our workflows changed – tying in what was happening to the vision and goals of transformation. Celebrating early successes together helped create the shared vision.

Mary Reeves, MD, Salida, CO

2.2 Quality Improvement Strategy Supporting a Culture of Quality and Safety

2.2.1 Use an Organized QI Approach. We deployed a change management team to evaluate low areas of performance and identify the causes. The diverse membership of this team validated the data to make sure it was correct by drilling down to the patient level. The team developed standardized workflows to ensure data was captured correctly. Documentation of tobacco cessation counseling increased from 14% to 99% on patients ages 12 and over.

Brenda Kennedy, DHA, MBA, BSN, RN, FAIHQ, Augusta, AR

2.2.1 Use an Organized QI Approach. QI is organizational and integrated across all silos and sites utilizing a QRS committee (quality, risk and safety).

Karen Funk, MD, MPP, Lafayette, CO

2.2.2 Build QI Capability, 2.2.3 Empower Staff, and 2.2.4 Share Learning. I created dashboards and reports. I shared this information transparently to drive change and improve accountability. I also utilized Radiology QI software Montage to collect data. This was shared with the staff routinely.

Sabiha Raoof, MD, FCCP, Queens, NY

2.2.2 Build QI Capability. There are process improvement facilitators imbedded in the work at all levels of the organization. The staff identifies areas of improvement and the leadership has created a structure to facilitate the spread of learning.

Montgomery Elmer, MD, Appleton, WI

2.2.3 Empower Staff, 2.2.4 Share Learning. Empowering staff is the most rewarding process to watch unfold. It is difficult because some staff members are initially uncomfortable with the responsibility. Many of them have spent an entire career in one role so now to rapidly expand that role and give more ownership takes some time to get used to. Now MAs take initiative on a particular issue, come up with a plan to improve efficiency, and then spread the word to the rest of the staff and physicians. For example, my MA recognized that we could save time on our Pre-Op assessments if the patients had their bloodwork and EKG done BEFORE we see them so we can review it in person. Once we started doing this, we shared this with the other teams so that they too could benefit from this efficiency.

Meggan Grant-Nierman, DO, Salida, CO

2.2.3 Empower Staff. Performance boards are in each of our clinics that display where we are at with our metrics. Both staff and providers are asked to conduct rounds around the boards at least monthly to discuss these metrics and identify ways to improve them. We have also included Kaizen forms that staff can fill out for opportunities to improve any area within the clinic.

Misty Parris, RCEP, Bellingham, WA

2.2.3 Empower Staff. In my small solo specialty practice, changing from doing task work to actually being part of patient care and working as a team made a huge difference to my staff. We also developed a mindset of continuous improvement, with everyone part of determining how to do things better. It was "our" practice data, not "my" data. I first asked what their ideas for solutions were and did not try to solve everything. We really did change to shared accountability. This improved our care and our metrics. For example, our data for obtaining Urine Microalbumin on our patients with diabetes went from 23% to 93% and remained high.

Carol Greenlee, MD, Grand Junction, CO

2.2.3 Empower Staff. I get out of the way. Each individual is given the resources they need to perform at the highest level, to their full scope of practice.

We have shared governance, we make important decisions as a team, each discipline/staff member is the expert of their function, we expect to listen and plan our workflows based on the input of the person who does the work.

Jane Anderson, DNP, APN, C-FNP, C-ANP, Minneapolis, MN

2.2.4 Share Learning. As a collaborative care psychiatrist, I run a quarterly call with a group of psychiatric consultants working in primary care. We use our quality aims data (number of patients engaged in each caseload, number of patients with psychiatric consultants and percentage of patients improved on PHQ-9 score for depression) to understand where there are opportunities for improvement. We share ideas about how we can each support achieving our quality aim goals and learn from each other's ideas and successes.

