Conflict of Interest

Debra Simmons, MSN, RN

I have no real or apparent conflicts of interest to report.
Who We Are

501c3 Clinical QI Consortium
Established 1993
NHLBI and CDC Recognition

• Data-driven QI Organization
• Network of 30 cardiovascular COEs across the Southeastern U.S.
Agenda

• Learning Objectives
• The Issue
• The Approach
• Challenges/Barriers
• Case Examples
• Conclusion
• Recommendations
Learning Objectives

• **Identify** challenges and opportunities in transitioning from fee-for-service to fee-for-value for providers serving high-risk populations

• **Illustrate** methods used to facilitate transformation in large and fragmented provider networks, including provider and patient engagement across large, unhealthy regional populations

• **List** tools, partnerships and processes used to achieve clinical transformation

• **Describe** outcome improvements which have surpassed goals to date: improving population health, reducing costs and transitioning participating practices to value-based care models

• **Recognize** barriers to provider adoption, alignment and active participation across one of the nation’s largest CMS practice transformation networks
Case Study 1
Primary Care Network Redesign at a Major Health Plan

Objective:
Transform the health plan network from an episode-driven, physician care delivery model to a population management-driven, team-based care delivery model
Year One Results

- Designed, developed, and deployed in less than 6 months
- Fostered practice-health plan collaboration
- Increased PCP appointments by ~30%
- In first 10 months, scaled efficiently to:
  - 440 Participating PCPs
  - 141,000 Attributed members

“Scaling across our 40 clinics was impressive... and it hasn't disrupted our physicians.”

“We’ve reinvested all of our CMFs into hiring 6 new staff members.”

“The Quality Navigator and I work together to close gaps in the care puzzle.”
Improvement in Quality Measure Performance-Major Health Plan
(January ‘14-November ’15)

- **Optimal Diabetes Care**: +25%
- **Optimal Vascular Care**: +40%
- **Optimal Chronic Kidney Care**: +69%
- **Hypertension**: +31%

$27 PMPM net savings
Our Current Work

QualityImpact PTN: A Collaboration for Better Care

We are a Center for Medicaid and Medicare Services' (CMS) Innovation Center Practice Transformation Network (PTN)

Serving
4,693 providers,
745 practice sites

Southeastern U.S. focus

4 year program
Supporting Practice Transformation Across a Diverse Network of Clinicians and Practices in 15 States

### Size and Scale

**Clinicians**
- 2,488 Primary Care
- 2,205 Specialty Care
- **Total**: 4,693

**Practice Sites**
- 443

**Patients**
- 1,262,784

**PTN YR4 Commitment**
- 4,040

### TOP SPECIALTIES

- Psychiatry
- Cardiology
- OBGYN
- Surgery

### Practice Size

- (Number of Clinicians)
  - <= 5
  - <= 25
  - <= 100
  - <= 500
  - > 500

**UNIQUE SPECIALTIES**: 49
The Issue

Why Healthcare Reform?
The Issue

• Public and Private payer marketplace is dynamic
  – The population continues to age and present with more chronic conditions
  – The U.S. continues to expect greater value from its healthcare “spend”
  – The bar continues to rise for attaining Performance goals and value-based compensation to keep practices surviving and thriving
  – Southeast ranked as the region with the highest prevalence of Cardiovascular Disease

(1) https://www.americashealthranking.org/learn/reports/2017-annual-report
The Issue

National health spending as a share of GDP

- **1960**: 5%
- **1980**: 8.9%
- **2000**: 13.3%
- **2016**: 17.9%
- **2025**: 19.9%

*Source: Centers for Medicare and Medicaid Services*
The Path Toward Accountability

The Rising Bar

- Fee For Service
- Pay for Performance/Incentives
- Episodic Bundling
- Shared Savings
- Capitation
- Full Risk
The Goal

- Shift care from emergent to preventive
- Provide care in the most effective and lowest cost setting
- Break the reliance on perverse incentives
- Manage the care of those who need it
- Utilize big data fully

*Shift from fee-for-service to Value*
The Focus

The Quadruple Aim

- Better care
  - Proven clinical quality improvement leveraging population health management
- More satisfied patients
  - Improved patient experience, engagement, and patient/provider collaboration
- Lower total medical costs
  - Protect & increase revenue through quality-based incentives, MA savings, contracts
- More satisfied providers
  - Team-based care empowering provider to focus on diagnosis and treatment

Making the right thing to do, the easy thing to do.

