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Comprehensive Care Learning Collaborative

Session One: Wednesday December 6th, 2023

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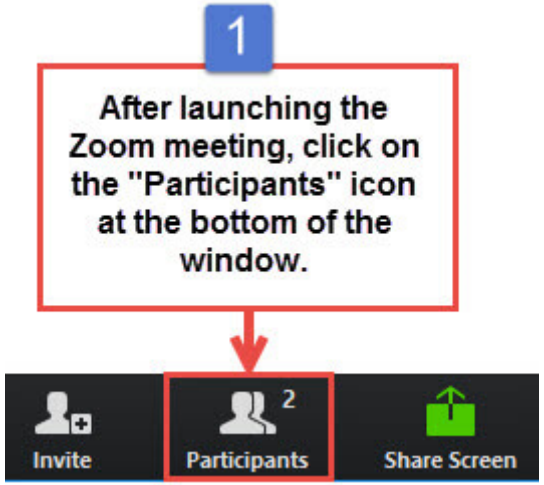
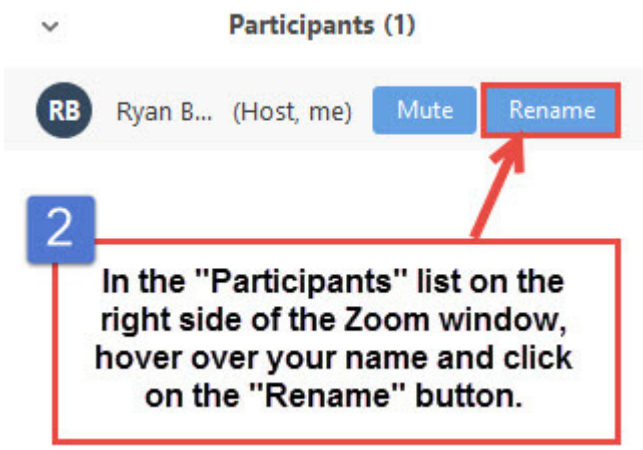
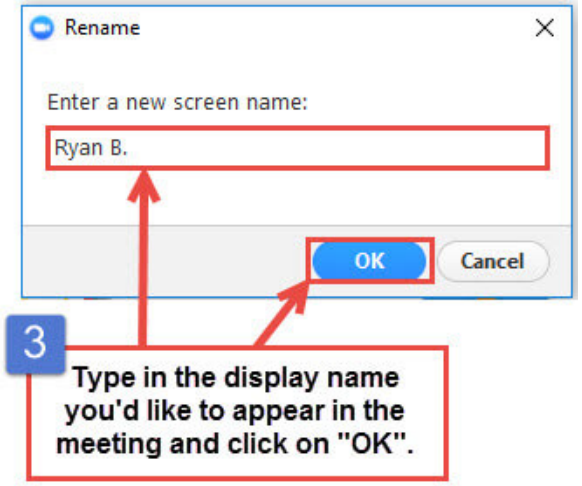
Get the Most Out of Your Zoom Experience

- Please keep yourself on MUTE to avoid background/distracting sounds
- Use the CHAT function or UNMUTE to ask questions or make comments
- Please change your participant name to your full name and organization
  - “Meaghan Angers CHCI”







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Session 1 Agenda

1:00 – 1:10	Introduction to CHCI, Collaborative Expectations, & Role of the Coach
1:10 – 1:25	Making Your Team Work: Role of Leadership & What Engaged Leadership Looks Like
1:25 – 1:40	Team Introductions
1:40 – 2:15	Fundamentals of Primary Care: Primary Care's Challenges
2:15 – 2:25	Quality Improvement: Assessing Your Practice
2:25 – 2:30	Q & A and Next Steps

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Community Health Center Inc. and NTTAP Introduction

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Learning Collaborative Faculty

NTTAP Faculty, Collaborative Design, and Facilitation

Amanda Schiessl, MPP
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Mentors, Coaching Faculty

Deborah Ward, RN
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Tom Bodenheimer, MD
- Physician and Founding Director, Center for Excellence in Primary Care

Rachel Willard, MPH
- Director, Center for Excellence in Primary Care

Evaluation Faculty

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Moses Weitzman Health System Affiliates

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Where health care is a right, not a privilege, since 1972

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Health Center, Inc.

