Quality Is Our Daily Business

May 30, 2012
Community Health Center, Inc.

Our Vision: Since 1972, Community Health Center, Inc. has been building a world-class primary health care system committed to caring for underserved and uninsured populations and focused on improving health outcomes, as well as building healthy communities.

CHC Inc. Profile:
• Founding Year - 1972
• Primary Care Hubs – 13
• No. of Service Locations - 218
• Licensed SBHC locations – 24
• Organization Staff - 700

Innovations
• Integrated primary care disciplines
• Team-based panel management
• Fully integrated HER, portal, HIE
• Extensive school-based care system
• “Wherever You Are” Health Care
• Centering Pregnancy model
• Residency training for new nurse practitioners
• Post-doc residency for clinical psychologists
• Data, dashboard driven QI

Three Foundational Pillars
Clinical Excellence
Research & Development
Training the Next Generation

QSEN Conference May 30, 2012
CHC Patient Profile

- Patients who consider CHC their health care home: 130,000
- Health care visits: 410,000 per year

<table>
<thead>
<tr>
<th>Top Chronic Diseases</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular Disease</td>
<td>Obesity/Overweight</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Chronic Pain</td>
</tr>
<tr>
<td>Asthma</td>
<td>Depression</td>
</tr>
</tbody>
</table>

Patient Care Model

- PCMH (NCQA Level 3)
- Advanced access scheduling
- “Planned Care” and the Chronic Care Model
- Integrated behavioral health services
- Integrated clinical pharmacist service – on site and virtual collaborations
- Comprehensive dentistry/oral health
- Clinical dashboards
- Expanded hours and 24/7 coverage
- Comprehensive HIV /AIDS & Hep C care
- Formal research program
- Residency training for nurse practitioners
- Neighborhood outreach, screening, enrollment

[CHC Patient Demographics Chart]

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Clinical excellence
Innovation and Research
Training the next generation
### Patient-Centered Approach To Care

<table>
<thead>
<tr>
<th>Domain</th>
<th>Key Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access and Communication</td>
<td>Advanced Access, Expanded Hours, Language Line, Integrated Care</td>
</tr>
<tr>
<td>Patient Tracking and Registries</td>
<td>Electronic Health Record, Clinical Decision Support</td>
</tr>
<tr>
<td>Care Management</td>
<td>Planned Care, Team Approach, Expanded Nurse Roles</td>
</tr>
<tr>
<td>Self-Management Support</td>
<td>Self-management training, patient empowerment</td>
</tr>
<tr>
<td>Electronic Prescribing</td>
<td>Electronic health record, prescribing support and safety</td>
</tr>
<tr>
<td>Test Tracking</td>
<td>Electronic system for testing</td>
</tr>
<tr>
<td>Referral Tracking</td>
<td>Centralized Referrals</td>
</tr>
<tr>
<td>Performance Reporting and Improvement</td>
<td>Performance improvement, clinical dashboard</td>
</tr>
<tr>
<td>Advanced Electronic Communications</td>
<td>Patient Portal, Health Information Exchange, Telemedicine, eConsults</td>
</tr>
</tbody>
</table>

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How did we build a culture for QI?

1. **Goals:** move beyond compliance with regulatory and accrediting
2. **Focus on engagement staff at all levels**
3. **Recognize investment of new resources in time and money**
4. **Identifying partnerships in/out of CHC**
5. **Develop strategies for staff training and communication**
6. **Incorporate into training programs**
CHC Quality Department, est. 2010

- Daren Anderson, Chief Quality Officer
- Deb Ward, QI Manager
- Patty Feeney, QI Coordinator
- Ianita Zlateva, Research Coordinator
- Sissi Wang, Data Programmer
- Khushbu Khatri, AmeriCorps Volunteer
- Jonathan Smith, Sr. Programmer (IT)
CHC QI Plan Highlights

- Clinical Microsystems
  - Activated front line teams
  - Trained Coaches

- Data-driven QI

- Partnerships
Clinical Microsystems

• Clinical Microsystems are the front-line units that provide most health care to most people.
• They are the places where patients, families and care teams meet.
• Microsystems include support staff, processes, technology and recurring patterns of information, behavior and results.
• Central to every clinical Microsystem is the patient.
Why Microsystems are the best way to test change?

