A Teaching CIN:

A Platform for Learner-Engaged Health Equity, Interprofessional, Population Health Education and Scholarship

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STFM Suggested Roundtable Ground Rules

- Approximately 25 minute presentation initially
- Chat comments and questions during presentation
- After presentation, participants should identify themselves when they comment or share in the discussion
- There is a strict time limit. Post-roundtable, we encourage you to use the "Forum Thread" in the conference to continue conversations or contact us by email

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Disclosures

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No other disclosures

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Background:

- HRSA PCTE Grant to Advance education in Medical Students, Primary Care Residents, & Faculty in Quality Improvement to Address Health Equity in Underserved Populations through improved access, quality of care, cost effectiveness
- *"...must focus on training for transforming healthcare system."*
- EVMS Vision to Become Recognized as Most Community Oriented Medical School
- Long standing teaching relationships with Safety Net Clinic Sites & ODU HP programs
- EVMS Medical Group Participation in a Clinically Integrated Network (CIN)

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A Clinically Integrated Network (CIN)

- A collaboration among independent providers and a hospital/health system that:
  - Develops a clinical integration program; which
  - Advances clinical initiatives to improve quality and delivery of health services; which
  - Leads to higher value care services.
  - Participation is voluntary

Transformative Education Advancing Community Health (TEACH)

- Overarching Goal: transform current outpatient underserved population clinical teaching sites into a CIN
- Trainees (medical and HP students; primary care residents; primary care faculty) will learn, provide clinical services and teach in CIN to improve outcomes for underserved populations

Participants

- Two Family Medicine residency clinics
- One Pediatric hospital based outpatient care clinic
- One hospital supported Free clinic-teaching IM/FM residents and HP students
- A Student Run Free Clinic
- Two Independent Hospital Supported Free Clinics (one rural) that taught FM resident and MD/HP students
- Two Academic Health Institutions
- MD students
- FM residents
- Pediatric residents
- IM residents
- PA students
- Dental Hygiene students
- DNP and CNS students
- Physical Therapy students
- Counseling Students
- Faculty for above

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Objective 1

To develop, implement, and evaluate a clinical network built upon existing community-based "safety-net" primary care centers (rural and urban) as clinical training sites using new health care systems models to expand their health workforce.

Obj Ia: Transformation Advisory Board
Obj Ib: Clinical Network
Obj Ic: Health Coaches
Obj Id: Data Management
Obj Ie: QI policies & procedures

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Objective 2

To leverage existing resources and partnerships with community organizations, hospitals, health departments, and other academic institutions to develop and expand curricular materials addressing primary care, population health, patient-centered medical home and accountable care principles.

Obj IIa: Review existing curricula
Obj IIb: Modify curricula to address multiple disciplines
Obj IIc: New course development

Objective 3

To develop, implement, and evaluate a clinical, team-based, experiential curriculum in which learners across disciplines and training levels partner with their patients to improve health outcomes through patient education and care management.

Obj IIIa: Learner teams matched to patient longitudinally
Obj IIIb: Care management meetings
Obj IIIc: Team-based projects
Obj IIId: Narrative experience

Objective 4

To implement newly developed and expanded curricula across disciplines and training levels to address learning objectives focused on clinical practice, teaching, and leadership of transformed healthcare systems.

Obj IVa: learners will define and describe social determinates of health
Obj IVb: learners will define, describe and participate in accountable care principles including practice registries, rapid cycle projects, practice and patient scorecards, etc.
Obj IVc: interprofessional collaboration to measure and improve patient population health outcomes
Obj IVd: interprofessional QI projects
Obj IVe: measure and utilize patient and population metrics to assess patient and population outcomes

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TEACH Advisory Board (TAB): Vision and Mission

- Vision: To provide Well Trained Healthcare Providers that Help Create Healthy Communities
- Mission: To provide a superior interprofessional educational experience for learners while providing high quality value based care for our communities underserved populations that improve health and reduce disparities

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TEACH Advisory Board (TAB): Goals

- To provide oversight in the development, implementation, and evaluation of a clinical network built of community-based "safety-net" primary care centers as clinical training sites interprofessional team of learners using new health care systems models
- To provide oversight in the development and implementation of curricular materials addressing primary care, population health, patient-centered medical home and accountable care principles for student, resident and faculty learners of TEACH partners
- To provide oversight for the delivery of measurable high quality value based care to TEACH service patient populations

Governance Committee

- Provide oversight and advise to TAB and Exec team on TAB membership needs
- Provide oversight and advise to TAB and Exec team on Board Bylaws
- Provide oversight and advise to TAB and Exec team on Professional Standards
- Provide oversight and advise to TAB and Exec team on expansion and/or reductions of individual and partner membership

Quality Improvement Committee

- Provide oversight and advise to TAB and Exec team of HIT
- Provide oversight and advise to TAB, Exec Team and Safety Net clinics on population health measures
- Provide oversight and advise to TAB, Exec Team and Safety net clinics on clinic QI measures

