Community Health Implementation Strategy 2013

Introduction

Tarrant County Hospital District d/b/a JPS Health Network is a 537-bed governmental hospital which serves a city and rural population of approximately two million people. Approximately 5,000 practitioners, nurses, ancillary and support service team members are part of the JPS Health Network (Network).

Special services include:

- **Trauma:** Tarrant County's only Level I Trauma Center
- **Intensive Care:** for adults and newborns
- **Healing Wings:** AIDS treatment health center
- **Inpatient Care:** for patients of all ages
- **OB/GYN:** health care services to meet needs of women - all private labor and delivery rooms

Trinity Springs Pavilion is a psychiatric facility that is utilized for crisis stabilization, short-term treatment and family education. It is located on the network's main campus.

JPS also has a psychiatric emergency center in John Peter Smith Hospital and operates a partial hospitalization program that is designed to help patients function within their homes and communities.

Identifying Health Needs

A community health needs assessment was completed in the Summer of 2013. Community input was provided through a regional stakeholder survey, county visioning sessions and focus groups with local leaders and medical providers as a result of the Network's participation in the Regional Healthcare Partnership Plan for Region 10 (RHP Plan). In addition, secondary data was compiled from demographic and socioeconomic sources as well as national, state and local sources of information on disease prevalence, health indicators, health equity and mortality.

This data was analyzed and reviewed to identify health issues of uninsured persons, low-income persons and minority groups, and the community as a whole. As a result of the analysis described above the following health needs were identified for the Region:

• Lack of Access to Services (Cost) • Obesity • Uninsured/Limited Insurance • Limited Access to Healthy Foods • Diabetes • Need for Patient Education Programs • Substance Abuse • Low Birthweight/Early Prenatal Care	• Shortage of Specialists • Lack of Access to Dental Care • Children in Single-Parent Households • Overuse of Emergency Department Services • Transportation • Shortage of Dentists • Violent Crime Rate

• Excessive Drinking • Behavioral Health • Cancer • Hypertension • Lack of Mental Health Services • Shortage of Primary Care • Children in Poverty	• Need for Culturally Competent Care • Sexually Transmitted Infections • Teen Birth rate • Lack of Awareness of Available Resources • Need for Care Coordination • Lack of Access to Healthy Foods • Heart Failure • COPD

The identified health needs were reviewed and priority areas, included in the table below, were selected by the Network and included in the RHP Plan.

JPS Health Network Priorities	Correlated Community Health Need
Behavioral Health & Palliative Care	Behavioral Health Lack of Mental Health Services Substance Abuse Excessive Drinking Shortage of Primary Care
Community Focused & Care Coordination (Focusing on Medically Underserved Populations)	Lack of Access to Services (Cost) Uninsured/Limited Insurance Need for Care Coordination Lack of Awareness of Available Resources Overuse of Emergency Department Services Need for Patient Education Programs Low Birthweight/Early Prenatal Care Children in Poverty
Specialized Services	Need for Patient Education Programs Lack of Awareness of Available Resources Need for Care Coordination Shortage of Primary Care Overuse of Emergency Department Services Diabetes Hypertension Cancer Heart Disease COPD

