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Comprehensive Care Learning Collaborative

Session Four: Wednesday March 6th, 2024

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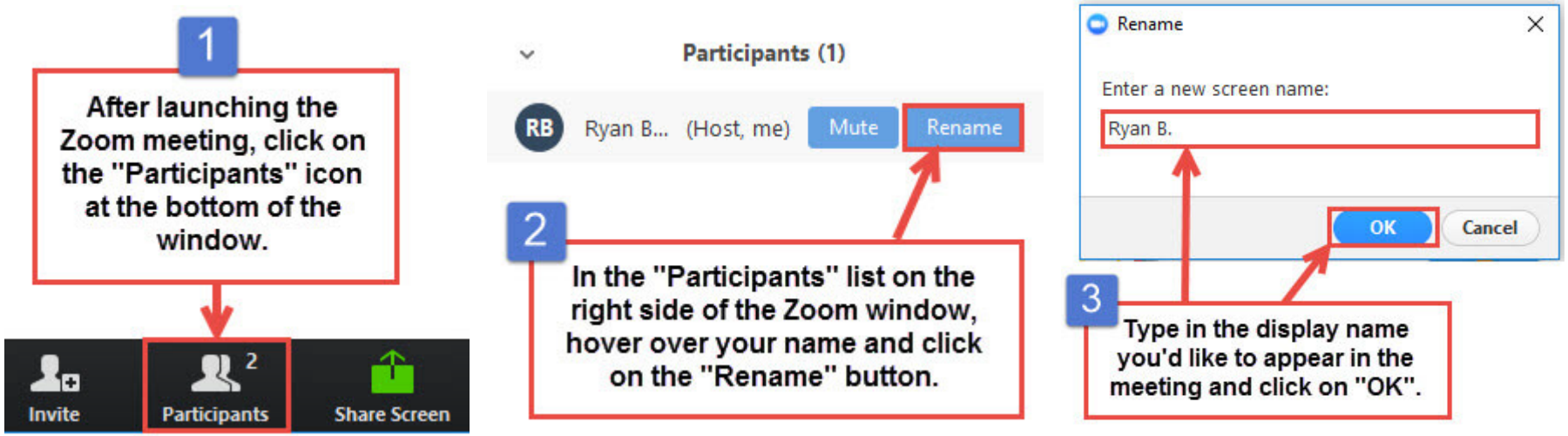
Get the Most Out of Your Zoom Experience

- 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 4 Agenda

1:00 – 1:05	Introduction
1:05 – 1:30	Role of MA and RN in Care Coordination & Utilizing Standing Orders
1:30 – 2:00	Team-Based Care: Understanding Barriers
2:00 – 2:20	Quality Improvement Refresh: Data and Specific Aim Statements
2:20 – 2:30	Q/A, Next Steps, and Evaluation

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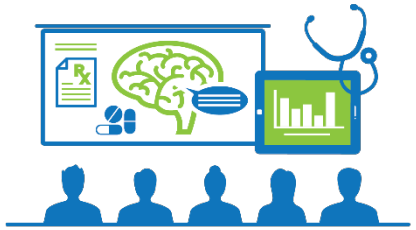
Clinical Workforce Development

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

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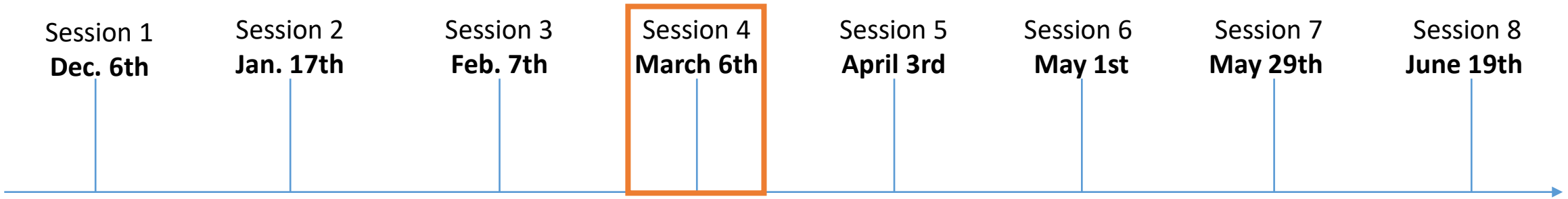
Collaborative Structure and Expectations