Interprofessional Collaboration Committee

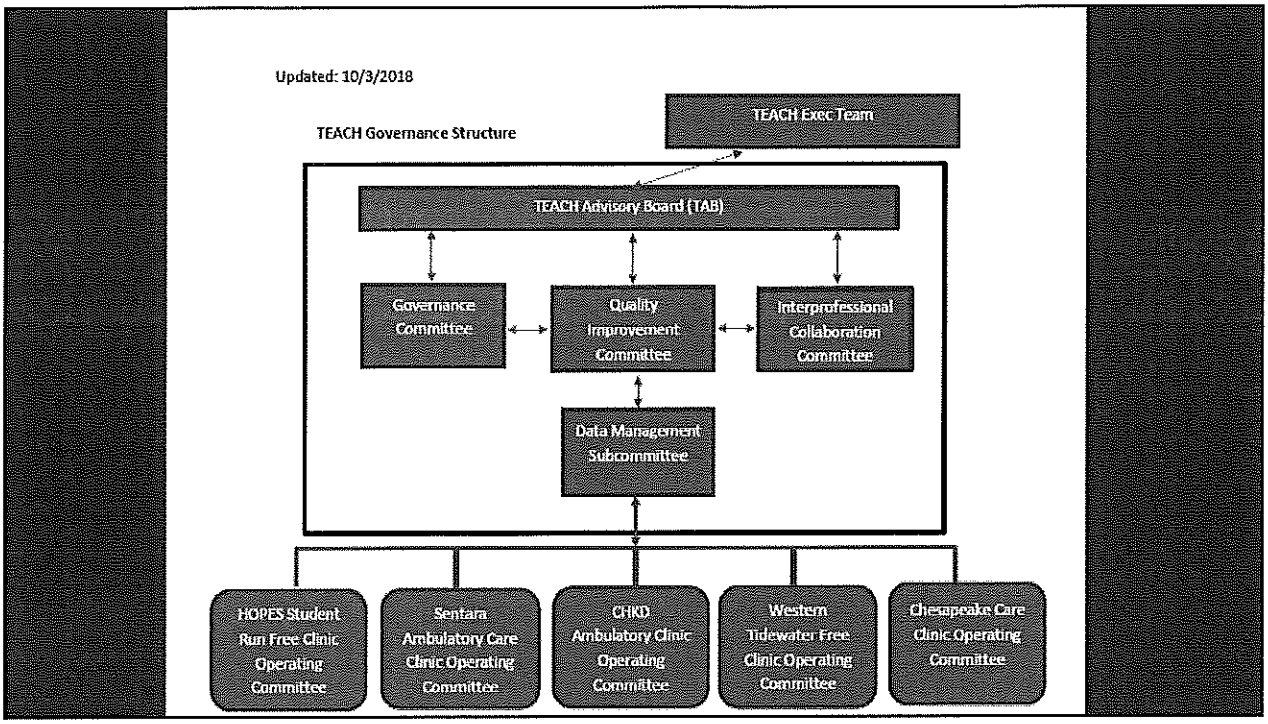
- Provide oversight and advise to TAB, Exec Team and Safety Net clinics on student learner curriculum initiatives and measures
- Provide oversight and advise to TAB, Exec Team and Safety Net clinics on resident learner curriculum initiatives and measures
- Provide oversight and advise to TAB, Exec Team and Safety Net clinics on faculty learner curriculum initiatives and measures

