NATIONAL ASSOCIATION OF Community Health Centers®

# ELEVATE NATIONAL LEARNING FORUM

elevate

**Care Teams & Workforce**
March 12, 2024

# 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.


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# Agenda

**Welcome**

**Elevate Journey**

**Care Teams**

- Optimizing Care Teams *WHAT, WHY, HOW*
- Standing Orders: Georgia PCA

**Workforce**

- Health center workforce wellness
- Featured NTTAP: Association of Clinicians for the Underserved
- Featured Health Center: Muskingum Valley Health Centers, Inc.
- Featured Health Center Resources from Southside Community Health Services
- Featured NTTAP: Moses/Weitzman Health System

**Q&A and Discussion**

**Closing**

# NACHC Quality Center

**Cheryl Modica**
Director,
Quality Center

**Cassie Lindholm**
Deputy Director,
Quality Center

**Holly Nicholson**
Deputy Director, Learning
and Development

**Tristan Wind**
Manager,
Quality Center

**Rachel Barnes**
Specialist,
Quality Center

# Elevate Journey

*Your transformation journey begins here!*

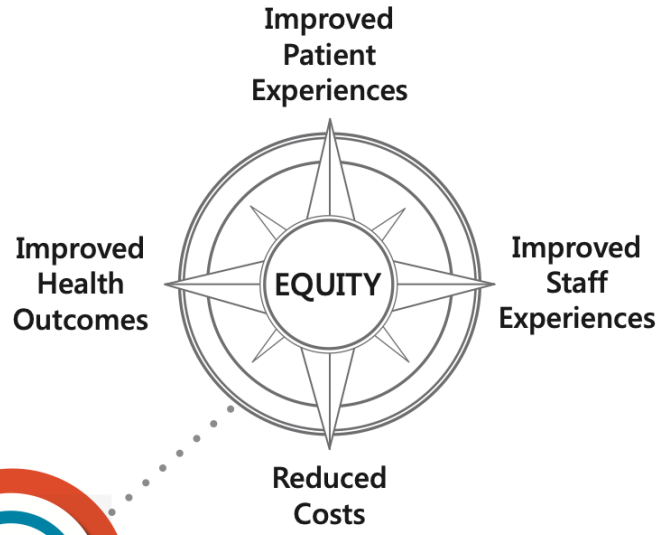

**STEP 1 - ENGAGE**
Register for Elevate and participate in the **FREE** health center learning community. Invite others

**STEP 2 – ASSESS**
Measure transformation progress using the Value Transformation Framework (VTF) Assessment

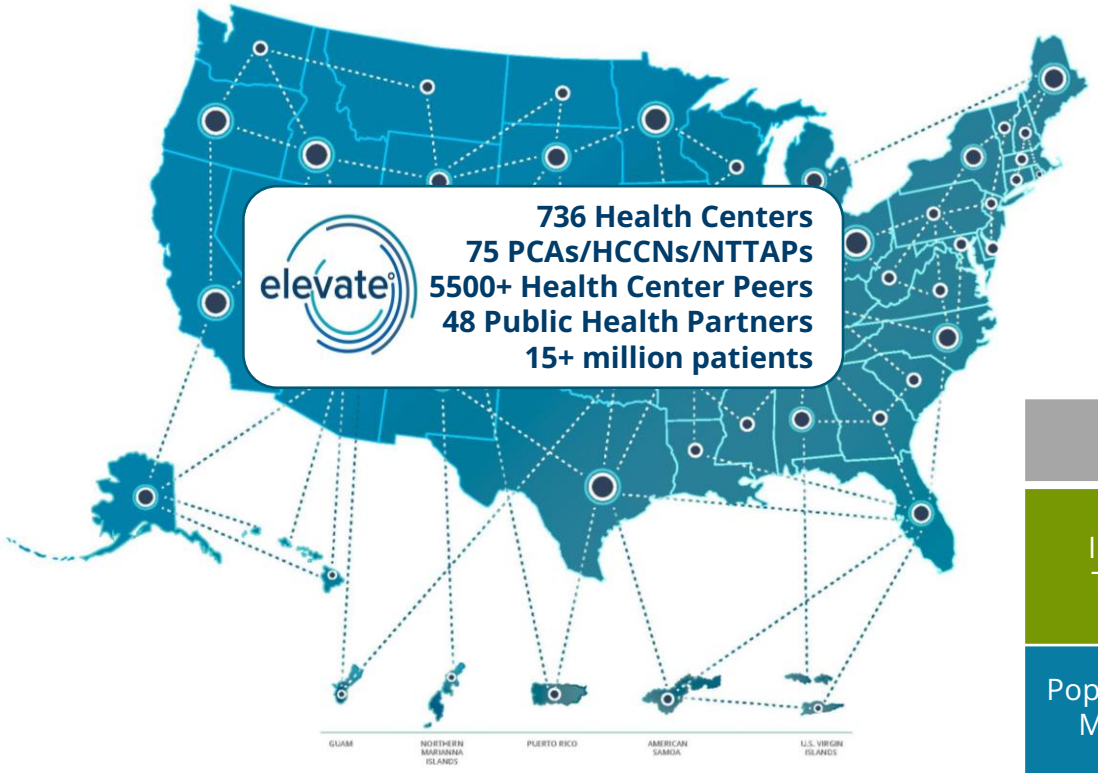
**STEP 3 – PLAN**
Incorporate transformation efforts into your Improvement Strategy

**STEP 4 – TRANSFORM**
Apply the VTF and suite of transformation tools and resources

**STEP 5 – REASSESS**
Measure transformation progress over time using the VTF Assessment; monitor, adjust, and improve



# VTF Assessment




VTF

STEP 2 – ASSESS

| VTF Assessment (2019-Current), n=1802 | | | | |
|---|---|---|---|---|
| Health Information Technology 2.89 | Improvement Strategy 3.12 | Policy 2.97 | Payment 2.83 | Cost 2.75 |
| Population Health Management 3.08 | Patient-Centered Medical Home 3.58 | Evidence-Based Care 3.28 | Care Coordination and Care Management 3.19 | Social Drivers of Health 3.09 |
| Patients 3.14 | Care Teams 2.98 | Leadership 3.01 | Workforce 2.85 | Partnerships 3.42 |

# Complete VTF Assessments ➡ Access FREE Resources

**Complete 3+ VTF Assessments:**

Health center is eligible for a 6-month trial membership to an online document management platform to support health center OSV preparation and ongoing compliance!

**Save the Date:**

***March 25, 2024, 1-2pm ET***

RegLantern Information Session for Health Center Compliance Tool Trial Subscription Register here!

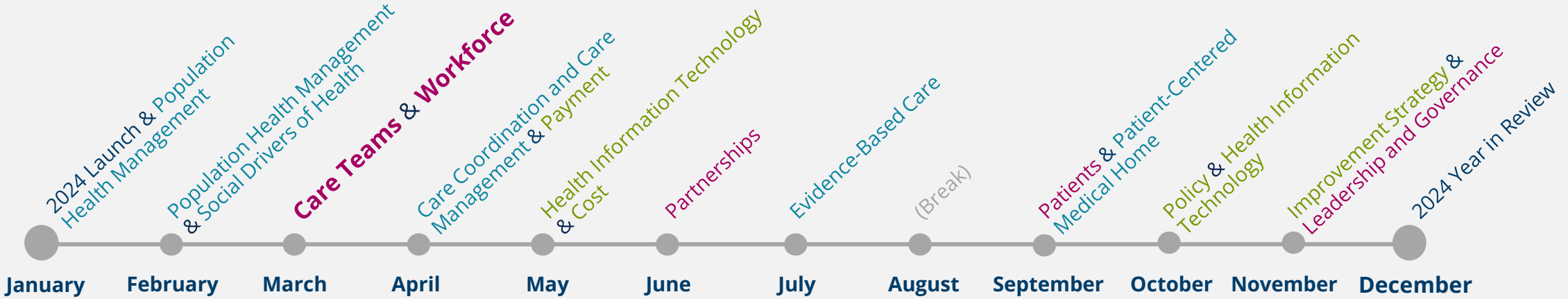
REGLANTERN

## RegLantern Continuous Compliance Tool

- Cloud-based platform that helps health centers move toward continuous HRSA compliance
- FTCA Application Tool
- Allows health centers to compile and organize all documents demonstrating compliance in one place
- Embedded with checklists, alerts, and reminders
- Allows a health center to share documents with on-site reviewers during Operational Site Visit (OSV) through Citrix ShareFile integration
- Access to exclusive discounts for health centers interested in continuing subscription after trial period.
- Free Form 5A Review

# Elevate 2024

## Monthly Learning Forums & Office Hours:




## Supplemental Sessions:

- Value-Based Care (Series)
- Care Gaps/CQMs

## Professional Development Courses:

- Lifestyle Coaching
- Care Management
- Quality Improvement
- Healthy Weight

**Elevate** is a program for health centers and partners that offers a guided approach to health center systems change and value transformation.

The forum is designed to leverage state/regional efforts to accelerate transformation results and impact.

*Schedule may be adjusted by the Quality Center as needed.

# Elevate Featured Health Centers: 2023 Health Center Quality Leaders!


ESPERANZA health centers

mainlinehealth systems, inc.

SOUTHSIDE Your Community Health Services


St. Croix Regional Family Health Center

care resource
Your Community's Source for Healthcare

MVHC

HealthLinc
YOUR COMMUNITY HEALTH CENTER®

CAMILLUS HEALTH CONCERN






WAIMĀNALO HEALTH CENTER




# Optimizing Care Teams


# VTF Assessment: Care Teams


## VTF Change Area: 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.*

| | 1. Learning | 2. Basic | 3. Applied | 4. Skilled | 5. Expert |
|---|---|---|---|---|---|
| **Care Team Processes** | | | | Health center uses extended care teams which include a broad range of support staff (e.g., community health workers, doulas, navigators, front desk staff, etc.) and staff with varying degrees and certifications, to provide care for a panel of patients in one or a few but not all health center sites. Health center leaders have systems in place to measure and report individual and team performance (accountability). Care teams maintain protocols for monitoring and reporting compliance. | |
| **Protected Time** | | | | Health center teams use protected time to meet/review quality data and progress toward improvement. | |

# WHAT are expanded & integrated care teams?

# WHY focus on optimizing care teams?

*"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." **

## 'Share the Care' Delivery Model

Transitioning to value-based care requires a significant shift in care delivery, infrastructure, and the way people are engaged in the health care system.