Eight 90-minute Zoom Learning Sessions



Between Session Action Periods

- Meet weekly as a team
- Conduct daily huddles
- Complete deliverables and upload to the Google Drive
- Use the Weitzman Education Platform to access resources and receive CME credit for learning sessions

Between Sessions

- Coaches meet with coach-mentors weekly
- Faculty support
- Complete deliverables

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2023-2024 Cohort

Organization	Location
Brockton Neighborhood Health Center	Massachusetts
Brooklyn Plaza Medical Center	New York
Klamath Health Partnership	Oregon
Migrant Health Center, Western Region, Inc.	Puerto Rico
The Wright Center for Community Health	Pennsylvania

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Role of MA and RN in Care Coordination & Utilizing Standing Orders

Mary Blankson, Chief Nursing Officer

Community Health Center, Inc.

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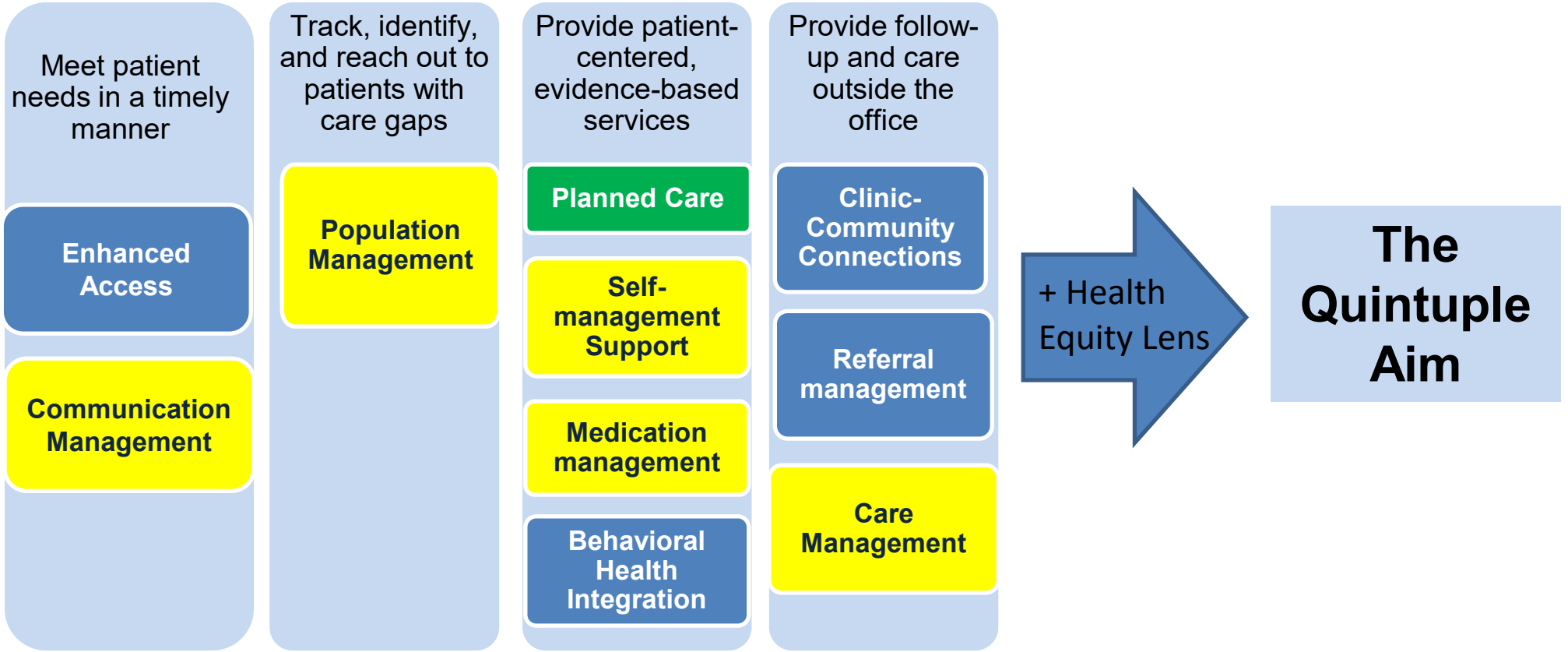
MA Involvement in Key Functions or Competencies