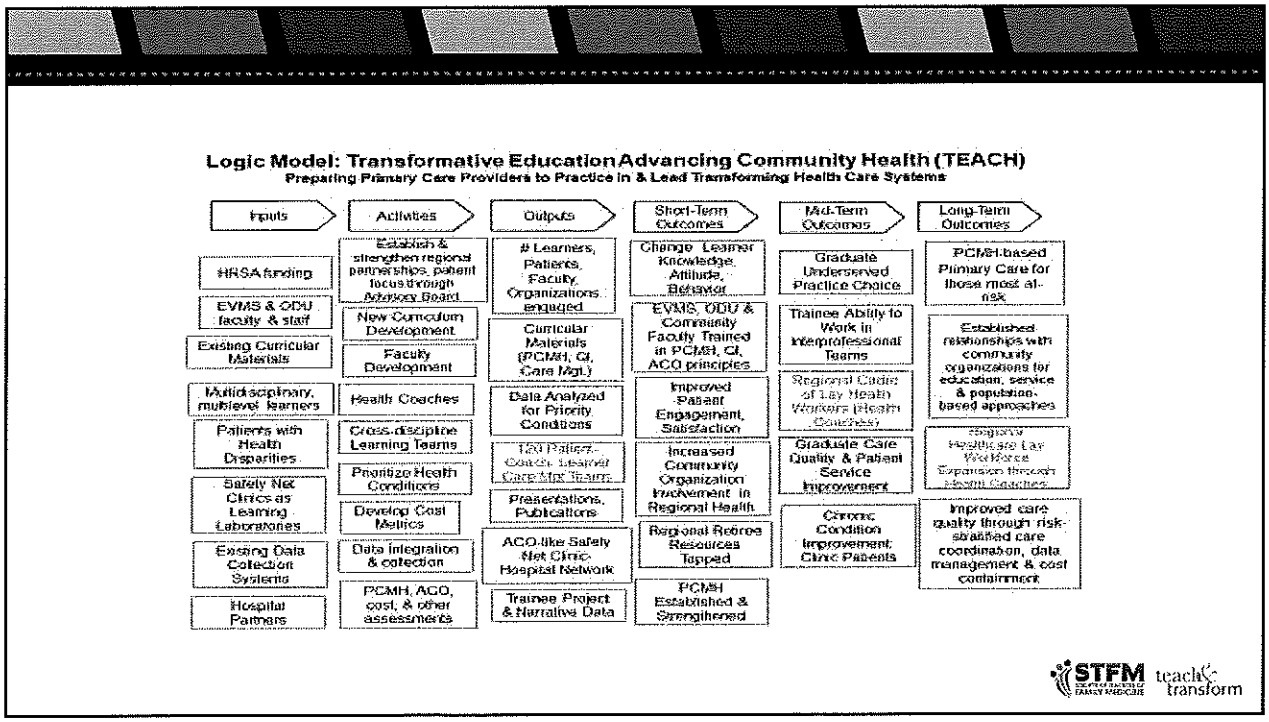
TEACH Executive Team

- Provide guidance and recommendations to TAB
- Provide Administrative Support Services to TAB and its committees
- Provide communications for TAB with outside partners in support of TEACH vision, mission, goals and objectives

Organizational Chart & Bylaws

- Organizational Based on CIN structure
- Bylaws based on Alumni Board Bylaws
- Stakeholders on Board
  - MD & HP Students
  - Primary Care Residents
  - Free Clinic Leadership
  - PriCare MD and HP faculty
  - Service Learning Leadership
  - Community Health Leadership
  - Health System/Insurance Leadership


Updated: 10/3/2018
TEACH Governance Structure
TEACH Exec Team
TEACH Advisory Board (TAB)
Governance Committee
Quality Improvement Committee
Interprofessional Collaboration Committee
Data Management Subcommittee
HOPES Student Run Free Clinic Operating Committee
Sentara Ambulatory Care Clinic Operating Committee
CHKD Ambulatory Clinic Operating Committee
Western Tidewater Free Clinic Operating Committee
Chesapeake Care Clinic Operating Committee


Logic Model: Transformative Education Advancing Community Health (TEACH)
Preparing Primary Care Providers to Practice In & Lead Transforming Health Care Systems
Inputs
Activities
Outputs
Short-Term Outcomes
Mid-Term Outcomes
Long-Term Outcomes
HRSA funding
EVMS & ODU faculty & staff
Existing Curricular Materials
Multidisciplinary, multilevel learners
Patients with Health Disparities
Safety Net Clinics as Learning Laboratories
Existing Data Collection Systems
Hospital Partners
Establish & strengthen regional partnerships, patient focus through Advisory Board
New Curriculum Development
Faculty Development
Health Coaches
Cross-discipline Learning Teams
Prioritize Health Conditions
Develop Cost Metrics
Data integration & collection
PCMH, ACO, cost, & other assessments
Learners, Patients, Faculty, Organizations engaged
Curricular Materials (PCMH, QI, Care Mgt.)
Data Analyzed for Priority Conditions
Tm Patient-Coach-Learner Care Mgt Team
Presentations, Publications
ACO-like Safety Net Clinic-Hospital Network
Trainee Project & Narrative Data
Change Learner Knowledge, Attitude, Behavior
EVMS, ODU & Community Faculty Trained in PCMH, QI, ACO principles
Improved Patient Engagement, Satisfaction
Increased Community Organization Involvement in Regional Health
Regional Resource Resources Tapped
PCMH Established & Strengthened
Graduate Underserved Practice Choice
Trainee Ability to Work in Interprofessional Teams
Regional Cadre of Lay Health Workers (Health Coaches)
Graduate Care Quality & Patient Service Improvement
Chronic Condition Improvement: Clinic Patients
PCMH-based Primary Care for those most at-risk
Established relationships with community organizations for education, service & population-based approaches
Regional Healthcare Lay Workforce Expansion through Health Coaches
Improved care quality through risk-stratified care coordination, data management & cost containment
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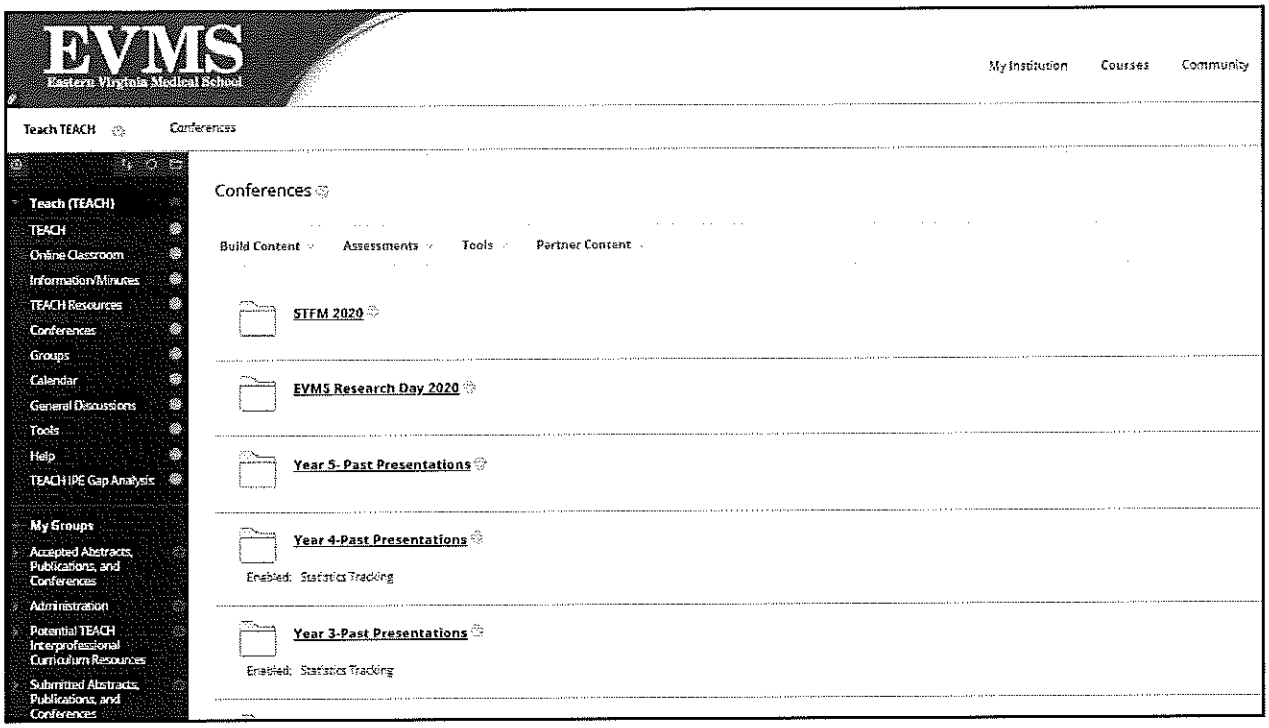