PRIORITY: Behavioral Health and Palliative Care

Project Name / Description	Summary Population	Outcome	Partnerships
Behavioral Health Discharge Management Program	All patients discharging from Trinity Springs Pavilion - 4,923 inpatient discharges annually	Decrease Behavioral Health /Substance Abuse 30-day readmission rate Decrease mental health admissions in criminal justice settings Increase ED appropriate utilization	MHMR
Create partial hospitalization programs and intensive outpatient programs as part of continuum of care (PHP)	2,425 psychiatric patients who will be served in new PHP and IOP service locations	Increase 7 & 30 Day Follow-Up After Hospitalization for Mental Illness Decrease Behavioral Health /Substance Abuse 30-day readmission rate Increase ED appropriate utilization	UNTHSC Providers
Behavioral Health expanding hours	Additional patients accessing outpatient behavioral health services in expanded hours/services - 457 unique patients annually	Increase 7 & 30 Day Follow-Up After Hospitalization for Mental Illness Decrease ED appropriate utilization	MHMR, UNTHSC Providers, Academic Counseling programs
Integrated Behavioral Health care	5,567 patients will receive integrated primary and behavioral health	Increase Depression management screening Decrease poor Diabetes care: HbA1c poor control (>9.0%) Decrease poor Diabetes care: BP control (<140/80mm Hg)	N/A
Virtual psychiatric	1,802 primary care physicians in Region 10 who will potentially address behavioral health issues in primary care settings for 489,000 patients.	Increase Depression management screening Increase Depression management: Depression Remission at Twelve Months	Region 10 Primary care providers, UNTHSC Providers
Palliative Care	1,208 patients who are terminally or chronically ill as approximated by the CAPC research.	Increase documentation of Pain assessment Increase documentation of Treatment preferences Improved cost savings	JPSPG, UNTHSC Provider

PRIORITY: Community Focused and Care Coordination

Project Name / Description	Summary Population	Outcome	Partnerships
Implement/Expand Care Transitions Programs- Care Connections for the Homeless	The 2011 point-in-time count of the Homeless was 2,169 people and the "annualized" HUD estimate of people experiencing homelessness was 4,847 people.	Improve poor Diabetes care: HbA1c poor control (>9.0%) Increase 7 & 30 Day Follow-Up After Hospitalization for Mental Illness Increase ED appropriate utilization	Healing Shepherd Clinic, Tarrant County Medical Society, MedStar
Establish/Expand a Patient Care Navigation Program– MedStar Patient Navigation	Medically underserved Medicaid & indigent patients and uninsured who are at risk for potentially preventable ED visits and hospital admissions. We anticipate enrolling a total of 6,525 patients in this program over the reporting period.	Decrease CHF 30-day readmssion rate Decrease Ambulatory care sensitive conditions readmission rate	North Texas Area Community Health Center, Project Access, MedStar
Community connect	This project will serve 5,000 unduplicated patients during the reporting period. The target population includes the residually uninsured patients who are currently using the ED or urgent care for their primary care needs or do not currently have access to primary care providers.	Decrease poor Diabetes care: HbA1c poor control (>9.0%) Increase ED appropriate utilization	North Texas Area Community Health Center, Project Access, MedStar
Expand Chronic Care Management Models-School Based Collaborative Chronic Disease Care Model	1,584 children and young adults (DY4 and 5) with a diagnosis of asthma and/or obesity/diabetes who are currently accessing primary care services within our school based health centers as well as our community health centers.	Decrease Pediatric/Young adult asthma emergency department visits Decrease Other 30 day readmit rate	Cook Childrens, Arlington ISD, Fort Worth ISD, UNTHSC School of Public Health
Journey to Life: Prenatal Care and Healthy Babies Initiative	Deliver services to 6,959 medically underserved, Medicaid, indigent, and underinsured prenatal patients in Tarrant County.	Increase Timeliness of prenatal/postnatal care Increase ED appropriate utilization	N/A

PRIORITY: Specialized Services

Project Name / Description	Summary Population	Outcome	Partnerships
Coordinated CHF Program	4,000 patients who annually visit the ED with a primary or secondary diagnosis of congestive heart failure.	Decrease CHF 30-day readmission rate Increase Patient satisfaction	JPSPG, MedStar, Integrative Emergency Services
Implement/Expand Care Transitions Programs – Develop, implement and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions	5,000 Medicaid and uninsured patients discharged from JPS Health Network inpatient or ED settings who are transitioning to a medical home. Estimated number of patients to be served over the waiver period.	Decrease All cause 30-day readmission rate Increase ED appropriate utilization	Homecare, Hospice, Community based care transition program
Develop rehab transition process for JPS Connections patients	The target population is JPS Health Network patients who do not qualify for Medicaid in Texas and lack private coverage enrolled in JPS' patient coverage program called JPS Connections.	Decrease Average Length of Stay Increase Patient satisfaction	Local rehab provider
Call Center - Enhance Urgent Medical Advice - 24/7	Estimated 200,000 patients and family members who access outpatient/ED services within the Tarrant County Hospital District.	Decrease All cause 30-day readmission rate Increase ED appropriate utilization	N/A
Expand specialty care for Ophthalmology and Wound Care	Current and future enrolled JPS Connection patients are the targeted population. Estimated 100,000 patients will be served over course of waiver period.	Increase Diabetes care - retinal eye exam Decrease Cost of Carefor patients with Pressure Ulcers Decrease time to 3rd next available appointment	UT Southwestern Provider
JPS Diabetes Chronic Care Management	17,000 current diabetic patients in primary care setting. We estimate that we will positively impact about 50% of the target population.	Decrease poor Diabetes care: HbA1c poor control (>9.0%) Decrease poor Diabetes care: BP control (<140/80mm Hg Increase Diabetes care: foot exams	N/A

