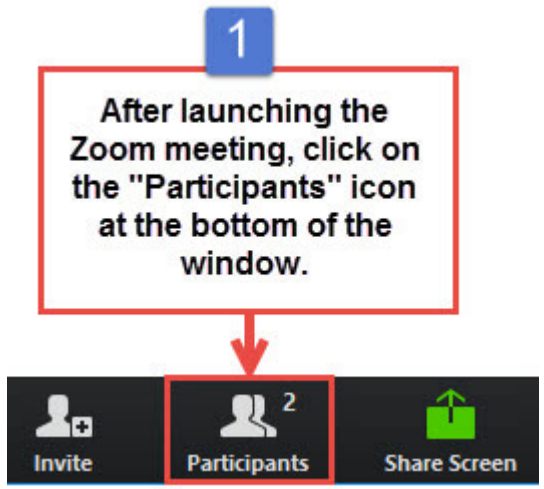
NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

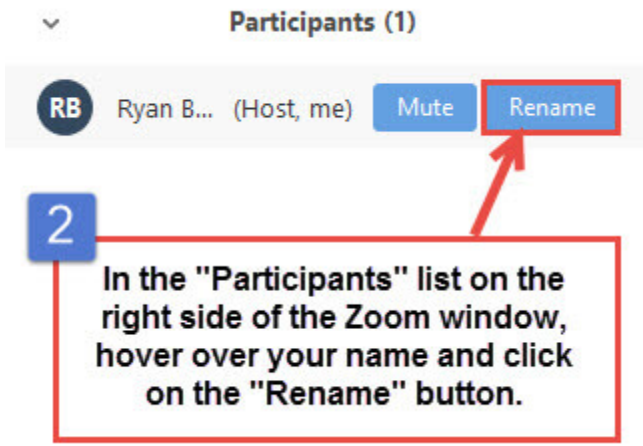
Comprehensive and Team-Based Care Learning Collaborative

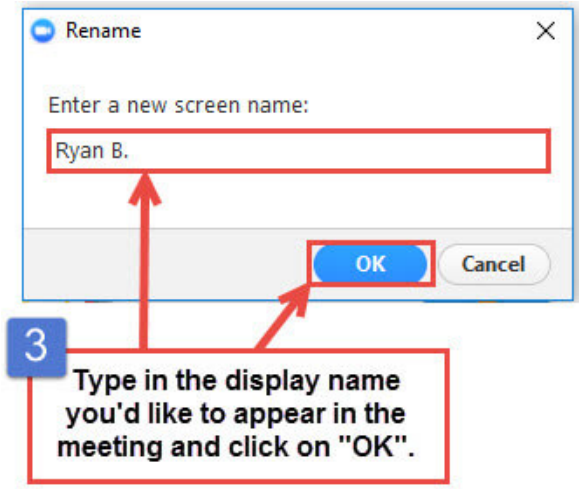
Session One: Wednesday November 13th, 2024

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”







NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Session 1 Agenda

- 1:00-1:10pm Introduction to CHCI, Collaborative Expectations, & Role of the Coach
- 1:10-1:30pm Team Introductions
- 1:30-1:45pm Role of Leadership in Supporting Team-Based Care
- 1:45pm-2:20pm Fundamentals of Comprehensive Care & Primary Care's Challenges
- 2:20-2:25pm Quality Improvement: Assessing Your Practice
- 2:25-2:30 Q/A, Wrap-Up and Evaluation

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Learning Collaborative Faculty

Tom Bodenheimer, MD

- Physician and Founding Director, Center for Excellence in Primary Care

Deborah Ward, RN

- Quality Improvement Consultant

Kathleen Thies, PhD, RN

- Consultant, Researcher

Margaret Flinter, APRN, PhD, FAAN

- Co-PI, NTTAP
- CHCI's Senior Vice President/Clinical Director

Amanda Schiessl, MPP

- Chief of Staff, MWHS
- Co-PI & Project Director, NTTAP

Meaghan Angers

- Senior Program Manager, NTTAP

Bianca Flowers

- Program Manager, NTTAP

MOSES/WEITZMAN Health System

Always groundbreaking. Always grounded.

Community Health Center, Inc.

A leading Federally Qualified Health Center based in Connecticut.

ConferMED

A national eConsult platform improving patient access to specialty care.

The Consortium for Advanced Practice Providers

A membership, education, advocacy, and accreditation organization for APP postgraduate training.

National Institute for Medical Assistant Advancement

An accredited educational institution that trains medical assistants for a career in team-based care environments.

The Weitzman Institute

A center for innovative research, education, and policy.