the national institute for
nimaa
medical assistant advancement

ConferMED™
Connecting Primary Care to the Future

CONSORTIUM
FOR ADVANCED PRACTICE PROVIDERS

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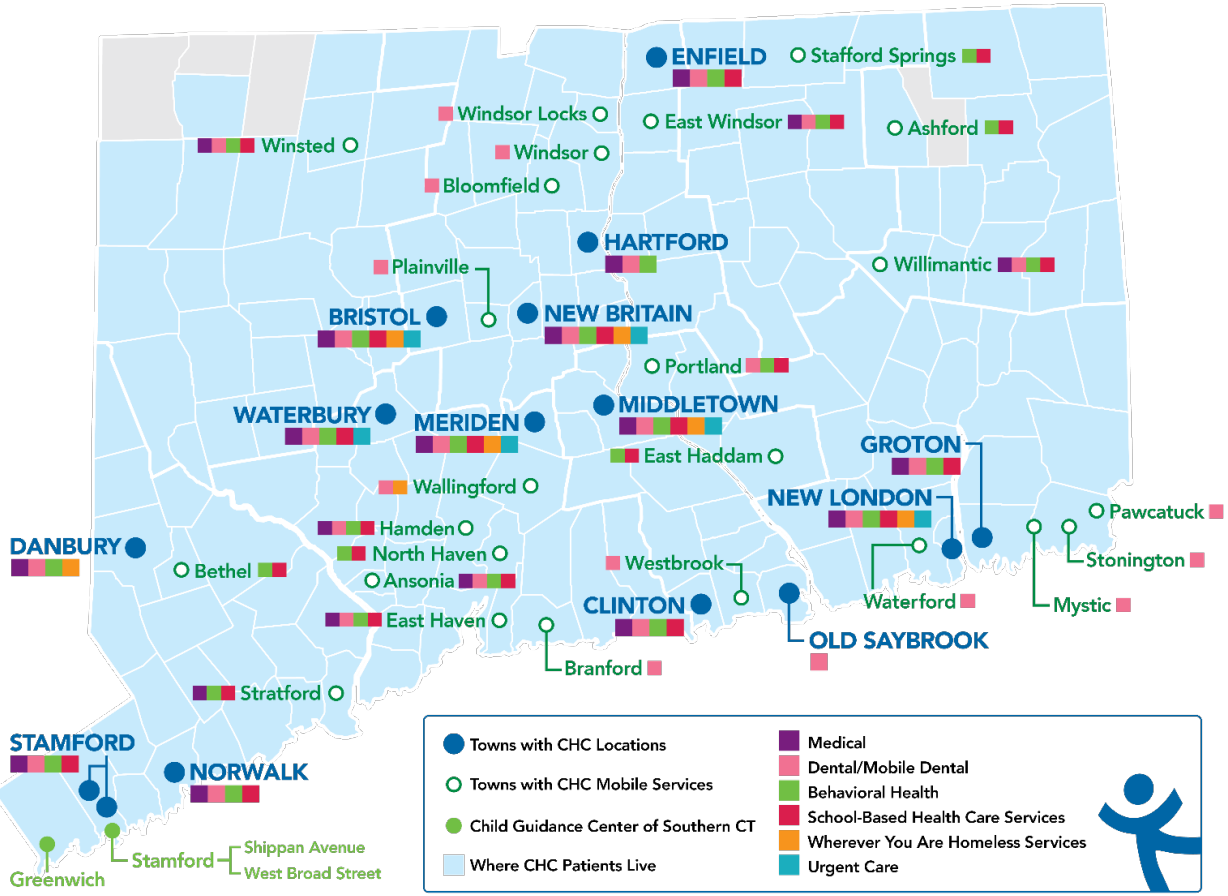
Locations and Service Sites in Connecticut



CHC Profile:

- Founded: May 1, 1972
- Staff: ~1,200
- Total Patients Served: 102,275
- Clinical Sites across CT: 19
- SBHCs across CT: 180+
- Students & Residents/year: 390
- Three Foundational Pillars:
  1. Clinical Excellence
  2. Research & Development
  3. Training the Next Generation

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NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A PROJECT OF
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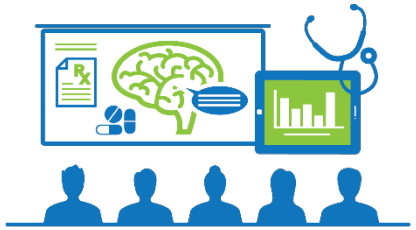
National Training and Technical Assistance Partners
Clinical Workforce Development

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

NTTAP National Health Center Training & Technical Assistance Partners Clinical Workforce Development
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2023-2024 Cohort

Organization	Location
Brockton Neighborhood Health Center	Massachusetts
Brooklyn Plaza Medical Center	New York
Klamath Health Partnership	Oregon
The Wright Center for Community Health	Pennsylvania

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Collaborative Structure and Expectations

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Welcome to the Comprehensive and Team-Based Care Learning Collaborative!

- The Comprehensive Care and Advancing Team-Based Care Learning Collaborative is **an 8-month participatory learning experience** offered by the National Health Center Training and Technical Assistance Partners (NTTAP), funded by the Health Resources and Services Administration, and hosted by Community Health Center, Inc.
- The Collaborative is designed to provide organizations that are:
  (1) Beginning or restarting their move to high performance team-based comprehensive primary care with knowledge about the basic principles and best practices of care and the strategies to plan for implementation; and
  (2) Provide transformational strategies and coaching support to help primary care practices implement and advanced models of team-based care.

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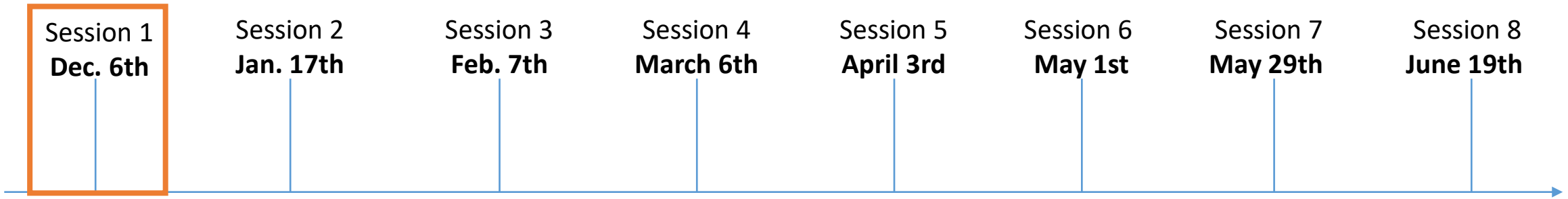
Collaborative Structure and Expectations

Eight 90-minute Zoom Learning Sessions



Between Session Action Periods:

- Meet weekly/regularly as a team
- Meet weekly with coach mentors
- Complete deliverables

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Collaborative Structure and Expectations

- You will use assessments of their current team based care model to identify areas for process improvement and role optimization.
- You will submit deliverables demonstrating participation in Learning Collaborative.
- You will contribute to the learning among participating practice teams by engaging in Learning Collaborative activities.

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Conditions of Success

- **Attendance** at collaborative learning sessions and engagement in weekly coach/mentor calls
- **Engagement** in work between sessions that included protected time to meet as a team, trust and respect.
- **Commitment** of trained coaches to improving their skills and helping teams achieve results
- **Support** of practice leadership for time, resources, spread and sustainability

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Roles and Responsibilities

Role of Coach Mentor	Role of Team Coach	Team Members
• Meet with Team Coaches weekly to discuss progress • Work directly with Team Coach to identify successes and work through challenges/barriers. • Mentors Team Coach on how to run an effective meeting for their team and develop their coaching skills • Be available for individual sessions with Team Coaches for specific team and program development	• Teach team how to prepare and facilitate effective meetings • Provide coaching support between and during weekly internal team meetings • Participate in weekly Zoom calls with Coach Mentors to discusses progress, challenges, and stuck points. • Help team follow timelines, complete assignments, and progress reporting • Share team's progress with the Coach Mentor and other Team Coaches during collaborative sessions	• Team members are staff from the care team who deliver specific services to the clients. They represent most or all patient facing roles. • Members are empowered and engaged to make decisions • They implement specific actions such as PDSA testing • They are based on complementary expertise and skills and not just their availability of time

