TCPi | Transforming Clinical Practice Initiative

TCPI Change Package: Transforming Clinical Practice

Driver Diagram

The TCPI Change Package, which is built on the driver diagram model below, describes the changes needed to transform clinical practice and meet TCPI goals. The driver diagram shows the relationships among goals, the primary drivers that contribute to achieving those goals, and the subsequent factors that are necessary to achieve the primary drivers. The change package is a compilation of the interventions developed and tested by others.

TCPI AIMs/Goals	Primary Drivers	Secondary Drivers
(1) Support more than 140,000 clinicians in their practice transformation work. **(2) Build the evidence based on practice transformation so that effective solutions can be scaled.** **(3) Improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other patients.** **(4) Reduce unnecessary hospitalizations for 5 million patients.** **(5) Sustain efficient care delivery by reducing unnecessary testing and procedures.** **(6) Generate $1 to $4 billion in savings to the federal government and commercial payers.** **(7) Transition 75% of practices completing the program to participate in Alternative Payment Models**	**Patient and Family-Centered Care Design**	**1.1 Patient & family engagement** **1.2 Team-based relationships** **1.3 Population management** **1.4 Practice as a community partner** **1.5 Coordinated care delivery** **1.6 Organized, evidence based care** **1.7 Enhanced Access**
	Continuous, Data-Driven Quality Improvement	**2.1 Engaged and committed leadership** **2.2 Quality improvement strategy supporting a culture of quality and safety** **2.3 Transparent measurement and monitoring** **2.4 Optimal use of HIT**
	Sustainable Business Operations	**3.1 Strategic use of practice revenue** **3.2 Staff vitality and joy in work** **3.3 Capability to analyze and document value** **3.4 Efficiency of operation**

Providers may use the TCPI Change Package to guide their transformation efforts. It is organized around three management functions that will drive performance, quality, and success.

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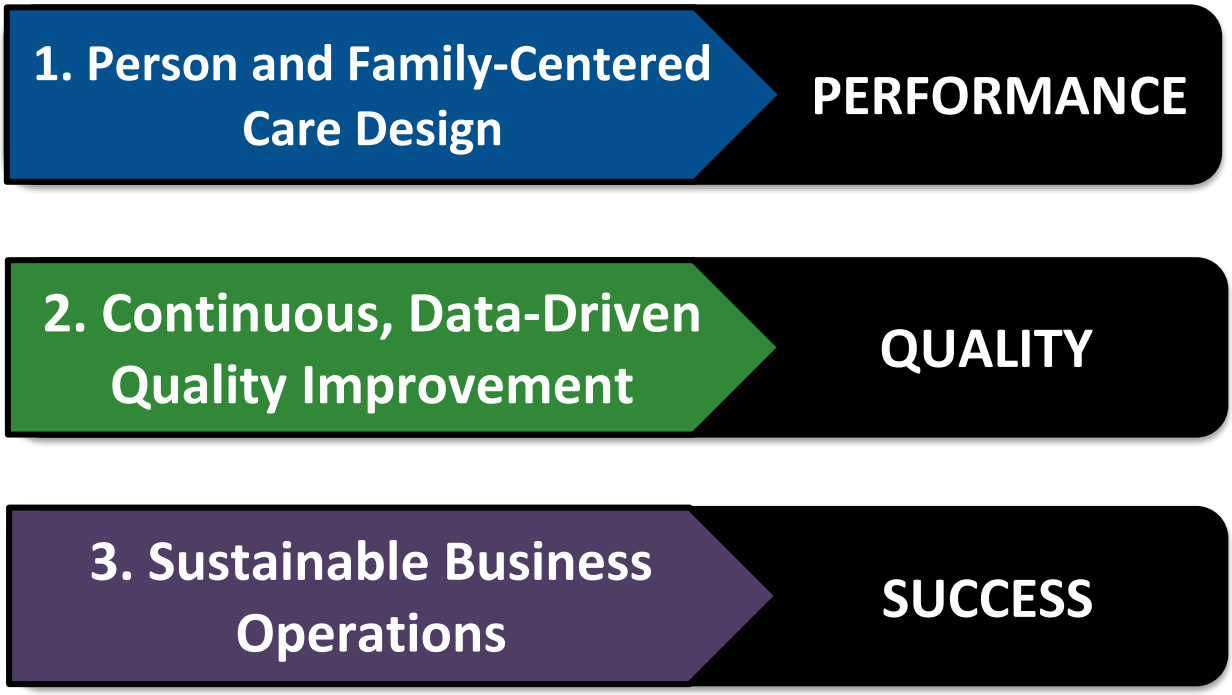
Primary Drivers



Person and family-centered care design allows the practice to combine the evidence base with the voice of the patient and family. It allows the practice to tailor care delivery to meet the needs of individual patients and the entire population served. Through the coordinated efforts of an expanded care team, in partnership with patients, families, and community, the practice can promise results.

Continuous, data-driven quality improvement reflects the practice's commitment to quality. It's about understanding performance at all levels and bringing systems, technology, and people together to make the practice better in many ways. It means empowering every person in the practice to innovate and improve.

Sustainable business operations provide the infrastructure and capabilities to support the right workforce, efficient workflows, and a high value product. Success is seen in positive patient experiences, staff that experience joy in their work, and resources for investing in the practice's future.

Secondary Drivers

1. Person and Family-Centered Care Design

To achieve a person and family-centered care delivery system, seven drivers should be considered.

1.1 Patient and family engagement
1.2 Team-based relationships
1.3 Population management
1.4 Practice as a community partner
1.5 Coordinated care delivery
1.6 Organized, evidence-based care
1.7 Enhanced access

2. Continuous, Data-Driven Quality Improvement

To achieve a practice culture of continuous quality improvement, four drivers should be considered.

2.1 Engaged and committed leadership
2.2 Quality improvement strategy supporting a culture of quality and safety
2.3 Transparent measurement and monitoring
2.4 Optimal use of Health Information Technology (HIT)

3. Sustainable Business Operations

To achieve a practice with long-term sustainable business operations, four drivers should be considered.

3.1 Strategic use of practice revenue
3.2 Workforce vitality and joy in work
3.3 Capability to analyze and document value
3.4 Efficiency of operation

Change Concepts

For each of the change concepts listed below, **change tactics** have been identified that represent ideas that a practice has successfully implemented. The change tactics can be found on the page number following each change concept.