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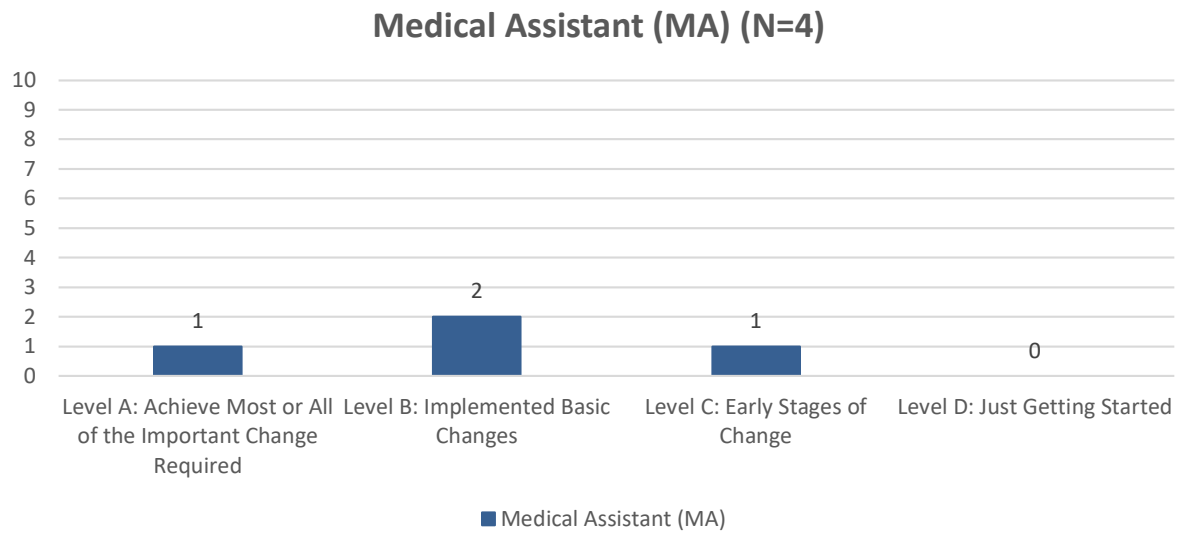
Team Practice Assessment:

How Do We Shift Levels Toward A?



Components	Level D	Level C	Level B	Level A
MAs in our practice….	Mostly take vital signs and room patients.	Perform a few clinical tasks beyond rooming patients, such as reviewing medication lists or administering a PHQ-2	Perform a few clinical tasks and collaborate with the provider in managing the panel (reviewing exception reports, making out-reach calls)	Collaborate with the provider in managing the panel, and play a major role providing preventive service, and service to chronically ill patients, such as self-management, coaching, or follow-up phone calls.
	1-3	4-6	7-9	10-12

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Role Activity Assessment

CLINICAL WORKFORCE DEVELOPMENT
Transforming Teams, Training the Next Generation

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inspiring primary care innovation

Advanced Team Based Care Role Activity Assessment and Optimization

Which roles align with the list of tasks and processes?

1. Add tasks you would like to include
2. Edit tasks to clarify expectations specific to your practice
3. Edit the roles to represent your core and extended team members
4. Note **current role** and function in one colored pen
5. Note using second colored pen **best role** for optimization based on education, license and training

Complete as a team or individually for the purpose of identifying opportunities for:

- reducing duplication of tasks
- optimizing roles : everyone working to their highest level of training, licensure, education
- defining roles and job descriptions

Enhanced Access and Communication

	Receptionist Front Desk	LPN LNA	CMA MA	RN	Triage RN	Care Coordinator	Care Manager	SW Case Manager	NP PA	MD	BH Specialist	Clinic Admin	Other
Schedules patients with a personal clinician for continuity of care													
Coordinates visits with multiple clinicians and/or diagnostic tests and procedures													

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What does it mean to implement TBC?

- Defining your Core and Extended Team Structure
- Meeting Regularly, Huddling Daily
- Creating new responsibilities and provide training
- Strategically redistributing work among team members
- Increasing communication among the team, practice, patients.
- Improving efficiencies (electronic and clinical workflows)
- Standardizing processes to reflect new model (making hundreds available, playbooks)
- Using a plan for optimizing model , spreading, and continuously improving

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Role of the Medical Assistant

- ✓ Pre-visit planning/planned care
- ✓ Begin process of medication reconciliation
- ✓ Scribing for providers
- ✓ Delivering or arranging preventive services
- ✓ Participating in quality improvement work
- ✓ Health coaching and motivational interviewing
- ✓ Providing telephone or in-person follow-up

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How do effective practices deliver planned care?