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Team Coach Role

- Help and support teams working together to use new skills, achieve their aims, document their work
- Help teams complete assessments and action period assignments to stay on track
- Help teams run effective weekly team meetings and facilitate teamwork

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Weekly CHCI Coach Mentor Meetings

- CHCI Coach Mentor Role: Deb Ward and Tom Bodenheimer
  - Provide support and resources for developing coaching and improvement skills
  - Assess progress and address challenges, help teams stay on track
  - Provide individual support as needed

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Role of Leadership on Creating Change and Partnerships

Margaret Flinter, Senior Vice President and Clinical Director

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Leadership's Role In Supporting Comprehensive Team Based Care

- Full Engagement
- Tangible and intangible support
- Communications strategy internal and external
- Investments
- Recognition

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Full Engagement

- Ties high performing, comprehensive team based care to the mission, vision, and goals of the organization
- Assigns senior leader as sponsor and champion as requested
- Engages visibly and publicly to support the work of the clinical and operational leaders engaged in the transformation
- Ensures that board members and relevant board committees understand the work and its importance

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Tangible and Intangible Support of Leadership

- Assignment and prioritization of resources
- Human Resources
- IT/Informatics/Business Intelligence
- Facilities
- QI/Lean/Practice Redesign
- Time!

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Communications

- Early and often throughout the organization
- Internal website
- Public facing website
- Patient welcome and orientation packets
- Town Halls

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Investments

- Staff
- Time and funds for training
- Roles
- Business Intelligence

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Ensuring Return on Investment is Measured and Monitored

- Quality awards
- Changes in performance on UDS
- Value based contracts and incentives
- Patient satisfaction
- Staff satisfaction

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Team Introductions

	Order of Introductions
1	Brockton Neighborhood Health Center
2	Brooklyn Plaza Medical Center
3	Klamath Health Partnership
4	The Wright Center for Community Health

- Name of your practice, size, etc.
- Names and positions of participating team members
- Goals for the learning collaborative

Brockton Neighborhood Health Center

"The ED can Wait" Team

ED UTILIZATION GROUP

- Patricia Augustin- Post Hospital Discharge Nurse Care Coordinator
- Luisa Schaeffer- Patient Engagement Specialist (ER Focus)
- Dr. Nikhil Gohokar- Provider Champion
- Ayotola Olugbenga- Population Health Manager
- DoPham Linh- Pharmacist
- Annette Thomas- QI and Lean Director
- Tahirah Ashby- QI Interns

GOALS

- To use an interprofessional collaborative practice to reduce the rate of frequent (but often preventable) ED utilization among BNHC patients by addressing a comprehensive range of patient needs, including review of medical history and current status, medication management, addressing health-related social needs, identifying and addressing behavioral health needs, and offering nursing assistance, to provide a holistic approach to care and minimize the risk of returning to the ER.
- To utilize a systematic approach utilizing performance improvement tools to reduce ED utilization

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Brooklyn Plaza Medical Center

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Klamath Health Partnership

The Wright Center for Community Health: Team Overview and Goals

Team:

- Colleen Dougherty, DNP - Chief Operating Officer
- Kathleen Barry, MS - Deputy Chief Operating Officer
- Marianne Linko, LPN - Deputy Chief Operating Officer Laura Sweeney, CMA - Co-Medical Assistant Manager

Goals for Collaborative

- Review key tools to help with problem solving and work efficiencies
- Define common language for a newly formed team to be on the same page
- Use this collaborative to work through new organizational issues we are focused on improving
- **Goal:** Define comprehensive team based workflow to improve screening and preventive initiatives (ie immunizations, testing, etc) for overall health center quality metric scores

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Fundamentals of Primary Care: Primary Care's Challenges

Introduction to CEPC, History of LEAP, & Building Blocks of Primary Care

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Center for Excellence in Primary Care (CEPC)

Situated in the UCSF Department of Family and Community Medicine, CEPC identifies, develops, and disseminates promising innovations in primary care to improve the patient experience, enhance population health and health equity, and restore joy and satisfaction in the practice of primary care.

http://cepc.ucsf.edu/

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Why do we need teams?

- A patient-care team is a group of diverse clinicians and practice staff who communicate with each other regularly about the care of a defined group of patients and participate in that care.
- Rather than a lone clinician being responsible for the care of a panel of patients, the team shares that responsibility.
- On an effective team, everyone on the team makes important contributions to the care of the team's panel of patients.
- Question: why are teams necessary in primary care? Please answer this question either by speaking or writing in the chat.

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Why do we need effective teams in primary care?

- Patient access is poor and getting worse
- Continuity of care is under stress
- Panel sizes are too large because not enough clinicians choose primary care careers (**clinicians are physicians, nurse practitioners and physician assistants**)
- Poor access and large panels are major contributors to burnout
- Effective teams can help solve these challenges; poorly functioning teams cannot
- Today we will focus on primary care's challenges. In the following two learning sessions we will focus on teams.

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Access is getting worse

- 2015 household survey: 48% of people in US who were sick could not obtain same/next-day appointment. [Commonwealth Fund, 2015 International Profiles of Health Care Systems]
- 2017 secret shopper calls to 2000 practices in 30 cities. New patient wait times for primary care appointments
- 2014: 20 days
- 2017: 30 days

Source: Merritt Hawkins 2017 Survey of Physician Appointment Wait Times

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Challenges to continuity of care

- Continuity of care means patients seeing the same primary care clinician or team whenever they need care, whether in person, by phone/video visit, or through the electronic patient portal
- US primary care acute visits per capita decreased by 30%, 2002 – 2015
- At the same time, more and more patients are seeking primary care in urgent care, retail clinic, and emergency departments
- As a result, many patients are seeing different primary care clinicians in different sites with little communication among the clinicians

Continuity of care is associated with:

- ✓ Better preventive care
- ✓ Better chronic care
- ✓ Greater patient satisfaction
- ✓ Lower healthcare costs

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Primary care panels are too large