Anna Ratzliff, MD, PhD, Seattle, WA

2.2.4 Share Learning. I accompanied my hospital team to the Vermont Oxford Network Quality Conference where I did a poster presentation on advocating for including patients and families in quality and safety work. I also spoke on various QI projects I was involved with at our hospital.

Desiree Collins-Bradley, Houston, TX

2.3 Transparent Measurement and Monitoring

2.3.1 Use Data Transparently. Scorecards were developed for key clinical and process measures. Scorecards are provided at the organizational, regional, facility, and clinician level to allow analysis at multiple levels. All these scorecards are shared across the entire organization through a monthly TOPS Report (Total Organizational Performance System) to encourage competition and sharing of successes. These reports are shared through clinic meetings, emails, and the organization's intranet. Sharing data has enabled us to improve adult weight screening by more than 200%.

Brenda Kennedy, DHA, MBA, BSN, RN, FAIHQ, Augusta, AR

2.3.1 Use Data Transparently. Data is transparent in our organization at all levels – system leadership all the way down to the provider level. Data is shared on a performance board within each clinic and talked about monthly with action items under those areas that need improvement. We have recently focused on total visits, which has improved slot utilization as well as total visits by 2-4% in a multiple different locations.

Misty Parris, RCEP, Bellingham, WA

2.3.1 Use Data Transparently, 2.3.2 Set Goals and Benchmarks. Without data we cannot transform and with informed data we are able to combine transformation with measured results. All of our reporting and monitoring is posted on our SharePoint site for all of the staff to view. We have administrative dashboards that display live data for monitoring of business and clinical measures. This data is displayed with trending lines and target designations.

Greg Wolverton, Augusta, AR

2.3.1 Use Data Transparently. Reports on gaps in care and progress towards clinical measures are tracked on an ongoing basis and reported monthly to all team members. One of the first and most successful ways data was used was to improve influenza vaccination rates in our primary care sites. By utilizing a team-based approach, we standardized work-flow and documentation, progress was tracked using dashboards. Successes were rewarded for all members of the staff.

Christine Rash-Foanio, PharmD, Chicago, IL

2.3.1 Use Data Transparently, **2.3.2 Set Goals and Benchmarks**. Quality data on performance of the organization is available within the organization as well as publicly through the Wisconsin Collaborative for Healthcare Quality (WCHQ). WCHQ is a statewide initiative on data transparency utilized internally and externally for benchmark purposes. Quality compensation is included in Primary Care compensation model. We are constantly adjusting goals and benchmarks based on internal and external performance from WCHQ and national metrics. Below are a few data points showing our improvements:

1. Diabetic control of blood sugar-A1c less than 8 improved from 62%-80% 2006-2016
2. Colorectal screening rates improved from 50%-81% 2006-2016

Montgomery Elmer, MD, Appleton, WI

2.3.2 Set Goals and Benchmarks. We have both system goals and targets as well as clinic goals and targets. We have set long term (5 year goals for many of the defined metrics) and also set monthly, quarterly or annual targets to work towards reaching the longer term goals. We also have defined 5 key areas to work on, which include provider and staff satisfaction, patient engagement/satisfaction, quality metrics (based on primary or specialty care), meeting financial targets and sustainability and access (visits and slot utilization).

Misty Parris, RCEP, Bellingham, WA

2.3.2 Set Goals and Benchmarks. In my program, we started with a pilot of collaborative care in one county. After one year, it was taking roughly 68 weeks for 50% of the patients to show improvement in depression symptoms, and this was not the level of care we hoped to achieve. We created quality aims for process measures related to core workflow steps and organizations had 25% of the payment for the program tied to these aims. After this change, we found teams worked to improve workflows and cut the time for 50% of patients to improve to approximately 26 weeks - almost twice as fast!

Anna Ratzliff, MD, PhD, Seattle, WA

2.4 Optimal use of HIT

2.4.1 Innovate for Access. We advanced in this driver by expanding to digital means of access with our online patient portal. I now do some of my follow-ups with patients electronically, which decreases cost to the patient, is often more convenient to the patient, and opens up access on the schedule for other more acutely necessary appointments. Through the portal, patients have better access to our providers for non-emergent correspondence.

