Elevate *Connect Session*

Care Teams

April 28, 2022

THE NACHC MISSION

America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.

Elevate Journey...
Your Way

📅 *2nd Tuesday, monthly, 1-2 pm*

📅 *4th Thursday, monthly, 1-1:45 pm*

🕐 *Self-paced*

Elevate Learning Forum

Elevate Connect

Online Platform

Learning Forum:
- Microlearning
- Field examples
- Human-centered design
- Discussion

Elevate *Connect*:
- Gather with peers
- Share & Discuss
- Exchange tools

Online Platform:
- Library of microlearnings
- Repository of tools & resources

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ELEVATE 2022 JOURNEY

- Leadership
- Empanelment
- Population Health: Risk Stratification
- Payment
- **Care Teams** — Utilize groups of staff with different skills to work together to deliver and improve care, offering a wider range of services more efficiently than a provider alone.
- Care Management
- Evidence-Based Care
- Social Drivers of Health (SDOH)
- Improvement Strategy
- Workforce
- Health Information Technology
- Patients
- Partnerships
- Policy
- Cost
- Patient-Centered Medical Home

IMPROVED HEALTH OUTCOMES

IMPROVED PATIENT EXPERIENCE

EQUITY

IMPROVED STAFF EXPERIENCE

REDUCED COST

Microlearning (April 12th) link
Care Teams...Expanded Care Teams

What?

STEP 1 Define Care Standards

STEP 2 Distribute Tasks to Meet Standards and Document Workflow

STEP 3 Update Job Descriptions

Why?

STEP 4 Train Staff

STEP 5 Monitor Task Performance in Dashboards

How?

STEP 6 Hardwire Accountability into Personnel Systems and Performance Reviews

STEP 7 Educate Patients on Redesigned Care Team

NACHC Care Teams Action Guide

Step 2:
Distribute Tasks to Meet Care Standards

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.

Ensure staff members are tasked with work that enables them to perform at the top of their licensure.

Implement standing orders to empower support staff to order or provide labs, referrals, and other services.

Expanded Care Roles

Consider which tasks can be delegated to technology. For example, use systems to send out automated reminders and schedule services for care gaps rather than tasking a staff member to manually call each patient.

Determine which tasks can be completed remotely and which require staff to be at the health center in-person. Create policies and provide VPN access for staff to connect to the EHR and work from home on designated tasks.

Distribute Tasks

Consider using or creating a tool to aid in the process of distributing tasks.

Consider all options for how a task can be completed:

- Start by identifying staff role, then identify staff members by name

- Technology

- In-person vs remote

- Primary vs back-up

RESPONSIBILITY / TASK	ROLE - Current	ROLE - Future	WHEN IN VISIT CYCLE	Notes
Check-in patient				
Verify and update insurance information				
Verify and update demographic information (address, phone, etc)				
Verify and update PCP selection	RN	LPN		
Print summary lists (meds, dx, allergy); give to patient to review	MA	LPN		
Verify and update missing preventive / chronic care services	Provider	Front Office		
Track and follow up on lab & imaging results	LPN	LPN		
Notify patient of normal results	Front Office	Front Office		
Notify patient of abnormal results	Pharmacist	RN		
Track and follow up on completion of referral visits, tests & procedures				
Receive/review reports or other communications from facilities notifying practice of service provided to patients				
Obtain notes from facilities – inpatient or rehab, emergency department, urgent care centers				
Review appointment history and follow up as needed				
Perform and document lab tests performed in-office				
Collect and/or process specimens to send to external laboratory				
Conduct clinic services (ECG, pulse oximetry, hearing & vision testing)				

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New Tool!

In-person & telehealth appointment worksheets available! (care coordination and management coming soon)

- Which responsibilities/tasks need to be completed?

- Which role will be assigned to each task?

- Which technology/systems are utilized to complete the task?

- Can the task be done by staff remotely?

Patient is scheduled for in-person appointment

	Responsibility/Task	Role	When	Technology/systems utilized	Can be done by staff remotely	Notes
Visit Prep	Remind patient of upcoming appointment; confirm					
	Flag overdue or missing preventive/chronic care services					
	Flag overdue or missing immunizations					
	Flag oustanding labs and tests	MA	Before Visit	EHR	Yes	
	Flag open referrals		▼			
	Obtain records from other facilities (specialist, ED, hospital, etc.)					
	Assemble documenation for PCP/Care Team members to review					
	Additional?					
	Additional?					
Check in	Complete COVID screening questions with patient					
	Check in patient					
	Verify and update insurance/sliding fee scale information					
	Verify and update demographic information (address, phone, etc.)					
	Verify and update PCP assignment					
	Print summary lists (meds, diagnosis, allergy); provide to patient to review					
	Assess and document patient communication needs					
	Additional?					
	Additional?					
	Room patient					
	Take and document vital signs (height, weight, BP, etc.)					

Questions: to guide team reflection and innovations in team structure[1]

- **What work can our team offload?**
  - Work that can be delegated to other staff outside the team
  - Work that doesn't require a team and can be done by individuals

- **What form of a team are we?**
  - Acknowledge and/or address new team configurations: part-time, remote, transient, etc.