- 7500 primary care physicians enter the workforce each year; 8500 retire each year
- Major increase in NPs/PAs helps relieve the shortage
- Clinician-population ratio going down (physicians, NPs, PAs)
- As a result, panel sizes are too large. U.S. average 2194. Norway: 1100
- With a panel of 2500, it takes a primary care physician without a team 26.7 hours per day to provide excellent care; **with an effective team it takes 9.3 hours per day**
- Panel size in FQHCs is smaller because FQHC patients have more chronic conditions, more severe chronic conditions, more problems with social determinants of health
- Write in the chat if you know the average panel size in your health center

Bodenheimer T. Revitalizing primary care, Parts 1 and 2. Ann Fam Med 2022;20:464-468, 469-478;
Porter et al. J Gen Intern Med 2022, July 1

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Poll #1

In your health center, nurse practitioners and physician assistants:

a. Have their own panels

b. Some have their own panels; others help physicians care for their panels

c. None have their own panels

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Primary care clinicians in health centers

- NPs and PAs are a critical component of the primary care system in low-income communities around the U.S.
- HRSA's 2020 UDS report: In FQHCs,
  - NP/PA FTEs (14,565)
    - Nurse Practitioners: 11,086
    - Physician Assistants: 3,479
  - Physician FTEs: 14,317

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Burnout

- National survey, % of physicians reporting burnout in 2020:
  - All physicians: 38%
  - Primary care physicians: Over 50%

Shanafelt TD et al. Mayo Clinic Proceedings 2022;97:491-506.

- Survey of 740 primary care clinicians and staff in 2 local health systems:
  - 53% of clinicians and staff reported burnout
  - Higher rates of burnout were associated with leaving practice.

Willard-Grace R et al. Burnout and health care workforce turnover. Ann Fam Med 2019;17:36-41.

- Burnout is strongly associated with reductions in work hours (Shanafelt TD et al. Mayo Clin Proc 2016;91:422-431)
- More burnout means more physicians leaving or cutting their hours, leading to more work for everyone else
- Effective teams can greatly mitigate burnout

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Poll #2

I feel that burnout:

a. Is a significant problem among staff, but not clinicians, at my health center

b. Is a significant problem among clinicians but not staff at my health center

c. Is a significant problem among staff and clinicians

d. Is not an important problem at my health center

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Burnout

- The Maslach Burnout Inventory measures 3 components of burnout
- Two of these are:
  - Emotional exhaustion
  - Cynicism
- Emotional exhaustion: “I have too much work.” Seeing too many patients too fast for too many days
- Cynicism: feeling alienated from the work: “I don’t like my work” – EMR documentation
- In one study,
  - 27% of the average physician’s day was face time with patients.
  - 49% was spent on EMR and administrative work

Sinsky et al.. Ann Intern Med 2016;165:753-760

Even with burnout, many primary care clinicians feel great joy in our work

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Burnout

- As access gets worse, burnout increases
- Patients are calling to get into the clinic or dropping in, creating chaos in the daily schedule
- As panel size increases, burnout increases
- Almost all burnout studies are about physicians; most nursing burnout studies focus on hospital nursing
- In a recent letter to the New York Times, a California family physician suggested that burnout is not the best term. It should be overwork.

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The devastation and the beauty of California

Emblematic of the 2 sides – burnout and joy -- of primary care

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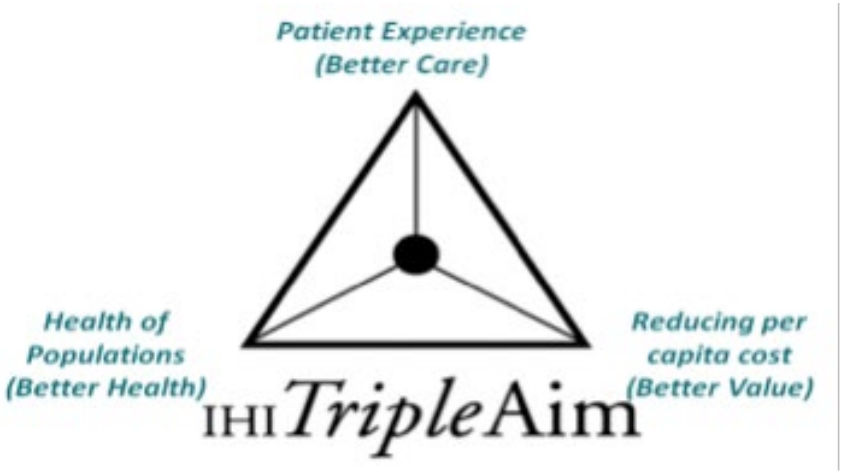
Don Berwick and the Triple Aim

- In 2008, Don Berwick, a pediatrician and the nation's foremost leader on improving health care, unveiled the doctrine of the triple aim
- The triple aim:
  - Improving the patient experience of care
  - Improving the health of populations
  - Reducing the cost of health care
- The triple aim was widely accepted as health care's overarching goals



Source: Berwick DM et al. The triple aim: care, health, and cost. Health Affairs 2008;27:759-769.

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The Quadruple Aim

- As evidence of clinician and health worker burnout grew, the idea was introduced that the three aims were not achievable without a satisfied health workforce
- This led to the addition of a fourth aim:
  - Improving the worklife of clinicians and staff
- The fourth aim helps to achieve the other 3 aims because health worker dissatisfaction is associated with: poor patient experience, reduced patient adherence to treatment plans thereby worsening population health, and higher costs of care

Source: Bodenheimer and Sinsky. From triple to quadruple aim: care of the patient requires care of the provider. Ann Fam Med 2014;12:573-576.

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The LEAP Project
Learning from Effective Ambulatory Practices

- Funded by the Robert Wood Johnson Foundation, chaired by Ed Wagner and Margaret Flinter
- 2012-2013: LEAP project teams performed detailed 3-day site visits to 31 primary care practices
- The practices had been selected through a careful process of identifying the highest-performing primary care practices in the country
- Extensive site visit notes were taken and the 31 practices participated in a learning community to identify and interpret themes from the site visits.