November/December 2014 Annals of Family Medicine. From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider
Methods used to Facilitate Transformation
A stepwise, iterative approach:

**DISCOVER**
Assessment of existing state and **readiness to adopt** new care delivery models

**BUILD**
**Promote innovation** by building practical, scalable models that address core transformational objectives

**IMPLEMENT**
**Drive change** at the point of care by providing hands-on clinical performance improvement, implementation expertise, and tools

More efficient, meaningful, quality-driven care.
# Key Domains of Value

<table>
<thead>
<tr>
<th>PATIENT- AND FAMILY-CENTERED CARE DESIGN</th>
<th>CONTINUOUS, DATA-DRIVEN QUALITY IMPROVEMENT</th>
<th>SUSTAINABLE BUSINESS OPERATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patient and family engagement</td>
<td>• Engaged leadership</td>
<td>• Strategic use of practice revenue</td>
</tr>
<tr>
<td>• Team-based relationships</td>
<td>• Quality improvement</td>
<td>• Staff vitality</td>
</tr>
<tr>
<td>• Community partners</td>
<td>• Culture</td>
<td>• Capability to analyze and document value</td>
</tr>
<tr>
<td>• Evidence-based care delivery</td>
<td>• Transparent measurement and monitoring</td>
<td>• Operational efficiency</td>
</tr>
<tr>
<td>• Enhanced access</td>
<td>• Optimal use of HIT</td>
<td></td>
</tr>
</tbody>
</table>

- PATIENT- AND FAMILY-CENTERED CARE DESIGN
  - Patient and family engagement
  - Team-based relationships
  - Community partners
  - Evidence-based care delivery
  - Enhanced access

- CONTINUOUS, DATA-DRIVEN QUALITY IMPROVEMENT
  - Engaged leadership
  - Quality improvement
  - Culture
  - Transparent measurement and monitoring
  - Optimal use of HIT

- SUSTAINABLE BUSINESS OPERATIONS
  - Strategic use of practice revenue
  - Staff vitality
  - Capability to analyze and document value
  - Operational efficiency
A Scalable Model

Collaborative Assessment

*Focus on accountable population across care environments*

Operational Strategy

- Transitions of Care
- High-Risk Complex Care
- Primary Care
- Specialty Care

Piloting

- Select Practice Locations
- Care Team Champions

Scale Up Implementation

- Standardized Processes
- Communication Protocols
- HIT Optimization
- Care & Team Management
- Education and Training of Staff
- Quality Targets
- Performance Improvement
- Measurement to Strategic Goals

Demonstration of Outcomes
Strategies to Overcome Challenges/Barriers
Key Challenges/Barriers

• Participation and Engagement
• Resources
• Variability and Disparity (or lack of EHRs)
Participation and Engagement

Key Practice Roles and Responsibilities

**Primary Contact**
- Communicate program updates
- Act as primary point of contact for the practice

**Clinical Champion**
- Lead clinical adoption
- Gain buy-in from providers
- Coordinate Protocol Adoption, Clinical Education

**Operational Champion**
- Support workflow implementation
- Liaise with practice staff
- Assist with prioritization of operational goals

**Technical Champion**
- Liaise with HIT Systems
- Lead Population Care adoption internally
- Re-train/train new Population Care users post-go live
Resources
Understanding needs and constraints

**CULTURE**
- Are you ready for change?
- What obstacles have you faced gaining physician buy-in?
- Leadership buy in?
- How are decisions typically made?

**RESOURCES**
- What HIT, data and communication systems do you have in place?
- What information do they provide (or not)?
- What have you learned from them?

**STRUCTURE**
- What processes do you already have in place?
- Are they successful? How are you measuring their success?
- Must you operate within an existing structure or are you looking to start anew?
**Assessment**