Outcomes

- Student/Resident/Faculty Academic & Clinical Quality Improvement Scholarly Activities
- Integration of Health Systems Sciences and Underserved Population Health into MD/HP curriculum
- Integration of meaningful Interprofessional Education and Team Care Clinical Experiences for MD/HP learners
- Later addition of Substance/Opioid Use Disorder Curriculum
- Relationships with stakeholders utilized as basis for more Grant Proposals
- Sustained Organizational Structure to continue collaboration of Academic Health Organizations/Underserved Patient Care Organizations to Measurably Improve Health of Community

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Questions to Consider

- What are the educational challenges of providing meaningful experiences that address LCME standards of scholarship, interprofessional education, quality improvement, population health, and health disparities/population health/health systems sciences?
- Does your Medical Group belong to a CIN or ACO?
- Does your school teach or provide clinical opportunities for Medical Students in Safety Net Clinics?
- Are other Health professions students at these same clinics?
- Think of who you could partner with to create a Teaching CIN organization?

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Thank you

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- AND OUR DEEPEST APPRECIATION FOR Kaethe Ferguson and Carmen Ingram-Thorpe

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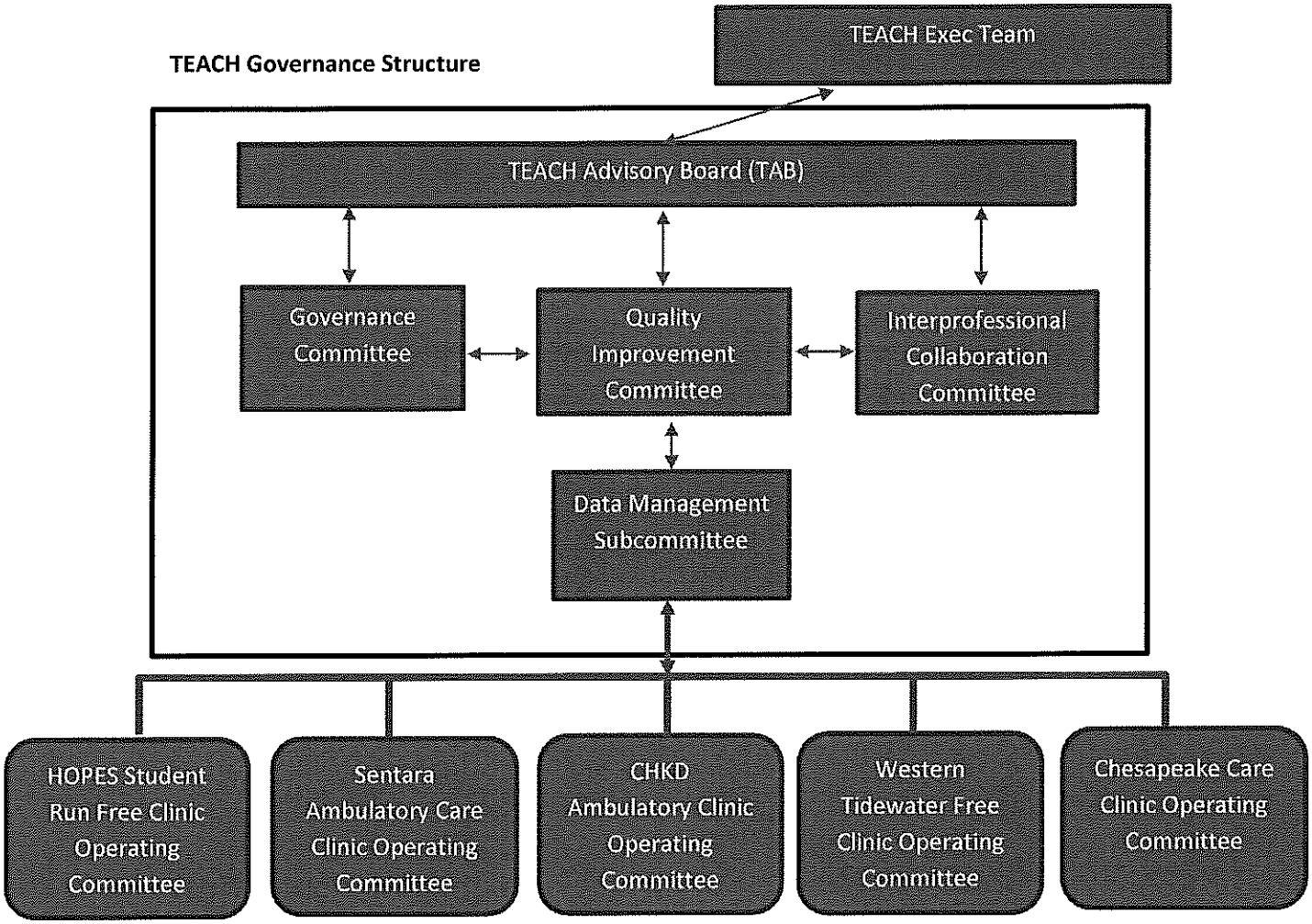
Updated: 10/3/2018