Identify the key clinical tasks associated with evidence-based care and decide who does them.

MA reviews patient data prior to the encounter to identify needed services.

Encounters are organized so that relevant team members deliver all needed care.

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How do effective practices manage medications?

- Medication reconciliation is a process, not a task.
- A critical intervention for both patient and practice—often begun by MA at intake.
- Pharmacists and RNs play important roles in complex med. rec., titrating medications, and addressing non-adherence and other drug problems.

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How do effective practices deliver planned follow-up and Care Management (outside of visits)

- Follow-up between office visits is a core function of the practice team.
- Care teams regularly monitor patients and promote self-monitoring.
  - Consider new technology with RPM
- Follow-up can range in intensity from periodic status checks by telephone or e-mail (MA) to active care management (RN).
- Higher risk patients (poor disease control, frailty, etc.) receive regular follow-up (monitoring) AND active care management.

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Role of the Registered Nurse

- Function within three domains of primary care:
  1. episodic/acute and preventive/routine care
  2. chronic disease management
  3. practice operations, including supervision of staff and practice improvement
- RNs can meet many of the patients' needs that providers either handled alone or did not have time to address, freeing up providers for visits that require their diagnostic skills while also improving patient care and satisfaction.

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Focus Areas of RN Practice

- **Standing orders**: developed by and executed under the authority of providers to manage common episodic health conditions or complaints, such as urinary tract infections (UTI), administer vaccines, order a retinal exam for patients with diabetes
- **Orders for Individual Patient**: developed by and executed under the authority of providers, and unique to an individual patient's plan of care, e.g., changing inhalers for a patient on an asthma action plan; titrating insulin
- **Complex care management**: proactively address the needs of sub-populations of patients, such as those transitioning from hospital to home, or with complex healthcare needs, such as patients with diabetes, HIV, or multiple co-morbidities, such as heart disease, depression and substance use; don't wait for patient to worsen between visits.

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Discussion Questions

- Do you provide time for MAs, LPNs and/or RNs to do both panel management AND pre-visit planning? Or do you treat these processes as one in the same?
- How do you engage MAs and/or RNs and increase their interest in the accountability of their patient panel?
- Where does panel management work happen? In the pod? Or elsewhere?
- What does the process of MAs and/or RNs checking for vaccines and Rx refills look like? How long does it typically take per patient?
- How do patients check out after visit? Do they do so in the room with the MA and/or RN? Or at the front desk?

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Team-Based Care: Understanding Barriers

Dr. Tom Bodenheimer
Center for Excellence in Primary Care
University of California, San Francisco

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What is a powerful team?

Remember from Learning Session 1:

- ✓ Primary care patient access is poor and getting worse
- ✓ Panel sizes are too large because few clinicians choose primary care careers
- ✓ Poor access and large panels are major contributors to burnout
- ✓ Powerful teams can help solve these challenges; poorly functioning teams cannot

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What is a powerful team?

- A powerful team is a team that adds capacity to see more patients, thereby improving access and reducing burnout
- Interprofessional team members add capacity by seeing patients independently, taking little or no clinician time
- Interprofessional team members help over paneled clinicians care for their panels, thereby reducing clinician burnout
- When interprofessional team members have standing orders to see patients independently, they often have greater work life satisfaction
- Medical assistants can also add capacity, saving clinician time by providing panel management functions

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What is a powerful team? Examples:

- In many states, pharmacists can independently care for patients with diabetes or hypertension -- including ordering and interpreting labs and adjusting medications – under collaborative practice agreements.
- Health centers can organize RN co-visits with the RN doing most of the visit and the clinician coming in at the end to check the RN's work and complete the orders the RN entered into the EMR. RN co-visits can add substantial capacity.

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Barriers to building powerful interprofessional teams

We can't recruit the personnel we need

Only practitioners are reimbursed

Who knows when the alternative payment model will actually arrive

No time to train and mentor staff in their enhanced roles

Scope of practice laws

Will patients accept their care?