**Key Success Factors of Value Based Care**

<table>
<thead>
<tr>
<th>Foundational</th>
<th>Emerging</th>
<th>Leading</th>
<th>Advanced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient and Family Engagement</td>
<td>● ●</td>
<td>● ● ●</td>
<td>● ● ● ●</td>
</tr>
<tr>
<td>Team-based Relationships</td>
<td>● ● ●</td>
<td>● ● ● ●</td>
<td>● ● ● ● ●</td>
</tr>
<tr>
<td>Enhanced Access</td>
<td>● ● ● ●</td>
<td>● ● ● ● ●</td>
<td>● ● ● ● ● ●</td>
</tr>
<tr>
<td>Practice as a Community Partner</td>
<td>● ● ● ● ●</td>
<td>● ● ● ● ● ●</td>
<td>● ● ● ● ● ● ●</td>
</tr>
<tr>
<td>Coordinated Care Delivery</td>
<td>● ● ● ● ● ●</td>
<td>● ● ● ● ● ● ●</td>
<td>● ● ● ● ● ● ● ●</td>
</tr>
<tr>
<td>Population Management</td>
<td>● ● ● ● ● ● ●</td>
<td>● ● ● ● ● ● ● ●</td>
<td>● ● ● ● ● ● ● ● ●</td>
</tr>
<tr>
<td>Organized Evidence-based Care</td>
<td>● ● ● ● ● ● ● ●</td>
<td>● ● ● ● ● ● ● ● ●</td>
<td>● ● ● ● ● ● ● ● ● ●</td>
</tr>
<tr>
<td>Quality Improvement Strategy</td>
<td>● ● ● ● ● ● ● ● ●</td>
<td>● ● ● ● ● ● ● ● ● ●</td>
<td>● ● ● ● ● ● ● ● ● ● ●</td>
</tr>
<tr>
<td>Transparent Measurements</td>
<td>● ● ● ● ● ● ● ● ● ●</td>
<td>● ● ● ● ● ● ● ● ● ● ●</td>
<td>● ● ● ● ● ● ● ● ● ● ● ●</td>
</tr>
<tr>
<td>Results Related to Aims</td>
<td>● ● ● ● ● ● ● ● ● ● ●</td>
<td>● ● ● ● ● ● ● ● ● ● ● ●</td>
<td>● ● ● ● ● ● ● ● ● ● ● ● ●</td>
</tr>
<tr>
<td>Engaged &amp; Committed Leadership</td>
<td>● ● ● ● ● ● ● ● ● ● ● ●</td>
<td>● ● ● ● ● ● ● ● ● ● ● ● ●</td>
<td>● ● ● ● ● ● ● ● ● ● ● ● ● ●</td>
</tr>
<tr>
<td>Optimized HIT</td>
<td>● ● ● ● ● ● ● ● ● ● ● ● ●</td>
<td>● ● ● ● ● ● ● ● ● ● ● ● ● ●</td>
<td>● ● ● ● ● ● ● ● ● ● ● ● ● ● ●</td>
</tr>
<tr>
<td>Strategic Use of Practice Revenue</td>
<td>● ● ● ● ● ● ● ● ● ● ● ● ● ●</td>
<td>● ● ● ● ● ● ● ● ● ● ● ● ● ● ●</td>
<td>● ● ● ● ● ● ● ● ● ● ● ● ● ● ● ●</td>
</tr>
<tr>
<td>Workforce Vitality and Joy in Work</td>
<td>● ● ● ● ● ● ● ● ● ● ● ● ● ● ●</td>
<td>● ● ● ● ● ● ● ● ● ● ● ● ● ● ● ●</td>
<td>● ● ● ● ● ● ● ● ● ● ● ● ● ● ● ● ●</td>
</tr>
<tr>
<td>Capability to Analyze Value</td>
<td>● ● ● ● ● ● ● ● ● ● ● ● ● ● ● ●</td>
<td>● ● ● ● ● ● ● ● ● ● ● ● ● ● ● ● ●</td>
<td>● ● ● ● ● ● ● ● ● ● ● ● ● ● ● ● ● ●</td>
</tr>
<tr>
<td>Operational Efficiency</td>
<td>● ● ● ● ● ● ● ● ● ● ● ● ● ● ● ● ●</td>
<td>● ● ● ● ● ● ● ● ● ● ● ● ● ● ● ● ● ●</td>
<td>● ● ● ● ● ● ● ● ● ● ● ● ● ● ● ● ● ● ●</td>
</tr>
</tbody>
</table>

*HIMSS19*
Disparate EHR Systems
Integrating Clinical Data across the PTN Network
Population Health Management

Utility at the Practice-Level

Pre-visit Planning
- Identify individual patient care gaps and enable targeted care improvement
- Enhance pre-visit planning for more activated visits

Population Health
- Utilize clinical suites/registries to drive a campaigned care delivery approach
- Identify patients for outreach and engagement
- Segment and manage population groups