Meggan Grant-Nierman, DO, Salida, CO

2.4.1 Innovate for Access. We offer same day access – 30% for the system, e-visits, phone visits, online virtual clinic, worksite health clinics, and urgent cares.

Beth Averbeck, MD, Minneapolis, MN

2.4.1 Innovate for Access. We have a secure patient portal that we use in 5 languages – providers and teams will translate the non-English text of a conversation in the note. Patients have direct access to their care team and we respond in under 8 hours on average to all inquiries. Patients will soon be able to make appointments online.

Kirsten Meisinger, MD, Boston, MA

2.4.1 Innovate for Access. We love the patient portal. Our new referrals/new patients were able to fill out much of their past medical history on the portal. We could share test results and recommendations directly with patients, they could ask questions, and request needed refills or appointments. If we changed a treatment, we could use the portal to follow up on how they were responding. This saved so much time vs phone tag but also improved connectivity with our patients. We could "schedule" reminders to check on how they were doing and then send a portal message to them to find out.

Carol Greenlee, MD, Grand Junction, CO

2.4.1 Innovate for Access. Access is key to long-term cost savings. By being open in the evenings and on the weekends, we can offer appointments to patients who would otherwise seek more expensive, uncoordinated care. In addition, offering same day appointments allows patients who might not be able to plan for future appointment to still get the care they need when they are able to see us.

Sarah Chouinard, MD, Central West, WV

2.4.1 Innovate for Access. The primary ways that the Clinical Pharmacy team communicates with patients is by secure email, patient portal messaging, and scheduled telephone visits. We understand that our patients lead busy and active lives, and we want to promote that by allowing for more convenient ways of communication. For instance, the clinical pharmacists co-manage select patients with diabetes using electronic or telephonic communication by enabling patients to report their glucometer readings and receive counseling and recommendations for medication titration via email or scheduled phone calls visits. It is our goal that by the next face-to-face encounter, the patients have made considerable progress on their chronic disease state goals in the interim.

Christine Rash-Foanio, PharmD, Chicago, IL

2.4.2 Share Information Through Technology. While some patients are not interested in the patient portal, those who are see the benefit in being able to communicate with us electronically. By sharing lab results through the portal we ensure that no message was lost or misunderstood regarding important tests. Our providers can type a note with instructions on the labs so that patients have our advice on next steps.

Sarah Chouinard, MD, Central West, WV

2.4.2 Share Information Through Technology. Technology means that not every visit needs to be a traditional 1:1 encounter! I drive four hours round trip several times a year to my son's specialist, mostly for medication refills. This involves pulling him out of school and taking an entire day off work. He is stressed when we get there, so is non-compliant. Since they can't really examine him, he sits on the floor while they interview me about his health status, school, behaviors, medications etc. Medicaid pays our mileage, meals and visit fees. This same result could easily be accomplished via Skype, Zoom or FaceTime; and perhaps one face-to-face visit a year. The impact would be improved efficiency and increased

Susan Brown, MPH, CPHIMS, West Des Moines, IA

2.4.3 Use Technology Supporting Evidence. We have imbedded decision support for all members of the care team which has increased efficiency, decreased visit cycle time, and includes clinical care and decreasing unnecessary testing.

Beth Averbeck, MD, Minneapolis, MN

2.4.3 Use Technology Supporting Evidence. Clinica Family Health uses technology supporting evidence through our Care Planner Tool to close care gaps.

Karen Funk, MD, MPP, Lafayette, CO

2.4.4 Use Technology for Partnerships. Our organization is partnering with a community behavioral health provider to integrate data across both systems for shared patients around medication and problem lists.