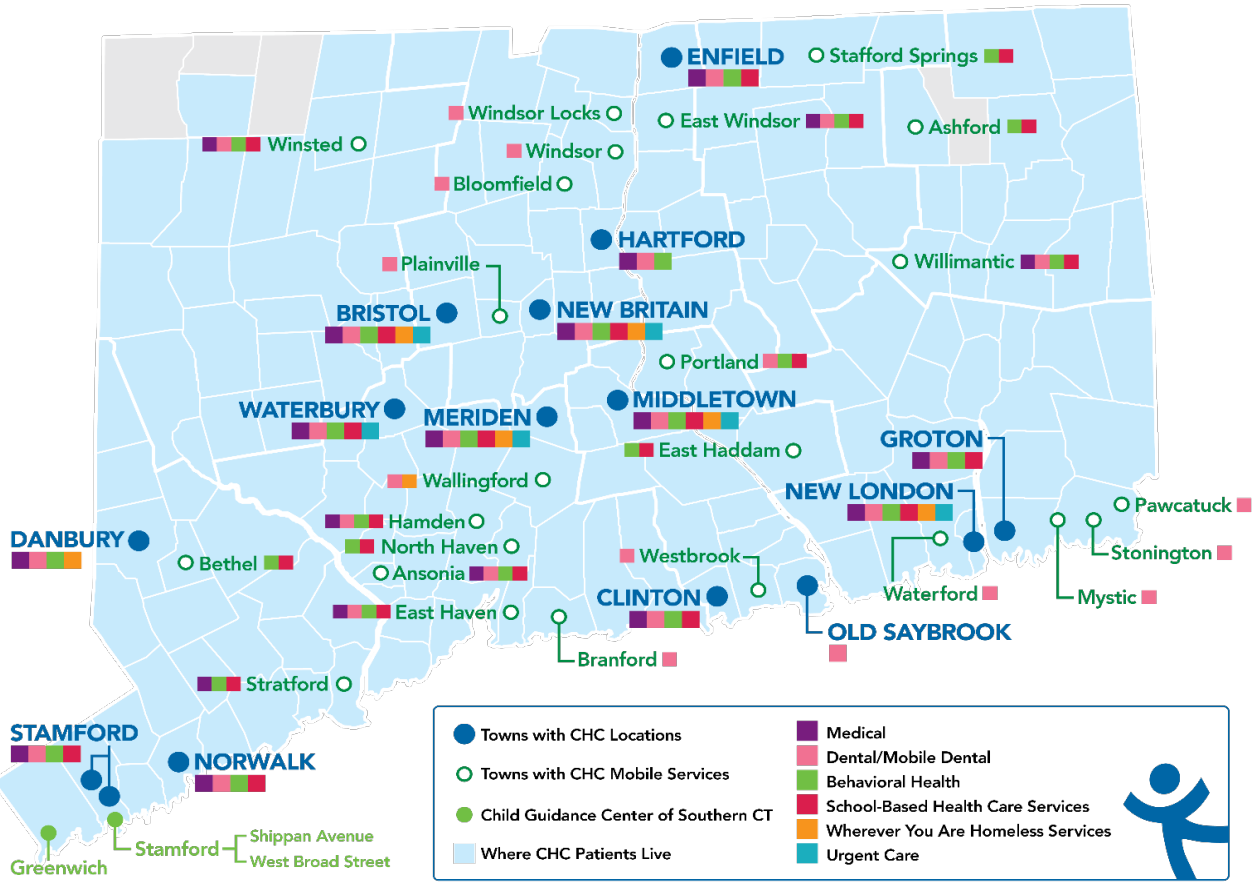
Center for Key Populations

A health program with international reach, focused on the most vulnerable among us.

MOSES/WEITZMAN
Health System
Always groundbreaking. Always grounded.

Community Health Center, Inc.

Locations & Service Sites



THREE FOUNDATIONAL PILLARS

1	2	3
Clinical Excellence	Research and Development	Training the Next Generation

Profile

- Founded: **May 1, 1972**
- Staff: **1,400**
- Active Patients: **150,000**
- Patients CY: **107,225**
- SBHCs across CT: **152**

Year	2021	2022	2023
Patients Seen	99,598	102,275	107,225

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

National Training and Technical Assistance Partners (NTTAP)

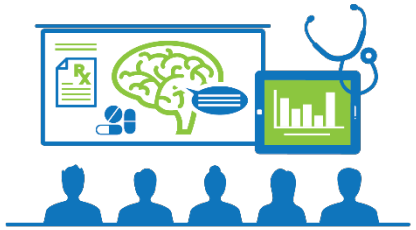
Clinical Workforce Development

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

2024-2025 Cohort	
Cherry Health	Grand Rapids, Michigan
Chestnut Family Health Center	Bloomington, Illinois
Community Health & Wellness Center of Greater Torrington	Torrington, Connecticut
Community Health Service Inc.	Moorhead, Minnesota
Complete Health DBA Community Health Center of Black Hills, Inc.	Rapid City, South Dakota
Excelth Inc.	New Orleans, Louisiana
HCCH Medical Clinics (Harrison County Community Hospital)	Bethany, Missouri
Klamath Health Partnership	Klamath Falls, Oregon
North Shore Community Health Inc.	Salem, Massachusetts
Primary Health Network	Sharon, Pennsylvania

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Learning Collaborative Structure & Expectations

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

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:
  - 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
  - Provide transformational strategies and coaching support to help primary care practices implement and advanced models of team-based care.

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Learning Collaborative Structure

- Eight 90-minute Learning Collaborative video conference sessions
- Weekly 60-minute calls between coach mentors and team coach
- Internal team workgroup meetings
- Access resources via the Weitzman Education Platform
- Use Google Drive to share your work

Learning Session Dates	
Learning Session 1	Wednesday November 13th
Learning Session 2	Wednesday December 11th
Learning Session 3	Wednesday January 8th
Learning Session 4	Wednesday February 12th
Learning Session 5	Wednesday March 12th
Learning Session 6	Wednesday April 9th
Learning Session 7	Wednesday May 14th
Learning Session 8	Wednesday June 11th

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Elements 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

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

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

Team Coach and Coach-Mentor Calls

- 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
- Attend Weekly Coach-Mentor Calls designed to:
  - 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

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Team Introductions

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

	Order of Team Introductions
1	Cherry Health
2	Chestnut Family Health Center
3	Community Health & Wellness Center of Greater Torrington
4	Community Health Service Inc.
5	Complete Health DBA Community Health Center of Black Hills, Inc.
6	HCCH Medical Clinics (Harrison County Community Hospital)
7	Klamath Health Partnership
8	North Shore Community Health Inc.
9	Primary Health Network

Cherry Health

Comprehensive. Quality. *Healthcare.*

OUR MISSION

Cherry Health improves the health and wellness of individuals by providing comprehensive primary and behavioral health care while encouraging access by those who are underserved.

WHO WE ARE

20+

One of Michigan's largest FQHCs

More than 20 sites in 6 counties

700+

Network of 100+ providers

A team of over 700 healthcare professionals

Recognized by HRSA as a Health Center Quality Leader

OUR SERVICES

HOW WE MADE AN IMPACT LAST YEAR

57,468
Patients served

470,201
Patient Visits

97%
Patient Satisfaction

OUR GOALS FOR THE LEARNING COLLABORATIVE

To educate all team members on team-based care and coach them to practice at the top of their license.

To optimize team-based care through applying PDSA thinking and iterative experimentation to increase the number of patients served by our team, by all billable team members.

Improve health outcomes for patients, increase job satisfaction (and decrease burnout) for team members.

Collaborate with health centers across the country to identify best practices to improve and innovate the care we provide.