TEACH Governance Structure

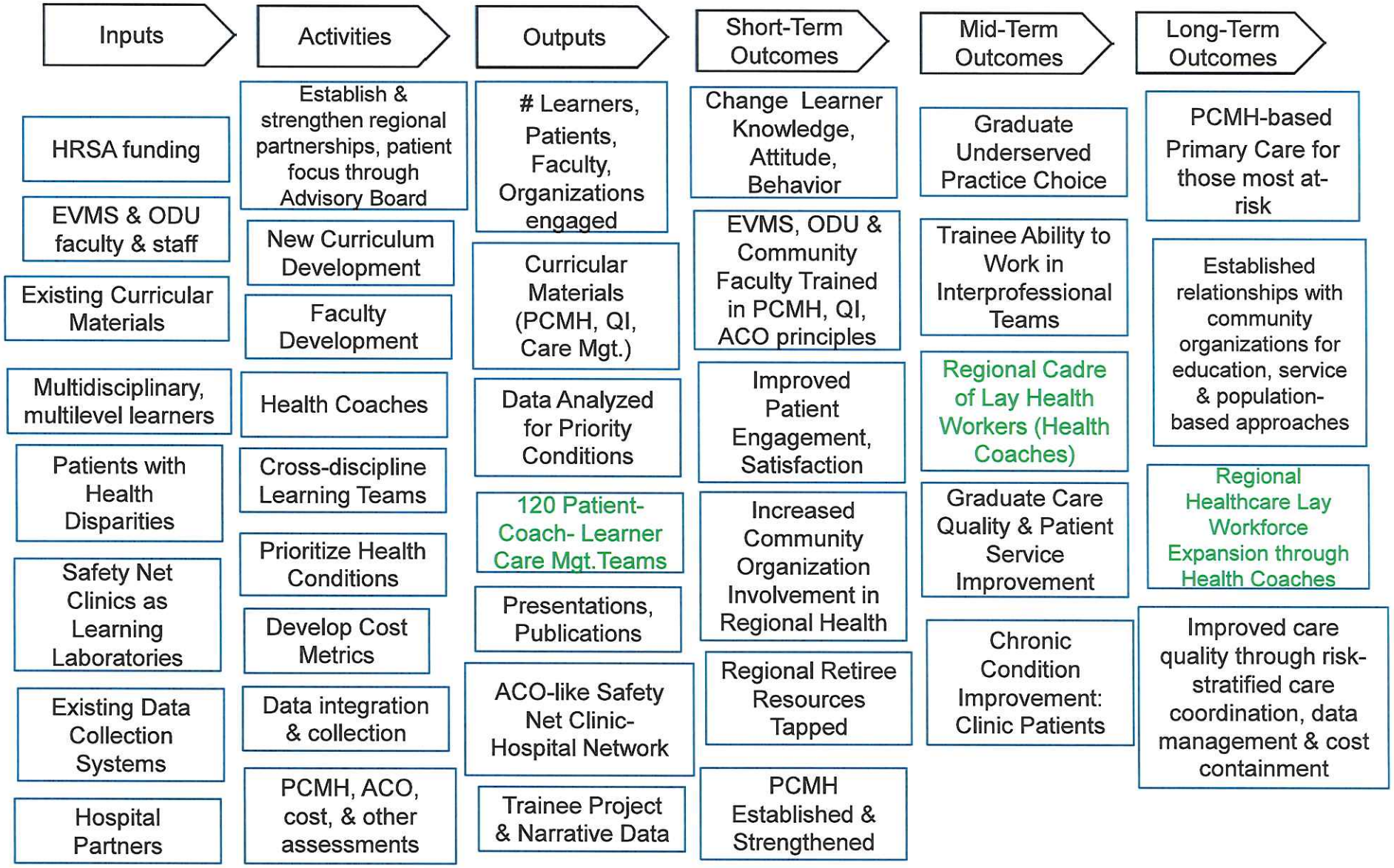


TEACH Advisory Board Membership

- **Membership: 26 Voting Members (range 24-34)**
- **Seven Classes of Voting Members**
  - Executive Leadership (3)
  - 1 Physician/Faculty from WTFC, ACC, CCC, CHKD, and HOPES (5)
  - 1 Resident from Primary Care Residencies(3)
  - 6 Students from HOPES- 4 MD students from each academic year, 1 PA student, and 1 MPH student (6)
  - 5 Health Professions-Counseling, Dental, PA, MPH, Nursing (5)
  - 1 Health Coach from each clinic (2)
  - 1 Community Partner each organization (7) –EVMS, Brock, WTFC, Sentara, ACC, Bon Secours, CCC

Logic Model: Transformative Education Advancing Community Health (TEACH)

Preparing Primary Care Providers to Practice in & Lead Transforming Health Care Systems



September 27, 2016, KP Ferguson draft

PEDIATRIC MEASURES TO TRACK FOR GENERAL ACADEMIC PEDIATRICS (GAP) CLINIC, CHILDREN'S MEDICAL GROUP

MEASURE	SQCN/OPTIMA	Metrics (A)	Total Population (B)	CALCULATION
HPV vaccine[A]		# 13 years old who have been patients at least 12 months with ≥ 2 shots	Total # 13 years old who have been patients at least 12 months	A/B x 100 = % received series
HPV vaccine		# 13-18 years old who have been patients at least 12 months with ≥ 2 shots	Total # 13-18 years old who have been patients at least 12 months	A/B x 100 =% received series
Mental health screen[A]		PHQ9 for all age 11-18	Total age 11-18 seen in last 12 months	A/B x 100 = % screened
STI screen[A]		GC & Chlamydia testing for all age 16-18		# tested/ total age 16-18 seen in last 12 months
Well visit 12-18[B]	X	previous 12 months		A/B x 100 = % well visit prior 12 months
tdaP/ Menactra by 13[B]	X	# ≤13 years old who have had vaccine and seen in last 12 months	Total 13-18 seen in last 12 months	A/B x 100 = % received vaccine by age 13
Asthma follow-up[B]	X	phone 7 days	Total with new asthma diagnosis or exacerbation in last 12 months	A/B x 100 = % followed up by phone
Asthma follow-up[B]	X	visit 30 days	Total with new asthma diagnosis or exacerbation in last 12 months	A/B x 100 = % followed up with office visit
ADHD med follow-up[B]	X	3 month follow-up, ages 11-18 diagnosed with ADHD seen in last 12 months	All age 11-18 diagnosed with ADHD seen in last 12 moths	# with follow-up/ total with ADHD diagnosis seen in last 12 months