Karen Funk, MD, MPP, Lafayette, CO

2.4.5 Drive Efficiency Through Technology. Technology is used to minimize steps required to complete a service/activity and improve performance level. For example, depression screening used to include six steps: review of record to determine if screening was due, printing a hard copy, documenting the information on paper, scanning the paper to the patient's electronic record, nursing recording the score, provider navigation to review results. Now the process includes 3 steps: nurse clicks on alert for depression screen (auto alert upon check-in), electronic document opens to be completed, and the score is automatically noted in the progress note for clinician review. This helped us improve our depression screening rates from 0 to greater than 90%.

Brenda Kennedy, DHA, MBA, BSN, RN, FAIHQ, Augusta, AR

2.4.5 Drive Efficiency Through Technology. Our medical staff rated our EMR as the most satisfying part of working at Cambridge Health Alliance. Seriously. We have a user-friendly, automated, and integrated EMR platform built on EPIC that enables efficient and patient centered care and allows providers to get their notes done quickly and with minimal effort.

Kirsten Meisinger, MD, Boston, MA

2.4.5 Drive Efficiency Through Technology. Technology is a strong-suit at ARcare and has evolved into a larger Health Center Network data tool. We are a HIMSS Ambulatory Stage 7 EMRAM and Davies Award for HIT use with demonstrable results.

Greg Wolverton, Augusta, AR

2.4.5 Drive Efficiency Through Technology. Actually using the patient portal drove a lot of efficiency in our practice; we also utilized our Health Information Exchange to track down missing needed info which was more efficient than calling another practice or facility for reports. We utilized "tickler file" ("action") reminders for lab or other follow up that was needed.

Carol Greenlee, MD, Grand Junction, CO

2.4.5 Drive Efficiency Through Technology. As part of my work delivering care in an integrated mental healthcare team, I use a registry to list all the patients that are enrolled in collaborative care. The care manager and I use this list and several different views or sorts to identify patients that need proactive outreach and engagement. The registry allows us to do this as part of our routine workflow so patients are able to be identified early and efficiently every week as just a few minutes of our hour long case review process.

Anna Ratzliff, MD, PhD, Seattle, WA

2.4.5 Drive Efficiency Through Technology. My special needs son thrives on his routine, and office visits are very difficult for him (and me!) when it interrupts his regular day. Recently his eyes were rolling back in his head as a possible medication side effect. The physician and I agreed that I would video this on my iPhone and email it to the nurse when it happened, versus scheduling an appointment and bringing him in. After capturing a 3-minute video, I emailed it directly to the nurse from my iPhone, and the physician assessed and adjusted his medication then and there. No visit and he is doing much better! Not every visit needs to be face-to-face in this age of technology, and the impact can include improved efficiency, improved outcomes, lower cost, and greater patient and provider satisfaction!

Susan Brown, MPH, CPHIMS, West Des Moines, IA

3.1 Strategic Use of Practice Revenue

3.1.1 Use Sound Business Practice. I have a core business team and management who work with all aspects of budget, coding/billing. We have ongoing evaluation and attendance to MN Community Measurement, best practices, monitor our data, change our practice behaviors based on evaluations.

Jane Anderson, DNP, APN, C-FNP, C-ANP, Minneapolis, MN

3.1.1 Use Sound Business Practice. We came up with a video series "Back to the Basics" that all employees were required to review. Its focus was on excellent customer service and how that looks. Simple strategies that didn't require a tremendous amount of resources.

Desiree Collins-Bradley, Houston, TX

3.1.2 Use Patient as Customer Feedback. We use Ratemyhospital app to get patient feedback. We have achieved a 4.7-4.8 out of 5 patient satisfaction score.

Sabiha Raoof, MD, FCCP, Queens, NY

3.1.2 Use Patient as Customer Feedback. We conducted patient satisfaction audits of our outpatient practices where patients were surveyed. After collecting the data we implemented the needed changes and repeated the audits. We saw an increase of the patient satisfaction scores after the changes were implemented.