Julee Geib, RN, BSN
Director of Practice Operations

Dan Grey, MS, RN
Associate Director of Value Based Care Teams

Curtis O'Neal
Site Manager-Adult Medicine/Durham Senior Health Center

Amy Pavlak, PharmD, BCACP
Pharmacy Clinical Services Manager

Andrew Ramsahoi, MD
Medical Director, Medical Services

Jasmin Stephens, LMSW
Clinical Manager, Behavioral Health Consultants

Elizabeth J. Warner, MD FACP CPE
Chief Medical Officer, acting Chief Dental Officer

Alice Wilson RN, BSN, MSM
Nurse Supervisor-Adult Medicine/Durham Senior Health Center

CHESTNUT HEALTH SYSTEMS | chestnut.org/cfhc

CHESTNUT FAMILY HEALTH CENTER

CFHC is a program of Chestnut Health Systems serving McLean County, IL residents since 2012

- 3 Sites, 1 Mobile Unit
- Primary Care, Integrated Behavioral Health, Psychiatry, Dental, Medication Assisted Recovery
- FY 2025 budgeted 33,068 encounters / 6,535 patients
- 78 staff (3 physicians, 3 family practice APRNS, 4 mental health certified APRNs, 1 BH clinician, 1 dentist, 2 hygienists)
- Family Medicine Residency Program Year 2 (11 residents, 3 faculty

CHESTNUT HEALTH SYSTEMS | chestnut.org/cfhc

CHESTNUT FAMILY HEALTH CENTER

Participating Team Members

- Dr. Jared Rogers, Medical Director
- Erica Quick, Nurse Manager
- Bekime Branch, Residency Nurse Coordinator
- Kirsten Waters, Integrated Program Coordinator
- Austin Howald, Director Integrated Community Services
- Pam Kouri, Integrated Health Care Coordinator
- Stephanie Paxton, Director Integrated Support Services
- Dietra Kulicke, VP of Integrated Care
- Tracey Arahood, Quality and Performance Improvement Coordinator

Community Health & Wellness Center

24

Towns served

3 Health Centers

7 Torrington Schools

3 Region One Schools

6,000 patients
33,000 annual visits

Services offered:

Primary Care	Dental
Behavioral Health	Podiatry
Chiropractic	Nutrition

Our Team & Our Goals

Our Team

- Ann Iannantuoni, Senior Director, Quality and Risk Management
- Michelle Jose, Director of Nursing
- Melanie Mollica, APRN, Clinical Director
- Amy Begnal, Health Informatics Specialist
- Alyssa Steel, Quality Improvement and Data Analyst
- Caitlin Baker, RN
- Cynthia Wonsitler, MA

Our Goals

- Obtain the skills and knowledge needed to develop and implement team-based care
- Enhance our current quality improvement processes
- Optimize the roles of the primary care team members
- Continue to build a culture of safety

CHSI Team:

Community Health Service Inc. (CHSI) is a network of federally qualified health centers in Minnesota and North Dakota, including clinics in Moorhead, Rochester, Willmar, and Grafton and a victim advocacy services office in Crookston.

~ 50 employees

Goals: TBD

Coach/Quality Improvement:

Aimee Bellingar, RN, CQI Manager

Co-Coach:

Mark Klampe, Site Manager

Core Teamlet:

Richard Mokua, APRN

Olga Gasca Mendoza, CMA

Trey Heckel, Patient Relations Representative (PRR)

Extended staff/Support team members:

Lizzy Angaran, RN

Gracia Do, LPCC

Mary (Lisa) Estrada, CHW, Insurance Navigator

Belinda Morin, IT Manager

Back-up:

Hope Barry, RN, Referral and Care Coordinator

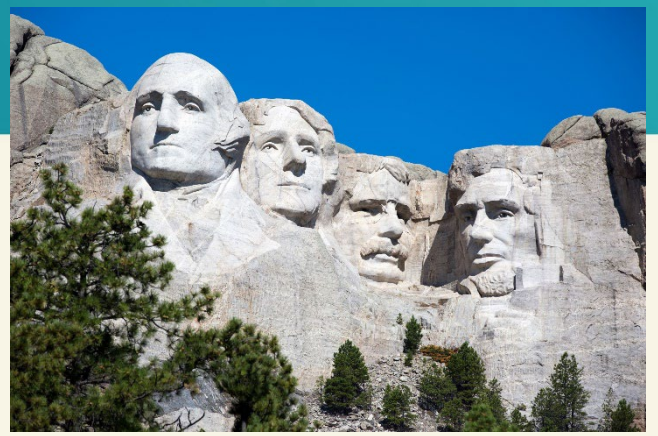
Cristy Moe, Regional Operations Manager

Leadership:

Rhonda Eastlund, CEO

Cynthia Woods, CMO

complete HEALTH™



Location: Rapid City, SD

Serve ~ 10,000 unique patients

- Medical
- Dental
- Behavioral Health/Counselors
- Sexual and Reproductive Health
- Iris Clinic – Transgender Youth
- 340B Pharmacy
- CHW's

Staff

- ~ 100 employees

Sites

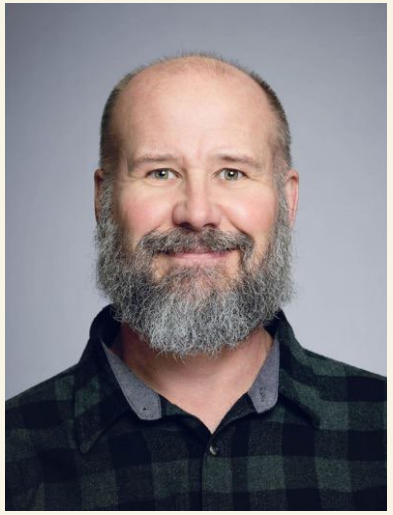
- Main Site
- OneHeart – Clinic
- General Beadle – School Based Clinic
- Men and Women's Mission

Goals

- Develop a Team Based Care Model
- Improve the case management of vulnerable patients
- Decrease the number of patients that seek out the ED or urgent care unnecessarily

