NATIONAL ASSOCIATION OF Community Health Centers®

elevate

Together, our voices elevate all.

Elevate *Learning Forum*

Care Teams

April 12, 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.

NATIONAL ASSOCIATION OF Community Health Centers®

Packaging and implementing evidence-based transformational strategies for safety-net providers

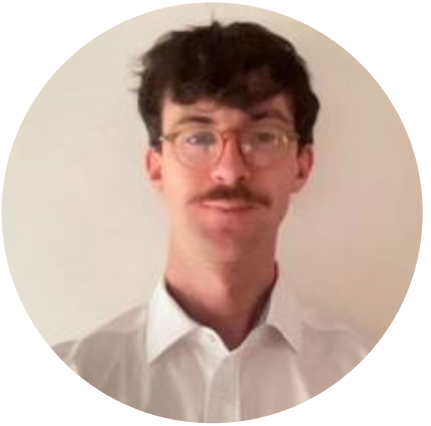
Bringing science, knowledge, and innovation to practice

Cheryl Modica

Director,
Quality Center

Cassie Lindholm

Deputy Director,
Quality Center



Addison Gwinner

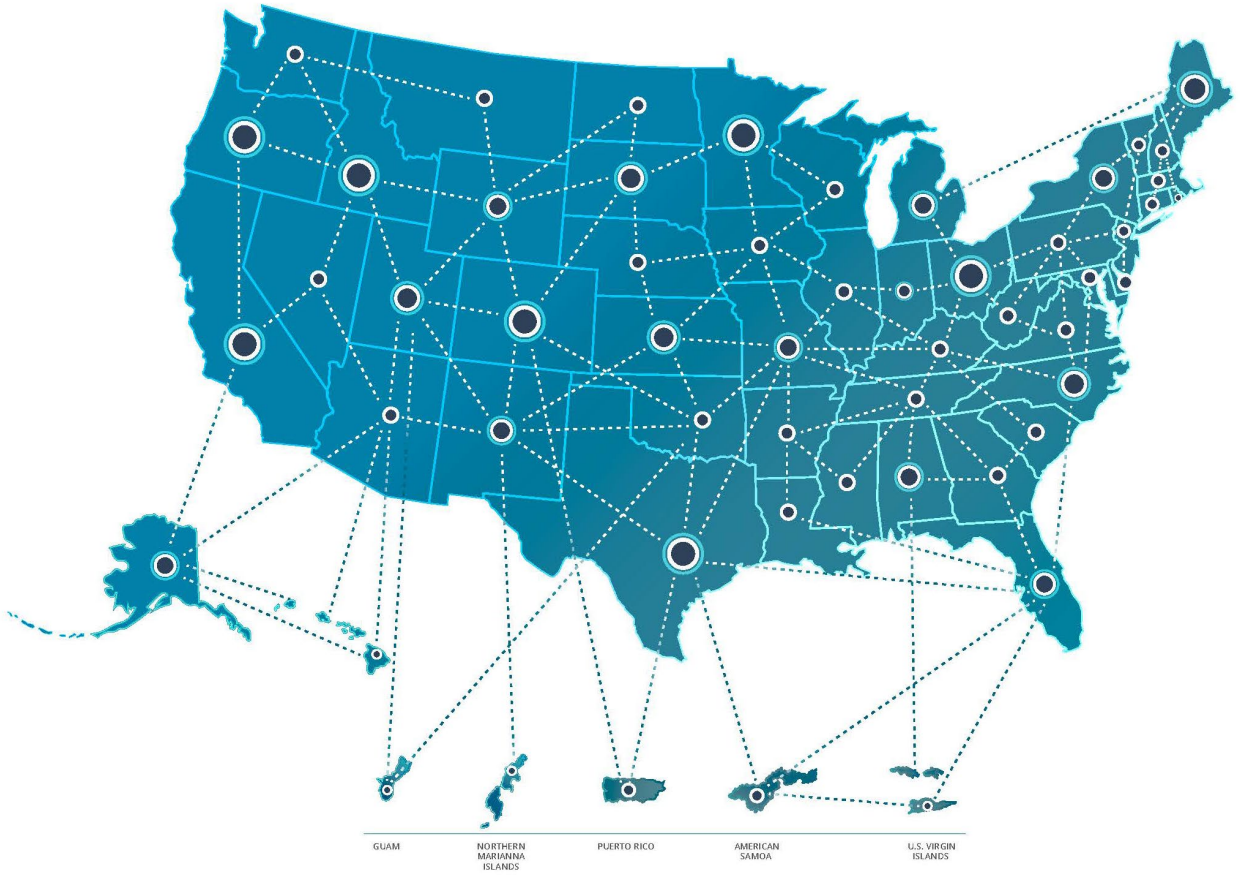
Specialist,
Quality Center

Joining Today's Call