- **What are the right norms of our team?**
  - Ensure self-awareness and psychological safety

- **What key processes and tools will support the work our team does?**
  - Acknowledge where processes may need to be redesigned to account for changing requirements
  - Explore innovation and rapid-cycle improvement approaches

[1]Singer, S., Kerrissey, K. (2022). Leading Health Care Teams Beyond COVID-19: Marking the Moment and Shifting from Recuperation to Regeneration. New England Journal of Medicine Catalyst @ link.

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Discussion Questions

Over the past 2 years...

How have your care team roles and responsibilities changed?

Which roles have been reassigned to different tasks?

Have staff been cross trained into new roles?

Are there tasks that the care team is no longer doing?

Are there new tasks that the care team has taken on?

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Discussion Questions

Over the past 2 years…

How has your care teams' use of technology changed?

Are more patients connecting to care team members virtually (for example, via phone, telehealth, texting, etc.)?

Are care team members using new systems to make processes more efficient and/or accessible? (for example, texting platforms, kiosks, appointment scheduling systems, etc.)?

Are care team members working from home?

Discussion Questions

Over the past 2 years…

How has care team communication changed?

Are huddles used? Are they done the same way?

How does each care team member know who is responsible for completing which task?

How do care team members communicate throughout the day?

Coming Next

- ✓ Leadership
- ✓ Empanelment
- ✓ Population Health: Risk Stratification
- ✓ Payment
- ✓ Care Teams

Care Coordination & Care Management

Facilitate the delivery and coordination of care and manage high-risk and other subgroups of patients with more targeted services, when and how they need it.

- Evidence-Based Care
- Social Drivers of Health (SDOH)
- Improvement Strategy
- Workforce
- Health Information Technology
- Patients
- Partnerships
- Policy
- Cost
- Patient-Centered Medical Home

Care Management
Expanded Care Team Reimbursement Opportunities
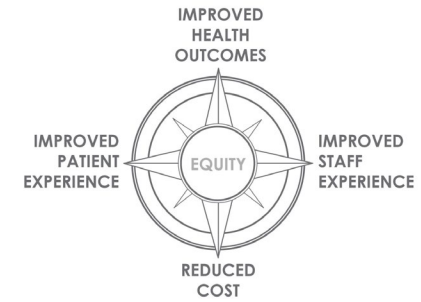
Care Management Services	Reimbursement*
Chronic Care Management (CCM)	$79.25
Principal Care Management (PCM)	$79.25
Transitional Care Management (TCM)	$209.02 (moderate) / $281.69 (high complexity) $97.24 (telehealth)
Psychiatric Collaborative Care Model (CoCM)	$151.23
General Behavioral Health Integration (BHI)	$79.25

*Above intended to provide a general picture of reimbursement potential using 2022 CMS reimbursement guidance. NACHC's Reimbursement Tips are in the process of being updated to reflect 2022 updates.

Elevate 2022 Participants:
QI Professional Development Opportunity

One year of free access to IHI's full catalog of online

courses within the Open School including:

- More than 35 continuing education credits for nurses, physicians, and pharmacists
- Basic Certificate in Quality and Safety

Open to registered participants who complete the VTF assessment

Submit interest here: https://bit.ly/Elevate_IHI
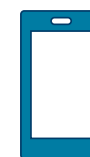**by May 16th** to be eligible for a scholarship

UPCOMING EVENTS

May 2022

SUN	MON	TUE	WED	THU	FRI	SAT
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

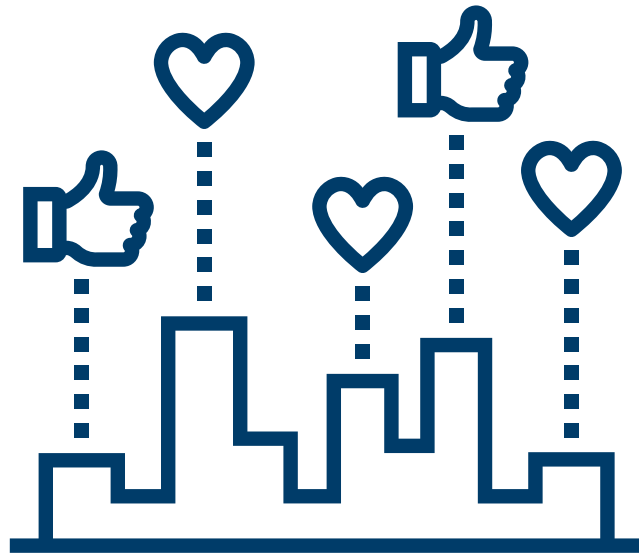**May 10. May Learning Forum -** Topic: Care Management, including billing & coding

May 26. Elevate Connect

Use this link to receive calendar invitations for all upcoming learning forums: bit.ly/Webinars22

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Provide Us Feedback

FOR MORE INFORMATION CONTACT:
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Next Monthly Forum Call:

May 10, 2022
1-2 pm ET

Next *Connect* Call:

May 26, 2022
1-1:45 pm ET

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Elevate

During **challenging** times....

With time, personnel, and resources **scarce**...

When it is **hard to imagine** even doing 'one more thing'...

*Learning, sharing, and leveraging the knowledge and experience of peers is **more vital than ever!***

The Quality Center Team
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