- They are the content experts
- They work at the level closest to the patients
- They know their job, it’s challenges and know what would make it better
- It is better to have ownership of change rather than just buy in
- Microsystems teams can include patient representatives
The Art of Clinical Microsystems Coaching

- Dartmouth 5-6 month learning and practice
  - Didactic and theory learning
    - Meeting facilitation / roles / timed agenda’s
  - Journaling
    - Reflecting on the personal experience
- Calls/ “open office hours”
  - Supported by the Dartmouth Faculty
- Assigned Dartmouth Facility member
  - Allows for frequent personal contact and coaching support for questions
- Homework and documentation of learning
  - Several books and journals along with proof of understanding of content
- Certification
  - Several levels of certification based upon the number of Microsystem teams coached

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Clinical Microsystems

- Specific Aim
- Global Aim
- Theme
- Assessment
- Change Ideas
- Measures
- Improvement Ramp
- PDSA
- PDSA
- PDSA
- SDSA

- Routine report-out at daily leadership meeting
- Quarterly report-out to the PI Committee

Improvement Ramp concept is from the book *Quality By Design* (by Eugene C. Nelson, Paul B. Batalden and Marjorie M. Godfrey) and the Dartmouth Institute.
**CHC Quality Improvement Ramp**

Leader: Kim Roy  
Coach: Daren Anderson  
Team members:  
Nwando Olayiwola: CMO  
Hartmut Doerwaldt: NL MD  
Maggie Tokarzewski: NB RN  
Johanna Rivera: NB MA  
Derek Nguyen: NB MD  
Diane Revolus: Norwalk MA  
Branden Green: Danbury RN  
Elena Tamayo Heinz: MDTW RN  
Aislinn Edwards: Mer MA  
Natalie Bycenski: Mer RN

100% of patients due and eligible for colon cancer screens, mammograms, A1C's and depression screening are offered appointments and referrals are made.

CHCI aims to improve patient outcomes by ensuring that our care team is prepared for each visit in advance. This is accomplished by developing effective, and efficient team pre-visit/ huddling system and ensuring that all teams huddle each day.

**Change ideas:**  
- visit to MSX  
- MA pre-work  
- CDSS  
- 5 min am huddle  
- using schedule print out  
- PM re-huddle  
- nurse reviews SM

Global aim

Team Charter

Assessment

Specific Aim

Change Ideas/ Brainstorming

Measures

PDSA

PDSA

PDSA

PDSA

SDSA

99.9 report-out

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The purpose of this Microsystem is to improve the health outcomes of our patient populations and build a healthy community in New Britain.
Example 1: Follow up of abnormal cancer screening tests

Incorporating six sigma, lean, and a “Kaizen” event
Kaizen: 6-Sigma/Lean
Abnormal Cancer Screen Process — Future State
Example 2: Increasing % of patients with DM or Hypertension at target

Treat Your Primary Care Practice
Plan-Do-Study-Act (PDSA)

Complete the Plan-Do-Study-Act worksheet to execute the Change Idea in a disciplined measured manner, to reach the specific aim:
Goal: To engage 8 patients who have uncontrolled HTN in the Home Blood Pressure Monitoring Program.

<table>
<thead>
<tr>
<th>Plan</th>
<th>How shall we PLAN the pilot? Who does what? When? With what tools? What baseline data will be collected?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tasks to be completed to run test of change</td>
<td>Who</td>
</tr>
<tr>
<td>Generate a report of patients who are not at target control who have a visit scheduled with Dr. Wilensky or Dr. Patel</td>
<td>Shanti</td>
</tr>
</tbody>
</table>

Workflow:
1. Elena will review the list on Wed and Friday with Dr. Wilensky and together determine which patients to focus on.
2. During the morning huddle, Elena will alert the PCP and MA that she would like to see the patient when they are addressed to explain the HBM program.
3. Elena will inform the PCP if the patient agrees to participate.
4. Elena will follow the policy for HBP.
5. PCP will review the medication lists and BP results.
6. PCP will document medication changes (V)

Elena Wilensky
Patel MA
Ward
Begin: 09/29/10
Report
EDW HBPm policy

1. Did Elena receive the report on time?
2. How many patients were listed on the report?
3. Did Elena discuss these patients at the morning huddle?
4. Did the MA inform Elena when the patient was reviewed?
5. How many patients agree to the HBPm program?
6. How many med order changes were documented for the nurse to implement based on pre-established orders?
7. How many patients moved into control following the HBPm program?
8. Was Elena able to fit this work into her daily routine?
9. How many SMG established?
10. How many patient came back for the second nurse visit.
Example 3: Integrating daily huddle into daily routine