Sonia Ayala, MA, LCSW
Interim Director of Quality &
Practice Transformation

ESPERANZA
health centers

Our Community: ELEVATE 2022



All
States & Territories

600+
Health Centers

70+
PCAs/HCCNs/NTTAPs

35+
CDC Grantees

6,000+
Peers

Millions
Patients

2022 Featured Health Centers

Su Clínica

ESPERANZA health centers

Charles B. Wang Community Health Center
王嘉廉社區醫療中心

evara HEALTH

PARK DUVALLE COMMUNITY HEALTH CENTER

Mountain People's Health Councils Inc.

NEW HEALTH
North End • Charlestown

Fish River Rural Health

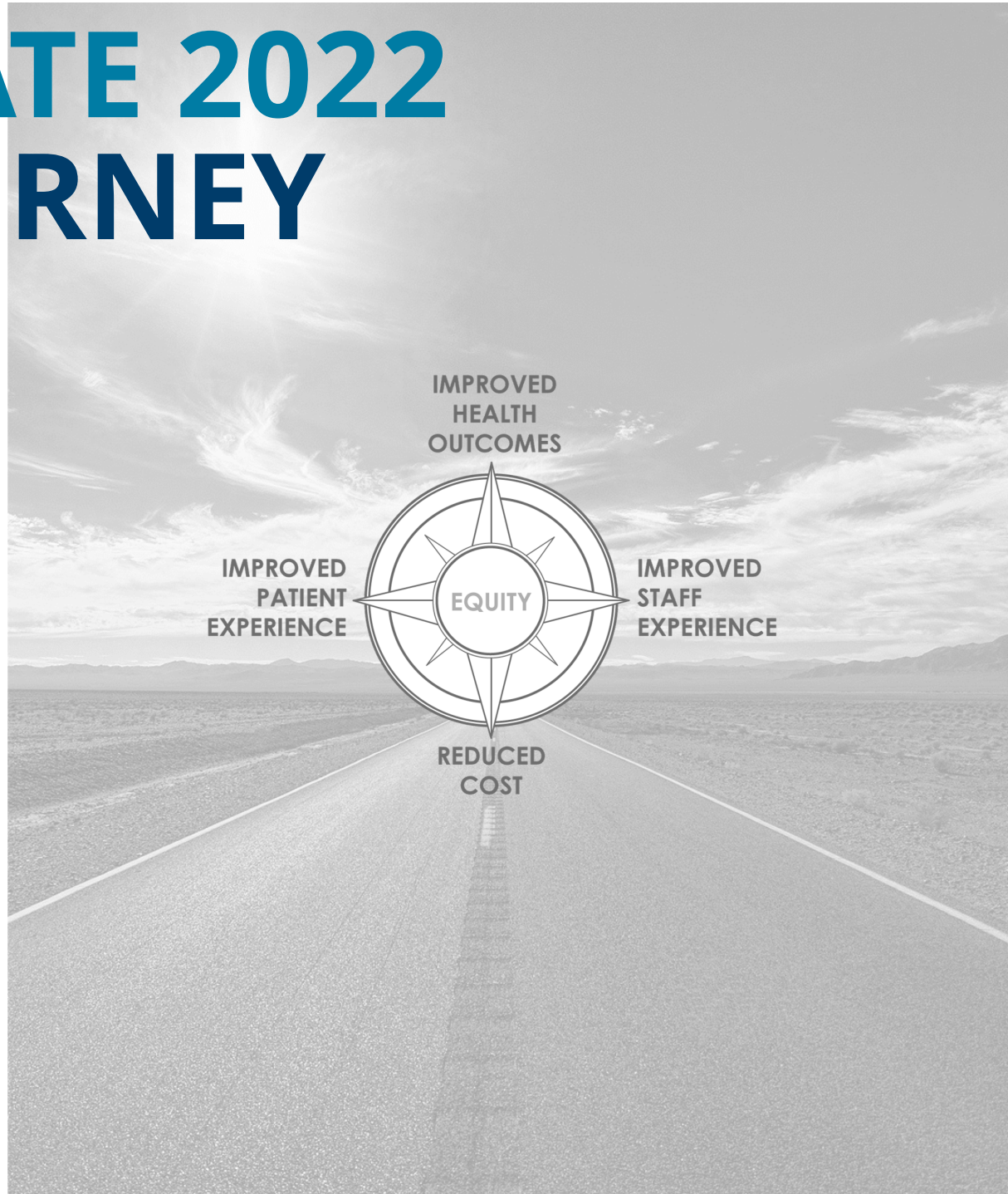
Keystone Rural Health Consortia, Inc.
One Team Working Together For Better Community Health Care