Optimizing the care team model—with more responsibility allocated from the primary care provider to other members of the care team—improves experience and outcomes for patients and improves experience for staff.

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

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

# **HOW** to optimize care teams?

**STEP 1** Define care standards

**STEP 2** Distribute tasks to meet care standards

**STEP 3** Document workflows

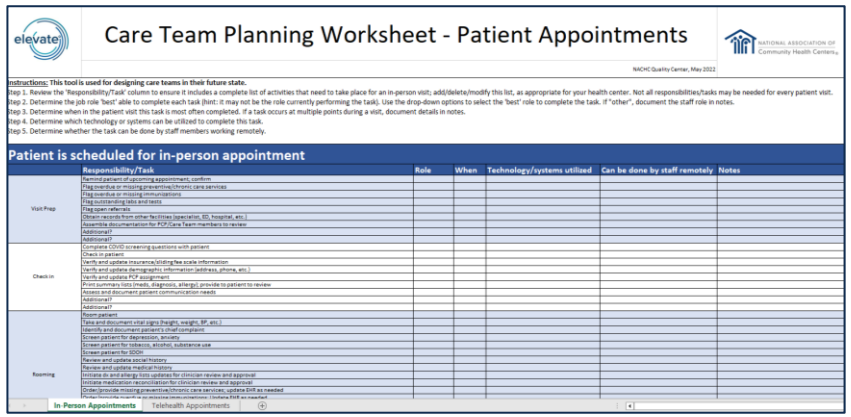
**STEP 4** Train staff

**STEP 5** Encourage patient engagement with extended & integrated care team members

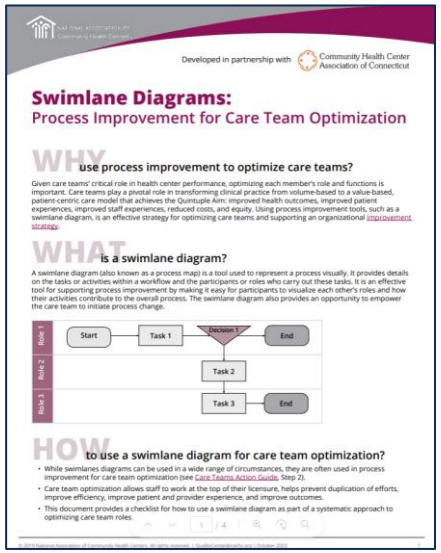
**STEP 6** Set goals and measure care team impact

**Care Teams Action Guide**

**Care Teams Microlearning**


**Care Team Planning Worksheet**




**Swimlane Diagrams: Process Improvement for Care Team Optimization**

# STEP 1

*DEFINE CARE STANDARDS*

## Identify the minimum set of care and services to be provided to patients by demographics, clinical conditions, and risk group.

**To define by demographics and clinical conditions,** determine which evidence-based care guidelines and clinical quality measures will your health center follow:

- U.S. Preventive Services Task Force (USPSTF)
- Healthcare Effective Data and Information Set (HEDIS)
- Centers of Medicare & Medicaid (CMS) electronic Clinical Quality Measures (eCQMs) (alignment with UDS)

Essentially, how is a 'care gap' defined for your health center?

**Cancer Screenings** (breast, cervical, colorectal)

**Immunizations**

**Behavioral Health Measures**

**Chronic Condition Measures** (A1c, BP)

# STEP1 CONTINUED

## *DEFINE CARE STANDARDS*

**To define by risk group,** determine your models of care.


- Care management support

- Care gap closure
- Open referral and outstanding lab follow up
- ED and hospitalization follow up

- Social drivers of health (SDOH) support
- Order prescriptions/refills
- Triage

**Frequency and Intensity of Support**

# STEP 2

## *DISTRIBUTE TASKS TO MEET CARE STANDARDS*

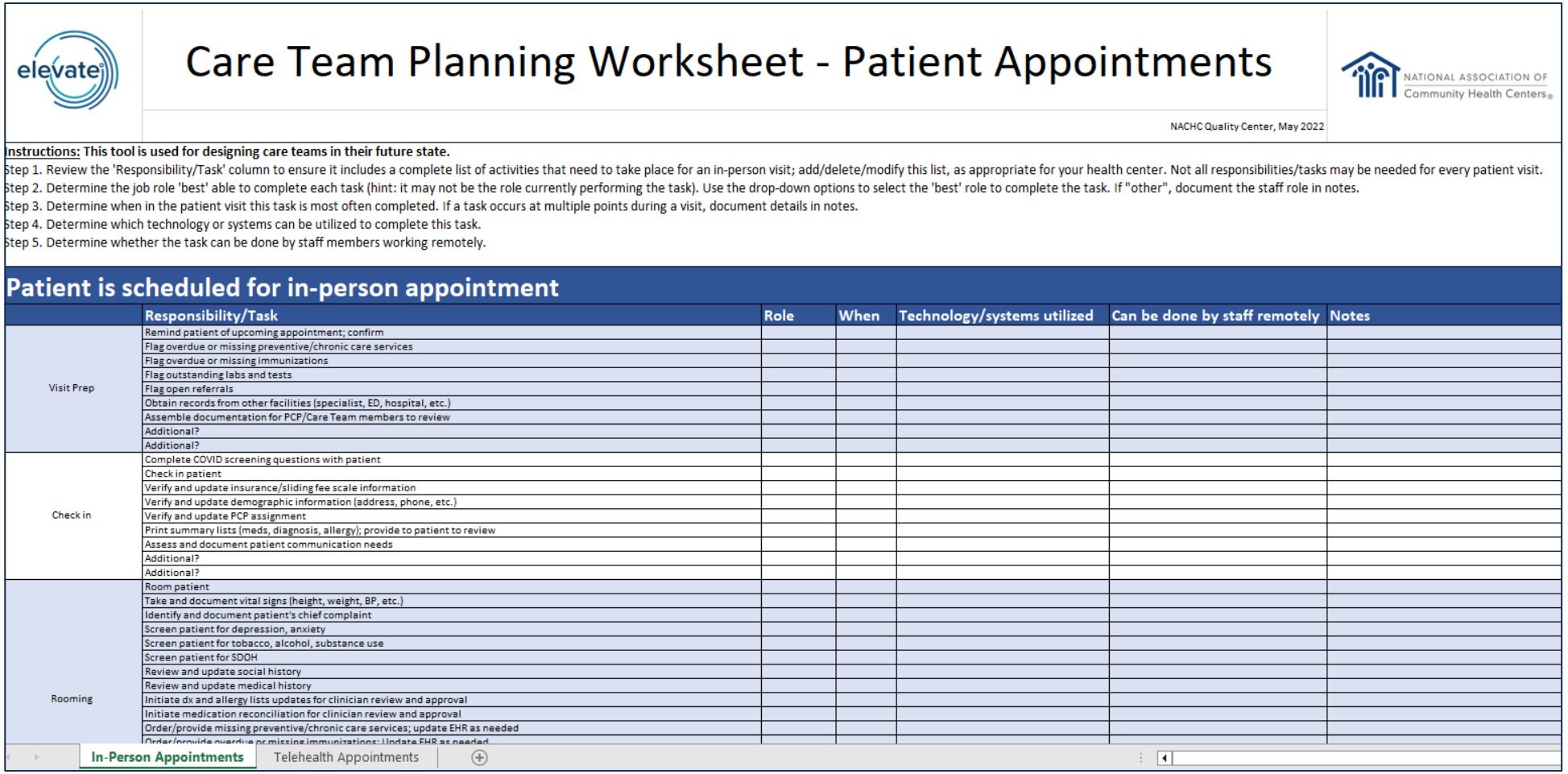
**Once your health center has determined the standards of care you will follow, the tasks necessary to accomplish these standards can be assigned to roles across the care team.**

- Ensure care team members are tasked with work that enables them to perform at the top of their licensure.
- Implement standing orders to empower care team members to order or provide labs, referrals, and other services.
- Leverage reimbursement opportunities driven by expanded care team roles (see NACHC Reimbursement Tip Sheets).
- Determine which tasks can be completed remotely and which require staff to be at the health center in-person. Create policies and provide remote access for staff to connect to the EHR and work from home on designated tasks.
- Consider which tasks can be delegated to technology. For example, use systems to send out automated reminders and schedule services for care gaps.