- Model is based on “Planned Care”.
- “We see you coming”.
- Proactive, not reactive.
- Particularly important for prevention, promotion, screening, and chronic disease management.
- But how can you get people to do it?
Huddle Workflow

- Prior Day Review Using CDSS (medical assistant)
- Same day review (Provider, M.A., RN)
- Afternoon brief huddle to review changes
- Weekly: team reviews of missed opportunities” report

“In primary care: its the sins of Omission, not Commission, that are likely to cause harm.”
Missed Opportunities: Site that started huddling

- Sum of A1C testing in patients with diabetes (6 months)
- Sum of Breast cancer screening
- Sum of Colorectal cancer screening by colonoscopy

Middletown

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Missed Opportunities: Site that didn’t start huddling

- Sum of A1C testing in patients with diabetes (6 months)
- Sum of Breast cancer screening
- Sum of Colorectal cancer screening by colonoscopy
- Sum of Depression Screening

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<table>
<thead>
<tr>
<th>PCP</th>
<th>A1C Testing</th>
<th>Breast Cancer Screening</th>
<th>Depression Screening</th>
<th>Colorectal Cancer Screening</th>
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<td>Aubone M.D., Susan-FP</td>
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<td>Thomas APRN, Bennette-FP</td>
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<td>Tracy APRN, Martha</td>
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<td>Wagner APRN, Monte</td>
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<td>Weinke M.D., Dan-FP</td>
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<td>Wilson APRN, Laura</td>
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<tr>
<td>Wynn M.D., Chris-FP</td>
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<td>4</td>
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</tbody>
</table>
Example 4. RN Care Coordination
Global Aim Statement for Care Coordination

- We aim to improve:
  
  *We will redesign the pod staffing model to provide PCMH-level care coordination while ensuring that quality routine care is maintained*

  (Name the process)

- In:
  
  *The New London site*

  (Clinical location in which process is embedded)

- The process begins with:
  
  *Identifying those patients who will benefit from Care Coordination*

  (Name where the process begins)

- The process ends with:
  
  *A system for coordinating care for complex patients, patients with uncontrolled chronic disease and patients who are transitioning from acute or sub acute care facilities.*

  (Name the ending point of the process)

- By working on the process, we expect:
  
  *Maintain excellent routine daily planned care nursing*
  *Increase communication between acute care facilities, specialists, and other community resources*
  *Decrease the occurrence of hospital readmissions*
  *Increase the patient and families engagement in self care*

  (List benefits)
Project Contract

Date __________________________
Project Title ________________________
Project Rationale _______________________
____________________________________
____________________________________
____________________________________
Key deliverables ________________________________
Critical milestones ______________________________
Customers/Suppliers who must be involved ________________________________
“Must-” in terms of the project scope ________________________________
Things definitely not in the project scope ________________________________
How the project will be measured ________________________________
How the team will be measured ________________________________
When the team must check with sponsor ________________________________
When the team has full authority to act ________________________________
When the sponsor has the right to veto ________________________________

Project Sponsor ________________________________
Project Team Leader ________________________________
CAP Coach ________________________________
Team Members ________________________________

Project title: Care Coordination to Improve Health Outcomes in New London

- Project Rationale: The PCMH model has been shown to improve patient outcomes and strengthen primary care. CHC has been recognized as a level III PCMH by NCQA, but has identified Care Coordination as a critical element of this model that needs to be strengthened. Care coordination is challenging in the current healthcare system which is characterized by a disjointed, uncoordinated care between primary care, multiple specialists, hospitals, emergency rooms, pharmacies and other sources of care. A recent study found that a typical Medicare patient receives care from 96 different sources in a year. Poorly coordinated care for patients with complex problems and multiple care sources leads to inefficiency, reduced quality of care, and errors. How care coordination is incorporated into daily work, who accomplishes the tasks, and how the team is staffed to accomplish this are key questions for CHC. Role definitions, staffing models and caseloads need to be defined along with outcome measures to evaluate the impact of these interventions.