ZUFALL HEALTH COMMUNITY HEALTH CENTERS

In the top 20 health centers nationally when looking at composite performance across measures for prevention and/or control of six high-cost, high burden conditions (2019 UDS): colorectal cancer, cervical cancer, HTN, diabetes, depression, & obesity

ELEVATE 2022 JOURNEY

- Leadership
- Empanelment
- Population Health: Risk Stratification
- Payment
- Care Teams
- Care Management
- Evidence-Based Care
- Social Drivers of Health (SDOH)
- Improvement Strategy
- Workforce
- Health Information Technology
- Patients
- Partnerships
- Policy
- Cost
- Patient-Centered Medical Home



Today's Learning Forum

- ✓ Leadership
- ✓ Empanelment
- ✓ Population Health: Risk Stratification
- ✓ Payment
- **Care Teams**
- Care Management
- Evidence-Based Care
- Social Drivers of Health (SDOH)
- Improvement Strategy
- Workforce
- Health Information Technology
- Patients
- Partnerships
- Policy
- Cost
- Patient-Centered Medical Home

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 along.

Microlearning:
Care Teams...Expanded Care Teams

What?

Why?

How?

STEP 1 Define Care Standards

STEP 2 Distribute Tasks to Meet Standards and Document Workflow

STEP 3 Update Job Descriptions

STEP 4 Train Staff

STEP 5 Monitor Task Performance in Dashboards

STEP 6 Hardwire Accountability into Personnel Systems and Performance Reviews

STEP 7 Educate Patients on Redesigned Care Team

NACHC Care Teams Action Guide

Care Teams…Expanded Care Teams

WHAT?

WHY?

HOW?

WHAT
are evidence-based strategies and considerations for expanded care teams?

Care teams are developed based on the needs of the **patient population** and the **availability of personnel**, services, and other resources.

Care teams may include:

- **Providers – build on empanelment work!**
- **Medical assistant(s)**
- **Nursing staff**
- **Care manager(s)**
- **Behavioral health professionals**
- **CHWs/patient navigators/health coaches**
- **Patients – they are central players in their own care!**