PRIORITY: Specialized Services (Continued)

Project Name / Description	Summary Population	Outcome	Partnerships
Redesign to Improve the Patient Experience	Patients and their families accessing care in the JPS Health Network. Estimated 300,000 patients will be served over course of waiver period.	Increase Patient Satisfaction	N/A
Expand Pain Management Care Services	Greater than 25,000 members of the underserved/Medicaid population of Tarrant County	Decrease Other admission rate – primary diagnosis code of pain	JPSPG
		Reduce ALOS for Oncology inpatient	
		Increase ED appropriate utilization	
Patient Centered Medical Home	Current and future enrolled JPS Connection patients. Estimated 100,000 patients will be served over course of waiver period.	Reduce ACSC admissions	Iowa Consortium, UNTHSC Providers, JPSPG, Cope
		Increased Breast Cancer screening	
		Increased Cervical cancer screening	

Reporting Deliverables for DY2 for each project are included in *Appendix I: 2013 Milestones and Metrics of this document.*

Needs Not Addressed

Some issues identified through the community health needs assessment have not been addressed in this plan. In initial discussion and subsequent prioritization, JPS Health Network's Needs Assessment Team considered the levels to which some needs were already being addressed by others in Region 10. Additionally, some community needs fall out of the geographic limits, scope of expertise and resources of JPS.

Next Steps

This Implementation Plan will be rolled out over the next three years, from FY2014 through the end of FY2016. The Team will work with community partners and health issue experts on the following for each of the approaches to addressing the identified health needs:

- Develop work plans to support effective implementation
- Create mechanisms to monitor and measure outcomes
- Develop a report card to provide on-going status and results of these efforts to improve community health

JPS is committed to conducting another health needs assessment within three years.

Adoption/Approval

JPS Health Network's Board of Directors approves the Implementation Strategy that has been developed to address the priorities of the recent Community Health Needs Assessment.

JPS Health Network will utilize this Implementation Strategy as a roadmap to collaborate with their community to address the priorities, particularly for the most vulnerable.

