Colorado Team-Based Care Initiative
Change Package Tool

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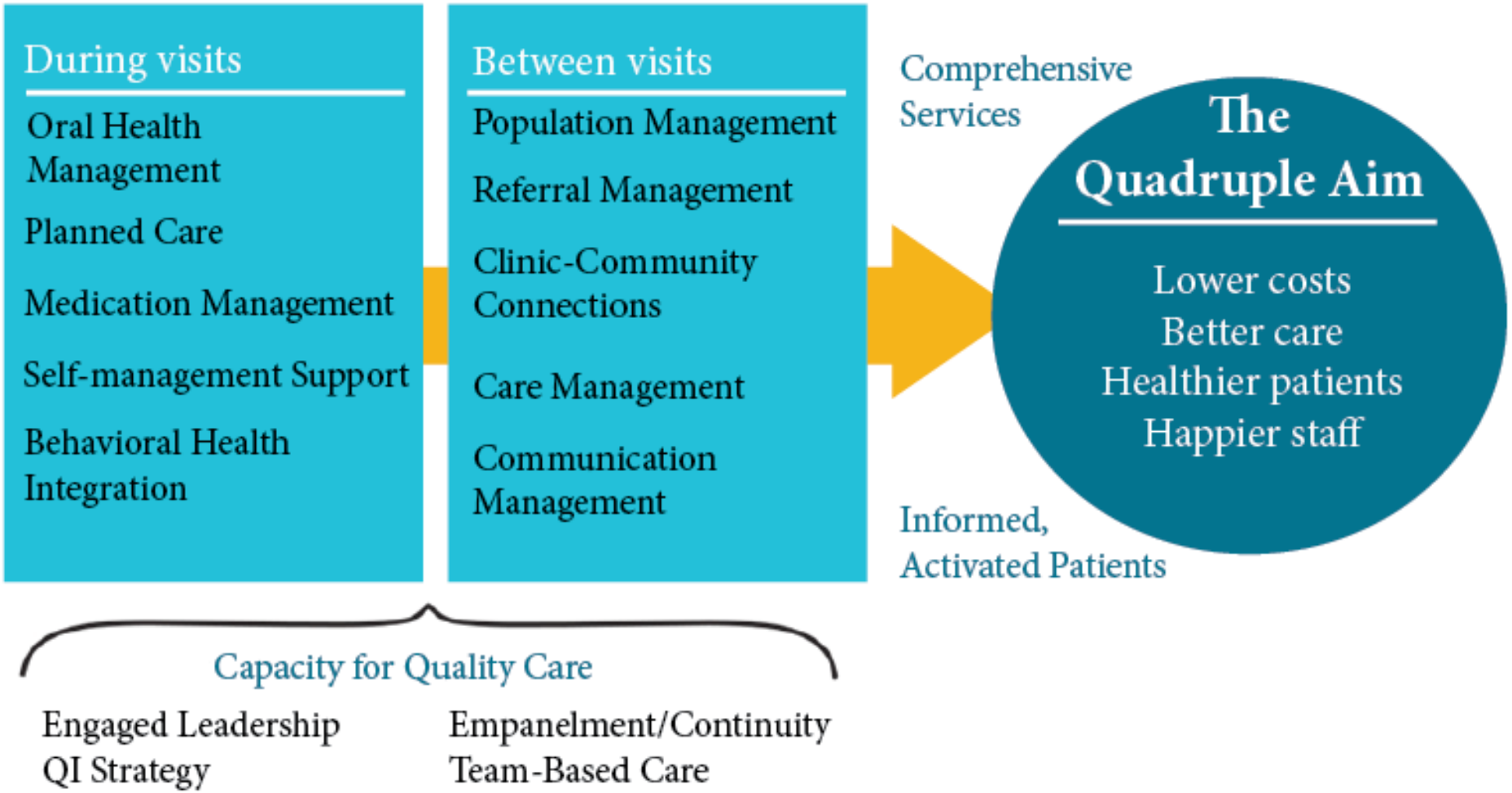
CO Team-Based Care Initiative
Change Package

The Change Package is a tool used to support practice transformation by serving as an evidence- and experience-based guide for both the program team and the participating practices. Based on the evidence and best practices around team-based care (TBC), this change package draws on the work of "The Primary Care Team: Learning from Effective Ambulatory Practices" (LEAP), the Institute of Medicine, and the CO TBC Initiative's faculty previous experience supporting team-based care through patient centered medical home and chronic care model initiatives. This change package is a public domain tool, made available free of charge to anyone interested in using it, in part thanks to funding from The Colorado Health Foundation. It is formatted on the MacColl Center for Health Care Innovation's extensive experience building toolkits and change packages for The Robert Wood Johnson Foundation, The Commonwealth Fund, the Agency for Healthcare Research and Quality and others. Information and resources on LEAP are accessible on the improvingprimarycare.org website.