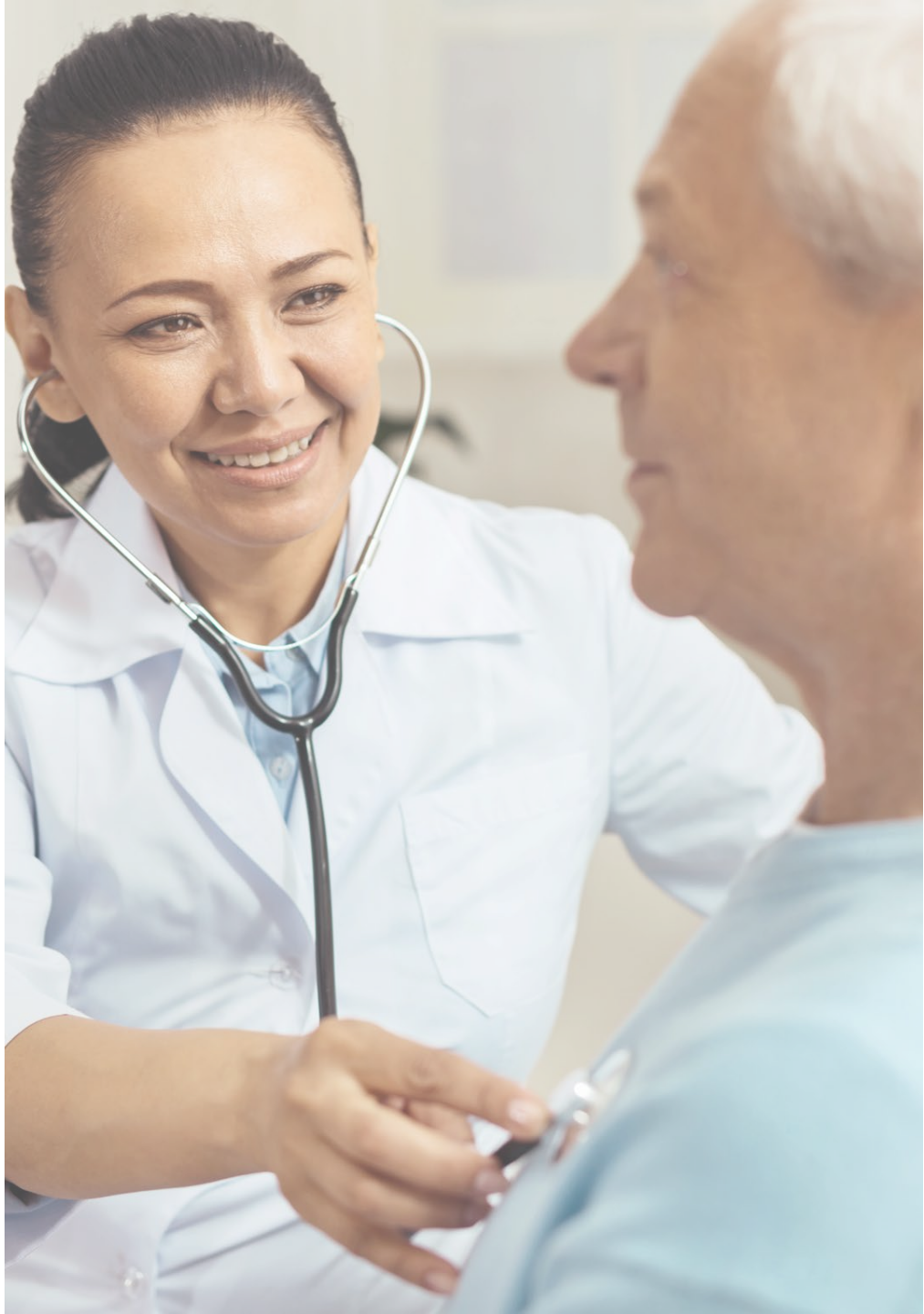
Care Teams...Expanded Care Teams

WHY
Focus on expanded care teams?

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.

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. In addition to improving service for chronic disease and preventive care.

Patient care is a team sport!



‘Share the Care’

Expanded care team delivery model

“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.”+

- Paradigm shift
- Concrete strategy for increasing capacity
- Redefine ‘team’ (clinicians and non-clinicians providing care to a panel of patients)
- Reallocate tasks and responsibilities
- From lone provider-with-helpers model to **reallocation of responsibility** to a team
- Design care teams where all members contribute meaningfully and to full capacity

+Ghorob, A. Bodenheimer, T. (2012). Sharing the Care to Improve Access to Primary Care. New England Journal of Medicine. 366, 1955-1957.

Care Teams...Expanded Care Teams

Step 1:
Define Care Standards

Identify the minimum set of care and services (care standards) to be provided to patients by age and/or risk group.

For example, which guidelines/measures will your health center follow: U.S. Preventive Services Task Force (USPSTF)? Healthcare Effective Data and Information Set (HEDIS)? Uniform Data Systems (UDS)?

Consider how a 'care gap' will be defined for your health center

- Cancer screenings (cervical, breast, colorectal)
- Immunizations
- Behavioral health screenings
- Chronic condition measures (A1c, BP)

Expanded Care Roles

Optimize technology! Set up alerts in your EHR to electronically track and flag care caps to discuss with patients at the point of care and reduce staff time spent performing patient outreach.

Step 1:
Define Care Standards
Build on Risk Stratification Work!