ADHD generic meds[B]	X	Generic ADHD meds prescribed for ages 11-18	All ADHD meds prescribed for ages 11-18	A?B x 100 = % ADHD generics prescribed

[A] Suggested by Dr. John Harrington, Medical Director GAP Clinic

[B] Identified by Children's Medical Group; information provided by Dr. Doug Mitchell, Medical Director CMG.

Draft 9/27/2016, KP Ferguson

QI Committee Recommendations for Health Status/ Guideline Adherence/ Utilization Measures

Measure	Metrics **(A)**	Total Population **(B)**	Calculation	Committee Recommendation	Notes
CONDITION: DIABETES					
Hemoglobin A1C	Poorly controlled patients: A1C ≥ 9.0	Age 18-75 with diabetes diagnosis seen in past 12 months	A / B x 100 = % of diabetic patients with poorly controlled A1C	Implement Year 2	
Eye Exam	Exam in last 12 months OR normal exam in prior year	Age 18-75 with diabetes diagnosis seen in past 12 months	A / B x 100 = % of diabetic patients meeting recommended screening guidelines	Implement Year 2	
Foot Exam	Smart phrase (EPIC): Those with diabetes who have had foot exam in last 12 months. Foot inspection template to be developed by 12/2016.	Age 18-75 with diabetes diagnosis seen in past 12 months	A/B x 100 = % meeting foot exam PQRS quality measure.		Sentara ACC residents developing (QI project) foot inspection template
Nephrology	Those having had urine micro OR ACE/ARB OR CKD in past 12 months	Age 18-75 with diabetes diagnosis seen in past 12 months	A/B x 100 = % of diabetic patients meeting recommended screening guidelines	Implement Year 2	
CONDITION:HYPERTENSION					
Blood pressure	Last BP taken age 18-59: <140/90 age 60-85: <150/90	Seen in last 12 months with hypertension diagnosis for > 6 months	A/B x 100 = % of hypertension patients with well controlled blood pressure	Implement Year 2	
WELLNESS					
Mammography	Mammogram in past 2 years	Females age 50-74,11 mos. seen in last 12 months	A/B x 100 = % of women meeting recommended screening guidelines	Implement Year 2	Add exclusions.
Colon Cancer Screening	FIT test in past year **OR** colonoscopy in last 10 years **OR** flexible sigmoidoscopy in last 5 years	Age 50-75 seen in last 12 months	A/B x 100 = % of patients meeting recommended colon cancer screening guidelines	Implement Year 2	