How Primary Care Teams Achieve the Quadruple Aim



MacColl Center for Healthcare Innovation, Kaiser Permanente Washington Health Research Institute 2017

Strategy 1: Build a foundation and culture to support team-based care

Function/ Change Concept	Key Changes	Examples
Engaged Leadership	• Provide visible and sustained leadership to lead overall culture change, as well as specific strategies to improve quality and spread and sustain change. • Ensure that the TBC transformation effort has the protected time to conduct activities beyond direct patient care and resources needed to be successful. • Ensure opportunities for continuous skill development and ongoing training. • Build the practice's values on creating a team-based medical home for patients into the staff hiring and training processes.	• Educate, promote, and discuss Team-based Care (TBC) frequently at a variety of organizational meetings, so that BOD members, providers, staff, and key partners are informed and activated • Incorporate TBC goals into organizational compliance plan and/or link to incentive programs; if possible, redesign compensation or bonus structure to promote the team model • Be visible at provider and staff meetings to support the team model and actively participate in TBC/QI team meetings • Integrate the TBC model into the organizational mission and vision • Dedicate necessary resources to support measurement, to build adequate training, to facilitate communication, to support team building • Create and fund career ladders for staff who expand duties to serve on teams • Establish expectations with timelines for team building priorities. • Actively share best practices for TBC implementation across teams and clinics • Provide platforms for staff to identify opportunities for improvement and to define action plans, e.g. staff surveys, suggestion boxes • Restructure clinic leadership responsibilities to guide transformation work • Incorporate vision of TBC into staff, provider, patient, and BOD member orientation • Modify job descriptions to support/reinforce TBC • Identify mentors to support new and existing employees in learning TBC change concepts • Develop TBC orientation materials to use with new e-learning platform • Send staff to trainings or conferences to learn about aspects of TBC and practice transformation

Function/ Change Concept	Key Changes	Examples
Empanelment	• Assign all patients to a provider and team panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis. • Assess practice supply and demand, and balance patient load accordingly. • Use panel data and registries to proactively contact, educate, and track patients by care gaps, disease status, risk status, self-management status and community and family need.	• Choose appropriate look back period of 12 to 18 month to determine active population • Assign providers to a team • If patients have never been on panels, assign patients by the 4-cut method to a team and a PCP. • Define goal panel size for the practice • Create fields in EHR to assign patient to PCP and team. Consider fields for extended care team such as pharmacist, specialist, dentist… • Assign members to team (providers, nurses, front office staff, MAs, etc.) • Develop policy for assigning panels to part-time providers • Assign every new patient to your practice to a PCP • Adjust panels transparently to create fairness and build trust • Use access measures, utilization data and continuity measures to adjust panels over time • Assign staff and develop workflow for monthly to quarterly clean-up and balancing of panels • Use chronic disease registries to create balanced panels • Consider risk-adjusting panels (age and sex vs acuity) • Develop procedure for provider turnover to reassign patients, keeping them on the same team whenever possible • Develop a procedure for patient requests to change providers/team • Develop process for staff to assign new patients to appropriate panels • Develop scripts for staff to inform patients of PCP/Teams at every contact • Understand the variation in panels/continuity/access in your practice
Quality Improvement	• Choose and use a formal methodology for quality improvement. • Establish and monitor metrics to evaluate improvement efforts and outcomes; ensure all staff members understand the metrics for success. • Ensure that patients, families, providers and care team members are involved in quality improvement activities. • Optimize use of health information technology to improve individual	• Assess QI training needs and act upon results • Develop communication plan clarifying organizational methodology for improvement • Design formal process for oversight of teams testing change • Develop just-in-time training tools for teams doing PDSAs • Invite patients to participate on QI team • Integrate methodology into organizational culture-including all staff in training, practice improves performance of the methodology • With leadership oversight, choose small tests of change • Before starting, use team conversations to predict what will be the outcome of a PDSA • Schedule time to study and learn from every PDSA • Design system to share results of historical tests for organizational learning • Invite patients to work on a team designing a PDSA or include them to give regular feedback during designing and testing a change • Develop procedure/process to adapt, adopt or abandon the change after from a test of change. Record outcomes and learning from all tests of change • Organize iterative PDSAs to optimize the proposed change • Design communication plan for sharing PDSA results with staff and patients.