Complete Health Team

Sarah Knight, RN
Nurse Manager



Kevin Queen, RN, MSN
Director of Quality

Christine Carey, CNP
Associate Medical Director

Elizabeth Moll, RN
Care Coordinator

Keiko Dominguez, MA

Michel Fiester, RN
CRN

Joel Kirst, CNP

Kirsten Belcher, RN

complete HEALTH™

HCCH MEDICAL CLINIC

13 EXAM ROOMS

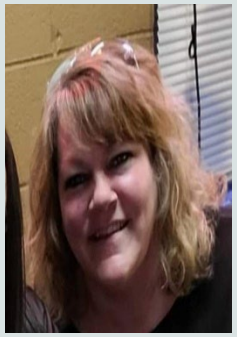
4-5 PROVIDERS IN THE CLINIC EACH DAY

SEE 90-100 PATIENTS EACH DAY

QUALITY IMPROVEMENT TRAINING TEAM



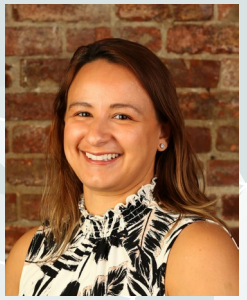

Robin Hogan – Coach – Medical Clinic Director – RN – Worked for HCCH for 13 years and in this role for 6 years
Angie Beaty – Co-Coach – Medical Clinic Nursing Director – LPN- Worked for HCCH for 4 years and this role 1 year
Tara Sherer- Team member – Office Staff Manager – Worked for HCCH for 27 years and one month in this role
Dr Kimberly Baker- Team member – Family Practice MD- Worked at HCCH for 2.5 years.



- Cindy Spencer, Medical Front Office Supervisor

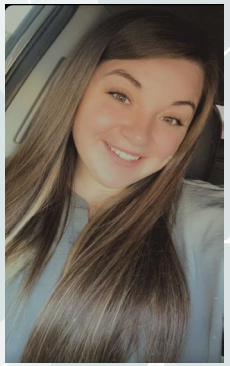
Klamath Health Partnership

- Jenniffer Rodriguez, FNP



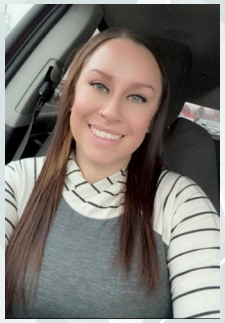
- Marlee Eudaily, MA

- Kegan Drake, Population Health RN

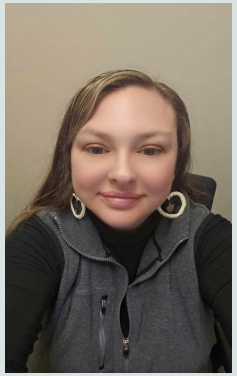


- Nia Hubble, CHW

- Kacie Cunningham, Compliance & Risk

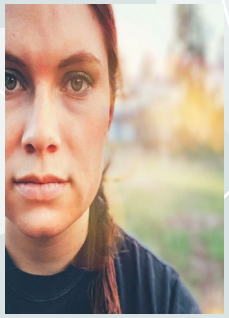


- Rebecca Baughman, Population Health



- Jacie Zahler, Team Coach Quality & Data Manager

- Angela Leach, Clinical Data Analyst



- Taylor Thompson, Quality Analyst

FQHC
Located in Klamath Falls, Oregon

- Klamath County population ~ 70,000
- Serve ~ 11,000 patients
- Medical, Dental, and Behavioral Health
- 4 Locations

Goal: Improve Depression Screenings

Team-Based QI Collaborative

November 13, 2024

NORTH SHORE COMMUNITY HEALTH

North Shore Community Health

- 3 main health centers in MA: Salem, Peabody, Gloucester
  - Primary care, BH, SUD, LGBTQ+, dental
- 2 school-based health centers
- ~14,000 patients/year

Salem, MA

NSCH
NORTH SHORE COMMUNITY HEALTH

Our Team

Primary Care Team:

- Kristin Darden, MD
- Kyle Krueger, RN
- Yasmin Santos, MA

Operations SME:

- Samantha Batista Oliveira

QI Coaches / Analytics SME:

- Cheralyn Johnson, FNP, IA
- Rosy Denton

NSCH
NORTH SHORE COMMUNITY HEALTH

Our Aim

- We aim to increase our # of Medicare patients with an up-to-date AWV from 0% to 10% in 8 months