**Update job descriptions to reflect the tasks assigned.**

# STEP 2
## CONTINUED

## *DISTRIBUTE TASKS TO MEET CARE STANDARDS*



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### Care Team Planning Worksheet - Patient Appointments

NATIONAL ASSOCIATION OF Community Health Centers®

NACHC Quality Center, May 2022

**Instructions: This tool is used for designing care teams in their future state.**

Step 1. Review the 'Responsibility/Task' column to ensure it includes a complete list of activities that need to take place for an in-person visit; add/delete/modify this list, as appropriate for your health center. Not all responsibilities/tasks may be needed for every patient visit.
Step 2. Determine the job role 'best' able to complete each task (hint: it may not be the role currently performing the task). Use the drop-down options to select the 'best' role to complete the task. If "other", document the staff role in notes.
Step 3. Determine when in the patient visit this task is most often completed. If a task occurs at multiple points during a visit, document details in notes.
Step 4. Determine which technology or systems can be utilized to complete this task.
Step 5. Determine whether the task can be done by staff members working 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 outstanding labs and tests | | | | | |
| | Flag open referrals | | | | | |
| | Obtain records from other facilities (specialist, ED, hospital, etc.) | | | | | |
| | Assemble documentation 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? | | | | | |
| Rooming | Room patient | | | | | |
| | Take and document vital signs (height, weight, BP, etc.) | | | | | |
| | Identify and document patient's chief complaint | | | | | |
| | Screen patient for depression, anxiety | | | | | |
| | Screen patient for tobacco, alcohol, substance use | | | | | |
| | Screen patient for SDOH | | | | | |
| | Review and update social history | | | | | |
| | Review and update medical history | | | | | |
| | Initiate dx and allergy lists updates for clinician review and approval | | | | | |
| | Initiate medication reconciliation for clinician review and approval | | | | | |
| | Order/provide missing preventive/chronic care services; update EHR as needed | | | | | |
| | Order/provide overdue or missing immunizations; Update EHR as needed | | | | | |

In-Person Appointments | Telehealth Appointments

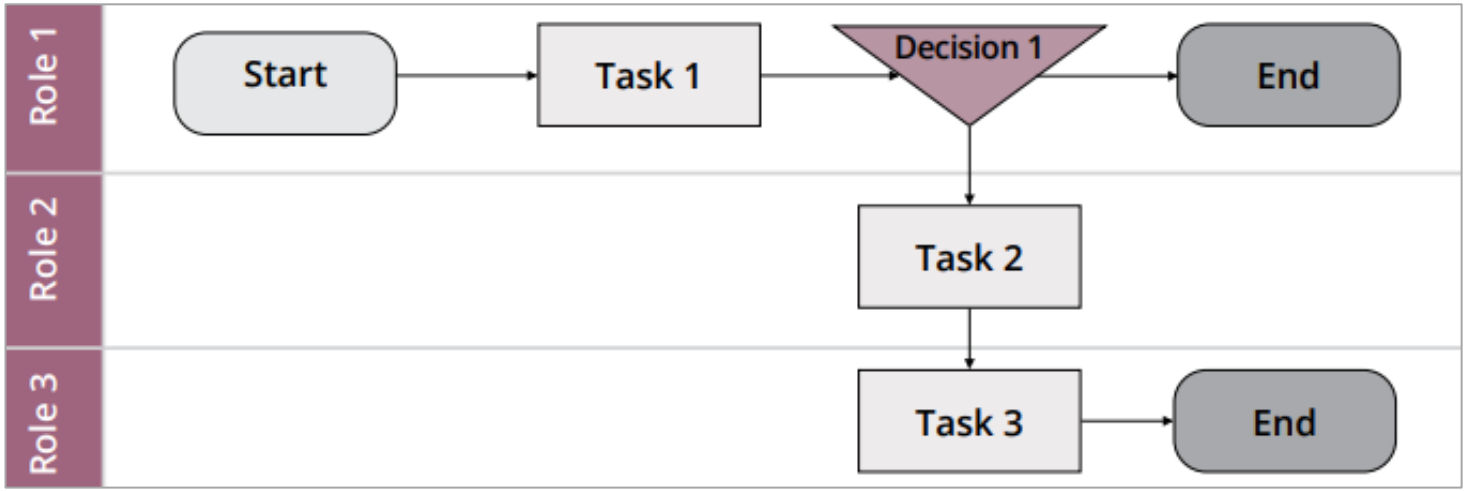
**NACHC Care Team Planning Worksheet - Patient Appointments**

# STEP 3

## *DOCUMENT WORKFLOWS*

Document workflows with step-by-step instructions detailing how to complete each task.

For workflows in need of optimization, use a swimlane diagram (also known as a process map) to represent the process visually and identify opportunities for improvement (see NACHC resource Swimlane Diagrams: Process Improvement for Care Teams Optimization).



# STEP 4

## *TRAIN STAFF*

Train staff in workflows and in quality improvement techniques to support care team involvement in continuous process improvement (see NACHC Improvement Strategy Action Guide).

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

# STEP 5

## *ENCOURAGE PATIENT ENGAGEMENT WITH EXTENDED & INTEGRATED CARE TEAM MEMBERS*

- Primary care providers champion patient engagement with extended and integrated care team members.
- Connect patients to extended/integrated care team members through warm handoffs, when possible.
- Support patients with the use of with technology that may be used by the care team (e.g., telehealth, patient portals, text messaging, remote patient monitoring, etc.).
- See the NACHC Patient Engagement Action Guide for more information.

# STEP 6

## *SET GOALS AND MEASURE CARE TEAM IMPACT*

- Set goals for care team performance. For example:
  - ✓ Reducing the number of open referrals
  - ✓ Closing care gaps for colorectal cancer screening
  - ✓ Increasing the number of patients enrolled in care management
- Involve care team members in process improvement activities.
- Display measure performance dashboards in a place where they are visible to the entire care team.
- See NACHC Improvement Strategy Action Guide for more information.

# **HOW** to optimize care teams?

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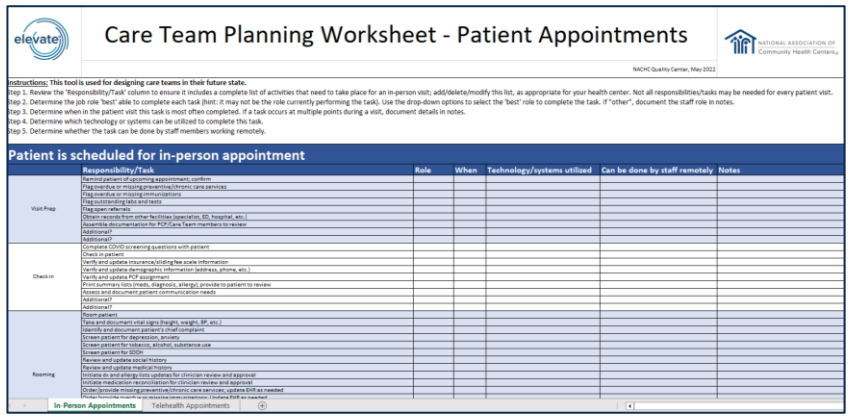
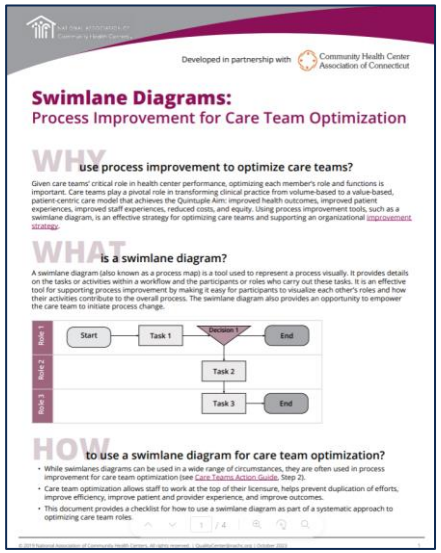



**Care Team Planning Worksheet**




**Swimlane Diagrams: Process Improvement for Care Team Optimization**

# Featured PCA

Georgia Primary Care Association

**Dr. Theresa Jacobs, MD, FAFFP**
Clinical Director
Georgia Primary Care Association

Dr. Theresa R. Jacobs is a board-certified family medicine physician providing the highest quality comprehensive health care to the uninsured and underserved at risk populations. She serves as the Medical Director for the Georgia Primary Care Association and the Georgia Family Planning System (Title X program). There are 232 clinical sites scattered throughout Georgia, servicing over 600,000 Georgians. She is also the Chair of the education and research committee for the Georgia Academy of Family Physicians.

Dr. Jacobs is a scholar who earned an Associate Degree of Science in Industrial Chemistry from Ferris State University, Big Rapids, Michigan; a Bachelor of Science in Microbiology from Eastern Michigan University, Ypsilanti, Michigan; and her Medical of Doctorate Degree from Michigan State University College of Human Medicine, East Lansing, Michigan. She completed her residency in Family Medicine at Morehouse School of Medicine, Atlanta, Georgia where she served as chief resident for one year. She is a Fellow of the American Academy of Family Physicians. She and her sister (Crystal Hammond) are the founders of "The John and Sally Horhn Foundation (JASH)", a nonprofit organization that's committed to helping disadvantage children excel academically.

# Featured PCA

Georgia Primary Care Association

## Standing Orders

- Standing orders are written protocols that authorize designated members of the health care team (e.g., nurses or medical assistants) to complete certain clinical tasks without having to first obtain a physician order.
- Using standing orders can improve efficiency by freeing physicians to focus on more complex care.
- The medical director is responsible for approving standing orders and supervising their use, but all clinicians should agree with them to avoid confusion, mistakes, and care lapses.

# Featured PCA

Georgia Primary Care Association

## Standing Orders – *Sample, Adult Medicine*

- Patients with diabetes: **A1C and Accuchek**
- Abdominal Pain or Lower Back Pain: **UA**
- Urinary concerns: **UA**
- Breathing concerns: **Pulse ox**
- Missed LMP: **Urine HCG**
- Adult Physical: **UA**
- Bleeding concerns: **Hgb or Hct**
- Dizziness/Fainting: **Blood Pressure and Pulse- Sitting, Lying and Standing**

# Featured PCA

Georgia Primary Care Association

**Let's practice! What would you do for the following patient before the provider enters the room?**

Patient: 40yo, male

Reason for visit: Annual physical

# Featured PCA

Georgia Primary Care Association

**Let's practice! What would you do for the following patient before the provider enters the room?**

Patient: 65yo, female

Reason for visit: Annual physical

# Care Teams & Workforce

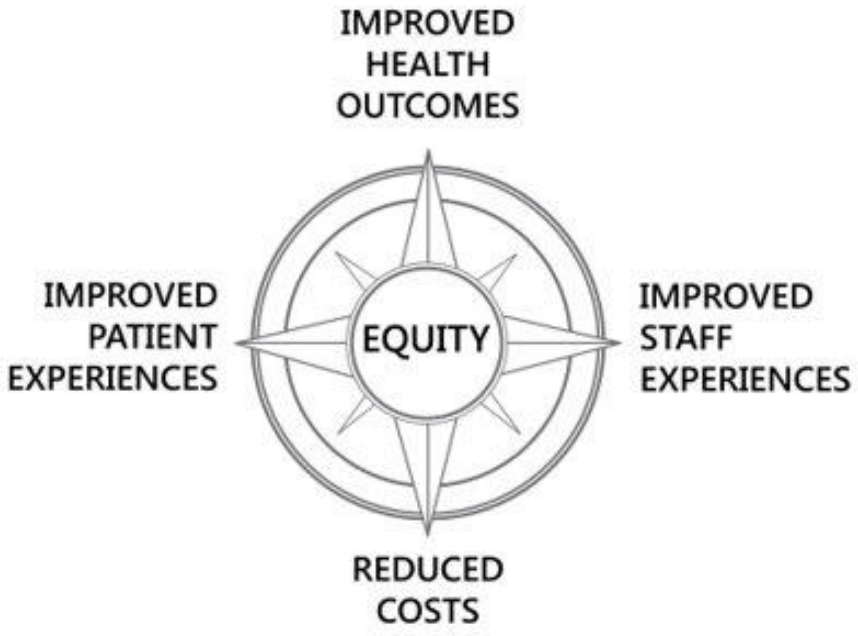
## Our Goal

**Improved Health Center Performance**

through

**Systems Transformation**

## Quintuple Aim Goals



# Workforce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Community Health Centers®

# The Value Transformation Framework (VTF)


## INFRASTRUCTURE

**IMPROVEMENT STRATEGY**
Define vision, goals, and action steps that drive transformation and improved performance.

**HEALTH INFORMATION TECHNOLOGY**
Leverage health information technology to track, improve, and manage the Quintuple Aim.