Function/ Change Concept	Key Changes	Examples
Teamwork	• Create shared goals.	• Ensure shared practice goals can be clearly articulated, understood, and supported by all team members. • With the patient and, where appropriate, family members or other support persons, establish shared goals that reflect patient and family priorities
	• Ensure clear roles for all members of the team including the patients.	• Develop clear expectations for each team member's functions, responsibilities, and accountabilities • Use peer-to-peer coaching to develop and enhance team orientation • Optimize team opportunities for both shared learning and sharing of knowledge Ensure effective training programs for all roles • Design educational scripts for communicating with patients about their team role • Optimize the team's efficiency and take advantage of division of labor
	• Develop mutual trust between team members, including the patient and family.	• Create strong norms of reciprocity and greater opportunities for shared achievement • Create intentional team structure • Use standing orders and support staff as they do this work
	• Build and leverage effective communication.	• Prioritize and continuously refine communication skills for staff and patients • Build a shared language for team communication and skills • Develop consistent channels for candid and complete communication language, which are used by all team members across all settings Employ huddles (planning) and debriefs (learning, problem solving and celebrating)
	• Measure and improve teamwork processes and training.	• Implement reliable and timely feedback on successes and failures in both the functioning of the team and achievement of the team's goals

Strategy 2: Ensure high quality core team performance of prevention and chronic illness

Function/ Change Concept	Key Changes	Examples
Population Management	• Ensure patients are linked to specific provider and team, see empanelment in Strategy 1. • Decide which patient populations and which data elements to track. • Create consensus among providers to follow selected evidence based guidelines. • Regularly generate actionable & trusted reports at the team level. • Select and train population management staff. • Develop and document criteria that specify who/when/how to take action.	• Ask staff which populations are most difficult to manage • Review current clinical outcomes to define high risk, high volume and or high cost sub-populations. Look for populations where you are meeting patient needs and/or clinical outcomes • Select a single sub-population to address • Set aim and measure for sub-population management • Chose evidence-based care algorithm for target sub-population • Providers review algorithms and endorse selected plan in a group meeting • Identify and resolve causes of clinical inertia • Create patient focus group to review plan and give feedback on tests of change • Develop new workflows and explicit roles for population tracking and outreach • Design tracking system that does not use the appointment schedule or medication refills • Develop script for staff to contact patients to educate and complete care plan • Test PDSAs of outreach scripts and workflows incorporating patient feedback • When process is stable, consider adding other sub-populations leveraging learning from early successes

Function/ Change Concept	Key Changes	Examples
Planned Care	• Assign delivery of key services to specific staff positions and ensure they are trained. • Use protocols and standing orders to allow staff to act independently. • Efficiently generate patient-specific data on services that are due. • Huddle with the core team and review patient information before clinic session. • Plan and ensure care plan follow-up	• Review delivery system design, decision support, IT systems and patient engagement strategies for opportunities of improvement • Develop strategy for sharing the care plan with patient and family at appropriate intervals. Include patient in the design process • Flow map current in-clinic process for populations of focus • Look for opportunities in flow map for improving process through PDSAs • Evaluate who is doing the work now and who could do the work • Develop and test template for workflows which define expectations • Design and test workflow for gathering important patient clinical information for the huddle • Develop and test workflow for staff to run the daily huddle • Design and test workflow for assuring patients have indicated work up before visit • Use missed opportunities to learn to improve in-clinic process design as a team • PDSA the process for sharing care plan with patient
Medication Management (Core Team)	• Routinely reconcile medications and prevent or address medication issues. • Develop individualized medication plans. • Involve patient and team in titrating medications. • Manage chronic pain and opioids safely, effectively and humanely • (See also Medication Management of Extended Team-Strategy 4).	• Partner with patients to help design meaningful medication reconciliation workflow • Involve patients in the design of a meaningful medication plan • Develop process to address clinical inertia in the medication management of identified sub-populations. Consider reviewing in PEER committee or case conferences • Consider population management strategies for patients on medications such as opioids, benzodiazepines, ADHD medications, anticoagulants. Use the Institute for Safe Medication Practices (ISMP.org) high alert medications for ambulatory care practices to select a focus population of patients using the highest risk medications (such as warfarin, carbamazepine, insulin, PTU, opioids, benzodiazepines) http://ismp.org/communityRx/tools/ambulatoryhighalert.asp • Run reports of chronic meds soon to expire and test workflow to refill them before the patient runs out of medication whenever appropriate (e.g. thyroid, OCPs, asthma controller meds, beta blockers for angina, anticoagulants…)