The barriers are real and need to be addressed. In making goals and action plans, consider the barriers and which would be the most difficult to overcome. But don't let barriers paralyze you.

Activity: 10 minutes

Let's pretend that you have set an overall goal to build a powerful interprofessional team. One specific goal focuses on RNs.

You would like your RNs to become care managers for patients with diabetes who see patients independently and can change medication doses under standing orders. Your first action plan is to hold a meeting with the RNs in the clinic to discuss their work, whether they are satisfied with their roles, what they might think about RN care management.

Write in the chat: what barriers you would need to overcome to move toward the goal of RNs becoming care managers?

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RN care management for patients with diabetes: Barriers and who is causing the barrier

	Federal/ state government, professional associations, professional schools	Health system leaders	Physician reluctance	Team member reluctance	Patient reluctance
We can't recruit RNs	Nursing associations and nursing schools emphasize hospital nursing. Lack of RN faculty restricts number of slots in nursing schools	Leaders prioritize the number of hospital nursing jobs over ambulatory jobs. They pay clinic RNs 60% of what hospital RNs make.			
RNs are not trained in primary care functions	Nursing schools usually don't teach ambulatory care nursing	Not interested in developing in-house ambulatory training for RNs	Providers may want RNs to only do phone triage, which shields physicians from patients wanting same-day care	RNs may be satisfied with more traditional RN functions such as triage, wound care, and patient navigation	Patients may want to see their doctor rather than an RN care manager
RNs are not allowed to do care management (especially adjusting medication doses)	State nursing boards may not allow RNs to adjust medication doses	Even when the state allows medication adjustment under standing orders, health system leaders may say No	Providers may not trust RNs to adjust medications and may refuse to write standing orders	RNs may not feel comfortable adjusting medication doses	
Lack of a business case. Only clinicians (doctors, NPs, PAs) are reimbursed. RNs are an expense and don't generate revenue	Medicare and Medicaid generally set payment rules, which insurance companies follow	Health system leaders may take a narrow view of business case. They want revenues to equal expenses each month. Rather than getting revenue from P4P for better metrics, or greater patient satisfaction bringing new in more patients.			

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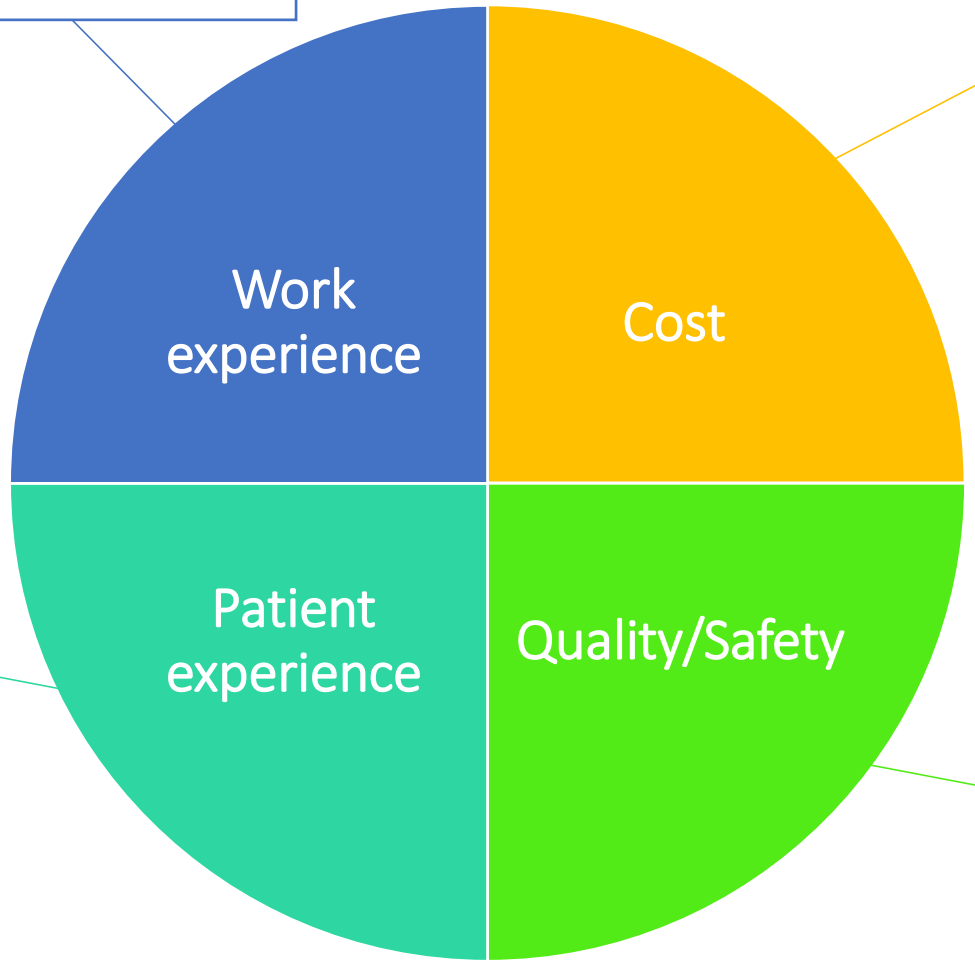
Metrics to watch for team-based care