1. Person and Family-Centered Care Design

1.1 Patient and family engagement

1.1.1 Respect values and preferences (p6)
1.1.2 Listen to patient and family voice (p6)
1.1.3 Collaborate with patients and families (p6)
1.1.4 Be aware of language and culture (p7)

1.2 Team-based relationships

1.2.1 Enhance teams (p7)
1.2.2 Clarify team roles (p8)
1.2.3 Optimize continuity (p9)
1.2.4 Define specialty-primary care roles (p9)

1.3 Population management

1.3.1 Assign to panels (p10)
1.3.2 Assign accountability (p10)
1.3.3 Stratify risk (p10)
1.3.4 Develop registries (p11)
1.3.5 Identify care gaps (p11)

1.4 Practice as a community partner

1.4.1 Community health needs (p12)
1.4.2 Community collaboration (p12)
1.4.3 Identify social determinants (p12)
1.4.4 Use community resources (p12)
1.4.5 Be transparent (p13)

1.5 Coordinated care delivery

1.5.1 Manage care transitions (p13)
1.5.2 Establish medical neighborhood roles (p14)
1.5.3 Coordinate care (p14)
1.5.4 Ensure quality referrals (p15)
1.5.5 Manage medication reconciliation (p15)

1.6 Organized, evidence-based care

1.6.1 Consider the whole person (p15)
1.6.2 Plan care (p16)
1.6.3 Implement evidence-based protocols (p16)
1.6.4 Decrease care gaps (p17)
1.6.5 Reduce unnecessary tests (p17)

1.7 Enhanced access

1.7.1 Provide 24/7 access (p17)
1.7.2 Meet patient scheduling needs (p18)
1.7.3 Create patient-centered spaces (p18)
1.7.4 Mitigate access barriers (p18)

2. Continuous, Data-Driven Quality Improvement

3. Sustainable Business Operations

Change Tactics

1.	Person and Family-Centered Care Design
1.1 1.1.1	**Patient and family engagement** **Respect values and preferences**: Respect patient and family values, preferences, and expressed needs
Change Tactics	• Train staff in cultural competency • Always ask patients about their preferences; don't assume • Develop a template form that can be used for patients and families to identif y preferences while waiting • Use a check-in approach to query patients about specific aspects of care delivery to determine their thoughts and preferences
1.1 1.1.2	**Patient and family engagement** **Listen to patient and family voice:** Implement formal systems for hearing the patient and family voice and using this input for strategic, quality, and business planning and performance success
Change Tactics	• Include a patient on the organization's board • Implement a patient and family advisory group • Regularly survey patients and families • Invite patients to operational meetings • Include patients and families in all quality improvement (QI) initiatives • Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms • Communicate to patients the changes being implemented by the practice. • Educate patients and community on what they should expect and look for in a physician. Currently, it is very difficult to know who the excellent providers are. • Transparency in data, (quality, complications, readmissions, etc. should be publicly available) • Run focus groups to obtain patient and family feedback • Include patients and families in staff feedback education events • Use patient stories to start each meeting • Use real-time electronic systems for capturing patient feedback
1.1 1.1.3	**Patient and family engagement** **Collaborate with patients and families:** Actively engage patients and families to collaborate in goal setting, decision making, health-related behaviors and self-management
Change Tactics	• Train staff in motivational interviewing approaches • Create a shared care plan for every patient • Use evidence-based decision aids to provide information about risks and benefits of care options in preference-sensitive conditions

	• Routinely share test results, along with appropriate education about the implications of those results, with patients • Engage patients, family and caregivers in developing a plan of care and prioritizing their goals for action, documented in the Electronic Health Record (EHR) • Incorporate evidence-based techniques to promote self- management into usual care, using techniques such as goal setting with structured follow-up, Teach Back, action planning or motivational interviewing • Use tools to assist patients in assessing their need for support for self-management (e.g., the Patient Activation Measure or How's My Health) • Provide a pre-visit development of a shared visit agenda with the patient • Provide coaching between visits with follow-up on care plan and goals • Provide peer-led support for self-management • Provide group visits for common chronic conditions (e.g., diabetes) • Provide condition-specific chronic disease self-management support programs or coaching or link patients to those programs in the community • Train staff in self-management goal setting • Standardized action planning and plan follow-up process so entire team can participate • Educate patients and families on health care transformation so they can be active, informed change agents. Use appropriate language, simple language, and pictures • Ensure patient leaves office with plan of care in hand
1.1 1.1.4	**Patient and family engagement** **Be aware of language and culture:** Assess and communicate in the preferred language, at an appropriate literacy level, and in a culturally appropriate manner
Change Tactics	• Maintain multi-lingual staff; contract for translation services where staff cannot be used • Use multi-lingual written and oral communication • Train all staff in cultural competency • Assess health literacy for all patients • Provide self-management materials at an appropriate literacy level and in an appropriate language • Consider hiring from within your community • Assess literacy and health literacy • Be aware of patient's sexual orientation • Use staff from the community to become experts/ teachers of staff
1.2 1.2.1	**Team-based relationships** **Enhance teams:** Enhance the care team for efficient and effective coordination to meet the needs of patient and family
Change Tactics	• Expand the concept of the care team to include individuals who interact with patients and families both directly and indirectly • Co-locate care team members to improve communication/ coordination by providing line of site among the team

	• Use multidisciplinary huddles for care planning each morning or at the start of each session • Use huddles to make just in time adjustments to schedule or staffing to accommodate unexpected situations • Cross train staff to enable the practice to better adapt to demand variation • Cross train staff to allow introduction of additional services • Maximize the role of the medical assistant • Use scribes to improve provider productivity • Look outside the organization for team members, including community health workers; peer advisors; medical, nursing, and pharmacy students; public health nurses; representatives of community agencies • Add team members to address specific population needs, such as diabetes educators and podiatrists, HIV nurse specialists • Implement a formal approach to integrating behavioral and oral health and pharmacy into the primary care team setting through a staff model, co-location, or contract relationships • Use a messaging system to communicate among team members • Define roles and distribute tasks among care team members, consistent with the skills, abilities and credentials of team members to better meet patient needs • Use decision support and protocols to manage workflow in the team to meet patient needs • Manage workflow to address chronic and preventive care, for example through pre-visit planning or huddles • Enhance team resources with staff such as health coach, nutritionist, behavioral health, pharmacy and physical therapy as feasible to meet patient needs • Monitor and reward compliance with huddles and team preparation • Give teams designated time to develop relationships; budget for team-building activities through care units of the team • Consider line of sight in care team space (e.g. colored flags on rooms) to communicate with team
1.2 1.2.2	**Team-based relationships** **Clarify team roles:** Define, distribute, and document the roles of all care team members to maximize skill set, training, and licensure/certification and communicate roles to patients and families
Change Tactics	• Inventory the work to be done prior to a patient visit, during the visit, and after the visit and determine who in the organization can do each part of the work by matching their training and skills sets • Use process maps or swim lane diagrams to clarify responsibilities once roles are assigned • Identify staff interest and talents and align these with available opportunities • Add fields to registry or EHR to capture care team member roles