Function/ Change Concept	Key Changes	Examples
Referral Management	• Assume team accountability for ensuring that all referrals meet the time sensitive needs of the patients and providers. • Select and train staff to track and manage referrals. • Reach out to specialists, hospitals and community service agencies to develop partnerships to facilitate the referral process. • Develop standard ways of exchanging referral information. • Create workflows to ensure the referral loop gets closed.	• Identify staff with excellent communication skills for working with patients, families and specialty care providers • Establish standards for assuring complete referrals to specialty care • Work with frequent referral providers to streamline the process for the patient • Use care compacts to list explicit expectations for referrals regarding return of information and the patient to the practice • Ask patients how to best support the referral experience • Reach out to all patients who fail to keep referral appointments-document reason for no-show. Understand and address no-show causes • Set up process to decrease the number of open referrals that includes confirming with the patient that they intend to go to the specialist (creating fewer referrals). Establish standards and scripts for confirming that the patient wants the referral • Use EHR tracking software to record all referrals • Set up process to close referrals once results are 1) returned and 2) reviewed by PCP • Set up process to track and follow-up all open referrals

Strategy 3: Enhance Patient Centered Care

Function/ Change Concept	Key Changes	Examples
Patient-Centered Communication	• Prioritize patient experience by regularly involving patients in the design and improvement of care processes. • Develop communication strategies such as agenda setting and teach back that become standard work in the primary care setting. • Ensure that core patient communication skills are mastered by all team members. • Educate all care team members on available patient engagement tools. • Identify the language and health literacy needs of patients and families. • Ensure provider and staff are responsive to the varied needs of a diverse and multi-cultural patient population.	• Consider forming a patient advisory committee. See resources for assessing practice and developing the patient voice at The Institute for Patient- and Family-Centered Care. http://www.ipfcc.org/ • Ask patients to participate in ongoing QI work • Solicit patient ideas through surveys or focus groups • Regularly gather feedback from patients on their care experience • Record patient testimonials on what works and doesn't work for them and share these at staff meetings • All staff are trained and achieve core competencies in active listening skills, health literacy and cultural competency • Try using a scribe to document notes in the EHR during the patient visits to improve clinician eye contact and communication with patients and family • Actively establish rapport and relationship with patients before, during and after care activities • Partner with the patients to develop a shared agenda for the visit • Explore the patients' and family's perspective on health, health care, and illness • Use "Teach Back" as a technique to ensure patient comprehension and investment in the care plan and to improve staff communication skills • Routinely include patient evaluation when planning measures for PDSAs • Share patient comments from satisfaction surveys with all staff in the organization • Employ patient centered observation forms for teaching, optimizing and evaluating staff communication skills. • Train staff in communication skills that enhance organization, efficiency, and effectiveness

