Attachment B: Pediatric – Transforming Clinical Practices Initiative Aggregated Report

Olympic Region P-TCPi Facilitator Coach Activities

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| **Clinics/Agencies Kitsap**  | **Action Steps & Quality Improvement** |
| **Bainbridge Pediatrics** | * Improving Reporting on clinical measures and Provider productivity
* Implementing PCMH quality goals; initiating ‘Meaningful Use’ module in EHR and training staff
* Implementing ‘’Family Experience Survey" in collaboration with Seattle Children’s; develop specific QI goals from results
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| **Kitsap Children’s** | * Immunization rates
* Patient education on proper use of ED
* Empanelment
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| **Kitsap Mental Health Services**  | * Integration with primary care; see regional project summary below
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| **Peninsula Community Health Services** | * Have graduated from P-TCPi, but will be included in MOA and best practice examples for other partner clinics; involved in several MOAs with regional clinics to improve primary care and BH integration
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| **One Heart Wild Education Sanctuary** | * Developing tools with outside Consultant to measure specific clinical outcomes
* Developing Patient and Volunteer satisfaction surveys
* Practice Facilitator conducted PDSA training for all staff and interns
* Have signed 2 MOAs with local PC clinics and referral relationship has been established
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| **Silverdale Pediatrics** | * Establishing new part-time Provider 1x day a week
* Developing new standard operating procedure of dictation in room with Pt; improving patient education
* Developing color code for charts with MA team to help with daily patient flow (Clinic uses paper charts)
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| **West Sound Treatment Center**  | * Developing a policy for establishing a Point of Contact/Support Person for every patient
* Have written a job description for a Care Coordinator
* Developing a community resource reference tool for Provider team
* Establishing a MOA with Peninsula Community Health Services
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| **Clinics/Agencies Clallam**  | **Action Steps & Quality Improvement** |
| **Lower Elwha** | * Lead MA conducted up-training on Child Profile and Immunizations for MA Team and Nurses
* Developing a recall process to clarify who is an active patient
* Building trust among the community through increased community engagement: Holding quarterly small events in partnership with local community partners including immunization day, to include Government Performance and Results Act data collection activities
* Practice Facilitator conducted PDSA training for staff
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| **Reflections Counseling Services Group** | * Practice Facilitator conducted PDSA training for all staff
* Formalizing process to assist all clients with establishing a medical home
* Recently implemented Relia Trax. Developing reports to track the following:
	+ Emergency Room visits
	+ Jail
	+ Residential placement
	+ No Show rates
	+ MAT referrals
* Through improved reporting, will improve the following over the next 6 months (beginning July 1):
	+ Reduce No Show rates by 10%
	+ Improve diversion from ED and Jail by 10%
	+ Ensure SBHO requirement of no more than 14 days between initial intake and follow-up visit
* Developing a community resource reference tool for Provider team
* Developing a standard operating procedure regarding client re-engagement
* Writing a formal employee handbook
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| **West End Family Counseling**  | * Tracking CFT (Child Family Team meeting) rates as required by SBHO. Goal of 75% success rate for all pediatric clients
* Tracking results of diagnoses tools used with pediatric population. Reduce identified symptoms by 10% over the next 6 months
* Improving referral relationships with primary care, Cedar Grove, Forks Abuse, and Concerned Citizen. Developing standard referral process and forms for each organization
* Developing a community resource reference tool for Provider team
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| **Enrolled Clinics: Jefferson** | **Action Steps & Quality Improvement** |
| **Jefferson Public Health School Based Health Clinics (Port Townsend and Chimacum)** | * Improved relationship and understanding with Billing department; developing new Billing reports
* Improved relationship with school nurse and Administration staff to improve immunization rates and overall referrals
* Credentialing Office Manager (also an MA) to do blood draws in clinic to improve efficiency
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**Regional Projects**

*Asthma population health:*

Kitsap Mental Health Services (KMHS) has identified a list of patients who have chronic asthma/over utilizing the ED for asthma. Cross referencing list with Peninsula Community Health Services, Silverdale Pediatrics, and Kitsap Children’s. Developing a curriculum for in-home assessments and patient/family education, potentially to include peer education. If successful, will extend out to other counties.

*Acronyms in use in this attachment: BH – behavioral health, ED – emergency department, EHR – electronic health records, MA – medical assistant, MAT – medication assisted treatment, MOA – Memorandum of Agreement, PC – primary care, PCMH – patient-centered medical home, PDSA – Plan Do Study Act, P-TCPi – Pediatric Transforming Clinical Practices Initiative, QI – quality improvement*