LOW RISK

RISING RISK

HIGH RISK

HIGHLY COMPLEX

Care management support

Care gap closure
Open referral and outstanding lab follow up
ED and hospitalization follow up
SDOH support
Order prescriptions/refills
Triage

Frequency and Intensity of Support

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 necessaryto 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)				

Team-Based Planning Worksheet

Step 3:
Update Job Descriptions

Ensure that staff members know what tasks they are responsible for completing, by updating job descriptions to include these tasks.

Expanded Care Roles

Job descriptions reflect staff roles and broad responsibilities that are allowable under state laws and licensure.

Job descriptions outline staff responsibilities that can be accomplished remotely.

Step 4:
Train Staff

Document workflows and processes for step-by-step instructions detailing how to complete each task.

Train staff in workflows relevant to job descriptions, and in quality improvement.

Incorporate necessary training into new hire orientations and offer ongoing professional development to retain staff and support performance.

Expanded Care Roles

Determine backups for key care team roles/tasks and cross train staff members.

Document who is trained in each role/task to have readily available for staff schedulers to access.

Step 5:
Monitor Task Performance in Dashboards

Use dashboards to monitor task performance and improvement. For example:

- Open referrals
- Care gaps for colorectal cancer screening
- Care management encounters

Share dashboard data with the care team to monitor and improve performance

Expanded Care Roles

Optimize technology to automate as many processes as possible through texting patients, using patient portals, or conducting screenings via phone. This can reduce the total staff time needed for a patient appointment.

Step 6:
Hardwire Accountability into Personnel Systems and Performance Reviews

Monitor staff performance (using individual and team dashboards) on an ongoing basis

Document overall progress in formal annual performance reviews.

Step 7:
Educate Patients on Re-Designed Care Teams

Providers' job responsibilities should include introducing patients to the broad role of the care team and reinforcing its importance.

Addressing with patients that care team members, including the MAs, RNs, CHWs, and more are highly skilled and trained professionals that can discuss screenings, perform tests, offer education, and provide other services.

Expanded Care Roles

Provide education and training to your patients on telehealth visits! If a provider (or other key care team member) is not able to come into the health center but can work from home, develop a process to quickly convert scheduled in-person visits to telehealth visits. Patients who are already comfortable with telehealth visits will be more willing to keep their visit scheduled and convert to telehealth instead of cancelling or rescheduling.

Esperanza

Expanded Care Teams

Sonia Ayala, MA, LCSW

Interim Director of Quality & Practice Transformation

Chicago, IL

Urban; 5 sites

Founded 2004

~50,000 Patients

Over 300 Employees

WHY
Our health center created expanded care teams

Mission: *to deliver **health** and **hope** for Chicago's underserved communities.*

Values:

- **Caring**: Bringing compassion, respect and understanding to all those we serve
- **Quality**: Striving for excellence and innovation in every aspect of our work
- **Family**: Building a shared sense of community where every person feels welcome and at home

NATIONAL ASSOCIATION OF Community Health Centers®

ESPERANZA health centers

Expanded Care Teams

WHAT?

WHY?

HOW?

Step 1:
Define Care Standards
Started with COVID-19…expanded to more

- **Care Coordination**
- **Care Management**
- **Contract Tracing Overview**
- **Population Health COVID Recovery**