Function/ Change Concept	Key Changes	Examples
Self-management Support (SMS)	• Develop a comprehensive self-management support plan for the practice. • Establish roles and responsibilities for team members to conduct pre-visit planning, initiate goal setting conversations, document goals and ensure follow up. • Train staff to help patients change behaviors and improve problem-solving skills. • Use the EHR to co-create and document the self-management goals and plan. • Identify and develop relationships with self-management resources in the community. • Develop workflow strategies to address self-management at every encounter.	• Train providers and staff on time-efficient goal setting and action planning • Create scripts that guide the conversation with patients • Use the methodology of agenda setting, hypothesis testing and understanding the patient perspective followed by co-creating a care plan. Relationship Communication and Efficiency Mauksch et al, July 14 2008, Arch of Intern Med • Practice goal setting, identifying barriers and scaling of importance and confidence skills in role plays for clinicians, nurses, behavioral health, RN care managers and MAs • Generate a document from the EHR for the patient to take home and/or receive by email that includes goals, strategies for barriers • Build electronic infrastructure to support SMS. Create documentation systems that alert all users of SMS plans, and that include simultaneous population of the care plan in appropriate EHR sections: patient centered care plan section, progress note, and after visit summary or patient instructions • Use a shared template for self-management goals so they can be viewed from any place in the EHR • Develop workflow where MAs open the self-management goal template so it is easy for the rest of the team to access during the course of the visit • Develop registry or reporting technique to identify patients due for follow-up on goals • Identify CDSMP programs in the community & link patients to them (e.g. Consortium for Older Adult Wellness (COAW) in Colorado at https://coaw.org) • Send a task from a new self-management goal to an identified staff person who can call the patient 10 days to 2 weeks later and inquire if patients need any support with self-management goal • All staff are trained and achieve core competencies in active listening skills, health literacy and cultural competency • Staff assess cultural health practices and incorporate them into the care plan • A team member telephones, emails or texts patients and families to support follow through on self-management goals after a primary care or specialist visit • Measure patient self-efficacy around goal setting using a scaling question for importance and confidence and adjust goal accordingly • PDSA a pre-visit questionnaire designed with input from those who will be receiving care which is sent to people in advance of a face-to-face visit and used by the team during the visit

Function/ Change Concept	Key Changes	Examples
Enhancing Access	• Evaluate the population assigned to the care team. • Match care team member skills to patient needs in order to "share the care." • Create alternatives to one-on-one, face-to-face visits. • Measure and improve continuity with provider and team. • Measure and balance supply and demand for established and new patients.	• Empanel all patients and develop operational process to manage all panels • Build high-functioning work teams with excellent communication skills • Set an aim: every patient can see their provider of choice when they want to see them • Create policy that continuity is the most important scheduling parameter • Redesign workflows to ensure optimal continuity. Create scripts for front office staff and MAs to reinforce the PCP and to help guide patients to PCP appointments whenever appropriate. Allow the patient to choose whether to come in on a day their PCP is not in the office • Measure and follow panel size compared to access measures • Understand variation. Adjust panel size up if meeting demand, adjust panel size down if creating backlog • Optimize the care team. Build core team and extended team to provide comprehensive primary care. Create clear, evidence based care protocols for team members (nurses, MAs, behavioral health…) other than the PCP • Measure and improve continuity rates for patients seeing their PCP • Measure either the delay (time to 3rd next appointment) or future capacity open • Measure appt. supply, demand and activity hourly/daily/weekly. Match supply and demand hourly/daily/weekly. Understand variation • Simplify appointment types. Redesign workflow for appointments that seem to require longer appointments (example: have nurse and pharmacist review new patients and patients discharged from the hospital, enter meds and do med reconciliation and document past medical history before PCP appointment • Do contingency planning. Create plans for busy periods such as back to school and cold/flu season. Plan for provider FMLA. Consider hiring additional float providers. Develop shared medical appointment (group visit) strategy for high demand supply mismatch times. Develop contingencies for when things get a little worse or a little better to avoid backsliding. Communicate that you expect some variation • Develop and test a process for post-vacation schedules (mini-backlogs). • Reduce backlog by creating temporary increase in supply of appointments. Add hours, add a slot at lunch, and hire temporary or new providers to work on backlog before establishing new panels. Comb future schedule for appointments that are unnecessary or duplicative • Reduce demand for office visits. Max pack 2 visits a day. Implement telephonic care where appropriate and preferred by the patient. • Evaluate visit intervals-review evidence for how often you bring the patient back • Move prevention visits to slow times of the year • Develop process for follow ups to begin with a phone call from team member the patient knows. Schedule follow ups with health coach or nurse. • Develop process for tracking and managing high risk patients that does not depend on booking them into the future schedule

Strategy 4: Build an expanded care team to enrich expertise, enhance care for subpopulations, and connect to the community