_____ _____

Chair, JPS Health Network Hospital Board of Directors Date

_____ _____

Chief Executive Officer, JPS Health Network Date

Appendix I: DY 2 Reporting Deliverables

Behavioral Health and Palliative Care

Project Name / Description	DY2 Milestones and Metrics
Behavioral Health Discharge Management Program	• Establish team to support project • Collect information on factors contributing to preventable readmissions within 30-days • Review interview data conducted by multidisciplinary team • Improve electronic reporting of readmission data • Develop electronic report on readmission data • Chart review/ determine baseline for all-cause 30-day readmission • Identify baseline high-risk patients analyzing DRG and/ or other data elements • Hire clinicians • Develop an assessment tool to identify high risk readmit patients • Identify evidence based frameworks that support seamless care transitions to impact 30-day readmit • Develop operations manual • Develop plans for a hospital care transition program • Evaluate and continuously improve care transitions programs • Conduct study to determine feasibility of providing a wellness, self-management and /or peer support program on hospital campus for patients with high-risk diagnoses. • Educate appropriate clinical staff on key contributing factors to preventable readmissions. • Conduct baseline study and annual reassessments of high-risk patients readmitted to hospital < 30 days to determine interval between hospital discharge and visit to PCP/ behavioral health provider. • Creation of Patient Experience of Care Council, • Project planning and engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans ; develop and test data systems behavioral health 30 day readmit rate • Project planning and engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans – mental health admissions to criminal justice settings • Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans – ED use
Create partial hospitalization programs and intensive outpatient programs as part of continuum of care (PHP)	• Identify licenses, equipment requirements and other components needed to implement and operate options selected. • Develop administrative protocols and clinical guidelines for projects selected (i.e. protocols for a mobile clinic or guidelines for a transportation program). • Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans follow up after hospitalization for mental illness • Develop and test data systems • Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans – BH/ substance abuse 30 day readmit rate • Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans ED use
Behavioral Health expanding hours	• Identify licenses, equipment requirements and other components needed to implement and operate options selected. • Develop administrative protocols and clinical guidelines for projects selected (i.e. protocols for a mobile clinic or guidelines for a transportation program). • Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans follow up after hospitalization for mental illness • Develop and test data systems • Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans ED use
Project Name / Description	DY2 Milestones and Metrics

Integrated Behavioral Health care	• Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa. • Number of referrals that are made outside of the location • Evaluate and continuously improve integration of primary and behavioral health services. • Project planning -engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans depression management • Develop and test data systems • Project planning -engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans – diabetes care • Manage data systems to prepare report indicating baseline percentage of behavioral health patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0% • Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans blood pressure control
Virtual psychiatric	• Conduct needs assessment of complex behavioral health populations and primary care providers who could benefit from telephonic psychiatric consultation. • Design psychiatric consultation services that would allow medical professionals in primary care settings to access professional behavioral health expertise via telephone, facsimile, and email) • Enroll primary care settings into the remote behavioral health consultation services.= • Determine the impact of the project • Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans depression management screening • Develop and test data systems • Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans depression remission •
Palliative Care	• Implement palliative care education and training programs for providers (physicians, RNs, PAs, NPs, etc.) that incorporates management of non-cancer patients • Develop an EHR/system (e.g. a rounding tool or a registry or software) that analyzes the palliative care system data to determine if the program is effective • Implement/expand a palliative care program • Establish benchmark and improvement target for measure I-9 for DY4 and DY5 • Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans pain assessment • Manage data systems to prepare report indicating baseline percentage of palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening • Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans treatment preferences • Manage data systems to prepare report indicating baseline percentage of palliative care patients with chart documentation of preferences for life-sustaining treatments • Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans cost of care • Manage data systems to prepare report indicating baseline percentage of palliative care patients with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss

Community Focused and Care Coordination

Project Name / Description	DY2 Milestones and Metrics
Implement/Expand Care Transitions Programs- Care Connections for the Homeless	• Conduct an assessment and establish linkages with community-based organizations to create a support network for targeted patients post-discharge • Develop a staffing and implementation plan to accomplish the goals/objectives of the care transitions program • Establish baseline rate diabetes poor control • Partner with identified agencies serving the mental health needs of the homeless community for project planning purposes for –identifying communication plan and resource needs, develop protocols to ensure appropriate access for mental health follow-up services • Partner with identified agencies serving the mental health needs of the homeless community in order determine baseline rates
Establish/Expand a Patient Care Navigation Program– MedStar Patient Navigation	• Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program. (Including frequency and costs of episodic care for traditional care model.) (911 RN triage, observation avoidance, HUG program, CHF program) • Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans • P-2: Establish Baseline Rates – Work with stakeholder group above to establish baseline rates of PPR for CHF • P-3: Develop and test data systems –Review process for tracking enrolled patients and EMR linkages for sharing patient assessment and treatment data • Written protocols and completion of capacity assessment to meet increasing demands for primary care services • Partner with MedStar Medical Control Authority, JPS emergency department and JPS case management staff to determine baseline rates specific to Ambulatory Care Sensitive Condition Admission rates for the Observation Avoidance Program • Develop eligible patient identification and referral system. Establish network for patient referrals and test appointment scheduling and referral
Community connect	• Conduct an assessment and establish linkages between community-based organizations to create a support network for targeted patients post discharge • Care transition Assessment: Submission of care transitions assessment and resource planning documents • Develop a staffing and implementation plan to accomplish the goals/objectives of the care transitions program • Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans for reducing patients with HbA1c >9.% • Establish baseline rates- Baseline rates will be established for HbA1c appropriate utilization specific to the low income individuals not receiving services at JPS • Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans • Baseline rates will be established for ED appropriate utilization specific to the low income individuals not receiving services at JPS