	• Share team roles with patients and families on paper and electronic systems • Empower medical assistants with coaching skills so that they can expand their role in supporting self-management
1.2 1.2.3	**Team-based relationships** **Optimize continuity:** Optimize continuity so that both patients and the care team recognize each other as partners in care
Change Tactics	• Measure and monitor continuity between patient and care team regularly • Develop a script to assist schedulers in providing appointment options with the care team to which a patient is assigned as well as to assign new patients to an appropriate team • Provide medical record access to provider/ care team members caring for patients after hours • Provide direct secure messages or web-based access to and from emergency departments (EDs) patients may frequent • Electronically share information with care providers outside the practice so that information or tests are not duplicated • In specialty care, assign accountability for each patient to a care team and ensure coordination with the primary care team to which the patient is empaneled • Measure continuity between patient and provider and/or care team • Use scheduling strategies that optimize continuity while accounting for needs for urgent access • Use a shared care plan to ensure continuity of management between within the practice and with consultants (for high risk patients) • Ensure that all providers within the practice and all members of the care team have access to the same patient information to guide care. • Develop contingency plans for when continuity is not possible • Create primary care provider identification cards that patients can carry with them throughout the health neighborhood
1.2 1.2.4	**Team-based relationships** **Define specialty-primary care roles:** Jointly implement criteria and processes for specialty referrals for episodic care, co-management, or transfer of care, as well as graduation back to primary care, as appropriate; communicate to the patient and family
Change Tactics	• Develop compacts between primary care and specialist practices that include defined referral criteria • Educate patients on resources and appropriate use of specialists • Assign responsibility for care coordination and referral management • Use structured referral notes to ensure referrals are appropriate • Establish care coordination agreements with frequently used consultants that set expectations for documented flow of information and provider expectations between settings • Systematically integrate information from referrals into the plan of care

	• Have a shared care plan used by primary care and specialist practices for co-managed patients • Have a reference list for use by specialist's front desk staff so that they can screen for "appropriate" referrals, or those that are usually urgent or non-urgent • Develop a system for handling "rebounds" of patients who are determined not to be appropriate for referral or transition
1.3 1.3.1	**Population management** **Assign to panels:** Use a data-driven approach to assign patients to panels and confirm panel assignments with both providers and patients
Change Tactics	• Use four-cut method or another approach to develop initial panel assignments • Review and update panel assignments on a regular basis • Provide ways for patients to identify their care team without remembering names, such as color designations, posted photos of care team members, or cards with the care team identified • Determine guidelines for panel size and patient complexity per panel • Refer to care team as a team as opposed to the physician/advanced practice clinician only • Pictures of care team when patients enter exam room will help with the linkage • Divide empanelment duties among entire staff with clear protocols • Determine panel size according to patient risk and utilization
1.3 1.3.2	**Population management** **Assign accountability:** Assign accountability for each patient to a care team
Change Tactics	• Ensure that every patient has a designated care team and that everyone on the team knows which patients have been assigned • Use visual cues to link patients with the accountable team • Assign responsibility for documenting assignments in the EHR and for communicating to patients/ families • Implement a system of cross-coverage in the event of absence of the accountable provider and team
1.3 1.3.3	**Population management** **Stratify risk:** Stratify the population based on risk and complexity and provide care appropriate to risk level
Change Tactics	• Identify a risk stratification approach and use it consistently • Assign responsibility for care management • Implement a standard approach to documenting care plans • Use a consistent method to assign and adjust global risk status for all empaneled patients to allow risk stratification into actionable risk cohorts • Use on-site practice-based or shared care managers to proactively monitor and coordinate care for the highest risk cohort of patients • Use panel management and registry capabilities to support management of patients at low and intermediate risk

	• Engage patients at highest risk in ongoing development and refinement of their care management plan, to include integration of patient goals, values and priorities • Use the Medicare Annual Wellness Visit with Personalized Prevention Plan Services for Medicare patients • Use social determinants of health in risk-stratification models • Assess patient engagement and willingness to address care gaps • Allow for the common sense addition to high risk or rising risk factor care team – no algorithm is perfect • Identify ways to graduate patients from care management when goals are met as appropriate Deliver care plan with patient and family • Five minute daily huddles to plan care for the day • Use risk level to identify best provider for the patient
1.3 1.3.4	**Population management** **Develop registries:** Use data to identify patient demographic and disease/ condition characteristics and develop registries based on population subsets
Change Tactics	• Report quality, cost, and utilization metrics for the entire population as well as subpopulations • Dedicate resources to population health management • Develop programs to address specific sub-population needs • Ask patients one thing they would change if they could on periodic survey • Send staff for special training – i.e., motivational interviewing when a need is identified • Ask patients and families to react to data on characteristics and needs they will see themselves differently • Use active listening to understand patients' unique barriers to adherence • Conduct 30 minute weekly meetings of entire team by topic using registries • Identify disparities in results and work with those populations to reduce them
1.3 1.3.5	**Population management** **Identify care gaps:** Use population data or registries to identify and act on gaps in care for prevention or defined diagnoses
Change Tactics	• In specialty practices, determine the diagnoses that are appropriate for care gap management and develop registries and reporting to facilitate closing the gaps • Determine which conditions or diagnoses are most prevalent in the practice and start with those • Schedule a regular meeting or huddle to review care gaps • Assign responsibility for responsibility review of each type of care gap report • Develop an outreach plan for patients determined to have gaps in care • Schedule diabetes day or flu shot days, etc. to get people in and quickly address patients on care gap reports • Empower the medical assistants to review care gap reports for prevention and to prepare the required referral forms or vaccines

1.4 1.4.1	**Practice as a community partner** **Community health needs:** Use a formal approach to identify and assess the health needs of the community and incorporate into strategic planning and QI systems
Change Tactics	• Work with hospitals and public health departments to obtain reports on research or data collection done on community needs • Partner with health departments to determine whether there are gaps the practice can fill
1.4 1.4.2	**Practice as a community partner** **Community collaboration:** Identify and collaborate with community partners to enhance both service offerings and patient and family engagement
Change Tactics	• Work with community agencies to enhance services available to patients • Use community health workers or peer advisors to provide self-management support • Engage with churches and schools to develop joint programs • Engage with recreational centers • Know the behavioral health crisis response in your community • Develop joint programs with community agencies • Engage employees to assist in developing worksite health programs • Create a document summarizing best community resources that patients and family can use as reference
1.4 1.4.3	**Practice as a community partner** **Identify social determinants**: Partner with the community to assess and address social determinants of health and health disparities
Change Tactics	• Work with the community to address needs related to social determinants of health affecting the practice's population • Find agencies within the community that track various aspects of social determinants and can be sources of data • Identify programs that address one of the social determinants to determine whether the practice's patients can benefit from referrals • Use asks and offers with community and government agencies to develop programs to address some aspect of social determinants within the community
1.4 1.4.4	**Practice as a community partner** **Use community resources:** Inventory available community resources and refer patients as appropriate to access services not available in the practice
Change Tactics	• Vet all potential referral providers and agencies • Leverage personal relationships to cultivate referral opportunities • Maintain an inventory of community resources that may be available to patients • Work with community agencies to enhance services available to patients • Maintain formal (referral) links to community-based chronic disease self-management support programs, exercise programs and other wellness resources with the potential for bidirectional flow of information • Provide a guide to available community resources