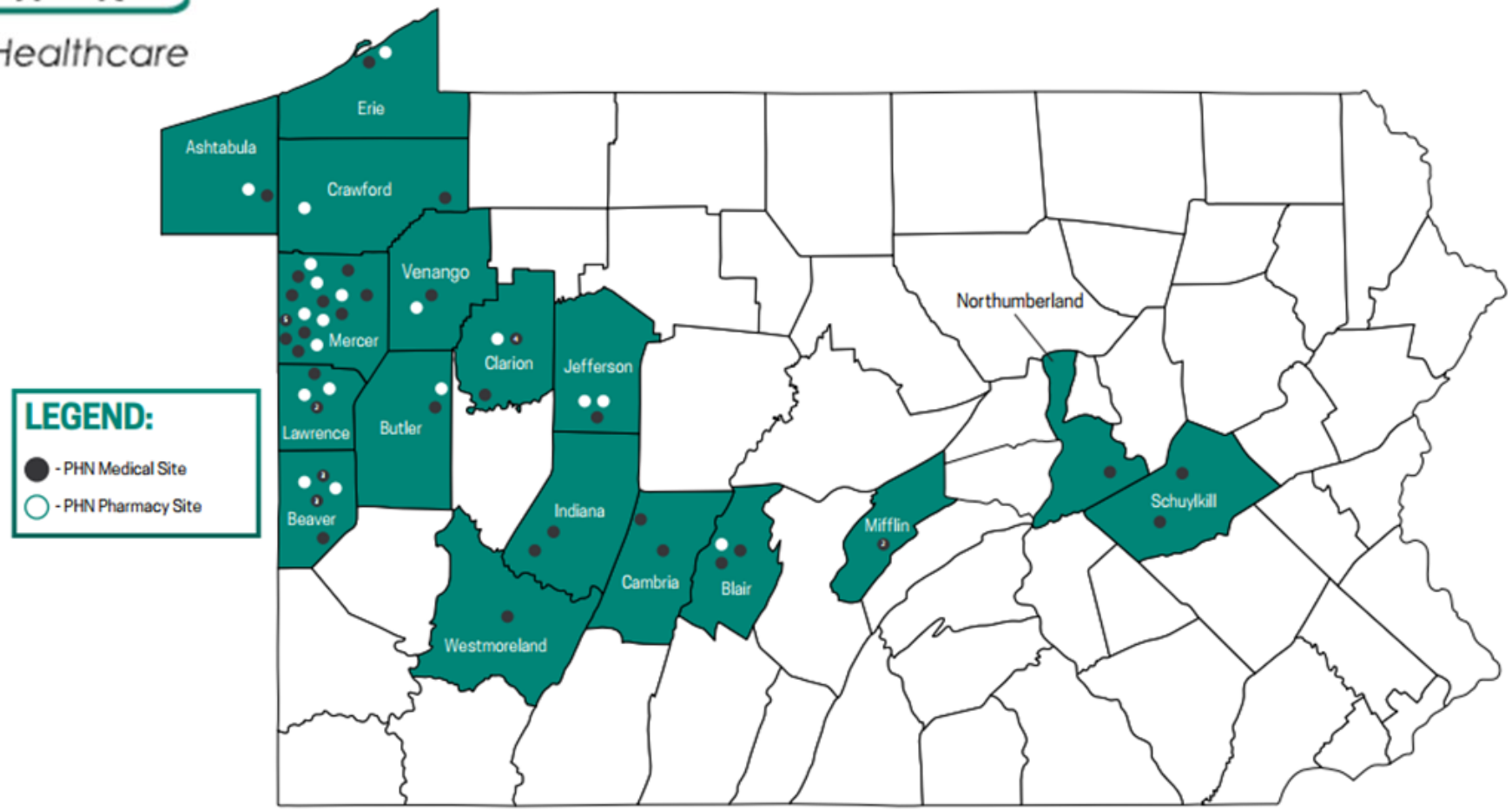
NSCH
NORTH SHORE COMMUNITY HEALTH

The Primary Health NETWORK

Embracing Excellence in Healthcare

- Founded in 1984
- Largest FQHC in Pennsylvania
- 16 counties in PA
- 1 county in OH

- 130+ Providers
- 500+



Our team

Angela Hogue, MD
Chief Medical Officer

Ryan Ochalek, CRNP
Primary Care Provider

Donald Rumbaugh, MD
Assoc. Medical Director

Chris Saba, DDS
Dental Director

Team members not pictured:

Gina Viano, RDH
Senior Director of Dental

Leah Baldwin, LPN

Kerri Hollidge, MOA
Practice Manager

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Role of Leadership in Supporting Team-Based Care

Margaret Flinter, Senior Vice President and Clinical Director

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Leadership's Role In Supporting Comprehensive Team Based Care

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

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

Tangible and Intangible Support of Leadership

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

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Communications

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

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Investments

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

Ensuring Return on Investment is Measured and Monitored

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

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

UCSF Department of Family & Community Medicine
Center for Excellence in Primary Care

Fundamentals of Primary Care: Primary Care's Challenges

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

Poll #1

At my health center:
- Most patients have prompt access to their personal primary care clinician
- Most patients do not have prompt access to their personal primary care clinician
- Most patients are not empaneled to a personal primary care clinician and see whichever clinician is most accessible
- Unsure

At my health center:
- On average, clinicians feel that they have the time and resources to care for their panel of patients
- On average, clinicians feel that they don't have the time and resources to care for their panel of patients
- Most clinicians do not have a panel of patients that they are responsible for
- Unsure

At my health center:
- We have teams and the same people are working on their team almost every day
- We have teams but people often work on different teams because of scheduling problems
- Unsure

At my health center:
- Burnout is a problem for both clinicians and staff, but a manageable problem
- Burnout is not a much of a problem
- Burnout is severe. Many clinicians feel that primary care is not do-able — too many patients to see and not enough help from teams to provide good care for their patients
- Unsure

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/

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.

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.

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

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

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

Poll #2

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

d. We do not employ nurse practitioners or physician assistants.

e. Unsure

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 2023 UDS report: In FQHCs,
  - NP/PA FTEs (16,696.71)
    - Nurse Practitioners: 12,765.36
    - Physician Assistants: 3,931.35
  - Physician FTEs: 15,489.65

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

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

Burnout

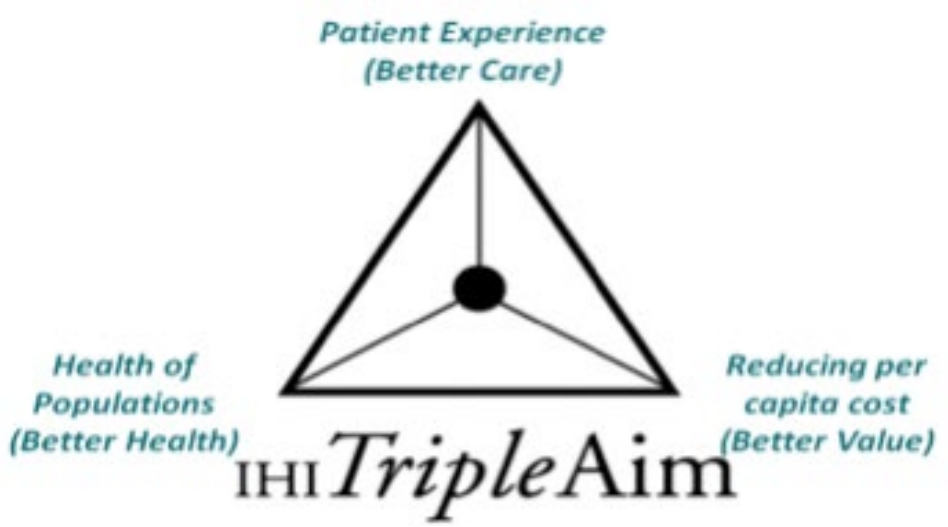
- As access gets worse, burnout increases
- Patients are calling to get into the clinic or dropping in, creating chaos in the daily schedule
- As panel size increases, burnout increases
- Almost all burnout studies are about physicians; most nursing burnout studies focus on hospital nursing
- In a recent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