Function/ Change Concept	Key Changes	Examples
Care Management	• Design a care management program to meet the needs of patients in transition and at high risk of major morbidity and hospitalization. • Shift RN roles toward care management. • Decide how patients will be referred for care management. • Establish relationships w/ key hospitals to co-manage patients discharged from the hospital. • Create protocols, standing orders and standard work flows for engaging these patients with the care team. • Ensure care managers have protected time to do their work. • Develop a support structure for care managers.	• Ask providers &/or use an algorithm to find out which patients may be "high risk." This may be based on medical and/or social support needs • Train registered nurses on self-management support & medication reconciliation to overcome clinical inertia • Support registered nurses to conduct independent visits with complex patients by creating standing orders for primary and secondary prevention. • Create scheduling protocols & explore billing codes to support independent RN visits • Physicians, behavioral health specialists or other RNs regularly meet to review data on high risk patients and discuss care management intervention (see Team Care for an example) • Registry or individual-level data reports are regularly used to help care managers organize their efforts • Review Emergency Department discharge records to ensure follow- up care is provided within 24/48 hours • Develop work flows for ED follow-up visits including communication methods between the hospital and primary care practice

Function/ Change Concept	Key Changes	Examples
Medication Management (extended team)	• Evaluate the practice capability to add clinical pharmacy services to the care team. • Optimize the role of existing clinical pharmacists in the management of patients with complicated medication needs. • Create pharmacist and pharmacy tech job descriptions that prioritize integration with the patient and primary care team. • Communicate to care team members and patients the services available from the clinical pharmacist. • Ensure that your clinical pharmacist is actively participating in team efforts to address chronic disease management and population management efforts by providing critical input on medication use and dosing. • Provide your clinical pharmacist with training in team-based care, warm hand offs and how to work effectively with patients, especially using motivational interviewing, and self-management support.	• Review state Board of Pharmacy requirements for delivering Medication Therapy Management • Identify populations in your practice who would most benefit from pharmacist medication therapy management. Consider patients with more than one chronic disease, patients with poly-pharmacy or complex medication regimens such as heart failure and HIV patients, and geriatric populations • Use the Institute for Safe Medication Practices (ISMP.org) high alert medications for ambulatory care practices to select a focus population of patients using the highest risk medications used in your population (such as warfarin, carbamazepine, insulin, PTU, opioids, benzodiazepines) - http://ismp.org/communityRx/tools/ambulatoryhighalert.asp • Develop a training program for pharmacists in collaborative team-based skills such as patient communication, warm hand-offs, teach back, and population management through outreach • Design and test workflow for a certified pharmacist to monitor and improve medication use and adherence in high risk patient populations by making recommendations to patients, caregivers, and health care professionals • Design and test workflow for certified pharmacist to review new patients to the practice, to substitute medications when appropriate and to complete medication reconciliation and the EHR medication list • Design and test workflows for certified pharmacists to review all care transition patients (hospitals and nursing homes) to substitute medications when appropriate and to complete medication reconciliation • Include pharmacists to work as part of the on-site core team with patients to solve problems with their medications and improve adherence • Arrange for pharmacist to consult with primary care team members about medication-related issues • Design and test pharmacists providing assistance to patients on multiple medications (polypharmacy) to help to simplify medication regimens