	• As a provider, employ the philosophy "You should only refer to a provider you would send your loved one to" • Create and maintain referral lists for medical residents in academic settings • Engage local health coalitions to identify resources in areas where resources are scarce • Find out how patients define quality of care and build those definitions into the practice model • Maintain a referral tracking system to assure "loop closure" (i.e. that patients make and keep appointments and that a report is received)
1.4 1.4.5	**Practice as a community partner** **Be transparent:** Transparently share performance results with patients and families as well as the community
Change Tactics	• Publish performance results in a newsletter or on website • Use data walls in public areas of the practice • Create dashboards that are color-coded and easy to understand
1.5 1.5.1	**Coordinated care delivery** **Manage care transitions:** Manage care transitions collaboratively with patients and families
Change Tactics	• Assign responsibility for care management of individuals at high risk for emergency department visits or hospital readmission • Follow up after every hospital discharge and ED visit with a phone call, home or office visit • Assure patients can get access to their care team when they need it to support reduction in emergency department use • Partner with community or hospital-based transitional care services • Routine and timely follow-up to hospitalizations • Routine and timely follow-up to emergency department visits • Encourage patients to rely on multiple team members as experts • Establish a mutual understanding of the information that should be shared when care is transferred or shared among providers • Develop agreements with specialists in the community that identify goals for communication • Have someone talk with patient and family to prior to each transition so they understand what the next step is and what it may mean • Review when care transitions are NOT optimal and look for themes • Use pharmacists to co-manage chronic disease states under collaborative agreements • Pre-plan transition of care appointments when able to • Ensure that useful information is shared with patients and families at every care transition • Engage payer disease management and complex care management staff to help avoid patient/family confusion

1.5 1.5.2	**Coordinated care delivery** **Establish medical neighborhood roles:** Establish clear expectations among primary care team, specialists and others in the medical neighborhood about the role each will play in a patient's care and the information that each will share
Change Tactics	• Define the medical neighborhood with which the practice works most closely • Develop both personal and electronic relationships among medical neighborhood providers to ensure information sharing • Develop formal written agreements or compacts that define information needs of all parties • Formalize lines of communication with local care settings in which empaneled patients receive care to ensure documented flow of information and clear transitions in care. • Ensure that useful information is shared with patients and families at every care transition; partner with patients and families in developing processes and tools to make that happen • Engage payer disease management and complex care management staff to help avoid patient/family confusion
1.5 1.5.3	**Coordinated care delivery** **Coordinate care:** Provide effective care coordination across the medical neighborhood
Change Tactics	• Develop compacts between primary care and specialists • Assign responsibility to specific staff members for care coordination and referral management • Establish systems for two-way exchange of information within the medical neighborhood • Follow up on all referrals to assure loop closure on information flow to care team and to patients • Participate in Health Information Exchange if available. • Use structured referral notes to standardize information shared and facilitate appropriate referrals • Establish care coordination agreements with frequently used consultants that set expectations for documented flow of information and provider expectations between settings • Track patients referred to specialists through the entire process • Systematically integrate information from referrals into the plan of care. • Allow primary care team to request urgent appointments for specialist consults • Have a shared care plan for co-managed patients • Establish a mutual understanding of the information that should be shared when care is transferred or shared among providers • In specialty practices, for each referral, notify the referring care team of the date of scheduled appointments, as well as of any cancellations and no shows

1.5 1.5.4	**Coordinated care delivery** **Ensure quality referrals:** Engage members of the medical neighborhood to ensure high level of service and quality of care
Change Tactics	• Vet all potential referral providers and agencies • Leverage personal relationships to cultivate referral opportunities • Maintain an inventory of community resources that may be available to patients • Work with community agencies to enhance services available to patients • Maintain formal (referral) links to community-based chronic disease self-management support programs, exercise programs and other wellness resources with the potential for bidirectional flow of information • Provide a guide to available community resources • Employ the philosophy "You should only refer to a provider you would send your loved one to" • Create and maintain referral lists for medical residents in academic settings • Engage local health coalitions to identify resources in areas where resources are scarce • Find out how patients define quality of care and build their definition into care design • Maintain a referral tracking system to assure loop closure
1.5 1.5.5	**Coordinated care delivery** **Manage medication reconciliation:** With patients and families, manage and reconcile medications to maximize use, effectiveness, and safety
Change Tactics	• Reconcile medications at each visit • Provide follow up on medication use after hospital discharge • Include a pharmacist on the care team • Conduct medication reconciliation at every encounter • Coordinate medications across transitions of care settings and providers • Conduct periodic, structured medication reviews • Develop a medication action plan for high-risk patients • Provide collaborative drug therapy management for selected conditions or medications • Provide support for medication self-management • Always think about health literacy when talking about prescriptions • Include a pharmacist review of all meds at initial visit/ consult; share information with all co-managing providers
1.6 1.6.1	**Organized, evidence-based care** **Consider the whole person:** Consider the whole person when planning care
Change Tactics	• Develop formal referral relationships with mental health and substance abuse services in the community • Ensure primary care providers and other clinical staff has been trained in principles of behavioral health care and are able to handle routine behavioral health care needs

	• Include use of non-clinical staff to provide screening and assessment of behavioral health care needs • Ensure regular communication and coordinated workflows between primary care and behavioral health providers • Conduct regular case reviews for at-risk or unstable patients and those who are not responding to treatment • Use the registry function of the EHR or a shared registry to support active care management and outreach to patients in treatment • Ensure that advance directives are included in discussions with patient and family and documented; Use web-based documentation support systems where available • Integrate behavioral health and medical care plans and facilitate integration through co-location of services when feasible • Integrate oral health services into primary care and specialty settings
1.6 1.6.2	**Organized, evidence-based care** **Plan care:** Plan care according to the evidence base and related patient needs and preferences, including social determinants of health
Change Tactics	• Develop patient visit agendas • Huddle regularly to assess patients' needs and plan accordingly • Provide patients annually with an opportunity for development and/or adjustment of an individualized plan of care, including health risk appraisal; gender, age and condition-specific preventive care services; plan of care for chronic conditions; and advance care planning • Use pre-visit planning to optimize team management of patients with chronic conditions • Use panel support tools (e.g., registry functionality) to identify services that are due for the patient • Use reminders and outreach (e.g., phone calls, emails, postcards, patient portals and community health workers where available) to alert and educate patients about services due • Use visit agendas to engage in shared decision-making • With patients and families create forms for patients/families to list their priorities
1.6 1.6.3	**Organized, evidence-based care** **Implement evidence-based protocols:** Use evidence-based protocols to improve patient care and safety
Change Tactics	• Develop evidence-based protocols in house or use those externally available • Document protocols through flow sheets, process maps, care maps, swim lanes or other visual depiction • Invite visiting faculty in academic settings to learn protocols embedded in EHR • Use protocols to guide communication with patients and families after a patient safety event • Embed protocols in the EHR