Don't just look at revenue vs. expense out

Clinician and staff satisfaction leads to less turnover. Turnover is a huge expense to the clinic



Increase in visits or panel size

Billable services by RNs, PTs, Pharmacists

Redeployment of staff to higher value activities

Patient experience surveys; good performance can lead to P4P money and can attract new patients

Improvements screening rates or disease control

Reduced readmissions

Reduced ED use

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Regulatory barriers: A case study

- California allows MAs to give injections for immunizations
- San Francisco General Hospital:
  - MAs give immunizations
  - Standing orders enable MAs to identify and administer immunizations without patient-specific clinician orders
- UCSF Health System:
  - MAs cannot give injections at all. RNs or LVNs give the injections.
- Many UCSF residents work at both SF General and UCSF hospitals; in one place they can rely on MAs to take care of immunizations by themselves while in another place the MAs cannot even give the shots

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Empowering MAs to give childhood vaccinations independently: Barriers and who is causing the barrier

	Federal/ state government, professional associations, professional schools	Health system leaders	Physician reluctance	Team member reluctance	Patient reluctance
We can't recruit enough MAs	The economy is in a worker-shortage period	MAs are poorly paid and don't choose medical assistant careers			
MAs are not trained to identify which kids need which vaccines; how to administer the vaccines safely	Low-quality commercial MA training programs. Better community college MA programs may have limited curriculum.	Health system lawyers may be overly cautious	Providers feel only they can decide which vaccines to give, even though there is a standard vaccine schedule. MAs would consult if there were questions for particular patients	MAs may be reluctant, feeling uncomfortable with the responsibility, or because they are already working too hard	Less of an issue because patients are used to staff giving vaccines
MAs are not authorized to decide on which vaccines and to give the injection	State regulations may require that only clinicians and nurses can administer injections	Even when the state allows MAs to give injections, health system leaders may say No	Providers may not trust RNs to decide which vaccines to give to which patients, and refuse to create standing orders	MAs may not feel comfortable with this responsibility	
Lack of a business case.	Medicare, Medicaid and insurance may pay little for vaccine administration	Health system leaders may worry that they would need to hire more MAs. Even though the time it takes clinicians, or the expense of using RNs, would cost more. Taking a narrow view of business case. Rather than saving clinician time and thereby increasing access and market share.			

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Take Home Points

- Powerful teams can make primary care more do-able: more trained people to care for overly large panels
- There are a number of barriers to building these teams. The big ones are:
  - Business case
  - Restrictive laws and regulations
  - Difficult to recruit team members
  - Training and mentoring is key and takes personnel and time
- It is necessary to analyze where is the barrier: government, health system leaders, physicians, staff, patients
- The business case is more complex than having revenues = expenses each month. Leaders should take a longer view and see improvements as an investment

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Questions?