Desiree Collins-Bradley, Houston, TX

3.1.3 Consider Non-Traditional Revenue. We were able to receive nontraditional revenue in the form of the Comprehensive Primary Care Initiative grant which was a risk-stratified per-member-per-month payment and use that to invest in our transformation. Another project we did recently was apply for grant funding through the Colorado Dept. of Public Health and Environment to expand our Well Woman Care and cancer screenings to underinsured patients. We are able to use this grant money to improve our processes for access to Well Women Care and this will help our successes in clinical metrics and milestones.

Meggan Grant-Nierman, DO, Salida, CO

3.1.3 Consider Non-Traditional Revenue. We participate in a capitated payment model with our state health plan. This model allows us to project the revenue for caring for this panel of patients, and it allows us to share any savings that we achieve. Having the opportunity to understand how to operate outside of the fee-for-service world has been illuminating and has taught us about how to become nimble in a world where we are reimbursed for comprehensive, thoughtful care instead of episodic care.

Sarah Chouinard, MD, Central West, WV

3.1.3 Consider Non-Traditional Revenue. Our institution was able to negotiate a Quality Improvement incentives-based contract with one of our largest commercial payers. By achieving clinical quality and patient satisfaction benchmarks, we are able to earn incentive money to finance care coordinators and clinical pharmacists to help us continuously achieve our clinical quality goals.

Christine Rash-Foanio, PharmD, Chicago, IL

3.1.5 Drive Performance Excellence. In my practice we are able to estimate the cost savings from delivering effective mental healthcare based on research data showing cost savings of roughly $1300 in general healthcare savings for every patient treated by an integrated mental health team. In 2015, our program served 705 patients which represents cost savings of approximately $916,500.

Anna Ratzliff, MD, PhD, Seattle, WA

3.1.6 Ensure Business Accuracy. We developed and instituted a coding, auditing, and compliance plan three years ago that has resulted in a 30% improvement in level and accuracy of coding across our organization.

Karen Funk, MD, MPP, Lafayette, CO

3.2 Workforce Vitality and Joy in Work

3.2.1 Encourage Professional Development. We have trained our site managers to become well educated in rapid cycle improvement strategies so that they can use those techniques to hold themselves accountable for monitoring progress. These employees were always good office managers, but they have become very good at understanding how to use PDSA to work on even the very smallest scopes of work and document their successes.

Sarah Chouinard, MD, Central West, WV

3.2.2 Hire for fit. Clinica Family Health has a very intentional team-based interview process for all care team roles that helps evaluate for fit.

Karen Funk, MD, MPP, Lafayette, CO

3.2.2 Hire for fit. Our clinic is not for everyone, we inform of the rapid change, the ambiguity, and growth. We inform of the need for autonomy and leadership in their position. I have learned by trial and error that this is not for everyone, some are looking for a more external structure.

We hire with primary care needs in mind; NPs, CMAs to do multiple tasks, non-centralized scheduling (Front desk) to do multiple functions; managing and leadership.

Jane Anderson, DNP, APN, C-FNP, C-ANP, Minneapolis, MN

3.2.3 Cultivate Joy. The providers in our office are getting in a little more quality time with their families because the documentation and administrative burden of providing health care to Medicare recipients is now shared. There is more communication and collegiality between providers and staff because they gather for a morning huddle before starting the day. We have been cultivating a corporate culture of teamwork and improved staff morale.

Meggan Grant-Nierman, DO, Salida, CO

3.2.3 Cultivate Joy. As a solo practice, having my staff work to "take care of patients", work as a team, and be part of the improvement process made work much more enjoyable for all of us. It gave all of us a bigger "why". Also improving connections and communications with referring practices provided more satisfaction, cooperation, and joy. Having the patient as a partner in their care also created a better approach and gave us a lot of "whys"!! The power of relationships helped us as did the reduction in burden we felt.

Carol Greenlee, MD, Grand Junction, CO

3.2.3 Cultivate joy. In my practice, I get to work with a care manager and support a team of primary care practitioners. It is incredibly rewarding to work as a part of a team and leverage my expertise as a psychiatric consultant to reach more patients than I would ever be able to serve on my own. This is such a fun way to work!