NATIONAL ASSOCIATION OF Community Health Centers®

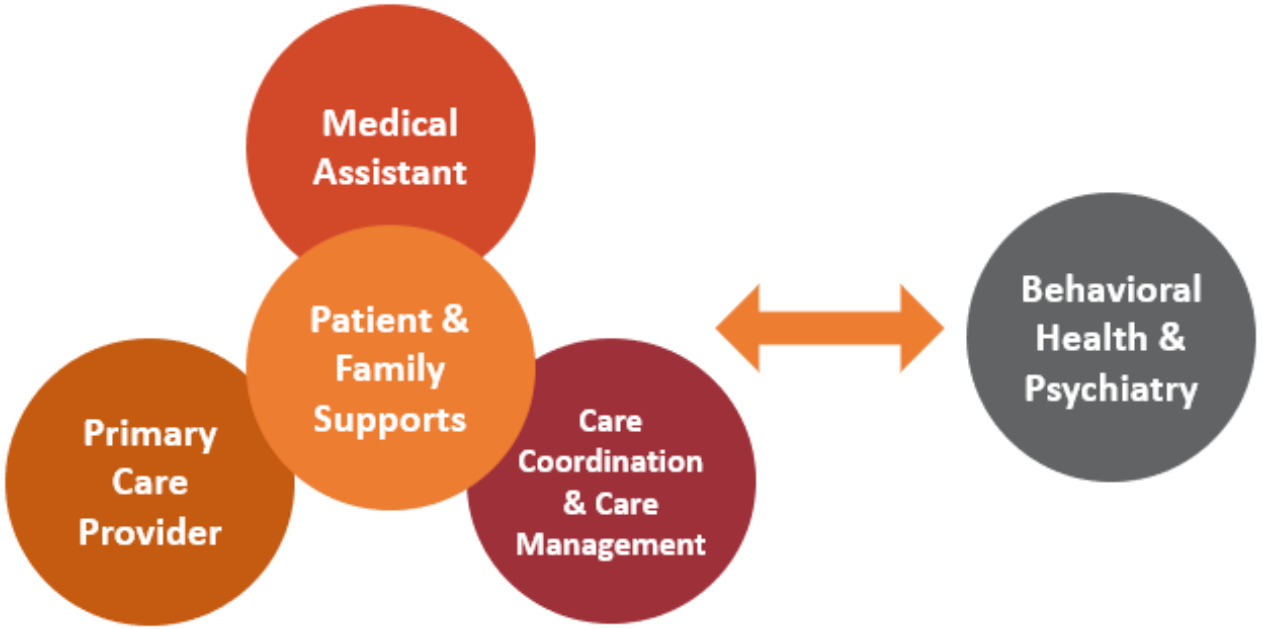
ESPERANZA health centers

Step 1:
Define Care Standards
Started with COVID-19…expanded to more

Aligning with Esperanza's overall mission, our view of Population Health Recovery looks to continue improving the overall health of our patients while, also, looking to bring back those who have fallen out of care due to the COVID-19 pandemic. This means expanding outreach and creating awareness about chronic and seasonal diseases along with issues that encompass the goal of treating the individual holistically.

- Colorectal cancer screening outreach
- Diabetes control outreach
- OB C-19 vaccine outreach
- VeggieRx Program

Step 2:
Distribute Tasks to Meet Care Standards & Document Workflow



Reassigned Care Coordinators and Care Managers to support other departments during the pandemic

Call Center & Nurse Line

ESPERANZA health centers

Step 3:
Leveraged current positions
Added new position

Care Coordination
Connect patients to community resources
Population health outreach
Patient Education
Internal Programs

Contract Tracing Team
Outreach to patients to connect to COVID testing and care
Population health approach allowed focus on other conditions

Care Management
High risk complex patients
Primarily payer specific
Create care plans in partnership with provider and care teams and support patients towards achieving those goals

Quality
Coach care teams around team dynamics and support teams to meet quality goals through QI methodology
Data and dashboards
Patient safety

ESPERANZA health centers

Step 4:
Train staff

Virtual and in-person team training

- **Care Coordination Team**
  - Refresher trainings on breast, cervical, and colorectal cancer screening, hypertension control, diabetes control, well child visits.
- **Contract Tracing Team**
  - How to outreach to patients for specific population health measures (breast, cervical, and colorectal cancer screening, hypertension control, diabetes control, well child visits).