Influenza vaccine	2 flu shots in past 2 flu seasons. May include patient report for past flu season.	Patients ≥ 18 seen in past 12 months	A/B x 100 = % of patients receiving recommended flu vaccine	Implement Year 2	
Pneumonia vaccine	Patients EVER having received a vaccine	All patients seen in last 12 months who are ≥ 65 OR ≥ age 2 with asthma or COPD OR ≥ age 19 or older with asthma	A/B x 100 = % of patients receiving recommended pneumonia vaccine	Implement Year 2	
Smoking status	Asked about smoking AND non-smoker OR smoker receiving counseling in past 2 years	Patients any age seen in past 12 months	A: # non-smokers + smokers receiving counseling. A/B x 100 = % of patients screened & given appropriate cessation materials	Implement Year 2	Counseling may include talking with patients, giving educational information, nicotine replacement
Depression	PHQ2/9-screened in past 12 months AND if + provided counseling annually	Patients ≥ 18 seen in past 12 months	A: # screened negative + # screened positive & provided counseling A/B x 100 = % of patients receiving depression screening & counseling according to guidelines	Implement Year 2	
Alcohol/ substance abuse	SBIRT screened in past 12 months AND if positive counseling OR referral	Patients 18-64 seen in past 12 months	A: # screened negative + # screened positive AND provided counseling A/B x 100 = % of patients receiving alcohol/ substance abuse screening and counseling according to guidelines	Implement Year 2	
Oral health screening	2 item screen 1. Have you seen an oral health care provider in past 12 months? 2. Are you having problems with	1., 2. Total patients seen in last 12 months.	1. A/B x 100 = % who have received care. 2. A/B x 100 = % reporting oral problems 3. % of those reporting problems who received care	Implement Year 2	Measures, screening methods &

	your mouth or swallowing?				
UTILIZATION OF HEALTH CARE SERVICES					
Emergency Dept	Admissions/ 1,000/ year from retrospective query of admissions	Patient list provided by clinic to Sentara each year	1. # patients in ED/ total patients in clinic 2. # admissions/ patient compared with total # admissions/ patient in clinic 3. Similar calculation, but specific to condition and diagnosis code	Implement Year 2	Sentara will need to provide PHI & diagnosis codes
Inpatient	Admissions/ 1,000/ year	Patient list provided by clinic to Sentara each year	Same as ED above.	Implement Year 2	Sentara will need to provide PHI & diagnosis codes
TRANSITIONS OF CARE					
ED or Inpatient	Patients receiving phone call within 48 hours OR seen in clinic within 1 week of discharge	Total clinic patients admitted to ED or Inpatient	A/B = % patients with appropriate follow-up after hospital	Implement Year 2	Sentara will need to provide timely PHI & diagnosis codes for follow-up
PATIENT EXPERIENCE					
Patient Experience	CAHPS Survey annually-patients sampled in waiting or exam room at random during all times clinic is open	Goal: responses from ?% of all patients (to be determined).	Comparison of CAHPS results with baseline year (2016).	Baseline data collected Year 1; repeat annually	Students conduct surveys in all clinics. 363 surveys to date.

BYLAWS OF THE

TRANSFORMATIVE EDUCATION ADVANCING COMMUNITY HEALTH

ADVISORY BOARD

Adopted May 2, 2016

Amended July 10, 2017

Amended August 13, 2018

Amended November 19, 2018

ARTICLE I
NAME, LOCATION, & MISSION

SECTION 1: Name & Location - The name of this organization shall be the Transformative Education Advancing Community Health (TEACH) Advisory Board (known as TAB). The principle address of the Association shall be the TEACH administration offices.

SECTION 2: Vision and Mission - Vision: To provide Well Trained Healthcare Providers that Help Create Healthy Communities

Mission: To provide a superior interprofessional educational experience for learners while providing high quality value based care for our communities' underserved populations that improve health and reduce disparities

SECTION 3: Term – The term of TAB shall be for the Life of the Health Resource Services Administration Grant

ARTICLE II
AUTHORITY OF THE TEACH ADVISORY BOARD (TAB)

SECTION 1: Under EVMS Authority - The TAB shall operate under the authority of EVMS through the Department of Family and Community Medicine. *SECTION 2*: *Incorporation and Tax Status* - The TAB shall NOT seek or be granted separate incorporation status or separate tax-exempt status.

ARTICLE III
TEACH ADVISORY BOARD MEMBERSHIP

SECTION 1: Membership – Shall be offered to Physician/Provider from Safety Net Clinics, Health Professions Provider/Faculty, Primary Care MD Residents, EVMS Students, Community Partner Administration and Community Health Coaches who are participating in the provision of education and patient care at partner safety net clinics.

SECTION 2: Classes of Membership –There shall be seven classes of membership.

A. Executive Leadership: the grant's principal investigator, evaluator, and program manager
B. Physician/Prescribing Provider: 1 member from each safety net clinic
C. Health Professions/Faculty: one member from each health professions program participating in TEACH program
D. EVMS Student: six members; one from each MD class and one from PA program serving at HOPES student run free clinic; one from the MPH program.
    - MD students will be chosen by HOPES leadership and MD advisor. M1 student will be chosen by January 1 of their M1 academic year.
    - EVMS students representatives shall be paired from each class into single vote
E. EVMS MD Residents: one from Family Medicine residency, one from General Internal Medicine Residency and one from General Pediatrics Residency
F. Community Health Coaches: one from each of the participating safety net clinics if available.

