NATIONAL ASSOCIATION OF Community Health Centers®

VALUE TRANSFORMATION FRAMEWORK

Action Guide

HEALTH CENTER

CARE DELIVERY | INFRASTRUCTURE | **PEOPLE**

CARE TEAMS

WHY

Focus on Care Teams?

Much has been written about the success of the "care team model" in delivering high-quality, low-cost, impactful health care. Developing an effective team-based model of care is at the heart of health center efforts to deliver on the Quintuple Aim: improved health outcomes, improved staff and provider experiences, lower costs, and improved equity.

Transitioning to value-based care requires a significant shift in the way care delivery, infrastructure, and people are engaged and deployed in the health care system. In the volume-based system, a primary care physician would need to spend an estimated 21.7 hours per day to provide all recommended acute, chronic, and preventive care to a panel of 2500 patients[1]. It is, therefore, not surprising that physicians face burnout and adults in the U.S. receive only 55% of recommended services[2]. The volume-driven model of care coupled with the complexity of preventive, acute, and chronic care needs in the context of a primary care visit, limits the quality of service delivered[3]. A reinvention of the care team model—with more responsibility given to supportive members of the care team—has proven to optimize the experience and outcomes of primary care for patients, providers, and staff[4]. In addition to improving service for chronic disease and preventive care, re-organizing care team roles can help address the widely-documented problem of primary care physician shortages[5,6,7].

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The Value Transformation Framework addresses how health centers can utilize groups of staff with different skills to work together to deliver and improve care, offering a wider range of services more efficiently than with a provider alone. This Action Guide offers proven strategies to develop effective health center care teams.

Ultimately, patient care is a team sport. All members of the health center team are accountable for the delivery of high quality care to patients. Patient engagement, also crucial to care, is addressed in the Patient Engagement Action Guide.

While many health centers report using a team-based approach to care, these systems may not be functioning optimally to achieve desired outcomes. This Action Guide offers steps to more effectively distribute, or share, responsibility and accountability across health center care teams.

"Sharing the care involves both a paradigm shift and a concrete strategy for increasing capacity. The paradigm (culture) shift transforms the practice from an "I" to a "we" mindset. Unlike the lone-doctor-with-helpers model, in which the physician assumes all responsibility, makes all decisions, and delegates tasks to team members [but cannot increase capacity], the "we" paradigm uses a team comprising clinicians and non-clinicians to provide care to a patient panel, with a reallocation of responsibilities, not only tasks, so that all team members contribute meaningfully to the health of their patient panel."[8]

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WHAT

Can Health Centers Do Differently When It Comes to Care Teams?

Team structure can vary by organization, and even within a health center. Care teams are developed based on the needs of the patient population and the availability of personnel, services, and other resources. Care teams are most commonly led by a provider and typically include medical assistant(s) and nursing staff. Some teams include behavioral health professionals, pharmacists, or administrative staff. Health coaches, patient navigators, community health workers, and partner organizations also play a critical role in delivering care as part of a team. Patients are central players in their own care, and should be recognized for their important role as part of the care team.

While 9 out of 10 health centers report using a care team, these teams often do not deliver desired outcomes. Formalization and mechanisms to ensure accountability to the model can help[9].

- **Formalization** refers to the development of procedures, clear job descriptions, training, and other mechanisms to more effectively structure the actions and activities of individuals and teams.
- **Accountability** refers to individuals and teams accepting responsibility for the actions and activities formally assigned to them. This requires a system to measure and report on individual and team performance, linked with systems for skill development and training, and tied to overall performance goals.

Team formalization (via job descriptions) meaningfully correlates with how a health center team is structured and implemented [9]. Health centers with greater degrees of formalization are more likely to have more teams, a greater diversity of team members, and expanded job roles. Most of the health centers with high degrees of formalization report having received [patient-centered medical home] PCMH recognition from a recognized entity[9].

HOW

To Develop Care Teams Using Formalization and Accountability

Given the critical role that care teams play in health center performance, it is important to optimize their role and function. A prerequisite to delivering quality care through teams is empanelment. A clear, up-to-date panel is critical for this type of shared responsibility[10]. Another key assumption in this Action Guide is the use of huddles that incorporate mechanisms to ensure psychological safety (see the Leadership Action Guide).