Clinical Quality Improvement
- Establish practice goals to drive quality improvement
- Align with QualityImpact support via best practice protocols, modules, and clinical coaching
- Equip providers with a means to track/measure quality
Focused Population Segmentation

Improving Clinical Care

- Asthma (> 2 years)
- Breast Cancer Screening (50-74 years)
- Cervical Cancer Screening (21-65 Years)
- Chronic Heart Failure (> 18 years)
- Chronic Kidney Disease (>18 years)
- COPD (> 18 Years)
- Colorectal Cancer Screening (50-75 Years)
- Diabetes (> 18 Years)
- Child & Adolescent Diabetes (Less than 18 Years)
- Child & Adolescent Hypertension (<18 Years)
- Adult Hypertension (18+ Years)
- Adult Ischemic Vascular Disease (> 18 Years)
- Child & Adolescent Preventative Services (2-17 Years)
- Child Immunizations (0-2 Years)
- Child & Adolescent Obesity (2 - 17 years)
- Tobacco Usage & Exposure (All Ages)
Case Examples

Large Integrated Network - High Risk Region
Independent Rural Practice
Academic Center Physician Practice Group
Case 2

- Located in Louisiana
- 46th to 50th in higher healthcare costs and lower quality outcomes
- Multi-specialty practice
- Primary provider in the Community
- Focus on fee for Service
- Over 400 providers
- Low performer
Population Health Management
Identifying Patient Care Needs

- Narrow down to a specific measure
- Selecting a list of patients who do not meet the measure
- Review measures that are due within the next 60 days
- Targeting patients that are outdated on visits
- Clinical Performance of Providers
Population Health Management

Using actionable data to close patient gaps in care

Highlights actionable opportunities to improve patient care

Seamlessly integrates clinical, claims, and practice management data
Established Internal CQI Process
Use of Trending Reports

4/2014-Best Protocol in 1 Practice

1/2016-"We agreed on a plan and a Protocol"
Clinical Improvement Outcomes

Optimal Hypertension Control

- 78% improvement

Key Strategies
- Access to Data
- Data Transparency
- Network Goals
- Systemized Protocol

Payor Contract Negotiations
Case 3

Primary Care and OB/Gyn

PTN-Practice Collaboration

Implemented Medication Management and Obesity Management Programs incorporating elements of:

- **Population Management** (risk stratification, identification of care gaps)
- **Patient & Family Engagement** (collaboration with patients and families using shared care plans, use of tools to assist patients in assessing need for self management support, staff training on self-management goal setting)
- **Organized, Evidenced-Based Care** (regular communication and coordination between primary care and behavioral health providers, co-location of behavioral health services)
- **Transparent Measurement & Monitoring** (transparent use of data by defining measures, monitoring them and sharing metrics with staff)
Risk Stratification

- Utilize data to generate chronic disease-specific patient lists for outreach
- Gap Analysis - Review out of compliance measures
- Identify and manage highest risk patients, filtered by disease burden and care opportunities
Patient and Caregiver Engagement

Patient & Caregiver Initiatives

1. Health Literacy, social determinants integration
2. Readiness to change and health confidence patient engagement tools
3. Tailored approach & community partnerships based on identified barriers
Transparency of Data
Sharing with Team

Performance Spotlight

Clinical Control Rates, %
May 2017 – July 2018

- Improved BP Control (<140/80) for Chronic Heart Failure patients by 38 percentage points
- Improved HbA1c <8% for high-risk patients (>65 yrs) by 20 percentage points
- Improved BP Control (<140/90) for Ischemic Vascular Disease by 18 percentage points

Blood Pressure < 140/80, CHF
HbA1C < 8 (Age >= 65), Diabetes
Case 4

• Metro-Tampa academic medical center and multispecialty CIN with 585 physicians seeing 483,974 outpatient visits/year

• Deployed a PHM provider for analytics to maximize Medicare Part B reimbursement and bonus payments

• 14 registry-based quality measures calculated at the group and individual levels across 30+ medical specialties
Outreach Campaign

Integrated Outreach Campaign

PHM provider helped close, not just expose, care gaps

In December 2017 an email flu shot campaign was deployed:

• 1st wave of emails sent to 61,000 patients without documentation of flu vaccination in past 12 months
• 2nd wave of emails sent to non-respondents
• 7.4% responded affirmatively with date and location of their flu shot
• 50.4% increase in # of patients with documented influenza vaccination within past 12 months
• MIPS measure performance improved from 13.2% (CMS Decile 3) to 40% (CMS Decile 7) for an overall increase of 203%
Results

Initial 6 Months Performance Optimization

*Showing percentage improvement in performance rates from data optimization efforts:*

- 203% Improvement in Influenza Vaccination
- 114% Improvement in Diabetic Attention for Nephropathy
- 80% Improvement in IVD: Use of Aspirin/Antiplatelet
- 44% Improvement in Controlling High Blood Pressure
- 23% Improvement in Breast Cancer Screening
- 11% Improvement in Tobacco Use Screening & Cessation
Key Improvements

MIPS Optimization with Three Facet Data Mining
Exceptional Performance Achieved in 2018

![Graph showing MIPS optimization with three facet data mining]
Achievements and Challenges
## Performance At-a-Glance

<table>
<thead>
<tr>
<th>Area</th>
<th>Description</th>
<th>Progress Toward Target Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engage Clinicians</td>
<td>Exceeded enrollment commitment by 116% with 4,693 clinicians vs. 4,040 commitment.</td>
<td>116%</td>
</tr>
<tr>
<td>Improve Health Outcomes</td>
<td>Improved high-impact measures in 98,529 of 73,465 total committed patients with CV-related conditions.</td>
<td>134%</td>
</tr>
<tr>
<td>Reduce Unnecessary Utilization</td>
<td>6,988 avoided all-cause hospital admissions and ED Visits out of commitment of 10,040.</td>
<td>69%</td>
</tr>
<tr>
<td>Generate Cost Savings</td>
<td>Achieved 77% of cost savings commitment of $59.5 million.</td>
<td>77%</td>
</tr>
<tr>
<td>Reduce Unnecessary Testing &amp; Procedures</td>
<td>Reduced 7,012 unnecessary low back pain imaging cases.</td>
<td>52%</td>
</tr>
<tr>
<td>Transition Practices to APMs</td>
<td>Graduated 36% of practices to APMs representing 258 practice sites.</td>
<td>36%</td>
</tr>
</tbody>
</table>
Key Success Strategies

**Clinical Management**
1. Establish Quality Improvement Process
2. Enable Data Transparency
3. Actionable Data Driven Improvement Plans
4. Share Provider Reports and Clinician Compare
5. Review Quarterly Performance Dashboard
6. Clinical Performance CME Program (Rapid Cycle Improvement)
7. Trend Patient-level Data

**Transformation Progress**
1. Enhance workflow design, process efficiencies, and appropriate utilization
2. Apply Guidelines & Expert Coaching
3. Guide development of Care Management programs
4. Implement Behavioral Health Support strategies and networks
5. Implement Pain Management and Opioid Use Strategies

**APM Readiness**
1. Drive Empanelment
2. Align with Payer Value Programs
3. Guide development of Post-Acute Networks
4. Integrate AWV, TCM & CCM
5. Optimize Billing & Coding
6. Ensure Business Acumen
7. Facilitate APM Readiness Consultations
Assertion 1

Achieving Performance Improvement

Pre and Post Changes in Control Rates

January 2018-December 2018
Cost Savings

Cost Savings to Commercial Payers

- June 2017: $3,285,524
- December 2017: $37,710,599
- April 2018: $43,414,858
- 4-Year Commitment: $59,590,172
Assertion 2:
The evidence base for practice transformation and performance improvement is credible and valuable

QUALITYIMPACT PTN 2017 MEMBER SURVEY RESULTS

Perceived value of specific areas of QualityImpact PTN support to practices to date

(1=Not at all valuable, 5=Extremely valuable)
**Challenge: Milestone Gaps**

**#8 – PANEL ASSIGNMENTS**

31% Need Improvement

Practice has assigned all patients to a provider panel and confirmed the assignments with providers and patients. Practice reviews and updates panel assignments on a regular basis.

**#10 – CARE MANAGEMENT**

36% Need Improvement

Practice has assigned accountability for care management and is piloting a process for standardizing care management for patients determined to be at highest risk of hospitalizations and/or complications.

**#15 – BEHAVIORAL HEALTH**

33% Need Improvement

Practice is able to consistently provide access to behavioral health providers but information may not always be shared in a timely or consistent fashion and coordination with the primary care team is likewise inconsistent.