Project Name / Description	DY2 Milestones and Metrics
Expand Chronic Care Management Models-School Based Collaborative Chronic Disease Care Model	• * Documentation of a care management program following evidence-based practices from the Wagner Chronic Care Model • Baseline/Goal: Documentation • Baseline/Goal: Partner with identified agencies serving the underserved pediatric and young adult population with a diagnosis of asthma to determine baseline data specific to Pediatric/Young Adult Asthma Emergency Department visits. • Establish community linkages focused on chronic care management for Asthma in the Pediatric and Young Adult Population • Partner with identified agencies serving the underserved pediatric and young adult population with a diagnosis of asthma to determine baseline data specific to Pediatric Asthma 30 day Readmission rates specific to our population
Journey to Life: Prenatal Care and Healthy Babies Initiative	• Document development innovational strategy and plan to increase prenatal and postnatal care and decrease the inappropriate utilization of the emergency department. This project plan will define necessary staffing and educational/training needs for implementation • Project planning to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans • Collaborate with identified agencies/partners s (both internal and external) serving the prenatal community to determine baseline rates of the timeliness of prenatal and postnatal care.) • To develop and test data systems to ensure validity of information regarding prenatal and postnatal care • Project Planning to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans • Establish baseline rates • Develop and test data systems to ensure validity of information regarding the inappropriate utilization of the emergency department

Specialized Services

Project Name / Description	DY2 Milestones and Metrics
Coordinated CHF Program	• Develop or implement best practices or evidence-based protocols (such as Partnership for Patients) for effectively communicating with patients and families during and post-discharge to improve adherence to discharge and follow-up care instructions • Using a validated risk assessment tool, create a patient identification system • Develop a staffing and implementation plan to accomplish the goals/objectives of the care transitions program • Establish baseline data CHF 30-day readmit & patient satisfaction
Implement/Expand Care Transitions Programs – Develop, implement and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions	• Establish a process for hospital-based case managers to follow up with identified patients hospitalized related to the top chronic conditions to provide standardized discharge instructions and patient education • Develop a staffing and implementation plan to accomplish the goals/objectives of the care transitions program • Project planning 30-day readmission rate • Establish baseline data for all-cause 30-day readmission rate • Establish baseline data for inappropriate ED utilization
Develop rehab transition process for JPS Connections patients	• Conduct an assessment and establish linkages with community-based organizations to create a support network for targeted patients post-discharge (Establish a formal contract with Rehab Provider Corporation) • Develop a staffing and implementation plan to accomplish the goals/objectives of the care transitions program • Develop and test data systems Average LOS • Develop CG-CAHPS-based patient satisfaction survey instrument and survey design and methodology to survey target population after initial stabilization (JPS) and again after institutional transition for inpatient rehabilitative treatment (Rehab Provider)
Call Center - Enhance Urgent Medical Advice - 24/7	• Collect baseline data, if medical advice line currently exists in RHP; Develop metrics specific to the medical advice line in use by the performing provider to track access to specified patient population determined by RHP • Documentation of baseline assessment • Establish clinical protocols for an urgent medical advice line within 4 years of the demonstration period with a vetting process within the RHP. ED clinical protocols are currently used by several hospitals and hospital councils in Texas to determine appropriate and non-appropriate ED visits • Establish/Expand nurse advice line by 20% of nurse availability base on baseline data to increase access to patients based on need within RHP • Verify and validate 30-day readmission data for all payors • Identify and engage stakeholders and determine focus areas. Identify population risk strategies. Include both internal and external resources • Analyze and interpret data, develop improvement plan to achieve outcome improvement targets • Verify and validate baseline data for current eligible Medical Home patients with the listed conditions that have also had an ED visit, stratify risk by condition and determine gaps in care