Care teams play a central and pivotal role in transforming to value-based care and achieving the Quintuple Aim. This Action Guide provides steps health center systems can take to maximize the role of care teams.

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CARE TEAM ACTION STEPS:

The below action steps assume a health center is practicing empanelment and team huddles with mechanisms to ensure psychological safety (see the Leadership Action Guide).

STEP 1 **Define Care Standards:** Identify a minimum set of patient services (standards), by age and/or risk group.

STEP 2 **Distribute Tasks to Meet Standards and Document Workflow:** Reconsider who within the care team completes tasks for each standard. 'Share the care': assign an appropriate staff position to each task defined. Map workflow.

STEP 3 **Update Job Descriptions:** Summarize tasks for each role within the health center. Include this information in updated job descriptions (formalization).

STEP 4 **Train Staff:** Train staff in job-specific tasks based on their redefined roles within care teams, including quality improvement.

STEP 5 **Montior Task Performance in Dashboards:** Provide dashboard access to each staff member and encourage regular performance reviews (accountability).

STEP 6 **Hardwire Accountability into Personnel Systems and Performance Reviews:** Create role-specific dashboards that monitor performance on job tasks. Create team dashboards that monitor team performance on key clinical, quality, and cost metrics. Document individual and team accountability via dashboards and performance reviews.

STEP 7 **Educate Patients on Redesigned Care Team:** Create patient education tool(s) that orient patients to new roles of care team members, including their own role with self-care.

STEP 1

Define Care Standards. Delivering on the Quintuple Aim requires attention to clinical measures, social risk, and other factors impacting health outcomes. For instance, has the health center pre determined a set of care and services to be delivered to a 50-year old woman or 30-year old male who comes in for care? Will care be measured against U.S. Preventive Services Task Force Grade A recommendations? Uniform Data Systems (UDS) measures? Healthcare Effectiveness Data and Information Set (HEDIS)? High levels of clinical performance on measures requires defining care and standardizing systems to consistently deliver agreed upon standards.

Using the 50-year old female example, a health center may establish that care to individuals in this age group includes: blood pressure, weight, body mass index, glucose screening, breast, cervical and colorectal cancer screening, depression screening, tobacco screening, immunizations, and sexual risk screening (which could trigger additional testing for HIV, chlamydia, gonorrhea, syphilis, or other diseases or infections). Other pre determined screenings or services could include a review of medications or social risk assessment. Clinical staff and leadership should establish the minimum set list of clinical, social, and other services by age group and/or risk stratification, recognizing that some patients may need additional or different care or services based upon individual risk, conditions, social factors, or other. This defined list can then serve as the basis for re-distributing care team tasks.

Action item: Identify the minimum set of care and services (care standards) to be provided to patients by age and/or risk group (e.g., 0-2 years, 2-17 years, males/females 18-39 years, males/females 40-49 years, males/females 50-64 years; and 65+ years).

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STEP 2

Distribute Tasks to Meet Standards and Document Workflow. Once a health center has agreed to a minimum set of care standards for each target group, the tasks necessary to accomplish these standards can be assigned to roles across the health center. In much the same way that airline pilots use pre-flight checklists, health care organizations can delineate each step to accomplish a clinical or service task and then delegate each task to a member of the team.

Health centers should avoid automatically assigning tasks to the staff person who has traditionally performed the work. Take the opportunity to move tasks to other staff, where legal and possible. The goal is to enhance the role of each care team member, target provider roles to essential tasks, and include other key members of the staff, including support and administrative staff. The goal is to maximize the professional capacity of non-provider staff, while freeing the provider to focus on diagnosis and treatment. Although a provider's recommendation is the most powerful influencer of a patient's decision to get screened for cancer,[11,12] for example, the task of discussing screening tests and test processes can effectively be completed by support staff using standing orders[11,12,13]. The provider's role centers on the clinical recommendation and answering questions not otherwise addressed by other members of the team.