**#19 – QI METHODOLOGY**

36% Need Improvement

The practice is beginning to incorporate regular improvement methodology to execute change ideas in the practice setting but the methodology has not yet been implemented in all areas of the practice.

**#21 – PROVIDER REPORTS**

50% Need Improvement

Practice regularly produces reports on how providers and/or care teams are performing and meeting quality goals, transparently shares them within the organization, and has an effective system for follow up.
Customized Performance Improvement

1. Practices & physicians/NPs opt in & identify champions
2. Data sources identified
3. CAP lead & physicians/NPs receive & review baseline report
4. Champion & lead physician develop action plan with QualityImpact
5. All physicians/NPs sign off on action plan & implement interventions with team
6. Bi-monthly clinical data review with QualityImpact
7. Apply changes to action plan as needed based on learnings
8. Final program impact evaluation

5 CME credits

5 CME credits

5 CME credits

10 CME credits
Promoting Transparency: Review and Action Reports
Assertion 3
Bringing forward exemplary practices that demonstrate transformed delivery systems and exceptional, high “value” performance

Primary Care
Huntsville, Alabama
Family Medicine
6 clinicians

Exemplary Practice

• Patient-centric redesign of provider office to improve efficiency, workflow and patient access
• High-risk care management
• Transitional Care
• Data Transparency
• Improved Clinical Performance

Clinical Improvement
62% ➔ 80% BP control for HTN (ages 60-85)
69% ➔ 78% BP control for HTN (ages 18-59)
65% ➔ 75% A1c control for DM (A1c < 8%)

Utilization
ED visit high performer with actual cost of 4.50/1000 vs. $224.00/1000 expected
Radiology Services high performer with actual costs at 81% of expected ($1,059.63 actual vs. $1,306.23 expected)

Cost
Total Cost of Care high performer with PMPM actual cost of $231.35 vs. $277.90 expected

Graduated to an MSSP at Phase 4
## Core Interventions & Strategies to Enable High Performance

<table>
<thead>
<tr>
<th>INTERVENTIONS</th>
<th>STRATEGY DRIVERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EVIDENCE-BASED GUIDELINES</strong></td>
<td>• Practice consensus on use of evidence-based clinical protocols and standing order sets</td>
</tr>
</tbody>
</table>
| **HIGH-RISK MANAGEMENT**          | • Implementation of a process to identify and manage high-risk patients  
                                  | • Focused care coordination-outreach to Patients with high utilization                                                                 |
| **MEDICAL NEIGHBORHOOD**           | • Formal agreements with referral providers to define expectations and enhance access for patients  
                                  | • Identified local community resources                                                                                                 |
| **HIT OPTIMIZATION**              | • EMR alerts for health maintenance, and overdue labs  
                                  | • Generated reports and a process for regularly reviewing quality reports                                                              |
| **STAFF ACCOUNTABILITY**           | • Pre-visit planning, morning huddles  
                                  | • Defined team member responsibilities during a patient’s visit (e.g., managing EMR alerts, placing standing orders) and provided quality improvement training to staff |
| **PATIENT AND FAMILY ENGAGEMENT** | • Integration of the use of the patient portal to schedule appointments, provide educational resources and collect patient feedback to improve the practice workflow  
                                  | • Adopted shared decision making, health literacy, social determinants, and disease education tools                                      |
Recommendations
Structural Components Considerations

Quality-Based Financial Incentives

Cloud-Based Population Health Analytic Tool

Practice Facilitation

Education & Clinical Training

Tools & Resources

- Actionable patient care gap analysis and registry functionality
- Workflow optimization and team-based care enablement
- Process improvement education, targeted clinical guidance and learning collaboratives
- Process tools and educational resources for patients
Recommendations

• Phased Approach to Implementing Change
• Recognize Current vs. Proposed
• User-friendly transparent robust data presented in real-time
• Making data actionable-internal reviews, provider compare reports, measurement, and trending.
• Engagement of healthcare team-clinical, operational and technology champions
• Learning and Alignment Training
• Use of CQI and incentives to instill new culture
Questions

Debra Simmons
COSEHC Executive Director
Wake Forest University Baptist Medical Center
dwirth@wakehealth.edu
https://www.linkedin.com/in/debra-simmons-42b28823/

Don’t forget!
Please complete the online session evaluation!