Anna Ratzliff, MD, PhD, Seattle, WA

3.2.3 Cultivate joy. Clinica Family Health has a current strategic focus on building joy and resilience in the workplace and is working on developing/selecting a resilience measure to regularly assess for our staff.

Karen Funk, MD, MPP, Lafayette, CO

3.2.3 Cultivate joy. As a team, our primary focus is patient care. As a leader, my primary focus is my team (which includes the patient and their family.) I support the team with feedback, caring and stability. I pay to the top of the scale that I can. I encourage curiosity/education, leadership, feedback to me, sharing "wins", and sharing tough situations. I am present and we encourage a culture of trust, avoid unproductive communication, and offer external resources when the concern might be me!

Jane Anderson, DNP, APN, C-FNP, C-ANP, Minneapolis, MN

3.2.5 Reward and Recognize. GEMS awards are given to selected employees at monthly department head meeting recognizing them for providing patient centered care.

Sabiha Raoof, MD, FCCP, Queens, NY

3.2.5 Reward and Recognize. We have used many tools to celebrate our successes and reward staff for going the extra mile. Examples include "shout outs" – emails to the clinic as a whole which recognize extra effort, social events to celebrate clinic and personal successes, and enrichment activities like "paint night" to allow staff to explore the non-medical sides of themselves.

Kirsten Meisinger, MD, Boston, MA

3.2.5 Reward and Recognize. I assisted in developing a campaign called "Catch Me Caring". It is a program that allows patients and families to recognize an employee that went above and beyond for them. They simply fill out a Catch Me Caring card and drop it in the box which is then forwarded to hospital leadership.

Desiree Collins-Bradley, Houston, TX

3.2.5 Reward and Recognize. It's important to find and celebrate champions who respond to patient and family needs in an exceptional manner. A care team for my son demonstrated exceptional patient-centeredness by their willingness to "cluster" many services together in a single visit at my request. This was outside the norm of a regular visit, but they had a positive willingness to try something different. As a result I wrote a heartfelt letter to their senior management, featured them in an article through work, and have recognized them repeatedly in presentations. The impact of recognition is to renew joy in work and increase vitality knowing that they can and do make a difference.

Susan Brown, MPH, CPHIMS, West Des Moines, IA

3.3 Capability to Analyze and Document Value

3.3.1 Manage Total Cost of Care. We use a Total Cost of Care metric to help identify areas of higher cost and/or utilization. We have a steering committee and the strategies are implemented across the medical group. We are about 10% lower in total cost of care compared to other groups in our state.

Beth Averbeck, MD, Minneapolis, MN

3.3.1 Manage Total Cost of Care. We have built several reports that help us analyze our cost per visit, overall RVU's, deductions (and reasons why), and other expenses. We have monthly meetings with system leaders to review both financials and quality metrics to ensure we are on track. When expanding services we can look at downstream effect to all specialty or ancillary services as well as hospital attributions.

Misty Parris, RCEP, Bellingham, WA

3.3.2 Develop Data Skills. A core team was assigned responsibility to develop/run reports to help ensure data reliability. This team validates data by drilling down to the patient level whenever concerns arise. This information is used to drive changes to processes and staff education. Example: Our internal reporting shows >90% compliance with depression screening. An external agency reviewing billing data shows <30% compliance. They sent us identifiers for patients they showed with a screen so that we could review the records and identify the documentation variance. We are now educating staff so that we can improve what is captured in billing.

Brenda Kennedy, DHA, MBA, BSN, RN, FAIHQ, Augusta, AR

3.3.4 Document Value. Cambridge Health Alliance has multiple mechanisms to document the value of the team based approach including reduced admission rates, cost of care, provider and staff surveys/joy in work.