The devastation and the beauty of California

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

Don Berwick and the Triple Aim

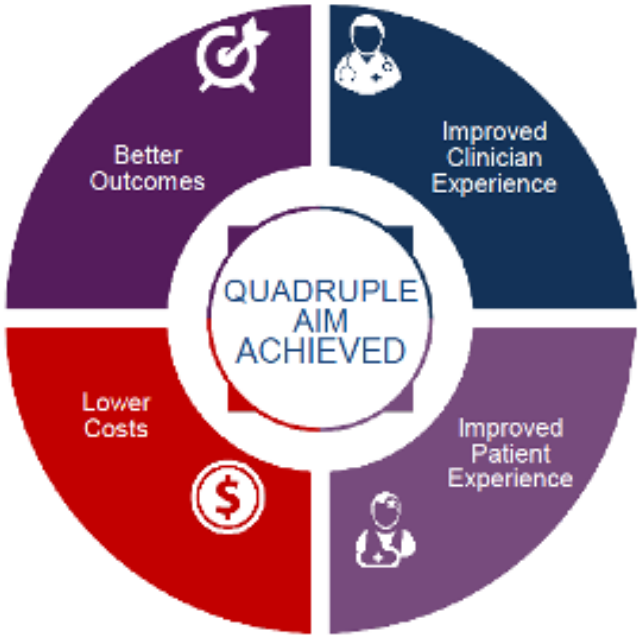
- In 2008, Don Berwick, a pediatrician and the nation's foremost leader on improving health care, unveiled the doctrine of the triple aim
- The triple aim:
  1. Improving the patient experience of care
  2. Improving the health of populations
  3. Reducing the cost of health care
- The triple aim was 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.

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:
  4. 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



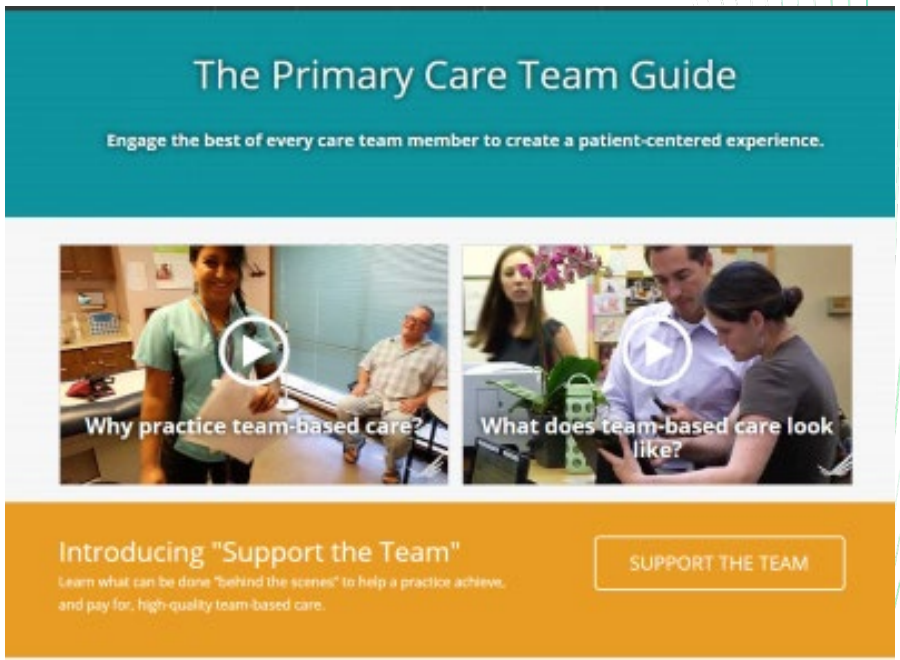
Source: Bodenheimer and Sinsky. From triple to quadruple aim: care of the patient requires care of the provider. Ann Fam Med 2014;12:573-576.

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.

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



NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

UCSF Department of Family & Community Medicine
Center for Excellence in Primary Care

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

What do we mean by "high-performing"?