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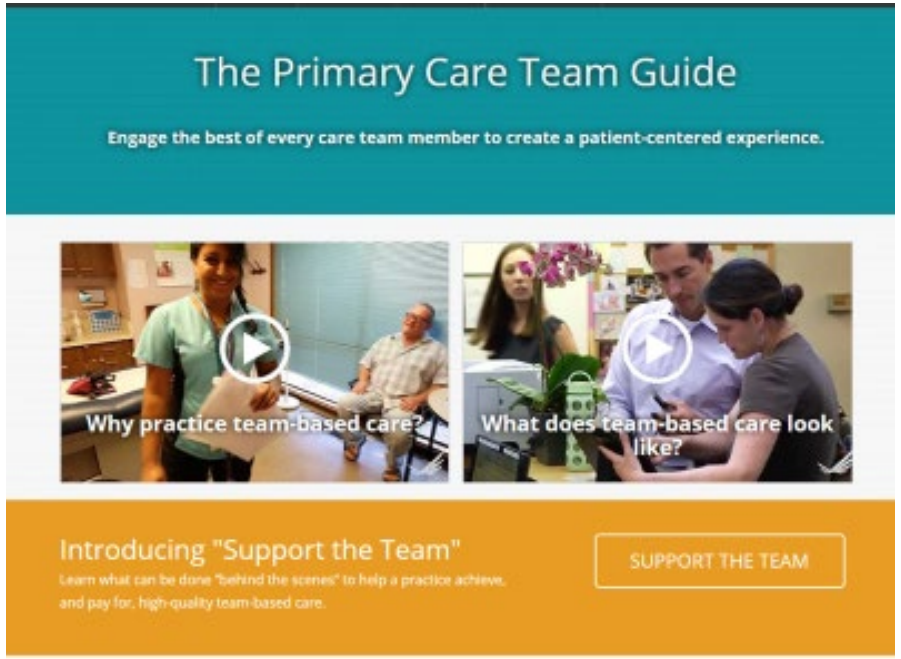
LEAP's Primary Care Team Guide

- LEAP has produced a terrific web-based primary care team guide
- The team guide offers learning modules, materials on the different team members, and practice assessment tools on team-based care
- It is worth spending time with this website



http://www.improvingprimarycare.org

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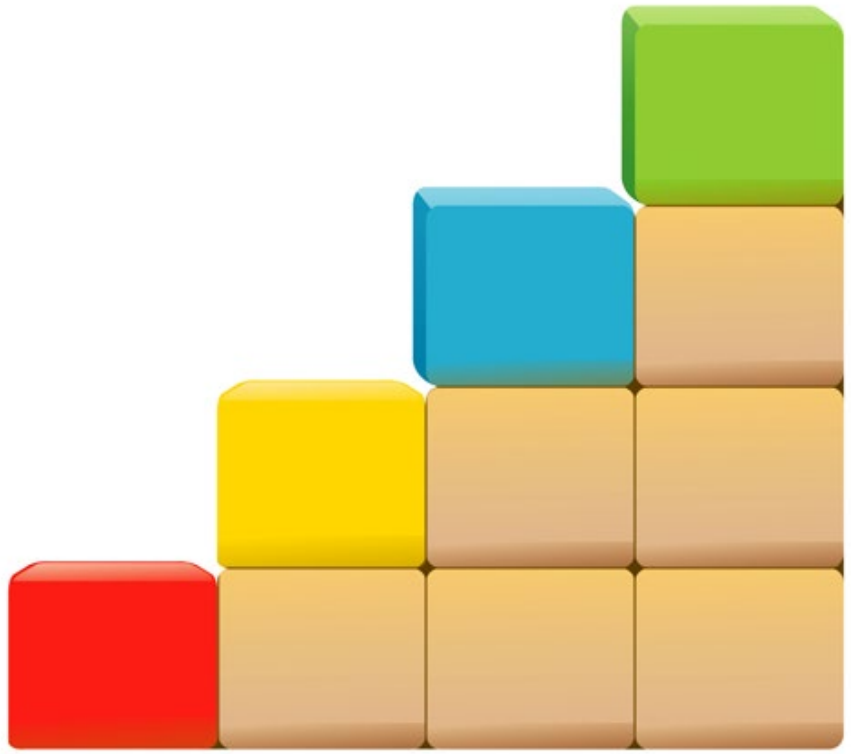
10 Building Blocks of High-Performing Primary Care



10 Building Blocks:
How were they developed?

Case Study Methodology

- Site visits to 23 highly-regarded practices
- Our experience as practice coaches at 25 additional practices
- Review of existing models and research

8 hospital-based clinics

7 integrated delivery system sites

6 FQHCs

2 independent private practices

7 of 23 had 5 or fewer physicians

What do we mean by "high-performing"?

- Practices known as innovators
- Reputation for high performance in one or more of the quadruple aims

23 High-Performing Practices

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These 23 are only a small sample of the many high-performing primary care practices in the U.S.

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Patient-team partnership

Population management

Data-driven improvement

Template of the future

Empanelment

Access

Team-based care

Comprehensiveness and care coordination

Engaged Leadership

Continuity

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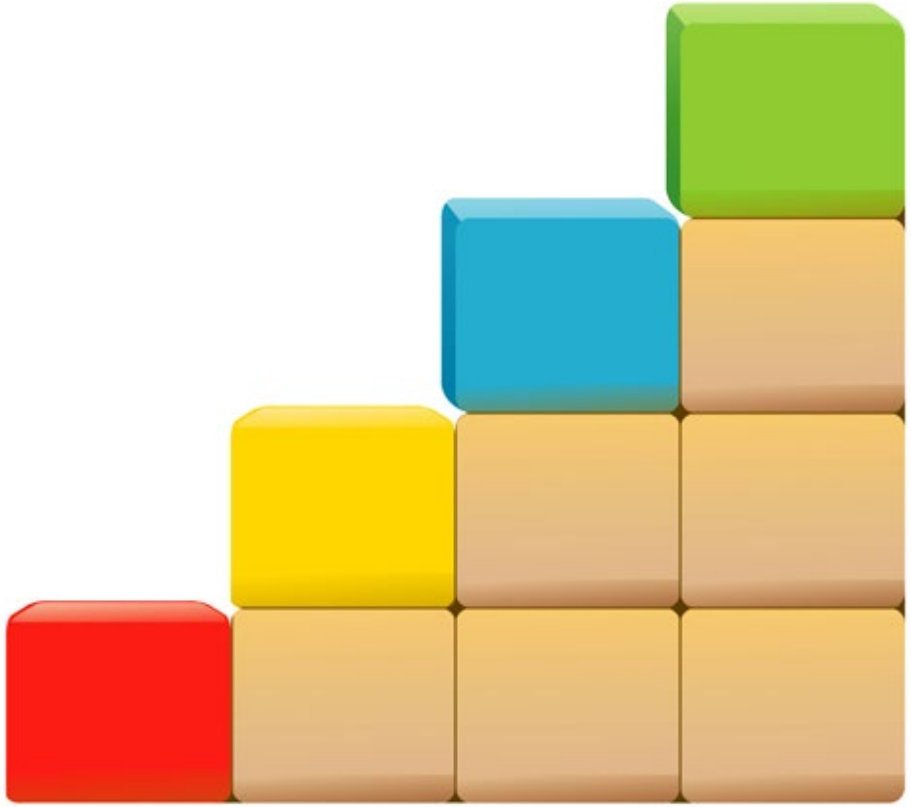
What are the foundational building blocks (1,2,3,4)?
Write in the chat which BBs need to be addressed first