**POLICY**
Pursue decisions, plans, and actions that help secure support and resources for health centers and expand access for under-served populations.

**PAYMENT**
Utilize value-based and sustainable payment methods and models to facilitate care transformation.

**COST**
Address the direct and indirect expense of delivering comprehensive primary care to health center patients while considering the total cost of care.

## CARE DELIVERY

**POPULATION HEALTH MANAGEMENT**
Use data on patient populations to target interventions that advance the Quintuple Aim.

**PATIENT-CENTERED MEDICAL HOME**
Employ a model of care that transforms the delivery of primary care into a comprehensive, patient-centered system focused on high quality, accessible, and coordinated care.

**EVIDENCE-BASED CARE**
Make patient care decisions using clinical expertise and best-practice research integrated with patient values and self-care motivators.

**CARE COORDINATION AND CARE MANAGEMENT**
Facilitate the delivery and coordination of care for high-risk and other patient segments through targeted services, provided when and how needed.

**SOCIAL DRIVERS OF HEALTH**
Address the social, economic, and environmental circumstances that influence patients' health and the care they receive.

## PEOPLE

**PATIENTS**
Intentionally and actively incorporate the patient perspective into governance, care system design, and individual care.

**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.

**GOVERNANCE AND LEADERSHIP**
Apply position, authority, and knowledge of governing bodies (boards) and leaders to support and advance the center's transformation goals.

**WORKFORCE**
Leverage a trained and fully engaged staff to successfully address the health center's mission and goals, with optimal joy in work.

**PARTNERSHIPS**
Collaborate and partner with external stakeholders to pursue the Quintuple Aim.

***Organizing framework*** to guide health center systems change and value transformation

***15 Change Areas organized by 3 Domains***
**Infrastructure Care Delivery People**

# VTF Assessment: Workforce


## VTF Change Area: Workforce

*Leverage a trained and fully engaged staff to successfully address the health center's mission and goals, with optimal joy in work.*

| | 1. Learning | 2. Basic | 3. Applied | 4. Skilled | 5. Expert |
|---|---|---|---|---|---|
| **Workforce Strategy** | | | | Leadership has an active workforce development* program (e.g., provides incentives for learning, supports training costs) with attention to diversity, equity, and inclusion (DEI). Recognizes and supports clinical and/or administrative champions. | |
| **Value-Based Care** | | | | Health center has a staff value-based care education plan and active education and training program specific to practice transformation and value-based care. | |
| **Culture** | | | | Health center leadership offers staff and providers meaningful engagement opportunities on steering committees, task forces, or advisory groups. | |
| **Staff Experience** | | | | Health center has named staff experience/satisfaction as an organizational priority within its strategic plan. Leadership regularly reports to the Board on staff experience/satisfaction and retention metrics; leadership uses survey data to inform workforce development program and adjust processes, as needed. | |



*Workforce development refers to programs, learning opportunities, and other efforts that allow employees to improve their skills and advance in their career.

# WHY focus on workforce?

- Workforce wellness impacts not only staff experience but also patient experience, safety, quality, and costs.
- High levels of burnout, depression, and suicide among health care professionals.
- Burnout is symptomatic of organizational issues and systems.
- Joy at work is possible!!!

A focus on

**systems change**

**can create, protect, and nurture** individual and collective **resiliency**.

https://nam.edu/a-pragmatic-approach-for-organizations-to-measure-health-care-professional-well-being/
https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2588814
https://pubmed.ncbi.nlm.nih.gov/29505159/
http://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Improving-Joy-in-Work.aspx

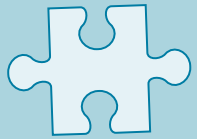
# **HOW** to address workforce wellness?

**Standardized, Flexible Systems**

- Standardization provides for reliability and the ability to successfully produce intended outcomes time and time again.
- Minimizes variation; allows for reliable and consistent application of evidence.
- Flexibility allows for adaptation and consideration of individual, cultural, or other personalization.
- Standardization allows for more effective staff training.

**Wider Care Teams**

- ‘Sharing the Care’ model and reallocation of responsibility to a wider group of care team members.
- Document workflows; train staff.
- Patient engagement with extended/integrated care teams.



**Deeper Partnerships**

- Define the role of patients as partners in their care.
- Develop strategies for partnerships with key stakeholders, including: providers, payers, purchasers, policy makers, producers, pioneers, and PATIENTS!

# IHI* Framework for Improving Joy at Work

## 4 Steps for Leaders:


*Institute for Health Care Improvement (IHI)
http://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Improving-Joy-in-Work.aspx
See Appendix B for Change Ideas to test.
See Appendix C for Assessment Tools.

# 9 Critical Components for Improving Joy at Work

Physical & Psychological Safety+

Meaning & Purpose+

Choice & Autonomy+

Camaraderie & Teamwork+

Recognition & Rewards

Participative Management

Daily Improvement

Wellness & Resilience

Real-Time Measurement

http://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Improving-Joy-in-Work.aspx

+These four components, along with fairness and equity, relate to Maslow's Hierarchy of Needs and are called out by IHI as fundamental human needs that must be met to improve joy at work.

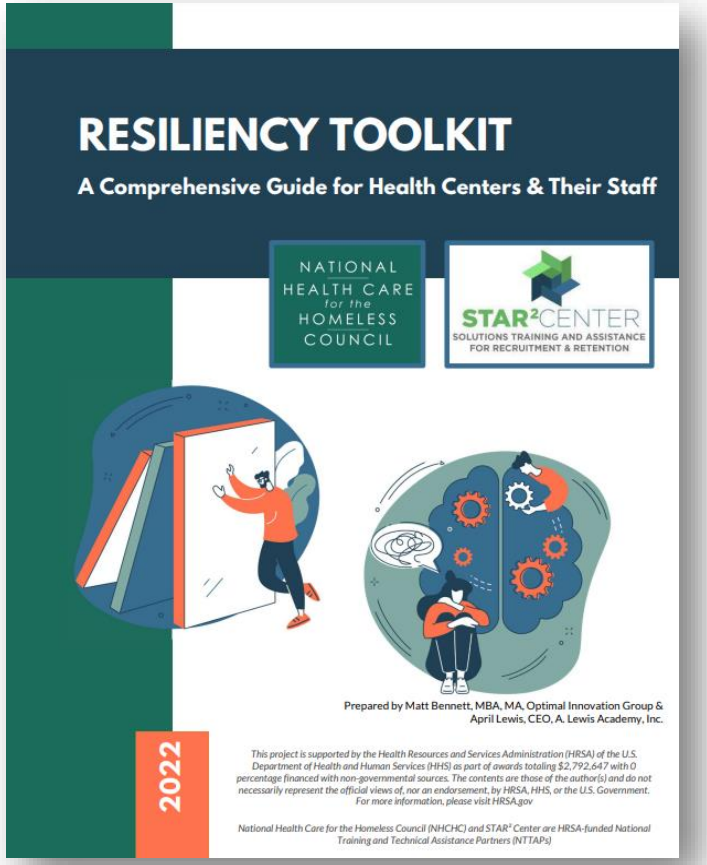
# Featured NTTAP

**Helen Rhea Vernier, MSc**
*(she/her)*
Associate Director of Workforce Development, STAR² Center
Association of Clinicians for the Underserved

Helen Rhea Vernier, MSc, is the Associate Director of Workforce Development, STAR² Center at ACU. She joined ACU in April 2021 and works at the STAR² Center on training and course development to advance health center workforce recruitment and retention. With a Master's degree in the Politics of Conflict, Rights, and Justice, Helen has a strong background in the underlying factors that impact individual and community health. Before joining the ACU team, Helen worked at the Community Health Association of Mountain/Plains States (CHAMPS) as the Programs Coordinator, Population Health. She received her Master of Science from SOAS, University of London, and her Bachelor of Arts from Lewis & Clark College.

STAR² Center Resources

# Featured NTTAP




**Resiliency Toolkit**

**Individual Health & Resiliency**

- Threats to resiliency, health, & productivity
- Stages of burnout
- The impact of burnout
- Resiliency & wellness

- **Organizational Strategies for Preventing Burnout & Building Resiliency**
- Job demands
- Job resources
- Engagement

**System Strategies for Resiliency, Engagement, & Performance**

- Technical skills (e.g., strategic planning, change management)
- People skills (e.g., communication, coaching & mentoring, etc.)