Project Name / Description	DY2 Milestones and Metrics
Expand specialty care for Ophthalmology and Wound Care	• Collect baseline data for wait times, backlog, and/or return appointments in specialties • Develop and implement standardized referral and work-up guidelines • Train care providers and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties • Verify and validate baseline data retinal eye exam • Review data and determine improvement implementation guidelines and resources needed • Engage stakeholders, identify resources needed, document implementation plans • Verify and validate data cost of care • Engage stakeholders, identify resources needed, document implementation plans 3rd next available • Verify and validate data 3rd next available appointment • Develop job descriptions and recruit to hire optometrists and support staff for 4 sites
JPS Diabetes Chronic Care Management	• Develop a comprehensive care management program • Formalize multidisciplinary teams, pursuant to the chronic care model defined by the Wagner Chronic Care Model or similar • Train Staff in the Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care • Expand the Care Model to primary care clinics • Plan with stakeholders • Metrics: Plan document HbA1C • Plan with stakeholders Blood pressure • Validate baseline blood pressure • Plan with stakeholders foot exams • Validate and analyze baseline data foot exams
Redesign to Improve the Patient Experience	• Appoint an executive accountable for experience performance or create a percentage of time in existing executive position for experience performance • Establish a steering committee comprised of organizational leaders, employees and patients/families to implement and coordinate improvements in patient and/or employee experience. Steering committee should meet at least twice a month • Write and disseminate a patient/family experience strategic plan • Develop a training program on the patient experience • Engage stakeholders, identify current capacity and resources needed, determine timelines, develop and document patient experience plan • Select a CGCAHPS vendor and implement the survey tool across the medical practice sites. • Disseminate baseline patient experience plan data to stakeholders. • Implement baseline dashboard
Expand Pain Management Care Services	• Conduct specialty care gap assessment based on community need • Launch/expand a specialty care clinic for pain management • Validate baseline data. Other admission rate • Review data and determine improvement implementation guidelines and resources needed • Validate baseline data. Other outcome improvement target – oncology pain • Review data and determine improvement implementation guidelines and resources needed. • Validate baseline data. ED use • Review data and determine improvement implementation guidelines and resources needed

Project Name / Description	DY2 Milestones and Metrics
PCMH	• Implement the medical home model in primary care clinics • Utilize a gap analysis to assess and/or measure hospital-affiliated and/or PCPs' NCQA PCMH readiness Comparative • Put in place policies and systems to enhance patient access to the medical home. Enhanced access to care is available through systems such as open scheduling • Reorganize staff into primary care teams responsible for the coordination of patient care. Teams can be designed in a variety of ways depending on the size and needs of the patient population and the resources of the practice. Ideally, primary care practices should be structured to respond to all common problems for which their patients seek care. Most successful practices are organized around an accountable clinician (usually a physician or advanced registered nurse practitioner or physician assistant) and a medical assistant dyad that interact continuously throughout the day. Other team members are usually responsible for providing self-management support (e.g., nurse or clinical pharmacist, or health educator) or arranging other resources (e.g., social worker). Regardless of team composition, care must be taken to keep the team size relatively small (fewer than five to seven members) because team functioning breaks down as teams grow. Other clinic staff members, including billing staff, receptionists, computer technicians, and laboratory personnel, complement the primary care teams. Each of these staff members can play important roles in engendering strong trusting relationships between patients and their) care team. • Develop staffing plan to expand primary care team roles; Expand and redefine the roles and responsibilities of primary care team members • Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans • Verify and validate baseline rates ASCS admissions rate • Test data systems to verify reliability • Develop tracking system for care coordination for inpatients with Ambulatory Care Sensitive Condition Admissions back to their Medical Home • Develop resources/systems to link with a Medical Home if not already on a panel • Verify and validate baseline rates breast cancer • Share data and baseline metric with clinical care teams to engage teams in focused improvement efforts •