Function/ Change Concept	Key Changes	Examples
Oral Health Management in Primary Care	• Define organizational vision and goals for integrating oral health into primary care. • Start with one primary care population of focus. • Define and train appropriate oral health competencies for members of the care team. • Develop, test and implement age appropriate oral health risk assessment. • Train and implement knowledge based oral health evaluation. • Implement evidence based preventive interventions using care team members. • Develop communication and education strategies for patients and families. • Define and target populations at risk for oral health disorders and/or populations whose oral health status impacts general health. • Create workflows to facilitate handoffs to dental professionals and closing the loop by following up with the primary care team. • Establish partnerships with dental professionals. • Move along the integration continuum towards fully integrated medical and dental primary care practice.	• Develop aims and define measures for access to primary oral health services. • Elicit patient and family input on oral health needs and barriers through patient and family advisory boards, participation as members of the oral health integration team, patient experience surveys, or focus groups. • Add dental staff to morning team huddles, and note patients who need oral health services. • Test and implement MA preventative visit workflow to include oral health assessment at well visits and setting self-management goal when chosen by the patient AAPD Caries Risk Assessment for children; ADA Caries Risk Assessment for adults • Train non-provider team members in dietary counseling, oral hygiene anticipatory guidance, smoking cessation and use of fluoride rinses for oral health. • Develop and implement a standing order for fluoride supplementation for children age 6 months to 5 years whose water supply is deficient in fluoride. • Train primary care providers and nurses in oral health evaluation which includes a focused oral health history, risk assessment, and performance of clinical oral screening. Smiles for Life clinician training program; AAP oral health course; HRSA Integration of Oral Health; HRSA Oral Health Home Page • Include oral health anticipatory guidance in well exams for all ages . • Develop and implement effective oral health education tools Maternal Child Health Oral Health Resources; ADA Mouth Healthy Eng ; ADA Mouth Health Span • Implement fluoride varnish program for children up to age 5 Cavity Free at Three in-person training: Cavity Free at Three Contact • Train team members to document the interventions and findings as structured data and use ICD 10 codes to organize information for decision support, measure care processes, and monitor clinical outcomes so that quality of oral health care can be managed. • Identify high risk segments of clinic population at high risk for dental disease (prenatal patients, diabetics, children with special needs etc.) and assure oral health screening for these populations. • Add high risk oral health patient to registry. • Strategies to facilitate referrals include primary care schedulers accessing dental appt book, warm handoff to dental clinic, fax referral, e-referral, drop-in "coupons." • Add in-house dental practice, dentist and/or dental hygienist to the extended care team. • Move towards fully integrated medical and dental primary care practice including EDR and EHR integration, scheduling, shared patients, and team partnerships HRSA Integration Oral Health and Primary Care; NNOHA Interprofessional Users Guide

Strategy 5: Integrate behavioral/social health capacity in primary care

Function/ Change Concept	Key Changes	Examples
Behavioral Health Integration	• Define behavioral health challenges of your population that need to be addressed. • Choose a behavioral health integration strategy that addresses the psychiatric and substance abuse problems of your population. • Enhance the capacity to provide evidence-based, collaborative care for all these populations. • Develop the team skills and capacity for warm hand-offs. • Based on frequency, consider the need for alcohol and substance abuse services.	• Work with patients individually and in focus groups to understand current barriers to behavioral health care in your community. • Identify and partner with community behavioral health service providers in your community. • Review integrated behavioral health models for collaborative care. Review the AIMS Center Implementation guide. https://aims.uw.edu/sites/default/files/CollaborativeCareImplementationGuide.pdf • Examine Core Competencies for Behavioral Health Providers Working in Primary Care (http://farleyhealthpolicycenter.org/wp-content/uploads/2016/02/Core-Competencies-for-Behavioral-Health-Providers-Working-in-Primary-Care.pdf) • Match behavioral FTE to behavioral health demand in your patient population. This may be only contracting for some BH specialist time or hiring one or more for your practice or teams. • Understand the acuity of behavioral health needs in your practice and match staff from navigators and community health workers to nurses, counselors, psychologists, social workers, to psychiatrists. See http://improvingprimarycare.org/sites/default/files/topics/BH-Step3-Table%20of% 20role% 20functions-from%20AHRQ%20Lexicon-pg23.pdf • Clearly define care team roles for behavioral and physical health staff. • Develop clinical flow chart for services and test models in practice. • Pilot a population based tracking system for outreach to behavioral health sub-population such as major depression, ADHD or substance abuse or patient complexity. • Choose evidence based clinical guidelines to follow in the primary care setting, and ensure clinical consensus around guidelines. • Develop access (internal or external) to alcohol and substance abuse services (Certified Alcohol Counselors, addiction specialists). • Use person-centered language (“person with substance use disorder” instead of “addict”) and begin changing from a culture of separate services (behavioral vs. physical health) into whole-person care.

