Planning Retreat- Change Ideas Worksheet

Categories (based on the Chronic Care Model)	Definition	Example	Example of change ideas being tested by BOOST teams	New Change Ideas
Self-Management Support	Emphasis on the importance of the central role that patients have in managing their own care	Educational resources, skills training and psychosocial support provided to patients to assist them in managing their care	* Patients information session and providing incentives. *Develop a missed dose plan with the client during initial visits. *Enrolling family support, when available implement peer-lead groups.	
Decision Support	Integration of Evidence based guidelines into daily clinical practice	*Wide dissemination of practice guidelines *Education and specialist support provided to healthcare team	* Standardizing nursing assessments. * Develop a missed dose sheet and bring to daily huddles to discuss follow up plans.	
Delivery System Design	Focus on the teamwork and expanded scope of practice for team members to support chronic care	*Planned visits and sustained follow-up *Clearly define roles of healthcare team	* Weekly outreach through visits to clients by NP and social worker. * Developing a protocol to refer clients “lost to care” to the Overdose outreach team *Have front-desk staff (MOA) to recall patients or send appointment reminders.	

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Clinical Information System	Developing information systems based on patient populations to provide relevant client data	*Surveillance system that provides alerts, recall and follow-up information. *Identification of relevant patient subgroups requiring proactive care	* The creation of an electronic flow care sheet (such as the OUD form on Profile EMR). * EMR Intervention to be entered for OUD patients who don't have an active Rx to flag care providers in having conversations related to decrease drug use with the goals of increase OAT uptake.	
Community Resources and Policies	Developing partnerships with community organizations that support and meet patients' needs	*Identify effective programs and encourage appropriate participation *Referral to relevant community-based services	* Partnership and with the pharmacy and develop a process to receive missed dose notifications. * Connect with non-Profit organization and improve collaboration/information sharing to engage more client population in OAT clinic. * Coordinate with stabilization clinics. * Connect with mental health teams to address comorbidities	