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

→ 8 hospital-based clinics

7 integrated delivery system sites

6 FQHCs

2 independent private practices

7 of 23 had 5 or fewer physicians

23 High-Performing Practices

Department of Family & Community Medicine
Center for Excellence in Primary Care

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

Patient—Team Partnership

Population Management

Data-driven improvement

Template of the future

Empanelment

Prompt Access to Care

Team-based care

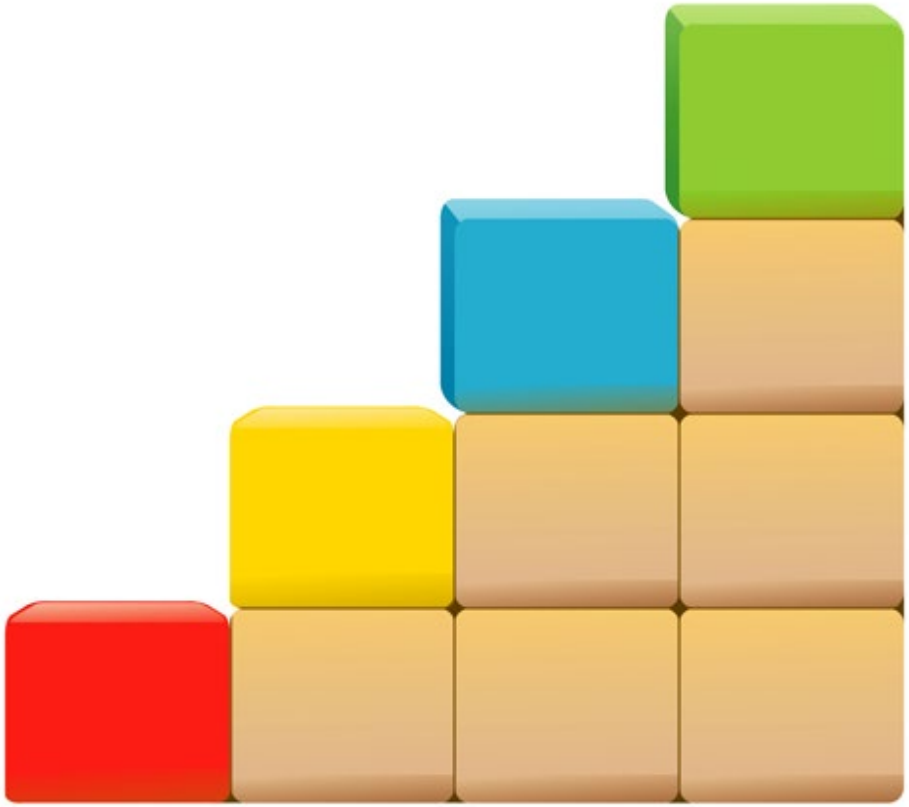
Comprehensiveness and Care Coordination

Engaged Leadership

Continuity of Care

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

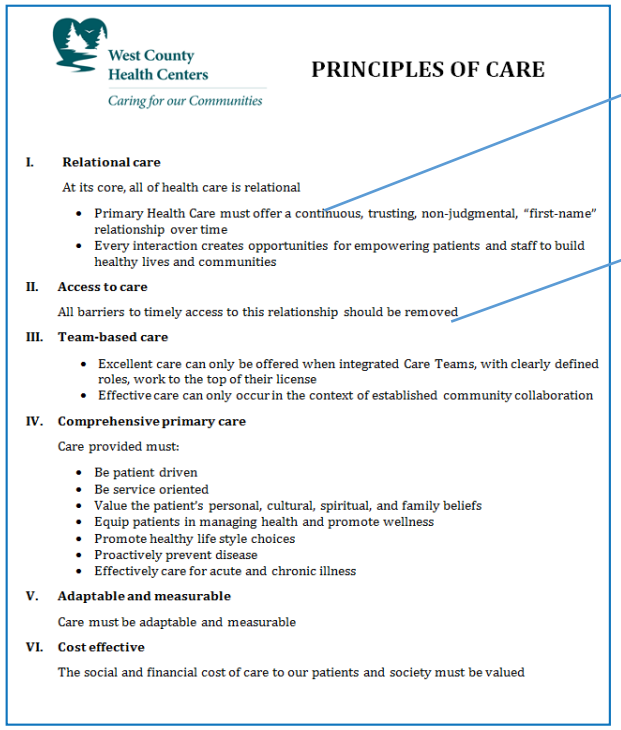
- Prompt Access to Care
- Data-Driven Improvement
- Template of the Future
- Patient-Team Partnership
- Engaged Leadership
- Continuity of Care
- Population Management
- Team-Based Care
- Comprehensiveness and Care Coordination
- Empanelment



The 10 Building Blocks of High-Performing Primary Care

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

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)

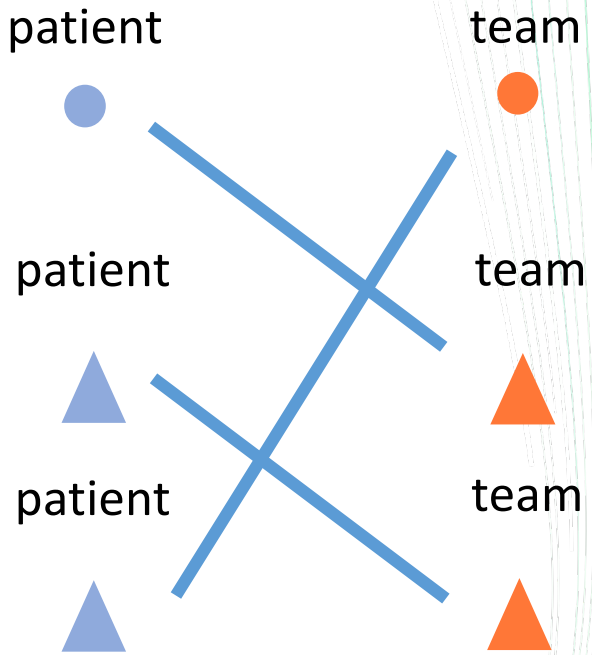
- By December 31, 2024, the % of diabetic patients with A1c > 9 will be reduced from 20% to 12%
- By July 1, 2025, all patients will be able to obtain an appointment with their own primary care clinician within 5 days of making the request

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

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

BB4 | Team-Based Care

Anatomy

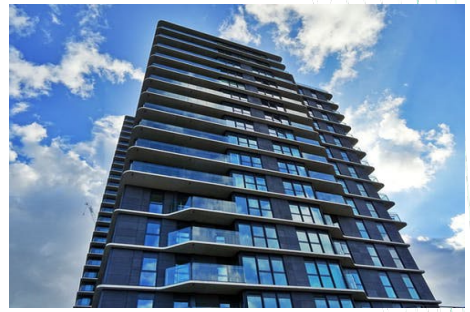
1. A stable team structure
2. Colocation
3. Defined roles
4. Standing orders or protocols
5. Defined workflows
6. Staffing ratios adequate to facilitate new roles
7. Ground rules

Physiology

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

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.

Questions?

Quality Improvement

Assessment of Your Practice

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?

NTTAP National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

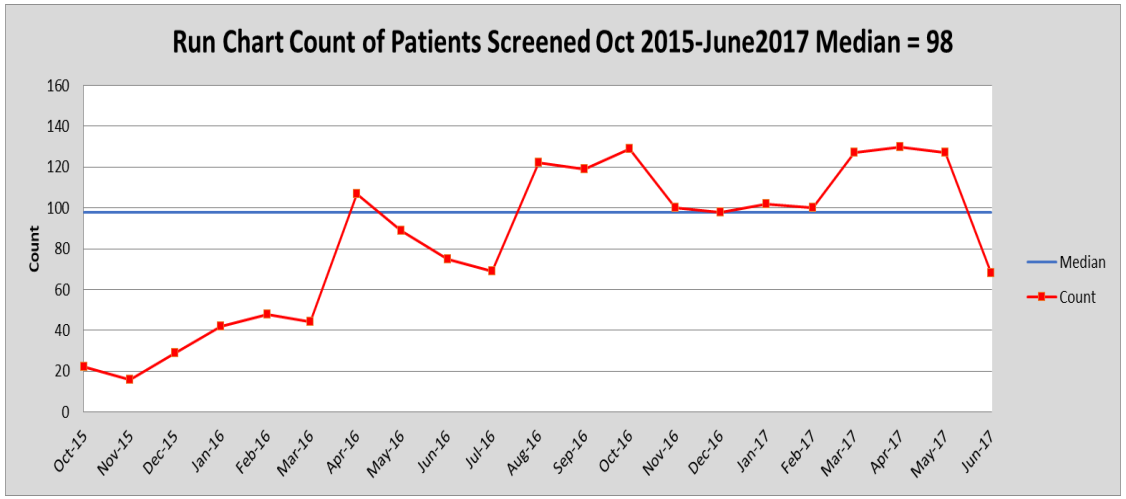
UCSF Department of Family & Community Medicine
Center for Excellence in Primary Care