	• Use condition-specific pathways for care of chronic conditions (e.g., hypertension, diabetes, depression, asthma and heart failure) with evidence-based protocols to guide treatment to target
1.6 1.6.4	**Organized, evidence-based care** **Decrease care gaps:** Use point of care reminders and population/ panel reports to decrease care gaps
Change Tactics	• Design EHR pop up reminders to appear as part of scheduling modules • Use EHR and payer care gap reports • Include medical residents' assessments, not just faculty, for care gap reports in academic settings • Use clinical decision support aids such as "ACR Select"
1.6 1.6.5	**Organized, evidence-based care** **Reduce unnecessary tests:** Use the evidence-base and best practices to reduce unnecessary testing and procedures
Change Tactics	• Empower staff to know and politely question any orders not meeting guidelines • Implement Choosing Wisely guidelines • Build best practice information order sets and documentation templates and incorporate these into the EHR where possible • Use shared decision aids
1.7 1.7.1	**Enhanced access** **Provide 24/7 access:** Provide 24/7 access to the care team
Change Tactics	• Create a centralized call center operation to more efficiently manage patient calls • Maintain a patient portal and encourage its use by patients and families • Set up a secure messaging system or use Direct Secure Messaging • Provide 24/7 access to provider or care team for advice about urgent and emergent care • Provide care team with access to medical record after hours • Ensure providers who are cross-covering have access to medical record • Protocol-driven nurse line with access to medical record • Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate small practices to provide alternate hours' office visits and urgent care). • Use alternatives to increase access to care-team and provider, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers). • Provide same-day or next-day access to a consistent provider or care team when needed for urgent care or transition management • Provide a patient portal for patient-controlled access to health information • Use warm hand offs for cross coverage • Implement a 24-hour nurse call line that is algorithm-driven

1.7 1.7.2	**Enhanced access** **Meet patient scheduling needs:** Provide scheduling options that are patient and family centered
Change Tactics	• Measure and balance supply and demand of patient access issues and then expand or modify hours as needed • Continuously test new access approaches • Offer alternative visit types to address patient care needs, such as nurse, care coordinator, pharmacist, group, electronic, and/or home visits • Identify external factors that create barriers to access and find innovative solutions • Commit to open access regardless of insurance type (e.g., pediatric, private, semi-rural) • Partner with community resources to eliminate or reduce barriers to treatment access • Value resident continuity whenever possible • In academic settings, implement a system wherein residents "hand off" information about challenging/complex patients that other residents will see • Designate one medical assistant to take acute phone calls • Learn about patient and family jobs and transportation • Set up a system to accept walk-in visits • Set-up clinics for special needs (e.g., flu shots, sports physicals)
1.7 1.7.3	**Enhanced access** **Create patient-centered spaces:** Consider patient and family needs when planning, designing, and locating practice spaces
Change Tactics	• Offer one-stop option for multiple services, (e.g. imaging and lab on site using internal staff or contract) • Hold non-traditional locations and services to the same standards as those of the primary site • Cross train staff to cover ancillary services • Minimize patient movement within the practice • Set-up on site pharmacy dispensing services • Engage patients and communities on how to best meet local needs, such as health prevention and wellness services • Consider providing some services in community spaces such as churches and schools
1.7 1.7.4	**Enhanced access** **Mitigate access barriers:** Assess and mitigate barriers to access
Change Tactics	• For patients with frequent "no shows", ask patients about reasons and develop potential solutions to address them • Ask patients before self-management goals are set what might get in the way of following through • Query the scheduling staff and outreach staff about things patients and families say to identify gaps and priorities for improvement

2.	Continuous, Data-Driven Quality Improvement
2.1 2.1.1	**Engaged and committed leadership** **Commit leadership:** Provide dedicated, visible and sustained leadership for the organization's transformation strategy
Change Tactics	• Document a plan for transformation and establish aims related to TCPI goals • Openly share the transformation vision and progress toward achieving goals with staff, board and community • Include leaders at all levels on QI teams • Celebrate both large and small successes • Ensure a leadership succession plan that will maintain the transformation vision and strategy • Communicate openly and frequently about organizational aims and performance both within and outside the organization • Make responsibility for guidance of practice change a component of clinical and administrative leadership roles • Allocate time for clinical and administrative leadership for practice improvement efforts, including participation in regular team meetings • Incorporate population health, quality and patient experience metrics in regular reviews of practice performance • Keep a working plan document visible on a wall; comments to be written on it • Use a dyad management structure at each clinical site • Structure periodic touch points with all staff to share vision and progress • Use push technology or screensavers to reach all key staff and residents • Create a leadership compact • Identify clinical and administrative leads • Let patients and families know who leadership is • Identify physician champions for the change process • Leaders join care team rounds • Sponsor improvement groups with a charter/ regular updates to leadership on progress and barriers
2.1 2.1.2	**Engaged and committed leadership** **Develop a roadmap:** Ensure that there is the compelling vision, strategy, capacity, and capability for change
Change Tactics	• Invest in improvement through systems, allocation of time, dedicated people • Create will by sharing the vision with all staff • Develop and support staff to create joy in work and a culture of empowerment • Align QI, strategic, operational, and business plans

	• Include QI and transformation topics on all regular staff meeting agendas • Align strategies to capitalize on environmental opportunities • Invest in improvement through systems, allocation of time, dedicated people • Create will by sharing the vision with all staff • Develop and support staff to create joy in work and a culture of empowerment • Align strategies to capitalize on environmental opportunities
2.1 2.1.3	**Engaged and committed leadership** **Create a shared vision:** Share the vision and goals across the organization to ensure that all staff members understand their role in achieving them
Change Tactics	• Use all meetings, website, blast emails to continually reinforce the organization's vision • Get staff involved in reviewing and possibly revising the vision to create ownership • During regular performance reviews ask staff members to describe how they contribute to achieving the vision • At the care team and department level, use regular meetings to take the vision and break it down into discrete parts that people can relate to their own job
2.2 2.2.1	**Quality improvement strategy supporting a culture of quality and safety** **Use an organized QI approach:** Use an organized approach to identify and act on improvement opportunities
Change Tactics	• Use an interdisciplinary staff committee to lead change and improvement within the organization • Use a defined model, like the Model for Improvement, as the QI structure • Establish a QI committee that includes staff from clinical and administrative settings as well as finance • Define specific timelines for improvement with identified opportunities
2.2 2.2.2	**Quality improvement strategy supporting a culture of quality and safety** **Build QI capacity:** Build QI capability and support the partnership of patients, families, and staff in improvement efforts
Change Tactics	• Include the transformation agenda and QI skills in new staff/provider orientation • Train all staff in how to act on data: how to interpret graphs and where to go and what do with the information to continue, accelerate or initiate improvement • Include involvement in QI as part of individual job expectations and job descriptions • Hire for fit with the organizational quality culture through effective pre-employment screening • Align the organization's QI plan with its strategic, operational, and business plans • Track progress toward goals at each site (if applicable) and individual provider level