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Quality Improvement Refresh

Data Collection
Specific Aim Statements

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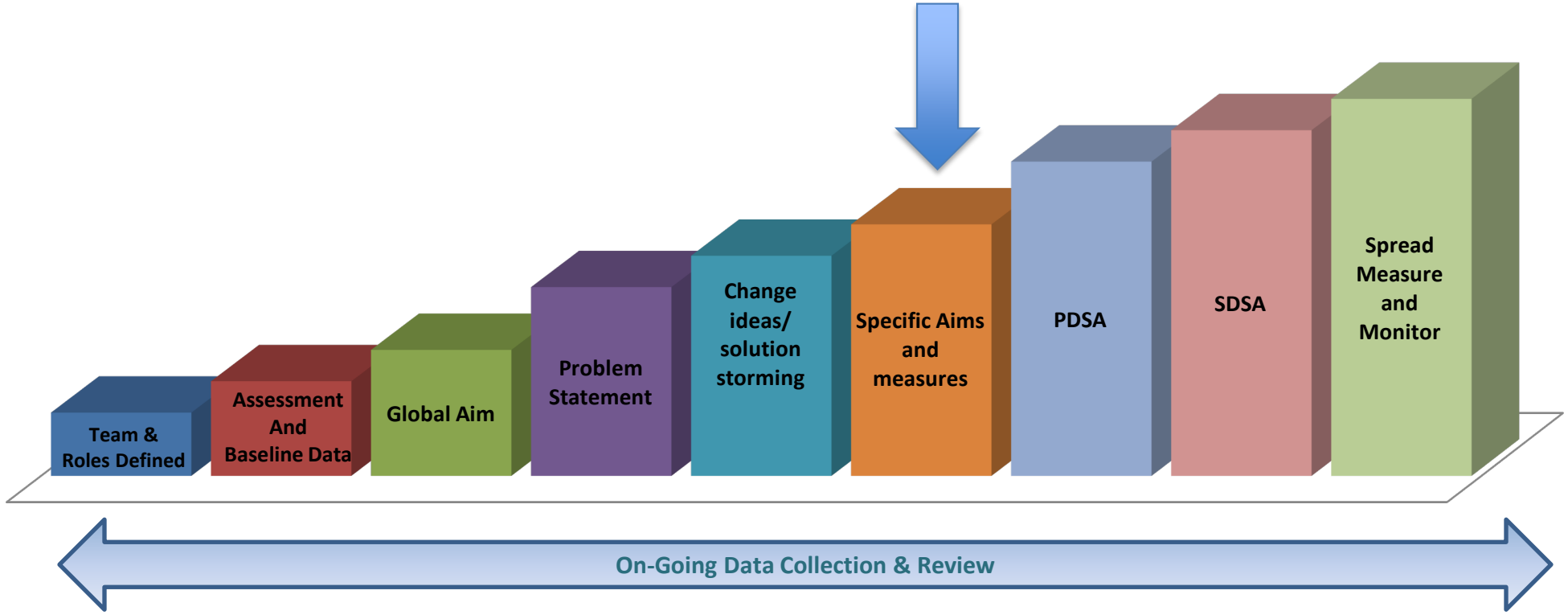
The Stages of Improvement

Step #6: Assessment and Baseline Data



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Key Takeaways

- ✓ Types and sources of data
- ✓ Numerators and denominators
- ✓ Percent v percentage points: how many patients is that?
- ✓ Data plan

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What kind of data do you have?

- Most of your data, such as UDS measures, involve *counting* patients or counting events in clearly defined groups/categories. It is ratio data with a natural zero so that you can divide, multiply, find percentages. Here are some common types of data that our teams work with:
  - No show data: *What is our no show rate?*
  - Screening data: *What is our screening rate for mammograms?*
  - Chronic disease measures: *What percent of our patients with hypertension are in good control?*

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Counting Data: Numerators and Denominators

KEY STEP: DEFINE YOUR GROUPS.

If you can't define your groups, you can't measure/count them.

- Groups can be patients, events (appointments), things (syringes).
- Use clear definitions for the population and the subset/sample.
  - Population is inclusive: Population A is all patients eligible for screening
  - Subsets are mutually exclusive: either a patient has been screened (Subset A1) or has not been screened (Subset A2); can belong to only one group
- **Numerator**: Subset A1 = all eligible patients who were screened (as evidence by documentation in the chart) (sample/subset of population)
- **Denominator**: Population A = all patients eligible for screening who should be screened (population)
  - Beware of small denominators! 5/6=83% 5/10=50% 5/16=31.2%

