

Microlearning: Care Teams...Expanded Care Teams

What?

STEP 1 Define Care Standards

STEP 2 Distribute Tasks to Meet Standards and Document Workflow

Why?

STEP 3 Update Job Descriptions

STEP 4 Train Staff

How?

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



WHAT?



WHY?



HOW?



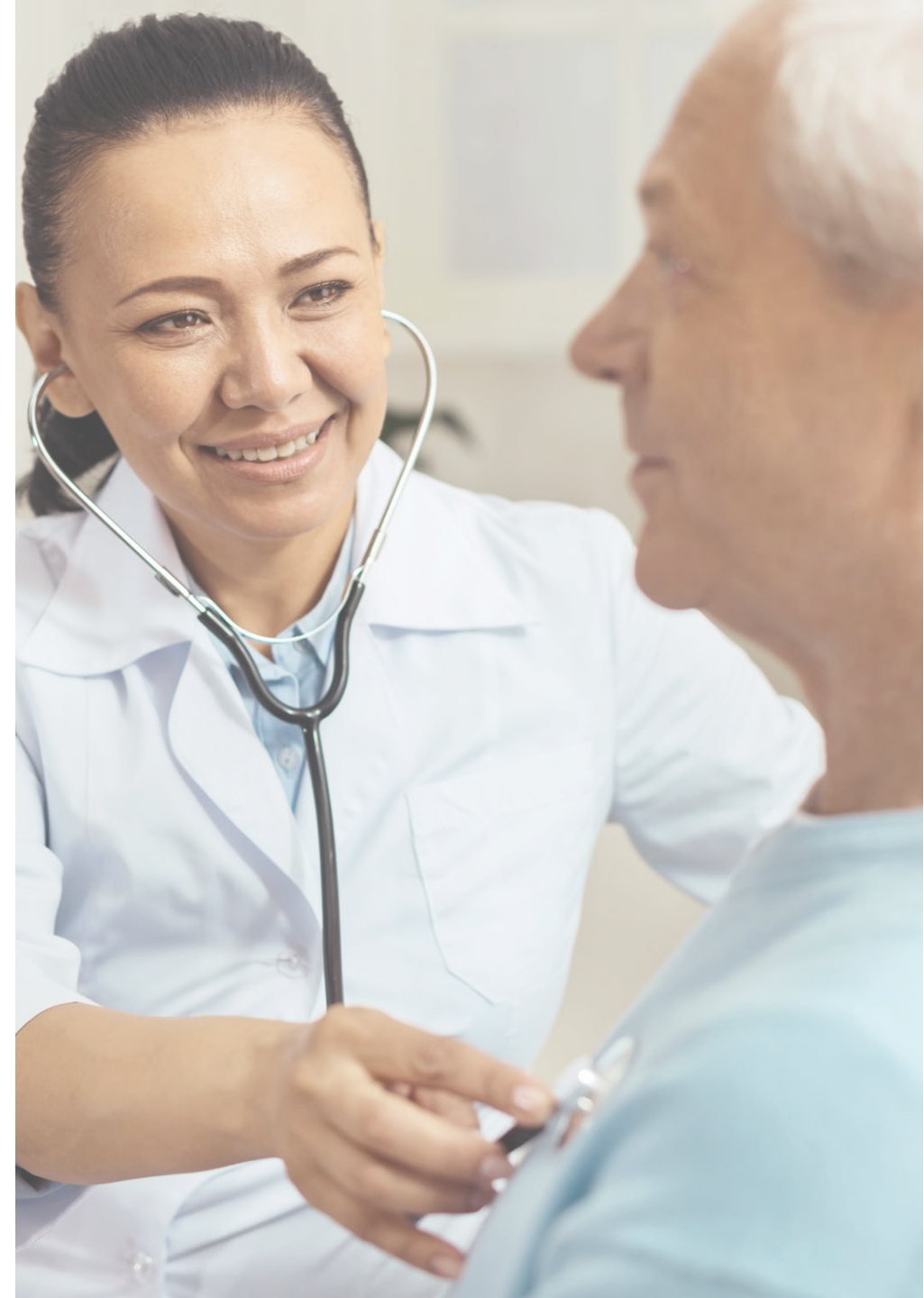
WHY

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'