- Care coordination for primary care includes three main elements: **Managing transitions** between inpatient and outpatient settings, providing **self management education and disease management** support for patients with poorly controlled chronic illnesses like diabetes or HTN, and **coordinating care** for patients with complex needs and multiple care sources.
Global Aim Statement: We will redesign the pod staffing model to provide PCMH-level care coordination while ensuring that quality routine care is maintained.

- **Project Sponsors:** Daren Anderson/Margaret Flinter
- **Project Team Leader:** Carla Ocampo/TBD
- **Coach:** Deb Ward
- **Team Members:**
  - John Monroe
  - Mary Blankson
  - Pat Decker
  - Pam Coury
  - Kim Wagner
  - Elaine Morisette
  - Kim Roy
  - Vicki Carter
  - Irish Pacantara
  - Melissa Johnson
## Project Contract

### Key Deliverables

- Staffing model/Task assignment list that incorporates care coordination into daily pod work.
- System for each POD to identify patients needing care coordination.
- System to manage transitions between inpatient and outpatient.
- System to provide self management and disease management for patients with uncontrolled diabetes.
- System for coordinating care for patients with complex medical conditions and multiple care sources.

### Critical Milestones

- Team formation and initial Microsystems training.
- Establishment of the population of focus (pts needing care coordination).
- First PDSA cycle.
- Establishment of mechanism to identify and manage L&M discharges.

QSEN Conference May 30, 2012
Key Deliverables

- System for each POD to identify patients needing care coordination
- System to provide self management and disease management for patients with uncontrolled diabetes
- System for coordinating care for patients with complex medical conditions and multiple care sources
- System to manage transitions between inpatient and outpatient care

Critical Milestones

- Team formation and initial Microsystems training- Completed
- Establishment of the population of focus (pts needing care coordination)
- First PDSA cycle
- Establishment of mechanism to identify and manage L&M discharges
<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Desired behaviors</th>
<th>Short term concerns</th>
<th>Short term wins</th>
<th>Influencing strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veena Channamsetty</td>
<td>Meet with the PCP’s to tell them about the project</td>
<td>Lack of buy in</td>
<td>Agreement to speak with the Meriden PCP’s</td>
<td>Speak with Veena Daren March 27, 2012</td>
</tr>
<tr>
<td>Team meeting with Meriden Clinical staff (include imbedded BH clinicians), Zoraida</td>
<td>Inform them of the CC model used by NL</td>
<td>Lack of buy in</td>
<td>Understanding and agreement to PDSA</td>
<td>Set the date (target April 13th) Veena/Daren/Deb March 27, 2012</td>
</tr>
<tr>
<td>NL CC team</td>
<td>To present the Project to Meriden</td>
<td>Schedules</td>
<td>Agreement</td>
<td>Contact Mary Blankson to explain the purpose and content of meeting Deb March 29, 2012</td>
</tr>
<tr>
<td>Senior Leadership</td>
<td>To receive an overview of the project and understand the impacts</td>
<td>Identify any barriers that might impact the spread of this process</td>
<td>Agreement</td>
<td>Meet with Senior leadership Daren TBD</td>
</tr>
<tr>
<td>Dave Landsberg</td>
<td>To review the pay structure, and potential issues with the role redesign, Any policies??</td>
<td>Any policy or labor law that will impact the role changes</td>
<td>Agreement to offer changes of roles to RN/LPN staff</td>
<td>Schedule meeting with Dave Daren March 30, 2012 TO DO: send JD to HR when completed TBD</td>
</tr>
<tr>
<td>Marcia Stein</td>
<td>To review the concept of CC with her and to identify any potential budget implications</td>
<td></td>
<td>Agreement</td>
<td>Schedule meeting Daren March 30, 2012</td>
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<tr>
<td>OSMD</td>
<td>To gain an understanding of the proposed changes</td>
<td>They will be concerned about how this change will effect wait times, and productivity for them</td>
<td>Agreement and understanding of the proposal</td>
<td>Schedule meeting with the OSMD group Daren Need to schedule TBD</td>
</tr>
<tr>
<td>NM group</td>
<td>Continue to gain understanding of the model and test changes at their site</td>
<td>Concern about open positions and unwillingness to try tests of change</td>
<td>Agreement of the PDSA plan roll out</td>
<td>Schedule meeting Deb April 6, 2012 Follow up TBD</td>
</tr>
<tr>
<td>All staff Meeting</td>
<td>To engage all sites and all staff disciplines in the project</td>
<td>They will not be concerned about communication (Te assignment, template changes, etc) Lack of buy in</td>
<td>Understanding of the project</td>
<td>Schedule time at all site meeting Daren/Deb July 2012</td>
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QI SharePoint
## Balanced Scorecard and Dashboard