G. Community Partner Administration: one from each of the partner's administration, currently this includes CHKD, Western Tidewater Free Clinic, EVMS, the Brock Institute, EVMS Office of Diversity & Inclusion, EVMS/ODU Masters in Public Health, Bon Secours, Chesapeake Care Clinic, and Sentara/Optima.

SECTION 3: Dues & Compensation - Dues will not be collected from members. Compensation for Board Duties will not be provided outside of expenses for travel and materials provided to support TEACH grant goals and objectives.

SECTION 4: Term of Offices

A. Shall last one year starting academic year beginning of July through end June.

B. New Appointments and Reappointments will be upon recommendation of Governance Committee to TAB at meeting prior to or electronically before end of July of each year.

SECTION 5: Resignation, Removal and Vacancies –

A. Any Board member may resign their position as such prior to expiration of term by delivery of written notice to the Board Chair. Resignation shall be effective upon delivery or upon later date as set forth in the written notice, without need for acceptance by other members of the board.

B. Any Board member may be removed upon recommendation of Governance Committee to Full Board and vote by majority of Board members.

C. Filling of TAB membership vacancies shall be recommended to full TAB by majority vote of the Governance Committee on recommendation by the TEACH Executive Team or TAB Chair for review. New members can be brought on with majority vote of TAB.

SECTION 6: Board Chair and Vice Chair – The Board Chair and Vice Chair shall be the Primary Investigator and the Co-PI of the HRSA TEACH grant.

SECTION 7: Meetings, Quorum, Vote, and Attendance of Board Members

A. Board Meetings will be regularly held at least once per quarter.

B. Special meetings may be called by TEACH Exec Team and/or TAB Board Chair with notice by approved email or phone call to all TAB members.

C. Quorum shall consist of at least half of current membership.

D. Each member shall have one vote.

E. Tie votes shall be decided by majority of committee chairs.

F. Each Board Member shall attend at least one of quarterly scheduled meetings per academic year.

ARTICLE IV
BOARD COMMITTEES

SECTION 1: Committee Formation and Membership

A. Membership roster will be recommended to TAB for review by Executive Leadership;

B. TAB will make additional recommendation on committee membership;

C. Committee membership shall include diverse variety of classes of board members with at least one member from Health Professions; one member from Community partners Administration and Health Coaches as available.

D. Each committee will elect a chair from within chosen committee membership;

E. Chair will establish meeting schedule. Meetings can be done electronically;

F. Committee Quorum will be at least half of committee membership;

G. Votes for Committee actions and recommendation will require majority of members present at meeting

H. In the absence of the Committee Chair, the TAB Chair may call for a committee meeting for urgent TAB needs

I. Non-standing committee and subcommittee chairs with Governance Committee will review goals and objectives of each committee and subcommittee for need and relevance to TAB goals and objectives.

J. Recommendation for dissolution of committees or subcommittees will be made by Governance Committee for vote by TAB.

SECTION 2: Standing Committee of the Board – The Governance Committee shall be the only standing committee of the Board. The Governance Committee shall be responsible for:

A. Reviewing qualifications of potential TAB membership;
B. Making recommendations to TAB board;
C. Monitoring effectiveness of other committees;
D. Reviewing Executive Team recommendations for other committee membership and chairs;
E. Review and monitoring of compliance with Governance processes and bylaws;
F. The Governance committee shall consist of Chair of Board, Vice Chair of Board and at least 5 other committee members;
G. Committee members shall include diverse variety of classes of board members with at least one member being from Health professions; and one member from Community partner;
H. Review proposed bylaws changes and make recommendations to full TAB.

SECTION 3: Initial Non-Standing Board Committees

A. Non-standing committees will be Quality Improvement and Interprofessional Collaboration

B. Under the Quality Improvement Committee, the Data Management SubCommittee will provide oversight for data management for clinical and educational measures.

C. Committee Chairs will be recommended by TEACH Exec Committee to TAB for majority vote approval annually.

D. TAB may establish New Committees having purposes, responsibilities, and powers that TAB deems appropriate from time to time and may be created through 2/3 vote of TAB

E. Subcommittees and Ad Hoc subcommittees can be created by committee membership majority.

F. Committee and Subcommittee meetings must have at least half of members present for recommendations to full board.

SECTION 4: TEACH Executive Team - Shall consist of TEACH Health Resources Administration grant supported faculty and administrative personnel of at least 5% Full Time Equivalent. The Executive Teams shall be responsible for:

A. Review and manage TEACH Grant Goals and Objectives;

B. provide support, advise and resources to further TEACH grant goals and objectives for TAB;

C. provide support, advise and resources to further TEACH grant goals and objectives for community partners and EVMS

ARTICLE V
AMENDMENTS TO BYLAWS

In order for these By-Laws to be repealed, revised, or amended, in whole or in part, at least half of the Board must be present to constitute a quorum. For any Bylaws changes, a minimum two-thirds vote of those Board members present is required, provided that the amendment has been submitted to the Board members in writing via regular or electronic mail at least ten (10) days prior to the meeting.