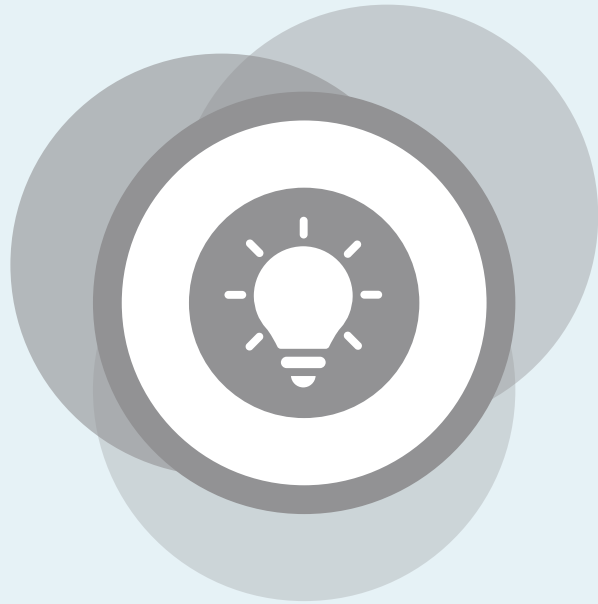
Expanded care team delivery model



- 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

"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."+

Care Teams...Expanded Care Teams



WHAT?



WHY?



HOW?



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 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)				



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.

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 patients¹. It is, therefore, not surprising that physicians face burnout and adults in the U.S. receive only 55% of recommended services². 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 delivered³. 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 staff⁴. 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}.

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."

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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

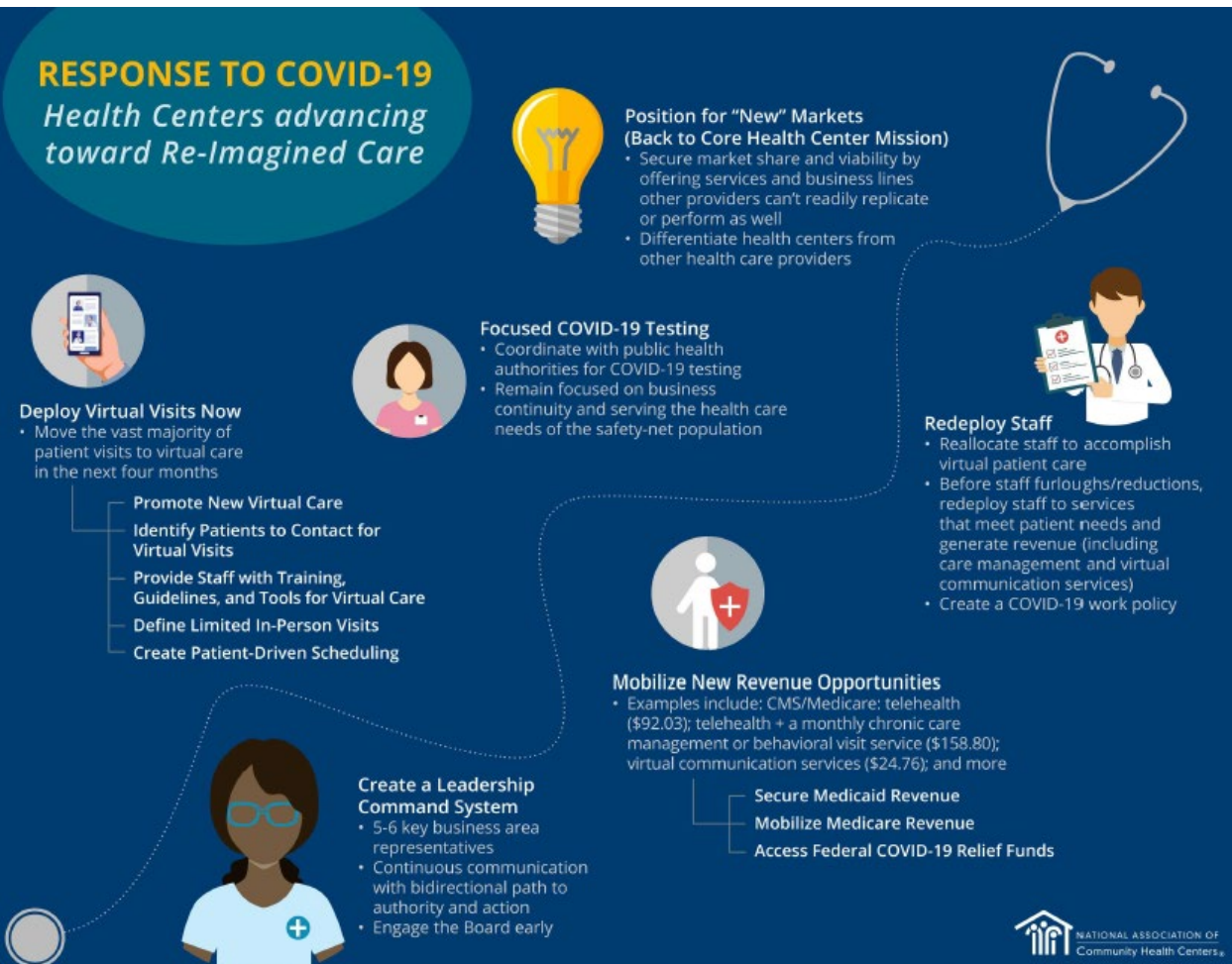
<http://www.safetynetmedicalhome.org/sites/default/files/Team-Planning.xls>

