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| **SESSION** | | **LEARNING OBJECTIVES** | | **NOTES/DISCUSSION** |
| 1 | Team vision | 1. Articulate the team’s vision of quality care for veterans – including delivery of evidence-based psychotherapies and pharmacotherapies (EBPs) – with quality work-life for team members. 2. Reflect on how the individual’s goals for professional service and work life align with the team’s vision. 3. Summarize how Modeling to Learn (MTL) will empower the team to make ongoing improvements in team quality of care and team quality of work-life | | JB: These versions for Sessions 1 & 2 might still need help from a clinician’s way of thinking. Session 3 may need help from a What you envision for the session point of view. Please edit ad lib! |
| 2 | Team data | 1. Describe the individual and aggregated patient data made accessible to the team through the MTL data tool. 2. Reflect on the implications for quality care or quality work-life of an observed trend in team data. 3. Use the MTL data tool to identify individual patients who make up observed team-level trends. | |  |
| 3 | Team need and plan | 1. Identify a trend in service delivery or outcomes that the team would like to improve. 2. Describe why this trend is important within the context of the team’s vision for quality care for veterans and quality work-life for team members. 3. Outline the team’s plan to focus on the identified need using MTL. | | JB: I had “(e.g., new patient wait times; provider overwork; etc.)” in #1 but I’d like to leave that out. OK? I doubt the terms “service delivery” and “outcomes” are in everyday use. What’s better? Is #3 appropriate; can Lindsey/Stacey improve on that? |
| **MODELING SESSIONS** | | LO-1. Explain (describe, outline, recount) how…  LO-2. Test hypotheses for (experiment with) changing…  LO-3. Evaluate (interpret, extrapolate, plan) changes to … | affect(s)…  to improve…  against improvements in… |  |
| CC | Return-to-clinic interval | The average return-to-clinic interval | New patient wait times | JB: OK to collapse “return-to-clinic time (i.e., interval)” and just say “return-to-clinic interval”? |
| CC | Appointments set aside for new patients | New patient appointment set-asides and booking goals | Ability to maintain desired return-to-clinic interval | JB: “Set-asides”? “Carve-outs”? What term here? Also, “booking goals”? |
| CC | Overbooking and missed appointments | Overbooking and missed appointments | New patient wait times and ability to maintain desired return-to-clinic interval |  |
| CC | Meeting demand without adding staff or compromising quality | Combining decisions within the team’s control | Ability to meet real-world demand without adding staff or compromising quality | JB: By the final, putting it all together, session of each model, can we say they should be able to “Formulate team principles for balancing [various decisions] in order to optimize EBP reach with current staff”; or “…balancing [decisions] to optimize their delivery of [service] to veterans”? |
| CC | Wait times and referrals | New patient wait times | Referrals to the team | JB: I think we should include this one – not call it a “bonus” session but list it above the All-decisions experiment. Facilitators can work with teams to determine how many sessions to devote to each model and which ones to use. |
| MM | Scheduling grids: Allocating appointments across services | The balance of clinic hours allocated to each service provided by the team | New patient wait times and ability to maintain desired return-to-clinic intervals for each diagnostic cohort |  |
| MM | Return-to-clinic interval | The average return-to-clinic interval for each diagnostic cohort | New patient wait times for each diagnostic cohort |  |
| MM | Appointments set aside for new patients | New patient appointment set-asides and booking goals for each diagnostic cohort | Ability to maintain desired return-to-clinic intervals for each diagnostic cohort |  |
| MM | Meeting demand without adding staff or compromising quality | Combining decisions within the team’s control | Ability to meet real-world demand without adding staff or compromising quality |  |
| MM | Overbooking and missed appointments | Overbooking and missed appointments for each diagnostic cohort | New patient wait times and ability to maintain desired return-to-clinic intervals for each diagnostic cohort |  |
| PSY | Patient engagement patterns | Patients’ visit completion patterns within their first three months in care | New patients started each week and patients completing an EBP |  |
| PSY | Overall appointments and appointments set aside for new patients | New patient carve-outs and the number of clinical hours assigned to psychotherapy | New patients started each week and patients completing an EBP | JB: TR had Topic: “Supply and New Patient Appointments” but wanted to ask if “supply” is a good term for the number of patient-facing hours offered each week? Does this edit help? |
| PSY | Step up/step down and return-to-clinic decisions | Step up/step down and return to clinic decisions (e.g., % completers who graduate, % new patients who return later) | New patients started each week and patients completing an EBP | JB: I’d rather not have “e.g.”s in the LOs; but I’m not clear enough about the terms here to propose an edit. Which of these are used: Step up/down? % completers who graduate? Is it clear that % new patients who return later doesn’t mean immediately, but after a hiatus? Can we use “EBP” in the LOs? |
| PSY | Meeting current demand without adding staff or compromising quality | Combining decisions within the team’s control | Ability to provide timely and complete EBP to all patients without adding staff | JB: Should last column say “…to MORE patients”? |
| AGG | Scheduling grids: Allocating appointments across services | Changing the clinical hours allotted to each service the team provides | New patient wait times and ability to maintain quality (i.e., desired return-to-clinic time) in each service | JB: Above I have replaced “quality” with the topic of the parenthetical i.e. Is it OK to do that, or are there more measures of quality they will look at in these experiments? |
| AGG | Improvements by service vs. improvements across the team overall | Individual service characteristics (e.g., target return to clinic intervals, patients per appointment, appointment length, average patient engagement time, etc.) | Where the improvement efforts will have the most impact on the ability to start new patients and maintain quality (i.e., desired rtc time) in each service | JB: I replaced the Topic, which was “Impact/Effort”. Is this an appropriate edit? |
| AGG | Overtime, quality, and burnout | Using overtime to see more patients | Missed appointments, ability to maintain desired return-to-clinic intervals, burnout, and patient satisfaction | JB: Is it “overtime” or “overbooking”? |
| AGG | Meeting current demand without adding staff or compromising quality | Combining decisions within the team’s control | Ability to meet real-world demand without adding staff or compromising quality |  |
| AGG | Referrals | New patient wait times and return-to-clinic intervals | Referrals to the team and referrals across services within the team |  |