Function/ Change Concept	Key Changes	Examples
Clinic-Community Connections	• Hire staff representative of the communities served. • Designate staff to coordinate community linkages. • Learn about community strengths and weaknesses. • Develop relationships and agreements with key community organizations. • Actively participate in community activities to improve health. • Systematically ask patients about their social care needs (for example PRAPARE tool, http://www.healthcarecommunities.org/ResourceCenter.aspx?Catego-ryId=831406&EntryId=87216)	• Identify evidence-based community resources already present (e.g. Living Well with Chronic Disease or Silver Sneakers). • Practice leaders meet with targeted community agencies to explore linkage opportunities. • Develop verbal or written agreements that include referral expectations. • Actively pursue funding &/or partnership opportunities to build needed community resources where there are none. • Develop workflow to solicit patient needs, link them to resources, and follow up. • Try a single screening question approach (e.g. asking a single question like "Do you find yourself struggling to make ends meet at the end of each month?").

Strategy 6: Communicate, celebrate your improvements & build infrastructure to sustain them.

Function/ Change Concept	Key Changes	Examples
Communication Management (Patient-Clinic)	• Develop standard work for handling major forms of communications. • Set aside time for staff to do same-day message management as part of standard work. • Designate and train staff to handle common types of communications. • Maximize first call or contact resolution to eliminate or at least minimize queues and handoffs. • Ensure necessary handoffs are efficient. • Routinely monitor demand and the extent to which communication goals are met.	• Have explicit goals, designated staff, and standard work in place for the monitoring of initial action for each request or message type. • Develop measures for communication standard work such as first contact resolution and share with staff and patients. • Designate a person responsible for form completion (e.g. prior authorization requests, vaccination requests, camp signoffs, workers comp, etc.) • PDSA workflows for form completion. • Let patients know who on the care team can help them get their questions answered. • Try using a scribe to document notes in the EHR during the patient visits to improve clinician eye contact and communication with patients and family. • Reduce the need for telephone triage and handoffs by ensuring same day access. • Set aside time for everyone on the team to respond to non-face-to-face request for care. • Use PDSA cycles to experiment with phone care when requested by the patient and clinically appropriate. • Regularly track and when necessary adjust panel size and supply and demand to ensure folks can get access to care. • Use a patient portal to facilitate accessible communication. • Develop processes that assist patients and family members in learning how to use portal functions. • Create clear roles for the team to manage portal messages from patients. • Create standing orders and protocols around common communication issues like medication refills and normal and abnormal lab results. Consider alternative visit types including virtual consultations/telehealth.

Function/ Change Concept	Key Changes	Examples
Change Management	• Develop a change management strategy for the organization. • Ensure alignment to organization vision and strategies before changes are tested. • Scale the preparation for the change to the size and significance of the transformation. • Include multiple tests of change for scaling up and spreading innovations. • Ensure leadership accountability and responsibility for implementing successful change identified by teams. • Clearly communicate shared purpose and urgency for change. • Develop communication and education strategies for patients and families. • Minimize variation in the new processes. • Build new human resources policies, including promotion strategies and resource allocation. • Leaders sustain change by monitoring measures and feedback as change becomes part of the organizational culture.	• Study effective change models: Leading Change, Kotter, 2012; The Heart of Change, Kotter & Cohen, 2002; Managing Transitions, Bridges, 1991; Who killed change? Solving the Mystery of Leading People through Change, Blanchard & Britt, 2009; Switch: How to Change Things When Change is Hard, Heath & Heath, 2010; Organizational Transitions: Managing Complex Change, Beckhard & Harris, 1987. • Select a model that aligns with organizational culture and size of the change. Using the same model over time allows staff to understand what is coming and what their role will be, making the change easier to incorporate. • Design clear leadership sign-off processes for steps from implementation of change to spread of successful changes. • Leaders support teams as their members' transition from the old model to the new model, including ensuring training needs are met, necessary technology is in place, and staffing is adequate; allot time to adopt the newly changed processes. • Leaders and management design and execute a communication strategy for each stage of change: creating urgency, supporting testing, and spreading the new processes. • Leaders and management assess and dismantle barriers such as old policies, processes, and behaviors to make way for the new model. • Human Resources revisits career ladders, performance expectations, compensation alignment, and job descriptions to incorporate new team-based care fundamentals. • Create opportunities for regular, meaningful, short-term wins to continue to build momentum. Reward change agents at all levels for commitment to the transformation. • Include new processes in the strategic plan. • Celebrate success of hard work and movement towards goals while being careful to maintain urgency for continued improvement in care delivery and population outcomes. Consider leadership potential for new processes in succession planning for management and leadership positions.

Team Based Care