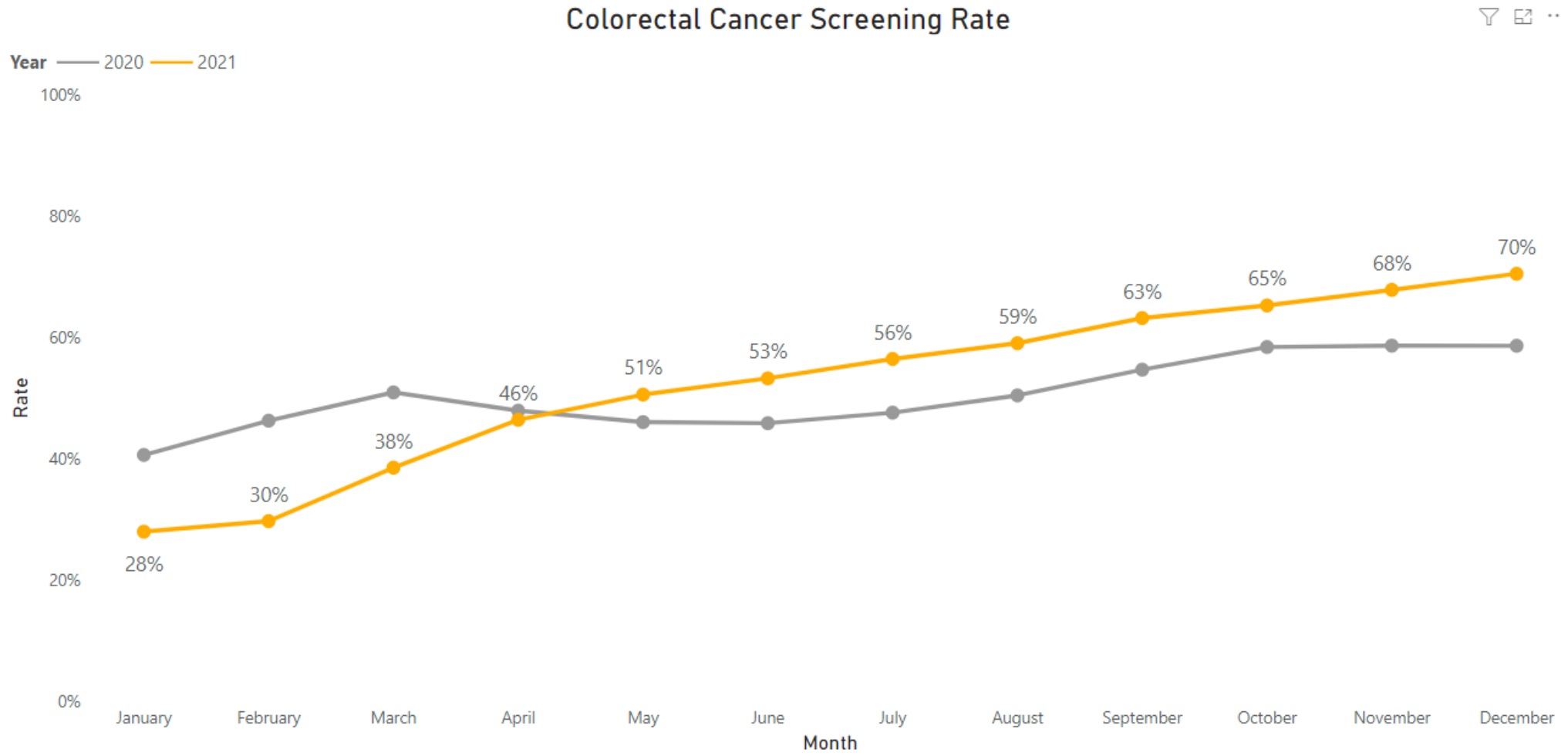
ESPERANZA health centers

Step 5:
Monitor Task Performance in Dashboards

COVID				Other Vaccines	Cancer Screening	Nutrition	Other…
Vaccination		Testing	Rapid Tests	Flu vaccines	Screening	VeggieRx	
~24k vaccinations	OB rate increased from 39% to 61%	~2,300 pts tested	22k distributed	~900 vaccinations	increased from 28% to 70% (2021)	2,600 boxes distributed	

ESPERANZA health centers

Step 5:
Monitor Task Performance in Dashboards



Step 6:
Hardwire Accountability into Personnel Systems and Performance Reviews

Having discussions across teams and departments to coordinate efforts and avoid duplication - more uniformity across the health center

ESPERANZA health centers

Step 7:
Educate Patients on Redesigned Care Team

Contract Tracing Team:

- *Patient Script* used for well-being checks
- Addressed any issues or barriers patient shared
- Connected patients with primary care, behavioral health services, community resources, etc.

ESPERANZA health centers

ESPERANZA
health centers

Any Questions?

Care Teams Highlights

Action Guide


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 (the Quadruple Aim). Developing an effective team-based model of care is at the heart of health center efforts to deliver on the Quadruple Aim: improved health outcomes, improved staff and provider experiences, and lower costs.

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].

CARE TEAMS

The Value Transformation Framework addresses how to 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 steps for health center's seeking proven strategies to develop effective 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 health centers can take to more effectively distribute, or share, responsibility and accountability across the team.