### Clinical Outcomes

<table>
<thead>
<tr>
<th>Clinical Outcomes</th>
<th>Summer 2011</th>
<th>Fall 2011</th>
<th>Winter 2012</th>
<th>Target*</th>
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<tbody>
<tr>
<td>Hypertension Control</td>
<td>May, 2011</td>
<td>Aug., 2011</td>
<td>Dec., 2011</td>
<td>Medicaid / Medicare</td>
</tr>
<tr>
<td></td>
<td>59.06%</td>
<td>60.94%</td>
<td>59.95%</td>
<td>66%</td>
</tr>
<tr>
<td>Diabetes Patients A1c</td>
<td>29.21%</td>
<td>29.81%</td>
<td>30%</td>
<td>29%</td>
</tr>
<tr>
<td>greater than 9 or not done</td>
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### Weekly Average of Planned Care Missed Opportunities (Screening and Prevention)

<table>
<thead>
<tr>
<th>Weekly Average of Planned Care Missed Opportunities (Screening and Prevention)</th>
<th>2nd Quarter 2011</th>
<th>3rd Quarter 2011</th>
<th>4th Quarter 2011</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1C</td>
<td>22</td>
<td>14</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>198</td>
<td>133</td>
<td>83</td>
<td>0</td>
</tr>
<tr>
<td>Mammogram</td>
<td>95</td>
<td>59</td>
<td>39</td>
<td>0</td>
</tr>
<tr>
<td>Depression</td>
<td>286</td>
<td>147</td>
<td>89</td>
<td>0</td>
</tr>
</tbody>
</table>

## CHC Clinical Dashboards for Primary Care Teams

### Hypertension Patients by PCP

### Diabetes Patients by PCP

### Chronic Opioid Patients by PCP

### Planned Care Missed Opportunities (Huddle Report)
America’s First Family Nurse Practitioner Residency Training Program

NP Residency Class of 2011-2012

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FQHCs and our patients need expert primary care providers prepared to manage social and clinical complexity in the primary care setting.

NPs overwhelmingly choose primary care, but are deterred from FQHC setting by mismatch between preparation, patient complexity, and available support.

We can provide new nurse practitioners with a depth, breadth, volume, and intensity of clinical and model training that prime them for FQHC success.

Train new nurse practitioners to a model of primary care consistent with the IOM principles of health care and the needs of vulnerable populations.

Create a nationally replicable model of FQHC-based Residency training for nurse practitioners.

Prepare new NPs for practice in any setting—rural, urban, large or small, with confidence.

Develop a sustainable funding methodology.
Structure of NP Residency Training

- 12 months, full time employment at CHC, Inc.
- Participate in on-call and weekend rotations
- Clinical committees and task force involvement
- Core elements:
  - Precepted “continuity clinics” (4 sessions/week); expert CHC NPs and physicians as preceptors
  - Specialty rotations (3 sessions/wk x 1 month) in orthopedics, women’s health/prenatal care, adult/child psychiatry, geriatrics, HIV care, Hep C care, derm etc.
  - “Independent clinics”: seeing patients as part of a CHC “team” (2 sessions/week);
  - Didactic education sessions on high volume/risk/burden topics (1 session/week)
  - Continuous training to CHC model of high performance health system: access, continuity, planned care, team-based, prevention focused, use of electronic technology
  - Strong evaluation component: personal, clinical, organizational throughout
  - *Immersion of performance improvement training, and leadership development
Community Orientation, CHC Orientation, Community Engagement

Initial weeks devoted to a deep dive into CHCI—model of care, technology, services, sites, data and their assigned community: health data, population data, walking tours, meeting with community leaders.

Assignment to a team, development of a panel, specific focus on PI Priorities and quality improvement

Throughout the residency, Residents participate in clinical microsystem training and development

Intensive review of current expertise with essential primary care skills:

QSEN Conference May 30, 2012
CHC’s QI Partnerships
Recess Rocks!!
Farmer’s Market, Middletown

Building Healthy Communities
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