# What is resiliency?

- "Safety first"
- Recognition of stress/stressors (self/others)
- Healthy management & coping with acute/chronic stressors
- Removal of, or disengagement from, threats to health/wellbeing
- Creating an environment where staff can exercise personal wellbeing strategies
- Creating an environment that reduces/eliminates stressors whenever possible
- Assessment of impact of stressors and proper mitigation of/healing from trauma
- Recovery from impact of stressors
- Learning from prior stressors and impacts

# What is not resiliency?

- A solely individual or organizational responsibility
- Getting used to stress or numb to traumatic situations
- A personal weakness or failing if one is not “resilient” to a situation or event

# Who is responsible for resiliency?

- Organization
- Leadership
- Departments/Teams
- Managers/Supervisors/Team Leads
- Individuals
- (And an individual's mental health practitioner of choice)

# Featured Health Center

**Jeanie Blake, RN, MSN, MBA**
Chief Experience Officer
Muskingum Valley Health Centers, Inc.

Jeanie Blake joined MVHC in 2011 as Chief Operating Officer and transitioned to Chief Quality Officer in May of 2014. She currently serves as the Chief Patient Experience Officer. Jeanie obtained her Master of Nursing from the University of South Alabama; Master's in Business Administration from Ohio University; Bachelor's of Science in Nursing from Bowling Green State University. She serves on the Nursing Advisory Boards for Ohio University, Mid-East Career & Technology Center, and Muskingum University. She also serves on the Head Start Advisory Board and Area Agency on Aging.

# Featured Health Center

## About Muskingum Valley Health Centers, Inc.

- Located in Zanesville, Ohio (6 service locations, plus: urgent care, pharmacy, addiction services, dental, women's health, and school-based services)
- 70,122 patients
- 550 employees
- MVHC participates in the Medicaid CPC and CMC programs, and the Medicare ACO Reach program
- MVHC is the largest health center in Ohio





# Featured Health Center


## Acquire and retain a workforce that is an optimum fit for our mission:

- Utilize motivational-based interviewing process to acquire high performers who are internally motivated for roles that match their interest so they can bring passion. (Adopted from the method developed by Carol Quinn).
  - The questions are situational, designed to identify individuals who believe there is a solution to a problem.
  - "Tell me about a specific time that you encountered a patient un-engaged in their care, what actions did you take? What was the end result? "
- Deliver a comprehensive, three-day orientation, including:
  - Presentations from the leaders on organizational mission, vision, strategic initiatives, quality and safety program, patient experience components, and employee benefits. Lunch with the new hires manager
  - A lunch for the new employee and their manager to foster the development of a meaningful relationship.

# Featured Health Center

## Acquire and retain a workforce that is an optimum fit for our mission *(continued)*:

- Provide a mentorship program:
  - Each new employee is assigned a mentor within their department who serves as a guide, advisor, and teacher.
  - Mentors are selected on a volunteer basis. The individuals must be proficient in their role, approachable, a good listener, strong communicator with a positive attitude.
  - The mentor and department manager develop a mentorship checklist comprised of key responsibilities for the mentee's role.
  - The mentor/mentee meet weekly throughout the six-month probationary period.
- Engage in regular performance reviews to provide ongoing feedback:
  - The manager conducts performance reviews with the new employee at 1, 3, and 6 months.
  - Annual performance review process was recently restructured to serve more as an open dialog between the employee and manager, rather than a traditional scoring system.

# Featured Health Center


## Utilize multiple pathways for communication:

- In-person monthly department meetings
- A text platform that enables each manager to send out updates to their entire team.
- Monthly newsletter to share information and highlight new hires, birthdays, and work anniversaries.
- CEO sends a hand-written anniversary card to each employee (all 550!).
- Host an annual employee recognition event during health center week, closing for an afternoon.
    - Gathering includes, food, activities and prizes/giveaways.
- An active Facebook and Instagram account that we utilize for both patient and employee communication.

# Featured Health Center


## Leverage team-based care to improve staff (and patient!) experience:

- Each provider has two clinical support staff who are a MA and LPN, in addition to the Care Manager.
- The MA is responsible for the rooming process, the LPN is the discharger. The Care Manager is an RN who is part of the population health team. The Care Manager provides ongoing formal care management for high-risk patients.
- SDOH staff embedded in the service line providing psychosocial support to the patient, affording the clinical team the ability to focus on the medical aspect of care. (This serves as a dual support to both the patient and the clinical team.)
- The service lines are open pods to enhance the ability of the teams to communicate easily throughout the day.

# Featured Health Center

## Muskingum Valley Health Centers Ratings and Trends

**About Glassdoor ratings**

Ratings may vary depending on what filters are applied, but ratings include reviews in all languages Learn More

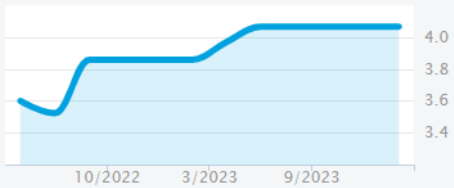
| | |
|---|---|
| Overall | 4 |
| Culture & Values | 3.9 |
| Diversity & Inclusion | 3.9 |
| Work/Life Balance | 4 |
| Senior Management | 3.2 |
| Compensation and Benefits | 3.4 |
| Career Opportunities | 3.1 |

100% Recommend to a Friend

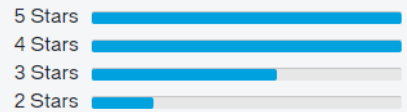
87% CEO Approval

88% Positive Business Outlook

Overall Trend




Overall Distribution




Home | Company reviews | Find salaries

**Muskingum Valley Health Centers**

3.9 ★★★★☆ 12 reviews

**Overall rating**

3.9 ★★★★☆

Based on 12 reviews

| | |
|---|---|
| 5 ★ | 3 |
| 4 ★ | 7 |
| 3 ★ | 1 |
| 2 ★ | 0 |
| 1 ★ | 1 |

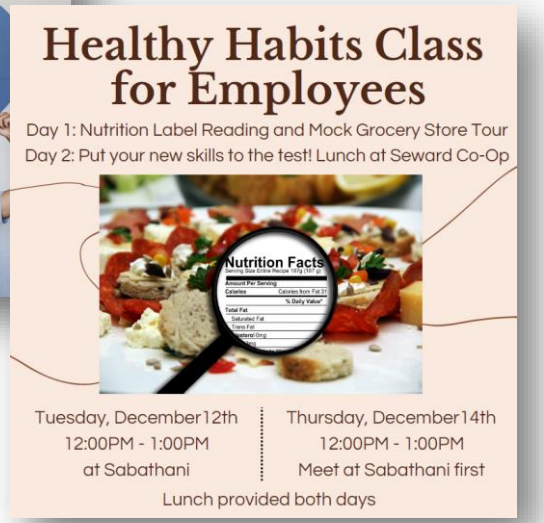
**Ratings by category**

- 4.3 ★ Work/Life Balance
- 4.3 ★ Compensation/Benefits
- 3.4 ★ Job Security/Advancement
- 3.4 ★ Management
- 4.0 ★ Culture

# Featured Health Center RESOURCES!

SOUTHSIDE
Your Community Health Services




- Staff Wellness Survey Questions
- Staff Wellness Survey Results Overview, Plan, and Intro to EAP
- Sample Newsletter – Organizational Update on Quality Awards and Employee Cooking Class Launch
- Employee Cooking Class Feedback Form
- Employee Healthy Habits Class Launch
- Employee Healthy Habits Class Feedback Form
- Relational Practices
- Quarterly Staff Survey Questions
- Quality Update Examples

**Access ALL these resources here**

NATIONAL ASSOCIATION OF Community Health Centers®

# Featured NTTAP

MOSES/WEITZMAN Health System

**Bianca Flowers**
Project Manager
Moses/Weitzman Health System

Bianca Flowers is the Project Manager for the Health Resources and Services Administration's (HRSA's) National Training and Technical Assistance Partner (NTTAP) on Clinical Workforce Development at Community Health Center, Inc. (CHC)/Weitzman Institute. In this role, she designs, implements, and oversees free training and technical assistance (T/TA) initiatives for health centers nationwide. Bianca manages project planning and communication with internal and external partners, facilitating national webinars and activity sessions focusing on key areas such as training the next generation, transforming teams, and addressing emerging issues. Previously, she served as Health Educator and Special Projects Coordinator at Suwannee River Area Health Education Center in Florida, emphasizing interprofessional learning for health professions students. Bianca holds a Master's in Public Health from Southern Connecticut State University and has been a Certified Health Education Specialist (CHES®) since 2019.

# Featured NTTAP

MOSES/WEITZMAN Health System

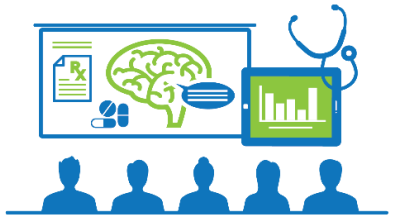
## National Training and Technical Assistance Partners
## Clinical Workforce Development

Provides free training and technical assistance to health centers across the nation through national webinars, learning collaboratives, activity sessions, trainings, research, publications, etc.