"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]

https://bit.ly/VTF_CareTeams

Actions

Focus on a 'Share the Care' model of care delivery

Redefine 'team' (clinicians and non-clinicians providing care to a panel of patients)

Implement evidence-based Care Team Action Steps

Reimagine

Resources

'Share the Care' Model
Ghorob, A. Bodenheimer, T. (2012). Sharing the Care to Improve Access to Primary Care. New England Journal of Medicine. 366, 1955-1957.

Team Based Worksheet
http://www.safetynetmedicalhome.org/sites/default/files/Team-Planning.xls

Workflow Mapping Tips
https://www.ahrq.gov/ncepcr/tools/pf-handbook/mod5.html

COVID Response…Reimagine

Infographic available here

Resource available here

“From Recuperation to Regeneration”[1]

Action Steps:

- **Focus on the team**
  - Attention to individuals is necessary but insufficient
- **Define and mark the moment of transition**
  - Create an event or occasion and give it meaning and purpose
- **Spur reflection that enables action**
  - Infuse a message of hope

[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.

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.

Coming Next

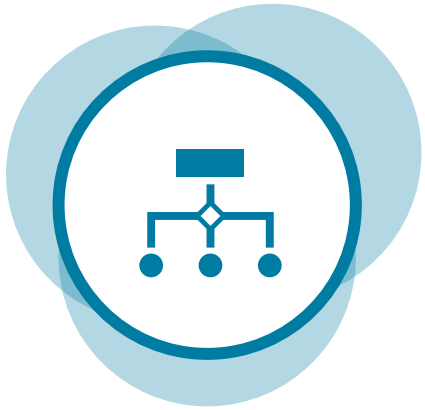
- ✓ Leadership
- ✓ Empanelment
- ✓ Population Health: Risk Stratification
- ✓ Payment
- ✓ Care Teams

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..

Care Coordination & Care Management

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

Why Care Management?



Essential population health activity

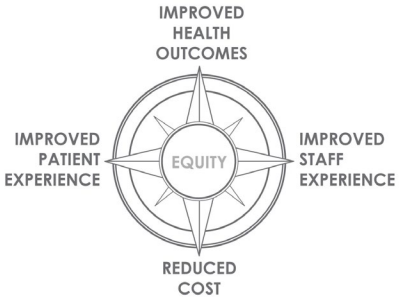
Improve health outcomes

Revenue potential*

*Health centers have the opportunity to obtain revenue above and beyond their federally-qualified all-inclusive flat rate when they offer, document, and bill for allowable care management services. This additional revenue has the potential to help fund systems change as health centers transition from a volume to value-based payment model.

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 Journey...
Your Way

2nd Tuesday, monthly, 1-2 pm

Elevate Learning Forum

Learning Forum:
- Microlearning
- Field examples
- Discussion

4th Thursday, monthly, 1:00-1:45 pm

Elevate Connect

Elevate *Connect*:
- Gather with peers
- Share & exchange tools
- Discussion

Self-paced

Online Platform

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

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!***

Elevate 2022 Participants:
Free Trial Opportunity

Institute *for* Healthcare Improvement

One year of free access to the IHI's full catalog of online courses including:

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

I can do

VTF

Open to registered participants who complete the VTF assessment

Fill out our brief interest survey here: https://bit.ly/Elevate_IHI
by April 29th to be eligible for a scholarship

UPCOMING EVENTS

April 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

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				

April 28. Elevate *Connect* - Topic: Care Teams

May 10. May Learning Forum - Topic: Care Management

May 26. Elevate Connect

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

NATIONAL ASSOCIATION OF Community Health Centers®

FEEDBACK

Don't forget! Let us know what you thought about today's session.

FOR MORE INFORMATION CONTACT:

qualitycenter@nachc.org

Cheryl Modica
Director, Quality Center
National Association of Community Health Centers
cmodica@nachc.org
301.310.2250

Next *Connect* Call:

April 28, 2022
1-1:45 pm ET

Next Monthly Forum Call:

April 10, 2022
1-2 pm ET

NATIONAL ASSOCIATION OF Community Health Centers®

NATIONAL ASSOCIATION OF Community Health Centers®

elevate°

Together, our voices elevate° all.

The Quality Center Team

Cheryl Modica, Cassie Lindholm, & Addison Gwinner

qualitycenter@nachc.org