	• Make inclusion of the patient/ family voice an element of every QI initiative • Train all staff in quality improvement methods • Integrate practice change/quality improvement into staff duties • Engage all staff in identifying and testing practices changes • Designate regular team meetings to review data and plan improvement cycles • Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff • Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families • Develop an education model to teach use of PDSAs, lean, sigma, etc. • Use informal champions in each role to align language of quality • Engage patients and families in improvement via patient and family advisory councils (PFACs) • Recruit and train families to develop PDSA and root cause analysis skills • Include concept of partnering with patients and families in position descriptions and performance evaluations • Regular meetings of site leaders and individual care teams to review data, celebrate success, identify opportunities, and develop improvement plan • Recognize and share best practices • Train staff in TeamStEPPS or other approach to enhance teamwork skills
2.2 2.2.3	**Quality improvement strategy supporting a culture of quality and safety** **Empower staff:** Empower each staff member to innovate and improve within their own work environment and across the organization
Change Tactics	• Use all opportunities for learning---errors, available improvement collaboratives, peer interaction--- to further encourage each person's role in QI • Encourage innovation through a formal system of suggestions and follow up • Eliminate blame when reviewing errors Have defined methods for individual staff to suggest improvement and lead change • Use the knowledge of frontline staff to shape QI efforts • Encourage staff to express interest in expanded roles in QI during performance evaluations • Use all opportunities for learning---errors, available improvement collaboratives, peer interaction--- to further encourage each person's role in QI • Encourage innovation through a formal system of suggestions and follow up • Eliminate blame when reviewing errors Have defined methods for individual staff to suggest improvement and lead change • Use the knowledge of frontline staff to shape QI efforts

	• Encourage staff to express interest in expanded roles in QI during performance evaluations • Validate the individual • Use guiding principles that are shared broadly like No Wrong Door to QI or Quality is Everyone's Job • Provide easy access to capturing ideas in the flow of work for all staff • Celebrate large and small successes • Practice "Just Culture" as one approach to keeping the culture blame-free • Encourage a blame free culture • Ask all staff who see a problem to bring it up, along with all the possible solutions they can think of • Always communicate "Why"
2.2 2.2.4	**Quality improvement strategy supporting a culture of quality and safety** **Share learning:** Actively participate in shared learning
Change Tactics	• Use case presentation formats and a peer review process to review identified issues and develop solutions • Encourage leaders and staff members to teach others about QI • Participate in meetings/ programs sponsored by professional organizations • Join local collaboratives or learning networks • Use online forums to interact with peers outside the practice
2.3 2.3.1	**Transparent measurement and monitoring** **Use data transparently:** Use data to continuously and transparently monitor and improve performance, quality, and service
Change Tactics	• Define measures that the practice will monitor, relate these to strategic aims, and use them to drive performance • Monitor measures as frequently as possible and share metrics with all staff • Use run charts to display data over time and link changes implemented to the data points • Adopt a philosophy of performance data transparency • Use data walls to share metrics and progress and celebrate success • Develop a database of PDSAs or other small scale tests that all staff can access to catalog tests of change and their results; use the data base to align and balance priorities for implementation of successful changes and spread • Include metrics on organization's website • Identify a set of EHR-derived clinical quality and utilization measures that are meaningful to the practice team • Regularly review measures of quality, utilization, patient satisfaction and other measures that may be useful at the practice level and at the level of the care team or provider (panel) • Use relevant data sources to create benchmarks and goals for performance at the practice level and panel level • Create data dashboard that functionally consolidates usable information

	for QI projects and lines of business activities • Create standard organization-level reporting and communication about QI work • Create meaningful, useful data displays for front-line staff evaluation of progress • Make data easy to access by maximizing information technology and use of business intelligence tools • Use a data wall in the lunch room and encourage staff questions and reflections • Investigate and use benchmarks from national organizations • Show inflection points as related to change in workflow or processes • Assign individual staff that can champion success in a certain measure • Provide readiness huddles daily to track progress toward goals • Ask patients how they define improvement in quality and service • Include patient satisfaction data and patient feedback about high performers in regular reporting to staff and community • Consider designating a data/panel/population health manager position • Use "Stop light" reporting on monthly progress • Use dashboards for data display
2.3 2.3.2	**Transparent measurement and monitoring** **Set goals and benchmarks:** Use relevant data sources to create benchmarks and goals for performance at multiple levels within the practice
Change Tactics	• Use data available from professional associations to benchmark the practice's performance • Use government data sets to set targets for the practice • Use practice aims to cascade down in the organization and have care teams and departments set corresponding targets for their own performance • Share goals broadly throughout the organization • Make goal setting and performance monitoring competitive and fun
2.4 2.4.1	**Optimal use of HIT** **Innovate for access:** Improve patient access to care through innovative use of technology
Change Tactics	• Use secure email visits • Use telemedicine visits for patients in rural areas or for specialty consultations • Use home tele-monitoring options • Instruct on receiving payment for e-visits and e-consults • Use text prompts to look at portal messages • Use text appointment reminders with permission • Home International Normalized Ratio (INR) monitoring • Protocols for monitoring urinary tract infection or upper respiratory infection with phone call

	• Use portal or texting to provide electronic reminders • Use patient portals to avoid unnecessary visits to provider and answer questions by appropriate care team member • Use apps – everyone has a cellphone (almost) • Have portal messages go to the team, not just provider • Implement a system for ongoing review of workflows and train on updates • Assess access in rural areas and consider alternative web access approaches • Use web-based video technology (e.g., Skype) for homebound patients
2.4 2.4.2	**Optimal use of HIT** **Share information through technology:** Use technology to share appropriate and timely information across the medical neighborhood and with patients and families
Change Tactics	• Participate in local Health Information Exchanges • Use standard interfaces for lab services and connect with most frequently used labs • E-prescribe where possible • Scan all paper reports received by other medical providers and include them in the EHR • Use direct secure messaging to share referral information and notifications to/from hospitals and emergency departments • Connect the EHR with state immunization and condition-specific registries to allow two-way sharing of information • Use an EHR certified by the Office of the National Coordinator • Connect to local health information exchanges, if available • Develop information exchange processes and care compacts with other service providers with which the practice shares patients • Use standard documents created by the EHR to routinely share information (e.g., medications, problem, allergies, goals of care, etc.) at time of referral and transition between settings of care • Use non-clinician workflows to systematically enter structured clinical data (e.g., paper and e- fax) from external sources into the EHR • Develop processes for communication with rural partners • Transfer results to a flow sheet so they can be queried • Enter data into discrete data fields whenever available to maximize potential of business intelligence tools • Standardize referral templates so appropriate information is shared • Implement protocols for strep test without appointment • Use secure text options for hospital/specialist/provider communications • Use telemedicine services to promote specialist access • Do not read the computer and enter data while with the patient – listen and make contact