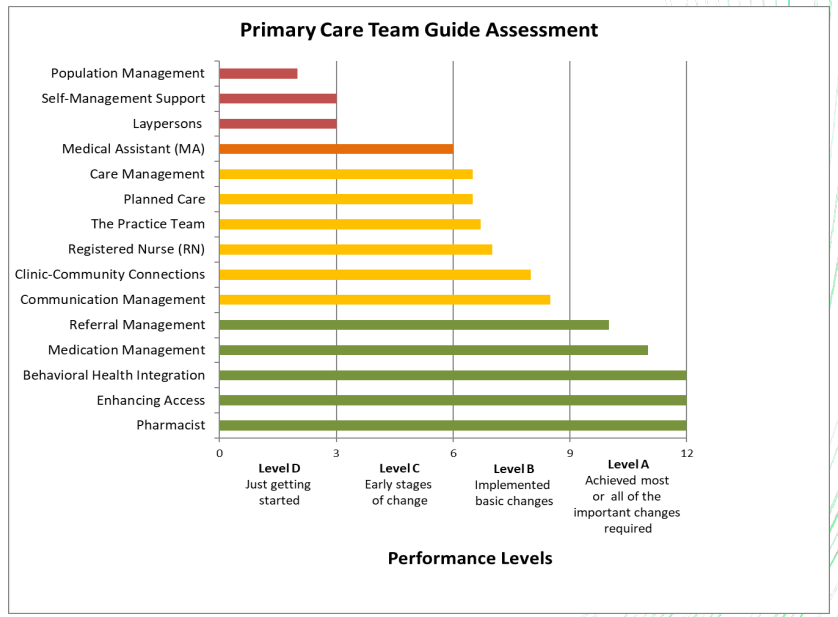
How do you share data with staff?

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?





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?

Sample Results from Primary Care Team Assessment Guide: Self-Reported Levels	
	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

Questions?

Action Period 1 Deliverables

- Conduct your weekly team meetings
- Coaches attend weekly Mentor calls
- Complete Step 1 in the Quality Improvement Workbook
- Complete Step 2 in the Quality Improvement Workbook

Access the Google Drive to upload deliverables:

Next Steps

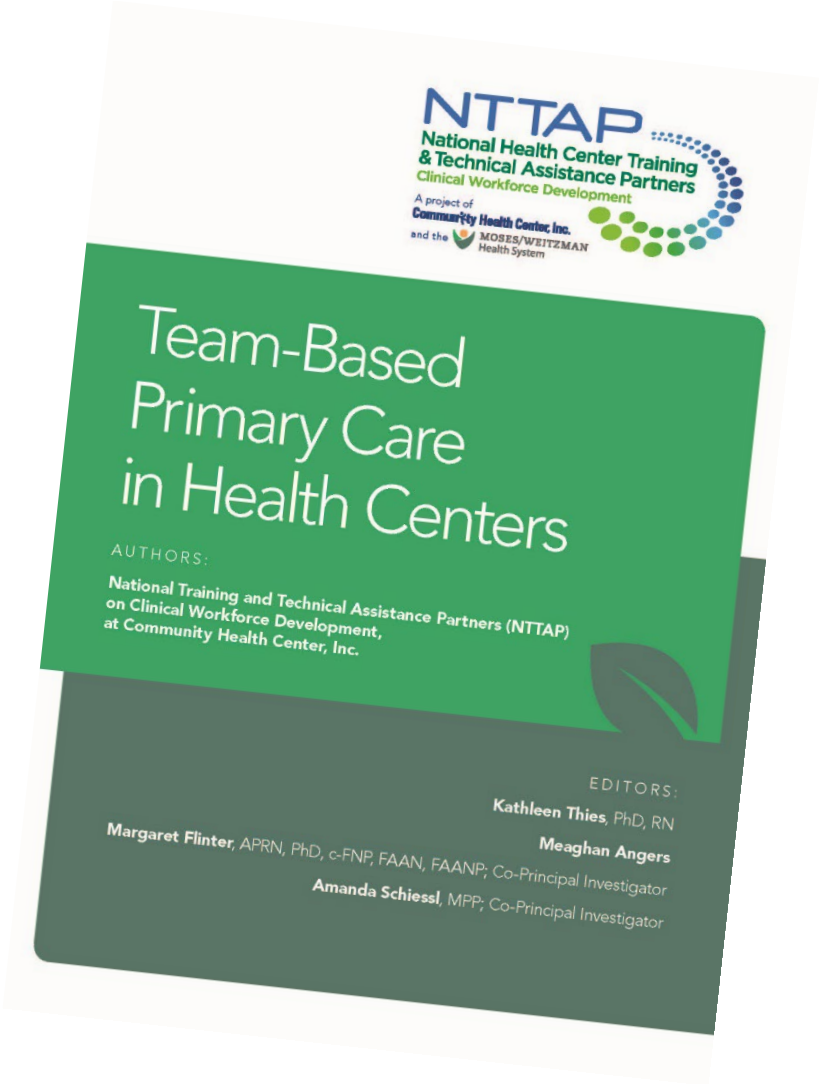
- **Coach Calls**
  - Wednesday November 20th 1:00pm Eastern / 10:00am Pacific
  - Wednesday November 27th 1:00pm Eastern / 10:00am Pacific
  - Wednesday December 4th 1:00pm Eastern / 10:00am Pacific
- **Session 2**: Wednesday December 11th 1:00pm Eastern / 10:00am Pacific

- Register for the Weitzman Education Platform to receive CME, resources, and more!

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Download our new book, *Team-Based Primary Care in Health Centers*!

https://www.weitzmaninstitute.org/wp-content/uploads/2024/09/Team-BasedPrimaryCareinHealthCenters.pdf



NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Explore more resources!

National Learning Library:
Resources for Clinical Workforce Development

https://www.weitzmaninstitute.org/ncaresources

Health Center Resource Clearinghouse

https://www.healthcenterinfo.org/

NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Contact Us!

Amanda Schiessl
Program Director/Co-PI
Amanda@mwhs1.com

Meaghan Angers
Senior Program Manager
angersm@mwhs1.com

Bianca Flowers
Program Manager
flowerb@mwhs1.com

REMINDER: Complete evaluation in the poll!

Next Learning Session is **Wednesday December 11th!**