- Access
- Data-Driven Improvement
- Template of the Future
- Patient-Team Partnership
- Engaged Leadership
- Continuity
- Population Management
- Team-Based Care
- Comprehensiveness and Care Coordination
- Empanelment



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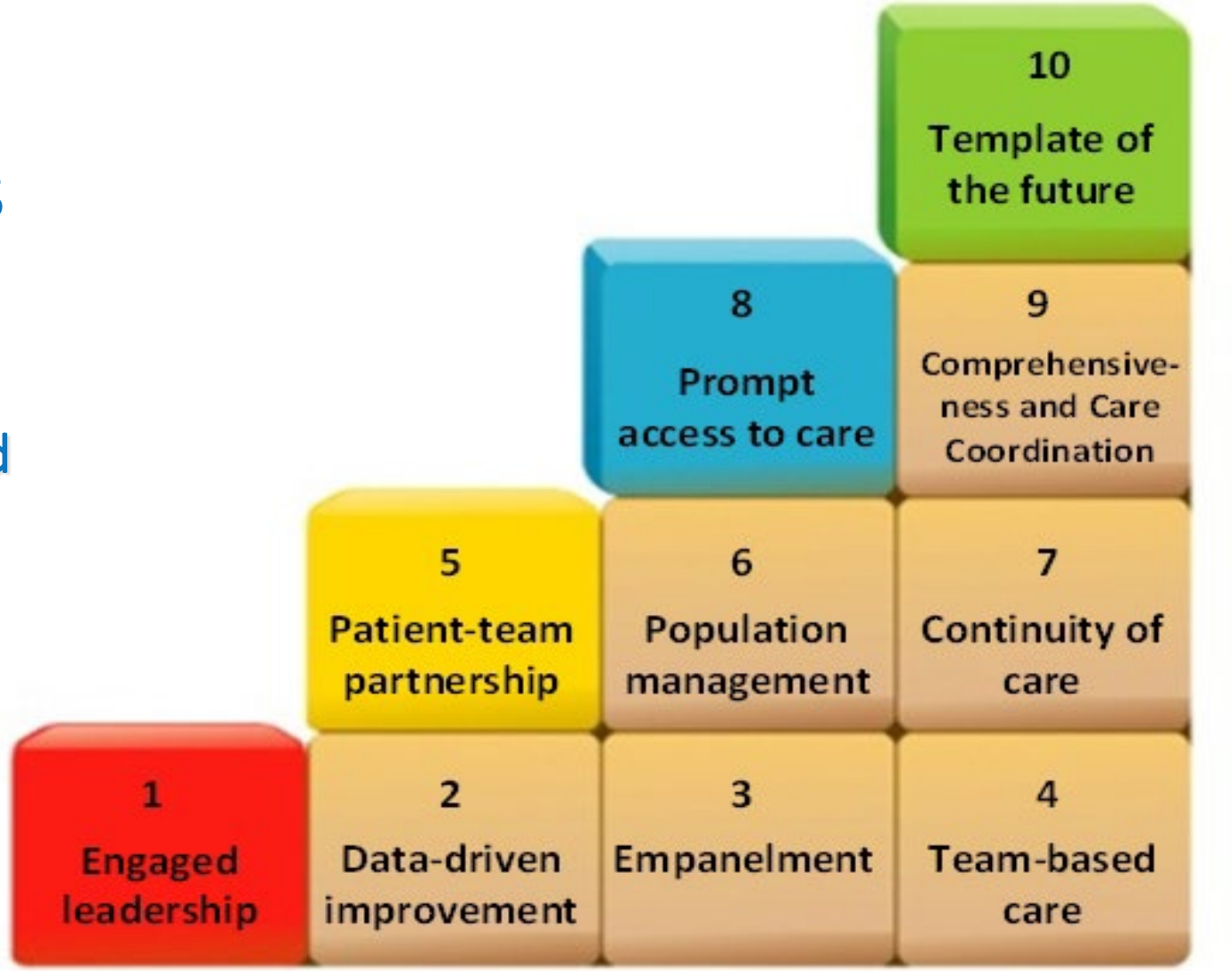
The 10 Building Blocks of High-Performing Primary Care