	• Develop or incorporate a solution (e.g., ImageShare) to allow for images to be shared securely through Internet
2.4 2.4.3	**Optimal use of HIT** **Use technology supporting evidence:** Use technology to support evidence-based care delivery and clinical decision-making
Change Tactics	• Produce and use gap reports from the EHR • Build reminders and alerts into the EHR • Use reports available from the EHR to support QI initiatives • Facilitate specialty and expert consultations through video or web-based connections • Develop capability for practice- and panel level reporting of Clinical Quality Measures derived from the EHR • Develop capability for electronic transmission of quality reports • Build disease and preventive registries to manage populations • Use decision support systems such as "ACR Select" • Develop a EHR solution to computerize the reporting of patient critical results
2.4 2.4.4	**Optimal use of HIT** **Use technology for partnerships:** Use technology to facilitate partnerships with patients, families, and the community
Change Tactics	• Encourage use of a patient portal • Use texting for self-management support (e.g. Text4baby) • Implement secure email correspondence • Provide patients with a tablet or provide kiosks for self-check in and update of demographic and history information • Implement a tablet-based system that allows for registration data capture as well as functions such as PHQ-2/9, co-pay collection through credit card, patient-specific education, and patient post-visit feedback • Introduce patients to the practice's capacity to communicate with them via electronic means • Use pre-made videos and online tools for patient education when appropriate • Web-based patient education • Run a contest of al staff to get patients signed up and using the portal • Practice using the portal when patients come to the office • Include patients and families in discussions about developing or improving the patient portal • Involve patients and family advisors in introducing the patient portal and showing patients how to use it • Use text reminders and care coordination messages for outreach • Use online meeting rooms for support groups and education
2.4 2.4.5	**Optimal use of HIT** **Drive efficiency through technology:** Use technology to support efficient practices and lower overall costs

Change Tactics	• Increase staff productivity and reduce commuting costs by using technology to conduct meetings • Use instant messaging between care team members rather than walking • Use robots to allow leadership presence without travel among sites • Use software that can accelerate claims filing by linking the claim to visit closure • Educate staff about email etiquette and importance of face-to-face when resolving conflict • Use the computer to do routine or repetitive work (querying data, assigning reminders, etc.) and use staff for interacting with patients and families • Use speech to text software to assist with documentation • Use recording white boards/tablets to capture minutes in real time • Work with payers to get you the data you need • Use bar coded insurance cards to direct data entry to system • Home blood pressure monitoring • Create care teams and assign staff to manage incoming and outgoing messages • Consider joining an organization that provides opportunities to observe successful organizations (e.g. Healthcare Value Network)

3.	Sustainable Business Operations
3.1 3.1.1	**Strategic use of practice revenue** **Use sound business practices:** Use sound business practices, including budget management and calculation of return on investment for all new programs
Change Tactics	• Use anticipated or actual medical loss ratio to assess return for proposed initiatives • Consider the return on investment (ROI) of both internal and external investments • Use and monitor budgets by service line or practice area • Document the business case for improvement activities • Develop a process for prioritizing practice changes requiring investment but necessary to improve patient outcomes and population health • Correct budget variation in real time • Develop profit and loss statements for the clinic • Develop a strategy for reinvestment in infrastructure/ replacement strategy • Estimate cost savings from operational or care improvements • Formal process for assessing financial and practice management data to identify QI opportunities
3.1 3.1.2	**Strategic use of practice revenue** **Use patient as customer feedback:** Use patient and family feedback and experiences as customers to inform the practice's business operations and opportunities for revenue enhancement
Change Tactics	• Capitalize on positive patient feedback by highlighting data in external publications and website • Use patient experience data in contracting negotiations • Use patients as spokespeople in public setting aimed at generating additional patient volume
3.1 3.1.3	Strategic use of practice revenue **Consider non-traditional revenue:** Maximize benefit of participation in alternative and performance payment arrangements
Change Tactics	• Engage in direct contracting with payers • Consider accepting capitated primary care plans for patients with high deductible plans • Explore inclusion of appropriate ancillary services • Consider setting up a drug discount program where eligible (e.g. 340b pharmacy) • Apply for grants as permitted • Evaluate whether and how to bill for phone care and telehealth • Consider hiring a consultant to assist you with transformation efforts • Develop a plan to expand practice capacity to drive more patient volume and growth • Consider retail clinics

3.1 3.1.4	**Strategic use of practice revenue** **Benefit from performance payments:** Invest in the capabilities and technology needed to drive performance excellence
Change Tactics	• Investigate and enroll in commercial health plan pay for performance and/or accountable care organization (ACO) programs • Enroll in available Medicaid Health Homes and shared savings programs • Learn about alternative payment models through state/national societies • Join a clinically integrated network • Participate in State Innovation Models or other non-duplicative projects • Enroll in bundled payment arrangements
3.1 3.1.5	**Strategic use of practice revenue** **Drive performance excellence:** Invest in the capabilities and technology needed to drive performance excellence
Change Tactics	• Manage equipment and develop routine protocols for replacement • Invest in a healthcare data expert who can build and distribute reports to members of the care team • Consider hiring additional staff to support transformation efforts such as a care transitions manager, social worker or other ancillary service providers • Invest in staff education • Create an opportunity for end users of services (e.g., patients) to be paired with developers
3.1 3.1.6	**Strategic use of practice revenue** **Ensure business accuracy:** Effectively manage the revenue cycle, including billing and collection processes
Change Tactics	• Minimize claims rejections from all sources • Review and adjust charge master to maximize alignment with allowable reimbursement • Review billing versus collection to assure payment accuracy • Maximize point of service collections • Provide data and feedback to staff about collection rates and rejections • Perform periodic coding audits • Educate continually and provide feedback to clinicians re: CPT coding • Assist families with Medicaid enrollment • Appeal all denials • Design a risk management protocol to hold bills for patients with bad outcomes • Use sliding fee schedule based on ability to pay • Right-size the revenue cycle staff • Ensure completeness of billing (e.g. chronic care management, palliative care, advanced directives planning) • Use dashboards and metrics to identify QI opportunities