**Team-Based Care**

- Fundamentals of Comprehensive Care
- Advancing Team-Based Care

**Training the Next Generation**



- Postgraduate Residency and Fellowship Training
- Health Professions Training

**Emerging Issue**

- HIV Prevention

**Advancing Health Equity**

**Preparedness for Emergencies and Environmental Impacts on Health**

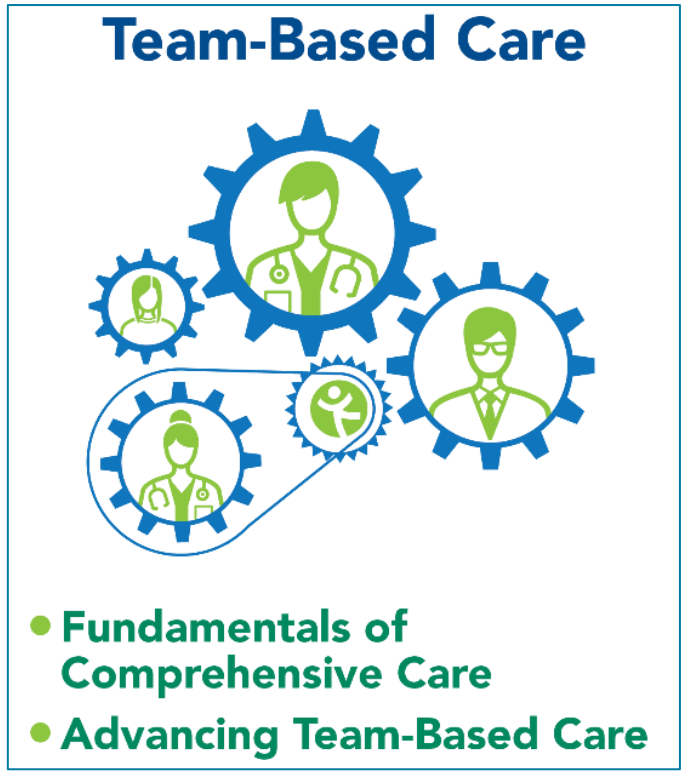

https://www.weitzmaninstitute.org/ncaresources

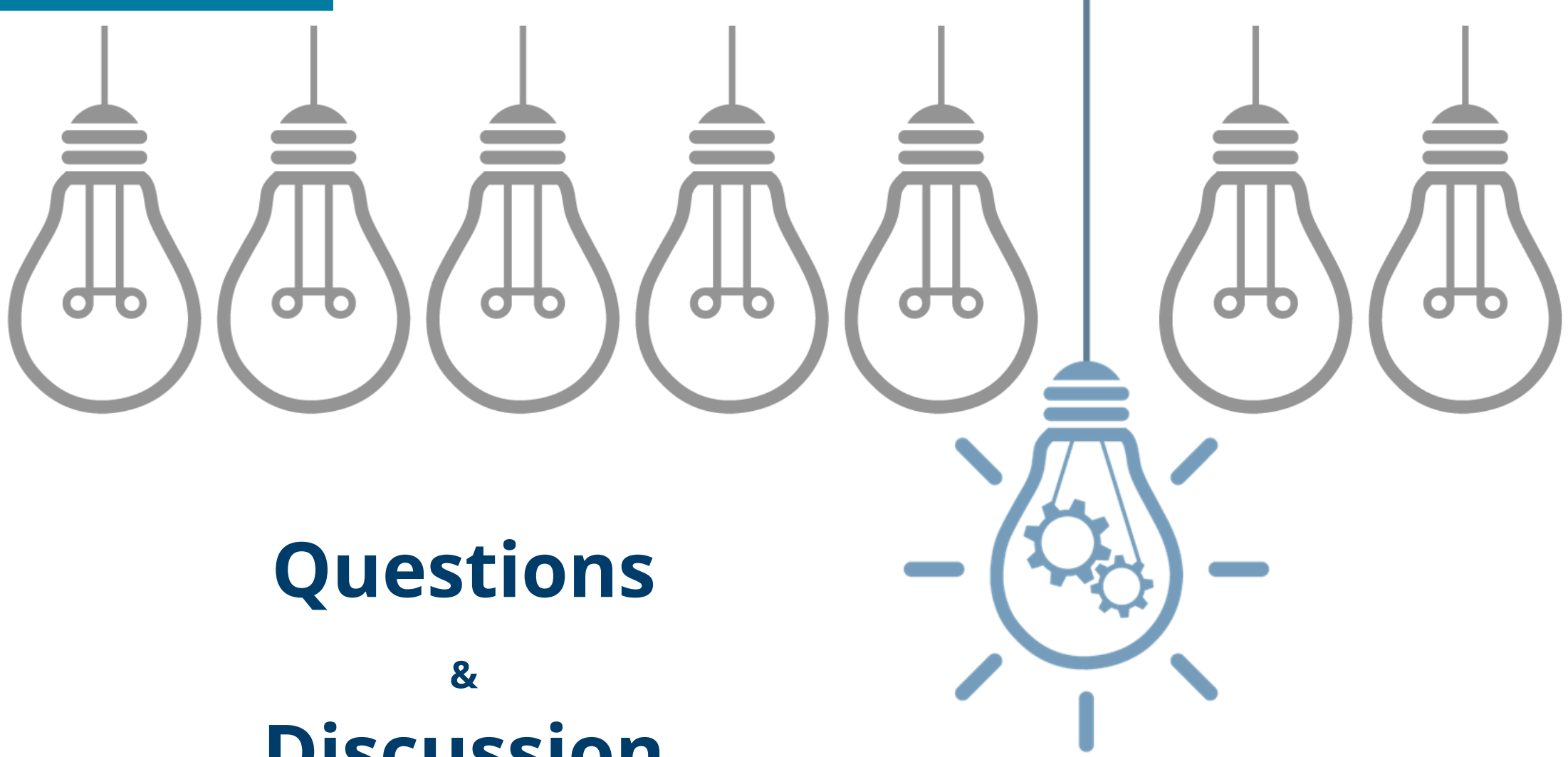
# Featured NTTAP

MOSES/WEITZMAN Health System

## Advancing Team-Based Care Learning Collaborate

- Free four-month participatory experience designed to provide knowledge, tools, and coaching support to help health centers and look-alikes implement advanced models of team-based care.
- In this Collaborative, health center teams will learn how to:
  - Identify a team to work on a quality improvement project centered around a UDS measure
  - How to run effective team meetings and collaborate amongst team members
  - Use quality improvement concepts and skills to facilitate their implementation of a model of high-performing team-based care
  - Conduct self-assessments of their current team-based care model to identify areas for process improvement and role optimization
- Learning Collaborative content includes:
  - Didactics on quality improvement tools and skills
  - Role of Data and Population Health Management in Team-Based Care
  - Role of the Medical Assistant (MA) and Registered Nurse (RN) in Team-Based Care
  - Integrated Behavioral Health
  - *And more!*
- For more information/questions, please visit the application link, or reach out to Meaghan Angers (angersm@mwhs1.com)





