DFMCH ReCHARGED Vision Conference
September 17, 2015
Clinical Care Mission Area

Vision Statements:

- In three years, train, support, and reward all staff and learners to provide innovative health care and education in and outside the clinic walls. This requires the development of a system and culture that incentivizes non-traditional, non-episodic care. Measures: Staff and patient satisfaction, Access to care, Improved quality metrics (i.e. ACO, WCHQ)
- Integrating body and mind into the practice to treat the whole person by increasing community engagement within one year. Will be part of the workday for team member at the clinics/DFMCH which may include teaching a health class at school, or a van with immunizations to an increased needs area (identify catchment area). Involve community leaders. Identify designated metrics such as increased immunization rates and/or decreased STI/teen pregnancy rates in designated areas in order to work with insurance providers to fund the program.
- Within 3-5 years our vision is to create a true patient focused community by: Increasing access with APP/physician teams, Expanding service lines including transportation/mobile services within communities, Multidisciplinary teams within communities and clinics (i.e. social work, pharmacy, mental health, PT/OT), Effectively utilizing EHR to capture QI/cost savings (example: decrease hospitalizations, readmissions, chronic disease management outcomes) to show our value to the larger system

Green Hat: Ideas to implement the Vision

1. If this were to be a new direction for the Department, what would we have to do to make it work?
2. What blocks would we need to be removed?
3. What Strategies would we need to create our ideal future?

Group #1

- Survey staff to determine level of interest and assess/survey community needs to determine scope of service and meet with community leaders
- Exceptional communication – who, what, when, why, how
    - Research other models
- Dictate/inform UW Health
    - QSI and Population Health: Jaffery, Berkson, Aulik, Bidar-Sielaf, Newcomer, Hauschild, Neely
- PCLC (Primary Care Leadership Committee)
    - Gail Allen – Peds
- Establish curriculum , training templates with a task force – everyone has a role
- Establish metrics and pilot community

- PDSA (Plan, Do, Study, Act)
- Implementation plan
- Negotiate with insurance → for support staff $
- Marketing
- Research ; publish and communicate findings

Group #2

- What do we have to do?
    - Change organizational philosophy at multiple levels to be inclusive of community needs
    - Identify logistical needs and solutions to quality offsite care
        - Access in/out of clinic
        - EMR security, phone, Wi-Fi
        - Hours/schedules/availability
        - Equipment/supplies
        - Billing/coding/insurance coverage
        - Transport
        - Policies for offsite visits
        - Designate point person for outreach
        - Write proposal
    - Write proposed business plan
        - Collect data/current practices/community needs assessment
        - Financial analysis
        - Review current workload – identify/eliminate/reassign tasks
        - Adjust panels as necessary
    - Identify test sites and measures
    - Evaluate and review (prepare to fail/make it okay to fail) before implantation
    - Change in culture that values this type of work (supported by written policies/procedures)

Group #3

- Determining what the compensation/funding/plan would look like re: APP/panel
    - Comparing other patient to APP ratio models
- Identifying and utilizing local business partnerships/resources for community rotation of residents
- Provide incentives and recognition
- Identifying existing and new markets
- Visibility/support of leadership
- Clarity of roles (role definitions) of the multidisciplinary team, training, and education – what does the model look like in each of the clinics. Team building.
- Buy in from UW Health
    - Show financial and operational data
    - ?? Pilot
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