Workflow Mapping Tips

<https://www.ahrq.gov/ncepcr/tools/pf-handbook/mod5.html>

COVID Response...Reimagine

[Infographic available here](#)



RESPONSE TO COVID-19

Health Centers advancing toward Re-Imagined Care

Responding strategically and decisively during this public health emergency is essential for health center survival and positioning for the post-pandemic period. The following list of recommendations and actions was gathered from discussions with many health center, primary care association, and health center-controlled network leaders who were at the epicenter of the pandemic at its start. This synthesis of insights is intended to guide health centers that have not yet experienced, or are just beginning to experience, a surge of COVID-19 cases. While these recommendations do not reflect the comments of any one person or organization, including NACHC, they offer a set of lessons learned that have been corroborated by many on the front lines of the COVID-19 pandemic.



Create a Leadership Command System

- Recommendation:** Organize a control and command system with key organizational leaders and open lines of communication among all levels of staff as a means to guide the health center through this emergency phase.
 - This leadership command group should consist of 5-6 key business area representatives, including: Chief Executive Officer, Medical Director, Finance Director, IT Director, and other key business areas such as dental, pharmacy, or behavioral health.
 - The leadership command group should meet in daily huddles, with key decisions and direction cascaded through the appropriate division leads (e.g., operational, clinical, financial, etc.). Mechanisms must be in place to gather input from front-line workers so information can run up and down the chain of command, with discussion and decisions as part of daily leadership huddles.
 - Engage the Board early so they have an understanding of what the transition to virtual care means and the importance of this transition to health center sustainability.
- Rationale:** The uncertainty and chaos of the changing environment requires open and continuous communication with a clear bidirectional path to authority and action. Ongoing communication is required throughout each day – informed by all levels of the organization – and structured for centralized, date-driven, and informed decision-making and direction.



Deploy Virtual Visits Now

- Recommendation:** Make plans to move the vast majority of patient visits to virtual care in the next four months, regardless of the volume of COVID-19 cases in your community. Exceptions may include: childhood immunizations, OB/GYN with complications, and other medically urgent needs.
 - To stop the spread of COVID-19, individuals are asked to stay home unless medically necessary. These instructions, along with patients' fear of acquiring COVID-19, have resulted in a sharp decline in patient visit volume...and, thus, revenue.
- Rationale:** To stay viable and competitive now and post-COVID-19, health centers must develop competency in providing virtual care. Current revenue-friendly provisions and relaxed regulatory requirements support the movement of care to a virtual setting.

[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






Questions: to guide team reflection and innovations in team structure¹

- **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

¹Singer, 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



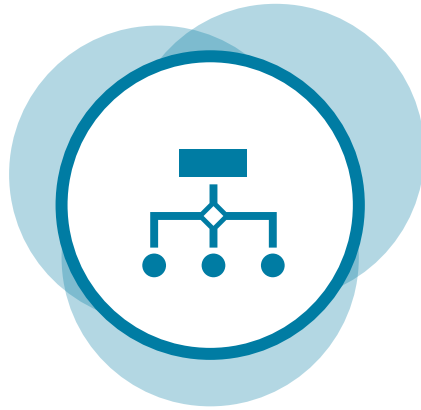
- ✓  Leadership
- ✓  Empanelment
- ✓  Population Health: Risk Stratification
- ✓  Payment
- ✓  Care Teams

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

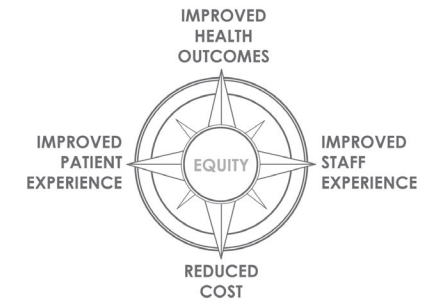


Revenue potential*

*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



Learning Forum:

- Microlearning
- Field examples
- Discussion

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



Elevate *Connect*:

- Gather with peers
- Share & exchange tools
- Discussion

 Self-paced



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





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



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

May 2022

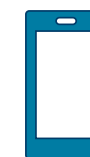
SUN	MON	TUE	WED	THU	FRI	SAT
1	2	3	4	5	6	7
8	9	10 	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26 	27	28
29	30	31				



May 10. May Learning Forum - Topic: Care Management



May 26. Elevate *Connect*



Use this link to receive calendar invitations for all upcoming learning forums:

bit.ly/Webinars22

FEEDBACK

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

FOR MORE INFORMATION CONTACT:

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Next *Connect* Call:

April 28, 2022
1-1:45 pm ET

Next Monthly Forum Call:

April 10, 2022
1-2 pm ET



elevate°

**Together, our
voices elevate° all.**

The Quality Center Team

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