# Questions

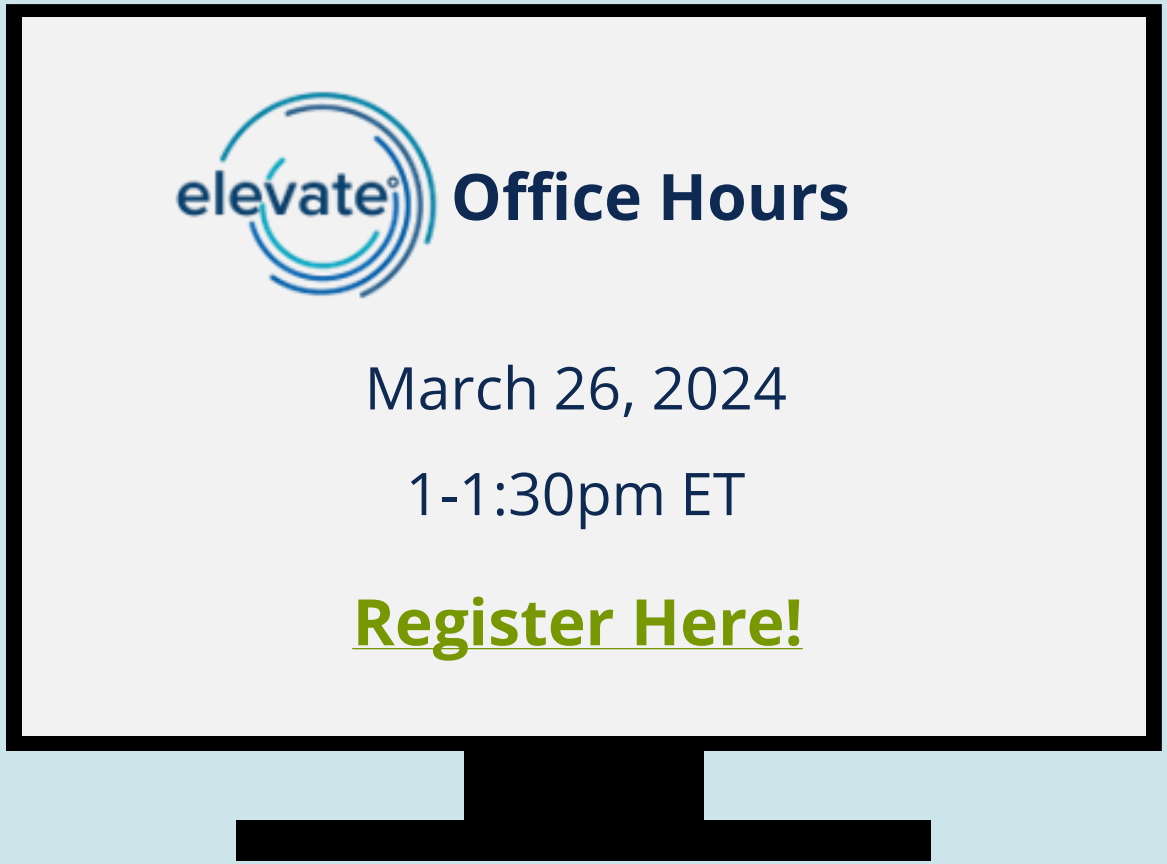
# &

# Discussion

# Join us for Elevate Office Hours!

## Join us for March Elevate Office Hours!

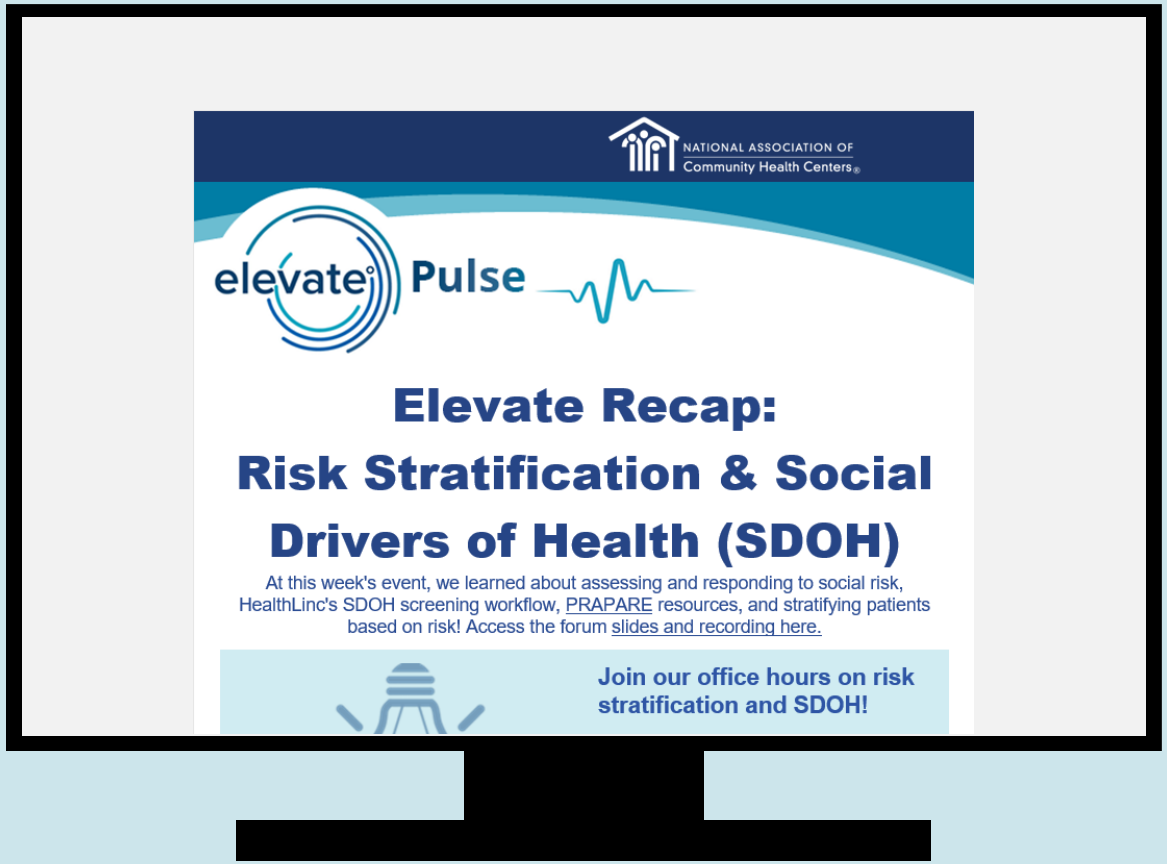
- Ask questions about this month's Learning Forum Topic *(Care Teams & Workforce)*
- Share challenges, best practices, and lessons learned
- Engage with Elevate peers across the country!



# Elevate Pulse

Be on the lookout for the **Elevate Pulse** from the **NACHC Quality Center:**

- ✓ Slides & recordings
- ✓ Tools & resources
- ✓ Upcoming opportunities



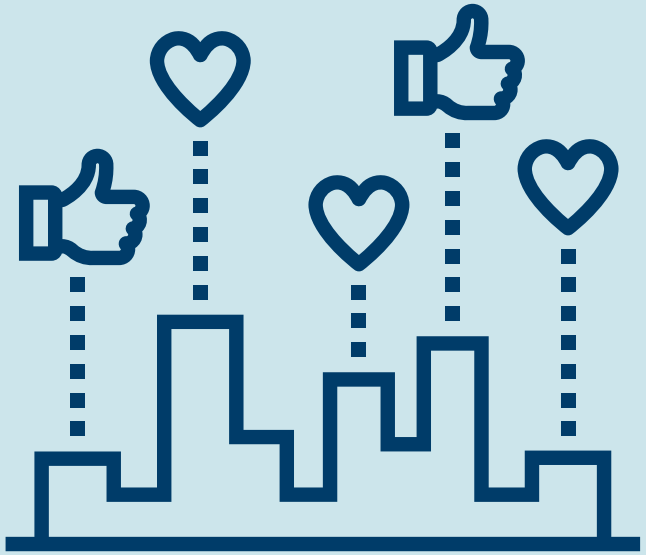
# NACHC's Learning Hub

***FREE* on-demand learning sessions, microlearning courses, and printable resources, developed by NACHC exclusively for health centers and partners!**

- ✓The Aging Population and Dementia
- ✓Patient Engagement
- ✓Care Management
- ✓Value-Based Care
- ✓Optimizing Care Teams
- ✓Elevate Session Recordings and Slides

**Access the NACHC Learning Hub here!**

**Need help signing in?**
**Click here for instructions!**



# Provide Us Feedback

# FREE Professional Development Trainings

## Lifestyle Coaching

Professional Development Opportunity

***For:*** *Health center staff with some knowledge of the National Diabetes Prevention Program who are interested in facilitating a PreventT2 lifestyle change program.*

## Healthy Weight

Professional Development Opportunity

***For:*** *Health center staff interested in enhancing care for people with higher weight, including those with diabetes and other related conditions.*

**Trainings begin late April/early May**

**Application available here, due March 29th!**

# Complete VTF Assessments ➡ Access FREE Resources

**Complete 3+ VTF Assessments:**

Health center is eligible for a 6-month trial membership to an online document management platform to support health center OSV preparation and ongoing compliance!

**Save the Date:**

***March 25, 2024, 1-2pm ET***

RegLantern Information Session for Health Center Compliance Tool Trial Subscription Register here!

REGLANTERN

## RegLantern Continuous Compliance Tool

- Cloud-based platform that helps health centers move toward continuous HRSA compliance
- FTCA Application Tool
- Allows health centers to compile and organize all documents demonstrating compliance in one place
- Embedded with checklists, alerts, and reminders
- Allows a health center to share documents with on-site reviewers during Operational Site Visit (OSV) through Citrix ShareFile integration
- Access to exclusive discounts for health centers interested in continuing subscription after trial period.
- Free Form 5A Review

CENTER FOR COMMUNITY HEALTH INNOVATION

# NACHC'S INNOVATION INCUBATOR

Use a **human-centered design approach** to build innovative solutions to improve health equity through **access to nutritious food.**

**Award Amount**: $30,000 / **Application Due**: March 22

**Email Questions to** innovation@nachc.org

## bit.ly/NACHC-CCHI-Incubator-2024




# National Committee for Quality Assurance

## Video Opportunity!

NCQA is creating an ongoing video series highlighting community health center success stories, *How the PCMH model assists health centers with serving patients & meeting the mission,* and **YOUR health center could be featured!**

- **Current video topic: *How PCMH helps health centers operate under value-based arrangements***
- Commitment: two days of on-site filming with video subcontractor
  - Staff & patient interviews plus "b roll" background footage
- Exact schedule prepared to minimize disruptions
  - Individual interviews take around 60 minutes

**If interested, email qualitycenter@nachc.org with a statement of interest and brief description of how PCMH helps your health center operate under value-based arrangements. The NACHC Quality Center will share all responses with NCQA for final selection.**

Previous videos in the series available here.

NCQA
Measuring quality.
Improving health care.

## 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 Monthly Learning Forum:**

Care Coordination & Care Management and Payment

elevate

March 12, 2024
1:00 – 2:00 pm ET

NATIONAL ASSOCIATION OF Community Health Centers®

elevate°

# Together, our voices elevate° all.


**The Quality Center Team**

*Cheryl Modica, Cassie Lindholm, Holly Nicholson, Tristan Wind, Rachel Barnes*

qualitycenter@nachc.org

# CLINICAL WORKFORCE PARTNERSHIPS

## NACHC partners to train new and diverse clinical leaders who are prepared to serve diverse communities with:

- **A.T. Still University**
  - 2 medical, 2 dental, 2 PA schools opened with NACHC
  - 200 CHC sites educate ATSU students and host 1,500 formal health center rotations
  - 740 ATSU students have been trained in CHCs
  - *NEW:* College for Healthy Communities & the Underserved (CHC-U) opened in 2021, 1st class of 88 Physician Assistants graduated in Sept 2023
- **The National Health Service Corps** (NACHC developed Clinical and PPR programs)
- **The Teaching Health Center Graduate Medical Education (THCGME) Program**
- **The Nurse Corps Scholarship Program** and other nursing workforce development programs
- **BHW, BPHC, NRHA, NCMW** and others

# HEALTH CENTER PROFESSIONAL DEVELOPMENT TO SUPPORT VALUE TRANSFORMATION

**NACHC's recently launched Health Center Professional Development Program courses include:**

- **Care Manager Essentials:** Training for health center care managers with years' experience
- **Care Manager Intermediate:** Training for health center care managers with over 2 years' experience
- **Care Manager Leading:** Training for health center staff who supervise care managers
- **Community Health Workers:** Training for new health center CHWs
- **Community Health Worker Supervisors:** Training for health center staff who supervise CHWs
- **Quality Improvement:** Training for health center staff in QI roles
- **Lifestyle Coach Training:** Training to provide the knowledge, skills, and experience to deliver a successful Diabetes Prevention Program
- **Person-Centered Care for Individuals who have Higher Weight:** Training in best practices to support individuals with body mass index
- **Health Center Nursing Professionals:** A learning community of health center nurses focused on the role of nursing in value transformation

***Health center participants from every HRSA Region, 40 states, DC, and PR!***

# NATIONAL RESULTS

## Outcomes

**Engagement (4.95)**
Interests and connectivity to work, colleagues and workplace

**Intention to Stay (4.86)**
Plans to stay at the health center

**Job Satisfaction (4.63)**
Sense of satisfaction working at the health center

**Burnout* (3.99)**
Feelings of emptiness, work overload, loneliness and exhaustion

Health center staff:

- ✓ Are highly engaged
- ✓ have high job satisfaction and do not plan on leaving
- ✓ Staff more likely to report they are *not* burned out