Kirsten Meisinger, MD, Boston, MA

3.4 Efficiency of Operation

3.4.1 Streamline Work. Depression screening used to include six steps: review of record to determine if screening was due, printing a hard copy, documenting the information on paper, scanning the paper to the patient's electronic record, nursing recording the score, provider navigation to review results. Now the process includes 3 steps: nurse clicks on alert for depression screen (auto alert upon check-in), electronic document opens to be completed, and the score is automatically noted in the progress note for clinician review. This helped us improve our depression screening rates from 0 to greater than 90%.

Brenda Kennedy, DHA, MBA, BSN, RN, FAIHQ, Augusta, AR

3.4.1 Streamline Work. We have several clinic workflow processes that we have streamlined that have become a standard of care. These include: check-in/registration, rooming, pre-visit preparation, chronic pain, diabetes protocol, hypertension protocol, and team roles. We have recorded improvement in diabetes, hypertension, proper billing and right work by right licensure.

Misty Parris, RCEP, Bellingham, WA

3.4.1 Streamline Work and 3.4.3 Maximize Provider Value. Since we developed team based care, the medical assistants do much of the pre-work in anticipation for wellness exams, pre-op physicals, and Durable Medical Equipment face to face visits. Much of this paperwork/documentation burden is addressed by the MA before the physician enters the room now so that the doctor can focus on the patient and not the paperwork/computer screen. With a morning huddle, the MAs have prepared the necessary shots that might be needed during the days for well child visits as an example. Our MAs have become more integral members of the care team and so they take it upon themselves to look ahead, note when one of our higher risk patients is coming in, and checks up on any specific needs that patient might have before their visit. For example, my MA called one of our high risk elderly patients and got him into an earlier appointment so he would not have to be out late at night when the snow was starting to fly. Having more people to anticipate the needs of the day helps find ways to be efficient during that day.

Meggan Grant-Nierman, DO, Salida, CO

3.4.1 Streamline work. As an integrated psychiatrist working with a care manager the evidence-based model called collaborative care, I am able to provide assessments and recommendations for 6-8 patients in roughly 2 hours of work time. This more than doubles the access to psychiatric services for patients in the practices I serve!

Anna Ratzliff, MD, PhD, Seattle, WA

3.4.1 Streamline work. We have created a total redesign of outpatient delivery model utilizing lean process improvement work. The creation of a "model cell" that then was spread throughout the primary care division.

Montgomery Elmer, MD, Appleton, WI

3.4.2 Eliminate Waste. Maximizing our use of technology and creating standardized workflows to reduce errors and rework has allowed us to reduce our total medical cost per patient by more than 13% in the last three years.

Brenda Kennedy, DHA, MBA, BSN, RN, FAIHQ, Augusta, AR

3.4.3 Maximize Provider Value. We have taken away tasks from the provider that can either be automated or designated to another team member. We have worked to decrease documentation time and in some recent pilots, have seen a reduction of 75% in the amount of time spent documenting at home.

Beth Averbeck, MD, Minneapolis, MN

3.4.3 Maximize Provider Value. Our providers largely do provider level work with our high functioning teams in place. Anything that comes into an "in basket" usually gets sent on to a trusted team member who will take care of the next step or steps. Workflows are in place to keep as many decision points with the correct team member whenever possible and not "float up" to the provider level unnecessarily.

Kirsten Meisinger, MD, Boston, MA

3.4.3 Maximize Provider Value. Creating teams has maximized provider value. By asking everyone to work to the tops of their degrees, the providers are using their medical degrees instead of doing administrative work. By having a care coordinator on the provider team, the providers are able to turn follow-up visits into more profitable visits such as Medicare Annual Wellness exams or Transitional Care Management visits when appropriate.

Sarah Chouinard, MD, Central West, WV

3.4.3 Maximize Provider Value. Team-based care improves access and reduces non-productive provider time – which maximizes provider value in our current fee-for-service world. All provider engagement in transformation has value and should be compensated.

Mary Reeves, MD, Salida, CO