Bodenheimer et al, Ann Fam Med 2014:12:166



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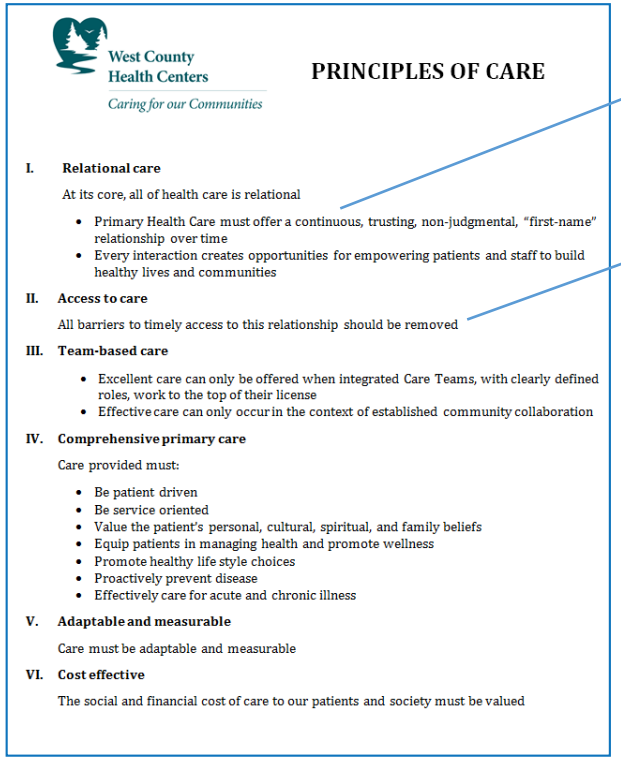
BB1: Creating practice-wide vision with concrete goals and objectives



West County Health Centers
Caring for our Communities

PRINCIPLES OF CARE

I. Relational care

At its core, all of health care is relational

- Primary Health Care must offer a continuous, trusting, non-judgmental, "first-name" relationship over time
- Every interaction creates opportunities for empowering patients and staff to build healthy lives and communities

II. Access to care

All barriers to timely access to this relationship should be removed

III. Team-based care

- Excellent care can only be offered when integrated Care Teams, with clearly defined roles, work to the top of their license
- Effective care can only occur in the context of established community collaboration

IV. Comprehensive primary care

Care provided must:

- Be patient driven
- Be service oriented
- Value the patient's personal, cultural, spiritual, and family beliefs
- Equip patients in managing health and promote wellness
- Promote healthy life style choices
- Proactively prevent disease
- Effectively care for acute and chronic illness

V. Adaptable and measurable

Care must be adaptable and measurable

VI. Cost effective

The social and financial cost of care to our patients and society must be valued

Primary Health Care must offer a continuous, trusting, non-judgmental, "first-name" relationship over time

All barriers to timely access to this relationship should be removed.

Concrete Goals (examples)

- By December 31, 2022, the % of diabetic patients with A1c > 9 will be reduced from 20% to 12%
- By July 1, 2023, all patients will be able to obtain an appointment with their own primary care clinician within 5 days of making the request

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BB2 | Data-Driven Improvement

- ❑ Relevant data
- ❑ Accurate data
- ❑ Shared and discussed with everyone
- ❑ Data drilled down to clinician/team level
- ❑ Data analyzed by race/ethnicity/income to uncover inequities

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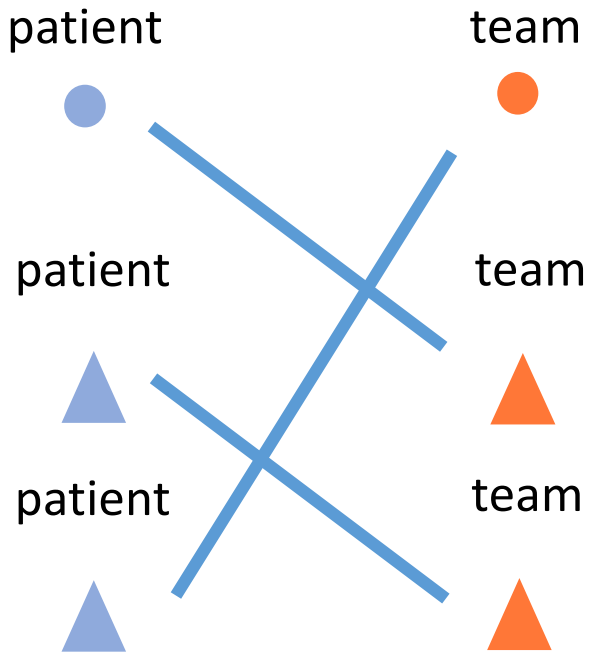
BB3 | Empanelment

- **Empanelment**: Linking patients with a primary care clinician/team
- **Advantages**:
  - Patient and clinician/team know each other
  - Allows clinic to offer and to measure continuity of care
  - Allows calculation of panel size
  - Provides denominator for quality measures



Empanelment Guide
http://www.improvingchroniccare.org/downloads/empanelment.pdf

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BB4 | Team-Based Care

Anatomy

1. A stable team structure
2. Colocation
3. Defined roles
4. Standing orders or protocols
5. Defined workflows
6. Staffing ratios adequate to facilitate new roles
7. Ground rules

Physiology

1. Culture shift: Share the Care
2. Training and skills checks
3. Communication

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Patients and Teams

- Primary care practices are getting larger
- But patients prefer small practices
  - Study of 367 practices of different sizes
  - Patients were asked | how was your visit?
  - Small practices | 64% excellent
  - Large practices |48% excellent
- Patients want to know their team members
  - “Physicians and staff knowing me is very important”
  - In small practices, patients report: “I know the people in the practice and the people in the practice know me”
- Teams can divide a large practice into smaller units that are more comfortable for patients

There will be extensive discussion of teams in the next 2 learning sessions.

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Questions?

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Quality Improvement

Assessment of your practice

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Assess Your Practice

What is your current state?

- Patient measures
  - Panel size
  - UDS measures re: diabetes and hypertension
  - Satisfaction surveys
  - Disparities between groups by gender, race/ethnicity, age
  - Process measures
  - UDS measures re: screening
  - Cycle time
  - No show rates
- Staff measures
  - Primary Care Team Guide Assessment
  - Team skills self-assessment
  - Role activity assessment
  - How accessible is your data? How reliable is your data? Who sees it?