## Drivers

**Mission Oriented (5.34)**
Alignment of goals of the organization and individual

**Meaningfulness (5.30)**
Sense of fulfillment, purpose and personal engagement

**Social Support (5.05)**
Formal and informal workplace help

**Supervision & Leadership (5.03)**
Guidance, engagement and motivation from immediate supervisors and senior leaders

**My Work Team (4.88)**
Communications, collaboration and cohesion amongst team members

- ✓ 17 drivers surveyed; all mean scores above the 3.5 cut point
- ✓ Lowest scores were for compensation (3.64) and workload (4.13)
- ✓ Staff feel strongly positive about mission orientation meaningfulness, social support and supervision

# Our Prescription for the Primary Care Workforce

## Recruitment

## Retention

## Reform

# How do we retain and assure the health of our workforce?

## *Teamwork – Time – Technology – Transitions*


REVIEW

MAYO CLINIC

### Effect of Organization-Directed Workplace Interventions on Physician Burnout: A Systematic Review

Paul F. DeChant, MD; Annabel Acs, MPH; Kyu B. Rhee, MD; Talia S. Boulanger, MS; Jane L. Snowdon, PhD; Michael A. Tutty, PhD; Christine A. Sinsky, MD; and Kelly J. Thomas Craig, PhD

**Abstract**

To assess the impact of organization-directed workplace interventions on physician burnout, including stress or job satisfaction in all settings, we conducted a systematic review of the literature published from January 1, 2007, to October 3, 2018, from multiple databases. Manual searches of grey literature and bibliographies were also performed. Of the 633 identified citations, 50 met inclusion criteria. Four unique categories of organization-directed workplace interventions were identified. *Teamwork* involved initiatives to incorporate scribes or medical assistants into electronic health record (EHR) processes, expand team responsibilities, and improve communication among physicians. *Time* studies evaluated the impact of schedule adjustments, duty hour restrictions, and time-banking initiatives. *Transitions* referred to workflow changes such as process improvement initiatives or policy changes within the organization. *Technology* related to the implementation or improvement of EHRs. Of the 50 included studies, 35 (70.0%) reported interventions that successfully improved the 3 measures of physician burnout, job satisfaction, and/or stress. The largest benefits resulted from interventions that improved processes, promoted team-based care, and incorporated the use of scribes/medical assistants to complete EHR documentation and tasks. Implementation of EHR interventions to improve clinical workflows worsened burnout, but EHR improvements had positive effects. Time interventions had mixed effects on burnout. The results of our study suggest that organization-directed workplace interventions that improve processes, optimize EHRs, reduce clerical burden by the use of scribes, and implement team-based care can lessen physician burnout. Benefits of process changes can enhance physician resiliency, augment care provided by the team, and optimize the coordination and communication of patient care and health information.



From IBM Watson Health, Cambridge, MA (P.F.D., A.A., K.B.R., T.S.B., J.L.S., K.J.T.C.); and the American Medical Association, Chicago, IL (M.A.T., C.A.S.).

The prevalence of physician burnout is substantial, with more than half of US physicians reporting at least one symptom of burnout, which is significantly higher than that in the general population.[1] Burnout is defined as a long-term stress reaction marked by loss of enthusiasm for work (emotional exhaustion), feelings of cynicism (depersonalization), and a lack of sense of personal accomplishment.[2] Causes of physician burnout include time pressure, chaotic environments, requirements for electronic health records (EHRs), and responsibilities outside of work.[3]

Physician burnout can affect physician health and quality of care.[4–6] As a result of stress, physicians may experience depression or anxiety, may engage in alcohol and/or drug abuse,[7] and have suicide rates that are 1.2 to 2.4 times higher than that of the general population.[8] Work-related stress can also lead to lower patient satisfaction and care quality and increased medical error rates and malpractice risk.[9–11] Burnout also has potentially serious financial implications for the health care system[12–14] by leading to physician shortages and in costs to replace a physician, which can exceed $500,000 to $1,000,000 per physician.[5,15]

Interventions to address burnout have been classified as either physician-directed or

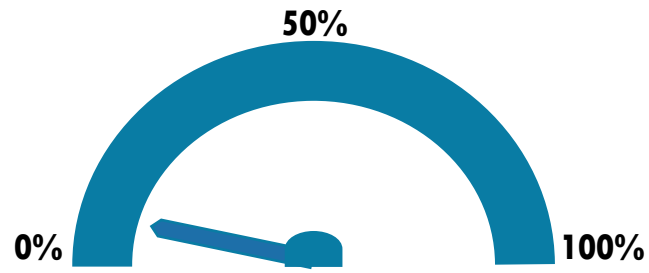


Mayo Clin Proc Inn Qual Out ■ December 2019;3(4):384-408 ■ https://doi.org/10.1016/j.mayocpiqo.2019.07.006
www.mcpiqojournal.org ■ © 2019 THE AUTHORS. Published by Elsevier Inc on behalf of Mayo Foundation for Medical Education and Research.

# Elevate Data Dashboard

| Health Centers that have taken the VTF Assessment YTD |
|---|
| 22 |

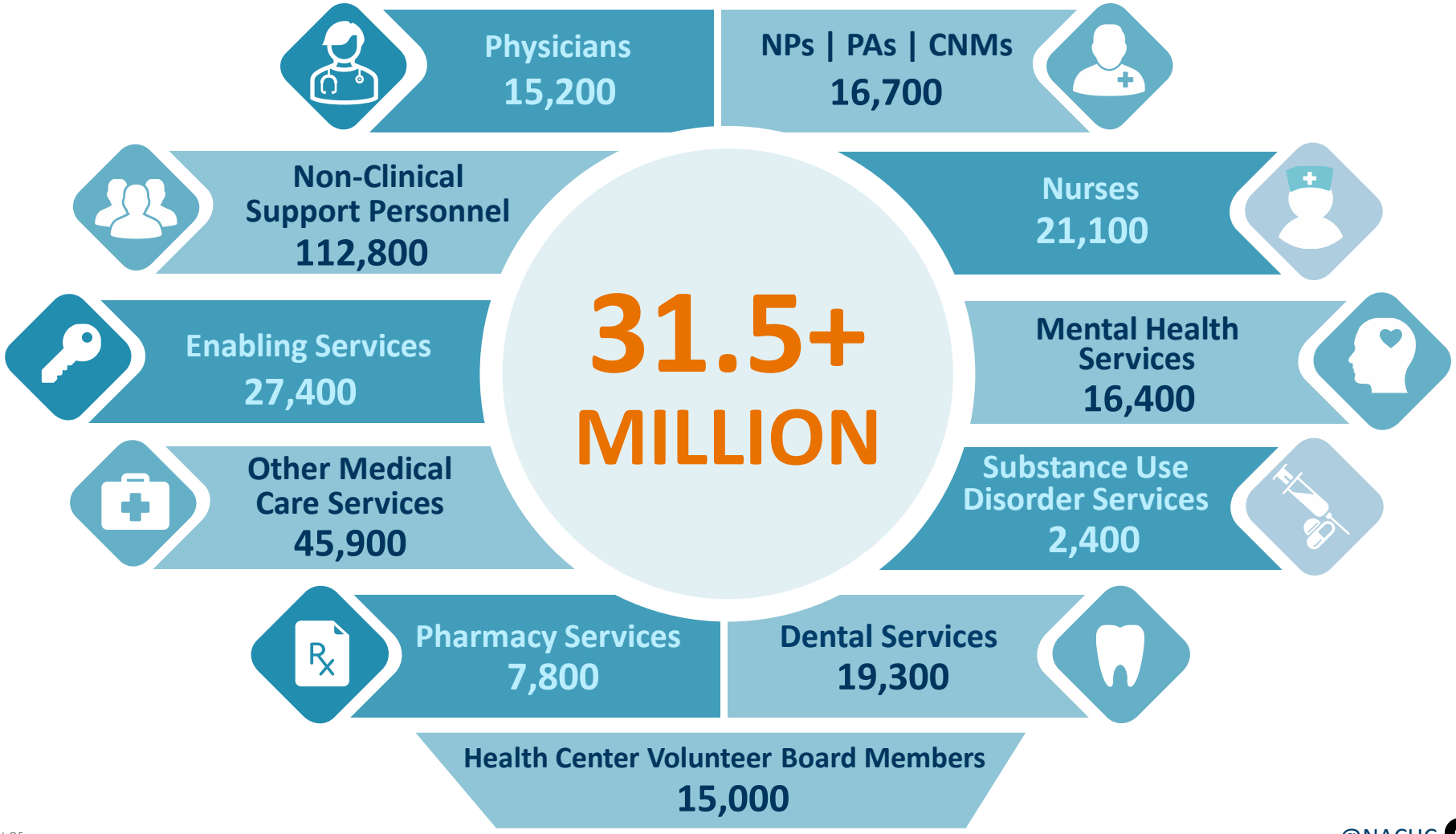
| Individuals Registered for Elevate | Health Centers Registered for Elevate | PCAs/HCCNs/NTTAPs Registered for Elevate | Public Health Partners Registered for Elevate |
|---|---|---|---|
| 5514 | 736 | 75 | 48 |




## YTD VTF Assessment Scores

| | | | | |
|---|---|---|---|---|
| Health Information Technology 2.91 | Improvement Strategy 3.23 | Policy 3.09 | Payment 3.00 | Cost 2.82 |
| Population Health Management 3.14 | Patient-Centered Medical Home 3.64 | Evidence-Based Care 3.64 | Care Coordination and Care Management 3.18 | Social Drivers of Health 2.82 |
| Patients 3.41 | Care Teams 3.14 | Leadership 2.68 | Workforce 2.68 | Partnerships 3.68 |

# CURRENT HEALTH CENTER WORKFORCE



# WHAT IS THE HEALTH OF OUR WORKFORCE?


| | |
|---|---|
| **Survey Administration:** | Nov. 2022 – Jan. 2023 |
| **Health Center Participation:** | **47%** (694) of all HRSA Funded health centers |
| **Completed Survey Responses:** | **36.4%** (52,357) of staff at participating health centers completed responses |
| **Scoring:** | 6-point Likert Scale<br>• 6 is "*Strongly Agree*"<br>• Anything above 3.5 is at least slightly agree<br>• 1 is "*Strongly Disagree*" |

# What is the Health of our Workforce? – National Results

## Outcomes

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