This simple, yet profoundly impactful, step of assigning accountability for the full set of tasks necessary to complete a set of care standards is not typically a part of health care operations. Health centers can create workflows to document and assign individual tasks, while acknowledging overall team accountability. Workflow maps are a visual representation of the actions, steps, or tasks needed to achieve a certain result. For a health center, registering patients for appointments, rooming patients, refilling medication, and ordering screening tests are all processes that happen daily. A workflow map breaks down each part of the process and helps everyone understand who is doing what, allowing for better coordination and less duplication. While delegation of tasks provides structure and accountability, all members of the team should generally have the freedom and authority to provide care and services as needed and appropriate, within their scope of practice.

Action items: Create workflows that document agreed upon processes and staff task assignments. Assign appropriate staff positions to each task needed to complete a defined set of standards.

Adapt the "*Team-Based Planning Worksheet*" developed by the Safety Net Medical Home. Utilize the capacity and licensure of team members to expand responsibilities beyond the primary provider. Consider applying care team tools available through the American Medical Association's STEPS*forward* initiative.

After having agreed to the core set of care standards, assigning staff to the tasks that accomplish this work, and defining the provider/care team responsible for each panel of patients (empanelment), workflow maps that define and standardize processes can be created. Consider the Agency for Healthcare Research and Quality workflow mapping tips.

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STEP 3

Update Job Descriptions. It is not enough to determine clinical and care standards, identify the tasks needed to accomplish the standards, and assign those tasks to members of the care team. These responsibilities then need to be hardwired into the expectations of staff. Staff job descriptions need to be updated to include the agreed upon set of tasks for each role. Job descriptions should also reference team accountability as well as individual tasks and patient engagement. Accompanying work processes, such as standing orders or protocols, should also be updated, as needed, following changes to job descriptions.

Action item: Update job descriptions for all members of the care team to fully reflect the set of skills and tasks required for each position. Include patient engagement as a responsibility across all staff.

STEP 4

Train Staff. Health centers improve performance by training staff in required skills and offering ongoing support and advancement. Appropriate training begins in new hire orientation and continues through the professional development of each staff member.

Action item: Train staff in job skills relevant to job descriptions, including quality improvement. Incorporate necessary training into new hire orientations and offer ongoing professional development to retain staff and support performance.

STEP 5

Monitor Task Performance in Dashboards. 'What gets measured gets improved'. Applying this concept to the newly defined tasks for each job role requires the step of listing tasks for each role into a spreadsheet or dashboard so performance can be measured, monitored, and shared. For instance, a medical assistant dashboard may track performance in completing tasks connected to: vitals, colorectal cancer screening, and depression screening. The provider dashboard may track the percent of patients with uncontrolled diabetes (per UDS guidelines) and percent of hypertensive patients who have blood pressure control (UDS measurement of <140/90). A team dashboard could also monitor performance on a series of measures that relate to the Quintuple Aim for a panel of patients.

Once the dashboard is used to measure and track progress, it will be important to regularly (e.g., monthly) share dashboard data on individual and team performance. Individual level data can be shared in care team meetings as well as meetings by job role (e.g., provider or nursing meetings). Individuals and teams with lower levels of performance should be offered appropriate training and support. Systems of formalization and accountability must be instituted within a supportive structure (see the Leadership Action Guide for information on instituting structure with 'psychological safety').

Action Item: Summarize job tasks for each role into a performance dashboard.

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STEP 6 **Hardwire Accountability into Personnel Systems and Performance Reviews.** Health centers should monitor staff performance (using individual and team dashboards) on an ongoing basis, and incorporate overall progress in formal annual performance reviews.

Action item: Update the organization's employee performance review process to measure against new job expectations and overall organizational goals.

STEP 7 **Educate Patients on Redesigned Care Team.** Providers' job responsibilities should include introducing patients to the broad role of the care team and reinforcing its importance. This includes addressing the fact that care team members, including the MA and RN, are highly skilled and trained professionals that can discuss screenings, perform tests, offer education, and provide other services. Tools such as fact sheets, letters, care team business cards, and other materials, may be used to help communicate the care team's role in patient care. Consider ways to visually distinguish and personalize care teams for patients (e.g., colors or graphics).

Action item: Create patient education tools that orient patients to updated care team member roles. Create or access patient education resources to help patients understand their own role on the care team, and improve their skills with self-care and making treatment decisions (see also Patient Engagement Action Guide).

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