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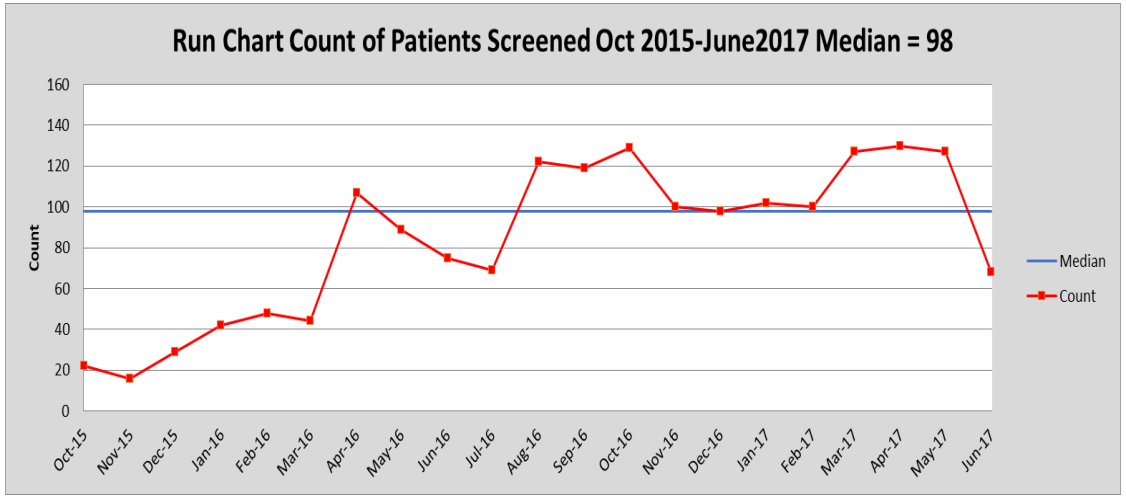
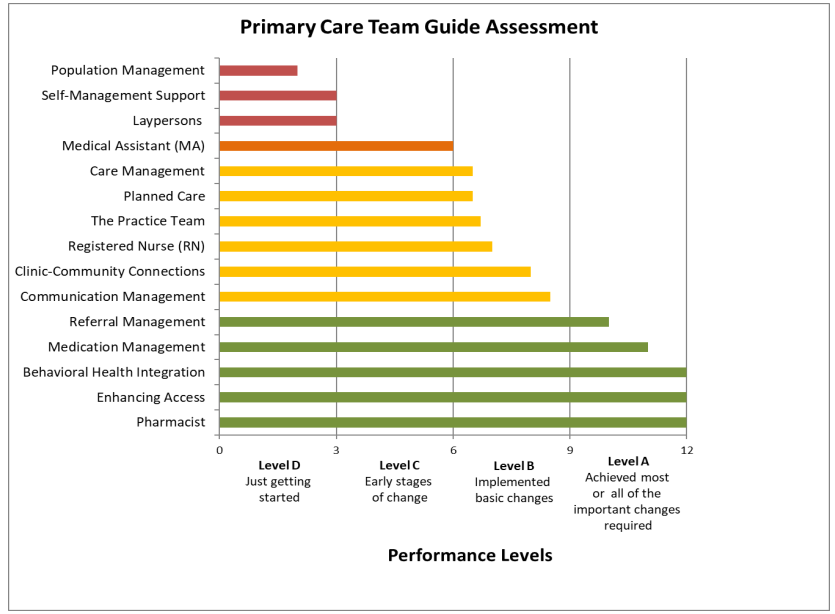
How do you share data with staff?

TABLE 2
Health Disparity report for: Team 6

Measures	Race/Ethnicity		Language		Gender		Insurance status		
	Black/AA	Other	English	Non-English	Male	Female	Self	Medicare	Medicaid
Number of patients	1510	410	1760	160	670	1250	21	69	74
%HbA1c<8	63%	61%	63%	62%	56%	66%	57%	71%	64%
% Scrn for Nephropathy	90%	90%	90%	87%	94%	88%	95%	92%	83%
%Ophtho exam	41%	29%	38%	37%	41%	36%	19%	46%	43%
%BP>140/90	47%	41%	47%	31%	44%	46%	47%	49%	41%

How accessible is your data?
How reliable is your data?
Who sees it?





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How do these building blocks and functions map to your practice assessment?

- Does your organization use data to drive improvement?
- Are workflows standardized? Roles defined?
- Who checks to see if a patient is due for colorectal cancer screening or an A1c? Who can order these?
- Who manages the care of patients with chronic conditions? How do they do that?

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Sample Results from Primary Care Team Assessment Guide: Self-Reported Levels March April 2021	
	ORGANIZATION NAME
The Practice Team	C
Medical Assistant (MA)	B
Registered Nurse (RN)	B
Laypersons	C
Pharmacist	D
Enhancing Access	A
Self-Management Support	C
Population Management	D
Planned Care	C
Care Management	C
Medication Management	D
Referral Management	C
BH Integration	A
Communication Mgt	D
Clinic-Community	C

Areas for Improvement:

Level C:

- The Practice Team
- Laypersons
- Self-Management Support
- Planned Care
- Care Management
- Referral Management
- Clinic Community

Level D:

- Pharmacist
- Population Management
- Medication Management
- Communication Management

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Questions?

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Action Period 1 Assignments

- Conduct your weekly team meetings
- Coaches attend weekly Mentor calls
- Discuss the results of your team's Primary Care Team Practice Assessment; Coach Skills Self-Assessment; and Team-Skills Self-Assessment in light of the presentation in Session 1.
  - What are your strengths and weaknesses?
  - What surprised you?
- **Assignment**: Submit Role Activity Assessment.
- **Assignment**: Develop a plan for how you will engage your colleagues and leadership regarding your participation in this Collaborative ("engagement plan" template available on Moodle)

CME and Resource Page

Access Code: TBC2023

https://education.weitzmaninstitute.org/content/nttap-comprehensive-and-team-based-care-learning-collaborative-2023-2024

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Next Steps

Coach Calls:

- Wednesday December 13th 1:00pm Eastern / 10:00am Pacific
- Wednesday December 20th 1:00pm Eastern / 10:00am Pacific
- Wednesday December 27th 1:00pm Eastern / 10:00am Pacific
- Wednesday January 3rd 1:00pm Eastern / 10:00am Pacific
- Wednesday January 10th 1:00pm Eastern / 10:00am Pacific

Session 2: Wednesday January 17th 1:00pm Eastern / 10:00am Pacific

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REMINDER: Complete evaluation in the poll!

Next Learning Session is **Wednesday January 17th!**

Explore more resources!

National Learning Library:
Resources for Clinical Workforce Development

https://www.weitzmaninstitute.org/ncaresources

Health Center Resource Clearinghouse

https://www.healthcenterinfo.org/