Note there can be multiple mutually exclusive subsets in a population: A1…A2…A3…

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From the Workbook

Definition	A no-show is a patient who did not show up for a scheduled visit within a specific time frame and thus was not seen. Patients who call to cancel are not "no-shows." Patients who are late but are eventually seen are not "no-shows."
Time frame	July 2019
Population and subsets	-- Population A: all patients who had an appointment in July 2019 whether they attended the appointment or not (N=100) --Subset A1: patients who had an appointment in July 2019 and attended appointment as documented (N=80) --Subset A2: patients who had an appointment in July 2019 and did NOT attend the appointment as documented (N=20)
Source of data/evidence	As documented in the EMR
Numerators and denominators	No show rate = Subset A2/ Population A = 20/100 or 20% in July --Numerator: Subset A2 --Denominator: Population A

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Challenges with data

- *Clarity of definition*: What is the definition of "patients who had an appointment in July 2019 and missed the appointment?"
- *Consistency with definition*: Check to be sure that your EHR collects the data in a way that is consistent with the definition you are using to sort your patients into groups, e.g., UDS.
- *Documentation*: Was the event documented correctly? What if someone showed up late but was still seen?
- *Population in the denominator*: How many patients don't belong in the denominator? They are no longer patients, they don't meet eligibility criteria, etc.

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Percent vs. Percentage Point

- We aim to increase screening rate for cervical cancer in eligible female patients by 15% from January to February.
  - Baseline?
  - If baseline is 22%, increase of 15% is: 22% * 1.15 =Target 25.3%
- We aim to increase screening rate for cervical cancer in eligible female patients by 15 percentage points from 22% from January 31 to 37% by February 28.
  - Baseline and target are more clear
  - Baseline 22% + 15 points = Target 37%

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How many more patients do you need to screen to hit your target?

Month	# eligible patients: population A+B	# screened eligible patients: Subset A	15% Percent increase	15 Percentage points increase
January 1 Baseline	150	33	Baseline 22%	Baseline 22%
February 28 Target %	150†		22% * 1.15 =Target 25.3%	22% + 15 points = Target 37%
How many more patients need to be screened in February?			Target 38 patients which is **5 more** patients	Target 56 patients, which is **23 more** patients

†Challenge: Obviously the January 1 baseline is based on December 31. What will you use for your denominator if you don't yet know how many eligible patients will actually keep their appointments? You can use the denominator from the previous month, or estimate it based on an average of previous time periods.

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Specific Aim Statement Template

We aim to _____ (*improve, increase, decrease*)
the _____ (*quality, number/amount, percentage*)
of_____ (*name the process*)
by _____ percent

OR

from _____ (*baseline data number/amount/percentage*)
to _____ (*number/amount/percentage*)

by _____ (*date*)

in _____ (*location*)

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Using data in a specific aim

We aim to increase screening rate for cervical cancer in *eligible female patients **by 15 percentage points from 22%** as of January 1 **to 37%** by February 28 at Clinic A.

- Who: *eligible female patients defined by UDS
- Who: eligible patients enrolled in the clinic based on at least one visit the past year.
- When: January 1 to February 28
- Where is the data: EMR
- What dates will you ask BI to collect? January 1- February 28
- Where: Clinic A
- How much: Does this reflect the current baseline and an achievable goal?

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Data Plan

Name of data	Definition: Numerator	Definition: Denominator	Dates of interest	How to get the data
Lipid screening	Number of patients who had a fasting lipid panel in the measurement year	Number of patients who are prescribed HIV antiretroviral therapy and who had a medical visit at least once in the measurement year	January 1, 2021-December 31, 2021	Where does the data live? Who has it? When to get it?

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Questions?

Action Period 4 Deliverables

- Conduct your weekly team meetings
- **Assignment**: Develop your Specific Aim Statement

Google Drive

https://drive.google.com/drive/folders/1VFv0Ar6VbdVDS_fkY6fPXQw36Tq0A1Wg?usp=drive_link

Reminders

Coach Calls:

- Wednesday March 13th 1:00pm ET / 10:00am PT
- Wednesday March 20th 1:00pm ET / 10:00am PT
- Wednesday March 27th 1:00pm ET / 10:00am PT

Session 5: Wednesday April 3rd 1:00pm ET / 10:00am PT

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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REMINDER: Complete evaluation in the poll!

Next Learning Session is **Wednesday April 3rd!**

Explore more resources!

National Learning Library:
Resources for Clinical Workforce Development

https://www.weitzmaninstitute.org/ncaresources

Health Center Resource Clearinghouse

https://www.healthcenterinfo.org/