3.2 3.2.1	**Workforce vitality and joy in work** **Encourage professional development:** Provide comprehensive orientation and onboarding support to all new staff and professional development for all staff
Change Tactics	• Include QI skills in orientation • Make sure performance standards and expectations are clear • Use peer to peer support and coaching as part of orientation • Create a physician compact for hiring and onboarding • Develop videos that reflect your culture and approach to practice transformation • Educate staff on disease management protocol • Orient staff to departments outside their own • Include mission, vision, and strategic plans in orientation • Conduct performance reviews at least annually
3.2 3.2.2	**Workforce vitality and joy in work** **Hire for fit:** Hire for alignment with mission as well as capability
Change Tactics	• Ensure an effective pre-employment screening process • Include peers as well as managers in the hiring process • Provide cultural competency training • Provide motivational enhancement training • Consider team-based interviews to measure for "fit" for a team • Define the culture to applicant during the interview process and get feedback • Use behavioral interviewing
3.2 3.2.3	**Workforce vitality and joy in work** **Cultivate joy:** Cultivate joy in work
Change Tactics	• Celebrate successes • Emphasize staff development and training • Make sure performance standards and expectations are clear • Implement reward and recognition systems for staff at all levels • Engage staff in redesign efforts • Communicate frequently and openly to all staff • Promote kindness to each other and to patients • Smile – it's contagious and makes people happier • Consider using gratitude practices in meetings • Get a masseuse to come give 15-minute chair massages every quarter • Patient stories, family stories, share in community • Practice joy in work committee • Institute for Healthcare Improvement (IHI) Joy in Work and Reducing Burnout series • Align compensation with team-based quality measures • Get staff/provider input at all levels • Hold fun social events together • Conduct staff health and wellness initiatives • Provide conflict resolution training

	• Provide nonviolence communicative training • Staff retreats • Include patient feedback in staff reviews • Use incentive plans to reward participation at multiple points/ data-driven and peer evaluated • Encourage each person to have a personal development that is updated annually • Use shout outs/ walls of success • Post quality data and gains • Involve staff in developing training for other staff
3.2 3.2.4	**Workforce vitality and joy in work** **Improve quality time:** Streamline workflows to improve efficiency and quality time for patient interaction
Change Tactics	• Integrate behavioral health • Reduce exam room interruptions • Use protocols for non-licensed staff • Expand number of support staff per provider; evaluate the model regularly • Eliminate phones from exam rooms/ knock if needed • Optimize exam room workflow • Use pagers for all staff to eliminate exam room interruptions • Standardize exam room layout and supplies • Do as much paperwork as possible before the visit
3.2 3.2.5	**Workforce vitality and joy in work** **Reward and recognize**: Recognize and reward innovation and contribution to organizational goals
Change Tactics	• Celebrate suggestions for improvement and solution ideas developed by staff • Have a contest for innovation • Give staff time for innovation • Create design sessions to facilitate creative thinking • Train staff in design thinking • Include expectations about participation in QI in performance reviews • Use incentives to reward improvement at the individual and team levels • Tie compensation to team, departmental and organizational goals
3.3 3.3.1	**Capability to analyze and document value** **Manage total cost of care:** Understand and manage total cost of care
Change Tactics	• Consider third party business intelligence tools • Use relations with payers to access claims data • Estimate costs of hospital and emergency department care saved through utilization reductions • Train appropriate staff on interpretation of cost and utilization information • Use available data regularly to analyze opportunities to reduce cost

	through improved care • Institute a fake appointment into your EHR to track how many ED visits you eliminate with enhanced access • Transparency with the entire team re: total cost of care • Educate staff about factors impact total cost of care • Use state professional association to collaborate with payers (American Academy of Pediatrics, American Academy of Family Practice, etc.) • Partner with the care continuum, especially small federated model • Ask staff to identify opportunities to manage cost to facilitate understanding • Know your visit costs and track and understand different components
3.3 3.3.2	**Capability to analyze and document value** **Develop data skills:** Develop skills in data extraction and analysis for all data sets accessible by the practice
Change Tactics	• Identify staff with responsibility for management of EHR capability and function • Engage regularly with EHR vendors about EHR requirements and for EHR-based quality reporting • Cross-train staff members in key skills in the use of health information technology to improve • Talk to other organizations using the same health information technology systems • Join EHR user groups
3.3 3.3.3	**Capability to analyze and document value** **Develop financial acumen:** Share financial data transparently with staff and providers and develop their capabilities in understanding the organization's finances and in using business practices and tools
Change Tactics	• Conduct business fundamentals training as a lunch and learn session • Make sure budget preparation occurs at the level the costs are incurred • Share financial implications of care decisions • Share prices charged for various services • Dedicate a meeting to explaining the practice's financial statements
3.3 3.3.4	**Capability to analyze and document value** **Document value:** Document the organization's business case at multiple levels and to multiple stakeholders
Change Tactics	• Analyze internal costs of care by service and by population characteristics • Use external benchmarks to compare internal cost and revenue metrics, such as cost per visit and revenue per provider full time equivalent • Determine profitability by site and service
3.4 3.4.1	**Efficiency of operation** **Streamline work:** Streamline workflows and increase value of all steps
Change Tactics	• Train staff in lean approaches and the concept of value • Consider hiring or training internal experts in process improvement • Use lean principles across the organization, such a defining waste and identifying value through the patient's eyes

	• Use process mapping to document workflows and identify value-add and non-value steps • Convene regularly to discuss and improve workflows to optimize use of the EHR
3.4 3.4.2	**Efficiency of operation** **Eliminate waste:** Eliminate waste whenever possible
Change Tactics	• Use just in time inventory approaches • Standardize exam room set up and supplies • Optimize staffing on a daily basis to assure minimal down time of staff and space • Centralized stock formulaic ordering with multisite facilities • Establish pull production principles • Put supplies in kits when frequently needed together • Use spaghetti diagrams to track movement through the practice • Cross train staff • Standardize workflow across care teams and site where possible
3.4 3.4.3	**Efficiency of operation** **Maximize provider value**
Change Tactics	• Integrate behavioral health • Reduce exam room interruptions • Use technology where possible to reduce effort required by staff • Use standardized approaches for scheduling • Translate productivity statistics to lost revenue to make the case to staff • Use protocols for non-licensed staff • Expand number of support staff per provider; evaluate the model regularly • Optimize number of exam rooms per provider • Use productivity measures that include non-visit related care • Incent effective team-based care • Eliminate phones from exam rooms; knock if needed • Define use case for exam rooms (e.g. nurse visit) • Optimize exam room workflow • Use pagers for all staff to eliminate exam room interruptions • Create a compensation model that does not create barriers to change • Move from relative value unit-based compensation to relative value units plus performance metrics • Develop a walk-in care model • Adjust schedules to account for no show